ABSTRACT

Title of Document: A QUALITATIVE ANALYSIS OF THE EXPERIENCES AND PERSPECTIVES OF FAMILY CHILD CARE PROVIDERS WHO CARE FOR YOUNG CHILDREN WITH DISABILITIES

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Increases in the number of parents in the paid labor force and welfare reform have resulted in more families requiring non-parental child care. Most often this care is provided in environments outside of the child's own home. There is also a trend to promote the inclusion of young children with disabilities in community-based settings. Families of children with disabilities often prefer family child care programs. However, limited research has been conducted on family child care providers who include children with disabilities in their programs.

The purpose of this study was to explore the experiences and perspectives of family child care providers who care for young children with disabilities, using the following research questions: (a) What factors encourage family child care providers to accept young children with disabilities? (b) What strategies do family child care providers use to include young children with disabilities? (c) What supports do family child care providers receive while caring for young children with disabilities? (d) What

barriers are reported by family child care providers who care for young children with disabilities?

A multiple case study design was used. Data collection involved: (a) interviews with licensed family child care providers, parents of children with disabilities and administrators involved in training and licensure; (b) observations of family child care providers; and (c) a review of documents. Case summaries were written for each provider. Then a cross-provider analysis was conducted.

All of the providers had some experience or exposure to children with disabilities in the past. They believed that all children were unique and special and demonstrated a positive attitude toward inclusion. Providers engaged in pre-service and in-service disability-related training. Providers and the parents established strong collaborative relationships. Strategies to include the children with disabilities ranged from using specialized equipment to simple modifications. Early childhood special education staff supported the providers in including the children. Other sources of support included membership in associations, as well as smaller informal networks. Barriers reported were related to lack of training opportunities and funding for specialized equipment, the needs of the child with a disability, and factors associated with the business.

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CARE FOR YOUNG CHILDREN WITH DISABILITIES

By

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CHAPTER I

INTRODUCTION

With the rising number of parents in the work force or participating in training or

education programs, child care has become an integral part of family and community life

for families at all income levels and across cultural and ethnic groups (Bromer, 2000).

Between 1950 and 1997, the percentage of children under six with mothers in the labor

force rose from 12% to 63% (Children's Defense Fund, 1998). Currently, almost two of

every three mothers with children under six years of age are in the labor force (U.S.

Department of Labor, 2001). Additionally, the Personal Responsibility and Work

Opportunity Reconciliation Act of 1996 increased the number of children in need of child

care by mandating new responsibilities for welfare recipients. Therefore, increasing

numbers of children are spending substantial amounts of time being care for by providers

other than their parents. In 2001, 61.2 percent of children from birth to six years of age

received non-parental child care (U.S. Department of Education, National Center for

Education Statistics, 2005).

Children with Disabilities and Child Care

Among the families who need child care are families of children with disabilities.

Families of children with disabilities often want to include their children in community-

based child care settings (Guralnick, 1994; Odom, 2002; Wolery & Wilbers, 1994).

Efforts to include young children with disabilities into educational settings with their

typically developing peers have increased substantially over the last two decades (Odom,

2002; Bailey, 2000). This emphasis is demonstrated through federal legislation, such as

the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of

1973, and the Individuals with Disabilities Education Improvement Act. Professional advocacy organizations such as the Council for Exceptional Children, Division of Early Childhood (CEC-DEC), and the National Association for the Education of Young Children (NAEYC) have also supported these efforts.

The Americans with Disabilities Act (ADA), Public Law 101-336, is the most significant federal law ensuring the full civil rights for individuals with disabilities. The purpose of the ADA is to eliminate discrimination against individuals with disabilities and guarantees access to every critical area of life. For example, community-based child care programs cannot exclude young children from their programs based on the presence of a disability. Children with disabilities have the right to participate alongside their peers in these programs. The ADA applies to all nursery schools, child care centers, family child care programs, and before and after school programs. This law requires child care programs to remove architectural barriers when "readily achievable," make "reasonable accommodations," and that will not constitute "undue burden" (United States Department of Justice, 2003).

Section 504 of the Rehabilitation Act of 1973 prohibits discrimination on the basis of disability in programs and activities that receive federal financial assistance. Specifically, the law states that "No otherwise qualified handicapped individual in the United States, as defined in Sec. 705 (20) of this title shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance (United States Department of Health and Human Services, 2003). The nondiscrimination

requirements of the law apply to child care programs that receive financial assistance from any Federal department or agency.

The most recent mandate, the Individuals with Disabilities Education Improvement Act of 2004 (IDEA 2004), also provides legislative support to date for the inclusion of children with disabilities into community-based programs. IDEA 2004 requires that children from birth to 3 receive early intervention services in the most natural environment, meaning those places where typically developing infants and toddlers spend their time (P.L. 108-446). IDEA 2004 also requires that preschool children, from 3 to 5 years of age be educated in the least restrictive environment. In many cases, public schools provide preschool services for children identified with early educational needs or disabilities. For young children with disabilities, natural environments and least restrictive environments may include family child care and center-based child care programs in the community.

For children with disabilities, child care programs can provide community-based, normalized placement options, as well as meet the increasing need for non-parental care for young children (Bruder & Brand, 1995; Buell, Gamel-McCormick & Hallam, 1999). A number of researchers (Odom et al., 1996; Odom, 2002; Peck, 1993) have used the ecological systems framework proposed by Bronfrenbrenner (1979) to study the inclusion of young children with disabilities in child care programs. This model provides a useful theoretical framework to study the implementation of a complex phenomenon such as inclusion. Bronfrenbrenner (1979) proposed that an individual's development is influenced by a number of nested systems outside the immediate setting in which the individual functions. In addition to the microsystem in which the child participates

directly, the model emphasizes the relationship between different settings (mesosystem), the influence of settings in which the child does not participate directly (exosystem), and the larger social, cultural and political factors which influence other components of the individual's ecology (macrosystem). Odom and colleagues (2002) used this model to examine the facilitators and barriers to preschool inclusion. The researchers studied factors within the classroom and factors operating outside the classroom setting. They viewed the preschool inclusion process from the family members' perspective, social policies at the local, state and national level and influences at the societal level. More recently, Bronfenbrenner (1995) expanded his original theory and renamed it the "bioecological systems theory" to reflect the development of individual children in particular environments, while considering both psychological and biological factors. This model includes the chronosystem and the construct of proximal processes, which examines the interactive relationship between a child, his family, and other environmental influences over time. I provide a more detailed description of the bioecological model in Chapter 2.

The benefits of inclusive programs for young children with disabilities have also been demonstrated in the literature (Diamond & Carpenter, 2000; O'Brien, 1997; Wolery & Wilbers, 1994). Researchers have found that children with and without disabilities become aware of the differences and similarities between themselves and their peers. Children with disabilities enrolled in inclusive settings demonstrated higher levels of social play and more appropriate interactions and are more likely to initiate interactions with their peers than children in segregated settings (Doherty-Derkowski, 1995; Diamond, Hestenes & O'Connor, 1994).

Although there has been research on inclusion in community-based program, families of children with disabilities often have difficulty locating high quality child care for their children (Maryland Developmental Disabilities Council, 2004; Neas & Mezey, 2003). The National Academy of Sciences' landmark report, *From Neurons to Neighborhoods*, identifies the main barriers reported by researchers that families face in accessing quality early childhood services:

> Like all families with young children, those whose children have a disability or special health care needs are faced with the challenges of finding quality affordable child care. But the inability or unwillingness of many child care providers to accept children with disabilities, transportation and other logistical problems, difficulties with coordinating early intervention and child care services, and the scarcity of appropriately trained caregivers…made the effort to find any child care a tremendous challenge for these families (Shonkoff & Phillips, 2000, p. 324, cited in Neas & Mezey, 2003).

Other researchers (Odom, 2002; Wolery & Wilbers, 1994) have identified barriers and confirmed these conclusions. Wolery and Wilbers (1994) stated that one of the greatest barriers to inclusion in early childhood is the lack of adequate preparation and training of general early childhood educators. Similarly, Shaw and colleagues (2001) identified the following major barriers, "lack of access to high-quality programs, insufficient or inconsistent information available to parents and providers, inadequate funding, lack of advocacy, differences in interpretation and application of relevant laws and statutes, and inadequate training and ongoing support of providers" (p. 1).

National and State Focus on Inclusive Child Care

Nationally, there has been a focus addressing inclusive child care. The Map to Inclusive Child Care project, sponsored by the Child Care Bureau, United States Department of Health and Human Services, existed for several years in approximately 25 states (Cryer & Clifford, 2003). The project began in 1997 and participating states developed teams that consisted of families of children with disabilities, child care providers, child care state administrators, Head Start representatives, and early intervention and preschool special education representatives. Each state received technical assistance and established a state plan for addressing multiple, interrelated aspects of their early childhood education and care delivery system for children with disabilities from birth through age 12 (Map to Inclusive Child Care Institute, 1999).

The state of Maryland has initiated many efforts to overcome the barriers and increase the availability and quality of child care for children with disabilities. For example, in 1988 the Maryland Committee for Children began providing enhanced child care resource and referral services to families of children with disabilities and special health care needs through the LOCATE service. Through this service LOCATE counselors provide parents or guardians with regulated child care program referrals in Maryland including family child care, child care centers, before and after school programs, summer camps, Head Start programs, nursery schools, part-day programs, and private kindergarten programs. Today this service is available to parents through an on-line database of child care programs. In 1995, the Maryland Committee for Children released its report, *Improving the Inclusion of Children with Disabilities in Community Child Care Programs*. The report was developed by a panel of families and child care

and disability professionals and included a series of recommendations to improve access

of community child and after-school care programs for children with disabilities. Many

of the recommendations were implemented by the Child Care Administration, in

collaboration with the Maryland State Department of Education and other agencies.

However, even with these efforts systematic barriers remained and were identified in a

survey of family and center-based child care providers conducted by the Maryland

Committee for Children in 2001. The barriers identified in their report, *Child Care for*

Children with Special Needs, were very similar for both types of providers and centered

on issues such as safety, aggressive behavior, liability, knowledge about disabilities, and

knowledge about regulations.

More recently, the Maryland Developmental Disabilities Council (2004, January)

developed a report on the barriers to quality child care as reported by families of children

with disabilities and special health care needs. The data were gathered from over 400

families throughout Maryland who responded to a survey and from four regional family

focus groups. This report documented that families continue to have difficulties

accessing and maintaining quality child and after-school care. When asked whether they

had difficulties in finding, obtaining, or keeping child care, 83% of respondents said

"yes." When asked the reasons for these difficulties, the number one barrier to obtaining

and/or keeping child care was a lack of provider willingness. In May of 2004, this report

and major advocacy efforts from families of children with disabilities led to the formation

of Maryland's Taskforce on Inclusive Child and After-School Care. The Taskforce was

required as a result of the passing of House Bill 1289 and Senate Bill 497. The Taskforce

consisted of representatives from state agencies and advocacy groups, child care

providers, and parents of children with disabilities. The recommendations involved policy restructuring and developing a comprehensive training infrastructure with mentoring components for child care providers.

Non-parental, community-based child care occurs in a variety of settings. In the next sections, types of non-parental, community-based child care programs will be described. Particular emphasis will be given to family child care programs, a common arrangement used by families of young children with disabilities.

Non-Parental, Community-based Child Care Programs

Care provided by a nonrelative in the caregiver's home is defined as "family child care." The term "relative care" is used to refer to the care of related children (other than the provider's own children) in the relative's home. Family child care and relative child care, where the children are cared for in the home, comprise the most frequently used child care arrangements among employed mothers with children under three years of age (Godwin & Schrag, 1996; Kontos, Howes, Shinn & Galinsky, 1995). Many families of young children with disabilities choose family child care programs when they are available (Devore & Hanley-Maxwell, 2000; Deiner & Prudhoe, 1990; Goelman & Pence, 1988). Fewell (1986) suggested that family child care probably serves more children with disabilities than any other arrangement. Family child care programs may be preferred because they are often located in the family's neighborhood, allow for a personal relationship with a primary provider, offer smaller group size, and have the potential for more flexible hours than center-based programs (National Association for Family Child Care, 2004; Weaver, 2002; Kontos, et al. 1995). In contrast to care that is

provided in a home environment, center-based programs provide children with care in a nonresidential setting.

In the state of Maryland there were 10,197 regulated family child care homes (The Children's Foundation and the National Association for Regulatory Administration, 2004a) and 2,626 regulated child care centers (The Children's Foundation and the National Association for Regulatory Administration, 2004b). Family child care programs are considered "regulated" if the provider has received a government-issued license or registration intended to make certain that minimal health and safety measures are followed. Although requirements vary from state to state, most states require family child care providers be regulated if they care for more than four children. Unregulated family child care can either be legal or illegal. Cryer and Harms (2000) describe legal unregulated care or "license exempt" care as that which is provided in homes for small numbers of family and nonfamily children. Many states have a voluntary regulation process for providers caring for four or fewer children, hence the provider makes the choice to become registered or not. Kin child care is another form of legal unregulated care where the children are cared for by family members. For example, a grandmother providing care for her grandchildren would be considered kin care. Other providers may operate illegally by providing care to children that exceed the limit defined by the state for exemption from license or regulation. For example, a family child care provider caring for six unrelated children without a license would be operating illegally. Hofferth and Kisker (1992) estimated that, nationally, between 550,000 and 1.1 million unregulated family child care providers with the capacity to care for 3.3 million children were serving children at the beginning of 1990" (cited in Cryer and Harms, 2000, p. 122).

Statistics on the percentage of children ages 0-6, not yet in kindergarten, by type of care arrangement are available. For instance, in 2001, 61.2 percent of children ages 0-6 received some form of care on a regular basis from persons other than their parents. Care in a home by a relative was provided by 23.1 percent of these children, 16.3 percent received care in home by a nonrelative and 33.4 percent received care in a center-based program. Because some children participated in more than one type of arrangement, the sum of all arrangement types exceeds the total percentage in nonparental care. National data on the number of children with disabilities in child care and the types of child care used by families of children with disabilities has been difficult to obtain. In the report developed by the Maryland Developmental Disabilities Council (2004, January) mentioned previously, when asked what types of child care families of children with disabilities had used, 30% of families reported using family child care providers, 27% reported using a family member or neighbor, 25% reported using child care centers, 23% reported using before and after-school care programs, 15% reported using in-home care, 8% reported involvement in a Head Start program, 6% reported using nanny or au pair services, and 2% reported using another child care arrangement. More data is needed nationally regarding child care and children with disabilities.

Lack of Family Child Care Research

Despite the number of families who use family child care and its popularity with families of children with disabilities, it has received limited professional attention in the literature. Tuominen (2003) stated:

Despite family child care's prominence as a primary form of paid child care, parents' preference of family child care for their very young children, and family

child care's existence as a source of employment for a large number of women, it

remains the least researched of all child care settings. (p. 15).

Compared to center-based child care, family child care has been under-researched (Cryer

& Harms, 2000; Kontos et al., 1995; Peters & Pence, 1992). Tuominen further contended

that there are four major studies that comprise the research base of knowledge about

family child care (Fosburg, 1981; Galinsky, Howes, Kontos & Shinn, 1994; Hofferth &

Kisker, 1991; Nelson, 1990). Peters and Pence (1992), in *Family Day Care: Current*

Research for Informed Public Policy, also contributed to the knowledge base on family

child care. This lack of research not only holds true in the United States, but across the

world. Statham and Mooney (2003) discussed when viewing family child care from an

international perspective that this form "has received very little attention from researchers

and policy makers, despite being an important form of child care in many countries" (p.

11). The researchers go on to further state that this lack of attention may be due in part to

family child care providers being viewed as "substitute mothers" and not seen as

"professionals" because of the limited training and qualifications that are required for

licensing. However, Cochran (1995) concludes that "family day care continues to exist

because it is popular with parents, not because it is popular with the profession" (p. 67,

cited in Statham & Mooney, 2003).

In addition to the lack of family child care research in general, it has also been

overlooked in research as a setting for children with disabilities (Buell, Gamel-

McCormick & Hallam, 1999). Previous research on inclusion in early childhood settings

has primarily focused on center-based care in model schools or university laboratory

programs (Devore & Hanley-Maxwell, 2000; Marchant, 1995). In studies where

providers' attitudes and experiences were explored (Buysse, Skinner, & Grant, 2001; Dinnebeil et al., 1998; Eiserman, et al., 1995; Gemmell-Crosby & Hanzlik, 1994), the majority of providers were working in center-based programs. Previous research (Trawick-Smith & Lambert, 1995; DeBord, 1993; Pence and Goelman, 1987;) has shown that there are significant differences between providers in family child care and center-based programs. For example, in family child care, only one person provides care for the children. The family child care provider is solely responsible for the child care group, as well as the administrative duties. Family child care providers are often required to have less formal training or education than center-based providers in order to be registered in most states.

Limited Research on Inclusion and Family Child Care

A limited number of studies have focused exclusively on the experiences and perspectives of family child care providers that serve children with disabilities or included this population as part of the participants (Devore & Hanley-Maxwell, 2000; Buell, Gamel-McCormick & Hallam, 1999; Dinnebeil, McInerney, Fox, & Juchartz-Pendry, 1998). On a whole, a review of these studies suggests that family child care providers reported high levels of experience, interest and commitment in caring for young children with disabilities. Buell et al., (1999) reported that family child care providers identified three barriers to inclusion in their programs: lack of knowledge about disabilities, fear of the impact the child with disabilities would have on the other children, and the need to purchase special equipment. These findings are consistent with earlier findings from Peters and Pence (1992). They found that barriers to child care for children with disabilities reported by family child care providers surround four major areas:

personal preparation and work load, liability issues, space and curricular restraints, and concerns about their own family and the other children in the program. More research is needed to understand family child care providers' experiences and perspectives in serving children with disabilities and the supports necessary for these providers to effectively serve children with disabilities.

Summary and Purpose of the Study

Dramatic increases in the number of parents in the paid labor force and welfare reform have resulted in an increasing number of families requiring non-parental child care. Most often this supplemental care is provided in environments outside of the child's own home. There is also a trend to promote the inclusion of young children with disabilities in community-based child care programs. This effort has been widely recognized in the literature and federal legislation over the last two decades. Although providers' perspectives regarding the inclusion of young children with disabilities into community-based program have been increasingly studied in recent years, relatively few studies have emphasized the perspectives and experiences of family child care providers.

Family child care is the preferred arrangement for families of children with disabilities as well as for infants and toddlers. Most studies to date have been conducted on center-based child care providers and have focused more on the barriers to inclusion in family child care programs. There is a need for a better understanding of the experiences and perceptions of family child care providers who include children with disabilities in their programs. We know very little about the aspects of family child care providers and how young children with disabilities enter and enroll in their programs. There is also limited information of how the providers include these children in their programs, the

supports the providers receive, and the challenges they face when caring for children with disabilities. Therefore, the purpose of this study was to explore these issues using the bioecological framework (Bronfenbrenner, 1995). This framework allowed the investigator to not only focus on the factors that were located within the family child care programs themselves, but also other powerful factors operating outside of the program. For example, it was essential to understand the policies and laws related to including children with disabilities in child care programs. The perspective of family members' was also investigated. Specifically, how the family located the family child care program and thus subsequently enrolled their child into the program was explored.

Guiding Research Questions

A multiple case study approach was used and the study was guided by the following four research questions:

1. What factors encourage family child care providers to accept young children with disabilities in family child care programs?

2. What strategies are used by family child care providers to include young children with disabilities in family child care programs?

3. What supports do family child care providers receive while caring for young children with disabilities in family child care programs?

4. What barriers are reported by family child care providers who care for young children with disabilities in family child care programs?

CHAPTER II

LITERATURE REVIEW

Over the last two decades, many early childhood professionals, parents and researchers have given considerable attention to the issue of including young children with disabilities in community-based child care settings. Increasingly child care providers are being asked to include young children with disabilities in their programs. One such setting is family child care, where care is received in the home of the provider.

The review begins with a discussion of federal legislation which has set standards and guidelines to promote inclusive practices. This is followed by a discussion of Bronfenbrenner's (1995) bioecological systems model, as a theoretical framework. I then briefly review related research strands on family child care providers and programs. The differences between center-based child care providers and family child care providers are discussed. I then review research related to inclusion of young children with disabilities in community-based programs, with a focus on the available literature related to family child care providers. I then review studies on interventions to improve services for young children with disabilities in family child care programs. Next, I briefly discuss child characteristics and family perceptions as they relate to early childhood inclusion. I then review the findings from reports on inclusive child care in the state of Maryland. Finally, I conclude with gaps in the literature and the purpose of the current study.

History of Federal Legislation Related to Inclusion

Several pieces of legislation promote the participation of children with disabilities in community-based settings. In 1973, Congress passed an amendment to the Vocational Rehabilitation Act that included a provision prohibiting discrimination against

individuals with disabilities in federally assisted programs and activities. Section 504 of

the Vocational Rehabilitation Act set the stage for passage of the most sweeping civil

rights legislation in the United States since the Civil Rights Act of 1964 (Hardman, Drew

& Egan, 1999). This civil rights legislation is the American with Disabilities Act of 1990

(ADA), PL 101-336. It provides a national mandate to eliminate discrimination against

individuals with disabilities in private-sector employment, all public services, and public

accommodations, transportation and telecommunications. It charged the federal

government with the duty of making certain that these provisions be enforced on behalf

of all people with disabilities (West, 1991).

The ADA protects any child or adult who: (a) has a physical or mental

impairment which substantially limits one or more major life activities such as speaking,

seeing, walking, learning, etc.; (b) has a history of this type of impairment (such as a

child with cancer now in remission); (c) is "regarded" as having the impairment (such as

a child with facial scarring who has no limitations, but is stigmatized); and (d) is

"associated with" any of the persons described above (so that a child seeking admission

to a child care program cannot be denied simply because her mother uses a wheelchair or

her brother has tested positive for HIV) (U.S. Department of Justice, 2002).

Almost all child care providers (family child care and center-based), regardless of

size or number of employees, must comply with title III of the ADA. Child care

providers must provide children with disabilities equal access to participation in their

programs. The exception is child care centers that are actually operated by religious

organizations such as churches, mosques or synagogues (U.S. Department of Justice,

2003).

The ADA requires child care programs to consider changes in three areas. First, they must make reasonable modifications in their policies, practices, and procedures to accommodate individuals with disabilities unless the modification would fundamentally alter the nature of the program and there are no reasonable alternatives. For example, if a child care provider served a child who used a wheelchair, they would have to reduce barriers and make any changes that they could afford. Moreover, funding and size of program weigh heavily on the extent of the provider's legal obligation in terms of what is considered "reasonable." Modifications for a child might include providing alternative foods at lunch and snack time for children with certain food allergies and/or making a schedule change for a child who takes medication and/or naps in the morning. (United States Department of Justice, 2003).

Second, child care programs are required to provide "auxiliary aids and services" for those with disabilities affecting hearing, vision, or speech, unless to do so would fundamentally alter the nature of the program or would impose an undue burden on the program and there are no alternative steps that can be taken. Auxiliary aids and services are services and devices such as interpreters, audiotapes and large print materials designed to ensure effective communication. An undue burden means a significant difficulty or expense. Finally, architectural barriers which prevent access to services must be removed if removal is readily achievable. Readily achievable means easily accomplishable and able to be carried out without much difficulty or expense. (United States Department of Justice, 2003).

The Education for All Handicapped Children Act, more commonly known as PL 94-142, was passed by Congress in 1975. This landmark piece of legislation required that school age children who may have a disability be identified, evaluated and given a free and appropriate public education. Public Law 99-457 (PL 99-457), The Education of the Handicapped Act Amendments in 1986 included provision for preschool-age children. This legislation established a new mandate extending all the rights and protections of school age children to preschool age children (ages 3 through 5). Additionally, for infants and toddlers (birth through age 3), a new program, Part H, was established to help states develop and implement programs for early intervention services. Every state now provides services for infants and toddlers with disabilities under what was formally known as Part H. In 1990, The Education of the Handicapped Act amendments was renamed the Individuals with Disabilities Education Act (IDEA), Public Law 101-476. Also, autism and traumatic brain injury were added as two new categories of disability. The amendments to IDEA, PL-105-17, in 1997 gave states and local education agencies the option of eliminating specific categories of disability for children ages 3 to 9 and replacing them with a general category of "developmental delay." Part H was changed to Part C in the 1997 Amendments to IDEA. Also, IDEA 97 requires that a child's IEP must include a statement of the child's present levels of educational performance and how it influences the child's performance in the general curriculum. The provisions also require that the IEP must include an explanation of the extent to which the child will participate with children without disabilities in the regular education setting. IDEA 97 also mandated that children with disabilities receive their education with peers without disability to the maximum extent appropriate. The least

restrictive environment (LRE) requirement of IDEA directs the placement of students with disabilities. This requirement states that students with disabilities should be:

> …educated with children who are not disabled, and special classes, separate schooling or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily. (IDEA, 1997 Part B, Sec. 612 (a)(5)(A))

For infants and toddlers, the "natural environment" or settings that the child would be served in if he or she did not have a disability is strongly emphasized. Natural environments may include the child's home, child care programs (family child care or center-based), play groups, religious activities or recreation programs in community centers. The amendments also encouraged states to expand their services to infants and toddlers at risk. In 2004, the Individuals with Disabilities Education Improvement Act (IDEA 2004) was passed and continued to strengthen the provisions of natural and least restrictive environments for infants, toddlers and preschool age children with disabilities.

In summary, by law, young children with disabilities have a right to participate in settings and activities with children without disabilities. As federal and state legislation demand inclusive practices, early childhood and early childhood special education professionals increasingly work with children with disabilities in community-based settings (Lieber, et al., 1997) as opposed to separate or parallel services. In the next section, I discuss a theoretical framework related to family child care providers and the inclusion of children with disabilities in their programs.

Bioecological Systems Model

As stated earlier, many researchers (Odom et al., 1996; Odom, 2002) have used Bronfenbrenner's ecological systems model to study the inclusion of children with disabilities in early childhood settings. Therefore, Bronfenbrenner's (1995) bioecological systems model provides an important framework for the study of family child care providers and inclusion. Factors at the level of the individual child, their immediate environment, and the wider social and political context in which family child care operates will be considered.

From the ecological systems perspective, a child's development is believed to be influenced by a network of interrelated, nested systems which exert mutual influence over one another (Bronfenbrenner, 1979). Bronfenbrenner originally proposed that there were four nested systems that influence an individual's development. Overtime, this model has been expanded and evolved into what is now referred to as Bronfenbrenner's (1995) "bioecological" systems model. This model was defined by Kaiser, Hester, and McDuffie (2001) as "an interactive relationship among four principle components: proximal processes, the developing person, the environmental context, and time spans during which the proximal processes take place (p. 143). Exploring the interactive relationships provides a way of understanding individuals in multiple, layered and interacting environments, in which they may or may encounter directly. His model recognizes that individuals do not develop in isolation, but in relation to their family and home, school, community and society. In order to develop intellectually, emotionally, socially and morally, a person requires active participation in reciprocal interactions with people, and social influences in the individual's immediate environment regularly and

over extended periods of time. However, these proximal processes will operate to cause outcomes of either developmental competence or developmental dysfunction (Bronfenbrenner & Morris, 1998).

Microsystem influences occur within immediate settings in which the child spends a significant portion of time. The people in the microsystem have the most immediate influence on the child. These influences directly affect the child and may consequently be affected by the child in what is referred to as bidirectional relationships. Therefore, the microsystem is the locus of proximal processes of development (Bronfenbrenner, 1995). Young children typically spend most of their time at home, in child care settings, or classrooms. Micro-level factors affecting early child development include things such as nutrition, shelter, stimulation, attachment and parenting style. These factors can have either negative or positive effects on development. An example of a bidirectional relationship would be the effect of a child's disability on the child care provider's ability to care for the other children in the program. Mesosystem influences involve interrelations and linkages among two or more major settings in which the child participates directly. For example, the relationship between family members and providers will influence the child's participation in the program, which in turn will affect the child's development. Further, how family child care providers who serve young children with disabilities work with and feel about children with disabilities is another example of a mesosystem factor. Exosystem influences include formal and informal social structures in which the child is not a direct participant, but that affect the child indirectly. For instance, if a mother's job is not flexible in giving her time off from work and her child has medical appointments related to his disability, the mother then may

have to rely on outside assistance. This can put extra stress on the parent which in turn can affect how she interacts with the child. The regulations set forth by the Child Care Administration are another exosystem factor. The macrosystem refers to the larger social, cultural and political factors influencing the other components of the system. Legislation, such as the Individuals with Disabilities Education Act and the Americans with Disabilities Act, are two powerful examples of a macrosystem element within the context of inclusion. Societal and cultural beliefs on the rights of individuals with disabilities emerge from the macrosystem to affect micro-, meso-, and exosystems. Finally, the element of time is vital to the bioecological model and is represented in the chronosystem. This system involves the temporal changes in a child's environment which produce new conditions that affect development. Factors within this system can be either internal, such as the natural maturation of the child or external, such as the death of a parent or a child care provider's unexpected retirement. The use of this theory allows for a holistic, integrative view rather than a fragmented view of the children with disabilities, their families and the family child care providers who care for them (Beckman, 1997; Odom et al., 1996).

In the next section, I describe the characteristics of family child care providers and family child care programs. I highlight the essential differences between family child care providers and center-based child care providers. It is extremely important to study these differences since the majority of the research on the inclusion of children with disabilities into community-based programs has been done in child care centers.

Family Child Care Providers and Programs

A Profile of Family Child Care Providers

Family child care refers to care for several children in the provider's own home (Cryer & Clifford, 2003). In 2001, the Maryland Committee for Children produced a report on family child care providers, *Family Child Care Providers in Maryland: A Profile.* The Committee conducted a survey to describe characteristics of family child care providers in the state. In this section, I compare data from this report with literature on family child providers. Many researchers (Goelman & Guo, 1998; Helburn, Morris, & Modigliani, 2002; Kontos, Howes, Shinn & Galinsky, 1995; Nelson, 1990) have presented a profile of family child care providers. In general, they report that almost all family child care providers are women who are mothers, mostly married, whose husbands work outside the home. This information was consistent with data from Maryland. On average, the income generated from the family child care program represents about a quarter to a third of the family's income. The average annual income of child care providers in Maryland had increased to slightly more than $18,000 by the year 2000. Most family child care providers have worked previously. Many opened their child care business when their own children were small and about half currently have a child of preschool age. Another group of providers started their business when their own children left home. The average age of family child care providers is between 30 and 40 years old and average years of experience is six years. In Maryland, slightly more than half of the providers surveyed have been caring for children for more than five years. The child care home is typically a single-family house with a designated indoor play area, a sleeping area where portable cribs or cots might be set up, and an outdoor play area. Most family

child care providers see their role as caring for the children's physical needs and being "like a mother" to the children. They represent diverse racial and ethnic backgrounds. In terms of education level, most providers have a high school degree and many have some advanced training. Small percentages have a bachelor's degree. In Maryland 92% of the respondents had attained a high school education. Over half attended college; and one in four has attained a college degree. Furthermore, Kontos et al., (1995) reported that there is little evidence that substantial professional training is considered important, either by the providers or by the families that utilize their services. Slightly less than half of the providers in the survey, reported having 11 or more hours of continuing training in child care in the last year.

