Child and Adolescent Services Research Center

SB 1703 Inclusive Child Care Program
Final Evaluation Report

Kids Included Together

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Report prepared by:

Mary G. Mueggenborg, MSW
Mary J. Baker-Ericzén, PhD
Barrie K. Owens, BS
Torrie Dunlap, BA
Mary M. Shea, OTR, MPH
Diana Strong, BS

Contributions made by:

Sara Couron, MPA
Jan Giacinti, BA
Jennifer Leich, MA
Stephanie Mello, BA
Monica Peffer, BA
Ginny Pettit, BS

An appreciation to all the staff, providers and families who committed their time to complete all of the evaluations that were necessary to accomplish this report. A special thanks to our SDSU and UCSD interns.

July 2005

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Executive Summary

Incorporated in 1997, Kids Included Together's (KIT) mission is to support recreational, child development and youth development programs that include children with and without disabilities. KIT's goals are to enrich the lives for all who participate and to increase understanding and acceptance of disabilities as a natural part of life.

California State Senate Bill 1703 was funded by the California Department of Education (Child Development Division) and implemented in San Diego County October 2003 through June 2005. The main goal of SB 1703 was to increase child care capacity for children with special needs. In San Diego County this occurred via training, technical assistance and systems coordination.

This evaluation report provides an overview of the KIT SB 1703 Inclusive Child Care Program's training and technical assistance, including descriptive information and outcome data. The major findings included in this report are summarized below.

Report Highlights

* 1555 providers and 228 children were served through the SB 1703 grant in San Diego County. 1447 providers received trainings and 187 received consultations; 79 received both types of services.
* Providers from all backgrounds were represented in training attendance: 28% White, 14% Black, 41% Hispanic and 12% Asian/Pacific Islander.
* Providers who attended trainings were fairly equally distributed across the geographic regions: 12.9% North Coastal, 7.2% North Inland, 21.3% North Central, 27.9% Central, 6.3% East and 14.5% South.
* There was a 13% increase in providers identified as having received training and/or experience working with children with disabilities or special needs.
* Overall, training participants showed a significant positive mean change in their attitude and topic knowledge regarding inclusion ($p<.01$).
* Providers who attended more than 2 trainings showed a significantly greater improvement in mean attitude and topic knowledge change scores than providers who attended only 1 training ($p<.01$), suggesting that providers benefit more from attending more than 2 trainings as was recommended.
* Overall, a high percentage of providers were satisfied (approximately 95% agreed or strongly agreed) with the inclusion trainings.
* Overall, there was a positive mean change in positive aspects of inclusion behavior from pre to post consultation assessment; some aspects changed significantly ($p<.01$).
* Overall, there was a significant negative mean change in negative aspects of inclusion behavior from pre to post consultation assessment ($p<.01$).
* Overall, a high percentage of providers were satisfied (approximately 88% agreed or strongly agreed) with the onsite consultations.

Introduction

Background

Incorporated in 1997, Kids Included Together-San Diego, Inc. (KIT) has increased inclusive opportunities for children with disabilities and/or special needs by providing training and technical support to out-of-school time social, recreational and child care facilities. The mission of KIT is to support recreational, child development and youth development programs that include children with and without disabilities. KIT's goals are to enrich the lives of all who participate and to increase understanding and acceptance of disabilities as a natural part of life.

KIT has become the recognized resource for teaching and supporting inclusive practices in San Diego County, and its unparalleled model for inclusion has gained national attention. Historically, KIT has focused on the school age years, and has worked with the larger, better-known organizations in the community, including Boys & Girls Clubs, YMCAs, before and after school programs on public school campuses, as well as park and recreation departments. In recognition of its success and leadership status, the California State Council on Developmental Disabilities has awarded KIT a program development grant two out of the past three years. This very competitive grant is typically awarded to fewer than ten agencies statewide per year and KIT's multi-year award is unprecedented.

In July of 2003 KIT's leadership role was again recognized when KIT was selected as the lead service provider for the SB 1703 Inclusive Child Care Program. This government grant was funded through the California Department of Education (Child Development Division) from October 2003 – June 2005. The main focus was the critical need to increase child care capacity for children with disabilities. It provided funding to all counties in California, based on population size, through local planning councils or state-funded resource and referral agencies. The grant allowed each county to determine how to use the funding. In San Diego County, the YMCA Childcare Resource Service (the resource and referral agency) was the grantee and fiscal agent. The SB 1703 funding was used to provide: 1) free training and technical assistance to child care providers, 2) enhanced resources and referrals for families with children with special needs, 3) printing and distribution of the manual, *Children with Challenging Behavior: Strategies for Reflective Thinking*, 4) train-the-trainer workshops by Linda Brault, one of the authors of the manual and 5) systems coordination.

The training, technical assistance and systems coordination portions were awarded to KIT. Through this grant, KIT expanded its reach to early childhood care providers serving children ages birth to five. The program involved the following collaborative partners:

> **Exceptional Family Resource Center (EFRC)**: Responsible for being the link to the community through its existing network of six satellite locations and for parent training. EFRC was also responsible for assisting with systems coordination, agency linkages, provider training and parent participation, as well as an educational resource for Resource Team members and parents. Hosted the 800 number as the first line of communication for families seeking assistance.

Family Health Centers of San Diego (FHCSD): Provided its expertise in the areas of speech/language pathology, occupational and physical therapy, social-behavior intervention, child development and health education. FHCSD provided nine out of the 23 consultants who worked on the project.

Child & Adolescent Services Research Center (CASRC): Involved in the development of the Service Delivery Plan ensuring quality assurance. CASRC was responsible for periodic evaluations of the project to ensure its effectiveness, in addition to an end-of-project evaluation.

YMCA Childcare Resource Service: The local state-funded resource and referral agency provided enhanced child care referrals for families of children with special needs seeking child care placement, educated parents to the services available through SB 1703 and linked KIT to the providers of those parents wanting those services.

San Diego Regional Center: Served on the Advisory Council and was a source for identifying the unmet child care needs and providing referrals.

San Diego County Family Child Care Association: Served on the Advisory Council and provided outreach access to family child care providers throughout San Diego County.

WestEd Center for Prevention and Early Intervention: Provided training and materials specific to the birth to five population to KIT trainers, family child care providers and center/program staff.

San Diego County is the third largest county in California. It has an estimated 634,773[1] children ages birth to 14, encompassing a vast array of race/ethnic groups, cultures and spoken languages. An estimated 40,759[2] children birth to 14 have been identified as having special needs. There are approximately 5,200 active child care centers (licensed and license-exempt) and licensed family child care providers in the County, with the capacity to care for approximately 92,000 children[3].

Trainings

San Diego County began implementing the SB 1703 trainings in January 2004. KIT offered a comprehensive training program consisting of four two-hour trainings on the following topics[4] throughout San Diego County:

1) Introduction to Inclusion
2) Respectful Accommodations
3) Positive Behavioral Support
4) Partnering with Families

KIT recommended that providers attend all four sessions in the order given above to optimally enhance skill acquisition; however, each session was self-contained and could be taken by itself and in any order. Trainings were offered in both English and Spanish. Trainings were also provided onsite for programs that had at least 15 staff

members who would attend. Each session was approved by the San Diego CARES program, San Diego's child care stipend program, for two hours of credit.

At each training, participants were asked to complete a pre-training and post-training questionnaire, which provided the basis for the training evaluations contained in this report.

Outreach for the trainings was conducted through direct mail, utilizing the local resource and referral's database of licensed and license-exempt child care centers as well as licensed family child care providers. Outreach also occurred with presentations at established meetings involving providers.

Technical Assistance

In January 2004, KIT implemented the SB 1703 technical assistance in the form of child-specific consultations. Consultations were initiated by either a provider contacting KIT, or a parent and provider being referred to KIT. KIT explained the process to the provider and had the provider obtain the parent consent form, as well as complete a pre-consultation questionnaire. Upon receipt of the completed required forms, KIT contacted the provider and obtained enough information about the child and issue(s) to identify the most qualified consultant. A KIT consultant was then deployed to observe the child and make recommendations to address the issue(s) identified. Recommendations included specific actions to be implemented at the facility, linkages to community resources (e.g., referral to San Diego Regional Center) and/or referral to another KIT consultant. A written Observation & Recommendations report was completed and mailed to the provider who had the responsibility of partnering with the family and sharing the information with the parent. Each KIT consultant followed up as appropriate and completed a written report for all subsequent visit(s). After the final consultation, a post-consultation questionnaire was mailed to the provider and to the parent. Results of these questionnaires are included in this report.

Outreach for the technical assistance was conducted simultaneously with, and in the same manner as, the training outreach. In addition, the free technical assistance was further promoted at each training, at San Diego Regional Center unit meetings, in the YMCA Childcare Resource Service Communiqué and other newsletters, and by EFRC at numerous venues where families with children with special needs were present.

To further increase outreach efforts for the technical assistance, KIT created the *KIT To Go*, a disability awareness package that was delivered by outreach inclusion facilitators directly to children in child care programs. The *KIT To Go* includes 5 hands-on activities that child care staff can present to the preschool children in their programs, a reading list of picture books that address ability differences, and small props that accompany the activities. When facilitators visited programs, they presented an activity called "Alike and Different." Following the activity, they reviewed the materials in the *KIT To Go* with the providers and made him/her aware of additional services offered through the Inclusive Child Care Project. The *KIT To Go* package is available in both English and Spanish.

Systems Coordination

From the outset of the SB 1703 grant, EFRC, KIT and CRS addressed families' child care issues in a coordinated fashion. EFRC and CRS enhanced their respective

processes and coordination with the other agencies to better serve the families and have sustained this upgraded level of service, which is now the standard.

Early in the grant period the San Diego Regional Center re-activated its child care committee. Service coordinators from SDRC and representatives from EFRC, KIT and CRS (Enhanced Referrals and Special Needs Unit) met monthly to address child care issues and brainstorm solutions. These efforts and committee have also continued post grant. These interactions have led to new program developments as well, which are highlighted in the Future Directions section of this report.

Additionally, a series of stakeholder meetings were held to address the child care issues that families of children with special needs are challenged with daily, and to create work plans to address these issues. On June 7, 2005, a one-day San Diego County Early Care & Development Inclusion Institute was held to move this work forward by attaining commitments to systemic change and ongoing coordination for the benefit of families. Twenty-four key decision makers participated. The action plan is being implemented under the auspices of the Special Needs Committee of the San Diego County Child Care & Development Planning Council.

[1] Based on SANDAG's 2000 Census Current Estimates, January 2004.
[2] Based on San Diego County Office of Education Special Education Pupil Count as of 12-1-03.
[3] Based on data provided by the YMCA Childcare Resource Service, January-March 2005.
[4] For descriptions of the four training modules, please see the Outreach Materials in the Appendix.

Inclusive Child Care Program Goals

To make the SB 1703 Inclusive Child Care Program successful, KIT collaborated with a variety of professionals to provide the trainings and onsite consultation services. KIT developed and enhanced the skills of these consultants through 50 hours of training, creating a cadre of professionals knowledgeable about inclusion. KIT worked with 15 trainers and 23 consultants. Thirty-one percent of these professionals served as both trainers and consultants.

As part of the SB 1703 Inclusive Child Care Program, KIT served 1555 providers and 228 children (unduplicated) from October 1, 2003 – June 3, 2005 throughout San Diego County. A total of 1447 providers attended trainings and 187 received consultations; 79 received both types of services.

Below are the measurable goals for the SB 1703 Inclusive Child Care Program.

SB 1703 Goals

1) Increase the number of licensed child care providers in the YMCA Childcare Resource Service (CRS) database that are identified as being trained and/or having experience working with children with disabilities or special needs. The YMCA CRS database lists all active child care providers in San Diego County.

Proposed outcome: 10% increase

Program Outcomes:

a) In October 2003, there were 1212 licensed family child care providers meeting this requirement. As of March 2005, there were 1346, representing an 11% increase.
b) In October 2003, there were 309 licensed child care centers meeting this requirement. As of March 2005, there were 355, representing a 15% increase.
c) In October 2003, there were 77 license-exempt child care centers meeting this requirement. As of March 2005, there were 99, representing a 29% increase.

2) Increase the number of children who received child/site specific interventions leading to retention in care and no disruption in child care placement.

Proposed outcome: A minimum of 350 interventions within 21 months (October 1, 2003 – June 30, 2005) and an estimated 350 unduplicated children served

Program Outcomes:

a) A total of 373 consultations were provided for a total of 558 service hours.
b) 228 children received onsite consultations.
c) 187 providers received onsite consultations for children in their care.
d) Of 74 children who had 6-month follow-up data, 80% (59) sustained in their child care placement. Note: 8 children left their child care placement due to family moving or no longer needing child care and were excluded from analyses.
e) Of 141 children who had 3-month follow-up data, 83% (117) sustained in their child care placement. Note: 9 children left their child care placement due to family moving or no longer needing child care and were excluded from analyses.

3) Increase the number of children for whom the specific intervention results in a sustainable alternative for child care.

Proposed outcome: 80% of all children who are placed in an alternative setting will be served for at least six months

Program Outcomes:

a) Only three children were placed in an alternative child care setting, and 100% sustained in their placement at 3-month follow-up. Two of these children also had 6-month follow-up data and 100% sustained in their child care placement.
b) Results from the pre-consultation questionnaire showed that children who dis-enrolled from their child care placement were rated significantly higher than children who sustained placement on the question, “Myself or another primary caregiver needs to spend extra time attending to the child” (4.212 vs. 3.657; $p<.05$).
c) Additionally, data from provider trainings and consultations may suggest that children of providers who attended a KIT training are less likely to dis-enroll from their child care placement than children of providers who did not attend a KIT training (11% vs. 18%; $p<.05$).

4) Increase the number of parents and providers who receive information about accessing resources for supporting children with special needs in child care settings.

Proposed outcome: 1000 parents and providers will receive information about accessing resources

Program Outcomes:

a) Over 16,000 professionals and parents received information from KIT and EFRC via mailings, fliers, meeting announcements and newsletters. Examples of these can be found in the Appendix.
b) 2161 parents and 647 service providers contacted the Exceptional Family Resource Center, a SB 1703 collaborative partner, where information about the Inclusive Child Care Program was provided and referrals made when appropriate.
c) KIT distributed, and provided demonstration for, a total of 82 *KIT To Go’s* from August 30, 2005 – May 31, 2005.

5) Providers will report a change in attitude and perception toward including children with disabilities.

Proposed outcome: 80% of providers who attend trainings will report a change in their attitudes and perceptions toward including children with disabilities.

Program Outcomes:

a) Of the 1185 providers with pre and post attitude training evaluation data, there was a significant positive mean change ($p<.01$) in total overall attitude scores. Sixty-two percent showed a positive change in attitude scores.
b) Of the 1187 providers with pre and post topic knowledge training evaluation data, there was a significant positive mean change ($p<.01$) in total overall topic knowledge scores. Eighty percent showed a positive change in topic knowledge scores.

6) Providers and parents will be satisfied with SB 1703 services.

Proposed outcome: 80% of all providers and 80% of all parents who receive SB 1703 services will be satisfied

Program Outcomes:

a) Overall, approximately 95% of providers who received trainings were satisfied (agreed or strongly agreed with the questions).
b) Overall, approximately 88% of providers who received onsite consultations were satisfied (agreed or strongly agreed with the questions).
c) Overall, approximately 65% of parents whose children received onsite consultations were satisfied (agreed or strongly agreed with the questions). Almost 90% of parents reported they would be interested in future onsite consultations for their children from KIT.

Trainings: Impact on Attitudes and Topic Knowledge

In order to evaluate the impact of KIT SB 1703 provider trainings, data on attitude and topic knowledge change were collected through pre and post training questionnaires. Demographic data were also collected. See the Pre-Training Questionnaire and the Post-Training Questionnaire in the Appendix for the evaluation questions used in data collection.

Numbers Served

KIT offered a total of 123 trainings from January 6, 2004 – May 31, 2005. A total of 2921 providers attended these trainings (duplicated). Of these, 1447 were unique providers (unduplicated). This report reflects outcome data collected from providers who completed evaluations at trainings offered from January 6, 2004 – January 31, 2005. During this timeframe, 94 trainings were offered and a total of 2487 providers completed evaluations at these trainings (duplicated). Of these, 1298 were unique providers (unduplicated).

Of the 1298 providers who completed evaluations at trainings during the data collection timeframe, 328 (25%) attended public trainings (offered in a variety of locations and times throughout San Diego County). One hundred sixteen of these providers (35%) attended only one training, 49 (15%) attended two trainings, 62 (19%) attended three trainings and 101 (31%) attended four or more trainings.

The remaining 970 providers (75%) attended onsite trainings at their centers. Of these, 509 (52%) attended only one training, 271 (28%) attended two trainings, 134 (14%) attended three trainings and 56 (6%) attended four or more trainings. Please note that providers who attended onsite trainings may not have had the opportunity to attend all four trainings. The majority of the 1298 providers (71%) attended Module 1: Introduction to Inclusion first.

Sample Demographics

KIT's SB 1703 training program served primarily Hispanic (41%) and White (28%) providers (see Figure 1). The remaining providers who attended trainings were 14% Black, 12% Asian/Pacific Islander, 3% Bi/Multiracial, 0.4% Other and 0.3% Native American/Alaskan Native. Two percent of providers declined to state their race/ethnicity. Approximately 44% of providers reported less than 5 years of experience working in the child care/before or after school/recreational field, 25% reported 5-9 years of experience and 31% reported 10 years or more (see Figure 2). Providers reported an average of 8.5 years of experience in the field.

The majority of providers (70%) were in center-based child care programs (including before or after school/recreational programs), 15% were in small family child care homes, 5% were in large family child care homes and 10% did not consider themselves direct caregivers (e.g. directors and other administrators) (see Figure 3). Most child care programs (65%) were licensed by the State of California (see Figure 4). Thirty-one percent of providers worked in license-exempt programs. License-exempt providers include three groups: 1) individuals who are not licensed by the State of California and are caring for child(ren) of one family only, 2) programs that are legally exempt from licensing (e.g. 6-to-6 school age programs, some Boys & Girls Clubs), and

3) centers that are licensed by the military or Indian tribes but are not licensed by the State of California. Of the license-exempt providers, 59% were licensed by the military.

Providers primarily served children ages 2-5 years (91%) (see Figure 5). Fifty-one percent of providers served children 0-23 months and 34% of providers served children 6-13 years (providers may serve more than one age group). The primary language spoken in child care programs was English (76%), and 23% of the programs spoke Spanish as the primary language (see Figure 6).

Providers who attended trainings were from all over San Diego County. Based on the Health and Human Services Agency Health Districts geographical map, 28% of providers were located in the Central Region, 21% in the North Central Region, 17% in the North Inland Region, 15% in the South Region, 13% in the North Coastal Region and 6% in the East Region (see Table 1).

Outcomes

Overall Outcomes

Training participants completed the pre-questionnaire directly prior to the start of the training, and completed the post-questionnaire immediately following the training. The evaluation gathered attitude and topic knowledge data in order to evaluate changes resulting from the training. Participants rated each question from 1 to 5, where 1=Strongly Disagree and 5=Strongly Agree. The data reported reflects answers from each participant's first pre assessment and last post assessment, regardless of the number of trainings attended. The number of trainings attended ranged from 1-7 (some providers attended all 4 trainings multiple times).

On the whole, training participants showed a positive mean change in their attitude and topic knowledge regarding inclusion from pre assessment to post assessment (see Figures 7 & 8). Paired t-tests showed a significant positive change ($p<.01$) on seven of the eight attitude questions and all six of the topic knowledge questions. Of the attitude questions, the largest mean change (+.364) occurred with the question, "I feel I would benefit if I had children with disabilities or other special needs in my care." The second largest mean change (-.337) occurred with the reverse-scored question, "I feel that including a child with disabilities or other special needs in my child care would require too many accommodations." Of the topic knowledge questions, the largest mean change (+.882) occurred with the question, "I have an understanding of the resources available to me regarding this area of training." The second largest mean change (+.878) occurred with the question, "I have the information regarding this topic area that I would need to provide appropriate child care to children with disabilities or other special needs."

In order to provide a composite attitude score, provider answers to questions 1-8 on the evaluation were added (after recoding the reversed items), for a possible total of 40 points. Composite topic knowledge scores were calculated by adding provider answers to questions 9-13, for a possible total of 25 points. Providers showed a significant positive mean change ($p<.01$) in both attitude and topic knowledge total scores from pre assessment to post assessment; 30.95 to 32.95 for attitude and 16.05 to 19.99 for topic knowledge (see Figure 9).

Attitude change scores were determined by subtracting the pre composite attitude score from the post composite attitude score. Topic knowledge change scores were determined by subtracting the pre composite topic knowledge score from the post composite topic knowledge score. The change scores are reported as percent of

“positive change” showing improvement, “negative change” showing a decline and “no change” showing no difference in scores. The majority of providers showed a positive change in both attitude (62%) and topic knowledge (80%) scores. Fourteen percent of providers showed no change in attitude and 23% showed a negative change in attitude. Twelve percent of providers showed no change in topic knowledge and 8% showed a negative change (see Figure 10).

Outcomes by Number of Trainings Attended

Data were analyzed by provider groups that were based on the number of trainings attended. Results showed no significant differences on pre assessment mean attitude or topic knowledge scores. Data analyzed by change scores, controlling for pre assessment mean scores, showed that providers who attended more than two trainings had higher mean attitude and topic knowledge change scores than providers who attended less than two trainings. However, due to error variances a statistical test could not be conducted to determine significance. Therefore, the meaningfulness of these findings is undetermined.

After creating different groups of providers by number of trainings, results also indicated that providers who attended one training, those who attended two trainings and those attending more than two trainings all showed a significant positive mean change in attitude and topic knowledge scores ($p<.01$) (see Figure 11). However, providers who attended more than two trainings showed a significantly greater improvement in mean attitude and topic knowledge change scores ($p<.01$) than providers who attended only one training. Additionally, providers who attended more than two trainings showed a significantly greater improvement in mean topic knowledge change scores ($p<.01$) than providers who attended two trainings. This suggests that providers benefit more from attending more than two trainings as was recommended.

Analysis of change scores by number of trainings attended revealed that the more trainings providers attended, the higher the percentage of providers that showed positive change, for both attitude and topic knowledge scores (see Figure 12). Of providers who attended more than two trainings, 66% showed a positive change in attitude, 9% showed no change and 24% showed negative change. Of providers who attended two trainings, 64% showed a positive change in attitude, 12% showed no change and 24% showed negative change. Of providers who attended only one training, 59% showed a positive change in attitude, 19% showed no change and 22% showed negative change. Of providers who attended more than two trainings 83.5% showed a positive change in topic knowledge, 8.5% showed no change and 8% showed negative change. Of providers who attended two trainings, 79% showed a positive change in topic knowledge, 12% showed no change and 9% showed negative change. Of providers who attended only one training, 78% showed a positive change in topic knowledge, 14% showed no change and 8% showed negative change. There appears to be an additive effect of participating in more trainings.

Outcomes by Race/Ethnicity

Data analyzed by race/ethnic groups showed that there were significant differences ($p<.01$) on pre assessment mean attitude scores by race. Native American/Alaskan Native, Bi/Multiracial, Other and Decline to State groups were excluded from analyses due to their small sample size. White providers had a significantly higher pre assessment mean attitude score than Hispanic and Asian/Pacific

Islander providers ($p<.01$), and Black providers had a significantly higher pre assessment mean attitude score than Asian/Pacific Islander providers ($p<.05$). There were no significant differences on pre assessment mean topic knowledge scores by race. There were significant differences ($p<.01$) on mean attitude change scores when controlling for pre assessment mean attitude scores. Asian/Pacific Islander providers showed the highest change, followed in order by White, Hispanic and Black providers. There were also significant differences ($p<.01$) on mean topic knowledge change scores when controlling for pre assessment mean topic knowledge scores. Again, Asian/Pacific Islander providers exhibited the highest change, followed in order by White, Black and Hispanic providers.

Providers from all race/ethnicities showed a significant positive mean change in attitude and topic knowledge scores ($p<.01$) (see Figure 13). Asian/Pacific Islander providers showed a significantly greater positive change in mean attitude scores ($p<.01$) than White, Black and Hispanic providers. White providers showed a significantly greater positive change in mean topic knowledge scores ($p<.01$) than Hispanic providers.

Analysis of change scores by race/ethnicity indicated that the Asian/Pacific Islander provider group had the highest percent of providers showing positive change in attitude (74%) while the Black provider group had the lowest percent of providers showing positive change in attitude (54%) (see Figure 14). White, Black and Asian/Pacific Islander provider groups had a slightly higher percent of providers showing positive change in topic knowledge (81%, 82% and 82%, respectively) compared to the Hispanic provider group (78%). Sixty percent of White providers showed a positive change in attitude, 17% showed no change and 23% showed negative change. Fifty-four percent of Black providers showed a positive change in attitude, 18% showed no change and 28% showed negative change. Sixty-two percent of Hispanic providers showed a positive change in attitude, 14% showed no change and 24% showed negative change. Seventy-four percent of Asian/Pacific Islander providers showed a positive change in attitude, 7% showed no change and 19% showed negative change. Eighty-one percent of White providers showed a positive change in topic knowledge, 14% showed no change and 4% showed negative change. Eighty-two percent of Black providers showed a positive change in topic knowledge, 12% showed no change and 7% showed negative change. Seventy-eight percent of Hispanic providers showed a positive change in topic knowledge, 11% showed no change and 11% showed negative change. Eighty-two percent of Asian/Pacific Islander providers showed a positive change in topic knowledge, 11% showed no change and 7% showed negative change. Data suggest some differences by providers based on race/ethnicity. This may suggest minor adaptations to trainings to be more culturally competent for specific cultural groups.

