

Including Youth with Disabilities into School-Age Childcare

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Phase I Final Progress Report

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PHASE I FINAL REPORT

The goal of this project is to make school-age child care (SACC) accessible to youth with moderate and severe medical, developmental and physical disabilities by producing a series of broadcast quality video-based staff training materials on including disabled youth (ages 5-21) in regular SACC programs.

The aim in Phase I was to develop, produce and evaluate one 30-minute training program on the topic of adapting regular curricula. The instructional aim of this program was to teach strategies for modifying activities to maximize the participation of disabled youth. A presentation format was proposed that blended documentary footage of model SACC programs, dramatized vignettes and brief interviews with real child care providers. Each targeted skill was to be demonstrated in contexts familiar to SACC staff, i.e., typical SACC activities such as checking in, inside games, outdoor games, socializing, snack, transitions, homework and quiet time. The research goal in Phase I was to evaluate the impact of the video program on: 1) the acquisition and application of knowledge about inclusionary strategies, and 2) the nature and extent of concerns about including youth with disabilities in school-age child care.

Program Development

Three focus groups were used to help the research team select and develop program content. The research team was comprised of the project director, the production manager and project consultants. The first focus group, conducted in Portland, Oregon, brought together special educators and child care program administrators to discuss specific issues to be addressed in the video series and methods for maximizing their effectiveness. Two additional focus groups were conducted at Northwest Media in Eugene, Oregon. One group consisted of parents of school-age youth with disabilities; the other was made up of SACC providers. Focus groups members discussed: 1) whether the proposed material addressed the needs, attitudes and problems of staff, administration, families and youth regarding inclusive strategies; 2) how to maximize the effectiveness and value of the program's content and format; 3) the suitability of the style, tone and language of the video treatments; and 4) whether the material adequately addressed cultural concerns.

Details of the findings of each group are described below.

Focus Group #1: Special Educators and Child Care Program Directors

Seven people, all women, two Hispanic American, two Black American and three Anglo American, were recruited by the ARC of Multnomah County in Portland, Oregon, to participate in the first focus group. Two participants were directors of child care centers, one was a trainer for a child care inclusion program and the remainder worked as Special Educators in the Portland Public Schools.

The project director had written a brief treatment, or synopsis, for the proposed Phase I video, *Adapting Regular Curricula for Disabled Youth*. Focus group members were asked to evaluate the treatment on the basis of its relevance, instruction value and cultural relevance. The group made the following recommendations:

- As kids age and mature, it becomes more and more difficult to keep them in inclusive environments, so it's important to show a range of ages and emphasize methods for including the older kids.
- Remember who your audience is (child care providers) and keep the script free of jargon and medical terminology.
- Don't try to cram too much information into a short time period. Don't try to cover every type of disability in every situation.

In addition, the focus group members were presented with a proposed list and description of video topics for the entire Phase I and II project (the proposed curriculum includes: Basic Instructional Strategies, Behavior Management, Socialization, Adaptations, Attitudes toward Inclusion, Overcoming Cost Barriers, and Partnerships with Parents and Professionals). Focus group participants were

asked to comment on the relevance of the proposed topics. The group made the following recommendations:

- Include information on liability and other insurance issues as a cost barrier.
- How about a program titled, *What to do when the chairs go flying?* The section on behavior management is the most important. It's the behaviors associated with these disabilities that make things difficult.
- Include schools in the parent/care provider partnership. Schools and teachers can't be left out of the equation. Special education teachers can be a resource for SACC providers.
- SACC providers are rarely included as part of the IEP team. Most SACC providers don't know what an IEP is or what strategies are being implemented. If a child is going to have a consistent life experience, his or her entire day has to be with the same rules. The child can't have the rules change and be expected to function well.

Focus Group #2: Parents

The second focus group consisted of eight parents (seven mothers and one father) of youngsters with disabilities. One parent was American Indian; the others were Anglo Americans. The group made the following suggestions for the proposed video on adaptations:

- It may not always be possible to adapt every activity for every child, but as you get to know a child, you should be able to give that child as wide a range of options as everybody else.
- Providers should learn what the child can do, what the child's interests are. They should find out how the child communicates and what she or he can do at home.

Parents made the following suggestions regarding the proposed curriculum topics:

- There is a lot of concern about behaviors, but you have to ask yourself: Are the other kids taunting the child, provoking the kid to do that? You have to look at what's going on. There's a reason for behavior.
- Parents need to hear what's good, what went well. Not just the problems.