Family child care programs are the least expensive among child care arrangements (Clarke-Stewart & Allhusen, 2005). The programs are typically located in the child's neighborhood (Weaver, 2002; Kontos, et al., 1995). Providers and families often develop a close relationship. Clarke-Stewart and Allhusen (2005) stated,

> the mother has more control over what happens to her child in a childcare home than she would in a childcare center because she can give instructions to a childcare home provider that she would not be able to give a childcare center teacher, who must attend to a large number of children and follow guidelines set up by the center (p. 173-174).

Several disadvantages of family child care program that have been reported in the literature. Because there is often only one adult present, the provider is less accountable to the parent for their actions (Cromwell, 1994; Clarke-Stewart & Allhusen, 2005). Cromwell (1994) further added that the children have fewer peers and adults to interact

with and there are typically fewer toys and activities than in a child care center. On the whole, the majority of family child care providers are not trained and are required by states to have minimal training for licensure and renewal as compared to center based providers.

Motivation to Become a Provider

Many researchers (Nelson, 1990; Tuominen, 2003) have investigated the reasons why individuals choose family child care as an employment or career choice. Nelson (1990) in her ethnographic and comprehensive study of family child care providers reported the following reasons: a commitment to stay at home, the enjoyment of working with children, the need to earn an income, and concerns about their own childcare arrangements in relationship to wage employment outside the home. Tuominen (2003) in a more recent in-depth analysis of why women choose family child care found that their decision was influenced by "an interaction of ideological and material forces of gender, race ethnicity, country of origin, family economic status, and local labor markets" and cited "a stable and permanent employment, a source of professional identity and continued mobility, and an alternative form of professional employment" as their motivation (p. 92).

The data from Maryland indicated two main reasons for starting a family child care home, which are consistent with the Nelson (1990) and Tuominen (2003) findings. A desire to be at home with their own children was reported by just under half (49%) of the providers. More than one-fourth (28%) of the providers said the primary reason was a love of children (LOCATE: Child Care Database 7/1/99 to 6/30/00, cited in Maryland Committee for Children, 2001).

Unique Characteristics of Family Child Care Providers

There are major differences between family child care providers and center-based child care providers. Trawick-Smith and Lambert (1995) highlighted five distinctive differences between family child care providers and providers in child care centers. The first difference highlighted is that, "family child care providers must, at one time, meet the needs of children representing an extremely broad developmental range" (Trawick-Smith & Lambert, 1995, p.26). Family child care providers often care for children representing an age range of 5 or more years and this range can go up to 12 years if they provide after-school services. Therefore, the children in their programs are at varying developmental levels. Typically in center-based child care, the providers work with children at a single developmental level and a two- or three-year age range. The second difference is that, "family child care providers work and live in the same space" (Trawick-Smith & Lambert, 1995, p.29). The third difference is that, "family child care providers often care for their own children within their programs" (Trawick-Smith & Lambert, 1995, p.29). In family child care programs, the parent and provider roles often coexist. The authors further stated that in a recent workshop for providers that more than 75% of the participants reported that they had at some point provided care for their own children in addition to other children in the program. Moreover, the majority of the providers described the experience as "difficult" or "a problem." These difficulties may arise as a result of the ages, temperaments, and previous social experiences of both the provider's child and other children in the program. For example, the authors related that if a provider's child is toddler or preschool age, ownership issues related to toys, space and caregiver attention may be a challenge. The fourth difference is that, "family child

care providers must administer and manage their own programs" (Trawick-Smith & Lambert, 1995, p.31). Family child care providers are both caregivers and administrators. Here again is another situation where the providers are operating in dual roles. The authors gave the example of the provider dealing with a parent that continuously picks up a child late. Finally, the fifth difference is that, "family child care providers are among the loneliest and least appreciated of all professionals working with children (Trawick-Smith & Lambert, 1995, p.32). Family providers work in isolation and often have very little adult contact during the day. Family child care providers are also among the least respected of all caregivers. Some common attitudes associated with the family child care business are that the providers are just "babysitting" and that any kind and loving person can take on this role. These attitudes may diminish the professional image of family child care providers. In contrast, center-based child care providers have the daily support of other professionals. Therefore, for the family child care provider, there are less opportunities to seek advice, problem solve around concerns and collaborate in planning. To assist in reducing these issues, networking and advocacy are two critical areas that must be addressed in training.

Quality in Family Child Care

Although this study did not look at quality of care in family child care home, researchers have established a link between quality of care and child care regulations (McGaha, Snow, Teleki, 2001). Kontos (1992) indicated that regulated family child care providers are, on average, better trained and provide higher quality care than unregulated providers. The study of Quality in Family Child Care and Relative Care (Kontos, Howes, Shinn, & Galinsky, 1995), the most recent large scale study of family child care,

demonstrated only 12% of licensed family child care programs provided good quality care and 75% of the programs provided adequate quality care. Researchers have examined other factors that predict quality in family child care programs (Burchinal, Howes & Kontos, 2002; Howes & Norris, 1997; Weaver, 2002). The studies have suggested that family child care programs where the providers are regulated, offer developmentally enhancing care, and have higher levels of education and training are associated with better quality programs. Both pre-service and in-service training have a positive impact on the quality of services (Mueller & Orimoto, 1995).

Models of Family Child Care Programs

Jones and Meisels (1987) further characterized family child care providers and programs by identifying three models of family child care programs. They contended that family child care programs are either 1) an extended family; 2) an extended family with planned activities; or 3) a mini-preschool. In the extended family model, the provider carries out her daily activities and household routines while supervising the children in the program. They further state that, "toys and equipment are available for children, but the children's interactions, rather than the explicit planning and involvement of the provider, form the core of the day's activities" (p. 3). In the extended family with planned activities model, specific activities, projects or field trips with the children are a part of the program. Lastly, they describe the mini preschool model as structured and may incorporate a particular method of early childhood education. In this setting, there are typically more children and may include up to 12 children instead of the maximum of 6 children found in most family child care programs. The providers in the mini preschool model are often former teachers.

Turnover of Family Child Care Providers

Factors related to turnover and job satisfaction have been reported in the literature. Helburn et al., (2002) reported that this research is inconsistent. Turnover rates remain high, ranging from 30% to 59% of the child care workforce leaving the profession each year (Kontos, 1992; Kontos et al., 1995). Kontos et al., (1995) reported a link between higher levels of compensation for family child care with less turnover and better quality of care. In contrast, lower compensation was associated with turnover, instability of and poorer overall quality of care (Manlove & Guzell, 1997). The career instability of family day care providers has implications for the young children in their care. Goelman and Guo (1998) identified burnout as a major factor for high turnover rates in family child care. The authors reviewed 23 previously published works and grouped the factors associated with burnout into six categories: wages and working conditions, roles and responsibilities, communication and social support, personal factors, education, and work experience. These factors in some respect overlap with the providers in Nelson's (1990) study who reported the perceptions about family child care as a profession, ongoing occupational dilemmas, attitudes toward alternative employment, and material needs as reasons for leaving the profession.

In Maryland, the turnover was 24% for family child care providers. The providers reported diverse reasons for making a career change. Family issues (25%) was the most reported reason, followed by getting a new job (19%), and burnout or retirement (16%). Other reported reasons included: provider moved, providing informal care, parent issues, general disinterest, money issues, and regulations.

Regulation of Family Child Care Providers

Licensing is intended to ensure safety and protect children from harm in child care programs (Azer, Morgan, Clifford, & Crawford, 2002). Kontos (1992) reported that the majority of family child care providers were unregulated and were unaware of the regulatory requirements for their states. Morgan and Azer (2000, cited in Clarke-Stewart and Allhusen, 2005) reported that all but three states require that family child care programs be licensed, but nearly one-third of the states consider a program as subject to licensing only if five or more children are being cared for in the home. In terms of training and education, only 16 states require either pre-service training or orientation and 35 states require some level of ongoing annual training once a provider is licensed (LeMoine, 2003).

Summary

In conclusion, many characteristics were associated with family child care providers and the family child care business. These characteristics included factors that were related to economics, parenting desires, motivation to enter and leave the profession, education and training, regulations, and job satisfaction and stability. Such factors have had both positive and negative effects on the quality of care delivered (Kontos, et al., 1995) and thus could affect the inclusion of young children with disabilities in this setting. As noted previously, there is limited research in the field on family child care providers and also providers that care for young children with disabilities. Frequently, research findings conducted in center-based settings is erroneously being applied to circumstances in family child care programs (DeBord, 1993; Trawick-Smith, 1995; Weinberger, 2000). In the next section, research strands related to

the inclusion of young children with disabilities will be reviewed. First, the rationale for inclusion of young children with disabilities in programs for typically developing children will be described.

<center>Inclusion in Community-based Settings</center>

Rationale for Early Childhood Inclusion

Several authors (Bailey, McWilliam, Buysse, & Wesley, 1998; Guralnick, 2001; Odom & McEvoy, 1988; Odom et al., 1996) have examined the rationale for the inclusion of young children with disabilities in setting with typically developing peers. Three basic arguments provide the underlying basis of inclusion: moral/ethical, educational, and legal. The moral/ethical rationale is based upon the premise that children with disabilities are, first and foremost, children. Basically this means that they have similar needs and interests as their typical peers, but may learn about and explore the world in a different way. Furthermore, this rationale reflects the belief that all children should participate with other children who have a variety of abilities, interests, and cultural backgrounds. Second, educational factors behind including children with disabilities in natural environments with their age-appropriate peers, reflects advantages to all children. Children with disabilities and children without disabilities become aware of differences and similarities between themselves and their peers (National Association for the Education of Young Children, 1997). As they play together, they develop a sense that everyone, regardless of ability or disability, has an important contribution. Third, as noted above, inclusion reflects national policy. IDEA mandates that public schools provide a free and appropriate education to children with disabilities, in the least restrictive environment (LRE).

Efforts to include young children with disabilities into educational settings with their typically developing peers has increased substantially over the last two decades (Guralnick, 2001; Odom; 2002; Scruggs & Mastropieri, 1996). Wolery and his colleagues (1993) conducted a survey in the United States to determine the extent to which general early childhood educators were or had been engaged in preschool integration. The authors mailed out 893 questionnaires and 483 (54.1%) were returned and coded. The results indicated that almost 75% of the programs that responded to the survey reported that at least one child with a disability was enrolled in their program. Additionally, they concluded that the proportion of early childhood programs that served children with disabilities increased from 37% to 74% over the period from 1986-1990. Bricker (1995) reported that the number of programs including children with disabilities has steadily increased from 1985 to 1990. These results strongly indicate that the inclusion of children with disabilities into settings with their typical peers is increasing.

The successful inclusion of young children with disabilities into programs with typically developing peers requires the involvement and participation of many groups of individuals. Teachers, child care providers, parents, administrators, and community groups each contribute in a unique manner to the quality of program outcomes and to the program's stability (Guralnick, 2001; Lieber et al., 2000). These groups of individuals have important roles in the effective and successful implementation of fully inclusive programs. Each individual carries a set of beliefs such as where children with disabilities are best educated, the role of the family in the child's early education, and the quality of community-based programs (Lieber et al., 1997; Odom, 2002).

Most studies exploring early childhood inclusion had been carried out in model, university-based settings. Odom et al., (1996) discussed the differences between the settings in the research and the settings existing in the larger community. He stated that because of these differences, the external and ecological validity of much of the research on early childhood inclusion might be questioned. Further, Marchant (1995) noted:

> Current notions of integration at the early childhood level stem from work researchers in model demonstration projects have done, yet most integrated programs for young children are taught by early childhood practitioners in real public schools or community settings. (p. 62)

The teachers in these settings are unlike most family child care providers who have minimal training requirements and faced with the challenges of operating their own business.

In the next sections, I discuss the literature related to family child care providers' experiences and perspectives as it relates to inclusion. This will be followed a review of training efforts geared towards family child care providers. Then, I briefly review the literature on child characteristics and family perceptions regarding inclusion.

Family Child Care Providers' Experiences and Perspectives

Teachers' beliefs are critical to designing and implementing a successful inclusion program (Lieber et al., 1998; Proctor & Niemeyer, 2001). "Previous research suggests that, among the many factors that determine successful implementation of innovation in the schools, teachers' attitudes play a central role" (Buysse, Wesley, Keyes, & Bailey, 1996, p 189). Lieber et al. (1998) reported that teachers' beliefs regarding inclusion centered around two perspectives. One group of teachers believed that children with

disabilities are a part of the whole group and are expected to conform to group norms. In these classrooms, the teachers presented the instructional material in a similar way to all the children. The second group of teachers modified their instruction so that children with varying abilities could participate in the activities. The authors also found that teachers choose to ignore, explain or celebrate the range of abilities among the children when facilitating peer interactions. Stafford and Green (1996) reported that teachers displaying positive attitudes toward the integration of young children with disabilities are more prone to have open communication with parents, administrators, and support personnel. Family child care providers are unlike center providers and preschool teachers in a variety of ways, so it is important to explore if theses findings can be applied to this population.

There are very few studies that have focused exclusively on family child care providers' beliefs and attitudes or have included family child care providers as participants in studies with center-based providers or preschool teachers in regards to the inclusion of young children with disabilities. The studies that were available were conducted in 1998 or later. The more recent focus on family child care providers in relationship to inclusion may be due in part to the IDEA mandates on natural environments.

Dinnebeil, McInerney, Fox & Juchartx-Pendry (1998) examined attitudes of providers in family child care and center-based child care programs towards the inclusion of young children with disabilities in community-based programs. The authors mailed out questionnaires to 698 community-based providers on the Ohio regional child care Resource and Referral mailing list. Questionnaires were mailed to 410 family child care

providers and 162 providers returned the questionnaire. Questionnaires were also mailed out to 288 center-based child care providers and 238 providers returned the questionnaire. The questionnaire consisted of 31 close-ended and 4 open-ended questions divided into five parts. A 5-point Likert-type scale was used to assess the following areas: interest in caring for children with special needs, inservice topics of interest, learning preferences, previous education, and personal information.

The results showed that providers reported high levels of experience, interest and confidence in caring for young children with disabilities. Perceptions of confidence seemed to be linked to experiences in caring for young children with disabilities. The most identified barrier to providing inclusive child care was lack of knowledge, while lack of confidence was identified second. Center-based providers were twice as likely as family child care providers to be confident serving children with disabilities. The authors noted that it is reasonable to assume that an increase in confidence levels would be linked to an increase in knowledge and experience, and therefore opportunities for professional development could positively affect the confidence levels of caregivers. Four percent of providers responded that children with disabilities should not be in settings with typically developing children.

The authors noted several limitations in the study. First, because a survey was used, the results were based on self-report data and providers' perceptions. Second, the generalizability of the findings may not be representative of the population. In addition to the providers who did not respond to the survey, there were other providers not registered through the resource and referral center. Most importantly in relation to the results for family child care provider, these results are extremely limited given that less

than half of the family child care providers responded. There may be significant differences between respondents and nonrespondents that differentially affected their responses.

With a sample of 189 providers, Buell, Gamel-McCormick and Hallam (1999) also examined the experiences and attitudes of family child care providers utilizing a survey. Specifically, the study assessed the relationship between experiences and attitudes with respect to the providers' willingness to care for a child with a disability. The researchers also examined the supports and barriers reported by family child care providers in serving children with disabilities. The respondents were participating in a statewide training conference organized by a state family child care association. The survey was distributed to 498 participants and was included as part of the conference materials. The conference was not geared toward children with disabilities, although information on serving children with disabilities was included in a few of the workshops. Other early childhood education personnel attended the conference and also received the survey. The authors adapted the Questions Teachers Often Ask about Mainstreaming and the Integration Self-Evaluation Checklist for Administrators (Striefel, Killoran, & Quintero, 1991) questionnaires to reflect the context of family child care settings. The first section of the survey included nine questions, using a 4-point Likert scale, focusing on providers' belief. The next section examined the providers' willingness to care for a child with a disability in the future. The response set was a dichotomous yes/no. The final section requested demographic data, including age, formal education level, and hours of training completed in the last year.   Three hundred and eighty-five respondents

returned the survey. However, only 189 of the respondents were family child care providers.

With regards to the providers' experience and willingness to provide inclusive care, 88 (47%) providers reported that they were willing to care for a child with a disability; 5 providers did not respond to the question. One hundred and five (55%) of the providers reported that they had cared for a child with a disability in the past; 3 providers did not respond to the questions. Most providers reported having had experience with children with one type of disability. Some providers had extensive experience with children with many types of disabilities. Providers who had previously cared for children with disabilities were more willing to provide services in the future. Additionally, providers who had cared for children with disabilities were more likely to support concepts of inclusion. Of the providers who had never cared for a child with a disability, 30 reported that they would like to provide care to a child with a disability, and 70 reported they would not like to care for a child with a disability. The supports most often expressed by both groups included increased information, the need for knowledge related to teaching strategies, and funds for special equipment

In terms of hours of training, of the providers who had cared for children with disabilities in the past, 40% of the providers had between 0 to 20 hours of training and 35% had between 20 to 40 hours of training. The number of training hours was positively related to the providers' willingness to care for children with disabilities, but not related to a belief in inclusion.

The limitations in this study were similar to the previous study (Dinnebeil et al., 1998). The providers were self-selected and had a certain level of professional affiliation

with the state family child care association. Second, the generalizability of the study

findings may be limited to family child care providers with similar characteristics

because the data was collected within one community context.

Last, to obtain a more in-depth understanding of providers' beliefs about

inclusion, Devore and Hanley-Maxwell (2000) used grounded theory to study how six

child care providers worked with a diverse group of children on a daily basis. The final

sample of participants consisted of three licensed family child care providers, two center-

based providers and one home-based group center provider. The main data source was

in-depth, open-ended individual interviews with the participants. The authors identified

five factors that contributed to the providers' ability to include the child with disabilities

in their program: a) the providers' commitment, b) finding the balance between resources

and needs, c) problem-solving with parents, d) access to emotional support and technical

assistance, and e) access to other supports. They described ways that the child care

providers starting caring for children with disabilities in their program. In some

instances, the providers were aware of the child's disability from the beginning. In other

cases, the providers learned about the disability once the child was enrolled in the

program. The authors described a situation where the parent did not inform the family

child care provider about the child who had ADHD prior to enrollment. However, the

provider made a commitment to include this child into her program and developed a

desire to seek out information on children with ADHD and other behavioral problems.

All of the providers expressed a willingness to learn and make inclusion work. The

experiences that shaped the providers' willingness was previous training in working with

children with disabilities, being aware of the need for child care in the local community,

and having grown up with a family member who was disabled. As in the Buell, et al., (1999) study, the participants' past inclusion experiences strengthened their commitment to caring for a child with disabilities in the future.   The providers had some level of training. The high representation of the providers' previous training and experience, and access to support services are not typically found among child care providers. The needs of the child were met in inclusive situations where there was a strong relationship between the provider and parent.

The authors pointed out the differences between home-based and center-based providers in caring for children with disabilities. For the family providers, the authors found that the decision to accept a child with a disability was based on their philosophy of inclusion. The providers considered their physical space, the needs of the other children, and the type of disability when deciding whether to include a child with a disability. They recommend that research be conducted to continue to investigate these differences.

Summary

The research focusing on family child care providers that serve children with disabilities in their program is extremely limited. As discussed earlier and demonstrated in the studies reviewed above, the issues for family child care providers are somewhat different from center-based providers. The knowledge base on inclusion in community-based settings is overly dependent on data from center-based settings and inadequately informed by studies on family child care programs. To facilitate participation in the community, it is necessary to expand this literature and conduct studies in various community settings, particularly family child care programs. With family child care

being a popular arrangement used by families of young children with disabilities, simply

placing children with disabilities into these programs does not ensure that the needs of the

children or provider will be addressed. The next section will review various training

models that have been developed to facilitate the inclusion of children in family child

care programs.

Interventions to Improve Services in Family Child Care Programs

Despite the lack of research examining family child care providers' attitudes and

perspectives, several training programs have been designed to increase the skills of

providers in caring for children with disabilities (Deiner & Whitehead, 1988; Giovinazzo

& Cook, 1995; Jones & Meisels, 1987; Kontos, 1988). Delaware First was designed to

train family child care providers to serve infants and toddlers with disabilities in an

inclusive child care program (Deiner & Whitehead, 1998). This program provided

ongoing support to families by incorporating out of home care into the Individualized

Family Service Plan so that early intervention services could be delivered in the context

of the family child care programs. Services provided directly to the family child care

provider included a lending library, training and technical assistance.

Project NeighborCare was a program designed to train family child care providers

to provide inclusive care (Kontos, 1988). The model was evaluated over a two year

period. Four child care providers participated in the first year, and eight child care

providers participated in the second year. The intervention included orientation

workshops to provide information on children with disabilities, followed by on-site

consultation and supervision based on the needs identified on two rating scales. The

participants were assessed on the Family Day Care Rating Scale (FDCRS). This scale

measures the child care environment and a modified self-report questionnaire of the Skills Inventory for Teachers (SIT), which was designed to assess their knowledge of early intervention. This study had a number of methodological weaknesses with the research design, sample, instrumentation, and data analysis. The researcher looked for "meaningful" change by assessing the providers on these scales before and after the intervention (Kontos, 1988, p. 7). The results indicate that the scores on the two scales increased after the intervention, but the changes were not statistically significant. The data from the first year of study was eliminated from the data analysis due to the small sample size. The validity and reliability of the instruments were not reported in the study. The criterion for meaningful change was not clearly specified, which makes it difficult to evaluate the effectiveness of the approach. Also, the author reported that the local early intervention staff did not cooperate with the researcher and expressed their resentment of the model by not referring a single child to the program. These finding have important implications for researchers attempting to intervene in community environments.

Jones and Meisels (1987) used a similar approach and described the short-term results of a three-year federally funded demonstration program designed to train family day care providers to work with children with disabilities. The goals of the project were to provide information on the characteristics of children with disabilities, to enhance interactions between the providers and all the children under their care, and to increase the providers' knowledge about child development. Workshops were conducted to share information about children with disabilities and a resource file was created on child development and how disabling conditions influence development. Visits to the family

day care homes were made to provide continuous support and consultation. Medical and educational consultants worked with parents and family day care providers. The participants were 13 family day care providers. Three outcome measures were used to assess the short-term effectiveness of the training program. The researchers developed the Classroom Integration Inventory (CII) to assess the attitudes of the providers towards children with disabilities. A case study of a child with a disability was developed and given to the participants. Participants were asked to suggest strategies to improve the child's interaction with typically developing peers. The Family Day Care Rating Scale was used to assess the environment of the day care program. The results did not indicate any significant change in the scores on the instrument used to measure attitude (CII) after six months of intervention. However, in examining the relationship between attitude and demographic variables, the researchers found that attitude was related to experience in working with a child with a disability, amount of formal education, and contact with other providers. These findings emphasize the need to provide opportunities to work with children with disabilities and support for family child care providers.

In designing the intervention programs, the researchers developed strategies a priori. Therefore the participants were not involved in planning and constructing the model. As a result, the strategies may not be meaningful to the participants and they might not feel a sense of ownership. These findings demonstrate the importance of the perspective that Trawick-Smith and Lambert (1995) emphasized when designing professional development activities for family child care providers. They discussed that trainers and family child care providers must work collaboratively in planning, designing

and implementing workshop sessions that take into the account the unique issues associated with family child care program.

A Review of Inclusion in Other Community-based Settings

More recently, research conducted in community-based early childhood settings has focused on the various forms of inclusion and attitudes and practices of families and early childhood practitioners, including teachers and administrators (Odom, 2002). Researchers as part of the Early Childhood Research Institute on Inclusion conducted studies to examine the barriers and facilitators of preschool inclusion over a five-year period.   In a review of the research on preschool inclusion, Odom and colleagues (2002) concluded with several points about preschool inclusion. The authors stated that:

1. Across a range of disabilities, positive outcomes are reported for children with disabilities and typically developing children in inclusive settings.

2. School systems are more likely to place children with mild disabilities in inclusive settings than children with severe disabilities, although there is some evidence that children with severe disabilities may profit from their placement in inclusive settings.

3. Inclusion means different things to different people. Inclusive preschool programs are located within different organizational contexts and follow different service delivery models.

4.   The quality of the early childhood environment in inclusive settings appears to be comparable to segregated special education classes and to community-based early childhood programs serving typically developing children.

5. Teachers report generally positive attitudes about including children with disabilities in their class. They feel more comfortable with and more prepared to include children with mild disabilities than children with severe disabilities.

6. Family members generally express favorable attitudes toward the inclusion of their children in inclusive programs, and positive attitudes increase over time. However, families also voice concerns about preschool inclusion.

Child Characteristics

Two dimensions of child characteristics, type of disability and severity of disability, are discussed in the literature on early childhood inclusion. Odom et al. (2002) stated that the disabilities most frequently identified in the research on preschool inclusion were hearing impairment, visual impairment, Down Syndrome, and autism. The authors reported that for children with hearing impairment, issues related to types of intervention, intensity of services, locations for service and the deaf culture are entangled with the issue of inclusion. In addition, they stated that placement of children with autism in inclusive settings is a continuing debate in the field.

Research has demonstrated that the severity of a child's disability affects the placement in inclusive or noninclusive programs. Several researchers have found that children with mild disabilities are more likely to be placed in inclusive settings than children with sensory, severe, or multiple disabilities. For example, Buysse, Bailey, Smith, and Simeonsson (1994, cited in Odom, 2002) revealed that more mildly disabled and higher functioning children were placed in inclusive programs as compared to children in segregated programs. Bruder and Staff (1998) found that for toddlers with moderate and severe disabilities, there were no significant differences in developmental

gain between children in inclusive settings and children in segregated setting, even though the amount of related services was greater in segregated settings.

Family Perceptions

Families of children with and without disabilities participating in inclusive settings generally have positive attitudes toward inclusion (Guralnick, 1994; Peck, Carlson & Helmstetter, 1992). In addition, although families identify concerns regarding inclusion, they have reported several benefits of inclusion for children with disabilities and children without disabilities. For children with disabilities, the benefits include: positive social contact and friendships with children without disabilities (Bennett, Deluca, & Burns, 1997; Guralnick, 1994; Guralnick, Connor & Hammond, 1995); increased acceptance from others (Bailey & Winton, 1987; Guralnick, 1994); preparation for the real world (Bailey & Winton, 1987; Guralnick, 1994); opportunities to learn (Guralnick, 1994); and developmental gains (Salend & Duhaney, 2002). For children without disabilities, the benefits include: increased knowledge of disabilities (Green & Stoneman, 1989); increased sensitivity and acceptance of differences (Green & Stoneman, 1989; Peck et al., 1992); increased empathy (Green Stoneman, 1989) and more responsiveness to other children (Peck, Carlson & Helmstetter,1992).

Several researchers have also examined the concerns expressed by families about inclusion. Families of children with disabilities report concerns about obtaining special services for their child (Guralnick, 1994; Peck et al., 1989); obtaining needed assistance and/or individualized instruction from teachers (Guralnick, 1994; Peck et al., 1989); negative attitudes towards people with disabilities (Beckman et al., 1998; Hanline & Halvorsen, 1989) and; inadequate preparation of teachers (Bailey & Winton, 1987; Green

& Stoneman, 1989; Peck et al., 1989).   Families of children without disabilities report concerns about the amount of time teachers will have to attend to their children and whether children with disabilities will negatively influence the behavior of their own children (Guralnick, 1994).

The effect of family-provider relationships on inclusion has also been investigated. One study investigated the parents' and service coordinators' descriptions of factors that influence collaborative relationships (Dinnebeil & Hale, 1996). Parents and service coordinator expressed that personal and family characteristics, ways of working together, knowledge base, philosophical beliefs and values, beliefs into practice, and outside influences were the major factors affecting collaborative relationships. A belief in family-centered practices was found to be central to effective communication.

In the next section, I highlight the results from several studies done on inclusion in child care programs in Maryland (Maryland Committee for Children, 2001; Maryland Developmental Disabilities Council, 2004). Findings related to families of children with disabilities and family child care providers experience in caring for children with disabilities will be discussed.

Inclusive Child Care in the State of Maryland

In April 2000, 13,901 surveys were mailed by the Maryland Committee for Children (2001, June) to family child care providers with a return rate of 11.2% (1,273 surveys). The survey inquired about their experience caring for children with disabilities, barriers they perceived, and training needs related to caring for children with disabilities. 67.7% indicated they had experience caring for children with disabilities and 32.2% reported that they were currently caring for a child with a disability. They were most

experienced with children with social emotional disabilities. 17.5% of the providers that had experience caring for children with disabilities had a child of their own with a disability.

The providers reported the following barriers to caring for children with disabilities in order of greatest identified: staff costs, capital costs, liability, knowledge about disabilities, safety, aggressive behavior, knowledge about regulations and diapering. Staff costs were related to providers not having the funds to hire another person when one-on-one attention was needed for children with severe disabilities.

The survey also examined provider perceptions regarding the availability of disability-related training. Of the providers surveyed, 41% agreed, while 42.3% disagreed when given the statement, "Professional training on the topic of special needs is not available." The opposite statement was given, "Professional training on the topic of special needs is available," and 46.3% of the providers agreed while 33.3% disagreed. The survey also asked providers to indicate their training preferences. The providers reported convenient locations, reduced training fees, Saturday trainings, and evening trainings as factors that would increase their attendance in available training. The top resources that providers needed to enable them to care for children with disabilities were: access to specialized equipment, one-on-one assistance, telephone resource line, support groups and a resource library.

More recently a survey was conducted with family members of children with disabilities regarding their experiences in locating child care. Families surveyed by the Maryland Developmental Disabilities Council (2004) reported many of the same barriers in finding and keeping child care as found in the literature briefly reviewed above.

Barriers identified included providers who were unwilling to accept the child, lack of quality programs, lack of provider knowledge, high cost of care, behavior issues and poor attitudes of child care staff. When asked what types of child care families had used, 30% of families responding reported using family child care providers, 27% reported using a family member or neighbor, 25% reported using child care centers, 23% reported using before and after-school care programs, 15% reported using in-home care, 8% reported involvement in a Head Start program, 6% reported using nanny or au pair services, and 2% reported using another child care arrangement. When asked whether they had difficulties in finding, obtaining, or keeping child care, 83% of respondents said "yes." When asked the reasons for these difficulties, the number one barrier to obtaining and/or keeping child care was a lack of provider willingness. Finally, parents reported that they had to quit their job (42%), rely on relatives or friends (33%), change jobs (15%), or retire (2%) when they were unable to find child care. Another 8% reported other alternatives including leaving their children under the care of siblings, taking family leave or taking their children to work.

