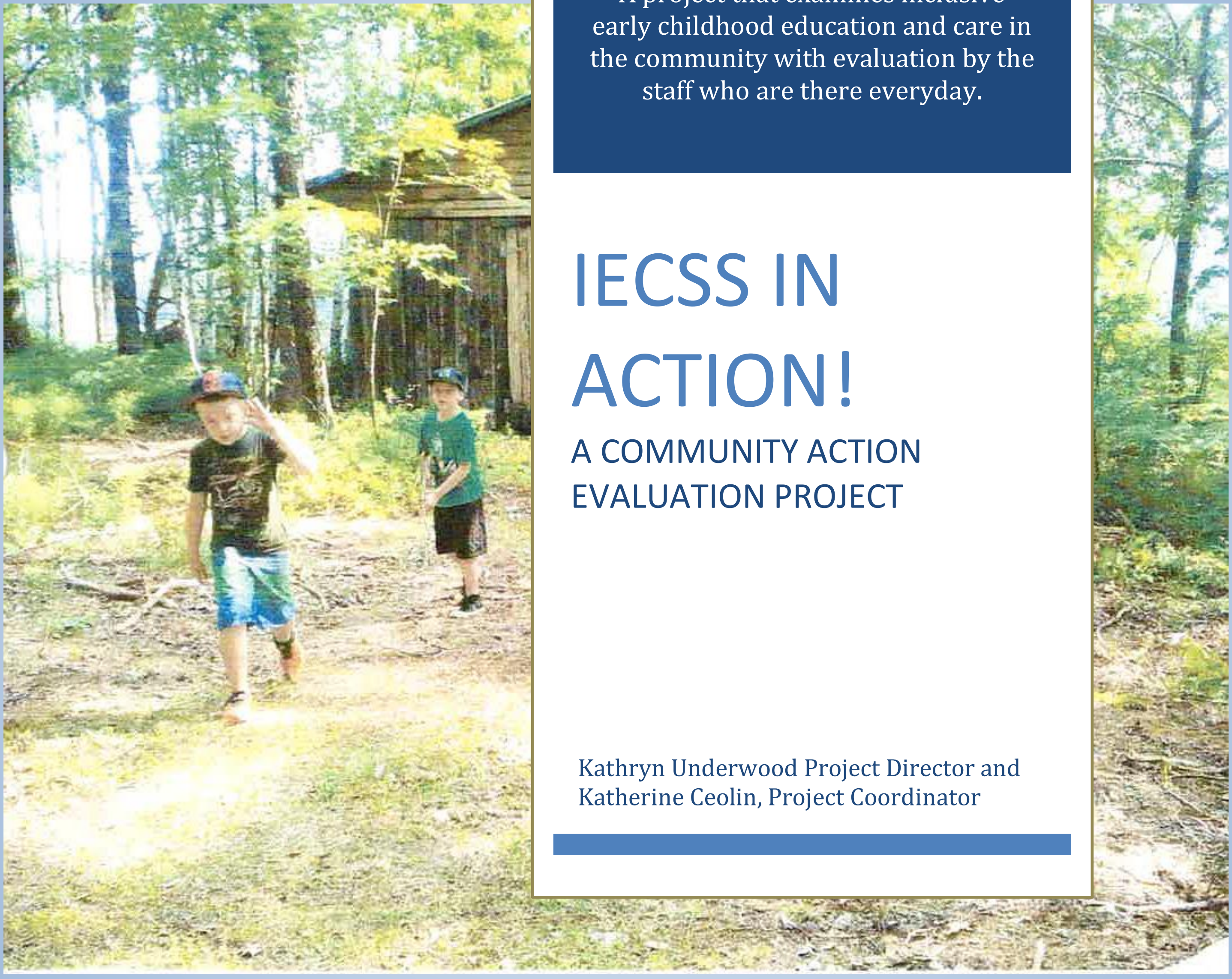

A project that examines inclusive early childhood education and care in the community with evaluation by the staff who are there everyday.

IECSS IN ACTION!

A COMMUNITY ACTION EVALUATION PROJECT

Kathryn Underwood Project Director and
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Cover photo © Jessette LeBlanc

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Contents

Summary

This report presents findings from seven community evaluation projects of early childhood programs in Ontario and British Columbia. Each of the projects aims to develop strategies for the programs to become more inclusive of children with diverse abilities. The communities are representative of rural, remote and urban locations, and serve families with a wide range of cultural viewpoints. Key in the experiences of families, as reported in these projects are challenges that result from poverty, lack of transportation and access to specialized services, concerns about relationships with professionals, and the need for services that are culturally relevant and organized to fit with the families' needs.

Key recommendations

Building an inclusive early-childhood education and care system will require that any new childcare spaces created across the country be prepared to accept any child. These childcare spaces:

- Need qualified and well-educated staff, with fair wages.
- Need ratios and program hours that recognize the need for staff to get to know children well, and for them to get to know families, communities, and other service providers.
- Will incorporate family support and make it central to any inclusion model. Including children means including their families and communities, and being available to help them with housing, employment, social assistance, healthcare, and other community agencies.
- Will have Resource Consultants present for regular periods of time in all childcare programs with access for all children. This will allow relationships and communication with staff, families and communities.
- Will be part of a system that recognizes the need for access to a range of qualified specialists and support professionals, particularly for childcare programs in rural and remote areas.

Systemically, there needs to be reorganization of services in order to better recognize disability as a legitimate experience. There needs to be

- Clear recognition of education, including early childhood education, care and intervention systems, as implicated in the construction of disability and a site of disablism.
- The system needs to be re-organized so that rather than diagnosis as a qualifying criteria, inclusion is about getting to know the children well and seeing them through an appropriate not necessarily norm-referenced lens that also sees their family and community.
- A goal of creating the conditions for frontline staff to be able to be inclusive. This means scaling up the structural conditions that each program describes rather than the specific strategies themselves. This will allow genuinely local—and locally responsive—policies to be developed.

Context

This project is part of the Inclusive Early Childhood Service System (IECSS) project, a longitudinal study that began in 2014. This $2.5 million study, funded by the Social Sciences and Humanities Research Council (SHHRC) and hosted at Ryerson University, was developed through a partnership and previous work with community, academic and policy organizations. The partnership spans ten geographic areas: the County of Wellington (Ontario); the District of Timiskaming (Ontario); the City of Hamilton (Ontario); the City of Toronto (Ontario); Constance Lake First Nation/Hearst (Ontario); Peel Region (Ontario); Brandon (Manitoba); Comox Valley/Powell River (British Columbia); Yellowknife (Northwest Territories), and Halifax (Nova Scotia). These partners offer diverse cultural perspectives that encompass different approaches to supporting families in rural, remote, and urban communities. In addition, our partners bring service experience from the childcare, early intervention, health, development, and Indigenous service sectors.

The IECSS project is informed by a social relational theory of disability that recognizes disablement as the result of an interaction between individual characteristics (such as genetic and environmental factors), social experiences (such as poverty and racialization), and access to community social capital (such as early intervention services, childcare, and culturally safe supports).

Through interviews with families conducted in its partnership development phase (2015–2018), the IECSS project has identified a number of structural barriers to inclusion and participation of children with disabilities in early childhood education, care and intervention services:

1. Accessing disability supports and services is a lot of work for families.
2. The system of services for young disabled children is predicated on a medical model, which makes diagnosis or designation of disability central to how the system works. This approach is not consistent with many cultural viewpoints regarding disability, and is used as a gatekeeper for services that may be central to inclusion and quality of early learning and childcare for children with disabilities.
3. Access to services has a geopolitical context. Different jurisdictions have varied service availability and priorities for early intervention and early childhood education and care.
4. Individual programs may be inclusive, but most families who have children with disabilities are clients of or participants in multiple services. Inclusion beyond single programs across the spectrum of services is rare.

Project Overview and Introduction

In recent years, increasing attention has been turned toward the social value of high-quality early learning and care, which has been touted as a critical anti-poverty, anti-discrimination, and equity-in-education strategy. High-quality early learning and care is often described as being inclusive, but it is less clear what government or childcare advocates mean by this term. The disability community has been calling for inclusive education practice at all levels of the education system since at least the 1960s, with many provinces adopting legislation in the early 1980s to allow the participation of disabled children in education settings. Yet we know that education systems continue to exclude disabled children. Recent findings from the IECSS project found real concerns with the exclusion of children from full-day kindergarten programs, a program that has directly stated its social justice and inclusion aims[1]. Further, educators continue to describe significant structural barriers to inclusive early childhood education and care practice[2].

This project represents an opportunity to think about what inclusion means. We start with the notion of disability. Disability is a culturally and socially constructed concept. The emerging field of disabled children's childhood studies recognizes "disabilism" as an experience of exclusion and discrimination on the basis of impairment or ability. This language and usage of the term disability is not in common practice in Canada. Differences in language use can hinder clear communication, but they also represent fundamental differences in the underlying worldview of those who use the terminology.

Disabled children's childhood studies draws theory from both disability studies and childhood studies, but recognizes the limits of each to actually represent the experience of disabled children.[3] We refer to "disabled children" in the introduction, recognizing that disability is not something a person has, but rather a descriptor of how one has been treated by people and institutions. Most importantly, disabled children are *children*, with families, cultures, and a broad range of characteristics that cannot be understood through psychological or medical concepts alone.

Authors throughout this report use the word "disability" in different ways. In Chapter 1, Lavallee and Lavallee discuss the cultural dissonance with Indigenous worldviews that the term disability creates. This is an important point in terms of recognizing widely held viewpoints about disability as a medical or clinical category, a view that is grounded in colonial ways of thinking. This report, however, is premised on the need for a focused discussion about disability in early childhood services. All children have a right to their identity, their culture and to define themselves in relation to the people who make them feel included. This means seeing each of them as unique individuals with something to offer their communities.

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[1] Kathryn Underwood, Elaine Frankel, Gillian Parekh and Magdalena Janus, "Transitioning Work of Families: Understanding Trans-Institutional Power in Early Childhood Programs and Services," (under review).

[2] Ruth Bancroft & Kathryn Underwood, "A Vision for Inclusive Childcare: From Principles to Policy," Our Schools/Our Selves, Vol. 24, no. 4 (Summer 2015); Kerri Graham & Kathryn Underwood, "The Reality of Rurality: Rural Parents' Experiences of Early Years Services, Health & Place, Vol. 18, no. 6 (2012); Colleen Thornton and Kathryn Underwood, "Conceptualisations of Disability and Inclusion: Perspectives of Educators of Young Children," Early Years, Vol. 33, no. 1 (2013);Kathryn Underwood and Marion Trent-Katz, "Contributions of Parenting and Family Literacy Centres in an Early Childhood Services System," Vol. 25, no. 1 (2015).

[3] Tillie Curran and Katherine Runswick-Cole, "Disabled Children's Childhood Studies: Critical Approaches in a Global Context. Chapter 1: My Story," in *Handbook of Disabled Children's Childhood Studies: Building Understandings*, ed. Katherine Runswick-Cole, Tillie Curran, and Kirsty Liddiard (London: Palgrave, 2017); Kathryn Underwood, Marisol Moreno Angarita, Tillie Curran, Katherine Runswick-Cole, and Donald Wertlieb, "An International Conversation on Disabled Children's Childhoods: Theory, Ethics and Methods," (in submission).

Further, it is critical to recognize the relationship between disability, impairment, and a number of social factors. We must recognize that poverty, colonization, geography, environmental toxicity (including through climate change), and social inequality are directly linked to increased health risks and resulting impairments. Childcare is often described as a critical poverty-reduction strategy without recognizing the intersection experiences of disability and income inequality.

Our Audience

While the focus of this report is on disability, many chapters have been written by Indigenous scholars and practitioners, as well as by practitioners working with and sometimes in First Nations and Métis communities. Each report is community-specific—and just as there is not one pan-Indigenous experience there is also not a pan-disability experience. All of the reports serve as valuable examples of how local communities that are engaged in understanding children and their families, play a central role in defining what it means to be included. Each of the chapters is also written for the community it profiles as a service to others who work in that community. This is particularly important for the reports that are informed by Indigenous experiences and worldviews: They will be read differently by different audiences. There are teachings that are specific to each nation and cultural group. The range of approaches offers concrete examples of culturally responsive and informed practice, sometimes in ways that the reader may not recognize because of his or her own experiences and worldview. We are all learning. The recommendations from these reports should be understood not as Indigenous teachings, but as methods that can inform how others engage with their own communities across the country.

The Partners

IECSS in Action! aims to identify inclusion strategies that recognize the systemic and cultural factors that shape the actual context within which inclusive services are delivered. While this project is informed by findings from local community action evaluations, it is premised on the assumption that it is critical for frontline staff to be involved in determining how evaluation should be translated into practice. The processes outlined in the reports are as important as the outcomes.

Staff attitudes are often cited as critical to inclusive practice. However, the IECSS project has found that significant structural barriers may actually be among the root causes of poor attitudes toward inclusion. Designing a project that situates frontline staff as the researchers ensures “useable” findings. The frontline staff we are engaging in this project are early childhood educators; in some programs they may also include resource consultants and early interventionists.

Seven organizations collaborated on this project, funded by Employment and Social Development Canada. These include:

- Three child-care service providers (Wellington County, Niwasa Kendaaswin Teg and the Temiskaming Native Women’s Support Group);
- One developmental service agency (Comox Valley Child Development Centre);
- One childcare embedded in a child protection agency (Native Child and Family Services); and
- Two family support programs (the Gerrard Resource Centre and Family Place).

Collectively, these organisations represent most of the types of services that children with disabilities in Canada might access. We asked each site to interpret their findings for a broader audience and to note whether they believe these approaches are relevant and can be scaled up. And although these seven sites are small, the IECSS project team has also engaged with hundreds of programs through our participants and will draw on our research findings to interpret these projects for a larger audience. Further, these seven sites collectively have many more staff than those who participated in the project. While not all of them took part in these project each site, all of the organizations anticipate implementing the strategies in some capacity across their programs and on an ongoing basis.

The specific project aims were to:

1) Identify strategies based on findings from the IECSS project (see list of references); and
2) Evaluate the processes and efficacy of these strategies. The project begins from the assumption that knowing the "on-the-ground" perceptions of frontline workers is critical if we are to understand how institutional processes operate and critical for the evaluation of the feasibility and implementation of the services they deliver.

Ultimately, we hope to make recommendations for a federal childcare policy that is inclusive of disabled children and to provide relevant examples for local programs and services.

The Strategies and Locally Developed Evaluation

Each site was given a small budget with which to implement a strategy that addressed the problems identified above. Many of the sites drew on other resources to support and sustain their projects.

The parameters for selecting and implementing the strategies were that they needed to be measurable and sustainable after the end of the project. For this project each site implemented one strategy, with some having multiple components (see Chapter 5). Each site also developed its own approach to documenting the implementations and outcomes. The partners had approximately three to six months to implement their strategies, which meant that no site had time to do capital building projects or hire a staff person who did not have previous training.

The implementation and evaluation of strategies were designed by the frontline staff, with support from a research assistant and the executive directors (or their designates) at the participating program sites, and their executive directors had approved their participation.

For this research project the research assistants and local staff were given an introduction to evaluation methods and training which included the use of the "Inter-disciplinary Program Evaluation" open access modules.[4] Each site developed its own evaluation strategy informed by the evaluation literature, with the recognition that community-based evaluation would involve a range of methods that are both consistent with the goals (as identified in step one) and the intended outcomes of the strategy.

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[4] Kelly McShane, Open Learning Interdisciplinary Program Evaluation Curriculum (2015), https://www.ryerson.ca/openlearning/projects/program_evaluation/.

The program evaluation methods ranged from focus groups and interviews with staff and families, to questionnaires (pre- and post-strategy), to journals and notes. Central to all of the evaluation approaches was communication with staff and families. Overwhelmingly, and perhaps not surprisingly, staff and families had positive feedback about the approaches. What is more interesting is the details about why these strategies were of value, which is discussed in the individual project reports.

The strategies responded to all the barriers identified in the problem-identification phase of the project as well as the four barriers identified in the IECSS study.

Defining Inclusion and Barriers to Inclusion in Local Contexts

The frontline staff at each partner agency were introduced to the four findings from the IECSS project, as described above. Staff discussed and identified any findings that were consistent with their own view of structural barriers to inclusive practice. From this discussion, we are able to identify some key barriers to inclusive early childhood education, care, and intervention programs from the standpoint of frontline staff. The discussion begins with consideration of barriers identified at the strategy stage, as well as key findings from the evaluation.

The most common barrier to participation, and one that was identified in most of the reports, was poverty. Different programs identified issues that arose as a result of poverty, including access to transportation, food insecurity, housing insecurity and employment issues, especially those related to flexibility and hours of work. The availability of childcare is inextricably linked with the capacity to work—often, without childcare in place, work cannot be secured. There is a real need for flexible program models that care for children not only while their parents are at work (see Chapter 7), as well as the recognition that an inclusive system has both childcare and family support options (see Chapter 3).

