INVESTIGATING THE PRACTICAL APPLICATION OF THE SOCIAL RELATIONAL MODEL OF DISABILITY. EXAMINING EARLY CHILDHOOD EDUCATOR'S INCLUSIVE EDUCATION

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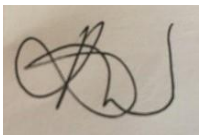
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October 2017

DECLARATION

I certify that the work in this thesis entitled "Investigating the practical application of the social relational model of disability. Examining early childhood educators' inclusive practice" has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree to any other university or institution other than Macquarie University.

I also certify that the thesis is an original piece of research and it has been written by me. Any help and assistance that I have received in my research work and the preparation of the thesis itself have been appropriately acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

The research presented in this thesis was approved by the Macquarie University Ethics Committee (Human Research). Reference number: 5201600667 on 9th November, 2016.

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ABSTRACT

The discussion over whether or not inclusion works is defunct, with research providing evidence that children directly benefit when strategic aspects of environments and intentional teaching are in place. Inclusive education is a human right, and there is growing promise of inclusive education, as explained in the United Nations Convention on the Rights of Persons with Disabilities (CRPD, 2006). However, barriers to the inclusion of children with disability in educational settings remain. Early childhood educators have a social responsibility to advocate for children's inclusive education, yet many educators report uncertainty about how to include children with diverse abilities. The purpose of this study was to identify links between the theory of the social relational model of disability, and educational practice. Bronfenbrenner's ecocultural theory was utilised to identify children within their different contexts. Educators and parents' perspectives of identifying and challenging barriers to doing, and barriers to being, were investigated within three early childhood centres. Eight educators working in early childhood centres in Sydney completed online educator questionnaires, and thirty parents from these centres completed online parent questionnaires. One interview was conducted with a centre director. This sequential design included quantitative and qualitative investigation. Data analysis allowed for identification of barriers within different aspects of early childhood contexts including communication, environments, resources, and attitudes. Through the findings, links were identified between the theory of the social relational model of disability and educational practice, together with gaps in the educators and parent's understandings of inclusion in these three centres. Findings from this study have implications for early childhood centre contexts, policy development of inclusive education, and for educator's inclusive practice.

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CHAPTER ONE: INTRODUCTION

1.1 Chapter overview

The main focus of the present study is on investigating the link between the theory of the social relational model of disability and educational practice, as evident in the reported perspectives and practices of educators and parents within three early childhood centres[1] (referred to as centres, hereafter). This chapter begins with an overview of inclusive education, and then explains the underpinning theoretical frameworks, including the medical model, social model, and social relational model of disability (Thomas, 1999, 2001, 2004). Current inclusive education within Australia is explored, and Bronfenbrenner's ecological theory (1977, 1979, 2005) is used to position the study within an early childhood context. The scope, aims and significance of the study are explained in this chapter, before an overview of the organisation of the thesis is presented.

1.2 Understanding Inclusive Education

The discussion over whether or not inclusion works is defunct, with research providing evidence that children directly benefit when strategic aspects of environments and intentional teaching are in place (Brereton, 2008; Clough & Nutbrown, 2009; Cologon, 2012; Cologon & Salvador, 2016; Connors & Stalker, 2007; Dempsey, 2011; Derman-Sparks, 2004; Mackenzie, Cologon & Fenech, 2016; Martinez-Bello & Martinez-Bello, 2016; O'Brien, 2006). Inclusive education celebrates human difference and diversity, and supports all children, as being uniquely capable and contributing individuals, in their participation (Ainscow Booth, & Dyson, 2006; Brereton, 2008; Carrington et al., 2016; Cologon, 2013, 2014; Mackenzie et al., 2016; Clough & Nutbrown, 2009). When educators practice inclusivity, they respect, value and respond to children's individualities in recognition of daily interactions as opportunities to facilitate inclusion (Carrington et al., 2012; Cologon, 2014). Cologon (2013, 2014) and Reindal (2016) explain that inclusion is based on equality and that, in early childhood centres, this is a social, structural and ethical issue. Inclusion not only incorporates how early childhood policies, practice and environments are organised to meet the diverse abilities but also incorporates ethical questions. Slee proposes that inclusion involves questioning, "Who is in and who is out? How come? And, what are we going to do about it?" (2013, p. 905). Slee (2006, 2011), Lalvani and Broderick (2015) and Reindal

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1 Early childhood centres in the present study incorporate long day care centres, occasional care centres, family day care, multi-purpose centres, preschools and kindergartens, as recognised by the Australian Children's Education and Care Authority (ACECQA). Throughout the present thesis, these early childhood centres are referred to as 'centres'. The three participating centres in the present study are long day care centres.

(2016) propose inclusive education as an educational movement for all students, where belonging, participating and achieving are facilitated through addressing barriers that prevent inclusion. Applying a social relational perspective to inclusive early childhood practice involves identifying and challenging barriers to doing and barriers to being, to facilitate individual children's inclusion (Cologon & Thomas, 2014).

Inclusion is about everyone, and this is the understanding of inclusion referred to throughout the present study. Most often, children from minority groups are excluded (Hobson, 2010; United Nations Children's Fund [UNICEF], 2013). People with disability are the largest minority group in the world (World Health Organisation [WHO], 2011). Therefore, the focus throughout the present study is on inclusion for all children with specific attention on inclusion for children with disability. In the present study, educators' and parents' perspectives on the links between the theory of the social relational model of disability and educational practice are investigated, within three early childhood centres in Sydney, Australia, with attention on educators' and parents' perspectives for identifying and challenging barriers to doing and barriers to being, within the centres (Cologon & Thomas, 2014; Thomas, 1999, 2001, 2004). Anderson, Boyle and Deppeler (2014), Miles and Singal (2010), and Duke et al. (2016), explain that children with disability continue to be excluded, as past exclusionary practice strongly influences current practice. Reindal (2016) and Slee (2013) propose that reflecting on inclusion and exclusion involves ethical considerations, with inclusion reflecting societal values.

Inclusive early childhood practice facilitates children's belonging, and this is important because children are developing their sense of identity and self-esteem (Department of Education, Employment and Workplace Relations [DEEWR], 2009; Docket & Perry, 2005; Clough & Nutbrown, 2009). Current legislation requires educators to practice inclusivity with all children. Education is an opportunity to experience diversity from the perspective of an individualised and humanistic focus (Connor & Gabel, 2010; Convention on the Rights of Persons with Disability [CRPD], 2006, 2016; Lalvani, 2016; O'Brien, 2006). Australia's commitment to inclusive education is evident in the ratification of the Convention on the Rights of the Child (CRC) (1989) and the CRPD (2006). Further evidence of Australia's commitment to inclusive education is identifiable throughout Australian documents including the Early Years Learning Framework (EYLF) (2009) and the Australian Curriculum (ACARA, 2012). Each of these documents identifies the importance of recognising children's diversities and facilitating all children's participation. However, together with these inclusive commitments, it is important to acknowledge that exclusion continues in Australia and worldwide (Anderson & Boyle, 2015; Cologon, 2014; CPRD, 2016; DEEWR, 2015; Graham

& Sweller, 2011; Mackenzie et al., 2016). With medical model perspectives and non-inclusive attitudes towards children with disability remaining, exclusionary practices continue (Barton, 1996; Lalvani, 2013b; Slee 2011, 2013).

1.3 Understanding Disability

In this section, various perspectives on disability are explained as they have shifted over time. Building on the extensive past exploration of the social and medical models of disability within and outside of education, it is important for early childhood educators to actively reflect on whether disability is biological or more multifaceted (Baglieri, Bejoian. Broderick, Connor, & Valle, 2011; Cologon, 2013b; Cologon & Thomas, 2014). Disability is recognised throughout the present thesis from the medical model of disability, social model of disability, and social relational model of disability perspectives (Finkelstein, 1975; Oliver, 2004, 2009; Thomas, 1999, 2001, 2004). Prior to the 1960's disability was understood as existing wholly within a person, and as being caused by impairment – an understanding that has since been referred to the medical model of disability (Oliver, 1996; Thomas, 2004). From a medical model perspective, disability was described as a biological feature of individuals, and was considered a deficit (Thomas, 2004). Obstacles and limitations were viewed as occurring from within people, and potential societal influences or problems were viewed as separate, whereby society was excused of any responsibility (Byrom 2004; Lalvani, 2013b).

Ableism is the discriminatory view of people with disability, where there is a divide between a 'normal' human and the "the aberrant (sometimes pathological) = subhuman" (Campbell, 2012, p. 215). Within early childhood contexts, this idea of a 'normal child' creates ablest impressions that are communicated through language and actions at individual and systemic levels. Cologon and Thomas (2014) argue that, underlying this ableist,[2] medical model, understanding of disability is the assumption that being 'normal' is preferred. Children not fitting into this stereotypical view of 'normal' are therefore seen as deficient, abnormal (Baglieri et al., 2010), and in a "diminished state" (Campbell, 2009, p. 9).

During the late 1950's and 1960's, the medical model of disability and the idea of disability as a personal tragedy were challenged. The social model conceptualised disability as separate from impairment, with disability viewed as the result of limitations from societal, environmental, and attitudinal barriers (Thomas, 2004). Oliver (2004) and Oliver and Barnes (2012) argue that the social model provides a lens for people with impairments to be viewed as more whole than in the medical model, with society and its restrictions preventing or inhibiting participation.

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2 Ableism is expressed through ableist views and ableist practice.

Thomas' social relational model of disability (1999, 2001, 2004) builds on the social model by acknowledging the lived experience of impairment, as well as the social relational implications of disability arising from societal restrictions. From a social relational understanding, disability is a form of social oppression that results from limitations within different contexts and social relationships (Thomas, 1999, 2001, 2004). These socially imposed restrictions are preventable through societal adaptations. Within the social relational model, restrictions are identified within three distinct groups: 1) barriers to doing; 2) impairment effects; and 3) barriers to being (Thomas, 2007) (see Section 2.3.3). In the present study, barriers to doing and barriers to being are investigated within children's contexts, in three centres (explained in more detail in Chapter 2).

1.4 Current Inclusive Education

General Comment 4 on the CPRD (2016) addresses the interpretation and application of Article 24 concerning the right to inclusive education. General Comment 4 was developed by the Committee on the Rights of Persons with Disabilities as concern was expressed that, although global commitment to inclusive education was evident, many barriers continued to exist. Despite the worldwide commitment and developments towards inclusive education, legislation is not yet in line with current practice (Brodin, 2010; Anderson & Boyle, 2015; Cologon & Salvador, 2016). Australia has committed to inclusive education. However, the first Australian report under the CRPD states that obligations to children with disability are not being met and educators are not currently supporting all children's right to inclusive education (DEEWR, 2015). More specifically, the early childhood sector[3] has improved quality of education and care but the non-application of the CPRD remains common (DEEWR, 2015). Researchers such as Anderson and Boyle (2015), Cologon (2014) and Mackenzie et al. (2016) argue that, currently in Australia, there is a disconnect between inclusive expectations and early childhood practice, with the option to exclude children still a reality. Boyle et al. (2011) and Anderson and Boyle (2015) explain that there are divides in policy and practice, and that one of the reasons for this is that Australia is without standards to determine the success of inclusive education, which leads to inconsistent inclusive cultures for children across settings. There are the Disability Standards for Education (DEEWR, 2005) in Australia; however, there are no standards specifically for inclusion.

Inclusive education is understood to be a process open to interpretation, with individual contexts defining their own inclusive cultures (Anderson & Boyle, 2015; Boyle, 2012; Boyle et al., 2011; Curcic, 2009; Nutbrown & Clough, 2006). School culture remains

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3 The early childhood sector referred to here incorporates all early childhood centres in Australia that cater for children birth to five years of age.

relevant to centres' cultures, in the present study, which is the "heart and soul of an organisation and can develop by osmosis or can be influenced by purposeful leadership" (Keefe & Carrington, 2007, p. 31). Boyle et al. (2011), and Graham and Sweller (2011) argue that the lack of a universal definition of inclusive education can be problematic, with each educational setting using "adapted curricula" (Boyle et al., 2011, p. 73). Each centre also makes their own adaptations and individualises their inclusive practice. Graham and Spandagou (2011) and Cologon and Salvador (2016) explain that inclusive education is often misunderstood, with a lack of uniformity across educational settings. Anderson et al. (2014), Anderson and Boyle (2015), Boyle (2012) and Nutbrown and Clough (2007) explain that centres' inclusive cultures are socially constructed and influenced by interconnecting contexts and relationships between children, educators and parents. In the present study, centres are acknowledged as defining their own individualised inclusive cultures. Bronfenbrenner's ecological model (1977, 1979) is utilised to position the present study's inclusive education focus, within early childhood contexts.

1.5 Bronfenbrenner's Ecological Model: A Theoretical Framework for this Study

Bronfenbrenner (1977, 1979) views learners within a social perspective where individuals exist within different influential and interconnecting environments and social contexts (Anderson et al., 2014). Children live within a variety of systems that affect their lives in all areas (Gonzalez-Mena, 2002), and these different systems can be viewed through Bronfenbrenner's ecological theory (Bronfenbrenner, 2005). Bronfenbrenner's ecological theory explains occurrences within and between specific systems as directly impacting on children's behaviour and development, and thus is a chosen framework for the present study (Bronfenbrenner, 2005). Children are acknowledged as being at the centre of Bronfenbrenner's ecological theory, and are recognised as having contributing, influential factors surrounding and interconnecting their "educational ecosystem – resulting in the ecology of inclusive education" (Anderson et al., 2014, p. 28). Bronfenbrenner's ecological theory provides the context for challenging social and environmental aspects of children's systems for their inclusive education, by positioning the present study within early childhood contexts (1977, 1979).

Bronfenbrenner describes five systems that learners exist within, as a "nested arrangement of structures" (1976, p. 5). The innermost system, or microsystem, directly connects with learners at the centre, and surrounding settings impact to varying degrees, dependent on their proximity to the learner. Bronfenbrenner described that "factors of place, time, activity, and role constitute the elements of a setting." (1976, p. 5). Early childhood centres are microsystems with factors affecting children including environmental setup,

resources, relationships, educator attitude, and teaching strategies (Bernheimer, Gallimore, & Weisner, 1990; Diamond & Odam, 1998). A second layer, or mesosystem, acknowledges the interconnections between the different contexts in the microsystem, such as with children's families or connections with other professionals (Bernheimer et al., 1990; Bronfenbrenner 1976; Diamond & Odam, 1998). The exosystem, or third system, includes influences that learners are affected by but are not in direct contact with, such as social and centre policies. Bronfenbrenner describes exosystems as structures that "impinge upon or encompass the immediate settings containing the learner and, thereby, influence and even determine or delimit what goes on there" (1976, p. 6). The macrosystem is the layer beyond this, and incorporates all preceding systems such as the cultural and social beliefs that impact on learners in their microsystem, including attitudes about disability. Variables within and between these systems also impact on learners. The fifth system, or chronosystem, signifies changes over time within and between systems. Relationships and systems interconnect, and aspects of different systems impact each other (Anderson et al., 2014).

Bronfenbrenner (2005) identified the systems as reciprocal influences; and central to inclusive education are reciprocal influences within children's five systems. If an inclusive classroom is recognised as a microsystem, it can be viewed as having inside and outside influences that contribute to inclusion or exclusion. Each of the surrounding systems has potential barriers that directly and indirectly affect children and inclusive practice. Cologon and Thomas (2014) suggest that early childhood educators can make changes in each of these to support children and their inclusion. Familiarisation with these various systems supports educators to identify and challenge potential barriers to doing and barriers to being in centres (Cologon, 2014; Connors & Stalker, 2007; Mackenzie et al., 2016).

The present study draws on Bronfenbrenner's ecological theory (1977, 1979) and the social relational model of disability (Thomas, 1999, 2001, 2004) to investigate how early childhood educators and parents identify and challenge exclusionary barriers within children's contexts in centres. There are a variety of factors within children's systems that interconnect and help or hinder inclusion. Reducing barriers to doing and barriers to being in centres has the potential to directly and positively impact individual children, and their wider societies (Cologon, 2014; Connors & Stalker, 2007; Mackenzie et al., 2016).

1.6 Scope and Aims of the Study

The primary research question in the present study is:

Research Question: Is a link between the theory of the social relational model of disability and educational practice evident in the reported perspectives and practices of educators and parents within three early childhood centres?

In the present study, educators' and parents' perspectives on barriers to doing and barriers to being (Thomas, 2007) were explored within the centres' social and environmental contexts. Data collection was conducted in a sequential design through a mixed methods approach (Creswell & Plano-Clark, 2011). This was done, firstly, through online questionnaires investigating educators' and parents' perspectives on identifying and challenging barriers to doing and barriers to being within the centres. This was followed by a semi-structured interview to gather more in-depth data on an educator's perspective on barriers to doing and barriers to being (Thomas, 2007) within a centre.

1.7 Significance of the Study

The present study has implications for educators, children, parents and policy makers within Australian inclusive early childhood education. Australian research proposes that many educators are struggling to practice inclusivity in early childhood centres and are uncertain how to include children with diverse abilities (Bossaert, Colpin, Pijl, & Petry, 2013; Cologon, 2012; Forlin Chambers, Loreman, Deppeler, & Sharma, 2013; Mackenzie et al., 2016; Valentine, Rajkovic, Dinning & Thompson, 2010; Walker & Berthelsen, 2008). Barton (2008) explains that inclusive education is not always simple to put into practice, with other research suggesting that many Australian educators are concerned about inclusive education (Cologon, 2012; Sharma, Forlin & Loreman, 2008; Tait & Purdie, 2000).

Findings from the present study are particularly significant for positioning the social relational model of disability (Thomas, 1999, 2001, 2004) within Australian early childhood contexts, with implications for facilitating children's inclusion in centres. There is limited research investigating the social relational models of disability in early childhood centres (Cologon, 2012; Connors & Stalker, 2007; Runswick-Cole, 2008; Mackenzie et al., 2016; Nind et al., 2010). It is envisaged that results from the present study will identify educators' and parents' perspectives on barriers and how best to challenge barriers to children's inclusion in centres. This study is significant in contributing to research investigating early childhood educators' and parents' perspectives on challenging barriers for children's inclusion in centres (Brereton, 2008; Cologon, 2014; Clough & Nutbrown, 2009; Mackenzie et al., 2016).

Supporting educators to practice inclusivity encourages respectful practice in centres. "Respectful educators will include all children", and this responsiveness is fundamental to

inclusive practice (Nutbrown & Clough, 2009, p. 192). However, with inclusion regularly misinterpreted and many early childhood educators struggling to know how to practice inclusivity, changes in educator attitudes and awareness is recommended (Armstrong, Armstrong & Spandagou, 2010; Cologon, 2012, 2014; Lalvani, 2013; Mackenzie et al., 2016). It is envisaged that the present study's investigation of barriers and how to challenge barriers will support educators' understandings of inclusion, enhance inclusive practices, and facilitate children's inclusion in centres.

1.8 Organisation of the Thesis

This thesis is presented in six chapters. Chapter One has introduced the study, positioning it within the social relational model of disability and Bronfenbrenner's ecological theory, together with inclusive education within current Australian early childhood contexts. Chapter Two presents detailed explanations of Australian inclusive early childhood contexts, and theoretical perspectives on disability. Literature is explored on inclusive early childhood practice, educator challenges to facilitating inclusion, and barriers to children's inclusion in centres. Chapter Three explains the methods used to collect and analyse data in the present study. Chapter Four presents the integrated results from the study, and Chapter Five draws connections between the study's findings and the relevant research and literature. Chapter Six concludes this thesis with implications for early childhood educators, centres and policy makers' inclusive practice. Limitations of the research, recommendations for future research, and strengths and importance to the sector of the research conclude the thesis in Chapter Six.

1.9 Chapter Summary

In the present chapter, inclusive education was explained and considered within an Australian context. Bronfenbrenner's ecological theory (1977, 1979) was discussed to position the study within an early childhood context. Medical, social and social relational models of disability (Thomas, 1999, 2001, 2004) were explored as the theoretical underpinnings for the present study. The next chapter explores the literature and current gaps in the research.

CHAPTER TWO: LITERATURE REVIEW

2.1 Overview of Chapter

In the preceding chapter, an overview of inclusive education, Australian inclusive education, and the underpinning theoretical frameworks for the present study were explained. In this chapter, inclusive education is firstly defined, before inclusion within an Australian early childhood context is examined. Overviews of three perspectives on disability are explored: the medical model of disability, the social model of disability and the social relational model of disability. This chapter concludes by highlighting research on inclusive early childhood education, explaining where the gaps in research position the present study, and justifying the application of the social relational model of disability for this study.

2.2 Inclusive Education

Education is never neutral, and is a political project that reflects current individual and societal principles (Freire, 1970). Slee (2011) describes *inclusive* education as a political act that challenges the attachment of the tiered value we place on different people, where we consider some more worthy than others. Inclusive education is an ongoing process of exploring an individual's diversities within socially constructed contexts, and where we try to recognise and address how barriers prevent authentic participation (MacRuairc, 2013; Slee, 2011, 2012). When we educate inclusively we do "not attempt to neaten the messes that are school environments", instead acknowledging the multitude of influential contexts that potentially include or exclude children (Anderson et al., 2014, p. 31). It is important to reflect on the purpose of education to make certain educators practise inclusively (Wolfe, 1994; Barton, 1996; Carrington et al., 2012; Slee, 2001a). Furthermore, Slee suggests that inclusive education "invites us to think about the nature of the world we live in, a world that we prefer and our role in shaping both of these worlds" (2011, p. 14).

Cologon (2016) and Reindal (2016) argue that inclusion involves recognising our connectedness as humans, and as free from discrimination. Researchers such as Brereton (2008) and Nutbrown and Clough (2009) posit that all children deserve to belong, and to be heard and learn in their own individual way, consistent with the right of every child to an inclusive education. Oliver and Barnes describe inclusive education as focusing on educating all children (2012); and Prosser and Loxley (2007) explain inclusion as a philosophy based on accepting and embracing children in all their diversities. Anderson et al. (2014), O'Brien (2006), Reindal (2016) and Wilkinson and Pickett (2010) suggest that recognising children's

individualities as increasing opportunities for creating connections improves equality, academic success and community building.

Ballard (2003), Slee (2008, 2011) and Carrington et al. (2012) propose that, when considering inclusion as an issue of social justice, reflecting on barriers to all children's participation in any school is important. Inclusion as a matter of social justice is just as applicable to children in early childhood centres, and is a lifelong human right. Ainscow et al. (2006) and Carrington et al. (2015) explain that inclusion is underpinned by principles of social justice that facilitate participation, respect and rights. Ainscow et al. (2006), Lalvani (2013b), Slee (2001), Ware (2003) and Ballard (2003) explain that inclusive education is not so much about disability as it is about social justice and reforming education to include all. Throughout the present study, inclusive education is recognised as all children's right.

Writers such as Freire (1970) and Dewey (1966, 1975) suggested that teachers have a social responsibility to advocate for justice by lessening oppression and discrimination within education. Freire (1970) believed that education should allow people to take part in the practice of freedom. Freire explained that education was best when focused on people's current lives and contexts, supporting individuals to solve their issues and make changes in their lives (1970). Dewey's concept of democracy "welcomes plurality and diversity and rejects barriers that exclude and divide" (1975, cited in O'Brien, 2006, p. 6). In the present study, inclusion is also recognised as welcoming children's diversities, and challenging barriers as exclusionary. Freire proposed that, to resist dominant discourse, "the radical, committed to liberation, does not become the prisoner of a 'circle of certainty' within which reality is also imprisoned" (1970, p. 39). When considering inclusive education, remaining in the 'circle of certainty' would involve continuing to accept medical model perspectives of disability. To resist the 'circle of certainty', Freire (1998) suggested engaging in critical reflection on social justice issues, as "true reflection leads to action" (Freire, 1970, p.48). Armstrong and Barton (2008), Cologon (2014) and Lilley (2013) explain that ableist practice continues to exclude and marginalise, and suggest challenging the 'circle of certainty' as critical for re-evaluating children's inclusion.