<div align="center">Significance of the Study</div>

Despite the research that has been conducted on including young children with disabilities in community-based settings, there are still areas in which more information is needed. Most of the literature on early childhood inclusion has focused on providers in center-based settings. However, the literature has shown that families of young children with disabilities may often prefer family child care programs for various reasons. In addition, there are major differences between family child care providers and providers in center-based programs. Family child care providers combine their own family structures,

economic conditions and face special challenges, in order to care for the children in their programs. There is a need to know more about the experiences and perceptions of family child care providers as they include young children with disabilities.

To obtain information from family child care providers regarding inclusion, it is necessary to record their experiences while they are in the process of including children with disabilities into their program. Compared to a retrospective or prospective study, research conducted during the occurrence of the event is likely to provide more detailed and comprehensive information about the process and the interactions between people and events (Bodgan & Biklen, 1998). Using the bioecological systems framework proposed by Bronfenbrenner (1979), it may be inferred that to develop a better understanding of family child care providers' perspectives, it is necessary to study providers' actions in the context in which it occurs.

The primary purpose of this study was to observe, describe and analyze the experiences and perspectives of the family child care providers as they care for young children with disabilities. Information gained from the study could serve as the beginning basis for future efforts aimed at evaluating, regulating or improving the quality of inclusive experiences for young children with disabilities in family child care programs. Without an understanding of the issues facing family child care providers, professional development activities, training, and support services geared towards family child care providers may be limited.

I identified four central questions to be addressed in the present study. The research questions are:

1. What factors encourage family child care providers to accept young children with disabilities in family child care programs?

2. What strategies are used by family child care providers to include young children with disabilities in family child care programs?

3. What supports do family child care providers receive while caring for young children with disabilities in family child care programs?

4. What barriers are reported by family child care providers who care for young children with disabilities in family child care programs?

CHAPTER III

METHODOLOGY

In this chapter, I describe the multiple case study method used to conduct this study. First, I discuss qualitative methodology and the multiple case study approach. Second, I present the research questions. Next, I introduce the setting and participants (more detailed descriptions are included in Chapter IV). This will be followed by a discussion of the data collection methods and data analysis. Then I describe the techniques that were used to verify the research findings. Finally, I present ethical considerations in conducting case study research.

Qualitative Methodology

This study used qualitative methodology based on multiple case study principles and techniques to analyze the experiences and perspectives of family child care providers who care for young children with disabilities in their programs. Lincoln and Guba (1985) and others constructed a language distinct from the traditional research language in order to emphasize the qualitative paradigm. Words such as "understanding," "discover," and "meaning" are commonly used to describe qualitative research. In addition, the language of qualitative studies is personal, informal, and based on definitions that evolve during the study.

Several authors believe that qualitative research is best used to discover themes and relationships at the case level, while quantitative research is best used to validate those themes and relationships in larger samples (Creswell, 1994; Marshall & Rossman, 1995). In this view, qualitative research plays a discovery or exploratory role. Additionally, in qualitative methodology the research design is emergent and inductive

logic exists (Lincoln & Guba, 1985). Categories emerge from data collected from

participants, rather than identified a priori by the researcher. This emergence provides

rich "context-bound" information leading to patterns or theories that help explain a

phenomenon (Lincoln & Guba, 1985).

According to Merriam (1988), qualitative research entails the following five

assumptions:

1. Qualitative researchers are concerned primarily with process, rather than
   outcomes or products.

2. Qualitative researchers are interested in meaning – how people make sense of
   their lives, experiences, and their structures of the world.

3. Qualitative research involves fieldwork. The researcher physically goes to the
   people, setting, site, or institution to observe or record behavior in its natural
   setting.

4. Qualitative research is descriptive in that the researcher is interested in process,
   meaning, and understanding gained through words or pictures.

5. The process of qualitative research is inductive in that the researcher builds
   abstractions, concepts, hypotheses and theories from details. (p. 19-20)

Thus, qualitative methodology is an appropriate way to understand the phenomenon

being studied from the perspective of the individual in the natural setting.   In this study,

it served as a way to examine the meanings that family child care providers attach to the

process of including children with disabilities in their child care programs.

Multiple Case Study Methods

A case study is one type of qualitative research described by Creswell (1998) as "an exploration of a bounded system or a case (or multiple cases) over time through a detailed, in-depth data collection involving multiple sources of information rich in context" (p. 61). Yin (2003) defined a case study as an "empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (p.13). Yin further stated that case studies can be used for different purposes: exploratory, descriptive, and explanatory. When researchers are interested in exploring and describing an event or phenomena, an exploratory or descriptive case study is used. In contrast, when the researcher's goal is to explain a set of events and answer how and why questions, explanatory case studies are conducted. There are several different types of case studies including single and multiple case studies, comparative case studies, instrumental case studies, life histories and those that use both quantitative and qualitative methods (Bogdan & Biklen, 1998; Creswell, 1998; Yin, 2003). The data collection is extensive and includes multiple sources of information such as interviews, observations and document analysis.

In summary, the case study approach is an appropriate method for addressing the research questions of this study by exploring the contextual factors that impact the process of including young children with disabilities into family child care programs. Since the focus of this study was on how family child care providers include children with disabilities into their programs, a multiple case study approach was used. Four family child care providers were purposefully chosen in order to explore the ways in

which they included children with disabilities. As stated previously, case studies can be used for different purposes. Given the current limited knowledge base available regarding the participation of young children with disabilities into family child care programs, the purpose of this study was exploratory and descriptive.

Research Questions

Research questions state what the investigator wants to learn. In qualitative studies, initial research questions help to focus the study and provide guidance on data collection (Miles & Huberman, 1994). These questions assist the researcher in defining from whom, when, how and what kind of data will be collected. In qualitative research, the research questions may be refined and more specific questions developed as data collection continues (Maxwell, 1996). Marshall and Rossman (1995) stated that, "initial questions for research often come from real-world observations, dilemmas, and questions and have emerged from the interplay of the researcher's direct experience, tacit theories, and growing scholarly interests" (p.16). This study was guided by the following four broad research questions:

1. What factors encourage family child care providers to accept young children with disabilities in family child care programs?

2. What strategies do family child care providers use to include children with disabilities into family child care programs?

3. What supports do family child care providers receive while caring for young children with disabilities in family child care programs?

4. What barriers are reported by family child care providers who care for young children with disabilities?

Setting

The study was implemented in a large, northeastern county in the state of Maryland. This county offers a diversity of populations and is representative of urban as well as suburban settings. At the time of the study the population in the county was approximately 773,810. The racial composition was 77.2% African American, 11.5% White American, 7.5% Hispanic, 3.3 % Asian/ Pacific Islander and 0.5% American Indian. Services for children with disabilities are provided through the local public school system. There were approximately 137,299 students enrolled in the public schools at the time of the study. A total of 11,922 of these students were receiving special education services from infants through 21 years of age. Approximately 3,400 children were receiving services through the Infants and Toddlers Program and Preschool Special Education Program. The Infants and Toddlers Program is part of the statewide program of early intervention services for infants and toddlers up to 36 months of age who are experiencing developmental delays, are at risk for developmental delays, or have a diagnosed condition. The Preschool Program serves children with disabilities from 3 years up through 5 years of age.

Recruitment

The main informants in this study were licensed family child providers who were currently caring for a child with a disability or developmental delay in their program. Parents of children with disabilities being cared for in the family child care programs and administrators/professionals involved in training, licensure and supporting family child care providers also served as key informants in the study. A purposive sampling technique was used (Patton, 1990), in which particular settings, persons or events are

chosen on the basis of their relevance to the subject of inquiry. Maxwell (1996)

emphasized that selecting participants who can provide the researcher with the

information needed to answer the research questions is the most important consideration

in qualitative sampling decisions. Purposeful sampling limits the generalizability of the

findings, but instead focuses on gaining an understanding of the conditions under which a

particular finding appears and operates (Miles & Huberman, 1994). The sample of

family child care providers was drawn purposefully based on the following three salient

variables:

- the provider had to be currently serving a child with a disability or developmental delay between the ages of birth to five;

- the child with a disability or developmental delay had to have been enrolled in the family child care program for a period of at least six consecutive months; and

- the child had to also be currently enrolled in either the county's Infants and Toddlers Program or Preschool Special Education Program.

The first two characteristics were chosen to understand how care is provided on a daily

basis, as well as over time. The third characteristic was chosen so that I was ensured that

the children in the study were formally and legally identified as having a diagnosed

disability or developmental delay and receiving services and not solely being identified

by the family child care provider.

Potential family child care providers were solicited using multiple methods. I

presented my study to service providers (i.e., special educators, physical therapists) and

administrators in the Infants and Toddlers Program (ITP) and Preschool Special

Education Program in the county. Service providers in the ITP may deliver services to

children in community-based settings such as family child care programs. These

providers have direct contact with family child care providers. They were asked to

identify potential participants and to take out a letter describing the study on their next

session. In addition, I presented the study to all the service coordinators within the ITP to

solicit their help in recruiting participants. I asked the service coordinators to find out if

any of the families were using family child care programs for their children. Of all of the

strategies that I used, this proved to be the most successful in obtaining participants. This

is likely due to the fact that the family child care providers were hearing about the study

through personal contact. However it took several months of contact with potential

participants before I recruited three family child care providers for the study through this

method. In several instances, the family child care providers initially agreed to

participate and later due to unforeseen circumstances were unable to participate. For

example, I contacted a potential participant who met the criteria and we scheduled a

meeting time to further discuss the study and sign the consent forms. I received consent

from both the provider and family and we scheduled the first interview. Before the

interview took place the participant called to inform me that the child in her program was

having surgery and she was not sure how long he was going to be out of care. She

contacted me about a week later and stated that the child was not back in her care and she

no longer wanted to participate in the study. In another instance, I contacted a potential

participant who had cared for many children with disabilities for several years. She

informed me that she had heard about my study through three different sources; a class

she was taking at the local community college, the program where she volunteered on

Saturday mornings and through a parent of a school age child with a disability currently

in her program. She was excited about the study and wanted to participate because of her previous years of experience including children with disabilities. She met the criteria and was currently caring for three children with disabilities, one of whom fell within the age range specified. However, because she was currently taking two classes and volunteering on the weekend, she asked if she could begin participating in about two months. We scheduled a time when I would contact her in the future. I made several attempts, without success, to contact the provider during our agreed upon time frame. I soon learned from the ITP provider that the family of the child was in the process of mediation with the local school system regarding special education services and that was why she never returned my calls regarding the study.

I contacted the local child resource and referral agency and obtained a listing of family child care providers in the county from their database. Figures at the time of the study revealed that the database at the resource and referral agency contained approximately 2,250 licensed family providers and 300 child care centers in the County. The database is continually updated as the agency receives copies of new licenses from the State's licensing agency.   The local child resource and referral agency provides training and technical assistance during and after the child care licensing process. The listing of family providers contained a general sample of 23 providers from across the county and included partial contact information. I researched and obtained the name and full address for 15 of the providers and mailed them a letter with information regarding my study. None responded in regards to participating in or finding out more about the study.

The two local family child care associations were also sought as sources for potential participants. These organizations include licensed family child providers in the county. The function of the associations is to provide support and assistance to family child care providers as they care for children, as well as bring the job stature of family child care providers to a professional standing. I contacted the Presidents of these associations and received permission to place information about my study in their newsletters. Four family child care providers contacted me after reading about the study. Of the four providers, one met the criteria and was selected as a participant in the study. Two providers met the criteria, but shortly after contacting me, the children were no longer attending their programs. In one case the family moved out of state and in the other case the mother of the child became unemployed and was temporarily discontinuing child care. The last provider did not have a child with a disability current enrolled in her program, nor had she cared for children with disabilities in the past. However, she contacted me because she was very interested in working with children who were deaf or hearing-impaired. She wanted to know where she could learn sign language, Spanish, and receive additional training on including children with disabilities. She stated that if a parent of a child with a disability came to her for child care services, she wanted to be prepared to receive the child. She further discussed the need for training for child care providers. She stated that she had taken the "special needs" classes that were required through the Child Care Administration, but wanted more information on continual training. As the conversation continued she revealed that her own son had learning disabilities. I provided her with information on sign language classes that were offered through the Family Support Network in the county. I also informed her that sign

language and Spanish classes were available through the local parks and recreation

program and through the community college. I e-mailed her links to appropriate websites.

In addition, I attended meetings held by the associations. I was given time at the

end to share information about my study. Approximately 20-30 family child care

providers attended. When asked if any providers had children with disabilities currently

in their program several providers indicated yes. I sought out the providers at the end and

provided them with written information about the study including my contact

information. I was also able to obtain contact information for a few of the providers.

Only one met the criteria because the children were either older than five years of age or

had not been enrolled in the program for at least six months. In the one case, the child

was within the age range, but the provider was also serving as the child's foster parent.

I continued my search for family child care providers and contacted the director

of an organization in the state that focused on improving child care services for children

with disabilities. This organization provides direct consultation to child care programs

(family and center). I described my study to the director and she agreed to mail out

information regarding my study to providers in the county that they had consulted with in

the past. Approximately 50 providers were listed. None contacted me as a result of the

mailing.

I again contacted the local child resource and referral agency and obtained a

second listing of family child care providers in the county. This list was more detailed

and provided full contact information including address and telephone number for each

provider. The second listing only included providers that had indicated they had previous

experience with children with disabilities. I started at the top of the list and made phone

calls to solicit participants for the study. I kept a record of the calls and conversations

that I had with each provider. Often when talking to providers that did not meet the

criteria, they provided contact information of other providers who they thought were

caring for children with disabilities. I contacted 8 providers from the list and 10

providers that were referred by the providers on the list. None were currently caring for a

child with a disability. Three were currently caring for a child with a disability and were

interested in participating. I arranged meetings with each provider to review the study

and leave the consent forms for the parents. In one case the child was not in the age

range. I explicitly remember this provider asking me the question "what's in it for me" in

regards to participating in the study. I could only tell her that she would have an

opportunity to share her story and possibly help other family child care providers include

children with disabilities. She was caring for a nine year old child with mental

retardation. The mother told her she was looking for child care for her two daughters, but

was not upfront about the oldest child having a disability prior to visiting her program. It

was not until the initial interview with the mother that the provider had a chance to

observe the child crawling around on the floor. She got down to the child's level to see

how she would respond to her. After interacting with the child, the provider agreed to

care for her and her younger sister. She reflected on her experiences and like almost all

of the providers previously, discussed the need for training for family child care

providers. She explained that providers also need money to purchase equipment and

materials to include children with disabilities. She expressed concerns about the younger

sister's development and felt certain that the she had a delay in communication, fine

motor and adaptive skills. She pleaded with me to use the younger sister as the subject

child so that she could participate in the study. However, because the child did not have a formal diagnosis and was not participating in the preschool special education program, she did not meet the criteria. She explained that her own son had a mild hearing loss that was detected when he was around two-years-old and demonstrated language as a toddler. I asked the provider if she knew of any other providers who were caring for children with disabilities, and she provided me with a name and phone number of one of her peers. I also asked her about ways to recruit other providers, since her initial question was "what's in it for me". She gave me language to use when contacting potential providers. She even offered to talk to other providers to describe the benefits of participating in the study from a child care providers' perspective. I was amazed at the transformation from our initial phone conversation to the end of the meeting. I sent her information related to the referral process for the ITP and preschool special education programs as well as local training opportunities. In another instance, a provider was caring for two young children with disabilities. The children were 2 and 3 years of age and were diagnosed with Autism and Spina Bifida respectively. The child with Spina Bifida used a wheelchair. The provider was very interested in sharing her stories of including children with disabilities, and I spent approximately two hours talking with her during the initial meeting. Because consent had not been received from the parents of the children, I made notes about the conversation to ensure that the information would be discussed in any subsequent formal interviews. At one point in the conversation, with tears in her eyes, she described how as a teenager, she and her sister would come up from the south every summer to assist her aunt with taking care of her cousin with multiple disabilities. During the summer once schools were closed her aunt could not find child care for her

cousin. She now understood what her aunt had experienced in the last twenty years

attempting to locate child care. The provider discussed the discrimination she heard from

other providers in accepting children with disabilities. She further went on to explain

how these experiences in her life was one of the main reasons why she readily accepted

children with disabilities into her program. Also as in previous conversations, the need

for training came up again as a barrier to serving children with disabilities during our

meeting. Unfortunately, despite her efforts, none of the parents agreed to participate in

the study. In the last instance, the provider and the parent both consented to participation

in the study, but the child was terminated from the program a short time later. I first

contacted the provider at the beginning of June and we scheduled an initial meeting.

During this meeting she informed me that she was in the process of moving and would be

available for the interviews and observations during the third week in July.   I contacted

her at that point and we conducted the first interview. However, when I tried to schedule

the observation, she informed me that the child was on vacation with his aunt and uncle

and would away for approximately 2-3 weeks. The child lived with his grandmother, but

the child's mother was responsible for providing the payment for child care services.

While the child was away with his relatives, the mother did not pay the provider. In

addition, she did not pay for the next month and the provider contacted the grandmother.

The grandmother would call to find out if her daughter had paid. Because of the family's

situation and the provider attended high school with the mother of the child, she held the

slot for the child for a longer period of time than normal. She contacted the grandmother

and gave her a deadline to receive payment or she would have to discontinue service.

During this time, the provider kept me updated on the situation and we did not schedule

any further interviews. I wanted to make sure that the child was going to continue in her

care before continuing with the interviews. Payment was never made, and the child was

terminated from the program. During our initial meeting and interview, the issue of

training and parent-provider relationships was discussed.

I continued the procedures described above until four family child care providers

were recruited for the study. Given the number of family child care providers in the

county, I was initially surprised with how difficult it was to find and retain providers that

met the criteria. During this process I often thought about the difficulty families of

children with disabilities reported in finding child care for their children. I discussed the

recruitment process in detail to note several common themes that emerged from my

conversations with the providers. All of the providers either had a child with a disability,

a family member with a disability or some other exposure or experience with children or

adults with disabilities prior to beginning child care.

Participants

The participants consisted of four family child care providers, Mrs. Shelly, Terry

Williams, Kathy Smith and Felicia Davis, who were caring for children with disabilities.

They all had previous experience in caring for children with disabilities in their programs.

As can be seen in Table 1, three of the providers were African-American and one was

Caucasian. The providers ranged in years of child care experience from 1.10 years to

17.5 years. They also ranged in terms of education from having a high school diploma to

receiving a Masters of Science degree. Additionally, all but one provider had children

living at home. The children were diagnosed with the following disabilities: Speech and

Language Impairments, Autism, Erbs Palsy (Brachial Plexus Paralysis), and Down

Table 1 – Description of Family Child Care Providers

Provider's Name	Years in Child Care	Ethnicity	Education	Previous Exper. w/Disability	Child's Name	Child's Disability	Age of child	# of Interviews	# of Program Observ.
Mrs. Shelly	1.10	African-American	M.S. Counseling	Son w/ ADD, Mental Health Counselor	James	Speech/Lang.	3	4	3
Terry	12	African-American	B.A. Business Admin.	previous children	Arianna	Erbs Palsy	2	4	3
Kathy	17.5	Caucasian	High School Diploma	family member	David	Autism	2	4	4
Felicia	7	African-American	A.A. Business Admin.	daughter w/Cerebral Palsy	Kevin	Down Syndrome	5	3	3

Syndrome. Detailed descriptions of each family child care provider and child will be presented in Chapter IV.

For each provider I scheduled an initial meeting to discuss the study. During these meetings, I explained the purpose of the study, the criteria for participation and discussed the data collection procedures involved in the study (i.e. interviews and observations). I further reviewed the consent form (Appendix A) asking permission to audiotape the interviews and emphasized that measures would be taken to ensure confidentiality. I answered any questions the providers had related to the study. After each provider agreed to participate, the consent form was signed and a demographic data form (See Appendix B) was completed. I thought it was important for the providers to have a chance to meet with me in person, before approaching the parents about participating in the study.

The parents of the children with disabilities being served by the family child care providers were also key informants in the study.   At the initial meeting with the provider, I left consent forms and highlighted my contact information. The consent forms stated that I would be conducting observations of the interactions between the provider and their child, and that I wanted to conduct an interview with the parent. Before any providers were selected for participation and initial interviews held, I obtained signed consent forms from the parents of the children with disabilities being served in the family child care program. I contacted the parents and scheduled interviews with them at their convenience. Three of the four parents were interviewed for the study.

Another group of informants were three administrators and professionals involved in training, licensure and supporting family child care providers (see Table 2). I had hoped to interview both of the presidents of the local family child care associations.

Table 2 – Description of Administrators/Professionals

Administrator/ Professionals	Organization	Position
John	Child Resource and Referral Agency	Special Needs Counselor
Regina	Organization focused on Education, Training and Advocacy for People with Disabilities	Director of Program that fosters inclusive childcare
Bill	State Child Advocacy Organization	Director of Training and Technical Assistance

However, when I contacted the one of the presidents, she was in the process of moving out of state, and therefore, unable to participate in the study. The other president was not able to participate at the time due to work and family related responsibilities. The Special Needs Counselor, John, at the local child resource and referral agency also served as an informant in the study. John conducts workshops on The American with Disabilities Act as it relates to child care and provides information on including children with disabilities in child care programs. He also assists parents of children with disabilities in finding available child care. Two administrators working at state level organizations that focused on improving child care for all children were also identified as participants. The first administrator, Regina, was the director of an organization that works together with families, child care professionals and other education and service agencies to collaborate in successfully including children with disabilities into community settings. The second administrator was Bill, the Director of Training and Technical Assistance at a child advocacy organization that works with parents, child care providers, advocates, employers, and policymakers to expand and enhance the early childhood education and child care available to children in the state. I contacted all of the administrators and professionals by phone. The nature and intent of the study was described and they all agreed to participate. An interview was scheduled at their convenience.

Maryland Family Child Care Regulations

In Maryland, a family child care provider is licensed by the Office of Child Care (Maryland State Department of Education, 2006). Providers can care for up to eight children in the home. This number includes the provider's own children if under age six. The provider may care for no more than two children under the age of two unless two

licensed providers are present at all times. Several steps are involved in the licensing

process. Potential providers must attend and complete two orientation sessions. The first

orientation session is primarily intended to familiarize the person with the application

process and the requirements to receive a certificate of registration. The second

orientation session is intended to assist potential providers with understanding how to

comply with family child care regulations, including regulatory requirements concerning

child health and safety, child supervision, and general program operations. Pre-service

training consists of a minimum of 8 clock hours of approved training in a topic or

combination of topics related to child development, program curriculum, child health and

safety, the care of children with disabilities or provider professionalism. A skills-based

CPR and First Aid Certification is needed and a SIDS (Sudden Infant Death Syndrome)

course is required if planning to care for children younger than two years old. Others

requirements are related to a home inspection for (1) safety, (2) properly equipped for

child care, and (3) fire safety. Minimal background investigations and medical check-ups

are conducted for all of the members of the household. Providers must have substitutes,

but can use them only for a very limited number of hours per year. At the time of the

study family child care providers were licensed for two years.

     Additional data available on family child care providers in the Maryland report

was related to association membership. Over one-fourth of the providers belonged to a

family child care association. In the county that this study was conducted in, 22.7% of

the providers were members of a local association.

Methods of Data Collection

Creswell (1998) defined data collection as "a series of interrelated activities aimed at gathering good information to answer emerging research questions" (p.110). The main sources of data were in-depth, open-ended individual interviews with family child care providers, parents of children with disabilities being served by the family child care providers and administrators/professionals. Observations of interactions between family child care providers and children with disabilities in their programs provided additional sources of information. Finally, a document analysis of the family child care providers' policies and procedures and state policies on licensing and regulations served as additional data sources. The use of multiple data sources allowed the data to be triangulated, which helped to enhance the credibility of the data (Merriam, 1998; Miles & Huberman, 1994).

I collected data from each family child care provider one at a time, returning to earlier providers as needed for follow-up data. This strategy was suggested by Bogdan and Biklen (1998) who argued that conducting research at more than one site at a time can become confusing. The following is a discussion of the rationale and the research procedures that were employed during the interviewing, participant observation and document analysis.

Interviews

In-depth interviewing is one of the most important data collection methods used by qualitative researchers. Bogdan and Biklen (1998) described in-depth interviewing as "unstructured," "open-ended," "nondirective," or "flexibly structured." They stated that the open-ended nature of the approach allows the subjects to answer from their own

frame of reference rather than from one structured by prearranged questions. Spradley (1979) described interviews as "as a strategy for getting people to talk about what they know" (p. 9). Loosely structured interview guides may sometimes be used, but most often the researcher works at getting the subjects to freely express their thoughts around particular topics.

Establishing rapport with the participants is a primary factor in interviewing. According to Whyte (1984), a significant part of the interview involves building a relationship, getting to know each other, and putting the participant at ease. Several strategies that facilitate the development of rapport have been identified. These include the formality of the interview and the form of questioning used in the interview.

Interviews should not be formal, questionnaire-driven exchanges (Eisner, 1991). It is important for the interviewer to build a relationship and put the participant at ease. The interviewer should not control the content too rigidly, but allow the participant to tell his or her story personally in his or her own words (Bogdan & Biklen, 1998). The researcher should have excellent listening skills and be skilled at personal interaction, framing of questions, and gentle probing for elaboration (Marshall & Rossman, 1995). A good interviewer is a listener rather than a speaker during an interview (Creswell, 1998). "Good interviewers communicate personal interest and attention to subjects by being attentive, nodding their heads, and using appropriate facial expressions to communicate" (Bogdan & Biklen, 1998, p. 95). Creating an environment where the interviewer engages in deep listening and the participant is regarded as the expert in what the researcher is interested in finding out, will produce more in depth and personal information.

The type of interview questions employed, in addition to the formality of the interview, can help develop rapport and lead to a more effective interview. Spradley (1979) described five main types of descriptive questions: grand tour, mini tour, example, experience and native language. Grand tour and mini tour questions describe broad experiences and then a specific event or activity. Example questions take some idea or experience and ask for an example. Experience questions ask about experiences in particular settings. Finally, native language questions ask about what certain words or terms mean to the participant.

Interviews: Research Procedures

In this study, using the guidelines stated above, I established rapport with the participants. I engaged in data collection for a period of approximately 1 ½ years, which assisted in establishing the rapport and developing the trust necessary to conduct this research. I contacted each participant by phone prior to the interview for confirmation. Written consent to participate was obtained before the initial interview begins. All interviews were audiotaped and transcribed verbatim. I also maintained fieldnotes on informal conversations and phone calls that occurred during the study.

As described above, I held initial meetings with the providers and obtained written consent from the provider and parents before the first interview was scheduled. Interviews were arranged at a location and time convenient for each family child care provider. I contacted each provider by phone a few days prior to the interview for confirmation. The majority of the interviews were conducted in the homes of the providers often after the children left in the evening. With one provider, in addition to her home, we held interviews at the library and in her vehicle. All of the interviews were

one-on-one, involved open-ended questions as recommended by Bogdan & Biklen (1998) and were audiotaped and transcribed verbatim. As suggested by Marshall and Rossman (1995) I created an outline of possible interview questions developed from the literature review (See Appendix C). The purpose of the first interview was to obtain background information (i.e., how did you become a family child care provider?) and to begin to gain trust and develop a relationship. As interviewees responded, I asked more focused and specific questions. I conducted follow-up interviews to clarify specific issues raised in the previous interview and to probe for additional information. I conducted subsequent follow-up interviews as needed until information regarding the inclusion process was exhausted. I conducted at least four interviews with each family child care provider. Each interview lasted from 1 ½ hours to 3 hours, depending on the interviewee's schedule and responsiveness. When the interviews started going beyond the 1 ½ to 2 hours period, I would check in with the provider frequently about stopping and rescheduling the next interview. For most of the providers we were meeting right after the children left which did not allow them time for their own family responsibilities, such as preparing dinner and conversing with their spouses. I wanted the provider to know that I respected and appreciated the time they were making for me in their already long day. I also conducted more informal interviews as needed, in the form of short conversations on the phone. I documented information from these informal conversations in fieldnotes.

In addition to interviews with providers, I also conducted an open-ended interview with three of the parents of the children with disabilities in the study. These interviews were audiotaped and transcribed verbatim. The interviews were conducted in

their homes at a time that was convenient for them and typically lasted no more than 1

1/2 hours. The one parent that I did not interview was going through a divorce and not

available for the interview. When discussing possible ways to schedule an interview with

this parent, the provider stated, "I can't get her to give me a change of clothes, so I doubt

if she will follow through with scheduling the interview." One of the main purposes of

interviewing the parents was to find out about any previous child care experiences and

how they located and enrolled their child in the current family child care program. I also

explored the parents' view regarding the inclusion of children with disabilities in family

child care programs and the relationship between the providers and parents. The parents

were also asked to complete the child demographic data form (See Appendix D).

Finally, interviews were conducted, audiotaped and transcribed verbatim with the

three administrators and professionals (see page 67) in the participants sections. The

interviews occurred in the participant's place of choice. I met two participants at their

office. One interview was held over lunch at a local restaurant with an administrator

before he attended another meeting. Although I was unable to   interview the president of

a local family child care association, I spoke with her after association meetings

regarding the participation of children with disabilities into family child care programs.

Participant Observations

A second source of data for the study was direct observations of interactions

between family child care providers and children with disabilities in their programs.

"Observation often enables you to draw inferences about someone's meaning and

perspective that you couldn't obtain by relying exclusively on interview data" (Maxwell,

1996, p. 76). Participant observation involves the researcher spending a substantial

amount of time in the setting, learning about daily life. Bogdan and Biklen (1998) define

participant observation as "the researcher enters the world of the people he or she plans to

study, gets to know them and earns their trust, and systematically keeps a detailed written

report of what is heard and observed" (p. 2-3). It differs from ordinary observation in

that the researcher concurrently reflects on his or her own reaction to what is observed.

Therefore, the researcher addresses the issue of objectivity, not by maintaining an

objective stand, but by understanding how he or she is influenced and in turn has

influenced the situation.

Generally, my position was "observer as participant" (Glesne & Peshkin, 1992).

This allowed me to hear, see and learn about behaviors and the meanings attached to

those behaviors.