All of the programs recognized that seeing children and their families from a “deficit” perspective was problematic. They agreed with the IECSS finding that the system requires diagnostic and assessment information to qualify a child and his or her family for service and noted that it is standard practice to rely on these assessments to understand the child. None of the partners required diagnostic information about the child for participation in their strategies. They also did not necessarily have information about which children were disabled. However, two programs expressly addressed the need for child-specific information (Chapter 1 and 2), and one program designed all their strategies around concerns about children’s behaviour (Chapter 5).

Niwasa Kendaaswin Teg developed a new, culturally informed tool (Chapter 1) that helped staff to know children in a new way. It also allowed staff to document details about children that families were able to use in their communication with other programs and with schools. Native Child and Family Services used the norm-referenced Ages and Stages Questionnaire (ASQ), implementing it along with a strategy to communicate with a child’s extended family and with the express purpose of using the information from this tool to include a child who had previously not participated in a childcare setting (Chapter 2).

Most programs noted that there is a lack of specialist services, including medical care that is accessible and available when families need it. This is particularly true for rural sites (see Chapters 4 and 6) and remote sites (see Chapters 3 and 5), where families must leave their communities for hours, days, or even weeks to access the care their children need. Both Palmerston and Powell River focused on developing local strategies for building connections between families and the right professionals in spaces that were safe, familiar, and local to families.

There is a need for good structural support for staff through policy. In particular, programs need qualified staff who have the time to build relationships with children, with families, communities, and with Resource Consultants and others with specialist knowledge (see Chapters 2 and 5). Further, Resource Consultants and other experts, such as Elders, should be located within programs, rather than be itinerant, and have reasonable caseloads so that they can build appropriate relationships (Chapters 5 and 6), and the time to allow for locally developed program features; those reported include outdoor learning, bringing the outdoors inside, and drumming, all developed with local Wisdom Keepers (see Chapter 5).

Although many of the reports find more than one barrier to inclusion and include all the following recommendations, we have grouped the reports into the following three themes:

Understanding the child.
Niwasa Kendaaswin Teg (Hamilton, Ontario)
Native Child and Family Services (Toronto, Ontario)

Connecting families.
Family Place (Powell River, British Columbia)
Palmerston Child Care and Learning Centre, (Palmerston, Ontario)

Designing responsive programs.
Temiskaming Native Women's Support Group (Kirkland Lake and Temiskaming Shores, Ontario)
Comox Valley Child Development Centre (Comox, British Columbia)
Gerrard Resource Centre (Toronto, Ontario)

Part 1: Understanding the Child

Chapter 1

Niwasa Kendaaswin Teg: Hamilton, Ontario

by: Brooke Lavallee and Monique Lavallee

Niwasa Kendaaswin Teg is a multi-service Indigenous agency located in Hamilton, Ontario. The early years department comprise Licensed Child Care, EarlyON Child and Family Centre, Culture and Language Outreach, and Cultural Safety.

In close proximity to the City of Hamilton, Six Nations of the Grand River is the largest reserve in Canada, with 25,000 members and approximately 13,000 members who live off reserve. It borders the Mississaugas of the Credit First Nation, which has 2,000 members. These two distinct nations have different linguistic and culture protocols and practices. Hamilton's Indigenous population is estimated to be around 17,000.[5]

At Niwasa Kendaaswin Teg, we honour two of the nations from this territory by offering programs, and services, in both the Annishinabemowin and Kanyen'kehà:ka languages, cultures and protocols. Niwasa Kendaaswin Teg serves all urban Indigenous peoples and respects the diversity of all First Nations, Métis and Inuit families. *Today, the City of Hamilton is home to many Indigenous people from across Turtle Island (North America).*

The City of Hamilton is situated on the traditional territories of the Erie, Neutral, Huron-Wendat, Haudenosaunee and Mississaugas peoples. This land is covered by the Dish with One Spoon Wampum Belt Covenant, which was an agreement between the Haudenosaunee and Anishinaabe to share and care for the resources around the Great Lakes. We further acknowledge that this land is covered by the Between the Lakes Purchase of 1792, between the Crown and the Mississauga of the Credit First Nation.

For the purpose of this article, we will be using the term "Indigenous" to represent First Nation, Métis and Inuit in Canada. The word "disability" will also be used; however, it should be noted that the word "disability" does not reflect an Indigenous worldview. The understanding of disability is impacted by cultural aspects such as norms or values. Historically, there is no word for disability in any of the diverse Indigenous languages spoken across Canada. Through an Indigenous lens, children with differences or disabilities are referred to as having gifts. The Indigenous worldview seeks to align the child's gifts with their role within the family and the broader community.

Problem Identification

To identify the problem and develop a strategy for the Inclusive Early Childhood Service System (IECSS) project, ten staff were engaged in a brainstorming session to discuss inclusion in the early learning environments and determine the barriers that affect

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[5] *"Profile of Hamilton's Aboriginal Residents"* Hamilton, 2015, http://www.sprc.hamilton.on.ca/wp-content/uploads/2015/04/Profile-of-Hamiltons-Aboriginal-Residents.pdf.

educators, families, and children. The barriers that the Niwasa Kendaaswin team identified were grouped into three major themes: accessibility, medical diagnosing, and colonial structure.

Accessibility: Educators observed that there are complicated processes to access services for children with disabilities, including long wait times to access the services, and limited access to advocacy for both the family and the child to be supported throughout the process. There are little to no culturally relevant or safe services available for Indigenous families in the current model. Due to these barriers, many parents and families are unwilling or hesitant to access disability services and supports.

Medical Diagnosing: The educators identified that they believe services were developed from a colonial worldview based on the idea of "deficit" or "lack," and that medical diagnosing results in a label that follows the child through the education continuum. This practice can also create exclusion for some children who would benefit from support but do not fit within a certain criteria. A child's identification in the Diagnostic and Statistical Manual of Mental Disorders and the label that accompanies their diagnosis does not support the view of the child as capable, competent, or resilient and therefore places children and families in a struggle for autonomy from system-imposed requirements.

The barriers identified by frontline staff at Niwasa Kendaaswin Teg correlate to IECSS findings that state that accessing disability supports and services can be daunting for parents and families as they are currently structured. As the IECSS outlines, medical and developmental diagnoses are at the forefront of barriers for access to disability support and services for children in the early years. The medical model often creates an increased likelihood for discrimination.

Strategy Description

Method

After identifying structural barriers, the Niwasa Kendaaswin Teg team identified the need for a strength-based culturally relevant inclusion tool that supports the Indigenous worldview of children and disability. A core group of educators worked together on a strategy to develop such a tool. Not wanting to take a pan-Indigenous approach, they based the tool on the medicine wheel and the wampum string, reflecting the cultures off both the Haudenosaunee and the Anishnaabe nations.

The medicine wheel is a tool that is widely used in Annishinaabe communities and holds powerful teachings throughout life including during a child's development. The medicine wheel is divided into four quadrants. For the purpose of this strategy, the quadrants represented mind, body, spirit and emotion. The Oneko'ha [wampum] string tool was also divided into segments to represent mind, body, spirit and emotion. Each bead of the wampum can represent a thought, idea or a concept. "When a bead is laced onto a string, Oneko'ha (wampum) the words that go into the string is an agreement between both sides".[6] For the purpose of the tool, the agreement represents the

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[6] Jonathan Kelly, in discussion with the author, September 20, 2019.

relationship and thoughts of both the educator and the family. The beads represent that those words have come together, like one mind.

Procedures

Educators used the culturally relevant strength-based tool to observe each child and note their strength in each area. Multiple educators documented observations of each child so that there would be diverse perspectives on each child's abilities. Over the course of eight weeks (June and July 2019), educators gathered observations for a total of 24 children, identifying each child's strengths in the areas of mind, body, spirit and emotion using either the medicine wheel or wampum string tool, depending on the child's nation. Educators also made weekly journal entries to record their experience working with the tools.

Focus groups were conducted to evaluate the culturally relevant strength-based tool's efficacy and determine if it had achieved the initial goal of focusing on inclusion in early learning environments that was based on cultural relevance rather than on deficits and diagnoses. Separate focus groups were conducted for parents and educators, and participants in each group were asked a set of open-ended questions in order to gather data on their experience with the culturally relevant strength-based tool that had been implemented over 8 weeks in their programs. Although the use of focus groups raises ethical concerns such as confidentiality, the Niwasa Kendaaswin Teg team opted to use this qualitative method so that all focus group participants could engage in meaningful discussion that allowed for a holistic understanding of the realities and impacts of the tool. Stick notes and chart paper were also provided to participants who wished to contribute data but did not feel comfortable sharing their experience verbally during the session. Lastly, interviews were conducted with Elders and Knowledge Keepers, to maintain the integrity of the cultural aspect of both the medicine wheel and wampum string tools, and enrich our understanding of how the medicine wheel and wampum string both relate to the Indigenous worldview and to the gifts that each child carries. Notes were taken to capture the words of the participants during all the focus group sessions, which were also audio recorded to preserve a solid data foundation. The recordings from both the focus groups and personal interviews were transcribed for data analysis.

Data analysis specifically focused on the accounts of both educators and the parents of the children that used the tool. The notes, chart paper, journals and recordings were coded; central themes were gathered to inform outcomes and recommendations. After the themes were identified from the data, three common strands emerged: relationships; shifts in views about inclusion; and combating stigma.

These overarching themes were important to both educators and parents. The importance of relationships among educators, parents, and children will be explored in the overall recommendations.

Outcomes

Educator's Voices. Educators observed that using the tool helped them shift their thinking about inclusion: while having a policy on inclusion is important, having a tool to operationalize the practice helped them see each child's strengths in a different way. The tool prompted educators to consider how each child's strengths could support their inclusion in the classroom. Educator's reported a change in their thinking about a child's development from a "deficit" perspective, which is reinforced by the medical model of diagnosis and intervention, to a "strength-based" perspective, with the focus placed on supporting each child where they are developmentally. Educators reported that having a deeper understanding of each child enriched their relationship with them and helped them to be more responsive to them, using the child's strengths identified by the tool's implementation to support growth and development in other areas. The educators wondered how they could invite professionals who are working with the children to view the children and families through the same lens.

Educators reported that when they shifted the way they thought about inclusion and how they engaged with and related to each child the dynamic and relationship between the educator and child also changed. This shift in relationship impacted the classroom environment and reduced undesirable behaviours, which supported inclusion for each child. Educators also indicated that a shift in the relationship with parents occurred. Parents were engaging with educators more often, including those parents who rarely engaged in their child's early learning program.

Parents' Voices and Recommendations. Parents were provided with copies of their child's inclusion tool and engaged in discussions with educators about supporting their children in the classroom. Parents attended a focus group session where they were asked to share their experiences.

Parents reported that when they reviewed their child's tool, they could see that educators really knew who their child was, and that they understood the child's needs from more than one perspective. Parents said that they were moved when educators shared their view of their child through the inclusion tool, and that they felt that their children were in an environment that respected their individuality and honoured their strengths. Parents reported that their relationship with the educators changed from a quick chat at the beginning and end of each day to a deeper conversation about their child's day. Parents noted that while their children are connected to additional system supports, that those service providers often identify the child's deficit. Parents also referenced school reports regarding their child's behaviour, what children were doing wrong and what needed to be fixed or changed about their child. Parents reported that they felt more able to cope with a diagnosis and/or access additional supports for their children when they had a tool to identify their child's strengths or gifts as opposed to their needs or disabilities. Further, parents indicated they felt less stigma regarding their child's disability and felt empowered to share their view of their child with service providers through the screening tool. Parents indicated that the tool would be useful during the transition to elementary school meetings. Lastly, parents indicated they appreciated the holistic view of their child and that they could see that the educators cared deeply about their child and acknowledged how they were in relationship with each child.

Recommendations

The Indigenous view of disability does not align with the medical model of diagnosis, labels and potential interventions; however, that does not mean that the Indigenous worldview of child development is invalid. Indigenous children with disabilities (gifts) have the right to culturally relevant services that includes their worldview regardless of where they reside. Articles 15 and 22 of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) state, "Indigenous peoples have the right to dignity and diversity of their cultures, traditions, histories and aspirations which shall be appropriately reflected in education and public information."[7] It continues: "1. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities in the implementation of this Declaration. 2. States shall take effective measures, in conjunction with indigenous peoples, to ensure that indigenous women and children enjoy the full protection and guarantees against all forms of violence and discrimination".[8]

From the project findings, it is apparent that UNDRIP, Articles 15 and 22 are not being implemented regarding discrimination against Indigenous peoples' worldview regarding disability. The project data indicated that the strength-based culturally relevant inclusion tool began to create a way to combat parental stigma regarding accessing services for their children. Indigenous children and families with disability should not be required to fit into a system; the system to support children with disabilities must respect Indigenous families' right to culturally appropriate and safe services and supports. As stated by the Truth and Reconciliation Commission of Canada Call to Action #12, "We call upon the federal, provincial, territorial, and Aboriginal governments to develop culturally appropriate early childhood education programs for Aboriginal families," and Call to Action #22, "We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients".[9] When accessing services for disability, a culturally relevant strength-based tool can assist children and families in a relational aspect, that honours their diverse needs.

Conclusion

Currently in Canada children and families who experience disability often receive services or supports based on a diagnosis or a need identified by an early years professional using standardized screening tools. The process of diagnosis, identification,

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[7] *"United Nations Declaration on the Rights of Indigenous Peoples",* (107th plenary meeting, 2007, 14), https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf.

[8] Ibid., 17.

[9] *"Truth and Reconciliation Commission of Canada: Calls to Action"* (Truth and Reconciliation Commission off Canada: Winnipeg, Manitoba, 2015, 3, http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf.

and intervention are based on a deficit model. This model and the current system impose a label on the child and interventions that can be perceived as oppressive according to Indigenous worldview. While children and families require early interventions that support healthy child development and inclusion, the system creates a power imbalance and stigma for families. Families are forced to access supports that reinforce their child as deficient of needing to be filled up, fixed or changed by the normative approach of colonial structures.

The implementation of culturally relevant tools allowed educators to improve and reflect on their own practice and approaches and to reflect on the constantly evolving needs of each child. The culturally relevant inclusion tool created new understandings of and perspectives on how one can engage with children to empower their ‘gifts’, or differences. The strategy provided the opportunity to build stronger relationships among educators, children and their families, which resulted in inclusive practice for all children. It is evident that educators who work directly with children and families have rich insights that can inform and shape policies regarding disability.

Chapter 2

Native Child and Family Services of Toronto: Toronto, Ontario

by Nicole Ineese-Nash

Thank you to Jessica Wilson, Khamini Sharma, and Amanda Persad

The Scarborough Child and Family Life Centre ("the centre") is a multi-service centre operated by Native Child and Family Services of Toronto (NCFST), an Indigenous led child welfare agency. The centre offers a licensed childcare program and an EarlyOn program as well as various culturally based programming for Indigenous[10] children, youth, and families. Located in the east end of Toronto, Ontario, the centre provides various child and family programs, including early intervention and screening programs, counselling, drop-in programs, education and job development programs, and community programming, all with a strong focus on Indigenous culture and teachings. The center is a multi-service hub in a large urban environment serving a diverse population, including Indigenous and non-Indigenous children and families.

The centre's mandate is to support quality of life, well-being, caring and healing for children and families in the Toronto Indigenous Community through culturally-based services that reflect the values of Indigenous people. The centre's service model, developed with Indigenous Elders and knowledge keepers, provides integrated services for healing, wellness, and family supports sufficient to provide Indigenous children and their families with multiple pathways to a quality life through prevention, case management, and service provision. The center offers various assessment related services, which result in referrals to clinical service providers in other organizations. The centre staff have been considering how to better serve families who may benefit from more intensive intervention as well as how to foster inclusion of children with disabilities within early childhood programs.

The IECSS research findings suggest Indigenous families may face additional barriers in accessing adequate early intervention services as compared to non-Indigenous families.[11] Cultural differences in the assessment and treatment of Indigenous children may lead to misdiagnosis and hinder appropriate support for a child's development. Ensuring that Indigenous children have access to their culture and feel proud of who they are is a priority for NCFST and is a basis from which programs and services are developed. Disability-related services are not often culturally oriented, which can lead to conflicting perspectives and undesirable outcomes for the child and family. Considering the cultural nature of service provision at NCFST, the center is well positioned to offer early intervention services to Indigenous children and families that may mitigate the problematic outcomes associated with culturally dissonant intervention.

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[10] The term "Indigenous" is used in this report to refer to First Nations, Métis, and Inuit peoples of Canada.