Outcomes by Caregiver Type

In order to look at the outcome data by caregiver type, providers were grouped into center-based providers and family child care providers (both large and small homes). Providers who reported themselves as “not a direct caregiver” were excluded from analyses. Results showed that there were no significant differences on pre assessment mean attitude scores between center-based and family child care providers. However, center-based providers had significantly higher pre assessment mean topic knowledge scores ($p<.05$) than family child care providers. There were no

significant differences on mean attitude change scores when controlling for pre assessment mean attitude scores. There appears to be no differences on mean topic knowledge change scores when controlling for pre assessment mean topic knowledge scores. However, a statistical test could not be conducted to determine significance due to error variances. Therefore, the meaningfulness of these findings is undetermined.

Both center-based and family child care providers exhibited a significant positive mean change in attitude and topic knowledge scores ($p<.01$) (see Figure 15). There was no significant difference in mean attitude change scores between center-based and family child care providers. However, family child care providers showed a significantly greater improvement in mean topic knowledge change scores than center-based providers ($p<.01$).

Analysis of change scores indicated that approximately the same percent of center-based and family child care providers showed a positive change in attitude. However, a higher percentage of center-based providers showed a positive change in topic knowledge compared to family child care providers (see Figure 16). Sixty-three percent of center-based providers showed a positive change in attitude, 14% showed no change and 23% showed negative change. Sixty-one percent of family child care providers showed a positive change in attitude, 15% showed no change and 24% showed negative change. Eighty-two percent of center-based providers showed a positive change in topic knowledge, 11% showed no change and 8% showed negative change. Seventy-seven percent of family child care providers showed a positive change in topic knowledge, 14% showed no change and 10% showed negative change.

Outcomes by Public vs. Onsite Trainings

Data were analyzed by the type of training providers attended: public or onsite. Providers who attended public trainings had significantly higher pre assessment mean attitude scores ($p<.01$) than providers who attended onsite trainings. There were no significant differences on pre assessment mean topic knowledge scores between the two groups. There were also no significant differences on mean attitude change scores between providers attending public and onsite trainings when controlling for pre assessment attitude scores. However, there were significant differences on mean topic knowledge change scores ($p<.05$) when controlling for pre assessment scores; providers who attended public trainings showed a higher change than providers who attended onsite trainings.

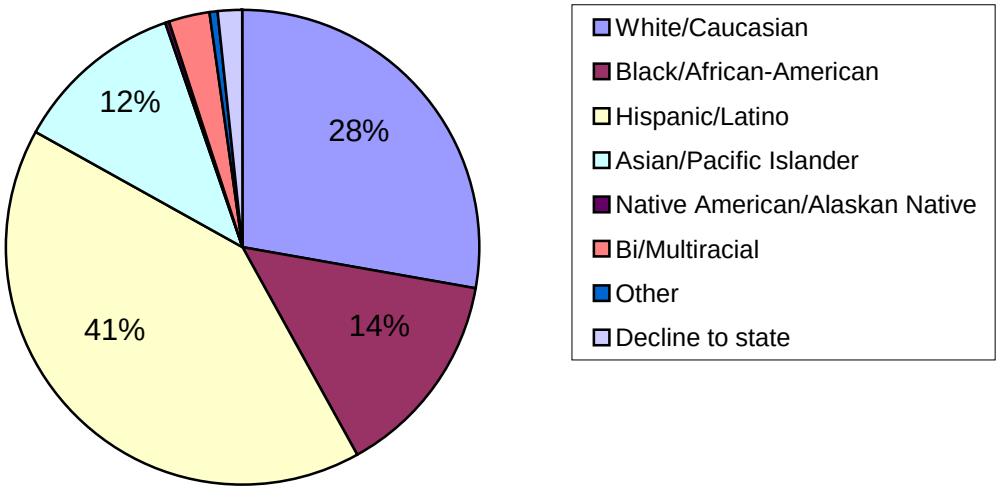
Providers exhibited a significant positive mean change in attitude and topic knowledge scores, regardless of type of training attended ($p<.01$) (see Figure 17). There was no significant difference in mean attitude change scores between the two groups. Providers who attended public trainings showed a significantly greater improvement in mean topic knowledge change scores ($p<.05$) than providers who attended onsite trainings.

Analysis of change scores indicated that a slightly higher percentage of providers who attended public trainings showed a positive change in attitude and topic knowledge compared to providers who attended onsite trainings (see Figure 18). Sixty-four percent of providers who attended public trainings showed a positive change in attitude, 15% showed no change and 21% showed negative change. Sixty-two percent of providers who attended onsite trainings showed a positive change in attitude, 14% showed no change and 24% showed negative change. Eighty-one percent of providers who attended public trainings showed a positive change in topic knowledge, 10% showed no

change and 8% showed negative change. Eighty percent of providers who attended onsite trainings showed a positive change in topic knowledge, 13% showed no change and 8% showed negative change.

Figure 1: Provider Ethnicity

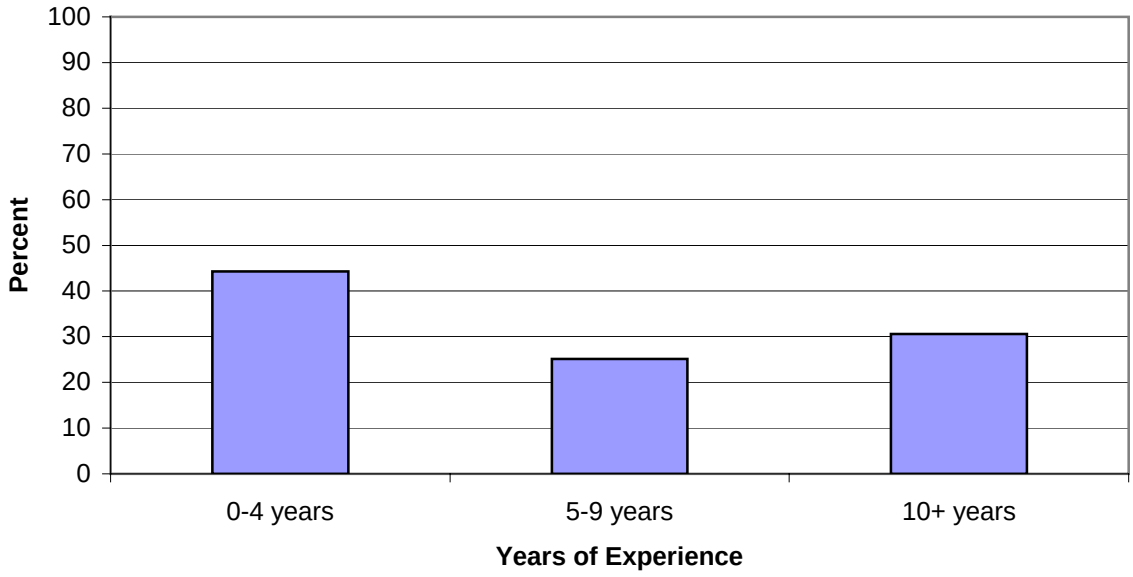
n=1258



- The majority of providers were Hispanic (41%) and White (28%).

Figure 2: Provider Years of Experience

n=1202

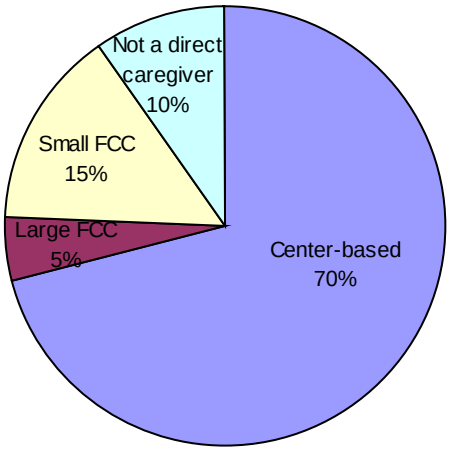


- Providers reported an average of 8.5 years of experience in the child care/after school recreation field.

Figure 3: Type of Caregiver in Programs

Caregivers are divided into four groups: 1) center-based providers, including child care centers, before or after school programs and recreational programs, 2) large FCC homes that care for a maximum of 14 children, 3) small FCC homes that care for a maximum of 8 children, and 4) not direct caregivers, including directors and other administrative staff.

n=1273



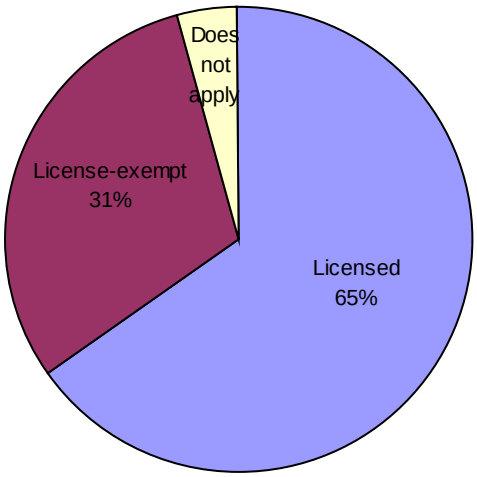
Note: FCC=Family Child Care Home

- The majority of providers were in center-based child care programs (70%).

Figure 4: License Status of Child Care Program

License-exempt providers include three groups: 1) individuals who are not licensed by the State of California and are caring for child(ren) of one family only, 2) programs that are legally exempt from licensing (e.g. 6-to-6 school age programs, some Boys & Girls Clubs), and 3) centers that are licensed by the military or Indian tribes but are not licensed by the State of California.

n=1293

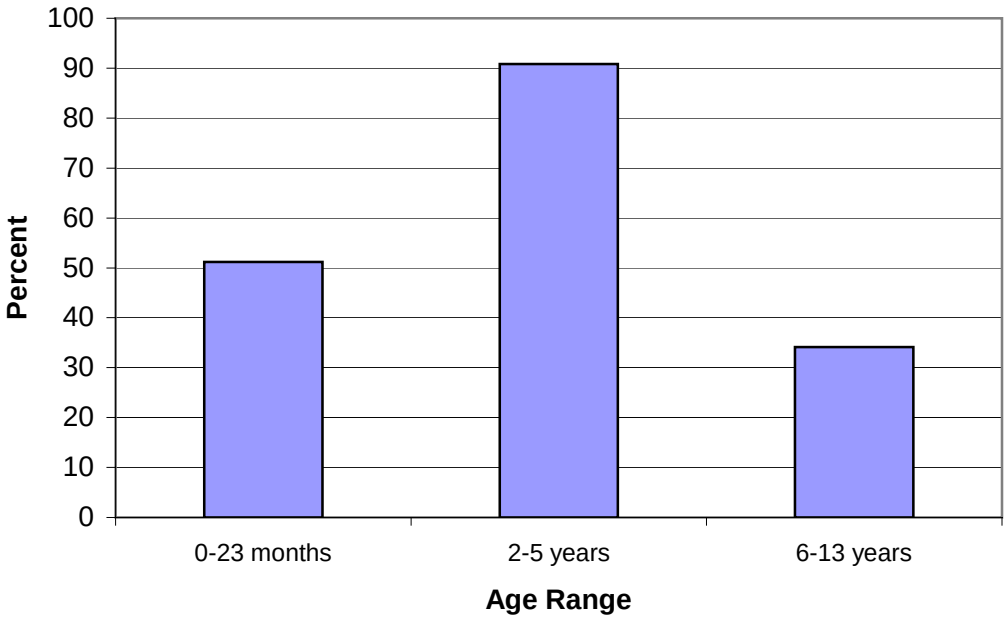


- Most child care programs were licensed by the State of California (65%).
- Of the license-exempt providers, 59% were licensed by the military.

Figure 5: Age Range of Children Programs Served

Providers were asked to report the age range of children their program serves. More than one age range could be checked for each program.

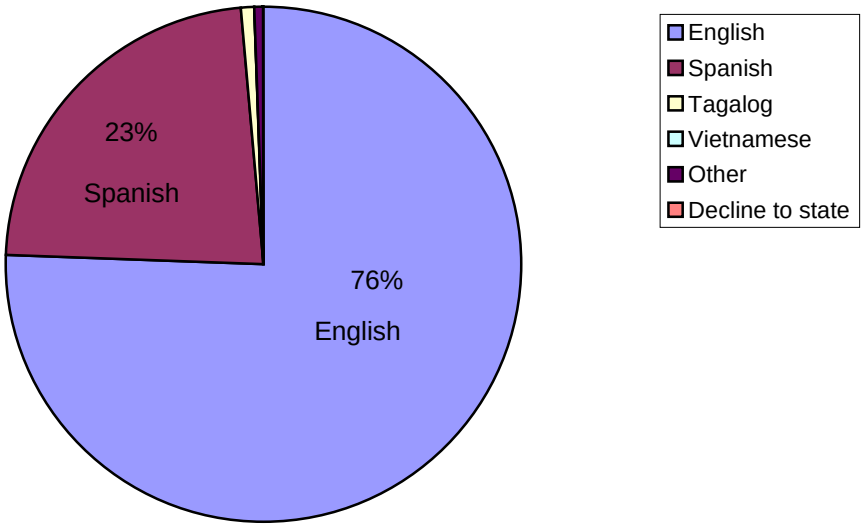
n=1257



- Approximately 90% of providers served children from 2-5 years of age.

Figure 6: Primary Language Spoken in Child Care Program

n=1262



- Child care programs were primarily English speaking (76%).

Table 1: Geographical Breakout of Providers

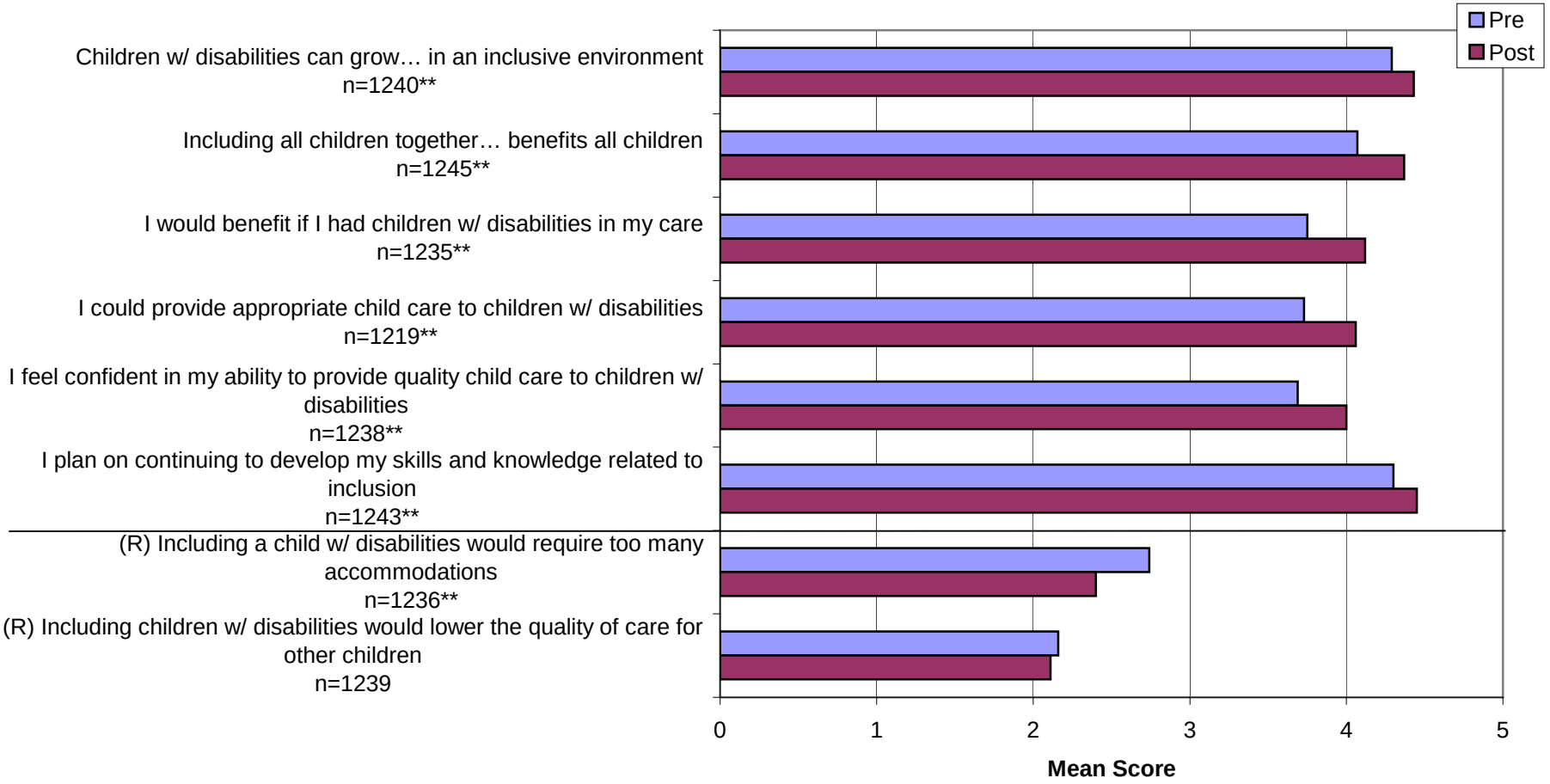
The Health Districts are determined by San Diego County's Health and Human Services Agency's geographical map.

Health District n=1200	**%**	**N**
North Coastal Region	12.9	155
North Inland Region	17.2	206
North Central Region	21.3	255
Central Region	27.9	335
East Region	6.3	75
South Region	14.5	174

- Providers were fairly equally distributed across the regions with the exception of the East Region.
- The two largest numbers of providers who attended trainings were from the Central (27.9%) and North Central (21.3%) Health Districts.

Figure 7: Attitude Across All Trainings

Training participants were asked to complete an evaluation immediately prior to and immediately following the training to gather attitude data. Participants rated each question from 1 to 5, where 1=Strongly Disagree and 5= Strongly Agree. The data below reflects answers from each participant's first pre assessment and last post assessment, regardless of the number of trainings attended.

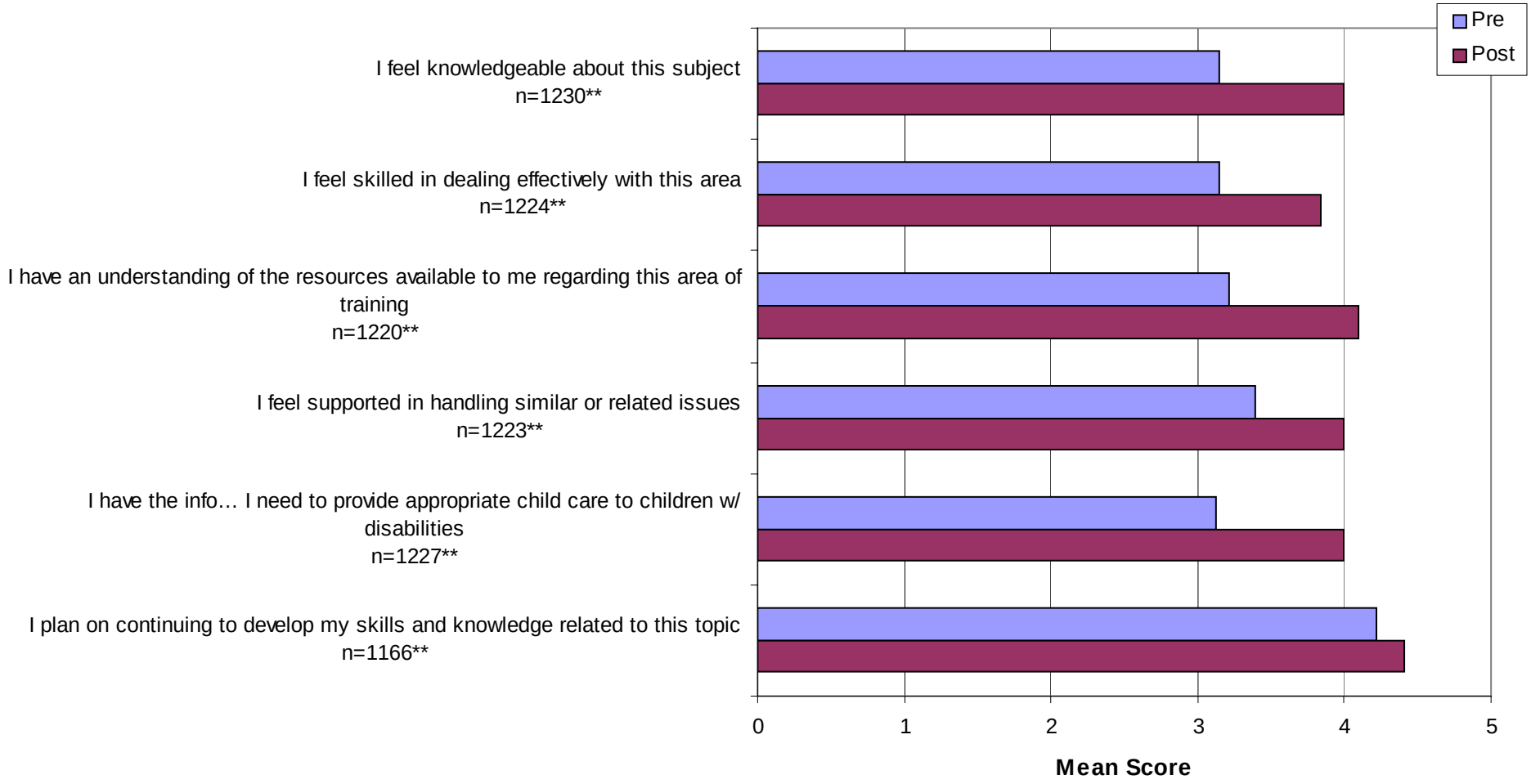


** represents statistical significance at p<.01 on paired t-tests
Note: (R) indicates a reverse scored question

- Overall, training participants showed a significant positive mean change in their attitude regarding inclusion.

Figure 8: Topic Knowledge Across All Trainings

Training participants were asked to complete an evaluation immediately prior to and immediately following the training to gather topic knowledge data. Participants rated each question from 1 to 5, where 1=Strongly Disagree and 5= Strongly Agree. The data below reflects answers from each participant's first pre assessment and last post assessment, regardless of the number of trainings attended.

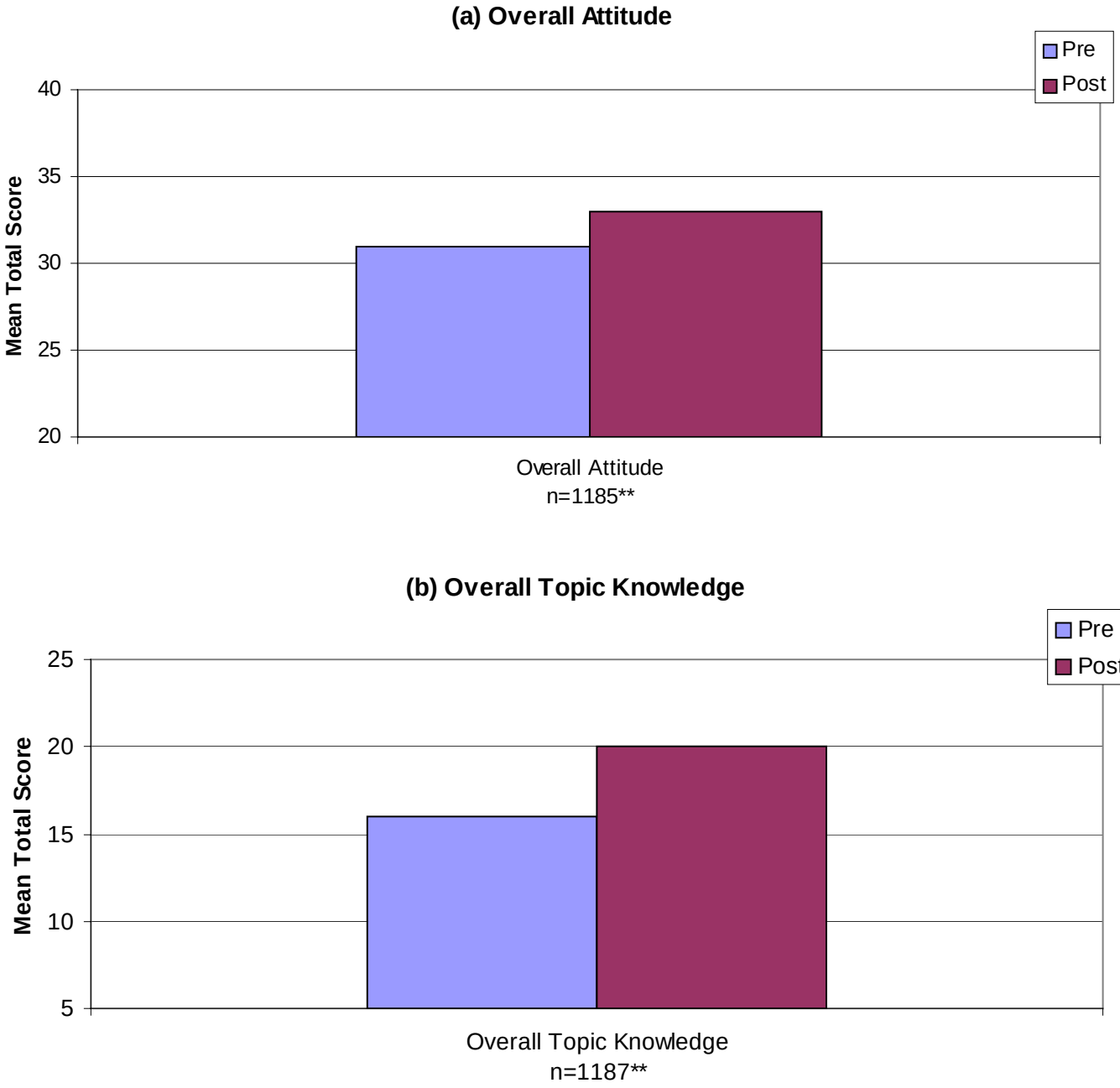


** represents statistical significance at p<.01 on paired t-tests

- Overall, training participants showed a significant positive mean change in their topic knowledge regarding inclusion.