Participant Observation: Research Procedures

The observations occurred during the family child care providers' normal

business hours, and the timing of the visit was when the child with disabilities was awake

and engaging in typical daily activities. I observed each family child care program at

least three times with the observations lasting from 2 hours to 4 hours. This allowed me

to observe the routine activities of the family child care provider and child, and make

detailed observations of people, interactions and events that occur (Glesne & Peshkin,

1992). I maintained a running record of major events in a field log. Extensive field

notes, both descriptive and reflective, were taken during the observations. Descriptive

field notes included the following: portrayal of the provider and child; conversations and

interactions between the provider and child; description of the physical setting;

description of program activities (i.e., free play, circle time, outdoor play); and my

observer comments and behaviors. For example, there were times when the children in

the program wanted me to read a story to them or engage in play activities. I tried to

remain passive, simply observing and writing fieldnotes, but never ignored the children.

Reflective notes highlighted my personal feelings, ideas, impressions, and concerns. I

often audiotaped myself while driving home in an effort to capture my impressions and

observations. I included these comments in that day's fieldnotes.

Document Analysis

To further support the data obtained from the observations and interviews, a

document analysis was conducted. This method was used for triangulation of the data.

Triangulation involves utilizing different sources and methods to study the same

phenomenon (Miles & Huberman, 1994). Document analysis was used to help confirm

or validate the data collected through the interviews and observations. Document

analysis is unobtrusive, nonreactive and can be conducted without disturbing the setting

in any way (Marshall & Rossman, 1995).

Documents such as policy statements (fees, absences, safety, withdrawal,

illnesses, etc.), daily/weekly activity plans, emergency plan, program brochures/flyers,

and parent newsletters were reviewed. These documents provided the researcher with

additional information regarding how the family child care providers met the needs of

children with disabilities and how they managed communication within the program, the

families whom they served and the rest of the community. In addition, I reviewed

various state documents concerning the licensing of and operation of family child care

providers and programs.

Data Analysis

Data analysis involves bringing order, structure and meaning to the voluminous

collection of data. Analysis of the data was based on procedures provided by many

qualitative authors (Bogdan & Biklen, 1998; Yin, 2003; Miles & Huberman, 1993;

Lincoln & Guba, 1985). In qualitative studies, data collection and analysis occur

concurrently. Analysis starts immediately after finishing the first interview or

observation and the researcher continues to analyze the data while in the field as well as

after the cessation of data collection. This procedure allows the researcher to identify the

salient, grounded categories and themes and directs future research activities. The

researcher is guided by initial concepts, but adjusts or abandons them as the data are

collected and analyzed. Specifically for case study research Yin (2003) suggested using a

general analytic strategy, either relying on theoretical propositions or developing a case

description, to facilitate analysis. Since the purpose of this case study was exploratory

and descriptive, developing individual case descriptions was used to organize analysis. I

analyzed incidents in the data for similarities that reflected general categories, themes and

patterns.

Data Analysis: Research Procedures

The first steps in the data analysis process in this study were transcribing the

interviews verbatim and coding of interviews and fieldnotes. I began coding procedures

early, as recommended by Miles and Huberman (1994) and Bogden and Biklen (1998).

Coding is a process of sorting and categorizing the data to capture meaning, occurrences

and any emerging patterns in the data. All field notes and interview transcripts were

coded by breaking down the data into small pieces of information. This process began by

reading and rereading through the data and identifying salient themes, recurring ideas or language and patterns of belief that were identified by the providers. I used colored highlighters to mark units of information and made notes in the margins on a line-by-line basis for all interviews and fieldnotes. I recorded every possible coding label that arose. I developed a list of codes and then expanded the categories or discarded categories as I continued to review and re-review the data. The refinement of the categories, their definitions, and the coding process was continual. The ongoing process allowed me to clarify ambiguities, and extend or test the emerging categories. I created files for each provider on the computer. As I collected data I coded, categorized and provided a definition for each category according to specific topics such as decision making, training, support, provider-parent relationships, child descriptions, and program descriptions. Within each file, units of information that were assigned a specific code were copied and pasted to that section.

Next, themes were developed from the grouped codes that described relationships among the categories. I used these initial steps in data analysis to create individual case summaries. I presented emerging themes within each case as they related to the research questions. As each of the case summaries were written I began conducting an analysis across the providers. The purpose of this analysis was to explore similarities and differences across the providers as they related to the research questions. Using the four main research questions as a guide, I coded information in the case summaries across providers.

Data Display

To assist in comparisons, I used visual displays to search for similarities and differences (Miles & Huberman, 1994). Specifically, I used matrices and charts (Lofland & Lofland, 1995; Miles & Huberman, 1994) to discover patterns in the data. From this analysis cross-provider themes emerged specific to each research question. I confirmed these emerging themes by going back to the original data. The findings from the cross-provider analysis are described in Chapter IV.

Verification of the Data

I used four techniques to ensure credibility of the research findings. They are prolonged engagement, triangulation, peer debriefing and member checking (Lincoln & Guba, 1985).

Prolonged Engagement

Prolonged engagement is defined as spending sufficient time in the field to accomplish three objectives (Miles & Huberman, 1994). First, the researcher should be able to understand the context of observations made. Second, the researcher should be able to detect any distortions in the data stemming from preconceived ideas or values or from the participants. Third, the researcher should establish trust and rapport with the participants. I collected data for 1 ½ years. I spent time with each participant, talking to them, listening to their concerns, and observing their interactions with children. Data saturation was determined when no new information emerged from the interviews with each participant and repetition occurred in what the participants articulated.

Triangulation

Triangulation is a second way to increase the credibility of research findings. Triangulation involves using more than one source of data to strengthen the study's findings (Denzin & Lincoln, 1998; Miles & Huberman, 1994). In this study, information was gathered from three sources: family child care providers, parents of child with disabilities, and administrators/professionals in the child care arena. I used informal, open-ended interviews, participant observation and document analysis. Each of these methods provided opportunities to double-check findings for consistency.

Peer Debriefing

In peer debriefing, the researcher enrolls the help of neutral peers to provide feedback on the study. The researcher supplies the peer with details of the investigation, and encourages questions and comments on methodological, ethical and substantive issues (Lincoln & Guba, 1985). A former graduate student with interests in inclusion and qualitative research served in the capacity of peer debriefer. I also discussed issues and emerging themes with members of my dissertation committee.

Member Checks

Member checks involve checking back with respondents about the accuracy of data, interpretations and conclusions. This process reduces the possibility of misinterpretations of participants' perspectives (Maxwell, 1996). Member checks occurred continuously during the data collection phase, allowing me to correct misperceptions, and allowing the participants to clarify and provide additional information. During the interviews, I often checked the accuracy of my understanding through the use of paraphrase and summary techniques. I also shared the case studies

with all of the providers and allowed them the opportunity to respond to my interpretations.

Ethical Considerations

Many authors have discussed the importance of ethical issues in conducting qualitative research (Bogdan & Biklen, 1998; Maxwell, 1996; Marshall & Rossman, 1995). Most importantly, the researcher has an obligation to respect the rights, needs, values and desires of the participants. The following strategies were used to protect the rights of the participants:

1. The research objectives were communicated verbally and in writing so that they are clearly understood by the participants.

2. Written permission to proceed with the study as defined (informed consent) was received from all participants. The participants were made aware that their participation was voluntary and that they could choose to stop participation at any time.

3. Verbatim transcriptions, written interpretations and case summaries were made available to all participants.

4. Pseudonyms were used for all participants, programs and organizations when information was reported or presented in the study. This helped to protect the privacy and preserve the anonymity of the participants. Also, information shared by a participant was not discussed with other participants in the study.

Researcher Reflections

"In qualitative studies, the researcher is the "instrument": Her presence in the lives of the participants invited to be part of the study is fundamental to the paradigm" (Marshall &

Rossman, 1995, p. 59). Data are mediated though this human instrument, rather than through inventories, questionnaires or machines. The researcher admits the value-laden nature of the study and actively reports his or her values and biases, as well as the value nature of information gathered from the field.

My perceptions of the process of inclusion have been shaped by my personal and professional experiences. Aside from being a doctoral student in early childhood special education, I also work as an infant and toddler specialist for the local Infants and Toddlers Program. This job requires me to provide center-based and home-based early intervention services to children with delays and disabilities from birth to age three. Our services are family-centered, so I not only work with the child, but also with the whole family. One of the biggest issues that I hear from families of young children with disabilities is that they can not find adequate child care for their children. They state that most child care programs will not accept their children because they have a disability. Families that have reported satisfaction with their child care status are ones that have their children being cared for by family members, or the child is in a program where the provider has some experience with children or people with disabilities. In addition, when I have provided services to children with disabilities in community-based programs, the setting has largely been in family child care programs. This is consistent with the research that suggests that families of young children with disabilities prefer family child care programs to center-based programs. The make-up of these family child care programs have varied greatly, as well as the ways that the providers have included children with disabilities into the program. These experiences largely influenced my desire to study how the family child care providers included children with disabilities.

Although I know much about the field of early childhood inclusion, I tried not to let this knowledge interfere with my observations. My purpose was to listen, observe and describe what was happening, not to use my knowledge to influence or change what the participants did or said. Because I was in the homes of the providers for an extended period of time, and they were aware of my background, several providers asked for suggestions on ways to "better" include the child in their program. Being aware of the issues "reciprocity," I told the providers that because I was conducting research that I could not offer suggestions at that time, but after the study was complete I would provide assistance, if they still so desired. Creswell (1998) defined reciprocity as "the need for the participants in the study to receive something in return for their willingness to be observed and provide information" (p. 248). In the same way that Walker (2003) found in her study, as I spent more time with the providers, I realized that I offered reciprocity just by being there. As discussed earlier, family child care providers report feelings of isolation and have limited adult contact during the day. They really enjoyed the adult conversation during our interview times. Terry stated, "…we're lonely people that's why I'm talking so much." They enjoyed participating in the study because it allowed them to reflect on the process of including children with disabilities. It validated their efforts to care for children with disabilities and empowered them to see themselves as more as than just "babysitters" as they were often referred to (Tuominen, 2003).

Finally, to keep my biases in check and make sure that my findings were based on the data, I did several things including writing detailed descriptions, keeping reflective notes, maintaining a chain of evidence, using data triangulation and member checking. I

approached this study with the perspective that the ways in which family child care

providers include children with disabilities into their programs is diverse.

CHAPTER IV

FINDINGS

In this chapter, I present individual descriptions of the four family child care

providers that participated in this study. I included the following descriptive information

for each provider: a provider profile, their path to the family child care business, a typical

day for the providers, and a description of the target child with a disability enrolled in the

program. The descriptions give the reader a sense of the unique qualities and issues of

concern to each provider. Tables 3, 4, 5 and 6 outline profiles of each provider. I then

describe the themes from a cross-provider analysis that emerged from the data as they

relate to the four research questions:

1. What factors encourage family child care providers to accept young children

   with disabilities in family child care programs?

2. What strategies are used by family child care providers to include young

   children with disabilities into family child care programs?

3. What supports do family child care providers receive while caring for young

   children with disabilities in family child care programs?

4. What barriers are reported by family child care providers who care for young

   children with disabilities in family child care programs?

As stated previously, I used several techniques to verify the data. I used member

checking both informally and formally throughout the study. Informally, I paraphrased

and summarized my understanding of the participants' responses and provided

opportunities for clarification as the interviews were conducted. Formally, I provided the

participants with copies of their case studies and gave them an opportunity to provide

feedback by asking "Does this capture your thoughts and comments correctly? Does this reflect what is going on in your program?" We conversed through e-mail and by telephone and all agreed that I had captured their thoughts and perceptions accurately. For example, in an e-mail from Mrs. Shelly she wrote

> I loved your case study. That Mrs. Shelly seems strangely familiar. I will read it again in more detail in case there needs to be additions. At this time it looks great and I don't think it will need to be changed.

I met and talked over the phone regularly with my peer debriefer regarding the data collection and data analysis. We discussed the codes and themes as they emerged. When reviewing the providers' policy and procedures and other documents such as their newsletters and daily/weekly activity plans, I found that there was no information specific to including children with disabilities. The information was general and related to the daily operation of the business and applied to all of the children and their families enrolled in the program. In the next section, I present a description of each provider.

<div align="center">The Family Child Care Providers</div>

Mrs. Shelly

Table 3 provides an outline of Mrs. Shelly as a family child care provider. Mrs. Shelly contacted me after hearing about my study through her involvement in a local association for family child care providers. During our initial phone conversation, I learned that she had been a family child care provider for almost two years and had four children with disabilities currently in her program. James was three years old and had speech and language impairments. Carl, one of her grandsons, was nearly seven, and in the process of being formally diagnosed with learning disabilities and Attention

Table 3   Provider Profile: Mrs. Shelly

Mrs. Shelly	
Provider Profile	- Married - Late forties, African-American - Mother of three boys, one ten, two adults 2 years as a family child care provider
Reasons for Entering Family Child Care	Left job as a mental health counselor for 25 years in part due to stress of September 11th incident
How Family Located the Program	Referral by James' aunt
Space Accommodations	- Single Family Home - Basement converted in the child care space
Children in Attendance	8 children totally enrolled 4 children with disabilities
Hours of Operation	6:30 a.m. to 6:30 p.m.
Daily Schedule	6:30 – 7:300 a.m. – Children arrive and have breakfast 7:35 a.m. – Monique and Brian catch the bus 8:10 a.m. – Paul and Damon catch the bus 8:35 a.m. – James catches the bus 12:00 noon – James returns from school 1:55 p.m. – James, Jamal and Mrs. Shelly go to elementary school to pick up four children for after school care 2:30 p.m. – Bus arrives with two children 2:30 p.m. – 6:30 p.m. – Homework, Snack, Free play time, - Dismissal

Deficit/Hyperactivity Disorder (ADHD). Ivy was eight and diagnosed with Attention

Deficit Disorder (ADD). Mrs. Shelly's own son, Brian, was in the 5th grade and had

ADD. James, Carl, Ivy and Brian were receiving special services through the local

school system. James had an Individualized Education Plan (IEP) and Ivy, Carl and Brian

had a Section 504 Plan which was implemented in their classrooms at school. James was

the focus of my study. After I explained the study procedures, we scheduled a time for

the following week to meet in person and review the consent forms.

On a cold winter day, I drove through Mrs. Shelly's quiet suburban neighborhood

located off of a major road. I was greeted warmly by an average-height attractive

African-American woman in her late forties, with short, gray and black hair. At first

glance, there was no indication that she operated a child care program. Her split-level

home had a spotless living room, with books and family photographs displayed on the

tables, and a very neat and clean dining room. She lived with her husband, a city

councilman, and Brian.

As we walked down the stairs to her basement, I saw a well-organized room with

a sofa and love seat, several tables and chairs, a computer work station, an easel, a book

case with books, and another short book case with art supplies, CD player and board

games neatly in place. Once completely downstairs, I saw a coat rack, television and

VCR, and an area with a food cart, microwave, small refrigerator, and a cabinet for food

supplies. The children's artwork, a calendar, the poison center's number and several

educational posters of division and multiplication tables, the writing process, emotions,

computer basics, and the map of the United States were displayed on the walls. There

was also a Happy Birthday poster with the children's names and birthdays listed on it.

On one wall there was a clipboard with information related to Mrs. Shelly's food

program, such as the breakfast and lunch menu for the week. She also had an office set

up in the basement. We sat down at one of the tables and began to talk about how she

became to be a family child care provider.

The Path to Family Child Care – I Just Can't Do This Anymore!

Mrs. Shelly has been a family child care provider for one year and ten months.

She has a Master's of Science degree in counseling. Before entering family child care

almost two years ago, Mrs. Shelly was as a mental health counselor for children and

families for 25 years. Several key factors influenced her decision to become a family

child care provider: her own mother, a need for balance in her family, her son's former

child care providers, and the incidents surrounding September 11, 2001. Her mother was

a center-based child care provider for many years and about 15 years ago, before she

died, they talked about combining their skills and starting a therapeutic child care center.

She recalled her initial feelings about making her program therapeutic:

> ...it's in the blood, yes it is…I said do I want to go in the direction of doing this
>
> like a therapeutic center and…no I just want to do the basic childcare
>
> program...for some reason I just attracted children who have special needs. ..so I
>
> do have a couple of children who do have special needs. It was not by design.
>
> Mom's probably up in heaven, like you know, this is what we talked about 15
>
> years ago. What are you doing? Come on, follow follow, she'd say, follow the
>
> plan.

After many years in the counseling field she sought out balance in her own family:

> I thought that I spent enough years in counseling but still wanted to work with
> children and work with families, but also wanted a lot more balance in terms of
> my own family. And providing family child care afforded me both, the
> opportunities still, you know, to work with children, help families, particularly
> working mothers and also be available for my own son, who is just 10 years old.
> I really think I got the best of both worlds right now . Still an ongoing career plus
> balance in my own family.

Brian's former family child care providers also influenced her and provided support and
information when she started. One provider had cared for Brian from infancy to about
the age of seven. She stated:

> …the one thing that I admired about her is her consistency. If she said she was
> going to do something she did. If she said that I'm preparing breakfast, lunch and
> a snack everyday, she did it.

September 11, 2001 also had a profound impact on her decision. Prior to this time, she
had gathered information on the requirements that were needed to become licensed, but
had wavered her decision making. After September 11th, her decision became final:

> Because when that day [9/11] occurred, I was mobilized with a lot of crisis teams
> of and we did a lot of debriefing of critical incidents, stress debriefing. It was just
> so incredibly draining...I just can not do this anymore...and we were just around
> the clock, just going, going, going…you had this whole devastation over there at
> the Pentagon. Because a lot of people either knew somebody or was related to
> somebody. We had a contract with the DC public schools and they had lost three

teachers and three students. …you talk about like being sore from moving a lot of furniture...I was literally, physically... I could feel it physically sore... Not to mention the fact that I was downtown, and my child was out here. I'm saying okay 25 years. Let this be the climax...that's it.

The Child Care Administration held a pre-service orientation on October 10[th,] and she was there.

She recalled:

…I didn't feel like I could do that level of intervention, mental health intervention consistently everyday. And when the day comes and I don't feel like I can consistently deliver what my families expect as far as child care, I won't be doing it.

After the pre-service orientation, she enrolled in the necessary training, including a first aid and CPR course. By the end of the year, she had completed the required paperwork and courses. She resigned from her job on February 28, 2002. By May of 2002 she passed the final inspections through the fire department and purchased furniture and supplies for her program. She received her official license in June 2002. When reflecting back on her decision making, she feels it was the right decision:

I'm very satisfied…I wouldn't reverse it. I wouldn't go back to what I was previously doing. Yeah. I think I made a good choice.

All of my interviews with Mrs. Shelly took place in her home, in the morning when the children were at school. We typically sat at a table in the basement for the interviews. Once when we stayed upstairs in the living room, she excitedly said that she

spends so much time in the basement with the children that she rarely sits in her living room and was happy to be upstairs.

A Day in the Life of Mrs. Shelly

Mrs. Shelly designed her program particularly for "working mothers", because she has extended hours "which gives them a little more cushion as far as commuting is concerned." Her program could be characterized as "an extended family with planned activities" model, as defined by Jones and Meisels (1987). She operates from 6:30 a.m. to 6:30 p.m. and is licensed to care for up to eight children from two to twelve years of age. She provides breakfast and snacks for the children daily. At the time of the study, eight children from three to ten years of age were enrolled in her program, including her own son. Four of the eight children had disabilities, ages three, six, eight and ten.

In her policies and procedures handbook, Mrs. Shelly divided her program into three components: the morning program, the afternoon program and "other" program components. The morning program consisted of breakfast, morning devotion, goals and rules, and school bus stop supervision as needed. The afternoon included picking-up the children from school, nutritious afternoon snacks, homework help, discussion groups, and a cultural, recreational and physical activity. She provided care during school vacations, took children on field trips, and held parent conferences and family workshops. The family workshops centered on topics such coping with stress, talking to children about drugs and alcohol, and balancing work and family demands.

Because Mrs. Shelly has a son of her own, her paid work day was interwoven with her unpaid work. For instance, she helped Brian get ready for school, fixed his

breakfast and breakfast for the other children simultaneously. At the same time she prepared for the arrival of the other children.

> …even though I open at 6:30, the day starts way before 6:30. I'm up at 5:30.
>
> And then I go into the kitchen to start laying things out, pulling things out for
>
> breakfast. ...And I take what I do very seriously, very seriously. My front light
>
> goes on at 6:30 am sharp, every morning. And when I open the door, I don't have
>
> on some flip flops and a robe…crust in my eyes. I am open for business.

Her hectic mornings included breakfast for the children and ensuring that five children got on three different school buses. There are two brothers, Paul and Damon that only attend Mrs. Shelly's program in the morning for before school care. Later things quiet down except when Jamal, her four-year-old grandson, attends and twice a month when James does not attend his special education preschool program due to teacher consultation. Jamal's care is inconsistent. "Now Jamal, I can not predict Jamal. Jamal is subject to come here at 7:30 in the morning or 2:30 in the afternoon." James returns from school around noon, and the other children return around 2:30 p.m. The first thing on the afternoon schedule is homework.

> Homework is mandatory. We don't do anything else until homework is done.
>
> We have board games. ...oh my goodness, we have computer programs, arts and
>
> crafts, you name it. But, you have to do your homework...I don't check it
>
> thoroughly. I think that's the parent's role. But you have to show me where you
>
> have at least completed your homework.
>
> Despite her long day, Mrs. Shelly felt that having a "fairly good group" of

children who were "well behaved and know what they are supposed to be doing most of

the time" made it easier for her to be a family child care provider. She has to "really closely monitor" Carl and James, both with disabilities in her program.

> Now James, he's tough. He can walk past somebody and bop them. …walk past and purposely try to hit them real quick without them realizing that they have been hit. And Carl, I just have to keep him from killing himself. …if I didn't watch him he would stand at the top of the stairs and just jump down as if he could fly like Superman. Or he would just get on top on the back of the sofa and just jump off the furniture. Carl, he's a daredevil.

She spoke at length about how often people view her job as "easy" or a "babysitter" for the children. This was a common theme discussed by all the providers in the study and in the literature. Mrs. Shelly stated:

> …I would not ever put easy and child care in the same sentence ever! If you're looking for something easy, go in another direction. …I have one lady who said she was tired of working so she was going to do a child care program. You don't know what tired is until you've done a child care program. You're tired of working, then don't go into child care. …you better find something else. Go sell cosmetics or something. …I'm like, what do you mean, all I have to do is just watch the children. You have 8, and I have to include Brian [her own son], 9 different personalities. …I have a brand new admiration and respect for teachers because they have 20 to 30. You see their triumphs and then their disappointments. …some days they're just in a bad mood…what's wrong, can you talk about it. And they don't even know why.

During the summer Mrs. Shelly structured her program around field trips and other community outings. She limits enrollment to five, not including her own son. "In the summer, I'm like I don't want to be stranded here, stuck in the house…" She tells parents when they can register for summer. Enrollment is on a first come, first served basis.

When I arrived for one interview, Mrs. Shelly and her son were planning the upcoming summer activities. She referred to Brian as her "business partner, advisor, idea man, and point man." They made special plans according to the day of the week. For example, Monday was going to be their "wild and crazy day" and they were going weekly to the local amusement park to enjoy the rides and swim in the wave pool. Tuesday was "cultural day." On Tuesdays, they were going to visit places such as the aquarium, the Blacks in Wax museum and the Smithsonian museums. Wednesday was their summer reading program day. In the previous year, her children participated in the summer reading program sponsored by the public library system and were featured in an article in a major newspaper. Thursday was considered "adventure day," and consisted of trips to the caves and caverns, the nature center, and a day trip to Pennsylvania to the Amish country. The end of the week involved going to the movies for "Friday flicks." Before I arrived, Mrs. Shelly and Brian had looked up the new movies that were due to be released during the summer on the internet. She found summer less stressful than the school year despite the busy daily schedule. "But it's looser and we're going different places and before you know it the day is over actually."

James and His Path to Mrs. Shelly's Program

James is a handsome and friendly little boy with brown eyes and a dazzling smile. At three, James had been enrolled in Mrs. Shelly's program for about a year. During my initial meeting with Mrs. Shelly, his bus arrived early from the early childhood center where he attended a public preschool special education program half a day in the mornings. She went outside to greet him and the bus aide who helped him cross the street. Once inside the house, she spent several minutes talking to James about his day at school. He had difficulty articulating certain letters and sounds and at times it was hard to understand what he was saying. Mrs. Shelly introduced me to James and told him to say, "hi Ms. Tracey." James looked up from searching his coat pockets for his Hot Wheels car and said, "hi Ms. Tracey." She asked James questions about the colors of the train and car that he pulled from his book bag.

His mother, Debra, a single-parent, described her only child saying, "He's really special...in his own little way...he was like a month premature." Debra and I talked at length about how she found Mrs. Shelly's program and the enrollment process. James' aunt told Debra about Mrs. Shelly's program. Debra stated a factor that led her to enroll James into the program was

> Because of the type of work she does. She actually literally works with the kids and she told me she had a child similar to James' disability. …She showed me some of the activities that she does on the computer versus verbally…I'm like yeah that's something he really needs to get into…

Debra also talked about James' behavior

...he wants to do things himself instead of doing what people tell him to do. ...he'll probably start off doing what they tell him to do, but yet he turns around and does something totally different and don't want to do what's told. So he's like gets a little tantrum...I get the same thing at home.

This behavior was consistent with my observations of the program. For example, one afternoon Mrs. Shelly told me that James had been having a difficult week, and that he was constantly disturbing the other children during homework. She was hoping that he had received his school report to see the comments from his teacher regarding his behavior. During the past week, James had been picked up by various family members other than his mother. We sat and talked while James played with small legos on the floor. After approximately five minutes, James began running from one couch to the other couch. Mrs. Shelly said to James, "We walk inside. Finish building your house." He complied and went back to the legos. Two minutes later James said, "I'm finished." Mrs. Shelly asked him to put the legos back in the box as she got down on the floor to help him. "Do you want to read a book or practice your letters on the laptop [a child's version]?" He jumped on the couch and hugged Mrs. Shelly from behind. He held onto her back while jumping on the couch, then jumped onto the floor, ran across the room and grabbed the laptop. She helped him find a game where he had to touch the letter as it was named. James played the game appropriately for a brief moment, and then started banging repeatedly on the keyboard using his fist. Mrs. Shelly responded calmly, "You need to use your finger so you will not break the computer." James continued banging on the computer as if he did not hear her. Mrs. Shelly told James, more firmly, "You will have to find something else to do if you can't use your fingers." Again, James continued

the banging. Mrs. Shelly took the computer, and James kicked the floor and screamed, "No, no, no." Mrs. Shelly ignored him while he continued the behavior for several minutes. James stood up and sat down on the turtle that was next to the bookshelf. He continued fussing and complaining about the removal of the computer in a quieter manner saying, "I want it. Give it to me." During my observations, I witnessed several explosive tantrums and throwing of toys. Other children in the program even talked to me about James' behavior and shared that he had hit, threw a pencil and wiped his dirty tissue on another child earlier in the day.

Terry Williams

Table 4 gives a profile of Terry and her program. Terry was referred to me by Janice, an occupational therapist in the Infants and Toddlers Program, who provided services to Arianna, a beautiful young girl with disabilities, attending Terry's family child care program. Janice told Terry about my study and she was eager to participate. I contacted her, and we set up a time to meet. Terry's townhouse was located in a suburban neighborhood. Her front yard was neatly landscaped with blossoming beautiful flowers and shrubbery. I knocked and an African-American woman in her early thirties opened the door. Terry was married and had a fifteen year-old daughter and a five year-old son. Like Mrs. Shelly, her living room and dining room were neat and her program was located in the basement. Terry had operated a family child care business in her home for the last three years, but worked in her mother's family child care program for

Table 4   Provider Profile: Terry Williams

Terry Williams

Provider Profile	• Married • Mid- thirties, African-American • Mother of 2, five-year-old son, 15-year-old daughter • 12 years as a family child care provider
Reasons for Entering Family Child Care	• Her mother was a provider, Dissatisfaction with previous job
How Family Located the Program	• Flyer advertising the business
Space Accommodations	• Townhouse • Basement converted in the child care space
Children in Attendance	• 8 children totally enrolled • 1 child with a disability
Hours of Operation	• 7:00 a.m. to 6:00 p.m.
Daily Schedule	• 7:00 – 8:00 – Children Arrive • 8:00 – 8:30 – Breakfast • 8:30 – 9:00 – Individual Curriculum • 9:00 – 9:30 – Group or Circle Time • 9:30 – 10:00 – Morning Snack • 10:00 – 11:00 – Outside Play • 11:00 – 12:00 – Lunch • 12:00 – 2:00 – Nap time • 2:00 – 2:30 – Play Time/Bathroom Break • 2:30 – 3:00 – Afternoon Snack/Bathroom Break • 3:00 – 3:30 – Afternoon Circle/Play Time • 3:30 – 6:00 – Free Play/TV Time/Dismissal

Approximately 12 years previously. The interviews took place in her home after the children left for the day.

Terry's basement was open and provided generous space for the children, ages nine months through five years, enrolled in her program. The bathroom was at the bottom of the stairs before entering the child care area. A cork board displayed Terry's current newsletter and other handouts for the parents. On one side of the room cubbies held various manipulatives, objects, and toys such as big and small blocks and puzzles. A child sized table was used for playing, art activities, and meal times. On the other side of the room a large screen television with a square rug strategically place in front of it, provided a boundary for the children when watching their favorite children's programs. Bobby, Terry's rabbit, lived in a cage on a stand next to the sliding glass door that led to the backyard.

The Path to Family Child Care – It's in the Blood

Terry's and Mrs. Shelly's path to family child care were similar in several ways. Like Mrs. Shelly, Terry's own mother (a provider for 30 years) influenced her decision. "It's in the blood." Terry used this statement several times when talking about how she became to be a family child care provider.

My mother was a family child care provider when I was growing up in school…coming home and seeing her with a house full of kids. My sister is the Director of a YMCA in the District so it's in the blood…taking care of kids.

She volunteered and assisted her mother and sister in their programs. Terry worked as a licensed assistant in her mother's program prior to completing the necessary requirements for family child care in her own home. She had a Bachelor's degree in Business

Administration and had worked outside her home before becoming dissatisfied with her job. She recalled, "I needed something that would be stable, and children are stable. People are always having kids." Terry researched the licensing requirements and enrolled in several classes while still working. Before jumping full fledge into family child care she wanted to know if it was something she would be interested in doing despite having worked with her mother for the past 12 years. She created a list of the pros and cons of family child care in relationship to the impact it would have on her own family. She asked questions such as, "Do I have room for it? Is this going to displace my family because it's in my home?" A major benefit was that she would be home when her children returned from school. The biggest drawback involved "having people in and out of our house and we're really private. But then it all worked out…cause I'm home with my kids." Her family supported her decision

> My daughter was all for it…she's down here everyday after school doing the same thing that I did with my mother…she's good with kids. My husband never complains…his thing was what if the parents don't pay you…what if you lose a child…could we be financially stable. So I had to reassure him…and as soon as I lived up to my word then he was fine...