2.3 Approaches to Understanding Disability

Underlying diverse disability perspectives are questions of whether disability biologically resides within people or is more multifaceted with societal and other complicated influences (Cologon & Thomas, 2014). Three models of disability will be explained in the present study: the medical model, the social model, and the social relational model of disability (Cologon & Thomas, 2014; Oliver, 2004, 2009; Thomas, 1999, 2001, 2004). The following overviews

provide foundational understandings of disability for the present study, and will be further built upon throughout this study.

2.3.1 The Medical Model of Disability and Ableism

Within the perspective of a medical model of disability, a person with disability is seen as 'broken' or 'defective', and therefore to be pitied for needing to be 'fixed' or 'cured' (Cologon & Thomas, 2014: Oliver & Barnes, 2012; Ryan, 1971; Slee, 2001a, Thomas, 2004). The focus is on what people cannot do, resulting in the medical model also being referred to as the tragedy or charity model (Cologon & Thomas, 2014). From this understanding, people with impairments are seen as needing sympathy and goodwill (Cologon & Thomas, 2014). Educating children from this perspective involves assimilation, which is not inclusion. Assimilation involves educators seeking to change children to fit within existing centres, as opposed to changing policies, practices and environments to suit children (Armstrong et al., 2011; Curcic, 2009; Lalvani, 2013). Assimilation is not inclusive practice, as it is based on the medical model belief that children with disability are in 'deficit' and not valuable or equal.

The medical model of disability perspective does not take into account the role society plays, failing to acknowledge the influence of people's social contexts on their relationships and lives (Cologon, 2014; Mackenzie et al., 2016; Slee, 2001a; Thomas, 2004; WHO 2002). Slee describes this disablement as a "cultural interplay characterised by unequal social relations" (2001a, p. 386). The medical model views people as living in isolation, as opposed to living multifaceted lives with complex relationships between their various social contexts (Slee, 2001). Mackenzie et al. (2016) argue that, when children are considered from the medical perspective and not individually within their environmental and relational layers, the potential positive impact educators have on children within centres is limited.

It can be argued that underpinning the medical model understanding of disability is a preference for 'normal' people (Cologon & Thomas, 2014). Dominant groups in society tend to define aspects of culture that determine who is and who is not able (Carrington & Robinson, 2006; Slee, 2011; Turner & Louis, 1996), and this social oppression is reinforced "every day by the media, 'care' assessments, medical forms and so on…" (Finkelstein, 2004, p.18). Like other types of discrimination and oppression of minority groups, ableism separates people who are viewed as 'able bodied' from those who are viewed as 'disabled' (McLean, 2008). Ableism considers people without impairments as 'normal' people, and as greater than those with impairments, who are considered 'abnormal people' (Baglieri et al., 2011; Cologon, 2015; McLean, 2008; Thomas, 2004). Alton-Lee describes minority groups as 'one of them' not 'one of us' (2003). From a medical model perspective, people with disability are

seen as 'broken' and lesser than 'able-bodied' people, therefore creating ableist impressions (Cologon & Thomas, 2014).

Within centres, educators with ableist and medical model understandings of disability focus on impairment as negative, and often default to wanting to 'fix' or 'cure' children (Cologon, 2014; Mackenzie et al., 2016). Considering children from this "diminished state" (Campbell, 2009, p. 9) is likely to "result in discrimination, inequity and injustice for children and their families" (Purdue, Gordon-Burns, Gunn, Madden, & Surtees, 2009, p. 135). Researchers such as Cologon (2013, 2015) and Martin (2016) argue that this fails to recognise impairment simply as a single aspect of multifaceted individuals, or to respect people and their diversities. Curcic (2009) and Thomas (2012) argue that inclusive educators should identify flexible approaches towards the concept of a 'normal' child and address preventable restrictions for those with impairments. Ableist educational practices are discriminatory and deficit based; and, as Carrington et al. (2012) explain, effects of exclusion are devaluing and marginalising. Ableism in early childhood contexts directly impacts educator practice, and is detrimental for children's inclusion.

2.3.2 The Social Model of Disability

Mills (1959) describes a problem with the medical model as considering disability as personal problems rather than as social responsibilities. Campbell and Oliver (1996), Oliver (2004) and Oliver and Barnes (2012) outline how exclusion and discrimination that resulted from systems built on the medical model led to the development of the social model of disability. The introduction of the social model turned the "understanding of disability completely on its head" by arguing for impairment being separate to disability (Oliver, 2009, p. 43). Thomas (2004) explains that questions were asked about connections between disability and impairment, with the social model conceptualising disability as separate from impairment and recognising impacts of societal influences.

In the social model, disability is thus considered separate from impairment, with disability defined as difficulties and restrictions experienced as a result of attitudes, environments or society (Oliver & Barnes, 2012; Thomas, 2004b). Oliver and Barnes (2012) explain that the social model views disability as caused by societal restrictions from people, structures, attitudes and institutions, as opposed to something from within individuals as per the medial model of disability. Campbell and Oliver (1996) and Oliver (2004) argue, from a social model perspective, that people with disability are considered as whole, and that society creates disability by failing to provide ways for all people to participate. People and their diversities are recognised and valued as living within societies. From this social model

perspective, society needs to change, not the person, because these problems are socially created. This perspective shifted thinking towards a person being considered disabled when "he or she is socially prevented from full participation by the way society is arranged" (Finkelstein, 1975, p. 34). Oliver (2004) explains that people with disability are an oppressed minority, who experience unaccommodating responses from economic, environmental and cultural influences. Finkelstein (1975) gives an example of this, of a person who uses a wheelchair being unable to access a building due to stairs. This disabling situation is caused by the stairs and not by the person's impairment. Oliver and Barnes (2012) describe this as a revolutionary way of thinking compared to the medical model, where disability was seen as something residing completely within individuals.

Oliver suggests that the social model is about "nothing more complicated than a clear focus on the economic, environmental and cultural barriers encountered by people with impairments" (2004, p. 21). Thomas (2004) and Florian (2007) explain the recognition of humanity as foundational to the social model, with differences recognised and equally respected, and environments and contexts challenged for individuals' learning. Carrington et al. (2012) and Cologon (2016) describe people through the social model as being recognised as living interconnected lives within societies. At different times and places, social constructs are "taken for granted and assumed to be real, with real effects for real people" (Carrington et al., 2012, p. 9). Oliver reminds critics that this model of disability is "only a model (not a theory) – but one that has demonstrated repeatedly, its power to politically mobilize people in campaigns to either advance or defend of disability rights" (2004; as cited in Thomas, 2012, p. 222).

The change in thinking away from the medical model of disability supports the acknowledgment of environments as potentially disabling (Campbell & Oliver, 1996). This shift in thinking also moved away from what Slee (2011) describes as exclusionary practice, where children are separated into pre-determined groups with unequal end points. Thomas's social relational model of disability (1999, 2001, 2004) builds on the social model by acknowledging disability as a combination of lived experiences, unbalanced social relationships, and unequal societal contexts, for individuals living with impairments.

2.3.3 The Social Relational Model of Disability: A Theoretical Framework for this Study

Within a social and social relational perspective of disability, whether or not disability is experienced is dependent on limitations within different levels of society (Reindal, 2008; Thomas, 1999, 2001, 2004). Disability is imposed through the unnecessary practices that exclude people from full societal involvement (Thomas, 2004). Thomas refers to the social

relational *understanding* of disability (1991, 1999, 2001, 2004), which has since been drawn on and/or referred to as a social relational *model* of disability (Cologon, 2016; Cologon & Thomas, 2014; Connors & Stalker, 2007; Mackenzie et al., 2016). Throughout the present thesis, this distinction is acknowledged, and the social relational *model* of disability is referred to, following the aforementioned more recent references. Within the social relational model, disability is recognised as: 1) barriers to doing, 2) impairment effects, and 3) barriers to being (Thomas, 2007). These are discussed next.

1. Barriers to doing

Barriers to doing are socially inflicted restrictions that limit or exclude access to participation, including those that are environmental and economic (Thomas, 2007). In early childhood centres, these can include interaction barriers where a range of communication options are unavailable, participation barriers where a variety of modified resources or activities are not available, enrolment barriers where children are not accepted due to their impairments, structural barriers where building access is limited, or family barriers including a lack of transport or financial difficulties (Connors & Stalker, 2007; Moore, 2012; Thomas, 2007).

2. Impairment effects

Thomas describes impairment effects as "direct and unavoidable impacts those impairments (physical, sensory, intellectual, emotional) have on individuals embodied functioning in the social world" (2010, p. 37). These effects are identified as bio-social, because they are a combination of biologically and socially constructed barriers (Thomas, 2010). Such effects include tiredness and pain that result from experiencing impairments in social contexts. In centres, an example of an impairment effect is a child who is finding it problematic to communicate with her peers. This bio-social effect could be eliminated with the child being given a range of communication options to suit her/his specific individualities. Enabling this communication would be socially valuable, and result in the removal of this biological and social impairment effect.

3) Barriers to being

Barriers to being have been described by Thomas as "psycho emotional disableism" (2007, p. 72), and by Connors and Stalker as "hurtful, hostile or inappropriate behaviour which has a negative effect" (2007, p. 21). These exclusionary barriers occur at individual or organisational levels, and can include intentional or unintentional words or social actions from people known or unknown, to individuals living with impairments (Thomas, 2007). The consequences can affect children's self-image, confidence, belonging, and sense of wellbeing,

are intense, emotional, psychological, potentially long term, and can create adverse impressions of impairments (Thomas, 2007; Connors & Stalker, 2007). In centres, these barriers include patronising attitudes, hurtful comments and language, discouraging interactions, low expectations, and unsuitable behaviours such as staring and talking down (Thomas, 2007). Cologon and Thomas (2014) describe these obstacles as negatively and directly impacting children's self-image and beliefs of what they feel they can and cannot do. Connors and Stalker's (2007) findings (as discussed further in Section 2.5 of this literature review) suggest that barriers to being have significant impacts during the early childhood years, because individuals' identities are forming alongside foundational and potential life-long self-confidence. Early childhood years are a pivotal time for social and emotional development, with individuals being supported or hindered (DEEWR, 2009).

The social relational model of disability (Thomas, 1999, 2001, 2004) builds on the social model of disability by acknowledging impairments alongside relational aspects, by recognising the interplay between impairment and disability, and by acknowledging societal and environmental influences on impairments (Martin, 2013). The potential stresses of these lived experiences are explored through barriers to doing, barriers to being, and impairment effects. The social relational model of disability (Thomas, 1999, 2001, 2004) is an inclusive model, as it distinguishes between "personal restrictions in social settings versus social hindrances that are imposed on top of these and which hinder the individual in achieving vital goals" (Reindal, 2008, p. 145). Equity and equality cannot be achieved through deficit perspectives (McKay, Carrington & Iyer, 2014); and when educators acknowledge the existence of impairments as only a single aspect of a child, they are more likely to recognise the reality of children's lived experiences (Lalvani, 2016; Connor & Gabel, 2010).

It is imperative for Australian educators to recognise "disablement as cultural interplay characterised by unequal social relations" (Slee, 2001a, p. 386). Shifting thinking away from the older models of disability leads to the recognition of impairment as only a single aspect of capable learners (Lalvani, 2016), and promotes reflective and adaptive practice for inclusive education (Martin, 2013). Focusing on identifying and challenging barriers to enable all children's participation (Cologon & Salvador, 2016) can prevent impairments from becoming disabling (Mackenzie et al., 2016; Reindal, 2008), and facilitates children's inclusion in centres.

2.4 Research on Challenging Barriers to Doing and Barriers to Being in Early Childhood Centres and on Inclusive Education

In Australia, commitment to inclusive education is evident through the ratification to the CPRD (2006). However, exclusionary and segregating practices continue, with a current divide existing between inclusive commitment and practice (Anderson & Boyle, 2015; Cologon, 2014; Graham & Sweller, 2011; Mackenzie et al., 2016). Slee (2013) argues that, despite all the focus and talk about inclusion, exclusion remains a present problem worldwide. One of the reasons exclusion remains is medical perspectives on disability continuing to be used to classify children into 'normal' and 'other.' Special education only exists because 'ordinary' centres limit and fail to support children's inclusion (Barton, 1996; Lalvani, 2013b; Slee 2004, 2013). Policy and practice in early childhood centres that exclude children contravene Australia's commitment to the CRPD (2006).

To facilitate true inclusion, it is imperative to challenge segregating and exclusionary practices (Carrington et al., 2015; Lalvani, 2013b; Slee, 2011, 2013; Wrigley, Thomson, & Lingard, 2012). Armstrong et al. explain inclusion and exclusion as "interrelated processes and their interplay constantly creates new inclusive/exclusive conditions and possibilities" (2011, p. 36). Therefore, advocating for inclusive education through eliminating exclusionary practices is advantageous (Slee, 2011; Wrigley et al., 2012). Further to this, Armstrong et al. (2011) and Cologon and Salvador (2016) suggest that, for inclusion to be realised, the possibility of exclusion needs to be removed, and inclusion should be non-negotiable. As Slee argues, "inclusive education is everybody's business" (2011, p. 83), and is a process where we consider the "complex ways in which barriers prevent students accessing, authentically participating and succeeding in education" (Slee, 2011, p. 84).

Cologon (2014), Connors and Stalker (2007) and Mackenzie et al. (2016) suggest that inclusion, as a fundamental aspect of early childhood practice, would encourage educators to critically reflect on and identify how to enhance their support for all children, therefore minimising children's experiences of disability. Slee (2013) argues that, to positively shape future participation and education for all children, current inclusive and exclusive education needs to be questioned. By bringing educators' attention and support to children's equal access to education, practice would be led towards commitments to the CRPD (2006).

Bossaert et al. (2013) and Forlin et al. (2013) explain inclusive education as being often misunderstood, with major confusion existing in Australia on how to practice inclusivity. A widespread barrier to inclusive early childhood education is the misinterpretation of inclusion as being assimilation (Harry, 2005). Slee suggests that we

should not start practising inclusivity by asking, how do we "move the special sector into the regular school and thereby overcome exclusion?", as this is assimilation, not inclusion (2001a, p. 388). Cologon (2014), Lalvani (2013) and Rietvald (2010) describe assimilation as requiring children to be nearly the same, or to learn how to fit into pre-existing environments and early childhood centres. This involves children being close enough to 'normal', and focuses on changing children to fit within pre-existing centres, as per the medical model of disability, leading to marginalisation and exclusion (Ainscow, 2000; Armstrong et al., 2011; Avramidis & Norwich, 2002; Curric, 2009, Lalvani, 2013; Messiou 2006; Rietvald, 2010; Wiebe Berry, 2006). Curcic (2009), Harry (2005) and Slee (2002, 2006) explain that moving children into pre-existing centres may involve co-existence, but that this does not address issues of children being separated into 'normal' and 'abnormal' groups, nor does it guarantee inclusion.

Assimilation fails to celebrate diversities, recognise children's capabilities, or support children's individualities. Research from Berry (2010) and Frankel (2004) indicates that, even when educators have positive attitudes towards inclusion, they can continue to be uncertain about how to practise inclusivity. A common barrier occurs when educators do not view inclusion as an everyday and commonplace practice (Purdue et al., 2009). This leads to the idea of inclusion as an optional extra or special effort, which can create ableist impressions and practices (Mackenzie et al., 2016).

Educators' beliefs, and the way these beliefs are implemented in practice, influences children's inclusion and centres' inclusive cultures (Diamond & Odam, 1998; Carlson Hemmings, Wurf, & Reupert, 2012). When educators acknowledge and welcome diversity as a resource (Brereton, 2008), and increase experiences of inclusive education, early childhood educators are reported to develop increased confidence and positive attitudes towards inclusive practice, and become more effective at teaching all children (Avaramidis & Norwich, 2002; Cologon, 2012; Finke, 2009; Jordan, Glenn & McGhie-Richmond, 2010; Purdue et al., 2009; 2012). Berlach and Chambers (2011) and Carlson and colleagues (2012) argue that educators' understandings of inclusion are critical for facilitating children's inclusion and contributing to inclusive cultures within centres.

Martínez-Bello and Martínez-Bello (2016) suggest that the best place to initiate and implement inclusive education is in educator development and learning programs. Preparing educators to provide for children with diverse needs impacts personal beliefs about inclusion, and leads to influential anti-bias approaches in contextual layers within centres (Martínez-Bello & Martínez-Bello, 2016), which directly affects children (Forlin, 2010; Frankel, 2004; Irwin, Lero & Brophy, 2004). Well-articulated inclusive education development and learning

is important because, as Forlin et al. (2013), Cologon (2012) and Conway (2013) suggest, there are currently disconnects between the aims of teachers' inclusive education development, learning, and outcomes, resulting in large numbers of educators reporting that they do not feel confident educating children with disability. It is necessary for educators to receive support, and changes in awareness and attitudes are essential to link inclusive practice and ideology (Wendelborg & Tøssebro, 2010).

A study conducted by Mackenzie et al. (2016) in Australia investigated educator attitudes towards the inclusion of children with autism in centres, through a social relational perspective (Thomas, 1999, 2001, 2004). Their findings suggest that, when educators' policies and practices follow a social relational perspective, inclusion is possible. More specifically, when educators challenge barriers to doing, impairment effects, and barriers to being, inclusion becomes imbedded (Mackenzie et al., 2016). Identifying how to challenge barriers, and making these strategies accessible to educators, supports the view of inclusion as being ordinary and everyday, as opposed to being an optional extra (Mackenzie et al., 2016).

In Connors and Stalker's (2007) study, the experiences reported by 26 children aged seven to fifteen years were investigated through a social relational model of disability perspective. Although these children were older than the present study's focus on the early years, these findings and identified barriers are transferrable (as explained in Section 2.3.3). Connors and Stalker (2007) conclude that children lacked appropriate and positive language to talk about difference. This has direct implications for educators' support for children's understandings of disability and difference for the benefit of all children's inclusive education. Martinez-Bello and Martinez-Bello (2016) and Derman-Sparks (2004) also identified inclusion as being advantageous for all children. More specifically, their findings identified that, when children are provided with accurate information on differences, this supports them to oppose prejudice and challenge misconceptions (Martinez-Bello & Martinez-Bello, 2016; Derman-Sparks, 2004). Connor and Gabel (2010) and Lalvani (2015) promote discussions with children on disability as part of human diversity, as a moral necessity.

Children benefit from exposure to people's similarities and differences through toys, books, and other age-appropriate resources and interactions, because it encourages respect and minimises prejudice (Harms, Clifford & Cryer, 2014). Incorporating diversities and differences as part of society supports children to move away from disability as a form of social oppression that restricts people from full participation (Thomas, 1999, 2004), and moves society towards upholding inclusive education as the right of every child (Brown &

Nutbrown, 2009). This is important lifelong learning for children's understandings of social responsibilities (Lalvani, 2015; Martinez-Bello & Martinez-Bello, 2016).

The findings from Mackenzie et al. (2016), Connors and Stalker (2007), Martinez-Bello and Martinez-Bello (2016) and Derman-Sparks (2004) are beneficial for the present study's focus on early years centres. As Anderson and Boyle (2015), Boyle (2012) and Nutbrown and Clough (2007) explain, each early childhood centre has its own culture, created by children, educators, parents and community members, which influences its context and inclusive education. Ainscow (2004), Booth (1996) and Slee (2011) describe inclusive school cultures as needing reflective changes to thinking and practice with children, programs, school structures and pedagogy. Reflective changes within inclusive cultures remains relevant to centres. Supporting educators in creating inclusive centre cultures is directly beneficial for children, their families and society (Nutbrown & Clough, 2006).

2.5 Gaps in the Research on Challenging Barriers to Doing and Barriers to Being in Early Childhood Centres and Inclusive Education

Australia's responsibility to inclusive early childhood education is clear; however, legislation is not yet aligned with the CPRD (2006). As Thomas states, "the Convention is not just a paper 'declaration' without any teeth" (2012, p. 212). Biesta (2009) and Thomas (2012) propose that barriers to inclusion can be erased, to allow people with disability freedom and equality, through clear discussions on the purpose and goals of inclusive education (Thomas, 2012). As the CPRD (2016) describes, barriers can hinder inclusive education. In early childhood contexts, inclusive practices and organisations need to be adapted to make certain that children's rights to inclusive education are met (DEEWR, 2015). Thomas explains that there are various ways to ensure that rights are respected to improve inclusion (2012). Identifying key components of inclusive practice and strategies is important for supporting educators in facilitating children's inclusion. Research also suggests that early childhood years are a critical period for encouraging and understanding disability (Favazza & Odom 1997; Innes & Diamond 1999; Killoran et al. 2004; Martínez-Bello & Martínez-Bello, 2016).

Lalvani (2015) suggests that there is little research on educators' understandings of disability and on educators' views on families with children with disability. More specifically, in Australia, there has been limited research on adapting early childhood practice to overcome barriers with the aim of increasing inclusion and decreasing exclusion (Cologon, 2014; Mackenzie et al., 2016). Research examining the social and social relational models of disability in early childhood centres is also limited (Cologon, 2012; Connors & Stalker, 2007; Runswick- Cole, 2008; Mackenzie et al., 2016; Nind, Flewitt & Payler, 2010). Clough and

Nutbrown (2009) and Reindal (2016) argue that research on inclusive education can be challenging, because it takes place in a variety of contexts, and this is the reason for many versions of inclusive education. However, it is important to note that General Comment 4 on the CPRD (2016) provides a shared concept of inclusive education.

As children's development is influenced by their experiences and environments, it is important that educators make certain that these influences are as beneficial and supportive as possible (Moore, 2012). Adapting strategies brings practices and environments closer to inclusive principles (Reindal, 2016). More specifically, children's belonging and full participation can be encouraged by challenging and overcoming barriers in an ongoing commitment to support individual's inclusion, and by regarding inclusion as commonplace (Connor & Goldmansour, 2012, Curcic, 2009: Frankel et al., 2010: Mackenzie et al., 2016; Theodorou & Nind, 2010; Vakil, Welton, O'Connor & Kline, 2009). Supporting early childhood educators' understandings and practices promotes inclusive education as more accessible, and fosters inclusion as an everyday and ongoing aspect of education. Considering inclusion as ongoing is important because inclusive practice permeates and influences all aspects of centres (Derman-Sparks, 2010; Martínez-Bello & Martínez-Bello, 2016).

The present study focuses on identifying and challenging barriers as an ongoing process to enable children's belonging and participation (Cologon, 2014; Dempsey, 2011). Carrington and Robinson (2004) and Clough and Nutbrown (2009) explain inclusion as an ongoing process of identifying and challenging barriers. Adapting practice to address barriers to inclusion involves identifying practical strategies that educators can implement for continuing inclusive education. Understanding the link between theory and practice motivates the research question in the present study (see Section 1.6). Educators' inclusive practice and acceptance of children's diverse abilities not only encourages children to celebrate differences but also challenges ableism and supports children to understand impairment as being an accepted and inevitable difference (Connor & Gabel, 2010). Educators' attitudes and practices promote acceptance and help prepare children for diversities in life.

To promote inclusion as more accessible, the present study challenges misunderstandings and concerns about inclusive education, by investigating adaptations to educational strategies, environments and practices. Inclusive education is recognised as being valuable for supporting children's individualities, distinguishing between differentiation and uniformity, and increasing personal, educational and societal participation (Biklen, 2000; Cologon, 2010; Conway, 2013; O'Brien, 2006). A deeper understanding of potential experiences and outcomes for children with impairments is possible through identifying and challenging specific barriers in centres. Martínez-Bello and Martínez-Bello suggest that, if

inclusion involves identifying and eliminating barriers, then educators need to ask "whether their classrooms are acting as barriers to inclusion?" (2016, p. 4). Is there only one way of doing things in an early childhood centre, or can practices be adapted to suit the changing needs of children? Mackenzie et al. (2016) argue that, when practices, environments and policies are adapted, children with impairments can be more authentically included in early childhood centres.