Figure 9: Overall Attitude and Topic Knowledge

Composite attitude scores were calculated by adding provider answers to questions 1-8 on the evaluation (after recoding the reversed items), for a possible total of 40 points. Composite topic knowledge scores were calculated by adding provider answers to questions 9-13, for a possible total of 25 points.

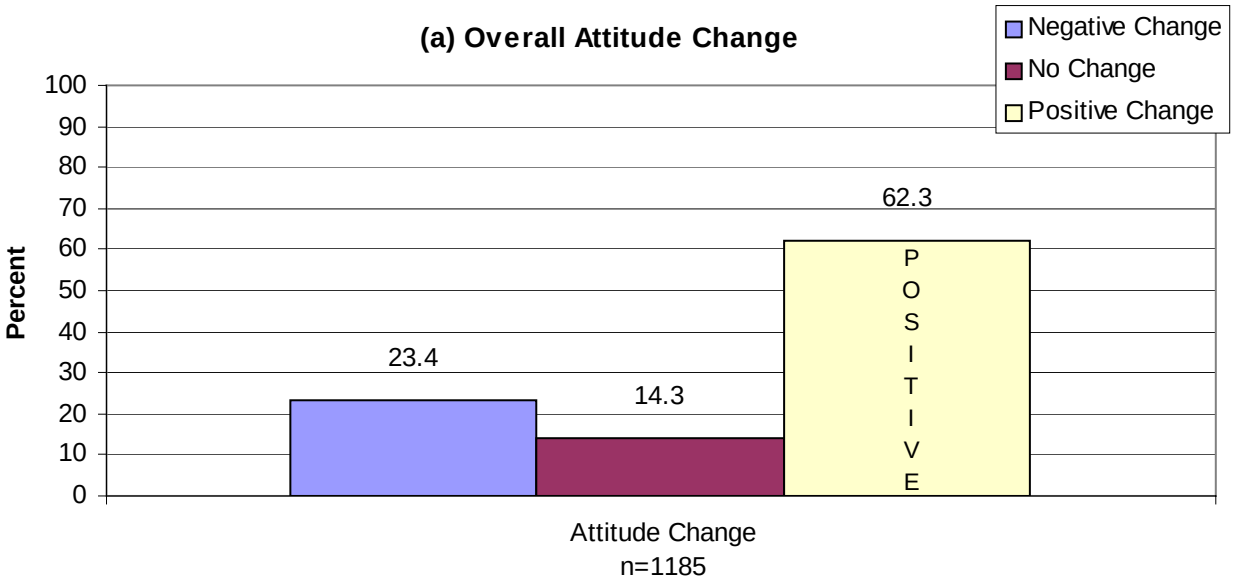


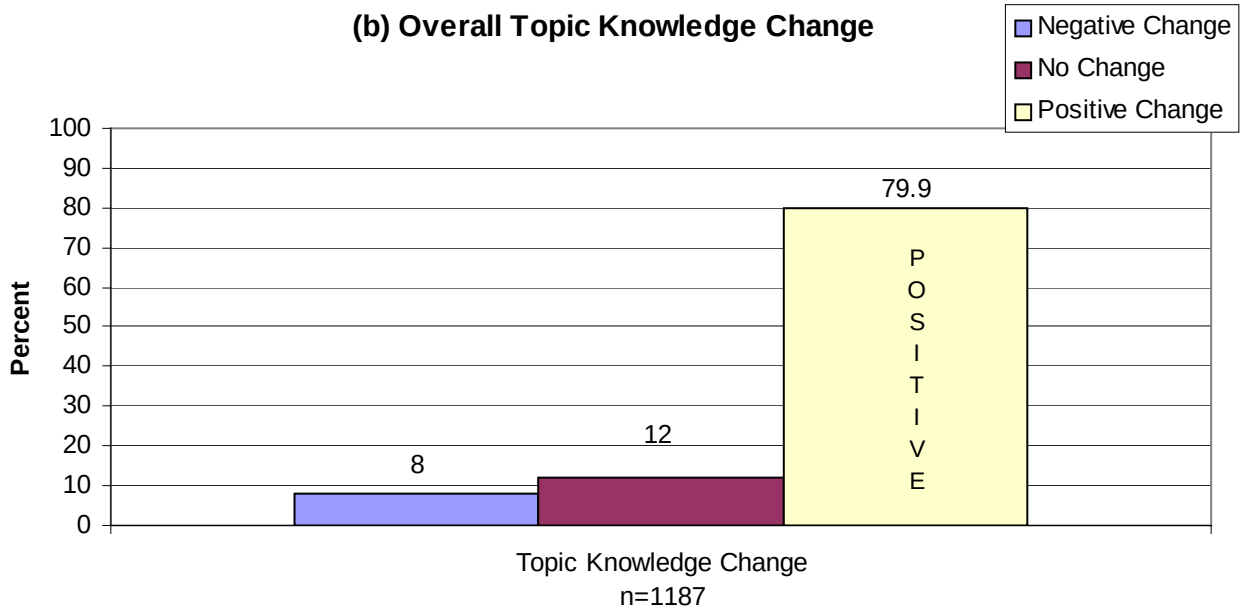
** represents statistical significance at p<.01 on paired t-tests

- Providers showed a significant positive mean change in attitude and topic knowledge.

Figure 10: Overall Attitude and Topic Knowledge Change

Attitude change scores were determined by subtracting the pre composite attitude score from the post composite attitude score. Topic knowledge change scores were determined by subtracting the pre composite topic knowledge score from the post composite topic knowledge score. The change scores are presented below as percent of "positive change" showing improvement, "negative change" showing a decline and "no change" showing no difference in scores.

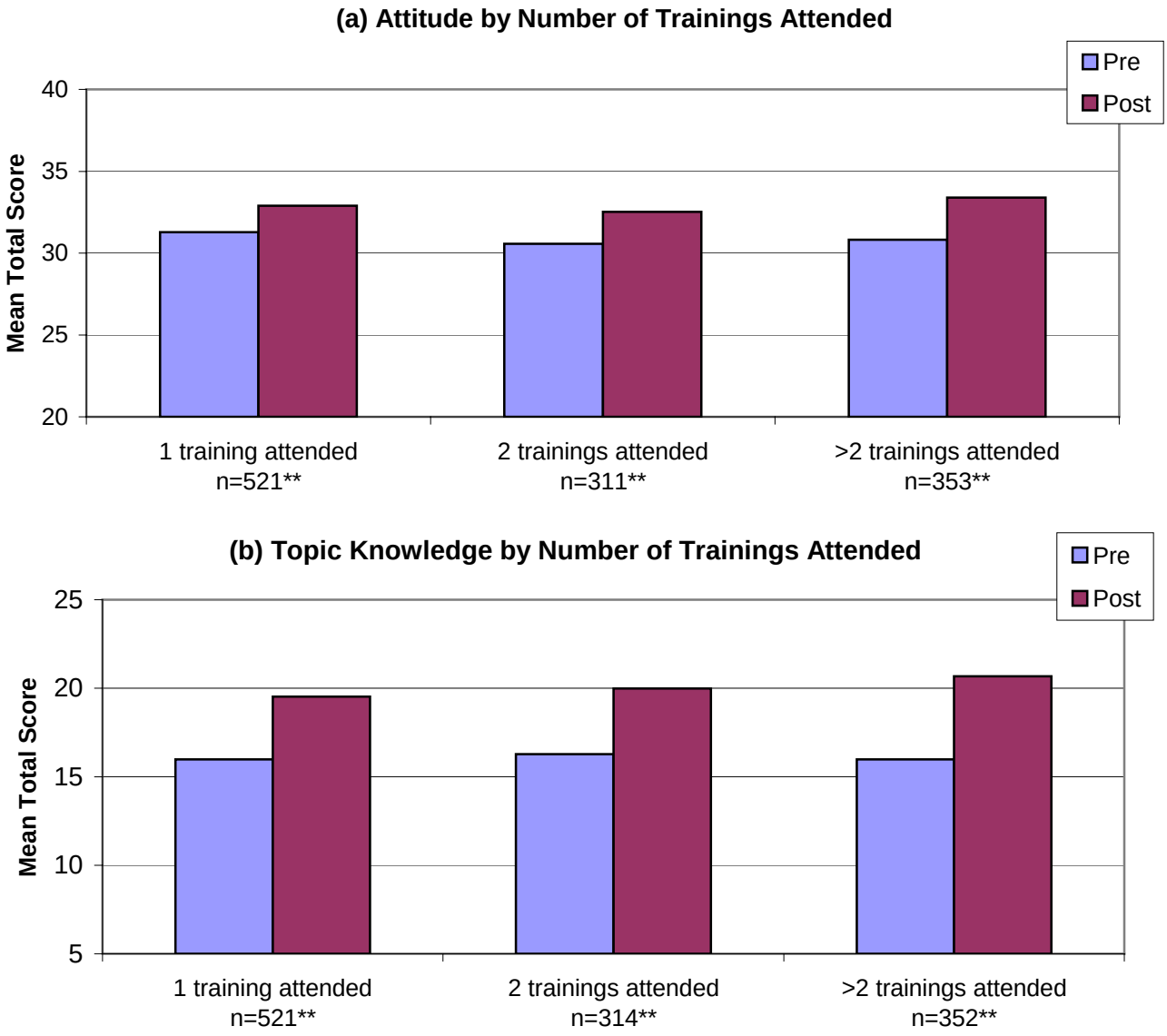




- The majority of providers showed a positive change in attitude and topic knowledge scores.

Figure 11: Attitude and Topic Knowledge by Number of Trainings Attended

Composite attitude scores were calculated by adding provider answers to questions 1-8 on the evaluation (after recoding the reversed items), for a possible total of 40 points. Composite topic knowledge scores were calculated by adding provider answers to questions 9-13, for a possible total of 25 points.



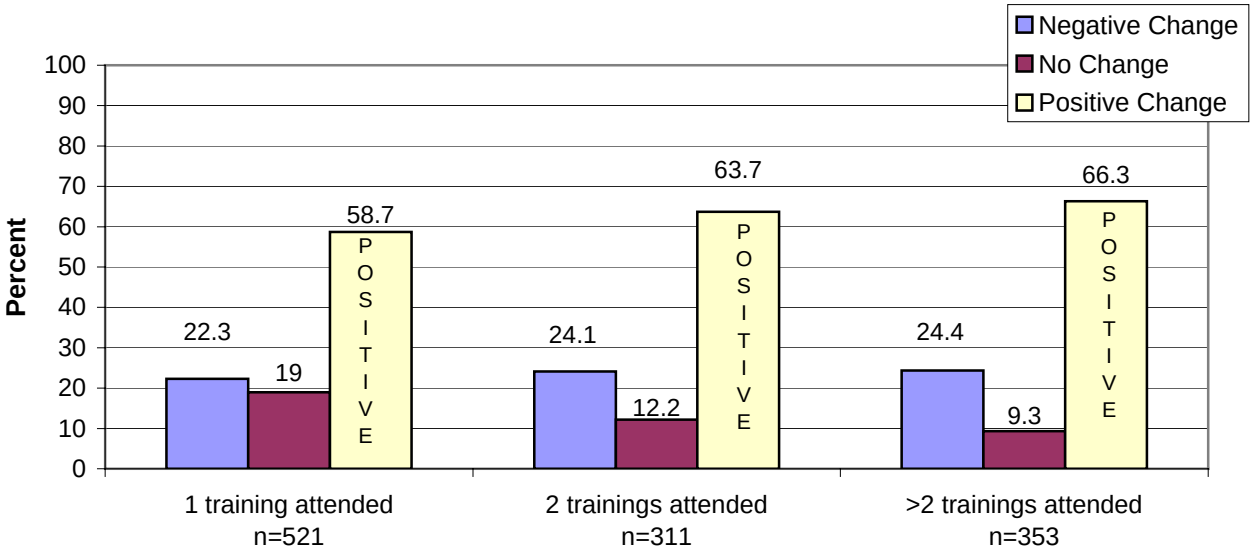
** represents statistical significance at p<.01 on paired t-tests

- Providers who attended 1 training, 2 trainings and more than 2 trainings all showed a significant positive mean change in attitude and topic knowledge scores.
- Providers who attended more than 2 trainings showed a significantly greater improvement in mean attitude and topic knowledge change scores (p<.01) than providers who attended only 1 training. Additionally, providers who attended more than 2 trainings showed a significantly greater improvement in mean topic knowledge change scores (p<.01) than providers who attended 2 trainings.

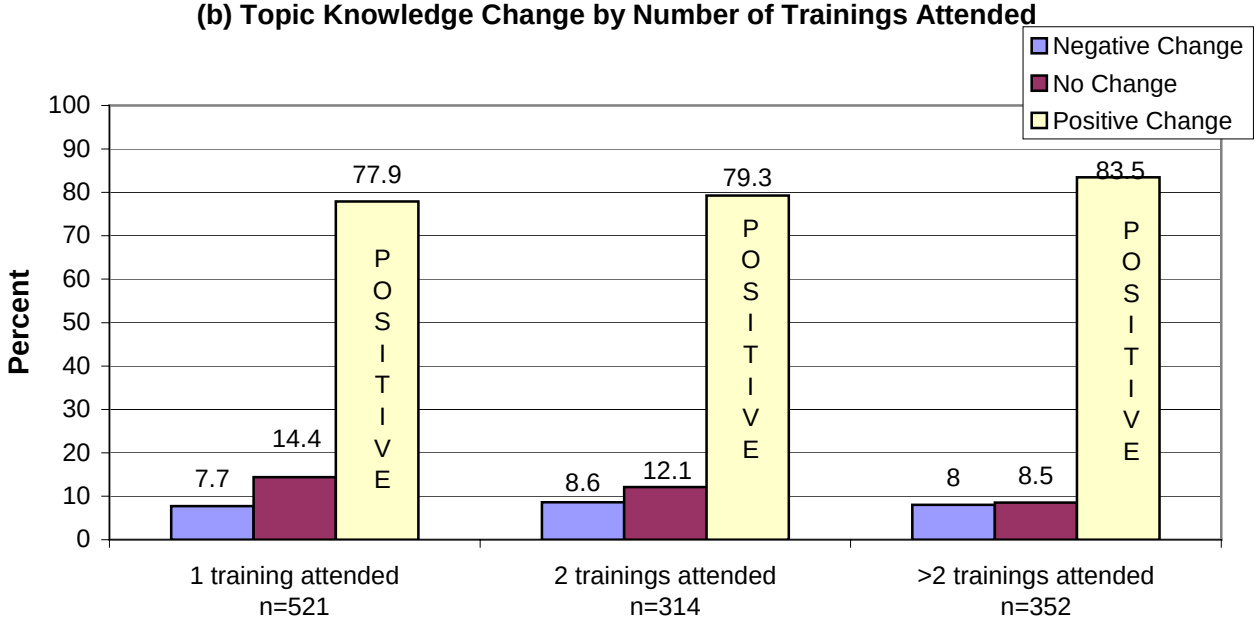
Figure 12: Attitude and Topic Knowledge Change by Number of Trainings Attended

Attitude change scores were determined by subtracting the pre composite attitude score from the post composite attitude score. Topic knowledge change scores were determined by subtracting the pre composite topic knowledge score from the post composite topic knowledge score. The change scores are presented below as percent of "positive change" showing improvement, "negative change" showing a decline and "no change" showing no difference in scores.

(a) Attitude Change by Number of Trainings Attended



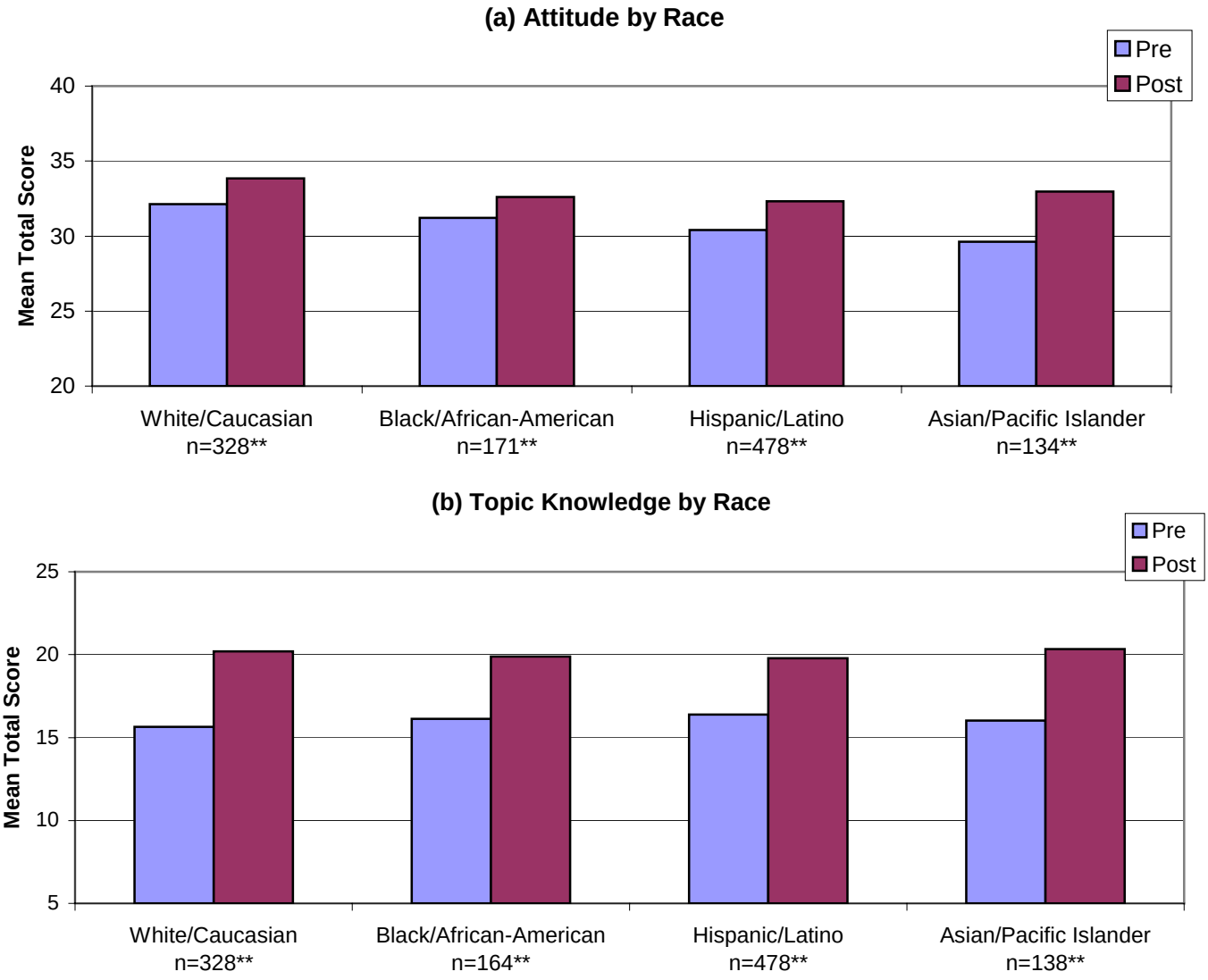
(b) Topic Knowledge Change by Number of Trainings Attended



- The more trainings providers attended, the higher the percentage of providers that showed positive change, for both attitude and topic knowledge scores.

Figure 13: Attitude and Topic Knowledge by Race/Ethnicity

Composite attitude scores were calculated by adding provider answers to questions 1-8 on the evaluation (after recoding the reversed items), for a possible total of 40 points. Composite topic knowledge scores were calculated by adding provider answers to questions 9-13, for a possible total of 25 points.



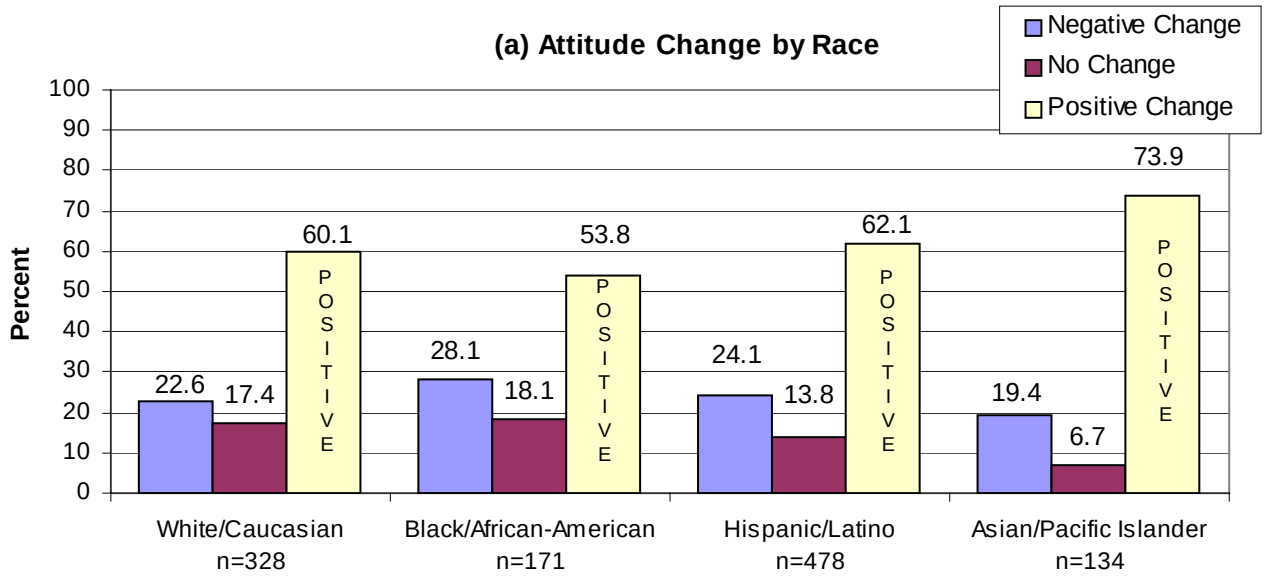
Note: Native American/Alaskan Native, Bi/Multiracial, Other and Decline to state groups were excluded from analyses due to their small sample size.

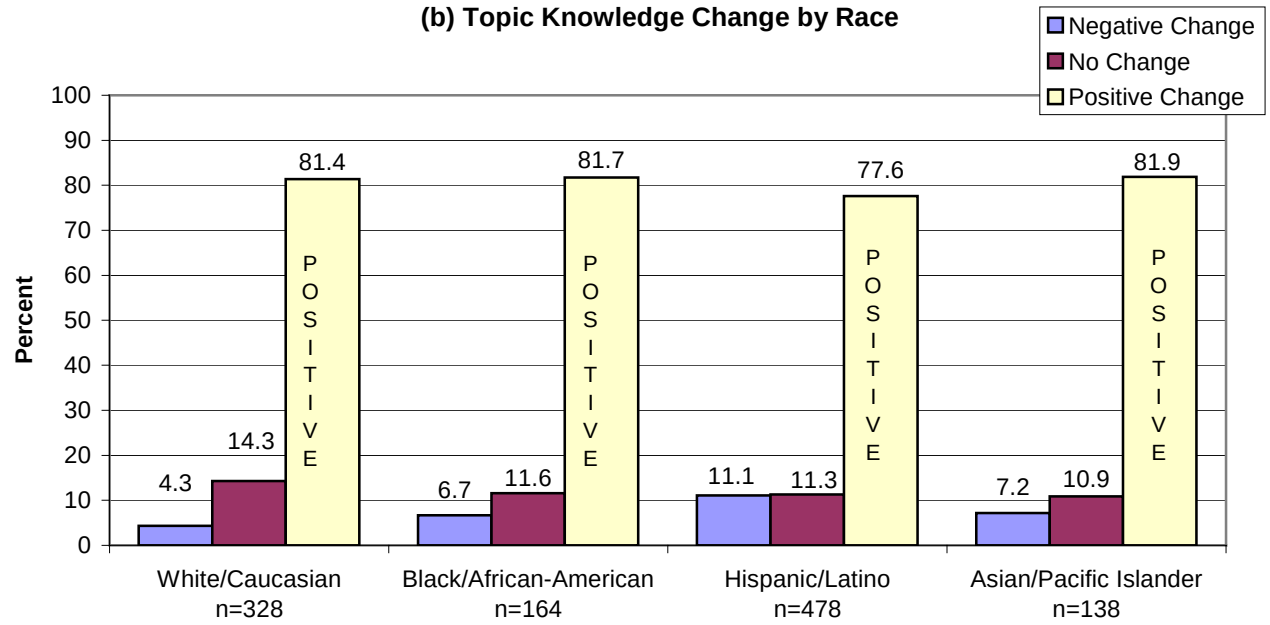
** represents statistical significance at p<.01 on paired t-tests

- Providers from all race/ethnicities showed a significant positive mean change in attitude and topic knowledge scores.
- Asian/Pacific Islander providers showed a significantly greater positive change in mean attitude scores (p<.01) than White, Black and Hispanic providers.
- White providers showed a significantly greater positive change in mean topic knowledge scores (p<.01) than Hispanic providers.

