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Setting the pace: Model inclusive Child Care Centers Serving Families of Children with Emotional or Behavioral Challenges

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**Setting the Pace:
Model Inclusive Child Care Centers
Serving Families of Children with
Emotional or Behavioral Challenges**



September 2003

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Research and Training Center on Family
Support and Children's Mental Health

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Preface

This study shines a bright light on nine child care centers that also take some children with a special need for extra attention, often due to emotional or behavioral challenges. The sample of centers from across the country had been nominated as noteworthy for their inclusiveness and for the quality of their program. What was it that set them apart, and might they represent a significant emerging resource for families?

The evaluative nominations were perceptive, but beneath the abstract concepts and lofty phrases, we hear the empirical reality of inclusion. This is an inside story observed and gleaned from center directors, staff, parents, and children. We learn how they do it and why. We learn of their philosophy and commitment, of core attitudes and ideas, of skills and thoughtful strategies, and of essential adaptive interactions among all participants. Let me point out some center characteristics most illuminating to me.

Inclusion. These centers weren't hung up on eligibility or gate-keeping. They weren't categorical about it. The burden of proof wasn't on the child to fit in or fail. These centers believed in taking any child and in doing what was needed. "We can do it!" Said with pride; done with a sense of mission. And these were not specialized centers created exclusively to serve children with challenging emotional conditions or behavior. What was learned has implications for any child care center down the street.

Dealing with fear. Fear is a barrier to inclusion. Fear of difference and the unknown. Fears about safety. "Will my child be safe with those children?" is a question for either parent, as is "Will my child receive enough individual attention?" "Will I be able to deal with the child's behavior?" is a question for the caregiver as well as for the parent. Children too have their fears, but not of each other.

Fears fade with familiarity, but in these centers they disappeared for a different reason. These centers really dealt with the fears. Do parents not ever worry about safety as they leave their child and head to work? One parent said, "I know she's safe," because she knew how well staff could deal with problems and would. A parent's sense that "my child is safe in care" was an achievement. They transformed those fears into acceptance, trust, and a feeling of safety. Knowing their child would not be kicked out, parents could be more open. In a trusting relationship they could stop withholding bad news and get the help they needed. In that trusting environment staff too are spared the fear of making mistakes. They could try something new with a child or get help from a colleague without fear of failure.

Fear was replaced by the joy of helping and by a collective pride of accomplishment. "Disability" was not a word that appeared in their lexicon of ordinary speech, but the challenges of individuals became an appreciated bond among children. Somehow, in a partnership in which all are learning from one another, the challenge of the few makes centers grow better at dealing with all the children.

Professional skills in a family-like atmosphere. To call something "a challenge" sounds a little like a euphemism for "difficult," and that might scare you off. Well, I'd say this work was difficult, but these center staff, who had a modest mix of educational backgrounds, ten years experience in child care on average and four years at this center, don't scare off easily. They accept the challenge, thrive on it, have fun at it, take satisfaction in it, and got good at it. And so can others.

How do they do it? Readers of this study will appreciate the level of skill and thoughtful strategies that were pursued. These have been detailed in a useful classification of issues faced. Some of these strategies are carried out directly with the children, some within the peer group of children, and some by modifying the center as an environment. Some involve responding to difficult behavior, others to preventing it. Experienced caregivers develop their bag of tricks, but don't look for a pat set of tricks. You don't need a cookie cutter if you're not making cookies. This was not intended to be a how-to manual, though it certainly gives you ideas. It is more a compendium of examples of useful strategies as reported by an experienced staff. To use the strategies, like they did, you have to do the thinking yourself. The level of skill is revealed in the planning and in the flexibility with which the center adapts to events. Flexibility creates a consistent, predictable environment, so the kids will know what is going to happen and feel in control. With pre-emptive planning, staff take the emotional temperature and stay two steps ahead, such as allowing one teacher to stay behind and work with a child who needs to cool down when early signs are recognized. What works in the morning may not serve by afternoon, with shifting attention and use of space for individuals and groups. "There are days I have plans and we didn't do any of that today." I found the staff's creative skills truly impressive.

About parents, staff said, "Their opinion is most valid as far as being the expert on their child." It is not surprising that the parents took note of a family-like atmosphere. Learning and fun, pet animals in the school, a typically developing child saying, "This is my friend," or a parent helped to get a driver's license, and staff talking about love. They loved the kids and their parents. No professional distance here. Parents kept saying, "It's like a family." Some 35 years ago I was studying informal arrangements for child care in the homes of friends and neighbors. Not of kin, but of kith who felt a little like kin. The monograph was called *Child Care by Kith*. Well, to listen to the parents describe it, we have here child care by kith in a center. They are skilled professionals, yet the parents feel like they're family.

A learning environment with expert community support. The investigators present their interviews and observational findings in chapters arranged by source of data from directors, staff, parents, and children. What emerges, however, is the center as an organic, interactive organization in which everyone is learning from everyone else. I was reminded of a parent item that worked well in measuring quality of child care: "My caregiver is open to new information and learning." These centers would have scored high on that item because directors and staff listened to parents with respect and learned from them. Together they learned what worked or didn't work with this child at home and in the center. Parents learned from staff and from other parents, and they all learned from the children. The children learned from one another. The concept of inclusion is not about a one-way relationship but about an interaction.

This report is a casebook on quality of care, showing how a ratio of three or four adults to ten children makes possible all of the above. Without that staffing, the programs would not be possible. But the center is not an island. Another prime characteristic of these centers was the way they used mental health consultants, seeking expert behavioral advice about a child or even incorporating them into center life as needed. This kind of support was seen as critical for the success and survival of this kind of program.

Prospects. What are the prospects for this kind of resource for families? This report illuminates a family-supportive resource within child care centers. This report documents a need that can be met in this way. This report presents detailed description of inclusion as a significant emerging dimension of child care services. Perhaps it is an emerging national movement, or could be. The potential is there, along with the latent demand. What would it take to make this a larger reality? This report makes recommendations to further that effort.

But there are barriers to overcome. I offer some thoughts, examining factors affecting demand for such a resource and available supply of it in the community. A realistic context in which to start is to look at how parents manage in the world they live in. The more challenging a child's needs, the greater the flexibility parents require, either at home, from those with whom they can share responsibility, at work in their job and work schedules, or from reliance on an accommodating caregiver. Unfortunately, many of these parents lack flexibility from work or family and therefore need extra caregiver flexibility. Too bad! No other category of parent encounters so much difficulty finding satisfactory care arrangements in the child care market, or experiences so much turnover in care arrangements as their child is asked to leave. Of all kinds of non-parental care, centers offer the least flexibility and not necessarily the most stability. Thus it is, the study is reporting on what is still a rare find.

It does not have to be an anomaly, but the task is to overcome the barriers preventing development of child care that is accessible, of high quality, widely available, and affordable. This will require more than subsidy of care facilities, more than training for staff and consultants, and more than supportive programs such as community mental health with expertise in children—though these are all critically important. In the community it also will require good information for consumers. Fortunately there is much to build on. In addition to child care resource and referral services for all families, there is an army of parents of children with special needs arising from an array of disabilities, developmental or emotional. On what other set of issues has there already been such a vital consumer movement? The bulk of this consumer effort has been in the private sector and done by volunteer individuals, advocacy groups, and agencies. There have been state commissions and federal grants such as Portland State University's Research and Training Center on Family Support and Children's Mental Health which has itself for years helped empower parents of children with serious emotional and behavioral problems. There are vast voluntary resources that have the potential to bring inclusion to the world of child care.

Also on the demand side, for help on issues of affordability and parent choice, serious policy change is needed, such as investing in the financial strength of families through tax reform, employee pay and benefits, leave policies, and flexible working conditions. This is what will allow parents to choose the amount of employment and child care they can manage, as well as a better quality of care.

Economists have been known to say there's no market for quality of care, because parents don't know what it is and wouldn't pay for it. I think the inference was made from wrong assumptions, mainly because what the highly professional care economists were calling "quality" largely wasn't there to choose. This study is further evidence that parents can assess quality of care and that their definition of it also takes quality of family life into consideration. I believe parents would gravitate increasingly to programs such as those reported here, the supply and demand building together.

Communities have a ways to go to build a supportive infrastructure for inclusion. It will take mobilizing a shared effort by families, employers, communities, and government at all levels. It's time to start beating the drums!

Arthur Emlen
June 4, 2003

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Our advisory committee members have provided sound counsel through the entire process of finding a diverse and successful set of centers to study, of struggling to develop interview instruments and observational procedures to capture the knowledge of key participants, of building theory from our results, and of writing this monograph. We would especially like to acknowledge the superb consultation we have received from Arthur Emlen, whose exceptional knowledge of child care research informed our study from beginning to end. We are also grateful for the insights into inclusion provided by Terry Butler, who presented eloquent arguments for the rights of children with emotional or behavioral challenges to have access to quality child care, and practical strategies to achieve inclusion. Julie Rosenzweig and Myrth Ogilvie helped us set the direction for this research, and Constance Lehman has provided research guidance and critiques of our writing. Family consultants Anne Brown and Sherry Archer have injected their unique knowledge into both the conduct of our research, and our presentation of results to a diverse set of audiences. Finally, we would like to acknowledge the singular help that we received from our colleague Lynwood Gordon, who co-authored the chapter on the results of our child observations. His insights as a researcher and as an expert child care provider helped shape the interpretations of our findings.

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As we approached a study at the intersection of the fields of child care, inclusion, and children's mental health, our team also had the good fortune to receive insightful consultation from some of the national leaders in these fields. Jane Knitzer, Director of the National Center for Children in Poverty, provided guidance concerning the scope and focus of our study during its earliest days. Karen Tvedt, the Director of Policy at the Child Care Bureau, furnished information and technical assistance as we prepared supporting documents and dissemination products. Ellen Galinsky, President of the Families and Work Institute, gave us sound advice about dissemination of our research and about becoming "multi-lingual"—speaking across disciplines. We are grateful for their time and consultation.

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Executive Summary

Setting the pace: Model inclusive child care centers serving families of children with emotional or behavioral challenges

Approximately 10% of American children experience an emotional or behavioral disorder that causes some level of impairment in their development, learning, or functioning in daily life, and the numbers of those affected appear to be growing (U.S. Public Health Service, 2000). With the entry of many family caregivers into the workforce, increasing numbers of children with these challenges are enrolling in child care settings that offer services to infants, toddlers, young children, or school aged youth (Shonkoff & Phillips, 2000). Child care settings can provide a unique opportunity to address the needs of children with emotional or behavioral challenges and their families, by fostering the children's social and emotional development and by providing links with mental health and family support services (Cohen & Kaufman, 2000; Knitzer, 2000; President's New Freedom Commission on Mental Health, 2003). However, interviews with parents of children having mental health needs convinced our research team that finding and maintaining child care arrangements is extremely difficult for these families (Rosenzweig, Brennan, & Ogilvie, 2002).

This monograph reports on an investigation of child care programs that have successfully served families of children with emotional or behavioral challenges in a fully inclusive way. Our research team defined inclusion as the delivery of comprehensive services to children with emotional and behavioral challenges in settings that have children without these disorders, and the participation of all children in the same activities, with variations in the activities for those children whose needs dictate the adaptation (Kontos, Moore, & Georgetti, 1998).

Literature Review

As part of the preparation for our study, our team reviewed the literature addressing child care as a support for employed parents of children with mental health needs, the relationship between structure and quality in inclusive child care, and the effectiveness of mental health supports in child serving settings. A full review of the literature appears in Chapter 1 of the monograph.

Family members reported that the care they found for children with challenges was often unstable and of low quality, and that their children were frequently dismissed

from child care due to their behavior (Emlen, 1997). Families of children with challenges required a variety of supports to be able to maintain jobs or engage in employment training, but these needed family supports have been very difficult to obtain (Rosenzweig et al., 2002).

An examination of the child care literature revealed that resources for children with any type of special need were in short supply (Heyman, 2002), due in part to the lack of qualified child care providers. Child care workers frequently left the field since their wages were extremely low and they had few benefits, or lacked a benefit program altogether; turnover in child care providers was frequent and rapid, especially for the less skilled aide positions (Lombardi, 2003).

We also reviewed prior studies addressing mental health supports for children in early childhood settings. If mental health consultants were available, child care providers often sought consultation as they addressed the challenging behaviors of children in their care. When the use of mental health consultation in child care settings was evaluated, associated improvements in child behavior and learning were documented, and children with mental health needs were retained in care (Fong & Wu, 2002). Additionally, evaluators found increases in center quality and staff self-efficacy due to mental health consultation (Alkon, Ramler, & MacLennan, in press). Consultation was reported to be most successful when the mental health specialists were well-integrated into early childhood settings and were considered to be part of the staff (Green, Simpson, Everhart, Vale, & Gettman, in press).

Although children with disabilities can be served in child care settings, and the Americans with Disabilities Act protects these children by assuring them of the right to participate in all activities and opportunities of living in a community including child care, many barriers still exist. Recent studies have shown that children with challenges are turned down by child care providers, child care financing for children with special needs is complex and fragmented, language and cultural barriers abound, and stigmatizing attitudes still work against the inclusion of these families (Kontos & File, 1993; Shaw et al., 2001; Webster-Stratton, 1997). However, when children were enrolled in inclusive preschool programs with stable, well-trained workers, barriers between children with special needs and typically developing children came down, and parental fears regarding the effects of inclusion on their children lessened (Stoneman, 2001).

Research Questions, Study Design, and Methods

Because the needs of families were so compelling, and the literature search uncovered few investigations addressing the participation of children with emotional or behavioral disorders in child care arrangements, our team embarked on an exploratory study of inclusion in child care programs. Our goal was to conduct a study which would provide

information that could be immediately useful to family members, administrators, service providers, and policy makers, and which would examine the supportive services child care workers and families used in their communities.

The project focused on identifying, describing, and analyzing key features of a selected group of model child care programs which met family needs for high quality, culturally appropriate, and fully inclusive child care. We investigated three major research questions:

1. What are the characteristics and practices of child care programs nominated for their inclusiveness which are associated with quality care for children and youth having emotional or behavioral disorders?
2. Which organizational factors contribute to the ability of child care providers to deliver high quality, culturally-appropriate services to children and youth having emotional or behavioral disorders?
3. What are the barriers to achievement of inclusive child care in these programs, and the strategies successfully used by providers and family members to overcome these barriers?

Many people were involved in planning and designing this research. We met regularly with our project advisory board of family members, experts in child care research, inclusion, work-life research, and special education. This advisory committee gave us guidance regarding the identification and selection of study sites, the substance of the interviews we conducted, the analysis of our data, the interpretation and reporting of our results, and the recommendations arising from our findings. Local and national experts also provided specific consultation at different points in the study.

We identified inclusive child care centers by asking state child care administrators, child care resource and referral networks, inclusion experts, participants in the Map to Inclusive Child Care technical assistance grant, and family support organizations to nominate examples of inclusive programs. This first step yielded a sample of 109 programs. Of these, 34 responded to our brief questionnaire requesting more information. We used this information to select the final sample of nine centers, which were diverse in size, structure, funding sources, history, geographical location, and population served. The centers were of very different sizes, ranging from programs serving under 50 to over 1,100 children; were located throughout the United States; and were found in urban, suburban, and rural settings. The children served by the programs ranged from infants through school-aged youth up to 12 years of age. More information about the methodology used is reported in Chapter 2; a description of each center is available in Chapter 3.

Families, directors, and staff from nine child care centers across the U.S. contributed their time, knowledge, and experience to make this qualitative research possible. The centers participating in this study were Little Angels Center, in Milwaukie, OR; Broken Arrow Club House, in Broken Arrow, OK; Saint Benedicts Special Children's Center, in Kansas City, KS; Fraser School, in Richfield, MN; Family Resource Center, in Morgantown, NC; Kinder Haus Child Care Center, Inc., in Morgantown, WV; River Valley Child Development Services, in Huntington, WV; Mc Cambridge Center Day Care, in Columbia, MO; and Wayzata Home Base, in Plymouth, MN. We interviewed more than ninety people on-site at five centers, and by telephone at four centers. We asked them about their experiences of child care in an inclusive setting, the challenges they faced, and the lessons they learned. All interviews were tape recorded and verbatim transcripts were made. Investigators produced handwritten observations of 25 individual children interacting with child care providers and peers. Researchers also made notes regarding observations, personal responses, and relevant theoretical issues during site visits, and collected program materials and training manuals.

Interview transcripts and child observation notes were coded and analyzed by at least three members of the research team. Relationships between categories of data were explored and interpretations were checked against source transcripts and notes. Results from the analysis of interviews of each group are reported in separate monograph chapters (Directors, Chapter 4; Staff, Chapter 5; Family Members, Chapter 6). Observations of children in the classroom (reported in Chapter 7), and print and electronic materials provided by the participating centers supplemented what we learned from the interviews. Major results are discussed in Chapter 8.

Major Results of the Research

The centers we studied were setting the pace by successfully including the families of children with challenges. When analyzing the transcripts of interviews with family members, administrators, and staff, and reflecting on our observations of children interacting with peers and their child care providers, we identified three major sets of findings. Each set was associated with a focal research question.

Characteristics and Practices of Centers that Include Children with Challenges

1. *Families were being supported in the centers.* Families indicated high levels of satisfaction with child care services, reported feeling confident that their children would be retained in care despite their difficulties, and had close connections with the child care staff. Directors and staff linked families to other needed services in the community, and practiced a comprehensive type of family support.

2. *Families played a crucial role in the centers.* Directors and staff recognized that partnership with families was critical to their success in including children with challenges. Families and staff were able to develop trusting relationships in which information could be exchanged freely for the benefit of the child.
3. *Attitudes toward inclusion were targets for change.* Exposure to children with challenges being successfully cared for in inclusive child care centers changed the attitudes of parents of typically-developing children and recently-hired staff members, and provided children with positive early experiences of differences in others.
4. *Child care practice was strategic.* Child care workers developed promotion strategies, which were practices designed to promote social and emotional development in children; they also employed transformational strategies to convert negative emotions and difficult behavior to positive feelings and actions.
5. *Mental health consultation was essential.* Consultants worked directly with both children and family members, and indirectly with program staff and administrators to insure that children with challenges received appropriate supports.
6. *Cultural competence was critical.* Staff strove to develop a greater awareness of the ways in which the cultural backgrounds of families affected their daily work, and to become more competent in respecting and dealing with children from different cultures.
7. *Competence in practice created confidence.* The skills administrators and staff used to address safety concerns and to communicate directly with families led to family confidence in the safety of their children and satisfaction with their care.

Organizational Factors that Facilitated Inclusion

1. *Clear goals were primary.* Each center had articulated a clear goal of meeting the needs of all children, including those with emotional or behavioral challenges; this goal informed the design and delivery of services, and was communicated to staff and family members associated with the center.
2. *Administrative leadership was required.* Directors worked to build commitment to inclusion both within their centers and throughout their communities.
3. *Personal values were paramount.* Staff valued their relationships with individual children and families; the warmth and welcoming they conveyed to families were of central importance to parents.

4. *Clear communication was a high priority.* Administrators and staff attempted to establish “personal accessibility” with family members and each other, and strove for frequent and clear communication.
 5. *Management practices mattered.* Staff and administrators reported an emphasis on maintaining the highest professional standards for their center, and spoke repeatedly about the importance of improved conditions of employment including health care benefits and flexible working hours.
 6. *Teamwork and a supportive culture were fostered.* Staff cohesion at the centers was high, with staff backing each other up in times of crisis and meeting frequently to develop strategies for caring for particular children; a safe climate was created in which staff could ask for help in difficult situations without fear of being seen as a failure.
 7. *Openness to learning and change was pervasive.* A wide variety of training modalities was used, ranging from informal supervision and mentorship to formal staff development programs or consultation; family members were frequently included in learning opportunities.
4. *Existing policies/advocacy for policy change.* Such regulatory barriers as inflexible funding streams and policies on the use of restraints were discussed as key obstacles; administrators took on the role of advocate for policy and system improvements.
 5. *Service gaps/advocacy and partnership with parents.* Long waits for mental health assessment and treatment were common in communities surrounding some of the centers, and transitions between one service system and another were not always smooth. These gaps were addressed by child care providers and parents forming partnerships on behalf of individual children; with older children, personnel from the schools were also involved in these partnerships.
 6. *Difficulties with collaboration/building relationships.* Partnerships with other child and family serving agencies generally went well, but difficulties in finding the time to work through arrangements or differences in approaches were major barriers to collaboration. Directors reported building up relationships with other partners over a period of years, overcoming barriers by patient adherence to a belief in inclusion and faithfulness to best practice to support families.

Barriers to Inclusion and the Strategies Used to Overcome Barriers

1. *Lack of resources/creative funding.* Administrators and staff identified resource deficits that affected their ability to provide quality care, including unstable funding, poor salary levels for staff, lack of funding for additional staff to support children in crises, and limited budgets for staff development. These challenges were met by creative funding packages that commingled funding streams, and that were put together with other agencies.
2. *Negative attitudes/persistent efforts to change views.* Child care providers worked to combat negative attitudes toward children with challenges and their families, particularly on the part of parents of typically developing children or newer staff. Administrators and staff held firm to their strengths-based approach and their belief in inclusion and worked patiently to change these attitudes and decrease the level of blame placed on parents for their children’s behavior.
3. *Cultural misunderstandings/outreach.* All three groups of participants discussed the challenge of working through language differences and cultural misunderstandings. These were offset by outreach to families by staff, and the use of skilled language and cultural interpreters.

An Agenda for Action

As our participants repeatedly told us, inclusion is no accident. It is the result of careful planning, organizational development, and intentional actions on the part of administrators and care providers. Based on our literature review, research results, and consultation with the project advisory committee, we offer fifteen recommendations as the basis of an action agenda to promote inclusion, which are discussed in detail in Chapter 9. Ten of the recommendations are focused on the program and community level, and five on the state and national level.

Recommendations for Program and Community Actions

1. **Foster Stable and Qualified Administration and Staff Who Embrace Inclusion.** Incentives should be put in place that will attract and retain staff who embrace inclusion and who have the qualifications and dedication to meet the challenge of providing care for children with emotional or behavioral challenges.
2. **Provide for Professional Development of Administrators.** All professional development curricula for child care administrators of early childhood and out-of-school programs should incorporate specialized information on inclusion of children with emotional or behavioral challenges.

3. **Promote the Professional Development of Staff.** Professional development trainings for providers should include information that supports their work with children experiencing emotional or behavioral challenges, especially successful inclusive practices, handling safety issues, use of mental health consultation, cultural competence, and parents as partners in care.
4. **Create, Document, and Publicize Successful Inclusive Practices.** These best practices should be investigated, documented, and disseminated to parents, care providers, and other supportive professionals so that a more comprehensive set of evidence-based practices can be established and more widely utilized.
5. **Make Mental Health Consultation Widely Available.** Mental health consultation should be available for every early childhood and out-of-school care setting to support the social and emotional development of children.
6. **Deliver Supportive Services in Naturally Occurring Activities in the Care Setting.** Mental health supports should occur in the child care environment as part of naturally occurring events, whenever possible.
7. **Enhance Professional Development for Mental Health Consultants.** Initiatives should support the pre-service and in-service professional development of mental health consultants.
8. **Encourage Family Participation.** Recognizing that parents are the adults with the most extensive experience concerning their children's emotional or behavioral needs, administrators and staff should encourage and support their participation in their children's care.
9. **Expand Family Support.** Although child care serves as a major support for families having children with emotional or behavioral disorders, other types of support should also be made available in conjunction with these services.
10. **Foster Community Partnerships.** The success of inclusive child care providers can be improved through the strengthening of partnerships among family-serving agencies, businesses, and human services organizations in the community.

Recommendations for State and National Level Actions

11. **Increase Accessibility.** In order to provide equal opportunities for children with emotional and behavioral challenges to experience the enrichment and support of child care settings, access should be increased to inclusive early childhood care settings and out-of-school care. Civil rights guaranteed by legislation

such as the Americans with Disabilities Act should be enforced.

12. **Enhance Affordability.** Families of children with emotional or behavioral challenges often need assistance to afford child care for their children; therefore new funding initiatives should be undertaken to increase the affordability of this key family support.
13. **Improve Availability.** Numbers of early childhood care programs and out-of-school care programs that provide inclusive care for children with emotional or behavioral challenges should be increased through governmental and private sector supports.
14. **Increase the Capacity of Child Care Settings to Serve Children with Emotional or Behavioral Challenges.** Child care settings need to be recognized as part of the systems of care (Stroul & Friedman, 1996) for children and families struggling with mental health issues, and additional supportive services should be provided in the child care environment.
15. **Fund Ongoing Research on Inclusion.** Organized research programs should be funded by the public and private sectors to investigate the potential of inclusive child care to benefit children's social and emotional development and mental health, and to build on family strengths through putting needed supports in place.

Child Care for the Future

Child care is a natural environment for many families and children, and providers are in a unique position to support families and children, and to identify problems. The child care centers in this study demonstrate how children with emotional or behavioral disorders and their families can thrive in a setting where they receive adequate support. Building inclusive centers requires the investment of time and resources, as well as changes in attitudes and practices.

According to the National Advisory Mental Health Council (2001) childhood mental health disorders will be one of the top five causes of sickness, disability, and death among children by the year 2020. By continuing to exclude families of children with challenging behaviors from supportive child care, many opportunities are wasted and families are forced to cope with their children's mental health needs in isolation (Friesen, 1996). There is an urgent need for action to build on what these child care centers have learned about providing accessible support for families.

Chapter 1:

Introduction and Literature Review

Inclusion of Children with Emotional or Behavioral Challenges in Child Care

Background and Significance of the Study

One in ten children in the United States experiences an emotional or behavioral disorder serious enough to cause some level of impairment in development, functioning, or learning and the numbers of children affected seem to be growing (Brimhall, 1999; Burns et al., 1995; President's New Freedom Commission on Mental Health, 2003; Shaffer et al., 1996). Identification of a child as having an emotional or behavioral disorder is a difficult process, and takes place in the context of developmental processes and the social environment. The Surgeon General's report on mental health considered mental disorders in children to be "serious deviations from expected cognitive, social and emotional development" (U.S. Public Health Service, 2000). These disorders would include disturbances such as Attention Deficit Disorder, childhood depression, or Obsessive Compulsive Disorder. Although children with neurological impairments such as those associated with autism or Tourette Syndrome also exhibit challenging behaviors, they are generally not considered to have mental disorders. Recognizing the need for assistance for children with emotional or behavioral challenges, the Surgeon General's Conference on Children's Mental Health set out an overarching vision in which mental health services would be integrated into all systems that serve children and youth (U.S. Public Health Service, 2000).

Emotional, behavioral, or mental disorders are found in children belonging to all socioeconomic, cultural, and religious groups, and in every family structure. However, children affected by poverty, violence, or family substance abuse have an especially high risk of developing mental health challenges that limit their capacities to engage in learning and reach their full potential (Knitzer, 2000a).

With the entry of their parents into the workforce (U.S. Department of Health and Human Services, 1998), particularly through the welfare reform movement, many children who have mental health disorders, or who are at risk for developing emotional or behavioral challenges, are being enrolled in programs providing child care for infants, toddlers, young children, or school aged children (Brennan, Caplan, & Ama, 2002). Child care settings are uniquely situated to address the mental health needs of young children with emotional or behavioral challenges (Schock, 2000), through the promotion of healthy social and emotional development (Shonkoff & Phillips, 2000), and by providing access to mental health services and family support (Ama, Berman, Brennan, & Bradley, in press; Brennan, Caplan, Ama, & Warfield, 2001; Cohen & Kaufmann, 2000).

Models of Inclusion in Child Care Project

The study discussed in this monograph is a unique investigation of child care centers that have successfully served families having children with emotional or behavioral disorders in a fully inclusive way. Following the lead of Kontos, Moore and Georgetti (1988), **inclusion** in the child care environment is defined as the delivery of comprehensive services to children with emotional and behavioral challenges in settings that have children without these challenges, and the participation of all children in the same activities, with variations in the activities for those children whose needs dictate the adaptation.

Inclusion has recently been recognized as a dimension of high quality child care, that benefits not only children who are faced with disabilities, but also their typically developing peers, who learn how to function empathetically in a more diverse world (Irwin, Lero, & Brophy, 2000). However, merely placing children with mental health challenges into high quality centers is not sufficient. Successful inclusion requires the commitment of administrators and staff, who have learned to provide individualized care for children with challenging affect and behavior, and can successfully collaborate with families and with community partners to gain access the specialized supports needed by the center's families (National Research Council and Institute of Medicine, 2001).

In October of 1999 our research team launched an investigation of programs and strategies in the United States that provided improved access to inclusive child care for families with children having emotional or behavioral disorders. We set out to find and study programs nominated as being inclusive, family-centered, culturally appropriate, and of high quality. In this study, we sought to "describe the lived experience of inclusion...[and consider the] multiple levels of influences operating jointly" (Irwin et al., 2000), thus making a unique contribution to the literature on inclusion of children with unique challenges in child care centers.

The project has been focused on identifying, describing, and analyzing key features of a selected group of model child care programs which met family needs for quality child care, and provider needs for training about serving children with emotional and behavioral disorders. Over one hundred child care programs which served children with emotional or behavioral challenges along with typically developing children were identified through a comprehensive nomination process. We selected and studied nine centers that delivered child care services in a culturally appropriate manner with well-qualified providers. The investigation focused on programs that met the child care needs of families that had children under 18 years of age living at home, who had emotional or behavioral challenges. Data were gathered through face-to-face or telephone interviews of key informants, and the surveys were supplemented by

observations of staff and children in the centers and by content analysis of program materials. Our research team chose to use primarily qualitative methods in order to explore in depth the experiences of the administrators, staff, family members, and to capture these direct reports in their own words.

The project had five objectives:

1. Identify and study model child care practices that provided quality care in community-based child care settings, which included children with emotional and behavioral disorders, and which were culturally-appropriate.
2. Identify and investigate successful training models that prepared child care providers to deliver high quality, culturally appropriate services to families having children with emotional or behavioral disorders.
3. Describe the barriers to achievement of inclusive child care for families having children with emotional or behavioral disorders, and the strategies used by providers and family members to overcome these barriers.
4. Understand the communication processes by which family members gained access to inclusive child care resources, participated in planning for inclusive child care services, and collaborated in the training of child care service providers.
5. Furnish families, child care providers, and mental health service providers with a better understanding of practices that increase the options for child care available to families having children with emotional or behavioral disorders.

The conceptualization, methodology, and analysis of the project has been guided by theoretical and research literature that addresses: (a) support that is necessary for families with employed parents and children with emotional or behavioral challenges; (b) the context of available child care arrangements; (c) the inclusion of children with unique challenges in child care settings; (d) the delivery of mental health services in child care environments; and (e) the policy and legal context of inclusion in child care. Based on the literature that lies at the intersection of the fields of child care, children's mental health, and services to children with disabilities, we analyzed our data according to overall guiding questions, described in the final section of this chapter.

Following the literature review and summary of the research questions in this chapter, subsequent chapters focus on our research methods and results. The monograph concludes with a discussion of our findings and a chapter outlining recommendations that are set forth for the use of family members, practitioners, trainers, policymakers, and advocates for children's mental health. We believe that this study can contribute to changes in practice and policy in today's society where family members with caregiving responsibilities for children with emotional or behavioral challenges are increasingly engaged in paid employment.

Literature Review

Child Care as a Family Support

A high quality child care setting strengthens the entire family, enabling family caregivers to pursue the employment, job training, or education they must have to provide for their own needs and those of their dependents (Lombardi, 2003). A stable, nurturing child care arrangement makes it more possible for family members to find a fit between their work and family responsibilities (Rosenzweig, Brennan, Wuest, & Ward, 2002). However, finding a suitably nurturing, appropriately trained supplemental caregiver who can cope with physical, behavioral, or emotional challenges may be both difficult and costly (Brennan & Poertner, 1997; Friesen, Brennan, & Huff, 1999; Harvey, 1998; Rosenzweig, Friesen, & Brennan, 1999; Warfield & Hauser-Cram, 1996). Indeed, recent research studies reveal the difficulty of finding appropriate child care for children with mental health needs. Focus groups involving 41 employed parents of children with mental health disorders discussed the challenges they faced in balancing work and family life (Rosenzweig, Brennan, & Ogilvie, 2002). A major issue that emerged from the families' discussions was the lack of appropriate child care resources experienced by these families. The parents reported that there were few trained caregivers who were willing to provide a nurturing environment for their children, and that the child care arrangements that they were able to put in place were costly and unstable. Parents who were employed full-time and who cared for children with emotional or behavioral challenges also reported in an interview study that they had to build in flexibility in both their work situations and family life to attain a fit between their responsibilities in these areas (Rosenzweig, et al., 2002). An additional problem that has been identified recently by the Federation of Families for Children's Mental Health is the isolation of family members from their friends and relatives because of a lack of child care that would allow them to participate in social and recreational activities (Federation of Families for Children's Mental Health, 2002). When families are supported, the health and well being of all family members is promoted, and they are able to function well and contribute to their communities (Friesen, Pullmann, Koroloff, & Rea, 2003).

The stress that family caregivers of children with disabilities experience in attempting to arrange accommodations in their lives can at times be nearly overwhelming unless sufficient supportive services are made available (Abidin, 1990; Anastopoulos, Shelton, Du Paul, & Guevremont, 1993; Freeman, Litchfield, & Warfield, 1995; Friesen & Koroloff, 1990; Kagan, Lewis, & Heaton, 2001; Lechner & Ceedon, 1994; Roberts & Magrab, 1991). Caregivers of such children must either miss work or give up employment altogether when care is not available. Holden reported that of 84 parents of children in mental health treatment, 56 (67%) indicated that they missed work or neglected other duties because of their children's emotional or behavioral problems

(Holden, 1998). Finding affordable child care is a key challenge for many parents attempting to move off welfare assistance and to take up employment while caring for children with emotional or behavioral disabilities (Olufokunbi & Boothroyd, 1999). The needs of parents engaged in job training or newly seeking employment are adding to the present demand for inclusive child care and related family assistance.

Available Family Support

Unfortunately, many child care settings are unprepared to nurture children with emotional or behavioral disorders and link them and their families with needed services. In fact, there is evidence that children with challenging behaviors are 20 times more likely than typically developing children to be dismissed from child care settings (Emlen, 1997). Furthermore this study found that parents of children with mental health issues rated the quality and stability of their care arrangements significantly lower than parents of children developing typically (Emlen & Weit, 1997).

Quality child care arrangements that can meet the need for positive, nurturing experiences for children with mental health challenges are clearly in short supply in the United States; many more families require these supportive services than can find them. Family support has been defined as "the constellation of formal and informal services and tangible goods that are determined by families" (Federation of Families for Children's Mental Health, 1992; p. 1). If a family receives appropriate support, the members are not overwhelmed by the behavior or needs of a child with a disability, but can strike an appropriate balance in the lives of all family members, including adult caregivers and siblings of the child with challenges (Friesen, 1996).

If this balance is to be attained, coordinated family-defined and family-driven services must be available from the systems that affect families with dependent children with complex needs (Rosenzweig et al., 1999). Child care providers can be key partners in developing this coordinated set of services.

In a recent interview study with 60 full-time employees who were also principal caregivers of children who had received mental health services, a few of the parents reported that they had found flexible, appropriate child care arrangements and were highly satisfied with their children's care (Rosenzweig et al., 2002). The parents told interviewers about family child care providers or child care centers that worked with their families so that parents could go to their jobs knowing that their children were being nurtured and looked forward to their time in care. It was because of these parent reports that our research team set out to find and study child care arrangements that successfully included children with emotional or behavioral challenges.

The Context of Child Care

Although the focus of our investigation was on families that have children with emotional and behavioral challenges, it is important to consider the multiple issues that influence child care provision in the United States. The aim of this section is to provide an overview of the broader context of child care. The following three questions are considered briefly: (a) How is the need for and use of child care changing? (b) How is child care organized? and, (c) What are the key components of quality child care?

Child care use

As discussed above, a growing number of children and their families use child care on a regular basis. Many factors, including increased participation of women in the work force, welfare reform, and increased work requirements for recipients of Temporary Assistance to Needy Families (TANF), have contributed to this growth in demand. More children, at younger ages, now spend significant amounts of time being cared for by non-parental caregivers (Hofferth, 1999; Lombardi, 2003). In 1995, three out of four children under 5 were in some form of regular child care arrangement in a typical week (Smith, 2000). Half of mothers return to work by six months after their child's birth (Hofferth, 1999). In 1999, about half (49%) of children aged 6 through 12, whose primary caregiver was employed, were in some type of child care arrangement (Ewen, Blank, Hart, & Schulman, 2002). In addition to higher numbers of children in child care arrangements, many school age children are unsupervised while their caregivers are at work. In 1993 to 1994, an estimated 5 million school age children were "latch-key kids," and yet only three out of ten public schools offered extended learning programs, despite the evidence that lack of adult supervision has a negative impact on children's academic performance, relationships, and social adjustment (Kaplan, 1998).

The organization of child care

One of the challenges in describing child care in the United States is that arrangements encompass divergent program types in a wide range of facilities. Two main forms of child care are out-of-home care (in either child care centers or family homes) and in-home care which is provided by either relatives or non-relatives (Zigler & Hall, 2000). Research on national trends in the use of child care indicate that more children are being cared for in child care centers, while fewer are being cared for in family day care arrangements (Casper, 1996, 1997; Casper & O'Connell, 1988). However, national patterns of child care use, including subsidized care, are not necessarily replicated in individual states. State patterns differ in significant ways, including both the proportion of children in parent care, and the type of child care arrangement used. For example, in Minnesota, Alabama, and Mississippi, preschool children are about twice as likely to be in center-based care than they are in California (Capizzano, Adams, & Sonenstein, 2000). Such differences in ways in which child

care is organized not only make it difficult to get an overall picture of child care availability, but also have important implications for the development of policy such as that addressing inclusion in child care. Data derived from federal tax returns shows that the majority of child care providers (including both employer and non-employer for-profit businesses, and non-profit centers) were small businesses (O'Neill & O'Connell, 2001). Relatively little is known about which factors predict the willingness of child care providers to include children with disabilities (Brandon, 2000). However, if child care is to meet the needs of more families, including those that have children with emotional and behavioral disorders, it is important to take account of the varying needs of programs of different size and structure.

If child care is to meet the needs of all families, the complexity of both supply and demand should be considered (Emlen, 2002a). Patterns of use of different child care arrangements may or may not reflect families' preferences. There is evidence that the use of different types of child care arrangements is associated with the age of the child, socio-economic status, ethnicity, geographical location, and the economic climate. For example, in poorer families, child care is more likely to be provided by relatives (Casper, 1996). Also, it is estimated that one in four low income families work evening or night shifts, and therefore require odd hour child care, which is less likely to be available (Ewen et al., 2002). Current child care resources are particularly inadequate for some types of families, such as low income two-parent families with preschool children, and single-parent families with school-age children (Sonenstein, Gates, & Bolshun, 2002). If these groups of families also have children with emotional and behavioral disorders, the barriers to finding appropriate child care may be almost insurmountable.

Quality child care and child care staffing

Recent research highlights the crucial role that early environments, including the caregiving environment have on children's development (Shonkoff & Phillips, 2000). As discussed above, the experience of care by non-parental caregivers is increasingly important in the lives of many children. Much of the research on the quality of child care over the past twenty years has focused on the perspective of providers and administrators of child care. The **supply side** point of view has identified basic criteria needed to provide quality child care. The quality of child care in relation to supply has been described in two broad dimensions: **structural quality** (how the arrangement is set up) and **procedural quality** (how the child care is run). Examples of structural aspects of quality include staff-to-child ratios, group size, staff qualifications, and developmental appropriateness of curricula. Examples of procedural aspects of quality include strong child-to-provider relationship, attention to the community and policy context, and drawing upon other resources to meet family needs (Erwin, 1996; Shonkoff & Phillips, 2000). While it is important to

understand this 'supply side' perspective, we are missing half the story by excluding the perspective of child care users, the **demand side**. Researchers have given less attention to questions concerning families' expectations and their need for support from their child care arrangements (Emlen, 2002b). This study addresses the demand side of care by asking both families and child care providers about their experiences of successful inclusive child care arrangements.

Studies of child care have consistently identified staff-child ratios and staff qualifications as cornerstones of high quality child care (Cohen, 2001). If child care providers are to meet the needs of all children, including those with emotional and behavioral challenges, sufficient numbers of well-trained staff are even more critical. However, there is considerable evidence to show that staffing is an ongoing challenge for child care.

The number of paid employees working in the child care industry more than doubled from 190,000 in 1992 to 468,000 in 1997 (Casper & O'Connell, 1988). However this growth does not match the increase in demand. The ratio of paid child care workers to preschool children with employed mothers was 1:24 in 1992. The unmet need for workers may be tied to low salary levels. Income data show a downward trend in the compensation of employees in child care centers in the past 20 years adjusted for inflation (O'Neill & O'Connell, 2001). Between 1982 and 1997 the average pay for a child care employee increased by from \$9,690 to \$11,096. In comparison, wages for all female employees increased from \$13,366 to \$16,849 during the same period (O'Neill & O'Connell, 2001). In addition to low wages, few child care employees receive benefits such as health insurance as part of their employment (Ewen et al., 2002)

High staff turnover is a major problem. It is estimated that one-third of the child care workforce leaves their jobs each year (Ewen et al., 2002). One effect of recruitment difficulties is the employment of staff with less education as replacements (Ewen et al., 2002). This is of particular concern as training of staff has been identified as a key factor in the child care outcomes research (Kaplan, 1998), as well as a dimension of child care most valued by parents (Hofferth, 1999). The Surgeon General's Report (U. S. Public Health Service, 2000) identified a number of areas of training required for child care providers. These included training in child development, developmental and cultural differences, and the recognition of early symptoms of mental health challenges. Recent state-level initiatives to address the training issues among child-care workers include scholarship programs to enable staff to earn basic credentials, funding for professional development, and differential payment for qualified staff (Ewen et al., 2002).

Poor working conditions for staff and inadequate training have important implications for the inclusion of children with emotional and behavioral challenges. High staff turnover makes it even more difficult for children who already face considerable obstacles, to develop stable

relationships with significant adults who can meet their needs. If child care staff are to be able to work successfully with children with challenging behaviors, and to support their families, education in child development and children's mental health will be necessary.

Inclusion of Children with Unique Challenges in Child Care

Despite the abundant research on child care in general, very little is known about child care usage or the quality of care received by children with disabilities (Shonkoff & Phillips, 2000), and few studies have addressed the particular situation of children with social or emotional challenges. What little research there is, suggests that children with disabilities enter child care at older ages, are enrolled for fewer hours and are less likely to be in a child care center than are typically developing children (Booth & Kelly, 1998; Warfield & Hauser-Cram, 1996). The limited evidence available indicates that even for those families who have found child care for their children with emotional and behavioral challenges, their needs are not being met. In a survey of 862 employed parents, 8% reported that they had a child with an emotional or behavioral problem that required special attention (Emlen, 1997). Parents who identified their children as having challenges were less satisfied with their child care arrangements. When asked about concrete details of their child care arrangements, this group of parents rated the caregivers as less skilled, and the arrangements as having more health and safety risks, as well in other ways as being of lower quality, in comparison to parents of children without challenges.

Promoting and defining inclusion

As part of an effort to promote inclusion of children with unique challenges in high quality child care, the Child Care Bureau and the U.S. Department of Health and Human Services funded the Maps to Inclusive Child Care Project, a technical assistance program which aimed at helping states to build capacity (Bruder, 1999). Through the Maps project a total of 31 states assembled teams of stakeholders to engage in a planning process, including child care providers and administrators, representatives of early childhood education and Head Start, and families of children with disabilities. Representatives were also drawn together in a national conference to examine funding strategies, policy issues, and provider training. In this project, only some states defined disabilities as incorporating emotional or behavioral challenges (Butler, 1997). One of the challenges of examining national progress towards the inclusion of children with disabilities in child care is the wide variation in how disabilities are defined in different states (National Child Care Information Center, 2002b).

Types of inclusion

Truly inclusive child care settings provide a curriculum and environment where children with unique challenges are permanent members of the group or class – as opposed to

Erwin's (1996) definition of mainstreaming, for example, where children visit typically developing groups temporarily only to return to a separate room or group. Guralnick (2001), based on models present in special education, has identified four basic types of inclusion in early childhood settings.

Fully inclusive environments include children with disabilities as full participants in the general environment. Curriculum is designed around children's individual disabilities. Community specialists and related services are well integrated into daily activities. The general child care teacher is responsible for the care of all children but specialized staff may be present (Guralnick, 2001).

Guralnick's second type of inclusive child care arrangement, the *cluster model*, is characterized by its essentially ad-hoc nature. Cluster inclusion occurs when a small group of children with unique challenges is "grafted onto an existing program that serves typically developing children (Guralnick, 2001, p. 10)." The new group of children with unique challenges often brings its own set of staff and is given a separate room within the center. Cluster inclusion falls just short of full inclusion. The general child care teacher is still responsible for all enrolled students but children with unique challenges are not expected to participate in all activities. Participation with all staff is essential to ensure integration of related services.

Reverse inclusion is Guralnick's third model of inclusion in early childhood environments. 'Reverse' environments began as special education centers that adapted curriculum to include a small number of typically developing children. Mainly staffed by special educators, centers of this model strive to provide the least restrictive environment for all children.

Guralnick's final model, *social inclusion*, is the most segregated form of inclusion. Although the environment may be located in the same building, children with unique challenges are relegated to separate rooms with separate teachers, curricula and educational philosophies. Socially inclusive environments are the tale of two programs. Typically developing children and those with unique challenges only come into contact with each other during 'free time' or other planned recreational activities. The emphasis is on unstructured interaction between children. There is no curriculum designed for inclusion and specialized services are only present in the unique challenges program.

Benefits of inclusion

Although there are different approaches to inclusion in child care settings, the benefits of providing contact between typically developing children and those with unique challenges appear to outweigh any difficulties associated with the practice. Positive outcomes for children with severe disabilities who were included in general education environments (public schools) have been well documented. McGregor & Vogelsberg, (1998) have synthesized research in the area. The list of positive outcomes included:

1. With adequate support, students with disabilities demonstrate high levels of social interaction with typical peers in inclusive settings (Fryxell & Kennedy, 1995; Kennedy, Shukla, & Fryxell, 1997; McDonnell, Hardman, Hightower, & Kiefer-O'Donnell, 1991).
2. The social competence, communication skills, and other developmental skills of the students with disabilities have improved in inclusive settings (Bennett, DeLuca, & Bruns, 1997; Hunt, Staub, Alwell, & Goetz, 1994).
3. Contrary to commonly held views, there is no evidence that the presence of students with disabilities compromises the performance of typically developing students (Hollowood, Salisbury, Rainforth, & Palombaro, 1994; McDonnell, Thorson, McQuivey, & Kiefer-O'Donnell, 1997; O'Connor & Jenkins, 1996).
4. Some evidence suggests that the costs of inclusive services over time are likely to be less than those of segregated forms of service delivery, in spite of the fact that start-up costs may initially be higher (Halvorsen, Neary, Hunt, & Piuma, 1996; McLaughlin, Henderson, & Ullah, 1996; Salisbury & Chambers, 1994).

It is reasonable to assume positive outcomes found in schools may also be found in truly inclusive child care arrangements where the staff members have been prepared to serve children with unique challenges, and where they have positive attitudes toward inclusion. As one might expect, many of the dimensions of quality identified in general child care research (caregiver sensitivity, developmentally appropriate practices, staff training, and physical environments that support social interactions) have also been identified as important in inclusive settings (Shaw et al., 2001). In general, an inclusive child care environment that exposes children with disabilities to social interactions with children that are developing typically may be particularly positive for the development of social competence and behavioral skills, although this may vary according to the child's level of functioning (Shaw et al., 2001).

Barriers to inclusion

Inadequate resources (Peck, Furman, & Helmstetter, 1993), provider attitudes and beliefs, including resistance to change (Kontos & File, Spring 1993), philosophical differences (Odom & McEvoy, 1988), restricted professional preparation, communication problems and professional turf issues (Rose & Smith, 1993), have all been identified as barriers to including children with disabilities (Erwin, 1996). The study by Rose and Smith also suggested that provider training in inclusion practice could lead to better outcomes for children (Rose & Smith, 1993).

An additional barrier that may particularly affect child care is that of negative family attitudes, beliefs, and perceptions. Family members are a primary source of information about different groups of people for their children. As children notice differences in others they are bound to ask their parents about them (Stoneman, 2001). If parents believe

inclusion of children with emotional and/or behavioral challenges into their child care arrangements is dangerous for their children, their own children are likely to also believe inclusion would be dangerous. Children tend to mirror their parents' emotional reactions to situations or people (Triandis, 1971). For example, when parents are visibly repulsed seeing children being tube-fed, their own children are likely to experience the same emotional response. Without avoiding contact with the other, in an inclusive child care arrangement children who are typically developing may not ever get to know the children with unique challenges in their group.

An inclusive child care environment provides an opportunity for all children to increase their understanding of individual differences, including those associated with disability. Although staff and families may be concerned about the possible negative effects of this environment, the limited evidence indicates that interactions with peers with disabilities provides opportunities for children to develop compassion and leadership behavior (Shaw et al., 2001).