The present study thus investigates the gap between theory and practice in centres, with a focus on investigating the link between the social relational model of disability and educational practice as evident in educators' and parents' perspectives, within three early childhood centres. Bronfenbrenner's ecological framework positions the study within early childhood contexts (1979, 1979). Educators' and parents' perspectives on barriers, and on how to challenge barriers, will be compared. Identified inclusive strategies have implications for educators' future inclusive education practice, development and learning.

2.6 Chapter Summary

Inclusive early childhood education is multifaceted. The review in this chapter of literature demonstrates the need to continue moving towards upholding Australia's current commitment to inclusive education. Identifying and recognising how to challenge barriers to children's inclusion in centres will directly support inclusive early childhood practice. The social relational model of disability (Thomas, 1999, 2001, 2004) provides an appropriate perspective for understanding impairments, disability and barriers to inclusion; while Bronfenbrenner's ecological theory (1977, 1979) presents a lens to investigate this within early childhood contexts. The next chapter outlines the methodology and research design of the present study.

CHAPTER THREE: METHODOLOGY

3.1 Overview of Chapter

The previous chapter outlined the literature review and positioned the arguments for completing the present study. In the present study, educators' and parents' perspectives on identifying and challenging barriers to children's inclusion in the three participating centres were investigated, through the social relational model of disability (Thomas, 1999, 2001, 2004) and Bronfenbrenner's ecocultural theory (1977, 1979). The present chapter presents the approach to the study, ethical considerations, data collection, and data analysis methods. The chapter concludes with the limitations of the present study.

3.2 Approach to the Study

In order to achieve the aim of this study, a case study research approach was adopted, which followed a mixed methods design with a pragmatic worldview (Creswell & Plano Clark, 2011). Pragmatism is common for mixed methods research, and was chosen for the present study as it is open to investigating and solving real-world problems and social structures (Creswell & Plano Clark, 2007; Feilzer, 2010). This flexible approach allowed concentration on the consequences and questions of inclusive early childhood education, which was not limited by the methods or type of data collected (Creswell & Plano Clark, 2011; Harwell, 2011). A pragmatic worldview was advantageous for examining this real-world focus, as it allowed the flexibility to choose research methods that specifically suited the study's focus and questions, while remaining open to the emergence of unforeseen data (Creswell & Plano Clark, 2011; Feilzer, 2010).

The present study followed a fixed mixed methods design, where the quantitative and qualitative methods were predetermined (Creswell & Plano Clark, 2011; Harwell, 2014). Quantitative and qualitative data presented different perspectives, each with its strengths and limitations (Harwell, 2014). Evidence and depth beyond a single method was needed in the present study, to enable strengths of one method to compensate for limitations of the other (Creswell & Plano Clark, 2011; Walliman, 2011). Offsetting this potential method bias facilitated a combined focus, for a more thorough understanding of the topic (Creswell & Plano Clark, 2011; Harwell, 2014).

This mixed methods approach followed a sequential plan (Creswell & Plano Clark, 2011). Initially, quantitative and qualitative data collection was conducted simultaneously though online questionnaires, with equal priority given to each type of data. Data from the questionnaires were collated and analysed to inform the semi-structured interview. This

sequential design allowed for "rigorous examinations of promising educational ideas" (Harwell, 2014, p. 22). Creswell and Plano Clark (2011) explain this approach as being beneficial when exploration and an explanation are required from more than a single data source. During analysis, data were considered separately and then merged for overall interpretation (Bryman, 2012; Creswell & Plano Clark, 2011). Descriptive statistical results were compared and contrasted, and qualitative data were used to support and strengthen the analysis (Braun & Clarke, 2006; Harwell, 2014). Triangulation of combined methods through a pragmatic view guided the deductive and inductive design, allowing the mixed methods approach to investigate this social phenomenon (Feilzer, 2010; Walter, 2013).

3.3 Ethical considerations of the study

The ethical aspects of this study were considered and approved by the *Macquarie University Human Research Ethics Committee* (Reference: 5201600667). A copy of this approval is in Appendices One and Two. This research met the requirements set out in the *National Statement on Ethical Conduct in Human Research* (2015). Voluntary Participation was explained in the information letters that invited educators and parents to the study (Appendices Four and Five). Individual consent was given through voluntary completion of the online questionnaire. Respondents were free to withdraw at any time, and were given details for support if distressed. Participants who met the criteria for the interview were invited to indicate their interest at the completion of the questionnaire (Appendix Six). Participation was explained as voluntary, and Molly (pseudonym) the interviewee was contacted privately to arrange a suitable interview time. Prior to the commencement of the interview, Molly was reminded that participation was voluntary, and she was free to withdraw at any time. To maintain confidentiality, any unique identifiers were modified and/or disguised, with each participant being allocated a code name; and all data were stored in a password protected computer.

3.4 Data Collection

In total, three centres participated in the present multi-case study, to allow concentrated and rigorous investigation. Initially, two centres participated in the study, and later a third centre was recruited to increase the number of respondents. Lambert (2003) and Walliman (2011) describe case studies as valuable research tools, in particular for investigating people within their varied contexts. This multi-case study allowed for data to be considered in detail through cross-centre comparisons and analysis (Lambert, 2003). Another advantageous feature of this multi-case design is the flexibility it allowed to choose the specific design of the present study (Walliman, 2011). This study's approach was designed to holistically investigate barriers and

adaptations to inclusive early childhood education, for a more complete understanding of inclusive implementation (Creswell & Plano Clark, 2011).

3.4.1 Selection of Centres

Centres with enrolled children aged between zero to five years that were located within geographical proximity to the site of the present research, were invited to participate in the present study. This decision was aimed at supporting the researcher when traveling to conduct interviews. Initially, two centre Directors were informed of the study via email, and were invited to participate (Appendix Three). After the two Directors agreed to participate, information forms with links to the online questionnaires were sent. Directors emailed these participation forms to educators and parents with enrolled children in their centres (Appendices Four and Five). This information and invitation process was also followed when contacting the third centre.

3.4.2 Online Questionnaires

The primary data collection was for separate educator and parent online questionnaires which took approximately 30-45 minutes to complete. The sample sizes were open, as participation was voluntary for educators and parents with children enrolled at the three participating centres. These questionnaires were open for three months, and were disseminated through Macquarie University via Qualtrics online. Questions were written concisely with simple wording, to encourage participation and responses (Wallamin, 2011). This flexible approach was chosen so as to access high numbers of educators and parents within the time and cost parameters of the study (Walliman 2011; Walter, 2013). Ten educator questionnaires were started, with eight completed (80% completion rate). 32 parent questionnaires were started, with 30 completed (94% completion rate). The educator questionnaires consisted of 27 questions (Appendix Seven), and the parent questionnaires comprised 17 questions (Appendix Eight). The questionnaire topics and types of questions are explained in Table 3.1. Table 3.1 also indicates the questions that were the same in both the educator and parent questionnaires.

Table 3.1: Topics explored in the questionnaire

Educator questions	Parent questions
Background questions on work experience (C), education (C and O), and support (C and O), for working with children with disabilities, sharing training with other educators (O), room leaders (C), local available supports (O), IFSP experience (C), inclusive understandings (L)	Background questions on enrolled number of children in the centre (C), ages of enrolled children in the centre (C), length of time with enrolled children in the centre (C), any children with disability (C), if so had the disability been diagnosed (C)
Personal experiences with the centre (L)	Personal experiences with the centre (L)

Communication within centres (L)	Communication within centres (L)
Resources, general environment and equipment (L)	Resources, general environment and equipment (L)
Children's environmental barriers, if so how were they overcome? (O)	Children's environmental barriers, if so how were they overcome? (O)
Children's communication barriers, if so how were they overcome? (O)	Children's communication barriers, if so how were they overcome? (O)
Children's attitudinal barriers, if so how were they overcome? (O)	Children's attitudinal barriers, if so how were they overcome? (O)
Children's resource barriers, if so how were they overcome? (O)	Children's resource barriers, if so how were they overcome? (O)
Children's other (self-identified) barriers, if so how were they overcome? (O)	Children's other (self-identified) barriers, if so how were they overcome? (O)
Disability definition (O)	Disability definition (O)
Inclusion definition (O)	Inclusion definition (O)
Barrier definition (O)	Barrier definition (O)

Key for Table 3.1: (C) are closed-ended questions, (O) are open-ended questions and (L) are Likert-scale questions

Quantitative data were collected through closed-ended questions, with categories and choices supplied (Creswell & Plano Clark, 2011). This quantitative data collection was considered important, because as Walter (2013) explains, it draws out "the meanings, perception, understandings that individuals and groups attach to behaviours, experiences and social phenomena" (2013, p. 20). A five-point Likert scale was also used to collect quantitative data, and to record responses rating how strongly participants agreed or disagreed with statements given (see Table 3.1) (Creswell & Plano Clark, 2011; Walliman, 2011). The Likert scale allowed educators' and parents' perceptions on the same statements to be compared, for overall scaled scores (Creswell & Plano Clark, 2011; Walliman, 2011).

Qualitative data were collected through open-ended questions, where respondents were free to answer in their own words and elaborate with more detailed information (see Table 3.1) (Walliman, 2011). The open-ended questions aimed to make meaning from responses and personal experiences of inclusive early childhood education, as well as providing more contextual details (Creswell & Plano Clark, 2011; DeVaus, 2013). Examples of included open-ended questions were educators' and parents' definitions of inclusion, barriers to inclusion, and disability (Appendix Ten). Although these questions were more time-consuming for participants to complete, they enabled freedom of expression to qualify responses on challenging barriers, without any potential bias or restriction from pre-determined responses (Creswell & Plano Clark, 2011; Walliman, 2011). Although the open-

ended questions permitted unplanned responses and required a different approach to analysis, they added depth to the data not possible from closed-ended questions alone (Walter, 2013). In combination, these mixed methods enabled a more comprehensive view of early childhood inclusive practice, and allowed comparisons between different contexts in the three centres (Creswell & Plano Clark, 2011).

3.4.3 Interview

The semi-structured interview was designed to sequentially follow the educator questionnaires. Interview topics were written with the aim of investigating merged quantitative and qualitative data collected from the questionnaires in more detail (Appendix Nine). This sequential design provided flexibility during the study, with data from the questionnaires being adapted for the interview (Feilzer, 2010). The interview selection criteria were provided by room leader participants, who completed an educator questionnaire, and who volunteered for an interview. The plan to locate interview volunteers involved participants leaving their details on completion of their questionnaire, which were to be de-linked. However, during the initial stages of the study, an issue with Qualtrics resulted in respondents being unable to leave their contact details. Attempts were made to identify the four interview volunteers by asking the centre directors to explain this situation to educators in their centres and ask those who had volunteered to contact the researcher directly to make interview arrangements. As none of the initial interview volunteers came forward, these four potential participants were unable to be identified and thus interviewed. In centre three, one interview volunteer was identified, who then participated in an interview in the present study.

The semi-structured interview allowed in-depth data collection in a less intrusive style than a more formal interview. The order of questions and the explored contexts remained flexible and responsive to the participant (Braun & Clarke, 2014). As Walliman (2011) explains, the interviewer in such semi-structured method can encourage further responses and clarify any misunderstandings. Topic areas were organised for discussion without an exact set of questions; and as Braun and Clarke (2014) suggest, this flexible approach enables the more complex aspects to be elaborated through further questioning and clarification. Examples of interview topics that expanded on collated data from the questionnaires included: strategies for encouraging inclusion; inclusion in practice; examples of medical and social relational model thinking in practice; training; mentoring; and how to challenge barriers. The semi-structured interview enabled a deeper and more multi-faceted focus on the respondent's perspectives and personal experiences than the questionnaires alone (Travers, 2013).

3.5 Data analysis

3.5.1 Analysing Quantitative Data

The raw quantitative data were collected from the online educator and parent questionnaires. Due to the sample size of the present study, meaningful tests of statistical significance were not suitable. Therefore, descriptive statistics were used to summarise pertinent data (Harwell, 2014), which Walter (2013) asserts are critical in supporting the researcher to clarify matters or problems. In the present study, quantitative data were analysed with the aim of identifying and challenging barriers to children's inclusion in centres. This quantitative data analysis followed a deductive theory, as it began with the social relational model of disability (Thomas, 1999, 2001, 2004) and then went on to examine the validity of this theory within the three centres in the study (Walter, 2013). Braun and Clarke describe this approach as "theory testing and deducing" (2006, p.89). The social relational model was the theoretical framework (Thomas, 1999, 2001, 2004) considered prior to the development of the study, and formed the foundation of the questionnaires (Walliman, 2011). Collected data relied on the probability theory to investigate descriptive statistical results that corresponded to challenging barriers to children's inclusion in these centres (Harwell, 2011).

3.5.2 Analysing Qualitative Data

Qualitative data were collected in the questionnaires and in the interview. These qualitative data were transcribed and analysed with *NVivo qualitative data analysis software*, Version 11 (QSR International, 2015). Inclusive barriers were investigated within the three centres through a naturalistic approach (Harwell, 2011). As these educators and parents were involved in the multi-faceted aspects of these centres, they were acknowledged as being able to interpret and bring meaning to the data (Harwell, 2014; Lambert, 2006; Walter, 2013).

A thematic analysis approach was used to identify themes from the data that either already existed or emerged through this study (Braun & Clarke, 2006; Walter, 2013). Thematic analysis involved "identifying, analysing and reporting patterns in the data" (Braun & Clarke, 2006, p. 4). First-pass coding was based on the frequency of themes identified by the researcher and from collated full responses, collated definitions, and text query searches. This process resulted in certain data being in more than one node[4]: for example, inclusion definitions were in both the medical model and the social relational model nodes. On completion of this first-pass coding, there were many specific nodes that appeared too broad to analyse clearly. Sharma et al. (2008) describe thematic analysis as requiring the

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4 A node is the name given to a group of data in NVivo qualitative data analysis software, Version 11 (QSR International, 2015).

identification of themes that depict the qualitative fullness of the phenomenon being investigated. First-pass coding did not yet identify the present study's themes.

During second-pass coding, data were collapsed into parent[5] and child nodes[6] to combine similar themes and organise the data more clearly. An example of this second-pass, clustered coding was a workplace support parent node, with child nodes underneath of local supports, mentors, individual family service plans[7], and individual education plans[8]. These collapsed nodes more clearly defined the data, as emerging themes moved beyond simply describing groups to identifying explanations and interpretations (Harwell, 2014). Second-pass coding facilitated more in-depth data analysis; or as Lalvani describes, "broader conceptual ideas" (2015, p. 382) were defined.

Finally, the interview transcript was included and three new nodes were added: children's involvement in inclusion, workplace challenges, and inclusion changes over time. To understand complexities in the data analysis, the researcher read, re-read and organised data, in a process Simons explains as "dancing with the data" (2009, p. 140). Analysing in *NVivo qualitative data analysis software*, Version 11 (QSR International, 2015), supported ongoing engagement and familiarisation with the data, which process has an aim to soak ourselves in the data (Willis, 2007). This immersion enabled focused attention on identifying patterns in data (Willis, 2007); and as Lambert (2003) suggests, this strengthened analysis through deep understanding. This thematic analysis process supported familiarisation and consideration of the data from multiple angles, which allowed the researcher to make sense of and identify the data themes (Braun & Clarke, 2006).

Inductive codes were identified as they emerged, and themes were used to move focus beyond simple descriptions, to ascertaining how the participant's responses linked to the social relational model (Thomas, 1999, 2001, 2004) and the present study (Willis, 2007). Word maps were used in the present study to visually display vocabulary from the respondent's definitions of disability and inclusion (see Sections 4.2, 4.3). Word maps were used to graphically organise the 40 most commonly used words in educators' and parents' definitions, to highlight respondents' dominant perspectives on disability and inclusion. This qualitative analysis was inductive, as explanations were constructed from the participants' responses rather than being pre-determined (Bryman, 2012; Harwell, 2014). Braun and Clarke

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5 Parent node is a main heading used to organise data in NVivo qualitative data analysis software, Version 11 (QSR International, 2015).
6 Child node is a subheading under a parent node, to organise data in NVivo qualitative data analysis software, Version 11 (QSR International, 2015).
7 Individual Family Service Plan (IFSP) is documents and processes of identifying and focusing on outcomes for children and their families.
8 Individualised Education Plan (IEP) is documents and processes concentrated on facilitating an individual child's inclusive education.

describe this as working from the data up (2006), where a social phenomenon is identified and researched prior to a theory being developed to explain the pattern (Walliman, 2011). This multi-directional analysis required reflexivity throughout, to ensure awareness of potential researcher bias (Willis, 2007).

3.6 Reliability analysis

An independent assistant was trained to independently code a random sample of educator and parent open-ended responses, and to identify the represented models of disability. This process of double-checking the data had the aim of establishing the reliability of the coding system for data analysis. Comparisons between the original coding and assistant's coding agreed with 97% accuracy on the random sample.

3.7 Limitations

The present study was purposefully designed within the limitations of time constraints, which may have affected the generalisability of the results. The study's collated results may also be ungeneralisable to the wider population because the focus was on trends within and between three centres in Sydney, Australia (Wallamin, 2011). Data were collected and analysed together from the three centres, therefore responses from the individual centres were not considered. From all parent participants, only one parent respondent in the questionnaire had a child with disability, which leaves 97% (n=29) of parent respondents without a child with disability. Therefore, the results may not accurately reflect perspectives of parents with children with a disability, or diverse educator and parent perspectives, beyond those from the three participating centres. Furthermore, children were not directly involved in the study, resulting in children's perspectives not being included. In future research, a greater diversity of perspectives could be investigated from a wider range of centres, to address these limitations.

Initially, two child care centres were invited to participate in the present study, as it was estimated that this would give sufficient responses. As there was a lower response rate than anticipated, this study was opened to a third centre with the aim of increasing the participation rate. The low response rate for the interviews was affected by participants being unable to leave their contact details and thus remaining unidentifiable. To address this in future research, specialised software support could be incorporated into the study preparation. There was a single interview conducted in the present study. Wallamin (2011) explains that in-depth interviews with smaller groups of participants leads to data being ungeneralisable to the wider population.

There is also potential bias in an interview where the researcher conducts the face-to-face interview and then codes the data (Cresswell & Pano-Clarke, 2011). In addition, the researcher in the present study has had 16 years' experience as an early childhood educator: it is acknowledged that this could have influenced the interview questions data analysis (Walter, 2013).

A combination of open-ended, closed-ended and Likert scale questions were used throughout the questionnaires. A potential limitation of incorporating closed-ended questions is identified by Wallamin (2011) and Walter (2013), who suggest that closed-ended questions limit possible responses. This potential limitation was identified; however, closed-ended questions were included for their ease of response, and for collecting data to compare educators and parent responses.

Several statements in each questionnaire were posed in negative and positive terms, because as Walter (2013) describes, this encourages deeper reflection prior to a response. An example of this from the educator's questionnaire, Question 17 was, *I am satisfied with how I communicate with families*, compared to *I experience communication barriers with families* (Appendix Seven). Several responses across these negative and positive statements appeared to give conflicting opinions, indicating that some educators may have responded with what they thought was the correct response, which differed from what was experienced. Therefore, some of the results may not be generalisable from this study; however, these discrepancies have been discussed in the thesis results and discussion chapter.

3.8 Chapter Summary

This chapter presented the mixed methods research design, data collection methods, and data analysis approaches, used in this study. The following chapter reports on the findings of the data in relation to the research questions.

CHAPTER FOUR

4.1 Overview of Chapter

In the previous chapter, the methodology of the study was outlined. The mixed methods research design, data collection methods and data analysis of the present study were explained. The present chapter presents the key results of the study. The presented results focus on educators' and parents' perspectives on identifying and challenging barriers to children's inclusion in centres, with specific attention to barriers to doing and barriers to being. Results begin with educators' and parents' definitions of and attitudes towards disability, and to barriers to inclusion and inclusion for children. The presented results then move on to educators' and parents' perspectives on barriers in centres, and how to challenge these barriers, within the areas of communication, resources, environment, and self-identified barriers. Educators' and parents' inclusive reflections are also presented and discussed. To begin the present chapter, firstly, contextualising information is presented.

4.2 Contextualising the Study

In Section 4.2, demographic data of the educators and parent participants are presented in an overview of the present study. Figures 4.1, 4.2 and 4.3 provide data on educators' highest level of education, whether educators were in the position of room leader, educators' work experience with children with disability, and whether a child with disability was enrolled in centres or groups at the time of them completing the questionnaires. Figure 4.1 presents educators' highest level of education, with qualifications ranging from certificate three[9] to masters[10] (see Appendix Eleven for educators' full demographic data table).

In the present study, 50% (n= 4) of educators were Diploma educated, and 25% (n= 2) had a master's qualification. Molly (pseudonym for the interviewee) had completed a three-year early childhood degree, with a fourth year in special education, and a postgraduate certificate in inclusive education.

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[9] According to Australian Children's Education and Care Authority (ACECQA), a certificate three qualified educator holds an approved certificate three qualification.
[10] According to (ACECQA), an early childhood teacher holds an approved qualification at either bachelor or master's level.

Figure 4.1 Educators' highest level of education

Working towards certificate three ■ Diploma ■ Degree ■ Masters
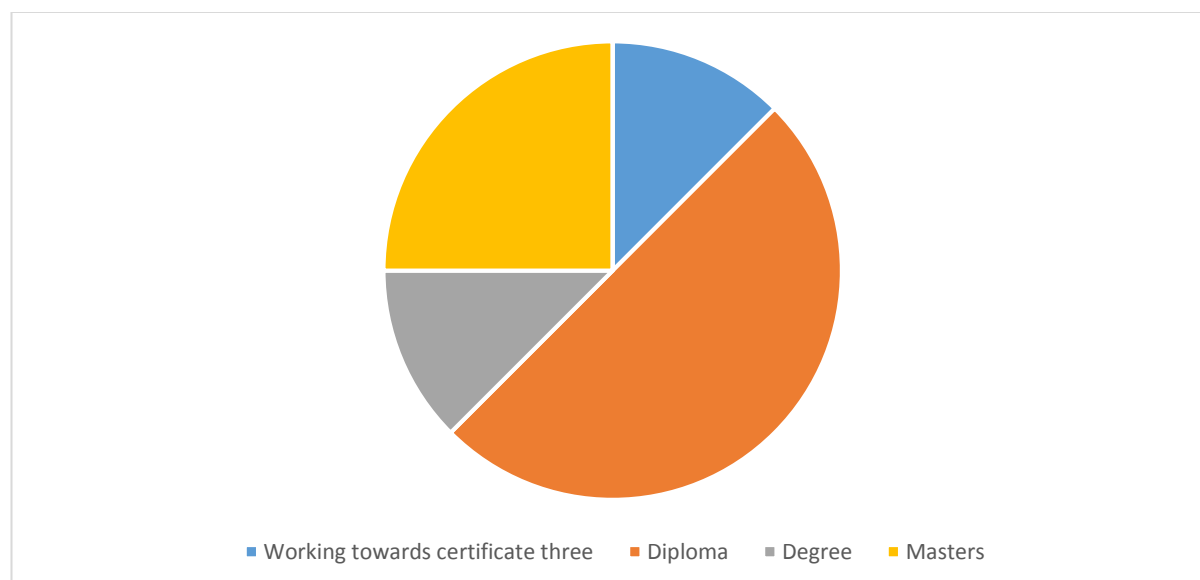
The educator respondents had worked in their centres for between nine months and nineteen years, with an average of five and a half years across all eight educators. Educators had worked in the early childhood sector for between one-and-a-half years and twenty-five years, with an average of eight-and-a-half years across the eight educators. 50% (n=4) of educators had worked in their current centres for the entirety of their working career in the early childhood sector. Figure 4.2 presents how many educator respondents were or were not room leaders at the time of completing the questionnaire.