> Terry is licensed to care for up to eight children (including two infants) from birth through 12 years of age. Her five year old son is included in this number. She was in the process of completing the Child Development Associate (CDA) program at the local community college.

A Day in the Life of Terry Williams

"My routine has totally changed. I'm not a morning person, but I've learned to be. I get up at six o'clock every morning. I try to do a little Pilates or something." This is how Terry described the beginning of her daily routine. Before her own family got up or the other children arrived, Terry prepared breakfast and lunch and completed paperwork. Although her hours are from 7:00 a.m. to 6:00 p.m., she had one little boy who typically arrived around six o'clock, but normally went right back to sleep. Others arrived between 7:00 and 8:00 a.m. The children stayed all day unlike those in Mrs. Shelly's program. Her program can also be characterized as an "extended family with planned activities" model (Jones & Meisels, 1987).

During the day, Terry worked individually with each child on specific skills. "That's my individual time with each one of them. While we're doing that, the other kids will either be reading or doing a puzzle." Like Terry, all of the children in her program are African-American. Arianna is the only child with a diagnosed disability, although Terry believes that another three year old child in her program is demonstrating delays in speech and language.

Terry gave me with a copy of the policies and procedures she gives to the families in her program. Terry included a "Home Child Care Provider Interview Sheet," which included a list of 34 standard questions and answers that a parent may have about Terry's program and services. Here are a few of the interesting questions and answers she listed:

1. What do you expect from me as a parent?

    Please communicate any learning, sickness, or other daily habits that you
    feel may impact the care of your child, i.e. likes, dislikes, etc.

2. Why do you work with children? What do you like most about caring for them? What do you dislike?

> I work with children because there is a need in my community. What I love most about children is their innocence and their willing to learn. Easy to train! There isn't anything that I dislike about what I do. I must say, however, if parents don't communicate with me on the progress of their child, there isn't much that I can do with them and that becomes a strain on my ability to care for their child.

3. How do you comfort children?

> Hugs, kisses and/or favorite activity.

Arianna and Her Path to Terry's Program

Arianna is a petite, soft spoken, pretty little girl with big round eyes. Always dressed neatly in the cutest clothes and accessories, everything matched perfectly from the beads on the ends of her long braids down to her shoes. I asked Terry if she knew how Arianna's mother found out about her program, since I was unable to schedule the family interview. As stated previously, Arrianna's mother was in the process of divorce was not available for the interview. Terry's daughter and Arianna's older brother attended school together, and she gave him a flyer about the program one day when Terry and she were distributing them throughout the neighborhood. The next day, Arianna's mother contacted Terry. She was upfront and readily informed Terry that Arianna was 18 months old, had Brachial Plexus, not yet walking, and would need accommodations to be included into the program. Brachial Plexus or Erbs Palsy is a nerve injury. Any or all of the nerves that control the muscles in the shoulder, arm or hand may be damaged. For

example, some children have no muscle control and no feeling in the arm or hand. Some children can move their arms, but have little control over the wrist and hand. Others use their hands well, but can not use the shoulder or elbow muscles. Arianna had damage in her shoulder, arm and hand on her right side. Her right arm typically stayed down and inactive by her side unless she used it for support of materials and objects while manipulating them with her left hand. The following day Arianna and her mother visited Terry for an interview. She explained, "I always ask the parents to bring the child because my personality may not mesh with the child's personality." Arianna drank from a bottle, was not talking, and whined to express her wants and needs. "Developmentally she was at about 12 months," stated Terry. She accepted Arianna into her program without reservation, and she has been enrolled for two years. Terry was Arianna's first child care provider.

Kathy Smith

As outlined in Table 5, Kathy is a petite Caucasian woman with a short haircut and a bubbly personality. She contacted me though e-mail after hearing about my study from an infants and toddlers teacher on a recent home visit. We had met previously at a family child care association meeting, and she indicated that she would be happy to help me with my study. I called her and we set up a time to discuss the study and review the consent forms. Kathy has been a family child care provider for a total of 17.5 years. Eight children were currently enrolled in her program, ranging from 20 months to 5 years old. She lived in a suburban neighborhood in a small city. In her front yard, surrounded

Table 5   Provider Profile: Kathy Smith

Kathy Smith

Provider Profile	• Married
	• Late forties, Caucasian
	• Mother of 7 adult children, 4 biological, 3 step-sons
	• 17.5 years as a family child care provider
Reasons for Entering Family Child Care	• To stay at home with her young children while earning income
How Family Located the Program	• Previously cared for sisters of child
Space Accommodations	• Single Family Home
	• Addition converted into child care space
Children in Attendance	• 8 children totally enrolled
	• 1 child with a disability
Hours of Operation	• 6:30 a.m. to 5:00 p.m.
Daily Schedule	• 6:30 – 7:00 – Greet Children – Daily health check
	• 7:00 – 8:00 – Breakfast
	• 8:00 – 9:00 – Free Play
	• 9:00 – 9:30 – Clean-Up/Bathroom
	• 9:30 – 10:00 – Structured
	• 10:00 – 10:30 – Mid-morning snack
	• 10:30 – 11:00 – Outdoor Play
	• 11:00 – 11:30 – Clean-Up/Bathroom
	• 11:30 – 12:30 – Lunch
	• 12:30 – 12:45 – Storytime
	• 12:45 – 2:30 – Nap time
	• 2:30 – 3:15 – Afternoon snack/Bathroom
	• 3:15 – 4:15 – Outdoor Play
	• 4:15 – 5:00 – Inside Games/Books
	• 5:00 – Clean-up/Departure

by shrubs and flowers was a sign that read "Smith's Child Care." Kathy lived with her husband and all of her children were grown. Her daughter is an undergraduate student in Early Childhood Education and helped Kathy during breaks from school. She had an addition built on her home especially for her child care program. Kathy greeted me warmly and invited me to sit down at a table in her kitchen. I could only partially see the child care space from my seat. Kathy immediately began telling me about David, who was recently diagnosed with Autism, and his two older sisters. His oldest sister, who had delays in communication and was now in elementary school, previously attended her program when she was two years old. David and the middle child were currently in Kathy's program. He was seven months old when first enrolled and was currently 28 months old. He received early intervention services and attended a toddler group three days a week in the mornings.

Kathy set up and operated her program like a mini-preschool (Jones & Meisels, 1987). There was a coat rack near the door. Although the space was small, she had a designated circle and large group time area, a pretend play area, a block corner, a listening center with tape recorders, books and headsets, a table for snack and mealtimes, a diaper changing area, and a computer work area. The children were not limited to the center space and went into the kitchen to put their dishes in the sink. The bathroom was located in the main part of the house and the children moved freely back and forth to use the toilet, wash their hands and brush their teeth. Kathy was very organized and carefully labeled every thing in her center. Large storage bins filled the shelves that were mounted up on the walls and out of the children's reach. The children's art work was displayed at eye level throughout the room. A monthly calendar and "question of the day" poster

hung on the wall in the circle time area. The outdoor play area was filled with fun and exciting equipment including a sand table, climbing set, bicycle merry go around, playhouse, see-saw, several slides and large ride-in cars and motorcycles for the children to enjoy.

The Path to Family Child Care – It Was Definitely in My Comfort Zone

Kathy's road to family child care was simple and straight forward in comparison to other providers in my study. She began providing family child care in the 70's when she was a young mother raising her children. Her husband, at that time, was in the construction business and they needed additional income to meet their family's needs. Kathy wanted to stay home with her children and started a family child care business to earn the extra money. She continued providing child care for approximately seven years until she divorced. "I was single parenting at that time and I just couldn't get these kids where they needed to be and in the house." Kathy worked as a substitute teacher in the local public school system for three years after giving up her business. She returned to family child care five and a half years ago when her youngest daughter started driving. Kathy did not realize that she would enjoy operating a child care business, since her initial motivation was purely for financial reasons and to stay home with her children.

> …once I got into it I just enjoyed having a house full of kids. I came from a large
> family and it was definitely in my comfort zone. I have a nurturing spirit. It just
> fills a need I have. It's what makes me happy.

A Day in the Life of Kathy

Kathy wakes up at 4:30 every morning and starts her day. Her operating hours were originally from 6:30 a.m. to 5:30 p.m., but had recently notified the parents that she was

changing her closing time to 5:00 p.m. She belongs to several professional organizations including the national, state, and local family child care associations, and often attends meetings in the evenings. During the time of the study, she also traveled to Virginia to attend a High Scope Curriculum Workshop on Saturdays. Kathy was in the final stages of completing the National Family Child Care Accreditation process and served as a mentor to three providers who were at the beginning stages. Her day was full of planned and structured activities. Each month focused on a different theme. The current theme was pets. Some days I felt tired just watching her in constant motion with the children. She encouraged the children to participate in all the daily activities, but was flexible.

Everybody is invited, but if they don't want to...as long as they're not disruptive, I don't mind what they do. It's rare that they don't come. There are days when someone is in a mood and they just want to be doing something else, then I don't fight that.

Kathy's policy and procedures handbook contained all the typical information such as fees, discipline and guidance guidelines and termination procedures. She included a section on volunteers and interns and had a separate handbook outlining the specific procedures and guidelines. Kathy welcomed high school students fulfilling required community service volunteer hours. Students were interviewed prior to being accepted into her home.

David and His Path to Kathy's Program

Kathy spoke in a soft quiet voice, often with tears in her eyes, when she talked about David. He was an infant when he first enrolled in her program. He engaged in "some little quirky things," but she attributed it as part of his unique personality, not an

indicated of developmental issues. Before he was a year old, he was saying

approximately 7 to 10 words consistently. David loved music and participated in the

routine activities throughout the day. Kathy noted, "The most peculiar thing that he

would do is fall out, just fall out in the middle of crawling. That to me was a little bit

strange." His parent were not concerned about this behavior and replied, "he just goes

until he can't go anymore." Since being in her care, David's schedule has fluctuated. He

initially attended every day, except Wednesday, the day his mother was off work. Last

summer his care decreased to two days a week. "That's when I noticed a big change,"

stated Kathy. His eye contact gradually decreased and he was not using as many words.

"He was in his own world." Kathy expressed her concerns to his father one day when he

came to pick him up.

> And I'll never forget the look on his father's face because he was holding him and
>
> he just closed his eyes and just kind of dropped his head and did this nod and he
>
> said, yes, I need to make a phone call. And I thought the man was going to cry.
>
> And I felt like crying at the point because I thought, oh God, this is horrible,
>
> because in that instant I realized that he was probably just waiting for me to
>
> validate everything, and I had such compassion at that moment.…

David's aunt, who is a doctor told his parents that he was "obviously deaf." What Kathy

was feeling was true. David's mother, Carol shared

> ...but she finally pointed out to me, although I did know something was wrong,
>
> she was the one...which is so good of her...she's like I'm not getting anything out
>
> of him and those were her exact words...

David often got upset and threw himself down to the ground, picked up and threw what ever was close by and pushed the other children. Carol expressed concerns about his behavior and how it affected the other children

> ...if they would get in his way and he would like freak out and plow through, they would get hurt and that was making me nervous...making me question...is it okay for him to be there...is it safe for him to be there.

However, he calmed down very quickly after his outbursts. David also demonstrated sensory issues which affected his performance in the daily activities. David did not enjoy play dough, finger painting and had no interest in using any kind of writing instrument. David displayed certain behaviors at child care and at home that he did not display at school. He would constantly put his hands in his pants. His mother tried putting a one piece undergarment on him, but he learned how to unsnap it. Kathy added

> And now he's found his nipples… …the other kids are upset…I don't think they realize what's going on when his hands are in his pants, but he's got the shirt down now…

Throughout the day, Kathy had to physically hold him or provide assistance to keep him in a particular area of the room or engaged in the current activity.

Kathy struggled with if she was doing the right thing by continuing to keep David in her care. She wondered if she was being fair to David. Was she being fair to the other children in the program? She worried that when she was meeting his needs in an appropriate manner, she was "short changing" the other children. "I try to find some kind of balance where I feel like I can give him some quality time each day that doesn't take away from the rest of the program." However she barely got the words out when

speaking of David not being in her care. "The thought of him being somewhere else, I just can't… I think he needs to be here. I'll just do the best I can with him." David's mother recalled a similar experience when talking to Kathy about the possibility of him transferring to a center based program that accepted children with special needs.

> She got choked up, no I'm gonna be okay. I'm gonna keep him, he's fine he's fine. ...but the reports aren't very good...it's like hard on our hearts...the fact that somebody else could get hurt because of his issues.

Felicia Davis

Energetic, full of life, and always on the go is the best way to describe Felicia. Her profile is found in Table 6. I approached her about participating in my study in the hallway of the early childhood center where I worked and where her daughter, Lisa, had previously attended school. She had heard about my study through Lisa's former preschool teacher. "Sure I'll help you out. Give me a call. I gotta run and pick up the boys." I called her and we set up a time to meet at the school to review the consent forms. We then set up an interview and observation for the following week. Felicia lived in a quiet suburban neighborhood with her husband, seven year old daughter and four year old twin sons. Her housing development included large three story homes with well maintained yards surrounding them. "Once you turn down my street, look for the house with all the round trees on your left." Her husband had neatly pruned and shaped all of the shrubs and trees on their property into a round shape, which caused the yard to stand out from the others on the block. I rang the doorbell and immediately saw the smiling faces of three boys peering through the window. Like many family child care providers,

Table 6   Provider Profile: Felicia Davis

Felicia Davis

Provider Profile	• Married • Early forties, African-American • Mother of 3, 4-year-old twin boys, 7-year-old daughter • 7 years as a family child care provider
Reasons for Entering Family Child Care	• To stay at home with her daughter born with cerebral palsy
How Family Located the Program	• Referral from staff in infants and toddler program
Space Accommodations	• Single Family Home • 2nd floor of her home devoted to child care space
Children in Attendance	• 7 children totally enrolled • 3 children with disabilities
Hours of Operation	• 6:30 a.m. to 5:30 p.m.
Daily Schedule	• 6:30 – 7:00 - Children Arrive • 7:00 – 7:30 – Breakfast • 7:30 – 8:00 – Free Play • 7:40 – 8:30 – Children Catch the Bus • 8:30 – 10:00 – Pick-up and Drop-Off to Schools • 10:00 – 12:00 – Morning Snack & Academic Program • 12:00 - 12:30 - Pick-up twins from preschool • 12:30 – 2:00 – Lunch & Nap Time • 2:00 – 3:30 – Afternoon School Pick-up/Bus Arrival • 3:30 – 4:00 - Snack • 4:30 – 5:30 – Homework Help/Discovery of Nature/Group Play • Parent Pick-ups

her home was taken over by her work, with the entire second level devoted to her program. She hoped that soon she would be financially able to convert her unfinished basement into a child care center. What normally would have been her living room to the right was converted into a play area for the children. Materials such as a toy chest, a work bench and a pretend stove and refrigerator set complete with food, plates, utensils, cups, pots and pans filled the space. The dining room area to the left contained a computer station, easel, coat rack, storage closet and small table in the middle of the floor. The walls displayed the children's names, a monthly calendar, a map of the United States and a human body poster. Her daughter's spelling words for the week were posted on the storage cabinet. A corkboard contained a copy of Felicia's license, emergency plan, CPR performance steps and a record of her fire/emergency drills. Seven children were enrolled in her program ranging in age from two to ten years old, 3 of whom had disabilities. Felicia's daughter, Lisa, was diagnosed with cerebral palsy shortly after birth. Kevin, the target child for the study, was five year years old and has Down Syndrome. Michael, an eight year old boy with Attention Deficit Disorder and Learning Disabilities attended her program for before and after school care. Felicia has been a provider for seven years and has an Associates' degree in Business Administration. We sat at a table while the children played for the initial interview. Many of our interactions took place outside her home, unlike the other providers in my study. One interview started briefly in her house and continued in her large sparkling sport utility vehicle, as we rode to pick up her twins from preschool. Another interview took place at a local library branch.

The Path to Family Child Care – I Want Them to Feel a Mother's Touch

"It was always a dream of mine to want to do daycare. I wanted to be able to offer children a place where they could always feel like they were at home." Felicia's journey to family child care reached back to North Carolina where she was born and raised. "Growing up I was an abused child. …mentally, as well as physically." As Felicia talked about the hurt she felt when her mother, an older, single parent, often told her that she would "not amount to anything and that she was going to be just like her father," it was difficult for both of us to hold back the tears. Her father at the time was an alcoholic.

> I thank God that He [God] instilled it in me just enough that I knew I wanted to be
>
> something better. …I could have stayed in a negative role…been drinking,
>
> smoking, out there in the streets doing all kinds of crazy stuff, but I didn't.

At seven years of age, she "adopted a family or should I say a family adopted me" who cared for and nurtured her through her teenage years. She lived at home, but spent many hours with her new family. Her "adopted" mother told her, "If you want something in life you have to work hard for it. If you want to learn something in life you have to study and educate yourself." When she was twelve years old, Felicia decided to leave her house the same night she graduated from high school and she did without letting her family members know her whereabouts. "I had to physically and mentally come to terms with who I was and who I wanted to be and what I didn't want to be." After two years she arranged a meeting with her family. "I just really needed them to know my story. Ever since that day it has been a major healing process." Today is she very close to her biological mother and adopted family. Her great compassion for children and starting a

family child care business were a result of her early experiences. She stated, "Doing the daycare…it was almost like a second opportunity for me to be home and to have a business and to educate myself."

Felicia worked as a marking representative for Kodak for ten years. Back in the early 80's when she first moved to the area, she started "Children Team Search" where she organized after school and summer activities for children in her apartment complex. "I had approached the manager and asked could I use the community center. Because I could get the children off the street. They were just hanging out." The birth of her daughter in May of 1998 solidified her decision to stay home and start a family child care business. Lisa was six months old when Felicia began researching the licensing process. She contacted several providers and met with each one individually. "I had three wonderful ladies who were like mentors to me, who are still mentors to me actually." In less than a year she had completed all of the requirements and was open for business. None of the providers she consulted with cared for children with disabilities.

> …the key thing was no one took special needs children. …that was, of course,
>
> close to my heart…with a special needs child now…it sparked me even more to
>
> want to do it…

Like the other providers in my study, Felicia noted that other people thought of her as a "babysitter. She admitted that even she did not initially realize what the job entailed.

> …[the children's] their future starts with me. I have to make sure I nurture them
>
> and I can academically educate them and work with their social and behavior. It's
>
> very serious. …most people they'll say…she's just a babysitter. No, no, no, no,
>
> no. I am a little bit more than that. I didn't know it took as much as it does.

Felicia's husband played a major role in her decision. She spoke of the added resources he provided: emotionally, financially and physically.

> …he knew it was a passion of mine, or a dream. …financially, it was a sacrifice, a major sacrifice. I had to put him down as my co-applicant, backup person. I do have to rely on him when I am in classes or if I am out sick…

Her husband's income covers all of the household expenses, and the money that she earns is used to buy food for her own family and materials for the program.

A Day in the Life of Felicia Davis

In contrast to the other providers, Felicia spent the majority of her day out of the house. She provided pick-up and drop-off services to school for several children enrolled in her program. She picked-up some children from home and took them to school, and she picked-up others from school only. She charged one fee for before and after care which included 2 snacks. There was an additional fee for pick-ups and drop-offs. She is licensed to care for up to eight children from birth to age twelve. At time of the first interview, she had two preschoolers who stayed with her all day. Kevin attended her program in the morning and went to a preschool special education program in the afternoon. Her twin boys attended a private preschool school everyday in the mornings. The remaining children were there for before and after school care. By the second interview, Felicia had discontinued services for both of the preschoolers because neither parent had signed a contract, paid the deposit or paid her in two weeks. Her program hours are from 6:30 a.m. to 5:30 p.m. I reviewed Felicia's contract, and it contained basically the same information that all providers include in their contracts. A unique feature of her program was that she provided overnight and weekend care.

Her academic program included letter, number and color recognition, and fine motor

activities such as coloring, cutting and pasting. However, her program was not always

inside the house. She preferred to take the children out into the community. "I'm going

to be honest; I try not to ever stay in the house." During the week of Spring Break, she

had "restaurant etiquette week."

> …we get the children's menu. I let them pick out what they want…they pay for it
>
> individually. …that's the math. It teaches…how to be in a restaurant in public, the
>
> proper way. I know the children are really young, but that's okay. Most parents
>
> think I'm crazy.

She gave several more examples of ways that she incorporated her academic program

into community outings. For instance when in Wal-Mart she has the children search and

find a particular item. "I tell them the letter it starts with…we sound it out…go down the

aisle and they get it for me." She stressed the importance of learning functional skills and

navigating in the community particularly when considering her daughter's special needs.

She stated

> It's not promised that I'm going to be here everyday. …they need to know about
>
> the world we live in. Class does not always have to be in a room. And that's how
>
> I like my daycare. …it's helping them not just for kindergarten and preschool, but
>
> it's helping them for life.

Kevin and His Path to Felicia's program

Kevin, who has Down Syndrome, had been attending Felicia's program since he

was two and a half. Felicia picked-up Kevin from home and dropped him off at school in

the afternoon. She described him as "really high functioning," but needing assistance

with fine motor skills, such as cutting, writing and buttoning his clothes. Kevin fed himself independently and indicated when he needed to use the bathroom. He was inconsistent when it came to identifying and labeling colors, numbers and letters. "Some days he would know it, some days he just didn't have a clue."

Kevin's mother, April, portrayed him as a happy, fun and outgoing child. "He can steal your heart if you let him." His former infants and toddlers providers highly recommended Felicia's program when April was seeking child care, and the following month she enrolled him in her program.

…After just sitting down and talking…I felt comfortable. …because she has a special needs child herself…they probably understand a little bit more of what you are experiencing.

April shared information about Kevin's diagnosis and also that he was a very strong-willed child. April mentioned several reasons she choose Felicia's program. They lived in the same community and their homes were about a block apart. Felicia was a Christian and she felt that she understood that Kevin was God's child and they were partnering with God to take care of him. April expressed that Felicia had a love for children. "I can just tell that she loves doing it." She also was excited that Felicia had two sons that were models for Kevin. Kevin enjoyed being in her program and he was making progress. April said, "Usually he gives me a sign if it's something he doesn't like." Felicia treated Kevin like one of her own children.

Themes

The themes that emerged from the data are presented below, as they relate to the

following research questions:

Research Question 1: What Factors Encourage Family Child Care Providers to Accept

Young Children with Disabilities in Family Child Care Programs?

In attempting to understand how the family child care providers included young

children with disabilities, it is important to first understand why the providers opened

their doors and hearts to the children and their families. Because family child care

providers are self-employed, they have a great deal of freedom in choosing the children

and families they serve. Various aspects of the providers' background were associated

with their willingness to accept the children. Themes that emerged were "First-hand

experience with disabilities," "It's not the law," "I needed to be prepared," and "This is

not my first child with a disability."

First-Hand Experience with Disabilities

Prior to becoming child care providers, three of the providers had

first-hand experience with children and people with disabilities in their own families.

They all stated that this personal experience influenced their decision to include children

with disabilities once they entered the child care business. They did not want to exclude

any child from their program because they did not want their own family members

discriminated against in any way. As noted earlier, Felicia and Mrs. Shelly both have

children with disabilities. Felicia's seven year old daughter was diagnosed with cerebral

palsy shortly after birth. She stated, "I have a passion for children with special needs

because of my own daughter." Mrs. Shelly's son was diagnosed with Attention Deficit

Hyperactivity Disorder. In addition, while working in the mental health field she

provided counseling service to children with disabilities. The program was part of a

consortium that provided services to children with behavioral disorders in the Chicago

Public School system. She augmented the services that were provided by the special

education teacher and school guidance counselor. Similarly, Kathy grew up with a

cousin with Down Syndrome which increased her comfort level around children and

people with disabilities. She stated

> …because I was raised with it, I was never intimidated by it. I was never
>
> uncomfortable with it. …that was just part of life…you are uncomfortable with
>
> things you don't know. I knew this all my life.

The link between having a family member with a disability and greater

acceptance of children with disabilities in family child care programs was initially

discovered during the recruiting process. While making phone calls to the list of eight

providers that indicated that had previous experience with children with disabilities, more

than half stated that they were parents of children with disabilities themselves.

Regina, the director of a program that promotes inclusive child care, and Bill, the

director of training and technical assistance for a state-level organization, also mentioned

that providers that accept children with disabilities are often parents of children with

disabilities themselves. Regina found that during disability-related trainings, there is

always at least one provider that has a biological child with disabilities. Bill noted that "a

lot of providers who take care of special needs children have children of their own who

have special needs, and that's why they're open to the idea of taking special needs

children." Related to having first-hand experience with children with disabilities was the belief that inclusion is the right thing to do.

It's Not the Laws, But an Attitude and Belief That All Children are Special

I asked the providers about the impact the Americans with Disabilities Act (ADA) and the other laws had on their decision to take children with disabilities. Interestingly, although all of the providers were aware of and had varying knowledge of the ADA, IDEA and Section 504, they did not report accepting children with disabilities because of the laws. The attitude and belief that all children are unique and special was more strongly illustrated and discussed by the providers than fear of enforcement of any of the laws. Both John, the special needs counselor, and Regina supported the idea that the laws had very little influence on whether providers accepted a child with a disability. John who conducts training on the ADA for child care providers on a regular basis stated that most of the time, providers do not even know the law exists.

They don't know and they're not aware until they stumble upon it through a parent, through a training that we're doing. They have no idea what it requires of them. …one of the most overwhelming things that I get from the group is they didn't realize how it affected them at all.

Regina expressed similar findings about how the ADA impacted family providers.

I don't think that it's made a difference…the majority of the family providers that we have come into contact with don't even know about the ADA…that's why I say it hasn't impacted them. …some of them have heard of it but don't know what it means or what it says.

The providers' belief was that all children are different and each child has their own individual needs. All of the providers displayed an attitude of "inclusiveness" and felt that children with disabilities have a right to be included just like children without disabilities. Kathy stated, "They're all special to me in a way. You just have your way of handling each and every one of them." She also talked about how the children learned compassion and tolerance from each other. Carol, David's mother, shared a recent comment Kathy made regarding the benefits of inclusion.

> …she said the kids need to know that some kids have special needs…that's part
>
> of life. They help David, they know what to do, they understand he has a hard
>
> time. So I though that was neat, so positive of her…that was good.

Felicia attributed her attitude and beliefs concerning the inclusion of children with disabilities in her program largely to her "life experiences" and raising a daughter with a disability. For her it was not about legal requirements. Ms. Shelly often used the term "whole group" when describing her program philosophy as it related to children with disabilities. Her philosophy not only applied to activities that took place in her home, but also to field trips and community outings, "This is how we work. We just go to things that are appropriate enough for the whole group." She believed that each child should feel like they belong and are a part of the group. She expressed, "The main thing is for everybody to feel like they are participating, that they have something to do, that nobody is sitting aside or sitting in a corner somewhere feeling left out."

Finally, in my interview with Bill he expressed how the concept of "all children are special in terms of how you adapt your classroom" is embedded into the training conducted through his organization. John believed that segregation did not work and

children needed to be a "part of the community and one of the first steps of being part of the community starts in child care." How the providers' beliefs were demonstrated through their interactions with the children and enacted in their programs is described later in this chapter.

<center>I Needed to be Prepared – Pre-service Training</center>

All of the providers in the study developed an interest in learning more about disabilities prior to being licensed. They all engaged in pre-service disability-related training to be "prepared" for children with disabilities. They enrolled in courses that were beyond what the state required for licensing. For example, Felicia stated, "I had to do a lot more research on development. It was for my child, but for other children… I tried to get as much credentialing and education that I could above what the state required." In like manner, Kathy recalled, "I started taking those classes and I had about six months or so to get myself where I wanted to be before I was operating."

Terry described the licensing process as "tedious and demanding." However, she not only met the minimal pre-service requirements, but completed classes that were above and beyond what was needed for licensing. She enrolled in courses related to children with disabilities prior to opening her business.

> …I did SIDS [Sudden Infant Death Syndrome]…and now they require those things…I did anger managements, how to relate to children, how to talk to children, special needs classes. …a lot of special needs, because that's where my passion was…

Terry's enrollment in disability-related courses changed her perceptions of disability. When hearing the word "disability" or "special needs" she automatically

thought of children who used a "wheelchair." She now understood that children with disabilities comprised more than children with physical needs and covered many different types of disabilities. She realized that the characteristics associated with disabilities are diverse and can range from mild to severe within any disability category. When she was approached by a parent of children with disabilities she invited the parents in for an interview to find out more about the individual child and their specific needs because of her increased knowledge about disabilities. After the interview process, she readily accepted both children into her program and approached the experience with a "let me see if I can do it" attitude. Mrs. Shelly's had taken courses and attended workshops related to children with disabilities as part of her training in mental health counseling, in addition to enrolling in courses towards licensing.

<p align="center">This is Not My First Child with a Disability</p>

Prior to accepting the current child with a disability, all of the providers had cared for at least one other child with a disability previously. This prior experience and the training they received gave them the self-confidence they needed to include children with disabilities. Mrs. Shelly had four children with disabilities at the time of the study, half of her licensing capacity. As discussed earlier, while family child care was her first teaching experience, she previously provided mental health counseling to children with disabilities. From the beginning, she attracted children with disabilities in her program. "For as long as I've operated, I have always had about half of my children who have had an IEP or 504 plan. Always, at least half of them." She had cared for children with developmental delays, speech and language impairments, learning disabilities, and ADD/ADHD.

Terry's first child with a disability was a seven year old girl with ADD, who attended her before and after school program. The child's mother was surprised when she agreed to care for the child. "When the mother told me, my child has ADD and I said okay…I think she expected me to say I can't do that cause she's gonna be a handful." Terry cared for the child for six months, until her outbursts became too much for her to handle, and she felt that she was not able to give the needed attention to the other children in her program. Nevertheless, this initial experience did not deter her from accepting Arianna into her program.