Figure 14: Attitude and Topic Knowledge Change by Race/Ethnicity

Attitude change scores were determined by subtracting the pre composite attitude score from the post composite attitude score. Topic knowledge change scores were determined by subtracting the pre composite topic knowledge score from the post composite topic knowledge score. The change scores are presented below as percent of "positive change" showing improvement, "negative change" showing a decline and "no change" showing no difference in scores.



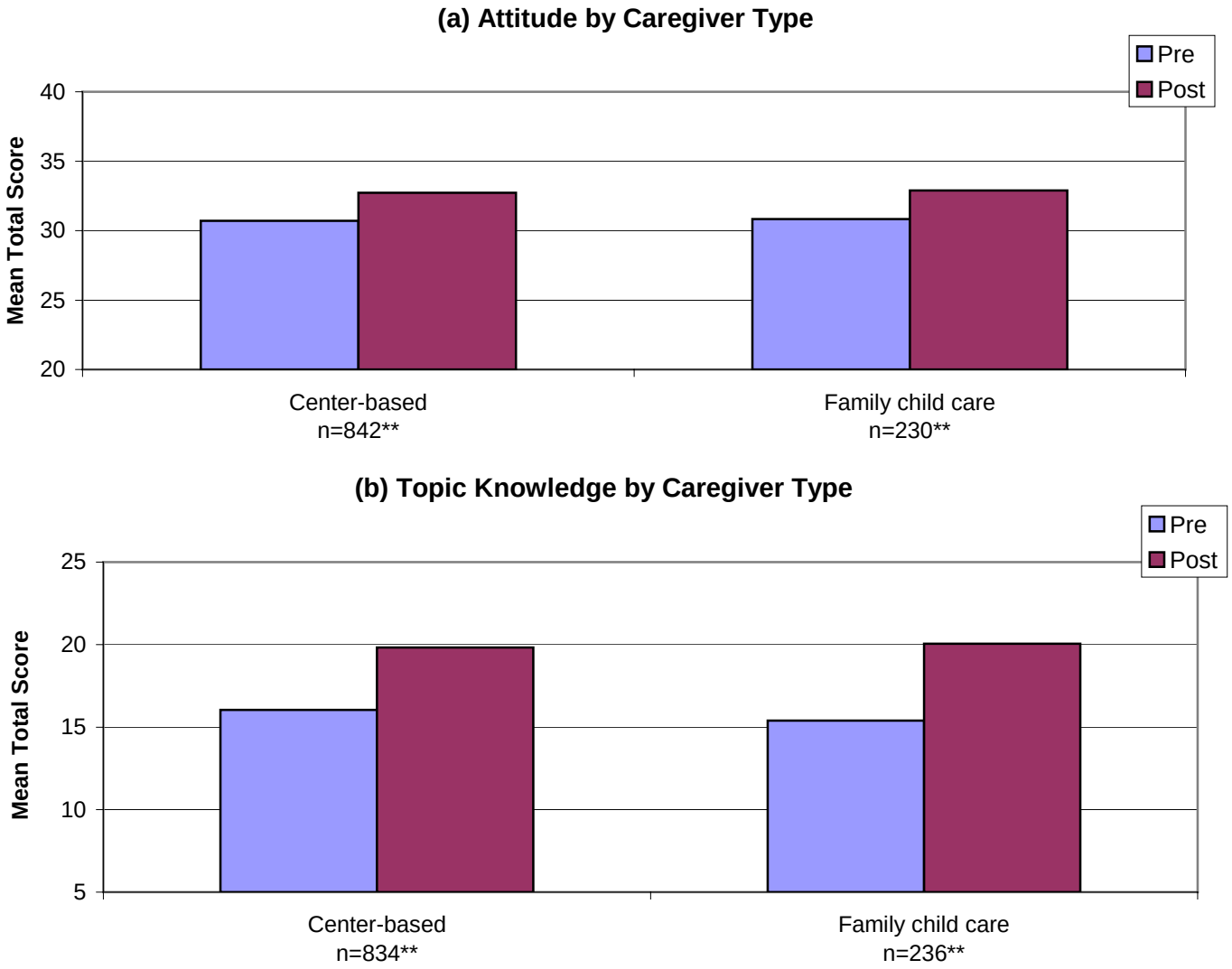


Note: Native American/Alaskan Native, Bi/Multiracial, Other and Decline to state groups were excluded from analyses due to their small sample size.

- The Asian/PI provider group had the highest percent of providers showing positive change in attitude; the Black provider group had the lowest percent of providers showing positive change in attitude.
- White, Black and Asian/PI provider groups had a slightly higher percentage of providers showing positive change in topic knowledge compared to the Hispanic provider group.

Figure 15: Attitude and Topic Knowledge by Caregiver Type

Composite attitude scores were calculated by adding provider answers to questions 1-8 on the evaluation (after recoding the reversed items), for a possible total of 40 points. Composite topic knowledge scores were calculated by adding provider answers to questions 9-13, for a possible total of 25 points.

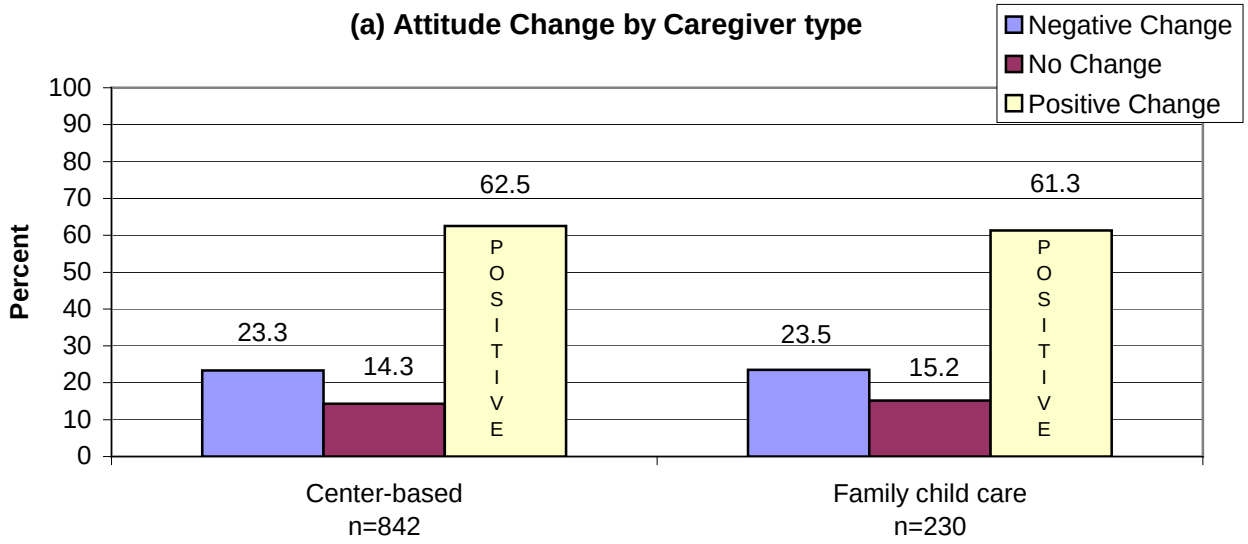


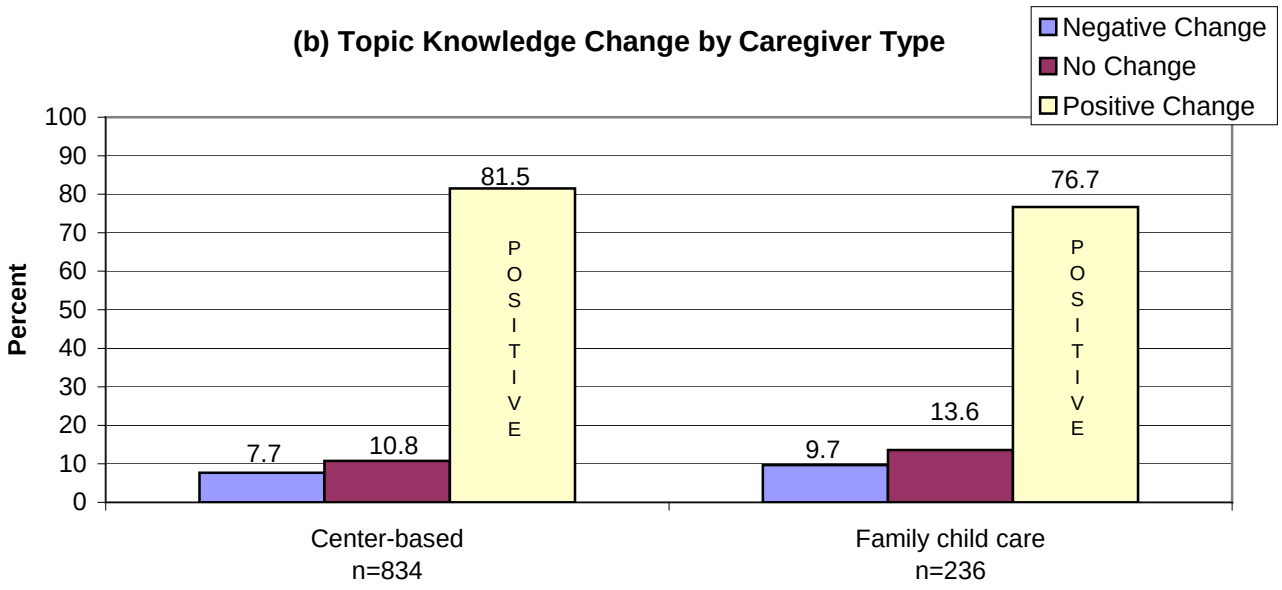
** represents statistical significance at p<.01 on paired t-tests

- Providers from both center-based and family child care homes showed a significant positive change in mean attitude and topic knowledge scores.
- There was no significant difference in mean attitude change scores between center-based and family child care providers.
- Family child care providers showed a significantly greater improvement in mean topic knowledge change scores than center-based providers (p<.01).

Figure 16: Attitude and Topic Knowledge Change by Caregiver Type

Attitude change scores were determined by subtracting the pre composite attitude score from the post composite attitude score. Topic knowledge change scores were determined by subtracting the pre composite topic knowledge score from the post composite topic knowledge score. The change scores are presented below as percent of "positive change" showing improvement, "negative change" showing a decline and "no change" showing no difference in scores.

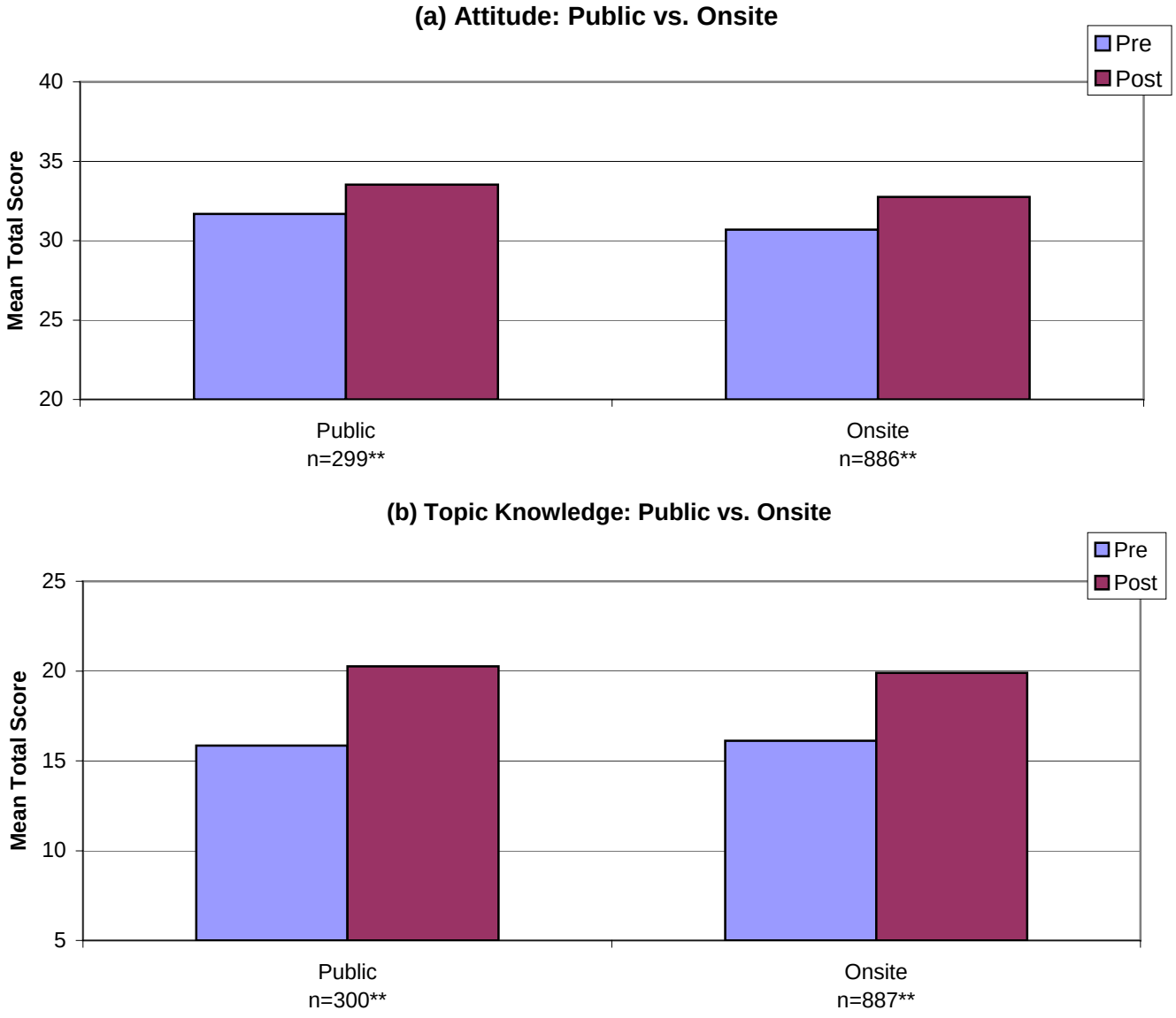




- Approximately the same percent of center-based and family child care providers showed a positive change in attitude.
- A higher percentage of center-based providers showed a positive change in topic knowledge compared to family child care providers.

Figure 17: Attitude and Topic Knowledge: Public vs. Onsite Trainings

Composite attitude scores were calculated by adding provider answers to questions 1-8 on the evaluation (after recoding the reversed items), for a possible total of 40 points. Composite topic knowledge scores were calculated by adding provider answers to questions 9-13, for a possible total of 25 points.

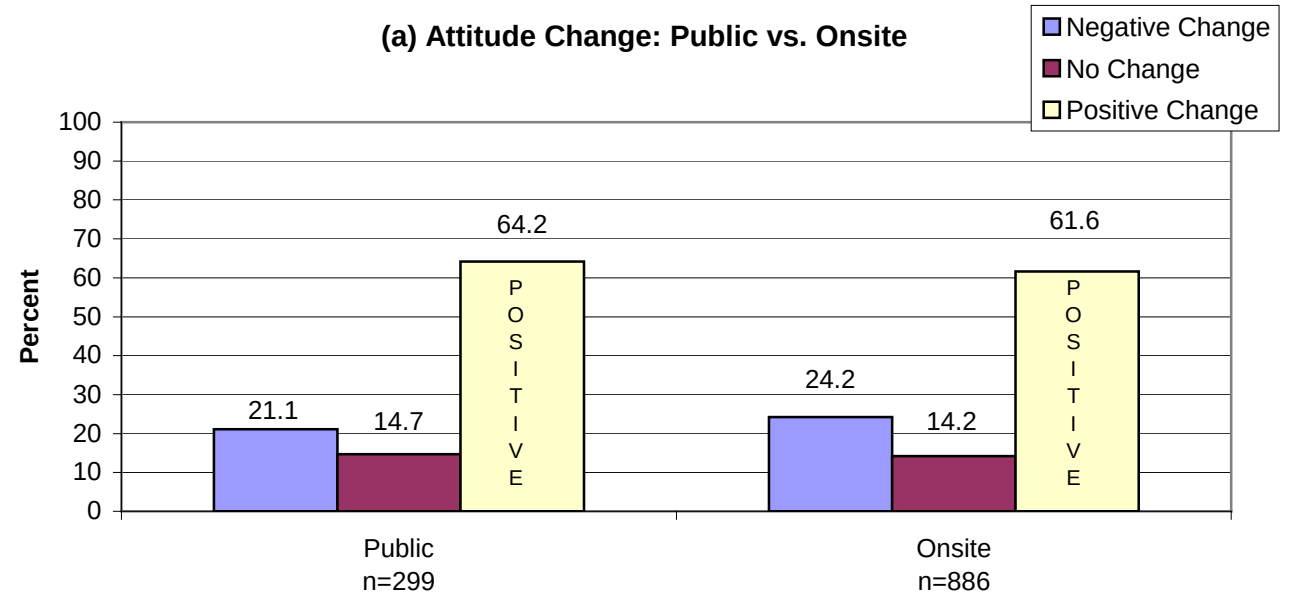


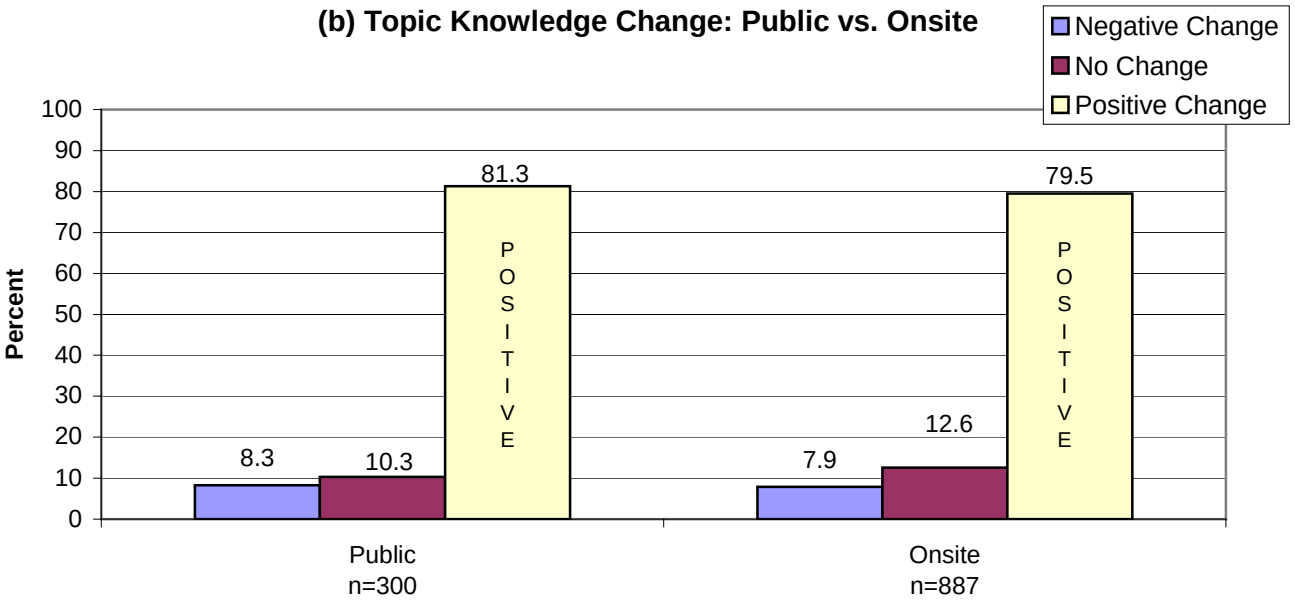
** represents statistical significance at p<.01 on paired t-tests

- Providers who attended public trainings and onsite trainings both showed a significant positive change in mean attitude and topic knowledge scores.
- There was no significant difference in mean attitude change scores between providers who attended public and onsite trainings.
- Providers who attended public trainings showed a significantly greater improvement in mean topic knowledge change scores than providers who attended onsite trainings (p<.05).

Figure 18: Attitude and Topic Knowledge Change: Public vs. Onsite Trainings

Attitude change scores were determined by subtracting the pre composite attitude score from the post composite attitude score. Topic knowledge change scores were determined by subtracting the pre composite topic knowledge score from the post composite topic knowledge score. The change scores are presented below as percent of "positive change" showing improvement, "negative change" showing a decline and "no change" showing no difference in scores.





- A slightly higher percentage of providers who attended public trainings showed a positive change in attitude and topic knowledge compared to providers who attended onsite trainings.

Onsite Consultations: Impact on Child Specific Behaviors

In order to evaluate the impact of KIT onsite consultations, data on child specific behavior was collected from providers through pre and post consultation questionnaires. Demographic data was also collected. In addition, data on child specific behavior was collected from parents through post consultation questionnaires. See the Pre-Consultation Questionnaire (Provider), the Post-Consultation Questionnaire (Provider) and the Post-Consultation Questionnaire (Parent) in the Appendix for the evaluation questions used in data collection.

Providers receiving onsite consultation(s) for children in their care completed the pre-consultation questionnaire prior to receiving the consultation service, and completed the post-consultation questionnaire approximately 2 weeks following the end of the consultation service. Parents of these children were also asked to complete an evaluation approximately 2 weeks after the end of services. The evaluation gathered child specific behaviors in order to evaluate changes resulting from the onsite consultation service. The child specific behaviors were rated by the provider and parent on a Likert scale, where 1 indicated the behavior was observed less than ¼ of the time (seldom) and 5 indicated the behavior was observed ¾ of the time or more (frequently).

Numbers Served

A total of 228 children received 373 onsite consultations from January 22, 2004 – June 3, 2005. Note: Of these, three children changed child care providers, and therefore another set of provider pre and post evaluation forms were completed on these three children. A total of 558 hours of consultation services were provided during this period. One-hundred eighty-seven unique providers received consultation services for children in their care.

Children received an average of 1.64 consultations, with a minimum of one consultation and a maximum of eight consultations. The average length of each consultation was 89.7 minutes, with a minimum of 20 minutes and a maximum of 240 minutes (4 hours). The average time between consultations was 12.7 days, with a minimum of 0 days and a maximum of 204 days (almost 7 months). The average time between the first onsite consultation and the last onsite consultation was 18.8 days, with a minimum of 0 days and a maximum of 204 days (almost 7 months). Note: the maximum number for time between consultations and the maximum time between the first and last consultations are the same because both reflect one case which had two onsite consultations far apart from each other.

Areas of consultant expertise were varied. Of the 23 professionals utilized for onsite consultations, 27% had experience in the behavior field, 20% in child development, 19% in inclusion, 8% in occupational therapy, 7% in speech/language, 10% in psychology, 3% in physical therapy, 3% in recreational therapy and 3% in health education.

This report reflects data collected on the consultation services provided from January 22, 2004 – April 15, 2005. During this timeframe, evaluation data was collected from providers for 190 children. Note: Two of these children changed child care providers, and therefore another set of provider pre and post evaluation forms were completed on these two children. One hundred sixty seven unique providers received

consultation services for children in their care. Additionally, evaluation data was collected from parents of 98 children. Demographic results reflect duplicated providers.

Sample Demographics

KIT's SB 1703 onsite consultation services were provided to primarily White (49%) providers (see Figure 19). The remaining providers who received onsite consultation services were Hispanic (20%), Black (15%) and Asian/Pacific Islander (10%). Six percent of providers declined to state their race/ethnicity. Approximately 24% of providers reported less than 5 years of experience working in the child care/before or after school/recreational field, 39% reported 5-9 years of experience and 37% reported 10 years or more (see Figure 20). Providers reported an average of 10.9 years of experience in the field.

The majority of providers (85%) were in center-based child care programs (including before or after school/recreational programs), 7% were in large family child care homes, 5% were in small family child care homes and 3% did not consider themselves direct caregivers (e.g. directors) (see Figure 21). Most child care programs (61%) were licensed by the State of California (see Figure 22). Thirty-nine percent of providers worked in license-exempt programs. License-exempt providers include three groups: 1) individuals who are not licensed by the State of California and are caring for child(ren) of one family only, 2) programs that are legally exempt from licensing (e.g. 6-to-6 school age programs, some Boys & Girls Clubs), and 3) centers that are licensed by the military or Indian tribes but are not licensed by the State of California. Of the license-exempt providers, 63% were licensed by the military.