[11] Nicole Ineese-Nash, Yvonne Bomberry, Kathryn Underwood, and Arlene Hache, "Raising a Child with Early Childhood Dis-ability Supports," Indigenous Policy Journal, Vol. 28, no. 3 (2017).

Problem Identification

The staff at the centre identified difficulties in adequately serving families whose children may require additional support or who experience disability. Family support programs in which parents were present were seen as more accessible to families, but also created communication barriers between the staff and parents in relation to the specificity of children's development. Within childcare programs, it is difficult to offer one-on-one support to children due to staff ratios. This also makes it difficult to develop and implement a cohesive plan of care with a child who may be accessing multiple support services. Families who are involved with the child welfare sector of the agency have access to case coordinators who may support the management of multiple services families access, though these may not be solely related to developmental priorities of the child. For the majority of families, staff were often unaware of which services a child was accessing and as a result were unsure of how to integrate intervention priorities into the programs the child attends. When staff are not made aware of the factors in a family's life that are affecting their access to services and the development of the child, they are less able to make appropriate referrals or to offer support within the centre's programs.

Inadequate staffing was identified as a primary barrier to successful inclusion. Staff ratios at the centre do not account for children who may benefit or require one-on-one support. Without designated staff to address this role, the centre felt unable to implement programming designed to support individual developmental priorities. Additionally, programs at the centre are focused on children, youth, and parents, and to a lesser extent the family unit. This means that professionals working with the family may work specifically with the child or the caregiver, rather than with the family across programs. The centre recently partnered with a resource consultant in order to better understand and access resources that may benefit children with disabilities and their families.

Strategy Description

Method

In addressing IECSS findings which suggest that many early-intervention programs do not include other members of the immediate and extended family in the planning of care or support inclusion across multiple programs**,** the staff employed a family-oriented approach to supporting inclusion at the centre. In particular, they sought to focus on a single case in which support was identified as required for a successful transition for the child into childcare. The staff determined a one-on-one family case management approach to supporting a child and family as they prepared to enroll into the centre's childcare program to be a strategy which could address issues of inclusion throughout multiple family support programs. The centre sought to evaluate the processes involved to achieve this outcome as a case for implementing family-centered case management and care as an inclusion strategy.

Procedures

The strategy was implemented over the course of six weeks and involved a preliminary consultation, pre-implementation evaluation, a developmental assessment, a developmental care plan and implementation, and post-implementation evaluation. The pre- and post-implementation evaluations were conducted through a questionnaire designed by the centre staff team to assess family priorities, barriers to access, and efficacy of program implementation over time.

The family was identified through outreach within the centre's family support programs. The family was interested in receiving intensive support in order to access developmental assessment and referrals to external services. The centre staff met privately with the family in their home for a preliminary consultation, a developmental assessment, and had them complete a pre-implementation questionnaire. During the discussion, the staff asked the family questions about their child, the types of programs they currently access, their perspectives on these services, and their goals for their child.

The staff then conducted an Ages & Stages Questionnaire as an assessment of the child's developmental with the caregiver. The assessment tool was used as a way to gain more information about the child and to determine appropriate interventions to implement within childcare and family support programs. The assessment and pre-implementation questionnaire determined that the developmental care plan would focus on behavioural and speech and language support for the child and family.

The developmental care plan was developed collaboratively with the staff and family to address areas of concern and determine appropriate interventions. The plan was documented and signed by the caregiver and staff. The plan was implemented at the centre with staff and the caregiver, with some strategies being implemented by the caregiver at home. The implementation took place in a variety of programs over the course of several weeks, facilitated by one staff member who worked with the child at each session and the caregiver. Following the implementation, the staff did a follow-up questionnaire to assess whether outcomes had been achieved.

Outcomes

The one-on-one support the family received enabled them to have increased access to the programs within the centre and ultimately succeeded in preparing the child to attend full-day childcare. Staff felt they were able to build meaningful relationships with the child and family by seeing them consistently through various programs. Having familiar faces seemed to make it easier for the child to focus on the learning objectives within the developmental care plan, even if the program or materials differed between settings. These relationships also facilitated a clear dialogue between the caregiver and staff, which became strengthened over the course of the intervention. When relationships were built, staff were able to not only support the child, but better understand how to support the parent as well by understanding more of the context of their lives. Staff also felt the collaborative approach to intervention was helpful in empowering parents to be able to implement strategies in the home, by modelling and providing information on which strategies may be useful. Staff felt that this allowed parents to feel like partners in the intervention process since they were able to make decisions about their child and also participate in the implementation of the strategies. This strategy aligns well with one of the goals of the centre, which is to support Indigenous families' self-determination.

According to the pre- and post-implementation questionnaire data, the family indicated they had gained an increased sense of understanding of their child's disability as well as an increased knowledge of where they might be able to access further support. The family shared with staff that they felt their culture was being respected during the process since engaging with the whole family seemed to be a more holistic approach to service delivery than child-focused interventions. The intervention enabled the parent to feel more supported in caring for their child while also giving them increased information about other programs available to them. However, because they had been made more aware of what the child could potentially access and benefit from, following the implementation the family was less satisfied with the services they were receiving.

The barriers identified in the preliminary stages remained throughout the implementation process. From the family's perspective, the primary barriers to facilitating the desired level of inclusion for the child and family were transportation and timing of programs. The caregiver felt unable to access interventions for their child during work hours and therefore seemed to appreciate the flexibility of a model of care that could be maintained across programs and at home. Staff articulated the major barriers to inclusion within their childcare centre was the lack of consistent funding for staffing to support one-on-one support for a child.

Recommendations

The centre staff identified many benefits to family-focused delivery of care in which a consistent team was able to support the child across programs. They recommended the following in facilitating inclusion within a childcare or family support setting:

- **Develop Collaborative Relationships**. A strength identified within the approach taken at the center was the collaborative relationship that was facilitated between the staff and family. In positioning the caregiver as a partner in the implementation of care for the child, the family is able to maintain strategies across environments and feel empowered in the education and development of their child. The relationships built through this collaborative process may also support the caregiver in accessing further programs that could benefit themselves or others in the family.
- **Maintain Consistency Across Programs.** Children thrive in environments wherein they understand the expectations and supports available to them. Staff at NCFST felt that maintaining a support person across various programs allowed for the child to feel safe and supported in different environments. This process also allowed for a genuine relationship to flourish between the staff and the child which led to more effective intervention. Staff recommended appointing a support person to work with the family and child over a long period of time. It is beneficial if this person can act as a liaison between programs, maintaining a consistent care plan for the child. This person can get to know the child and family starting from early years programs and as they transition into childcare and school.
- **Ensure Flexibility and Compatibility with the Family.** Staff felt the intervention was effective in the case of this family because they were able to

meet the specific needs of the child and caregiver. Meeting in the family home increased accessibility and allowed for natural observations and assessments of the child. The caregiver felt this could be improved by having services offered during the evenings so that it would not interfere with work scheduling. Additionally, the care plan for the child was adapted over time as new priorities (such as the transition to childcare) came up. This flexibility allows for authentic work with the child, focused on goals as they emerge. Flexibility allows for the staff and caregiver to reassess the efficacy of the work being done and to make changes if necessary to ensure a good fit.

- **Respect Culture and Community.** All children belong to a community and deserve to have full access to participate in their community at large. The staff at the centre were able to observe and work with the child in various settings, both within and outside of the centre itself. Support for inclusion does not end at the front door of the building and should translate into the external programs and events of the organization. This may mean increasing staffing during community events to ensure families feel welcomed and supported to attend. When offering intervention, it is also important to consider cultural biases that may be imparted through the interventions themselves. Working as a team with the caregiver allows for staff to discuss cultural values as well as developmental priorities. The centre recommends a mixed approach to early childhood intervention where cultural and more clinical support can both be offered in combination.

Conclusion

Childcare and family support spaces can be critical sites for inclusion, as well as cultural identity formation. However, the current structure of disability-support services hinders access and participation when it is not organized with families in mind. Support should be developed collaboratively with professionals, childcare providers, and the family to ensure that the services offered are culturally safe and appropriate. Assumptions made about the developmental goals and the strategies to address them can deter family participation in the process and lead to inconsistent care across environments. Ensuring there is a consistent team to develop a care plan that accounts for the scope of programs the child and family access can increase the time spent working on developmental goals and facilitate improved relationships among the child, family, and service provider. The funding structure of disability-related services requires revision to ensure there are funds available to support the ongoing and consistent care of children in the changing contexts of their lives. Funds provided for disability-related supports should not only be allotted to early intervention or clinical agencies, but also to centres who deliver culturally based programming so that children can access both cultural and developmental supports at the same location. Empowering Indigenous families to meaningfully access and participate in the education and care of their children begins in the early years and requires holistic models of care that allow for self-determination and relationship building.

Part 2: Connecting Families

Chapter 3

Family Place: Powell River, British Columbia

by Laura Cocksedge

This paper will discuss an evaluation project conducted at Family Place, a program for young families in Powell River, British Columbia. The objective was to increase access and engagement for caregivers in the system of care through a strategy to provide an opportunity for caregivers to meet local professionals and to facilitate discussions regarding caregiver experiences.

Powell River is an isolated community, accessible only by air or water, and has a population of close to 21,000 people spread out over a large geographic area that includes two islands. 27.7% of the population are seniors, 10% higher than the provincial average. The average income is below the provincial average. Poverty rates have increased over the last few years: approximately 1 in 4 children live in poverty.[12] According to the Provincial Early Development Instrument[13], approximately 39% of the children in this region are vulnerable or at risk in at least one area of development (physical, social, emotional, language, and/or communication) compared to the provincial rate of 32.5%.

Powell River Family Place is a resource program for families with young children. It fosters opportunities for families to gather, encourages a sense of community, and provides information and referrals to other community services in town. Family Place operates primarily as a drop-in centre for information and resources, which include a clothing exchange, the Good Food Box (a low-cost box of produce), computer and Internet access for caregivers, and healthy snacks. Programs include Parent-Child Mother Goose, Fun in the Sun summer programming, Open Space Parent-Led programming, and Toddler Time. In Powell River, Family Place is predominantly attended by families living in poverty.

Family Place is part of the British Columbia Association of Family Resource Programs, a not-for-profit provincial organization dedicated to promoting and supporting community-based family resource programs (FRPs). FRPs are parent/child (aged 0-6) community hubs where families can access support, opportunities for engagement, and community resources.[14] Their vision, mission and values are:

- Our vision at FRP BC is for all BC families to have the supports they need in their communities to raise healthy children;
- Our mission is to build capacity in family-centered programs through research, education, advocacy and provincial standards and to connect families to local programs and resources; and

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[12] Christien Kaaij and Janet Newbury, *Powell River Regional Social Planning Program: Final Report* (2019), https://powellriver.civicweb.net/document/57383

[13] Human Early Leaning Partnership. *EDI (Early Years Development Instrument) report*. Wave 6 Community Profile, 2016. Powell River (SD47). Vancouver, BC: University of British Columbia, School of Population and Public Health; October 2016.

[14] *Family Resource Program of British Columbia*, Employment and Social Development Canada (2016), http://www.frpbc.ca/

- Our values at FRP BC are community, connections, inclusion, respect, and relationships, in all that we do.

Problem Identification

In their 2016 Research Report[15] the BC Association of Family Resource Programs identified some of the challenges parents experience that are a focus for FRP staff. Some of these challenges are expected: parenting questions, child development, nutrition, discipline, and child care. Staff may also offer assistance for more complex challenges, such as those to do with employment, financial issues, food security, transportation, or housing. However, Family Place staff are unequipped to assist with more serious challenges, yet are affected by them on a regular basis. These include caregiver isolation and mental health concerns, family conflict, personal safety concerns both for caregivers, and themselves, disability, and drugs or alcohol abuse.

Family Place is in an ideal position to support young families. In many ways, and for many caregivers, this support is already being delivered. However, research still struggles to identify how parents choose one program over another[16] in early intervention programming; for example, differences were noted for gender of parent, cultural background, and couple versus lone parents. The authors conclude that parental choice of programming that emphasizes improvement of parent and child functioning are best. Parents also preferred shorter programs and the inclusion of food and childcare. The complexities of choosing one program over another by caregivers with diverse needs and diverse abilities, influenced by socio-economic status and the lack of viable transportation options, impact the extent to which caregivers participate in local programming. Knowing why families choose not to use a service can be as illuminating as why they do.

The Inclusive Early Childhood Services System (IECSS)[17] research has found the following four areas to be true for families accessing disability services. This evaluation project echoed these findings.

1. Accessing disability supports and services is a lot of work for families. Many of the families accessing Family Place rely on public transportation. When you factor in strollers, bags, and multiple children, this is a profound impediment to accessing services, and adds to a parent's isolation.

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[15] Ramsay Malange, Sherry Sinclair and Sue Khazaie, *Monitoring Family Resource Programs in British Columbia: 2016 Research Report*. BC Association of Family Resource Programs. (Langley, BC: 2016), http://www.frpbc.ca/media/uploads/files/Monitoring_FRPs_in_BC_-_Research_Report_2016_1.pdf

[16] Gregory A. Fabiano, Nicole K. Schatz, and Stephanie Jerome, "Parental preferences for early intervention programming examined using best-worst scaling methodology," *Child & Youth Care Forum, 45, no. 5 (2016):* 655-673, https://doi:10.1007/s10566-016-9348-z.

[17] *Inclusive Early Childhood Services System (IECSS) Project (blog website*), Ryerson University (n. d.), http://iecss.blog.ryerson.ca/people/

> "It's never been about the services not being there. The barriers exist in living in poverty, transportation, and trust in the agency people," said one Parent Café participant.

2. The system of services for young disabled children is predicated on a medical model, which makes diagnosis or designation of disability central to how the system works. This approach is not consistent with many cultural viewpoints regarding disability and is used as a gatekeeper for services that may be central to inclusion and quality of early learning and childcare for children with disabilities.

   > Said the mom of a baby with a rare auto-immune disease, "When I was down at the hospital in Vancouver for my baby the social worker would not give me the $25 gift certificate for food unless I told her about my family circumstances in Powell River. I told her to shove the gift certificate."

   For some families, accessing services means opening themselves up to judgement and giving up their privacy. Families living with poverty and those who are minoritized have far greater involvement with BC's Ministry of Children & Family Development (MCFD) than higher-income households. The medical model puts the child at the centre of the service without understanding the needs of the family. When we can support the *family* with early intervention, care and education we ultimately support the child and increase inclusion.

3. Access to services has a geopolitical context. Different jurisdictions have varied service availability and priorities for early intervention and early childhood education and care.

   There are no behavioural specialists, pediatricians, or disability assessment services in Powell River for brain-based challenges such as fetal alcohol spectrum disorder (FASD) or autism spectrum disorder (ASD). Families must get a referral to a pediatrician on Vancouver Island from their family doctor in Powell River. The pediatrician refers to Sunny Hill Children's Hospital in Vancouver. This process typically takes about 18 months and then the family must stay in Vancouver for at least three days for the multi-team assessments. Reports are generated within six months. Cognitive testing is often inconclusive for children under 7 or 8 years of age, making diagnosis for this population incomplete; a family must go through the assessment process again when their child is a few years older. It is up to the family to remember to retest at a later age. Pediatricians often recommend waiting until the child is at least 7 years old before beginning the assessment process.

   The two main barriers to this process are transportation to Vancouver and support in Powell River. Without personal transportation the caregiver must rely on bus or air services then use public transportation to navigate through the city on public transport. Vouchers for hotel and food are provided but are usually insufficient. Caregivers with more than one child have complex barriers to assessment regardless of whether they bring their other children with them or find someone in their home town to care for them.

With no behavioural specialists in Powell River, caregivers with young children with developmental delays have limited access to programming that supports the family. ASD diagnoses come with funding for specialists (who come from Vancouver or Vancouver Island at additional expense to the family) but young children often do not yet have a confirmed diagnosis of ASD. Children with FASD, for example, are not eligible for extra behavioural support until they reach school age (preschool or kindergarten) and then the support is only available in the school setting, not at home even though ASD and FASD behaviours can be similar. Young children with undiagnosed disabilities are often excluded from preschool and daycare settings. The priorities for early intervention, education, and care are predicated on the family's ability to access services which may or may not be available or inclusive.

4. Individual programs may be inclusive, but most families who have children with disabilities are clients of or participants in multiple services. Inclusion beyond single programs across the spectrum of services is rare.

   Early intervention programs are fragmented and siloed; families must access each service individually, fill out multiple forms, and often travel great distances (certainly for rural communities) to access those services. Case management across all the services is rare; it is up to the parent to distribute reports and connect providers.