Kathy had included David's older sister, who at the time was two years old and had delays in communication, into her program. Kathy was not aware that she had a disability when she was first enrolled. Because of her knowledge of child development, Kathy immediately recognized that she demonstrated a delay. "Right away I knew something wasn't right, and I wasn't sure what it was, but she lacked communication skills." At short time later, Kathy shared her concerns with David's parents. "They told me that they thought her development might have been more on the slow end of children her age, but it wasn't anything that we should be concerned about." Kathy then began documenting behaviors that she observed, such as the child not responding to verbal commands and needing physical assistance to transition from activity to activity. It was not until the pediatrician raised concerns with the parents that they had her tested and she began receiving special education services. She cared for David's sister until she was five years old. As stated previously, David was an infant when he first began attending Kathy's program and did not show any signs of Autism. Kathy was the one who again approached his parents about her concerns. She witnessed the regression in his

developmental skills and the progression of Autism first hand. "I watched him develop [Autism] right before my eyes," she stated with tears in her eyes. How she came to care for him is a common scenario expressed by other providers of children with disabilities. In my interview with Bill, a director of training and technical assistance, he also found that this was the case with many providers. He stated, "They'll have a child who they've had from infancy who as the child has grown, it's been obvious there's a need there, and from that they take an interest in the child and then again they grow into it." Kathy mentioned briefly that there was another child that attended the local preschool special education program, whom she was going to care for, but was unable to due to scheduling conflicts.

Like Mrs. Shelly, Felicia had lots of experience in including children with disabilities into her program prior to Kevin. She had cared for children who were diagnosed with cerebral palsy, autism, bi-polar disorder, and speech and language delays. She recalled a time when she cared for a five year old boy with more significant delays in her program for two years.

> His diagnosis was cerebral palsy. He could walk. He couldn't talk. He could feed himself, but he had major behavioral issues. …it wasn't the fact that he was fighting or biting…he would pull his pants down and play with himself. Or he would be in the bathroom and he would be chewing my toilet seat. He would walk around the living room and urinate. Most high functioning special needs children they could play away from you…I needed him beside me at all times, because he had to learn not to reach in his pants, because I had other little girls in my day care.

She changed the structure of her program and incorporated many behavior modification strategies into her day to accommodate his needs. In every situation, once the providers had initially cared for one child with a disability they continued to accept children with disabilities into their programs.

In summary, several key factors contributed to the providers' willingness and commitment to include young children with disabilities in their programs. Inclusion efforts were related to the providers' background experiences and training, personal decisions and a belief that all children are individuals. Once the providers welcomed the children into their programs, there were other factors that made the inclusion process continue.

Research Question 2: What Strategies Do Family Child Care Providers Use to Include Children with Disabilities?

I wanted to find out what strategies providers used to include the children in their programs. The themes that emerged fall into three major categories: Instructional Practices and Activities, Collaboration with Parents and Training.

Instructional Practices and Activities

The attitude and belief in "inclusiveness" and that each child is unique was discussed by all of the providers. During my observations with the providers I looked for ways in which the providers enacted and demonstrated their beliefs with the children in their programs. I also talked to parents about ways that providers included the children in the program. Several types of instructional practices were documented. The providers used specialized equipment and materials, fostered language and social development, and made modifications and adaptations to the activities.

Specialized Equipment and Materials for Children with Disabilities

Felicia and Kathy used several materials that were designed for children with disabilities. Felicia incorporated picture communication symbols (PCS) in her program. PCS can be line drawings or pictures of real objects, food items, or activities that are used to increase a child's understanding or as a way for the child to communicate. She used PCS to help Kevin understand the sequence of using the bathroom and to assist with behavior challenges. Initially, he required a lot of assistance with toileting training. He wore pull-ups and Felicia would frequently ask or remind him of the need to use the bathroom . In the bathroom, were PCS that showed major steps in the process such as pulling down pants, getting toilet tissue, flushing the toilet, and washing hands. Felicia used this with Kevin consistently, and he could perform almost every step independently. She still needed to occasionally remind him to use the bathroom, and she provided assistance with pulling his pants down/up and opening/closing the fasteners.

When Kevin needed to sit in time-out for throwing toys or objects, Felicia used a PCS of "time-out." She showed Kevin the picture as he sat in the chair and told him that when the picture was removed he could get up. She attempted to get Kevin's parents to use the strategy at home with no success. However, Kevin's teacher used it at school. Felicia recalled, "She [Kevin's teacher] started seeing those same behaviors at school… So she started using it [time-out pcs] and she said it worked." Felicia had learned the technique from a psychologist that was treating a child she had previously in her program that severe behavioral issues. She often talked to the psychologist about strategies to deal with the behaviors in her home. Felicia also maintained a close relationship with her daughter's former teachers and therapists, and they provided her with resources to use in

her program. They were available to answer her questions about other children with disabilities that she cared for over the years.

Kathy used a special brush and brushing technique that she learned from David's occupational therapist to help him relax and focus on the activities. She typically used the brush when David came in the morning or when she realized that he was having difficulty during a period in the day. The occupational therapist also let her borrow a weighted vest for David to wear during the day. Kathy paid close attention to how David was responding to the activities and put the vest on him when needed. David's special education teacher provided her with PCS for meal times, outdoor play and diapering. During lunch when the other children verbally requested a food item or drink, Kathy provided David with a placement with PCS for the food item and assisted him with using sign language to say "please," request "more" and indicate when he was "finished." David's mother noted individual attention Kathy gave him and how she taught the other children to sign as a way of communicating with David. "All the kids know sign language. She puts him on her lap a lot. She keeps him in that kind of comfort zone that he needs."

Language Development Activities

The providers offered opportunities for the children with disabilities to develop their language skills. This allowed the children to be able to engage in conversation and social activities with the children without disabilities. These opportunities were embedded in the daily routines such as play time, snack/lunch time or during a specific activity. I observed all the providers modeling appropriate language and encouraging the children to imitate them during the day. For example, when Arianna was playing with

another child and wanted to see a toy, Terry told her to say, "May I have that please."

Arianna repeated the sentence and the child shared the toy with Arianna. Mrs. Shelly

also assisted James with his delays in speech and language. She helped him with the

articulation of certain sounds. When James' speech was not clear or he mispronounced a

word, Mrs. Shelly would ask questions to further understand what he was trying to

communicate or she would model the correct pronunciation of the word. James' mother

commented on the improvements she had noticed in his pronunciation of words since

being in Mrs. Shelly's program.

Fostering Social Interactions between the Children

During the daily routines, the providers fostered interactions between the children

with disabilities and the children without disabilities. The providers structured situations

and used the children without disabilities as peer models. Because David experienced

significant delays in his social/emotional development, Kathy facilitated opportunities for

him to interact with the other children in the program. David often preferred to play

alone and would frequently walk away from group activities. During a free play period

when David was sitting at the table alone Kathy encouraged Mark, another child in the

program, to assist David with putting dice into a container. She stated, "Mark, can you

help David? David show Mark how you put them in." When another child joined the

play, Kathy encouraged the boys to take turns putting the dice into the container. She

modeled appropriate language use, by telling the boys to say "it's my turn, it's your turn."

A similar episode occurred another day. One morning while playing outside Kathy

helped David play baseball with several other children. She provided hand over hand

assistance so David could hit the ball with the bat when it was his turn. She encouraged

David to say "swing" as he hit the ball. Kathy also had play equipment that fostered social interactions such as a merry go around that required two or more children to peddle the wheels to make it move and see-saws. When David showed an interest in any of the equipment, Kathy immediately invited another child who were nearby to join David in play.

While in Felicia's program, Kevin spent most of his time interacting with her twin boys. There were many instances when she instructed of one her sons to help Kevin or serve as a model during an activity. One morning Kevin and Felicia's son were playing with a motorized race car and track. She instructed her son to show Kevin the steps in placing the car on the track and pushing the button to make it move. There were other times during the day that I noted Felicia encouraging her sons to assist and interact with Kevin. During snack time, when the boys were eating a yogurt push up treat, Kevin learned how to squeeze the tube to push the yogurt to the top by imitating their behavior. Felicia praised him by saying, "That's right. Squeeze it."

Modifications and Adaptations Made During the Day

The providers demonstrated strategies that increased the child's level of participation during the daily activities. They incorporated objects and materials that specifically benefited the children with disabilities. Another strategy involved their "level of involvement" with the children during the day.

Kathy provided David with assistance during every activity as long as he stayed with the group. When David wandered off away from the group, Kathy encouraged him to come back, but did not force him to engage in the activity. During routine activities such as circle time, art time and lunch, Kathy usually started the activity with David

either in her lap, positioned right next to him or within arm's reach of David. She often

provided him with hand-over-hand assistance during the activities. One morning during

art time, when David was sitting at the table with another child, Kathy assisted him and

the other child with cutting out a picture of a dog and gluing it on a house.

Mrs. Shelly noted that "in my program even though he's [James] included in all

the activities, some things do have to be modified." She had materials that were

appropriate for all the ages in her program. For instance, there were books appropriate

for preschool age, kindergarten and upper and lower elementary age children. She also

had computer software that was appropriate for children of various ages. She felt that the

modifications had been "subtle and transparent, but not major" mainly for James and

Carl.

> …but the modifications do not have to be major…the most significant thing is
>
> actually my level of involvement, because I may do more coaching and
>
> instructing…more explaining the process…provide more assistance.

Mrs. Shelly stated that she tried to have "activities that are similar to what the other

children are doing, but not the same activity and that's appropriate for that child's skill

level." For example, she gave James "homework" focused on preschool academic areas

such as colors, alphabet and numbers, like the other children in the program. I observed

James sitting at the table with the other children coloring and working on an activity

sheet focused on the numbers from 1 to 10.

Mrs. Shelly had discussions with the children on the books they read and

described how she adapted the activity for James and the younger children.

…they give us an overview and whether they liked it or did not like it. And if

they were the author, what would they have done differently. My little people

who might not get the discussion part…might be too much for them, I just have

them draw a picture of what they read.

Mrs. Shelly had specific ways to help James calm down and manage his temper

tantrums. On occasion she had to remove James from the group for his own and the other

children's safety.

I don't give into James…he's a very strong willed man…he gets so intense that

typically whoever is dealing with him does give into him…so this kind of

behavior…it's been reinforced because he has learned that if he screams to top of

his voice and bangs on the wall and throws things that he'll get his way…when

he's just bouncing off the wall I'll get his little Mickey Mouse pillow and his little

Mickey Mouse cover…and I put him down for a nap…and two seconds later he's

out. After his nap, he's a lot calmer. He'll come down, he'll play with the legos

or he'll work on the computer.

Terry encouraged Arianna to play with toys that required both hands as a way to

include her therapy in the daily activities. Arianna participated in the play activities

along with the other children in the program. Terry said,

I never treated her like she had a disability. I would put her bad arm in front of

her so that she would remember to use it. I learned this in one of my special

needs classes at [the community college]. Children have to learn to live with the

disability when they're younger, because it will be with them their whole life.

And it worked. Now she uses both arms to hold her baby doll.

On morning during free play, I observed Arianna playing with a pretend tool set. She used her right hand to hold the large nail and her left hand to bang the nail through the hole with a hammer. Terry commented that she specifically purchased the toy with Arianna in mind to work on her bi-lateral hand skills. Arianna's occupational therapist suggested skills to work on to increase her hand, arm and shoulder strength, and Terry purposely looked for toys and objects that required the use of the targeted skill while manipulating the toy.

When Terry cared for the child with ADD she described an effective method to decrease the tantrums and engage the child in an appropriate favorite activity.

…I got her some colored pencils and a drawing pad…when she had a bad day…[I would say] I need another picture…and she sat at the table, the kids didn't bother her… That is what saved me 99.9% of the time.

Felicia incorporated a creative strategy to assist Kevin and the children with putting together puzzles. She made a color copy of each puzzle once it was put together, which served as a visual reference for where each piece need to be placed. During "restaurant etiquette" mentioned earlier, Felicia used another interesting approach to make sure that the children with disabilities were included. She called the restaurants ahead of time and informed the manager that she and the children would be coming to dine. She explained any special accommodations that were necessary based on the children's needs. For example, the year she included a child with Autism she requested that they have a table that was away from the door to lessen the distractions for the child.

The providers found ways to incorporate the children with disabilities into all the activities in their programs, and in Felicia's case in the community. During my

observations, I never observed a child sitting off to the side or not being encouraged to participate in activities with the children without disabilities. The providers spent time nurturing and responding to the children during the day.

<div align="center">Collaboration with the Parents</div>

The providers discussed how they worked together with the parents and kept the lines of communication open when including the children with disabilities. The sub themes that emerged were, "Feeling safe to share information," and "It's a partnership."

Feeling Safe to Share Information

Every provider in this study had parents who were forthcoming with them regarding their child's disability before enrolling them in the program, and the communication continued once the children were enrolled. The only exception was Kathy who cared for David as an infant, before he displayed any signs of autism.

In Mrs. Shelly's case, James had not yet been formally diagnosed, but Debra, his mother, told her that he had delays in speech and language as well as behavior issues. Mrs. Shelly said "she would be glad to take him." Debra added

> I know a lot of people don't want to deal with kids with bad behavior. I actually tell people up front this is how he is…this is his problem…you can either take him and see how he is, or you don't have to take him at all.

Mrs. Shelly provided Debra with referral information to have James' speech and language skills evaluated through the local school system. Debra felt his language had improved since being enrolled in these two programs and recalled that previously

> I couldn't even understand half the stuff that he said. I had to actually ask him to point it out or show me. But now that he works with Mrs. Shelly and the school, I

can tell what he's saying. ...And it really shocked me one day when he came back and said his hard C's. I'm like what did you say...say that again and he said it. I said you said it right!

Mrs. Shelly further added that her program was focused on knowing where the children were academically and what strengths and weaknesses they displayed. She wanted to be informed about the child's educational goals and objectives and asked the parent to share copies of the child's IEP or 504 plans and comments from the report cards.

Terry stressed the importance of open and honest communication between her and all the parents in her program. She learned from a previous experience to write down anything that happened to the children while in her care and to talk to parents when they drop off the children in the morning.

I'll do an ouch report if they have a scratch, if they fell and bumped something. I've had another situation before where a child fell that morning at the parents house…he was groggy…lethargic all day…this is not him…the mother did not tell me that he fell off the changing table. I communicate with you, you communicate with me. The parents just want to drop them off and get to work. I take the initiative cause they won't, they're rushing.

She also does a "once over in the morning," checking the children "from head to toe" for prior scratches, bumps or things of that nature for her own protection.

Terry now felt "extremely comfortable" talking to the parents in her program about almost anything. She said, "I used to feel really intimidated. How they're gonna take it if I don't do this one thing, and then I'm like wait a minute this is my program."

Unlike the other providers, she did not feel this same comfort when addressing unidentified or undisclosed disabilities or special needs. She was trying to figure out a way to make a parent aware of her son's delays in speech and language and up to this point had been indirect in her communication.

> I really don't feel comfortable with talking about if a child has a special need. Because I'm with them all the time and I know, or at least I think I know, what type of level they're supposed to be on and they're not there. I'm still not comfortable with that portion of daycare. Now in one case I have a parent…I would hear other conversations that she would have with her doctors. …the doctor had the nerve to tell me that he wasn't speaking correctly…and I'm thinking to myself well he's really not. …I have but in so many words said he has gotten *better* on his speech to let her know that before it wasn't better. But once again it's the parents that need to let me know what you want to do…they're authorities…

In my interview with John, a special needs counselor, we discussed how often providers are the ones who first approach the parents about developmental concerns and provide the family with referral information. Because of their experience in caring for children, the providers were able to recognize when "something wasn't right" and when they had concerns about the child's development. He went to add that either the parents are not forthcoming with the information, or they do not realize that there is a concern. In the recruitment process, a potential provider shared that the mother of a child with mental retardation in her program did not tell her about the disability prior to the interview. Parents often do not disclose information to providers in fear of their child

being rejected because of their disability. Their hope is that once the child was enrolled, the provider would continue to care for them. The providers in this study stated that because the parents had provided them with necessary information related to the child's disability, they were then able to plan activities and make accommodations for the child. How this kind of relationship between the providers and parents was demonstrated in other ways will be discussed next.

It's a Partnership

During the course of the interviews with the providers and parents, they described examples of how they were working together to build the partnership and provide assistance to the child in the program. For instance, Debra (James' mother) informed Mrs. Shelly of his Individualized Education Plan (IEP) meeting, and Mrs. Shelly offered to go with her. She viewed this as an opportunity to offer support to Debra and to converse with James' teacher and speech therapist on strategies she could incorporate into her family child care program.

> I particularly wanted to go to James' IEP meeting, just to hear what his teachers and other staff, the speech therapist, what they thought about his progress. What he needed from this point on and what their plans are for him. And then also how can my program support what is happening at school and in speech therapy.

Debra also talked about her relationship with Mrs. Shelly. She had considered taking James out of the program because of her work schedule, but kept him enrolled because Mrs. Shelly provided a stimulating environment and was willing to help James.

> It's mainly because of the education she gives him…plus she went with me on his IEP…so she'd know how to help him just the same at her daycare. And that's

> why I like her. She's taking the initiative to want to help too, and she showing the
>
> help by listening to him and seeing the different things he does. That's why I
>
> definitely want him to stay where he is now. …I know she's willing to help…I'm
>
> not gonna take him away from her to put him with another stranger just because
>
> of my work. No. He's getting the education he needs, that's where he's gonna
>
> stay, and that's why I'm willing to stay as long as I can with her.

Mrs. Shelly not only supported James' mother and expressed that she viewed her role as a
"partner with the parents." She provided consultation to the parents in her program when
needed. She spent a few minutes "checking in" with the parents during pick-up to
determine if they were facing any difficult family issues. If the family was dealing with a
more complicated situation, she scheduled a separate appointment time. Mrs. Shelly
remained "connected with the mental health community" and made recommendations or
referrals to appropriate resources when needed. However, she clearly pointed out that her
program was "not therapeutic."

> I make it very clear from the very beginning because people know what my
>
> background is... this is not a therapeutic program . I'm not doing therapy within
>
> the scope of my program. If I recognize something, I will of course make certain
>
> recommendations or certain referrals…because that puts the program on a totally
>
> different level. …a different cost structure…it would not be just a regular
>
> childcare fee…if I was providing counseling and therapy in addition to childcare
>
> that'll be like two for one.

April (Kevin's mother) talked about how she and Felicia problem solved together.
She was willing to adjust her schedule to accommodate changes in Kevin's family. One

year when April worked part-time, Felicia picked Kevin up from home and put him on

the bus for school. April was grateful. "Because of her flexibility…a lot of my

challenges and obstacles really were resolved. …I know it was a sacrifice…because she

still had other kids."

Carol (David's mother) was also grateful that Kathy was "so supportive" and that

she was working very hard to keep David in her program. Kathy made adjustments in the

other children's nap schedule, in order to get David off the bus on the days he attended

the early childhood center program. Carol realized that Kathy could not provide David

with the one-on-one time he needed during the day and tried to assist her when possible.

"She really doesn't have time to sit and massage him and I don't expect her to. How can

she? So I try to do that before he leaves [in the morning]…to keep him calm." On

several occasions, David's parents voluntarily offered to find another child care

arrangement for him, but Kathy insisted that she wanted to keep him in her care. Carol

shared a conversation she had with Kathy, "You can't take him away…I want to keep

him…tears coming out of her eyes. I'm like okay. I thought it would help if we took

him away, but she didn't want that." The following school year, David was scheduled to

attend the early childhood center three mornings a week. Carol stated, "It will give her

mornings free with the other kids, and they can have circle time calmly."

Kathy assessed the children's developmental levels in her program twice a year

and held conferences with the parents to review the results. Initially she provided only

written feedback, but found that the one-on-one time gave her an opportunity to converse

with the family about any concerns without making them defensive. "I always try to start

with something positive and end with something positive and then slide anything messy in there, and I try to do it as delicately as I can."

In addition to the collaboration between the provider and parents in including the children in their programs, the providers demonstrated other strategies. Their desire for professional development is discussed in the next section.

Training

The providers discussed two separate but related strategies related to training that helped them include children with disabilities into their programs. First, they continued to enroll in disability-related classes and workshops in general on a regular basis. The second was to seek specific training based on the needs of the children in their program.

The Training Continues – In-service Training

The providers not only engaged in training prior to being licensed, but also on-going training. They discussed the importance of and the need to attend additional disability-related trainings as well as other workshops after being licensed. Felicia stated, "It's up to the individual to do continual education…to learn more about the field. The classes are out there…"

Mrs. Shelly and Kathy scheduled professional development days in their calendars and put it in writing in their contracts. Mrs. Shelly informed parents at least two months in advance of her plans to allow them time to make other child care arrangements. The benefits were two fold for Mrs. Shelly; to keep abreast of the current knowledge in the field and help to reduce the isolation associated with being a family child care provider. She did it

… to stay current, to stay fresh, to not have cobwebs grow up there in the brain. …you're always looking for resources and techniques and theories or information that is going to help you stay fresh and stay excited about what you're doing. I have most of my contacts with people who are not quite three feet tall…you need some contact with adults.

Kathy had recently moved her closing time up by a half hour to allow her to attend workshops and meetings that were scheduled in the evenings. As noted earlier in the chapter, Kathy was enrolled in an extensive two year High Scope Curriculum course that met on the weekends. Although, the providers were engaging in on-going disability-related training on a regular basis, they felt the need to learn more information about specific disabilities.

I Needed to Know How to Deal with the Disability

Terry sought out specific training related to Arianna's needs to increase her comfort with including Arianna in the program. She recalled, "I was terrified…I had no choice but to get out there and try and find as many classes as I possible could…once I did that…I was a little bit more sure of myself and how I cared for her." If there was something Terry needed to know about a disability or issues of concern, she searched for a class that would give her the answers. She said

…every time I feel like I got to learn this…there has to be a class…so I get on the phone…I'm calling everybody…I'm looking in the book, I'm looking at the resource center. I got to know how to handle colicky babies…my special needs child…

She enrolled in a class on communicating with children with special needs and learned several strategies that were useful with Arianna.

Regina concurred with Terry's need for training and Mrs. Shelly's feelings of isolation. She stated

> I find that family providers are more invested in training…maybe because they're on their own. …if they accept a child with a disability either they have one [own child]…they really need the assistance because there is no one else they can go for support, but themselves. …they generally sincerely want to take trainings…they call and they say I want to go to this training on ADHD, they mean it because they really need to learn…

Because Kathy had been caring for David since he was an infant, she had developed a bond with him. When he began demonstrating delays, she actively sought out training and other resources to help him. "I've read… gone to conferences and workshop…anything I've been able to get…especially with Autism and special needs." Carol also described how Kathy looked for ways to help include David into her program. She stated, "I know she's taking or planning on taking additional classes on special needs. She's always trying to get resources [for him]." In the next section, I discuss the ways the providers received support.

Research Question 3: What Supports Do Family Child Care Providers Receive While Caring for Young Children with Disabilities?

All of the providers discussed the need for outside support and received this support in various ways. Two broad themes emerged, "Access to technical assistance," and "Emotional support." Sub themes that emerged under access to technical assistance

were "Special Needs Counselor as a Resource" and "Collaboration with early

intervention and preschool staff." The sub themes that fell under emotional support were

"The need to connect with other family child care providers," "I needed a more intimate

connection," and "Networking with other providers during the day."

<div align="center">Access to Technical Assistance</div>

I asked the providers about mechanisms that were in place to help them include

children with disabilities. Other than the special needs counselor, all of the providers

responded that they were not aware of any specific resources besides the disability-

related classes and workshops that were offered through the resource and referral center.

Special Needs Counselor as a Resource

Two providers mentioned that John, the special needs counselor who regularly

taught the Americans with Disabilities Act class, as someone they could call about

questions. Mrs. Shelly stated, "I think if you just called up at the resource center and say

can I speak to John…you might be able to have a brief conversation with him." They

also received support through the children's enrollment in the Infants and Toddlers

program or preschool special education program.

Collaboration with Early Intervention and Preschool Staff

In some capacity, all of the providers collaborated with the school staff on ways

to assist the children with disabilities. A component of the Infants and Toddlers Program,

(in which both David and Arianna participated in) was a "home visit." On several

occasions, Kathy's and Terry's invited the staff into their programs for the "home visit."

They were open to suggestions and willing to learn ways to address the developmental

needs of the children. Kathy learned about the Infants and Toddlers Program several

years ago while attending a workshop and had since referred families to their services. (Ironically, as we talked further, it turned out that I had been the presenter for the workshop.) She was very willing to work with the program staff. "I make myself available to the Infants and Toddlers Program, take whatever resources I can get. I'll work with him. The teacher can come here. I'll go there. I'll do whatever." David's teacher and Occupational therapist provided Kathy with many resources to use in her program, including materials for David's sensory and communication needs.

A meeting for Arianna was held at Terry's house with her mother, special educator, occupational therapist, and service coordinator in attendance. For a short time frame, before Arianna began attending the center-based toddler group, the special educator and occupational therapist conducted the session at Terry's house. The ITP staff showed Terry ways to work with and incorporate therapy exercises into Arianna's day. Terry recalled

> Janice [occupational therapist] was really helpful in telling me…as far as the physical things, what I could do to help her wrist. …turn it this way, have her sit this way, and I would do it. And it helped her a lot…I do that with her every so often…exercises to get that range of motion. Her teacher gave me a lot of vocabulary, because her vocabulary was very limited, and a book of pictures to help her recognize things.

Terry's approach was much more open than that of other providers I had met in my experience as a teacher in the Infants and Toddlers Program. Family child care and center based providers are not always open to having early intervention staff in their

programs. At times I was invited in, but was given a small space to work with the child without the participation of the providers.

As mentioned earlier, Mrs. Shelly attended James' IEP meeting as an opportunity to talk with his classroom teacher and speech therapist on how she could assist him in her program. Felicia talked with Kevin's teacher every day, when dropping him off to school. They shared strategies for working with Kevin and handling his behavior. Like Mrs. Shelly, Felicia wanted to incorporate the strategies used by the teacher in her program. Earlier in the chapter, I described the instructional strategies that were put in place by the providers, often as a result of collaborating with the school staff.

<div align="center">Emotional Support</div>

The Need to Connect with Other Family Child Care Providers

All of the providers except Terry belonged to one of the two county family child care associations. Kathy and Felicia belonged to the same organization. Although they felt that the associations did not provide direct support for caring for children with disabilities specifically, but did provide them with emotional support to do the job. Mrs. Shelly expressed, "That's one of the reason why I try to get to as many of these association meetings…because that's really how you meet your emotional needs." In addition to giving the providers an opportunity to connect with one another, the associations served other functions. The purpose of the associations was to enhance the quality and professionalism of the business. Meetings were held monthly and centered on a topic of importance relevant to the providers, or there was a workshop given by an outside presenter. Information on legislative and policy updates was provided during the

meetings. Each association distributed a quarterly newsletter (which is how Mrs. Shelly found out about my study) to keep providers up to date on current events.

A mentoring component was a part of both associations. Kathy served as a mentor to new providers and to providers that were completing the National Family Child Care Accreditation process.

I Needed a More Intimate Connection

Each provider had developed a smaller network of providers outside of the large association network for additional support. These networks offered a more intimate and personal connection to other providers. Kathy explained, "…we rarely have an agenda, we'll bring whatever we have and we just sit there for hours and talk about common issues. They just love having that kind of relationship…" Mrs. Shelly also got together with her sub-group of providers and took the children for outings in the community.

Although Terry did not belong to one of the county association, she developed her own network. Her group typically met every other Friday evening. "When we get together, the first thing we do is get a glass of wine…we validate each other. That is our only means of support. That's exactly why I do what I do." She had formed a network of providers who were caring for children with disabilities. The group started when she introduced herself to other providers during disability-related training classes, passed out her business cards and then called on the providers when she needed assistance. When Terry accepted Arianna into her program and wanted to learn more about her disability, she said, "I would go up and ask people do you have any experiences or have you heard about this."

The women who Felicia consulted with when she first started the business, continued to be a source of support for her. "I call them every week. I have to. I need that connection from them. I still need that support. I still need that somebody to hold my hand every once in a while." Networking between the providers not only occurred in person, but in other ways during the day.

Networking with Other Providers During the Day

Kathy stated, "My phone starts ringing in the morning about 6:30 and that's because we're all up and we're getting ready for kids…I'm talking to providers between 6:00 and 7:00 in the morning." Nap time was another common time that providers connected with each other. Felicia's telephone networking time was from 1:30 to 3:00 in the afternoon. Kathy used e-mail to communicate with other providers on policy updates, lobbying efforts at the state capital, and she also sent out jokes. "It's a great support, you need that…otherwise you're just be by yourself. I'm only as good as the resources I got…a one person operation isn't too good…"

Terry's former child care provider for her son, Mrs. Danielle, helped her during the licensing process and served as an example of a good provider. In addition, Mrs. Danielle has cared for a child with significant physical disabilities for many years.

> She was wonderful when she had my son in her daycare, and I would just watch her and the things that she would do with me being a parent. I'm on the other side now and my policy always was and still is…I want to be the provider I wanted for my son.

Terry talked to Mrs. Danielle almost daily about issues that she faced while providing care. She had often experienced similar situations and was able to provide Terry with solutions. Terry stated

> I need an outlet…employees have employees assistant programs, we have to call on each other. We don't have an outlet…so I call her…and it just makes me feel so good that she has gone through most of this…and I know if she can do it, I know I can.

Felicia also needed adult stimulation during the day, because as a family provider she was only around children. She described her networking time as a "support group" where the providers nurtured each other during the day. She added, "when your husband come home you won't talk him to death and stress him out…" She initially went to Wal-Mart as an outlet and to seek adult conversation. "That was my release. Every Friday night, I'd go to Wal-Mart after 8:00 when I put my children to sleep." People were drawn to her and would begin sharing their whole life story. "I needed them just as much as they needed me."

In addition, to all the factors associated with the providers including the children with disabilities, they expressed barriers to the inclusion process. The providers faced many daily challenges that were associated with the business. These barriers will be discussed next.

Research Question 4: What Barriers are Reported by Family Child Care Providers Who Care for Young Children with Disabilities?

The providers identified barriers that are commonly reported in the literature on inclusive child care, including the need for training and ongoing support of providers and

funding for equipment and resources. These barriers will be discussed along with

suggested ways presented by the providers to overcome some of these barriers. During

my interactions with the providers, the most remarkable barriers I found centered on the

nature of the family child care business. The overall themes that emerged are "Need for

Training and ongoing support," "Providers are Scared," "Where's the funding," "Needs

of the Child" and "The Nature of the Business." I identified several sub themes under the

Nature of Business. These were: "It's just me, I'm the only one," "It's a business,"

"Program hours," and "Supervision regulations."

<center>Need for Training and Ongoing Support</center>

When asked about the barriers of including children with disabilities in their

programs, all of the providers stated that lack of disability-related training was a major

barrier. They wanted training that expanded their knowledge beyond the beginning level

and that was not focused on ADD/HD or Autism. Bill (director of training at state level

organization) validated the concerns of the providers. When his organization conducted a

survey on training needs, the child care providers indicated a need for training at the

advanced level. He stated that the advanced training that the providers wanted was more

in the form of technical assistance rather a particular workshop or course. In the past, his

organization offered information and technical assistance to providers beyond the

beginning level, but their budget had been cut in this area. He noted, however, that they

had expanded their website and most of the information was available on-line.