Providers primarily served children ages 2-5 years (94%). Fifty percent of providers served children 0-23 months and 35% of providers served children 6-13 years (providers may serve more than one age group) (see Figure 23). The average reported age of children receiving consultation services was 4.7 years with a range between 0.5 and 14. The primary language spoken in child care programs was English (94%), with 6% of the programs speaking Spanish as the primary language (see Figure 24).

Providers from all over San Diego County received onsite consultation services. Based on the Health and Human Services Agency Health Districts, 42% of providers were located in the Central Region, 20% in the North Central Region, 11% in the East Region, 9.5% in the North Coastal Region, 9.5% in the North Inland Region and 8% in the South Region (see Table 2).

On average, at the post evaluation, providers had received 1.6 consultation visits regarding the particular identified child (range between 1 to 5 visits), and 1.9 consultation visits overall regarding any child (range between 1 to 7 visits).

Children who received onsite consultations were most often referred by providers for child behavioral reasons (74%), followed by "other" (23%), developmental (9%) and health (0.5%) (see Figure 25). Of those children referred for "other" reasons, 82% were referred for speech/language issues. Approximately 6% of children were referred for more than one reason.

Pre assessment data were analyzed by number of consultations, referral reason and age of child. Significant differences were found for number of consultations and referral reason but not age of child. Specifically, providers who received one consultation for a specific child in their care rated the question, "Parents of other typically developing children make positive comments about the inclusive environment" significantly lower ($p<.05$) than providers who received more than one consultation.

There were also significant differences in provider ratings for children who were referred for behavior reasons compared to any other reason. Providers rated the question, “The child stands out as ‘different’ from his/her peers” significantly higher ($p<.05$) for children referred for behavior reasons. Likewise, providers also rated the questions, “Myself or another primary caregiver needs to spend extra time attending to the child” and “The child exhibits ‘acting out’ behaviors” significantly higher ($p<.01$) for children referred for behavior reasons. In addition, providers rated the questions, “The peers of the child provide support rather than the facilitator’” and “Parents of other typically developing children make positive comments about the inclusive environment” significantly lower ($p<.01$ and $p<.05$) for children referred for behavior reasons. Analyses of the child specific behavior questions at the pre evaluation showed no significant differences on any question by the age of the child.

Outcomes

Child specific behavior questions were categorized into two groups: positive and negative aspects of inclusion behaviors. Overall, there was a positive mean change in positive aspects of inclusion behavior based on provider report (see Figure 26). Paired t-tests showed a significant positive mean change ($p<.01$) on two of the five behaviors. The largest mean change (+.686) occurred with the question, “The peers of the child provide support rather than the ‘facilitator’”. The second largest mean change (+.663) occurred with the question, “The child appears happy and interested in his/her peers.”

In general, there was also a negative mean change in negative aspects of inclusion behaviors based on provider report (see Figure 27). Paired t-tests showed a significant negative mean change ($p<.01$) in three of the four behaviors. The largest mean change (-878) occurred with the question, “The child exhibits ‘acting out’ behaviors”. The second largest mean change (-.615) occurred with the question, “The child stands out as ‘different’ from his/her peers.”

Post assessment data were analyzed by number of consultations, referral reason and age of child. There were no significant differences on any question when comparing providers who received one consultation for a specific child to providers who received more than one consultation. There were also no significant differences on any question for providers who referred children for behavior reasons compared to any other referral reason. However, providers of children 6 years old and higher rated the question, “The child appears happy and interested in his/her peers” significantly lower compared to providers of children ages 0-3 years ($p<.05$) and children ages 4-5 years ($p<.01$).

Additionally, providers were asked whether or not “an introduction of the child with special needs was made to all children in the program, and specific questions from the other children were answered as appropriate.” This question was asked at both pre and post, and the analysis was based on children where this question was answered at both time points (n=53). At the pre evaluation, 43% indicated yes and 57% no. At the post evaluation, 72% indicated yes and 28% indicated no. Parents were also asked this question at post. The majority of parents (65%) did not know, 32% indicated yes and 3% indicated no (n=60).

When comparing provider vs. parent ratings of child specific behaviors at the post evaluation, parents generally rated the positive aspects of inclusion behaviors higher than providers (see Figure 28). Based on paired t-tests, there was a significant difference ($p<.01$) in perception for the question, “The child appears happy and interested in his/her peers" (mean difference of .647). Though the difference in

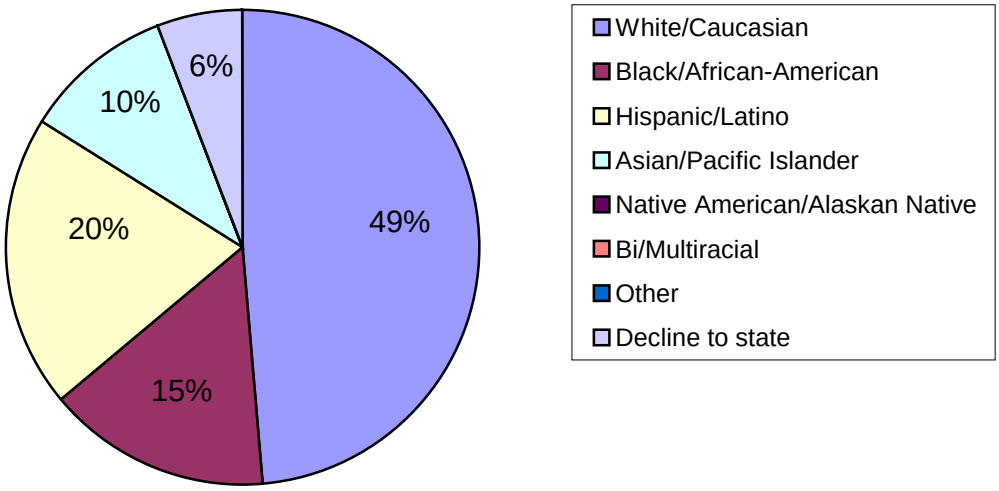
perception was largest for the question, “Parents of other typically developing children make positive comments about the inclusive environment” (mean difference of .743), it was not significant due to a smaller sample size for that question.

Likewise, parents generally rated the negative aspects of inclusion behaviors lower than providers (see Figure 29). Based on paired t-tests, there was a significant difference ($p<.05$) in perception for the question, “The child exhibits ‘acting out’ behaviors” (mean difference of .559). The second largest difference in perception was for the question, “Myself or another primary caregiver needs to spend extra time attending to the child” (mean difference of .360), though this difference was not significant.

Parent post evaluation data were analyzed by number of consultations, referral reason and age of child. Parents of children who received one consultation rated the question, “My child stands out as ‘different’ from his/her peers” significantly higher ($p<.01$) than parents of children who received more than one consultation. There also were some significant differences when comparing child specific behavior questions for children referred for behavior reasons compared to any other referral reason. Parents rated the questions, “My child spends the day as an integral part of the ‘group’” and “The peers of my child provide support rather than the ‘facilitator’” significantly lower ($p<.05$ and $p<.01$) for children referred for behavior reasons. Furthermore, parents rated the question, “My child’s provider or another primary caregiver needs to spend extra time attending to my child” significantly higher ($p<.05$) for children referred for behavior reasons. Lastly, there were also significant differences on child specific behavior by the age of the child. Parents of children 6 years and older rated the questions, “My child stands out as ‘different’ from his/her peers” and “My child’s provider or another primary caregiver needs to spend extra time attending to the child” significantly higher than children ages 0-3 and children ages 4-5 ($p<.01$). Additionally, parents of children 6 years and older rated the question, “A ‘facilitator’ is needed with my child for my child to be part of the group” significantly higher ($p<.05$) than children ages 4-5.

Figure 19: Provider Ethnicity

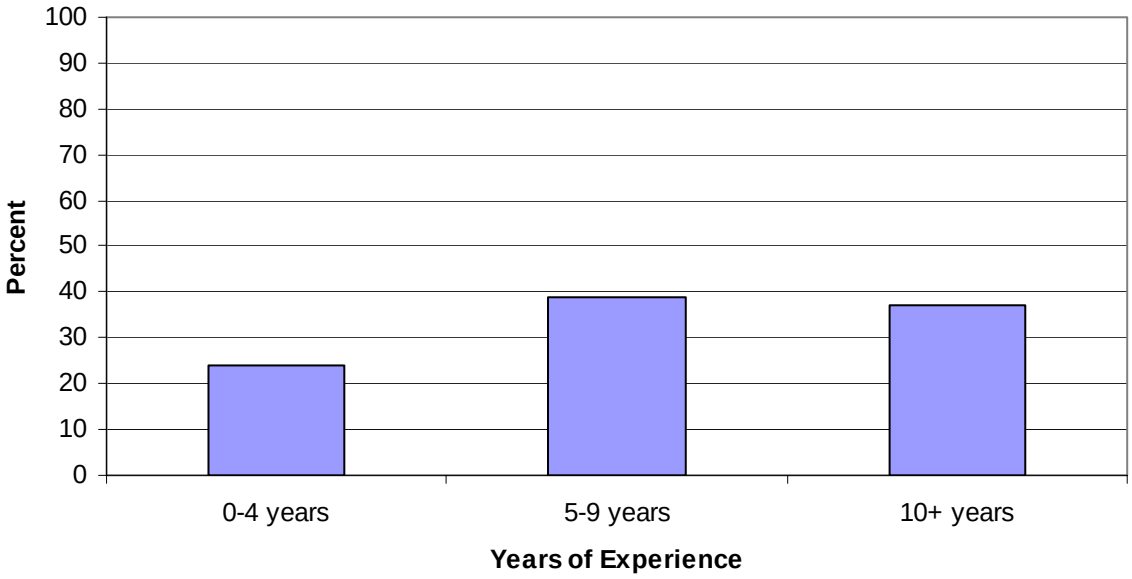
n=169



- The majority of providers were White (49%).

Figure 20: Provider Years of Experience

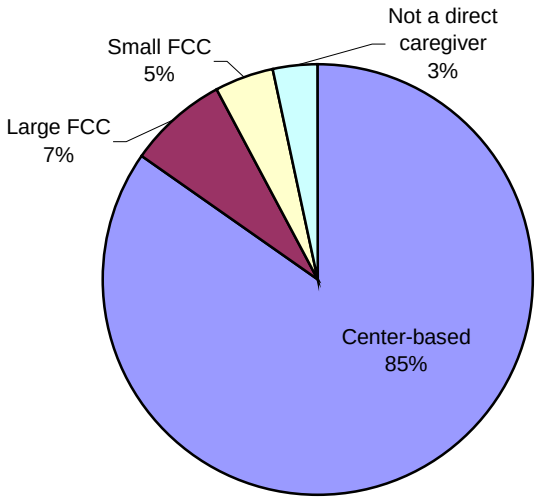
n=167



- Providers reported an average of 10.9 years of experience in the child care/after school recreation field.

Figure 21: Type of Caregiver in Programs

Caregivers are divided into four groups: 1) center-based providers, including child care centers, before or after school programs and recreational programs, 2) large FCC homes that care for a maximum of 14 children, 3) small FCC homes that care for a maximum of 8 children, and 4) not direct caregivers, including directors and other administrative staff.



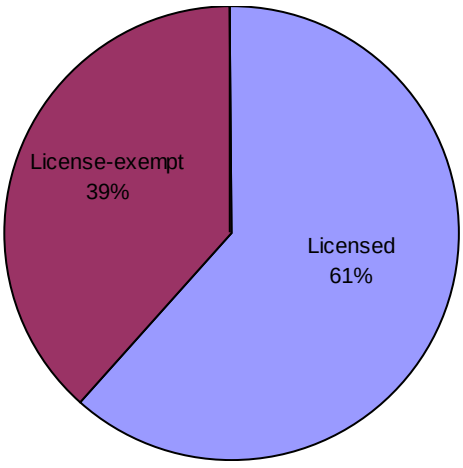
n=176

Note: FCC=Family Child Care Home

- The majority of providers were in center-based child care programs (85%).

Figure 22: License Status of Child Care Program

License-exempt providers include three groups: 1) Individuals who are not licensed by the State of California and are caring for child(ren) of one family only, 2) Programs that are legally exempt from licensing (e.g. 6-to-6 school age programs, some Boys & Girls Clubs), and 3) Centers that are licensed by the military or Indian tribes but are not licensed by the State of California.



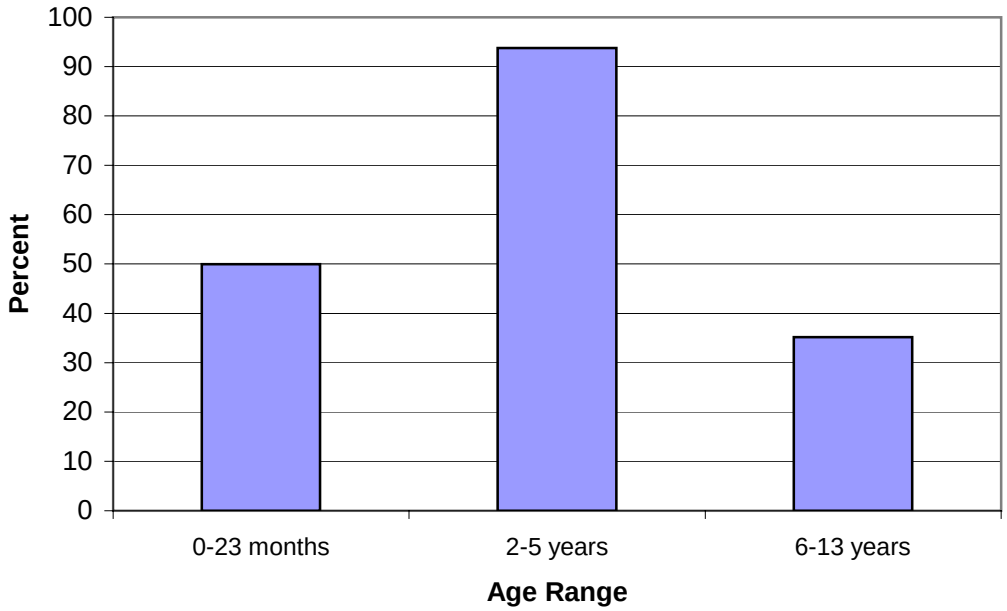
n=176

- Most child care programs were licensed by the state of California (61%).
- Of the license-exempt providers, 63% were licensed by the military.

Figure 23: Age Range of Children Programs Served

Providers were asked to report the age range of children their program serves. More than one age range could be checked for each program.

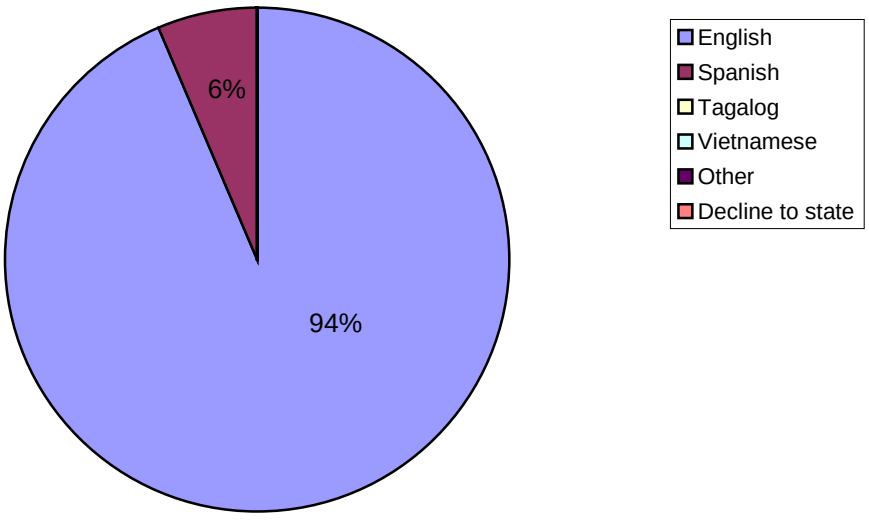
n=176



- Approximately 94% of providers served children from 2-5 years of age.
- The average reported age of children receiving consultation services was 4.7 years.

Figure 24: Primary Language Spoken in Child Care Program

n=175



- Child care programs were primarily English speaking (94%).

Table 2: Geographical Breakout of Providers

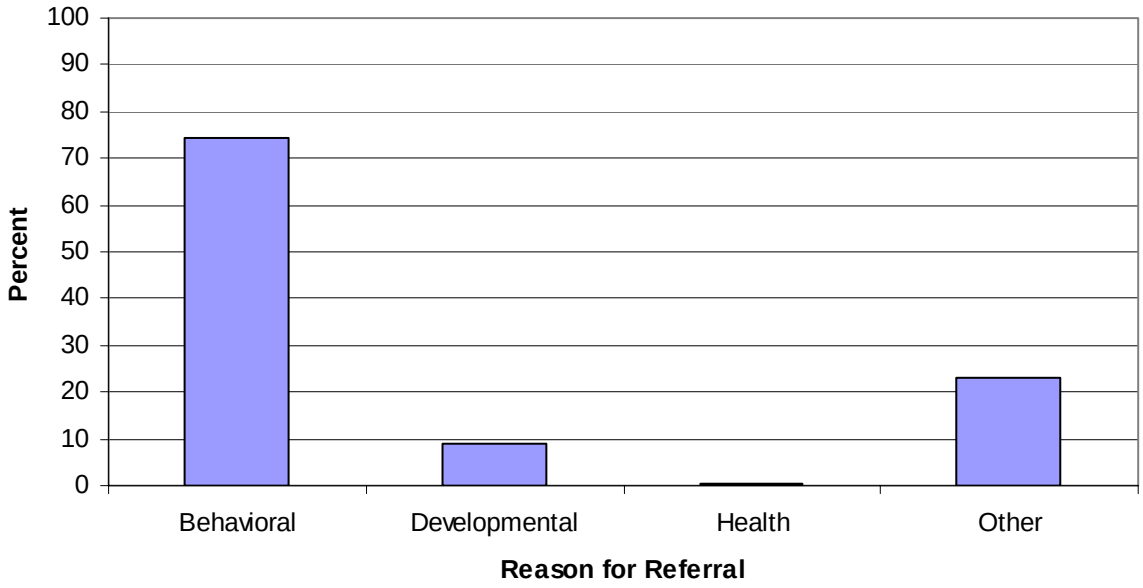
The Health Districts are determined by San Diego County's Health and Human Services Agency's geographical map.

Health District n=158	%	N
North Coastal Region	9.5	15
North Inland Region	9.5	15
North Central Region	20.3	32
Central Region	41.8	66
East Region	11.4	18
South Region	7.6	12

- The majority of providers attended trainings from the Central (41.8%) and North Central (20.3%) Health Districts.

Figure 25: Reason for Referral to Consultation

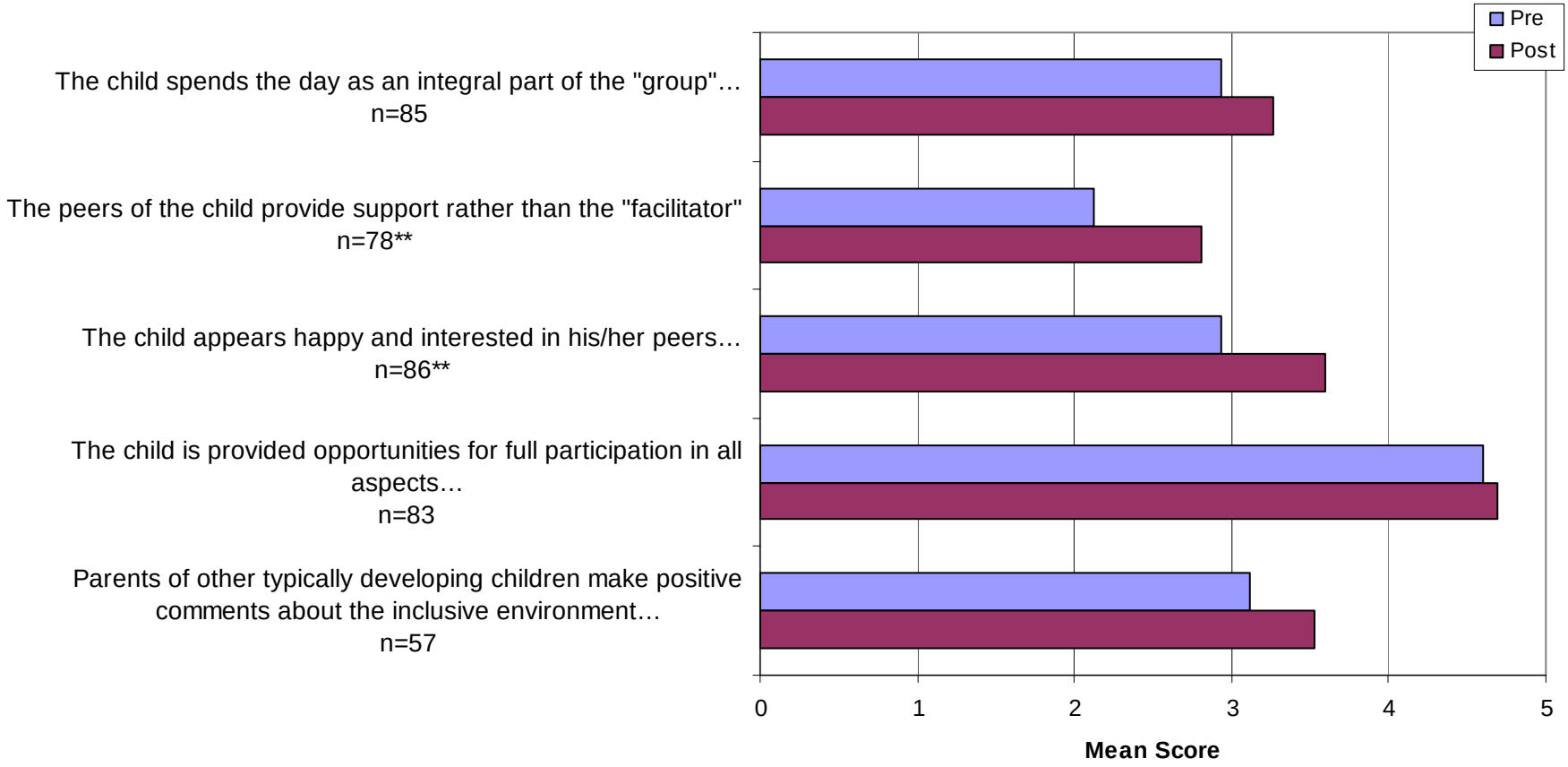
n=190



- The majority of providers asked for consultation services for child behavioral reasons (74%).
- "Other" reasons for referral most often included speech/language issues (82%).
- Approximately 6% of child consultations were referred for more than one reason.

Figure 26: Child Specific Behaviors – Provider Perception of Positive Aspects of Inclusion Behaviors

Providers who received onsite consultation services for children in their care were asked to complete an evaluation prior to receiving services and approximately 2 weeks after the end of services to gather child specific behavior data about the success of the inclusion setting. Providers rated each question on a Likert scale from 1 to 5, where 1=Less than ¼ of the time (seldom) and 5= ¾ of the time or more (frequently).