Parental attitudes not only affect the behavior and beliefs of their children but also have a significant influence on child care centers and their ability to successfully include children with unique challenges. Child care staff need support and input from family members (Allred, Briem, & Black, 1998). Families can be important sources of information about a child's behavior, his or her likes and dislikes. The importance of family involvement takes on further significance when caring for children with unique challenges. Staff members have reported that inclusion of children with disabilities is hindered when there is little parental involvement and limited communication between the staff and the parents of children with unique challenges (Buysse, Wesley, & Keyes, 1998).

Parent attitudes towards inclusion may also affect child care center policy in more direct ways. By choosing not to select a center that includes children with disabilities, parents may force many for-profit centers into changing their policy of inclusion in order to fill enrollment slots. Parents of children already enrolled in inclusive arrangements may also demand the release of specific children, ask that children with unique challenges be placed in separate rooms, or request staffing and personnel changes (Stoneman, 2001).

Much of the research on parent perceptions over the past twenty years has focused on potential benefits and drawbacks of inclusive environments. Parents of both children who were typically developing and children with unique challenges were asked about their perceptions of early childhood inclusion (Bailey & Winton, 1987; Bennett et al., 1997; Bennett, Lee, & Lueke, 1998; Guralnick, 1994; Green & Stoneman, 1989a; Reichart et al., 1989; Winton, Turnbull, Blacker, & Salkind, 1983). Both sets of parents worried about a possible trade-off in their child care arrangements: parents feared that as their center included more children with disabilities, the overall quality of care would decrease. Both

sets of parents appreciated the positive social outcomes afforded their children from relationships with children who were different. Both sets, however, worried the center would not have adequate staff training, materials or ratios to meet the demands of all children in their care (Erwin, Soodak, Winton, & Turnbull, 2001).

Many parents of children who were typically developing were concerned their children would not receive adequate attention from staff members, while parents of children with unique challenges worried other children (or parents) might stigmatize themselves or their children (Bailey & Winton, 1987; Reichart et al., 1989). Despite these fears (or, possibly, because of them), parents of children with disabilities reported feeling isolated from other parents and tended not to interact with other parents (Bailey & Winton, 1987; Blacher & Turnbull, 1982).

Parents of children enrolled in inclusive early childhood programs tended to have more favorable attitudes towards inclusion than did parents of children enrolled in non-inclusive centers (Diamond & LaFurgy, 1994; Green & Stoneman, 1989b; Stoneman, 2001). There could be any number of explanations for this finding, including the parents' attitude being affected by their children's exposure to peers with disabilities. Obviously, parents who have positive attitudes towards inclusion are more likely to enroll their children in inclusive child care arrangements. Yet there are many factors parents must consider when selecting a child care program that best meets the needs of their families, including hours of operation, proximity to home and school, child-to-staff ratio, and the overall quality of the program. The presence of children with apparent disabilities may be the deciding factor for a few parents, but such parents are in a small minority (Stoneman, 2001).

Promoting Mental Health in Child Care Settings

All the adults who are involved in regular care of children should promote their social, emotional, and cognitive development. As children spend more of their waking hours with child care providers (Ranson, 2002), greater attention is being given to the role of this group of adults as important nurturers of the social and emotional health of children. Effective interventions in children's natural environments can increase the likelihood of adaptive outcomes (Shonkoff & Phillips, 2000). For example, a child can learn to substitute verbal requests for aggressive acts, given consistent prompting by a skilled caregiver.

In the rich social environment of child care, children who are experiencing difficulties with their affective responses can connect with caring adults in a safe and stable environment, receive empathic responses from these caregivers, and learn to express their emotions in a healthy, appropriate manner (Koplow, 1996). Child care staff can design activities promoting social interactions between children with challenges and their peers (Shonkoff & Phillips, 2000), and assist them to learn to work out conflicts, recognize and

manage their feelings in social situations, and behave in acceptable, positive ways (Saarni, 1999).

Mental health consultation in child care settings

Child care providers often meet high levels of challenge as they seek to help children attain awareness, regulation, and appropriate expression of their emotions, work with them to develop the ability to relate well socially, and strive to promote empathy for others. Consultation about these challenges with mental health service providers can make a great difference in the success children have in child care settings (Donahue, Falk, & Provet, 2000).

When delivered to young children in child care environments, mental health consultation not only can have a significant impact on the formation of social and emotional competency but also can positively affect the development of school readiness (Knitzer, 2000b). Consultation in programs serving school aged children can also assist staff to retain children with emotional challenges in these settings, and provide assistance to families with the difficulties they may face at home.

Mental health consultants deliver services directly to children and their families, and indirectly by working with administrators and staff on organizational and programmatic development (Cohen & Kaufmann, 2000; Donahue et al., 2000). Donahue asserts that in order to be effective, consultants must engage families, collaborate with administrators, and work with teachers and other staff members in a wide range of contexts (Donahue et al., 2000). Consultants may intervene in a variety of ways. Possible interventions include assessing the needs of children for mental health treatment, working with families to obtain needed services, designing activities to assist an individual child that are carried out by staff in the classroom for all class members, or providing support to early childhood educators who are struggling to cope with disruptive behavior in a child experiencing a family transition. The findings of a recent study of promising practices in children's mental health may provide a useful framework for the delivery of mental health consultation. In this research (Simpson, Jivanjee, Koroloff, Doerfler, & Garcia, 2001), services identified as innovative and effective were also found to be family centered, individualized, comprehensive, community-based, coordinated, built on a high level of family participation, focused on developmental needs, and built on strengths and resilience of the children and families served.

Recently mental health consultation programs serving child care organizations have been documented and discussed at national conferences (Bowdich, 2001; Fong & Wu, 2002). However few investigations have been conducted to establish the effectiveness of mental health consultation in child care settings in improving center quality, assisting staff performance, and promoting child social and emotional development.

An evaluation of a mental health consultation initiative in 44 child care centers in San Francisco, California examined staff job satisfaction, and outcomes for children receiving mental health services. Tyminski (2001) concluded that targeted, child-centered services were effective, since children receiving interventions went from being 20 months behind their age-mates in measures of social maturation to a 9-month lag in a period of 8 months from pre-test to posttest, a statistically significant result. Staff and center results were not significant, which was attributed to constraints affecting the timing of measurements in the evaluation (Tyminski, 2001). One of the San Francisco consulting agencies, the Fu Yan Project, conducted a separate, internal evaluation (Fong & Wu, 2002) and found that there were differential project outcomes by gender, with girls becoming more assertive and less shy and withdrawn, and boys improving in their control of aggressive, impulsive, or disruptive behaviors. Children of both genders were rated as more able to stay on task, learn, and tolerate frustration at posttest, which was attributed to the results of the consultation.

A second evaluation of mental health consultation services provided by four agencies to 25 child care centers in the San Francisco area reported positive outcomes (Alkon, Ramler, & MacLennan, in press). The most frequent activities reported by consultants were child observations, director consultations, meeting with individual teachers, consulting with individual families, and conferring with groups of staff. Centers that had received consultation services for one year or more showed significant increases in center quality, as assessed by the Early Childhood Environments Rating Scale (ECERS), in reported self-efficacy of teachers, and in teachers' ratings of competence (Alkon et al., in press). Since 1997, mental health consultation has been provided to child care staff and families on behalf of children at risk in Cuyahoga County, Ohio through the Day Care Plus program. A collaborative approach has been used to improve the social, emotional, and behavioral development of children in nearly 85 child care settings, with the goal of retaining children exhibiting challenging behaviors in child care. (Albright, Brown, & Kelly, 2001). In 2001, 259 children who were identified as being considered for expulsion were able to be retained in their child care settings after receiving these services (Cuyahoga County Early Childhood Initiative, 2001).

Mental health services in Head Start

Mental health consultation has also been a key component of Head Start, a key federal initiative serving low income families and preparing children for later success in school through programs focusing on social and emotional development, as well as cognitive development. Two recent investigations have examined mental health consultation in Head Start settings. Project SUCCEED (Supporting and Understanding Challenging Children's Emotional and Behavioral Development) was designed to develop, implement, and evaluate an approach integrating curriculum

development and consultation assisting family members and staff to meet the needs of young children with emotional and behavioral challenges who were enrolled in Head Start programs in Northwest Oregon (Saifer, Friesen, Gordon, Banek, & Tuner, 2002). Begun in 1998, Project SUCCEED developed a curriculum for Head Start teachers and family members on meeting children's behavioral and emotional needs. The curriculum was delivered by family members and staff who served as trainers, and augmented by on-site consultation that took the form of biweekly direct coaching and resource provision by project staff. Project staff produced an extensive and user-friendly manual for programs wishing to replicate the project. Evaluation of the training curriculum as the primary intervention was carried out in 8 intervention and 6 comparison classrooms. Although both intervention and comparison classrooms improved significantly in Devereaux Early Childhood Assessment ratings of protective factors, self-control, and initiative from pre- to posttest, only the intervention classrooms improved in attachment and did not show an increase in behavioral concerns. Reports of teacher stress decreased in the intervention, but not the comparison classrooms.

A second study, *Guidance for Program Design in Early Childhood Settings*, investigated the potential benefits of an integrated model of mental health consultation in Head Start programs (Green, Simpson, Everhart, & Vale, 2002). Researchers interviewed 63 administrators and staff at 5 sites within 3 Head Start programs. The programs were chosen for their diversity in location, the ethnicity of families served, and their approaches to mental health consultation. Green et al. (2002) found that, in contrast to programs with staff reporting less connection to their mental health consultants, programs with more integrated consultants had staff who were more likely to see everyone (as opposed to specialists) as responsible for children's mental health, who reported higher levels of parent involvement and services integration, and who expressed belief that consulting services were more effective.

These early investigations indicate that mental health consultation is effective, particularly when it is delivered by providers who are seen as well-integrated into the natural settings, and who involve parents in a meaningful way. Both direct services provided to children and families, and indirect services, including staff consultation, curriculum adaptation, and assistance to administrators, have been shown to have favorable outcomes. Unfortunately, a number of reports have identified a severe shortage of professionals with expertise in both child development and mental health who are truly prepared to provide consultation in these settings (U. S. Public Health Service, 2000).

The Policy and Legal Context of Inclusion in Child Care

Legislation is one important influence on practices and attitudes toward the inclusion of all children in a range of settings including child care. Federal law supports the principle of including children with unique challenges in child care programs. Laws that are relevant to child care include the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 (ADA), and the Individuals with Disabilities Education Act (IDEA) adopted in 1990.

The Rehabilitation Act of 1973 was the first federal law passed to protect the civil rights of persons with disabilities. Under Section 504 of the Rehabilitation Act, entities such as child care centers that receive federal funding are not permitted to discriminate on the basis of disability against otherwise qualified individuals (ShIPLEY, 2001). Section 504 considers a person as "disabled" if he or she suffers from a physical or mental impairment that substantially limits one or more major life activities, such as learning, walking, seeing, hearing, breathing, working, and performing manual tasks.

In 1992, the ADA extended legal protection for the civil rights of individuals with disabilities beyond recipients of federal financial assistance (Zirkel & Aleman, 2000). Title III of the ADA prohibits discrimination on the basis of disability and requires places of public accommodation and commercial facilities to be designed, constructed, and altered in compliance with the ADA accessibility guidelines. Since child care providers are considered public accommodations, they cannot automatically exclude a child from their services solely on the basis of the child's disability (California Institute on Human Services, 1999). Child care centers must make reasonable modifications in policies, practices, and procedures in order to accommodate individuals with disabilities. A modification is not required if it would "fundamentally alter" the goods or services of a child care setting (Washington State Department of Health, 2001). In principle, the ADA affords children with mental or physical disabilities the opportunity to participate in all activities and opportunities of living in a community, including child care.

Although the Americans with Disabilities Act (ADA) of 1990 protects the civil rights of children with disabilities the law is unevenly enforced. One study (Eisenman, Shishler, & Healey, 1995) found that one third of child care providers in their sample reported turning down children with disabilities over a 3-year time period.

The Individuals with Disabilities Education Act (IDEA), formerly the Education for All Handicapped Children Act of 1975, is a federal law mandating that all children with disabilities have available to them a free, appropriate public education, that emphasizes special education and related services designed to meet their unique needs and prepare them for employment and independent living. It is a federal entitlement law that provides federal funds to states on the condition that they do not engage in certain discriminatory

behaviors, such as segregating students simply because they have disabilities. This statute applies to infants, toddlers, pre-school students, and to students ages 6 through 21.

Early intervention services for children with disabilities from birth through age 2 are provided under Part C of IDEA, while Part B applies to preschool-age children. The purpose of each of these amendments to IDEA is slightly different, yet both fully support inclusive practices. Part B covers all children ages 3-21 and states that children with disabilities must be provided a free, appropriate public education in the least restrictive environment. Part C recognizes that early intervention services can provide great benefits to children with disabilities. Family involvement is also seen as a critical component under Part C, as families take an active role in developing service plans for their children (Stowe & Turnbull, 2001).

Child Care Regulations

The regulation of child care is often contentious due to ideological differences about parental choice and the role of government in family life, and to tensions between state and federal authority. Regulations applicable to child care may encompass a range of issues such as health and safety, staff-child ratios, staff training, and immunization policy. There is considerable variation among states in both the methods of regulation, and how regulations apply to different types of child care arrangements. Different approaches to regulation include mandatory licensing, and registration or certification. In general, licensing specifies minimum requirements, which are assessed by an initial inspection with periodic follow-up inspections. Registration and certification typically involve self-reporting. In addition to differences among states, policies within a state may vary according to such criteria as the number of children cared for, the ages of the children, whether or not the center receives public funding, and the source of the funding received. Examples of child care arrangements that are exempt in some states include religiously affiliated centers, school-based pre-school programs, and facilities on federal, state or local government property (Cohen, 2001).

Some child care providers go beyond regulatory requirements by obtaining accreditation for their programs. This demonstrates the high quality of their programs, and may enable them to receive higher reimbursement. A number of national organizations have developed standards and accreditation services. These include the National Association for the Education of Young Children (NAEYC), the National Association for Family Child Care, and the National Early Childhood Program Accreditation Commission (Cohen, 2001). In addition, the American Academy of Pediatrics and the American Public Health Association have developed voluntary health and safety performance standards to reduce the frequency of accidents and to protect children in child care settings.

Child care funding and funding for inclusive child care

It is increasingly being recognized that investment in high quality care during the developing years in children's lives can have wide-ranging implications for well-being, social and cognitive development, education, welfare reform, economic development, and crime prevention (Capizzano, Adams, & Sonenstein, 2000; Groginsky, Powell, & Davis, 2000). The evidence suggests that there is a substantial gap between what child care funding assistance provides and what families must pay for quality child care services (National Child Care Information Center [NCCIC], 1996). Families below the poverty line pay a much larger proportion of their income for child care than more affluent families. In 1993 child care expenses required about a fifth of the income of families below the poverty line, in comparison to less than a tenth (7%) of their income for families above the poverty line. Thus child care may be least affordable for those families most in need. If families have a child with unique challenges, child care is likely to be even more expensive, and thus less accessible even if facilities are available. The use of relatives or other 'low cost' options for child care is less likely to be available to families who have children with emotional and behavioral challenges.

In the U.S. the financing of child care derives from a variety of sources including federal funds, state funds, local funding, private funds, and public-private partnerships (Groginsky et al., 2000). Tax credits are one way in which eligible families can receive financial support for child care. These may be through federal child care tax credits for employment-related child care costs, or through state child and dependent care tax provisions. Regulations regarding eligibility criteria, such as income and age of the child, vary across states. In eight states the child care tax credit is refundable, and thus can benefit those who do not owe taxes (Groginsky et al., 2000). In 2001, of the 42 states with income tax, 27 provided child care assistance through the tax system (Ewen, Blank, Hart, & Schulman, 2002). This included assistance to families, or tax incentives to business partners to support child care.

The primary source of federal child care funding is the Child Care and Development Fund (CCDF) which finances child care services low-income families (Groginsky et al., 2000). The CCDF incorporates the former Child Care and Development Block Grants (CCDBG), and combines four existing child care programs into a single stream of funding (Kaplan, 1998). This fund comprises mandatory funds, matching funds (based on number of eligible children in the state, and state spending on child care), and discretionary funds which are appropriated annually by Congress (Groginsky et al., 2000). In 2001, CCDF funds included \$817 million in discretionary funding and \$200 million in mandatory funds (Ewen et al., 2002). The CCDF have a minimum set-aside (currently 4%) for improvement of the quality of child care, for example provider training, or expansion of infant care. Additionally, in applying for funds, states must indicate how they will give priority to children

with special needs, as defined by each state. Some states, however, have not chosen to include children with emotional or behavioral disorders within their definition of special needs (Brennan, Ama, Caplan, Warfield, & Archer, 2002).

Despite increased investment in child care assistance in recent years, a report by the Children's Defense Fund concluded that "investments are sorely insufficient in contrast to the growing need" (Ewen et al., 2002). In some states, sliding scale co-payments are required for child care expenses. This may restrict families' choices to lower cost, and often lower quality facilities. Facilities with fewer resources are less likely to include children with emotional and behavioral challenges.

In addition, funding for child care is closely linked to welfare reform through the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). This legislation represented a fundamental shift in policy. Cash assistance formerly available through Aid to Families with Dependent Children (AFDC) was replaced by benefits contingent on work activities and subject to time limits. Benefits and work requirements are reviewed periodically under the reauthorization process for allocation of funds. Adults must be engaged in work activities within two years of being on welfare, and are subject to a limit of five years of lifetime assistance (Collins, Layzer, Lee Kreader, Werner, & Glantz, 2002). Under this welfare reform states receive a block grant for Temporary Assistance for Needy Families (TANF), which is a fixed amount regardless of the number of families requiring assistance. States have considerable discretion regarding the work regulations for TANF recipients. For example, 22 states require work participation of mothers whose youngest child is under age one (Gilman & Collins, 2000). Increased work requirements place new demands on child care resources. States can transfer up to 30% of TANF funds to the CCDF, and thus use it directly for child care. These transferred funds are also subject to the CCDF quality set-aside requirements. The provision of reliable and affordable child care is clearly a key component of movement from welfare to paid work.

In addition to transfers into the CCDF fund, 10% of TANF funds may be transferred into the Social Services Block Grant Program and thus used for eligible children and families with an income less than 200% of the poverty level (Kaplan, 1998). As TANF funds are administered by individual states, decisions about allocation of subsidies vary considerably across states (Collins et al., 2002).

One of the weaknesses in the use of TANF funding for child care is that in times of economic recession, when welfare caseloads increase due to high levels of unemployment (Bonbright Thompson, 2002), these funds become vulnerable (Schumacher, 2002). Insecure funding makes it difficult to engage in long-term planning for high quality child care services that meet the needs of all families, including those who have children with emotional and behavioral challenges.

Another possible source of child care assistance is social services funding. States receive capped funds from the Title XX Social Services Block Grant (SSBG), allocated according to the population of the state. These funds may be used for a range of social services including child care for eligible families. In 1997, 14% of SSBG funds were spent on child care (Groginsky et al., 2000). Eligible child care providers can receive reimbursements for meals, as well as administrative costs, and training in nutrition and food safety, via the Child and Adult Care Food Program (CACFP). Eligibility criteria vary, but they include the type of provider, for example whether they are licensed, not for profit or for profit, and the proportion of children receiving SSBG funds (Groginsky et al., 2000).

A recent report on the use of child care subsidies across 17 states, concluded that fewer than a quarter of eligible children received subsidized care (Collins et al., 2002). Other studies indicate that in the year 2000, only one in seven of the eligible children received federal assistance (Mezey, Greenberg, & Schumacher, 2002). Waiting lists are a major problem in many states (Ewen et al., 2002). In addition, fears of creating a demand that could not be met limited outreach to the low income non-TANF population (Collins et al., 2002). Other barriers to assistance included a lack of awareness among families of the subsidies available, administrative barriers such as excessive paperwork, and stigma associated with government assistance. If families are already experiencing stress due to the difficulties of dealing with children with emotional and behavioral challenges, finding appropriate child care arrangements and pursuing child care assistance may be particularly difficult.

Child care arrangements that include children with special needs may also be eligible for funding from other sources such as education and health (Whitney, 1999). Early intervention services can be funded under the federal Individuals with Disabilities Act, either under Part C for infants and toddlers, and Part B for preschool age and older. Children aged between three and five years who have a disability may be eligible for early childhood education services provided by Head Start. Some states have Early Head Start programs which provide family support services for eligible infants and toddlers. In some states, collaboration between child care providers, early childhood education, Head Start and Early Head Start, has broadened access to funds for which child care would not otherwise be eligible (Groginsky et al., 2000).

Children with a medically proven physical or mental condition that lasts 12 months, or is expected to result in death, can receive Title II of the Social Security Act, SSI (Supplemental Security Income) Disability Benefits. Some children may be eligible for health care funding such as Medicaid, which is available to low income children under Title XIX of the Social Security Act. This type of funding may provide additional support such as consultation that enables a child to remain in a child care setting. Although

subject to national guidelines, individual states set eligibility standards for Medicaid and define the scope of the services. The Medicaid program includes Early and Periodic Screening, Diagnosis and Treatment services (EPSDT) in many states. This provides entitlement to screening and 'any medically necessary service' (NCCIC, 2002a). States can also provide health care assistance to children under 19, whose families are not eligible for Medicaid but are unable to afford private health insurance, through Title XXI of the Social Security Act, State Children's Health Insurance Program (SCHIP). These children are also entitled to EPSDT. Children with developmental disabilities or chronic illnesses may be eligible for services such as child health and specialized health services which can be funded by the Maternal and Child Health Block Grant Program (CHIP; Whitney, 1999).

Other possible sources of funding for child care include funds from unions and employers, state and local government taxes, property taxes, cigarette tax, local special taxes, voluntary donations, for example, motor vehicle registrations and renewals, tobacco settlement funds, 'sin' taxes (e.g. gambling revenues), health care funds, lottery funds, foundations and public-private partnerships (Groginsky et al., 2000; [NCCIC], 1996). Financial assistance for the construction of new child care centers has been provided by a variety of programs such as loans, loan guarantees, bonds and technical assistance (Groginsky et al., 2000). In a few states parental care for infants is supported through tax credits or by exempting welfare recipients with infants from work requirements (Groginsky et al., 2000). Other approaches include extension of the federal Family and Medical Leave Act (FMLA), or insurance programs such as the use of unemployment insurance (UI), and the use of temporary disability insurance (TDI).

It is evident from this brief review of child care funding that support for child care is complex, and subject to frequent changes. Even if families are eligible for assistance they may face obstacles arising from the need to deal with different agencies, each with their own regulations and eligibility criteria. Language and other cultural barriers may prevent families from receiving services. These difficulties are likely to be exacerbated if a child also requires a range of services such as mental health treatment, health care, and family support. While financial assistance is crucial for many families, the receipt of subsidies is not sufficient in the context of inadequate supply of high quality child care that can meet the needs of all families (Bonbright Thompson, 2002), including those with children experiencing emotional and behavioral challenges.

Research Questions

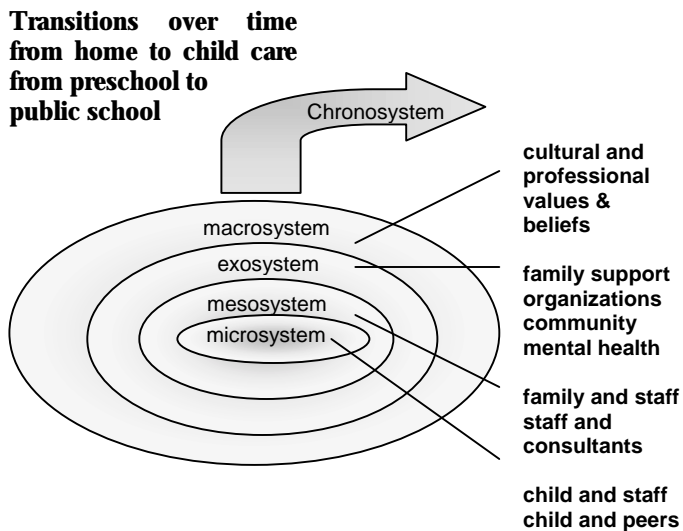
The impetus behind the study undertaken by our research team was to provide information that would be immediately useful for family members, administrators, practitioners, and policy makers who sought to create and support child care environments that would welcome children with emotional

or behavioral challenges, and who design and deliver trainings for service providers. We were striving to capture the experiences of administrators, staff, family members, and children involved in successful, supportive environments that could serve as models of practice and staff development. As we framed guiding questions for the interviews and observations we used to gather our central data, we adopted an ecological approach to the investigation that enabled us to take a comprehensive view of the complexities of the environments in which the children and child care staff existed. Therefore as other researchers of inclusive child care environments (Irwin et al., 2000; Odom, et al., 1996), we employed as a guiding framework Urie Bronfenbrenner's ecological approach to understanding the interlocking systems that affect the experiences of the developing child or youth (Bronfenbrenner, 1979, 1986, 1995).

The Ecological Framework

Bronfenbrenner posits that there are five environmental systems that may affect the development of an individual person: the microsystem, the mesosystem, the exosystem, the macrosystem, and the chronosystem. Each one of these levels is pertinent to the investigation of the development of the individual child within inclusive child care settings, as can be seen in Figure 1.1.

Figure 1.1: The ecology of inclusive child care for children with emotional or behavioral challenges and their families.



In the microsystem, the developing person experiences patterns of roles, activities, and interpersonal relations in a particular setting. For a child in an inclusive child care setting, the microsystem involves direct relationships and activities with individual staff members (including mental health staff), and with peers. The child is also involved in the microsystem of the family in which he or she experiences direct relationships and engages in activities with parents, grandparents, siblings, and other key family members. At the

microsystem level, our research team worked to determine the strategies used by administrators and child care staff to include children with emotional or behavioral problems in their child care classrooms and programs, and to discover the patterns of communication they used with the children and with each other. Observations of classroom interactions between staff and children, and children and peers were used to investigate microsystem patterns as well.

At the mesosystem level, the interrelations among the microsystem settings in which the child actively participates were examined. It is at the mesosystem level that meetings happen on behalf of the child; family members and staff collaborate with the child's mental health service provider, for example. As part of our investigation of the mesosystem level, our research group probed the strategies administrators and staff used to work with the families of the children in their centers, their partnerships with mental health consultants, and their contact with the educators working with school aged children in their care. We also asked family members about the ways in which their children's experiences in child care affected their lives at home, and their behavior at school.

At the third level, exosystem designates the settings that do not directly involve the child as an active participant, but in which events occur that have an impact on the microsystem containing the child. For inclusive child care settings, the agencies that provide training opportunities for child care professionals, as well as organizations providing mental health services and other forms of family support are key exosystems. Parents of the children also interact with their places of employment and with family support organizations in exosystems that ultimately affect their children. Therefore, we looked at strategies used by administrators to assist staff to better serve the children and families at the center, including providing training opportunities, and we asked staff to discuss the community resources that they used to assist children and families served by their center. We also asked families about the work, training, and educational endeavors they were engaged in while their children were in care.

Macrosystems are the cultural, value, and belief consistencies in lower-order (micro-, meso-, or exo-) systems. Inclusive child care settings are immersed in the cultural and professional belief and value systems of our society. Often the staff in these settings encounter challenges in adapting to families from differing cultural and belief systems, and their practices are shaped by societal expectations and regulations. Our questions to administrators and staff involved explorations of cultural challenges they have encountered in their work with the families they served. We also asked them about regulations that affected the centers and about funding supports for the services they offered.

Finally, Bronfenbrenner (1995) has added the concept of chronosystem to give life and shape to changes experienced by the developing child moving through environmental events and transitions over the life course. Our study captured data at one point in time for each center, visiting sites for about one work week, and interviewing staff and families by phone over a period of a few months. Nevertheless, we asked family members about the changes they experienced in having their child served at the model center as opposed to earlier child care experiences. Also in the course of interviews, family, staff, and administrators discussed their perceptions of the transition of children with mental health challenges between preschools and public schools, capturing the chronosystem in a limited way.

Research Questions in an Ecological Framework

The ecological framework has given shape to the three major questions that have guided this study:

1. *What are the characteristics and practices of child care programs nominated for their inclusiveness which are associated with quality care for children and youth having emotional or behavioral disorders?* In answering this question, we also planned to investigate the perceptions of family members and child care providers about what Irwin et al. (2000) termed the abstract factors that are related to successful inclusion, such as commitment, funding, the basic structure of programs, and family participation.
2. *Which organizational factors contribute to the ability of child care providers to deliver high quality, culturally-appropriate services to children and youth having emotional or behavioral disorders?* Here we hoped to explore the ways in which the organizations functioned, and the means by which staff members were trained on site by other staff, through their contacts with parents, and by means of informal and formal educational programs to adhere to the highest standards of service delivery.
3. *What are the barriers to achievement of inclusive child care in these programs, and the strategies successfully used by providers and family members to overcome these barriers?* Finally, we sought to learn directly from family members, administrators, and staff about the barriers they saw to inclusion, and ways that they believed those barriers had been, or could be, overcome. To that end we investigated the perceptions of family members of children with mental health issues, as well as parents of children who were developing typically. We also talked with administrators and staff concerning their personal and professional challenges in their work, and explored their creative solutions to these challenges.

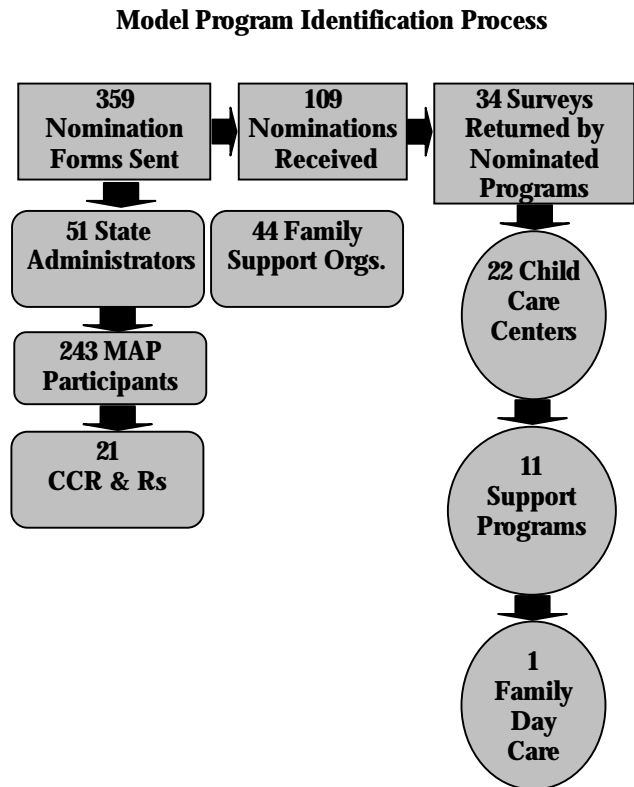
Chapter 2: Methods

This chapter describes the process of designing the research and collecting the data for the Models of Inclusion Study. The overall goal of the project was to identify best practices in child care arrangements that include children with emotional and behavioral challenges. Thus the first step was to identify child care arrangements that successfully include this group of children along with typically developing children. The second step was to choose data collection methods that would facilitate an in-depth understanding of inclusive child care, and capture the experience of both families and providers.

Identifying the Centers

The process by which child care centers were identified and selected for the study is illustrated in Figure 2.1 below.

Figure 2.1 The Nomination Process



A total of 359 nomination forms was sent to state child care administrators, family support organizations, child care resource and referral agencies (CCR&R), and participants in the Map to Inclusive Child Care (a technical assistance grant funded by the Child Care Bureau and the U.S. Department of Health and Human Services between 1998 and 2000). This process resulted in 109 nominations of programs representing every region of the United States. Each nominated program was sent an 8-item brief survey to collect further information, such as the services provided, the families served, and the role of families in the program, together with a consent form for research participation. A response rate of 31% (n = 34) was obtained.

The data from these 34 centers were analyzed, and from this analysis, 9 child care centers were selected for in-depth study. The selection of sites for study was done by a coordinating group consisting of project staff, two experts on child care, experts in family support and children's mental health, and consultants who are parents of children with emotional or behavioral challenges. Selection criteria encompassed: (a) inclusion of children with emotional or behavioral disorders in the program along with children who were developing typically; (b) reputation for high quality service delivery or training; (c) attention to the delivery of culturally-appropriate services; (d) participation of family members in design and execution of program features; (e) use of model communication strategies to link parents and providers effectively; (f) representation of a diverse set of programs; and (g) the opportunity to learn from the selected program.

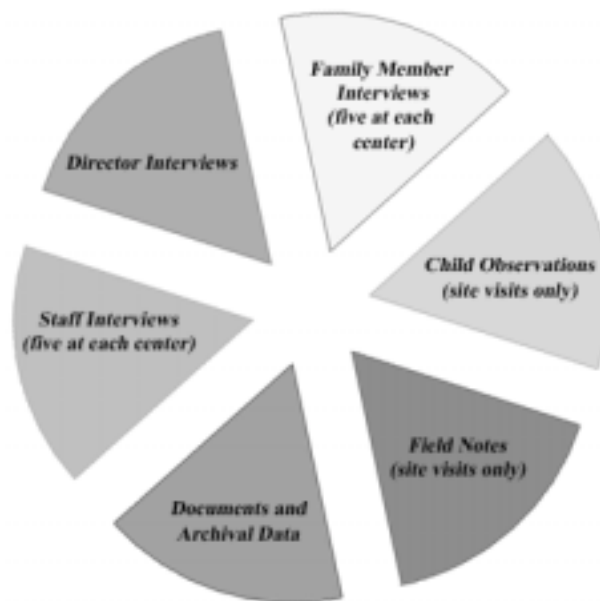
In-depth Study of the Centers

Recruitment and consent forms were sent to the nine centers that were selected and agreed to participate in the study. The data collection plan for each center is described in Figure 2.2. Data were collected from February 2001 through July 2002.

Of the nine centers, data were collected on-site from five centers, and by telephone from four centers.

A qualitative approach, based on case study methodology using multiple sites and multiple informants, was selected as the most appropriate method to gain insight into the perspectives of providers of inclusive child care, and the families who used their services. Data were collected by a variety of methods, including individual interviews, naturalistic observations, field notes recorded during site visits, and archival documents.

Figure 2.2: The Site Data Collection Plan



Interview Schedules

The goals of the study, consultation with the project advisory group, and a review of previous research informed the design of the interview schedules. Pilot interview schedules were revised in response to interviewee feedback. Separate schedules were prepared for the directors' interviews, family members' interviews and the staff interviews. Each schedule included both closed questions (e.g. demographic information, center characteristics, services offered) and open questions (e.g. What can we learn from your experiences? [family member]; What are your special challenges? [staff and directors]). As Table 2.1 on the following page shows, some questions were common to each of the three groups, while others were tailored to be more relevant to the specific experiences of the interviewee group.

Once informed consent forms had been completed, the directors from the selected child care centers were contacted by telephone to schedule individual interviews. These interviews lasted from 90 to 180 minutes.

The center directors then facilitated recruitment of the remaining study participants by distributing an information packet to staff and family members. This packet included a description of the purpose of the study, recruitment flyers, and appropriate consent forms. Confidential individual interviews, lasting 60-90 minutes, were conducted by appointment, recorded with permission, and transcribed verbatim. All of the interviews were recorded, except one not recorded due to technological failure. Family members and staff who participated in interviews received a payment of \$30.00. All participants in the study were assured that the findings would be presented in collated form, so that family members and staff would not be identified individually.

Table 2.1. Summary of items included in interview schedules

Question Type	Family Member Interviews	Director Interviews	Staff Interviews
Closed interview question topics	<ul style="list-style-type: none"> • Employment information • Child care arrangements • Child characteristics • Standardized quality of child care scale* 	<ul style="list-style-type: none"> • Center Information • Services provided • Families served • Staff characteristics 	<ul style="list-style-type: none"> • Job information • Education, training, experiences • Children served • Demographic information
Open-ended interview question topics	<ul style="list-style-type: none"> • Employment information • Child care arrangements • Child characteristics • Standardized quality of child care scale* • Reasons why center selected • Previous child care experiences • Experiences of working with staff in center • Involvement in Center • Experiences of an inclusive environment • Concerns about child care in the center • General concerns about child care • Lessons to be learned • Suggestions for improvement • Any other information 	<ul style="list-style-type: none"> • Center Information • Services provided • Families served • Staff characteristics • Training • Program goals • Cultural challenges • Role of families in the center • Communication with families • Community Resources used • Challenges and barriers • Lessons to be learned • Suggestions for improvement • Any other information 	<ul style="list-style-type: none"> • Job information • Education, training, experiences • Children served • Demographic information • Ways of working with families experiencing difficulties, including an example • Cultural issues • Role of families • Communication with families • Resources used • Challenges • Lessons to be learned • Suggestions for improvement • Any other information

* Adapted from (Emlen, 1997) Interview Schedules

Field Notes

Researchers also made jotted notes (Bailey, 1996) regarding observations, personal responses, and relevant theoretical issues during site visits. Field notes recorded conversations, informal discussions, staff meetings attended by researchers, and other encounters with staff outside of the formal interviews, such as meetings with administrators who provided collateral information about the centers.

Archival Data

In addition to the interviews, the research team also obtained information from available printed and videotaped sources such as mission statements, brochures, intake forms, staff handbooks and training materials, historical documents, and other policy documents. Researchers photocopied printed materials that were available. Directors offered additional

documents as a result of information exchanged during the formal interviews. These data were used in conjunction with interview data as the basis for the descriptions of the nine centers which are presented in a later chapter.

Child Data

Two researchers simultaneously observed an individual child in one-hour observation blocks following consent by the parent and with assent from the child. The purpose of these naturalistic observations was to investigate the role of caregivers in inclusion practices and evidence of inclusion in child-to-child interactions. Observations were scheduled during a transition time, such as preparation for lunch. A total of 25 child observations were completed (five at each of the sites visited). The sample, which included children with

and without challenges, is described in more detail in the report of the findings in chapter 7. In addition parental and child consent was obtained to conduct face to face interviews with five school-age children. These children were asked what they were learning, what they liked or did not like about being at the center, and how it compared with other centers they had attended. Researchers recorded the child observations and interview responses by hand.

Analysis

Quantitative data on demographics was entered into SPSS, which was used to analyze descriptive statistics. The qualitative data were analyzed using a grounded theory approach (Strauss & Corbin, 1990). Interview transcripts were coded and analyzed by a minimum of two members of the research team. The transcripts were coded separately using 'working labels' (Morse, 1994) to interpret the data.

The interpretations of the individual researchers were then discussed to examine reliability, and to discuss the validity of the coding scheme. Data interpretations were also checked with family members. The coding scheme developed by the research team was entered into NUD*IST (Qualitative Solutions and Research Pty Ltd, 1993) for further analysis. This facilitated further exploration of the data to analyze relationships between categories (Gahan & Hannibal, 1998), and similarities and differences across the study sites (Miles & Huberman, 1984).

The Participants

As discussed above, the research was designed to encompass the perspective of both families and child care providers including staff and directors. Table 2.2 lists the participating centers, and gives an overview of the final sample of participants in the study. Additional information about the centers and the participants is provided in later chapters.

Table 2.2. The final sample for the study

Site	Location	Family Member Interview	Child Interview	Director Interview	Staff Interview	Observations
1	Little Angels Center, Milwaukie, OR	6	1	1	5	5
2	Broken Arrow Club House, Broken Arrow, OK	5	3	1	5	5
3	Saint Benedict's Special Children's Center, Kansas City, KS	5	1	1	5	5
4	Fraser School, Richfield, MN	6	-	1	5	5
5	Family Resource Center, Lenoir, NC	6	-	1	6	5
6	Kinder Haus Child Care Center, Inc., Morgantown, WV	4	-	1	3	-
7	River Valley Child Development Services, Huntington, WV	1	-	1	4	-
8	McCambridge Center Day Care, Columbia, MO	2	-	1	2	-
9	Wayzata Home Base, Plymouth, MN	5	-	1	4	-
	Total	40	5	9	39	25

Chapter 3: Profiles of the Model Centers

Broken Arrow Club House Broken Arrow, OK

Broken Arrow Club House, in Broken Arrow, Oklahoma, currently serves children ages three to thirteen, with all programs at one site. The facility is conveniently located just outside of Tulsa, OK on approximately one acre of land, near a major thoroughfare. Broken Arrow Club House currently serves children ages three to thirteen, with all programs at one site.

Services

Broken Arrow Club House was founded in 1978. It is sponsored by the Wagner County Learning Center, Inc. Broken Arrow Club House serves 100 children, offering an early childhood education program that includes a preschool program, private kindergarten, before and after school care, vacation and drop-in care, as well as a summer program. The center provides families with mental health consultations, transportation services, and child care resource and referral counseling. Additionally, Broken Arrow Club House serves the community by providing trainings and technical assistance to staff members at other centers, and by consulting to other child care providers.

Mission Statement

The mission of Broken Arrow Club House is to introduce children to (life living) skills at their developmental level, and to assist each child in developing a firm foundation that will sustain them toward becoming contributing adults. The Broken Arrow Club House philosophy is built on trust and respect for each child and all that encompasses the child.

Families

The majority of parents utilizing the services at Broken Arrow Club House are employed full-time. Well over half of the children served reside in families that are headed by a single parent and live in a suburban setting. Of the children currently enrolled at the center, more than half are European Americans in families with middle- or upper-level incomes. One in five of the families served have an income that falls below the state poverty level. Of the children served at Broken Arrow Club House, nearly half are typically developing children.

Funding

Broken Arrow Club House receives funding from State child care subsidies, State welfare funds and parent private funds. The center receives additional funding through the Child Care Developmental Block Grant and through contracts with the Creek and Cherokee Nations.

Staffing

There are currently seven full-time and seven part-time staff members employed by Broken Arrow Club House. Staff turnover rates are low. Many staff member have been with the center for several years, including a teacher who has worked at Broken Arrow Club House for 20 years and a van driver who has been with the center for 15 years. In addition to the child care staff, the center also has a mental health counselor that works on-site half a day each week.

Quality

Broken Arrow Club House is rated as meeting the highest standard of licensing set by the State of Oklahoma. Approximately one-third of the current staff members had special training in child care prior to working at Broken Arrow Club House and every staff member has completed 20 hours of additional training per year. Staff/student ratios are: 1:8 for two to four year olds; 1:10 for three year olds; 1:12 for four and five year olds; and 1:17 for school-age children. In addition, there is a master teacher for every twenty children in the building.

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Broken Arrow Clubhouse, Broken Arrow, OK



Private spaces and cubbies maximize space and allow children to feel safer at the Broken Arrow Club House.



Children play at a 'manipulatives' table.



Circle time at the Family Resource Center – note the ratio of adults to children



Family Resource Center Lenoir, NC

Family Resource Center, in Lenoir, North Carolina is housed in a multipurpose facility, designed for children and families, located in a large retail setting. The center houses multiple agencies and projects, and has been in operation since 1995. It is a collaborative organization sponsored by the Family, Infant, and Preschool Program (FIPP) of the Western Carolina Center. Family Resource Center currently serves children ages seven months to eight years, with additional services provided at West Lenoir Elementary School, and an apartment unit at the nearby Housing Authority.

Services

Serving over 10,000 children and family members annually, the Family Resource Center primarily provides resources for children birth through five and their families. It offers play groups, art and music groups, parent support groups, parent education, drop-in respite care, a parents' afternoon out program, child care resource and referral, early intervention activities, child evaluations, contextually mediated intervention and therapy, as well as a comprehensive family literacy program with an ESL component. In addition, the Family Resource Center provides adult education, nutrition classes, a foster care program, and a lending library. The Family Resource Center also serves the child care community in Caldwell County by providing technical assistance and training for child care providers to promote successful inclusive practices in child care and preschool programs. Collectively, the agencies and projects with office and program space at the Family Resource Center offer a wide range of services to the community.

Mission Statement

The Family Resource Center collaborates with other agencies to provide a variety of family-centered resources to families with young children. It is designed to be a program where inclusion happens easily and naturally. The center is strengths-based. The lead agency's (FIPP's) mission is to promote the growth and development of young children by supporting and strengthening families and building caring, responsive communities.

Families

The majority of children served at the Family Resource Center reside in families that are headed by two parents and live in a rural setting. Most of the children currently participating in services are European American; substantial numbers of families are Hispanic/Latino. The majority of the families have low-middle to middle class incomes, with one in five children living in families that have incomes below the State poverty level. The Family Resource Center strives to partner with families to promote health and readiness to learn among children.

Funding

Funding comes from collaborative agencies, businesses, grants and fund raising activities. Family Resource Center is a recipient of the Even Start grant and also receives Smart Start funding. The center receives funding through a Ross grant to provide child care services to residents of the Housing Authority. The Parents Afternoon Out Program is funded through parent fees.

Staffing

There are currently 12 full-time and 20 part-time staff members employed by the various agencies of the Family Resource Center. A behavioral specialist, employed by the Foothills Area Mental Health Program and funded through Smart Start, provides home visits and consultation services to staff and families.

Quality

Ninety percent of the staff members at the Family Resource Center had special training in child care before working at the center. One of the lead teachers in the Family Literacy Project is a certified birth to Kindergarten teacher. Each staff member of the Family Literacy Project is required to participate in at least one State conference every year and lead agency (FIPP) staff participate in substantial ongoing in-house training. Community volunteers serve on the center's Resource Council and the steering committee for the center's fundraising campaign. Volunteers also provide direct services, including music activities, storytelling, reading time, and art activities. The Family Resource Center also utilizes college student interns to provide services. The Staff/student ratios are: 1:4 for children aged birth to two; 1:5 for children aged two to three; 1:5 for children four to school age; and 1:5 for school aged children. As the center provides no more than four hours of child care at a time, the Family Resource Center is exempt from State licensing requirements.

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Fraser School Richfield, MN

Fraser School is located just outside of Minneapolis, in the suburb of Richfield, Minnesota. It is housed in a large brick building with one and a half acres of outdoor space, and all programs are provided on site. In addition to the spacious playground area, there is a large gymnasium, several outdoor courtyards, and extensive therapy and play equipment. Fraser School currently serves children from three months to six years of age.

Services

Fraser School is a non-profit organization that was founded in 1935 and is sponsored by the Fraser organization. Fraser School serves 325 children, offering infant care, toddler care, preschool, extended care for children three to six years old, early childhood special education, therapeutic services, parent support services and respite care. Music therapy is provided to all children within the classroom setting and is also available on an individual basis. In addition, Fraser School provides transportation services for children and parents to and from the program as needed, as well as home or in-center visits with a family worker.

Mission Statement

Fraser's mission is to serve children, adults, and families with special needs to assist them in maximizing their abilities and realizing their potentials. Fraser School believes in celebrating differences, as well as similarities, and strives to collaborate with all of the systems and people involved in the life of a child.

Families

The families receiving services from Fraser School come from a variety of socioeconomic levels, cultural backgrounds and family structures. Just under half of the children served come from middle class families, with nearly one in five children living below the state poverty level. Over half of the families live in urban settings, with the remaining children residing in suburban settings. Of the children currently enrolled at Fraser School, the majority are European Americans residing with two parents. Fraser is family-centered, parent-driven, and believes in supporting families, thus enabling parents to have more opportunities to enjoy their children.

Funding

Parent private funds provide a large proportion of the funding for Fraser School, but the school also receives funds from child care subsidies, public school funding for early childhood special education, county funding, and from corporate donations and fundraising efforts.

Staffing

There are currently 30 full-time and 35 part-time staff members employed at Fraser School. The staff includes an occupational therapist, music therapist, physical therapist, speech and language pathologist, social workers, and a registered nurse. Staff members are provided a variety of training and supports to ensure that each child's needs are met.

Quality

Fraser is NAEYC accredited and licensed under Minnesota Rule Three. Three quarters of the staff have had training in child development or child care and the majority of the classroom assistants are currently college students. All staff members participate in seven in-service training days per year. Staff/student ratios are: 1:3 for children aged birth to two; 1:5 for children aged two; and 1:8 for children three to school age.

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Social development as a foundation for learning.'



Kinder Haus Child Care Center, Inc. Morgantown, WV

Kinder Haus Child Care Center currently serves children 8 weeks to 12 years old and has three locations: Kinder Haus, Kinder Tots, and Bundles of Joy. Kinder Haus is located on the ground floor of an office building, one mile south of the Morgantown city limits. Kinder Tots is housed in a freestanding two-story building within one mile of the Kinder Haus site. The Bundles of Joy location is housed in an office and retail complex in Westover, just west of Morgantown.

Services

Kinder Haus Child Care Center is a for-profit agency that was founded in 1985. Kinder Haus serves 226 children, offering child care, early childhood education, Head Start, summer care, transportation, and before and after school care. In addition, Kinder Haus serves the community by providing child care consultation and provider training for staff at other child care facilities.

Mission Statement

The program objectives for Kinder Haus are to provide experiences which promote the individual child's physical, emotional, intellectual and social growth. Kinder Haus has a qualified staff dedicated to serving children, and has a primary goal of providing quality inclusive child care services.

Families

The majority of the children served are European Americans, living with a single parent in a rural setting. Most of the children served by Kinder Haus reside with a parent that is either working full-time, or attending a full-time educational program. Sixty-five percent of the children live in families with an income that is below the state poverty level. Of the 226 children enrolled, 97 of these children are state subsidized, and 120 qualify for free or reduced meals. Family participation in planning for individual children is encouraged through volunteer opportunities in the classrooms, and program evaluations where parents share their ideas and suggestions for improving the center.