Regina's (director of program that promotes inclusive child care) organization

also used to provide intensive on site, one-to-one consultation to licensed family

providers and center-based program throughout the state. They observed the child in the

program, arranged a meeting with the providers and family, made recommendations, supplied necessary equipment and materials and provided on-going support for the program. She stated, "Family providers are like please help me, please help me. Just come in…and you see more of a sincere need." She believed that "staying with people" and providing on-going support was what made their organization successful in helping providers including children with disabilities. Providers needed to know that there is someone out there to assist them when necessary. Recently, the funding for the training and technical assistance division had been cut by 75%, which reduced their staff by half. Therefore, they were not able to provide the same level of services to the providers and programs. They were in the process of redefining and determining how they were going to provide services with the limited staff, while still meeting the needs of the child care community.

One afternoon, Terry called and asked if I knew other places where she could take a "special needs" class. She was in the process of fulfilling the requirements for the child care credentialing program, in which "special needs" was one of the six areas. She had basically taken all of the courses that were offered through the local resource center. I suggested she look at the training that was available in other nearby counties to see if they offered something different. She had the listing for the other counties, but most of the trainings were offered in the evening and with the commute time being even longer, she would not have arrived on time. She later stated, "It's just a funny subject for all of us cause you want to provide quality care, but you don't know how to do it, if you don't have the resources."

All of the providers and administrators talked about possible ways to overcome the barriers that were associated training issues. They all agreed that a "on the spot or hot line set-up" would assist providers in caring for children with disabilities. For example, Bill stated, "I think there is a lot we can do not necessarily by formal training, but by having someone available by telephone. They need to be able to talk to someone to get a quick answer. If there's an extended problem they may want somebody to come out to their home to take a look at it." He thought that mentoring programs were great, but not effective in terms of children with disabilities and were really labor and time intensive. In addition, the funding was not available to provide this level of support. Previously in the county, there was nurse who was available by phone to assist the providers with the children in the program. However, I learned through my involvement with the Inclusive Taskforce that the funding had been cut for her position. Terry stated, "I used to call her all the time now she's nowhere in sight."

<center>Providers are Scared</center>

Closely related to the lack of information and training was the notion that providers felt apprehensive and inadequately prepared to care for children with disabilities. Providers needed exposure to and experiences with children with disabilities to alleviate their fears and increase their comfortable level with children with disabilities. Terry described her initial fear.

> …I was one of those providers that was scared until I got a little girl and just fell
>
> in love with her. …they're scared they're gonna do something wrong…gonna hurt
>
> them more…not gonna be able to give them the right kind of attention they
>
> need…scared that the parent is gonna say you didn't do this right…afraid that

you're gonna hurt them more than they already are…I look at them as being

fragile physically, fragile mentally, emotionally…

John (special needs counselor) shared a personal story when he was a teacher and had a

child with severe disabilities in his classroom.

She had profound mental retardation…the thing that scared me the most was this

feeding tube. I was so scared…the father showed me how to feed the child. It was

icky. I was uncomfortable, but the child had to be fed, so I watched him do it and

then it was my turn, and then I did it…and then I did it again…and after awhile it

got easy, and I got very comfortable. I was scared…uncomfortable…at the

beginning, and I think that's normal. I'll like providers to realize that these

feelings can be normal…

John went on to add that feeding this child was the fastest and easiest out of all the

children and he spent more time monitoring the other children during meal times.

Felicia and Kathy belonged to the same family child care association and were

working with the President on ways for the providers to engage in volunteer activities in

inclusive settings. They had considered the local early childhood centers and a motor

development program that was operated through the community college on Saturday

mornings. This would give the providers an opportunity to have direct contact with

children with disabilities and their families on a consistent basis.

<div align="center">Where's the Funding</div>

The providers had found that resources and materials were necessary to include

children with disabilities, and they did not have the funds to do it.   The income they

generated basically provided for their own family and was used to replenish the supplies

for their program. They did not have additional funds, nor did they have access to funds or resources. They talked about the need for funding to purchase special equipment and make accommodations, particularly if caring for children with specific disabilities, such as physical disabilities. Terry talked extensively about the pressure that the state was putting on providers to include children with disabilities, but they were not providing the funds to family child care providers. They felt that if the law stated that they could not deny services to children with disabilities, then state and federal agencies needed to supply the funding for them to "be prepared" to readily accept these children into their homes. The law states that providers can not charge parents of children with disabilities if they need to make accommodations or purchase equipment or supplies to include them in child care programs. Providers were to spread the cost among all the children in their program. Terry was frustrated that this was not feasible in her program. She stated, "Then you won't be able to keep any kids. You keep raising…I'm not a center. I can't charge two hundred fifty dollars a week for a two year old in a family daycare home." She further discussed her advocacy efforts on behalf of family providers.

> I've been to Annapolis a million times…talking about funding for family daycares and yeah special needs was our biggest topic. …if we have to meet the needs of special needs children and you're telling us we can't turn away…then you need to give us the funds to meet the needs…you told me in your law I can't charge any more so where is this money coming from? …all the money that the parents are giving me is going straight to the upkeep of this house…I don't have ten dollars to go get a board to put at the front to make a ramp.

Terry felt that the state offered more support and resources to center-based programs

allowing them to make needed accommodations and modifications to their programs.

…the Government is meeting the centers' needs and parents are liking this…the

parents are saying this center is great cause it has a ramp for my child with the

wheelchair, this center has a bar for my child to do her walking…we don't, so

you're gonna take your special needs child to a center that can accommodate.

Although, Terry made these statements, a few months later, she called me and

shared a story of a father who was seeking child care for his a six- year-old child who

used a wheelchair. Terry met with father and agreed to enroll the child even though her

home that was not physically accessible. However, because of school boundary

restrictions, the child was not able to be transported to her program.

Regina concurred that more resources were available to center-based providers

and programs.

The resources that center-based providers or centers would have, family providers

don't…even when you do training and they have to purchase materials it's like

where do I get my funding? …a center might give them the money or just sponsor

them, they [family providers] have no one.

Many providers belonged to family child care associations which offered monthly

meetings, support and workshops related to the business, but no financial assistance for

the purpose of purchasing materials and equipment for including children with

disabilities.

The materials and equipment that Kathy and Felicia used to include David and

Kevin in their programs were costly and provided by the staff at the early childhood

centers. Kathy was loaned a weighted vest for David, which typically costs around $70. David wore the vest daily for short periods throughout the day. The Picture Communication Symbols (PCS) that she used during diapering, circle, snack and other times during the day were also produced and given to her by David's teacher. The Boardmaker program software used to make the PCS is also very expensive, costing about $350. Kathy saw the benefit of using PCS to assist David particularly during snack time and was looking for grants to purchase the software for the association. Resources and materials such as the Boardmaker program, weighted vests, sensory brushes, adapted seating and equipment are readily available to the early childhood center staff when caring for children with disabilities, but not to child care providers. Before the recent budget cuts, Regina's organization provided adaptive equipment, resources and materials to child care providers. They now had to consult with another division, which also had limited funding, to get the equipment for providers.

Terry believed that if family child providers received extra compensation to take a class or purchase materials, they would more willing to accept children with disabilities.

> An incentive is always good for family child care providers because we don't
> have anything, we don't go nowhere, we don't see anybody, so I mean our
> incentive comes from seeing a child grow up and seeing the disabled child learn
> the stuff that you taught them.

Needs of the Child

Several months after I had finished my interviews and observations with Mrs. Shelly and Kathy, I received updates that James and David had been terminated from their programs due to behavior challenges and the need for one-on-one attention. Since

my last interaction with Mrs. Shelly, several events had transpired. First, Debra had moved to a neighboring state, which meant that James attended a new special education preschool program and child care the following school year. However, Debra felt that James was not getting the help he needed in this environment and transferred him back to the original school system during his kindergarten year. Debra contacted Mrs. Shelly over the summer about re-enrolling him in her program, but she did not hear back from her and enrolled another child in the open slot. Once a space became available, Debra re-enrolled James into Mrs. Shelly's program. When James returned he was demonstrating more explosive and frequent outbursts, tantrums, and throwing of materials and objects. He also engaged in self-injurious behaviors, such as hitting himself with his fist or other objects (shoes, block, toys). Mrs. Shelly found herself constantly having to separate James from the other children and staying close by him to intervene at a moment's notice. She also agreed with Debra that going to the new school seemed to be a set back for James. She stated that the strategies that she used to assist James when he was younger were no longer appropriate. "When I had James at 2, 3, and 4, I could put him down for a nap. When he came back to me, he was older and in school all day, so a nap is not possible." James only attended the preschool program half a day, and twice a month he was with her all day, so he had an opportunity for the one-on-one attention in her program. Now that James was back, she felt that he engaged in certain behaviors to seek that same attention from Mrs. Shelly that he was used to receiving previously.

She talked to James' mother about his behaviors and Debra informed her that he was receiving behavior therapy in a program through the nearby children's hospital. The doctors had recently diagnosed him with Attention Deficit Hyperactive Disorder

(ADHD), but Mrs. Shelly felt that it was more because of the self-injurious behaviors he demonstrated. Mrs. Shelly told Debra that she would try and work with James. She even wrote up her observations and concerns about James and forwarded them to the behavioral therapist for suggestions she could incorporate in her program, but had not received any feedback. Mrs. Shelly had developed a behavior chart and reward system on her own that she was going to implement, until a recent incident lead her to terminate his services. James knocked over a table, which hit another child, but fortunately it did not cause major harm to the child. Because of the frequency of James' inappropriate behaviors, she was sure that the other children in her program were sharing the daily incidents with their parents. "It's my business and my liability. The first time something major happens, how would I defend myself in court?"   She did not want to risk losing the other children in her program or her business due to James' behavior. When Mrs. Shelly informed Debra that she would have to terminate his services, she did not give her an exact date because she wanted to assist her in securing other child care arrangements. Debra understood Mrs. Shelly's decision. During pick-up times at James' elementary school and other nearby schools, Mrs. Shelly talked to providers that were also waiting for children and inquired about their programs and the services they offered. This method ensured her that James would be able to be picked-up from the school. She provided Debra with a list of three programs that she thought would meet James' needs. All of the programs were center-based and had additional staff available to work with the children. Debra chose an after-school tutoring and activity program for James. Mrs. Shelly kept abreast on his progress by talking to his tutor during pick-up times. The tutor stated that James was doing well, but he still displayed tantrums in this program as well.

Mrs. Shelly pointed out that despite his continual challenges; he was still enrolled in the program.

Interestingly, Mrs. Shelly later found out through James' grandmother that the behavior therapy was mandated because of suspected neglect. She told Mrs. Shelly that James would call her to pick him up, when he was often left home alone. After several similar phones calls, the grandmother reported Debra to Child Protective Services. She also shared that James had been sexually abused when he was around 18 months old by a teenage male cousin, which may have contributed to his behavior problem. In addition, Debra was currently in an abusive relationship.

Kathy also made the decision to terminate services for David after caring for him and his sisters since 2000. He was the first child she had terminated. She gave several reasons why she made the decision. Kathy had a shoulder injury and was receiving therapy. The physical demands of caring for David was increasing and causing her more pain. She tried to keep him in her care until he turned three years old. He would then transition into the preschool program 5 mornings a week, which would give her a reprieve. Kathy stated,

> Most importantly, I finally got beyond my pride and ego and realized that I am
> not all that. I was not comfortable with where I was. When I could engage him, I
> was losing some of the others, and when I was engaged with the others he was
> getting shortchanged.

Like Mrs. Shelly, Kathy researched other options for David before informing his parents that she was terminating services. She visited a nearby center-based program that had a reputation for including children with disabilities. About a year ago, the center was

bought by parents of a child with significant disabilities and they redesigned the program to include their daughter and other children with disabilities. When they first began taking children with disabilities, several of the parents of children without disabilities pulled their children out of the program. The events that unfolded from the new ownership to the withdrawal of the children without disabilities were reported in the local newspaper on several occasions. After observing the program, Kathy felt that it would meet David's needs. She shared the information with his parents and gave them the termination notice. She continued to stay in touch with David's family, and they reported that he is doing well in the new setting. His language is increasing, he's enjoying the outdoor playground and he's napping, which he rarely did while in Kathy's program.

Kathy noted, "…until he was gone, I never really had a clear picture of the impact his needs had on my day. I guess when you're in the middle of it, you just do it." She felt that the answer to her problem was having another adult to assist her with David, and that she could not manage him alone. She added, "Unfortunately, in family child care, financially that doesn't work."

Mrs. Shelly and Kathy had to terminate services for the children with disabilities in their programs for several reasons. A major factor was that they could not provide the level of care that was need by these children being the sole provider. In addition, the behaviors they displayed had a huge impact on the other children in the program which in turn had the potential to affect their business financially. As I continued to talk with and observe the family child care providers, it became clear that the "family child care business" itself was associated with barriers to inclusive child care in the programs.

Nature of the Business

Several aspects of the family child care business served as "unintentional"

barriers or challenges when including children with disabilities into this setting. These

issues are unique to family child care providers and typically not found in center-based

programs.

It's Just Me, I'm the Only One

All of the providers expressed how as a family child care provider you are the

sole person responsible for every aspect of the business. Many of the providers admitted

how they did not consider this factor, until they were faced with it on a day to day basis.

For example, Mrs. Shelly stated:

> …you are just responsible for every aspect of the program. You are the
>
> custodian, the cook, the financial manager, the administrator and then the person
>
> who provides the direct service to the children and the *parents*. I was like wow.
>
> When I was at my office downtown somebody came in and cleaned the bathroom.
>
> …another person who ordered the supplies. But as a family child provider you do
>
> everything. You don't think about it until you are hit with it...it doesn't even
>
> come to your mind until you are actually doing it. I guess I was just so excited
>
> about working with the kids; it didn't occur to me that when one of them throws
>
> up I got to clean it up. I'm like oh that's me. I'm looking around like
>
> housekeeping, housekeeping. You're housekeeping.

Felicia added, "We're not just day care providers, we're psychologists too," when

referring to support she provided to the families in her program. During the day, the

providers had no breaks, except for when the children were napping. Even then they

were washing dishes from lunch, preparing the afternoon snack, doing paperwork and when possible networking with other providers.

Being the sole provider in family child care created barriers when the severity of the disability and needs of the child increased. For example, James and David engaged in behaviors that often required Mrs. Shelly's and Kathy's immediate attention to protect the other children in the program. Both providers were concerned about leaving the children unsupervised even briefly to use the bathroom during the day. Mrs. Shelly's bathroom was located upstairs and Kathy's bathroom was in the main portion of her house, and they both shared how their body's had adjusted to them not using the bathroom during the day. When Mrs. Shelly did go upstairs to use the bathroom, she often took James with her and had him stand outside the door until she was finished.

Terry discussed the child with ADD whom she had previously cared for and the impact her behavior had on the other children, because she had to devoted time to this child. The child had tantrums that sometimes lasted for an extended period of time. Terry expressed,

> I have to take time out, hours, sometimes an hour and a half to sit down and hold her and then restrain her from hurting my other kids. In a family daycare home where am I going to go? I'm not gonna take you upstairs…I don't have a nurse's office. It was just me. I don't have a staff…the other kids were playing at the time, so I had to sit everybody down…stop them from their developing and their socializing. I felt bad now for the other kids…I couldn't give quality care to the other children…and that's what hurt

The mother's lack of support was a major factor in her decision to terminate care. The child's teacher frequently called Terry to pick her up instead of the child's mother, because she was constantly not available. She stated, "…I have a responsibility for seven other kids. I cannot leave seven kids in here when it's just me. Now I'm a family home. I don't have a staff."

Working in isolation also did not allow the provider the opportunity to talk about problems or concerns that arose during the day. There was no one to give them respite when a child was having a particular hard day. In center-based programs there are other adults to brainstorm with during the day and also some who could take the children in their classroom if only for a brief moment to give the provider a break. Regina and John both acknowledged the differences between family and center providers when it came to including children with disabilities. Regina stated,

> …the center you have other staff people, your director could come in, you and
>
> other co-worker can collaborate on different things. …you don't have other
>
> professionals or other co-teachers where you can bounce your frustrations
>
> off…it's a more scary process…from a family providers vision or perspective…
>
> it's hard…you are the person…when you accept a child with a disability, it is you.
>
> So if it doesn't work you can't blame anyone else but you…

John (special needs counselor) noted that center providers could talk to the staff or director to generate ideas that might assist the child. Again, this is not possible with family child care providers. Family providers are the center staff. John compared the isolation factor associated with family child care to an island.

…a lot of people go to work…whether around their colleagues…you can share information, share what's going on… People who do family child care are all these small little individual islands that are out there. They have a little bit of interaction with their communities through the parents that come to them, but it's not like going to work… other employees…so they can feel very alone out there, and sometimes they don't know the resources, they don't know the ADA, they don't know things because they're just not exposed to it, it's just not within their work environment, and that's why it's sort of up to us to find a way to get that out there to them and sometimes one of the messengers to get to a family child care provider is the parents themselves, they are our biggest messengers beyond the training.

Carol (David's mother) recognized the difficult that Kathy experienced by being "the only one" when including David into her program . "I think if she had a helper consistently then it would be great. …the biggest challenge is it's just one of her." She felt that providers who cared for children with disabilities needed an assistant. She considered hiring an advocate to help her secure money to pay for an aide for David, because she knew that Kathy could not afford to employ an assistant. She stated, "In the early childhood center you have two people or more…is there any legislation."

Although not specifically related to caring for children with disabilities, Mrs. Shelly added that there is a certain level of anxiety that comes with the job when you are the only one.

As the sole provider you just...you always want to make sure that you're able to provide all the services everyday. …family child care providers have lives that

come with a certain amount of family obligations. Things happen unexpectantly. You know, a relative might get sick. You might get sick. ...you have to have the mindset that even though you're the sole provider you can't do it...you just can't do 100%. You're probably doing 95%. But you got to have that little window where you have some backup in case you have to go to the doctor or take a relative. Take your own child to the doctor… And it's always that anxiety that something is going to happen where you're not going to be able to provide your child care service.

It's a Business

The providers were honest in relating how currently having a child with a disability or accepting a child with a disability impacted their business. They were constantly faced with the challenge of balancing the needs of the children with a disability with the needs of the other children and how that affected their business. Again, the impact was greater when the child's needs were greater.

Terry believed that if she had continued to care for the child with ADD, she would have risked losing the other children in her program. She feared the child would hurt other children and cause their parents to make other child care arrangements, which meant a loss in her income. She explained

…I can't afford for her to hurt my other kids and then have another parent say you knew she was ADD and then they may not even understand…you had this girl and she hit my baby and she kicked my baby, and what did you do about it…I can't do it…putting my business in jeopardy.

She related a story of a parent asking her if that child had scratched her son during one of her tantrums. Terry explained that her son already had the scratch on his arm and she showed the parent where she had documented the scratch when she did the "once over" at 8:45 that morning. She added, "I would have lost a couple of kids if I would have kept her. I would be sacrificing my business. I'd be sacrificing what I love to do."

Kathy discussed the impact that caring for children with disabilities had on her program in terms of the ages of the other children she enrolled. For instance, the child care fee for an infant, which by regulation is a child under 18 months, is greater than the fee for an older child and providers can care for up to 2 infants. Infants and toddlers need more individualized attention to basic care such as feeding and changing diapers. At the time of the study, she had a slot available for an infant, but chose to enroll an older child because of the time that was required to care for David. She explained,

I had slots for a little one, but with David's behavior now, I wouldn't be comfortable having a real little one…an infant, there's no way in the world I would do that right now and that's more money for me. I'm giving up money that I could be getting, but that's a choice I made. I could have had that infant, I could have been out of my mind. I know when I'm gonna be comfortable in what I can handle. I won't put myself beyond…my hands are full…because I don't stop moving all day.

She felt that if providers had an open slot and they had to decide whether to take a child with a disabilities or a child without a disability that most providers would choose the child without disabilities, because of their comfort level and the impact the child with a disability would have on the other children in the program. "Yeah you're gonna take the

one that doesn't have special needs. I'm at the point where the way I do it is…what am I comfortable with…what am I feeling is fair to the other children."

Program Hours as a Barrier

Classes and workshop for child care providers are typically held in the evening. Most trainings start around 6:00 or 6:30 p.m., making it impossible for many family child providers to arrive on time or attend at all. For example, all of the providers in the study ended their day at either 6:00 or 6:30, except for Kathy, who had recently changed her closing time to 5:00 in order to attend meetings and workshops   It is very difficult for the providers to attend evening training, especially when accounting for parents picking up their children late and the commute time involved. In addition, once the child care children left, the providers' day was not over. They needed to prepare dinner for their own family, run errands, do household chores and prepare for the next day among many other things. Regina's organization typically offered their trainings in the evening, but had started offering Saturday training so more family child care providers could attend. They offered "community trainings" to center-based programs on site, but logically could not provide training for one family provider. She explained,

> We can go to a center and open up a community training there because they have
>
> more staff that can attend, and most of the centers open it up to the public…but
>
> when we have those trainings, family providers are not available. I feel for
>
> them…there needs to be a way that family providers can get the assistance they
>
> need.

 When providing private trainings to centers, Regina would ask the center directors if family providers could attend. She also shared information on any conferences with the

providers as another way to increase their training opportunities. She had noticed that they have more family providers in attendance on Saturdays and when they presented at local conferences, which typically were on the weekends. Trainings and workshops offered at nontraditional hours would encourage more family child care providers to attend.

Bill (director of training and technical assistant) also talked about how his organization had to address the needs of family providers when it came when the training was held

A big concern with training for family child care providers is do it at a time that they can attend. So it's not only an evening which was explored as more appropriate than the daytime…they've done the twelve hour day…evening is not the most appropriate time. So we also provide it on Saturdays.

Supervision Regulations

Intersystem regulations created a barrier to inclusion. Supervision regulations for family child care providers, coupled with the regulations that governed the transportation of students with disabilities set forth by the state department of education, presented a challenge in including David into Kathy's program. David attended a center-based toddler group three mornings a week at the early childhood center and was transported by bus back and forth to Kathy's program. Maryland supervision regulations require that family child care providers stay within sight of the children in their programs. The assistants that accompany children with disabilities on the buses are not allowed to walk on private property. David was not able to walk back and forth from Kathy's door to the bus independently and required her assistance. However, because there were other

children in her care, she could not legally leave the children inside alone while she met David at the bus. She explained the situation with frustration

> I cannot stand at the door and let David walk to the bus because he isn't… The aide won't walk up to the door and get him. But if I leave all those kids looking at me while I walk out the door and walk David to the bus, then I am in violation of supervision regulation. …but what really is bad is in the afternoon when all the kids are sleeping and the bus pulls up, and I've go to wake all the kids up to walk to the end of the driveway to get David off the bus.

When she contacted the regulatory office, she was told to have her substitute come and watch the children while she got David off the bus. She stated, "…that's when you feel like reaching through this phone and grab them by the throat. I could have my sub come out here. I'm making beau coup bucks. I've got nothing to do but pay someone to…" David's parents began taking him to school in the morning and his father would leave work to meet him at the bus in the afternoon. This situation can be common for family child care providers when bus transportation is provided through the school system. The providers are essentially left with no other solutions except to have another adult present or take the children outside with them. In my experience, I have known other family child care providers, particularly when the programs are located in the provider's basement, that have not been able to care for children with disabilities because of the two separate regulations. In Terry's case, she and the other children went outside to meet Arianna. Because the other children in Mrs. Shelly's program were school age they were not there when James came from school.

CHAPTER V

DISCUSSION

This study explored the experiences and perspectives of family child care

providers who care for young children with disabilities. After summarizing the

conclusions, I use Bronfenbrenner's (1995) bioecological system theory to discuss how

the findings are linked. I provide information on how different system level factors

influence inclusion in family child care programs. Next, I discuss the limitations of the

study. Finally, I present the implications and areas for future research based on my

findings from this study.

The Family Child Care Providers

The family child care providers in this study appeared to be extraordinary. They

demonstrated a belief in inclusion and made a personal commitment to providing

inclusive childcare. They seems to "go the extra mile" when including the children in

their programs and developing relationships with their families and early childhood

personnel.

The profiles of the providers were similar and different in many ways to the

literature (Goelman & Geo, 1998; Nelson, 1990) on family child care providers in the

field. The main similarities were that they were all women, married and had been

employed previously outside the home. Three of the providers were caring for their own

children in their programs. The major differences between the providers in the current

study and the providers reported in the literature were in terms of education and training.

First, on average family child care providers have a high school diploma. In the study,

Felicia had an Associate's degree, Terry had a Bachelor's degree and Mrs. Shelly had a

Master's degree. In terms of participation in pre-service and continuing education and professional development, they engaged in more training hours than average. Although Kathy did not have a college degree, she was currently enrolled in a two year High/Scope training program.

In terms of the motivation for becoming a family child care provider, the reasons stated by the providers in the study were consistent with the Nelson (1990) study and as reported by providers in the state. For example, Kathy and Felicia indicated that they wanted to stay home with their young children, but needed to earn an income at the same time. In like manner, Mrs. Shelly and Terry stated they wanted to be home with their children during after school hours, and family child care allowed them to do so. The second main reason, enjoying children, was expressed by many of the providers. Kathy stated, "I just enjoyed having a house full of kids."

The providers' experiences and perspectives in including children with disabilities, also study closely resembled the participants discussed in the findings by Devore and Hanley-Maxwell (2000) in many respects. The characteristics demonstrated by providers in the current study and in the study mentioned above are not typically found among family child care providers. First, both set of providers engaged in higher levels of education and training as described above. Second, they all had prior experience with children or adults with disabilities which affected their willingness to welcome children with disabilities into their programs. These experiences came through caring for children with disabilities in the past or having a family member with a disability. Devore and Hanley-Maxwell (2000) reported that two of their participants grew up with family members who had disabilities, and five participants had prior experience working with

people with disabilities. They established strong collaborative relationship with the parents in their programs. Throughout the day, the providers in this study used many strategies to ensure that all children were welcomed and included in the activities. They faced barriers and challenges that were often beyond their control, yet strived to include the children. When it became too difficult for them to continue caring for the child, they sought out alternative child care for the families before terminating services.

Factors that Influence Acceptance in Family Child Care Programs

The first research question examined the factors that encouraged family child care providers to include young children with disabilities in their programs. The factors that were found in this study are consistent with the studies conducted by Dinnebeil et al. (1998), Buell et al. (1999), and Devore and Hanley-Maxwell (2000). Various aspects of the providers' background, training, and personal goals assisted in their willingness to include children with disabilities. Before accepting the current child with a disability, all previously included other children with various disabilities. Two were parents of children with disabilities and one had a family member with a disability. First-hand experience with disabilities increased their comfort level and willingness to accept children with disabilities. This is consistent with previous research findings by Devore and Hanley-Maxwell (2000) and Buell et al. (1999) in that providers who had previously cared for a child with a disability were more willing to provide services in the future.

These results also support findings of previous training projects such as Delaware First (Deiner & Whitehead, 1998) and Project Neighborhood (Kontos, 1988) in that providers who engaged in disability-related pre-service and in-service training are more comfortable with and willing to care for children with disabilities. Although training

related to children with disabilities is offered during the pre-service process, providers

have a choice and are not required to take any disability-related training. In the study all

of the providers had an interest in learning about children with disabilities and actively

sought out such training prior to becoming licensed. They wanted to "be prepared" to

welcome any child into their program. They also enrolled in specific training related to

the disability of the child who was in their care. Therefore, the likelihood that they were

familiar with the causes and characteristics of the specific disability was increased. They

also may have learned strategies that were necessary to include the child in activities.

Inclusion requires a positive attitude about accepting children with varying

abilities (Gay, 2001). These providers believed that all children are special and unique

regardless of their abilities. Although all had knowledge of the laws associated with

inclusion, the laws did not have a major impact on their decision to accept children with

disabilities. Once children were enrolled they engaged in practices that demonstrated a

philosophy of inclusion. The children were active participants in the same manner as the

other children without disabilities. Their commitment to inclusion is consistent with the

family child care providers reported by Devore and Hanley-Maxwell (2000) and the

preschool teachers in Lieber et al. (1998).

<center>Strategies Used by the Providers</center>

The providers in the study used several strategies to include the children into their

programs. My study confirms findings from Devore and Hanley-Maxwell (2000) in that

supportive relationships between the providers and parents were associated with children

with disabilities being enrolled in family child care programs. These collaborative

relationships were established in diverse ways. Parents felt free to share information

about their child and the child's disability with the providers. The providers expressed

that because the parents had provided them with necessary information related to the

child's disability, they were then able to plan activities and make accommodations for the

child from the beginning. In many cases, when the parents had concerns, the provider

gave the parents information on places to get further assessment for the children. The

providers attended school meetings related to the child's educational goals and objectives

and invited school personnel to discuss the child and ways to further their development.

These results are consistent with the findings from Stafford and Green (1996) in that

teachers (in this case providers) who display positive attitudes toward inclusion are more

prone to have open communication with parents.

These providers continued to enroll in disability-related training once they

received their license. They felt it was their professional duty to keep up-to-date with the

practices in the field. They consciously sought out additional training related to the

disability of the child in their program.

Once the children were enrolled, the providers used many strategies to include the

children in the daily routine and activities. Similar to one group of teachers in the

findings by Lieber et al. (1998), the providers made modifications and adaptations that

were often easy and simple, yet made a difference in the child's ability to participate.

They used techniques to communicate and increase social interactions with the children

without disabilities during the day. Many of the providers also used specialized

equipment and materials that were given to them by the early intervention or preschool

special education staff. The survey data (Maryland Committee for Children, 2001) from

the state on family child care providers indicated that access to specialized equipment

was a resource providers indicated would enable them to care for children with disabilities. In addition, Buell et al. (1999) and Deiner and Whitehead (1998) reported that providers indicated a need for special equipment and knowledge related to teaching strategies when including children with disabilities.

<center>Supports Received by the Providers</center>

Several sources of support were reported by providers. They received technical assistance and support from personnel at the early childhood centers where the children were enrolled. In two cases, the personnel were welcomed into the providers' homes and provided them with strategies and resources to increase the child's participation in the activities. These findings are consistent once again with the findings from Devore et al. (2000). They found that the providers relied on the early childhood special education staff for support and technical assistance while including children with disabilities. In addition, the providers desired greater access to support in the form of "on the spot" consultation. In the current study Terry wished there was a "1-800" number or "hot-line" for providers to have increased access to support when they needed information or had questions.