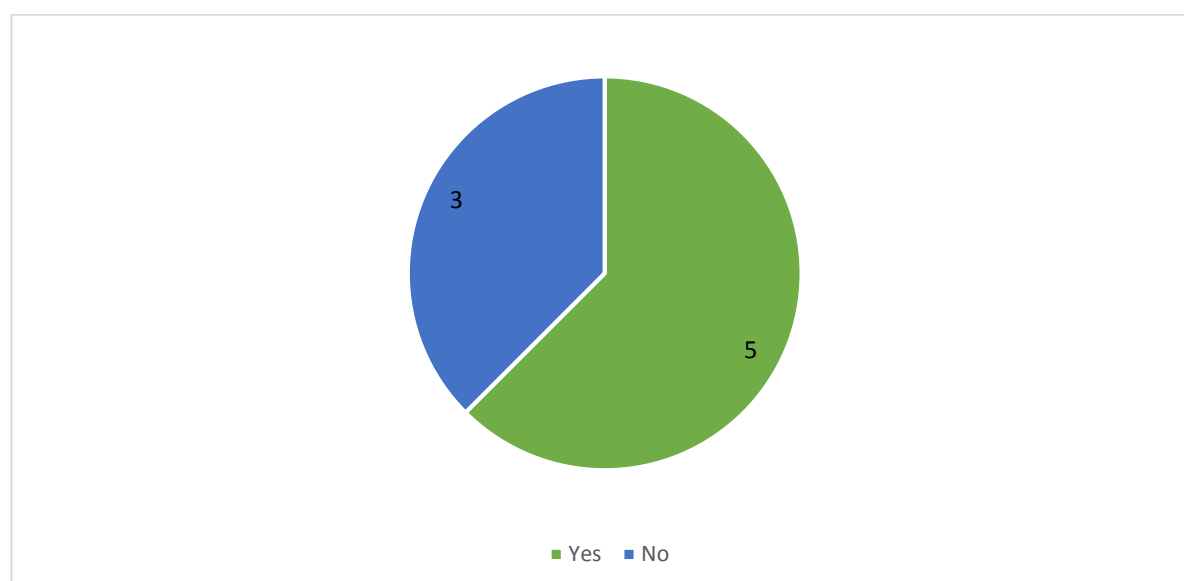**Figure 4.2: Room leaders**

■ Yes ■ No

Figure 4.3 presents educators' work experience with children with disability throughout their careers, and educators' present work with children with disability enrolled in their centres and/or in their groups at the time of completing the questionnaire.

Figure 4.3: Educators' work experience with children with disability
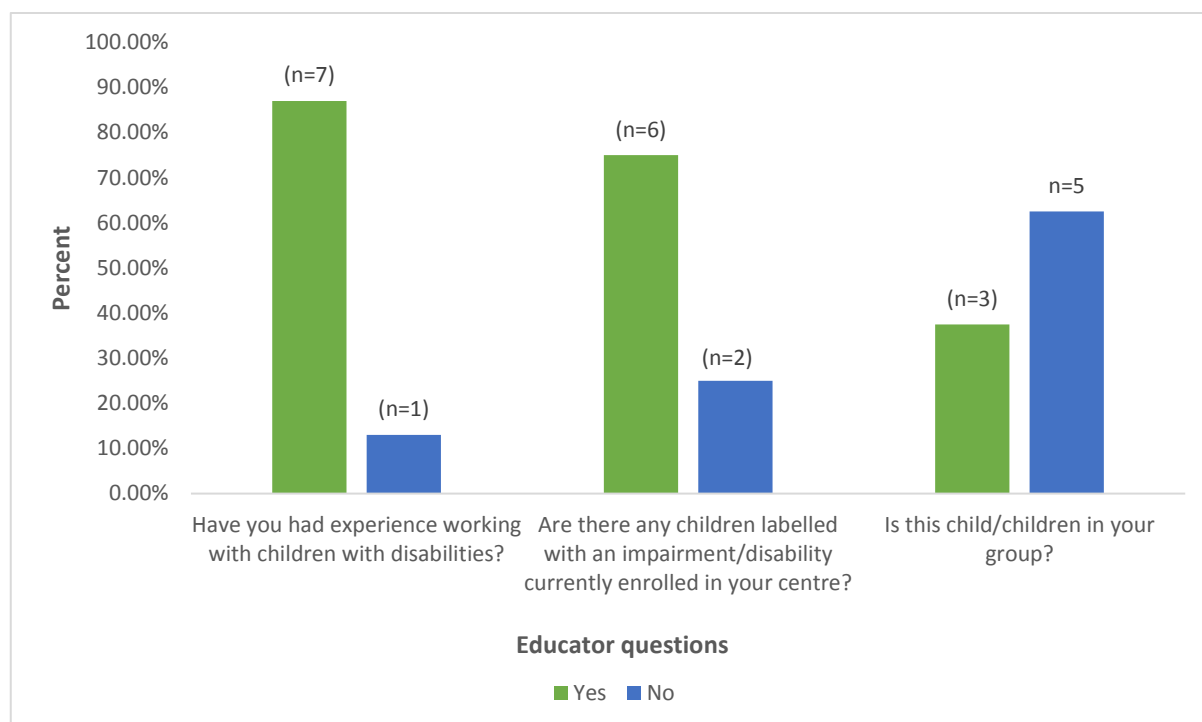
Figure 4.3 presents data indicating that most educators had experience working with children with disability, as well as most having an enrolled child with disability in their centre when completing the questionnaire for the present study.

Parents' demographic data presented in Figures 4.4, 4.5 and 4.6 indicate how many enrolled children parents had in the centre, ages of enrolled children, overall length of time with enrolled children in the centre, and parents who had a child with disability (see Appendix Twelve for parents' full demographic table). Figure 4.4 presents the ages of the parent respondents' children who were enrolled in the centres at the time of completing the questionnaire. According to question one responses, for the 30 parent respondents, there were 39 enrolled children in the centres.[11]

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11 This resulted in nine enrolled children's ages not accounted for in Figure 4.4. This may have been due to some children being the same age, or in the same age bracket, as other children in their family.

Figure 4.4 Ages of parent respondents' enrolled children
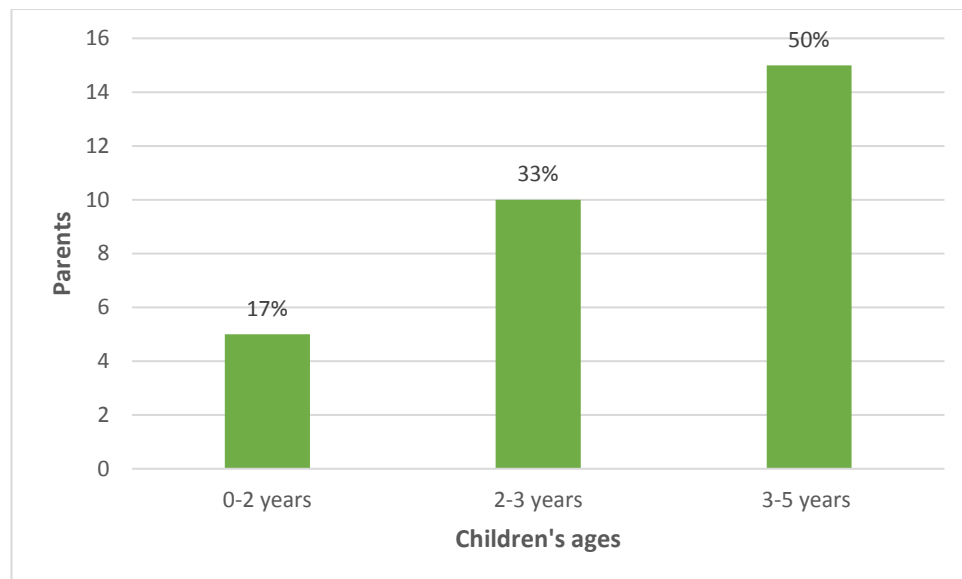
Figure 4.5 presents data on how long parents had children enrolled in their centre.

Figure 4.5: Length of time parents had children enrolled in their centre
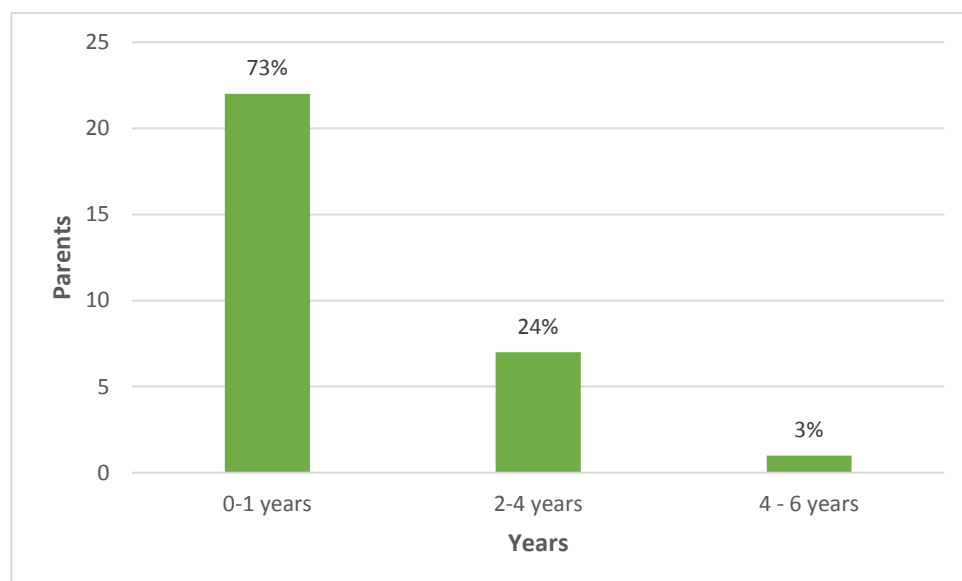
Figure 4.6 reports an important point for the present study: that the majority of parent respondents did not have a child with disability at the time of completing the questionnaire. Collated demographic data provided in Section 4.1 set a contextual overview of the educator and parent respondents for the present study. Educators and parents were asked to define disability, barriers to inclusion, and inclusion. Responses are compared throughout the present chapter, with educators' and parent's disability definitions discussed now in Section 4.3 (see Appendix Ten for all respondents' disability definitions).

Figure 4.6: Parent respondents with a child with a disability

Legend:
- Parents with a child with a disability (green)
- Parents without a child with a disability (blue)

Values shown: 1 (green), 29 (blue)
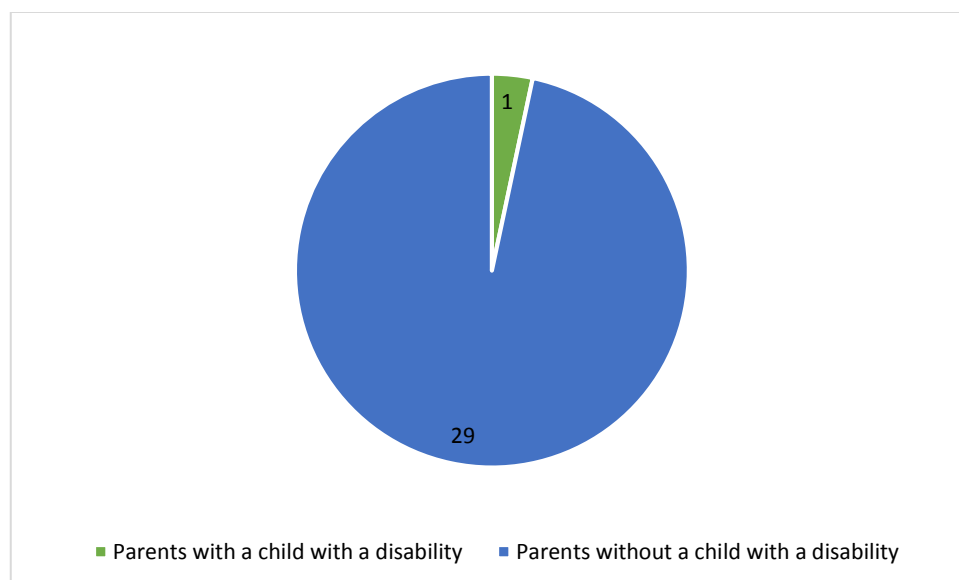
4.3 Educator and Parent Definitions of Disability

The majority of educators, 75% (n= 6), and 100% (n=30) of parents' definitions of disability, included a medical model of disability or ableist words. The 40 most commonly used words by educators included, when defining disability, are displayed in Figure 4.7[12]. Word maps were used to graphically organise the 40 most common words used in disability and inclusion definitions. Separate word maps are presented for educator and parent definitions, to highlight dominant perspectives on disability and inclusion throughout the present study (see Section 4.3 and 4.4).

In Figure 4.7, the perspectives presented in educators' disability definitions are highlighted. The five most commonly used words, in descending order from the most common, were condition, physical, society, mental, and ability. Examples of educators' disability definitions, that referred to children through a medical model of disability or with ableist words, include the following:

> *Any physical condition that impacts on one's ability to perform tasks or participate fully and confidently (educator five, questionnaire).*

> *A physical or mental condition that might limit someone's ability to function (educator six, questionnaire).*

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12 The larger the words appear in the figure, the more regularly the word was used in the definitions.

Figure 4.7: Educators' disability definitions
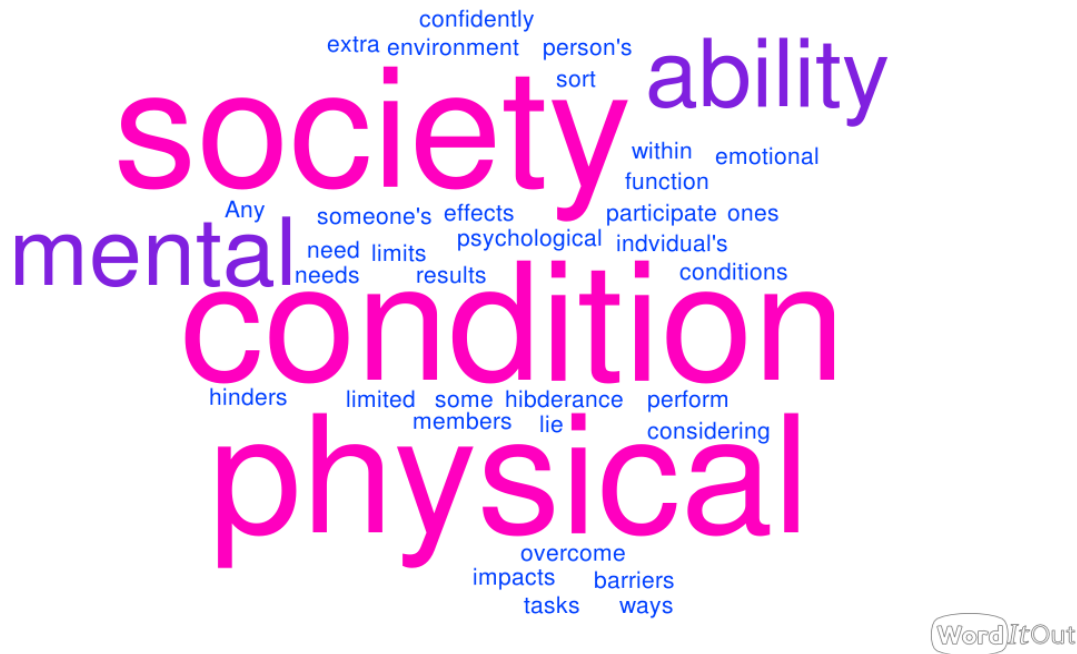
Two examples of educators' disability definitions that referred to children through a social perspective of disability are as follows:

I understand that disability does not lie within a person, but is a construct of society. Disability results from society not considering the needs of all its members and not providing ways for them to be included (educator three, questionnaire).

A person who is limited by their environment (educator eight, questionnaire).

Even with educator definitions of disability predominantly indicating a medical model of disability and/or ableist impressions, social perspectives of disability were also present.

The 40 most commonly used words throughout parents' definitions of disability are illustrated in Figure 4.8.

In Figure 4.8, the perspectives in parents' disability definitions are evident. The five most commonly used words, in descending order from the most common, were physical, condition, normal, being, and disability. Examples of parents' disability definitions that referred to children through a medical model of disability or with ableist words include the following:

A physical or mental disadvantage when compared to a normal functioning human being (parent seventeen, questionnaire).

Something that hinders a person from doing what the norm is doing (parent twenty eight, questionnaire).

Figure 4.8: Parent's disability definitions
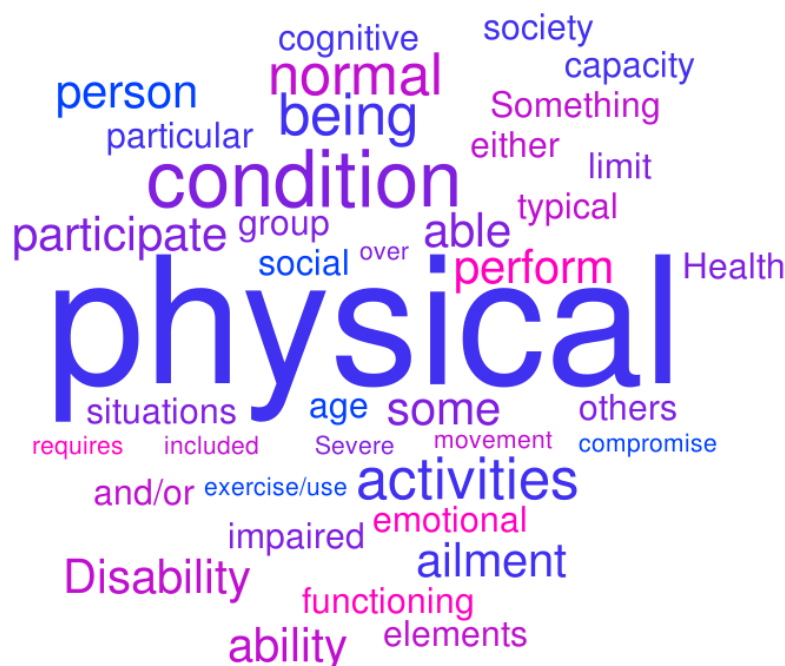
Therefore, parents in this study tended to represent the dominant medical model of disability and ableist impressions when defining disability. The medical model of disability and ableist perspectives, represented in the collated educator and parent definitions of disability, contrast with the predominant social model perspectives in educator and parent definitions of inclusion, which are outlined in Section 4.4.

4.4 Educator and Parent Definitions of Inclusion

Educators and parents were asked to define inclusion, and responses predominantly focused on inclusion for all children (see Appendix Ten for all respondents' inclusion definitions). Educators' 40 most commonly used words when defining inclusion are presented in Figure 4.9.

Figure 4.9 highlights the dominant social perspectives in educators' inclusion definitions. The five most commonly used words, in descending order from the most common, were all, environment, children, resources, and attitudes. Examples of educators' inclusion definitions that referred to children through a social model and inclusive perspective include the following:

Inclusion is the process of removing that hindrance whether it be by adjusting something in the physical environment or educating people within the environment. Enriching the environment with relevant resources. Coming up with strategies that will minimise hindrance. The main outcome is to have everyone equally included in the environment (educator two, questionnaire).

Inclusion means changing environments, perceptions, and attitudes so that all children are included (educator three, questionnaire).

Figure 4.9: Educators' inclusion definitions

An example of an educator's inclusion definition that described inclusion for all and also indicated underlying ableism was the following:

Practices and attitudes that support the individual to participate in society to a degree that is fulfilling and meaningful for that individual; support for all individuals to achieve a 'typical' level of participation (educator four, questionnaire).

Parents' 40 most commonly used words when defining inclusion are presented in Figure 4.10.

Figure 4.10: Parents' inclusion definitions

Figure 4.10 highlights the dominant social model of disability and inclusive perspectives in parents' inclusion definitions. The five most commonly used words, in descending order from the most common, were included, everyone, participate, differences, and being. Examples of parents' inclusion definitions that referred to children through a social model of disability and inclusive perspective include the following:

> *Inclusion means considering the needs of all participants in a particular context, and making modifications as required (parent six, questionnaire).*

> *Having access for everyone to everything equally (parent seventeen, questionnaire).*

Both educator and parent definitions of inclusion indicated understandings of inclusion for all children, through predominantly social and inclusive perspectives. Inclusive attitudes were further demonstrated when educators and parents defined barriers and discussed strategies for challenging barriers within centres to facilitate the inclusion of all children. When reflecting on barriers, both educator and parent respondents acknowledged barriers within centres; however, predominant responses to barriers beyond this differed. These differences in perspectives on barriers are now discussed in Section 4.5.

4.5 Barrier Definitions and Inclusive Attitudes

Educators and parents were asked to define barriers to inclusion, reflect on attitudes to inclusion, identify attitudinal barriers, and discuss how identified attitudinal barriers were

challenged within centres (see Appendix Ten for all respondents' barrier definitions). Molly also reflected on barriers, inclusive attitudes, and how to best support inclusive attitudes in centres.

Molly identified the formation of an inclusively compatible team of educators with inclusive attitudes as being essential to inclusive practice. To identify similar inclusive attitudes, Molly opened dialogue with potential employees prior to employment, as explained in the following:

> *We're very, very selective. If you've got a problem [with including children with disability] you're not going to cope, because they're coming, and they're going to keep coming, and they're not going away.*

Molly discussed the importance of opening communication about inclusive values and forming strong teams. However, even with inclusive intentions, there was evidence of 'othering'[13], where children with disability were repeatedly described as 'they.' Further evidence of 'othering' was identified throughout the present study, as represented in parent two's barrier definition:

> *Something that hinders a person from doing what the norm is doing (questionnaire).*

Molly discussed clear understandings of inclusive education as being fundamental to inclusive attitudes, practice, and respectful inclusive discussions. Molly described the importance of challenging attitude barriers and opening conversations as follows:

> *I think it's breaking that barrier we are talking about. People get scared, yep, they make funny noises, big deal, it's a funny noise, yes, they might have a tic, yes, they might have a tube coming out, but they're just a person, just like you. I think just breaking that barrier makes all the difference.*

Molly's response indicates the value of an educator's well-articulated inclusive beliefs to facilitating communication and inclusive attitudes. Although Molly's intention was explained by her support for inclusion and opening communication about children with disability, there was a strong focus on the medical aspects of disability with evidence of underlying ableism. Even with Molly identifying inclusive attitudes as being essential for inclusively compatible teams, the presence of ableism throughout her explanations highlighted a perspective combining social and medical models of disability.

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13 "The process of creating a 'them' and 'us' so that the person, or group of people, are made 'other' to 'ourselves' – not 'one of us'" (Cologon, 2014b, p. 60). (See Section 2.3.1 for further explanation).

Inclusive teams were further evident in the questionnaire responses, with 75% (n= 6) of educators, and 100% (n= 30) of parents, agreeing that their centres did not have attitudinal barriers towards children with disability. Within the 25% (n= 2) of educators who responded that there were attitudinal barriers, an educator explained:

Lack of staff understanding is a big barrier. I know that it is not intentional but some comments used make it clear that they have a medical model understanding of disability. Person first language is not used by all staff – this is not intentional however it would be great if it could be changed! (educator six, questionnaire).

Further evidence for educators' inclusive attitudes came from educators' barrier definitions, which primarily focused on barriers as potentially temporary and as able to be challenged. This is evident in the following educator's barrier definitions:

I see barriers as anything that has to be worked on or overcome and can be in regard to the child, their family, the environment, the curriculum (educator five, questionnaire).

Something with time, or support can sometimes be overcome (educator eight, questionnaire).

Barrier definitions by educators five and nine indicated educators' understandings of challenging external barriers to support children's inclusion. Collated educator responses highlighted the importance of getting to know individual children prior to challenging barriers, to make certain adaptations suited to individualities. The interviewee described this personalised focus as follows:

All children are unique, so we're constantly adapting to their needs.

Molly discussed children as individuals, and identified her supporting role in personalising practice. An educator's inclusive attitude was evident when educator six suggested how to challenge attitude barriers:

Education is probably the best way to address these attitudes (educator six, questionnaire).

A further suggestion for supporting educators' own inclusive understandings and learning was given by educator seven, who proposed that inclusive attitudes could be promoted by:

Being more informed through workshops, books etc (educator seven, questionnaire).