Funding

Kinder Haus receives funding through State and Federal child care subsidies, a grant from the Monongalia County Head Start, an Educare grant, and parent private funds. Assistance is available to some low-income families through the Department of Health and Human Resources.

Staffing

There are currently 80 full-time and 15 part-time staff members employed by Kinder Haus. Staff turnover is low. While the average length of service for the teaching staff is four years, Kinder Haus currently has two teachers who have been with the center for fifteen years. On average, the teaching assistants remain in that position with the center for one year, but typically move up into teaching positions. At present, only two of the lead teachers did not start as teaching assistants. In addition to the child care staff, Kinder Haus has access to a mental health specialist. Through a grant from Head Start, the center also has two family service workers.

Quality

Kinder Haus is NAEYC accredited and is licensed by the State Department of Health and Human Resources, the State Department of Health, and the State Fire Marshal's Office. Kinder Haus also participates in the Federal Child Nutrition Program. Staff members attend at least six trainings or workshops per year and receive a minimum of eight hours of first aid training annually. Kinder Haus is registered with the Department of Labor as a certified apprenticeship sponsor, allowing its staff access to training and certification after completion of a two-year course. In addition, each location has security cameras and monitors as a component to their quality structure, and every parent has full access to the video taped recordings. Staff/student ratios are: 1:4 for children birth to two; 1:8 for children aged two to three; and 1:10 for children four to school age.

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Little Angels Center Milwaukie, OR

Little Angels Center is a non-profit organization which opened in 1999. It is located near the Portland metropolitan area, in the suburb of Milwaukie, Oregon. The center is housed in a 2500 square foot church building, with three classrooms and a large fenced playground area. All programs are provided on site.

Services

Little Angels Center serves approximately 35 children on a regular basis from four months to twelve years, although its primary age group ranges from six weeks to five years. The agency offers an inclusive child care program for children with and without special needs, respite care and support services for families, information and referral services, training and internship opportunities, and volunteer opportunities. 120 children were served last year (7/01 – 6/02) in respite care – over 5000 direct service respite hours in all.

Mission Statement

The primary mission of the Little Angels Center is to provide affordable quality child care to children with special needs in a safe and enriching environment. The staff have adopted the following philosophy, “The Little Angels Center values each child’s individuality and special gifts and we respect the family as experts regarding their child. Little Angels recognizes that each child is an individual and this is reflected in the care that they provide.” The children at the center are grouped according to abilities and interests, not age or disability.

Families

Of the children currently enrolled at the center, over 85 percent are European Americans. More than half of the children live in families with middle-class incomes, while 10 percent live below the state poverty level. The majority of the children served by the center reside in families headed by two parents and live in an urban setting. 90% of the children at the center have special needs.

Little Angels Center offers a Parent Co-op Program for families. This program is designed to allow parents to work 20 hours per month at the center in exchange for a discount on their child's tuition. Program activities can include, but are not limited to, child care, office work, sanitation, yard work, and maintenance.

Funding

Little Angels Center receives funding from a range of sources including the Clackamas County Commission on Children and Families child care block grant and Family Preservation dollars. Oregon Community Foundation grants, parent scholarships from Portland Community College, State subsidies from Oregon Development Disabilities Council in partnership with the Child Care Division, and from fundraising efforts. Past sources of program support include: Meyer Memorial Trust, Pacific Gas and Electric, and the Arlene Schnitzer Foundation.

Staffing

There are currently five full-time and five part-time staff members employed by Little Angels Center. The center has a physical therapist on site eight hours per week who provides behavioral consultations and developmental assessments. Little Angels also has a nurse who is available by phone for medical consultations. Little Angels Center was one of the first sites working with pilot project consultation with mental health professionals and behavioral specialists.

Quality

Little Angels Center is certified through the State Child Care Division. In addition, additional specialized training is provided for those who wish to extend their training. Staff/student ratios are: 1:4 for children birth to thirty months; 1:4 for children aged thirty months to three; average 1:4 for children four to school age; and average 1:4 for school aged children. A ratio of up to 1:6 may be utilized depending on the ages, abilities and needs of child in the group.

McCambridge Center Day Care Columbia, MO

Mc Cambridge Center Day Care is located in Columbia, Missouri, a college community with a population of 75,000. The center is centrally located, approximately one mile from downtown, with day care services provided in an attached building.

Services

Mc Cambridge Center Day Care is sponsored by the Family Counseling Center and serves 10 children, between birth and thirteen years. The organization offers center care, summer care, drop-in care, before and after school care, child care resource and referral counseling, early childhood education, individual, group and family therapy, play therapy and parenting classes. Of the children enrolled, about half have mothers with a history of chemical dependency who are attending a local residential and outpatient substance abuse program.

Mission Statement

The Mc Cambridge Center's mission is to serve children with special needs in an inclusive environment. First and foremost Mc Cambridge Center Day Care seeks to provide a safe and healthy atmosphere for each individual child. Each child shall be assured of achieving success in his or her environment through a multi-dimensional arena of experiences, including social, emotional, cognitive, motor skills, and language acquisition at an age-appropriate level.

Families

The majority of the children served at the center are African American or European American and live in a single parent family. Most of the children live in a suburban setting, and have parents that are employed full-time. Ninety-two percent of the families served live below the poverty level. More than 80 % of the children at McCambridge Center have emotional or behavioral challenges. The center specifically seeks typically developing children in order to provide an inclusive environment.

Funding

Mc Cambridge Center provides services through the use of state welfare funds, State child care subsidies, funds from the Department of Mental Health, Division of Alcohol and Drug Abuse, The City of Columbia grant funding, parent insurance for mental health services, and parent private funds.

Staffing

There are currently three full-time and six part-time staff employed by Mc Cambridge Center Day Care. In addition to the child care staff, the center has a licensed Masters-level counselor who provides individual and family therapy.

Quality

Mc Cambridge Center is licensed by the Division of Family Services and is NAEYC Accredited. All staff members have had special training for work in child care before coming to Mc Cambridge Center. The Director of the center has a Doctorate in Clinical Psychology, while the majority of the child care staff has completed some college coursework. All employees receive a minimum of 30 hours of training per year. Staff/student ratios are: 1:4 for children birth to two; 1:10 for children aged two to three; 1:10 for children four to school age; and 1:10 for school aged children.

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River Valley Child Development Services Huntington, WV

River Valley Child Development Services, located in Huntington, West Virginia is the second oldest child care program in the metropolitan area. It is a non-profit organization that was founded in 1972 and serves children and families in twelve counties. The agency has three centers located within the city limits, including a site at Marshall University. The organization also has two smaller, rural centers in Lincoln County and in Mason County, housed at a vocational school. The school-age programs are located at six elementary schools, five in Campbell County and one in Wayne County.

Services

River Valley Child Development Services serves 336 children between the ages of 6 weeks and 12 years, offering an after school program, child development program, summer program, Birth to Three Early Intervention Program, family day care food program, parent education and visitation program, and child care resource and referral services. The organization has an apprenticeship program for child development specialists. This training program was developed in coordination with the U.S. Department of Labor, Bureau of Apprenticeship Training for persons working in early child care and education programs. Additionally, River Valley Child Development Services serves the child care community by providing behavior management consultation to licensed child care centers, as well as educational, and resources related to training opportunities and the allocation of child care resources.

Mission Statement

The River Valley Child Development Services mission is to provide high quality, educational and developmental services to children and their families in a nurturing and individually appropriate setting. River Valley Child Development Services envisions a society in which all children and their families have access to a full spectrum of educational, social and developmental programs, regardless of their cultural, social, and economic backgrounds, or their physical, mental or emotional differences.

At River Valley Child Development Services families and staff are partners in providing care for children. The organization has stated its commitment to advocating on behalf of children and families and to the importance of family in a child's life. The staff works as a team with the families, and acknowledges the dignity and uniqueness of each individual.

Families

River Valley Child Development Services has a long history of accepting children on a first-come, first-serve basis without regard to their abilities. The families of the children served vary in income, family structure, and education. The

majority of the children's parents either work or attend school. Thirty-three percent of the families served have an income that is at or below the state poverty level. River Valley Child Development Services makes efforts to involve parents through parent advisory committees, parent conferences, volunteer opportunities and providing suggestions for activities that parents can do with their children at home.

Funding

River Valley Child Development Services receives funding from state and federal child care subsidies, state welfare funds, state funds for early intervention, a grant from the West Virginia Department of Health and Human Resources, a grant from the Department of Education, and parent private funds. An additional source of financial assistance comes from assessments on student tuition at Marshall University, since the center serves the children of students from this university.

Staffing

All of the teachers at River Valley Child Development Services have received special training for work in child care prior to becoming employed at the center. In-service trainings are provided each year for all staff members and each member of the staff has an individual professional development plan. To be a teacher with River Valley Child Development Services, an individual must at least have a child care apprenticeship certificate from a two-year program, but several teachers and assistants currently at the center have bachelor's degrees. River Valley Child Development Services utilizes student interns and Foster Grandmothers to assist with classroom activities and the nurturing aspects of the child care.

Quality

River Valley Child Development Services is licensed by West Virginia Department of Health and Human Resources, accredited in 1990 and 1994 by the National Academy of Early Childhood Programs and is NAEYC accredited. Staff/student ratios are: 1:4 for children birth to two; 1:7 for children two to three years of age; 1:10 for children four to school age; 1:15 for school aged children.

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St. Benedict's Special Children's Center Kansas City, KS

St. Benedict's Special Children's Center was founded in 1989 and is sponsored by Catholic Community Services. The facility is located in a convenient urban setting in Kansas City, Kansas. All the programs are provided at a single site, housed in a building that was a former Catholic school.

Services

St. Benedict's is licensed to care for 91 children, offering day care, early childhood special education services, transportation for children to and from the school, parent education, home visits, and a teen parenting program. The center has collaborative agreements with Project Eagle Early Head Start, Head Start, and Wyandotte County Special Education Cooperative.

Mission Statement

The St. Benedict's Special Children's Center is dedicated to giving quality day care to children in the Wyandotte County area, especially those with special needs, from two weeks to six years of age. We maintain an atmosphere of attention, acceptance, encouragement and security to fortify each child's self-esteem.

Families

St. Benedict's Special Children's Center serves families who live in the poorest neighborhoods in Wyandotte County. Most of the families of children at St. Benedict's earn less than \$12,000 per year. Almost all of the children are members of families who qualify for the State of Kansas free lunch program. (In order to qualify for the free lunch program, a family of four must make less than \$22,000 annually.) Of the children enrolled at the center, nearly 80 % are Latino or African American; one in five have developmental delays or handicapping conditions; one in five use English as a second language; and one in four have teenage mothers who attend high school.

Funding

Parent fees and reimbursements only cover 40% of St. Benedict's operating budget. The remaining \$350,000 per year is obtained from fundraising through Catholic Charities' development effort from individuals, corporations and private foundations. St. Benedict's receives Early Head Start and Head Start funds and some funding for staff members comes from the Kansas City, Kansas School District, as well as from categorical aid.

Staffing

There are currently 25 full-time staff members and one part-time staff member employed by St. Benedict's Special Children's Center. Through the Wyandotte County Special Education Cooperative, St. Benedict's has a consulting early childhood special educator, a social worker, an occupational therapist, a physical therapist, and a speech pathologist. Through a grant from Children's International, St. Benedict's also has nursing services available to the children that are provided by the University of Kansas School of Nursing.

Quality

Nearly 70 % of the lead teachers have had special training for work in child care prior to coming to St. Benedict's. Two of the lead teachers have Master's degrees in Early Childhood Education and one has a Bachelor's degree. The center works with the University of Kansas Early Childhood and Special Education Program to coordinate practicum experiences for Early Childhood Special Education students who volunteer at the center. St. Benedict's also has Masters-level social work students on site. Staff/student ratios are: 1:3 for children aged birth to two; 1:5 for children aged two to three; 1:6 for children four to school age. St. Benedict's is currently working toward becoming NAEYC accredited.

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Wayzata Home Base Plymouth, MN

Wayzata Home Base is located in Plymouth, Minnesota and currently serves children aged five to fourteen years. Before and after school services are provided at seven elementary schools, with the summer program hosted at a middle school. Each program is located directly on-site, providing easy access for children and parents. Each Home Base location has designated classroom space, as well as full use of the playground, computer lab, and gymnasium.

Services

Wayzata Home Base, a non-profit organization, was founded in 1981 and is sponsored by Wayzata Public Schools, ISD #284. Wayzata Home Base serves 1,300 children, offering before and after school care, summer care, transportation services, vacation care, mental health consultations and drop-in care. Wayzata Home Base has been designed to serve the child care needs of District 284 parents with children enrolled in grades kindergarten through fifth. Additionally, Wayzata Home Base serves the broader community by providing child care consultation services to other child care providers.

Mission Statement

Wayzata Home Base is a place where each child is a cherished member of the team, where each child's unique personality and talents contribute to the beauty and diversity of the group. Each child at Home Base will be nurtured, kept safe, and encouraged to grow and develop at his/her own pace and in the direction of his/her own choosing. Through all our activities and interactions we are striving to show children how to feel good about themselves, make choices, negotiate differences and contribute in healthy ways to their community. We believe peace is possible and it can grow and flourish right here. We regard children as intelligent human beings, respect them and treat them with gentle care.

The staff at Wayzata Home Base have stated they view their work with children as both a job and a joy. They describe their role as crucial to the lives of children who might otherwise be home alone.

Families

The children served by Wayzata Home Base are predominately European Americans from dual income families with middle- to upper-middle class incomes. The majority of the children served at Wayzata Home Base are typically developing students who live in a suburban setting. Family participation is encouraged through opportunities for parents to volunteer on the Wayzata Home Base Advisory Board.

Funding

Services are parent fee-based and the majority of the funding for Wayzata Home Base comes from the families. Scholarships are available for children who lack the necessary resources, and a small number of families receive child care subsidies from the county.

Staffing

There are currently 65 full-time and 40 part-time staff members employed by Wayzata Home Base and employee retention rates are high. Three-quarters of the staff have had special training for work in child care prior to being employed with the program. Twenty-five staff members have an Associates degree, while 6 have Bachelors degrees and 50 have previous experience working in child care centers. Several staff members are college students working on degrees in elementary education or social work. Wayzata Home Base partners with the school district, working with school social workers and assisting in developing behavior plans. In addition, Wayzata Home Base provides paid internships for two elementary education students and one social work student.

Quality

In-service trainings are provided for all staff members one time per month. Safety issues are addressed through a restraint training that is provided to all staff members. Staff/student ratios are: 1:12 for children five years of age and 1:15 for children six to twelve years old.

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Chapter 4: Directors' Perspectives “That’s Our Challenge—to Make a Real Difference for the Children.”

Center directors provided insight into the reasons that the nine programs selected for our study were able to provide effective child care for some of the most challenging children in their communities. The interview with each director served as the entry point for our research team into the center, and was the first data collection activity for each site. Directors set the context for our staff and family interviews, our observations of the directors, children, and staff participating in the life of the center, and our collection of center resources in the form of published materials, videotapes, and pictures.

Interviews ranged from one to two hours in length, and were conducted by the principal investigator. Of the nine directors interviewed, seven were female. The directors managed child care programs of varying sizes, organizational structure, location, and history. A description of each of the nine centers is presented in Chapter 3. The number of children enrolled in the centers ranged from 32 to 1300, with a median number of 150. The directors managed between 4 and 80 full-time staff, and between 1 and 40 part-time staff. The median number of full-time staff was 25, and of part-time staff was 10. The centers included both non-profit and for-profit centers.

Directors responded to specific questions concerning the characteristics of their centers, their staff, and the families they served. They were also asked broad questions which attempted to gather information on the ways that the families of children with emotional or behavioral challenges were included fully in their centers, and on the organizational dynamics that made it possible to serve these children together with typically developing peers. Because we also wanted to focus on the social ecology of the centers, we asked directors to reflect on the supports they received and challenges they faced within their communities.

Four major sets of findings emerged from our qualitative analysis: (a) the philosophy and mission of the centers; (b) the centrality of families in the organizations; (c) the emphasis on committed staff, solid practice strategies, and use of specialized supports; and, (d) the community contexts of the centers.

The Philosophy and Mission of the Centers

While directors were never explicitly asked to reflect on the philosophy guiding their work with children and families, all nine of them addressed the philosophical basis of practice in their centers. Directors stated that they intentionally communicated the center's mission to the staff, and worked to have staff members adopt the program's philosophical principles. Although five common principles were identified through our qualitative analysis, some inter-center differences in philosophy were also detected.

Value and Accept All Children

All nine directors spoke of a universal valuing and acceptance of children, regardless of their abilities or challenges. One director put it this way:

We have a long history...of accepting children on a first-come, first-served basis without regard to their abilities...We try so hard to support all children regardless of their abilities, their socioeconomic status, their family structure. We try not to make an issue of that at all.

Another director stated, "I think that we are really succeeding with the kids that are at risk, not feeling in any way that they are different from the other children." Emotional or behavioral disorders were considered to be a special need no different than physical differences or medical needs. Directors also emphasized that they were striving for complete inclusion of children with emotional or behavioral challenges in their centers, not just physical integration into the same environment. One administrator stated that it was not satisfactory to merely have parallel play, but the staff worked to have children with mental health needs "interacting with the other kids and being successful."

Although all centers included children who were typically developing, a few of the directors stated that their mission was specifically focused on children with special needs. Sometimes this took the form of preference for admitting children who were in need of the special services offered at the center. A founding director stated that if the center was full and one slot opened up, she would give that slot to a child with special needs, since "special needs children are our top priority." Another director targeted children with emotional or behavioral challenges for recruitment to the center, since "we want to make sure we bring in kids [from the community] that are going to benefit from this program." Others strove for inclusion of all children that approached their centers for services, and did not have criteria for enrollment. One of the administrators of a comprehensive program said:

The program needs to be designed so that all children can fully participate. And that shouldn't mean that the kids that have disabilities or are at risk feel like they are being inserted into a program. It should just be for them as much as it is for everybody else.

Provide a Natural Environment for Care

Several of the directors spoke about the provision of a natural environment as essential for their inclusion efforts.

The conceptualization of this place always was that it would be a place where inclusion would happen very successfully and very naturally...We have figured out that the best way to do this is to set up environments where all children...and all families can come and fully participate.

When specialized services such as behavior management or specific types of treatment were needed, the directors opted for work embedded within the natural setting of the classroom or playground. They attempted to limit the delivery of services by the "pull out" model which removes the child from his or her peers.

Directors also emphasized that inclusion of children with challenges in the natural environment benefited both those children and the children developing typically.

We wanted kids who were typically developing working with our children with special needs, to assist our children with special needs to be challenged and to enjoy everything...Our children who are typically developing...don't see the differences...while they are eating lunch there is a child who is getting tube-fed sitting next to them, and it doesn't faze them at all...There is not the fear that you see...out in the community.

The administrator of a program that provided care for school aged children reported that children with typical development gained much from their socialization with children with special needs, including how to deal with children with explosive behavior and how to communicate with children that were not verbal. "They don't find it odd to communicate with 'Suzie' [a pseudonym] with sign language, because that is just what you do!"

Adapt the Program to Meet Individual Needs

The majority of the directors discussed the need for the program to adapt to the children that were enrolled, rather than require the child to adapt to the program. One of the directors espoused the philosophy of the founder of her well-established center: "Children would be accepted regardless of ability and resources would be found to support those children who had special needs."

Administrators devoted time to finding out what would work with an individual child, and then doing staff in-service trainings on that child's behavioral and emotional challenges and strategies that were tailored to assist that child. Additionally, the directors worked with the staff to learn about mental health issues: "We also educate ourselves on terms, so we know how to talk to the professional, so we know what the symptoms are." As one director put it, "If you get in there and get to know the specific child and what their needs are, you end up being more successful."

Deliver Family-centered Services

In all of the interviews, directors made it clear that they provided services to support families. When talking to the staff, one director gave the message: “We’re not the parents; [the staff members] are only here to complement the parents.” One center used administrative resources to enable the parents to set the schedule of care for their children, and allowed part-time and shifting schedules: “We work really hard to accommodate our families and what is best for them.”

Although directors were realistic about some of the challenges that faced families, several explicitly stated that it was crucial to have a strengths-based approach and adopted the philosophy that it was central to the mission to discover and work with family assets. A director of a multiservice center stated:

We have...professional staff that are well trained and that understand an asset-based family centered philosophy... We try to help families... to figure out how to solve problems [like domestic violence and alcoholism] rather than just blame them and attack them for those problems.

The directors also stated that an essential part of working with the families was to maintain personal respect even when there have been difficulties in relationships with either the child or the parents. After recounting a particularly thorny incident, a director reflected on her professional philosophy:

I think a lot of it is the fact that you have to always maintain that respect with the parent and respecting the child and where they are at. They are not always intending to do something...to get your goat, necessarily.

This statement reveals her willingness to not assume negative intentions on the part of the child or the parent even in difficult situations.

Promote a Successful Experience for Children and Families

Mindful of family histories marked by failures in previous child care settings, directors expressed a desire to have children and their families experience success at their centers. Notably, a director reported:

A lot of times in school age programs, what happens is when a child has emotional or behavioral difficulties, a staff right away jumps to kind of a punitive discipline model of “write them up, suspend them, kick them out.” And so...[we have developed] the culture at our program that we exist so that kids don’t go home alone. That means we do everything we can to make a child be successful so that they can make it in our program.

It was clear that directors felt a partnership with parents was necessary for success:

I’ll get a staff person that’s fairly new, and they’ll say: “Why don’t you suspend a child?”...We’d much rather try to have the child be successful here and work with the family and try to keep the child at the center.

Directors took a variety of approaches to ensure the predominance of positive views of the child and the promotion of success. One director said:

We try to build our kids up; they just often don’t have good days in school. Anything they do here that’s worthy of telling the parents, we tell them...I’m a firm believer in that parents need to see their children in a different light...We always tell them three positive things first before...anything negative.

The Centrality of Families

Center directors viewed families as essential to the mission of their programs. As one experienced director put it: “The role of families? Well, they’re why we’re here! I like to tell teachers that they write our checks. So if they don’t like our program they’ll go somewhere else.” Interview participants answered two broad questions with respect to the families they served: “What is the role of families in your program?” and “How do you communicate with the families in your program?” From their answers to these and other related questions, three major themes emerged through data analysis: (a) family support as a major goal of the programs, (b) family participation as critical, and (c) communication as a key priority.

Family Support as a Major Goal

If family support is defined as “the constellation of formal and informal services and tangible goods that are determined by families” (Federation of Families for Children’s Mental Health, 1992, p. 1), then family members are empowered to take the lead in specifying their needs and in choosing services that will meet the needs of their children and family. Belief in family support was clearly exemplified in the services provided by the centers: “We are trying to strengthen families by helping to increase their knowledge and their ability to nurture their children. And also to help them to access the resources that they need just to function and to have the good quality of life as families.”

Some of the centers went beyond the goal of providing the family support of child care. Services also included work with the families, such as counseling, home visits, parent training, and resources and referral. A multiservice center director stated: “Because we are comprehensive, we can match the resource to the family. So one family might benefit most from the home visit, another family might benefit most from the mental health behavioral specialist coming in and working with them on-site here in the classroom.”

One center provided daytime respite care, much like an extended family, for families facing crises:

It could be domestic violence, it could be that the family has been displaced and are trying to find housing. It could be that they are just dealing with a chronic issue within the family or with the child and they just need a break a couple of times a week.

Building the self-esteem of the parents was seen as one role of these centers. By the time many of the parents found these centers, they were fairly “brow-beaten” and needed to be built up, according to the directors. The centers’ staff members provided support and shared information with parents so that staff and family members became more effective partners in the care of their children and could better manage the difficult behaviors the children presented: “We’re not here to overtake parenting responsibilities and duties. But, at the same time, I think we’re here to educate our parents as to what’s going on with their children.” Another director stated, “I think our parents do a good job carrying our ideas into the home.” Parents also shared ideas that worked at home with caregivers, who were more effective in the classroom when they implemented home practices.

On the other hand, access to even the basic services was difficult for particular population groups, and this presented a challenge to child care centers.

Our biggest challenge is that I would actually like to see more awareness and more utilization in the low income community and in families that we are underserving. I think we could serve more African American families; we could serve more Hispanic families ... I’d like to see more of those families coming in. And just being able to accommodate more families.

Some centers were actively engaging in outreach efforts to address these issues, although this was limited by the resources available: “We are trying to take the show on the road, but we don’t really have enough staff and enough resources to do that.” However one center wrote a grant to “... do outreach and awareness, specifically focused on the low income community.” Finally, the lack of transportation was also a significant barrier in some centers. “There is a big problem with transportation in this county, and there are a lot of families that just can’t get here.”

Family Participation as Critical

When reflecting on the roles of families in their programs, directors pointed to the importance of families participating: as partners in the care of their children, as members of the learning community that the centers had become, as networking with each other to provide information and mutual support, as providers of center resources, and as involved at the program level and beyond.

Families as partners in care. Family members were viewed as being in partnership with staff members to include the children fully in the life of the center. All directors emphasized the necessity of bringing parents into the planning process when children presented challenging

behavior at the centers. The openness of directors and staff to this partnership and their dedication to having children succeed in their settings usually resulted in establishing this key alliance: “We are not looking to ‘get rid of your kid;’ we are looking to help them have more success. I think when parents find that out, they are more willing to work with us... We are there to help their child out, not to just be another person saying, ‘Your kid is out of control.’”

This partnership process was well described by one director:

So at first it is just some general communication with the parents...a phone call...setting up some ideas on what direction to go. Then sometimes it will be a meeting that we will [use to] talk through where we are at, where we are going, what needs to change... The odds are high that they are having some similar challenges at home, so you want to be empathetic to that situation as well, and use them as a team player and a partner in working with their kids.

A director discussed a planning session with parents of a 3 year old boy with challenges:

We tailor what we do to what the needs and interests and resources and concerns of the family are. [This young boy] wouldn’t stay in bed, wouldn’t sleep through the night, and he was...[also difficult to manage] during the day, too...we helped the [parents]... to basically come up with a behavioral plan for the child, and also to deal with some of the stressors that they were dealing with as a family.

At some centers family members were asked to and agreed to give rewards at home, such as extra story time to children who exhibited positive behavior during the center day. They also participated in curricular assignments which brought early childhood learning into the home setting. Directors reported partnering with parents through regularly scheduled parent-teacher conferences and through setting up mechanisms to get feedback on the extent to which the family members were satisfied with the success of their children at the centers. Finally, two directors mentioned that parent and staff alliances were crucial for getting child care professionals invited to the table when Individualized Family Service Plans (IFSPs) or Individualized Education Plans (IEPs) were to be put into place for a child.

Families as members of the learning community. When discussing the ways in which families participated in the life of the center, directors talked about family members being active in the community of learners. Centers were seen as places where knowledge was exchanged, and families were invited to participate in staff training. As one director stated, “Families are seen as the experts on their children.” Staff relied on them to provide accurate information on their children, and sometimes invited them to participate in formal in-service trainings:

Their child was a younger child who was new to our program, and I think they were a little worried that staff weren’t going to get it or understand their child’s needs. So [participating in

the training] seemed like a way to empower the parent and make them feel like they had some control... They also knew a lot about their child's disability.

Family members were also invited at the majority of the centers to special parent training sessions held at the facilities, and sometimes to participate in planning and delivering those sessions. For example, one program held a parenting forum on bullying and did a substantial part of the planning with interested parents.

Some centers also offered joint in-service training sessions for family members and staff. A director remarked that in a recent training on behavior management, teachers and parents collaborated: "[Parents realized] 'Oh, you have the same problems I have at home.' So there was some continuity too... If you are using the same kind of techniques at home as they do in day care, you may get better results."

Families networking and supporting each other.

Although small groups of parents attended parent education sessions or joint trainings, center directors observed much greater turnouts in celebration events they hosted. Some of the events focused on ethnic celebrations: "We encourage our parents to come as much as possible. We had a Cinco de Mayo celebration a couple of weeks ago, and we had a lot of families come for that." During our visit, we also observed a large turnout for a kindergarten graduation celebration that marked the end of the children's preschool experience. Directors noted that these events brought parents into contact with one another, and informal support networks of parents formed. One of the multiservice centers also referred family members to the local parent-to-parent program for additional support and advocacy training on inclusion issues.

Families as providers of center resources. All of the centers had family members who took on the traditional role of classroom volunteer, assisting with parties, co-supervising field trips, answering the phones, helping with mailings, and organizing the play groups. This was much less possible in communities with low incomes, since parents often worked two or more jobs to make ends meet.

Family members also worked on development activities at the non-profit centers, assisting with fundraisers and contributing resources over and above tuition. At some of the for-profit child care settings parents who were grateful for their children's care would help with maintenance, or give donations: "Computers, equipment, rocking chairs. We just say we need something, and if they can afford it, they'll give it." They also participated in drop-in activities as they were able, reading to children or engaging in play groups. To promote cultural enrichment at the centers, families also sent in materials for discussion around cultural events and holidays.

Families involved at the program level and beyond. The majority of the centers had formed parent advisory boards, and involved family members in key decisions. They also worked to have parents garner resources from other organizations. The director of an after school program said,

"The goal of our parent advisory boards is to get [our parents] involved in site councils and also in the school district...[to get the leadership to] know that it is an important program to them [and needs to have its space needs met]."

Challenges in promoting family participation. Directors acknowledged that getting families to participate was a challenge, especially when rigid work schedules, multiple jobs, and outside pressures intervened. They also reported that staff needed to be trained to promote appropriate family participation, particularly in planning for behavior management. Finally, several of the directors reported that children were sometimes asked to leave centers when their family members would not cooperate in seeking needed supports. An administrator reflected on her experiences, "We've never had a situation where parents work with you that we have been unsuccessful. But on those rare occasions when parents do things like, 'You are picking on my kid. No, I'm not going to help you.'...[for the safety of] the other children and staff, we have had to ask them to leave."

Communication as a Key Priority

Establishing early and ongoing communication with families was given top priority among center directors. One administrator at a large center described her efforts to make sure that each parent was greeted by her face to face during the care week, so that they would feel that they had "personal accessibility."

Establishing personal accessibility. Relationships with parents, staff, and key community members were built up through formal and informal means of communication. Many of the formal mechanisms of interaction were mandated by regulation or dictated by practice: incident reports, infant-toddler daily care logs, written documentation for mental health consultants, records for Individualized Family Service Plans, parent conferences, or regular staff meetings. But informal contact was also seen as crucial, often in the form of letters, notes, or most preferred, face-to-face encounters. Additionally, centers produced informal newsletters, maintained bulletin boards and websites with updates, and used phone calls, voice mail, e-mail, pagers, and cell phones to keep in touch with parents, staff, and community partners even outside of center working hours. One center director noted that she rarely called parents at work or at school, unless there was high priority information that was needed during the day. When resources permitted, centers had staff participate in home visits to further build relationships. Focus groups of parents were tried unsuccessfully by one administrator, who admitted that "We seem to do better one-to-one."

Solid relationships were particularly important when children exhibited difficult behavior and incidents required staff to communicate unpleasant circumstances to family members. The discussions often included offering emotional support to parents. An administrator stated:

The staff are very professional in the way that they do interact with parents...sometimes it's just a commiseration, "What are we going to do next?" We've got one that's a biter...and we were talking with her mother last week, and she's just as frustrated as we are... We've tried [so many approaches; we have now agreed] to see if the physician...[has] any suggestions.

Perhaps the most difficult communication between staff and parents involved the discussion of the possible need for mental health services for a child who was having difficulties in the care setting. A director recounted: *"Sometimes you have parents, unfortunately, who say: 'You are picking on my child; they don't do this at home.'"*

For the most part, administrators and staff could handle the situation without assistance, but sometimes outside consultants were called in to facilitate the process. *"We're very dependent on our director of special services here in the agency...[who] is out there facilitating those kinds of communication...outside the comfort level of the staff."*

Directors were also particularly careful to communicate clearly with the parents of children developing typically who were distressed at their children being the targets of aggressive behavior.

Sometimes parents of kids that are typically developing [say]... "I don't want my kid in a classroom with a kid that's like that"... We're real upfront: "These are the kids that we work with, these are the kids that we serve. If this is not appropriate for your child, then we can't help, and you'll need to find another place." And very rarely do the parents go: "Oh, OK!"

In fact, the parents of children without challenges were reported to need to hear from the teachers how the behavior was being handled, and what was being done to change it, and to vent a bit. After this communication, *"The parents have really been OK. They just needed an opportunity to say: 'I don't like it; it bothers me.' But they send their kids back."*

Confidentiality as a vital element. Several administrators talked about the necessity of maintaining appropriate confidentiality when staff members were discussing the special needs of children, especially behavioral challenges. One director stated that she encouraged staff members to talk with parents about the challenging behaviors of their children in a place where neither the children nor other parents could hear the discussion: *"We tell the staff, 'You don't want to be there telling the parents these terrible things the child did today while their co-workers are walking in picking up their very well-behaved children.'"*

Barriers to communication. Communication efforts were made more complicated by cultural and language barriers between staff and family members. The administrators called upon a variety of resources, including staff who were bilingual and bicultural, practicum students and interns who came from the same language and cultural background as immigrant parents, and community partner agencies who supplied translation for personal and written

communications. A center director reported that she annually asked about cultural customs in the family and sometimes got requests for changes in classroom practices, for example the celebration of holidays. *"One family ...was opposed to St. Patrick's Day and wanted to assure that [their child did not participate]...So we respected that and found some alternative activities."*

Practical arrangements made also personal communication between staff and family difficult. Directors particularly mentioned the isolating effects of transportation services provided by their own organizations to families who rarely saw the teaching staff. Also discussed was the complexity of arranging for personal communication with parents who dropped their children off and picked them up outside the scheduled time of their children's classroom teacher. Then teacher aides who provided extended care served as the conduits of second hand information from the teachers to the families.

Center Staff, Practice Strategies, and Specialized Supports

The administrators of the centers attempted to attract, train, and retain dedicated staff, to foster inclusive child care practice, and to seek and utilize special mental health supports for the children and families that needed them.

Center Staff

Staff-child ratios. As is apparent from the descriptions of the centers in Chapter 3, directors viewed high staff-child ratios as integral to the success of their centers. Staffing was an important element of creating and maintaining a stable environment in which the children in the center could be successful. Directors also commented on how families using the center valued having smaller classes and stable, qualified staff.

...really pushing for more stability in the routines and the adults that the kids have to interact with...

...the ratios are...way high...So there really very seldom is chaos... We also do have substitute staff that are available

I think a lot of what we do is the smaller class size, the higher staff child ratios, just having support staff on site to handle the different situations...

Employment conditions, staff recruitment, and retention. The problems of attracting and retaining a well-qualified workforce in the field of child care are widely recognized. Administrators talked about a number of ways in which they addressed this issue, through pay and conditions, flexibility, and various efforts to create an organization in which staff wanted to work.

In many centers, the employment conditions were better than those available in other local child care centers. Directors emphasized the importance of attracting and retaining good staff to the center. Being competitive was

particularly important in times of low unemployment when there was a smaller labor pool. In at least one center, fundraising to pay for benefits for part-time staff was underway: *"We do offer a full benefit package, health insurance, life insurance, disability insurance, retirement all of those things..."*

The centers varied in their hours of operation. However, the importance of flexibility was recognized by all directors both for families and for meeting the needs of staff. In at least one center, children could be enrolled on a flexible schedule basis. *"We allow part-time involvement...The parents set the schedule in which the kids are enrolled."* Directors also noted how adequate staff-ratios enabled them to also meet the needs of their staff for some flexibility in their working hours: *"Our ratios allow us to have our staff...have that flexibility [e.g. to attend a doctor's appointment]. We try to care for our staff as we care for the child..."* Another way in which some centers provided flexibility was by allowing staff to work during the school year and permitting the substitution of summer hires: *"We allow our staff to take the summer off without losing their position for fall. So we do have some summer new positions."* One director commented that there was less staff turnover in their after-school program when *"we gave people their fall hours before school year ended last year ..."* and both the worker and the administration knew that they would return for the next academic year.

Staff recruitment and retention is related not only to what the center offers, but also to other opportunities available to potential employees. In some locations, the directors aimed to attract and retain staff by being competitive with the local school district, though that was challenging, *"Basically I've increased wages to be on a par with the school district."* Some directors reported *"low turnover in our teacher population,"* but more difficulty due to *"a higher rate of turnover in our assistant population."*

In addition to pay, benefits, and flexible hours, directors attracted the "right" staff by being explicit about the mission and values of the organization. In all centers inclusion was regarded positively, and as fundamental to the success of the center. Some staff were attracted to the center because they shared these values.

[We've attracted] the professional staff because this is a unique place. ...it is clear what our mission is, and it attracts people who agree with that mission, and work really hard to fulfill that mission... We have really promoted that whole idea of we can't really call ourselves a successful program if we are excluding kids because of their behavior and their need...

Management style: helping staff to be successful. It is evident from the directors' interviews that they held their staff in high regard, and worked to create a culture in which staff felt valued and successful in their work

I think the philosophy of what we do is really pretty special. And we have just such an incredible group of staff that really make that all work. Really including all of the kids. The staff

has an ability to make it look so easy and it is not as easy as it looks. But they make it look really easy.

Some directors noted the overlap between aspects of the center valued by the families using the center, and aspects valued by employees. Providing child care that met the needs of families was interwoven with attention to how staff experienced the work environment, and success in working with children with emotional and behavioral challenges.

[Staff turnover is low] for a lot of the same reasons that...parents come here. For one, it is a fun place to work ...We have a reputation for being a really creative, quality place. And staff are treated well. And it is fun.

Some directors drew explicit parallels between the "care for the staff" and "care for the children": *"We are a strengths-based place ... We treat the staff as much as possible in a strengths-based way. We try to tailor as much as we can and work to their strengths."*

Training and staff development. Training and staff development was also an important element of facilitating success in the organization. As one might expect in centers that varied in size and number of employees, no single model of training was used in all centers. However, it was evident that the directors invested considerable time and resources in training and developing staff. They described entry level training, staff support, supervision, mentoring and consultation, and review of practice at different levels in the organization.

In most centers, staff who were hired had at least some training or relevant experience in child care. In some centers, the completion of basic training was a condition of hiring.

I'd say 90% [have prior training in child care] ... It is the exception when we hire somebody that has not had any... If there is somebody...[that] really has the potential ... we will usually hire them as a substitute ...give them a chance... under lots of supervision ... We tell them they have to go get at least credentials 1 and 2 ..at the community college... We wouldn't let anyone work without agreeing to do that ...and then we pay for them to do that.

At teacher level, staff had a variety of qualifications in education, child development, social work, psychology, and counseling. Some staff had completed specialized training in child care such as an apprenticeship program, while others had completed relevant training at a university through bachelors and masters level degrees. All directors regarded specialized training of teachers as necessary: *"...They have to have credentials and special training in early childhood before they can be called a teacher."*

At least one center took a different approach to staff development by creating a system of internal promotion that gave staff opportunities for career advancement. In this center the majority of teachers' positions were filled by internal candidates. *"There are only two...lead teachers who didn't start out as an assistant here. The rest started out as an assistant and they worked their way up to teacher ..."*

Challenges of Training and Staff Development

While a high level of high level of knowledge and expertise among staff was required to meet the diverse needs of the children, this was also a challenge.

The hard part is that every disability is different and each situation is different.

There's a lot of things going on, rather than specializing on any one thing...you really have to try to be good at so many different things.

The directors discussed a variety of ways of implementing continuing education and developing staff, including formal training such as attending conferences and external workshops, in-service training, internal training through mentoring, supervision, demonstrations, and self-directed study. In one center, staff had individual development plans. The directors were knowledgeable about what training was available in their local area, and often supported staff to attend external courses. In centers that were involved in programs such as Head Start, staff participated in this training, as well as learning from Head Start staff in the classroom.

We have a whole list of appropriate things ... [staff] can do, but each staff person does have an individualized staff development plan.

... We do a lot of training, not as much as I would like, but we do train all the staff. The paraprofessionals are trained also and talk about the mission a lot and we send them a lot of papers to read and things. We send them to trainings.

We are so fortunate to have access to Head Start and they do trainings for us at least once a month...having these people here from Head Start to do a lot of modeling, going in the classroom.

Directors also recognized the value of having joint training with staff and family members: "Last year we had a training that we did, it was a cooperative training with our staff and all the moms. Everybody who has a child in our day care was invited ... I'd like to do more of that, but we have done that in the past too."

Staff support. In addition to training, the directors discussed the importance of staff support. They recognized that child care work was demanding, and that working with children with emotional and behavioral disorders could be extremely difficult. Thus it was important to provide adequate support for staff, while continuing to meet the needs of the children. Maintaining adequate staffing was an important factor in this.

Avoiding staff burnout. Maintaining a balance of staff to children. And it's real tricky when we start hitting like where we're at right now at the cusp of being at ratio with all the staff we have, and one more kid ... means another staff person. So it's making that balance. At what point do we hire and train another person? At what point do we open up our classroom?

Moreover, the directors emphasized the importance of establishing a work environment in which it was acceptable to be open about the frustrations inherent in the work, and to acknowledge difficulties. They worked to create a positive environment by reminding staff of their successes and recognizing their achievements in helping children to be successful. As illustrated below, the directors described a work culture in which staff felt able to ask for help without fear of blame. The challenge was to provide enough support but to do it in a way that empowered staff.

We remind each other of our success stories: "Remember five years ago when 'So and So' was at this level, and now look where they are. We can do this, and we did this before." Sometimes we just have to know there's success around the corner somewhere.

If it is a situation you are not comfortable with, asking for help. Or if your frustration level gets too high, asking for help. But also if you see a person who is handling a situation and they are not asking for your help, don't intervene, let them handle it until they let you know that they do need some support ...

Openness to learning. In addition to openness among staff, directors talked about the importance of developing and maintaining flexibility and openness to change. A philosophy of continuous improvement in the context of a clear guiding vision was regarded as essential to the success of the center.

I think part of what we've always done is everything is open-ended and if it is not working need to get a group together to resolve or make some changes. We work hard to involve our staff in those discussions.. I think that is probably the key to any of this, you have to be so open-ended and so creative both in people and resources in programming that you do, and really, really flexible...the reality of the kids and the families we serve is there is no way you can be black and white. There is just no way. Flexibility is really the key...the bottom line for me is what is best for the program and the kids. And then go from there in making the decisions on whether or not we should be doing it.

Directors worked in different ways to create and maintain an environment that fostered continuous learning and openness to change. Examples included supervision, mentoring, consultation, and review of practice through staff meetings, classroom reviews, and formal and informal evaluations. Having a supervisor that was immediately available was an important means of providing support for staff working with children with challenging behaviors, and promoting their learning.

Supervisors are directly accessible [to staff] all of the time. So if they have questions or issues or concerns or just someone threw up and another kid is pitching a fit and they need some help, they could get it really quickly. So that kind of keeps a level of calm. And I think that is a really important part of it

In addition to specific technical assistance, a number of the centers described the importance of providing training to ensure that staff understood the center's mission and philosophy, and how they could work effectively with families.

[Staff] have participated in some trainings on asset-based practice and on family-centered practice and some of those kinds of things which help to keep a good relationship between them and the parents. I think that is also really key...the mission is definitely based on parent partnerships. It is based on empowering families through knowledge and through skills. We train the staff on all of that...it is a constant ongoing process

The directors emphasized the importance of an analytical approach to problems. This was applied at a number of levels, including reflection and incident analysis by individual staff, reviews of individual children, and classroom review. Staff were encouraged to learn continuously from their experience in their day to day work, and to record and analyze contextual and behavioral data. For example, as illustrated by the quotations below, staff analyzed and recorded incidents. The accumulated data derived from these analyses could be used to design interventions for a particular child.

There is an incident report that goes to parents, but there is also a staff reflection, where staff need to reflect on what they did. ... We also make staff answer the question, "How could this incident have been avoided or what could be done differently next time?" Also the time of day, what was going on, if there was a competitive game or where there is any kind of structured activity going on. All that stuff gets recorded. ...[as] part of my job [as director] I go back and look for patterns ...

In some centers this was a formal process of review, which was conducted at a specific time that was scheduled away from the classroom on a regular basis. Directors and program managers were closely involved in the programs, and could draw on their close knowledge of the children and their families to support staff.

My education directors do a lot of observations. We have weekly staffing when we get together. Each class we take an hour during that time, they have coverage, they leave the room with the director ... and another person, and they would just talk about the children, what the needs are, what they can do to help the children. Sometimes it is the overall classroom.

[Supporting staff to work with children with challenging behaviors] would probably be more the technical assistance and consultation model ...It is also not really a passive process ...[Program directors] are hands-on type supervisors. So they are in the rooms a lot and they know what is going on and they see the kids and they know all the kids by name, they know all the parents. So if staff is having a concern or an issue...their supervisor is probably going to observe that ...That relationship with the supervisor is really important and the access to the professional resources when they need them.

Staff in the centers worked with children with a wide range of conditions. Despite having highly trained staff, directors also recognized the need to approach each child and situation on an individual basis, and also draw on other resources as required. Finding enough time to mentor staff was sometimes a challenge for directors in the context of the other demands on their time.

Administratively you fall into a lot of crisis management, even whether it is with staff or with families or just program things that come up...You don't always get the time that you really want to be out there and show them how to do it and to be right there for them.

Inclusive Child Care Practice

Center administrators reflected on the general principles that they used to direct child care practice in their organization, and expressed explicit ideas about their preschool and school age programs. Specific child care practices were discussed extensively by the staff in their interviews and will be reported in Chapter 5. In some instances director interview results will be placed in the context of our observations at five of the centers, and of our interpretation of supplementary materials.

General principles of child care practice. The majority of directors mentioned individualization of programming; as one supervisor put it, for children that had emotional or behavioral issues "*programming affects behavior.*" A key to successful inclusion practice was seeking knowledge about the needs of the individual child and then adapting curriculum and routines to meet those needs.

My goal is certainly to work with the kids in whatever they present, not design a program that the kids have to fit into...I think because of the variety of kids, we are also required to be pretty individualized in a lot of what we do, both for curriculum planning and as well as for routines that the children participate in.

Although practice in all of the centers was based on a planned curriculum, and some of the directors mentioned the use of set curricular models, they were clear about the need to adapt their practice. So blends of models such as Creative Curriculum or High/Scope were sometimes employed, in order for staff to be able to adjust their practice. "*Teachers have learned to be open and to adopt what works...We do some [visually based]...activities...a lot of tactile stuff...because what works with one kid, doesn't necessarily work with another.*"

Developmentally appropriate practice was the foundation for curriculum choice mentioned by several directors and emphasized in manuals that our research team examined, but directors made sure that the interests and needs of the individual children were also emphasized in the activities planned by the staff. An administrator remarked, "*Our educational philosophy is learning by doing. It is interest-based learning*

and it is based on giving children a broad range of learning opportunities then letting them... make decisions and follow their interests."

One director focused on the visual nature of much of the material in the center's preschool classrooms. This was useful for individual children with visual learning styles or behavioral challenges, and children learning English as a Second Language.

There's not any one curriculum that does as much visual stuff as our classroom teachers do...the schedule is visual, when they're working with this child individually, he's got his little flip chart, and it's visual...Again [we're] looking at this child individually and going, "OK, this is what works," and using that.

The curriculum at several of the centers included activities that involved family members. Directors at these centers urged teachers to include home-based activities in their lesson plans for the week. A multiservice center even lent kits that families could take home and use to engage in creative or learning activities with their children. An administrator talked about the difficulty of involving parents in efforts to have consistent learning or behavioral practices carried on at home,

I can't even begin to imagine how difficult and challenging it must be sometimes when you have a child that doesn't sleep at night, and you can't go to sleep because your child's not sleeping. We certainly talk to the parents [about consistency]...but we have to know that it's not necessarily going to happen.

Several of the larger programs also emphasized the importance for practice of developing standard policies to guide services given to children with special needs. *"Being intentional...you just spell it out in black and white. This is what we are doing. it is a policy now; we expect you to do it."*

Preschool practice: child care as nurturing foundation. Directors of centers offering preschool programs explicitly emphasized their goal of providing the social and emotional foundations for their young charges. Especially for younger children directors focused on providing a stable group of nurturing care providers, which one director called the *"attachment model of care."*

The curricula also had social and emotional goals: *"We definitely work on the pre-academic skills in a lot of what we do. But the bottom line is really the social and emotional components: working with their peers, feeling good about themselves,...respect for others, recognizing that we are all different, but that is a good thing."* Some directors focused on socializing children to see children with challenges as basically the same as themselves. This socialization of sameness was actually sought as a goal by some of the parents of preschoolers who were developing typically. A preschool administrator said, *"Families of children who are typically developing...have brought their kids here because they want them to be in school with children with special needs, and to eliminate the fear of being around [them]."*

Because preparation for academic learning was considered to be based on socioemotional readiness, one administrator stated, *"The focus of the preschool educational materials...is based on social and emotional development, as opposed to academic development."* An experienced director spoke of attempts to bring about self-regulation of aggression on the part of a preschool child who was not affected by sensory dysfunction. She instructed teachers to *"pay attention to the victim first,"* and have children who witnessed the aggression provide comfort to the child who was hurt. The attention of the class and teacher was then directed away from the child with aggressive behavior, who eventually learned to gain attention in more positive ways. Children who were the targets of aggressive or hurtful acts were also taught to forestall the child on the attack by expressing their unwillingness to be hurt. Any academic activity was to be set aside momentarily for these key socioemotional lessons.