   Case management and team consultation for caregivers of children with a disability are useful in collating information both for the family and the professionals. This process helps foster inclusion across multiple services. While this aspect of care is often performed on an annual basis in agencies where multiple services are managed by one organization and case management is an established practice, inter-agency collaboration is much more challenging for individual agencies. Assigning a case manager and time planning for and scheduling case management meetings is a consideration; so is the issue of confidentiality, since agencies have differing levels of confidentiality requirements depending on their funders.

Strategy Description: Parent Café
Performance measure: A preliminary survey of ten families that use Family Place showed that they were unaware of many of the services and providers in Powell River available to their young children. These families also indicated they were overwhelmed by the difficulty of accessing the system of care given that many of them rely on public transportation and were wary of professional involvement. A Parent Café program was introduced on Fridays. Staff at Family Place facilitated the sessions with a family counsellor present.

Performance indicator: This program consisted of two parts: for one part caregivers were encouraged to choose the topics, and discussions were predominantly caregiver-led. The second part consisted of Family Place staff inviting in guests who represented other programs and services in the community. The purpose of this project was to increase a sense of inclusion in the system of services available to the families and encourage their engagement by inviting service providers to come into the caregiver-led space (as opposed to families individually accessing the providers in multiple offices).

Short-term Outcomes: One parent in particular, who is a bit shy and wary of any system but comfortable with Family Place staff, felt motivated to participate in many of the Parent Cafés. Participation led to a local service provider agreeing to see this participant's child at Family Place rather than their own office. At the end of the project the participant said, "I am very thankful for the help and effort you guys put into me. Thanks." The service provider's willingness to understand that often families do not want professionals in their homes and are reluctant to go to offices meant that, for this family, services were, indeed, family-centered. This parent and service provider found an easy solution which increased system inclusion. Other parents agreed that this was a helpful option open to them and several parents indicated a willingness to explore it.

Method

Overall there were twelve Parent Café meetings. Six meetings had guest speakers representing local services. Six meetings were staff-facilitated discussions on the topics chosen by the caregivers.

Procedures

This project utilized an ongoing focus group to create opportunities for relationships intended to foster a sense of inclusion and trust. While confidentiality was an issue, the intent was to create connections that would help individuals to feel more confident about giving full responses. This process also enabled the researcher to spend time observing interactions and recording responses from caregivers in a non-clinical environment. All meetings included lunch and child-minding.

Recruitment

The Friday Parent Café was advertised through posters at Family Place, the Family Place Facebook page, and word-of-mouth. Since Family Place is typically closed on Fridays, participation could be interpreted as being based on a desire to attend rather than on convenience. Participation per session varied between two and ten caregivers. The participants were predominantly women; two men attended occasionally. All the participants self-reported that they live in poverty.

Guest speakers. The Parent Cafés with guest speakers served as opportunities for the caregivers to meet local service providers, gain an understanding of their services and how they could be accessed, and to ask questions. Some of the caregivers, those with older children, were familiar with the services and providers already. The service providers were a speech and language therapist; a fetal alcohol spectrum disorder key worker; a dental assistant; a supported child-development worker; a public health nurse; and, the district Strong Start coordinator.

Facilitated discussions. The remaining six Parent Cafés were discussions. Topics were chosen by the caregivers after they were encouraged by the Family Place staff to write ideas on an idea board. The topics were "What do standardized assessments for ability mean?"; "The myths of parenthood"; "Time management"; "If not the medical model, then what?"; "What is mental wellness?"; and "Managing the perception of judgement." A family counsellor was invited to attend all the meetings to ensure safety for the participants.

Outcome Evaluations

Guest speakers. Relationships with local service providers increased individual uptake to services. Three of the service providers reported referrals into their programs as a direct result of the Parent Café sessions. Two caregivers requested that their sessions with service providers take place at Family Place rather than at the service provider's office; Family Place staff assisted in advocating for this. Family Place is centrally located in Powell River, in a mall that is also the main bus hub. Ease of access as well as a non-judgmental environment were reported as being important to the caregivers. They also appreciated that because food is always available at Family Place they could count on snacks for their children and a welcome place for their toddlers to play.

Facilitated discussions. Overwhelmingly, regardless of the chosen topic, caregivers expressed a need to feel "good enough" as parents. For example, two of the mothers in the group separated from their partners during the three-month project. Family Place was used by one family as a supported visitation site. This caused stress in relationships among all the participants at Family Place, fueled by comments made on social media, which impacted trust in group discussions for a time. These families are also burdened by living in poverty, an issue that came up at every session. "There is so much going on at home, you know?" said one participant. "Like, how am I supposed to get through making meals and snacks, doing laundry, cleaning, packing the buggy, taking the bus with a baby and a toddler, not having money for groceries, and coming to Family Place for a break to find out people are arguing over something someone said on Facebook? Then I go to my appointment with [speech and language] and she tells me I have to do homework with A [child]. I'm just tired at the end of the day."

Unmet needs and overall fatigue formed the base from which all experiences were expressed. The caregivers spoke of judgment and exclusion, stigma and fear of the assessment process. "We have to make alliances with people we don't really trust or want in our lives in order to function. We are reliant on others when we don't really want to be." Another mother felt that "professionals treat your child like a 'job' rather than caring. It's hard to know who to trust; that takes time sometimes." One mother shared that she did not access services if she believed they might take her child away; there were only certain professionals she would agree to see.

Family Place staff observed that, in their experience, behavioural concerns with toddlers are growing as are the number of young families living in poverty are both growing, as are mental health issues, and that parents are struggling to cope. A Family Place staff member commented, "How do we, as professionals or peers, translate what parents need?

How do we know what they are asking for? Whenever we try to create a new system, it smacks too much of the old system. Clients don't trust it [the system] or us."

When asked what parents and caregivers need to feel included in the system of services, responses included:

- The ability to ask for help, for example, for gas cards or bus tickets to get to and from appointments in town (like the current system of free passes to take the ferry or plane for medical appointments on the Island or Vancouver).
- Snacks and a place for toddlers to play during the appointment.
- The ability to connect with other parents going through the same thing with their kids.
- Recognize parents as advocates for their children.
- Do not assume the parent does not care if they miss appointments. It is really hard to remember all the appointments you have to go to.
- Understand that disability affects the whole family, not just the kid. "Doctors need to keep this in mind when they send us all over the province for appointments."
- Maintain respect for diversity of culture, values, beliefs, and attitudes about parenting and disability.
- Acknowledge that partnership with parents and caregivers is a process, not an event.
- Reduce the amount of paperwork caregivers need to fill in. "Every service requires yet another pile of forms to fill out with personal information I do not always want to give. I just want someone to help my child."

Outcomes

Childhood vulnerability. Powell River has a particularly high vulnerability rate for young children as identified by the Provincial Early Development Instrument[18] (EDI): Wave 2 (2004 to 2007) showed 28% of Powell River children were vulnerable compared to the most recent Wave 6 (2013 to 2016), which indicated that vulnerability has significantly increased, to 36%. Vulnerability was measured on 5 scales: physical, social, emotional, language, and communication. Poverty rates for children aged 0 to 5 years in Powell River are at almost 1 in 4.[19]

Evaluation project. Children are vulnerable in families, not as isolated statistics. This evaluation project reflects the need for services that address the family's needs as well as the child's. While most services call themselves family-centered, families report not feeling included in the system of care. For this study, caregivers reported not only feeling

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[18] *Wave 6 Community Profile, 2016: EDI (Early Years Development Report, Powell River (SD47),* Human Early Learning Partnership. Vancouver, BC: University of British Columbia, School of Population and Public Health, October 2016. http://earlylearning.ubc.ca/media/edi_w6_communityprofiles/edi_w6_communityprofile_sd_47.pdf.

[19] Census profile, 2016 census: Powell River Regional District, Statistics Canada (2016). https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CD&Code1=5927&Geo2=PR&Code2=59&SearchText=Powell%20River&SearchType=Begins&SearchPR=01&B1=All&GeoLevel=PR&GeoCode=5927&TABID=1&type=0

more included in the process, but also appreciative of advocacy support that met their needs. Feedback is important to maintaining programs that offer what caregivers need; if input and feedback is lacking, we need to ask differently, and to invite parents and service providers to help design the system that they are working in, in the community they live in.

Recommendations

Caregivers need more centralized services. Rather than locating early intervention specialists at hospitals or in medical buildings, create centres that co-locate these services with daycares and preschools. Welcoming spaces that offer food, play areas, and gathering spaces invite inclusion while reducing time spent accessing multiple services in multiple buildings. Co-location also encourages collaboration of service providers including reducing confidentiality requirements (and paperwork) and enabling better case management.

These centres need to be brightly decorated with modern furnishings. All too often places like Family Place become rundown, with no money to replace appliances or furniture. The value of aesthetics is often underestimated, but shouldn't be: a cheerful, nicely-furnished facility sends a clear message that families matter.

Conclusion

1. If money were not a consideration, what would you invest in first to support inclusive practice?

   The ability to practice inclusivity in early-years programming is dependent on well-trained and supported staff. Family Place is in a unique position: programming is predominantly caregiver-led yet the staff are able to play a vital role by recognizing and advocating services for suspected delays or disabilities. I see investment on two levels. First, ongoing access to training is imperative in maintaining best practice. Unlike urban communities, Powell River is an isolated community that relies on planes and ferries to take advantage of "free" training opportunities in larger centres. It is cost-prohibitive at present. The Family Place program would not be possible without extra financial and administrative support from the Powell River Employment Programs Society, the host organization.

   Second, investment in creating collaborative hubs where the definition of "family-centered" comes from the families as well as the professionals. For example, by co-locating a program like Family Place with disability services, in a central location with easy bus access, families can be supported by things like child-minding services while the caregiver is accessing those services.

2. What is the greatest barrier to full participation of young children with disabilities in the early-years sector?

   Access to services is a huge barrier for Powell River:

   - Powell River has two private schools and a French school from a different district. These three schools do not have access to the local speech and language pathologist, for example; this service is only for School District 47 schools.

- Education Assistant (EA) support is limited in all schools, but especially in these three schools; one school employs parents as assistants (as opposed to EAs) because their budget is too small. Behavioural concerns for children with undiagnosed disabilities is increasing in the classroom. Children are being excluded from preschool because of their behaviour. The Supported Child Development program needs to be enhanced and allowed to support children in kindergarten.
- Powell River does not have a pediatrician or independent behavioural consultants who specialize in diagnosing or working with diagnosed developmental delays.
- More home support is needed. For example, FASD is estimated to be as high as 10% of the population with 90.7% of children experiencing behavioural problems and 81.8% experiencing a receptive language disorder.[20] We should be writing prescriptions for more home-based behavioural support for the child but also for housekeeping, cooking lessons, and transportation to support the family in supporting their child. The issues of poverty and parents with disabilities themselves have not been addressed. The child may not be directly at risk of a delay but vulnerable because of the parent’s struggle with his or her own delay.

3. Are there geographic or cultural/linguistic considerations that should be attended to?

   Powell River is accessible only by water or air. Services are limited as is choice of the service provider. Government funding for many smaller support programs that have been operating for many years, like Family Place, have not been reassessed for applicability to the current population using the service. Funding is also based on models that were created in larger urban centres with access to greater resources than are available in smaller rural towns like Powell River. For example, Family Place is attended mostly by young mothers living in poverty. This population requires supports that are more directed at addressing vulnerabilities rather than just programming for fun mother-child activities. Some of these mothers have disabilities themselves, may be single parents, or have mental health challenges.

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[20] Shannon Lange, Jurgen Rehm, and Svetlana Popova, “Implications of higher than expected prevalence of fetal alcohol spectrum disorders,” *American Medical Association, 319, no.5 (2017):* 448 449, https://canfasd.ca/wp-content/uploads/sites/35/2018/02/Implications-of-Higher-Than-Expected-Prevalence.pdf

Chapter 4

Palmerston Child Care and Learning Centre: Palmerston, Ontario

by Caitlin Wood

The rural community of Palmerston, located in Wellington County in Southern Ontario is at least a one hour's drive from any main urban area, and has a population of roughly 2,500.[21] This case study was created in partnership with Wellington County and Registered Early Childhood Educators (hereafter referred to as "Educators" at the organization's request) from the Palmerston Child Care and Learning Centre. The project began by holding a session with Educators to brainstorm and discuss the IECSS findings concerning the barriers to successful inclusion of children with disabilities. After this discussion Educators identified how these barriers impacted children and families within their community. Following this, Educators were invited to conceptualize a strategy that would be implemented and evaluated in their childcare centre. It is however important to note the specific barriers to inclusion the Educators identified within this specific community before discussing the implementation and evaluation strategy they selected.

Problem Identification

Though a number of complex barriers were noted, elaborated on, and explored, three overlapping themes could be identified: the first was the low socio-economic status of community members; the second was how the remoteness of the community from the children's therapeutic services impacted the amount of direct contact between families and their children's therapy providers; and the third was the varying literacy levels of parents and caregivers. The following section will elaborate on each specific theme in more detail.

Socio-economic status (SES). Consistent with the research on barriers to inclusion,[22] Educators in the community named low SES as a challenge faced by many of their families in accessing disability support services. When elaborating on how this impacted the accessibility of supports, Educators noted that that in addition to creating difficulties with reliable transportation, challenges of purchasing specialized equipment for their children, and precarious work status and/or hours of work which presented complications of attending their child(ren)'s scheduled appointments,[23] that additional barriers were felt by families in this particular region.

In 2018, through the Government of Canada's 2016 Social Infrastructure Fund and the Government of Ontario's Investment in Affordable Housing for Ontario Program, $1.5M

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[21] Statistics Canada, Town of Minto, Ontario, Census Profile (2016).

[22] Katherine. E. Pickard and Brooke R. Ingersoll, "Quality versus Quantity: The Role of Socioeconomic Status on Parent-Reported Service Knowledge, Service Use, Unmet Service Needs, and Barriers to Service Use," *Autism* 20, no. 1 (May 2015): 106–115; Themba Carr, Wendy Shih, Kathy Lawton, Catherine Lord, Bryan King, and Connie Kasari, "The Relationship between Treatment Attendance, Adherence, and Outcome in a Caregiver-Mediated Intervention for Low-Resourced Families of Young Children with Autism Spectrum Disorder," *Autism* 20, no. 6 (August 2015): 643–652.

[23] Consistent with the work of Pickard and Ingersoll (2016) and Carr et al. (2016).

was allocated for the construction of affordable housing for families in Palmerston.[24] Eleven new geared-to-income housing units were created in the community and families from across the County (some as far away as an hour or more) were relocated to better support their housing needs. Though the importance of affordable housing cannot be overstated, this change in community for some families inadvertently created additional barriers. Two such barriers, cited by Educators, were that i) many families were thrust into a new town and consequently cut off from the supportive networks that they had previously built, and ii) that many families began to experience additional financial burdens associated with travelling greater distances to both their places of employment as well as to attend their child's or children's therapy and service appointments. In some cases, families were closer to their child's therapy and had greater access to services before their move, but had precarious housing. Now, though they have stable housing, they face barriers to attending the services/therapies their children require to thrive. This brings us to the second theme and barrier to inclusion: the remoteness of the community.

Remoteness of Community/Lack of Direct Contact with Service Providers. Because the community of Palmerston is roughly an hour's drive from any urban centre, many families face difficulty acquiring necessary diagnoses for their children, and later face difficulties accessing the disability support services their children require. There is no public transit in Palmerston reliable enough to depend on to travel to appointments, which means families have to drive themselves. As such, attending these appointments often becomes a stressful and financial burden. Travel expenses include the cost of gas and mileage, lunch out, childcare for other children not requiring services in the city, and sometimes a loss of income for taking a day off work. This, for obvious reasons, creates obstacles for many families to actually receiving the services their children need.

In an attempt to alleviate this burden, Inclusion Support Service (ISS) workers will make visits during the day to the childcare to provide the identified children with their necessary therapies. Though this appears to be an effective way of bringing the services to the children that need them, this approach creates an additional dilemma as family members who are at work during the day rarely get an opportunity to speak to ISS professionals directly working with their children. Educators noted that families often become frustrated with this process and frequently feel helpless. Parents and caregivers notice supports are changed or dropped for their children while often experience long wait-periods between supports with little-to-no understanding of why this is occurring. Though attempts are made by ISS workers to connect with families, these attempts are predominantly done in writing, through hand-written notes, surveys, and information forms, which may be suitable methods of correspondence in some instances, but create additional barriers for families who struggle with literacy, which is the third theme that was identified.

Varying Literacy Levels. Educators spoke at length about an additional barrier faced by its community members—that of varying literacy rates. Many parents and caregivers in the community cannot fully comprehend the written correspondence provided by ISS

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[24] Wellington County, "County Announces 11 New Affordable Housing Apartments Coming to Palmerston," press release, December 7, 2016.

workers. Moreover, due to the stigma of illiteracy many parents and caregivers are unwilling to disclose their difficulties even to trusted staff with whom they have built relationships with. This subsequently leaves many parents and caregivers largely in the dark about what services their child may be receiving. It also makes the already complicated and confusing process of navigating services and supports for their children even more overwhelming, subsequently shaking caregivers' sense of confidence in navigating supports for their children, affecting their sense of agency and autonomy, and negatively impacting their self-esteem as parents.