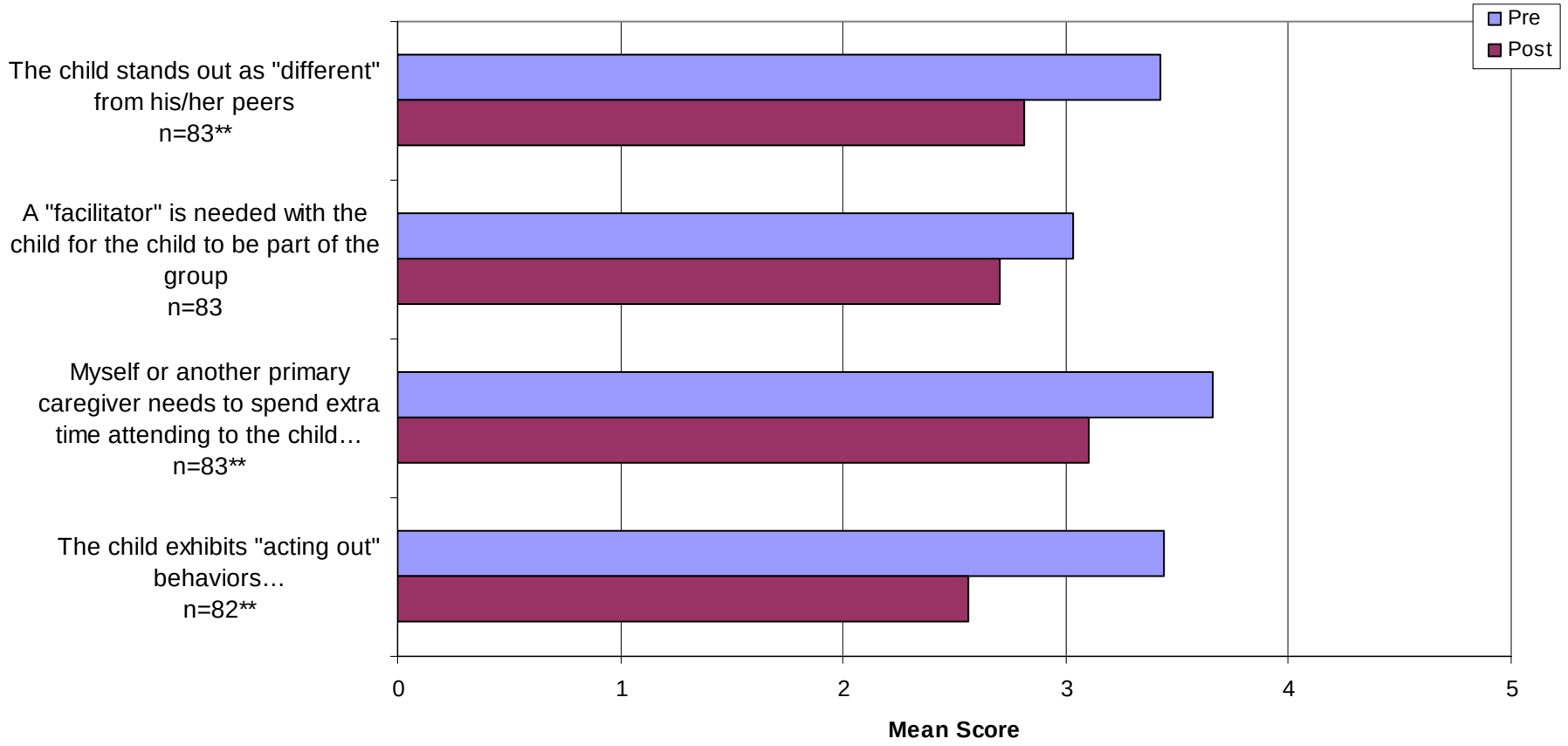


** represents statistical significance at p<.01 on paired t-tests

- Overall, there was a positive mean change in positive aspects of inclusion behavior; some aspects changed significantly.

Figure 27: Child Specific Behaviors – Provider Perception of Negative Aspects of Inclusion Behaviors

Providers who received onsite consultation services for children in their care were asked to complete an evaluation prior to receiving services and approximately 2 weeks after the end of services to gather child specific behavior data about the success of the inclusion setting. Providers rated each question on a Likert scale from 1 to 5, where 1=less than ¼ of the time (seldom) and 5= ¾ of the time or more (frequently).

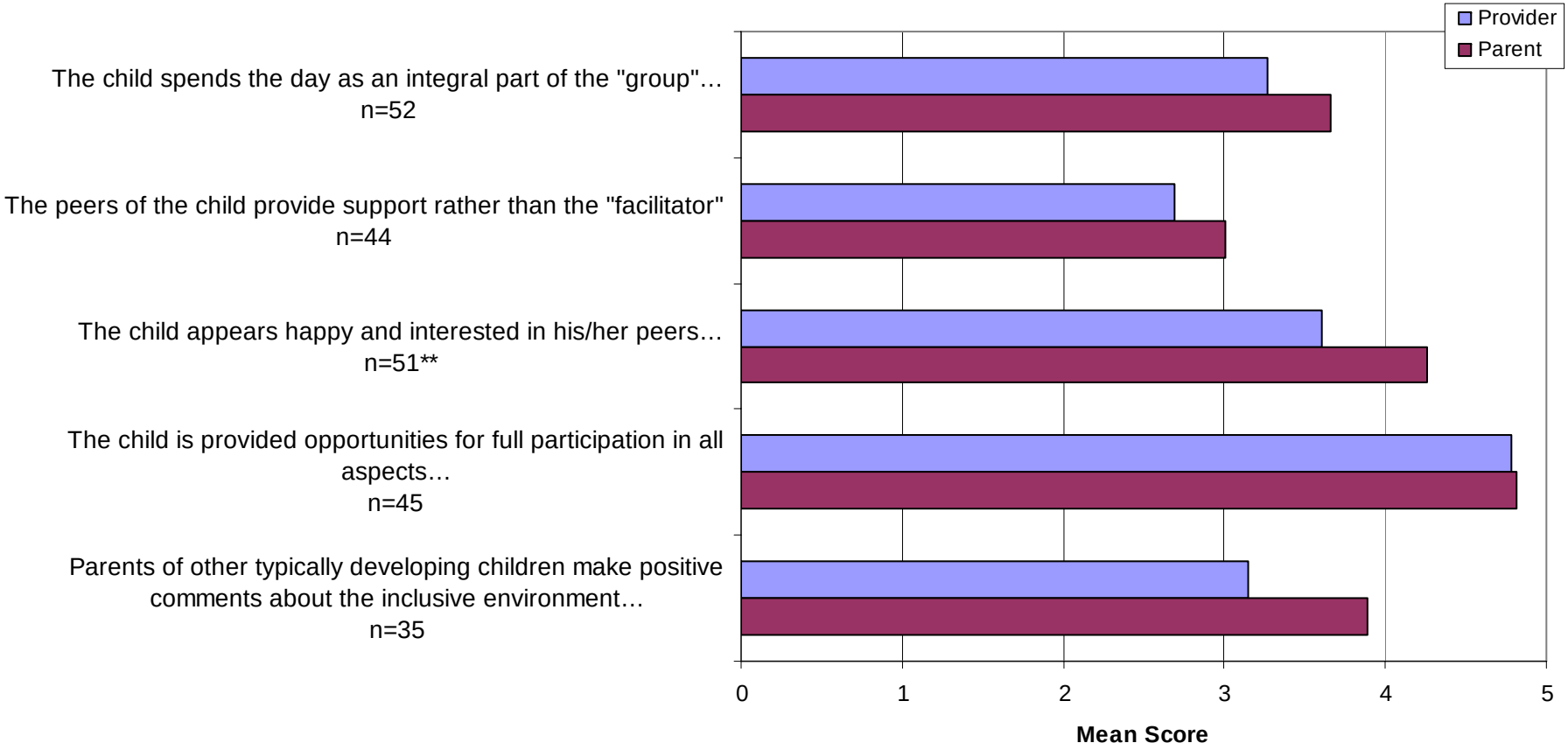


** represents statistical significance at p<.01 on paired t-tests

- Overall, there was a significant negative mean change in negative aspects of inclusion behavior.

Figure 28: Child Specific Behaviors – Provider vs. Parent Perception of Positive Aspects of Inclusion Behaviors at Post Evaluation

Providers who received onsite consultation services for children in their care and parents of these children were asked to complete an evaluation approximately 2 weeks after the end of services to gather child specific behavior data about the success of the inclusion setting. Providers and parents rated each question on a Likert scale from 1 to 5, where 1=less than ¼ of the time (seldom) and 5= ¾ of the time or more (frequently).

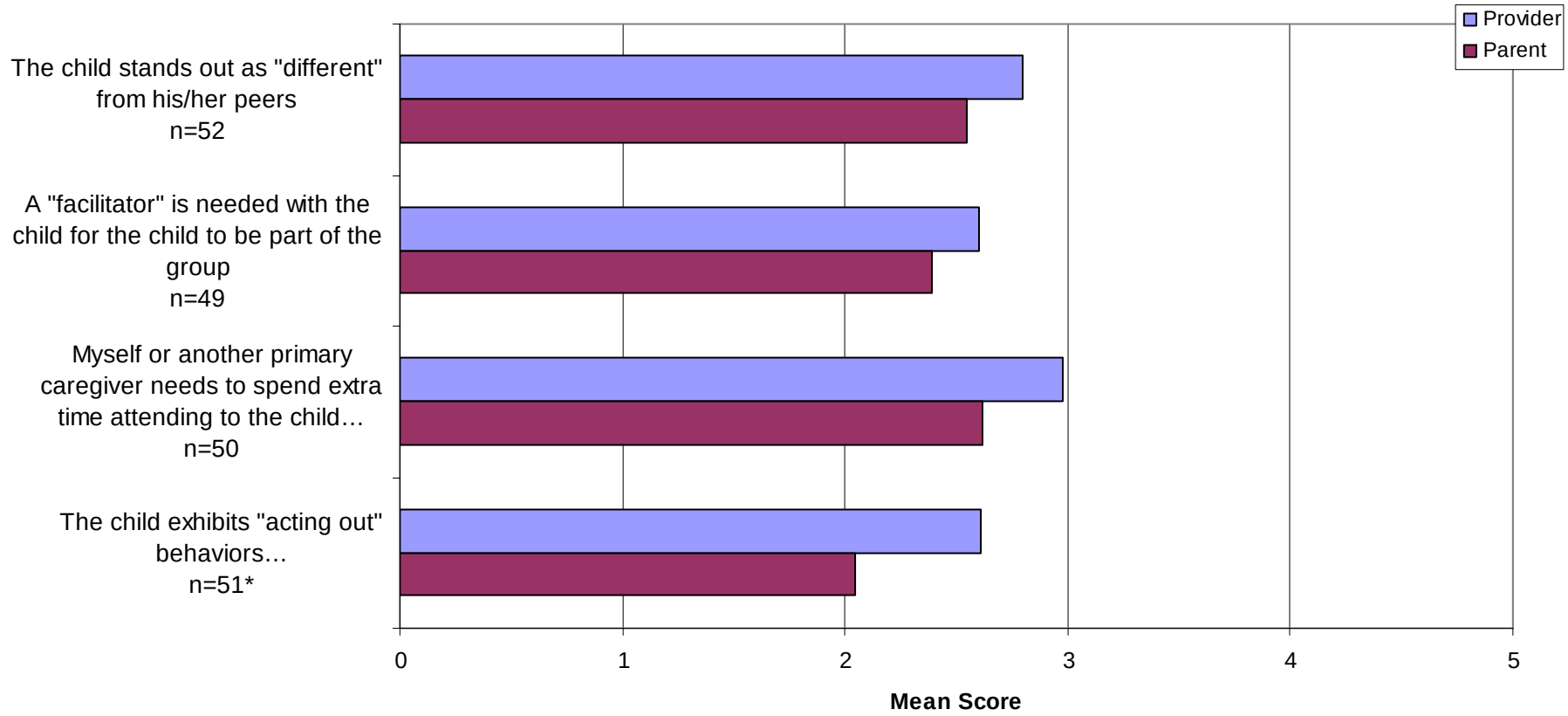


** represents statistical significance at p<.01 on paired t-tests

- Parents generally rated the positive aspects of inclusion behavior higher than providers.
- Though the difference in perception was largest for the last question, it was not significant due to a smaller sample size.

Figure 29: Child Specific Behaviors – Provider vs. Parent Perception of Negative Aspects of Inclusion Behaviors at Post Evaluation

Providers who received onsite consultation services for children in their care and parents of these children were asked to complete an evaluation approximately 2 weeks after the end of services to gather child specific behavior data about the success of the inclusion setting. Providers and parents rated each question on a Likert scale from 1 to 5, where 1=less than ¼ of the time (seldom) and 5= ¾ of the time or more (frequently).



* represents statistical significance at p<.05 on paired t-tests

- Parents generally rated the negative aspects of inclusion behavior lower than providers.

Satisfaction

For the purpose of evaluating satisfaction with KIT services, satisfaction data were collected from providers for both trainings and onsite consultations. In addition, satisfaction data were collected from parents for the onsite consultations. See the Post-Training Questionnaire, the Post-Consultation Questionnaire (Provider) and the Post-Consultation Questionnaire (Parent) in the Appendix for the evaluation questions used in data collection.

Trainings

Providers completed the training satisfaction questions immediately following the training. Participants rated each question from 1 to 5, where 1=Strongly Disagree and 5=Strongly Agree. During the reporting period from January 6, 2004 – January 31, 2005, 94 trainings were offered and a total of 2487 providers completed evaluations at these trainings (duplicated). Of these, 1298 were unique providers (unduplicated). The results reported reflect participants from all trainings (duplicated count). Overall, approximately 95% of providers were satisfied (agreed or strongly agreed) with the inclusion trainings (see Figure 30).

Almost all providers (98%) were satisfied with the information presented. Ninety-eight percent of providers also felt the trainers were knowledgeable and easy to understand as well as organized. Approximately 97% of providers were satisfied with the training overall and would attend another training sponsored by KIT. Ninety-six percent of providers reported the handout materials were useful. Ninety-five percent believed the content would be useful in their work with children who have disabilities. The same percent of providers (95%) would refer another provider to a training sponsored by KIT. Lastly, 93% of providers thought the trainers used a combination of teaching methods (e.g. hands-on activities in addition to lecture).

The satisfaction questions were broken down into four constructs for further analysis: 1) satisfaction with training information, 2) satisfaction with trainers, 3) satisfaction with training content, and 4) satisfaction with the training overall. Satisfaction with information scores were calculated by adding provider answers to questions 15 and 16 on the post evaluation, for a possible total of 10 points (see Figure 31). There were no significant differences in satisfaction with information between the four modules. There were significant differences ($p<.05$) in satisfaction with information by race; Hispanic providers had a higher mean satisfaction score than Black providers ($p<.05$). Family child care providers had a significantly higher mean information satisfaction score ($p<.01$) than center-based providers. Providers who attended public trainings had a significantly higher mean information satisfaction score ($p<.01$) than providers who attended onsite trainings.

Trainer satisfaction scores were calculated by adding provider answers to questions 17-19 on the post evaluation, for a possible total of 15 points (see Figure 32). There were no significant differences in satisfaction with trainers between the four modules. There were significant differences ($p=.05$) in satisfaction with trainers by race; Hispanic providers had a higher mean satisfaction score than Black providers ($p<.05$). Family child care providers had a significantly higher mean trainer satisfaction score ($p<.01$) than center-based providers. Providers who attended public trainings had a

significantly higher mean trainer satisfaction score ($p<.01$) than providers who attended onsite trainings.

Content satisfaction scores were calculated by utilizing provider answers to question 20 on the post evaluation, for a possible total of 5 points (see Figure 33). There were no significant differences in satisfaction with content between the four modules. There were significant differences ($p=.01$) in satisfaction with content by race; White ($p<.01$) and Hispanic ($p<.05$) providers had a higher mean satisfaction score than Black providers. Family child care providers had a significantly higher mean content satisfaction score ($p<.01$) than center-based providers. Providers who attended public trainings had a significantly higher mean content satisfaction score ($p<.01$) than providers who attended onsite trainings.

Overall satisfaction scores were calculated by utilizing provider answers to question 21-23 on the post evaluation, for a possible total of 15 points (see Figure 34). There were no significant differences in overall satisfaction between the four modules. There were significant differences ($p<.01$) in overall satisfaction by race; White ($p<.05$), Hispanic ($p<.01$) and Asian/Pacific Islander ($p<.05$) providers had a higher mean satisfaction score than Black providers. Family child care providers had a significantly higher mean overall satisfaction score ($p<.01$) than center-based providers. Providers who attended public trainings had a significantly higher mean overall satisfaction score ($p<.01$) than providers who attended onsite trainings.

As part of the training satisfaction evaluation, providers were asked to respond to two open-ended questions at each training: 1) What did you find most helpful? and 2) How can KIT improve? Please note that percentages may add up to more than 100% because some respondents mentioned items that were coded in multiple categories. There were a total of 1630 providers who responded to the “helpful” question (see Table 3). Of these, 43% found some aspect of the workshop content most helpful (e.g. good information, resources and support, handouts, etc.). Workshop style (e.g. concrete examples, active, hands on, sharing valuable experience, etc.) was reported by 28% of providers. Approximately 10% of providers thought that everything was great and 6% of providers liked the trainer/presentation. Another 25% of providers made comments specific to the individual modules they attended. Table 3 further breaks down the categories by module for comparison.

There were a total of 909 providers who responded to the “improve” question (see Table 4). Of these, 21% thought the workshop style could be improved (e.g. more hands on, better visuals, specific examples, etc.) and 20% felt the class features could be improved (e.g. longer class, shorter class, alternate class times, etc.). Fifteen percent of providers reported the workshop content needed improving (e.g. more detailed information, more/better handouts, etc.). Eight percent of providers thought that KIT needed to advertise more and do better outreach and 4% of providers thought the trainer needed improvement (e.g. speak louder, more professional, etc.). Another 37% reported that KIT needed no improvement. Moreover, 42% of providers who responded to the “helpful” question (indicating they were amenable to answering the open-ended questions) had no response for the “improve” question, suggesting they had no ideas for improvement. Table 4 further breaks down the categories by module for comparison.

Consultations

Providers and parents completed the onsite consultation satisfaction questions approximately 2 weeks following the end of the consultation service. Providers and parents rated each question from 1 to 5, where 1=Strongly Disagree and 5=Strongly Agree. During the reporting period from January 22, 2004 – April 15, 2005, data were collected from providers on 190 children. Additionally, data were collected from parents on 98 children. The results reported reflect providers and parents from all onsite consultations (duplicated count).

Provider Satisfaction

Overall, a high percentage of providers were satisfied (approximately 88% agreed or strongly agreed) with the onsite consultations (see Figure 35). Almost all providers (98%) felt the consultant was knowledgeable and easy to understand. Ninety-five percent would refer another provider to KIT for onsite consultation and 94% would request future onsite consultations from KIT. Approximately 91% of the providers believed the consultant gave practical and concrete examples and 90% thought the information provided was useful. Eighty-eight percent of providers felt the consultant was prepared and well organized, and another 88% were satisfied with onsite consultation overall. Eighty-seven percent of providers thought the content would be useful in their work with children who have disabilities, and 79% felt the materials provided were useful.

Provider satisfaction questions were analyzed by number of consultations received, by referral reason and by the age of the child. Providers who received one consultation rated the questions, “The information provided was useful,” “The materials provided were useful,” and “The content will be useful in my work with children who have disabilities” significantly lower ($p<.05$) than providers who received more than one consultation. Additionally, providers who received one consultation rated the question, “Overall, I am satisfied with the onsite consultation provided” significantly lower ($p<.01$) than providers who received more than one consultation. There were no significant differences in provider satisfaction by referral reason or by the age of the child.

As part of the onsite consultation satisfaction evaluation, providers were asked to respond to two open-ended questions at the end of the consultation service: 1) What did you find most helpful? and 2) How can KIT improve? Please note that percentages may add up to more than 100% because some respondents mentioned items that were coded in multiple categories. A total of 85 providers responded to the “helpful” question (see Table 5a). Approximately 72% of providers thought the suggestions, recommendations, information, examples and materials were most helpful. Sixteen percent felt the outside, objective view and reassurance was helpful. Another 15% reported the consultants were knowledgeable and nice and 6% liked the fact that the consultation involved/helped the parent. Two percent of providers liked the ongoing follow-ups. Five percent did not think the consultation service was helpful.

A total of 55 providers responded to the “improve” question (see Table 6a). Approximately 22% of providers thought more materials, information and examples would have been helpful. Fifteen percent would have liked the consultant to spend more time observing and 9% thought the consultant should involve all teachers and provide more training for all. Five percent of providers would have liked more follow-up, and 4% thought more communication should have occurred with parents. Another 4% thought the consultant should have used more appropriate wording on reports. Two percent of

providers would have preferred less paperwork, 2% thought the consultant should have had more realistic expectations, and 2% felt that KIT should advertise more. Additionally, 40% of providers didn't think KIT could improve the consultation service or were generally happy with the consultations. Four percent weren't sure how KIT could improve.

Parent Satisfaction

Overall, parents were somewhat satisfied (approximately 65% agreed or strongly agreed) with the onsite consultations (see Figure 36). Approximately 89% of parents reported they would be interested in future onsite consultations for their children from KIT. Sixty-eight percent were satisfied with the onsite consultation overall, and 66% thought the information provided was useful.

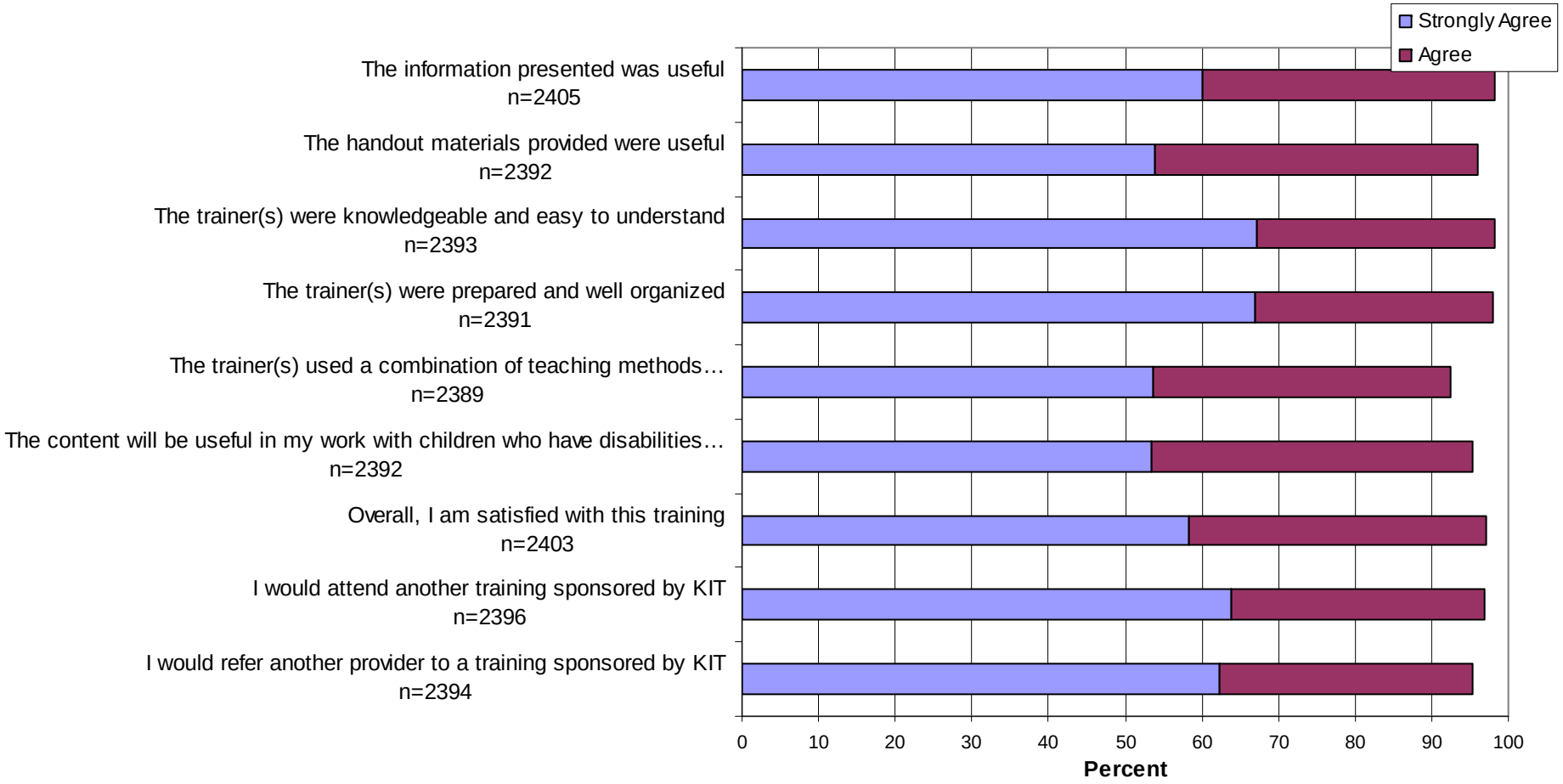
Parent satisfaction questions were analyzed by number of consultations received, by referral reason and by the age of the child. Parents of children who were referred for behavior reasons rated the question, "The information provided was useful" significantly lower ($p<.05$) than parents of children who were referred for any other reason. There were no significant differences in parent satisfaction by number of consultations received or by the age of the child.

Parents were also asked to respond to two open-ended questions at the end of the consultation service: 1) What did you find most helpful? and 2) How can KIT improve? Please note that percentages may add up to more than 100% because some respondents mentioned items that were coded in multiple categories. A total of 60 parents responded to the "helpful" question (see Table 5b). Approximately 63% liked the advice, suggestions, information, feedback and resources. Thirteen percent reported the consultations helped/improved their child, and 8% were generally happy and satisfied with the consultation service. Seven percent of parents thought the consultant's knowledge and awareness was most helpful and another 7% liked the neutral, objective view that the consultations provided. Three percent liked that the consultation service was onsite. Additionally, 15% of parents reported that they did not get any feedback or were not included, 5% didn't know how the consultations were most helpful, 3% reported the consultations were not helpful and 2% thought the observation should be longer.

A total of 47 parents responded to the "improve" question (see Table 6b). Approximately 40% thought there should be more communication with parents, and 17% wanted more follow through and for KIT to provide more/better services. Nine percent thought KIT should advertise more and obtain more funding. Additionally, 17% of parents thought no improvement was necessary and 17% didn't know how KIT could improve.