The physical facilities of the preschool programs we observed also revealed a nurturing environment for young children, appropriate to the individuals they served. Posters featured pictures of children with diverse ethnicities and abilities. Large, comfortable spaces were subdivided into smaller activity areas. These classroom areas and playgrounds were rich with equipment and learning materials, however care was taken to dampen down the levels of stimulation for some children. Noise levels were kept low, and in some classrooms opaque materials were stretched over ceilings to dim the effects of bright lights. Another director noted that integration of sensory input was particularly difficult for some children, *"So many children are so incredibly over stimulated by noise, by lights, by colors...We try to tone that down some...[Children with sensory integration difficulties] get over stimulated really, really easily."*

One notable example of a child needing lower levels of stimulation was a young boy who kept running from his classroom. A director noted, *"When I would observe him, he would put his hands over his ears every time before he would run. I think that he had some auditory problems and he was getting incredibly over-stimulated, and that was his way of decreasing the stimulation; just getting out of the room."*

The directors did not emphasize the use of behavioral techniques to promote social skills and emotional control. Rather they urged staff to modify routines or change activities. *"I won't allow [staff] to do time outs. We will take breaks, go for walks, that sort of thing...It is not that I don't believe in time outs in general...[this technique is better saved for] parents...because they don't have the back up."* Times that are particularly difficult in the preschool day are transitions, in which children are being prepared to move from one activity to another. One director addressed activity change difficulties through a specialized staff training on transition games.

Administrators also spoke about setting up practices of having staff cover for each other when preschool children exhibited extremely challenging behavior, and of reducing ratios by the use of aids or volunteer staff.

School age practice: child care as community. School aged children were cared for in child care centers that combined aspects of family and community life. The centers that we observed had school aged children use spaces that were subdivided into small home-like activity centers or that were small classrooms dedicated to activity groups. Developmentally appropriate posters emphasized respect for diversity and acknowledgment of feelings. There was an emphasis on providing environments where children could unwind and seek some solitude after stimulating days. Directors emphasized the importance of breaking groups down into manageable sizes:

Our programming in general has things like interest groups...where 15 kids are doing soccer, and 15 kids are doing memory book making...and maybe 15 kids are doing chess. It is easier to do that socialization with kids with special needs because they are truly getting that smaller ratio to cause them to have more success.

The community aspect of school aged care was a key focus for one center which had as a goal “teaching life-living skills on the child’s developmental level.” This center had developed a constantly evolving, but well-established school age program over two decades. The program emphasized the acquisition of social and emotional skills, learning to handle choices, and meeting responsibilities within the small social system of the school aged children and their teachers.

The director spoke of the importance of learning to regulate emotions, and the enforcement of consequences when a child was acting out of control: “In the summertime, if their body’s out of control, and we’re getting ready to go on a field trip that they’ve chosen to go on...[I would say to the child] ‘why would I take you somewhere when you’re out of control? The consequence is that you stay here.’” Children learned to vacuum floors, wash windows, and straighten up play areas as a way of both contributing to the community and working through excess physical energy caused by emotional activation. The consistent application of consequences was crucial, and gave the children an opportunity to “contribute to the society they live in.” Children were paid for the jobs they performed, and could earn money for snacks, which were served in small groups of six or fewer children.

Choice was also emphasized in this school age program. Committees had been established to make plans and decisions. Children contributed their ideas and suggestions by signing up for committees of their own choice. “We have a playground committee. Last year we gave them \$60. They brought in all of these circulars; they decided what they wanted to buy [and which age groups would use which equipment.]”

Children were encouraged to take responsibility for both animals and equipment in the center. The director assigned the job of feeding and caring for some of the numerous pets in the center to children struggling with attachment issues, “If you don’t feed and water the animals, they die, and we get real attached to our animals.” The school aged children had access to much attractive equipment, including sand trays with figures of family members and adults in different roles. The children could check out the equipment by leaving behind a personal item, such as a shoe, and were held responsible for any resource they borrowed or any supplies that they damaged.

The director told the story of a fourth grader who was having problems managing his anger the previous week:

I told him to go back outside and get his body under control and come back in [to the inside activity space]... Well, he was mad and he hit the door really hard with his hip instead of turning the doorknob, and he broke the door knob. So he immediately got his body in control...[and said] “Get me a screwdriver and I can fix this.” I said “This will be your responsibility, but you realize that if you can’t fix it, then I’m going to charge you \$2 for this doorknob.” He said “My mom will bring the money from home.” [I replied] “No, we don’t want your mom’s money, this is your responsibility. We don’t want your allowance, you’ll have to work it off”...He worked 45 minutes on the doorknob that day before his mother came, and couldn’t get it fixed. The next day he had to do a job, and the next day... ”

As part of the school aged community, children not only took on responsibilities but were taught to participate in family style eating arrangements, and learned some basic life skills such as cooking, sewing, home repair, and self-protection that their employed parents did not always have the time to teach.

“We teach children those skills that nobody’s teaching them anymore...We [also] work a lot on the social skills and manners. ‘Please and thank you and I’m sorry and forgive me. And I love you.’”

Specialized Mental Health Supports

Successful inclusion of children with mental health challenges in comprehensive child care centers was sustained in all nine cases through specialized mental health supports. The directors revealed that they drew upon a wide variety of mental health supports, either through staff members who were qualified to assist children with serious mental health challenges or through use of community specialists and resources. The mental health specialists and consultants provided both direct and indirect services, offered to administrators, staff, families, and the children themselves, according to our interviews. Finally, our analysis of interviews revealed that the process of seeking and obtaining mental health supports was complex and could take a variety of pathways.

Sources of mental health support. The majority of the centers had administrators or staff members who had specialized professional training in the provision of mental health services. When the director or an assistant had advanced training in special education, psychology, or counseling, mental health consultation was seamlessly blended into the normal mentoring and supervision of staff. *“We don’t actually tell our staff we are in there consulting with them; it is more mentoring. Sometimes it is the supervision piece that we need to do, but a lot of it is consultation with classroom staff and mentoring them.”*

Several of the centers also had mental health consultants, behavior management specialists, social workers, or inclusion specialists as full-time or part-time members of the staff. The staff mental health providers rendered services to child care workers, parents, and children either on a regular basis or on call. In some cases, the mental health specialists on staff also consulted with other agencies and provided off-site services.

Directors also reported that they drew on resources that were available through Head Start, Smart Start, Birth to Three or other grant-funded programs. In some cases, children in their centers had been identified for these services, so mental health supports were funded and supplied through specialists connected with these outside resources. Describing a county mental health specialist who was funded to support families that had children with emotional or behavioral problems who were in child care settings in the county, a director said:

Unlike most of the other mental health staff, there is no charge for what he does, because his position is paid for by Smart Start. So he is able to actually get down on the floor with the kids and the teachers and the providers, or meet with the families in their homes and helps them address whatever issues that there would be.

Other sources of support for individual children were obtained through identification of children as needing services through the school system, particularly through programs such as Part B or Part C of IDEA. With permission from family members, and the cooperation of the school system, child care administrators could draw upon special education and counseling consultation services for their children, and sometimes were able to consult with private therapists who were paid from governmental or insurance funding.

Finally, some directors used ties with mental health agencies or hospitals, or child development programs situated in university settings to get assistance for children whose behavior was challenging even after the usual supports had been drawn upon. Although these outside sources of support were highly valued, directors were sometimes frustrated because of age or eligibility requirements, or due to long waiting lists. *“They’ve got an unfortunately very long waiting list, so sometimes when we refer the kids, they won’t be seen until eight months down the road.”*

Types of mental health supports. As can be seen in Table 4.1, on the following page, directors reported that the mental health personnel represented diverse professional backgrounds, held a variety of positions serving children and families, and provided varied mental health services. Among the supports provided was assessment of the needs and challenges of children, which sometimes resulted in a formal diagnosis of a mental health disorder, or the determination of eligibility for specific services. The mental health providers also supplied consultation which was of two types: consulting with family members and staff concerning an individual child’s challenges, and consulting with staff and directors concerning programmatic and classroom changes designed to improve the social and emotional development of the children at the center. Directors also reported that mental health personnel provided support for themselves and their staff, as well as the families dealing with the emotional or behavioral challenges of the children in care. When resources were available, mental health specialists provided direct intervention in which children were worked with in classroom settings, individual therapy sessions, or in guidance groups. Directors also had established connections with some of the mental health providers to intervene in crisis situations, if they were not able to handle the children with center staff. Additionally, mental health providers met with staff and parents to serve as a resource for training events, and supplied technical assistance in the form of information to staff and administrators. Finally, collaboration with family support specialists and organizations on behalf of the centers was reported by one of the directors.

Table 4.1. Mental health provider professional backgrounds, agency roles, and mental health services rendered as reported by directors of nine child care programs.

Mental Health Provider Professional Identification	Mental Health Provider Community Role	Mental Health Services Provided
Behavioral Specialist	Child Care Administrator	Assessment
Counselor	Child Care Mental Health Consultant	Individual child & family consultation
Family Support Specialist	Inclusion Consultant	Program consultation
Pediatric Specialist	Mental Health Specialist	Family support
Physical Therapist	Early Intervention Consultant	Staff & administrator support
Psychiatrist	School District Special Educator	Onsite intervention with individuals or groups
Psychologist	School District Psychologist or Counselor	Crisis intervention
Social Worker	Head Start or Smart Start Consultant	Referral
Special Educator	Birth to Three Consultant	Training events
	Child Development Specialist	Technical assistance
	Private Practitioner	Consultation with family support organizations

The mental health support process. Center directors described the complex process of putting appropriate supports in place when a child experienced emotional or behavioral challenges. The process of seeking and obtaining supports may take many different paths, and is not easily characterized. However it is possible to identify three distinct phases of mental health support: screening, intervention, and follow-up.

During the **screening phase**, administrators and staff tried to understand the challenges presented by the child. One director expressed a wish to have more time to learn about the children's needs, "I would love to have two weeks to prepare for the individual child before they begin here." Sometimes the child's behavior really took the director aback: "Lots of times we don't know what the children are going to be like until they're actually here. Then they get here and we're like: 'Ah!'" Given very little advanced notice, directors and staff specialists were sometimes called in to observe the child's behavior in the classroom or on the playground, after it had proven to be

problematic for teachers and aides. A director with mental health training stated that "I'll also come in, and sometimes it is just making observations, because...[we want to avoid] behavior plans...[We see] if there are other adaptations we can make to the environment." In some instances provisional adjustments worked, the child's situation was stabilized, and other mental health supports were not necessary.

However, staff would sometimes identify the need for a concerted program of intervention, and would often speak with parents to gain their assistance with this process. In some cases the administrators wished to call in outside specialists, and they requested the parents' permission: "We offer to have someone like the Head Start consultant come in and observe or offer to make a referral to the ...county preschool special education...Some parents will agree and other times they won't. Without their permission we can't do any of that." These early observations and provisional assessments frequently took into account the risk factors that individual children brought with them. The administrators identified the following risk factors that some of the children in their centers experienced: biological challenges, communication difficulties, prenatal drug exposure, developmental delays, and such family factors as poverty, neglect, physical abuse, and parental mental health and substance abuse issues. One director stated: "We have children that the only time they get a good meal is here. We have children, who although there may not be a substantiated case from child protective services, there certainly have been referrals time and time again."

In the **intervention phase**, administrators and staff have made the decision that they cannot address the child's challenges adequately with ordinary practices. "So usually the consultation is going to be coming in to assist us in stabilizing the situation. It is usually onsite." They called upon either a staff specialist or an outside person to provide mental health support. In one case a director talked about the provision of services by one of her specialists to an outside care provider: "There's really close ties,...[they call for a specific person]... 'You've got to send me some help. We've got this new child, and I need some support.'"

Once the mental health specialist was called in, a variety of approaches were taken, depending on the available resources and the child's situation. In several instances, the directors talked about the first step being onsite observation of the child. "Typically...he will observe the entire classroom setting [and] the child within the classroom setting." This may be either preceded by or followed by intensive discussion of the child's needs and strengths, "The teacher and [one of the administrators] would also talk with them just as far as what the concerns are and what we are looking for as far as outcomes." In centers that have more extensive resources, this might be supplemented by a home visit and observations there, and direct work with the parents. An administrator with mental health training stated, "I made home visits with that family; our inclusion person made home visits with that family...[We] helped them directly to come up with a plan to deal with the child's behavior."

After the observation period the mental health specialist might engage in program consultation, and recommend further program changes to support the child: *“There have been times when he has just made recommendations to the teachers about rearranging the environment, maybe some subtle techniques for them to use with that particular child.”* At other times, the mental health specialist might instead consult on the individual child through meeting with the staff and family members: *“There have been other times...in more severe cases, where he has asked the parents to come in and we have sat down and worked out a behavior...plan to be used at home and at school.”* In these consultations, plans for support of positive behavior and transformation of negative emotions and behavior were worked out.

In a few instances, directors reported that mental health support took the form of direct intervention with the child or groups of children, sometimes as part of the child’s Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP). One school age program had a counselor who regularly met with children or staff members, who could approach him directly to talk out issues. In an administrative interview, an inclusion specialist in another school age program reported conducting counseling groups of children,

I just called them friendship groups, and basically staff would identify kids who had a real hard time socializing and tended to have behavioral difficulties. And they would come to my groups and we would just talk about things like cooperation, and practice being friends...

For younger children, direct intervention was reported to sometimes take the form of “*floor time*” during which the mental health provider would interact with the individual child in the classroom setting. In one large preschool the director stated that a clinical social worker worked one-on-one providing play therapy on a weekly basis: *“Most of the kids that we have had in play therapy have been children where there are some behaviors that are concerning to us, or we know that there is some family situation where the child is in need of some support to talk through that.”*

Staff members and administrators also used mental health supports to assist them with their efforts at including children with emotional or behavioral challenges. When the administrative staff possessed mental health training, other staff could look to them for supervision and mentoring, which sometimes took the form of coaching, consultation, or emotional support. Social and emotional support came from the mental health specialists as well. One director put it this way:

[Our] counselor does “caretaker talk”...He’ll say things like: “That was good, and what you did was good. Next time, add this to it.” Or “I can’t add anything to what you’re doing; you’re doing a great job,” Or “I’m going to write that down and pass that on to someone else.” So he always validates and uplifts my caretakers, so they’ll want to go on another week.

Finally, caregivers and administrators also benefited from technical assistance that mental health support personnel provided. *“Sometimes it will be pooling resource information, articles, that sort of thing.”* At other times, the directors and staff participated in trainings with mental health specialists about the individual child: *“Every kid is so different...If you get in there and get to know the specific child and what their needs are, you wind up being more successful.”*

The third and final part of the mental health support process is **follow-up**, during which directors reported that the specialists sought additional outside services for the child with serious mental health issues. These services sometimes included a full-scale assessment of the child’s strengths and challenges, or additional outside mental health supports for the child and his or her family. Caregivers would occasionally be asked to participate in the formal assessment process, since they could provide valuable information concerning the child’s behavior in peer group settings *“Professionals have told me that they get a better picture when...our child care staff [completes a behavior rating scale]...because they’re in group care.”* In a few cases, follow-up consisted of recommending re-placement in another care situation.

We had a child with autism... [and we had] a huge incident with him here, and there were safety issues... with himself, with staff, as well as some of the animals in the building. So we utilized [a mental health consultant] and had a meeting with the family just to say these are the various program options that are out there...In reality this environment was way too stimulating for him; it was too much. He needed to be in a less stimulating environment and has been there for two weeks and is doing beautifully.

An experienced director talked about building long-term relationships with mental health support personnel and letting them know how much their services have helped children in her care: *“Professionals need to be uplifted too. Every once in awhile, I’ll send them a note: ‘This is what [the child] is doing and this is how she’s improving, and just thought you’d like to know.’”*

Barriers to Inclusion

The extensive support available meant the exclusion of a child was a rare occurrence. A decision to exclude a child was generally based on safety issues:

The only thing that I would say we have deferred enrollment is if there is a significant safety issue with the child.

... We’ve only excluded one child from care, and that was due to child’s size and behaviors were posing a danger to the staff ... We look at it if it’s a behavior we can control in our environment ... If we can’t keep everyone safe in that ratio [1:4] with the materials we have, then the child can’t be here.

The Community Contexts of the Centers

Policy and Legal Contexts

Since the regulation of child care varies considerably from state to state, there were differences in the regulatory requirements for the centers in the study. In addition, as explained in the descriptions of the centers, some programs were under the auspices of social services and education, and thus subject to different controls.

The most common areas described as subject to licensing or other regulation were building size, equipment, staff qualifications, staff-child ratios, health and safety regulations, public health and food handling regulations, and fire regulations. In many cases, the directors noted that their centers exceeded the state requirements. Some centers were required to comply with standards in relation to particular funded programs or contracts, such as Educare, the Child Adult Care Food Program (CACFP) or contracts with tribal nations. In addition, some centers participated in accreditation by external bodies such as the National Association for the Education of Young Children (NAEYC): *"We exceed the licensing standards in ratios and staff training and in curriculum kinds of things we do and space also."* and *"[We] are working on accreditation... Right now, we just have to meet the minimal health and safety standards."*

One of the issues raised by the directors was the considerable administrative burden arising from compliance with different sets of standards for regulation and accreditation for different programs. The cost in time and resources often made it difficult to participate in voluntary accreditation processes: *"I have purposefully not [sought NAEYC accreditation] first of all because of the amount of work, but secondly in [this state] there has not been any initiative to reimburse accredited centers at a higher rate..."*

The impact of external standards on training requirements for staff varied, depending on the state requirements for different centers. Some directors commented that state requirements were low, or that that training was highly regulated.

...A small requirement for directors [is] that they have to have a high school diploma and at least nine hours of course work in early childhood, child development, or related services. They're really low.

The state ... is 8 [hours]. And then NAEYC requires something and then Educare requires more. I think Educare is 45 hours. We have all of these regulations.

Centers that were involved in several programs also had training standards associated with accreditation for these programs, *"We are a Two Star facility ... Your director has to have forty hours of director training, all your staff have to have 20 hours of training per year by [an] approved source."*

Funding

As described in the earlier chapter, both private and non-profit centers were included in the research, and the centers were funded by a variety of sources. Financial resources were discussed by all the directors in relation to the impact of funding on facilities, and staffing, and services. Funding challenges included not only restrictions due to the amount of finance available, but also barriers arising from funding structures and procedures.

The way in which funding was allocated was sometimes related to structural divisions such as county, rather than need. In addition issues such as delayed payments made it difficult for some centers to operate.

It depends on what county you are in which rate you get ... One mile down the street the day care ... gets a higher reimbursement rate...because they are on the other side of the county line.

Funding is the biggest [challenge]... We just never know, literally, if our doors will be open next month ... we just budget almost day to day

... The federal money was messed up and it took a long time to get it and we couldn't hire.

In addition, some families that required services were not eligible for funding. *"... We want to take these out-of-control children ... [but if the family is] on Title 20 welfare assistance... we... get hardly any funding from that. That's very frustrating."*

Directors discussed the importance of adequate funding to support the child in whatever way was needed, and that significant additional funds were required in some cases.

That's [fundraising] a big challenge - when 40%-50% of the cost has to be raised.

... The only barriers are to make sure that we have the right supports available for us. Some of the kids that we are presented with might need increased funding to assure the staffing ratios are appropriate for that child ... Not all kids have access to that ... A lot of our fundraising... comes in ... to help support the programs in different ways.

... We really need more staff in order to expand and in order to increase quality.

I'd like to have a counselor on-site with an office where parents can just go in and talk to them periodically...

Another challenge was getting access to funds when the child was in more than one program, or in transition between programs. It was evident that the funding was not always structured in a way that most benefited the child. In some cases this was complicated by criteria for insurance coverage which sometimes led to a diagnosis that was not necessarily helpful for the child or for the center staff.

Funding is always a big challenge, both for us as well as to really promote and encourage other programs to provide more intensive supports for kids, knowing that they don't always have the financial resources.

..The [day treatment center]...is really wanting to get the kids in a more natural environment...[and] will...refer the kids over here... [but] funding sources don't always want that.

..We're having a mental health crisis in [this location] right now... ADHD, ADD, and ODD are not covered under some of the insurance policies, but bipolar is ...so there's a real problem with that diagnosis...

Sometimes changes in billing requirements caused successful programs to end:

..We used to have a program...with Early Intervention Birth to 3; we would include the program and we had mixed staff and kids...but then there was some Medicaid billing changes, and Birth to Three had to pull out of that contract, because they couldn't create a way to bill effectively in a child care setting

Financial resources were also cited as an important factor in staff turnover and retention. Some centers were trying to raise additional funds to improve the working conditions of staff.

We can't compete with public school salaries... We are a non-profit and it is never going to be highly competitive.

I wish I could pay my staff; they deserve double the salaries they get now. That's a big issue.

..One of the goals of our fundraising campaign is that we would like to pay our part-time staff benefits ...

The lack of financial resources restricted the extent to which centers could expand their facilities and services. "...Some of our rooms are smaller than we want them to be..." And "It would be better if we could expand our physical plant ..."

Collaboration and Community Connections

The directors described the importance of close connections with the community to the success of the centers. Some of the directors were also founders of the center, and thus as illustrated below, advocacy and generating support within the community was an important part of their success.

[I stood up] at meetings ...yapping and saying: "But what about the children with special needs? What about the children with special needs?" until it became a high priority on their agenda.

I learned to schmooze, to put things the right way to get your point across, and to get what your program needs...

[Starting a center] ..is not going to be an easy process. It's going to take a while. There's a lot of resources to get there, and you have to be able to get those resources.

Even for more established centers, connections with the community were seen as very important. The centers were highly regarded in the local community, and the directors developed relationships that enabled the center to gain access to a wide range of resources, including staff recruitment, to meet the needs of the families they served.

I think we are highly regarded because we make the effort to make it [inclusion] happen and we have just set the bar high. This is what we are going to try to accomplish and sometimes we don't meet it. But a lot of programs don't even have a bar set up.

What I've seen is if it is someone from the community who knows a lot of people in child care, that they do a lot better job at recruiting some of those key positions.

I advocate for these kids and I advocate for this day care.

Centers built relationships with agencies that gave them access to, and provided mentorship for, volunteers who could support the work of the center staff. Several of the centers worked collaboratively with social service agencies and educational institutions, including public schools, community colleges, and state universities which provided resources for and used the centers' specialized services. Some centers also had internship placements from a range of disciplines and backgrounds.

We have volunteers come in to do music activities, storytelling, reading time, art and a variety of things.

We have a foster grandparent program locally so they support them through some training and mentoring. Then there is a stipend system that they can access as well ...and then the majority of the rest of our volunteers are actually individuals, adults with disabilities.

We have one intern that is in a two-year program for child development ...last year we had a large group actually of RN's that came through...

Center of excellence. In view of their considerable experience and success in promoting inclusion, the centers also provided resources for others in the community. A number of directors were actively involved in designing and providing training for other programs, and thus were recognized for their expertise outside of the center.

We have been working with [the state] to develop inclusive child care models and also actually developed the consultation program ... Fifty percent of my job, I would say is outside program development and resource development.

We've done a lot of training; virtually every child care provider in the county has been in this building at a training of some kind or another.

I do training for others ... not employed by our agency.

Some of the directors held leadership positions in their professional associations, and thus had an in-depth knowledge of practice and problems within the field.

I was president of the state director's association for a while, and I don't understand why they [other centers] don't open to doors to more community agencies. There is just a wealth of information and resources out there and they really would like to help. And that is what I have learned and think that other programs could learn.

In addition to connections within fields related to child care, the centers also built broader relationships within the community. For example, in some centers staff members were involved in local organizations such as Rotary and the Chamber of Commerce:

I pay for [a staff member] to be on the Rotary. And that is like the best \$600 a year that we spend, because it has put her in contact. The Rotary in this community takes itself really seriously. It is really like the civic leaders and business leaders. That has been a great investment. We are also in the Chamber of Commerce, and that's been very helpful. So things that maybe even service organizations wouldn't normally do, and at least in our community that has really been vital to our success.

Developing and maintaining partnerships. The directors also described the efforts they had made to build partnerships with different individuals and agencies so that the centers were better positioned to meet the needs of the children they served. They discussed some of the challenges collaboration involved, the importance of recognizing that it was sometimes difficult, the need to continually reinforce the process, and the commitment required to overcome the difficulties.

The way to do that [grow in quality], in my opinion, because this is a very low income area, was to try to work with other programs. And that is how we got started with Head Start ... We just worked with the school and the local agencies. That gives us some credibility.

It's taken years of building relationships with the individuals and staff, building their knowledge and their confidence. We still sometimes have just real basic turf issues. "Who's responsible for this? This is my classroom and you're telling me what to do." Sometimes that will happen. But we're able to work those issues out a lot easier now than what we did ten years ago. ...Working together in a team, and it doesn't always go smoothly, and knowing that it doesn't always go smoothly, but you can get up and go to work tomorrow and see what we can do tomorrow to make it work. The staff are committed to doing that.

We've really tried hard to work with our partners to first of all explicitly discuss [our asset-based and family centered approach] before they become partners, especially if they are actually based here... but just because we have had that conversation doesn't mean that everyone gets it at the same level or is as committed to it... That is just an ongoing effort, we just constantly talk and have conversations.

Directors discussed the need for persistent efforts to influence attitudes and practices for the benefit of children being served.

... Some partners or folks in the community ... don't understand what strengths-based is... An awful lot of deficit and blaming the parents and that sort of thing... there are times when we are not the most popular people in town ... sometimes it is a bumpy road.

Administrators found value in sharing their knowledge, and learning from other professionals and agencies, without competition or self-aggrandizement:

I think the only reason we have been able to do this is that we asked for and received help from other agencies. We opened our doors to them... not being afraid to say we need help.

And we say, "We don't know what we're doing; how do we do this?" We invite the professional into our building... and try to keep an ongoing communication with some of the professionals that we deal with.

Community collaborations on behalf of families. The importance of building bridges between different agencies involved with the same family was recognized. One way in which this was achieved was having child care represented at meetings of agencies involved with the family. In some centers, child care was explicitly linked to the family support system. Several programs had special funding to support a mental health consultant who had the flexibility to work with families and providers in different locations, including the home.

A representative of the day care... can come in [to the staff meeting] and we can problem-solve as a staff ... we know a lot about the parents of our children... working as a team to deal with [a difficulty] ... A week or so ago ... it really worked well to have the day care director and the therapist of the mother working together ... So the director attends one staff meeting and one of the teachers attends another to give them both that perspective.

If we have children in the IFSP or IEP process, our child care participates in this ... They'll go to the IEP meetings for three to five year olds, IFSP meetings for birth to three ... We've worked really hard with local providers to try to integrate them into that process.

One administrator stated that he and the center staff engaged in a "...high level of collaboration, and not just from the partners that are in the building but from the community, from the business community and from parents and other volunteers" on behalf of center families. A full list of resources that administrators in the nine centers reported drawing upon for families appears in Table 4.2 on the following page.

Table 4.2
Community resources used by administrators in the model centers to assist families.

- Child care resource and referral agencies and networks
- Head Start
- Early Head Start
- Parent education programs
- Public school system
- Community college – adult education classes
- Research and training centers
- Counseling agencies
- Consulting mental health therapists
- Churches
- County services (e.g. respite, home visits, family support services, parent education)
- County health department
- Medical providers
- SSI Medicaid
- The Association for Retarded Citizens
- Easter Seals
- United Cerebral Palsy
- Respite care programs
- Adult and family services, income maintenance
- Food banks
- Federal nutrition programs (e.g. WIC, Food Stamps)

Chapter 5: Staff Perspectives “Everyone Is Included; We Find a Way.”

During individual hour-long interviews, 38 staff members talked with us about their work with children and families at the inclusive child care centers. Staff descriptions of their job duties indicated that they held a variety of positions, including teacher, pre-school teacher, teacher aide or assistant, family service coordinator, counselor, and special needs manager. Staff members reported caring for children with a wide variety of challenges including emotional or behavioral disorders, developmental disabilities, speech delays, and physical challenges. However the largest number of children they cared for were reported to be typically developing.

The majority (95%) of respondents was female and European American (87%). The other ethnic groups represented among the interviewees were African American (7.5%), Asian American (1%) and Native American (1%). The age range of staff was 18 to 55 years, with a median age of 33 years. They worked a median of 40 hours a week. In general, respondents were educated, experienced, and had worked in the center for some time. More than one in four of the interviewees were educated to graduate level. This included those with a graduate degree (17.5%) and those who had completed some graduate study (10%). Almost a third (32%) of the respondents had at least some college education, including associate degrees and apprenticeship training. Finally, one in eight of the respondents indicated that high school graduation was their highest level of education. All of the respondents participated in continuing professional development while working at the center, such as in-service training, workshops on special topics, and conferences. A variety of levels of experience was represented in the study, ranging from six months working in child care to 25 years, with a median of 10 years experience. The median length of employment in the child care center was four years, with a range of three months to 21 years.

Staff Beliefs Supporting Inclusion

Although staff members were not directly asked questions about their philosophy of inclusion, 29 of them discussed principles that guided their approach to children with challenges and their families.

Few staff members used the term “philosophy” in their interviews, but nearly three-fourths discussed their deeply held beliefs about the ways in which children with challenges should be looked upon and treated in child care arrangements. These beliefs were in alignment with those expressed by the center directors, but were underpinned by staff experiences in the classroom and practical knowledge gained through first-hand work with the children on a daily basis.

Value and Accept All Children

Teachers and support staff endorsed the ideal of valuing and accepting all children that families wished to enroll. One teacher at a large preschool stated her “*philosophy of inclusion: everyone is included; we find a way.*” Reflecting on the policies of her center, a lead teacher said: “*They do not turn away anyone, no matter what kind of special needs that they may have. There is always someone here on staff that can help that family member or that child.*” One experienced teacher in an inclusive early childhood classroom articulated her belief that all children had a right to their individuality regardless of their behavioral challenges, “*Not one child is denied their right to be or to express [himself or herself].*” She went on to say,

We've had behavior disorders: kicking fighting biting I've gone home with bruises. But I get up the next day and I come back because it's like an acceptance thing. If you and I are going to be friends, I'm going to be your friend because of who you are. . . I'm going to take what's there and I'm going to work with it and build on it.

Staff members strongly expressed their displeasure with the stigmatizing of children with mental health challenges: “*They are not outcasts; they should not be looked at as outcasts. I wish other people would see that.*” One preschool teacher reflected on the importance of person-first language that she had adopted and which was not yet universally used at her child care center:

Just to say he is a little boy first, and not a little boy with special needs before he is a person. It always disturbs me out in society or at school to hear when people say “He is autistic. . .” instead of saying. . . “He has autism. . .” Just acknowledge the human being before the disability.

Provide a Natural Environment for Care

Several of the staff members talked about setting up in their classrooms: “*an environment that is open to all, that is inclusive.*” As one teacher put it, reflecting on the high quality that her center strove to attain:

If you have good quality and good developmentally appropriate settings, then inclusion will be a lot easier. It will be more natural to locate each child's individual needs. So you really won't have to think up any special accommodations. . . If we could just raise the bar of how the quality is, then things will go a lot more smoothly.

At a center providing care to school-aged children, a staff member discussed the importance of a family atmosphere, including pets, in her work with children with emotional or behavioral challenges: “*The animals in our school [are] a big part of the family atmosphere. . . The kids really bond to animals, and we have made strides with children in some of the emotional and behavioral issues just through the animals alone. . .*”

It was in a high quality, natural environment mixing children with challenges and children who were typically developing that staff saw benefits to both groups. First, a teacher discussed the lessons learned in the classroom by children without challenges:

The piece that people generally don't think of right away is that it is helpful for the kids who are typical and don't have special needs. That it reflects society. . . To see that they can learn that respect of kids who have some behavioral or emotional issues is a really big thing.

Another stated that the children who were developing typically could say, “*This is my friend. Not: ‘Huh, what's wrong with that child?’*”

Second, the staff also saw greater benefits in a fully inclusive environment for children with emotional or behavioral disorders who engaged in activities with their peers, than in prior arrangements that segregated children with challenges. “*It just seems that when kids learn what is OK and what is not OK, what is socially acceptable by their peers or to be part of a group. . . it has a more lasting effect, than it did when all of the kids had similar issues and were together.*” Staff expressed their belief that a natural environment with all types of peers was the place to learn about societal standards. As one teacher put it, “*You need to challenge [them]. . . and help them be able to operate in a society that expects certain things of them.*”

Adapt the Program to Meet Individual Needs

Teachers and support staff were clear about the willingness of child care providers to “*put the child's needs first. . . [They] are willing to be creative and do whatever they can to make it a good experience for the kids.*” They learned “*more of different strategies that might work things out.*” One teacher stated that staff needed to learn about each child as an individual: “*He is not like other children but he has something unique about him, and you need to challenge him, instead of bring him down to a level.*”

An experienced child care provider recounted her work with a boy who had multiple challenges, and her attempts to help him through difficult times:

. . . When I first found out I was going to have him, I thought, “Oh man, how am I going to do this? And I just met him, and I fell in love with him, and started to learn all I could about him, and he blew away all my ideas that I had about autism. . . I had heard that they wouldn't make eye contact; they did not like to be touched. And he would come up to me, when

he would get frustrated...and take my hand and put it on his forehead...He wanted me just to stroke his head. That was real comforting for him.

Deliver Family-centered Services

A support staff member at a large preschool stated the approach of many of the care providers to families, *"You can't really serve the whole child until you really try to meet the needs of the family as well."* Staff provided emotional support to family members who experienced distress over their children's challenges, worked with families to get them the resources that they needed, and cheered them on in their successes. One teacher at a multiservice center said that her goal was to *"give every family a fighting chance."*

Family members were viewed by staff both as experts on their children and as allies in their care. A teacher saw her role with families this way, *"Just really being a listener and letting them know that we feel their opinion is the most valid as far as being the expert on their child... We are here to help everybody kind of work together and make that connection for that child's best interest."* This focus on family was a priority expressed by some staff members since they sought to understand the assets families carried with them into child care, *"We really work hard at trying to find the strengths in those families and in those children."*

Promote a Successful Experience for Children and Families

The care providers were clear about the ways in which staff expectations affected the success of children in the inclusive centers. Reflecting on the experiences of children who had been asked to leave other centers, a teacher stated that their success in the current program had *"a lot to do with the expectations of the staff. We've had some staff who are just great, 'That may be true there [in previous child care arrangements] but that doesn't mean they are going to be like that here.' Sometimes that has almost been enough to kind of turn the tide for the child... Kids are very smart and they can read what is going on."*

A key strategy employed by the staff was to use consultation and other supports in their classroom so that children could experience greater success. After obtaining the consent and cooperation of a mother, a classroom teacher enlisted the support of a consultant who made a home visit and then integrated mental health supports in the classroom for a boy experiencing difficulty controlling aggression.

"The behavior specialist ...really seemed to help her and the child just by spending a lot of one-on-one in the home, and giving her ideas and solutions, and the teachers as well."

The emphasis on success carried over to the language that was used in the classroom and the goals set for individuals. One teacher talked about using positive language, such as *"walking feet"* instead of *"no running"* so that children would have a better chance to succeed at complying with her requests. Realistic, but ambitious goals were set for each individual in many classrooms, and staff worked so that

every child could attain them. *"We're not just babysitting them; we're helping them to develop as much as we can to reach their goals."*

Recognize Socioemotional Development as a Precursor to School Success

Although short-term gains and the attainment of immediate goals provided satisfaction to staff, several of them expressed their belief that in working on social and emotional development of children with challenges, they were laying the foundation for school success. *"We are professionals... What we are accomplishing here; we are doing them some good for their future and building a foundation for learning."* A preschool teacher laid it out explicitly: *"It is the social-emotional pieces that really make for a child's school success... They are able to attend to task, they are able to cooperate with peers, they are motivated to learn. Those are the things that are really important for kindergarten readiness."*

Establishing an Inclusion Mindset

Caregivers at five of the centers discussed the importance of establishing a positive attitude toward inclusion in all of the staff. One teacher said, *"I think it [takes] a commitment on the part of the staff and the entire program, administration down, to make [inclusion] work. From the CEO down to the kitchen, everybody here wants kids to succeed in this setting."* A staff member said that, *"If your director is committed and every single teacher is committed to making it work, then you have that support system with other adults to do it successfully."* To get buy in, staff members reported that inclusion was discussed at hiring and that *"they train people and they have the philosophy and they mentor people who are new."*

If a staff member fully embraces an inclusion philosophy, there can be a great deal of satisfaction, as is evident in this statement from an early childhood special education teacher:

"...the school district says, 'Come work for us,' but I love inclusion. I could never go and teach in a self-contained classroom [exclusive to children with special needs]... Because you lose that side of working with kids who are typical. You don't have that balance."

Practice Strategies to Achieve Inclusion

When our research team asked child care workers about the ways they were able to successfully include children with emotional or behavioral challenges, or requested that they recount stories about their recent experiences with an individual child, they offered compelling approaches to practice. We have characterized these approaches, which are based on formal education, practical training, and wisdom gained through experience in child care settings, as **practice strategies**. Our analysis revealed that practice strategies were of two types: those used to promote positive emotions and prosocial behavior (**promotion strategies**), and those designed to transform negative emotions and deal with challenging behaviors (**transformation strategies**).

Each of the strategies involved adults, peers, and the child care environment. In each case, the child care worker took on an active role, the peers of the children with challenges played a vital part, and the child care program and environment underwent key modifications or provided important supports for the strategy to bear fruit. Although talked about as separate strategies, it should be noted that in our observation of center operations, these approaches were woven nearly seamlessly into the day-to-day life of the center.

Promoting Positive Emotions and Prosocial Behavior

Child care staff members were clear about the importance of encouraging the development of positive social and emotional growth in children. An experienced counselor who was part of a child care program staff observed *“It’s not about warehousing kids... the whole program is very nurturing. The fact of giving kids choices, and treating them with respect and giving them responsibility at an early age is going to pay off substantially as they get older.”*

Staff approaches to fostering social and emotional development for children with challenges are displayed in a schema in Table 5.1 on page 65. Nine promotion strategies have been identified that have particular importance for work with young children, and three additional approaches that especially apply to school aged children are also outlined. It is important to note that although every one of the strategies is part of solid practice for all children, they have been adapted to meet the needs of children with higher levels of emotional distress and challenging behavior.

Promotion Strategies for Practice with Young Children.

Two of the strategies used by staff to promote social and emotional development in preschoolers and younger children are based on the care provider taking the initiative to build relationships.

Through **Promotion Strategy 1, Build a Relationship with the Individual Child**, staff members made a special effort to form and maintain a bond with each child in the center, taking exceptional care to get to know children with emotional or behavioral challenges and to learn to read their signals of distress. When a new child entered the center, teachers planned to spend as much time getting to know the child as possible: *“my first step...now is that I need to bond with him more. I need to get that connection with him.”* In another preschool which espoused an attachment model of care, a family consultant said about her colleagues *“that relationship that they develop with that child becomes a big thing...If adults are respectful to them and show...appropriate affection or nurturing to them, it makes a world of difference as to how they are going to behave in the classroom.”* The adult observed the child closely, and became attuned to the child’s moods and needs:

Every little opportunity I have, just kind of talk with him, maybe chit chat about anything. If he’s been playing ball that day, then I want to talk about ball, and just start a conversation going there, and then let him lead us down the path were he wants it to go or he doesn’t want it to go.

The relationship was the basis of day-to-day sensitivity to the needs of the child and obtaining information about changes that he or she may have been experiencing: *“Like if a kid didn’t get to go to sleep the night before or something; didn’t have a place to sleep. Or maybe they are just having a really rough time. Maybe just keep an eye on them and make the day a little easier for them.”* Staff members also made sure that the relationship was maintained and the child continued to be supported even after challenging behavior had diminished: *“...Letting teachers know that they still have to be patient...Just because [the child] makes a change doesn’t mean it is going to change for certain in this child’s mind, and continue to support them.”*

Promotion Strategy 2: Team with Family Members is based on forming positive and productive relationships between staff members and the child’s family: *“This is a team effort between the parents, the classroom, and then whoever we may need to call in for help.”* Teamwork begins by meeting with parents and striving to *“set some goals for things the parents are interested in.”* The goal-setting process leads staff to work on the things that matter to families, *“so we can be consistent between home and school.”* Based on a foundation of knowledge of family strengths, challenges, and priorities, staff members work on issues piece by piece. *“You look at their lives: the doctor’s appointments, the psychologist appointments the school people...plus they have a family life to try to maintain...Saying to them, ‘What is the toughest piece of your day? Let’s work on that!’”*

Staff members also spoke about gaining knowledge of the cultural beliefs of the family and then looking *“at what their belief system is and [coming] up with some ideas within that belief system that is the safest or most appropriate or most helpful for the child.”* The cultural practices and family languages also become part of the center environment, so they are a basis for learning on the part of both staff and children. Communication between staff and family goes on in the family’s language, using translation if necessary, and learning materials are made available in languages spoken by segments of the school’s population. Many of the staff mentioned the importance of documenting notable events in the child’s day and then making sure *“We let the parents know.”*

Operating from the basis of solid relationships with their families, staff members employed **Promotion Strategy 3: Work from Knowledge about Individual Children and their Challenges**. Child care providers looked to parents as *“experts on their child,”* and learned about their history in child care and important events in their lives. If the child was known to have emotional or behavioral problems at entry, *“we generally talk about it a lot beforehand, meet with the parents, find out what works for them, what strategies do they try at home...so that we are prepared for the first day.”* This dialog with families

continued for teachers: *"You know, we are seeing some of this. Are you seeing that at home?"* If the staff and family were not able to jointly come up with ways to promote desirable behaviors, they had a *"meeting with a few more people...and talk about different strategies."*

As they sought ways to work more effectively with individual children, staff members learned on a daily basis from their interactions: *"I think this also helped me broaden my understanding. I've worked with a lot of children with autism, but every child is different. And just learning more of different strategies that might work things out."* In some cases, the staff and family were assisted in their quest for specialized knowledge about the child's particular challenges by inclusion specialists, speech therapists, mental health professionals, or other consultants: *"The mom helped a lot with bringing in resources from the different people who have given her written information and just sharing things. She also met with us, with the augmentive communication specialist and we just looked at how we were going to do all of this together."*

The specialized knowledge about the needs and challenges of individual children then could be used to plan specific therapeutic activities benefiting the child that could be carried out in the general classroom environment. These activities were incorporated within classroom curricula founded on **Promotion Strategy 4: Build a Developmentally Appropriate Curriculum**. As noted by the directors, a flexible approach to curriculum building was maintained by staff in these centers, and activities were planned based on the developmental levels of children in individual classrooms. What they counted as important was *"developmentally appropriate practice. Because if you are doing that, you are serving children with all needs... You are providing them with things that are going to challenge them, [and also] things that they can really do simply, so that they can really feel great!"*

An extended example of developmental practice was given by an experienced special education teacher who discussed preschool circle activities that met the needs of individuals:

"Oh look, I'm looking at our schedule here and all the kids are sitting down, legs crossed, hands in their laps. Let me see who's ready!" (Which is a behavior management technique for the whole group, but may really be targeted toward those one or two really squirrely people in the classroom.) *We're using a visual schedule with everybody because we know we've got five kids on IEPs in the classroom, who are truly visual learners, and if you just tell them, they are not going to really get it. But if they have something to see, that provides more information...We are making soup and drawing out everything...Here are some dry noodles for everybody all the way around the circle which then gives the antsy ones something that they can legitimately fiddle with while we're making the list about what needs to go in the soup... The kids are focused because it is hands on.*

Within the inclusive classrooms, such as the preschool just discussed, **Promotion Strategy 5: Balance Consistency with Flexibility** was put into practice. Consistent, predictable environments were established by staff. The caregivers knew how to *"give kids choices and set limits in a reasonable way...the noise is pretty high, but everyone's in control, and everyone knows what the expectations are and everyone's doing their own thing and that's OK."* Structured schedules and curricula were put into place, but teachers were prepared to make changes based on interests and needs of children. For example, an individual child might be allowed to withdraw from a noisy group activity because she was not ready to handle the stimulation, or a schedule might be changed based on needs. *"Some days all these kids will come in and it is like everything is fine and we go with our routine. There are other days when one of them won't want to get up and go to lunch [and staff must deal with that]...As the year goes on it does get easier, once they get the routine down and they know the staff."*

In the view of some of the teachers, providing a structured environment was essential for children with challenges to feel safe, and for staff to utilize **Promotion Strategy 6: Assist Children to Feel Safe and Calm**. One kindergarten teacher said *"My room is very structured, because I think children are secure when they're in a structured environment. They know what's going to happen next. They feel like they have control."*

Nearly one third of the staff members expressed a belief that achieving a sense of safety was necessary for some children who had emotional or behavioral challenges to stay calm in stimulating environments. In one preschool where staff served children at risk, a teacher stated *"With a lot of our children...the 2 ½ hours that they spend here every day is like the one time that they have where they can be a kid, and not have all these outside factors that they have to deal with and that they can feel safe."* Her concern then was to figure out *"what is going to make them calm, and what is going to make them feel safe."* Staff verbally assured children that they were safe and attempted to create spaces that individual children could retreat to in order to regain a feeling of calm. *"A lot of our classrooms have those little kinds of cubbies underneath the countertop. There is a little space and some of the teachers have put pillows or blankets under there."* Fluorescent classroom lights were covered with light absorbing materials to lessen the stimulation, rocking chairs were made available for self-soothing by children of a variety of ages, and lofts and reading nooks were reserved for the use of one child at time. With children who had trouble remaining calm, key work was accomplished in the less threatening environment of small groups of mixed age, where the stimulation was not as strong, and was targeted.

Staff also encouraged children to express their feelings in art, which raised the serenity level of some children. With the youngest children, caregivers spent time in close proximity to individual children to calm them and help them stay in control of their feelings and behaviors, and sometimes temporarily removed them from busy classrooms and stimulating situations where they did not feel safe: *"So my first*

train of thought is working with the child to...get them to feel safe and to be calm. Initially I try to do that in the classroom...If it becomes apparent that they are not going to be able to do that...they may come...and do something one-to-one with me for awhile until they can feel safe."

For young children who exhibit emotional or behavioral challenges, verbal expression of feelings and listening skills are often underdeveloped. Therefore some staff had adopted **Promotion Strategy 7: Use Multiple Sensory Channels.** The preschool mantra "Use your words" was often repeated by staff members and observed in use in the settings we visited. However this refrain was sometimes received by children who were experiencing much frustration by not understanding what others were saying to them or by not being able to express their feelings. Staff made very clear statements about what they expected children to do: "I will know you are calm when your voice is quiet and your body is still." They also used what a speech therapist termed "visual structures," pictorial representations of schedules, activities, desirable behaviors, and positive feelings, as graphic supports for their interactions with children:

We have...several different social scenarios drawn out in stick figures so that we can point to the little picture and say, "Here you are, [child's name], your legs crossed, your hands are in the lap, you have a smile on your face."...so that we are very clear with the child about...when we will know that you're ready....Sometimes kids don't...have the words...If we're not very intentional about providing that, they're still kind of floating out there doing whatever.

Staff members also used physical guidance and touch to convey messages about staying calm and focused, "Sitting behind a child maybe while someone else is presenting at circle time, providing deep massage or a bear hug, to help this kid be calm and focus and stay with whatever is going on in front of him."

For young children some of the most confusing and frustrating times in the child care day are transition periods, when activities, surroundings, and even staffing or peer groups can change. As one staff member put it, "right at lunch time or nap time...if the kid's going to fall out, that's when they're going to do it." These are so problematic, that care providers had developed **Promotion Strategy 8: Support Children through Times of Transition.** Especially with younger children, making the transition from home to center was difficult, and preschool staff would make sure that they had one-to-one time with children who were having trouble with "drop off."

We've got a few children who...when they first get dropped off...[would] rather be with their parents. And usually we will hold them for awhile, keep them in our lap, keep them close to us, cuddle them, and make sure that we reassure them that their parents are coming back. They promised they would, they came back yesterday to get them, they are going to come back today.

Staff would also build warnings about pending transitions into the day, "In a minute you are going to have to put toys away. In a minute you are going to have to come inside." so that children could adjust to the change gradually. In fact, staff watched signals being given by children to smooth transitions, "If he's really into an activity, he's slow to transition to something else. So we usually make him the last one so that between the time we [change the activity of the first child] to the last one, maybe what we're doing on the other side of the classroom will attract him." For children with extraordinary difficulties, another staff member may remove the child from the classroom setting to run an errand or to take a little walk, so that the change will have happened by the time the child comes back to the classroom.

Perhaps the most heart-wrenching form of transitional difficulty was found in children who did not want to leave the center to go home. One of the supervisors assisted a teacher who witnessed a preschooler put up a physical struggle every day before he was to get in a van to go home. "One of the things that we worked out for this teacher...is that she gave him one thing from the classroom that he could take home with him, which to him made him understand that he was coming back again tomorrow."

Transitional objects would not solve the problems of children who had difficulty transitioning from child care to the public schools. These transitions were only eased by joint planning that involved public school and child care personnel to support children with challenges. "We will work with the family to make that transition. We usually try to even catch people in the spring when there is still staff around. Maybe have a conference with the school staff, give them information."