Strategy Description

Method

In response to these barriers, Educators brainstormed and then selected, designed and implemented a strategy that they hoped would alleviate some of the stressors that complicated the inclusion process for their community members. To begin the brainstorming session, the IECSS study's findings were shared with Educators, who were encouraged to select at least one of the IECSS findings to tackle. The Educator team decided on "Navigating support services is a lot of work for families." The strategy they designed to achieve their goal was to hold an open-house-style event where ISS professionals could mingle with children and families, share information about their services, and build relationships with families new to the community as well as with other families and community members.

Procedures

The open house was held in the childcare facility on a summer evening. Three ISS providers were in attendance: a speech and language pathologist, a social development consultant, and an occupational therapy specialist. It was estimated that family turnout was roughly 75% to 80%. Educators introduced families to service providers who were working with their children or would be in the near future. The ISS workers in attendance came with a variety of information materials that could be shared with families, including information display boards that could be used as conversation guides as well as information that could be sent home. Educators chose to evaluate the success of this strategy by way of administering questionnaires before and after the open house. Attempting to support varying literacy levels of the caregivers, the questionnaires were set up on childcare iPads and Educators who had relationships with caregivers helped them to read and record the answers to the different questions by way of short interviews. Parents were asked to rate questions 2 to 7 on a 5-point scale, with 1 being "Not at all" and 5 being "Extremely":

1. What agencies/services are you and your family currently using to support your child's learning and development?
2. How confident are you that your child is receiving the supports/therapies they need to learn and thrive (not just in childcare but through other services and agencies as well)?
3. Do you feel comfortable asking questions about what your child is learning in childcare and how they are progressing in their supports/therapies?

4. Do you feel comfortable bringing up issues that concern you regarding your child's learning and development?
5. Do you feel confident that you know the best supports/therapies available to you and your child?
6. How satisfied are you with the level of support that is being provided to you and your family—both at childcare and through other agencies?
7. Do you feel confident finding additional supports for your child?

Outcomes

15 questionnaires were administered before the open house and 9 after the open house were collected. The responses indicated that families ranked their degree of awareness of and confidence in the supports provided to their children as quite high on both pre- and post-tests. The mean of the combined pre-intervention scores and the post-intervention scores was consistent at 4.6/5. Although there were differences between pre- and post-tests on individual responses, which will be discussed in the next section, it is important to note a possible reason for the pre-test scores being so high. Knowing that many parents and caregivers are not confident about their literacy levels, Educators chose an evaluation method that would avoid further alienation and discomfort for families; they also decided that those Educators who already had a relationship with caregivers would be the ones to administer and record the answers of the questionnaires. This strategy, designed to make the process for caregivers as simple and seamless as possible, may have inadvertently skewed the results, since it is possible (perhaps even likely) that caregivers provided responses they felt Educators would like to hear rather than their honest opinions.

Nevertheless, some interesting and suggestive differences between individual questions should be noted. The first important finding is that for all questions that addressed the parent's/caregiver's "confidence" and "satisfaction" (questions 2, 5, 6, 7), all mean scores went up after the open house. Even though scores only increased slightly (and therefore not statistically significant), findings suggest that the open-house model was helpful for parents/caregivers.

Though there were certainly limitations to the evaluation strategy (i.e., the size of the sample, the reliability of responses, and the fact that the short period of time this project ran there was only one open house to measure), it is important to recognize that there are other ways to mark the success of the program. During the writing of this report, the supervisor shared the following story:

> The Educators work hard to develop relationships with the families in our childcare centre. As that relationship develops, families will share their joys and their struggles with the Educators that they have come to know best. The Educators will then begin to guide families to information, strategies or services that can support them. Sometimes these conversations can be difficult for both the family and the educator. During the time of this study, one particular instance stands out. A family developed a positive relationship with their child's Educator and then felt confident enough to share their struggles at home. The Educator gave them several ideas, including strategies

> and places that they could access supports—one of which being a referral for ISS supports at the childcare centre. The family did not feel that they could move forward with sharing their story with an unknown individual and therefore did not access any of the suggested supports. During the family open-house event, the Educators introduced families to the ISS staff who had been coming to the childcare to help support their children. They also made sure to introduce the ISS staff to all families and to share with them what their role was. This allowed all families to ask questions and get answers without having to fill out forms or make a phone call. In this instance, the family who refused the supports was able to talk with the ISS staff who would normally be calling them, writing them notes, and visiting their child at the childcare centre if a referral had been made. This introduction created a safe space for the family to ask questions and begin to create a positive relationship with a professional who they most likely otherwise might see once a year or only talk to on the telephone. The family in turn felt confident, was able to move forward with a referral for additional supports for their child, and entered the complex system feeling safe and finally comfortable enough to discuss their child's individual needs.

This anecdote, which paints a more vivid picture of the effect on a family and a child of the family open-house event than the results of the questionnaire alone, demonstrates the impact that such a meeting can have.

Recommendations

Though Educators agreed that the family open house was a successful event, when coming up with recommendations on how to best support children and families in their community they pointed to larger systemic changes that were required. These fell largely into three areas: the importance of adequate, inclusive, and affordable childcare for all families; the necessity of localizing disability services, supports, and programs; and the provision of additional resources that would be necessary to properly create inclusive spaces.

Educators argued that many children in the community need disability supports and services but because their families are not able to afford childcare (which is often the first point of entry into additional support services) they are forced to wait until their child is old enough to enter the elementary school system. This lack of affordable childcare therefore creates an additional barrier to inclusion for families to overcome.

Next, Educators reiterated the importance of providing disability services, supports, and programs to families within their own communities. Though the open-house model provided a good opportunity for the service providers to meet the families where they were, Educators acknowledged that these one-off type events are not enough. Instead, these programs should be housed within the community to provide greater access to those who need them.

Finally, Educators insisted that more resources are necessary to properly practice inclusion. Educators stated that they required greater training in best practices related to inclusion, and expressed a need for more money to build and/or adapt physical spaces (such as by adding ramps, widening doorways, building larger storage spaces for adaptive equipment, and so forth) to support inclusion. Educators also acknowledged the importance of providing opportunities for knowledge-sharing across agencies and organizations so that pertinent information can be shared among service providers about the specific needs of community members and to help eliminate any unintentional barriers that they themselves may be creating.

Educators in Palmerston argued that we must "see all of our children as our future, not a problem to be solved"; they continued by saying that if we make these changes we can provide "our children with accessible learning spaces that give them a chance to participate however they wish to."

Part 3: Designing Responsive Programs

Chapter 5

Keepers of the Circle Learning Centre: Kirkland Lake and Temiskaming Shores, Ontario

by Ronda Guenette, Lisa Sloan, Fiona Traynor, and Arlene Haché

> *Land, known as mother earth, is not a metaphor…earth is a being, a source of life that gives birth to all living creatures and sustains the life of her children…land is a place of birth, growth and development, and death. Land and formal education share important characteristics. Both provide a focus for livelihood and survival, sustain life, validate the individual and assure the future.*[25]
> (Keith Basso, Wisdom Sits in Place)

This report provides an overview of intervention methods used by Keepers of the Circle, an Indigenous Hub situated in the District of Temiskaming in Northern Ontario. Keepers of the Circle operates two centres, one at each end of the District: one in Kirkland Lake and one in Temiskaming Shores. Each offers early learning and family support programming and childcare. Both use similar Indigenous cultural and land-based interventions with children aged 0–12 years, although for this project access to the on-the-land component was restricted to children aged 4 years and older. Beginning in fall 2019, children aged 2 ½ and older will be involved in on-the-land programming. Keepers of the Circle is a critical resource for Indigenous families living in an urban setting, especially for those living away from their communities. It is also important for non-Indigenous families who choose to access childcare services at Keepers of the Circle, in part because of our program approach and in part because of our policy around inclusiveness that endeavours to "leave no one behind." Both sites have environments that are welcoming and where Indigeneity is visible. These are smudge-friendly spaces and the smudge table is open to everyone at any time. The sound of the drum is in harmony with Grandmother Marilyn's voice as she sings with the children in the classrooms. Nookomis[26] Roberta shares the Ojibwe language with the children and their families in the outdoor learning space.

Although the two Keepers of the Circle Centres are located at separate sites, they operate under the umbrella of the Temiskaming Native Women's Support Group and are part of a larger collective that serves as an Indigenous Hub. Keepers of the Circle is guided by a council of Wisdom Keepers, with members from each First Nation in the territory, and the Temiskaming Métis Community Council. The Wisdom Keepers led the development of an Indigenous-specific plan for the delivery of early learning, family support and childcare services in the District of Temiskaming. Their visionary perspective, outlined in "The Journey Together: The District of Temiskaming Indigenous Community Hubs"[27] report in 2017 revealed that Indigenous languages, local Indigenous Traditional

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[25] Keith Basso, *Wisdom Sits in Places: Landscape and Language among the Western Apache* (Albuquerque, New Mexico: University of New Mexico, 1996).

[26] "Nookomis" is an Ojibwe word that means "grandmother." We use both words here because that is how the people have asked others to address them.

[27] "The Journey Together: The District of Temiskaming Indigenous Community Hubs," 2017.

Knowledge and cultural practices, an outdoor learning environment, and involving everyone from the community in creating a learning environment are all essential to the healthy development and inclusion of all children. "The Elders" Council stresses the importance of engaging local Elders and cultural teachers in service delivery because they alone understand the history, customs and tribal relationships in the territory."[28] Following the Journey Together report, Keepers of the Circle has worked diligently to implement the findings by transforming our spaces and programming models to include on-the-land learning options so that Indigenous peoples, including children, could feel a greater sense of belonging.

This environmental and programming shift within the organization informed decisions and newly implemented practices in early learning, family support and childcare programming. The IECSS project presented us with an opportunity to evaluate the impact of those changes in relation to identifying and addressing one or more major barriers children with disabilities face in accessing our services; we selected on-the-land programming and its effect on behaviours that are perceived to be negative or problematic as the most pressing. As frontline and highly experienced child educators, staff know these perceived behaviours are the primary reason Indigenous children are being excluded from childcare settings. The comprehensive and child-led interventions contained in this report are important additions to the focus of this research project. These responsive interventions included changes to the physical spaces within the centres and, most importantly, a fully instituted On-the-Land Learning Program that began in May 2019.

Problem Identification and Strategy Description

On May 18, 2019, Keepers of the Circle hosted an agency-wide consultation led by Wisdom Keepers, on the inclusion of children with disabilities in Kirkland Lake. This meeting was a response to the experiential knowledge that Indigenous children, whether they are diagnosed with a disability or not, are often excluded from school and other learning settings. This meeting brought together Wisdom Keepers, management, early-childhood educators (ECEs), parents, and grandparents to discuss this issue, and to look for solutions that could be incorporated into the operations of the early-learning, family support and childcare programming.

Issues

Findings from this consultation highlighted the disconnected nature of services that are available for children experiencing learning disabilities and/or behavioural issues. Participants noted these additional issues:

- There is no single plan for children
- Plans are cookie-cutter and are not shared with the ECEs
- There is over-reliance on professionals
- Parents who are just learning about a diagnosis and young parents looking for a cure rely on professionals to tell them what to do
- Poverty and low income contribute to misdiagnosis

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[28] "The Journey Together," 2017.

- There is a lack of resources/transportation to get children to therapy
- Parents always sense that they are being judged in public or are asked to leave public spaces
- Parents sometimes feel alone and confused
- Parents who need respite care are required to enter into an agreement with CAS
- Intervention plans often focus on making children comply with what is accepted as “normal” behaviour within society
- The system creates children who are isolated
- Children with disabilities are not often seen “out and about”
- Society thinks that a child should be perfect
- Children on the Autism Spectrum are powerful and attuned and should be recognized as very smart.

Solutions

- Community-based supports are needed
- Children should have access to on-the-land programming
- Provide regular access to outdoor spaces
- What you really need is parenting skills
- Unconditional love
- Need to accommodate children
- More funds to finance equipment to support children with disabilities
- Care providers need to build a relationship and trust with the parents, not be judgmental
- Value differences—let them be
- Everyone has a place and we have to support them in finding it
- Stay away from labels
- Provide respite programming
- One-on-one support and special-needs teachers
- Have safe spaces in public places for children and fidget boxes
- Have somebody on-site and on staff to accommodate children with special needs rather than outsourcing to professionals who are seldom available.

This consultation added guidance for the interventions already used in the early learning, family support and childcare programming.
Importantly, Keepers of the Circle is grounded in a model of inclusion, cultural safety and Indigenous traditions. Its Mission Statement reflects these tenets:

> …We support public education and advocacy, the revitalization of our languages for culture, the elimination of all forms of oppression and genocide, the attainment of self-sufficiency and the protection of Mother Earth for future generations…

The Inclusion of people with disabilities is informed by Indigenous perspectives on the term “disability.” Some Indigenous communities consider people with disabilities as having special gifts or powers which enable them to communicate with the spiritual world.[29] That positioning places high value on the inclusion of and respect for people with disabilities. While many Indigenous communities embrace the definition described by the social model of disability, there is an overriding belief in collective responsibility for the wellbeing of the whole. By including the community collective within our understanding of disability, we conclude that inclusion and honouring are the foci for action. These actions are premised on, as will be shown here, the importance of cultural, emotional, mental, social and spiritual wellness for children.

Implementation Process: Temiskaming Shores Intervention: On-the-Land Learning Program

On-the land learning has been a main focus of programming in 2018–2019. This nature-based learning environment is natural to Indigenous people. It is a holistic approach to learning, one involving all five senses while in the presence of Mother Earth. Keepers of The Circle Centres are continually working to create such an environment for the children to explore, learn and grow in. Starting in 2018, the coordinator of the early learning and childcare programs visited different forest schools with the Quality Assurance Advisor from the District of Temiskaming Social Services Administration Board. The knowledge they gained was shared with the childcare supervisors at each site and the staff. This knowledge was instrumental in creating a plan to institute our own land-based learning program.

Starting in May 2018 and continuing until the end of October, the children (ages 4 to 12) explored the community of Temiskaming Shores until they found an area they wanted to investigate more closely. Small groups of children visited their space several times a week. The children began to build their own community, developing a sense of ownership of and pride in their space. The curiosity that was sparked on the land was brought back to the indoor classroom. When learning occurs in a natural way it allows for the flow of continual scaffolding knowledge in such a way that the children are not even aware they are being taught. When children feel trusted, capable, and competent they expand their learning scope.

With the change of season came changes in the program schedule. In the fall, Hopi Martin from the Martin Clan generously shared his experience in learning about his Indigenous roots later in life. Having grown up in the Western world with linear concepts, he had wonderful input on how we, as non-Indigenous staff, can change our way of thinking to that of a circular, holistic way. He honoured the staff with the gift of sharing the knowledge his Auntie gave him about his Anishinabek traditions and teachings.

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[29] Rudy Wiebe and Yvonne Johnson, *Stolen Life: The Journey of a Cree Woman* (Toronto: A. Knopf, 1998), 423.

The playground became the learning environment. The children enjoyed building forts and shelters, and were introduced to different shelters for winter weather. The children's time outdoors was then increased, allowing for longer periods of uninterrupted play.
In May of 2019, it was decided that the location for the On-the-Land Learning in Temiskaming Shores would be a site close to the location of the Indigenous Health Team, Mino M'shki-ki. As it is necessary to involve all community members in the On-the-Land Learning, it was thought to be an ideal spot. Wisdom Keepers Liliane Ethier and her husband George, as well as Grandmother Marilyn, are members of the health team and they participated in the On-the Land Learning programming. A second location on Dorothy Lake, a beautiful spot with a variety of rural terrain and access to water, is also used for On-the-Land Learning.

Children attend the On-the-Land Learning program a minimum of three days a week. While on the land they are free to explore and learn at their own levels. Culture is embedded in the program through the use of language, customs, and teachings. Upon arriving on the land, the children offer tobacco to Mother Earth, say their morning prayer and smudge, bringing positive thoughts and energy to their space and spirits. The families' response to the program has been very positive. Two children who were not attending childcare this summer because the families felt it no longer met their needs returned after hearing about their younger sibling's experiences with the On-the-Land program.

Outcomes. While on the land, there is a strong sense of belonging and engagement with the children. The children's well-being grew stronger and they gained a better understanding of their abilities and existing knowledge. A strong sense of autonomy, self-confidence and pride was being sparked within the children's spirts. As the medicine wheel teaches, it is important to engage in all aspects of ourselves—the physical, spiritual, emotional, and intellectual. The On-the-Land Learning Program supports this holistic model of learning.