Responses by educators six and seven indicated that developing further understandings of difference and inclusion encourages individuals to challenge attitudes, which in turn positively impacts attitudinal barriers. Mentoring was also identified by educators six and seven as being beneficial in their centres, as educator six explained:

I realize the importance of mentoring from a more experienced staff member. When I witnessed true inclusive practice, it made it easier to understand how I might implement it myself.

Mentoring was further identified as being advantageous by educator seven, who explained the value of educators with more inclusive experience accessing up to date inclusive information and regularly putting new plans into practice. Educators' barrier definitions and inclusive attitudes, incorporating those supported by mentoring, contrasted with parents' predominantly non-inclusive barrier definitions (see Appendix Ten for all respondents' definitions).

When parents defined barriers, their responses mainly focused on the associated adverse consequences of barriers, including negative impacts, obstacles, hindrances, difficulties, road blocks, and preventing inclusion. Parents described barriers as follows:

Anything that negatively impacts on a participant's access, enjoyment and interaction (parent fourteen, questionnaire).

Any elements that prohibit that participation, including communication, physical movement, emotional accessibility/connection, and comprehension of environment (parent sixteen, questionnaire).

Responses by parents fourteen and sixteen reflect the dominant parental view of barriers as being negative and potentially exclusionary. Molly also identified parents' non-inclusive attitudes, and described these as follows:

You get that attitude of why are they here, and why is that allowed, and why is – why are their shoes getting catapulted across the room at my child's head during group time.

Molly's response was deficit focused and 'othering', therefore presenting the perception of an ableist parent perspective. Molly went on to suggest that parents who had not seen inclusive education in practice were most likely to question the inclusion of all children in centres, particularly children with disability. Responses by parents fourteen and sixteen,

and by Molly, indicated parents' tendency to consider barriers as detrimentally affecting children's inclusion in centres.

Overall, educators' and parents' barrier definitions and reflections on attitudes within centres demonstrated that, even with both groups of respondents acknowledging the presence of barriers to inclusion in centres, attitudes towards barriers differed. Educators predominantly focused on barriers as being able to be challenged; whereas parents predominantly focused on the potential negative impacts and the fixed nature of barriers. These contrasting viewpoints highlight fundamental attitudinal differences between educators' and parents' perspectives on barriers in centres, with direct impact on children's inclusion. Further to these disability, inclusion, and barrier definitions, educators and parents were asked to reflect on their experiences, children's experiences, and specific barriers within their centres, as discussed next.

4.6 Enacting inclusivity in practice

Educators and parents were asked to reflect on their experiences and their children's experiences in their centres, with specific focus on inclusion and barriers within areas of communication, resources, indoor and outdoor environments, attitudes, and other self-identified barriers. The following section focuses on children's and families' inclusion, and children's and families' barriers to inclusion.

4.6.1 Educators' and Parents' Perspectives on Inclusive Practices

Educators and parents reflected on questionnaire statements about their personal experiences with centres (Appendix Seven, educator question eight; Appendix Eight, parent question six). These statements comprised how well centres included and supported children and their individualities, how barriers were challenged, how families were included, and how well diversity was celebrated in their centres. Figure 4.11 presents the two responses that differed the most between all educator and parent personal experience statements. These two statements incorporated how well families were included in centres, and barriers to family's inclusion in centres.

Figure 4.11: Inclusive reflections
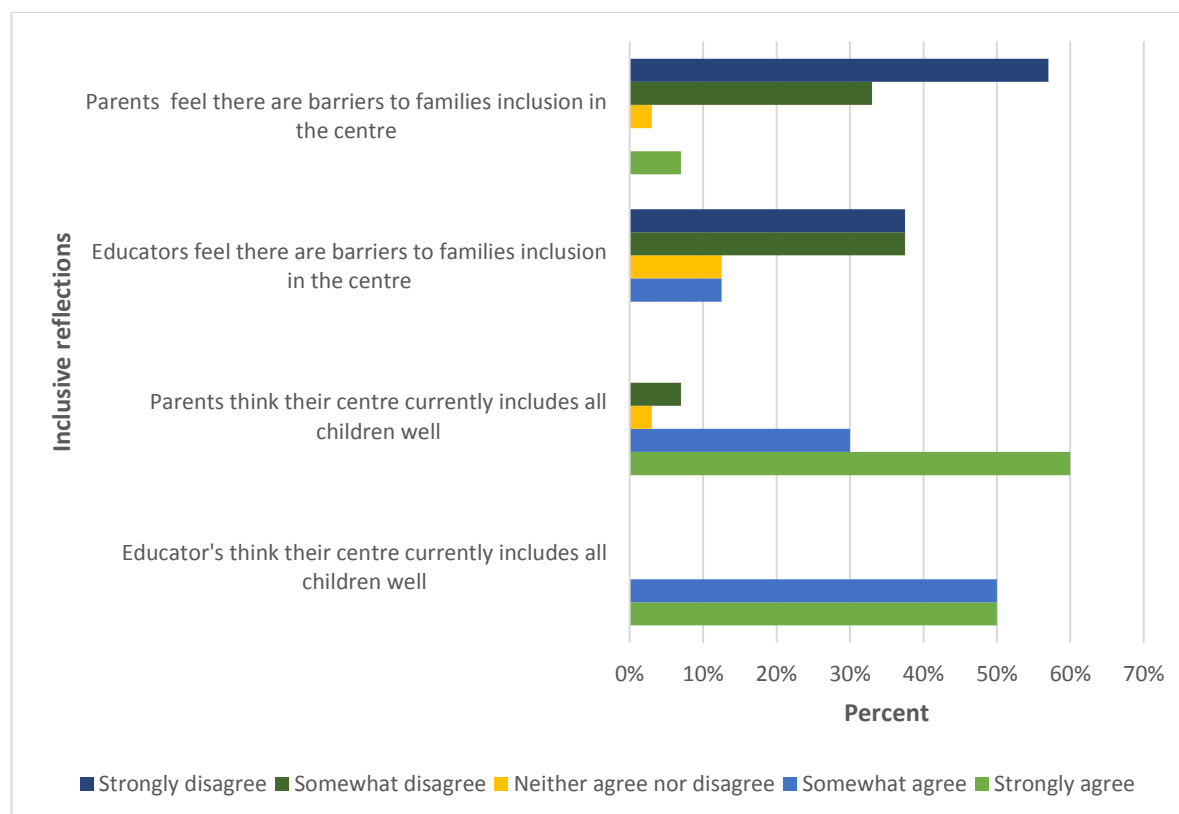
When reflecting on personal experiences with centres, the majority of educators and parents agreed that their centres included all children well. From the educators and parents combined, 7% (n=2) of parents were the only respondents who 'neither agreed nor disagreed' that their centres included all children well. These responses were further supported with 13% (n= 1) of educators and 7% (n=2) of parents agreeing that there were barriers to families' inclusion in centres. Therefore, parents answered more consistently about their experiences with centres, as the same number of parents disagreed that their centres included all children well, and also agreed to there being barriers to families' inclusion in centres. This contrasted with educators initially responding that centres included all children well (which was 10% higher than for parents); but 5.5% more educators than parents agreed that there were barriers in their centres. This indicated that educators acknowledged there being barriers to children's inclusion, but still viewed their centres as including all children well. Thus, educators viewed barriers and inclusion separately; whereas parents appeared to associate the presence of barriers within centres with not including all children. Participants were also asked to reflect on specific types of barriers within their centres, and how best to challenge these barriers for children's inclusion. These responses are now explained.

4.6.2 Self-Identified Barriers Within Centres

Educators and parents were asked whether they identified that children experienced specific types of barriers in their centres, including communication, resource, environment, attitude and other self-identified barriers; and if so, how these barriers were challenged (see Appendix Seven, educator questions 19-23; Appendix Eight, parent questions 9-13). All parents (n=30) responded that their children did not experience any resource, attitudinal or other barriers in centres. One parent (4%) reported their child as experiencing communication and environmental barriers within their centre (as explained further in Section 4.6.3). This indicated that parents were predominantly satisfied that their children did not experience barriers in these centres.

The majority of respondents, 75% (n=6) of educators and 100% (n=30) of parents, agreed that there were no other self-identified barriers for the inclusion of children, apart from those specifically identified within the study (communication, resource, environment, and attitude barriers) (see Appendix Seven, educator question 23; Appendix Eight, parent question 13). A minority group of educators, 25% (n=2), responded that there were other barriers in their centres, with Molly explaining another type of self-identified barrier as follows:

> *I guess what the – the only drama for us sometimes is that maintaining of the ratio as well. So, feeding a child through a tube can take up to an hour, because it needs to be slow and careful, right, you don't want to get an air bubble or do anything like that. So, you really need to be able to have someone there to feed that child.*

The difficulty of applying for funding and maintaining ratios was identified by Molly as a self-identified barrier foundational to the daily care of children (discussed further in Section 4.6.4). The next section discusses respondents' perspectives on communication barriers within their centres.

4.6.3 Inclusive Communication Within Centres

Educators and parents were asked to reflect on statements about communication between educators and parents, communication barriers, and respect for families' choices. Molly also discussed communication between educators, and explained a few communication strategies implemented at her centre. Figure 4.12 presents collated data on the two communication responses that differed the most between educator and parent responses (see Appendix Seven, educator question 17; Appendix Eight, parent question 7).

Figure 4.12: Communication within centres
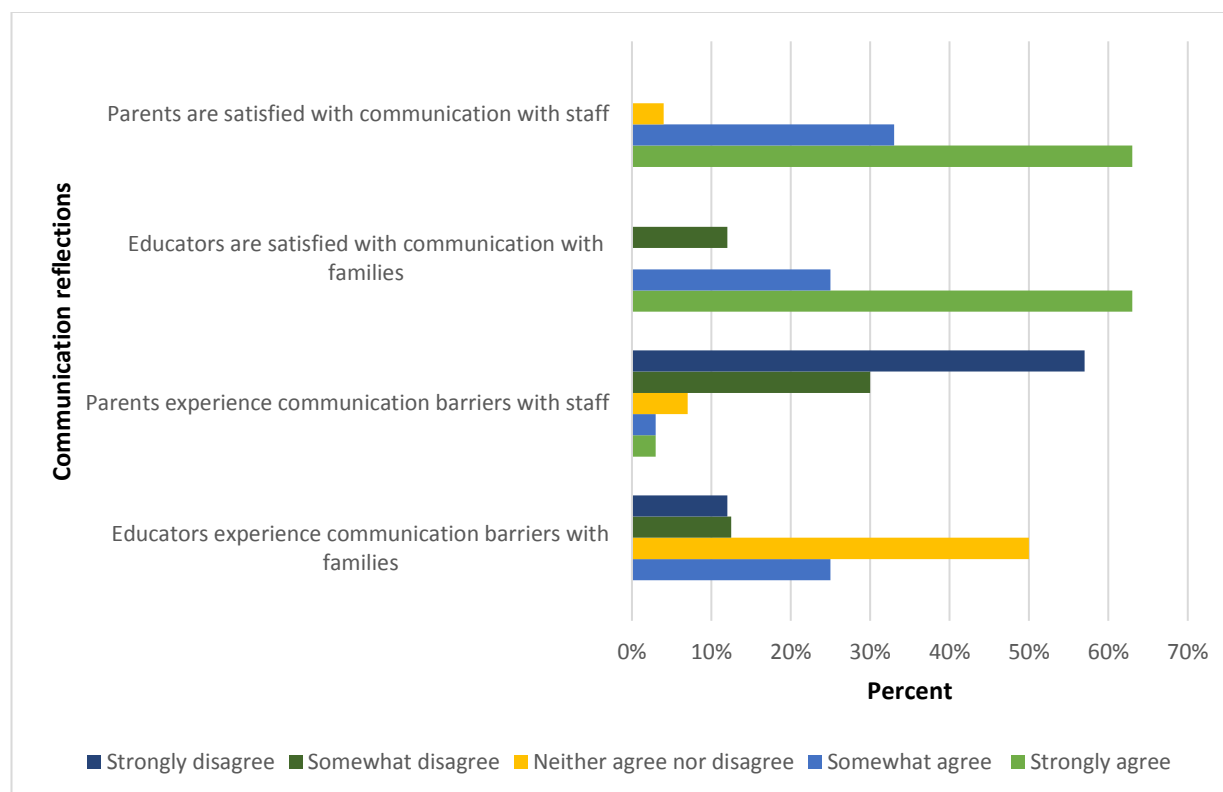
Overall educator and parent perspectives on communication within centres were similar. Both educators and parents predominantly responded as being able to openly communicate with educators and parents, with 63% of educators (n=5) and 63% (n=19) of parents reporting feeling as though choices were respected when communicating. The majority of educators and parents reported being satisfied with their communication with each other; however, 13% (n=1) of educators responded that they were unsatisfied with communications with parents. This dissatisfaction in communication was further demonstrated when 25% (n=2) of educators reported experiencing communication barriers, and 50% (n=4) 'neither agreed nor disagreed' to there being communication barriers. This indicated that educators reported higher dissatisfaction with communication, and perceived more communication barriers with parents.

In comparison, 7% (n=2) of parents reported communication barriers with educators, and 7% (n=2) 'neither agreed nor disagreed' regarding communication barriers. This indicated that a small group of parents were consistently unsatisfied with their communication with educators, and reported barriers across these communication statements. However, parents predominantly reported satisfaction with their communication with educators, despite 7% (n=2) experiencing communication barriers. This indicated that parent's communication

barriers with educators did not notably affect their overall communication satisfaction with educators.

Molly identified open and supportive communication between educators as being able to prevent other self-identified barriers within centres. For example, Molly explained educators as needing clear instructions on children's individual needs, such as how to correctly feed a child through her feeding tube. To encourage educator flexibility and collaboration when adapting to children's individualities and changing needs, a communication strategy of using a social media platform group was implemented at Molly's centre. Molly gave an example of what was posted in this group:

> *So I might say, you know, such and such really needs X, Y, Z. What do you think? How to approach it? Where should we go? Can we work with it? (interview).*

This private group was identified as beneficial because it was accessible, and therefore encouraged contributions on a range of topics from each team member. Molly described this as group as "constantly evolving", because educators regularly used this group to communicate on a range of topical issues. The social media group was described as also supporting this team's flexible and reflective approach to inclusion, as it encouraged "everybody at all levels to get a say" (Molly), and as encouraging contributions towards making considered decisions. This social media platform was reported as being beneficial for collaboration and communication; however, no issues of security, confidentiality or information ownership were identified as potential issues.

Educator six reported another beneficial communication strategy as participating in casual conversations and sharing information, including articles and resources. Molly further supported this sharing of information with team members after training workshops. After completing training, her team completed forms outlining what they had learnt. Educators then had the option of casually or formally presenting this information at staff meetings, or sharing training handouts with their team. This multitude of communication options aimed to empower educators to decide how to share what they had learnt, and to keep their team up to date on inclusive education. Molly described this sharing of information as "cross training", as educators collaboratively discussed their learning.

Questionnaire respondents were also asked to reflect on children's communication and communication barriers within centres. The majority of parents, 96% (n= 29), responded that their children did not experience communication barriers in their centres. Parent one explained that her son experienced a communication barrier because "he mainly speaks Chinese at home, so he may not talk as much in the centre as in the home." Although

bilingualism barriers were outside the present study's disability focus, it is important to note that this communication barrier did not come from within this child, who was able to communicate. This communication barrier resulted from educators within the centre being unable to reciprocate this child's communication. This example is similar to a communication barrier from an ableist perspective, where a child's preferred communication method is not reciprocated, therefore resulting in a communication barrier.

Predominantly, educator respondents, 87% (n=7), agreed that there were no communication barriers for children with disability in their centres. Seventy-five per cent (n=6) of educators had a child with disability enrolled in their centre, and 37.5% (n=3) of educators had a child with a disability in their group. Most agreed that there were no communication barriers for children with disability in their centres. Educator five was the one educator who identified that there were communication barriers for children with disability in the centre, explaining:

> *Some children with disabilities are unable to speak which creates a communication*
> *barrier (educator five, questionnaire).*

Initially, this response appeared to be from a deficit focus; however, educator five then went onto suggest that this barrier could be overcome by:

> *Reading facial and body cues, communication with family members with close*
> *knowledge of the child (educator five, questionnaire).*

Educator five had work experience with a child with disability and had a Diploma of Children's Services. Educator five's response is representative of educators in the present study who acknowledged their role in minimising barriers, such as environmental and pedagogical barriers, to facilitate inclusion. An example of how a potential communication barrier for a child with disability was challenged was given by Molly. Educators and children learnt Key Word Sign in their centre, to aid their communication with a child who was Deaf. This change resulted in a potentially disabling environment becoming more inclusive. Discussed in the next section are educator and parent reflections on statements about resources and barriers within their centres, including toys and equipment.

4.6.4 Inclusive Resources Within Centres

Educators' and parents' questionnaire statements on resources focused on how well resources suited all children's needs, how well resources were adapted to suit all children's needs, and whether a greater variety of resources would benefit these centres (see Appendix Seven, educator question 18; Appendix Eight, parent question 8a). Figure 4.13 presents the two

responses that differed the most between educators' and parents' perspectives on resources in centres.

Figure 4.13: Resource barriers (including toys and equipment)
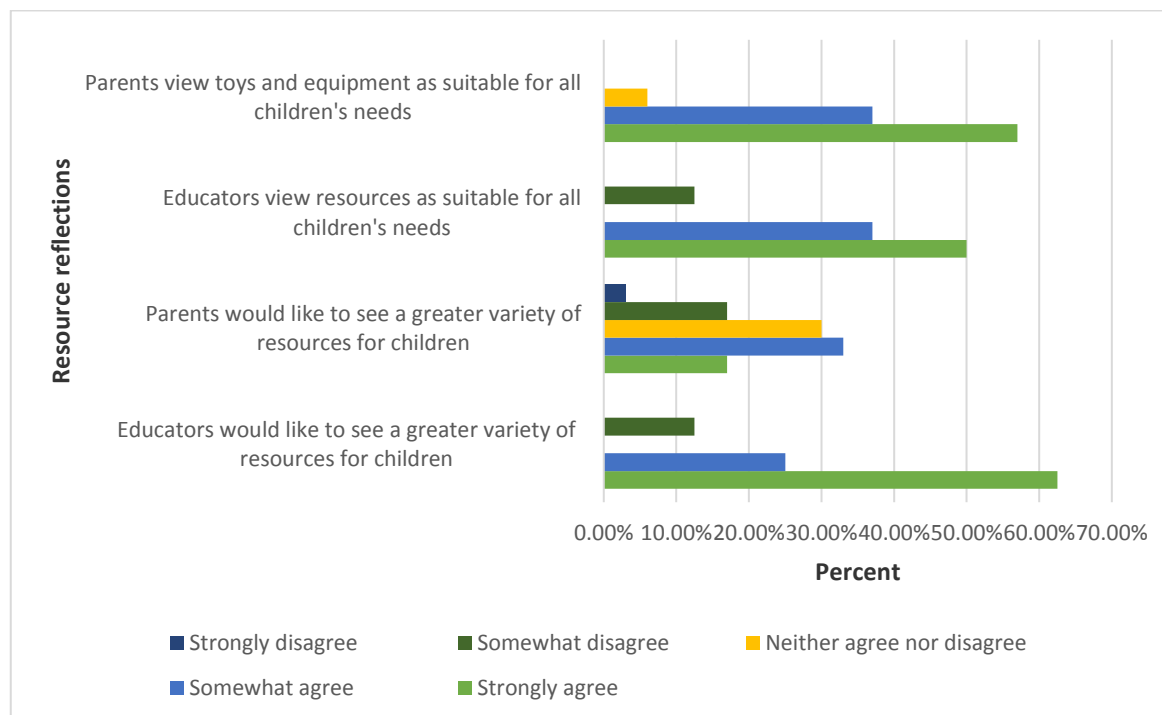
Educators and parents predominantly agreed that available resources within centres were suitable for all children's needs, with only 13% (n=1) of educators, from all respondents, disagreeing. Further to this, 25% (n=2) of educators agreed that resource barriers could be identified in their centres. When educators and parents were asked if they would like to see a greater variety of resources within their centres, 87% (n=7) of educators and 50% (n=15) of parents agreed. Educator eight explained that providing more resources was a way to overcome resource barriers. Therefore, this indicates that, even though educators and parents agreed on resources as suitable for all children's needs, both groups would prefer a greater variety of resources to be available.

A barrier to providing more resources was identified by educators six and seven in terms of managing financial priorities. Molly agreed that expense was a resource barrier, and explained how she had to regularly re-assess and re-prioritise spending for centre resources. To facilitate financial prioritising and sustainable approaches to resourcing, Molly accessed support from an equipment library. Molly described equipment libraries as being helpful for accessing equipment without much financial outlay, and explained that, without equipment libraries, she thinks:

We'd struggle. It's that fine line between do we need this because we may not have another child with quadriplegia.

Molly described it as advantageous to know directly where to go for reliable information and support. This indicated direct benefits of specific support for educator-for including children with disability, for centres' inclusive practice, and for educators' reassurance and confidence.

A resource barrier that potentially affected all enrolled children was identified by Molly as being the decision whether to include certain activities in their daily routine. More specifically, an example was given of adding a marble activity to the indoor three to five-year-old classroom, when a child tended to put things in his mouth with potential for choking. Educators had to balance this child's needs with the provision of the opportunity for other children in the group. Molly explained her team's focus as being on flexibility, with decisions made daily in consideration of the children present. To facilitate safe play and challenge potential barriers to inclusion, compromises such as only including the marble activity at the times of day when educator ratios were highest were practiced.

Overall, educators and parents agreed that available resources were suitable for all children's needs; however, respondents predominantly agreed that they would like to see a greater variety of resources available. Further to these resource reflections, educators and parents were asked to consider statements about their centres' indoor and outdoor environments, as discussed next.

4.6.5 Inclusive Indoor and Outdoor Centre Environments

The indoor and outdoor environment questionnaire statements focused on how well indoor and outdoor environments catered for all children, and how well indoor and outdoor environments were adapted to cater for all children (see Appendix Seven, educator question 18; Appendix Eight, parent question eight). The majority of respondents, 100% of educators (n=8) and 93% of parents (n=28), agreed that their indoor classrooms suited all children's needs. All educators (n=8) and most parents, 77% (n=23) agreed that adaptations were made to indoor classrooms to suit children's needs in their centres. However, the responses on outdoor areas catering for all children, and centres changing outdoor areas to suit different needs, differed considerably between educator and parent responses in the present study. Figure 4.14 presents the two outdoor area responses that differed the most between educators' and parent's inclusive outdoor responses.