Child care staff acknowledged the contribution that early childhood settings and out-of school care made to preparing children for academic work. This contribution was expressed in statements leading to **Promotion Strategy 9: Promote Social and Emotional Development as Necessary for Learning.** Centers with preschool programs monitored children carefully to make sure they developed the self-regulation and behavioral skills necessary for academic accomplishment, and made modifications where necessary. "The kids are focused because [classroom activities are] hands on; It's a demonstration."

Several staff also mentioned that the development of literacy was one of the primary goals parents had for their children. Therefore staff worked to make materials available so that family members could participate in pre-academic activities with their children. Centers sent home books in English or Spanish, lent activity kits to parents so that they could engage in learning experiences with their children, and encouraged parents with low reading skills to participate in family literacy programs. Older children and volunteers served as "reading buddies" so that children had greater exposure to language-based materials.

Table 5.1 Practice Strategies for Promoting Positive Emotions and Prosocial Behavior in Young Children with Challenges

Adult Roles	Peer Roles	Environmental Modifications
Promotion Strategy 1: Build Relationship with Individual Child.		
<ul style="list-style-type: none"> •Build a relationship with the individual child based on trust and respect. -<i>Learn individual signals</i> -<i>Stay attuned to child's day-to-day challenges and emotional states.</i> -<i>Continue support of child with challenges after behavior becomes more positive.</i> 	<ul style="list-style-type: none"> •Develop peer relationships with all children in the classroom including those with challenges. 	<ul style="list-style-type: none"> •Activities are structured so that teachers and children interact positively and frequently with each other. •One-on-one time with child is available when first enrolling at center.
Promotion Strategy 2: Team with Family Members.		
<ul style="list-style-type: none"> •Form a team with family members to work toward the child's success. -<i>Determine family goals for child.</i> -<i>Work toward consistency between home and school.</i> -<i>Learn about child's home culture</i> -<i>Build on parents' expertise and the strengths of the family.</i> 	<ul style="list-style-type: none"> •Peers are not present when adults discuss challenges. •Children participate in diverse cultural experiences. 	<ul style="list-style-type: none"> •Time is set aside for communication between staff and family members. •Documentation is maintained regarding children's notable experiences. •Activities and expectations are based on culturally appropriate models.
Promotion Strategy 3: Work from Knowledge about Individual Children and their Challenges.		
<ul style="list-style-type: none"> •Work from a base of knowledge about individual children. -<i>Learn what works at home from parents.</i> -<i>Know key events in child's life</i> •Seek consultation on individual children.. 	<ul style="list-style-type: none"> •Engage in therapeutic activities as appropriate. 	<ul style="list-style-type: none"> •Individualized activities are developed that support children with challenges. •Therapeutic activities are incorporated into the classroom. •Mental health, inclusion, and speech therapy consultation support children.
Promotion Strategy 4: Build a Developmentally Appropriate Curriculum.		
<ul style="list-style-type: none"> •Create and support a developmentally appropriate curriculum that meets the needs of all children at the center. 	<ul style="list-style-type: none"> •Engage in common activities with all children in class. 	<ul style="list-style-type: none"> •Classroom activities are appropriate given the individual needs of children with challenges.
Promotion Strategy 5: Balance Consistency with Flexibility		
<ul style="list-style-type: none"> •Create a consistent, predictable environment while maintaining flexibility. -<i>Establish classroom rules and consequences.</i> 	<ul style="list-style-type: none"> •Peers model normative behavior. •Peers receive attention, rewards for prosocial acts. 	<ul style="list-style-type: none"> •Small, homelike, structured classroom areas. •Consistent schedules with choices available.
Promotion Strategy 6: Assist Children to Feel Safe and Calm.		
<ul style="list-style-type: none"> •Assist children to feel safe and calm. -<i>Teach self-soothing behaviors.</i> -<i>Use artistic expression of feelings.</i> -<i>Remove child to quiet space when overstimulated.</i> 	<ul style="list-style-type: none"> •Let peers withdraw to "safe" space when feeling anxious. 	<ul style="list-style-type: none"> •Appropriate levels of stimulation are maintained in the classroom. •Key work accomplished in small groups. •Spaces in the environment permit child to feel more secure and safe.

Table 5.1 (Continued)

Adult Roles	Peer Roles	Environmental Modifications
Promotion Strategy 7: Use Multiple Sensory Channels		
<ul style="list-style-type: none"> •Use multiple sensory channels when working with children with challenges. •Attach words to positive feelings and actions, through graphic representations. •Use physical guidance and touch. 	<ul style="list-style-type: none"> •Peers also engage in activities using varied sensory experiences. •Non-native English-speakers acquire English more rapidly. 	<ul style="list-style-type: none"> •Visual schedules and visual prompting materials for activities are provided. •Physical proximity of adults supports children.
Promotion Strategy 8: Support Children through Times of Transition		
<ul style="list-style-type: none"> •Support children through times of transition. -Warn children about coming transitions. -When necessary, remove them from the scene of the transition. -Spend time with child at drop-off. -Work with staff of other schools to ease transition to public school environment. 	<ul style="list-style-type: none"> •Model suitable affect and behavior during transitions. 	<ul style="list-style-type: none"> •Build a stable staff, and consistent staffing patterns. •Schedule warnings about transitions. •Provide transitional objects from classroom to take home for children with challenges. •Support available for interschool transitions.
Promotion Strategy 9: Promote Social and Emotional Development Necessary for Learning		
<ul style="list-style-type: none"> •Provide opportunities for children to master behavior necessary for learning. •Utilize the family cultural context to work toward literacy skills. •Seek consultation when behavior is interfering with learning. 	<ul style="list-style-type: none"> •Peers model behaviors promoting learning. •Engage older children in “reading buddy” activities. 	<ul style="list-style-type: none"> •Books in the home language available for family use. •Activity kits promote learning at home. •Consultants assist with acquisition of behaviors necessary for learning.
Additional Practice Strategies for Promoting Positive Emotions and Prosocial Behavior in School Aged Children with Challenges		
Promotion Strategy 10: Develop Age Appropriate Out of School Activities		
<ul style="list-style-type: none"> •Create and support a wide variety of out-of school activities, both enrichment and academic supports. - involve children in planning activities 	<ul style="list-style-type: none"> •Engage in common activities with all children in classroom. 	<ul style="list-style-type: none"> •Classroom activities are appropriate given the individual needs of children with challenges. •The numbers of children participating in an activity at one time are limited by planned class size and space.
Promotion Strategy 11: Set Clear Boundaries and Expectations		
<ul style="list-style-type: none"> •Set clear boundaries for acceptable behavior while maintaining flexibility. -Establish classroom rules and consequences. -Set expectations for responsible behavior from all children. 	<ul style="list-style-type: none"> •Peers model normative behavior. •Peers receive attention, rewards for prosocial acts. 	<ul style="list-style-type: none"> •Small, homelike, structured classroom areas; no “herding” of large groups. •Consistent schedules with choices available. •Clear structure and expectations for conduct.
Promotion Strategy 12: Teach Empathy and Responsibility		
<ul style="list-style-type: none"> •Teach empathy and responsibility through care of animals, plants, and younger children. 	<ul style="list-style-type: none"> •Let peers model responsible care. 	<ul style="list-style-type: none"> •Animals and gardens are included in the center environment. •Cross-age experiences available under staff supervision.

Finally, because of the goals of the parents, and the focused attention of the staff, children who had not met the social or emotional developmental milestones needed to learn in the public schools were referred by staff for assessment so that they could receive supplementary support services.

Additional Promotion Strategies for Practice with School-aged Children

Building on the key strategies used with younger children, out of school care providers also discussed three more strategies that were appropriate for school-aged children. **Promotion Strategy 10: Develop Age Appropriate Out of School Activities** involved creating and implementing a wide variety of sports, enrichment, and academic support activities. In an informal after-school program, a teacher said, “*They don’t have all the kids together in one place, they have choices. They can be sitting over here [in an activity center] or they need to go get in a loft and be quiet and read a book...It sets a tempo, and it definitely gives them a place after school to wind down and relax, get rid of some of the energy, and then go home.*” These activities were often planned in conjunction with groups of the children that were served in the program. The needs and challenges of children were also factored in, and special activities that were available to all were targeted to promote their social and emotional growth. For example, one large out-of-school program offered small group sessions discussing issues around making and keeping friends. Activities were structured for small groups that never exceeded fifteen children in even the largest programs.

Promotion Strategy 11: Set Clear Boundaries and Expectations is developmentally appropriate for school-aged children. Teachers clearly communicated their expectations for behavior of the older children, and established class rules and consequences. “*We’re still there as guiding adults...They know they can’t work us over, that we’re going to be loving but...you can’t act out of control around us.*” Systems were set up to foster responsibility: “*It’s done with lots of respect, consequences are reasonable and understandable.*” Children earned privileges and treats, were expected to be responsible for equipment that they checked out, needed to clean up after themselves, and were encouraged to treat their peers with respect. Peers communicated the expectations, and older children showed the younger ones the ropes. “*It is amazing to watch this one young lady who’s here; how naturally she knows that system because she was raised in it [and conveys it to younger children].*” Out of school care providers were able to monitor these systems since they were working with children in small groups: “*children are not herded like cattle around here.*”

Promotion Strategy 12: Teach Empathy and Responsibility was thought by staff to be especially effective for children who were working on difficulties of attachment to others. Several of the centers used the care of plants and animals to teach basic lessons in empathy and responsibility. School-aged child care environments included gardens and pets; children who were struggling with attachment took responsibility for their care and became bonded to living beings that depended upon them. “*I see that as a very strong characteristic of our program...that we’re encouraging children to have empathy for others. We start on a very basic line of animal care; hopefully it will show them responsibility to work with their peers and have respect for peers and adults.*” These children with challenges were also observed working with younger peers, under the watchful eye of caregivers, and developed solid relationships with them, with the eventual goal of developing real friendships with their age mates, who were more demanding.

Transforming Negative Emotions and Challenging Behavior

Staff of child care centers are beset each day by negative emotions and behaviors that are difficult to manage or troublesome, but within the range of feelings and actions that can be expected of children developing typically. Additionally, they can see problem behavior that is symptomatic of a disorder that may require modifications of their classroom practices or even intervention by a mental health professional. Two dimensions of behavior problems have been identified by clinicians: problems of undercontrol and problems of overcontrol (Achenbach, 1991, 1992). Campbell (2002) has characterized **externalizing behaviors** as undercontrolled, those which are “expressed outward against others or have an impact on the child’s environment,” and are exemplified by fighting, overactivity, tantrums, destructive acts, and defiance. On the other hand **internalizing behaviors** are overcontrolled, and Campbell (2002) defines these as being “reflected in social withdrawal, fearfulness, unhappiness, and anxiety” and as representing “self focused expressions of distress.”

When asked to talk about their recent work with children, although most staff spoke of children with externalizing behavior, children struggling with internalized distress were also discussed. Strategies that staff used to deal with symptomatic behaviors of children with challenges are illustrated in Table 5.2 on the following page; these strategies also helped them cope with troublesome behaviors of children developing more typically.

Table 5.2 Practice Strategies Used by Child Care Staff to Transform Negative Emotions and Challenging Behavior in Children with Emotional or Behavioral Challenges

Practice Strategies for Transforming Negative Emotions and Challenging Behaviors of Young Children		
Adult Roles	Peer Roles	Environmental Modifications
Transformation Strategy 1: Engage in Pre-emptive Planning.		
<ul style="list-style-type: none"> •Engage in pre-emptive planning to minimize negative feelings and behaviors. -<i>Staff watch for signals of emotional build up.</i> -<i>Parents communicate challenges they have experienced recently at home.</i> 	<ul style="list-style-type: none"> •Children assist their peers “having a bad day.” 	<ul style="list-style-type: none"> •Child placed in classroom with an appropriate mix of peers. •Child temporarily removed from overstimulating environments. •Flexibility in scheduling used to fine-tune activities.
Transformation Strategy 2: Develop Formal Behavior Plans through Consultation.		
<ul style="list-style-type: none"> •Develop formal behavior plan to manage challenging behavior. -<i>Document incidents.</i> -<i>Use supervision and consultation.</i> -<i>Involve family members in planning.</i> 	<ul style="list-style-type: none"> •Peers learn to express their needs and feelings to child with challenges. 	<ul style="list-style-type: none"> •System of consequences and rewards put in place. -<i>Modifications in classroom routines and activities established.</i> -<i>Communication about child’s progress with parents frequent.</i>
Transformation Strategy 3: Assist Child to Use Verbal Self Expression.		
<ul style="list-style-type: none"> •Work with child to be more verbal and express needs and frustrations in words. -<i>Enlist help from speech therapists.</i> -<i>Use signs with children having low verbal skills.</i> 	<ul style="list-style-type: none"> •Peers model verbal expression of needs, frustrations. 	<ul style="list-style-type: none"> •Posters illustrating the use of words to express needs are displayed. •Visual representations of signs are posted.
Transformation Strategy 4: Substitute More Appropriate Behavior.		
<ul style="list-style-type: none"> •Substitute more appropriate behavior -<i>Suggest alternate behaviors in positive terms rather than as prohibitions.</i> -<i>Use art as a vehicle of expression.</i> -<i>Use drawings to illustrate desired behaviors and to indicate negative behaviors.</i> 	<ul style="list-style-type: none"> •Peers model appropriate behavior. •Peers use artistic self-expression. 	<ul style="list-style-type: none"> •Post signs, prompts for positive behavior and feelings. -<i>Art supplies are available to children.</i>
Transformation Strategy 5: Foster Problem Solving.		
<ul style="list-style-type: none"> •Teach problem-solving to children -<i>Talk through issues with verbal children.</i> -<i>Use drawings to illustrate working through issues.</i> -<i>Use action figures to act out situations.</i> 	<ul style="list-style-type: none"> •Peers engage with child in problem-solving. 	<ul style="list-style-type: none"> •Make figures and other toys available for use in working through issues. •Use posters as prompts for problem-solving.
Transformation Strategy 6: Employ Redirection.		
<ul style="list-style-type: none"> •Employ redirection to have child stop negative behaviors. -<i>Use alternate, positive activity to distract child from distressing emotion.</i> -<i>Use alternate physical activity</i> 	<ul style="list-style-type: none"> •Peers engage in new activity with child. 	<ul style="list-style-type: none"> •Provide a rich variety of attractive materials to be used without much set-up time.
Transformation Strategy 7: Focus Attention Appropriately.		
<ul style="list-style-type: none"> •Ignore some of the negative behavior. -<i>Learn which provocative behaviors individual children use to gain attention.</i> -<i>Comfort victims of aggression or children displaying positive behaviors.</i> 	<ul style="list-style-type: none"> •Peers are taught to ignore most negative behaviors. 	<ul style="list-style-type: none"> •Environments are of an appropriate scale so that children interact with teachers in smaller groups.
Transformation Strategy 8: Plan for Safety of Children.		
<ul style="list-style-type: none"> •Plan strategies to keep children safe from their own actions and those of other children. -<i>Parents, supervisors, consultants collaborate to put plan in place.</i> 	<ul style="list-style-type: none"> •Peers are taught to speak out to children acting aggressively. 	<ul style="list-style-type: none"> •Environment has quiet places for children to self-soothe, to lower emotional arousal.
Transformation Strategy 9: Work as a Team to Address Negative Behavior.		
<ul style="list-style-type: none"> •Employ other staff to assist with negative behavior. -<i>Other staff will back teacher up, bring “fresh patience.”</i> -<i>Team meetings used to plan strategy.</i> 	<ul style="list-style-type: none"> •Peers get to interact with different teachers, since team approach. 	<ul style="list-style-type: none"> •Structure classrooms so that sufficient back up staff are always readily available.

Table 5.2 (Continued)

Additional Practice Strategies for Transforming Negative Emotions and Challenging Behavior in School Aged Children		
Transformation Strategy 10: Establish Limits and Set Consequences for Negative Behavior		
Adult Roles	Peer Roles	Environmental Modifications
<ul style="list-style-type: none"> •Consistent limits are set by staff and communicated to children -Choice is emphasized with school-aged children. -Consequences are set up for negative behavior that are framed as restitution or contributions of positive work for community that is the center. 	<ul style="list-style-type: none"> •Peers model adherence to system of limits and choices. 	<ul style="list-style-type: none"> •Written materials are available on limits and expectations for both children and family members.
Transformation Strategy 11: Regulate Own Emotions		
<ul style="list-style-type: none"> •Staff de-escalates the emotional level of the classroom -Staff consciously work not to feed child's anger. -Other staff members back up when necessary 	<ul style="list-style-type: none"> •Peers learn to "back off" and regulate their own emotion. 	<ul style="list-style-type: none"> •Sufficient staff are present to provide back up in times of high emotion, "we can wait them out."
Transformation Strategy 12: Engage the School Aged Child in Working through Challenges		
<ul style="list-style-type: none"> •Child participates in developing formal behavior plan. -Staff and consultants work to engage child and family in planning process. 	<ul style="list-style-type: none"> •Peers assist child to have success. 	<ul style="list-style-type: none"> •Consequences are set and communicated to child, staff, and adults in family. •Progress is discussed with child.

Transformation Strategies for Practice with Young Children.

A child care worker at a large preschool stated her primary approach to dealing with difficult behavior, "A lot of what we do is try to change the environment, or do things that are preventative rather than waiting for the crisis to happen and having a crisis plan." This approach was discussed repeatedly in staff interviews, giving rise to **Transformation Strategy 1: Engage in Pre-emptive Planning**. Workers carefully observed children with challenges to detect signals of emotional build up, and got to know what was going on at home or school for the children in their care. In this way, they anticipated difficulties and modified the environment in ways that short-circuited difficult behaviors. "We had a group of kids a couple of years ago...whose moms were all having babies, and we were anticipating challenges. And so we tried to bring in [resources about adjusting to a new baby] to prepare those kids, because we were anticipating we were going to see some behavior challenges at school." Because of the flexibility in the environments, teachers reported changing activities when children signaled their restlessness or emotional build up "We're so flexible to say: OK, nobody here is interested in the toys that are out, let's get something else." They also removed children from challenging situations that they could not handle: "You've got a kid that just can't stand [organized classroom activities] for fifteen minutes, and they may be able to do it for the first ten minutes, and then you say, 'Oh, so and so, come on and let's do such and such' so that they can be appropriate." Finally, the assistant director of a larger center had the ability to assess the level of challenges in the classroom before adding a child to the mix: "Is this already kind of a highly stressed room and one more would just send them over the edge?" If so, the child would be placed in another classroom, or more resources would be added.

Although most issues with troublesome behavior were handled by staff on a daily basis at the centers, there were some problem behaviors for which the workers sought assistance and employed **Transformation Strategy 2: Use Consultation to Develop Formal and Informal Supports**. After experiencing some frustrations, staff reported calling on supervisors, therapists, or consultants who worked at the centers for some ideas: "A lot of time they [consultants or therapists] will have just really good ideas on ways to deescalate children." When simple solutions did not work, consultants used observation or even directly worked with the child. Sometimes when a "child is having a persistent unacceptable behavior, then we will write a behavior plan." One consultant spoke of his efforts to individualize these plans: "my personal philosophy is kind of, no two behavior plans should really be exactly the same, because no two kids are exactly the same." The formal plans staff discussed were developed by consultants teamed with the care providers, the parents, and the supervisors. A teacher remarked: "[the consultants] will come in and observe the child and look for the specific behaviors...and they work hands-on with the parents and the child to resolve those issues." In the vast majority of cases, teaching staff praised the work done by consultants, who helped children maintain enrollment in the centers.

Drawing upon consultation, formal training, supervision, and informal learning from a variety of sources, staff members reported the final ten strategies for working with individual children or groups of children experiencing difficulties. **Transformation Strategy 3: Assist the Child to Use Verbal Self Expression** was particularly widely used with very young children, but also was employed with those youngsters who had speech delays and used unacceptable behavior to express their feelings. One of the staff illustrated the change that took place in a girl who had difficulty with

aggression: "At one time she wasn't able to communicate, and when she would get angry, it would be screaming and throwing and tearing other children's faces and arms open with her fingernails." A caseworker from the school district helped the staff put the girl on a picture system: "They give them a picture of ...someone pinching and a big X through it, and words saying 'No, that hurts, that's not OK'...that helped a bit...This child has been in speech therapy for three or four months now, and has just made dramatic leaps...She has some way to communicate other than...scratching their faces." Staff used picture forms both to promote positive behavior and deter negative behavior, but reported the largest gains when children were given support in learning to communicate, by signs if necessary, and then by words.

Staff found that children who could express themselves verbally still needed guidance to stop their negative behavior, and so reported using **Transformation Strategy 4: Substitute More Appropriate Behavior** with some of their most difficult practice challenges. At one center a worker spoke of practice with a boy who had just turned three: "He would start biting himself and start screaming and crying and running...[developing] an area that had been gnawed on quite a bit." A teacher and consultant repeatedly observed him in the classroom, and noticed that the biting happened when he was unable to get his needs met. The direction "Don't bite yourself!" did not work with him. What did work was a clear request to deal with his peers verbally, "Go and tell her it is your turn." A new, more appropriate behavior was substituted. "We downplayed the biting thing...He has been gaining social skills, he has been enjoying play. It was just like this light bulb."

For some children art became a valuable vehicle for self-expression, transforming negative feelings and leading to verbal expression. "He'll draw himself sad, and just that activity seems to help him de-escalate, and then once he's calmer it's easier for him to get to the words and to have a conversation instead of having him falling out in the classroom." Perhaps one of the most dramatic stories of transformation was told by a preschool teacher who had a girl placed in her classroom after she was not able to be screened for kindergarten, since she would not speak to or make eye contact with, anyone other than her immediate family members. Her breakthrough came several weeks after she entered the preschool classroom:

The day that she spoke to me, we were drawing and she was making me guess at her picture. She had gotten to the point where she would sign or shake her head yes or no...Then all of a sudden she whispered something about one of her pictures. I am just like, "Don't overreact. Don't scare her." So I just whispered back. The only way she could talk to me for the first couple of weeks was through her pictures or through some little kind of prompt. The things she was drawing and talking to me about were things that were most important to her...Most of the things...were not happy things, were not good things. And then it went from there to us being in a...big cardboard [refrigerator] box...just the two of us, then she would talk...I still don't know why she chose me [to talk with] but I felt honored.

Several teachers discussed the importance of having children work through difficulties they were having with adults, peers, or the class routines by means of **Transformation Strategy 5: Foster Problem Solving**. A boy who did not know how to get the attention of adults properly gradually learned the culturally appropriate way to do this from his teacher who talked to him about the steps: getting up out of his chair, standing in front of an adult, and directly speaking to him or her saying what he wanted. Teachers would help individuals think through what should be done first and what second. Two of the staff talked about using drawing to assist children in talking through problems and issues, with both child and teacher adding to the drawing. A teacher discussed working with a child who refused to go to lunch:

I just started drawing. And he refused to look, and then he just started to calm down and started looking and I'm like: "What are we going to do next? What should I draw here? I see grandma [a foster grandparent] setting the table. Hmm. You know you're going to have to wash your hands...What do you think would be next? Do you want to draw it on here?" And we just moved him on.

Some of the settings also provided figures of people in families or in various occupations placed in trays of sand so that children could work through problems in play, sometimes alone, sometimes with teachers who guided them in thinking through issues.

Problem solving often took some time to diffuse negative feelings but was especially effective with more verbal children. Younger children were often able to be quickly distracted from negative or troublesome behavior by **Transformation Strategy 6: Employ Redirection**. Teachers discussed having attractive activities or toys at the ready for redirecting the attention of a child from annoying behavior. One child care provider recounted an episode in which one child was imitating adult swearing for the benefit of another. "I would separate the two kids, and I would get one kid distracted with a toy and have them do an activity, and the other kid come in another area and work with me...before I would say, 'You do not say that in class!'" With older children negative energy was often redirected to physical activity, such as the chores that the directors spoke about in school aged programs (See Chapter 4); these activities were taken up with the intention of expending energy from emotions in positive physical acts. Children vacuumed and earned credits for treats as they learned to self-regulate their feelings of anger and impulses to act aggressively.

Often accompanying redirection was an additional **Transformation Strategy 7: Focus Attention Appropriately**. Through this approach, teachers made sure that unless a matter of safety were involved, only appropriate attention-seeking behaviors were successful. When a child injured another through an aggressive act, several of the teachers talked about the strategy of paying attention to the

victim and having the peers also comfort the victim first. Ignoring the aggressor would often be enough to stop hurtful behavior in short order. However there were some children with multiple challenges who needed more concentrated work. The oldest preschool child of a pregnant single mother with a toddler *“was having extreme negative attention-seeking behaviors, to the point of hitting everyone around, throwing things.”* He was also exhibiting *“self-injuring behaviors.”* With the assistance of a behavioral specialist the staff was able to put together a coordinated effort, *“in terms of ignoring a lot of behaviors and redirecting him. It just seemed to work well over time.”*

In our interviews with staff, a central concern for staff was the safety of children, especially those who exhibited undercontrolled behavior or the targets of aggressive activity of these children. This led to a very key **Transformation Strategy 8: Plan for Safety of Children** which was even necessary for very young children with challenges. Staff considered the needs and risks of individual children and had plans in place to deal with challenges. Safety plans sometimes dictated that environments include beanbag chairs for children who threw their bodies around, and needed to *“thrash around”* in a place where they would not self-injure, that staff needed to be trained to restrain children from hurting themselves or others, or that the child’s peers needed to have lessons to speak up for their own safety. A teacher told children, *“You just need to tell him you don’t like it when he pushes you. Speak up...Let him know that you are not happy, that you are not going to play with him if he treats you this way!”*

Safety plans and other approaches worked well because of **Transformation Strategy 9: Work as a Team to Address Negative Behavior**. Staff members reported their willingness to back each other up, and to bring in *“fresh patience”* when a child’s persistently annoying or troublesome behavior had *“pushed the buttons”* of the regular caregiver. A special education lead teacher said, *“The fact that I’m in the building when somebody absolutely loses it, I can say: ‘Well, here, let me take so and so, and we will go for a walk. See if we can calm down.’...Just being there makes a great difference.”* Staff members shared knowledge about individual children and jointly devised approaches that might work. They also traded strategies and agreed to be consistent about the ways in which they dealt with behavior issues. Discussing one child who presented challenges to the entire staff during a difficult time in his life, a teacher said, *“We were going through a period of power struggles with him, and we talked about it at our team meetings a lot, about all being consistent, about not enabling behaviors. [And about] ‘how do we move him on?’”*

Additional Transformation Strategies for School-aged Children.

Working with children in out-of school programs, caregivers applied **Transformation Strategy 10: Establish Limits and Set Consequences for Negative Behavior**. Program

rules were made clear to the children and their parents, as well as the consequences for negative behaviors. One teacher reported saying to young children, *“You need to come to the table and wash your hands, or you can’t have snack or lunch. That is the rule in school that we have to wash your hands before we eat.”* The enforcement of consequences was generally structured within the idea of choice so that children did not feel as though they were hearing an ultimatum. *“Instead of saying ‘Pick them up or else’ we give him choices...about what his limits are, and he does have choices. But he has kind of learned how to make the right choices now. That’s come a long way, too, this year.”* Consequences for negative actions were sometimes framed in a restorative sense, so that the child paying the consequences for negative behavior would contribute directly to the children in the program:

It’s an idea that says every time something happens, let’s say two kids aren’t getting along instead of giving them a punishment or something like that you try to help them make it up. Like if somebody destroys a mailbox you try to help them figure out a way to replace the mailbox. Or if somebody hits somebody, you try and help the kids get along again, and make sure that the kid that did the hitting does something that helps make the kid that got hit feel better.

In all of this work, staff talked about a key method that was used both at the personal and the staff level, **Transformation Strategy 11: Regulate Your Own Emotions**. Staff began by acknowledging to each other that work with children with emotional or behavioral challenges was difficult, but recognized that these children could *“pick up on what people think about them, and if people want to be around them or not.”* For the staff it was crucial to *“de-escalate”* the emotional level in classrooms for the good of the individual child, and model positive self-regulation: *“Because if he sees that we are getting at our wit’s end, it just provokes him more, and he just keeps doing it. So we have kind of learned to back off and be real patient with him, and it really has improved the episodes [of explosive behavior].”*

An intriguing part of the work for out of school care staff is embodied in **Transformation Strategy 12: Engage the School Aged Child in Working through Challenges**. Since older children can begin to reflect on their own actions and their consequences and learn from them, staff members have used *“teachable moments”* to have children struggling with emotional or behavioral issues learn from their difficulties. Perhaps one of the most optimistic statements was that made by an inclusion specialist at a large out of school program who talked about the importance of both tailoring a behavior plan to the individual child and engaging him or her: *“So really trying to make it unique to them and something that they are excited about. And trying to make it fun and make it interesting for them.”* In this way, the child got to see his or her own progress, and felt more in control of emotions and behavior.

Building a Staff that Can Achieve Inclusion

As discussed in the previous chapter, the directors recognized the essential role of their staff in enabling the inclusion of children with emotional and behavioral challenges in the center. One staff member noted that, “*the first priority [is] you have to have the staff to be able to take care of these children.*” It was evident from the staff interviewees that the successful provision of inclusive child care was both rewarding and challenging, and required that “*a lot of pieces [be]...in place to make a program successful.*” Staff members talked about a range of issues that in their experience enabled the centers to meet the needs of children with special needs. These included: personal qualities of individual staff members, a shared value system that included a strong commitment to the success of the children, a commitment to building and maintaining relationships among coworkers, a supportive organizational structure and culture, access to additional support resources, and training and development opportunities.

Personal Qualities of Individual Staff Members

In addition to educational qualifications, interviewees noted the importance of personal qualities in working with the children in these child care centers. It was evident from interviewees that a love of working with children was an important dimension of their work. Staff commented on “*the love the teachers have for the child*” and “*just being there*” on both good and bad days, as well as conveying respect for the child.

The staff is also welcoming to the kids, and we all really love kids a lot, so there's warmth...

There is a genuine basic empathy and caring that [staff]...have. Because it is not about the money they make.

A respectfulness that some people just have naturally for children. I think that makes a big difference ...just their whole attitude in how they set up the classroom and how they teach the children, and how theycommunicate their expectations to each child.

Several staff members noted the importance of the qualities of their coworkers, and described the “*caliber of the staff*” and the “*commitment level*” and “*dedication*” of their colleagues, who were “*here because they care. [They are] here for the children.*” They also noted that it was important “*for workers in the child care business to have patience [and] to work on getting patience*”, and to have “*a lot of tolerance.*” One staff member described her coworkers as “*just the right group of people with the right heart*” and as “*people who invest so much in who they are and how they are...[in the hope of]...building a better future for the little ones.*”

Shared Values among Staff

In addition to the qualities of individual staff members, interviewees also discussed the role of both personal and organizational values in guiding their work in the center. This included a positive approach to children's disabilities and valuing of coworkers and their contributions.

It's challenging...the kids, you know, obviously that's what we're here for is children with special needs, disabilities, behaviors, but they are wonderful children and I love being here.

...and the children are just, each one of them is special in every way, in their unique ways, they're very, even though they have behavior problems, ...they still have that loving part of them that I just love ...I can go home at the end of the day and say: I've done something good.

A number of staff explained the positive aspects of working with children with special needs, as they described the intrinsic rewards that motivated them to do the work they did.

[working here] is very rewarding ...I know some people who talk to me know that it isn't work and they can tell.

[These children] make our lives more interesting. That's why we are here. We are here to try to meet the needs of kids with unique personalities and unique little people. I think a lot of times, and this is a huge challenge, to try to help people understand, to look at it as an incredible opportunity, instead of a huge bummer ...you really have to be committed to sticking it out for the long haul if you really want to get a lot of benefits. Even though in what other job do you get so many hugs and smiles.

I think it's an incredible gift to be here ...to be a part of these kids' lives and their families.

Some staff members described how the culture they had built in the organization had an impact on the families who enrolled their children in the center, and how caring values were transmitted to the children.

I just feel this being here 18 years, that there is a confidence here, that they [parents] feel that people here [staff] will truly let their child be a child and enjoy the experience of childhood. But in addition to that, meet the needs where they are...here our motto is, 'A kid is a kid'. A child is a child first, so what can we do to help that child really have a lot of fun and learn through play and peer challenges and all that, but still also meet the needs that they have with the speech therapy and the physical therapy and all those other needs that may be more specific to that child's diagnosis.

We have so many kids with different special needs ...It is just how staff handle things too, and don't make a big deal out of everything ...The other kids want to help and make everyone happy...I think it is just part of our environment

Commitment to Building and Maintaining Relationships with their Coworkers

In addition to their commitment to the children, staff described a strong sense of community and the importance of relationships and respect for each other. They felt that team work was essential. Close relationships among the staff, and a high level of trust enabled staff to work closely together for the benefit of the child.

I think the staff respects each other. We have a great day care director. And the staff is just full of personal integrity ... people have developed a relationship. They're just very professional. And I don't know how you teach that.

There is not one person or one child in this building that I wouldn't do something for. But you find the other staff does the exact same thing.

The high level of commitment to coworkers was demonstrated in a number of ways. For example, one staff member talked about how staff donated their sick leave to a coworker to enable her to take time off during a family illness. Loving, caring, and respecting each other, were strong values which permeated relationships with coworkers and with the children and families, and informed their personal approaches to inclusion.

It's that type of [caring] environment, and it goes from the staff to the kids.

You've been with somebody from the time they're eighteen months until they're five, you love that person. It's not just a job.

A number of staff described the close bonds they had developed with others in the center, and explained in terms of a "family atmosphere" in the center which extended to coworkers, staff members, and families with children enrolled in the center.

I would honestly say that I have never been closer to people...[I work with] in my life. I feel like they are my own family.

I'm very close to my staff because I feel they are very, very special, and I would say that I'm also very close to the children here. ...Being here I know that every day when I go home, whether I've had a rough day or a good day, regardless, I've made a difference in a child's life. And if it wasn't for us...the whole team here, what would happen to these children?

We give them [families] a lot of support and love...we feel like we're family members. We treat everyone as if they're our family. So really we're here for the support and needs of all the parents.

The respectful and trusting relationships among staff were an important basis for enabling them to work together for the benefit of the child and to manage conflicts, such as those arising from different views on the appropriate intervention, by focusing on the child's needs.

Any time you deal with a person who's an individual with their own way of doing things, it's a learning experience for everyone. If you are always questioning my motives or what I was going to do next or it was OK to be around me, then you would never get that comfortable feeling to where a person could grow...I think here we develop that trust and encourage that comfort so that the true you, or the true them, or the true us, can shine through to anybody that comes in the door.

Feeling valued was also important to enable staff to do the work they did. "The majority of the people here are happy and like their job. The administrator goes out of her way. You know, she does things outside of day care for the employees...overall she treats the staff very well."

Recognizing the Value of the Contribution of Each Team Member

Despite the demands of the work, some staff described a fun and friendly atmosphere. They also recognized the importance of the team, and felt that each staff member had an important contribution to make. Working effectively as a team also meant being able to utilize the unique contributions that an individual could make.

There is such a diverse group that works here...each one of those individuals brings so much to the program. I think it takes everyone working together to achieve what we have here.

We play, we laugh, we joke, we have a good time ...[Staff] welcome you in ...[as a new staff member] ...everybody is part of the team ...[Program planning is] not just dependent on one person to sit and ...come up with everything ...everyone has a piece to play ...we have meetings where we all brainstorm together. It's a team. It's a family, it really is here.

It was evident that the children benefited from open sharing of information among staff about practice with an individual child. For example one staff member described how exchanging information with coworkers was essential to creating a consistent environment to support a specific child: "We share the drawings with the other staff to let them know that this works, '[With] this child this works,' and then we all do the same thing." Another interviewee reported, "We always try to do the same thing always follow up. That way if I'm doing something the other staff is not doing something to have a negative [and opposite effect]."

The Need for Support

Staff did not downplay the challenges of the work they were involved in, and were clear about the importance of adequate support in enabling them to be successful in meeting the needs of children with emotional and behavioral disorders. *"We are letting the classroom staff know that, man, these kids have some behaviors that just drive up the wall. And so we're very open about admitting it."*

A support system founded on a commitment to inclusion at all levels of the organization was essential for successful inclusion.

A lot of places, they are battling either the administration because they don't want the kids in because it is causing too many problems. And all the other parents are mad because this child keeps biting, and they are going to all get out of here and dis-enroll...It is a tough job and you really have to have that support system with the other adults to do it successfully.

Staff described a number of dimensions of support including the structure and culture of the organization, access to additional support systems, and training and development opportunities.

Support and the Structure and Culture of the Organization

How the Structure Supports Staff

Staff interviews confirmed the view of the center directors that a high quality child care environment is an essential foundation for the inclusion of children with emotional and behavioral disorders. Staff members recognized the importance of the physical environment of the center. One interviewee noted that having *"a well maintained facility...play[ed] a part"* in the success of the center. As might be expected as a result of difference in the centers studied, staff also experienced challenges arising from the physical environment. These are discussed further in a later section of this chapter. The significance of having a high number of staff in relation to the number of children in the center for the success of their work was noted by almost all the staff interviewees.

Our ratio between adults and children are very high, especially compared to any true child care centers.

We have a maximum of 10 children to a 3 staff ratio, and sometimes 4, because we have a volunteer...We are able to give the attention to that child that they need for that day.

Staff talked about the importance of adequate staff-child ratios not only for problem prevention and successful practice, but also for stress management and for staff support. Although staff identified the role of the skills they had developed as individuals to deal with stressful incidents, this was in the context of having the option of back-up when

required. For example, one staff member described how she dealt with difficult situations by saying *"usually I just do a deep breath and just let it out really slow."* However she also emphasized the importance of having the option to leave the scene: *"If that doesn't work, or I feel like I am too frustrated to even handle the situation, I can always call on somebody else to deal with it ... that is one of the things they are really big on in our program, is always having that be available."* Another staff member discussed how having sufficient numbers of staff enabled them to create a system of peer support.

And we talk about the fact that we're lucky we've got lots of staff, when you feel like you've really had it, pass [the child] off to somebody else. That's an option we've got.

Take turns with certain children that need the one to one attention and that way if we keep on switching on and off, one person doesn't get so frustrated that they're just going to pull their hair out, we can all keep our cool, and I think that's probably better for the children too.

Adequate staffing gave them the flexibility to move between classrooms in the event of a crisis, and *"to give an extra hand, to kind of get the pressure off the teacher."* Having sufficient staff also enabled them to detect potential problems in early stages and *"give each other a clue that something is starting"* Early recognition of signs that *"that child needs to cool down and relax"* was important in preventing the escalation of incidents. However, adequate staff was also necessary if a dangerous situation arose in the classroom, because it allowed one teacher to *"remove the rest of the children"* and one teacher to *"stay behind and work with that child."*

In addition to staff-child ratios, staff also noted the importance of having long-term staff, who were experienced in caring for children with emotional and behavioral disorders. *"We've got people who have been here ten, twelve years, which is almost unheard of in child care."*

As discussed in the previous chapter, the directors emphasized the importance of a positive work environment for staff. Staff interviewees indicated that administrators played an important role in providing staff support. One staff member noted that *"this is one of the most positive work experiences I've had."* Staff also noted the importance of feeling valued and that managers were in touch with the classroom.

Administrators who ...sometimes come in the classroom ..[and]...are actually curious about what goes on in the classroom even if they are not always coming to check.

The administrator goes out of her way. You know, she does things outside of day care for the employees ...overall she treats the staff very well.

Maintaining an organizational structure that facilitated staff support was an important aspect of the success of the centers. Some of the challenges and barriers that staff experienced are discussed later in the chapter.

How the Culture of the Organization Supports Staff in their Work

In addition to structural issues such as staffing and administrative support, staff identified aspects of the culture of the organization as essential to the staff support system.

Developing close working relationships. As noted above, staff placed a high value on relationships with the children and with coworkers. They described how close working relationships enabled them to “work off of each other and support each other,” and how a “happy” staff “will in turn keep the children happy.”

They described their coworkers as being “full of personal integrity” and as being “just very professional.” Openness, trust, and a positive problem-solving approach also enabled staff to be open about their own needs, for example by asking for help, seeking support, and “taking a break.” One care provider stated: “All of the teams are really very open about what’s going on that’s driving them nuts.”

They also described the benefit of being able to vent with a peer, and “sometimes just having someone you can unload on can release frustration.” Staff members were encouraged to develop awareness of their own support needs, and to recognize their own “breaking point with a child.” As one teacher put it, “Sometimes we just need to get away from that child and let them have a break from us...and the other teachers here are very understanding and we work together on that.”

One interviewee talked about how the opportunity to take a “break” from a frustrating situation, enabled her to “de-escalate myself and get unfrustrated so that I can keep the environment...happy and care-free.” Another staff member discussed the importance of encouraging staff to monitor their needs and ask for help: “If you need some help, you need to be able to let us know that...we try to be very empowering with staff that way.”

It was important not only that support was available, but also that staff felt that they could ask for support without being seen as a failure.

I think it is important to recognize that child care providers do need support sometimes...Any of us need support sometimes, and recognizing that as a strength in those people to ask for it. And making sure that this is always available for child care staff, in some form or function.

Managing conflict

An important aspect of a supportive organization culture is being effective in resolving the conflicts that will inevitably arise, particularly in the context of stressful work such as caring for children with emotional and behavioral challenges. Some staff identified the importance of staff willingness to be open about problems and views. One staff member said, “We’re open about sharing problems or if there’s something that another teacher sees that, or had [a] different opinion. we’re pretty open about it.”

Staff were also aware of how their own behavior in the classroom in relation to dealing with conflict had an impact on the children, many of whom had difficulties in regulating their emotions. Two staff members described the importance of being a role model in the classroom.

I want to be a good role model and I want my assistant to be a good role model. And we work well together to be positive role models, to see that we are not aggressive. We don’t scream and things like that.

[The children] can’t see the adults not being happy or satisfied with what’s going on in the classroom. They need to see the adults working together...so that [the children] are learning and knowing and have this great fun experience.

Keeping the child’s needs in view, “sharing information,” and maintaining a focus on the shared goal of working for the benefit of the child was also important in resolving difficulties.

If you know that ..[getting help] ...is not a personal statement about who you are or how you are as a teacher, if you know you’re not getting through to that child, and this staff person can, it’s not an ego thing, you’re working for this child. You get up and you let this person do it.

Additional Support Resources

Individual differences among the children in the centers meant that even experienced staff were exposed to situations that were unfamiliar. In these instances, they described the importance of knowing that expert help was available. In one center, staff described how they had access to “a wonderful staff of psychologists, neuro-psychologists” and the importance of having “someone right there that you can call, and say ‘Help!’” As discussed in the previous chapter the resources available varied across centers. In at least one center, staff had access to a counselor who worked at the center once a week. This support was “available to everyone here. Staff, kids, parents. There’s no perimeter on it; it’s pretty open.” Thus a formal mechanism for supporting staff was seen as an integral part of the work done within the center to meet the needs of the children enrolled there.

Although staff had access to a range of sources of expert support, it was clear from the staff interviews that the availability of such resources is not in itself sufficient. It was essential that they could “all work as a team.” Working with other professionals, often with different values and perspectives could be challenging. One staff member described the challenges of working with “school district staff,” and the need for commitment from staff to work through these differences.

I would do my lesson plan with my other co-workers, but then when the school district staff would come in, things would change, they weren't happy with the way things were, so it was conflict. It was like so and so's idea was better than this, let's try this. It takes a lot of work, a lot of patience and you have to know that all of this is for the children.

As discussed below, joint training with other professional groups was one strategy used to increase understanding about different roles and perspectives. Being able to manage this type of conflict was important not only for the staff, but also was seen as having a direct impact on the children's learning environment.

So whatever your differences are, you have to come up and decide what is best for the children, because ...within the fifteen children you have all these different needs that need to be met, and they can't see the adults not being happy or satisfied with what's going on in the classroom. They need to see the adults working together, so that the children are learning and knowing and have this great fun experience in what they are doing. You have to be very patient.

The culture of the center had an important influence on the extent to which staff were open to learning from "outside experts," and consultants needed to be able to work in a non-judgmental way with child care staff. As one staff member described, building a relationship based on trust and mutual respect, and one that facilitated open communication was essential if consultation was to be effective.

Putting together a program where everybody involved is feeling fairly comfortable and able to feel safe communicating with each other. It takes time, because for the child care staff and the special ed. or mental health staff, whoever you've got, to be able to effectively work together, they have to be able to trust each other. I have to be able to trust what when I tell you this child's driving me crazy, your response isn't: "Well you're just not a very good teacher." Or, "Well you need to do it this way, and I know what I'm talking about because I'm a professional and you don't have a degree and you need to listen to me." That's just not going to work.

Viewing differences as an opportunity for learning and being open to new ideas was central in staff's abilities to managing conflict: "There is no single way to do anything. There's always more than one way to do everything, and everybody has to be open to that."

Opportunities for Staff Development and Training

The high value placed on professional development by the center directors was reflected in staff members' responses when asked about training. In addition to the personal qualities described above, interviewees noted the importance of having staff that were "well trained," as well as providing mentoring for new staff.

[This center] does a much better job [of including children with emotional and behavioral disorders] because they train people and they have the [inclusive] philosophy and they mentor people who are new.

Staff also talked about the value of the knowledge and expertise held by the staff, and developed over many years of experience of working with children in the center.

[The staff]...know what they are doing. They have been here a long time and they are experts ...some of the best people are the employees here already ...they know their stuff, they know children, that's what they do. They know their children.

Types of Training Reported by Staff

Table 5.3 on the following page summarizes the types of work-based training and professional development reported by staff. They participated in general training in child care including entry level training, training specific to the center and the program, and training to meet mandatory requirements such as state licensing. Staff also engaged in self-directed learning to support their work with specific children by, for example, searching the internet for information for themselves and for parents. Some centers collaborated with agencies within the community to expand the range of training available to staff. For example, one center worked with a local hospice to provide training on children's experiences of grief. Staff from a shelter provided training on sexual abuse. Some centers had staff that participated in training curricula such as that developed by Sonoma State University (Kuschner, Cranor, & Brekken, 1996) and available through state level outreach in Project Exceptional (Project Exceptional Minnesota, 2003). The training team for Project Exceptional included a trainer from education, special education, and a parent of a child with special needs. Centers had also developed partnerships that enabled their staff to attend training provided by Head Start, Educare, and Birth to Three programs.

Table 5.3 Examples of work-based training reported by staff interviewees.

General Training in Child Care & Meet Mandatory Requirements	Center & Program Specific Training	Specialized Training	Training on Mental Health Issues
Entry-level training such as an apprenticeship program or an Associate degree.	Center policy & procedures.	Training on specific impairments such as vision, hearing, cerebral palsy, and autism.	Preschool mental health.
Curriculum development & lesson planning.	Weekly curriculum meetings for individualized care planning.	Brain development & neurological conditions.	Emotional/behavioral issues for preschool children.
First aid, safety, resuscitation, food handling.	Inclusion policies.	Therapeutic child care.	Working with spirited children.
Americans with Disabilities Act regulations.	Communication & center procedures for working with families.		Keeping children safe.
Positive discipline.			Dealing with negative or challenging behaviors.

As discussed by the directors, centers often had staff training requirements above the mandatory state requirements. Although the centers experienced the challenges of finding funding for staff training, collaboration with local agencies enabled them to support the professional development of their staff. An interviewee describes collaborative training efforts within one of the centers.

I work with the Family Support Network very closely to coordinate these trainings. ...we realize that we can't be experts on everything...we pull in different people...hospice [provided training] on working with children with grief, we had someone from the shelter home doing one on recognizing sexual abuse. We've pulled in different people in the community or in the state ...to do these different trainings.

In some cases staff participated in joint training with parents. One staff member described the value of learning first-hand about “just what the parents are going through” and then applying what they learned about parents’ needs to ask “What can we do to help support that?”

Training also played an important role in helping staff to feel supported in their work.

Caring for children with emotional and behavioral challenges clearly requires a high level of skills and expertise. Staff recognized the importance of keeping up to date with current research and practice, and the role of training in professional support. “If we keep on connecting and hearing more of other people’s ideas, we will just be better supported. ...I know I just try to [continue my education] for myself, because you need other people’s ideas and other people’s energy.”

In addition to engaging in structured training, several child care workers noted that it was crucial that staff be open to new ideas and “willing to learn.”

[If] you’re going to be working with these types of children, you need to be prepared. Or you need to be willing to learn...[Willingness] to learn what it takes to deal with these kinds of kids...needs to be there. If it’s not there then it doesn’t work, and those are the people who no longer work here, because they’re just not open enough.

The value placed on learning was also evident from staff members’ descriptions of doing their “own research on the internet,” and seeking information from families, from directors, and from others involved in the center: “You can either learn from everybody you meet, or you can just hold fast to what you think. But it’s learning [opportunities] all the way around. “

The Added Value of Joint Training with Other Professional Groups

Providing child care for children with multiple needs requires that child care staff be able to work with a variety of people from different professions. Some members of staff recognized the potential benefits of training with other professionals. In addition to increasing their knowledge from the content of the training, the process of discussing the training could be a vehicle for increasing collaboration. “[School staff] are all trained already in special education, and most of us are just regular education teachers, so if we could ...participate in their workshops...so that we all know [the content] and were able to sit down and discuss it together...and come up with big collaborative ideas and stuff.”