Figure 30: Training Satisfaction Across All Trainings

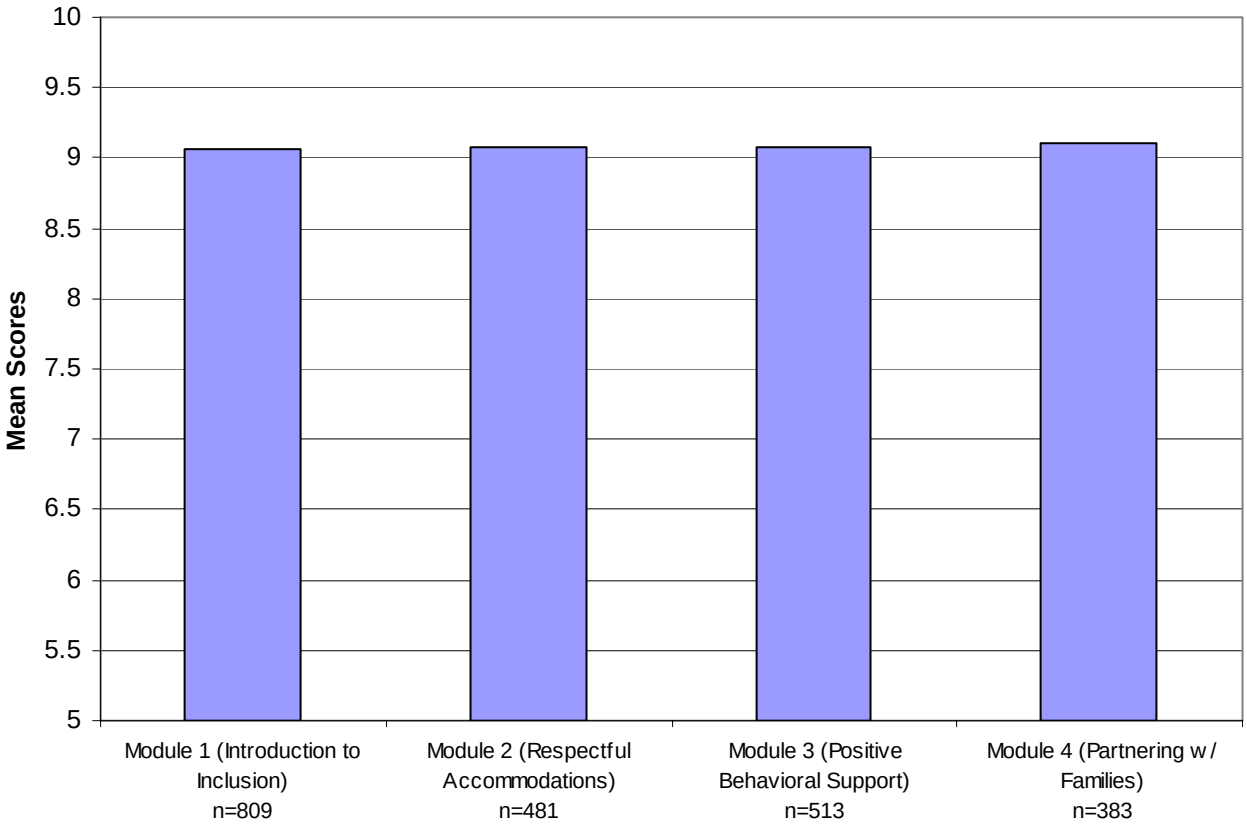
Training participants were asked to complete an evaluation immediately following the training to gather satisfaction data. Participants rated each question from 1 to 5, where 1=Strongly Disagree and 5= Strongly Agree. The data reflects participants from all trainings (duplicated count).



- Overall, a high percentage of providers were satisfied (approximately 95% agreed or strongly agreed) with the inclusion trainings.

Figure 31: Satisfaction with Training Information by Module

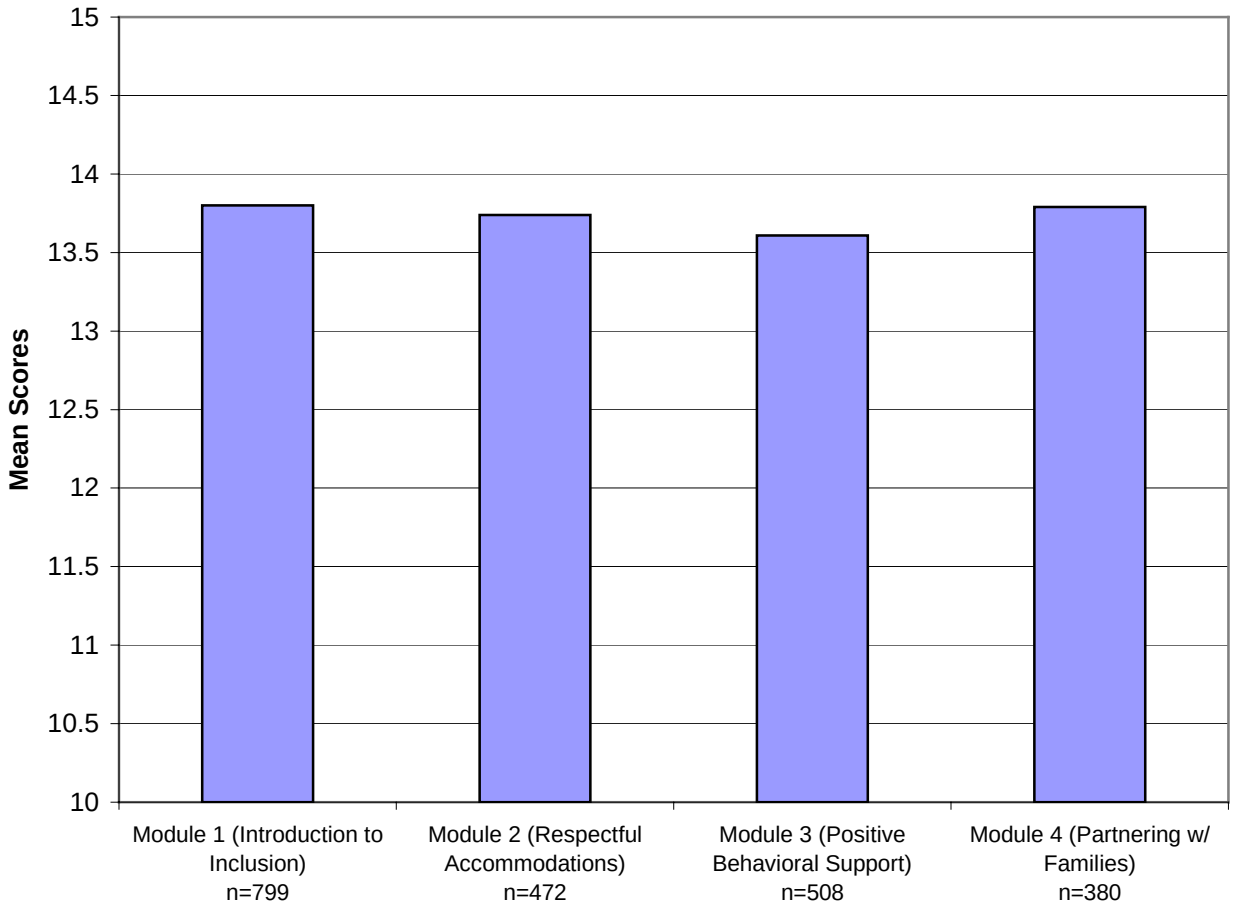
Satisfaction with information scores were calculated by adding provider answers to questions 15 and 16 on the post evaluation, for a possible total of 10 points.



- There were no significant differences in satisfaction with information between the four modules.
- There were significant differences ($p<.05$) in satisfaction with information by race. Hispanic providers had a higher mean satisfaction score than Black providers ($p<.05$).
- Family child care providers had a significantly higher mean information satisfaction score ($p<.01$) than center-based providers.
- Providers who attended public trainings had a significantly higher mean information satisfaction score ($p<.01$) than providers who attended onsite trainings.

Figure 32: Satisfaction with Trainers by Module

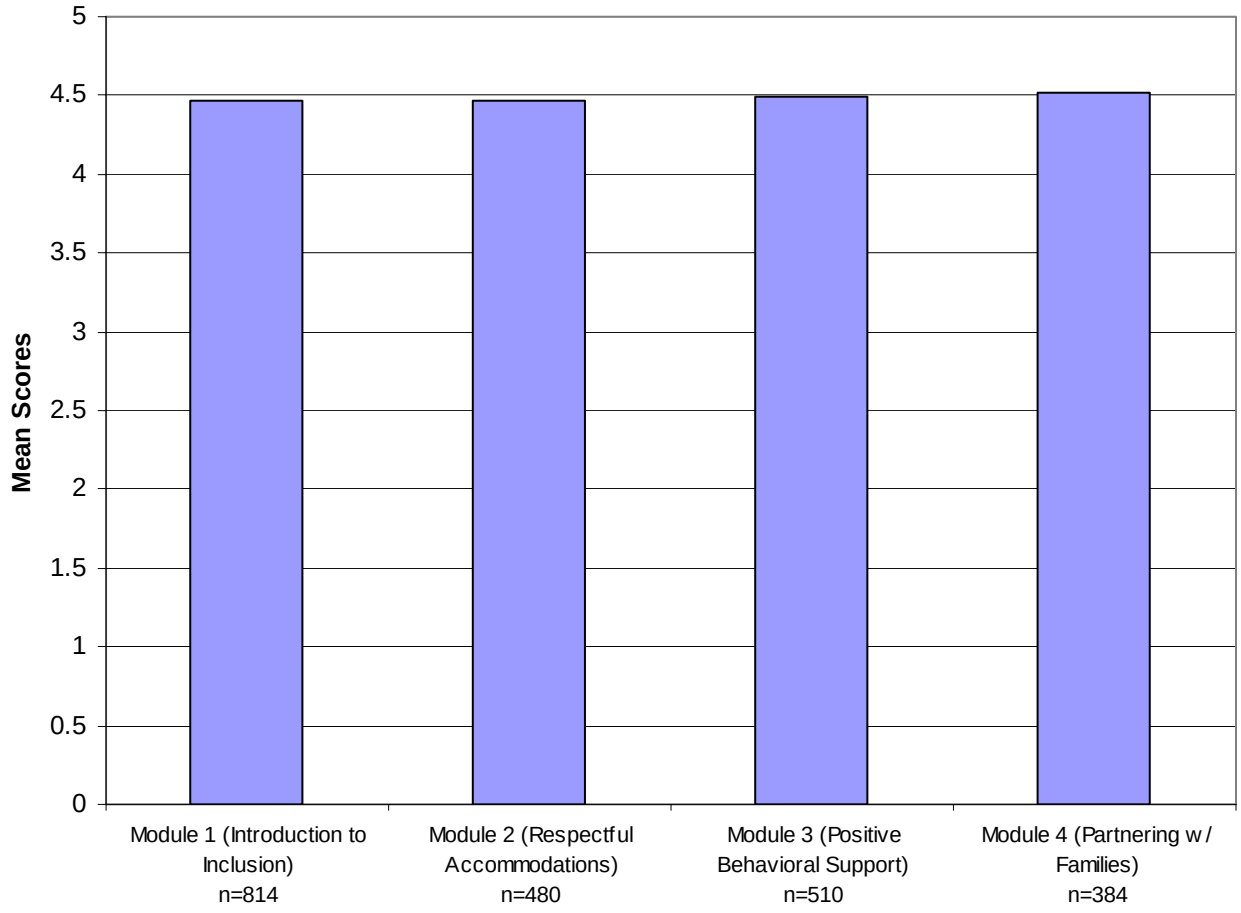
Trainer satisfaction scores were calculated by adding provider answers to questions 17-19 on the post evaluation, for a possible total of 15 points.



- There were no significant differences in satisfaction with trainers between the four modules.
- There were significant differences (p=.05) in satisfaction with trainers by race. Hispanic providers had a higher mean satisfaction score than Black providers (p<.05).
- Family child care providers had a significantly higher mean trainer satisfaction score (p<.01) than center-based providers.
- Providers who attended public trainings had a significantly higher mean trainer satisfaction score (p<.01) than providers who attended onsite trainings.

Figure 33: Satisfaction with Training Content by Module

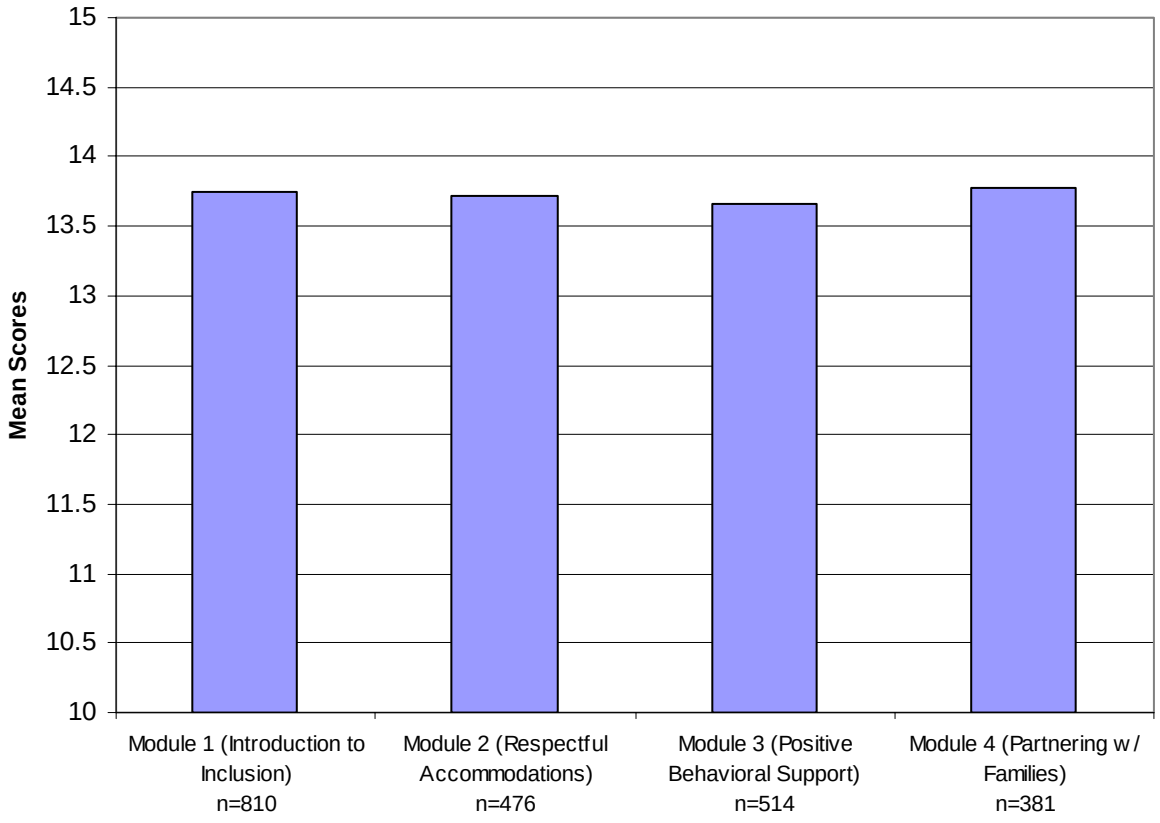
Content satisfaction scores were calculated by utilizing provider answers to question 20 on the post evaluation, for a possible total of 5 points.



- There were no significant differences in satisfaction with content between the four modules.
- There were significant differences (p=.01) in satisfaction with content by race. White (p<.01) and Hispanic (p<.05) providers had a higher mean satisfaction score than Black providers.
- Family child care providers had a significantly higher mean content satisfaction score (p<.01) than center-based providers.
- Providers who attended public trainings had a significantly higher mean content satisfaction score (p<.01) than providers who attended onsite trainings.

Figure 34: Satisfaction with Training Overall by Module

Overall satisfaction scores were calculated by utilizing provider answers to question 21-23 on the post evaluation, for a possible total of 15 points.



- There were no significant differences in overall satisfaction between the four modules.
- There were significant differences ($p<.01$) in overall satisfaction by race. White ($p<.05$), Hispanic ($p<.01$) and Asian/Pacific Islander ($p<.05$) providers had a higher mean satisfaction score than Black providers.
- Family child care providers had a significantly higher mean overall satisfaction score ($p<.01$) than center-based providers.
- Providers who attended public trainings had a significantly higher mean overall satisfaction score ($p<.01$) than providers who attended onsite trainings.

Table 3: Training Qualitative Data – What Did You Find Most Helpful?

MODULE:	MODULE 1 INTRODUCTION TO INCLUSION	MODULE 2 RESPECTFUL ACCOMMODATIONS	MODULE 3 POSITIVE BEHAVIORAL SUPPORT	MODULE 4 PARTNERING WITH FAMILIES	TOTAL (ACROSS ALL MODULES)
NUMBER OF RESPONDENTS:	n=641	n=361	n=365	n=263	**n=1630**
WORKSHOP CONTENT					
• Good info (generally) • Disability education • Specific disabilities (e.g. Autism, ADHD) • Resources and support • KIT as an available resource • Handouts • Kids/families/community • Inclusion philosophy & specific strategies	331 (52%)	148 (41%)	116 (32%)	114 (43%)	**709 (43%)**
WORKSHOP STYLE					
• Concrete examples • Active, hands on • Easy to understand • Q & A format • Visuals • Sharing valuable experience	145 (23%)	98 (27%)	111 (30%)	102 (39%)	**456 (28%)**
INFORMATION SPECIFIC TO MODULE					
	150 (23%)	46 (13%)	152 (42%)	61 (23%)	**409 (25%)**
EVERYTHING/ALL IS GREAT					
	64 (10%)	35 (10%)	37 (10%)	26 (10%)	**162 (10%)**
LIKED TRAINER/PRESENTATION					
	45 (7%)	36 (10%)	12 (3%)	12 (5%)	**105 (6%)**

Note: Columns may not sum to 100% because some respondents mentioned multiple coded items. No responses/indecipherable responses were excluded from analyses. One provider responded "did not like it."

- "I found everything very helpful for my class and I will share with my friends at my job."
- "To know that if we want to work with children with disabilities that there's help."
- "I love the personal stories, it makes situations come to life in such a positive manner. It makes you really consider the tremendous benefits in inclusion."
- "Everything! You just can't name one most helpful [thing]."
- "The information she gave was always supported by example."

Table 4: Training Qualitative Data – How Can KIT Improve?

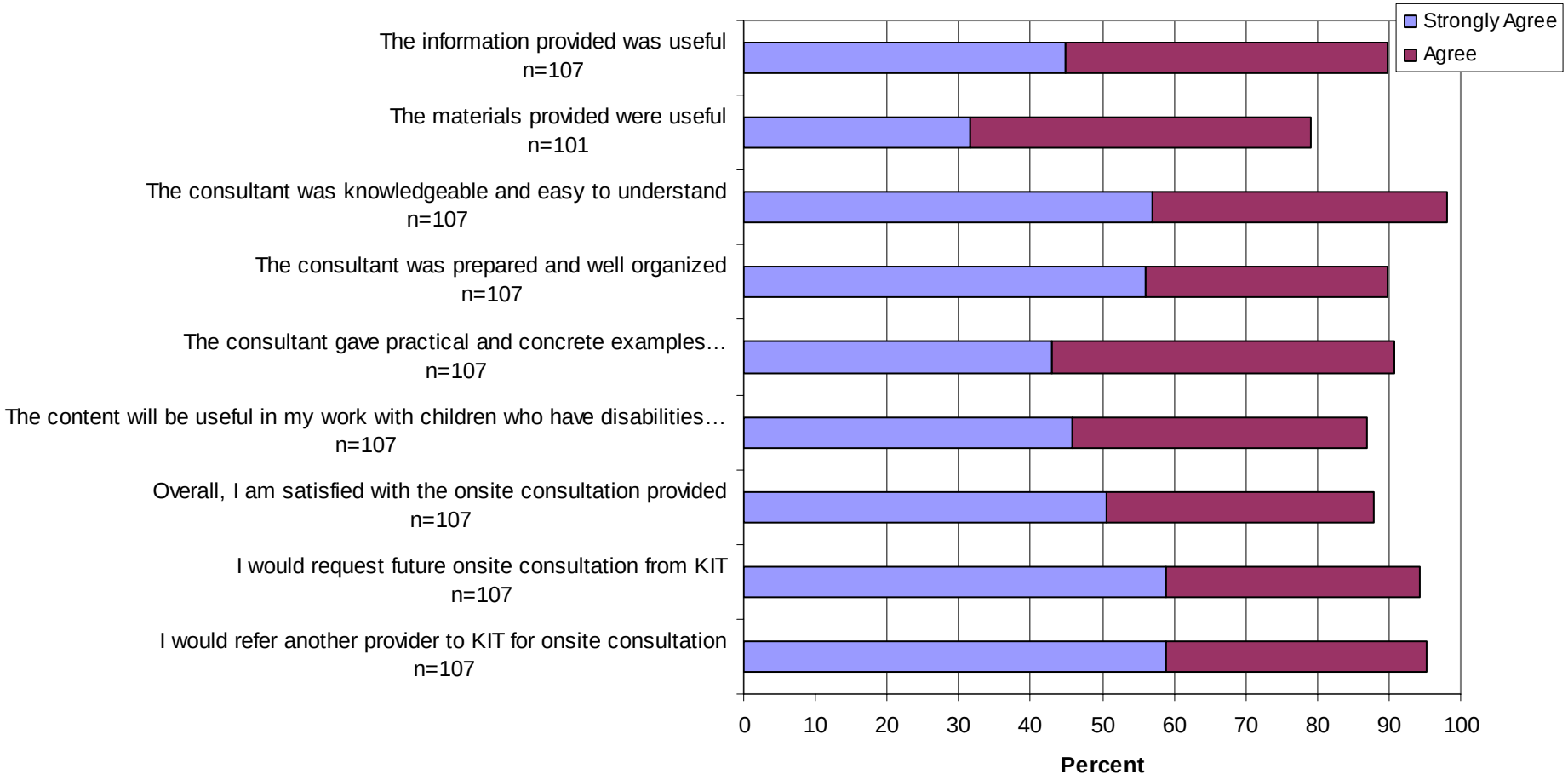
MODULE:	MODULE 1 INTRODUCTION TO INCLUSION	MODULE 2 RESPECTFUL ACCOMMODATIONS	MODULE 3 POSITIVE BEHAVIORAL SUPPORT	MODULE 4 PARTNERING WITH FAMILIES	TOTAL (ACROSS ALL MODULES)
NUMBER OF RESPONDENTS:	n=341	n=190	n=215	n=163	**n=909**
WORKSHOP STYLE					
• Specific examples • More hands on • Offer Spanish language class • Better visuals • More use of personal testimonies	45 (13%)	34 (18%)	67 (31%)	43 (26%)	**189** **(21%)**
CLASS FEATURES					
• Longer class/shorter class • Less time between classes • Alternate class times • Offer more trainings • Make me more comfortable	59 (17%)	52 (27%)	37 (17%)	34 (21%)	**182** **(20%)**
WORKSHOP CONTENT					
• More detailed information • Disability education (wider range of disabilities) • More onsite KIT training and support • Handouts (more, better)	75 (22%)	30 (16%)	15 (7%)	13 (8%)	**133** **(15%)**
ADVERTISING AND OUTREACH					
	38 (11%)	14 (7%)	6 (3%)	16 (10%)	**74** **(8%)**
TRAINER					
• Speak louder, start class on time • More professional, more knowledgeable • Involve all participants	16 (5%)	6 (3%)	11 (5%)	4 (2%)	**37** **(4%)**
NEEDS NO IMPROVEMENT					
	114 (33%)	69 (36%)	91 (42%)	60 (37%)	**334** **(37%)**

Note: Columns may not sum to 100% because some respondents mentioned multiple coded items. No responses/indecipherable responses were excluded from analyses.

- "More visual presentations of children with disabilities and how to accommodate them. More knowledge of variety of disabilities of children."
- "Have a guest speaker (actual provider) that successfully accommodates special needs. (That has transitioned their program to be inclusive.)."
- "I would like to see more examples, maybe on videotape, on how other teachers implement different activities for children with special needs."
- "They need to involve the audience more so they can participate too. More dynamic training where people can talk about what they know, and share their ideas."
- "More exposure and advertising, I only found out about your trainings today. Enjoyed it very much, would have been here sooner if I'd known about KIT."