Focus Group #3: SACC Providers

The final focus group consisted of eight SACC providers, two males and six females, one Hispanic American and the rest Anglo American, with experience working with school-age youth with disabilities. Their comments on the proposed adaptations video were:

- The ratio of kids to providers has to change when there are kids with disabilities.
- People need to change their attitudes. I've heard staff say, *I'm not going to work with that kid because he's autistic and he's a handful.* It's a new way of thinking for care providers.
- The staff needs to be trained because they're the ones who are going to be working with them the most. But it's not just the staff—administrators need to be aware that it's not enough to say, *you're going to have autistic children and deal with them.*
- Tell how to get access to help. I don't agree that help isn't available because I've had specialists come in and talk to you for thirty minutes about a specific kid. If there's a behavior specialist working with a specific kid, more often than not they'll come in and do hands on training and write up something.
- If the parents request it, we can be part of the IEP team. And it depends on the rapport you have with that parent. We get a permission that allows us to talk to the school teacher, school counselor. The resources are there, you just need to learn to tap into them.

The group made the following recommendations for the proposed curriculum topics:

- Let people know there's help available. Last year we had a child with autism and we didn't have enough staff and we got an aide.
- If the training you've been given doesn't work, you get cynical. So understanding the nature

of the disabilities and the things that work and don't work, in terms of behavior management and communication strategies, all need to be part of the training.

- Decide with the parents when they'll get called; or what child will be excluded for. Work these things out ahead of time; know what behaviors are likely to be problematic
- There's a degree to which programs have to not only be understanding to the child that's exceptional, they also have to safeguard the rest of the kids in the program. And that's a policy decision; what's okay and what's not okay to happen at that site.

Program Content

A 28-minute video program, titled *Including All Kids! Including Youth with Special Needs in School-Age Care*, was produced. The video is attached as Appendix A. As the video program opens, viewers see youngsters with and without disabilities shooting hoops, creating artwork and making cookies. Meanwhile, care providers are heard expressing their initial concerns about working with youth with disabilities:

We didn't have much experience, so there was a lot of apprehension about not knowing what we were getting into and not sure we could handle that... My concern was as far as the other kids accepting him... When Leland first came, we weren't sure how we'd meet his needs as well as our own.

While viewers continue watching youngsters tossing footballs, swimming and doing homework, the narrator states:

While it's natural for care providers to feel concerned about including kids with special needs, youth with disabilities have been successfully included in all types of programs... Care providers who've successfully included kids with special needs tend to rely on a few basic strategies.

After the opening sequence, the majority of the program is devoted to describing and demonstrating five basic strategies. These five strategies and some excerpts from the video program follow:

- Offer a range of activities:
There's no need to limit activities when you include youngsters with special needs. In fact, it's best to offer a variety of activities appealing to many abilities and interests. When you're thinking of activities, try to come up with ones that are distinctly different from each other. From loud to quiet, physical to mental, social to solitary, offering a rich selection of choices makes it likely that every youngster can participate in something they like.
- Maintain a consistent routine:
Routines offer kids the consistency they need to go about their day with maximum independence and ease what may otherwise be troublesome transitions between one activity and the next. When there's consistency and continuity, it's easier for all kids to stick to the rules. Even when a youngster's disability necessitates flexibility, basic routines can be maintained.
- Give the right kinds of help:
Adapting activities for an individual's abilities is a common type of help. For instance, to adapt a game that's too difficult, consider changing a rule or two. Sometimes kids need direct help—either hands-on assistance or spoken directions. Whatever the type of help, try to give just enough, but no more help than the child needs.
- Encourage social interactions:
Specific ways to encourage socializing include the buddy system, encouraging kids to invite each other to play, doing what you can to bring kids close (from games and activities to the arrangement of space), and making meals and snacks opportunities for social interaction.

- Encourage kids to participate in **all** parts of the program:
For kids with disabilities to become full-fledged members of their care programs, they need opportunities to do small jobs and hold responsibility, as well as to abide by the same basic rules as everyone else. For teens with disabilities, it's especially important to recognize their growing initiative and desire to make decisions. Giving teens responsibility and opportunities to make choices is critical to their growing sense of autonomy.

The program ends by revisiting care providers who had expressed apprehension and hearing them describe their actual experiences in working with youngsters with disabilities.

I think they do accept him... They include him in all the activities they do... We did a lot for him when he first came here, but now there's more interaction with the kids and less with the teachers... After you start working with him, he's just another person.