The Challenges Experienced by Staff

Staff interviewees were asked open-ended questions about the challenges and barriers they experienced and about their suggestions for how to improve the services in the center. They described a number of challenges both within and outside of the center, including expulsion, attitudes toward child care and inclusion, issues related to resources and services, and structural issues that affected families. Staff were also asked a specific question about “any cultural challenges you meet when you work with the families in your program?” Staff views on overall challenges are considered first, followed by their views on cultural challenges.

Expulsion

Expulsion of a child was a rare occurrence at these centers. Staff talked about a few examples when inclusion was not successful. The primary reasons were threatening situations, and families that did not work with the center staff.

We have had a few kids who have been so violent that it has been a fearful situation for staff safety...Probably in my 18 years there have been two kids we really had to say, "This setting is not working for this child because there is too much stimulation"...Just very violent where you fear, "If I am in room alone with this child, will I come out alive?"

I have personally only met one ...[child] I had to dis-enroll, which is totally unheard of for us. The reason why is because we had no support from the family. We have to have family support.

Negative Attitudes toward Inclusion

In addition to barriers to including specific children, staff also talked about more general difficulties in including children with special needs. Some of the challenges arose from negative attitudes toward children with disabilities, and lack of commitment to inclusion of all children. A staff member talked about her experience in other centers, where sometimes "classroom teachers ...just [did] not want to deal with it," and expressed the "wish that more people would be a little more open, a little more receptive and give them a chance." Staff who worked in more than one center described how a commitment to inclusion was not always shared by others in the field: "A lot of people [in other centers] think that you should still isolate the children who have behavior disorders, just send them home, 'We don't need them here because they are causing too many problems.'"

An additional challenge identified was the interpretation of behavioral problems especially for children without visible disabilities. As one interviewee explained: "If you have a child who can walk and talk and seems to be developmentally OK but bites kids or kicks or swears, it is easier to be frustrated in thinking that that are doing that on purpose, or they can stop." A staff member noted the value of a successful program in changing the views of staff that "this is too hard" and of staff being able to "actually see [inclusive child care] implemented" successfully. This was illustrated by another staff member, who described how this center contrasted with her former experience, and the changes required to see beyond expulsion as the only option when there were difficulties: "This is a big change...In previous facilities...if we had...some of the problems that have come up here, then our only issue was to ask the child to leave...So my big obstacle [was overcome by] learning and watching."

Handling the concerns of other parents was also an important challenge for staff. Sometimes this was because of attitudes towards children with disabilities, and a view that "I don't want my [child] around those kids." On other occasions, families were concerned about the well-being of their children when they were exposed to behavioral problems or aggression in the classroom.

The most challenging thing for me is maybe other parents. If you have a child with some behavioral problems in the classroom,...those parents want you to fix it ...They don't want their children maybe to be subjected to that and sometimes just to get them to be patient long enough to see that things are going to turn around and things are going to be OK.

If a child who has behavior difficulty...is physically aggressive toward another child ...then you have a parent of the victim being upset and putting pressure on you as to whether or not a child should be in your program.

Insufficient Resources and Services

Several members of staff noted the high demand for child care for children with special needs, but the lack of availability of services.

We need more centers like this. There obviously [aren't]...very many, and there's a lot of children out there that need the special help that we give here.

We seem to be the only [center in this state] ...It's also hard to believe ...I wish there was more and more centers that could meet the needs of the children because every emotional and behavioral child ..gets kicked out of a center ...parents are driving [30-40 miles] because they know that we can work with these children and get through it.

Most centers had a waiting list. However one member of staff noted that sometimes a "window of opportunity" was lost for some at-risk families, because services were not available when required. There was a "need to get them in the next day," rather than putting them on a waiting list, because "by the time you try to contact them, their phone has been disconnected or they have moved and they are gone."

Staff also talked about gaps in services available for children. For example, when children left the supported environment of the child care center where "kids are able to function well" going to "elementary school is going to be a whole different ballgame." Some staff described how about child care was not well understood by those working outside of the field, including education. One staff member who worked as a consultant noted that "daycare is very time-consuming and labor-intensive" and that there was a need "to continue to educate our administrators about it." Another staff member discussed the tensions arising from how child care was perceived by special education teachers in the schools, and the lack of an equal partnership between the school system and the center, when children were of school-age.

The impact of financial constraints was a recurring theme during interviews with staff. They noted that additional funding would enable them to improve the environment by having customized buildings, rather than “old warehouses” that are “just not designed to meet a child’s needs,” and to purchase additional equipment. In some centers much of the funding came from short-term grants or special projects, and thus there was a need for more sustainable funding. Budget cuts or non-renewal of grants resulted in a loss of successful services, including transportation and support services, such as behavioral specialists. One staff member, whose position was partly funded by a grant, noted that “our funding has changed every year since I have been doing this” and that it was necessary to “just keep applying for different things.” Staff also identified a need for flexibility in how funding was used, for example to facilitate more intensive services and “additional assistance at certain times” so that staff could meet the dynamic needs of the children.

Staffing Issues

Staffing was among the most frequently discussed resources. A number of interviewees felt that the center would benefit from having more teachers, including cover for absent staff, and in particular to enable them to provide one to one care when needed at times by a specific child. In addition, some staff expressed a need for additional specialist resources such as a play therapist and a counselor. They also talked about the challenges of staff turnover and “constantly trying to train people in,” and the resulting “problem with consistency and familiar faces for the child.” Frequent staff changes also made it more difficult to maintain good communication among staff. Turnover was a particular problem among the teachers’ assistants. This position was sometimes a transition job for students, and thus a high turnover was inevitable: “You will have a staff person you’ll talk to and they will [be]...on board on the ideas...and then they will quit and we are ground one again...[The] revolving door of child care is always a challenge.”

Staff talked about the difficulties of retaining staff when child care employment did not “pay what you can make other places doing other things,” and when trained staff such as special education teachers are “not going to work [in child care] for minimum wage.” In addition to low starting wages, staff noted the lack of financial reward for experienced staff. One staff member noted that a co-worker who had been in the center for 15 years “made \$7.50” per hour.

Complex Needs of Children and Families

Some of the challenges experienced by staff arose from the complex needs of the children and families, especially when children had emotional and behavioral problems. One interviewee expressed the view that “it is probably ten times as difficult to include kids with emotional and behavioral disabilities as it is with kids with physical or other developmental disabilities.” Inadequate resources were one dimension of this problem. As noted by one staff member, “When it is emotional and behavioral issues ...there are not as many resources” available.

Although centers often sought help in including children with behavioral problems, the children “don’t necessarily have an identified need.” This made it more difficult to obtain services even if they were available. In addition some families were unable to access services because they were not covered by their health insurance policies, or they had neither the insurance nor the financial resources to pay for needed services such as counseling.

Within the classroom, planning individualized care for children with multiple needs was demanding, and required considerable paperwork and juggling of resources. Some staff felt that they would benefit from “more connection with parents and even more involvement” and expressed the wish to have “more time to be able to have families to get together in my center.” However this was difficult to achieve in the context of the structural barriers that many families experienced, due to the demands of “working two and three jobs,” or working hours that resulted in the children sometimes being at the center at “6:30 in the morning and not picked up until way long after [the teacher leaves].” Such demands limited parents’ availability for day-to-day contact with their child’s teacher and with other families in the center. Even in centers that had the resources for home visits, parents’ work hours sometimes made this difficult.

Although staff members’ appreciation of family circumstances could enable them to be more effective in meeting the children’s needs, they also talked about their feelings about the difficulties that some children experienced in life outside of the center.

Some of the kids ...they’ve got school, they’ve got home, they’ve got day care, or the home might be mom’s this day, dad’s this day, grandma’s this day....We want to make sure that we’re not creating a totally different space here...[so that]...there’s some continuity...[But] if they’ve got six different places they go throughout the week, it’s kind of hard.

The children come sick, without the kind of meals they need, watching horrible movies or just being left unsupervised... You just kind of hate to let them go because you’re going to send them home to a horrible home life...It really keeps me up at nights pacing the floor, and I just can’t change that.

[Sometimes] you know a child’s going home [and will be] hungry...Something [like] that you’re not in control [of]... You can’t walk up and say: “Here’s ten dollars,” because you know they’ve got their pride too.

One staff member described the tension involved in defining her role in such circumstances, and defining the boundary between the parent role and her role as a child care provider: “There are some things that are not appropriate for little children to be dealing with, but they have to deal with, and that’s hard for me, and it’s hard for me to know when to step in and where to step back.”

Staff Experiences of Cultural Challenges

Child care centers in the U.S. are increasingly required to meet the needs of families from varied ethnic and cultural backgrounds. Emotional and behavioral disorders occur in all segments of the population, but families from racial or ethnic minority groups are less likely to receive services and needed care (U.S. Department of Health and Human Services, 2001). Staff working in child care have regular contact with culturally-diverse young children and their families, and thus are in a unique position to identify problems early, and to enable families to obtain the services they need. Thus it is especially important to learn more about staff experiences of the cultural challenges in their work.

In some programs, staff noted that approximately half of the classes were “of another culture” or “don’t speak English.” All interviewees were asked, “Are there any cultural challenges you meet when you work with the families in your program?”

Staff Views of Culture and Cultural Challenges

Staff reports of the cultural challenges that they experienced in their work with families varied considerably. They discussed a range of perspectives on cultural issues in their work, including the benefits of having diverse cultures, links between culture and inclusion, the influence of structural barriers, and a view of culture as “not a problem.” Interviewees also described examples of cultural challenges arising from language differences, from differences in visible dimensions of culture, such as customs, and from differences in invisible dimensions of culture, such as norms and beliefs. A discussion of staff perspectives is followed by examples that staff gave of the challenges they experienced.

The Benefit of Diverse Cultures

One staff member noted how the children benefited from the exposure they received to “the different cultures and the different languages,” while another reported that some parents chose the center “as a place to expose their kids to diversity and to kids of all abilities and cultural backgrounds.” Working in a multicultural environment, and the emphasis of the program on the rights of the individual child was a source of satisfaction for some staff.

I think the high point of this whole program, and what has kept me here for ...[so many years]...is that it is multicultural and is very respected because of that. No one child is denied their right to wear, or to be, or to express, and it is so neat to sit in the classroom ...[and to hear] the unique sharing [among children of different native languages] that goes on.

Culture as a Dimension of Difference

One view of culture was to define it as one of several dimensions to be considered when applying an inclusive philosophy to child care. Examples of the differences identified varied among staff. Some staff included “cultural diversity” and “the abilities of the children” as differences. Others used a broader framework that included other differences such as race, socioeconomic status, immigrant status, and educational placement of children (in regular or special education).

I think it is very diverse. It’s diverse culturally, racially. It’s diverse in terms of economic status. I mean we’ve got kids from the projects, we’ve got kids from solidly middle-class homes, and everything in between, and that’s for the regular ed. and the special ed. kids [children enrolled in regular or special education programs].

There’s all sorts of families out there, it’s amazing. A child with disabilities is not prone to just one certain type of family. It’s all of them. And so you have to be open to [resident] aliens, people who have no money, people who have lots of money, people who are educated, uneducated. There’s a grand spectrum. Families are a grand spectrum, and we kind of embrace them no matter what, and do what we can to help their kids.

Meeting the needs of children from diverse cultural backgrounds fitted with the central tenet of the program to create an environment in which all children could feel that they belonged, particularly if they had special needs: “[In] our program, we want to include cultural diversity and the special needs because we want the kids with special needs to feel that they belong in with the regular kids, too. That they’re not excluded.”

Another staff member described how children’s learning about differences, including cultural differences, was integrated into the program activities.

When we have behaviors come up surrounding ...any kind of harassment or diversity issues, we have activities set up where the kids can read children’s books about diversity to learn about the differences and commonalities that people have in different cultures and turn it into a learning experience.

Structural Barriers

One interviewee described the need to pay attention to how structural barriers in society influence the work of the center as they try to meet the needs of all families: “Unspoken lines of racial segregation. The center does a good job of bringing Hispanics and Whites together. Even [staff] has had their own problems but have grown in their ability to integrate. [However] we’ve had only three African American families.”

An example was given of how the center's ability to refer a family to a different program enabled staff to meet their needs.

The mother was refusing to have any other kind of services...[The child] was moved to another center...where there was a director who was of the same racial background who could help ...She was African American ...this new director was African American ...she didn't feel like she was being attacked ...they have worked themselves out to where she is willing to receive services for her child, to know that he was being helped. She was afraid of labeling

Culture as: "Not a Problem."

Some interviewees, reporting on their experiences of cultural challenges, made comments such as "I've never come across any problems." One explanation for the absence of cultural challenges in their work was their limited exposure to families from diverse racial or ethnic groups, as described by one staff member who said "I haven't really run into any of that ...I wouldn't say we are very diverse in that way." Other members of staff felt their experience enabled them to meet the needs of different groups of families.

We have a lot of foreign children and foreign parents, but we have not ever had any difficulties relating to them.

I know I've not had any [challenges] because I've had such a wide range of experiences working with very diverse [groups] ...so I don't see it as a problem at all.

Examples of Cultural Challenges Experienced by Staff

Several interviewees gave examples of challenges experienced in their work with families. They talked about communication with families that spoke different languages, cultural beliefs and norms that influenced both how staff interpreted the behavior of families and children, and how families interpreted the practices in the centers. Staff also noted cultural influences on roles in the families and on views of disability.

Language

Language barriers were one of the most frequently cited sources of cultural challenge.

There are a few kids ...who only speak Spanish at home, or they only speak whatever language at home. I think that ...the language barrier is really tough ...

We have a couple of families where the parents speak very little English and it is hard to communicate...one family that speaks Russian, there is another family from AfricaI'm not sure which language they speak.

One staff member described an incident that illustrates some of the communication challenges involved: "I wasn't able to communicate to [the mother] that I wasn't using her diapers [that she brought to the center], that I was providing...diapers...so the natural assumption was 'You're not changing my baby.'...So [the translator] took her through it step by step."

Assessing language development skills in children from families that did not have English as their first language sometimes posed difficulties, as described by one member of staff who also consulted to other centers: "[Sometimes] I am called out because of a concern about speech delay and it is because that child just isn't speaking English at home at all, and so while they are at preschool this is the only time they are getting those words, and it takes a lot of time."

Centers used a variety of strategies to address the language problems, including the use of interpreters, staff members, students, or volunteers with language skills. In some centers interpreters were used for specific events, such as "for IEP or something that we need to make sure the parents understand." In some instances, interpreters acted as cultural informants by providing informal coaching for staff, "Our translator...will say, 'In our culture'...and it helps so much to understand what's going on. She's great at sharing that."

Even if translation resources were available, staff commented on the difficulties of "going through a translator" or of the difficulties experienced in keeping in touch with parents on a day-to-day basis.

I have really felt as though I have not been able to give the parents of some of the Spanish speaking kids the kind of support I give the English-speaking parents because I know how to tell them stuff. Or it's going through a translator, a backup ...I just sometimes feel like it's not as good.

I know it is probably not realistic to have an interpreter here all day, every day, but just to be able to relate back and forth how the kid's day was ...it is really hard to communicate to [the family] if they are not feeling well, or if they did have a great day. The parents want to know that.

Access to translation resources could be particularly difficult for centers that used home visits.

In some centers, language matching was possible, and families could be referred to a program "where the staff actually speak their language," though resources were more difficult to obtain for some language needs: "It is always a challenge in this area, finding people who speak the native language and the families, especially, when you are talking about Hmong ...finding one person who knows the different dialects is a challenge."

In some cases the children acted as interpreter for the family, though this role could pose dilemmas for those involved.

If they [parents] are trying to give us some information about their kid, a lot of times kids end up translating, so it makes it hard to keep information from them. If you don't want the kid to know that you are talking to their parent about something or don't want to put them on the spot or make them feel bad about something that happened, they are kind of stuck.

In addition to the hiring of interpreters, staff described a variety of resources that they used to deal with cultural challenges. Some centers had materials translated so that they could better meet the needs of families. These included “a daily sheet...in Spanish and English,” classroom materials such as “Spanish labels with the colors, the shapes, the numbers,” information in Spanish about specific topics such as fieldtrips in the newsletters, guidance for parents about child development to help parents prepare for IEP meetings, and take-home activities. Graphic information was also a useful resource to help staff communicate with children without English language skills.

Other forms of language could also be a challenge. One interviewee described how she learned “the most respectful way to work with an interpreter” while working with a family with hearing impairments. Another staff member described the importance of attending to the family’s use of language, and to use their terms when possible, as a means of improving communication: “When I am working with parents, I try to use the same language, the terms that they use ... words that they are familiar with ... use the terms that they are understanding, whether it is the parents or the kids.”

Staff also talked about the challenges of communicating with co-workers with limited English language skills. While they were often a resource, it was also difficult at times.

We also have some staff members here who are also learning to speak English. So it is really interesting ... but it can also get frustrating during the day when it is hard to communicate with other staff members, when you have to communicate your needs or children's needs.

Challenges arising from Visible Dimensions of Culture

One of the most frequently identified sources of cultural challenges related to objective or visible aspects of culture such as customs, celebrations, and food preferences or prohibitions. Barriers arising from religious differences were sometimes expressed in terms of beliefs about food, such as “[families] that don't believe in eating pork.” One member of staff reported that “probably the biggest cultural challenges...that stand out has to do with meals ... children who don't eat pork...or beef.” Others reported that they “do meet the needs of those children ... [who] cannot have meat products.”

Religious and other celebrations were also identified as examples of cultural challenges. In some centers, staff noted that “we aren't allowed to celebrate any religious holidays.” One approach was to have events that included a variety of celebrations, such as a December “holiday musical program” that included “Hanukkah, Christmas, and Kwanzaa.” Celebrations were seen as a vehicle of getting “the family involved, get to know them, make them feel welcome, which we try to do all the time.” In some centers, staff encouraged parents to share their traditions with children and staff, “A lot of times parents will come in and talk about Hanukkah, if that is what their family celebrates, those kinds of things.”

One member of staff noted the effort required to develop and maintain cultural awareness, and the importance of getting information directly from the families.

We try, but it is very hard. Sometimes you forget that you have children from other countries, and they don't always celebrate the way we do and stuff. So we try to get the parent to give us some information on what they do during the holidays, and what holidays they celebrate and how they do it and things like that. That was a big challenge for us. But I think we have done well over the years. We've learned a lot of the customs.

Sometimes there were particular dilemmas in meeting the needs of children from bicultural families, when there were unresolved conflicts, “Families that are split up and one family wants them to have one culture and another family wants them to have another. And we are kind of stuck. We have had a lot of that ... we get stuck in the middle a lot.”

Challenges Arising from Invisible Dimensions of Culture

Staff also gave examples regarding the impact of norms and beliefs that affected their work in the centers. Some of the ways in which cultural differences were manifested included communication behaviors, parenting practices and discipline, norms of private and public boundaries, parents' expectations of the child and their beliefs about education and disability, and gender roles. One staff member described her learning experience.

My first year working with these [primarily Hispanic/Latino] families, there were a lot of things I had to learn. Just the nature of the children, the things that they would do differently, and the reasons behind it, because of the way things are at home that are different than the children from our culture.

Communication behaviors

Although language was an important barrier described by staff, it was evident that it was not just verbal language, but also more subtle norms of communication that influence how staff worked with families. One staff member described the challenge of cross-cultural communication, and noted that “it seems like we get little tidbits sometimes with our identified kids when we have a family conference” and the potential pitfalls of

"maybe we've interpreted that they're not interested, [because] they don't communicate with us." Other staff members described the experience of different non-verbal communication styles, such as eye contact. For example, a mother "just wasn't used to looking [staff] in the face ... and her child was one that had a severe emotional need, and we were needing to connect a lot. She would be looking down all the time." Another staff member talked about the impact of the teaching methods that she used, and how she changed her interpretation of the behavior of one group of children through the process of developing cultural knowledge.

When I am talking to children I have always asked them to look at me, just so they can understand what I'm saying to see that I get the response. But I found that the Hispanic and Latino children ... would look to the ground....I just thought they were being obstinatethen I found out it was a cultural thing, that they saw it as being disrespectful to look at me when I was talking to them.

Family culture and boundaries between private and public behavior

Cultural norms of privacy sometimes resulted in challenges for staff in their attempts to work with families in the program. One staff member described the importance of "really making sure that you are not doing anything to offend" and that for some families "it is very difficult to share information about their private lives." It was a challenge to be "very in tune to what families are comfortable with." There was a tension between the feelings of staff that "the only way we can truly do our job is to have all this information," but at the same time a need to "respect what they are comfortable with [sharing]."

Staff also described how they worked with the family with different norms of dress in the home, and how they supported a child to change the way he expressed his needs.

[A child] had a tendency to always want to take his clothes off when he did something ...like running into the room and [was asked] to stop running ...His way of getting even with us, I guess, was to strip down and take all his clothes off ...so we talked to the family. And apparently the family, they don't believe in wearing clothes at home, I guess....it was hard to get [the child] to understand thathe is in a public place ...but the parents worked with us and we finally got around to it in a few months.

Parents' expectations of their children, parenting practices, and discipline

Staff reported cultural challenges arising from "just differences in what is OK or not OK or what is expected of children." It was important to get "some sense from [families] of what are your expectations" so that staff could avoid "asking a kid to do something that they're never going to want to do at home." A staff member involved in a parent education class noted that

"parent education beliefs surface all the time [and] that can be problematic." A second example of a potential challenge was parents' expectations regarding appropriate infant feeding at different ages. One interviewee noted that although while working in a group, "everyone has their different opinions" and the challenge to "make sure everyone feels as though their opinions are respected," while at the same time "challenge everyone to have an open mind, too."

One staff member described the potential pitfalls of lack of cultural knowledge. In this case, differences in parents' expectations of their children, and the age at which they are held "responsible for their own actions" influenced how a mother viewed a therapist's helping behaviors.

During a therapy session...mom was watching and the speech therapist was trying to encourage the child do to what she was asking and was ...doing hand-over-hand things [guiding the child using hands] ..Mom found that very offensive, and felt like it was very questionable behavior and was very upset.

Although the relevant cultural information was learned in a later workshop, staff commented that "if we had known it ahead of time [it] would have been really good."

A recurrent theme in the interviews was the role of culture in influencing parents' views of appropriate methods of discipline for a child. Differences among the norms of society, family, and the center sometimes led to challenges. For example, staff reported that in some families "spanking is more acceptable." Regional differences and personal experiences of parenting were also identified as a source of influence on parents' preferences and practices in areas such as discipline.

The different cultures we face every day as far as those that were raised in the North and they have moved to the South...I really think that is a big cultural challenge, just depending on how they were raised ...Living within the Bible Belt, [people] ...have very strong ideas of raising children according to biblical readings, one of which is "Spare the rod and spoil the child." And they take that as you have to spank your child, that's the only punishment.

A particular challenge occurred if parents engaged in physical discipline of their children while in the center building. This posed a difficulty for staff who felt obliged to intervene and to "pull a parent aside and say....'It's not OK to [physically discipline your child] in the building... [because other parents] might think you are a staff person.'"

In addition to parental beliefs about disciplining children, staff also noted the impact of differences in the tolerance for physical violence within different community groups and family cultures. One staff member commented on the challenges of working with children who experienced difficulties in regulating their behavior in the context of their normative experience when "all they see at home is physical violence."

Culture and disability.

Cultural explanations of disability sometimes made it difficult for staff to provide inclusive care for children with emotional and behavioral disorders. A staff member describes some of the challenges of working with a child from a Hmong family.

[Their] cultural beliefs about children with special needs were such that it was challenging for this little boy to be even included within his family. Because their culture believed you just leave them alone, and let them be, so he really wasn't even engaged in his family...[We faced the challenge of] helping them recognize the value of him being involved at the day care, and appreciating the fact that he was down on the floor with the other babies rather than always in his crib.

Gender roles

Staff also described how cultural beliefs about gender roles influenced the work of the centers. For example, in centers that did home visits, it was unacceptable for some families to have a male member of staff “go into the home alone if the father isn't present.” In some families, mothers did not make decisions on their own, and one staff member described how “everything we ask them they have to ask their husbands.” Staff also noted that cultural beliefs about which “behaviors are not accepted” varied not only according to the child's age but also according to the child's gender.

Developing cultural awareness

As discussed above, some staff members had participated in training, either to increase their culture-specific knowledge, or more general “diversity training.” Educating staff could be also be a challenge: “Providers get really frustrated and don't understand why these people just don't want to speak English...so helping the parents and providers try to find a means for supporting that child but also respecting their need to have their child speak their native language. So that is tricky.”

Although some staff expressed an eagerness to develop their language skills, there was also tension associated with limited resources for training: “If I had to choose between going to the conference and taking Spanish, which they'd pay for, I want to take Spanish for a semester.”

It is apparent that if child care professionals are to meet the needs of diverse family groups, including children with that require a high level of attunement, they require opportunities to continue to develop their cultural sensitivity. One staff member described how her own attempts to learn another language helped her momentarily to step into the shoes of a parent for whom English was a second language: “She stopped [talking in English] and started in Spanish and told me ‘Your turn.’ I was just; I didn't know what to say. And then me and her and [the translator] sat down. She said, ‘Now you know where I'm at.’ For that brief moment, I understood where she was at.”

The Centrality of Families

As is clear from the earlier discussion of how staff viewed inclusion and how they worked with children, the families were seen as central to the success of the child and the center. This section extends the discussion of the role of families in the center. Interviewees talked about: how the families participated in the life of the center, how they kept communication lines open with family members, their appreciation of the high levels of stress in the lives of the families, and how the centers supported the families through stressful times.

Family Participation in the Life of the Center

A Positive View of the Family

In general, staff were positive about parents' level of involvement in the center. For example, they noted that “it seems like families are really involved here” and that “for the most part [parents are]...very supportive” and that families were “wonderful” and “involved in their children's care.” Staff viewed parents as “basically a part of the whole center,” and noted that “Families are everything. Families have a lot of input.” Several staff expressed the view that family participation was not only desirable, but that they were essential members of the team if their children were to be successful.

Families in our program...we require that they must work with us, with the development of their children, because it is...a three-way team to be able to provide the proper care...It takes a child and the family members and ourselves or the counseling staff, we all work together as a team to provide that care.

Facilitating Family Participation

Family participation was also facilitated through organized events, including open days, and a wide variety of social events, such as holiday celebrations, birthday celebration, festivals, sports events, and field trips. One staff member described how such events “really gets the family involved” and provided opportunities for staff to “get to know [the families and]...make them feel welcome which we try to do all the time.” Social events also provided opportunities for families to meet other families with shared experiences. One staff member noted the importance of having “people here that are in the same situations.” Families were actively involved in volunteer activities, including fundraising for some centers. Staff also reported a few of the centers also had formal structures such as advisory boards or policy committees that included parents in center planning and development. The child care providers also consulted parents, either formally for example through surveys, or informally by telephone or face-to-face, to ascertain their views about the center's programs.

Keeping Communication Open

One of the key lessons learned by staff members was that “*the biggest thing is keeping communication open between the parents and the staff and all the kids.*” In the effort to keep communication lines open, care providers worked on building rapport with families, used a variety of communication modalities, worried about confidentiality issues, and struggled to overcome a number of barriers.

Building Rapport with Family Members

Several of the staff members discussed building a “*communication system*” in which they attempted to “*communicate with each parent every day.*” In the process of “*touching base with each parent,*” staff members tried to establish a foundation of rapport and trust that would carry over to the times when they needed information and cooperation from the family members in order to address difficult issues. “*Just keeping them up-to-date on what is going on, and then just kind of being able to set aside a time to be able to talk with them, and express your concerns with them, and try to be on the same page.*” Differences among families in “*how much they want to know about the child’s day*” were also acknowledged.

Staff members who functioned as expert consultants were especially careful to communicate clearly and to “*use the same language*” as family members, avoiding terms that were unfamiliar.

With one parent, she is always talking about how her kids are always “dinging around” and not listening to her. So I say, “When he is ‘dinging around’ what do you do?” I try to use the terms that they are understanding, whether it is the parents or the kids, rather than words that they don’t understand, which is going to irritate them even more.

Another consultant also mentioned that she tried to make sure she set things up so that communication flowed directly between care provider and parent “*because that will help to eventually wean myself out of the situation.*”

Communication Methods

Daily face-to-face meetings were the preferred mode of communication, and several child care professionals talked about being careful to structure drop off and pick up times so that they could exchange greetings and information with family members. Staff also communicated using a variety of formal and informal written materials: regular newsletters, bulletin boards, calendars of events, brochures, letters, notes, report forms, and progress reports. One particularly helpful format used in two settings was a notebook for each child in which notable events, including therapy sessions, were recorded each day. These notebooks followed children who received care or services in more than one location, so that other service providers and parents would know what the child had experienced each day. Messages, enrichment materials, and library resources were also sent home with the children in their backpacks by center staff. When incidents

happened in which children were injured, every center filled out an incident report for their records and made sure family members received a copy on the day of the incident. If child care personnel needed more immediate contact, they used the telephone, pagers, e-mail, and voicemail to reach family members.

All of the centers also held formal conferences between family and staff; some were at regularly scheduled intervals, other conferences were scheduled at the request of family or staff members when concerns about the child’s development surfaced. Particularly important was gathering information from families and making sure that they participated fully in conferences regarding the IEP and IFSP. One center even developed a form to gather information from parents so that they could be prepared to partner with staff in IEP/IFSP development.

Confidentiality Concerns

Several of the teachers discussed their uneasiness around matters of confidentiality regarding children with challenges. Particularly problematic was the curiosity that other parents showed about specific challenges. “*How do you balance educating parents and not breaking that confidentiality of a specific child? We haven’t found a way to do that yet.*” One experienced teacher explained how she addressed this issue with inquiring families: “*You want to talk with me about your child, we can talk about [him or her]. But I have to respect my other parents.*”

Barriers to Communication

Despite their best efforts to keep channels open, there were obstacles that faced staff with respect to talking with family members. For teachers who spent the largest part of the day with children, there was often little chance to visit with parents who dropped children off earlier and picked them up later than classroom hours. Messages were then conveyed indirectly through teacher’s assistants or other child care staff, and extra precautions were taken to make sure there was coordination.

Staff members also reported that communication became difficult with some families when they were contacted by staff about concerns regarding the emotional or behavioral development of the children. One provider talked about family “*denial*” of the seriousness of the problem. In some cases, much communication had to go on before families acknowledged their children’s difficulty.

Some of the stuff we saw at school they didn’t see at home...Because at home, it’s mom and grandma and kiddo and that’s it. In the classroom, it’s three teachers, foster grandma, all these other kids making noise and moving around and this kid is kind of like a ping pong ball bouncing off the wall. And you don’t see that at home because it’s not like that at home.

Another staff member also discussed the difficulty of “pushing parents to seek more [services]...than we can offer.” However the staff were working in such supportive environments, that one experienced staff member stated that “I can’t think of an instance where we have ever left a family hanging.” This atmosphere of support helped family members to be open and trust providers with sensitive information, and most parents did not “have any trouble communicating with the staff.”

Supporting the Family

While staff reported that high levels of family candor and involvement were necessary for the children’s success, these expectations co-existed with a system that provided high levels of family support. As discussed by the directors in the previous chapter, the centers were able to offer families a wide range of supportive services. An important aspect of the staff members’ ability to support families and to promote family participation was the emphasis on relationships with family members. One staff member described a “comfortable close-knit relationship between the parents and the staff.” This was also promoted by the commitment of staff to serving all children and the high level of support available, since families learned that staff would “pretty much do all that we can” and thus were “more trusting of us here.” One staff member described how some program participants changed from seeing staff as a “person that provides me with a service” to gradually becoming “not a resource, but someone they depend on.” It was noteworthy that staff did not confine their helping role to traditional child care activities, but viewed it in terms of supporting the family. Staff members described how they elicited family needs, provided information, and made suggestions about appropriate services.

As one staff member declared, “if there is something wrong, we will try and help the family try and solve that problem, even if it’s something outside of what’s going on here.” A view of the whole family as the client, rather than just the child, was expressed by a staff member who said that “the family knows their child best and we are there to do what we can for the family.” Staff members talked about how the center’s ability to meet the needs of families was integral to the center’s success in working with the children. One staff member commented that “if families have needs we figure out what to do.”

We really try to make that connection with families, let them know that we are here for them by offering resources, offering support, helping them track down the services that they might need in addition to ours.

Another staff member commented that she had “not seen one need that [the center personnel] have not taken care of,” and depicted the center’s role in terms of unconditional love and support for the family, both within and outside of the center.

We don’t care about race, what you believe, what you don’t believe, what your family believes, what you don’t believe. We are here to love you, provide any service we can to make your day right. And if we can make it right when you get home, that’s fine too.

Interviewees identified the importance of being “there for the family” and being “willing to help.” In some cases, staff took a proactive role which included not only increasing families’ awareness of what was available, but also prompting parents to seek additional services for their child. “Here are some different ideas, and we need you to check that out.” One staff member described how she supported the family by ensuring that families could get access to the services suggested, as she explained: “I never want to refer parents to someplace that they are going to get there and it is not going to be covered.”

Staff Appreciation of Family Stressors

Staff members were sensitive to the level of stress experienced by many families with children enrolled in the center. This appreciation had an important influence on how they responded to families, as the example below shows.

Parents know that they can call five or six times, and we’re not going to say: “Jeez, would you quit calling, you’re kid’s fine.” That’s great if that’s what they need to do, we’ll work with that. We realize that a lot of parents already have a lot of issues because their children have disabilities and behavioral issues and everything

They also talked about the importance of having realistic expectations of the parent and enabling them to be successful. One staff member explained that families’ “lives are very full,” especially for parents with a special needs child who “are overwhelmed already” and have numerous appointments to keep, as well as a “family life to try to maintain.” Thus it was important to proceed at a pace that worked for the family by encouraging parents to “come up with one thing” to focus on. For example, it was preferable to, “instead of giving [parents] six things to do, [to suggest that they] try this one thing and if you can do that consistently and you see a change, then we can move to recommendation number two.” By giving families “a little piece, a little ray of sunshine” even it was the “easiest thing on your list of ideas of what could help this child,” staff acted to avoid “setting [the family]...up for failure, because it is too much.”

Staff members’ competence in dealing with challenging behaviors and the belief that it was their job to handle the children’s crises rather than “interrupting [parents’] work time to discuss their children’s behavior or anything like that” was an important way in which the centers supported the family. One staff member talked about the importance of ensuring that “both parent and child are respite[d]” while a child is enrolled in a respite program, by “not burden[ing] the families with their child’s problems during the program unless it is an emergency.”

Having an inclusive program, in which children could receive many of the services they required “*in one place*” was also an important way of supporting the families and children. Without this, many families would be required to access services by numerous visits to different specialists in different locations. This was particularly stressful for children with emotional and behavioral challenges, and could have prevented parents from engaging in employment or other activities of daily living.

In addition to the stress of having a child with disabilities, families experienced co-occurring stressors, such as poverty, divorce, domestic violence, and other hardships that placed the children at additional risk. Some centers had resources to visit families at home. For example, social workers or other professionals provided a bridge between the family and the home. They could involve family members in activities that the child was pursuing in the center, and promote parent involvement in their child’s development by, for example, “*role modeling*” or teaching parents “*different techniques on how to be able to truly empathize with the child.*” In addition, consultants were able to share information with staff about the family that allowed child care workers to adapt to the needs of the children based on a more intimate knowledge of the life of families. One staff member described the importance of appreciating the child’s home environment, and how this knowledge helped her “*just keep an eye on [the child]...and make the day a little easier for them in the classroom.*”

Staff members’ understanding of families’ lives allowed them to be more open to working with the families wherever they were. One staff member described the importance of a non-judgmental stance. “*I think a big thing I’ve learned is to give families a chance, not to judge them when they walk in the door ...or [believe that] they are too far gone to do anything with or that kind of thing.*” For some children, the enriched environment of the center provided a safe haven, which enabled them to “*make really huge steps.*”

Examples of Help Provided for Families

The problems experienced by families ranged from difficulty with “*potty training a child*” to “*I don’t have anywhere to live.*” Staff described various types of help available to families including securing basic needs such as food, clothing, help with transportation, information, strategies to manage a child’s behavior at home, referral to specialist services, and enabling access to resources that “*would not be open to parents without our help.*”

In addition, some centers had specific programs that were designed to simultaneously help both parents and children by providing training in skills such as literacy, alongside early education for the children. This type of comprehensive approach provided unique opportunities for direct interventions with parents and children, as well as enabling parents to build support networks within the center. The workers themselves were part of these networks and had

high praise for some of the families who poured themselves into collaborating with the staff and gaining the help that their children needed. This was clearly expressed by one of the teachers who said, “*The families are incredible, when you get to know parents [and] their commitment to their children. Parents who are quiet, shy people are forced to be these advocates out in the community and fight for services and they rise to the occasion. I marvel at that.*”

Chapter 6: Family Members’ Perspectives “Our Serenity Level Has Gone Up.”

This chapter describes the experience of families in child care, why they chose their current arrangement, why they think it “works,” and how being enrolled affects their lives. Along the way, we also get a glimpse of strategies staff use and the day-to-day workings of a successfully inclusive child care program from the perspectives of family members.

“Parents are key,” one staff member told us. There has been much research on families and how they help, or hinder, the effectiveness of a child care program (Stoneman, 2001). Parental attitudes not only affect the behavior and beliefs of their children but also have a significant influence on child care centers and their ability to successfully include children with special needs. When parents have positive attitudes which lead to their involvement in their children’s child care center, children can have better outcomes in terms of social, emotional, and academic development (Lombardi, 2003).

The importance of family involvement takes on further significance when caring for children with special needs. Staff members have reported that inclusion of children with special needs is hindered when there is little parental involvement and limited communication between the staff and the parents of children with special needs (Buyse, Wesley, & Keyes, 1998).

Families can be important sources of information about a child’s behavior, and his or her likes and dislikes. Surprisingly, most of the research over the past twenty years has focused on the impact parents have on a child care center from a staff member’s point of view. While it is important to understand this “supply side” perspective, we are missing half the story by avoiding the impact child care arrangements have on the families who use them -- the “demand side” of the problem. Only recently (Emlen, 1997) have researchers begun to study child care from the parents’ point of view. By talking with parents enrolled in recognized inclusive centers, this study directly asked how their child care arrangements affected their daily lives.*

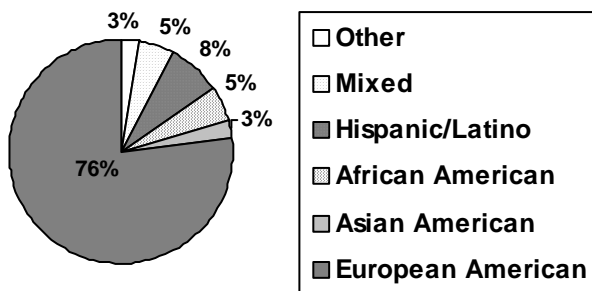
* Parts of this chapter are taken from a Master’s thesis by Shane Ama in the Department of Sociology, Portland State University.

Family Participants

Forty parents were interviewed in all. Twenty-five interviews were conducted in person, on-site at their child care arrangement. The remaining parents were interviewed over the telephone. Interviews were recorded and transcribed for analysis in NUD*IST, a qualitative software package. Interviews ranged from 30 minutes to one hour in length and were conducted by one member of the project staff. Participants were compensated with a \$30 stipend for their time.

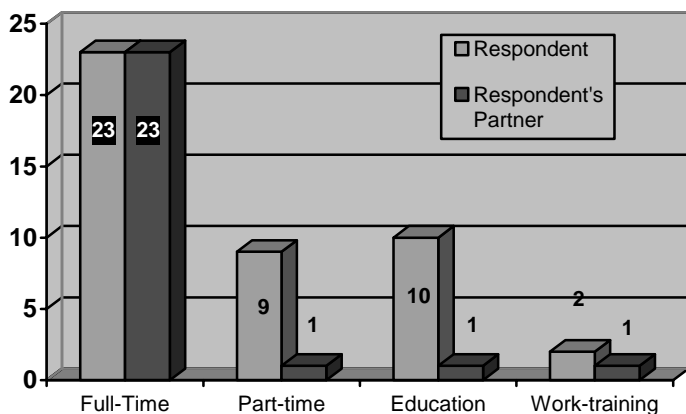
Most parents ($n = 30$) identified themselves as European Americans, 3 endorsed Hispanic or Latino, and the remaining 7 fell into the following ethnic categories: African American ($n = 2$), Asian American ($n = 1$), Mixed ($n = 2$), and Other Ethnicity ($n = 2$), as can be seen in Figure 6.1. Seven of the family members were single parents.

Figure 6.1. Ethnicity of family member participants ($n = 40$).



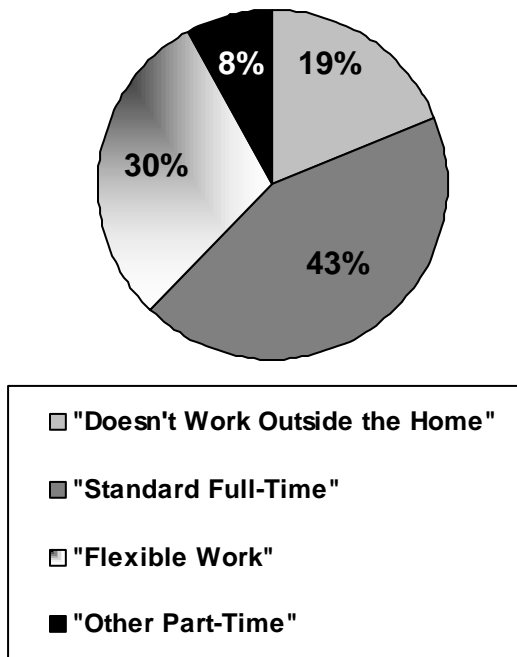
Most parents in the study ($n = 23$) worked full-time, 9 worked part-time, and 12 participated in either a work training program ($n = 2$) or were pursuing further education ($n = 10$) (see Figure 6.2).

Figure 6.2 Respondent employment status ($n = 40$).



Of those who were employed, less than half (43%) worked standard full-time shifts, while only 30% reported working a "flexible work shift," as can be seen in Figure 6.3.

Figure 6.3 Work schedule of family participants



Children of Participants – A Unique Sample

There was some confusion about the meaning of "emotional and/or behavioral disorder" among the participants. This should come as no surprise. There is much confusion about the meaning of terms referring to child mental health disorders in general. State governments currently have the discretion to define "special needs." The result is a mish-mash of definitions that may or may not include children with emotional and/or behavioral challenges depending on the state.

Respondents were asked the following question: "Considering the child (children) using this child care program, how many have each of the following characteristics?"

- Physical disabilities/challenges?
- Developmental or cognitive delays?
- Speech impairment or delays?
- Emotional or behavioral challenges?
- Medical disability?
- Typically developing?

While responses were somewhat evenly distributed (see Table 6.1), the largest group ($n = 23$) reported emotional and/or behavioral challenges. When asked if their children had received a diagnosis “for an emotional or behavioral disorder,” 21 parents responded “yes,” and indicated diagnoses ranging from Attention Deficit Disorder to Reactive Attachment Disorder.

Table 6.1 Parent report of children’s developmental challenges

Developmental Challenge Present	“Yes”	“No”	“Unsure”
Physical Disability or Challenge	32	7	1
Developmental or Cognitive Delay	21	18	1
Speech Impairment or Delay	21	18	1
Medical Disability	25	12	3
Emotional or Behavioral Challenge	15	23	1
Typically Developing	23	16	1

(Note: $n = 40$)

Family members were not given definitions for any of these categories, but if they responded yes to “emotional or behavioral challenge” they were asked whether the child had ever received a diagnosis of the problem. If the child had been diagnosed with a DSM-IV childhood disorder or if family members had reported problems with maintaining child care due to emotional or behavioral problems, these children were categorized as having an “Emotional and/or Behavioral Challenge.”(Note: Autism is classified as a developmental disorder). One family member identified her child as typically developing, then reported a child care history of repeated expulsions for behavioral problems. This child, for example, is listed as having an Emotional and/or Behavioral Challenge. All other family members who described their children as typically developing are identified in this paper as such.

As befits truly inclusive environments some of the children enrolled in participant centers had a variety of disabilities and were progressing at a number of developmental stages. Twelve family members reported a medical disability present in their children. Developmental or cognitive delays were reported by 18 participants. Twenty-three family members reported an emotional or behavioral challenge for their children. Nineteen of them had received diagnoses for the problem. All but one of the parents who reported other disabilities also reported an emotional and/or behavioral challenge.

In total, 60% of families participating in this study reported an emotional and/or behavioral challenge. This is an uncommonly large proportion of children with mental health needs in relation to those who are typically developing ($n = 16$, or 40%). The U.S. Census Bureau (1997) places the overall number of children with disabilities at 11% for school age children (including physical disabilities and speech impairments). Because participating centers were nominated for successfully including children with emotional or behavioral problems, the relatively large number of children with special needs should come as no surprise.

These centers served families that, for the most part, are not usually being included in child care centers. Experiences shared by parents in this study very likely are rare experiences among families in child care. Thus the uniqueness of the sample might be further illustrated by comparisons with data from other surveys even if the samples are somewhat different. For example, in the year 2000, the Oregon Population Survey found that of all children under 13 in paid center care in Oregon ($n = 235$) only 13, or less than 6%, of parents reported “lasting disabilities” present.

Considering one variable from Emlen’s (1997) Quality of Care Scales, parents in this study and families in the Oregon Population Survey (2000) were both asked if their child felt “safe and secure” in their current child care arrangement. Keeping in mind the differences between the two samples, we can learn about the perceived quality of the centers from the groups’ responses (Tables 6.2 and 6.3; Note: seven family members in the current study did not answer questions from the Quality of Care Scale).

Both studies are comparable when looking at total responses. Seventy-three percent of all families in the Oregon Population Survey said their child “always felt ‘safe and secure in care’”, compared with 70% of parents in this study. Looking only at parents who reported their children as typically developing, the percentages are identical for both studies –75% saying “always” and 25% reporting “less than always.”

Table 6.2. Safety and Security as Reported by Families in the 2000 Oregon Population Survey

“My child feels safe and secure”	With Lasting Disability (n = 13)	Typically Developing (n = 222)
“Always”	38%	75%
Less than “Always”	62%	25%

Table 6.3 Safety and Security as Reported by Families in This Study.

“My child feels safe and secure”	Emotional and/or Behavioral Challenge (n = 21)	Typically Developing (n = 12)
“Always”	67%	75%
Less than “Always”	33%	25%

It is not until we look at the responses of families with “lasting disabilities” or emotional or behavioral challenges that we begin to see real differences. In the Oregon Population Survey, only 38% ($n = 5$) of families who reported their child had a “lasting disability” said their child “always” felt safe and secure in care. Sixty-seven percent of the responding families in the current study ($n = 14$) who reported an emotional or behavioral challenge or another disability present said their child “always” felt safe and secure in care.

Again, comparisons between the two studies are limited at best. We can draw no statistically significant conclusions from the disparate groups. On the other hand, we can say that the families with children who have emotional or behavioral challenges and who are enrolled in centers participating in this study appear to feel more confident about safety concerns than parents in a population-based sample of parents whose children had disabilities and who were using centers for paid care. As we will soon see, safety concerns are a huge barrier for any family looking for child care, but they are especially acute for families with children who have mental health issues. It is a testament to the positive nature of the families’ experience in the inclusive centers that so many of them felt their children were secure.

Qualitative Results: Major Themes

Why Families Chose their Child Care Arrangements

Many families chose their arrangements simply because they were convenient.

Families enrolled their children in particular child care centers for a variety of reasons (see Table 6.4). Participant responses can be divided up into two separate groups, those of family members with typically developing children and those of family members with children who had emotional or behavioral challenges. For families with typically developing children, finding high quality, inclusive child care was most commonly a lucky occurrence. Inclusion was not mentioned as a factor in their decision to enroll. Location

and convenience were typical responses when parents were asked “Why did you choose your present child care arrangement?” One parent of a typically developing child said, “Well, first of all, they’re convenient, they’re very close.” Flexibility (a concept we will revisit) was particularly important for families when choosing a child care provider. The hours the center were open, for example, made it easier for many to fit pick-up and drop-off times into their work schedule. The mother of a child with emotional and/or behavioral problems compared her current arrangement to a less family-oriented previous arrangement in another state:

In [my earlier child care arrangements], I was always afraid I was going to lose my job because my employer didn’t have flex time, and there was not a before school program. So I had about fifteen minutes between the time I could drop off my daughter at school and race up to my job. Whereas out here, before and after school programs are commonplace. Far more reasonably priced and just more available. I was really, really pleased. It was quite a relief for me to find that kind of support because I just didn’t have it back East.

Table 6.4. Child care choice: Similar concerns, separate priorities of families of children with and without special needs.

Families with Children Who Are Typically Developing	Families with Children Who Have Special Needs
<ul style="list-style-type: none"> •A lucky occurrence, program was convenient •Program had a reputation for high quality. •Wanted child to learn to accept differences. •Felt encouraged by staff attitudes. 	<ul style="list-style-type: none"> •Arrangement accepted them, had expertise. •Child needed boundaries, routines. •Wanted child to learn “sociability.” •Felt encouraged by staff attitudes.

Many families felt they had little choice in choosing child care arrangements that would both meet their children’s needs and the parent’s work schedules.

Most parents (both of typically developing children and of those with emotional or behavioral challenges) felt they were down to their last hope of blending their work schedules with acceptable child care. Flexibility in scheduling was important for a number of families. One mother compared her current arrangement with a typical child care center.