Intervention: Bringing the Outdoors Indoors

Staff made the decision to rearrange the rooms in the Kirkland Lake centres to see if the behaviours of children attending programs would change. Aspects of this change included replacing the overhead fluorescent lighting with lamps that provided more natural and softer lighting. Rooms were decluttered and rearranged to have an "open concept" flow. Brightly coloured furniture was replaced by pieces with natural tones. Prior to this change some children refused to co-operate and follow routine schedules. One child would start to run around the room, throw toys, spit on the tables and hit his friends. As the educators worked with this child, the other children would get worked up and follow his lead by running away from the educators. Childcare staff observed that transition times were difficult and some children used biting and hitting as their way to deal with issues or frustrations instead of using their words.

Outcomes. Staff observed that children were calmer and more engaged in activities in the new environment. There is less running around and fewer acting-out behaviours. While some children are still busy, the group as a whole is not following or participating in the disruptive behaviour. (Previously, it was observed that when one child was showing undesirable behaviours many others would often follow that child's lead, and the room would become chaotic.)

Intervention: Drumming

Staff included drumming every morning at the centre and the On-the-Land program co-ordinator led this practice. If Grandmother Marilyn was at the centre, she led the drumming. The children took the lead on the timeline of the drumming activity. Staff observed that if the children were very involved, they participated in drumming for an hour to an hour and a half. Drumming was also done in the halls as the children moved to other classrooms. The co-ordinator visited each room, singing songs in the Indigenous language.

The coordinator also did a morning smudge around 9:30 a.m. and the children were invited to join in. Smudge was also brought to different rooms at the beginning of the day.

Outcomes. It is noticeable that when the children hear the drum, they are drawn towards it. Any conflict or undesired behaviour stops and the drumming becomes the children's focus. The children show respect for the drum and wait patiently for their turn to play it.

Intervention: One-on-One Care

Staff observed that children who are provided individual care feel like they have some control over their situation. When children were overstimulated or showed an undesired behaviour, the supervisor would take the child from the environment, go outside or walk around with him or her in a quieter environment; the child was given the opportunity to express how he or she was feeling and staff would discuss with the child more appropriate options for next time. This was not used as a punishment or discipline, but as a method to help the child self-regulate and gain an understanding of their emotions.

Outcomes. Children appeared to be more in touch with their emotions and were able to name them. The children learned to stop and think before reacting. Over time there was no longer a need to leave the room—a simple conversation sufficed.

Intervention: Resource and Behaviour Consultants

Typical practice is for the behaviour consultant to observe a child in the classroom and create a plan for the educators to follow specific to that one child. The educators were not necessarily present for the observation plan nor did they have any input into the plan. The supervisor requested that the behaviour consultant's observation/plan be shared, and that educators be more involved in planning. This intervention led to a more holistic approach to programming and was central to the physical changes to room settings (see above). This intervention has supported a better understanding of the child as the educators have a longer-term relationship with him or her than the behaviour consultants do.

Outcomes. Instead of creating a plan for one child in the hope that they change, a more global perspective on change was adopted. Refocusing how to institute change—away from an individual child, to the physical environment—has created a plan that meets the needs of many children, not just one. It has been very effective; including the educators in the plan promotes better support for the children. No one is the "expert" and this approach encourages team-based solutions.

Next Steps

The On-the-Land learning coordinator, alongside the Wisdom Keepers, is working on creating a curriculum rich in Indigenous traditions, teachings and language that will be presented in a holistic way so the children can be themselves while learning who they are and where they come from. The curriculum will be based on the seasonal teachings and moon phases.

Children will be introduced to different tools to be used while on the land. Community feasts will be celebrated during seasonal solstices. Children will begin to cook over the open fire while on the land; the length of time on the land will increase so that eventually the children will enjoy their naptimes in the fresh air. In September 2019, the children in the toddler, preschool and Early Learning School Readiness programs will be attending On-the -Land programming.

Implementation Process: Kirkland Lake

Intervention: On-the-Land Learning Program

Staff at the Kirkland Lake centre have taken the school-age children to Dorothy Lake for about two hours a day three times per week. Some trips have been with a group of four children and other trips have been with the whole group (from ten to 17 children).

Nookomis Roberta has accompanied the group on some of the trips and shared an Indigenous perspective of the land. She guided everyone through opening circles, drumming and singing, giving thanks, harvesting medicines, and teaching about the nature all around us.

Once at Dorothy Lake, staff and children gathered and started with an opening circle allowing everyone to state their intention for the day. The children established their own boundaries and came up with some ground rules. Starting in a familiar place each time allowed the children to become comfortable in their surroundings and the space became their own.

After the opening circle, the children were encouraged to explore the space in their own way and at their own pace. They did this in a variety of ways: they built structures, took walks, played freeze tag, listened to the wind rustling through the trees, and even caught dragonflies. The educators followed the children's lead, supporting them as needed.

When it was time to wrap things up, the group gathered at the home base and they had a closing circle. Each child was encouraged to talk about something they were thankful for. The children named a few different things like the animals, the songs they sang, and the nice weather. An important observation is that one child commented on how everyone had a good time and "there was no fighting."

Outcomes. Staff observed a reduction in negative behaviours such as conflict, throwing toys, yelling, and so on. Also notable was the calmer/quieter room after lunch (when the younger children are napping). There appeared to be an increase in the children's confidence (such as taking on tasks they might not normally take on), and reflective thinking (commenting on how the day was going, observing that "everyone is happy and there is no fighting").

There is also a noticeable increase in co-operative and collaborative play (working together to build structures, carry large logs, and search for blueberry leaves). Children looked out for one another (reminding each other of the boundaries; using the group call, "Caa! Caa!" to call their friends back when they can't see them), and demonstrations of empathy (showing concern when someone was hurt).

Children also exhibited increased ownership and stewardship of the space by talking about how to ensure their structures are safe so they can play with them the next time they come, laying food waste by a tree with some tobacco for the creatures on the land, and helping teachers remove garbage from the area.

Intervention: One-on-One Care

When children were overwhelmed by or struggling with the classroom environment, a staff member took them out of the classroom to give them time to regain control of themselves. The supervisor's office, where there was a basket of fidget toys, a book, and some other items to take the children's mind off what was happening in the room, was used for this purpose.

Children were guided to focus on being calm and were provided with positive responses. This time was framed as an opportunity to take a break from the classroom, not as a punishment. If there had been behaviour that was unsafe (such as throwing objects or hitting others), the staff person explored with the child the idea of them not feeling safe and the goal of ensuring their safety.

Sometimes the office was too confining a space or the things in the office were too distracting. When this became apparent, the staff member headed outside with the child, where the child had more space to work out the feelings in his or her body.

This was a child-led exercise. If children needed to run or jump, they were encouraged to do so. When one child chose to go outside and began jumping in a mud puddle, staff commented that he really liked the mud puddle, and he continued to jump and enjoy himself. He found several mud puddles and staff encouraged him to describe how they were different.

Following the child's lead also meant waiting for them to be ready to return to the classroom. Staff avoided bringing a child back indoors before they showed that they were calm, and they waited for the child to say that they would like to go back to the room. If they had not initiated going back to the room, staff asked if they were ready to go back. If they said they were not, staff spent more one-on-one time outside with the child.

Importantly, there was very little discussion about the behaviour in the classroom; staff wanted the focus to be on the child's positive attributes. Instead, the child led the discussion. If the child was angry or frustrated, staff helped them to explore those feelings by saying, for example, "'When Sally took your toy, it made you feel angry. How does your body feel when you are angry?" This allowed the child to know that it was all right to feel the way they feel.

However, the child did need to stay safe. So, if the child did something that was unsafe, staff were firm and explained the consequences of their actions and stuck to those consequences. Consistency and reliability were important.

Outcomes. The children enjoyed having some positive one-on-one time and talked about the things they had done together with the staff. One child came to the school-age room with a staff member and watched her clean our toad tank. Later that day, he said, "Remember when we cleaned the toads?"

The children built positive relationships with the person who was working one-on-one with them. They responded in positive ways when that person entered the room. They were not afraid because they were not being punished.

Staff observed that the children learned to self-regulate. When they were given opportunities to remove themselves from negative situations and shown strategies/tools to mitigate their feelings, they began to make positive choices about how to deal with things that upset them. They asked for an object that made them feel calm or looked for an educator with whom they felt comfortable.

Because the staff focused on the positive interactions, the children were able to see good things about themselves. They felt proud because they helped clean up a mess, or happy because they got to jump in the puddle. When a staff member took two school-age girls outside to run off some energy, they began rolling some tires around to make an obstacle course. One of the girls was proud because she found a bigger tire and could roll it.

Staff see a sense of independence developing in the children as a result of the on-the-land programming. The girl who was proud of her big tire also practiced some independence. The other girl wanted to help her, but she said, “No, don’t help. I can do it!” Sometimes just being able to try something on their own made a big difference in their behaviour because it built their confidence in themselves. Instead of thinking about what they did wrong, they focused on what they were doing right.

Recommendations

- Governments must invest in and support the development of Indigenous On-the-Land Learning Programs and Indigenous culture and language programs in Indigenous-led organizations.

- Governments must recognize that outdoor learning is the natural learning environment for Indigenous children. Indoor classroom learning that isolates Indigenous children from the community and the land is not the norm and, in fact, is detrimental to learning for Indigenous children.

  > “We need to teach on the land; maybe have a land base in the bush. Teach the children where we came from so that they don’t get lost in the system. We have our own classroom.”[30]

- Governments must support the inclusion of Indigenous knowledge and methodologies when evaluating Indigenous programs.

- Governments must commit to invest in and support Indigenous-led On-the-Land programs, and not replace Indigenous knowledge with a colonial framework that is found in programs such as those using the Forest School method.

- Governments need to understand the size of the district and population that is spread over a wide area and provide resources to hire more behaviour facilitators. For example, there are only two behaviour facilitators for an area between the towns of Haileybury and Kirkland Lake (which are 90 kilometres away from each other). The facilitators service all childcare centres and home childcares in this large area. At the New Liskeard LC alone, as of August 2019, there are five children using the services of the behaviour facilitator. From June until the end of August there was only one behavior facilitator.

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[30] “The Journey Together,” 45.

- Fund to hire more resource consultants. In the District of Temiskaming there is a long wait-list for the resource consultants who offer speech and language therapies. Staff at the Learning Centres (LCs) report that children in need of these services do not receive them until they are in the provincial school system.

- Provide behaviour and resource services to children who do not attend licensed childcare centres. When parents are unemployed (which is not uncommon in small towns throughout the district), and children do not attend childcare, the child's special needs might not be diagnosed and serviced.

- Provide more outreach services for families who do not regularly access the LCs. The local health unit has a Healthy Baby program and its goal is to stay in touch with new parents and children to offer support and address any concerns they may have. The health unit sends out screening resources but with no explanation of the purpose of the screening. Parents are left to figure things out on their own. This a gap in services for vulnerable families.

- Cut wait-lists and provide regular access to specialists such as pediatricians or psychiatrists, as these are clinicians who have the authority to make a diagnosis for a child, and a diagnosis is necessary in order to access services. The Temiskaming District does not have regular access to these specialists, who only travel to the area a few times a year. For example, if the parents do not have a referral from a doctor to test for a learning disability, the parents need to arrange for testing on their own and cover the cost. This is a barrier for families living in poverty.

> *"Mental health is something I feel is neglected in childcare services. It seems that the focus is on the symptoms such as undesired behaviour or low testing scores in the schools. There is not enough focus on the actual issue. Children need to be taught coping skills. Many of the children in our care come from foster homes. They did not learn many skills necessary to be successful in social settings and when one is not socially accepted, they become labelled or ignored. I believe the true issue is being ignored. Disciplining a child for not understanding the way society expects him/her to behave does not help. The child only knows what he/she has been shown; it is up to us to teach them. The trauma that occurs when a child is taken from all they know and placed in an unfamiliar home with people they do not know can be devastating. It breaks my heart to see these little ones try to hold onto some control of their lives. All those emotions need to be dealt with, but not with high expectations or discipline but with understanding and patience. The one-on-one care from a social worker or child-and-youth worker is needed—*

> *not a group setting but one-on-one, helping that child make some sense of what is happening. Allowing them to feel and act out in a safe way. Build their confidence and self-esteem so they can be successful. This would be my priority if money was no object. We focus too much on cognitive development and not on social and emotional. A child who believes in him/herself will take risks and be open to more opportunities, thus more successful."*
>
> Lisa Sloane, RECE, Site Supervisor
> Keepers of the Circle, New Liskeard

- Streamline service provision. If a child has a resource plan in place, then this plan should continue once they transition to the provincial school system. Currently, behaviour and resource services and plans that are in place for children enrolled in the childcare centre end once the child enters school. Once the child is in school, families must apply for specialized services and are often put on wait-lists—again. Unfortunately, many parents are not aware of this process and thus the child loses out on services and gets further behind.

- Embed comprehensive services for children and families in childcare centres. Staff support the concept that capacity within childcare centres should be developed so that specialized supports and services specific to individual children, families and communities can be provided as regular programming within centres. Currently, supports and services for children are outsourced to programs that have a wide-reaching territory of service. This means that these supports and services are only available to the children for one to two hours per week, when the resource/behaviour consultants have scheduled time with the child.

    - If every centre had its own supports and services program, they could ensure that each child could access the supports and services they need when they need them. The supports and services could be tailored to the children, families, and communities accessing the programs. The support staff would be able to get a truer picture of the needs of the educators, children, and families because they would see everyone daily.

    - Having a supports and services program in the centre would also allow much more preventative care to take place. Supports such as one-on-one care could be used not only when a child has become overwhelmed but just as a regular part of the day. The support staff could take time to work with any of the children individually and build a strong, supportive relationship with them.

> *"If money was no object, I would create this sort of program in our centre. I would hire child advocates that would observe the children and the program; develop a*

program plan and individualized child plans; support the educators to implement the plans; provide supports such as one-on-one care and activities targeted to support particular skills; advocate for additional services for children; coordinate services and meetings; provide resources to parents, educators and families; and facilitate the transition from childcare to school."

Ronda Guenette, RECE, Site Supervisor
Keepers of the Circle, Kirkland Lake

Chapter 6

Comox Valley Child Development Association: Comox Valley, British Columbia

By: Joanne Schroeder, Angie DeJersey, Kathy Cruickshank and Laura Feltham

Problem Identification and Strategy Description

The preliminary findings from the IECSS project show that families often interact with many professionals within organizations and during referral processes. One consequence of having contact with multiple professionals is that families are asked to share their story multiple times and develop relationships with many people. At each of these interactions, families are asked to do more work and become vulnerable to new professionals.

The Comox Valley Child Development Association (CVCDA) is a multi-service agency providing services to children with diverse needs and to their families. One of the CVCDA's programs is Supported Child Development (SCD), whose mandate is to support the inclusion of all children, regardless of need, in regular childcare settings through consultation support for families and centre staff, and by providing extra staffing when needed. Some SCD funding is focused specifically on supporting Indigenous children and there is one staff member who leads the Indigenous programming. The activity that the CVCDA implemented as part of the IECSS in Action project was to have that staff member on-site at the local Aboriginal Head Start program one full day a week to facilitate access to the children, their families, and the centre's staff.

The on-site consultant directly supports one of the Inclusive Early Childhood Service System (IECSS) project's findings: "Individual programs may be inclusive, but most families who have children with disabilities are clients of or participants in multiple services. Inclusion beyond single programs across the spectrum of services is rare." Having the staff member on-site at the Head Start program gives her more opportunities to build relationships with both centre staff and families. Specifically, it allows family members to meet the staff member in a less formal setting and for the staff member to reach out to people "where they are" rather than have families attend an additional appointment at an alternate facility. For many families involved in the program, their experiences with service providers has not been entirely positive and in some cases it is necessary to gain their trust more slowly. An added benefit to having the staff member on site at Head Start is that she can also complete the intake process to other needed services and facilitate communication between active service providers, which all facilitates inclusion across programs and lessens the load on families.

"Accessing disability supports and services is a lot of work for families" was another of the IECSS project's findings that the CVCDA felt its on-site consultant addressed. As previously mentioned, when families are repeatedly asked to share their personal lives with various professionals, this contributes to the work they are being asked to do. Reducing the number of relationships that need to be built with professionals is a way of reducing families' workload and the accompanying stress.