Other sources of support were providers' connections to other family child care providers. All except one belonged to a large network of family child care associations in the county. In addition, each had formed smaller networks of providers based on their needs. Terry had formed a separate network of providers that were caring for children with disabilities. Because she was committed to caring for Arianna, she proactively sought support and information from other providers during disability-related trainings. These actions enabled her to form lasting relationships with the other providers. Because family child care providers work in isolation, there is a need for outside support.

Trawick-Smith and Lambert (1995) discussed that unlike center-based providers, family providers do not have opportunities to seek advice from, problem solve around concerns, or collaborate with colleagues during the day. Therefore, networking with other providers on different levels affords them the support they need.

<center>Barriers and Challenges to Caring for the Children</center>

The lack of adequate training was a barrier to including children with disabilities. Their training needs reached beyond what was currently being offered through the county and state. For example, the providers discussed that most of the disability-related training centered on ADHD or Autism. In addition, they sought training that was beyond the beginning level. Linked to the need for training and increased information was the notion that providers were scared to care for children with disabilities. They did not feel family child care providers were adequately trained and prepared to include children with disabilities. As the literature has shown (Buell et al., 1999) increased training is associated with increased comfort levels in caring for children with disabilities.

Providers did not have the resources themselves, nor were the resources available elsewhere to purchase specialized equipment and materials or make modifications to their homes to increase accessibility. Despite this, some went to great lengths to ensure access to their program. For example, Terry was willing to care for a child who used a wheelchair even though she had a set of stairs going into her house and her program was in her basement.   When the child's father inquired about child care for his son, she invited him to come for the interview despite the fact that her home was not accessible. She brainstormed ideas with the father on how to get the child inside the house. She was willing to purchase a piece of wood to make a ramp using her own funds. However, she

felt strongly that if the ADA required that providers not discriminate against children or adults with disabilities, then the state agencies needed to provide resources and funding to make necessary modifications and accommodations. Again, similar finding are reported in the research by Devore and Hanley-Maxwell (2000).

All were frustrated with other family child care providers who often stated openly that they did not take children with disabilities. Other providers would tell parents that they were full or they did not take children with disabilities without regard for the law. Providers in their networks often viewed the participants in this study as "having the patience," "being special," or "having a big heart," and were told "I don't see how you do it." They found that the providers who accepted children with disabilities became known as "the special needs providers" and other providers would refer families of children with disabilities to them. The "special needs providers" were a sub-culture within the larger culture of family child care providers. This notion of "the special needs providers" was demonstrated during the recruitment process. When seeking participants, providers passed on names of other providers who they knew took children with disabilities.

Felicia and Kathy were researching ways to have the providers in their association volunteer and spend time in the classrooms at the early childhood center where Felicia's daughter and Kevin received early intervention and preschool special education services. Felicia spent many hours talking to the therapists and sitting in her daughter's classroom to learn way to include children with disabilities in her program. She was active in the Parent Teacher Organization and often mentored and assisted other families of children with disabilities navigate through the special education process (i.e., IEP meetings, transition from program to program).

The Nature of the Family Child Care Business

Ironically, one of the major findings was that the same reasons why families of children with disabilities often chose family child care instead of center-based family child care, were the very same reasons that made it difficult for providers to care for children with disabilities in these programs. Researchers (Devore & Hanley-Maxwell, 2000; Goelman & Pence, 1988; Fewell, 1986) have identified a primary adult, personal attention, flexible hours and a consistent environment as reasons why families of children with disabilities choose family child care. Several factors associated with the nature of the family child care business and beyond the providers' control served as challenges to including children with disabilities. For example, because the provider is responsible for all aspects of the business, responsibilities extended well beyond caring for the children (e.g. administrative tasks, cleaning).

The providers, the children and their families often formed close bonds. However, being "the only one" and needing to give the children individual attention was a challenge to including children with disabilities. Additionally, being self-employed had an impact on caring for the children with disabilities. The providers often struggled with balancing the need of the children with disabilities with the needs of the children without disabilities and the impact it had on their families.

The parent provider relationship served as a barrier in a sense. Because the providers had developed trusting and close relationships with the family members, it made the decisions to terminate care difficult. They struggled with the notion that families needed child care, but at the same time needed to consider their business and the other children in the program. They often asked, "Will the child's needs be met?" "Will

the family's needs be met?" "Will I meet the needs of both the children and the family without negatively impacting the needs of all other children and families in my programs, if I continue to keep the child in my care?"

Their program hours (full-day, full-week schedule) made it difficult to attend trainings that were offered in the evenings. The administrators in the study recognized this unique challenge for the providers and provided opportunities for training during the weekends.

<div align="center">Links to Bronfenbrenner's Bioecological Systems Theory</div>

The finding from this study gave insight into factors at various levels of the system that impact inclusion efforts in family child care programs. Using the experiences of Mrs. Shelly, I provide examples of these factors. I then discuss the links to the theory in relationship to the other providers as a whole.

From Chapter 4, we know that James was three years old, had delays in speech and language and displayed behavior challenges in Mrs. Shelly's program, at home and in the classroom. He attended a special education preschool program in the mornings. Mrs. Shelly had been providing care for James for about a year. She included other children with disabilities and made a commitment to inclusion in her program. It became increasingly difficult for her to continue to care for James because of his frequent outbursts, tantrums, and throwing of objects. Mrs. Shelly was not able to provide him with the one-on-one attention that he needed, while still meeting the needs of the other children. She became fearful that James was going to hurt another child. She also considered the impact on her business in the event something happened to another child prompting the family to discontinue services. Losing a child meant losing income, even if

only temporarily, until the slot was filled. Debra, James' mother, was a working single parent. She talked about adjusting her work schedule so that James could continue in the program. Mrs. Shelly and Debra established a strong relationship, and Mrs. Shelly even attended an IEP meeting with Debra. She desired to find a way to help James' academic and social/emotional development. Since being enrolled in Mrs. Shelly's program and the preschool program, James had shown improvements in his language development. The roles that Mrs. Shelly, Debra and James' preschool program played when interacting together resulted in positive developmental outcomes for James.

James moved to another state, attended a different program, and then came back to Mrs. Shelly. Mrs. Shelly and his mother noted that he had regressed in his development and his behaviors had escalated. This regression may have been directly linked to the fact that Debra was in an abusive relationship and often left James alone. It can be assumed that her involvement in his care and education was affected. High levels of parental involvement have been associated with enriched learning opportunities in school. As a result of her actions, Debra was reported to Child Protective Services, and James was ordered to receive behavior therapy. We do not know what kinds of social supports or access to community resources were available to Debra. The availability of these resources may have helped Debra adjust to demands and stress that were in her life, which in turn may have resulted in more positive outcomes for James. In considering other proximal processes as related to James, there has been research to show that behavior challenges at an early age can contribute to later school failure (Stacks, 2005). employability and criminality. As noted earlier, the child is seen as active in creating his own developmental environment. At the same time, the child is viewed as part of the

family proximal environment, both influencing and being influenced by these environments. What happens at home influences what happens at child care and what happens at child care will likely influence family interactions. In addition, the community at large is expected to affect proximal processes and a family's ability to provide necessary support for their child. An example of an exosystem influence, is when Debra was reported to CPS requiring that James attend behavior therapy, which may have a positive impact on his social/emotional development. This was brought about by societal policies operating outside of James' immediate environment that state that children under a certain age are not to be left alone and unsupervised. Chronosystem factors involve temporal changes in the child's environment and as stated previously can be internal, such as the natural maturation of the child. As James aged it became increasing more difficult for Mrs. Shelly to handle his inappropriate behaviors and use strategies that were effective when he was younger. For example, when he was two and three years old, it was appropriate to put James down for a nap. This would help him calm down and also give Mrs. Shelly a break. Naturally, as children age, they no longer need or require naps during the day.

In applying the theoretical framework on a more broad and general level to the study, microsystem structures were the children with disabilities, their families, the family child care providers and their programs and the school settings. Bronfenbrenner (1995) highlights the importance of bi-directional interactions with caring adults in the child's life. He stated the child must have on-going, long-term mutual interactions with adults who care about their development. For many of the children, this was the first time they were in a child care setting and developing relationships with adults outside

their immediate family. Although this study did not specifically explore these areas, this connection may have helped the children develop cognitively, emotionally and socially. The skills and confidence developed during these initial relationships will increase the child's ability to effectively explore and grow from outside activities (Bronfenbrenner, 1995). The children had varying disabilities and needs. Factors such as complications with the child's birth, genetic makeup and presence of a disability interact with the child's environment and can contribute to outcomes in development. All of the providers in the study had certain characteristics that encouraged them to accept the children in their programs, such as previous exposure and experience with disabilities. They were nurturing, open and focused on the needs of the children.

The mesosytem includes relationships between these microsystems. The providers and parents established collaborative relationships and worked together to include the child in the program. Even when Mrs. Shelly and Kathy had to terminate services, they ensured that the parents had options for alternative child care. Kathy even visited the program to "check it out" and determine if she felt it would meet David's needs. In both cases, the providers talked about how they maintained contact with the children and their families once they left their programs. The providers collaborated with early intervention and special education personnel to increase the participation of the children with disabilities in their programs. Daily the providers incorporated strategies they had learned from the school personnel to increase the children's development.

The exosystem system factors are those that operate at the large societal level in which the child does not function directly. Exosystem factors found in this study included many of the barriers to inclusion in family child care programs. For example,

the state child care regulations regarding supervision and the state department of education's transportation regulations when meshed together serve as a barrier to the inclusion of children with disabilities in family child care programs. Because of the regulations, Kathy had to take all the children outside during nap time to get David off the bus, because the bus assistant is not allowed to walk on private property. In this case, these exosystem influences had a huge affect on David's family. They had to rearrange their work schedules to be able to transport him to school in the mornings. Fortunately, his father's job was close by and his boss allowed him the flexibility to leave work so he could meet David at the bus. Also, as discussed earlier, there were many factors associated with the organizational structure of family child care programs that served as a barrier to inclusion, which may have affected the children's development directly or indirectly. For example, because the training that was offered through the state was typically held in the evenings, many of the providers were not able to attend. Therefore, if family child care providers are not able to gain information and knowledge on the child's disability, the child's development may be negatively impacted. Luckily, the providers in this study found ways to continue to engage in training. Henderson (1995) stated that as a society at large, we must cultivate attitudes that value work done on behalf of children at all levels: parents, teachers, extended family, mentors, work supervisors, legislators.

At the macrosystem level the Americans with Disabilities Act, Section 504 and IDEA 2004 were factors that impacted the inclusion in family child care programs. These laws help define the belief in our society that individual with disabilities are not to be discriminated against and valued as productive citizens. IDEA 2004 ensures that children with disabilities receive a free and appropriate education in natural and least restrictive

environments. For young children these environments include the home, child care and preschool settings. Therefore, these laws dictate that children with disabilities be afforded the same rights as children without disabilities. Given the examples above, it is clear that the relationships operating at the various levels are bi-directional and interrelated in a complex and ever changing atmosphere.

<div align="center">Limitations of Study</div>

Limited Family Data

One limitation of the study was that I was not able to interview one of the parents of the children with disabilities. She gave consent for the observations and the interview, but I was never able to connect with her. The provider had informed me that she was in the process of divorce and she (the provider) was also having difficulties with the mother following through with child care related requests. I had to rely heavily on the provider's perspective in this case, possibly missing critical aspects of what the mother might have shared related to her daughter being included in a family child care program.

Characteristics of the Providers

As I spent more time with the providers, it became clear that the providers themselves were limitations to the study. When attempting to apply the findings from this study, several factors related to the characteristics of the providers must be considered. The educational level of the providers in this study was higher than what is typically found among family child care providers. One provider had a Bachelor's degree and another provider had a Master's of Science degree. Therefore, these findings may or may not pertain to providers without college degrees. Providers in the study had engaged in trainings and workshops, especially disability-related training, at a much

higher rate than is typically found among family child care providers. Another possible limitation involves the setting from which the participants were drawn. All of the providers resided within one county in the state. Although the county is diverse in terms of rural, urban and suburban environments, all of the providers lived in a suburban environment. Therefore, due to these factors the findings may not be applicable to other family child care providers who live in rural or urban environments.

Methodology and Study Design

Limitations based on the study's methodology and design should be considered. First, the purpose of the study was exploratory and descriptive. Since this study focused on only four family child care providers, results cannot be generalized to other family child care providers. It was never my intention to generalize findings to other providers, but rather to discover the commonalities and diversity among the providers. The findings provide insights and themes rather than definitive conclusions generalized to larger populations. Second, by using a multiple case study design my desire was to capture the variability and diversity among the family child care providers. I believe this goal was achieved. However, looking across four providers did limit how in-depth I could go with each person. For example, had I conducted a more in-depth single case study, I could have focused more on the collaboration with the early intervention and preschool special education programs. I could have observed their interactions and identified ways that the providers learned specific strategies and then incorporated them into their programs.

Lastly, a potential limitation in the study has to do with the nature of qualitative research. The possibility that my values, biases, and perceptions influenced the data collection and analysis is a factor that must be taken into account. All of the providers

were aware of my position as an infant/toddler educator. The possibility exists that I may have "led" the providers in my manner of questioning (Patton, 1980). Peshkin (1988) described several strategies to limit the effects of subjectivity and preconceived assumptions that were used in this study. I took detailed field notes that included my reflections, and I shared the interpretations of events I observed with the providers to check for the accuracy of my data.

Implications

The findings of the study point to several practical and policy implications. I describe these in the next section.

Training needs

First and foremost, researchers and trainers need to provide professional development activities that reflect respect for and sensitivity to the unique role of these providers. Organizations need to offer training during non-traditional hours such as on the weekends when providers are free from work responsibilities. The results of this study continue to confirm and support the existing literature on the need for training for child care providers to increase their willingness to accept children with disabilities. (Devore et al., 2000; Buell et al., Diener & Whitehead, 1988). Information related to children with disabilities needs to be embedded into all existing training areas (i.e. nutrition, child development, community) that are a part of the state based training. Having the information embedded into all training, would allow the providers to begin learning about and children with disabilities outside of disability-related trainings. Training on sensitivity and disability awareness highlighting individual differences and

commonalities among all children must also be a component of training efforts. These endeavors could increase the cadre of providers that accept children with disabilities.

Providers often knew which other providers typically cared for children with disabilities and called them "special needs" providers due to their experiences and willingness to care for children with disabilities. Current and new providers need to have opportunities to hear providers that have experiences in including children with disabilities share their stories. Training may take the form of seeing other family child care providers who are including children with disabilities. These providers may serve as mentors to providers that want to provide inclusive childcare. Devore and Hanley-Maxwell (2000) also suggest that "parents, special education teachers, and therapist who have worked as on-site consultants together with the childcare providers contribute to the presentations and discussions" (p. 253).

The providers in this study requested information about specific disabilities and management of children with attention and challenging behaviors. Family child care providers may suggest additional topics for further training opportunities. Trawick-Smith and Lambert (1995) suggested that collaborative planning between providers and trainers is necessary.

Hands-on Component

Both in this study and others researchers (Devore et al., 2000) have found that previous exposure to children with disabilities in some capacity was associated with increased willingness and comfort in caring for children with disabilities. This study revealed that there was need for hands-on experience at the pre-service and in-service levels in addition to traditional training methods (lecture, written materials, videotape,

group activities, and stimulation activities). Providing "hands-on" experience along with traditional training at the pre-service level would allow the providers to see the range of children with disabilities and become comfortable providing services. Changing the attitudes of child care providers and their beliefs about children with disabilities is of great importance. The providers in this study had identified several ways that other providers in their association could receive this "hand-on" experience.

Supports

As demonstrated in this study, a positive and supportive relationship between the providers and parents is necessary for the successful inclusion of children with disabilities in family child care programs. Providers and parents must be made aware that the quality of their relationship is vital and mutual sharing of information is fundamental. Increased collaboration between providers and early intervention and preschool special education personnel to provide on-going support is needed. The providers in the current study had a source of on-going support as they cared for the children with disabilities. This support came through consultation and technical assistance from the early childhood and preschool special education personnel. As noted earlier, the providers work in isolation and rely on each other for support. In center-based programs, support and assistance is available through the other providers and administrative staff, center director, assistant director, etc. In the state, the Office of Child Care, which serves as the regulatory organization recently moved under the State's Department of Education, so there is already a structure in place for collaboration. Program procedures should be established to facilitate the communication between families of children with disabilities, child care providers and early intervention and

preschool special education staff. Giving providers opportunities to observe or sit in inclusive classroom or gain exposure to children with disabilities is necessary. Partnerships can be developed between the providers and the early childhood centers in their districts. This would give providers a source of on-going support when they have questions or concerns. This is how Felicia gained a lot of her information and exposure to other children with various disabilities. In addition, creating collaboration and linkages among early childhood special education staff, providers and families could create more opportunities for families of children with disabilities to enroll their children in inclusive child care settings. Experienced family child care providers can work with other providers to provide peer support in assisting them with including children with disabilities in their programs.

All of the providers in this study were knowledgeable and had information on the services that were available under Part C and Part B of IDEA. In many situations, they were the ones who provided the families with the referral information. Therefore, ensuring that all family child care providers have this information is critical.

In my personal experience as a teacher in the Infants and Toddlers Program, family child care and center based providers are not always open to having early intervention staff in their programs. In addition, there have been times when I was invited in, and was given a small space to work with the child without the participation of the provider. Also, I am often asked by families of children with disabilities for the names of child care providers or programs when they are seeking child care and typically have only been able to offer a few names. I typically refer the families to the Locate Child Care Services through the resource and referral center or refer them to their service

coordinators. However, because many of the service coordinators and staff are aware of my interests in inclusive community-based program, they often refer to me for the information. Because the early childhood special education is often unaware of many providers who are willing and able to make reasonable accommodations, the options for inclusive and natural placements are limited.

Volunteers from parent groups, students in early childhood and early childhood special education, senior citizens and service organizations can be used to provide special support for children with disabilities (Sciarra & Dorsey, 1998). However, training for the volunteers must be arranged.

Policy

National and state organizations need to develop inclusive regulations, policies and procedures that do not conflict or serve as barriers when including children with disabilities. In addition, the providers need resources and funding to provide high quality services to children with disabilities in their programs. Funding to pay for substitutes needs to be available to allow providers to attend training and allow them to gain experience and exposure to other children with disabilities either through visiting another family child care programs or a local early childhood center for children with disabilities. Reimbursements for providers who include children with disabilities may widen the pool of available providers who care for children with disabilities.

Having the resources available to purchase equipment and material could serve as an incentive for family child care providers to include children with disabilities. The providers in this study did not have the funds to make any necessary accommodations or modifications to their program to welcome children with disabilities. Providers that are

willing to accept children with disabilities should be rewarded with incentives, materials, training opportunities and on-going support.

Although compliance with the ADA did not appear to be associated with the providers' acceptance of children with disabilities in this study, child care providers need to be thoroughly knowledgeable of the law and their obligation. Terry, who often goes to the state capital to advocate for family child care providers, pointed out that if the law mandates serving children with disabilities, then they need to provide the funding for such efforts. When providers are knowledgeable it gives them a voice and legitimate reason to advocate for funding for special equipment and resources.

<center>Future Research</center>

Since the sample size in this study was small and included family child care providers that in many respects were not considered typical family child care providers, additional research is need regarding provider perceptions and behaviors that contribute to the inclusion of young children with disabilities. Additionally, the providers in this study had many characteristics that have been associated with a willingness and commitment to include children with disabilities. Studies need to be conducted on providers that are caring for young children with disabilities for the first time. Factors related to the supports these provider need when caring for the child for the first time should be examined. Future research is also needed to examine the experiences of family child care providers that are including children with other types of disabilities.

In the current study, the instances where two of the providers had to terminate care, was when the child displayed behavior challenges. However, the providers showed empathy for the families and helped them find alternate child care. Recently, researchers

at the Research and Training Center of Family Support and Children's Mental Health at Portland State University (Models of Inclusion in Child Care Project), conducted studies at 10 model child care centers that included children with emotional and behavioral challenges (Brennan, Ama, Caplan, Warfield, & Archer, 2002). They reported that providers used the following strategies to include these children.

- Referring children for assessment or mental health intervention

- Using paid mental health consultants

- Working with the child's own therapist

- Engaging social workers to provide family support

- Providing intensive staff training on children's mental health

- Communicating with parents about the child's medication

- Developing innovative and adaptive care strategies

They also designed settings with reduced stimulation, concentrating on positive aspects of the child's behavior and working with families to develop consistent strategies or techniques to be used at home and at the center. Future research needs to be focused on the needs of family child care providers that are including children with behavioral challenges. Questions such as, would having accesses to the above resources allow family child care providers to include these children in their programs, need to be examined.

Future research efforts should also be focused on the interactions between family child care providers and the children with disabilities in their programs. Although this was not a direct focus in this study, a closer examination of how the providers communicate with the children on a daily basis should be explored. It would be interesting to look at the literature of interactions between child care providers and apply

it to family child care providers interactions with children with disabilities in their program. Finally, factors associated with high quality such as providers being licensed, having higher levels of education and training and engaging in pre-service and in-service training (Kontos et al., 1995), were present in the current study. Studies that continue to focus on quality in family child care programs should be conducted

It is imperative that child care providers have opportunities to learn about inclusive practices and are supported in their efforts to include children with disabilities. However, in order for this to be accomplished, the issues surrounding family child care programs needs to be further explored.

Appendix A – Consent Forms

INFORMED CONSENT FORM

Identification of Project	A Qualitative Analysis of the Experiences and Perspectives of Family Child Care Providers Who Care for Young Children with Disabilities
Statement of Age of Subject	I state that I am over 18 years of age and wish to participate in research conducted by Tracey Wayne, a doctoral student in the Department of Special Education at the University of Maryland, College Park, MD 20742. The study is being conducted under the supervision of Dr. Paula Beckman of the University of Maryland.
Purpose	The purpose of the research is to understand the experiences and perspectives of family child care providers who include young children with disabilities in their programs. I understand that the student investigator wants to learn about my program and identify facilitators, barriers and supports to participation of young children with disabilities in family child care programs.
Procedures	The procedures involve at least two interviews with the student investigator, Tracey Wayne. The purpose of the interview is to learn about my program and my experiences in including young children with disabilities. The following are types of questions I will be asked during the interview:

1. Describe your program.
2. What are your experiences in teaching young children with and without disabilities?
3. What are your feelings about having children with disabilities in family child care programs with children without disabilities?

The interviews will last approximately one hour, and will be audiotaped. The student investigator will also observe and take notes while the child with a disability is attending my family child care program. The purpose of the observation is to see the strategies I use and how I interact with the child with a disability

during the daily routine. Each observation will last approximately 3-4 hours.

Confidentiality	All information will be kept confidential to the extent permitted by law. My name, the name of my family child care program or any names of the children attending my program will not be identified at any time. The information I provide will be grouped with information others provide for reporting and presentation. I understand that tapes and transcripts will be stored in a locked file cabinet in the home of Tracey Wayne, student investigator and destroyed at the completion of the study.
Risks	There are no known risks to my participation.
Benefits, Freedom to ask questions and withdraw	I understand that the information I provide is not designed to help me personally. The information that I provide will be used to understand the process of including children with disabilities into family child care programs, and to generate ideas so that young children with disabilities can be included in community-based settings. I understand that I can ask questions, decline to participate in any part of the study, or decline to answer specific questions. I am free to withdraw from participation at any time without penalty.

Tracey Wayne
1308 Benjamin Building
University of Maryland
401-405-1959

Printed Name of Subject _____

Signature of Subject _____

Date _____

INFORMED CONSENT FORM

Identification of Project	A Qualitative Analysis of the Experiences and Perspectives of Family Child Care Providers Who Care for Young Children with Disabilities
Statement of Age of Subject	I state that I am over 18 years of age and wish to participate in research conducted by Tracey Wayne, a doctoral student in the Department of Special Education at the University of Maryland, College Park, MD 20742. The study is being conducted under the supervision of Dr. Paula Beckman of the University of Maryland.
Purpose	The purpose of the research is to understand the experiences and perspectives of family child care providers who include young children with disabilities in their programs. I understand that the student investigator wants to identify facilitators, barriers and supports to participation of young children with disabilities in family child care programs.
Procedures	The procedures involve at least one interview with the student investigator, Tracey Wayne. The intent of the interviews will be to better understand how I view the process used to include my child into the family child care program. The following are types of questions I will be asked during the interview:

1. Describe your child.
2. What have been your experiences in the family child care program?
3. What are your feelings about having children with disabilities in family child care programs with children without disabilities?

The interviews will last approximately one hour, and will be audiotaped. The student investigator will also observe and take notes while my child is attending the family child care program. The purpose of the observation is to see the strategies the family child care provider uses and how she/he interacts with my child

with a disability during the daily routine. Each observation will last approximately 3-4 hours.

Page 2 of 2
Initials ____ Date ____

Confidentiality

All information will be kept confidential to the extent permitted by law. My name, my child's name, the name of the family child care program or any names of the children attending the program will not be identified at any time. The information I provide will be grouped with information others provide for reporting and presentation. I understand that tapes and transcripts will be stored in a locked file cabinet in the home of Tracey Wayne, student investigator and destroyed at the completion of the study.

Risks

There are no known risks to my participation.

Benefits, Freedom to ask questions and withdraw

I understand that the information I provide is not designed to help me personally. The information that I provide will be used to understand the process of including children with disabilities into family child care programs, and to generate ideas so that young children with disabilities can be included in community-based settings. I understand that I can ask questions, decline to participate in any part of the study, or decline to answer specific questions. I am free to withdraw from participation at any time without penalty.

Tracey Wayne
1308 Benjamin Building
University of Maryland
401-405-1959

Printed Name of Subject _____

Signature of Subject _____

Date _____

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Purpose	The purpose of the research is to understand the experiences and perspectives of family child care providers who include young children with disabilities in their programs. I understand that the student investigator wants to identify facilitators, barriers and supports to participation of young children with disabilities in family child care programs.
Procedures	The procedures involve at least one interview with the student investigator, Tracey Wayne. The intent of the interviews will be to better understand how I view the process of including children with disabilities into family child care programs. The following are types of questions I will be asked during the interview:

1. Describe your program.
2. What are your feelings about having children with disabilities in family child care programs with children without disabilities?
3. What kinds of resources or assistance does your program provide to family child care providers who include children with disabilities?

The interviews will last approximately one hour, and will be audiotaped.

Confidentiality

All information will be kept confidential to the extent permitted by law. My name or the name of any family child care program will not be identified at any time. The information I provide will be grouped with information others provide for reporting and presentation. I understand that tapes and transcripts will be stored in a locked file cabinet in the home of Tracey Wayne, student investigator and destroyed at the completion of the study.

Risks

There are no known risks to my participation.

Benefits, Freedom to ask questions and withdraw

I understand that the information I provide is not designed to help me personally. The information that I provide will be used to understand the process of including children with disabilities into family child care programs, and to generate ideas so that young children with disabilities can be included in community-based settings. I understand that I can ask questions, decline to participate in any part of the study, or decline to answer specific questions. I am free to withdraw from participation at any time without penalty.

Tracey Wayne
1308 Benjamin Building
University of Maryland
401-405-1959

Printed Name of Subject _____

Signature of Subject _____

Date _____

Appendix B

Family Child Care Provider Demographic Data Form

Name: _____

Name of Family Child Care Program: _____

Address: _____

Phone: _____

1. What is your origin?

    a. African-American   c. Caucasian

    b. Asian   d. Hispanic

    Other (please specify) _____

2. How many years have you been in family childcare? _____

3. How many children currently enrolled in your program? _____

4. What is the age range of the children in your program? _____

5. How many children with disabilities currently enrolled in your program? _____

    Please indicate age(s) of child(ren) _____

6. Is this the first time that you have included children with disabilities in your program?

    Yes   No

7. Do you have any previous experience in childcare?   Yes   No

    If yes, please specify. _____

8. Have you received any training in including children with disabilities in family child

    care programs?   Yes   No

    If yes, please specify. _____

9. What is your highest education level? _____

Appendix C

Interview Guide

<u>Family Child Care Providers</u>

Background Information

- How did you become to be a family child care provider?

- What role, explicity or implicity, did your family play in your decision?

- Do you remember any early experiences that affected your decision?

- When you first became a provider, were there any colleagues or mentors who influenced you?

- Can you think of early experiences that continue to influence what and how you operate your business now?

- How have you changed as a provider over the years?

Program Information

- Tell me about your program.

  How long have you have you operated a family child care program?

  Describe the children.

  Describe the children with disabilities.

  Describe a typical day in your program.

Caring for the Children with Disabilities in Your Program

- Tell me about your experiences in teaching young children.

- What lead you to enroll children with disabilities?

- Describe your experiences in working with children with disabilities.

- How do you include children with disabilities into the daily program activities?

- Tell me about some of the things that have assisted you in including children with disabilities in your program.

- Who do you turn to for support?

- Has there been any person or strategy that you have relied on?

- What mechanisms exist that help you?

- What are your feelings about having children with disabilities in family childcare programs with children without disabilities?

- Tell me about the obstacles or challenges associated with including children with disabilities in your program.

Parents of Children with Disabilities

- Tell me about your child.

    Describe a typical day for your child.

- Tell me about your experiences in the family child care program.

    How did you find out about the program?

    What made you decide to enroll your child in the program?

    What information did you provide about your child's disability to the family child provider?

    How does the family child care provider include your child into the daily program activities?

    What factors have led you to keep your child enrolled in this program?

- Describe any previous child care experiences.

- Tell me about any obstacles or challenges associated with including your child into the program.

- What are your feelings about having children with disabilities in family childcare programs with children without disabilities?

Key Personnel

- Tell me about your program.

- Tell me about your role in the program?

  What are your major responsibilities?

  How long have you have you been working in the program?

- What kinds of resources or assistance does your program provide to family child care providers who include children with disabilities in their programs?

- What are your feelings about having children with disabilities in family childcare programs with children without disabilities?

Appendix D

Child Demographic Data Form

Name: _____

Address: _____

Phone: _____

Child's name: _____ Child's age: _____

Child's disability: _____

1. What is your origin?

   a. African-American   c. Caucasian

   b. Asian   d. Hispanic

   Other (please specify) _____

2. Does your child receive services through the Infants and Toddlers Program or

Preschool Special Education Program? _____

       If through the Infants and Toddlers Program, where are services delivered?

       a. Home   b. Family Childcare Program   c. Early Childhood Center

3. What Early Childhood Center does your child attend? _____

4. What services does your child receive?

      a. Special Education   e. Vision Services

      b. Occupational Therapy (OT)   f.   Service Coordination

      c. Physical Therapy (PT)   g.   Other _____

      d. Speech/Language Therapy

5. How long has your child been attending the current Family Childcare Program? _____

6. Did your child attend any childcare program previously? Yes No

If yes, was the childcare program a Family Childcare program? Yes No

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