It works that she can stay at school all day, where I have time to get off work and actually go get my other daughter if I want to, or do some other things before actually coming to get her. I don’t have to pick her up at a set time every day, they give me a leeway time, and as long as she’s picked up before 5, it’s fine.

The father of a typically developing girl explained his family was “having a hard time finding a babysitter, because some days I didn’t go to work, some days I would have to take [my daughter with me].” The same father also told us a little of how he heard about the center.

We had a hard time finding a stable day care, that we can afford, a good day care for [my daughter]. So we heard it through a friend, and my niece and nephew [who] come here [the same building that houses the child care center] to play basketball, they told us about [the child care] and we thought it might be a good idea to put her here, because it’s closer to our house. . . [And] it turned out great.

Compare this experience with that of a mother of a boy with mental health challenges:

I was really at the end of my rope, she explained. So it didn’t really matter what I [wanted]... I mean, the lady that introduced us [to the center] said that she [the center director] was great and that she’d meet [my son] and maybe take him. So I was all for it. It was either that or quit my job.

Both sets of parents feared having to make a difficult choice, basically, “my child’s well-being or my job.” The difference was in the degree of desperation apparent in their responses. The father of the typically developing child mentions affordability and proximity to his home as criteria for child care. The mother of the child with mental health problems was in no position to require anything from her child care arrangement – “it didn’t really matter...” In general, parents of children with emotional or behavioral challenges face most of the problems faced by parents of typically developing children – only more so. They are caught in a double bind.

Parents reported troubled child care histories.

Many parents of children with emotional or behavioral problems, when asked why they chose their current arrangement, answered simply, “They agreed to take my child.” Long histories of young children being expelled from three or four centers were the norm. Most families of children with challenging behavior bounced from one center to the next. One mother of a child with behavioral problems described her child care history:

[My son] was in a Montessori preschool and that was a good place. But that was before he was old enough that we had identified any difficulties. By the time we did, it was in the Montessori program, in which he was OK for awhile... But then he got to the stage where he wasn’t speaking and he started biting and he got expelled... [Then he] went to a different child care center for about a year and didn’t eat lunch for a year, because it was such a zoo. It was OK.

Note what becomes acceptable for a parent of a child with emotional or behavioral challenges. He didn’t eat lunch for a year but given the circumstances, “It was OK.” The same mother continued her story:

But then he went back to the Montessori school when he seemed to be fine and then he got expelled again when he started biting again... So it was a rocky road until we got to [our present child care arrangement].

This “yo-yo” phenomenon for parents and their children with behavioral challenges is a common one. Expelling a child for behavioral problems was much more likely than dealing with a child’s behavior in many parents’ previous child care experience. One mother told us a previous center “actually accepted [my son] then called me back and said: ‘We’re not going to accept him.’” Families with special needs got used to having the rug pulled out from under them.

In past arrangements, parents feared telephone calls at work, worried that they signaled yet another behavioral problem, or worse, another expulsion. Because of these concerns, very few parents of children with emotional or behavioral problems said having their children around typically developing children was a high priority in selecting child care. Instead, they looked for a place that would: (a) accept their children, and (b) work to address the children’s problems rather than expel them. When asked why she chose her present arrangement one mother of a child with behavioral challenges said:

Because they deal with behavioral challenged kids, and I was at my wit’s end trying to find a day care with my son because he got kicked out of three for behavioral problems and biting. And [this center] agreed to take him on and try to correct the situation or intervene with the situation instead of just throwing him out of a day care.

Most family members said inclusion of children with special needs alongside typically developing children was not originally a prerequisite for a child care arrangement.

Parents did not talk about “inclusion,” as a concept they were looking for in a child care arrangement. Most said a benefit of having their children in a child care center was the social skills they would learn being around other children in general. When asked whether the “presence of children with apparent disabilities affected their children,” many had to stop and think about the definition of “apparent disabilities.” One mother of a typically developing child told us,

Well, I am hoping that they will be more accepting of people with disabilities, and realize that these people are people, too, and they just happen to have a little challenge. I like them to see people who are different. I don’t mean something bad about different, but I like them to be exposed to reality, what they are going to be facing in the world. And hopefully they will go at it with a little more of an open mind.

Another mother of a typically developing child said she thought the presence of children with disabilities “probably helped the program.”

Socialization was also an important factor for parents of children with special needs. One mother of a child with physical disabilities, explained her concerns: *“That’s the only down part, because [my son’s] not in a normal classroom right now, so he’s not getting the social or emotional, behavioral types of norms that he would be getting with normal children.”*

It should be noted that although the center this mother was involved in had fewer typically developing children than some of the other centers in our study, there were children without any special needs present. This response illustrates the blurry definitions we have for “normal classrooms.” Is a classroom that has one child with special needs a “normal classroom”? Two children with special needs? No children with special needs? The answers to these questions and our willingness to ask them directly address some of the problems families with children having special needs face in child care.

The same mother (of a boy with physical disabilities) continued:

But [my son] does enjoy being around children who are like him [have physical disabilities]. So that helps out. He feels more secure. When he had the feeding tube, it wasn’t a big deal. When we’d stop at my daughter’s day care [all typically developing children], they all wanted to see him. They wanted to see the feeding tube. He was the sideshow. Where he goes now, there’s other children like [him], so he helps out and he babies them. He encourages them, too. I think he knows. He’s really good with people believe it or not.

Parents of children with special needs reported a shortage of quality child care that is especially acute for families with children who have disabilities.

“There’s not enough people out there to take care of disabled children,” one parent of a child with mental health challenges told us. *“I’ve looked all over. I tried a few other day cares, and they denied [my son], even though legally they’re not supposed to because of his disabilities.”*

Few parents mentioned legal protection for their children (The Americans with Disabilities Act, for example). The two parents who did mention the law prohibiting child care centers from refusing care to children with disabilities because of their special needs did not ever mention this to any of their previous providers. Parents of children with special needs felt they ought not “rock the boat.”

When families with children who have emotional problems find a center that will accept their children they often “jump at the chance” to enroll. One parent of a child with mental health challenges remembered:

[My son] got kicked out of a normal day care because of his behavioral issues. He’s aggressive, at times he fights and screams and kicks and cusses. [This center] said they were used to that, and they can deal with it. I decided to take him here. There’s no one else who would take him.

Many family members reported fears associated with sending their children to any new child care arrangement, especially a center that includes children with special needs.

The fears of parents having children with physical or mental health challenges may be contrasted with those of family members having typically developing children. Safety was a universal for both sets of families. The parent of a child with emotional problems told us about her own concerns:

...At the time when they were first opened, they had all the kids in the same room, which made me kind of not, I wasn’t too sure about sticking my other child in that day care at that time because I had a baby. So I was kind of worried about my baby and his safety. Now they have the children in different rooms, but I wasn’t too sure about safety issues, so I put the other two kids elsewhere. That’s not ideal, because they should honestly be all together, but I have to do what I have to do.

Notice the evolution of the center’s policy. Environmental change (moving children into separate rooms, for example) was a common method centers used to address problems and ease parent concerns.

The most consistent safety concern for parents was that their children would be bitten, or jumped on by children with emotional or behavioral challenges. The mother of a typically developing daughter, and son with behavioral problems, explained how her center dealt with these kinds of challenges.

[My daughter] did have a bad experience there with another child who was a child with special needs and had befriended her and then was upset when [she] was playing with other kids and used to attack her and scratch her and bite her. But the interesting thing was...that incident resulted in the staff discussing and creating policy to address that kind of situation, that they could support the staff, but still help the kids at the same time. So I’ve seen a lot of positive evolution in just the way the staff handles things, just since when we started.

Curricular flexibility and adaptation to individual children is a recurrent theme for inclusive centers. The same mother explained, *“I think that the program is better now than it was in ’93. It was good in ’93, but I think that probably they have learned from the various special needs kids who have passed through.”*

This response suggests programs may actually get better at providing care for all children because of the presence of children with special needs. In other words, more inclusion equaled higher quality. Certainly, experience helped. Low staff turnover at participating centers clearly made a difference in their abilities to include children with emotional or behavioral problems. Like many parents, the mother of a child with mental health challenges realized the importance of committed and trained staff: *“And they have also gotten staff who have some background in special ed. In fact the director, I think he actually has some background in special ed...”* She explained that, although there were rules for “two or three day suspensions” in

“extreme cases...for the most part, if you have staff that are well trained and vigilant you are not going to have those situations.”

Parents seemed to know when staff members were capable of addressing these types of behavioral problems. Parents reported a *“professional, yet nurturing approach”* from the staff.

These are trained people. They are real teachers. They are professional child care people. There are helpers that aren't, but they are all very nurturing people and they all ... just seem to enjoy what they are doing. They really like working with the children. It's very obvious.

Parents believed they had found the right people for the job. The next section will explore the relationship families developed with staff members.

Why Parents Think their Child Care “Works”

Parents reported consistent communication with all involved with their child care arrangement.

Experienced staff may be able to prevent difficult situations (*“freak-outs,”* for example). Constant communication with staff members who are dedicated and *“vigilant”* help parents endure the *“extreme cases.”* Another mother of a child with mental health challenges explained:

They talk with me, they just don't send him home with a note or something like that, they actually, if there's a problem or if there's something that I can work on at home, they let me know that. They'll mention it to me, or “Hey, he's doing this,” or “Have you noticed this at home?” It's the communication, is the key.

She also described how this spirit of openness spilled over into her relationships with other families enrolled at the center.

You see other parents that have behavioral kids that have behavioral problems, you tend to discuss that with them, and say: “Well, [my son] does this or [another child], for instance, does this or something at that instance.” And you just get to talking and you can relate to one another, and so you can talk out problems or suggestions or: “Well, I tried this or I tried that.” And it's just kind of like a support group.

It is this sense of community that reduces stigma and allows parents to feel comfortable leaving their children in care. The father of a typically developing child explained.

I don't have to worry about [safety at this center], because there's some place that you would take your kid and then you would leave, you still have thought in your head: “Is my daughter going to be safe there, today? Tomorrow? For the day to come?” But here [at this center], we don't have to worry about that, because as long as she come here, she's here in this building, I know she's safe.

Most parents identified strong, ongoing relationships with staff members as a major factor alleviating their original fears.

Parents of typically developing children were concerned that the presence of children with apparent disabilities would limit the amount of attention their own children would receive from staff members. As Table 6.5 illustrates, this was not the case for families enrolled in model centers. Parents of children with mental health challenges worried their children would be singled out by staff or expelled. All of these concerns were alleviated through trusting relationships built up with staff members and directors.

Table 6.5 Easing fears for both sets of parents

Families with Children who are Typically Developing	Families with Children who have Special Needs
<ul style="list-style-type: none"> •Safety •Poor behavior modeling from peers •Child will not receive adequate attention 	<ul style="list-style-type: none"> •Safety •Child will be teased by peers •Child will be singled out by staff
Fears Alleviated Through:	Fears Alleviated Through:
<ul style="list-style-type: none"> •Communication, trust with staff 	<ul style="list-style-type: none"> •Communication, trust with staff

Parents trusted staff members to learn from experiences and not simply expel their children automatically. This trust led to relationships with staff members that went well beyond the stereotype of child care as babysitting.

But I've never felt [my son] would be asked to leave. It is possible that if he did something really awful he could be suspended. If he does something to injure another child...But every year [the staff] have gotten better at addressing issues for kids with special needs and had extra help when they needed.

Participants in the study did not talk about *“quality”* or *“inclusion”* when they discussed their child care arrangements. They did not mention *“cultural competence”* or *“family support.”* Instead, families discussed the role the centers played in their daily lives.

Every adult who came into contact with a child, worked together in these successful environments to ensure the best possible outcomes for that child. A mother with a school-aged child diagnosed with Autism described the process as a *“joint effort.”*

It is [the child care center], it is the teachers during the day, the special education staff at the school, they all talk to each other. If he has had a difficult time in the morning the [child care] teacher will tell his regular teacher, or the [aide] that works in the school will tell the [child care] teacher if [my

son] has had a particularly difficult afternoon. So they are able to help him through difficult times...So it is almost like one big family of people and everybody really knows everyone else. The school is not that big. So it is a very nurturing environment.

Entire families benefited from these types of environments. Based on this family-centered approach and the terminology of the respondents we have combined many key concepts into the theme of “family environment.”

Parents identified a “family environment” in their current child care arrangement.

Many parents identified very closely with the highly motivated staff of their child care centers. “The staff are genuine,” another mother of a child with physical disabilities said “and they [the staff] genuinely care about the children. They love the kids, they love what they do and you can tell.” The relationships staff formed with children allowed parents to feel good about leaving their children in child care. Parents trusted that their children would get what they needed from staff members. When asked what was unique or special about her arrangement, one mother described how the atmosphere of care affected her children’s ability to be comfortable with her child care providers.

I'd say a family feeling, the family type feeling, the warmth, the welcoming. I think [my] girls feel comfortable. So if they needed to tell somebody something, they [would]. I think this was especially true when [my husband] was ill and then when he died, just afterwards. It gave them something normal to go to...

“Something normal” was just the beginning of the benefits parents reported from their child care arrangements.

Due, in part, to a commitment centers shared to providing care for all children, regardless of developmental pace or special need, parents thought of their child care arrangements as an “extended family” who supported them “no matter what.” Child care centers provided a service to the entire family. “It’s almost like getting counseling in how to help raise [my son]...” one mother of a child with mental health challenges told us.

I've learned a lot in the last several years... I tell people out there in the world: “Well, this is what I do, because that’s what my day care did,” and so I pass along what [this center] did to people out there in the world.

The next section addresses positive outcomes identified by parents in successfully inclusive child care.

Positive Outcomes

Many parents linked the family atmosphere of their child care center to positive outcomes in not only their child’s development but also to an improvement in the family’s quality of life in general.

Participants called their child care centers a “second home” and referred to the staff as “part of the family.” One mother of a child with significant behavioral challenges compared her current center’s nurturing environment to her former “custodial-style” arrangement.

Custodial care is not what most kids need. It is OK for babies as long as they are getting good custodial care, the nurturing. But I think there are a lot of kids who suffer because they just get indifferent custodial care in their after-school programs, instead of this kind of program. I will be eternally grateful to the staff for the support I've gotten from them and the help they have given to [my son] since he started with them. I think that one of the reasons that he is functioning as well as he is, is because he has had that interest and loving support from these people. It is a good place.

The parent was not only expressing a positive outcome for her child but also for the effect the child’s success had on the entire family. Many participants had similar responses. In line with the concept of “child-centered and family focused” systems of care (Stroul & Friedman, 1996), successful child care centers need to support entire families if they are to properly care for enrolled children. All working families, but especially working families with children who have mental health problems, are under an enormous amount of pressure that adequate child care can address.

One mother of a child with significant behavioral problems shared how her current child care arrangement had changed her family life.

Well, I used to go to work in tears, and sometimes with bruises, and I would have to do the holding therapy that they taught me at the hospital umpteen times a day. Those happen maybe once every six months now. Our serenity level has gone up.

Brothers and sisters of children with behavioral problems are often themselves at risk for emotional and/or behavioral disorders. As this mother continued her story, we learned that her other children also had difficulty coping. “I even had my oldest in counseling for a while,” she explained, “because it was so much of a strain on all of us...” The strain associated with emotional problems can tear at the fabric that holds a family together. Proper, inclusive child care can go a long way to alleviating much of this strain. The same mother stated:

Now I look forward to the weekends. I used to look forward to Monday mornings to when I could go to work, but now I look forward to being at home. And there are several components to that: he’s been on medication; we went through counseling and this place [the child care center]. I think the three of those all coupled up together have contributed to our higher state of comfortableness.

This “higher state of comfortableness” is a hard won result of the ongoing commitment of every adult who came into contact with the family.

Some parents reported a better link with mental health services through their child care arrangements than they had previously experienced.

Like I said, it's almost like free counseling in a way... it's almost having a readily available support system. I discuss with them all the time what's going on at home, and they want to know. They have so many resources. Put all their minds together, man, they're so full of stuff. I've learned just as much from the staff here as I have any support group or counseling I've been to.

This type of communication and support, not only between staff and families but also staff-to-staff and staff-to-mental health professionals was not common in the participants' previous child care experiences. One mother of a child with mental health problems said,

"The interactiveness of the therapist being able to come in and communicate with the teachers one on one [is unique]. The teachers are willing to communicate [with the mental health consultants] and actually implement what they suggest – very, very rare."

Many parents reported a spillover effect that positively influenced school-readiness and fostered a "love of learning."

The ability, rare as it was, to produce positive results, to "do what they say they would do," created a "spillover effect" into the home and school-life of children. A father from the same center said the things his typically developing child was learning at the center surprised him.

They have taught her reading. Not just reading, but how to play with others, and how to act when someone is going to be abusive to her, towards her, she learned how to act on that. That is something that I really like. [Staff] take their time to show kids that they care, that there's someone outside of the family, besides the family member, who cares for them and gives them attention as they need it, as a kid. Because I feel that a kid needs as much attention as they can get while they're little kids.

Another parent of a child with mental health challenges explained what was most important to her.

The social part. They have a lot of fun, they have a lot more stuff that he can play with and stuff. Because at home you can't have all the stuff that they have here. They have a lot of manipulative stuff, he did have a little trouble with his fine motor skills, and his fine motor skills are getting better. Through his class he is learning to do things that he wasn't learning [in previous arrangements].

Consistency between home, child care and school helped children understand what was expected of them and what they should expect of others. When parents, child care professionals and teachers all respected each other as experts, consistent expectations greatly increased a child's self-efficacy in the views of the family members.

It's like a cycle, they do things [at the center] that my husband and I have reinforced at home. We try to be consistent with what's going on [at the center] and, in turn, I contact the [general education] teacher, and I say: "You know this is what [the child care teacher] does in this situation," and they're like: "OK, great, we'll do that." So between home, [child care], and school, we try to be as consistent as possible and it's really helped [my son] to know what's going on. And that consistency has really helped him at school a lot.

As families saw their children thriving in one environment, they felt comfortable their child could achieve in many others. A mother of a child with mental health challenges reported her son had fewer behavioral problems at home because of her child care arrangement. She explained:

I can deal with his behavior problems a lot better because they have shown me and taught me how to deal with certain things, and they have let me listen to tapes on positive discipline and not to get frustrated with him and to just give him something else to do, and use the vocabulary they use; "Get your body in control," for example. It's just really helped me deal with him in a positive way instead of lashing out in a negative way.

Parents reported a significant stress reduction as a positive outcome of their child care arrangement.

"Lashing out in a negative way" may be more common among parents who have children with emotional or behavioral challenges. Families forced to juggle the demands of work and child-rearing are under tremendous strain. Adding an emotional or behavioral problem to this already volatile mix increases the potential for an explosive family life. It is reasonable to assume, for example, that the risk of child abuse may increase as parental stress levels increase.

Parents of children with an emotional and/or behavioral challenge have reported greater levels of stress than parents of typically developing children. Responses suggest that parental stress can manifest itself in a number of ways ranging from time missed from work to child abuse. An important finding from this study was that family members who worked closely with qualified child care staff reported lower levels of stress, learned strategies and techniques for addressing their child's needs, and shared helpful strategies with the child care staff.

Many of these stressors induced by self-blame may be reduced by inclusive, high quality care. Participants reported relief at learning, for example, that they weren't a "bad parent." "It's not my fault," one mother said. "I've done the same things I did with [my other, typically developing child]." Children with emotional or behavioral challenges require different strategies and environments to meet their needs. Once these conditions are present, family members felt a tremendous sense of relief and even developed a richer understanding of their children. The family members also gained insight about their children's place in the world from a experiences in a positive child care environment. "[I've reached] an understanding that [my son] is OK," one mother of a child with mental health problems reflected, "that he's not bad, and that he has a great deal to offer people around him."

Many parents saw the inclusion of children with special needs alongside those who are typically developing, as a positive model for children in dealing with others who were different from themselves.

Children who were typically developing routinely became "helpers" for their friends with physical or mental health challenges. After enrollment, family members soon learned that developing empathy among all children was an important goal for many of the staff members. One mother explained the importance of setting these goals both for her and her child and the dedication of the staff in meeting them.

They've taught her how to walk in a timeframe which I didn't think she would be able to [meet] because of the rate they were going but they made it their goal, and actually the always make their goals before they're due. They do their homework. They do what they say they're going to do; they don't just say it. They would walk her everyday around the gymnasium, which is a huge gymnasium for a little kid. She had the little one year olds and the ten month olds helping her walk, it was the cutest thing, because she was taller than all of them, but they were helping her try to walk across the gym. And our goal was to have her walk by February. Before Christmas she was walking. It was a big thing.

Setting attainable goals and reaching them was crucial for many parents. Although this child did not necessarily have emotional or behavioral challenges, this response illustrates how inclusive environments can model behavior in the youngest children to overcome a variety of differences. Children were recruited and encouraged to help each other with their unique obstacles.

One mother of a typically developing child described the effects her child care center had on the way her daughter interacted with others.

They provide more of a family setting to all the children, and it's weird because even though you have children of different learning levels, different disabilities or some kids don't have disabilities at all, but different races, they all treat them the same. And it helps my daughter a lot because she doesn't notice a difference in people, and I love that because it's very rare.

When asked how being around children with apparent disabilities affected his typically developing daughter, one father replied,

There's no difference. To [my daughter], there is no difference because we don't teach her, or tell her, that those people are different from you, we just teach her, and try to tell her that everybody does have feelings, and everybody should be respected, because I feel that it is very important if you teach kids when they're young when they grow up, they're going to have that with them, they're going to have an idea, and to me, it's like there's no difference.

Families reported that centers were culturally competent and accepted differences.

Other social barriers also became less daunting due to the family atmosphere present in the model centers. Family members reported cultural sensitivity from staff members. One mother, newly immigrated to this country, reported learning most about American culture from the child care staff. Staff also helped her obtain her driving license, speak English, and write an effective letter. "I learn here," she responded. "I learn so many things that are good for [me and my child]."

A father of a typically developing child (and a recent immigrant to this country) also described accommodations staff made for cultural differences (many more adults picking his child up at the end of the day, for example). This flexibility helped the entire family. This sort of flexibility and the respect for diversity present in the center resulted in positive outcomes for his child. "[This center] has kids from different backgrounds, and different races and religions, and they're all here in one place. This teaches my daughter that when she grows up, she doesn't have to be scared or feel awkward about being Asian."

Many parents expressed similar gratitude for the acceptance modeled for their children by staff members. A common hope among both sets of parents, those with children with emotional or behavioral challenges and those with children who were typically developing, was that their children would be more accepting of children with disabilities and the differences they would "experience in the real world." "Hopefully," one mother of children with mental health problems responded, "They will go [into the world] with more of an open mind." That parents were raising their expectations in such a way for the kinds of goals their children could achieve from a child care arrangement was a vast difference from their earlier, more "custodial care."

Conclusion

Family members consistently identified a "family environment" as a crucial element to providing high quality inclusive care. Family members both with typically developing children and those with children who had emotional or behavioral challenges talked about past child care arrangements being stressful for them. Parents reported being "treated as the enemy" who "knew nothing" about raising

their own children. Staff members in previous arrangements had “no time or desire” to talk with family members, would not explain problems that occurred throughout the day accurately, but would expect parents to take responsibility for their children’s actions. Language and cultural barriers combined to make these situations worse, but most parents described the problem as a lack of communication.

In contrast, parents reported a sense of belonging within their current child care arrangements. A mother of a typically developing child (not a native English speaker) described a bond above and beyond the typical babysitter view of most child care arrangements.

They [staff] are so special because they don't do like only caregiver. They do like a family. And it is good for [my daughter], because she doesn't have a grandmother or a grandfather here. So, for example, when [my] daughter was little, like 8 or 9 months, she was in the infant group. The woman that is in the infant room, they were so secure [with my daughter], so lovely, and they just picked her up.

Participants explained that this was simply how families operated. A family environment in their child care arrangement meant the staff did what they could to help enrolled children and their families, just as a family would.

Raising a child is hard work. Raising a child and maintaining a full-time job is tougher. Raising a child with emotional and/or behavioral challenges and maintaining a full-time job is nearly impossible – without help. There is no “magic bullet.” Parents did not have long lists of tricks child care staff used to deal with challenging behaviors. Instead, parents talked about long-term relationships with staff that, just like a family, accepted their children (not to mention their parents) for who they were. And just like a family, everybody involved learned how to live with each other. As a result of this family atmosphere, parents saw positive outcomes in the quality of their family lives, in the ability of their children to learn, and in a more understanding approach to dealing with others who were different.

This is how inclusive, high quality child-care appeared to those families who were lucky enough to find it. A mother of a boy with emotional and/or behavioral problems reflected on the family support present at his child care center.

[My son] has challenges and that's going to be difficult in the best of times... It's nice to know there are places that they can go and learn to fit in, and learn social skills, and overcome some of those challenges...I remember feeling so lost in what was going to happen to my child, and who was out there that was going to be able to help me help him to grow up and be a nice decent individual. I think finding a program like this really helps relieve some of that stress. Because, no matter what, [my son is] always going to have those social barriers to overcome, and being in a program like this is just that much more support I get as a working mom.

Chapter 7: An Observational Study of Children and Staff: “You’re My Best Buddy.” with Lynwood J. Gordon

Child care can provide cognitive stimulation and a natural environment for social development for children that have challenges (Shonkoff & Phillips, 2000), particularly as they interact with other children developing typically in these settings. Brennan, Caplan, Ama, and Brown (2000) have also made the case that typically developing children in child care settings who are not exposed to children with disabilities, including emotional and behavioral challenges, are not being prepared for life in inclusive schools or a diverse society.

In truly inclusive settings (Guralnick, 2001), children lagging behind in social and emotional development can learn to interact with supportive adults, to become part of a peer group, and to regulate their behavior and their expression of affect. At these centers, children who would benefit from early intervention can be identified and receive services, and their families can be engaged in supportive services as well.

This chapter reports results of an analysis of data gathered through an observational component of our investigation that examined the behavior of children and care providers in model child care settings under study by project researchers. These data are part of the larger set of data collected as described in the methods chapter above. Through direct observations of activities, conversations, and social interactions involving children with emotional or behavioral challenges, researchers investigated practices child care staff used to include these children in their programs, child to child interactions, and supports put in place for times of transition between activities. Data gathering was timed to take place during transitional periods, the most difficult times for children with emotional or behavioral challenges.

The observations were focused on the following major research questions:

1. What are the ways in which caregivers work toward inclusion of the child in classroom activities in social interactions?
2. Do interactions among children give evidence of inclusion?;
3. In what ways is the child supported by center staff during transition periods?

Table 7.1 Characteristics of child care centers that served as observational sites

Center Characteristic	Center Name				
	Broken Arrow Clubhouse	Family Resource Center	Fraser School	Little Angels Child Care Center	St. Benedict's Special Children's Center
Location	Broken Arrow, OK	Morganton, NC	Bloomington, MN	Milwaukie, OR	Kansas City, KS
Location Type	Suburban/Rural	Rural	Suburban	Suburban	Urban
Ages Served	3-13 years	Birth-8 years	Birth-6 years	Birth-6 years	Birth-5 years
Program Types	Preschool, Kindergarten; Before-After School; Summer.	Infant-Toddler Care; Preschool; Respite Care.	Infant-Toddler Care; Preschool.	Infant-Toddler Care; Preschool, Respite Care.	Infant-Toddler Care; Preschool.
Approximate Enrollment Size	100	150	325	37	80
% with Emotional/Behavioral Challenges	40%	15%	11%	8%	50%
% Families below Poverty Level	19%	20%	14%	11%	80%
% Child Ethnicity					
African American	2%	2%	12%	8%	40%
Asian American	0%	0%	3%	0%	5%
European American	87%	91%	81%	87%	5%
Hispanic/Latino	5%	5%	1%	5%	50%
Native American	6%	1%	1%	6%	0%
Mixed Heritage	0%	1%	0%	0%	0%

Participants

At each of the five child care centers visited 5 children were observed, for a total of 25 participants. Caregiving staff designated 8 of the children as typically developing, with the remaining 17 reported to evidence emotional or behavioral challenges. The children's mental health challenges included Attention-Deficit/Hyperactivity Disorder, depression, and attachment disorders. Children observed in the selected centers were of varied ethnicities including African

American, Asian American, European American, Native American, and Mexican American; 11 of the children were male. Participant children ranged in age from 10 months to 11 years ($M = 4.2$, $SD = 2.1$). Written consent was obtained from parents for their children to participate in the research, and children over 6 years of age also gave their assent to be observed.

Procedure

Each child was studied in natural settings by two researchers in the same one hour time block; settings included classrooms, indoor and outdoor playgrounds, art rooms, lunch settings, and napping facilities. Observational blocks were selected so that each involved times of transition such as lunch periods, going out to or coming in from play, or preparing to leave the child care center for school. Two independent researchers recorded by hand all activities, behaviors, and conversations involving the child targeted for study during the observational block, using a semi-structured format. The resulting qualitative data were coded for major themes and subthemes by three independent coders. Coders met to reconcile differences in interpretation of the field observations, and further develop subthemes.

Results

Analyses of observation field notes revealed processes resulting in substantial inclusion of children with emotional and behavioral challenges in center activities and social interactions. Our report of results considers each of the three research questions separately (inclusive practices of staff, child-to-child social interaction, support during transition), and lays out the subthemes that we found in our observations. Each subtheme is illustrated with an excerpt from the observational data, presented in italics. All names of children have been changed to maintain confidentiality.

Inclusive Practices of Staff

In answer to the first question, “What are the ways in which caregivers work toward inclusion of the child in classroom activities and in social interactions?”, four major findings emerged. First, child care staff set up environments and routines to encourage cooperation and self-regulation. Physical and social environments were structured so that the children participated in an inclusive manner in center activities. In one center caring for school aged children, an 11 year old girl with an attachment disorder was put in charge of animal care for the center’s doves. Her teacher structured the situation so that she could work with a younger child on the task, and begin to develop a relationship with him. Our notes revealed that “[Amy] is the ‘supervisor’ of [Brad] during the dove feeding, helping him, reminding him to clean his hands. She nicely explain[s] to [Brad] that if people don’t wash their hands after feeding doves they could catch diseases. [Brad] eventually washes his hands.”

In a second recurring theme in our observations of inclusive practices, staff built upon strong relationships with individual children and anticipated social and emotional challenges. Teachers at one center anticipated the needs of a 5 year old boy with autism spectrum behaviors and hyperactivity challenges by permitting him to take a small set of plastic trains with him from activity to activity. The trains gave him a focus for his attention, and their manipulation helped him

to remain calm, even during transitions between activities. In one of several difficult situations during our observational hour, his class was being moved from the lunch room into the art room of the center.

[Lead Teacher] takes 3 of the children to next room.
[Chad]: “Oh-oh my trains!” [Lead Teacher]: “Where are they?” [Chad]: “The other room.” [The Lead Teacher gives her permission to retrieve the calming toys.] [Chad] runs and gets them; returns to room.

A third subtheme addressing inclusion revealed that peers were taught to respond appropriately to challenging behavior and to the special needs of their classmates. Another 5 year old boy with aggressive behavior challenges was observed at a particularly difficult time—his last day at the preschool. After he hurt a female classmate, the lead teacher directed her attention primarily to the victim, as did the other children, who were previously taught to respond to aggression by paying primary attention to the victim. “[Darren] is whipping his puppet around and hits a girl who starts crying. [Lead Teacher comforts the girl who was hit] ‘I’m sorry my friend hurt you. [Darren is told by the teacher]: ‘You hurt your friend.’ Another child comforts crying child. The tension with [Darren] disappears.” In this situation, the aggressive behavior was stopped and altruistic behavior was encouraged, the outcome desired by the child care staff.

Finally, we observed in the fourth subtheme in our data that mental health service provision was integrated into scheduled center activities. Two school-aged boys were seen struggling to control their aggression at an organized soccer game in an after school program. Both a staff counselor and lead teacher were present at the game. “Disruptive dispute between older boys [one punches the other] stops game. Counselor and teacher work with each boy separately. Game resumes without the two boys. The two boys finish with the adults and re-join the game.” The counselor and the teacher used this actual experience to assist the boys with anger control, to keep the other children safe, and to model the peaceful working out of disputes.

Interactions among Children

Our second research focus targeted peer social exchanges in our model settings and responded to the question, “Do child-to-child interactions give evidence of inclusion?” We observed that, building on opportunities structured by teachers, children accepted differences in their peers with challenges, and included them in activities and friendships. An example of teacher-structured child-to-child interactions took place at a preschool activity center. A 3 year old boy with emotional and behavioral challenges was observed in a water table play activity. Another boy was also at this station and they were joined by the lead teacher and a teaching assistant, who used the opportunity to teach social skills. “The two boys are sharing toys, taking turns washing figurines down a slide on a water table... [Evan] talks about Grover getting washed down slide. [Teaching Assistant]: ‘Is he taking turns with Winnie?’

[Evan] says 'Grover can go.' [Grover is the figurine the other boy is playing with.] 'It's his turn'...Both boys play with both figures, walking them around and around the water table... [Both teachers] are helping them by taking turns and talking to them." In this example, the teachers made use of the time in which part of the class was attending another activity outside of the classroom for intensive social skills work and imaginative play.

A second example of child-to-child interaction involved children both acknowledging and accepting differences in their peers in outdoor playground activities. The observations centered around a 5 year old participant with developmental and speech delays as well as emotional and behavioral challenges. She was interacting with her peers who had formed a queue to slide down the highest board in the playground. "[The Lead Teacher] follows [Flora who] grabs a toy school bus from inside and brings it out. [The Lead Teacher] follows her to slide where [Flora] appears to be getting ready to slide the bus down – on top of another child sitting at the bottom. [The teacher] warns [the other child] who moves and [Flora] just lays there [on top of the slide] for awhile. Other kids come over to help her down the slide. 'Wasn't that fun?' they ask her. [Flora] comes back up for more. Kids help again and tell each other to watch out. [The teacher] asks a boy at the bottom of the slide to move some socks [Flora has been putting on/taking her socks off repeatedly]. The boy removes the socks while other kids at the top of the slide...[encourage her] to go down slide. Kids wait semi-patiently for her to go. She won't. [The teacher] comes over to help. [Flora] drops bus down and, eventually slides down herself. Other kids clap."

A final subtheme that emerged from the data was the inclusion of children with special needs in peer activities and friendships. In a preschool art class, a 5 year old boy with emotional and behavioral challenges was approached by a friendly, playful classmate. "[Greg] paints slowly and carefully. Another child says 'Hello' through an empty cardboard tube to [Greg, who] ignores him and goes on painting. [Greg declares] 'I've finished my painting' [and] goes to the door. [The other child] hugs him saying: 'You're my best buddy' to [Greg]."

Support during Transition Periods

Our observations had been set up to especially target transitional periods so that we could explore the support staff gave during this time, and thus answer our third and final question: "In what ways is the child supported by center staff during transition periods?" Analysis revealed four subthemes that emerged from the observations. These were: (a) predictable schedules; (b) multiple cues that were developmentally appropriate; (c) physical calming techniques to ease children with challenges through transitions; and, (d) multiple staff members with well-rehearsed roles, working to facilitate transition times.

Predictable schedules and developmentally appropriate cues. In observing the classroom environments in the centers, researchers found that a frequent structuring device was the use of predictable schedules posted for the children.

These schedules were used by teachers to remind children of transitions, referred to as the day progressed, and frequently reviewed by the teachers. Additionally, transition times were signaled by teachers to prepare children for the changes in activities that challenged so many of the children. For example, in one preschool center, a girl who had been singing the alphabet song at "Circle Time" received a prompt from her teacher to take part in a new game at an activity center, posted as activity time on the wall. "As the teacher points to the letters, [Hillary] recites them...Teacher announces that there is a new game; they are going to take turns with it. The children gather around. She says, 'I need everyone on their name.' [Hillary] complies immediately." Another example of cueing was seen at an outdoor game, involving a boy with behavioral challenges. "[The lead teacher] gives group a seven minute warning [to go inside]. [Isaac] plays by the rules set by group of children, but there is another dispute with the goalie. Counselor is there. Boys work it out...they play on. Teacher counts down time until they all need to go inside."

Physical calming techniques. Physical calming techniques were also used by teachers to help facilitate difficult transitions for children. For one five year old girl who had developmental delays and behavioral challenges, settling down for nap time was particularly problematic. "[Juanita is playing] around with her blanket and she begins to put a part of it into her mouth. Seeing this, [the lead teacher] sits next to her, but doesn't talk to her. When [Juanita] puts blanket over her head, [the lead teacher] helps her onto cot; lays blanket on her...The lead teacher leaves the room, [Juanita disturbs]...the chair [the lead teacher was sitting in]; younger teaching assistant moves chair and sits on floor next to child and rubs her back. [Juanita] mellows out with teacher's hand on her back and falls asleep."

Staff roles. Finally, transition times were observed to involve multiple staff members playing well-rehearsed roles in order to facilitate the children's movement between the scheduled times. An example occurred at a preschool setting involving children who had been in classroom activities in two rooms coming together for free play in an indoor gym. A four year old girl with multiple emotional and behavioral challenges had contact with three teachers as she made this transition, and worked to find a desirable toy to ride in the gym. "[Kayla] goes to line up spot and stands on a number, before lead teacher announces "Line up." The teacher had said, 'We're going to the gym'. Her teaching assistant says, 'We are in the gym,' [pointing to a door-sign that tells people where the class is located]...[Kayla] goes to a large bike and backs it out [from its holding place]. The teaching assistant says 'That bike doesn't work;' she gets a wagon out instead and pulls it around the floor. [Unsatisfied, Kayla] goes to another teacher and holds her hand...[Teacher points to functioning tricycle, and Kayla] picks up a working trike and rides behind a big group of 'bikers' who are circling the gym." Here, the needs of the individual child were met as she felt free to appeal to different teachers who were used to working with the larger combined class, and who knew the challenges of the children in both classes.

Implications of Results

The study has demonstrated that staff members of child care centers are able to structure environments and social interactions that successfully include children with emotional or behavioral challenges. Using developmentally appropriate practice as a basis, staff employed techniques that addressed individual children's needs in a culturally appropriate way, facilitating their retention in the child care centers. Children in these centers were observed to have staff support as they moved through the day, learning social skills, self-regulation, and academic content. Although some highly stressful days, for example, a last day in a preschool and the end of the school year in an after-school program, were selected for observation at the centers, staff were able to meet the challenges the children presented. They used the situations to teach about social skills and self-management. Staff built healthy relationships with the individual children, and used these attachments to promote social and emotional well-being (Collins et al., 2003).

Typically developing children had been prepared to deal with challenging situations and seemed to be socialized to accept differences in their classmates. Our observations corresponded well to information we had obtained from interviews with staff members who discussed working with the typically developing peers. Staff discussed peers modeling positive behaviors and social skills, and their work with the typically developing children to help them deal with the challenges their peers with mental health needs presented.

The findings of this observational study affirm the capacity of child care staff to promote social and emotional development, and for child care service providers to play an important part in integrated mental health service delivery. These natural environments are logical settings for the delivery of mental health services to the children that need them. Participants at the March, 2001 meeting of the National Leadership Forum on Child Care and Mental Health recommended "Incorporat[ing] children's mental health services into existing child care and early childhood education services." (Child Care Bulletin, 2002, p. 8). The specialized resources observed in these centers, such as therapeutic equipment and onsite mental health providers (Cohen & Kaufmann, 2000; Donahue et al., 2000), were certainly instrumental in allowing the successful inclusion of children with emotional and behavioral challenges.

As child care providers work with children with mental health challenges, the availability of mental health consultation has also proven to be critical. Evaluation researchers have begun to establish the success of mental health consultation in promoting gains in social maturation on the part of children with challenges (Alkon, Ramler, & MacLennan, In Press; Tyminski, 2001), and have provided evidence for the achievement by these children of greater ability to stay on task, learn, tolerate frustration, and behave age-appropriately when consultation is available (Fong & Wu, 2002).

Additionally, it should be noted that the National Leadership Forum participants also recommended that mental health consultants, such as those found in Head Start programs (Yoshikawa & Knitzer, 1997), be funded for other child care settings, and that model initiatives be supported (Child Care Bulletin, 2002). Funding must be augmented to subsidize the supports that centers require to serve the needs of children with emotional and behavioral challenges, and of their families, who frequently have been excluded from child care centers. Priority should also be given to the funding of research that can establish evidence-based practices that promote children's mental health in the natural environment of child care settings (Phillips, 2001).

Chapter 8: Discussion

“We Need to Just Raise the Bar”

This study was designed to advance our knowledge of how children with mental health needs can be successfully included in child care settings, alongside their typically developing peers. To reach that goal, the members of the Models of Inclusion research team immersed ourselves in the ecology of nine child care centers nominated for their success in this field. We interviewed center directors, staff, and family members concerning their perspectives on the ways in which children were cared for and families were served in these settings. We observed children and staff interacting during some of the most challenging times of the day. And we examined program documents designed for training, for communication with parents, and for collaboration with other agencies.

The aim of this chapter is to discuss what we have learned about inclusive child care from the combined voices and experiences of these centers, to link our findings to existing literature, and to provide answers to the major research questions proposed in the study. Specific recommendations based on our research are presented in the subsequent chapter.

Three major research questions informed our study:

1. What are the characteristics and practices of child care programs nominated for their inclusiveness which are associated with quality care for children and youth having emotional or behavioral disorders?
2. Which organizational factors contribute to the ability of child care providers to deliver high quality, culturally-appropriate services to children and youth having emotional or behavioral disorders?
3. What are the barriers to achievement of inclusive child care in these programs, and the strategies successfully used by providers and family members to overcome these barriers?

These questions have been answered by examining the social ecology of the centers (Bronfenbrenner, 1979, 1995). Our analysis of interview transcripts, observational notes, and archival data has revealed the complex interweaving of relationships and supports that helped children with emotional or behavioral challenges flourish in child care settings, and that allowed their families to obtain the services they needed. Center directors and staff built collaborative networks with mental health providers, social service workers, faith-based organizations, business communities, and others to secure training resources and to gain access to supports for children, family members, and staff. Although the centers were not formally linked to mental health systems of care for the children (Stroul & Friedman, 1996), it was clear that the child care staff were acting as agents of both mental health promotion and intervention.

Characteristics and Practices of Inclusive Child Care Centers

The first focus of the study was to examine the attributes and practices of child care centers that facilitated the successful inclusion of families having children with mental health needs. Our analysis revealed that the centers supported families, had parents take key roles, and worked to establish positive attitudes toward inclusion. Additionally administrators and staff developed strategic practices to promote socioemotional development in children and to transform negative affect and behavior; they also called upon consultants to assist them with inclusion. Finally, staff worked to understand the cultures of the families enrolled in the center, and to help all parents feel confident that their children were well cared for and safe.

Families Were Being Supported

The centers in this study are setting the pace for inclusive child care practice by successfully serving families of children with emotional and behavioral disorders. Directors, staff, and families talked enthusiastically about their successes and revealed their challenges. Families evidenced a high level of satisfaction with the child care services they were receiving, reported close connections with staff to the point of considering them extended family, and felt confident that their children could be maintained in the centers despite their ongoing emotional or behavioral concerns, or acute episodes of difficult behavior.

Contrasting with this finding, in a recent study of barriers to inclusive child care in California, the WestEd Center for Prevention and Early Intervention found that 27% of parents of children with special needs who were not accepted or asked to leave child care attributed this to their children's behavior problems (Shaw et al., 2001). Even when parents were able to make child care arrangements for their children with emotional or behavioral challenges, they were often costly and lacked necessary flexibility (Rosenzweig, Brennan, & Ogilvie, 2002)

In our research interviews, directors and staff talked about the paucity of programs outside of their own center, and families discussed the difficulties of finding child care if a child had emotional or behavioral challenges. Child care choice was very limited for these families. Too often the choice was *"either [this center] or quit my job."* Many of these families recounted experiences of recurrent rejection and expulsion from previous child care arrangements, and the concomitant negative impact on the child and stress for the family. In contrast, families with children that were developing typically revealed their selection of the center was based on priorities of location and convenience.

As discussed in the introductory chapter, under United States law all children have the right to participate fully in society and to receive services in the least restrictive environment. As greater numbers of children spend more time in child care (Lombardi, 2003), inclusion in this setting has become increasingly important. If families cannot access the child

care they require, children are denied the opportunity to participate alongside their peers, and caregivers are prevented from engaging in paid work and other activities of daily living (Heymann, 2000).

Family support over and above child care was provided by staff and administrators who facilitated connections between family members and individuals and organizations providing needed resources in the community. Our interviewees mentioned assistance ranging from introductions to health and social service providers, to help negotiating the everyday requirements of life; family support was practiced in a comprehensive manner (Friesen, 1996).

Families Played a Crucial Role in the Centers

Parents were as much a part of the centers we visited as the centers were a part of the family. In fact, many parents said the child care professionals had become like members of their extended families. The feeling was mutual. Directors felt they could not do what they did without the support and cooperation of the parents and formed genuine "caregiving partnerships" (Safford, Rogers, Habashi, & Kabha, 2001) with family members.

Parents gave staff members tips on how best to understand their children, and sometimes directly participated in staff trainings. The tips also went both ways. Staff members who formed solid relationships with children often learned about their young charges' new interests that appeared during the child care day, and reported these to their parents. Child care providers went to great lengths to keep families informed about new developments, new goals achieved, and the day-to-day happenings in their children's lives. For children with emotional or behavioral disorders this often meant new strategies for overcoming such challenges. Family members, staff members, and even the children themselves, all cooperated in developing new strategies; caregiving was a work in progress with constant tinkering and daily feedback. Families enrolled in the nine centers participated in volunteer activities; they helped raise funds, sat on advisory panels, and donated equipment. But the family members in this study also involved themselves in the life of the centers in a more integral way. Families accepted and supported staff members (not to mention other families enrolled in the center) through difficult times and trying behaviors. Because staff cared for their children, families came to care for the staff members. Families trusted staff to help their children reach their goals. It was this trust that, in the end, allowed staff to successfully include all children in their care, regardless of disability or developmental stage.

Relationships between centers and families were partnerships in the truest sense of the word. Families were accepted as they were. Families who had very little time to invest were not asked to invest a great deal of time. Adjustments were made in center procedure (pick-up and drop-in times, for example) to fit families' unique needs. Families were not responsible for conforming to center policy. Instead, the impetus was on the center to adjust to the strengths of their families. Parents greatly appreciated this flexibility.

Attitudes toward Inclusion Were Targets for Change

Previous research in school settings (Pivik, McComas, & LaFlamme, 2002) has shown that favorable attitudes toward inclusion are associated with positive experiences for staff, family members, and children. In this study, it was evident from the accounts of both child care providers and families that exposure to the successful practice of inclusion was a powerful force in changing negative attitudes toward inclusion, and in reducing resistance and fears. Staff talked about their personal learning, and the rewards of knowing that they were making a difference in the lives of the children and families in the center. The challenges of their work provided opportunities for professional development, and enabled them to build skills that were of benefit to all children. Families gained because the centers gave children the opportunity to learn about differences in a positive way, and reduced fears of being different or of others' differences. Some parents expressed the goal that their typically-developing children would be less isolated from children with disabilities, while others wanted their children to be more tolerant as a result of their experiences in the center.

Child Care Practice Was Strategic

Evidence from our research supports the contention that child care centers can promote positive social and emotional development, even of children who have serious challenges to their optimal development. Our interviews and observations revealed that child care workers structured activities and developed environments that helped these children make gains in self-regulation, attachment to adults, peer relationships, communication, and self-esteem. The child care staff also worked in preventive and innovative ways to support vulnerable children with temperamental difficulties and "from environments that placed them at developmental risk" (Wasik, 2003, p 3), so that behaviors that were annoying or troubling did not persist. Although some of the children had little success in previous child care environments, and may even have been diagnosed as having emotional or behavioral disorders, they were able to function in this social ecology, where their levels of "disability" were lessened (Pledger, 2003).

Directors and staff clearly worked intentionally to promote positive mental health, and to assist children with their emotional and behavioral challenges through interventions embedded in daily practice. Our analysis of interviews and observational notes revealed that two types of practice strategies were employed: promotional strategies that assisted all children to develop positive emotional states and prosocial behaviors, and transformational strategies that helped to change negative emotional states and challenging behaviors. Of particular interest was the strategic emphasis on approaching children as individuals and finding sensory channels to reach all children, helping them to feel safe and calm, and assisting them to focus on relationships and learning. As critical as verbal communication was, visual and tactile communication were also employed in targeted ways by the child care providers, particularly with young children.

When faced with challenging behaviors or emotional crises, child care workers and their directors used some conventional practice approaches such as redirection, attending to positive actions and ignoring negative behaviors, and assisting children to substitute verbal self-expression for aggression. They also employed creative strategies such as using art or physical activities for children struggling to gain self-regulation, devising safety plans to guard against aggression or self-injury, and engaging in pre-emptive planning based on detailed knowledge of children and their family environments. Child care staff also discussed how language delays could lead to frustration, and often resulted in challenging behavior in young children. (See Campbell, 2002 for a discussion of the empirical evidence for such a link). Their innovative practice strategies included the use of alternate means of communication, such as signing or drawing, with children having delays in language production or comprehension. Using sign language or pictures, the children got their social and emotional needs met, without building up frustration or resorting to aggression. Finally, we observed practice strategies developed for school aged children that included: involving youth in planning age-appropriate curricula, emphasizing small group activities, setting clear boundaries and expectations, and teaching empathy and responsibility through care of plants and animals.