Figure 4.14 Inclusive outdoor areas in centres
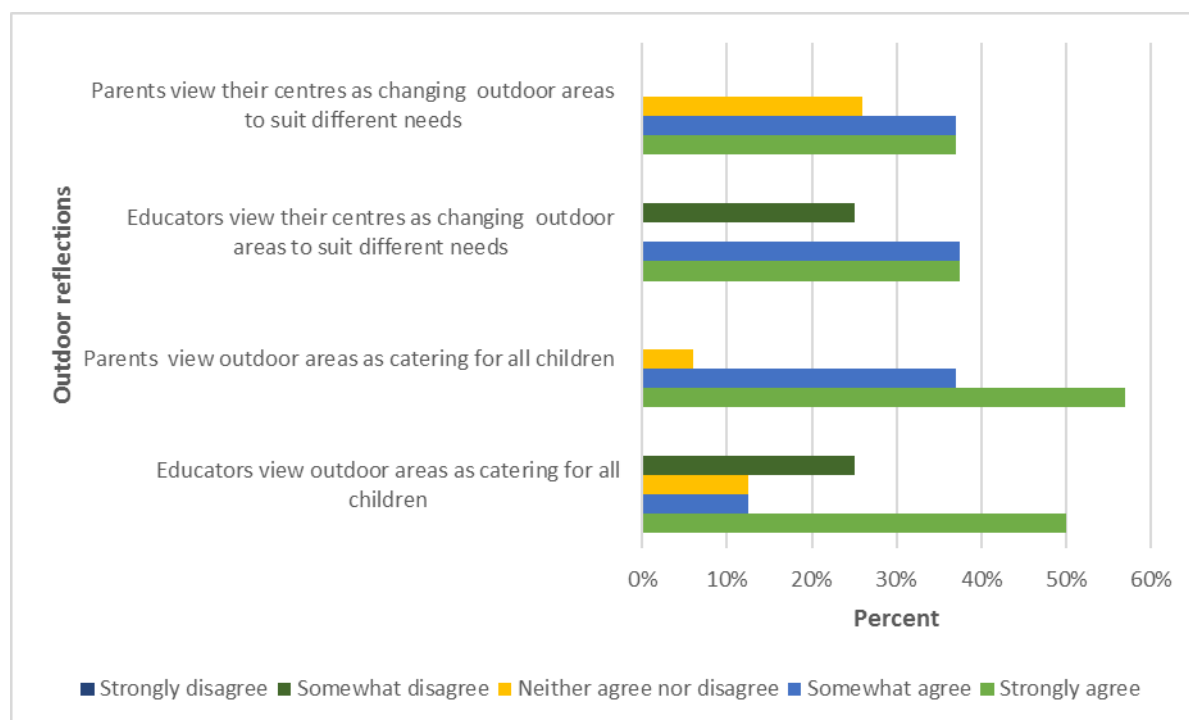
Half the educators (n=4) agreed that there were no outdoor environmental barriers for children with disability in their centre, and 100% (n=30) of parents responded that their child had not experienced any outdoor environmental barriers in their centres (see Appendix Seven, educator question 19; Appendix Eight, parent question 9), therefore indicating that educator and parent perspectives on outdoor environmental barriers in the centres differed considerably. These results could have been influenced by 88% (n=7) of educators having experience working with children with disability, and only 3% (n=1) of parent respondents with a child with disability. For the 50% (n=4) of educators who agreed that there were environmental barriers in their centres, all explained these barriers as being a lack of ramps. Educators' explanations of outdoor environmental barriers included:

> *Physical barriers e.g. lack of ramps to access certain areas of the playground*
> *(educator five, questionnaire).*

A further item in the questionnaire asked the educators (who identified barriers) how this barrier could be addressed (see Appendix Seven, educator question 19a). The majority of these 4 educators, 75% (n=3), suggested the solution of building ramps to support children's access in their centres. An educator suggested:

Yes, a ramp could be built! This would allow access for all children, and be helpful for other purposes such as wheeling bikes to storage in the afternoon (educator six, questionnaire).

This is an important response that highlights an educator's inclusive understanding that challenges a barrier within a centre's environment for one reason as also having wider benefits. The dominant response, of building ramps for challenging environmental barriers, suggested this as the principal identified environmental barrier within these centres.

Educator seven described inclusion more holistically than considering ramps alone, and suggested adjustments in environments as well as "educating people within the environment." This important point suggested value in informing educators on how to challenge barriers within centres. Overall, indoor environments were identified as being inclusive for all children in these centres; however, outdoor environments were found to include barriers to children's inclusion, with the predominant barrier identified as being a lack of ramps.

4.7 Chapter Summary

In this chapter, results were presented from the present study. Qualitative and quantitative data were integrated to provide descriptive statistical data. Educators, parents and Molly's responses were compared to identify barriers to inclusion in centres within attitudes, communication, resources, environments, and self-identified barriers. Adaptations to identified barriers were compared, with strategies for inclusion integrated throughout. The next chapter discusses the present study's findings.

CHAPTER 5: DISCUSSION

5.1 Overview of Chapter

In the preceding chapter, the study's results were explained. In the present chapter, results are discussed with parallels drawn to previous research. Links between the present study's results and Thomas's (1999, 2001, 2004) social relational model of disability are discussed, together with connections to Bronfenbrenner's (1977, 1979) ecological theory to position the study within early childhood contexts. Results are discussed as attitudes and understandings of disability, inclusive attitudes, mixed understandings of disability, and identifying and challenging barriers to inclusion, inclusive cultures, and reflective practice.

5.2 Attitudes to and Understandings of Inclusion

In Section 5.2, educator and parent attitudes to and understandings of inclusion are discussed, in two sub-sections. Inclusive attitudes within centres are initially explained; before mixed understandings of disability that were evident throughout the present study are discussed.

5.2.1 Inclusive attitudes

Inclusive attitudes were evidenced with the majority of participants agreeing that there were no "attitudinal barriers for children with disability" within centres (see Section 4.5). Children were reported as being included, with most participants agreeing that the centre includes children and families. Inclusive attitudes were evident in educators' disability definitions (see Section 4.3). The educators who, in their disability definitions, recognised and focused on their role as adapting practice to facilitate inclusion, reflected social relational perspectives (Thomas, 2004). From a socially constructed perspective, responses from educators three and eight reflected social contexts and interactions, where children with impairment were considered as disabled by their social and environmental contexts (Lalvani, 2012; Slee, 2013). Therefore, society and centres were identified as needing to adapt to include children in their diversities.

Social relational understandings of disability (Thomas, 1999, 2001, 2004) were identified in the collated barrier to inclusion definitions (see Section 4.5). Inclusive attitudes and practice were also evident when educators and parents agreed that there were no other self-identified barriers in their centres apart from those specifically identified within the study (including communication, resource, environmental and attitudinal barriers) (see Section 4.6.2). Most responses reported children in the three centres as being within interconnecting social contexts and environments, with diversities celebrated and families included well. Therefore, Bronfenbrenner's ecological theory (1977, 1979) was evidenced in practice, with

children identified as being at the core of their influential and interconnected social and environmental contexts in centres, each with inclusive and exclusive potential (see Section 4.4).

5.2.2 Mixed Understandings of Disability

Educators' mixed understandings of disability were evident in the combination of social relational and medical model perspectives in disability definitions. Parents' definitions of disability included a medical model of disability perspective and ableist language. Underlying deficit views of disability remained throughout educators' and parents' responses.

Freire describes critical reflection as resisting the "circle of certainty" (1970, p. 39). Slee (2011) discusses the importance of recognising that exclusion has been common throughout history when critically reflecting. Lalvani and Broderick (2015) and Srinivasan (2016) propose that understandings of disability oppression are intentionally and unintentionally picked up in society, influencing beliefs and educational practice. Lalvani and Broderick (2015) describe unrecognised understandings about disability oppression and inequity as "ableist privilege" (2015, p. 169). The mixed views on disability throughout the present study reflected the mixed societal perspectives on disability (Srinivasan 2016), including "ableist privilege" (Lalvani & Broderick, 2015, p.169). Beckett (2009), Cologon (2012), Lalvani (2013) and Lalvani and Broderick (2015) note that critically reflecting supports educators in identifying and challenging discriminatory views that cause barriers to children's inclusion. To identify and challenge any ableist or medical model views, educators and parents in the present study would benefit from examining beliefs and assumptions about disability, challenging any deficit views, and learning how to disestablish underlying ableism.

Encouragingly, the centres in the present study were reported as being inclusive, and social relational perspectives were identified. However, it is important to recognise that inclusive attitudes do not automatically translate into inclusive practice (Diamond & Odom, 1998; Berry, 2010; Carlson et al., 2012; Frankel, 2004). Underlying ableism was evident as 'othering' language, and a medical model perspective was evident throughout the present study with definitions of disability including the terms "condition", "physical", "mental", and "normal" (see Section 4.3). Evidence of underlying ableism in the present study raises questions about understandings of inclusion, and whether the reported levels of inclusion reflect some level of ableist misunderstandings of inclusion.

An example of Molly's 'othering' was identified when, in explaining the importance of identifying inclusive attitudes, she continually referred to children with disability as "they" (see Section 4.5). This example highlights Molly's tendency for 'othering', where children

with disability were separated from a centralised group of 'normal' children. Another example of a respondent who believed themselves to be inclusive, but appeared unaware of underpinning ableist beliefs, was parent 17. Parent 17 described inclusion as "having access for everyone to everything equally' (see Section 4.4). Parent 17 then went on to define disability as "a physical or mental disadvantage when compared to a normal functioning human being" (see Section 4.3). This parent's explanation of inclusion for all contrasts with the view of people with disability as being a 'disadvantage' compared to 'normal' people, therefore indicating underpinning ableism. An example of an educator reporting inclusive beliefs but demonstrating underpinning ableism was educator four, when describing the aim of inclusion as supporting "all individuals to achieve a 'typical' level of participation' (see Section 4.4). This educator's suggestion of a 'typical' level implies that there is also an 'abnormal' level of participation, indicating underpinning ableism.

Molly, parent 17 and educator four's responses are examples of "dysconsciousness" (King, 1991, p. 134), with a disconnect between expressed inclusive intentions and underlying ableism. Although King (1991) was referring to "dysconscious racism" (1991, p. 133), the potential impact of unidentified discrimination, including ableism, remains relevant to the present study. Ableism is discrimination that also effects children's inclusion in centres. Disconnects between inclusive intentions and practices can be further explained with Sergiovanni and Starratt's concept of "espoused theory" (1988, p. 366). Beliefs and intentions commonly unrecognised yet evident in practice are described as a "theory in use" (Sergiovanni & Starratt, 1988, p. 366). Barton (1996), Cook et al. (2000), Carrington et al. (2015), Lalvani (2013b), Lalvani and Broderick (2015) and Villegas (2007) explain educators identifying personal beliefs of disability and discrimination as directly affecting inclusive practice, with unexamined assumptions and beliefs eventuating in barriers to inclusion. In the present study, unexamined assumptions and underlying ableism, evident throughout responses, has the potential to eventuate in exclusion in the three centres (as further discussed in Section 5.4).

When discussing collated responses, it is important to consider parents' disability definitions together with their demographic data. Only one of the parent respondents in the present study had a child with disability. Therefore, the majority of parents did not define disability from the personal experience of parenting a child with disability. Lalvani (2012) and Slee (2013) explain socially constructed views as being developed in intended and unintended ways, through encounters with media, educational settings, social contexts, and interactions. Views of disability are perceived from "sociocultural meanings ascribed to the constructs of disability, normalcy and parenthood" (Lalvani, 2015, p. 380). In the present

study's definitions of disability, children with disability were predominantly separated into 'abnormal' groups, identified as deficit and needing to be 'fixed' to fit in (see Section 2.3.1). Deficit views of disability contrasted with respondents' dominant view on inclusion for all children, therefore representing their "dysconsciousness" (King, 1991, p. 134).

Deficit views of disability in the present study reflect those within current wider society, where ableism remains a common experience for children with disability (Haller, 2010; Lilley, 2013). Underlying deficit views on disability tend to remain in current educational settings, as educator's pedagogy and practice is influenced by socially constructed views (Carrington et al., 2015; Lalvani, 2013; Sze, 2009). It is important to consider socially constructed views of disability together with Slee's reminder that exclusion was "part of the grammar of our past. It is the wallpaper of our daily lives. Exclusion is everywhere and it has been there for a long time" (2011, p. 48). Although recognition of exclusion throughout society can explain where "ableist privilege" eventuated, it is crucial to recognise that ableism makes implementing inclusive education problematic (Lalvani & Broderick, 2015, p.169).

Evidence of inclusive attitudes in the three centres is a positive result in the present study. However, it is important to recognise that inclusive attitudes do not automatically equate with inclusive practice (Diamond & Odom, 1998; Berry, 2010; Carlson et al., 2012; Frankel, 2004). Positive and inclusive attitudes can be interconnected with "dysconsciousness" (King, 1991, p. 134). Educator's inclusive understandings linking directly to inclusive practise is crucial, particularly in current educational contexts with increasingly diverse ranges of children (Anderson et al., 2014; Blackmoore 2009; Mergler et al., 2016; Rashid & Tikly, 2010; Voltz, Sims & Nelson, 2010; Srinivasan, 2016). "Dysconsciousness" (King, 1991, p. 134) is evident in the present study with a disconnect between educator and parent "espoused theory" (Sergiovanni & Starratt, 1988, p. 366) and underpinning "theory in use" (Sergiovanni & Starratt, 1988, p. 366) (see Sections 4.4, 5.2, 5.3). Educators and parents in the present study would benefit from identifying and challenging differences between their identified and unidentified beliefs, therefore addressing any "dysconsciousness" and challenging discrepancies between inclusive attitudes and practice, and preventing this as a potential barrier to children's inclusion in centres (King, 1991, p. 134). The next section discusses educators' and parents' perspectives on identified barriers in centres, and how to best challenge these barriers in centres.

5.3 Identifying and Challenging Barriers to Inclusion

Predominantly, educators' roles in identifying and challenging barriers to facilitate children's inclusion were acknowledged as critical for inclusive practice. According to Cologon and

Thomas (2014), Connors and Stalker (2007) and Mackenzie et al. (2016), inclusive education presents opportunities to overcome barriers to children's inclusion. The identification of respondents' dominant social relational perspectives on barriers in the present study is important, as there is limited research on adapting early childhood practice to overcome barriers for children's inclusion (Brereton, 2008; Cologon, 2014; Clough & Nutbrown, 2009; Mackenzie et al., 2016). There is also minimal research investigating social relational models of disability in Australia (Cologon, 2012; Mackenzie et al., 2016).

Respondents predominantly acknowledged barriers within children's interconnected contexts as influencing children's inclusion, and acknowledged educators' roles in identifying and challenging barriers to facilitate children's inclusion. Therefore, Bronfenbrenner's ecological understandings (1977, 1979), together with social relational perspectives (Thomas, 1999, 2001, 2004), were recognised as important in the present study, for supporting children's inclusion in centres.

There was a disconnect in the present study between respondents acknowledging the importance of identifying barriers and the reality of identifying specific barriers within centres. It is a positive result that examples of barriers to children's inclusion were identified and reportedly challenged in the study (see Section 5.3). However, examples of specific barriers were limited, and predominantly barrier examples were explained from the perspective of a deficit focus. These barriers included staffing considerations and attitudes, resource barriers to inclusion, and environmental barriers to inclusion.

5.3.1 Staffing Considerations and Attitudes

Staffing was identified by Molly as a barrier, in terms of maintaining ratios. Molly noted that children's individual needs had to be factored into planning, with extra educators needing to be available for busy times of the day. However, if Molly could have recognised that maintaining ratios for children's individualities is part of daily practice, this would shift the focus. Educator five explained a child being unable to speak as being a communication barrier. This initial deficit focus was challenged when educator five identified other ways this child communicated, including facial and body cues (see Section 4.6.3). An educator focusing wholly on children from a strength-based perspective would only consider how children can communicate. Educators' shifting perspectives toward what children can do can support children's inclusion (Bikeln, 2000; Biklen & Burke, 2006; Cologon, 2012; Greiner, 2010). It is important for educators to have high expectations for all children's capabilities, and to provide opportunities to achieve (Harte, 2010; Underwood et al., 2012). Educators in the present study would benefit from support to focus on children from a strength-based

perspective, particularly when learning to identify and challenge barriers to children's inclusion (Cologon & Thomas, 2014; Connors & Stalker, 2007; Mackenzie et al., 2016).

It would be advantageous for respondents in the present study to learn how to identify and challenge specific barriers to doing and barriers to being in centres, to facilitate inclusion. When social relational understandings are applied to inclusive practice, barriers to doing and barriers to being can be identified and challenged in centres, and children can be recognised as diverse and capable individuals (Cologon & Thomas, 2014; Connors & Stalker, 2007; Mackenzie et al., 2016).

5.3.2 Resource Barriers to Inclusion

There were discrepancies in responses on resource barriers within centres in the present study. Most respondents agreed to the available resources being appropriate for all children, and most also wanted a greater variety of resources in their centres. Purdue (2009) suggests that resources be considered within centre contexts and cultures, to avoid a deficit focus and non-context specific resources. Resources and funding are examples of barriers in the exosystem, which children are not in direct contact with but are affected by (Bronfenbrenner, 1976). Slee (2006) describes funding in education as complicated and needing further comprehensive discussion.

Funding was also acknowledged in the present study as a potential barrier to children's inclusion in centres. A respondent's reported solution to the challenge of a funding barrier was an equipment library. Resources and equipment were accessible through the equipment library, therefore challenging resource barriers without the financial outlay of purchasing (see Section 4.6.4). An equipment library is an example of how educators can organise and plan for challenging barriers to children's inclusion in centres. This example of identifying and challenging a barrier to children's inclusion gives evidence of theory being applied to practice and facilitating inclusion.

5.3.3 Environment Barriers to Inclusion

Barriers to children's inclusion were acknowledged by educators in outdoor centre environments, with the main barrier explained as a lack of ramps (see Section 4.6.5). Predominantly, respondents agreed that their centres' indoor environments suited all children's needs. No identified indoor barriers, and the dominant outdoor barriers being ramps, both indicated a limited understanding of environmental barriers for children's inclusion in centres. According to Ferguson (2008), identifying aspects of inclusive environments is important for creating inclusive physical spaces.

Environmental barriers to inclusion and strategies for challenging these barriers will differ between centres and their different contexts. Educators in the present study would benefit from developing further understandings of identifying and challenging barriers in specific environments to facilitate children's inclusion. Inclusion is an ongoing process that changes over time and between contexts, and it is imperative for educational centres and communities to continue professional and inclusive development and learning, within centres' contexts (Ainscow, Booth & Dyson, 2004; Carrington, 2012; Carrington & Robinson, 2002; Duke et al., 2016). The next section of the chapter discusses educators' and parents' perspectives on aspects that contribute to inclusive cultures, including the importance of reflective practice.

5.4 Inclusive Cultures and Reflective Practice

Educators and parents in the present study reported positive and inclusive attitudes, indicating inclusive cultures in the three centres. However, it is important to consider reported inclusive cultures together with the understanding that inclusive cultures are multifaceted and do not involve ableism. Educators and parents sharing inclusive visions and aims is advantageous for developing collaborative relationships within inclusive cultures (Booth, 2011; Cologon, 2014; Keen, 2007; Lalvani, 2015). Anderson and Boyle (2015), Boyle (2012) and Nutbrown and Clough (2006) note that every centre has its own inclusive culture. Aligned strengths-based attitudes within centres' inclusive cultures are crucial for the successful implementation of inclusive education (Avramidis & Norwich, 2002; Baglieri, 2008; Carrington et al., 2016; Cologon, 2012, 2014; Curcic, 2009; Hoskin, et al, 2015; Jordan et al., 2010). Curcic extends on this, and notes that inclusive cultures foster inclusion through "philosophy, climate, democratic leadership, collaboration among school professionals, attention to learner diversity, resources, and liaison with parents" (2009, p. 535). Identifying inclusive cultures was an important result for supporting children's inclusion within the three centres.

Flexible, collaborative and reflective approaches were identified throughout the present study, with examples from educators five, six, and eight, and Molly, highlighting the importance of personalising practice for children's inclusion (see Section 4.6.2). Molly's suggested strategy to support collaborative decision making was a private social media group (see Section 4.6.3). However, there was no mention of associated confidentially, ethical or legal implications. In the Early Childhood Australia's Code of Ethics ([ECACOE], 2016), educators' responsibility to maintain professional accountability is made clear. Ethical responsibilities require educators to understand their position of trust and to "respect and maintain the rights and dignity of children, families, colleagues and communities" (ECACOE, 2016). Educators sharing content related to children in their centre via social media raises

questions about the right to share information. It is imperative that educators maintain their confidentiality obligations, and uphold intellectual property rights if sharing content. Further complications can also arise from social media platforms collecting information on the people, groups, interactions and information that is shared online (Facebook Inc., 2016). Collaboration has been identified as an important aspect of inclusive practice, and as Forlin (2011) explains, challenging obstacles collaboratively is a supportive and favourable team practice. The strategy of a social media platform as reportedly facilitating collaboration and communication needs further exploration in terms of the confidentiality and ethical considerations discussed above.

Molly's second collaborative communication strategy, cross-training, was reported as maximising educator's professional development and learning by sharing information with teams (see Section 4.6.3). McKay et al. describe the knowledge acquired from linking learnt theory to educational settings as "multiplicity" (2014, p. 3), and as resulting in establishing new knowledge. Although McKay et al. (2014) were referring to learnt theory from educators' university education, this term remains applicable to the present study's discussion on the benefits of educator's professional development and learning. The social media group and cross training strategies reportedly aimed to empower educators to collaboratively communicate and to share inclusive learning. Although the identified collaborative communication strategies would benefit from further critical reflection for best inclusive practice, they demonstrate collaboration for inclusive practice.

Responses throughout the present study indicated that inclusive cultures within the three centres were important for children's inclusion. However, it is important to consider this together with observations by Ainscow (2004), Booth (1996), and Slee (2011), who note that, even when schools have inclusive cultures, critical reflection on pedagogy and practice remains beneficial. The concept of critically reflecting on pedagogy and practice within school inclusive cultures also translates to early childhood centres, as reflective practice remains relevant to early childhood inclusive practice (DEEWR, 2009). Critical reflection was identified throughout the present study as an important strategy for challenging assumptions and beliefs, identifying ableist assumptions, maintaining inclusive understandings, and facilitating children's inclusion (see Sections 5.2.2, 5.4). When educators critically reflect on and clarify beliefs, assumptions and impacts on practices, inclusive principles, environments, experiences and practice are supported (Carrington et al., 2012; Carrington & Saggers, 2008; Cologon, 2012; Cologon & Thomas, 2014; Lalvani & Broderick, 2015; Mergler et al., 2016). Russell (2005), Larrivee (2008) and McKay at al.

(2014) propose that reflective practice is an important skill that educators can learn, and is an important part of educators' professional development.

Broderick et al. (2008), Cologon (2012), Lalvani (2013), Lalvani and Broderick (2015) and Slee (2001) suggest that educators benefit from support in challenging deficit and ableist thinking, and to move towards recognising and celebrating diversities. Lalvani and Broderick suggest that educators need to reflect on their own "ableist privilege and interrogate the ways in which we explicitly position ourselves and our roles when it comes to the dismantling of ableism" (2015, p. 171). To develop this awareness, Carrington et al. (2014) and Larrivee (2000) explain critical reflection as being the process of considering and monitoring personal and professional beliefs, which can lead to deliberate and purposeful inclusive practise. Disability definitions in Section 4.3, and responses discussed in Section 5.2.2 identifying underlying ableism, are examples where educators in the present study would benefit from examining beliefs and assumptions, to make certain that inclusive intentions and practice are aligned.

5.5 Chapter Summary

In the present chapter, connections in the study between Thomas's (1999, 2001, 2004) social relational model of disability and Bronfenbrenner's (1977, 1979) ecological theory were examined. Results were discussed to give evidence of how the theory of the social relational model of disability linked to educational practice, from educators' and parents' perspectives, throughout the present study. Discussion focused on attitudes, understandings of disability, identifying and challenging barriers to inclusion, inclusive cultures, and reflective practice in centres. The next chapter provides the conclusion to this thesis.

CHAPTER 6 CONCLUSION

6.1 Chapter overview

The purpose of the present study was to identify links between the theory of the social relational model of disability and educational practice. Educators' and parents' perspectives on identifying and challenging barriers to doing and barriers to being were investigated within three early childhood centres. In the previous chapter, the results of the present study were discussed, with parallels drawn to literature, the social relational theory of disability (Thomas 1999, 2001, 2004), and Bronfenbrenner's ecological theory (1977, 1979). In the present chapter, key results are connected to implications for educators, parents, centres and policy makers.

6.2 Inclusive Attitudes with Underpinning Ableism

Most respondents viewed inclusion as being about all children, recognised barriers as impacting inclusion, and regarded disability from a deficit perspective. Social relational perspectives of inclusion, and barriers to inclusion, were reflected in responses that viewed social and environmental aspects within centres as disabling children (Thomas, 1999, 2001, 2004). Predominantly, inclusive understandings were paired with underpinning ableist and medical model perspectives on disability. Identifying and challenging discriminatory views is important, as unexamined assumptions and underlying ableism have the potential to eventuate in barriers to children's inclusion in centres (Barton, 1996; Cook, Tankersley & Landrum 2000; Carrington, et al. 2015; Lalvani, 2013b; Lalvani & Broderick, 2015; Villegas, 2007).