Leader's/Viewer's Manual

A manual was produced for leaders and viewers of the video program. The manual, an 18-page brochure with photographs captured from the video program, contains the information needed to conduct a workshop on inclusive SACC training. Topics included: Why Inclusive Care? Advantages and Barriers to Inclusive Care, Enrollment and Getting Help, The Big Five Strategies for Inclusion, and Adaptations for Inclusion. The manual is attached as Appendix B.

Project Evaluation

Subjects

Initially, 122 SACC providers from Lane and Multnomah counties in Oregon were recruited for participation. A final sample of 85 SACC providers completed the study. Subjects were predominantly female (89.3%), reflecting the demographics of the child care employment field. The average age of participants was 34 years, with a median age of 31 years. The ethnic composition of the group was as follows: 2.5% Asian American, 3.3% African American, 4.2% Native American, 89.2% White/Caucasian, and .8% Other.

We asked how much experience subjects had in providing child care. The largest portion of the group (45%) had more than 5 years experience, followed by 3-5 years (28.3%), 1-2 years (14.1%) and less than one year (12.5%). We also asked their level of experience in caring for youngsters with disabilities. Sixty-two percent had none or less than one year of experience. Fourteen percent reported 1-2 years of experience; 9.9% reported 3-5 years of experience and 14% reported more than 5 years.

Procedure

Informational flyers were distributed to 800 SACC providers by the Child Care Resource and Referral agencies in Multnomah and Lane counties. Interested participants returned a stamped postcard to Northwest Media. Subjects were randomly assigned to receive materials in either video or written form. The written (workbook) materials are attached as Appendix C.

Subjects were mailed pre-intervention materials: a consent form and knowledge/attitude questionnaires, along with a self-addressed stamped envelope. Subjects were notified by telephone of the impending arrival of the materials. Subjects who did not return the materials promptly were contacted by phone.

Intervention materials (video or written), questionnaires (knowledge, attitude and social validation measures) were mailed to subjects. Seven days after mailing the materials, follow-up phone calls were made to subjects who had not returned the materials.

Three weeks later, a final set of knowledge, attitude and social validation measures were mailed to subjects. Checks were sent to those returning the final questionnaires and follow-up calls were made to those who had not returned the final set.

Measures

The measures described below, as well as the background information and consumer satisfaction questionnaires are attached as Appendix D.

Knowledge measures. The two types of knowledge measures described below were derived from a taxonomy developed by Bloom (1956) and colleagues in which cognitive operations (knowledge, comprehension, application, analysis, synthesis and evaluation) are conceptualized as hierarchically ordered from simple to complex. In this theoretical framework, any given level of cognitive operation involves, by definition, all of the lower level ones. For the Phase I feasibility study, we used lower-order measures of recognition and recall knowledge, and application of that recognition and recall knowledge, to investigate impact of viewing the video program.

A) *Knowledge Recognition and Recall.*

This knowledge measure was a 15-item curriculum-referenced multiple choice test on recognition and recall of the concepts covered by the video and written materials. Essentially, this level of knowledge measurement is of remembering. We followed test development procedures that derive the measure directly from the video/written curricula, which include response alternatives that represent common misinformation or misunderstanding, and that result in adequate psychometric characteristics (internal consistency reliability and content as well as construct validity). An example of such a knowledge recognition/recall item follows.

- What's the best strategy for organizing daily activities to include youngsters with disabilities?
 - a) do activities that are easily mastered by a child with a disability.
 - b) maintain the activity routines you've already established.
 - c) limit the number of activities offered at any one particular time.(Answer is b)

B) *Knowledge Application.*

This measure was a 10-item test on applying remembered information to solve novel problems. In this level of knowledge measurement, neither the test question nor the context in which it is asked assists the learner to decide which previously learned information must be used to solve the problem. We developed written descriptions of 10 novel problem (application) situations and related holistic scoring rubrics to assure interscorer agreement on scoring. We have recent experience with developing and using such "application of learning" items (See Johnson, 1995). Examples of novel application problems and related scoring rubrics follow:

- Item 1)
If a child doesn't understand spoken language, how can you let her know that it's time to stop one activity and start another?
- Item 1 Answer Key
 - 1) adhere to a daily routine and
 - 2) use non-verbal communication such as sign language, physical prompts, signals (lights or music) or pictures.

- Item 2)
Karen is an 11 year-old who uses a wheelchair. Because her chair doesn't fit at the activity table, she's not participating in board games and art activities. How can Karen's care providers help her participate at the activity table?
 - Item 2 Answer Key
 - 1) remove wheelchair tray so she can sit with peers and
 - 2) adjust height of the table so she can sit at it.