Although these practice strategies went a long way toward insuring that children with challenges developed social and emotional strengths, staff and administrators counted on the support that they got from consultants.

Mental Health Consultation Was Essential

Professionals with mental health training worked with administrators, staff, and family members to ensure that children received appropriate assistance with their mental health needs and could remain in the child care settings. Usually consultants were called for support when children exhibited challenging behavior or difficult emotional states that persisted over time and interfered with their social relationships or learning. In some cases, consultation took the form of program-level interventions (Cohen & Kauffman, 2000), which resulted in staff members changing their schedules, activities, or classroom environments to better support children's learning and socioemotional development. At other times, the consultants intervened directly by spending "floor time" observing and working with the child, nearly always in the context of the classroom (Donohue, Falk, & Provet, 2000). Similar to the results of recent studies of Head Start mental health consultation, (Green, Everhart, Gettman, Gordon, & Friesen, 2003; Green, Simpson, Everhart, Vale, & Gettman, in press; Yoshikawa & Knitzer, 1997) the consultants in the nine centers we investigated also took on a variety of other roles including meeting with family members, staff training, arranging for formal assessment, referral for mental health services, and support of staff.

Consultants represented a wide variety of disciplines, and were well integrated into the programs they served, sometimes even as full-time employees of the centers. The interventions and behavior plans they designed in partnership with family members, staff members, and administrators were carried out by the partners in the home and center contexts. In most cases, center interventions took the form of activities that all children in the classroom joined, and these activities added to the quality of the child care experience for all children. Replicating the results found by evaluators of the San Francisco High Quality Mental Health Consultation Initiative (Bleeker & Sherwood, 2003), consultation services were viewed by administrators and staff as contributing to the overall quality of the child care setting.

Cultural Competence Was Critical

Staff working in the child care centers we studied attempted to develop greater awareness of the ways culture shaped their work with children and families on a daily basis. Examples of the relevance of culture discussed by interviewees included family beliefs about appropriate behavior for children, parents' expectations of their children, attitudes about parenting roles and practices including discipline, and norms for communication. Child care providers used their knowledge of families' culture to shape classroom activities, and to facilitate their meetings with parents.

There is substantial evidence that families from racial or ethnic minority groups have greater difficulty than other families obtaining mental health services that meet their needs (U.S. Department of Health and Human Services, 2001). Providers have unique access to many families and young children in the natural environment of child care and can link them with needed services, helping to prevent more serious mental health problems (Early Head Start National Resource Center and Zero to Three, 2003). However, outreach to diverse families through child care centers will require adequate resources including training and support services, language, and interpreter services.

Competence Created Confidence

Nearly all of the parents were satisfied with the care that their children received. They described staff who were not only nurturing, but also professional and well-trained. Parents expressed concerns about the safety of their children, but also saw that problems were not avoided, but were addressed and resolved. Indeed problem resolution sometimes contributed to new policy development within the center and shaped organizational practices.

Organizational Factors Facilitating Inclusion

The second focus of our research involved examination of the ways in which the centers functioned as organizations and enabled staff to be inclusive in their practice. We analyzed the data to determine the shared goals and values, the sources of leadership, the facilitative management practices, the patterns of communication and collaboration, and the extent to which the centers were open to learning and change.

Clear Goals Were Primary

Although the centers varied in the programs and services offered, every center had the explicit goal of providing child care that could meet the needs of all children, including those with emotional and behavioral challenges. Each program accommodated children that were typically developing as well as children with special needs. The directors were "intentional" about communicating their program's inclusion policy to staff, family members, and others who came into contact with the center. The goal of inclusion provided a focus that informed the design and delivery of services, the allocation of resources, management policies, classroom practice, and methods of working with families (Bradley, Brennan, & Cawood, in press).

Administrative Leadership Was Required

As Irwin, Lero, and Brophy (2000) pointed out in their study of Canadian child care, successful inclusion also requires a significant commitment to implement this goal. While defining a clear mission to be an inclusive child care center might have been relatively simple, implementing it successfully was not. The center directors played a key role in building commitment to inclusion within and outside of the center, revealing qualities of both internal and external leadership (Espinosa, 1997). They described "constant conversations" in their efforts to embed the philosophy in all aspects of the organization, including the policies and the day to day activities of the center. Several of the directors and staff viewed themselves as advocates for the children in their care. They worked to build and expand the web of resources that enabled the center to meet the varied needs of individual families, through the development and nurturing of partnerships with a variety of agencies.

The directors were leaders not only in the centers, but also in the local and professional community. Locally, the reputation of each center attracted new families, and enabled some of the centers to raise additional funds within the community. Directors and staff shared their professional expertise and contributed to the development of knowledge about inclusion through their involvement in training. The centers provided service opportunities for community members through internships and volunteer positions, and at the same time benefited from the contributions of local organizations and advocates, including faith-based agencies and business leaders.

Personal Values Were Paramount

Administrators shared the view that the role of the center was to promote the success of all children whatever their challenges or impairments. It was evident from the staff who were in day to day contact with families that they were intrinsically interested in working with children. They talked about love and respect for youngsters, and the warmth of the center. And staff paid a great deal of attention to the development of the personal relationships with individual children that provide the building blocks of healthy development for all children (Collins et al, 2003; Knitzer, 2001; Shonkoff & Phillips, 2000).

The values of staff were of central importance to parents who commented on the *“the family type feeling, the warmth, the welcoming”* at the center. They observed that the staff *“genuinely care for children,”* and that they *“just seem to enjoy what they are doing.”* They noted the positive impact of the *“interest and loving support”* of staff on the ability of the child and the family to deal with the challenges they faced.

Clear Communication Was a High Priority

Communication lines were intentionally kept open by administrators and staff who attempted to establish *“personal accessibility”* and to forge working relationships with parents (O’Brien, 1997), consultants (Collins et al., 2003), and other support personnel. Emphasizing the need to avoid jargon, to be clear, to provide frequent up-dates on the child’s progress, and to respect confidentiality, staff members worked to be in contact with every family every day if possible, and employed a wide variety of communication media. Staff met often, strove to overcome their reluctance to share their challenges with other workers, and reaped the benefits of fresh ideas and support that they received from fellow child care providers. Communication was found to be essential to establish the collaborative working relationships that were the foundation for access to the supports needed by the children and their families.

Management Practices Mattered

The directors recognized the essential role of staff in enabling the center to achieve its goals. In their interviews they emphasized the importance of being explicit about the mission of the program when hiring new staff. This attracted and retained staff who shared the essential values of the center.

Caregivers can have a significant impact on the lives of children (Lombardi, 2003; Shonkoff & Phillips, 2000), but conditions of work for child care employees often do not reflect the importance of the work they do. In these centers, most directors had improved conditions of employment to include health and retirement benefits for full-time staff, and some were striving to institute benefit coverage for part-time staff. Some centers also had family-friendly policies such as flexible working hours. These practices helped to reduce the high turnover that characterizes child care employment (Whitebook, Howes, & Phillips, 2001). Staff talked about the benefits of having experienced, long-term coworkers. Parents saw the rewards of consistent relationships, and having *“someone outside of the family...who cares for [my child] and gives them attention as they need it, as a kid.”* Consistent care was especially important for children who had difficulty with transitions.

The directors’ efforts to promote the success of each child extended to how they managed their staff. They recognized the contributions of each individual and the value of building on and using existing staff strengths. They also provided opportunities for ongoing professional growth and development so that staff could continue to build their competence. Internal training requirements usually exceeded external regulatory standards. Training was viewed not only

as a means of improving knowledge or skills, but also as a source of new energy and an opportunity to learn more about other professional roles and develop new collaborative partnerships.

The structure of the organization enabled staff to be successful in their work. The directors recognized that mere compliance with licensing requirements for staff-to-child ratios was inadequate. Children’s needs were dynamic and additional staff members were required to provide the flexibility to respond to individual children, to prevent problems, and to provide back-up in a crisis.

Teamwork and a Supportive Culture Were Fostered

The majority of the directors were hands-on managers whose close involvement in the work of the center provided them with intimate knowledge of children and their families. They appreciated the daily challenges of the work, and were able to step in during crises to provide a helping hand, direct supervision, or other necessary support. They recognized the importance of creating a safe climate in which staff felt free to ask for help without fear of being seen as failures.

Staff described having fun at work, and the integrity and professionalism of their coworkers. They talked about the need to be open about the frustrations inherent in the work they did, and that it could be a *“tough job.”* The child care providers were open with each other about their own challenges and were able to monitor their responses and *“take a break”* if they needed it.

Teamwork was essential to both meet the needs of the children and to support each other. However working together was not always a smooth process, particularly when different professional groups were involved. Differences in professional values and approaches were managed by making the child’s needs the priority, and putting the desires of individual staff members to adopt a particular approach into perspective.

Openness to Learning and Change Was Pervasive

New staff members received mentoring from their more experienced coworkers. Staff were aware of how the children learned from observing their teachers, and therefore took steps to be good role models in the classroom. In interviews, the child care providers discussed a wide variety of training modalities that prepared them to work with children having emotional or behavioral challenges. Staff development opportunities ranged from participation in formal training programs on inclusion, to informal meetings with mental health consultants or family members regarding individual children.

Directors and staff also described the importance of tapping into the parents’ expertise on their children to assure effective care. The need for individualized care (Collins et al., 2003) meant that the staff had to be open to getting to know about the family context and learning about each child. This was an ongoing process as they analyzed the problems that arose, selected solutions, and learned from responses. Staff

recognized that the involvement of parents in exchanges of information about each child, and in the care of their child, was crucial for the child's success. Children's needs were dynamic and required flexible responses. Being open to change and striving to continue to seek information and improve services to meet the needs of families was an important part of the success of the centers. It is notable that some parents observed a "positive evolution" of the program and commented on how they felt that the program improved during their time at the center.

Parents said their children had "a lot of fun" and learned "to do things" not learned in other environments. As parents experienced the commitment of the center staff to work with their child whatever the difficulties, they became more open about problems that they experienced. Thus they were able to seek and accept assistance from staff. They talked about how staff helped them to learn to deal with their child's behavior in a more positive way.

Barriers to Inclusion and Innovative Strategies

Interviews with parents, staff, and administrators revealed a set of major barriers to full inclusion of children with emotional or behavioral disorders in child care: lack of resources; negative societal attitudes; cultural misunderstandings; existing policies blocking inclusion; gaps in services; and, difficulties in collaboration. Although the obstacles were formidable, center personnel had devised innovative strategies to overcome the challenges to inclusion that the barriers presented.

Lack of Resources/Creative Funding

When asked about challenges, or what could make their program even better, staff and administrators discussed resource deficits that affected their centers and child care providers in general. They identified: poor salary levels that affected their ability to retain staff; insufficient funding for additional staff to support children on a one-to-one basis when needed; lack of resources to grow programs or improve facilities; and limited budgets for training or staff development. The lack of qualified mental health consultants who were able to work with children was also noted (Knitzer, 2001; Phillips, 2002). Creative funding packages were put together around individual children, or groups of children in order to increase service levels, and administrators worked hard to increase salaries and benefits. However many resource challenges remained for the programs, including securing sustainable sources of funding. Unfortunately by the time of publication of this monograph, one of our study sites, Little Angels in Milwaukie, OR had closed due to funding problems and a state economy with revenue deficits and few new sources of support

Negative Social Attitudes/Persistent Efforts to Change Views

Unfavorable attitudes toward children with emotional or behavioral problems and blame attributed to their families were also seen as permeating society; these attitudes were capable of affecting the child care environment at all levels

(Webster-Stratton, 1997). Some of the staff themselves reported undergoing a transformation in their own attitudes as they learned about the difficult contexts in which families lived, and the bases of the children's challenges. Administrators and staff reported that they had trouble working with some parents of typically developing children who wondered why children with these challenges were being served by the centers. Although staff competency and patience overcame many of the attitudinal barriers, they were still troublesome enough to be discussed repeatedly in our interviews.

Cultural Misunderstandings/Outreach

All three groups of participants discussed culturally-based difficulties which were identified as presenting major obstacles to inclusion. Language barriers were common, and although translators were available for preplanned conferences, few of the centers had translation services onsite, or staff who spoke the home languages of some of the children. Even if language was not a barrier, families and staff struggled to reach common understandings about key cultural areas such as the level of challenge experienced by the child, discipline practices, or culturally different approaches to child care. On the other hand, given the outreach of staff to families, and the high levels of participation by culturally-diverse families at the centers, cultural issues were seen by service providers as more of a challenge and less of a threat to inclusion.

Existing Policies/Advocacy for Policy Change

Administrators in particular saw existing policies as roadblocks to their inclusion efforts. Access to funding for individual children was sometimes impeded by inflexible funding categories. Billing policies in several of the states also prevented child care centers from collecting subsidies for care of children with disabilities in a timely fashion. Additionally a state level policy forbidding the use of any type of restraint by child care providers was reported as endangering children's safety by one of the staff members. As a result of these experiences, some of the administrators became well known as advocates for policy change at the state level.

Service Gaps/Advocacy and Partnerships with Parents

Although the center staff and directors were able to connect many of the families with resources in their areas, they also discussed the notable service gaps they faced. Long waits for assessment and treatment were common in some of the communities. Families that obtained services for their children in preschool settings had to struggle once more to get service plans in place for their children when they reached school age (Lehman, Friesen, & Brennan, 2001). In some cases, child care providers were not welcomed to the table at which school-based services were discussed, although they had years of experience with the child and family requesting assistance. The staff and administrators attempted to overcome service gaps through their advocacy and their partnerships with parents.

Difficulties with Collaboration/Building Relationships

The final barrier was perhaps one of the most daunting, difficulties with collaboration. As families, staff, and administrators described their work with consultants and outside agencies, several talked about the lack of time to make these relationships successful. Another related issue that surfaced was differences in philosophy regarding inclusion that made collaboration problematic. Some service providers wanted to pull children out of the classroom setting to avoid distractions, instead of providing services in the natural environments as program directors wished. Other partners were determined to “fix” families of children with troubling behavior rather than work from an asset-based approach. Patient adherence to practice principles and inclusion philosophy were reported to be crucial although one director said, “*There are times when we are not the most popular people in town . . . Sometimes it is a bumpy road.*”

Fortunately in several of the centers, the ideal held out by Collins et al. (2003) seemed to be attained: “Promoting mental health in child care settings occurs most readily when services are co-located, when providers are cross-trained, and when staff members enjoy good relationships with one another, with consultants, and with families” (p. 45).

Limitations of the Research

This research is one of the first major empirical studies on inclusion of children with emotional or behavioral challenges in child care settings. An in-depth qualitative study using a grounded theory approach (Strauss & Corbin, 1990) was selected as the most appropriate method for research at this early stage of work. The findings from this study provide insights into how children with emotional and behavioral challenges can be included successfully in child care settings. However, because of limited resources the investigation focused on only nine centers nominated as being successful, and was not designed to provide a representative picture of child care centers in the United States. The final choice of centers may have been influenced by unknown biases in the nomination process. Child care centers represent only one section of child care provision. Other types of settings such as Head Start, family child care, in-home caregiving, or extended family care are not investigated in this study.

The staff and family member interviewees participated in the study on a voluntary basis, and were rewarded with a stipend. Directors played a role in the recruitment process by distributing information about the study. Reasons why participants did or did not choose to be interviewed are not known, and thus sampling bias within the center cannot be excluded. Due to resource constraints, only five of the nine centers were studied by on-site data collection. Although the same data collection instruments were used for both on-site and telephone interviews, the potential effect of differences in the level of contact on participants' responses is unknown.

Future Research Directions

The possible benefits of mental health promotion in some child care centers are clear from the results of this research and from the findings of studies that have investigated the effects of mental health consultation (Alkon et al., in press; Bleeker & Sherwood, 2003; Green et al., in press; Safford et al., 2001; Tyminski, 2001). However, as yet we have learned little regarding how widespread inclusion of children with emotional or behavioral challenges is in child care settings, and what mental health and other supports are available for families and workers to draw upon. Particularly, we do not know how inclusion is practiced in some types of child care that serve substantial numbers of American children: family child care, in-home care, and care given by extended family members; further, researchers have not investigated the mental health supports these inclusive caregivers need and use. Clearly, a more comprehensive survey of child care directors, staff, consultants, and families is needed to provide guidance for funding agencies and program designers.

Additional research on the process of mental health consultation in child care is also needed. Answers to questions about the use of various consulting modalities, the effectiveness of these approaches, and their costs need to be pursued through continuing studies in various types of child care settings, and with culturally diverse populations.

We also need to intensively study the types of child care practice that promote social and emotional development of children with challenges and that are effective in transforming negative emotions and troubling behavior. One promising approach, which has been adapted from work with children having developmental disabilities, is positive behavior support. This method, which is research-based and also provides for family support, has been used successfully in early childhood settings with children having serious behavioral challenges (Fox, Dunlap, & Cushing, 2002; Fox, Dunlap, & Powell, 2002). Some of the mental health consultants who gave assistance to staff in the centers in this study incorporated elements of this approach in their work.

Recently researchers have raised questions regarding the relationship between social and emotional difficulties experienced by young children and their participation in child care. These questions were posed by members of a network of researchers conducting a major longitudinal study funded by the National Institute of Child Health and Human Development (NICHD) which has been examining the effects of child care on a sample of over 1,000 American children born in 1991. Perhaps most notably, recent papers have concluded that higher levels of behavior problems were associated with lower quality of care, instability of care, and more time spent in care (Early Research Network, NICHD, in press, 2003). In some cases, these effects interacted with family characteristics and risk factors in complex patterns. Although some indicators of emotional or behavioral challenges, such as child participation in IFSP or IEP programs have been collected (personal communication A.

Clarke-Stewart, April 12, 2002), and children with behavior scores in the clinical range can be tracked through this data set, no separate analysis of their outcomes has yet been published. This type of analysis would be helpful in investigating the interaction between child care use and social and emotional development for children with challenges.

Another major issue that surfaced during our present investigation was the difficulty of making the transition between child care and schools for children with emotional or behavioral disorders. Research is needed to explore the types of support that are essential for families and children to successfully move from early childhood settings to the school environment.

Finally, efforts at the state level to bring mental health supports into child care settings need to be documented and analyzed. In order to gauge the level of progress toward inclusion in this country, it is necessary to investigate: the relationship of child care and mental health services at the state level; planning for inclusion; family outreach and participation; training of service providers; and, state level initiatives promoting inclusion. This is the next step for our research team, and we have already begun to have conversations with state-level child care administrators regarding their state's progress toward inclusion of children with mental health challenges.

In order to reach the goal of supporting children with emotional or behavioral challenges in natural environments such as child care, and promoting the mental health of all children, we need to design and conduct studies that will guide advocates, practitioners, and policymakers. In the words of one of the staff members we interviewed, "*We need to just raise the bar*" and ensure that all of our children, including those with unique challenges, experience supportive, high quality care that can contribute to cognitive gains and school readiness, and promote social and emotional development.

Chapter 9: Recommendations to Promote Inclusion

As the preceding chapters have demonstrated, children with difficult or troubling behavior can be cared for in child care centers along with children who are typically developing. Parents and child care providers we interviewed reported that the benefits of successful inclusion are many: children with challenges gain skill in regulating their behavior and are retained in child care settings; typically developing peers accept differences in their classmates and learn to be empathetic; parents are able to engage in employment, education, or training; and families are supported by services that add quality to their lives. Additionally, young children who make strides in social and emotional development are better prepared to take on the demands of academic work in school settings. Inclusive preschools and school age care can provide a vital opportunity for children to interact constructively in group settings with peers and adults, together with valuable preparation for the acquisition of language, literacy, and other cognitive skills in classrooms.

An Agenda for Action

As our participants have repeatedly told us, inclusion is no accident. It is the result of careful planning, organizational development, and intentional actions on the part of administrators and care providers. Therefore our research team and members of our advisory committee have reflected on the lessons we have learned from inclusive child care centers and offer fifteen recommendations as the basis of an action agenda to promote inclusion. Ten of the recommendations are primarily focused on actions that should be taken at the program and community level to foster inclusion. The remaining five suggest changes at the state and federal level that can enhance the infrastructure of child care in order to better serve these children and their families, who have the right to be included in this community-based service.

Recommendations for Program and Community Actions

1. Foster Stable and Qualified Administrators and Staff Who Embrace Inclusion. As we have learned from the child care directors and staff we interviewed, a pervasive belief in the importance of inclusion is central for success in child care settings. Incentives should be put in place that will attract and retain staff who embrace inclusion and who have the qualifications and dedication to meet the challenge of providing care for children with emotional or behavioral challenges. These vulnerable children are in particular need of stable relationships with care providers. Although we recognize that all child care providers should be compensated more appropriately for the vital work they perform, extra resources should be made available for those qualified to provide inclusive care.

- a. Administrators and staff providing care for children with mental health needs should be compensated appropriately for their additional skills, and should receive suitable health care and other benefits.
- b. Administrators and staff should be awarded scholarships, and rewarded with higher pay scales for engaging in professional development leading to greater levels of qualification for work in inclusive child care.
- c. Care providers should receive increased pay for their longevity in inclusive child care settings.

2. Provide for Professional Development of Administrators. All professional development curricula for child care administrators of early childhood and after-school programs should address the following topics around inclusion of children with emotional or behavioral challenges:

- a. Developing and supporting an inclusive philosophy and a clear mission;
- b. Building and maintaining an organizational structure that enables staff to practice in line with the mission of the organization;
- c. Mentoring and supporting staff working with children with challenges, and promoting an environment that facilitates continuous learning by child care providers;
- d. Understanding mental health issues in early childhood and school aged years;
- e. Accessing needed mental health consultation and supports;
- f. Working with parents as partners caring for children with challenges, and striving to respect and incorporate the cultures of the families in the care of these children;
- g. Keeping communication lines open with parents, while respecting confidentiality; and,

- h. Enlisting community supports and developing strategies to work successfully with different professional groups and multiple stakeholders.

3. Promote the Professional Development of Staff. Professional development trainings for providers should include information that supports their work with children experiencing emotional or behavioral challenges, in addition to knowledge about child development. Training in inclusion should be integrated into existing child care training programs and should cover:

- a. Methods of developing and nurturing relationships with children having troubling or difficult behavior;
- b. Inclusive practices that support positive behaviors and decrease challenging ones;
- c. Safety issues when dealing with children with emotional or behavioral issues, and state and federal regulations that apply to children with disabilities;
- d. The use of mental health consultation, administrative supervision, and peer mentoring to serve children with mental health needs more effectively;
- e. The influence of culture on families, including parents' views of disability, and their expectations and practices regarding behavior management; and,
- f. Parents as partners in the care of their children with challenges.

4. Create, Discover, and Publicize Successful Inclusive Practices. The use of culturally-appropriate and successful inclusive practices should be fostered at the program and community levels. These best practices should be investigated, documented, and disseminated to parents, care providers, and other support professionals so that a more comprehensive set of evidence-based practices can be established and more widely utilized.

- a. Inclusive practice in settings that have successfully cared for children with emotional or behavioral challenges should be intensively studied, along with other models developed through academic research.
- b. Successful inclusive practices should be disseminated both to child care providers and other support professionals.
- c. Technology should be used to facilitate communication among providers and the sharing of successful practices through the development of web discussion groups and web sites that provide easily accessible resources.

5. **Make Mental Health Consultation Widely Available.** Mental health consultation should be available for every early childhood and out of school care setting to support the social and emotional development of children.
 - a. The number of qualified professional mental health consultants should be increased by means of recruitment, training, and retention efforts.
 - b. Observation, assessment, and early intervention, direct support, or referral to community resources, should be provided for children experiencing more serious social, emotional, or behavioral challenges and their families.
 - c. Mental health consultants should provide assistance with transition from preschool to elementary school programs for children with identified social, behavioral, or emotional challenges.

6. **Deliver Supportive Services in Naturally Occurring Activities in the Care Setting.** Mental health supports should occur in the child care environment as part of naturally occurring events, whenever possible.
 - a. Both direct and indirect services that promote positive social and emotional environments for all children and staff should be provided in the context of the classroom, using appropriate strengths-based approaches.
 - b. Policies on billing should be adjusted to allow reimbursement for mental health services (including adapted individual and group activities) occurring in the natural environment of the classroom, family child care setting, or after school program.

7. **Enhance Professional Development for Mental Health Consultants.** Initiatives should support the pre-service and in-service professional development of mental health consultants.
 - a. Appropriate curricula should be developed that will prepare mental health specialists for work with children and their families in care settings.
 - b. Innovative programs should be widely available to provide specialized training and certification of professionals in mental health fields for work in early childhood and out of school care settings.
 - c. A concentrated effort in workforce development should provide scholarship support for pre-service training in mental health consultation in child care settings.

8. **Encourage Family Participation.** Recognizing that parents are the adults with the most extensive experience concerning their children's emotional or behavioral disorders, administrators and staff should encourage and support their participation in their children's care.
 - a. Mutually supportive relationships between child care providers and family members should be encouraged; an atmosphere of care and trust will provide a foundation for their partnership in the care of children.
 - b. Educational and social opportunities for family members and staff to learn and interact together should be supported.
 - c. Family members should be encouraged to share information concerning their child's development and challenges, and strategies for success with the staff.
 - d. In order to benefit from their unique perspectives and experience, family members should be included in the planning and delivery of training and professional development for administrators, staff, and consultants.
 - e. Because planning for care of children with challenging behavior is ongoing, family members should be as involved as they wish to be in their children's care, in setting up behavior plans, or in the mental health consultation process.

9. **Expand Family Support.** Although child care serves as a major support for families of children with emotional or behavioral challenges, other types of support should also be made available in conjunction with these services.
 - a. Lists of local family support resources should be compiled and distributed to child care resource and referral agencies, child care centers, and family child care providers.
 - b. Child care providers should extend the family support function by linking family members to other types of supports, including transportation, mental health services, respite care, income assistance, or health care assistance.
 - c. Organizations such as mental health programs and family support networks should recognize child care as an essential family support need.
 - d. The belief that families and children with challenges should be worked with on the basis of their strengths and assets, rather than their problems and deficits, needs to be conveyed to all agencies that support families.

10. Foster Community Partnerships. The success of inclusive child care providers can be improved through the strengthening of partnerships among family-serving agencies, businesses, and human services organizations in the community.

- a. Public relations campaigns should be undertaken to get the word out to possible community partners about the need for, and benefits of, inclusive child care.
- b. Alliances among family-serving agencies are essential to augmenting the abilities of child care providers to support families of children with emotional or behavioral challenges; providers should serve as sources of ideas, inspiration, and support to one other in the spirit of cooperation.
- c. The advocacy and support of the business community for inclusive child care should be sought, since these care arrangements allow family members to be more effective employees, and to have resources to be business customers.
- d. Partnerships between child care providers, universities, community colleges, educational service districts, and human service organizations should be encouraged, since the partners can foster learning exchanges, assist each other in identifying the needs of family members, and collaborate on funding requests.

Recommendations for State and National Level Actions

11. Increase Accessibility. In order to provide equal opportunities for children with emotional and behavioral challenges to experience the enrichment and support of child care settings, access should be increased to inclusive early childhood care settings and out of school care.

- a. A campaign of public education must be undertaken which addresses the need for and benefits of inclusive child care, and the legal rights of children with challenges to have access to child care environments.
- b. Education about the rights of families of children with mental health needs to receive services in natural environments should be available for child care providers.

12. Enhance Affordability. Families of children with emotional or behavioral challenges often need assistance to afford child care for their children.

- a. All states should include emotional or behavioral disorders in their definitions of “special needs” within Child Care Development Fund or child care strategic plans.

- b. Families of children with emotional or behavioral challenges, along with children with other special needs, should have child care subsidy funding earmarked through the Child Care Development Fund and other governmental programs. Flexibility should be built into funding so that it pays for the services that children actually need, rather than a prescribed set of services.
- c. Subsidies should have an eligibility age range that is appropriate for children with social or emotional disorders or developmental disabilities who continue to need supervision after the age of twelve.
- d. Special care should be taken to support those parents who are transitioning from Temporary Assistance to Needy Families into employment, and who have children with mental health needs.
- e. Sustainable funding for child care must be a major goal (Lombardi, 2003); as a specific step, increased tax credits for parents of children in child care who have mental health or other special needs should be legislated.
- f. Policy barriers need to be removed to permit the blending of funding streams and the sharing of resources across programs and agencies.

13. Improve Availability. Numbers of early childhood care programs and out of school care programs that provide inclusive care for children with emotional or behavioral challenges should be increased through governmental and private sector supports.

- a. States should involve culturally-diverse stakeholders in local communities in identifying child care needs and culturally appropriate responses to those needs.
- b. Inclusive early childhood programs should increase in number through funding that provides access to a comprehensive set of child care arrangements in every community.
- c. More universal funding for out of school programs should be in place in order to increase the availability of inclusive experiences for school aged youth with emotional or behavioral disorders.
- d. Child care resource and referral networks should mount campaigns: to train their referral staff regarding the needs of families having children with emotional or behavioral challenges, to identify and recruit providers with relevant training and experience, and to refer families to an expanded pool of qualified providers.

14. Increase the Capacity of Child Care Settings to Serve Children with Emotional or Behavioral Challenges. Child care settings need to be recognized as part of the systems of care (Stroul & Friedman, 1996) for children and families coping with mental health issues.

- a. Flexible funding strategies should be available to provide individual children with sufficient staff time, and even one-to-one support, during occasions when they need intensive staff attention, and so appropriate staff-child ratios can be maintained.
- b. Public and private sectors should be encouraged to develop appropriate classroom curricula that can be adapted to the social, emotional, and cognitive strengths and needs of the children served.
- c. Sufficient resources should be provided so that center environments can support children's positive development through safe and appropriate physical arrangements and equipment.
- d. Best practices should be used to set governmental policies on safety issues, such as restraint, to make sure that children and staff can be kept safe.
- e. Funding should be made available so that appropriate supportive services are at child care sites for all children and families who need them, including mental health consultation, speech therapy, and family support.

15. Fund Ongoing Research on Inclusion. Organized research programs should be funded by the public and private sectors to investigate the potential of inclusive child care to benefit children's social and emotional development and mental health.

- a. Based on representative population surveys, states should strengthen their ability to plan for inclusion by tracking the type and amount of child care needed and used by families of children with emotional or behavioral disorders.
- b. Research on inclusion in child care should be expanded to explore settings other than centers, such as family child care, in-home care, and extended family care.
- c. The potential of child care arrangements to identify children needing early intervention should be explored.
- d. The effectiveness of specific inclusive practices in promoting positive behavior and reducing undesirable behavior should be studied.
- e. Research should be conducted so that mental health consultation can be more effectively targeted to the needs of children and families.

- f. Evaluative research is needed to investigate the long-term effects of inclusive, culturally-appropriate, and high quality child care on cognitive, emotional, and behavioral development of children with mental health needs, and to determine the outcomes of inclusive care for their families.

Now is the Time for Action

There is clearly an urgent need for wider availability of inclusive child care arrangements. The centers we studied met the needs of a diverse and grateful set of families, largely due to the sacrifices and ingenuity of dedicated staff and administrators, their collaboration with family members, and the partnerships they forged with community allies. We recognize, however, that these centers were chosen for their exceptionality. A strong case can be made for their replication in other communities, so that children with mental health needs and their typically developing peers will have the opportunity to learn and grow together. With ever greater numbers of families of children with challenges looking for care arrangements for their children, the time is right to build an infrastructure that will provide needed care in every community in this country.

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List Of Selected Online Resources

1. Child Care Bureau

<http://www.acf.hhs.gov/programs/ccb/>

The Child Care Bureau's mission is to enhance the quality, affordability, and availability of child care for all families and particularly for low-income families. The Child Care Bureau administers federal funds to states, territories, and tribes to assist low-income families access quality child care for their children, while the parents of such children work or participate in education or training.

2. The Caring for Every Child's Mental Health Campaign

<http://www.mentalhealth.org/child/default.asp>

The campaign, which began as a national public information and education campaign, strives to help families, educators, service providers and young people increase awareness of mental health problems and solicit support for needed services. The campaign is through the Center for Mental Health Services (CMHS), a component of the Substance Abuse and Mental Health and Human Services. Information in Spanish is located at

<http://www.mentalhealth.org/espanol/>

3. Head Start Bureau

<http://www2.acf.dhhs.gov/programs/hsb>

Head Start is a federally sponsored, nationwide early childhood program that aims at increasing school readiness of preschool children in low-income families. The program serves children of ages 0-5, pregnant women and their families by providing comprehensive services focused on child development.

4. Committee for Children

<http://www.cfchildren.org/default.html>

Committee for Children is a non-profit organization, which promotes the safety of children by addressing social and emotional learning and violence prevention among children.

5. Federation of Families for Children's Mental Health

<http://www.ffcmh.org>

The Federation of Families for Children's Mental Health is a national non-profit organization that is parent-run and which focuses on the needs of children and youth with emotional, behavioral and mental disorders. The organization also serves the families of these children.

6. Family and Work Institute

<http://www.familiesandwork.org/about/index.html>

Families and Work Institute (FWI) is a non-profit center for research that provides data to inform decision-making on the changing workplace, changing family and changing community.

7. Healthy Child Care America (HCCA)

<http://www.nccic.org/hcca/>

Healthy Child Care America is a program that works to enhance the health and safety of children in child care settings, through the collaborative efforts of health care professionals, child care providers and families.

8. Institute for Training in Infant and Preschool Mental Health

<http://www.ycs.org/instituteoverview.html>

The Institute established in partnership with Rutgers University Graduate School of Applied and Professional Psychology, offers various training programs focusing on the assessment and treatment of infants, preschool-aged children and the infant/child-parent relationship.

9. The National Center on Children in Poverty (NCCP)

<http://cpmcnet.columbia.edu/dept/nccp>

The mission of NCCP is to identify and support strategies that prevent child poverty in the nation and those that increase opportunities for children from low-income families. The center has produced a number of mental health related reports including: *Building Services and Systems to Support the Healthy Emotional Development of Young Children*, *Lessons from the Field: Head Start Mental Health Strategies to Meet Changing Needs*; and the series *Promoting the Emotional Well-being of Children and Families*.

10. The National Technical Assistance Center for Children's Mental Health

<http://gucdc.georgetown.edu/cassp.html>

The Center works with families and other players in the field of mental health, by providing technical assistance to aid the reform of services for children and adolescents with mental health needs.

11. Research & Training Center on Family Support and Children's Mental Health (RTC) – Portland State University

<http://www.rtc.pdx.edu/index.html>

The Center's activities focus on promoting effective community-based, culturally competent, family-centered services for children with or at risk of mental, emotional or behavioral disorders and their families.

12. Research & Training Center for Family Support and Children's Mental Health, Department of Child & Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida

<http://rtckids.fmhi.usf.edu/>

The Center focuses on addressing the need to enhance mental health services for children with serious emotional and behavioral disorders and their families.

13. ZERO TO THREE: The National Center for Infants, Toddlers, and Families

<http://www.zerotothree.org/>

ZERO TO THREE is one of the nation's leading resources on the first three years of life. It aims at strengthening and supporting families, practitioners and communities who work to promote the healthy development of babies and toddlers.

14. National Institute of Mental Health

<http://www.nimh.nih.gov>

NIMH strives to reduce mental illness and behavioral disorders through conducting research on the mind, brain and behavior. It is part of the National Institutes of Health (NIH), the principal biomedical and behavioral research agency of the United States Government.

15. National Mental Health Information Center

<http://www.mentalhealth.org>

Formerly known as Knowledge Exchange Network (KEN), SAMHSA's National Mental Health Information Center is a clearinghouse sponsored by The Center for Mental Health Services (CMHS) to provide information on mental health issues to the families, policy-makers, providers, and the media. The Center also has information on Federal grants, conferences and other events.

16. Substance Abuse Mental Health Services Administration (SAMHSA)

<http://www.samhsa.gov>

SAMHSA is a federal agency within the U.S. Department of Health and Human Services that has the mandate to improve the quality and availability of substance abuse prevention, addiction treatment, and mental health services in the nation.

17. American Academy of Child & Adolescent Psychiatry (AACAP)

<http://www.aacap.org>

AACAP is a non-profit organization whose membership is comprised of child and adolescent psychiatrists who actively research, assess and treat psychiatric disorders among children and their families.

18. National Alliance for the Mentally Ill (NAMI)

<http://www.nmha.org>

NMHA promotes mental health through advocacy, education, research, and service.

19. National Child Care Information Center

<http://nccic.org>

The National Child Care Information Center (NCCIC) is a project of the Child Care Bureau that works to ensure that all children and families have access to quality child care services.

20. The Children's Defense Fund

<http://www.childrensdefense.org>

The Children's Defense Fund aims at ensuring that no child is left behind and that every child: starts life with a healthy body and mind; has healthy child care and early education; grows up in a family and community that is safe and economically secure; and gets the opportunity to be taught enduring values.

21. National Association for the Education of Young Children

<http://www.naeyc.org>

NAEYC consolidates the efforts of individuals and groups working in healthy development and education of young children. NAEYC is committed to improving the quality of programs for young children.

22. National Association for Family Child Care

<http://www.nafcc.org>

The National Association for Family Child Care is a non-profit organization that is devoted to promoting quality child care by offering technical assistance and strengthening family child care.

23. Family Support America

<http://www.familysupportamerica.org>

Family Support America, formerly Family Resource Coalition of America, strives to strengthen and support principles of family support practice in setting in which children and families are present.

24. Child Care Aware

<http://www.childcareaware.org>

Child Care Aware is a program of NACCRRA that helps families find the best information on child care and child care resources in their communities, as well as their local child care resource and referral (CCR&R) agency.

25. ERIC/EECE Clearinghouse on Elementary and Early Childhood Education

<http://ericps.ed.uiuc.edu>

Located at the University of Illinois at Urbana-Champaign, ERIC/EECE provides information on the development, education and care for children and adolescents to educators, families and the general public.

26. National Parent Information Network

<http://npin.org>

NPIN provides information based on research, about parenting and about family involvement in the education of their children.

27. Americans with Disabilities Act

<http://www.usdoj.gov/crt/ada/childq&a.htm>

The link takes you to a website that provides answers to frequently asked question on child care centers and the Americans with Disabilities Act.

28. Project EXCEPTIONAL Minnesota

<http://www.projectexceptional.org>

Project EXCEPTIONAL Minnesota is a statewide network that provides leadership and administrative support, and trains and consults with childhood care and education providers, school-age care providers, and families, in an effort to support providers and parents of children with special needs.

29. Circle of Inclusion

<http://www.circleofinclusion.org>

The Circle of Inclusion is a Web Site primarily for early childhood service providers and on effective practices of inclusive educational programs for children of ages 0-8. One of the model centers of this study, St. Benedict's Special Children's Center in Kansas City, KS, is featured.

30. Oregon Child Care Resource and Referral Network (OCCRRN)

<http://www.occrn.org>

The Oregon Child Care Resource and Referral Network (OCCRRN) is comprised of 16 community based child care resource and referral agencies that seek to improve the quality, affordability and accessibility of child care for families in Oregon.

31. Northwest Regional Educational Laboratory

<http://www.nwrel.org/cfc>

The Child and Family Program of NREL works to ensure that educators, human service professionals and family members have the knowledge, skills, and resources necessary to meet the needs of children and families at all stages of life.

32. Beach Center on Families & Disability

<http://www.beachcenter.org/>

The Beach Center on Families & Disability, funded in part by the National Institute on Disability and Rehabilitation Research (NIDRR), is a Rehabilitation Research and Training Center (RRTC) dedicated to research and training on policies affecting families who have children with disabilities.

33. Federal Interagency Coordinating Council

<http://www.fed-icc.org/>

The council facilitates federal, state and local activities related to serving children of ages 0-5, who receive services under the Individuals with Disabilities Education Act (IDEA). FICC is also an advisory body to federal agencies working to increase the opportunities for children with disabilities.

34. Parent to Parent Programs (P-P)

<http://www.eparent.com/resources/directories/p2pinfo.htm>

Parent to Parent (P-P) programs are support and information programs for parents who have a family member with special needs.

35. Sibling Support Project

<http://www.seattlechildrens.org/parents/sibsupp.htm>

The Sibling Support Project is a national program that aims to boost peer support and education opportunities for siblings of people with special health needs as well as developmental needs.

36. Children & Adults with Attention Deficit/Hyperactivity Disorder (CHADD)

<http://www.chadd.org/>

CHADD is a nonprofit parent-based organization formed to better the lives of the individuals with attention deficit disorders and those who care for them. Their activities include education, advocacy and support.

37. Attachment Disorder Network

<http://www.radzebra.org/>

Attachment Disorder Network provides support to children and families affected by Attachment Disorder.

38. ARCH National Resource Center/Respite Care

<http://www.archrespite.org/ARCHserv.htm>

The ARCH National Respite Resource Center seeks to strengthen and support families and caregivers, by promoting respite services for children, families and caregivers.

39. Parent Advocacy Coalition for Educational Rights (PACER)

<http://www.pacer.org/>

Based on the idea of parents helping parents, PACER Center strives to increase opportunities and improve the quality of life of young people with disabilities and their families.

40. Technical Assistance (TA) Alliance for Parent Centers

<http://www.taalliance.org/>

The Alliance offers technical assistance to create, develop, and coordinate Parent Training and Information Projects and Community Parent Resource Centers under the Individuals with Disabilities Education Act (IDEA).

41. Families and Advocates Partnership for Education (FAPE)

<http://www.fape.org/>

FAPE has the objective of enhancing the educational outcomes for children with disabilities by connecting families and advocates in dialogue about the Individuals with Disabilities Education Act (IDEA). A total of 6 million children with disabilities are represented by the project.

42. ERIC EC Clearinghouse on Disabilities and Gifted Education

<http://ericec.org/abouterc.html>

ERIC EC is a federally funded clearinghouse contained within the ERIC system, a nation-wide information network sponsored by the U.S. Department of Education's National Library of Education. ERIC EC collects and disseminates information and resources on the education and development of people who have disabilities and/or are gifted.

43. National Information Center for Children and Youth with Disabilities

<http://www.nichcy.org>

NICHCY is a national center that furnishes information on disabilities and disability-related issues, focusing on children and youth (birth to age 22).

44. Center for Mental Health Services (CMHS)

<http://www.mentalhealth.org/cmhs/about.asp>

The Center for Mental Health Services (CMHS) is the leader in the national system that provides mental health services. The system aims at providing treatment and support services for adults with mental disorders and for children with serious emotional problems.

45. American Bar Association (ABA) Center on Children and The Law

<http://www.abanet.org/child/home.html>

The ABA offers full-service technical assistance, training, and research programs addressing a repertoire of law and court-related matters relating to and affecting children.

46. Bazelon Center for Mental Health Law

<http://www.bazelon.org/>

The Bazelon Center for Mental Health Law is a national leader in legal advocacy for people with mental illnesses. The center represents the interests of people with mental illnesses both in court and in congress.

47. The Disability Rights Education and Defense Fund, Inc. (DREDF)

<http://www.dredf.org/>

The Disability Rights Education and Defense Fund, Inc. (DREDF) has the role of protecting and advancing the civil rights of people with disabilities through legislation, litigation and advocacy. Other activities of the organization include education and training for people with disabilities.

48. The N. Neal Pike Institute on Law and Disability

<http://www.bu.edu/pike/home.html>

The N. Neal Pike Institute, housed at Boston University School of Law, is committed to the development and advancement of disability law through study and research.

49. Child Welfare League of America

<http://www.cwla.org/>

The Child Welfare League of America promotes and supports initiatives that are geared at protecting and strengthening America's children and families.

50. National Center for Mental Health and Juvenile Justice (NCMHJJ)

<http://www.ncmhjj.com/about/>

The center's objective is to promote awareness of the mental health needs of youth in the juvenile justice system. The center also assists in developing improved policies and programs based on the best available research and practice.

51. Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda

<http://www.surgeongeneral.gov/cmh/childreport.htm>

The report was prepared by the Department of Health and Human Services and documents the proceedings of the Surgeon General's Conference on Children's Mental Health held on September 18-19, 2000. The report sets out a multidimensional blueprint for addressing children's mental health needs in America.

52. Data Trends

<http://rtckids.fmhi.usf.edu/rtcpubs/datatrends/datatrends.php.htm> and

<http://www.rtc.pdx.edu/pgDataTrends.shtml>

These are a series of one-page briefs produced by the collaborative effort of the Research and Training Center at Portland State University and the Research and Training Center at the University of South Florida. The briefs address current themes, summarize recent literature, and present new developments in the field of children's mental health.

53. Relationships, Resiliency and Readiness: Building a System of Early Care and Education Mental Health Services: Conference Proceedings

<http://www.aap.org/advocacy/hcca/mentalhealth.pdf>

This report published in April 2000 by Health Child Care New England, summarizes information and strategies discussed at the Healthy Child Care New England Conference. Its aim is to link public health resources and services to child care, in an effort to enhance the health and safety of children. Model State programs from CO, GA, MS, MI, MN, NJ, OH, and VT are presented.

54. National Association of Child Care Resource and Referral Agencies (NACCRRA)

<http://www.naccrra.net>

NACCRRA provides leadership and support to community child care resource and referral agencies as well as promotes national initiatives dedicated to child development and education.

55. National Child Care Association

<http://www.nccanet.org>

The National Child Care Association promotes the growth of and upholds quality child care and education provided by licensed, private entities.

56. National Black Child Development Institute (NBCDI)

<http://www.nbcdi.org>

NBCDI is a non-profit organization that provides resources and supports programs for African American children, their families and communities, in matters of: early childhood and elementary education; health; secondary education; and child welfare.

57. National Association for Regulatory Administration (NARA)

<http://www.nara-licensing.org>

By representing all human care licensing, NARA's mission is to promote quality in human care and service regulation.

58. Frank Porter Graham Child Development Center National Center for Early Development and Learning

<http://www.fpg.unc.edu/>

The Frank Porter Graham Child Development Institute (FPG) works to improve the lives of young children and their families through research and education activities in child development and health.

59. National Head Start Association (NHSA)

<http://www.nhsa.org>

NHSA is a national forum that strives to ensure the continued enhancement of Head Start services for children of ages 0-5 and their families.

60. National Institute for Early Education Research (NIEER)

<http://nieer.org>

The National Institute for Early Education Research supports early childhood education policies and programs by providing objective, independent, research-based information to policy makers, researchers, education professionals and the media.

61. National Resource Center for Health and Safety in Child Care (NRC)

<http://nrc.uchsc.edu>

NRC has the role of promoting the health and safety of children in out-of-home child care placements throughout the nation.

62. The Trust for Early Education (TEE)

<http://www.trustforearlyed.org>

The Trust for Early Education (TEE) strives to ensure that every child in the nation has access to quality Pre-K education.

63. National School-Age Care Alliance (NSACA)

<http://www.nsaca.org>

NSACA promotes national standards of quality after-school programs for children and youth of ages 5-14 years. NSACA also grants accreditation to programs meeting these standards.

64. Policy Analysis for California Education (PACE)

<http://pace.berkeley.edu>

PACE is a policy research center that has the primary objective of strengthening education policy discussions with sound analysis and hard evidence, by defining issues thoughtfully and assessing the relative effectiveness of alternative policies and programs. PACE provides analysis and assistance to California policymakers, education professionals, and the general public.

65. USA Child Care

<http://www.usachildcare.org>

USA Child Care aims at effecting policies that improve child care for low- and moderate-income families, by representing the views of direct service providers working with these families in national and state child care policy dialogue.

66. Center on the Social and Emotional Foundations for Early Learning (CSEFEL)

<http://www.csefel.uiuc.edu>

The center is a program designed to enhance the capacity of Head Start and other child care programs to support young children's social and emotional development and prevent challenging behaviors.

67. Early Trauma Treatment Network

<http://www.nctsn.org/>

Housed in San Francisco General Hospital, this is a project working to improve the treatment of trauma among children of ages 0-6 and their families.

68. A Good Beginning: Sending America's Children to School With the Social and Emotional Competence They Need to Succeed

<http://www.nimh.nih.gov/childhp/monograph.pdf>

This is a report commissioned by the Children Mental Health Foundations and Agencies Network (FAN), to raise the level of awareness about the challenges that face children who begin kindergarten without having attained social and emotional competence.

69. Center for Evidence-Based Practice: Young Children with Challenging Behavior

<http://www.challengingbehavior.org>

The Center aims at supporting the use of evidence-based practice to address the needs of young people with behavioral problems, through setting up a database of positive, evidence-based practices.

70. Off to a Good Start

<http://www.nimh.nih.gov/childhp/goodstart.cfm>

This is a report on research carried out on the risk factors for early school problems and selected federal policies, which affect children's social and emotional development and school readiness.

71. OSEP TA Center on Positive Interventions and Supports

<http://www.pbis.org>

The Center offers information and technical assistance to schools, to help them identify, adapt, and sustain positive, school-wide disciplinary practices.

72. Research and Training Center on Positive Behavioral Support

<http://www.rtcpbs.org>

The Center is undertaking the development and dissemination of positive, evidence-based practices that will improve the lives of persons with disabilities and problem behavior.

73. Project SUCCEED in Head Start

<http://www.rri.pdx.edu/pgProjectSUCCEED.shtml>

Project SUCCEED (Supporting and Understanding Challenging Children's Educational and Emotional Development) is a research and demonstration project whose purpose is to develop, provide, and evaluate an approach in which family members and Head Start personnel can address challenging behaviors displayed by young children.