To support educators and parents in identifying underlying discriminatory views, it is beneficial to recognise disability as being socially constructed. It is important to acknowledge ableism throughout current society (Haller, 2010; Oliver, 2004; Lilley, 2013) and that underlying deficit views of disability remain (Carrington et al., 2015; Lalvani, 2013; Sze, 2009). Views of disability are formed from a multitude of influences; however, attitudes towards inclusion are frequently left unexplored (Cook et al., 2000; Lalvani, 2013b; Oliver, 2009; Slee, 2013). It is crucial that educators and parents critically reflect on personal and centre beliefs of disability, to resist the "circle of certainty" (Freire, 1970, p. 39), and to identify any "dysconsciousness" (King, 1991, p. 133) that could affect centres' inclusive cultures. Action comes from true reflection (Freire, 1970), and is foundational to disestablishing ableism, and for identifying attitudes towards disability and inclusion.

Opening communication on disability and inclusion can be initiated within centres by sharing information in pamphlets, newsletters, noticeboards, and through educator-parent

information sessions. Topics to explore include critically reflecting on disability beliefs and ableism, identifying and challenging barriers to children's inclusion, recognising inclusive principles, linking social relational perspectives of disability to practice, focusing on children from a strengths-based perspective, and celebrating all children as individuals (Beckett, 2009; Carrington et al., 2012, Carrington & Saggers, 2008; Cologon, 2012; Cologon &Thomas, 2014; Lalvani, 2013; Lalvani & Broderick, 2015; Larrivee, 2000; Mergler et al., 2016, Thomas, 1999, 2001, 2004). Considering inclusion as respectful practice, and being "for the purpose of something", encourages educators and parents to identify and discuss disability and inclusion from a strengths-based perspective and encourages communication between educators and parents on inclusive cultures (Reindal, 2016, p.1).

Educators critically reflecting on disability beliefs, and identifying and challenging any stigmatising views or "ableist privilege", are also important (Lalvani & Broderick, 2015, p.169). Undertaking critical reflection facilitates shifting perspectives towards inclusive principles and celebrating diversities (Beckett, 2009; Broderick et al., 2012; Cologon, 2012; Lalvani, 2013; Lalvani & Broderick, 2015: Slee, 2001). Critical reflection also supports educators to recognise that challenging barriers facilitates inclusion and leads to deliberate and purposeful inclusive practice (Carrington et al., 2012, Carrington & Saggers, 2008; Cologon, 2012; Cologon &Thomas, 2014; Lalvani & Broderick, 2015; Larrivee, 2000; Mergler et al., 2016). Lalvani explains that it is crucial for educators to "interrogate their own complicity in perpetuating oppressive discourses", as educators' opinions can be communicated as knowledge to children and parents within their centres and communities (2014, p. 1231). Critical reflection is an important skill that can be learnt, and is a crucial aspect of educators' professional development and learning (Carrington et al., 2015; Russell, 2005; Larrivee, 2008; McKay et al., 2014). Educators can learn to differentiate between their "espoused theory" (Sergiovanni & Starratt, 1988, p. 366) and "theory in use" (Sergiovanni & Starratt, 1988, p. 366), to develop critical reflection skills and facilitate children's inclusion.

Professional development and learning that supports educators' inclusive understandings focuses on shifting thinking away from deficit perspectives of disability (Lalvani, 2016), and on how to adapt practice for inclusive education (Martin, 2013). The EYLF identifies inclusion as "taking into account all children's social, cultural and linguistic diversity (including learning styles, abilities, disabilities, gender, family circumstances and geographic location) in curriculum making processes" (DEEWR, 2009, p. 24). Learning how to take diversities into account will support educators in facilitating inclusive practice and communicating this within inclusive centre cultures. Educator and parent learning, through in-centre development and learning sessions, regular discussions, and newsletters, presents

opportunities to foster partnerships with families (DEEWR, 2009), maintain inclusive cultures within centres, and supports ongoing inclusive practice.

Policy makers can promote inclusion as everyday practice, beyond views of inclusion as an optional addition (Mackenzie et al., 2016). Inclusive development and learning sessions can focus on teaching, critical reflection skills for inclusive practice (Carrington et al., 2015; Russell, 2005; Larrivee, 2008; McKay et al., 2014), giving children every opportunity to achieve through enacting high expectations (Biklen & Burke, 2006; DEEWR, 2009; Underwood et al., 2012), and strengths-based approaches (Cologon & Cocksedge, 2014; Harte, 2010).

Future research can focus on identifying strategies for critical reflection, and on investigating how educators can articulate and link their inclusive understandings to practice. Clarifying inclusive attitudes, and supporting educators to link inclusive practice and ideology, are important for supporting educators' confidence, and for continuing inclusive early childhood education (Avramidis & Norwich, 2002; Carrington et al., 2016; Cologon, 2012; Jordan et al., 2010; Petriwskyj, Thorpe & Tayler, 2014; Wendelborg & Tøssebro, 2010).

6.3 Barriers to Children's Inclusion

Predominantly, respondents in the present study recognised barriers as affecting children's inclusion, and as potentially temporary. In comparison to the number of respondents acknowledging barriers as impacting children's inclusion, the recognition of specific barriers within the study's categories, of communication, resource, attitude, environment and self-identified barriers, were minimal (see Section 5.3). Respondents in the present study predominantly recognised children within their microsystems and interconnecting social and environmental contexts (Bronfenbrenner, 1977, 1979), and acknowledged barriers to inclusion within each context. It is important to recognise children within their interconnected systems, as barriers to children's inclusion exist within these systems (Cologon & Thomas, 2014; Connors & Stalker, 2007; Mackenzie, et al., 2016).

Learning to identify and challenge specific barriers to doing and barriers to being in centres supports the practical application of the social relational perspective to practice (Cologon & Thomas, 2014; Mackenzie et al., 2016). This is beneficial for educators and parents in facilitating children's inclusion in centres (Cologon, 2012; Connors & Stalker, 2007; Runswick-Cole, 2008; Mackenzie et al., 2016; Nind et al., 2010). With inclusion regularly misunderstood, and many early childhood educators uncertain how to practice

inclusivity, it is important for educators to learn how to facilitate inclusion (Armstrong et al., 2010; Cologon, 2012, 2014; Lalvani, 2013; Mackenzie et al., 2016).

Information sharing and educator-parent development and learning sessions, suggested in Section 6.2, remain applicable. Educators and parents recognising how to identify and challenge barriers to facilitate children's inclusion involves learning how to selectively adjust practice, attitudes and environments for individual children (O'Donoghue & Chalmers, 2000; Curcic, 2009). Forlin (2011) proposes a team approach to challenging obstacles as being the most supportive strategy for inclusive practice. Educators and parents learning to collaborate in identifying and challenging barriers to children's inclusion would support ongoing inclusive practice in centres.

Educators would benefit from continuing to develop "multiplicity" (McKay et al., 2014, p. 3) by linking social relational perspectives (Thomas, 1999, 2001, 2004) and ecological theory understandings (Bronfenbrenner, 1977, 1979) to inclusive practice (Cologon & Thomas, 2014; Connors & Stalker, 2007; Mackenzie, et al., 2016). More specifically, educators recognising children's individualities within interconnected contexts presents opportunities to identify and challenge barriers to children's inclusion (Cologon & Thomas, 2014; Connors & Stalker, 2007; Mackenzie et al., 2016). In recognition of inclusion as an ongoing process that is context specific and changes over time, it is crucial for educators to participate in inclusive development and learning in context (Ainscow et al., 2004; Carrington, 2012; Carrington & Robinson, 2002; Duke et al., 2016).

Development and learning sessions held in individual centres can focus on identifying and challenging specific barriers. Topics to incorporate into the development and learning could include: flexibility and adaptability (Horne & Hurley, 2011); accommodating approaches for individual children (Ferri, 2012); personalising aims (Underwood et al., 2012); organising and preparing (McCathren & Watson, 2009); and continually evaluating practice to support children's participation and belonging. The EYLF explains the importance of educators and families forming partnerships as "working together to explore the learning potential in everyday events, routines and play so that children with additional needs are provided with daily opportunities" (DEEWR, 2009, p. 12). This collaborative focus is beneficial for inclusive practice (Booth, 2011; Cologon, 2014; Keen, 2007; Lalvani, 2015). However, shifting perspectives away from perceiving children with disability as having additional needs, and towards all children as having needs, is a more inclusive focus.

There is limited research on identifying and challenging barriers to facilitate children's inclusion in early childhood centres (Brereton, 2008; Cologon, 2014; Clough & Nutbrown, 2009; Mackenzie et al., 2016). Research on identifying and challenging barriers to doing and

barriers to being in centres would be advantageous for supporting future early childhood practice, particularly as research investigating the social and social relational models of disability in early childhood education is limited (Cologon, 2012; Connors & Stalker, 2007; Runswick-Cole, 2008; Mackenzie et al., 2016; Nind et al., 2010). It would be advantageous for policy makers to support this future research, to build on current understanding of adaptations in centres supporting children's inclusion (DEEWR, 2015), and to focus on aligning inclusive commitments and practice.

6.4 Inclusive Cultures

Educators and parents reported aligned inclusive understandings, views of disability, and supportive relationships, within their centres. Sharing inclusive visions and aims is advantageous for developing collaborative relationships within inclusive cultures (Booth, 2011; Cologon, 2014; Keen, 2007; Lalvani, 2015), and for the successful implementation of inclusive education (Avramidis & Norwich, 2002; Baglieri, 2008; Carrington et al., 2016; Cologon, 2012, 2014; Curcic, 2009; Hoskin et al., 2015; Jordan et al., 2010). Anderson et al. (2014) explain that school cultures exist within children's exosystems, and directly influence children's school experience. The concept of influential cultures on children's educational experiences remains relevant to early childhood centres' inclusive cultures. Educators benefit from clarifying inclusive visions and aims, to make certain they can: clearly communicate inclusive beliefs and practice; address personal and centre discriminatory systems (Lalvani, 2013; Lalvani & Broderick, 2015); support inclusive centre philosophy; maintain collaborative relationships; and facilitate children's inclusion (Curcic, 2009).

Collaboration is foundational and ongoing in inclusive practice, and educators would benefit from learning strategies to collaborate with other educators, parents and professionals (Beresford et al., 2012). Building strong connections with children and families to support belonging and participation is identified as being essential to children's lives (DEEWR, 2009), and is facilitated in ongoing inclusive practice (Connor & Goldmansour, 2012, Curcic, 2009: Frankel et al., 2010: Mackenzie et al., 2016; Theodorou & Nind, 2010; Vakil et al., 2009). Strategies for encouraging belonging include creating purposeful connections, and establishing routines such as personalised greetings, accessible information boards, and journals with updates on daily happenings (Beresford et al., 2012). It is imperative that educators make time to communicate with parents, as building trust and support is crucial for continually discussing and practicing high quality inclusion (Horne & Hurly, 2011). Promoting family involvement through family centre visits and social gatherings also encourages interactions and collaboration within inclusive cultures (Beresford et al., 2012).

Established support and guidance for educators across educational contexts tends to nurture a more inclusive culture, with positive and inclusive attitudes (Keefe & Carrington, 2007; Petriwskyj et al., 2014). Collaboratively planning and critically reflecting with teams promotes diverse input, shared inclusive responsibility, and inclusive practice, and is advantageous for clarifying and communicating inclusive expectations (Beresford et al., 2012; Harte, 2010). To support collaborative inclusive approaches in centres, Cologon (2012) suggests that educators get to know and build relationships with individual children, identify local supports and resources, and identify strategies for working collaboratively with teams. To further support collaborative inclusive focus and understandings, Lalvani (2012; 2013; 2013b) suggests that professional development and learning for educators focus on: the benefits of inclusive education, different interpretations and theories of disability; identifying attitudes and stigma (throughout history) towards people with disability, to support, identifying and challenging segregation and marginalisation; and how to open communication and involvement in inclusive education. Incorporating social relational understandings of disability into educators' professional development and learning can support educators in recognising their roles in identifying and challenging barriers to children's inclusion in centres (Cologon, 2012; Connors & Stalker, 2007; Runswick-Cole, 2008; Mackenzie et al., 2016; Nind et al., 2010). Educators have also been reported as developing confidence in facilitating inclusive practice from increased experiences and support with inclusive education (Avramidis & Norwich, 2002; Carrington et al., 2016; Cologon, 2012; Jordan et al., 2010; Petriwskyj et al., 2014).

Future research investigating how to facilitate context specific inclusive practice in centres would support ongoing inclusive early childhood practice. Examining how to identify and challenge barriers to children's inclusion in centres supports children, families, centres, and educators, in facilitating inclusive early childhood practice.

6.5 Strengths and importance to the sector

The present study has contributed to existing research on inclusive early childhood education, and has identified links between the social relational model of disability and educational practice. Results from this study build on current understandings that well-articulated understandings of disability and inclusion are essential, for linking beliefs directly to inclusive practice. In addition, the present study's results highlight the value of investigating educators' and parents' perspectives when examining inclusive early childhood education in centres.

Implications from the present study highlight the importance of investigating educators' and parents' perspectives on inclusion in centres. Inclusive practice is recognised

as context specific, and each centre has their own inclusive culture. Misinterpretations of inclusive practice can continue to be identified and challenged through future research, and further investigation of how educators implement inclusive practice in early childhood centres will directly support the facilitation of children's inclusion. Results from this study highlight the importance of identifying and challenging barriers within early childhood centres, for facilitating children's inclusion. While further research is needed to investigate specific barriers within centres, results from the present study signify this as relevant for ongoing inclusive early childhood education.

The present study has identified links between the theory of the social relational model of disability and educational practice; and argues that, even though these three centres are practicing inclusion, gaps are evident in the educators' and parents' understandings of inclusion. Therefore, there is still work to be done in terms of the inclusion of all children in early childhood centres, to personalise and adapt practice to meet children's strengths and interests, and to facilitate belonging and participation. "The definition of disability is tricky" (parent seven, questionnaire); however, when we consider that inclusion is about everyone, we can focus on including *all* children, in *all* our early childhood practice.

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APPENDIX ONE

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9 November 2016

Dear Dr Hadley

Reference No: 5201600667

Title: *Investigating the practical application of the social relational model of disability. Examining early childhood educator's inclusive practice*

Thank you for submitting the above application for ethical and scientific review. Your application was considered by the Macquarie University Human Research Ethics Committee (HREC (Human Sciences & Humanities)).

I am pleased to advise that ethical and scientific approval has been granted for this project to be conducted by:

- Macquarie University

This research meets the requirements set out in the *National Statement on Ethical Conduct in Human Research* (2007 – Updated May 2015) (the *National Statement*).

Standard Conditions of Approval:

1. Continuing compliance with the requirements of the *National Statement,* which is available at the following website:

http://www.nhmrc.gov.au/book/national-statement-ethical-conduct-human-research

2. This approval is valid for five (5) years, subject to the submission of annual reports. Please submit your reports on the anniversary of the approval for this protocol.

3. All adverse events, including events which might affect the continued ethical and scientific acceptability of the project, must be reported to the HREC within 72 hours.

4. Proposed changes to the protocol and associated documents must be submitted to the Committee for approval before implementation.

It is the responsibility of the Chief investigator to retain a copy of all documentation related to this project and to forward a copy of this approval letter to all personnel listed on the project.

Should you have any queries regarding your project, please contact the Ethics Secretariat on 9850 4194 or by email ethics.secretariat@mq.edu.au

The HREC (Human Sciences and Humanities) Terms of Reference and Standard Operating Procedures are available from the Research Office website at:

http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human_research_ethics

The HREC (Human Sciences and Humanities) wishes you every success in your research.

Yours sincerely

Dr Karolyn White
Director, Research Ethics & Integrity,
Chair, Human Research Ethics Committee (Human Sciences and Humanities)

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research* (2007) and the *CPMP/ICH Note for Guidance on Good Clinical Practice.*

APPENDIX TWO

Re: Ethics application response ref: 5201600667 - Outcome of HREC review

APPROVED
By Fran Thorp at 10:19 am, Mar 10, 2017

Fran Thorp

Fay Hadley

Mon 27/02/2017 9:31 AM

To:Ethics Secretariat <ethics.secretariat@mq.edu.au>;

Cc:Katie Wright (HDR) <katie.wright1@hdr.mq.edu.au>; Kathy Cologon <kathy.cologon@mq.edu.au>;

Categories: HUM; Executive

Dear Fran

please find below our explanation for the two questions you have asked.

1. We are proposing that we make up the numbers of participants as we are falling short of proposed numbers for stage 2. Our ethics application stated:
A maximum of 20 early childhood educators because this is the number of staff employed at two early childhood centres. This number will allow for data to be compared and contrasted with the current literature and research on inclusive practices for children who experience disability.
We currently have well below this figure, with two participants volunteering for stage two.

2. For the third early childhood setting, the proposal is to contact a local setting that in close proximity to Macquarie University. The co-investigator had a pre-existing relationship with this centre as her son attended here part time in 2013. There has been minimal contact with this setting since then, including a two hour observation period for a university assignment. This setting has been chosen as they are supportive of university students, and the Director's interest in working with children with disabilities.

Please let us know if you require anything else

Kind regards
Fay

APPENDIX THREE

Department of Educational Studies
Faculty of Human Sciences
MACQUARIE UNIVERSITY   NSW   2109

Phone: +61 (0)2 98509833

Email: fay.hadley@ mq.edu.au

Dear Directors,

We are writing to invite the staff and families in your centre to participate in a questionnaire for a study about barriers to children's inclusion in early childhood settings. We want to find out about staff and family views on how to best challenge barriers to children's participation. This information aims to support greater inclusion of all children, with a specific focus on including children with disabilities. We would like to hear from all staff members and parents from your centre through a questionnaire and following this, we'd like to interview room leaders who agree to this. The study is titled 'Examining early childhood educator's inclusive practice.'

The study is being conducted by Dr. Fay Hadley, Dr Cologon and Katie Wright from Macquarie University (please see our contact details at the end of this form). The project will be undertaken as part of the requirements of the Masters of Research, under the supervision of Dr. Fay Hadley.

Parents will be invited to participate in a questionnaire about their experiences of children who have a disability in child care settings. Staff will be invited to participate in a questionnaire on identifying barriers that children experience, their experience working with children with disabilities and lastly, views on disability, inclusion and barriers. The questionnaires are voluntary and confidential and will take approximately 30-45 minutes to complete. The centre would be agreeing to email the information about the study which also provides the link to the online questionnaire.

Room leaders will also be invited to participate in interviews that will clarify and deepen collated information from the questionnaires. The interview will take between 30mins to an hour and with permission, will be audio recorded.

The ethical aspects of this study have been approved by the Macquarie University Human Research Ethics Committee. If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Committee through the Director, Research Ethics & Integrity (telephone (02) 9850 7854; email ethics@mq.edu.au). Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

Chief Investigator   *Co-investigator*

Fay Hadley

Institute of Early Childhood

fay.hadley@mq.edu.au

Phone: (02) 9850 9833

Kathy Cologon

Institute of Early Childhood

kathy.cologon@mq.edu.au

Co-investigator

Katie Wright

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katie.wright1@hdr.mq.edu.au

APPENDIX FOUR

Department of Educational Studies
Faculty of Human Sciences
MACQUARIE UNIVERSITY   NSW   2109
Phone: +61 (0)2 98509833

Email: fay.hadley@ mq.edu.au

Chief Investigator's / Supervisor's Name & Title: Dr Fay Hadley

Participant Information and Consent Form

Name of Project: Examining early childhood educator's inclusive practice

Dear educators,

Thank you for considering participating in this research project. We are looking at parent and early childhood staff views and experiences of children with a disability in early childhood settings. Through your participation, you will be helping us to understand how to best challenge barriers to children's participation. This information aims to support greater inclusion of all children, with a specific focus on children with disabilities within early childhood settings.

The study is being conducted by Dr. Fay Hadley, Dr Kathy Cologon and Katie Wright from Macquarie University (please see our contact details at the end of this form). The project will be undertaken as part of the requirements of the Masters of Research, under the supervision of Dr. Fay Hadley and Dr Kathy Cologon. Parents will be invited to participate in an online questionnaire about their experiences of children who have a disability in child care settings. Staff will be invited to participate in an online questionnaire on identifying barriers that children experience, experience working with children with disabilities and lastly general questions regarding views on disability, inclusion and barriers. The questionnaires are confidential and will take approximately 30 – 45 minutes to complete. The centre has agreed to email this information about the study which also provides the link to the online questionnaire.

Room leaders will also have the opportunity (if they elect to) to participate in an interview that will clarify and deepen collated information from the questionnaires. These interviews will take between 30minutes to an hour and will occur in a place that is convenient to the educator and outside of their work hours.

Participation in this study is entirely voluntary: you are not obliged to participate and if you decide to participate, you are free to withdraw at any time without having to give a reason and without consequence.

Any information or personal details gathered in the course of the study are confidential, except as required by law, and only Fay Hadley, Kathy Cologon and Katie Wright will have access to this data. No individual will be identified in any publication of the results. A summary of the results of the data will be shared with you on completion of this study.

If you experience any distress during this study, please contact Lifeline with online tools, information and counselling on 131114 or at https://www.lifeline.org.au/,Relationships Australia for counselling and family assistance on 1300 364 277 or at http://www.relationships.org.au, or your GP's for support.

The ethical aspects of this study have been approved by the Macquarie University Human Research Ethics Committee. If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Committee through the Director, Research Ethics & Integrity (telephone (02) 9850 7854; email ethics@mq.edu.au). Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

Please click on the button below if you choose to complete the survey. (Clicking on this button indicates that you agree to consent to participating in this research.)

If you are interested in participating, please complete the questionnaire by clicking on the link below.

Survey Link:

https://mqedu.qualtrics.com/SE/?SID=SV_82EcxkGF0b8m9i5

Chief Investigator

Fay Hadley

Institute of Early Childhood

fay.hadley@mq.edu.au

Phone: (02) 9850 9833

Co-investigator

Kathy Cologon

Institute of Early Childhood

kathy.cologon@mq.edu.au

Co-investigator

Katie Wright

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APPENDIX FIVE

Department of Educational Studies
Faculty of Human Sciences
MACQUARIE UNIVERSITY   NSW   2109
Phone: +61 (0)2 98509833

Email: fay.hadley@ mq.edu.au

Chief Investigator's / Supervisor's Name & Title: Dr Fay Hadley

Participant Information and Consent Form

Name of Project: Examining early childhood educator's inclusive practice

Dear families,

Thank you for considering participating in this research project. We are looking at parent and early childhood staff views and experiences of children with a disability in early childhood settings. Through your participation, you will be helping us to understand how to best challenge barriers to children's participation. This information aims to support greater inclusion of all children, with a specific focus on children with disabilities within early childhood settings.

The study is being conducted by Dr. Fay Hadley, Dr Kathy Cologon and Katie Wright from Macquarie University (please see our contact details at the end of this form). The project will be undertaken as part of the requirements of the Masters of Research, under the supervision of Dr. Fay Hadley and Dr Kathy Cologon. Parents will be invited to participate in an online questionnaire about their experiences of children who have a disability in child care settings. Staff will be invited to participate in an online questionnaire on identifying barriers that children experience, experience working with children with disabilities and lastly general questions regarding views on disability, inclusion and barriers. The questionnaires are confidential and will take approximately 30 – 45 minutes to complete. The centre has agreed to email this information about the study which also provides the link to the online questionnaire.

Room leaders will also have the opportunity (if they elect to) to participate in an interview that will clarify and deepen collated information from the questionnaires. These interviews will take between 30minutes to an hour and will occur in a place that is convenient to the educator and outside of their work hours.

Participation in this study is entirely voluntary: you are not obliged to participate and if you decide to participate, you are free to withdraw at any time without having to give a reason and without consequence.