- Item 3)
Even if Karen can sit with the other kids, her poor muscle control makes it difficult for her to move a game piece around the board or manipulate the paint brushes or scissors. What can be done to help her participate in these activities?
 - Item 3 Answer Key
 - 1) enlist peer to help her move game piece or manipulate brush;
 - 2) offer art activities that require less physical dexterity; or
 - 3) use adaptive device to enable her to manipulate game piece or brush.

Attitude Measures. We used a specific attitude-type measure particularly suited to our Phase I feasibility study research focus.

C) *The Stages of Concern Questionnaire* (revised).

This standardized self-report measure was used to assess the impact of viewing the video program, or reading related materials, on child care provider concerns about inclusion of children with disabilities in school-age programs. The construct of "concerns" refers to "the composite representation of the feelings, preoccupations, thoughts, and considerations given to a particular issue or task" (Hall, George, and Rutherford, 1986, p.5); and seven stages (0-6) of concern are postulated. Stage 0 is *Awareness*; Stage 1 is *Informational*, wherein the focus of concern is on knowing more about an innovation—what it is/does; Stage 2 is *Personal*, or knowing more about how an innovation will affect participants personally; Stage 3 is *Management*, in which the focus of concern is on implementation questions—how, when and where the innovation is to be implemented; Stage 4 is *Consequences*, or the extent to which the innovation will have a positive impact; Stage 5 is *Collaboration*, or concerns about cooperation necessary to accomplish the innovation; and Stage 6 is *Refocusing*, in which the focus is on evaluation of the innovation regarding possible needed modifications to enhance effectiveness.

The construct of Stages of Concern is based on the premise that change that incorporates innovative practice is an ongoing, personal experience that is mediated by the extent to which the content and processes of training, learning and experience match the needs and concerns of individuals considering the innovation. *Of particular relevance/validity for our proposed use, "concerns" are hypothesized as developing in approximately the sequence of stages represented in the instrument. Thus, as detailed below, we hypothesize that the video program will have impacts on viewers that include changes in "concerns" from pre-intervention status at the Awareness, Informational, and Personal levels to post-intervention status more at Management and Consequences levels.*

Psychometric data regarding reliability and validity of the Stages of Concern measures are provided by Hall et al. (1986) and Bailey and Palsha (1992), who have developed a revision of the original measures specifically designed for use with early intervention educational personnel. The revised measure consists of 15 items across five factors (two sets of two subscales from the original seven-factor measure have been combined to increase internal consistency reliability and decrease intercorrelation of factors), and has been used effectively by Bailey and Palsha (1992).

Social Validation Measures. We used these measures to understand the experiences and beliefs of those affected by the intervention and its value foundations (Kazdin & Matson, 1981). We were interested in related consumer perceptions, whether or not we demonstrated effects on any of the measures described above.

D) A set of scales was used to assess subjects' perceptions of the *importance* of elements of the content domain of inclusion, *acceptability* of the intervention/contrast condition content and format, and *perceived effectiveness* of the intervention/contrast condition. These were in the form of summated four-point Likert-type rating scales.

E) Consumer satisfaction measures were also included. Participants rated the quality, relevance and value of the training intervention/materials/process, and how it compared to other possible delivery approaches regarding convenience, instructional value, etc.

Hypotheses

- 1) SACC providers in the video intervention group will demonstrate a) knowledge recognition and recall gains and b) knowledge recognition and recall gains greater than those by the contrast group.
- 2) SACC providers in the video intervention group will demonstrate a) knowledge application gains and b) knowledge application gains greater than those by the contrast group.
- 3) SACC providers in the video intervention group are expected to demonstrate "higher" stages of concern from pre- to immediate and delayed post-intervention observations when compared to SACC providers in the contrast condition.
- 4) SACC providers in the intervention group are expected to value as more important the inclusion of youth with disabilities in their programs, from pre- to post-intervention and when compared to providers in the contrast condition.

Results

Preliminary analyses were conducted to test for pre-intervention equivalence of groups on demographic data collected from all participants. No significant differences were apparent between the video intervention and workbook contrast groups on the variables of age, ethnicity, education, years experience providing child care, years experience with children with disability, and number of children cared for. Age differences were tested with a t-test for independent means, and chi-square tests were used for all other variables which were categorical in nature. There was a significant gender difference between the two groups ($p < .01$), with the video intervention group including 12 males in 61 subjects (20%), and the workbook contrast group including only one male in 61 subjects. No other results in the study nor any related literature provide any basis for interpreting the gender difference as meaningful. Additionally, preliminary analyses documented that the two groups were not statistically different on any pre-intervention knowledge, attitude ("concerns") or social validity measures.