The team at the CVCDA discussed a third finding when reviewing the IECSS project's report: "The system of services for young disabled children is predicated on a medical model, which makes diagnosis or designation of disability central to how the system works. This approach is not consistent with many cultural viewpoints regarding disability and is used as a gatekeeper for services that may be central to inclusion and quality of early learning and childcare for children with disabilities." The CVCDA has an organization-wide commitment to making services accessible to children and families from all cultures and minimize the need for diagnoses as a requirement to receive services when they can. While this is a system-wide challenge, this initiative did address this finding in a limited way. Being on location at the centre allows the staff member to provide specialized support to all of the children who are in the program, regardless of their diagnosis or referral status. Being on site makes it easier for this staff member to support children themselves and to consult with other staff members, increasing their capacity to support child as well.

Method and Procedures

The goal of moving the frontline staff member into the Aboriginal Head Start program one day a week was to facilitate better communication between the CVCDA staff and centre staff, and to facilitate relationship-building and access for families. A focus group (conducted in June 2019) was used as an evaluation technique to discuss with staff at the centre their thoughts on having the SCD consultant on-site at the Head Start program part time and if they had felt that this supported a change in their relationship. The focus group was used to have an open discussion about the communication and relationship-building between the staff, with this goal of addressing the IECSS finding that "Individual programs may be inclusive, but most families who have children with disabilities are clients of or participants in multiple services. Inclusion beyond single programs across the spectrum of services is rare." The focus group also discussed if having a staff member in the Head Start facility helped to facilitate better inclusion among services and programs for both staff and families. Focus groups were used to evaluate the program as they allowed multiple staff members to share together, letting staff discuss issues and share observations and ideas in an open-ended and flexible manner.[31]

The additional activity of having the SCD consultant conduct the intake process was intended to build relationships with families and reduce the number of professionals with whom they have to interact and share their stories, to ameliorate the IECSS finding that "accessing disability supports and services is a lot of work for families." To evaluate if the program moved towards reaching this goal the consultant asked families how they felt about the staff member leading the Indigenous programming being on-site at Head Start and providing the option for them to access other services through this office. To evaluate the program the on-site staff focused on opening the conversation with families about what they feel is going well in the program and how they would like things to possibly change. The frontline staff documented the families' responses in a journal. Staff also self-reflected and noted how they felt the overall strength of their relationships with

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[31] Katherine E. Ryan, Tysza Gandha, Michael J. Culbertson, and Crystal Carlson. "Focus Group Evidence: Implications for Design and Analysis." *American Journal of Evaluation* 35, no. 3 (2014).

families was impacted. The collaboration between families and staff in the self-evaluation of the project takes up an action research approach to evaluation..[32]

Outcomes

Findings both from the focus group and the family inquiries suggested overall that having the SCD consultant's office in the Head Start centre facilitated both access to needed services and the effectiveness of the child's inclusion within the Head Start program. Feedback from staff and families in the evaluation of this program change found that having the SCD consultant at the Head Start centre made it easier to provide families with information about other services they were interested in accessing or had been referred to. Being able to provide families with information about other services also supported inclusion among services, which was a goal of implementing this program change.

Developing the relationship between the SCD consultant and the Head Start staff was further facilitated by having the SCD consultant on site. The Head Start staff reported that they used more resources and tools/activities provided by the SCD consultant since they had the opportunity to communicate and receive continual feedback on their progress. Collaboration with the Head Start family networker enabled an integrated intake for the family both to Head Start and CDA services. This collaboration also allowed families who were being introduced to CDA services to ask questions on site at the Head Start centre and to put a face to who they were being referred to at CDA.

"Relationship-building" was a theme that emerged from the evaluation, both from families and the Head Start staff. Communication with families and staff was improved overall. If staff or families had questions for the SCD consultant, they could often be answered immediately as opposed to having to wait until the next time the SCD consultant visited the Head Start centre. More frequent communication supported relationship-building with staff and families. It was also noted that new staff built relationships with the SDC consultant much more quickly; it was felt that this was a result of having more opportunities to communicate in person.

The SCD consultant was able to support families more holistically, supporting families with issues that extended beyond directly participating in a program. These included home issues, family trauma, issues with other children in the families, and so on. The setting promoted a family-centered approach to service-providing that also promoted more cultural safety for families. Having the opportunity to build relationships and trust with families led to learning about other needs of families and supports. Having this knowledge gave opportunities for the SCD consultant to direct families to resources within the community to help support their identified family needs.

Recommendations

When governments fund new childcare spaces, structural considerations need to be

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[32] Lorelei Lingard, Mathieu Albert, and Wendy Levinson. "Grounded Theory, Mixed Methods, and Action Research." *Bmj* 337, no. aug07 3 (2008).

addressed in order to ensure that every childcare space is prepared to include any child. These structural considerations include the physical accessibility, staffing, and hours of operation.

This program evaluation confirmed the importance of thinking systemically about inclusion, which is not just about the child, but about their family, their culture, and the staff providing services. Inclusion is facilitated when the interactions among specialized services, families, childcare staff, and the child are open and welcoming.

It is recommended that all childcare spaces have inclusion consultation on site at least part time and that the inclusion consultant be closely linked to other specialized services, enabling easy access to other required services—specifically, so that the inclusion consultant can provide integrated intake to other specialized services within the childcare setting. This reduces the burden for families in accessing multiple services.

For Indigenous children in particular, it is important to have inclusive childcare offered in a program such as Head Start, which is more broadly culturally aware and tailored to the cultural context of the children and their families. Within that context, having an inclusion consultant who is also culturally aware is also important.
Due to the shortage of qualified personnel and the low wages within the sector, keeping childcare staff is always a challenge. One benefit of having the inclusion consultant on site is that it enables continuous learning and adaptation of programming with all staff as well as the building of stronger relationships.

Potentially, the biggest challenge these recommendations face is the availability of resources. Having the staff member on-site at the Head Start program recognizes the importance of taking time in building relationships between the inclusion consultant, childcare staff, families and children. Particularly for families who may have had difficult interactions with services, it takes longer to build trusting relationships. This means that the consultant is able to support fewer families at one time and requires additional resources so that wait lists can be minimized.

1. If money were no object, what would you invest in first to support inclusive practice?

The first areas to invest in to support inclusive practices in the early years is staff. Staff have a large responsibility for supporting inclusive practices but often are not supported or equipped to create inclusive environments. Supporting inclusive practices entails having staff who are qualified and appropriately educated to apply a family-centered inclusive lens to early-years education and support. It also includes having professional development opportunities for staff throughout their careers to enrich their practice in the field. These professional development opportunities should not be an onerous add-on but treated as part of their job, with time allotted and paid for through their salary. Having centre-based training that continues throughout staff’s careers supports context-specific growth and embeds inclusive practices in lifelong training to support inclusion.

One of the main points made repeatedly in the program evaluation was the importance of relationship-building to support inclusive practices. Building relationships is something that takes time and trust. If we want professionally trained staff to stay in the early childhood field and to decrease burnout, it is important to create optimal working conditions for them, including salaries, benefits, and professional development opportunities that are appropriate for these challenging positions and that reflect their education, knowledge and experience. With lower burnout and optimal working conditions they can stay in positions for longer periods of time which gives families the opportunity to build relationships with them; less staff turnover due to poor working conditions leads to the building of relationships that support inclusive practices.

Such relationship-building takes time and that time should to be considered work. When staff have the opportunity to build relationships with each other there can be more opportunities for them to share inclusive practices with each other and share situations where they need more support. When various professionals spend more time face-to-face they can have more conversations about new policies or programs being implemented. When staff can model inclusive practices from within it sets up a better foundation for them to support inclusion of families.

For financial purposes most early-years settings operate with the fewest staff allowed while still maintaining staff-to-child ratio. However, this staffing does not support relationship-building. If the minimum number of staff are on a childcare floor it can become challenging for staff to have in-depth conversations with families and also be present and active on the childcare floor. Having the financial support to have enhanced ratios would help to support opportunities for relationship-building. CDA also suggested updating and refreshing resources to have materials for both staff and families. When new information is released, having it easily accessible to staff and families reduces their amount of work.

2. What is the greatest barrier to the full participation of young children with disabilities in the early-years sector?

One of the barriers to full participation of young children with disabilities in the early-years sector is the lack of availability of spaces, and therefore long wait lists. When families are told that early intervention is important and/or necessary for their child but are also told that they may have to wait years for program spaces to become available it can often cause family stress. The cost of programs is often a barrier for families, which can particularly affect families with a young child with a disability that may be paying for other services on top of childcare or recreational programs. We felt that staff need to be the first thing to be invested in to support inclusion; not having properly staffed programs (which includes appropriate compensation for the staff’s work) is a current barrier to supporting inclusion.

The geographic and cultural contexts in which the programs take place both have an impact on the barriers to program participation that exist for families. Times and locations of programs that are being offered can create barriers for families, for example.

Daytime programming can be a barrier for parents and caregivers that work full time during the day, leading to them either missing a program or taking time off work to attend, which can impact the family's income. Transportation can be another large barrier for many families. Childcare availability in general can be challenging, and for families needing childcare during non-traditional work hours it can be an even greater challenge. When creating programs that truly aim to support the widest variety of families, it is necessary to take their diversity into consideration to support participation.

Public transit is something that varies greatly from community to community. Comox Valley's public transportation system is a barrier to attending programs for some families. Having local programs and taking into consideration how families may commute to programs is important when thinking about how to support full participation and inclusion for all families. It is necessary to understand the contextual barriers that exist for families; program planning must take into consideration who the program is intended for and what barriers to participation they may face.

Chapter 7

Gerrard Resource Centre: Toronto, Ontario

by: Catherine Moher and Laura Feltham

Problem Identification

Accessing childcare is a problem plaguing many families in Canada. Childcare 'deserts' throughout the country—areas where the number of children needing childcare far outweigh the supply of childcare spaces available in that community[33]—make it extremely challenging for families to find childcare.[34] However, lack of availability is often not the only barrier that families face when searching for childcare. Affordability is another factor that affects families' ability to access childcare. Even if families are fortunate enough to secure it, increasing fees make childcare an unfeasible option for many families.[35] Many families currently rely on a patchwork of care for their children.[36] Families who may need short-term childcare outside of the traditional childcare system to address emergency issues have limited or no options available to them to help support them in these situations.

Families who need short-term childcare to attend medical, legal or housing appointments also face obstacles, and families who have children with disabilities can face even greater challenges. The number of appointments for both caregivers and children may increase when a child has a disability. The staff at the Gerrard Resource Centre (GRC) have long recognized the need for emergency and respite childcare to support all families but particularly recognize that families who have a child with a disability may have more situations when emergency childcare is needed. The GRC supports families as a whole and knows that families may need childcare for a variety of reasons, including emergency childcare for siblings while parents are attending appointments with their child with a disability, visiting specialists or service providers, attending school meetings, and so on.

Strategy Description

Method

The GRC's Emergency Child Care program was designed to support parents who need time to address emergencies, attend legal, housing, or health-related appointments or are in need of parent relief. Emergency Child Care is available to all families for children from birth to 6 years old, Monday to Friday from 9:00 a.m. to 1:00 p.m. There are no fees for this program; donations are gratefully accepted.

The Inclusive Early Childhood Services System (IECSS) project found that accessing disability supports and services is a lot of work for families. The Emergency Child Care program is a direct service designed to help reduce the stress and some of the workload for families, including by addressing issues related to their child's disability. The

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[33] David Macdonald, "Child care deserts in Canada," Canadian Centre for Policy Alternatives, 2018.

[34] Ibid.

[35] David Macdonald and Martha Friendly, "Developmental milestones: Child care fees in Canada's big cities 2018," Canadian Centre for Policy Alternatives, 2019.

[36] Rhonda Breitkreuz, Kerryn Colen, and Rebecca Horne, "Producing the Patchwork: the Hidden Work of Mothers in Organizing Child Care," *Journal of Family Studies*, 26 June 2019.

Emergency Child Care program provides care for other siblings while parents take a child with disabilities to appointments, attend personal appointments, or receive parent relief. This service acknowledges the workload, including numerous appointments, as well as the additional stress placed on these parents.

The IECSS project also found that "individual programs may be inclusive, but most families who have children with disabilities are clients of or participants in multiple services. Inclusion beyond single programs across the spectrum of services is rare". Programs can aim to create an environment that welcomes all children and families, creating equitable care, however, for families accessing multiple services, this approach may not exist in more than one program or service. The Emergency Child Care program staff committed to taking note if families share other services or programs and support families' connection to other services through a system of "warm referral," a term used by human service organizations to refer to the act of making a relational referral or connection to a supportive organization and/or individual by giving the family or individual a specific contact.[37] The "warm referral" method aims to create opportunities to support families in gaining entry into other services or programs they are interested in accessing by increasing communication, and working together to reduce the workload on families.

Procedures

The Gerrard Resource Centre has been offering emergency childcare for families with children from birth to 6 years old for over 30 years as part of its menu of family-support services. This program has offered a flexible model of childcare to families for a variety of reasons. Families have used this program to attend legal, housing, medical and health-related appointments, to study, to seek employment, to work and for parent relief needed in times of stress or illness. The Government of Ontario recently announced that it would no longer fund any emergency/respite programs and funding was eliminated in 2019. The funding provided through the IECSS in Action project enabled the GRC to offer emergency childcare and support to families that have a child or children with disabilities. One of the first activities of the project was to promote this program by sharing the flyer with families, with a focus on supporting children with disabilities. At the same time, questionnaires were created so that staff could get a better understanding of the reasons families were using this service and how the Centre could better serve children with disabilities and their families. The questionnaire provided a method to discover the reasons families used the service and also a way to start a conversation with families about their service needs.

Accessing disability supports and services is a lot of work for families

One of the primary goals of the Emergency Child Care program was to reduce the amount of work and stress that families face in their efforts to use supports and services. The goal of lowering families' stress was assessed in an optional survey that was completed by families at the end of a day's visit to the program. Questionnaires were chosen as an evaluation method as they produce values that can be compared, to note if

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[37] Catherine Moher, "Putting families first: A strengths-based approach to serving families with young children," *International Journal of Birth and Parent Education*, Vol. 6, Issue 3 (2019).

change is occurring or if the goals set out by the program are being met.[38] The third question in the survey was “Were you experiencing stress before using this service? If yes, please fill out Question 4.” (The response options were ‘yes’ or ‘no’.) The fourth question asked families to rate the Emergency Child Care program’s ability to lower their overall stress level using a 5-point Likert scale where 1 was no change and 5 meant yes, there was change.

Another goal of the questionnaire was to develop a greater understanding of the reasons that families were accessing the emergency childcare program and, more specifically, if the program was supporting families that were using developmental or disability services. The optional survey question 2 asked families why they requested emergency care for their child or children. The response options included “Attending a personal appointment”; “Attending an appointment with my other child”: “Needing parent relief”; “Attending to a family emergency”; and “Other,” followed by a space for adding further information if they wished. This question enabled staff to start a conversation with families interested in sharing why they use the Emergency Child Care program. To further assess whether the goal was met an appreciative inquiry strategy was also implemented. This evaluation strategy focuses on a program’s positives as a way to start an informal conversation about families’ thoughts and feelings about that program.[39] Appreciative inquiry was used to ask families what they liked about the Emergency Child Care program. Staff kept a journal and took notes about the families’ thoughts about the program. This method was used to evaluate if families were using the program to help make accessing disability supports and services less difficult.

Outcomes

1. Assessing the use of the Emergency Child Care program by families who have a child with a disability or who are accessing disability services is a nuanced task that the IECSS in Action project discussed when deciding on an evaluation technique. It was important to our team that all families could access the childcare program and that they understood that they did not need to disclose why they were using the service. The team also understood that early in a child’s life a family may just be starting the process of coming into contact with disability or developmental services and therefore may not yet self-identify as users of these services. Children did not need to have a diagnosis to be counted in the IECSS in action project—an important point, since families can benefit from support in the form of emergency childcare no matter what stage they are at in accessing services. Having run the Emergency Child Care program for 30 years the staff also knew that families had used the program not only for the child who was accessing disability services but also for their siblings so that a caregiver and the child accessing the services could attend an appointment.. The team feels that it is important for future policy to take into account that programs that are not

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[38] John W. Creswell, *Educational Research: Planning, Conducting, and Evaluating Quantitative and Qualitative Research*, 4th ed. (Upper Saddle River, NJ: Prentice Hall, 2012).

[39] Lillian Hung, Alison Phinney, Habib Chaudhury, Paddy Rodney, Jenifer Tabamo, and Doris Bohl. “Appreciative inquiry: Bridging research and practice in a hospital setting.” *International Journal of Qualitative Methods* 17, no. 1, 2018.

specifically disability services support many families that are somewhere in the process of accessing disability services, however, it may be challenging to quantify.