Any information or personal details gathered in the course of the study are confidential, except as required by law, and only Fay Hadley, Kathy Cologon and Katie Wright will have access to this data. No individual will be identified in any publication of the results. A summary of the results of the data will be shared with you on completion of this study.

If you experience any distress during this study, please contact Lifeline with online tools, information and counselling on 131114 or at https://www.lifeline.org.au/, Relationships Australia for counselling and family assistance on 1300 364 277 or at http://www.relationships.org.au, or your GP's for support.

The ethical aspects of this study have been approved by the Macquarie University Human Research Ethics Committee. If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Committee through the Director, Research Ethics & Integrity (telephone (02) 9850 7854; email ethics@mq.edu.au). Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

Please click on the button below if you choose to complete the survey. (Clicking on this button indicates that you agree to consent to participating in this research.)

If you are interested in participating, please complete the questionnaire by clicking on the link below.

Survey Link:

https://mqedu.qualtrics.com/SE/?SID=SV_4Po8IzbTUBR84eh

Chief Investigator

Fay Hadley

Institute of Early Childhood

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APPENDIX SIX

Department of Educational Studies
Faculty of Human Sciences
MACQUARIE UNIVERSITY   NSW   2109
Phone: +61 (0)2 98509833

Email: fay.hadley@ mq.edu.au

Phase 2 of the Examining early childhood educator's inclusive practice project

Dear Early Childhood Educator,

You are invited to participate in a study that will investigate early childhood educator views and experiences of children with a disability in early childhood settings. This study will form part of a Master's Degree program. The purpose of the study is to develop greater insight into understanding how to best challenge barriers to children's participation. Research informs us of the value of inclusive education and yet, it can be unclear how to put this into practice.

You have been invited to participate in an interview as you are a room leader in a centre that participated in the first phase of this research project, via questionnaires. We aim to develop information to provide educators with practical ways to identify and challenge barriers to children's participation in early childhood settings. The interview will take 30-60 minutes and will be conducted in a place and time that suits you.

The study is being conducted by Katie Wright, who is a Master of Research student at the Institute of Early Childhood, Macquarie University. Katie Wright is under the supervision of Dr Fay Hadley and Dr. Kathy Cologon, Senior Lecturers, within the Institute of Early Childhood, Macquarie University.

I would like to invite you to participate in the research through an interview during June 2017 to unpack your experiences of including children and ways to overcome barriers to participation.

Involvement in this study is purely voluntary for all participants. Participants are free to withdraw at any time throughout the study and should feel confident that there will be no adverse effects from their choice to withdraw. Any information or personal details gathered in the course of the project are confidential. No individual will be identified in any publication of the results. The investigators, research assistant and transcriber will be the only people who have access to the data. Any publication would be identified for example as participant 1. A summary of results will be given to your early childhood setting.

The ethical aspects of this study have been approved by the Macquarie University Human Research Ethics Committee. If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Committee through the Director, Research Ethics and Integrity (telephone (02) 9850 7854; email ethics@mq.edu.au). Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

If you have any further questions, please contact Dr Fay Hadley, Dr. Kathy Cologon or Ms Katie Wright (Research Student), listed below. I look forward to hearing from you.

Chief Investigator

Fay Hadley

Institute of Early Childhood

fay.hadley@mq.edu.au

Phone: (02) 9850 9833

Co-investigator

Katie Wright

Institute of Early Childhood

katie.wright1@hdr.mq.edu.au

Co-investigator

Kathy Cologon

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kathy.cologon@mq.edu.au

Educator questionnaires

Q1 What is the age group of the children you're currently teaching?

○ Birth to 1 year (1)

○ 1-3 years (2)

○ 3-4 years (3)

○ 4-5 years (4)

Q2 What is the size of the group of children you're currently teaching? (How many children are in each group?)

___

Q3 What are the staff ratios in the group you're currently teaching?

1:4 (1)

1:5 (2)

1:10 (3)

other (4) _____

Q4 What is your highest level of education?

○ Working towards Certificate 3 (1)

○ Certificate 3 (2)

○ Diploma (3)

○ Degree (4)

○ Masters (5)

○ PhD (6)

Q5 How long have you worked in this centre?

_____

Q6 Are you currently in the position of room leader in this centre?

○ Yes (1)

○ No (2)

Q7 How long have you worked in the early childhood field?

Q8 These questions refer to your work with children with disabilities.

	Yes (1)	No (2)
Have you had experience working with children with disabilities? (1)	○	○

Are there any children labelled with an impairment/disability currently enrolled in your centre? (2)		○		○	
Is this child/children in your group? (3)		○		○	

this child care centre.   Please mark your response from strongly agree to strongly disagree. There are not right or wrong answers.

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
I think our centre currently includes all children well. (1)	○	○	○	○	○
I feel children and their individualities are recognised and appreciated. (2)	○	○	○	○	○
I think that by challenging barriers, our centre could include all children. (3)	○	○	○	○	○
I think staff have positive attitudes and are open to including all children. (4)	○	○	○	○	○
I feel our centre celebrates diversity well. (5)	○	○	○	○	○
I feel there are barriers to families' inclusion in our centre. (6)	○	○	○	○	○

Q9 These questions refer to your education for working with children with disabilities.

	Yes (1)	No (2)
Have you received education for working with children with disabilities? (If your answer is no, please move to question 12). (1)	○	○
Was this education helpful? (2)	○	○
Was this education a personal choice? (3)	○	○
Was this education encouraged by your workplace? (4)	○	○
Was this education part of your study/course? (5)	○	○

Q9a What type of education have you had for working with children with disabilities? How long was this education? Who provided this education?

_____

_____

Q10 From your education, what information/support did you find helpful for your early childhood practice? Why?

_____

Q11 Did you share the information you received from this education with your workmates? If so, how (e.g. casual conversations or group sharing)?

○ Yes (1) _____

○ No (2)

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Q12 These questions focus on support for your work with children with disabilities.

	On the job education (1)	Early childhood journals (2)	Early childhood books (3)	Staff meetings (4)	Conversations with staff (5)	Other (6)
Support I currently receive for my inclusive practice includes (1)	○	○	○	○	○	○
Support I would like to receive for my inclusive practice includes (2)	○	○	○	○	○	○

Q13 If you answered 'other' in question 12, please explain this here.

Q14 Do you know any local supports that are available for your work for families with children with disabilities? If so, please give details.

Yes (1) _____

No (2)

15 Have you completed an Individual Family Service Plan (IFSP) or an Individual Education Plan (IEP)? If so, what support was most helpful for this?

Yes (1) _____

No (2)

16 Based on your experience and thoughts about including children with disabilities, please respond to the following statements by indicating between strongly agree and strongly disagree. There are no right or wrong answers.

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
All children can be included when we adapt our setting/practice. (1)	○	○	○	○	○
I am able to identify barriers that children with disabilities may experience. (2)	○	○	○	○	○
I feel confident challenging barriers that children with disabilities experience. (3)	○	○	○	○	○
I am supported to challenge barriers for children with disabilities within this early childhood setting. (4)	○	○	○	○	○
I know where to go for support for including children with disabilities. (5)	○	○	○	○	○

Q17 These questions refer to communication with this child care centre. Please mark your response between strongly agree and strongly disagree. There are no right or wrong answers.

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly disagree (5)
(1)	○	○	○	○	○
I am satisfied with how I communicate with families (e.g. emails or conversations). (2)	○	○	○	○	○
(3)	○	○	○	○	○
I am able to communicate openly with families. (4)	○	○	○	○	○
(5)	○	○	○	○	○
Our families' choices are respected. (6)	○	○	○	○	○
(7)	○	○	○	○	○
I experience communication barriers with families. (8)	○	○	○	○	○
(9)	○	○	○	○	○
I feel heard and any problems are looked after. (10)	○	○	○	○	○

Q18 These questions refer to this child care centre's general environment, toys and equipment. Please mark your responses between strongly agree and strongly disagree. There are no right or wrong answers.

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
(1)	○	○	○	○	○
The indoor classroom caters for all children. (2)	○	○	○	○	○
(3)	○	○	○	○	○
The outdoor area caters for all children. (4)	○	○	○	○	○
(5)	○	○	○	○	○
Toys and equipment suit all children's needs (e.g. books and teaching equipment). (6)	○	○	○	○	○
(7)	○	○	○	○	○
Our centre changes the indoor classroom to suit different needs. (8)	○	○	○	○	○
Our centre changes the outdoor area to suit different needs. (9)	○	○	○	○	○
I would like to see a greater variety of resources for children. (10)	○	○	○	○	○

Q19 Are there indoor or outdoor environmental barriers for children with disabilities within this early childhood setting?

○ If yes, what? (1) _____

○ No (please move to question 20). (2)

Q19a Are there ways you can overcome these indoor or outdoor environmental barriers? If so, how?

_____

Q20 Are there communication barriers for children with disabilities within this early childhood setting?

○ If yes, what? (1) _____

○ No (move to question 21). (2)

Q20a Are there ways you can overcome these communication barriers? If so, how?

○ Yes (1) _____

○ No (2)

Q21 Are there attitudinal barriers for children with disabilities within this early childhood setting?

○ If yes, what? (1) _____

○ No (move to question 22). (2)

Q21a Are there ways you can address these attitudes? If so, how?

☐ Yes (1) _____

☐ No (2)

Q22 Are there resource barriers for children with disabilities within this early childhood setting?

○ If yes, what? (1) _____

○ No (move to question 23) (2)

Q22a Are there ways you can overcome these resource barriers? If so, how?

○ Yes (1) _____

○ No (2)

Q23 Are there other barriers to the inclusion of all children that you can identify within this early childhood setting?

○ If yes, what? (1) _____

○ No (move to question 24). (2)

Q23a Are there ways you can overcome these barriers? If so, how?

○ Yes (1) _____

○ No (2)

Q24 What do you understand disability to mean?

_____

Q25 What do you understand inclusion to mean?

_____

_____

Q26 What do you understand barriers to mean?

_____

Q27 Do you have any additional comments you would like to make?

_____

_____

Q28 If you are a room leader would you be interested in being interviewed for this project?

○ Yes (1)

○ No (2)

Skip To: End of Survey If Q28 = No (2)
Skip To: Q29 If Q28 = Yes (1)

Q29 Thank you for considering an interview for this project. Please leave your details below so one of the researchers can contact you to arrange a suitable time.

○ Name (1) _____

○ Phone (2) _____

○ Email (3) _____

Parent questionnaire

Q1 How many children do you have enrolled at this child care centre?

○ 1 (1)

○ 2 (2)

○ 3 (3)

○ 4 (4)

Q2 What are the ages of your enrolled children? (please tick all the appropriate boxes)

○ 0-1 year (1)

○ 1-2 years (2)

○ 2-3 years (3)

○ 3-4 years (4)

○ 4-5 years (5)

Q3 How long have you had children enrolled at this child care centre?

○ 0-1 year (1)

○ 1-2 years (2)

○ 2-3 years (3)

○ 3-4 years (4)

○ more (5)

Q4 Do you have a child with a disability?

○ Yes (1)

○ No (2)

Q5 If so, has this disability been diagnosed?

○ Yes (1)

○ No (2)

Q6 These questions refer to your experiences with this child care centre. Please mark your response between strongly agree and strongly disagree. There are no right or wrong answers.

	Strongly agree (1)	Agree (2)	Somewhat agree (3)	Neither agree nor disagree (4)	Strongly disagree (5)
I think our centre currently includes all children well. (1)	○	○	○	○	○
I feel my child/children are supported and included. (2)	○	○	○	○	○
I feel my child/children and their individualities are recognised and appreciated. (3)	○	○	○	○	○
I think that by challenging barriers, our centre could include all children. (4)	○	○	○	○	○
I think staff have positive attitudes and are open to including all children. (5)	○	○	○	○	○

I feel our centre celebrates diversity well. (6)	○	○	○	○	○
I feel there are barriers to my families inclusion in our centre. (7)	○	○	○	○	○

Q7 These questions refer to communication with this child care centre. Please mark your response between strongly agree and strongly disagree. There are no right or wrong answers.

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
I am satisfied with how I communicate with staff (e.g. emails or conversations). (1)	○	○	○	○	○
I am able to communicate openly with staff. (2)	○	○	○	○	○
Our families choices are respected. (3)	○	○	○	○	○
I experience communication barriers with staff. (4)	○	○	○	○	○
I feel heard and any problems are looked after. (5)	○	○	○	○	○

Q8 These questions refer to this child care centres general environment, toys and equipment. Please mark your responses between strongly agree and strongly disagree. There are no right or wrong answers.

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
The indoor classroom caters for all children. (1)	○	○	○	○	○
The outdoor area caters for all children. (2)	○	○	○	○	○
Toys and equipment suit all children's needs (e.g. books and teaching equipment). (3)	○	○	○	○	○
Our centre changes the indoor classroom to suit different needs. (4)	○	○	○	○	○
Our centre changes the outdoor area to suit different needs. (5)	○	○	○	○	○
I would like to see a greater variety of resources for children. (6)	○	○	○	○	○

Q9 Has you child/children experienced any barriers to being included in the classroom or outdoor area in the centre? (e.g. too many steps, tables too high).

○ No (please move onto question 10). (1)

○ Yes, please explain. (2) _____

○ If these barriers were overcome, how? (3)
_____

○ If these barriers were not overcome, how do you think they could have been addressed? (4)
_____

Q10 Has your child experienced any communication barriers?

○ No (please move onto question 11). (1)

○ Yes, please explain. (2) _____

○ If these barriers were overcome, how? (3)
_____

○ If these barriers were not overcome, how do you think they could have been addressed? (4)
_____

Q11 Has your child/children experienced any attitudes that have stopped them from being included in the centre?

○ No (please move onto question 12). (1)

○ Yes, please explain (2) _____

○ If these barriers were overcome, how? (3)
_____

○ If these barriers were not overcome, how do you think they could have been addressed? (4)
_____

Q12 Does your centre provide the most appropriate resources for your child/children? (e.g. communication tools, bathroom aides, toys).

○ Yes (please move onto question 13). (1)

○ No, please explain. (2) _____

○ If not, how do you think this could have been addressed? (3)
_____

Q13 Are there any other barriers you or your child/children have experienced that have stopped you from being included in the centre?

○ No (please move onto question 14). (1)

○ Yes, please explain. (2) _____

○ If these barriers were overcome, how? (3)
_____

○ How did staff best help with this? (4) _____

○ If these barriers were not overcome, how do you think they could have been addressed? (5)
_____

Q14 What do you understand disability to mean?

_____

_____

Q15 What do you understand inclusion to mean?

_____

_____

Q16 What do you understand barriers to mean?

_____

Q17 Do you have any additional comments you would like to make?

_____

APPENDIX NINE

Room leader interview topics

This is a current idea of the general topics to be discussed in the semi-structured interviews room leaders.

- Share a story as an example of how inclusion has worked and an example of how inclusion has not worked for a particular child or family. Explain why they think this was or was not successful.

- The possibility of inclusion for all children

- General understandings of disability

  o The social relational model of disability understandings?
  o Examples in centres?

- General understandings of barriers

- General understandings of inclusion

- Development and learning on inclusion
  o What was helpful?
  o What practical information was given?
  o Was this training individual or in a group?
  o Were barriers to inclusion discussed?

- Environmental barriers?
  o How to challenge them?

- Communication barriers?
  o How to challenge them?

- Attitude barriers?

- How to challenge them?

- Resource barriers?
  - How to challenge them?

  - Any other self-identified barriers?
    - How to challenge them?

  - Mentoring? or have been mentored?
    - Examples – helpful and/or not?

  - Any other comments or questions?

APPENDIX TEN

Educator Question 24 - What do you understand disability to mean?

physical, emotional or psychological barriers that need extra support to overcome

A hibderance of some sort

I understand that disability does not lie within a person, but is a construct of society. Disability results from society not considering the needs of all its members and not providing ways for them to be included.

Any physical or mental condition that limits or hinders a person's full participation in society

A condition that impacts on ones ability to perform tasks or participate fully and confidently

indvidual's conditions that effects how they operate

A physical or mental condition that might limit someone's ability to function.

A person who is limited by their environment.

Parent Question 14 - What do you understand disability to mean?

A physical or mental difficulty which is outside the "normal" challenges a person may face

Disability is a physical or mental condition (either born or developed over time) which may hinder a person normal course of development (movement, sense, physical activity)

can't move by oneself,

have limits on physical or mental condition

Disability is a wide reaching team that can include physical, emotional, cognitive, and other sensory elements. Generally, it implies some "compromise" or limit to the exercise/use of those elements that often requires some accommodation in particular situations.

Being unable to participate in or undertake activities which the majority of others in a similar age group can, due to an inherent condition (mental and/or physical)

Disability means you have a condition that impacts your accessibility to, enjoyment of, and interaction with people, situations and objects.

Severe specificities that makes difficult achievement of usual activities.

A physical or mental disadvantage when compared to a normal functioning human being.

Physical or mental characteristics that differ from normal

a physical or mental ailment that would limit capacity to perform tasks.

A physical or mental or health condition that in "our society" causes that person to be impaired or not included in various activities.

Impairments to standard functioning - either physical, intellectual, social, emotional, cognitive, etc.

Health (mental or physical) issue, compromised ability to perform tasks/participate

Physical or mental limitation

A child having different or impaired ability in a particular area (e.g. Physical, mental, social) to that which is typical for their age group

A genetic condition that may impact a person's physical and/or mental capacity to participate in activities.

Something which hinders someone from being able to do things as easily as others

some ailment that stops one from being able to do or perform something that they might have been able to if the ailment was not present

anything that might affect ability to participate in typical society

Educator Question 25 - What do you understand inclusion to mean?

everyone has the same opportunities

Inclusion is the process of removing that hinderance whether it be by -adjusting something in the physical environment or --educating people within the environment -Enriching the environment with relevant resources -Coming up with strategies that will minimise hindrance   The main outcome is to have everyone equally included in the environment

Inclusion means changing environments, perceptions, and attitudes so that all children are included.

Practices and attitudes that support the individual to participate in society to a degree that is fulfilling and meaningful for that individual; support for all individuals to achieve a "typical" level of participation

To include all children and families regardless of any physical, emotional, cultural

to involve all equally

To include all children with any condition in an educational institution by providing appropriate resources.

A condition or environment that can be adapted to suit everyone's needs

Parent Question 15 - What do you understand inclusion to mean?

What do you understand inclusion to mean?

including everyone, no matter what their differences are

To accept all people and provide alternative ways so as everyone is included.

To understand and to make another person feels being loved and included.

Inclusion means that those accommodations are provided/made available and that all individuals, regardless of personal "limitations, are able to participate in the environment.

Being aware of and recognising different levels of ability and cultural/personal difference, and adapting activities to these differences in order to encourage participation

Inclusion means considering the needs of all participants in a particular context, and making modifications as required.

The provision of adapted measures to include a kid in activities with the others kids.

Having access for everyone to everything equally.

Accommodating people into social/work/education environments

Being able to participate in all tasks equally, regardless of differences.

To be included in society no matter what abilities and/or disabilities one possesses. To have a sense of belonging.

Efforts made to provide equal opportunity and consideration of all people

Providing adjustments to the environment and/or practice to ensure all despite their abilities or disabilities feel included

Involvement

All children being included in activities sometimes through use of supports or mosifykng of the activity

Feeling able to participate where you would like to, asked my opinion and feeling listened to.

Ensuring that everyone is included, despite any differences.

where everything or everyone belongs to a Whole.

enabling everyone to participate no matter what? on an equal footing

Educator Question 26 - What do you understand barriers to mean?

something with time, or support can sometimes be overcome or faced.

Barriers prevent inclusion from Occurring These can because of mind set of others, the physical environment, lack of information about inclusion and so on

In terms of disability I believe that barriers are imposed upon people affected by disability by a society that is unwilling to change. It doesn't have to be this way. I'm not sure what it would take for this to change.

Any circumstance, either due to physical or social factors, that inhibits the individual's meaningful participation in society

I see barriers as anything that has to be worked on or overcome and can be in regard to the child, their family, the environment, the curriculum

features thatt cause hindrance

An Environment that might impede someone's ability to function.

A limitation to an individual's movements/creativity/thinking.

Parent Question 16 - What do you understand barriers to mean?

something which prohibits someone moving forward or accessing something

Something that hinders a person from doing what the norm is doing.

an obstacle

Barriers are any elements that prohibit that participation, including communication, physical movement, emotional accessibility/connection, and comprehension of environment.

Hindrances (recognised or un-recognised, physical or structural/organisational) which prohibit or restrict individuals from participating in activities

Barriers are anything that negatively impacts on a participants' access, enjoyment and interaction.

The lack of inclusion.

Things that prohibit inclusivity

Situations/rules/environments that block or discourage participation

Something that gets in the way of being able to do something

Something that hinders someone from doing something.

Challenges that prevent inclusion, whether systematic or incidental

Objects/activities/practices that prevent some individuals from participation

where there procedural or physical things in the way of inclusion

Difficulties / road blocks

Something that prevents you from undertaking or participating in an activity.

Something which separates people, or makes life more difficult for them.

things that come in the way or hinder progress

anything that prevents or inhibits access to experiences

APPENDIX ELEVEN

	What is your highest level of education?	How long have you worked in this centre? This one could be done on averages Less than 1 year 1-X t=yrs etc	Are you currently in room leader position?	How long have you worked in the early childhood field? This one could be done on averages	Have you had experience working with children with disabilities?	Are there any children labelled with an impairment/ disability currently enrolled in your centre?	Is this child/ children in your group?
Educator 1	Masters	9 months	No	10 years	No	Yes	No
Educator 2	Masters	10 months	Yes	11 years	Yes	Yes	No
Educator 3	Diploma	2 years	No	2 years	Yes	Yes	No
Educator 4	Degree	19 years	Yes	25 years	Yes	Yes	Yes
Educator 5	Diploma	6 years	Yes	6 years	Yes	Yes	Yes
Educator 6	Working towards certificate 3	2.5 years	No	2.5 years	Yes	Yes	Yes
Educator 7	Diploma	3 years	Yes	10 years	Yes	No	No
Educator 8	Diploma	1.5 years	Yes	1.5 years	Yes	No	No

Questionnaire Identifier	How many children do you have enrolled in this centre?	What are the ages of your enrolled children?	How long have you had enrolled children at this centre?	Do you have a child with a disability?	If so, does this disability been diagnosed?
Parent 1	1	2-3 years	0-1 years	No	No
Parent 2	1	0-1 years	0-1 years	No	No
Parent 3	1	2-3 years	1-2 years	No	No
Parent 4	1	1-2 years	0-1 years	No	No
Parent 5	2	3-4 years	2-3 years	No	No
Parent 6	1	3-4 years	0-1 years	No	No
Parent 7	2	3-4 years	1-2 years	No	No
Parent 8	1	2-3 years	1-2 years	No	No
Parent 9	1	2-3 years	1-2 years	No	No
Parent 10	1	2-3 years	2-3 years	No	No
Parent 11	1	3-4 years	2-3 years	No	No
Parent 12	1	3-4 years	0-1 years	No	No
Parent 13	1	3-4 years	2-3 years	No	No
Parent 14	1	3-4 years	1-2 years	No	No
Parent 15	1	3-4 years	0-1 years	No	No
Parent 16	2	4- 5 years	1-2 years	No	No
Parent17	2	3-4 years	2-3 years	Yes	Yes
Parent 18	1	0-1 years	0-1 years	No	No
Parent 19	2	4- 5 years	1-2 years	No	No
Parent 20	2	4- 5 years	3-4 years	No	No
Parent 21	2	2-3 years	1-2 years	No	No
Parent 22	2	4- 5 years	3-4 years	No	No
Parent 23	1	1-2 years	0-1 years	No	No
Parent 24	2	3-4 years	0-1 years	No	No
Parent 25	1	3-4 years	more	No	No
Parent 26	1	2-3	0-1	No	No
Parent 27	1	2-3	1-2	No	No
Parent 28	1	2-3	0-1	No	No
Parent 29	1	1-2	1-2	No	No
Parent 30	1	2-3	1-2	No	No