Figure 35: Consultation Satisfaction – Provider Perception

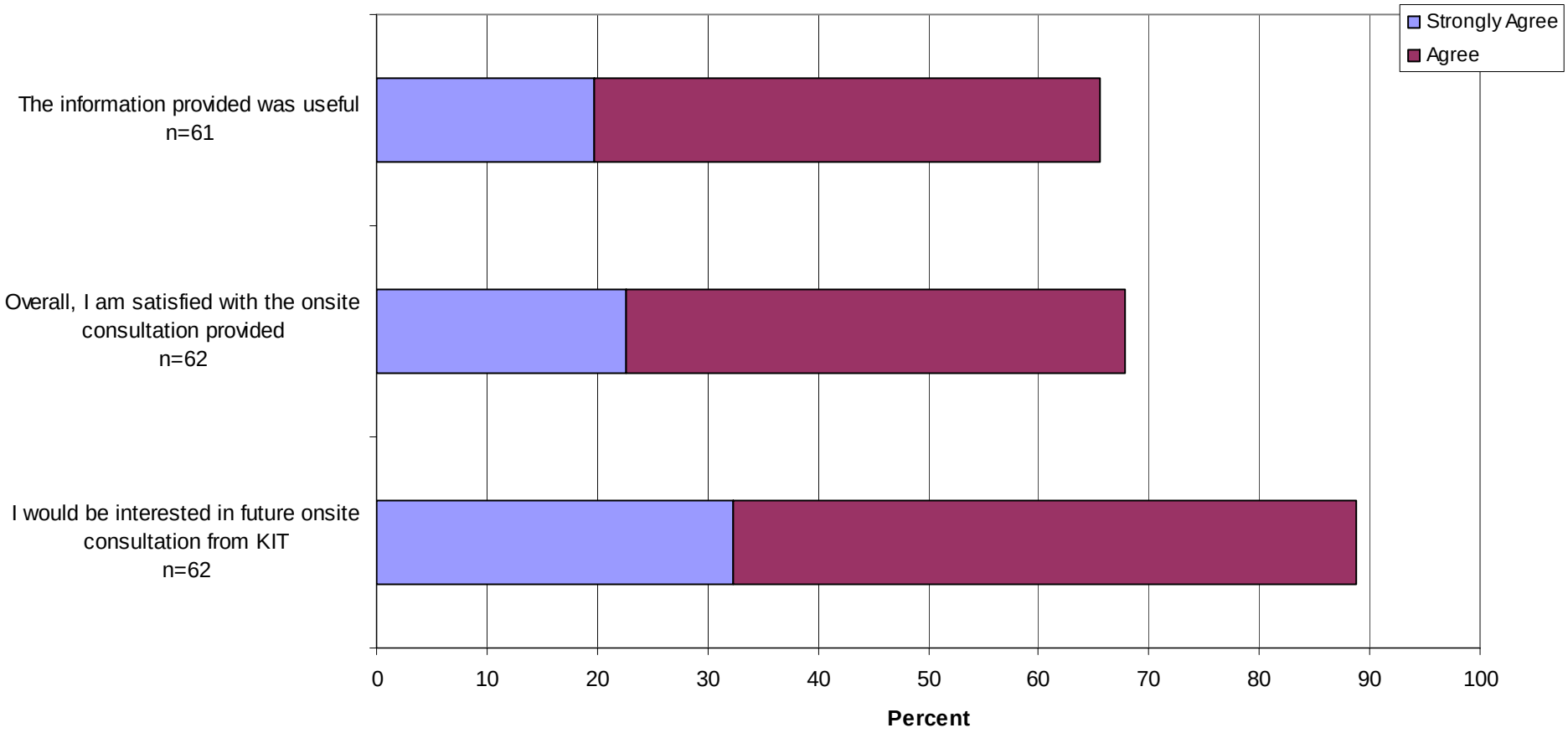
Providers who received onsite consultation services were asked to complete an evaluation approximately 2 weeks after the end of services to gather satisfaction data. Providers rated each question from 1 to 5, where 1=Strongly Disagree and 5= Strongly Agree. The data below reflects providers from all consultations (duplicated count).



- Overall, a high percentage of providers were satisfied (approximately 88% agreed or strongly agreed) with the onsite consultations.

Figure 36: Consultation Satisfaction – Parent Perception

Parents of children who received onsite consultation services were asked to complete an evaluation approximately 2 weeks after the end of services to gather satisfaction data. Parents rated each question from 1 to 5, where 1=Strongly Disagree and 5= Strongly Agree. The data below reflects parents from all consultations (duplicated count).



- Overall, parents were somewhat satisfied (approximately 65% agreed or strongly agreed) with the onsite consultations.
- Approximately 89% of parents would be interested in future onsite consultations for their children from KIT.

Table 5: Consultation Qualitative Data – What Did You Find Most Helpful?

(a) PROVIDER RESPONDENTS (N=85)

CATEGORY / THEME	N	%
Suggestions / recommendations / information / examples / materials	61	72%
Outside, objective view / reassurance	14	16%
Consultants knowledgeable / nice	13	15%
Involved parent / help for parent	5	6%
Ongoing follow-ups	2	2%
Did not help / could not help	4	5%

Note: Columns may not sum to 100% because some respondents mentioned multiple coded items. No responses/indecipherable responses were excluded from analyses.

- "Her recommendations and examples of how to communicate with the child. I knew they needed concrete directions but didn't know how simple and examples helped a great deal."
- "Information was professional and useful in the classroom. We hope funding continues for the program!"
- "The objectivity of our consultant was amazing. She was concise and to the point; was being so positive and supportive that I was able to learn more info in short time. Thanks."
- "So much! The sensory suggestions and the sign language have both made a big difference already! Thanks."

(b) PARENT RESPONDENTS (N=60)

CATEGORY / THEME	N	%
Advice / suggestions / information / feedback / resources	38	63%
Helped / improved child	8	13%
Generally happy / satisfied	5	8%
Consultant's knowledge / awareness	4	7%
Neutral / objective view	4	7%
Onsite aspect of consultation	2	3%
Did not get feedback / was not included	9	15%
Don't know	3	5%
Not helpful	2	3%
Observation should be longer	1	2%

Note: Columns may not sum to 100% because some respondents mentioned multiple coded items. No responses/indecipherable responses were excluded from analyses.

- "Third party person with experience coming in and giving advice. Objective opinion. KIT was great! Didn't realize the extent to which KIT could help my child! Great!"
- "Having the avenue to turn to/support/offering a solution to kicking out of the program, because of biting."
- "Onsite. Didn't have to go to different place where he would feel awkward/shy. Teachers/ caregivers included/questioned during consultation. Same day feedback from child development center about consultation report."
- "Difficult to answer because I was kept out of the loop. I was not provided a copy of the report until we withdrew from the program."

Table 6: Consultation Qualitative Data – How Can KIT Improve?

(a) PROVIDER RESPONDENTS (N=55)

CATEGORY / THEME	N	%
More materials / information / examples	12	22%
Spend more time observing (longer / more days)	8	15%
Involve all teachers in consultation / more training for all	5	9%
Follow-up	3	5%
Communicate more with parents	2	4%
Use more appropriate wording on reports	2	4%
Less paperwork	1	2%
Have more realistic expectations	1	2%
Advertise more	1	2%
Can't improve / happy and satisfied / continue as is	22	40%
Not sure	2	4%

Note: Columns may not sum to 100% because some respondents mentioned multiple coded items. No responses/indecipherable responses were excluded from analyses.

- "Maybe have a consultation be a couple of days rather than one to get a clearer picture of the child in our environment."
- "Provide some material regarding the behavior that we are dealing with so that we have reference material to consult after the specialist is gone."
- "They are great for the service they provide, but more specific resources/handouts on the reason for visit would have been helpful."
- "I have no complaints. Appointments were scheduled quickly, consultants kind, understanding and knowledgeable. Suggestions were golden. I put them in place and positive changes began immediately! I'm so grateful for your help as are the parents. Thank you."

(b) PARENT RESPONDENTS (N=47)

CATEGORY / THEME	N	%
Communicate more with parents	19	40%
Follow through / provider more/better services	8	17%
Advertise more / more funding	4	9%
No improvement necessary	8	17%
Don't know	8	17%

Note: Columns may not sum to 100% because some respondents mentioned multiple coded items. No responses/indecipherable responses were excluded from analyses.

- "Better feedback and communication with the parents about their visits and findings."
- "Have parent involved in feedback conference with teacher and consultant."
- "Mail information directly to parents' home. We were not informed about feedback in a timely manner. Day care assumed we received a copy of the evaluation when we did not."
- "Can't really. Happy that consultant information and observation information was passed on to parent. Also happy that KIT keeps in touch."

Satisfaction: Resource Team Reflections

As part of the SB 1703 Inclusive Child Care Program, KIT established a Resource Team made up of trainers, consultants and representatives from collaborative partner agencies. The Resource Team met 12 times between November 2003 and March 2005 to discuss inclusion philosophy, program implementation, procedures, processes and the role of evaluation. During this time, Resource Team members also received training in 1) the KIT trainings, 2) presentation skills, 3) disability awareness, 4) child development for birth to five and 5) community resources. In addition, the Resource Team meetings allowed ongoing feedback between the professionals providing services out in the field and the KIT project staff.

The March 8, 2005 Resource Team meeting included a 3-hour focus group to gather qualitative information from the professionals involved with the SB 1703 grant. See the Focus Group Questions in the Appendix for the specific questions asked. The following are the salient themes that emerged from this focus group.

Overall, the Resource Team members felt proud of the impact that the Inclusive Child Care Program had on San Diego County. In particular, they cited the transformation of attitudes in child care and recreational staff toward children with disabilities and other special needs as a very valuable outcome of the project. The Resource Team members witnessed the increased awareness of community resources, as well as a rise in confidence among child care and recreation providers who participated in the training and technical assistance through this project.

The Resource Team also reported that they have experienced a great deal of personal and professional growth from participation in the project. They benefited from the Resource Team trainings, where they were made aware of community resources through agency presentations, trained on the four core modules and had the chance to network and share strategies with other professionals. They appreciated being able to guide the direction of the project, and having the opportunity to be part of the solution when challenges arose. This collaborative process created community linkages between agencies that will exist long after the SB 1703 Inclusive Child Care Program ended.

From spending so much time in the field, training and providing consultations, Resource Team members had ideas for expanded services to assist child care and recreation providers. They would like to see providers continue to receive information on community resources, including checklists on developmental norms for children, disability specific information, free services in hearing and vision screening and explanations of the Individual Family Service Plan (IFSP) and Individualized Education Program (IEP) process. The Resource Team members felt that providers could benefit from written information on how to talk to parents about concerns and how to access Early Start. They would also like to see providers receive more information about accommodations for specific disabilities and to include resources for funding for structural accommodations that should be made to facilities. They felt that an incentive program (using CARES funding, or books and games) may help providers increase the number of children with disabilities they serve.

Through working with child care and recreation providers in San Diego County, the Resource Team members were able to generate some ideas about future services that could be offered. The list included a curriculum for relationships and friendship

development that could be presented to both children with and without disabilities in programs, site-specific consultations that would assess the quality of the environment for children with and without special needs and ongoing support (perhaps through a website). The Resource Team members would like to see more direct support to parents of children with disabilities and an ongoing way to manage the cases of children with disabilities in child care programs.

The SB 1703 Inclusive Child Care Program has begun to shift attitudes, create community linkages and provide valuable training for child care and recreation programs in San Diego County. The members of the Resource Team stated they will continue to promote the philosophy of inclusion in San Diego by modeling person first language in daily professional interactions and advocating for enhanced public transportation for people with disabilities so that they can get their children to programs. Team members will also speak about inclusion in colleges and professional associations and strive to keep web resources up to date so that parents and providers can continue to access community agencies. In addition, results of the SB 1703 Inclusive Child Care Program will be shared throughout San Diego County and published in national journals.

Lessons Learned

The SB 1703 Inclusive Child Care Program gave KIT and its collaborative partners the opportunity to serve a new audience of organizations in a unique way. A coordinated effort of training and child-specific consultations was provided using an intricate network of systems in San Diego County. This project allowed KIT and its collaborative partners the chance to discover what is missing in San Diego County, and how to fill in the gaps in services for child care providers and the families they serve. In addition, KIT refined its training processes through the training-of-trainers and gained insight into a new audience base of those who serve children from birth-5. The following are lessons learned from this project.

1) **Utilize public and site-embedded training to promote onsite consultation services to providers. In addition, increase viable outreach efforts targeted to parents.**
   While it was initially intended that the referrals for onsite consultations would be provided by EFRC from its incoming 800 information calls, far fewer referrals (6%) were generated through that access point. Most child care related calls received by EFRC involved the need for child care and were referred to the Enhanced Referral Inclusion Specialist at the YMCA Childcare Resource Service (CRS) who, in turn, would offer the services of SB 1703 to parents. However, the requests for SB 1703 services received from parents through the YMCA CRS were a disappointing 4%. The majority of onsite consultation referrals were generated from providers, not parents (88% vs. 12%). Of the provider-initiated referrals, 50% resulted directly from trainings. If outreach efforts targeted to parents are to be successful in the future, exploration into the reasons why parents did not initiate referrals needs to occur.

2) **Establish a mechanism for case management for families in order to ensure proper communication between consultants, providers and parents.**
   Case management was not a specific component of the grant, and none of the agencies working with families considered it their responsibility. If agencies are unwilling to take on case management, consultants should be trained in and responsible for case management as well as the onsite consultations. Including case management into the project might have prevented the lack of communication with parents that occurred with the onsite consultations. As an agency, KIT works with providers. As part of the consultation process the KIT consultant addressed partnering with the family, including sharing the consultation information with the family. However, this often did not occur, leaving parents uninformed about what was happening with their child in the child care program.

3) **Ensure that child care providers have some information on the philosophy of inclusion prior to the onsite consultation visit.**
   Resource Team members (a consortium of trainers, consultants and representatives from collaborative partner agencies) consistently found that child care and recreation program providers were the most supportive of the consultation process when the philosophy of inclusion had already been addressed. Thus, in programs where they had already received the Introduction to Inclusion training module, the receptiveness from the program staff was the highest. Regardless of training attendance, some information on the philosophy of inclusion should always be given prior to a consultation visit.

4) **Recruit consultants needed for onsite consultations as early as possible in the process, as opposed to waiting for the need.**
   Bringing in professionals from a variety of related fields early in the project would allow time to train them in the philosophy of inclusion and the consultation process. It would also provide the ability to pair more novice consultants with seasoned consultants to gain more specific hands-on experience.

5) **Offer trainings that are interactive, recognize attendance and are scheduled at times that are convenient for the providers.**
   KIT found that providers appreciated training sessions that affirmed their prior experience and knowledge and included opportunities for practicing skills through hands-on learning. Additionally, KIT found that CARES credit (a YMCA Childcare Resource Service program, which provides stipends to child care providers who attend a designated number of hours of training) was a valuable incentive, and that certificates of attendance given after each training were appreciated. Finally, great care was taken to schedule trainings at times that were convenient for child care providers (primarily weekday evenings).

Future Directions

Participation in the SB 1703 project has allowed KIT to experience a great deal of growth in a relatively short period of time. Expanding the target age group from school age to include birth to five has created a whole new market for KIT. Since the grant period began in October of 2003, KIT has explored a variety of new methods for spreading the word about inclusion.

In the fall of 2004 KIT hosted the first national conference on inclusion for out-of-school time providers, *After the Bell Rings: Developing Your KIT For Including ALL Children*, in San Diego. The conference was tremendously successful and had representation from 13 states. The second annual conference is scheduled for March 2006, again in San Diego.

KIT also began to develop materials that would enhance its training modules. A new edition of KIT's training manual, *Together We're Better, A Practical Guide to Including All Children in Out-of-School Time Programs*, was published and reflects current data and best practices. The manual also functions as a workbook for staff providing direct service to children with and without disabilities. Three training DVDs, *Introduction to Inclusion*, *Respectful Accommodations* and *Positive Behavioral Support*, were produced in an effort to provide support to organizations where the staff turnover is high, possibly precluding staff from receiving adequate training in inclusion. KIT also created an 18" x 24" educational poster titled "What is Inclusion?" and a disability awareness package, *KIT To Go*, that includes five hands-on activities that child care staff can use with their preschool children.

Over the past year KIT has also contracted with several national organizations and affiliates of national organizations to provide training and technical assistance. One of those contracts was in San Francisco East Bay with Easter Seals Bay Area and Livermore Parks and Recreation. KIT anticipates training in Oregon, Minnesota, Hawaii and Washington, as well as additional counties in California in the coming year.

In addition, KIT launched its first replication model by opening KIT – Los Angeles in July 2005. KIT will provide direct services and support to three different organizations in year one including LA's BEST and the Boys & Girls Club of Santa Monica. The third organization is still to be determined at this writing.

KIT's experience in transforming organizations through the inclusion of children with disabilities, enhanced by the work done as part of SB 1703, will lead to an exciting future direction in 2006 and beyond.

<u>A National Training Center on Inclusion</u>

In early 2006 KIT will relocate its offices and expand its services as a part of the Naval Training Center Promenade at Liberty Station in San Diego. For 70 years the Naval Training Center in San Diego served as a training hub for thousands of young men and women as they embarked on their military careers. Now, 26 of the original historic buildings are being renovated to provide residence opportunities for some of San Diego's finest not-for-profit organizations. Having been invited as one of the first 18 resident groups to inhabit this historical corridor, KIT will establish a National Training Center on Inclusion, providing training, technical assistance and consultations to all resident groups and the greater community. KIT's vision for the National Training Center

is to be a headquarters and focal point for inclusion training in San Diego, as well as cities throughout the United States that seek KIT's expertise and support. A typical day at the National Training Center will include working with the child care facility as a pilot program to ensure inclusion at the child care level, training students from High Tech High and High Tech Middle Schools to be inclusion aides in programs around the county, conducting workshops for dance and creative arts groups to teach them how to incorporate inclusion into their artistic programs and conducting workshops and site visits for out-of-town guests who attend a 2 ½ day conference on inclusion.

Other Outcomes Related to SB 1703 Inclusive Child Care Program

Specific Local Projects

In October 2005, KIT will be directly involved in, and provide support to, the YMCA Child Care Resource Service (CRS) that has been awarded a State Council on Developmental Disabilities grant for two onsite teen programs at local high schools. The programs will be licensed child care sites in specific homerooms. Students with developmental disabilities will check in during after school hours and be supported by licensed providers. The goal is to have teens transition to typical activities and clubs or sports programs that occur on the high school campus. Noteworthy is that KIT has been involved in the design as well as advocacy and strategic planning to bring this Teen Project to fruition. KIT will be contracted to assist with implementation as well.

KIT will design the evaluation piece of the Teen Project with special emphasis on measures of belonging rather than measuring participation levels. There has been some research in the field with middle school students but very little with high school students. There will also be an intentional effort to address some avocational or vocational outcomes from the pilot programs with the hope of some meaningful supported employment opportunities after graduation. The more typical scenario would find these young adults being relegated to sheltered workshops, being isolated at home or joining the ranks of unemployed or under-employed adults with disabilities.

KIT will also provide training and technical assistance to the Teen Project and will work with students from the University of San Diego who volunteer in some capacity as inclusion facilitators. KIT also anticipates working with the special day class faculty at the schools, as well as parents, to complete interest inventories and conduct functional analysis of tasks involved in the job or activity where the students express interest. Disability awareness and sensitivity training for some populations at the school (sports teams, coaches, club members or faculty assigned to clubs, etc.) will be provided as needed.

Addressing Systems Coordination

Through the SB 1703 Inclusive Child Care Program, KIT and its collaborative partners were instrumental in bringing about systems coordination. From the beginning of the project, the Exceptional Family Resource Center (EFRC), the YMCA Childcare Resource Service (CRS) and KIT worked closely together to ensure successful child care placement. For example, this collaboration provides families with children with special needs enhanced child care referrals and provider support through training and technical assistance. As a result of these efforts, EFRC proactively links families to CRS, and CRS ensures families receive names of child care providers and/or centers

that are trained or experienced in working with children with special needs. These enhancements and coordination will continue, and undoubtedly be further enhanced, as additional family needs are identified.

Another systems coordination effort involves the San Diego Regional Center, along with EFRC, CRS and KIT. The San Diego Regional Center holds a monthly meeting for service coordinators to address child care issues and brainstorm solutions. The Teen Project was brought to fruition from this forum. These systems coordination efforts will continue into the future.

In June 2005, the first San Diego County Early Care & Development Inclusion Institute was held. Twenty-four key representatives of county-wide agencies and systems that support families with children with special needs met to address access to quality child care for their children. This group committed by consensus to:

- Work together to improve coordination and access to child care
- Explore issues and share ideas and resources
- Work outside individual silo boundaries to expand capacity and improve quality of child care programs
- Continue efforts to insure that quality inclusive child care is available
- Institutionalize the collaboration on an organizational level
- Be willing to follow through on the integration of services and goals
- Think more horizontally across agencies and within each organization
- Design a multi-system plan using current and potential resources to increase capacity and improve quality child care
- Understand the identified needs, seek out resources and explore/facilitate child care systems change to benefit all children and families

At the June Institute, more inter-agency collaboration was identified as a future direction. Specific commitments were made between 211 (the countywide health and human services referral line), CRS and EFRC, and Public Health Nursing and CRS. In addition, suggestions were made that would result in the San Diego City Schools Special Education teachers knowing how to refer families to CRS, as well as the adoption of a universal packet on how to select quality child care. Future plans include creating an umbrella organization for sharing information, identifying a “child care expert” within each organization, proactively writing legislation to increase child care capacity for children with special needs (e.g., additional subsidies for caring for children with special needs) and ongoing support of families with child care issues. There will be an emphasis on training child care providers and agency staff on inclusion, as well as parent education on how to select quality child care.

In addition, semi-annual San Diego County Early Care & Development Inclusion Institutes will be held. The next institute will include at least three more non-traditional systems (e.g., law enforcement, medical and transportation). The Institute and the ongoing systems coordination activities is being implemented under the auspices of the Special Needs Committee of the San Diego County Child Care & Development Planning Council.

Program and Policy Recommendations

The following are other key areas that should be addressed by KIT and other collaborating organizations as a result of the SB 1703 Inclusive Child Care Program.

1. Implement and sustain systems coordination

There is a ***need for increased, continued and sustainable coordination between the systems that serve children with disabilities and other special needs.*** There are a number of agencies that exist to provide services to families of children with disabilities and other special needs, and individual agencies often meet one or more needs of the family. However, the systems themselves often fail the families in many ways as they are not seamless. While the SB 1703 Inclusive Child Care Program in San Diego County addressed systems coordination and began a collaborative effort to ensure they become seamless, there still remains the implementation and sustainability of this effort.

Families of a young child in particular are often overwhelmed with the process of recognizing and accepting that they have a child with a disability or special need. Once medical or health issues are addressed, the family must begin the process of finding specialists including physicians, therapists, early interventionists and case managers. The early months and years are exhausting and complicated as they are introduced to the State Department of Developmental Services and California Early Start, where hopefully they receive early intervention programs and services in a timely manner. At three years of age their children are transitioned to local school districts where they once again must devote considerable time and effort coordinating therapies and programs. Anywhere along this process of "birth to five" they may also be in need of, or looking for, early childhood programs in natural environments. This search continues through school age and even teen years. While most of these families express a need for child care services so that they can continue to receive income and health benefits, they are often not successful in finding quality child care for their child with a disability. Some may find willing providers; however, with the conclusion of SB 1703, there will be once again ***a lack of training and technical support for the provider who welcomes the child with a disability and for new program staff***. In addition, while the system of identifying, interviewing and securing child care placement was enhanced for families with children with special needs, it runs the risk of becoming extremely time consuming and frustrating again without the support made available through SB 1703.

The ***primary solution is to develop a comprehensive effort to implement and sustain "systems change" that will support families of children with disabilities and other special needs as well as support child care providers who serve children with disabilities and other special needs.*** Specifically, there is a need to ensure that the local child care resource and referral agency assigns ***adequate numbers of trained staff members to assist families in finding quality child care*** and that there be additional funds to ***support ongoing case management*** of children with disabilities who are seeking or have entered child care placement. This case management is critical for tracking difficulties, suggesting interventions or resources, ensuring providers and parents are equally supported in the process and ensuring that the placement will be successful and hopefully consistent or long term. There is also a need to improve access to the Regional Center's purchase-of-service funding for early

interventionists, behavior specialists or therapists so that supports can be delivered to providers in a timely and appropriate manner.

2. Increase opportunities for training and technical support for providers

Future directions should also include ***creating a more comprehensive system of training*** child care providers and ensuring that training is affordable, available geographically across the county, available in English and Spanish, and institutionalized through community colleges, adult education programs, community trainings and through the child care resource and referral agency on an ongoing basis. ***Core curriculum should be standardized*** and designed to support adult learners and different learning styles. This effort would include a training-of-trainers plan so that training and workshops could be offered regularly at conferences and through professional development channels. Training and support could be offered through web casts, video conferencing and chat rooms run by training consultants such as Kids Included Together. This training would be very beneficial to providers who often work all day and attend school part-time. Courses and credit could be offered online through colleges and universities for those providers who are seeking associate degrees, bachelor's degrees and/or master's degrees.

3. Identify and recognize quality programs in the community that can be models for other programs

These would be family child care homes and center-based programs that have committed to inclusion, served children with disabilities, successfully identified community support and collaborations and have developed strategic and fiscal plans that will ensure sustainability. These programs should also work effectively and respectfully with families ensuring their stakeholder voices throughout the process of design, implementation and evaluation of inclusive programming.

4. Reach out to pediatricians, hospitals and clinics, as well as the education community, with information about accessing quality child care for children with disabilities and other special needs as well as all children

Continue educating public health nurses, California Early Start, Local Education Councils and Special Education Local Plan Areas (SELPA) on how to link families with child care resources, an effort begun through the June Institute. Military programs and Native American reservations' health care providers and clinics should also be included.

5. Advocate at the local, state and federal levels for increasing and improving access to, and quality of, child care programs for children with disabilities and other special needs

Raise awareness of both the legal mandate as well as the issue of social justice in providing services for ALL children. This includes ensuring that the local child care and development planning councils involve representation of inclusive child care in all discussions and subcommittee work (e.g., needs assessment, public policy, quality assurance, education and training, marketing and public information, universal preschool, infant-toddler and the First 5 Commissions).