2. The Emergency Child Care program offered care for 19 children during the IECSS in Action project. Three families reported having a child with a disability or developmental concern. Taking up a holistic view of supporting families, more families that were accessing disability or developmental services may have used the Emergency Child Care program than is represented in the evaluation of the program. Fifty-three percent of the families attending the program used the childcare service to attend personal appointments and 26% used the service for some parental relief. Although some of the families had a child with a disability or developmental concern, on the survey they did not indicate if their emergency childcare need was for a sibling while they attended a specialist appointment with another child. Promoting the program is an important aspect of raising families' awareness of it and of its availability to families who have a child with a disability. The short duration of this project and our ability to reach other service providers to make sure they were aware of this program was limited.

3. The staff collected surveys from the parents and also kept a journal that recorded discussions between parents and staff. The survey responses indicated that 63% of parents were stressed before using the service. 74% selected "5" on the Likert scale of 1 to 5 (where "1" indicated "No change in stress level" and "5" indicated "Yes"—that is, their stress level was lowered after using the service. Further discussions with the staff also indicated that they were very happy with the Emergency Child Care program. Through these discussions, staff found out that one of the parents needed care for a sibling while the parent took her child with developmental concerns to the hospital. The parent also used the Emergency Child Care for both children so that the parent could receive parent relief and "could have a break." Appreciative inquiry enabled staff to get a deeper understanding of the family as a whole, the specific needs of the child or children, and the services that parents were currently accessing or might need in the future.

The staff also attempted to implement a system of "warm referrals," unfortunately without success. It was noted that implementing a system of "warm referrals" requires staff time to develop rapport and connection to other service providers as well as the time to have deep conversations with the families in order to effectively address their needs. Staff reflected that relationship-building is needed to support inclusion across services.

Recommendations

Understand why a family needs care. The most common reasons that families use childcare programs include needing care for their child or children while they work full time, while they study full or part time, and/or to provide their children with early-learning and education opportunities. Most often families are required to utilize childcare spaces on a full-time basis between the hours of 7:00 a.m. and 6:00 p.m. and our current licensed childcare system meets the needs of families working or studying full time. But not all families require full-time spaces. Some parents who have chosen to stay at home or are working or studying on a part-time basis may only require childcare to go to personal appointments, specialist appointments with one of their children, to study or to receive parent relief. But the provision of childcare for a few hours a day is not an option commonly open to families, and families requesting part-time care must select a full-day option. The Emergency Child Care program at the GRC was designed to meet the needs of families requiring only part-time, occasional childcare.

Structurally, childcare programs need to consider all the reasons that families need childcare so that it can be truly flexible, accessible, and accommodate the diverse needs of our families and their children. In a flexible model of childcare, the reasons care is needed go beyond working or studying full time. Discovering the reasons that a family requests emergency childcare requires trust between parent and service provider, especially when the request is made for parent relief. A parent's fear of being judged by a service provider when he or she are in need of parent relief can occur unless the service provider is explicit that *any* request is an acceptable request. Supporting families by connecting them with other services through "warm referrals" may require more time to support parents until they decide to articulate their need for other services and programs.

Understanding the stresses that contemporary families face and their diversity, including their economic, social, cultural differences, as well as the dis/ability among family members, is needed to create places of inclusion and belonging. Developing relationships and understanding each family within a childcare or early-learning setting requires time. Many demands are placed on staff within licensed childcare settings, where the most important activity, naturally, is the care of the children. Increases in the documentation staff are required to provide has resulted in even less time to engage with families beyond urgent safety and health concerns. Whereas the focus of family support programs is two-fold, it supports the caregiver and the child or children. Inclusion can only be successful in the context of the relationships built between the service providers and whole family, including caregivers and their children A strong case can be made for the integration of family support and licensed childcare as hubs of service delivery where the family is known to the agency and the entire family feels a sense of belonging.

1. If money were no object, what would you invest in first to support inclusion practice?

Investment would include a family-support component attached to each childcare or community-based service. This could be a program such as an EarlyON Child and Family Centre or similar family support program (nationally, programs have different names), or a staff person within a community-based organization whose primary role would be to support families who have a child with a disability or other related family issues. It is important for families to have a support system. The burden is especially great for families that have a child with a disability; the knowledge that they have a support system and someone who is there with them on this journey is key to the wellbeing of the family members. A person who is there to listen to stories without judgment and to support the parents decision-making and offer both emotional and concrete support when needed can be essential.

This investment would contribute to inclusionary practices. Most inclusionary practice has naturally focused on the child or children with disabilities and on developing appropriate program plans for the child to ensure that he or she is receiving the necessary supports for optimum growth and development. However, little support is given to the family members other than a “to-do” list of appointments and activities to support their child’s growth. How many supportive services stop to ask what the families are going to need to ensure this list is followed, or how the family members are coping? All family members must feel a sense of belonging for inclusion to be successful. If a parent feels included, then by extension they will feel that their children are included. Inclusion goes beyond a program’s plans and activities—it must include the development of relationships between families and service providers, so that families feel welcomed and comfortable within the program.

Family support programs are designed to reduce isolation for families by providing emotional and concrete resources where possible. How best to reduce a family’s responsibilities can be subjective and therefore may be beyond the scope of the program, but creative problem-solving is not. Many family support programs have a “think-outside-the-box” attitude and their staff see other possibilities—in fact, the Emergency Child Care program developed from this very attitude. Staff received requests from families for short-term childcare so that they could attend to tasks such as housing or legal support meetings or personal health appointments. Accomplishing these tasks presented extra challenges for families with many children. Staff quickly recognized an unmet need that they could quickly fulfil since they were training early childhood educators and believed they could provide quality care in the context of the program. Funding cuts and government policies have stalled this creativity, unfortunately, and hindered the continuation of Emergency Child Care, which has been filling many families’ gaps in childcare.

The linkages to service providers in multiple sectors are also a component of family support programs, as is the expectation that programs will support families by making referrals to other community services. Family support staff often link families to childcare, recreational and health services and specialized services such as speech and language services. As well, some programs refer families to housing, legal and employment services. Traditionally, these have been agency-to-agency referrals. Of late, many organizations are starting to make “warm referrals” whereby families are given a personal contact known to the family support staff within another agency. This is an attempt to make the task of connecting to another agency easier and less time-consuming for the parent. The “warm referral” system requires some resources on the part of the agencies to build relationships between service providers.

2. What is the greatest barrier to full participation of children with disabilities in the early-years sector?

Barriers to full participation of children with disabilities in the early-years sectors requires acknowledgement:

- Physical barriers preventing families from fully participating. For example, lack of elevators, accessibility doorways, quiet spaces, availability of specialist equipment, etc.
- Fear of judgement by others. For example, if a family experience discomfort while participating in a program because their child is developmentally delayed, they may feel judged
- Flexibility of the program. For example, the hours of service, criteria to participate such as age vs ability, fees associated with participation, “lock in” referring to the fact that families must commit and pay for services in order to secure a space.

3. Geographic and cultural/linguistic considerations

Family-support detailed above addresses barriers to full inclusion that communities face will look different in different communities. Specific geographic and cultural considerations should be addressed when supporting inclusion for families. Our location within a diverse social, cultural, and linguistic context requires a good understanding of the diversity and the intersecting aspects of the lives of families and their children. Meeting the needs of families from diverse backgrounds and histories requires an understanding not only of cultural norms but of all the geopolitical landscape of the family’s country of origin. The family’s history and story can add further complexity beyond the disability of their child. Many families who are new to Canada are also adjusting to a new home, a new language, and new service systems. Early-years staff may need time to participate in training or at a minimum research different social and cultural norm.

The distance that families are travelling to access services is often a consideration. In the IECSS in Action project at the GRC, the majority (63%) of families travelled under one kilometre to reach services, 16% of the families travelled between one kilometre to three kilometres, and a few (21%) travelled over five kilometres. Families used different methods of transportation; some were within walking distance while others took public transit or drove to the centre. The project did not ask how they travelled to the program. Transportation to programs is something that should be considered when planning programs.

Bibliography

Basso, Keith. *Wisdom Sits in Places: Landscape and Language among the Western Apache*. Albuquerque, New Mexico: University of New Mexico, 1996.

Bancroft, Ruth, and Kathryn Underwood. “A Vision for Inclusive Childcare: From Principles to Policy. *Our Schools/Our Selves* 24, no. 4 (Summer 2015), 95–106.

Batisse, Ann and Arlene Hache, 2017. “The Journey Together: The District of Temiskaming Indigenous Community Hubs.” Kirkland Lake ON: Temiskaming Native Women’s Support Group, 2017.

Breitkreuz, Rhonda, Kerryn Colen, and Rebecca Horne, “Producing the Patchwork: the Hidden Work of Mothers in Organizing Child Care.” *Journal of Family Studies*, 26 June 2019.

Carr, Themba, Wendy Shih, Kathy Lawton, Catherine Lord, Bryan King, and Connie Kasari. (2016). “The Relationship between Treatment Attendance, Adherence, and Outcome in a Caregiver-Mediated Intervention for Low-Resourced Families of Young Children with Autism Spectrum Disorder.” *Autism* 20, no. 6 (August 2015): 643–652. https://doi.org/10.1177%2F1362361315598634.

Census profile, 2016 census: Powell River Regional District, Statistics Canada (2016). https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CD&Code1=5927&Geo2=PR&Code2=59&SearchText=Powell%20River&SearchType=Begins&SearchPR=01&B1=All&GeoLevel=PR&GeoCode=5927&TABID=1&type=0

Creswell, John W. *Educational Research: Planning, Conducting, and Evaluating Quantitative and Qualitative Research*, 4th ed. (Upper Saddle River, NJ: Prentice Hall, 2012).

Curran, Tillie, and Katherine Runswick-Cole, “Disabled Children’s Childhood Studies: Critical Approaches in a Global Context. Chapter 1: My Story.” In *Handbook of Disabled Children’s Childhood Studies: Building Understandings,* edited by Katherine Runswick-Cole, Tillie Curran, and Kirsty Liddiard. London: Palgrave, 2017.

Family Resource Program of British Columbia, Employment and Social Development Canada (2016), http://www.frpbc.ca/

Fabiano, Gregory A., Nicole K. Schatz, and Stephanie Jerome, “Parental Preferences for Early Intervention Programming Examined Using Best-Worst Scaling Methodology.” *Child & Youth Care Forum, 45, no. 5 (2016):* 655-673, https://doi:10.1007/s10566-016-9348-z.

Graham, Kerri, and Kathryn Underwood. “The Reality of Rurality: Rural Parents’ Experiences of Early Years Services.” *Health & Place*, 18, no. 6 (2012), 1231–39. http://www.ncbi.nlm.nih.gov/pubmed/23034104.

Human Early Leaning Partnership. *EDI (Early Years Development Instrument) report*. Wave 6 Community Profile, 2016. Powell River (SD47). Vancouver, BC: University of British Columbia, School of Population and Public Health; October 2016.

Hung, Lillian, Alison Phinney, Habib Chaudhury, Paddy Rodney, Jenifer Tabamo, and Doris Bohl. “Appreciative inquiry: Bridging research and practice in a hospital setting.” *International Journal of Qualitative Methods* 17, no. 1, 2018.

Ignace, M., Ann Batisse, Arlene Hache, B. Johnson, and Betty Daley. “Review of Successful Models of Language Nests and Adult Language Acquisition Programs.” Yellowknife, NWT: Yellowknife Women’s Centre, 2005.

Inclusive Early Childhood Services System (IECSS) Project (blog website), Ryerson University (n. d.), http://iecss.blog.ryerson.ca/people/

Ineese-Nash, Nicole, Yvonne Bomberry, Kathryn Underwood, and Arlene Hache. “Raising a Child with Early Childhood Dis-ability Supports,” *Indigenous Policy Journal*, Vol. 28, no. 3 (2017). Shakonehya:ra's ne shakoyen'okon:'a G’chi-gshkewesiwad binoonhyag ᑲᒥᓂᑯᓯᑦ ᑫᑕᓲᐧᐃᓇ ᐊᐧᐊᔕᔥ ᑲᒥᓂᑯᓯᑦ ᑲᐧᐃᔕᑭᑫᑕᑲ: Ga-Miinigoowozid Ga-Izhichigetan Ga-Miinigoowozid Gikendaagoosowin Awaazigish (2018).

Kaaij, Christien and Janet Newbury, *Powell River Regional Social Planning Program: Final Report* (2019), https://powellriver.civicweb.net/document/57383

Lange, Shannon, Jurgen Rehm, and Svetlana Popova, “Implications of higher than expected prevalence of fetal alcohol spectrum disorders.” *American Medical Association, 319, no.5 (2017):* 448 449, https://canfasd.ca/wp-content/uploads/sites/35/2018/02/Implications-of-Higher-Than-Expected-Prevalence.pdf

Lingard, Lorelei, Mathieu Albert, and Wendy Levinson. "Grounded Theory, Mixed Methods, and Action Research." *Bmj* 337, no. aug07 3 (2008): a567-a567.

MacDonald, David. “Child care deserts in Canada.” Canadian Centre for Policy Alternatives, 2018.

Macdonald, David and Martha Friendly. “Developmental milestones: Child care fees in Canada’s big cities 2018.” Canadian Centre for Policy Alternatives, 2019.

Malange, Ramsay, Sherry Sinclair and Sue Khazaie, *Monitoring Family Resource Programs in British Columbia: 2016 Research Report*. BC Association of Family

Resource Programs. (Langley, BC: 2016), http://www.frpbc.ca/media/uploads/files/Monitoring_FRPs_in_BC_-_Research_Report_2016_1.pdf

Mallett, Rebecca, and Katherine Runswick-Cole. *Approaching Disability: Critical Issues and Perspectives*. New York, NY: Routledge, 2014.Thornton, Colleen, and Kathryn Underwood. "Conceptualizations of Disability and Inclusion: Perspectives of Educators of Young Children." *Early Years: An International Journal of Research and Development* 33, no. 1 (2013), 59–73. http://www.tandfonline.com/doi/abs/10.1080/09575146.2012.682975#.VTj2PpMsCFU.

McShane, Kelly. "Open Learning Interdisciplinary Program Evaluation Curriculum." (2015). https://www.ryerson.ca/openlearning/projects/program_evaluation/.

Moher, Catherine. "Putting families first: A strengths-based approach to serving families with young children." *International Journal of Birth and Parent Education*, Vol. 6**,** Issue 3 (2019).

Pickard, Katherine E. and Brooke R. Ingersoll. "Quality versus Quantity: The Role of Socioeconomic Status on Parent-Reported Service Knowledge, Service Use, Unmet Service Needs, and Barriers to Service Use." *Autism* 20, no. 1 (May 2015): 106–115. https://doi.org/10.1177%2F1362361315569745.

"Profile of Hamilton's Aboriginal Residents" Hamilton, 2015, http://www.sprc.hamilton.on.ca/wp-content/uploads/2015/04/Profile-of-Hamiltons-Aboriginal-Residents.pdf.

Ryan, Katherine E., Tysza Gandha, Michael J. Culbertson, and Crystal Carlson. "Focus Group Evidence: Implications for Design and Analysis." *American Journal of Evaluation* 35, no. 3 (2014): 328-345.

Statistics Canada. Minto, Town [Census subdivision], Ontario. 2016 Census. Retrieved from https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CSD&Code1=3523043&Geo2=PR&Code2=35&SearchText=Minto&SearchType=Begins&SearchPR=01&B1=All&GeoLevel=PR&GeoCode=3523043&TABID=1&type=0.

"Truth and Reconciliation Commission of Canada: Calls to Action" (Truth and Reconciliation Commission off Canada: Winnipeg, Manitoba, 2015, 3, http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf.

Underwood, Kathryn, and Marion Trent-Kratz. "Contributions of parenting and family literacy centres in an early childhood services system." *The School Community Journal* 25, no. 1 (2015), 95–116.

Underwood, Kathryn, Marisol Moreno Angarita, Tillie Curran, Katherine Runswick-Cole, and Donald Wertlieb, "An International Conversation on Disabled Children's Childhoods: Theory, Ethics and Methods." (in submission).

"United Nations Declaration on the Rights of Indigenous Peoples", (107th plenary meeting, 2007, 14), https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf.

Wave 6 Community Profile, 2016: EDI (Early Years Development Report, Powell River (SD47), Human Early Learning Partnership. Vancouver, BC: University of British Columbia, School of Population and Public Health, October 2016. http://earlylearning.ubc.ca/media/edi_w6_communityprofiles/edi_w6_communityprofile_sd_47.pdf.

Wellington County. "County Announces 11 New Affordable Housing Apartments Coming to Palmerston." Press release, December 7, 2016. Retrieved from https://www.wellington.ca/Modules/News/index.aspx?feedId=44678d8e-66d0-4745-9af9-31ac1a8c708d,59962eb8-8b65-41da-8794-e3abaebca375&newsId=21b385cd-e8f9-44dc-a4ac-3fb2625d0bc8.

Wiebe, Rudy and Yvonne Johnson. *Stolen Life: The Journey of a Cree Woman.* Toronto: A. Knopf, 1998.