Knowledge Recognition and Recall

A repeated measures MANOVA was used to test for differences in knowledge recognition/ recall at pre, immediate post and one-month post-intervention observations. There was a significant time effect between T1 and T2, $F(2, 138)=55.01$, $p < .000$, and no Group x Time interaction nor other Time effects. Knowledge recognition and recall increased from pre- to immediate post-intervention for both groups, with no additional gain (or loss) at one-month post-intervention.

Knowledge Application

A repeated measures MANOVA was used to test for differences in knowledge application at pre, immediate post and one-month post-intervention observations. Using a scoring rubric with a score of 0 for no correct responses and a score of 1 for one or more correct answers, there was a significant Time effect between T1 and T2, $F(2, 166)=5.06$, $p = .007$, with no Group x Time interaction nor other Time effects. Knowledge application increased from pre- to immediate post-intervention for both groups, with no additional gain (or loss) at one-month post-intervention.

Levels of Concern

A repeated measures MANOVA was used to test for pre/post/one-month post intervention differences in participants' levels and types of concerns about including children with disabilities in

after-school child care. Using raw scores on the five subscales of items comprising the Levels of Concern measure, results were as follows.

On the Awareness subscale there was a significant overall Time effect, $F(2, 164)=8.44$, $p=.000$, with Time contrasts significant between T1/T2, $F(1, 89)=12.51$, $p=.001$, and T1/T3, $F(1, 83)=10.7$, $p=.002$, with no group x time interaction. Concerns regarding Awareness decreased from pre- to immediate post-intervention and from pre- to one-month post-intervention, for both groups, with no additional drop (or gain) from immediate post-intervention to one-month post-intervention.

On the Personal subscale, there was a significant overall Time effect, $F(2, 164)=3.34$, $p=.038$, with a Group x Time interaction effect for the two groups at T1/T2, $F(1, 89)=4.39$, $p=.039$ and a Time contrast significant for T1/T3, $F(1, 83)=4.43$, $p=.038$. The video intervention group had a higher level of Personal concerns at pre-intervention than did the workbook contrast group, and subsequently had a significantly greater decrease at immediate post-intervention.

On the Management subscale, there was a significant overall Time effect, $F(2, 164)=6.93$, $p=.001$, with Time contrasts significant between T1/T2, $F(1, 89)=11.32$, $p=.001$, and T1/T3, $F(1, 83)=4.31$, $p=.041$, and no group x time interaction. Concerns regarding Management decreased from pre- to immediate post-intervention and from pre- to one-month post-intervention for both groups, with no additional drop (or gain) from immediate post-intervention to one-month post-intervention.

On the Impact subscale, there were no significant Time effects. There were Group x Time interaction effects approaching significance at T1/T2, $F(1, 89)=3.32$, $p=.072$, and T2/T3, $F(1, 82)=3.29$, $p=.073$. The video intervention group had a higher level of Impact concerns than did the workbook contrast group at pre-intervention, and subsequently had a greater decrease at immediate post-intervention. And the video intervention group had a greater increase of Impact concerns than did the workbook contrast group at one-month post-intervention.

On the Collaboration subscale, there were no significant Time effects. There was a Group x Time interaction effect for the two groups at T2/T3, $F(1, 82)=4.71$, $p=.033$. The two groups were not different in level of Collaboration concerns at pre- and immediate post-intervention, but the video intervention group had a significantly higher level of Collaboration concerns at one-month post-intervention.

Social Validation

Both groups rated the inclusion principles and methods presented in their respective programs as highly Important. On a scale of 1 (low) to 4 (very high), mean Importance ratings were 3.50 (midway between "high" and "very high") for the video intervention group and 3.58 for the workbook contrast group, with ranges of 2.45 to 4.00 for the video group and 2.64 to 4.00 for the workbook group.

Both groups also rated the principles and methods presented in their programs as highly Acceptable for their own use in their programs on the same 1 to 4 scale. Mean Acceptability ratings were 3.46 for both groups, with a range of 2.64 to 4.00 for the video group and 2.18 to 4.00 for the workbook group.

Because the focus, for purposes of this investigation, was on the video program intervention, only that group was asked to rate Effectiveness of the video program in facilitating their learning of principles and methods for including children with disabilities in after-school child care. The mean Effectiveness rating by the video intervention group was 3.15, with a range of 1.90 to 4.00. The four lowest rated items were rated a 1 (low) or 2 (moderate) by approximately 25-40% of respondents.

Discussion of Project Feasibility

The purpose of this project was to investigate the feasibility of a video-based training program for assisting after-school child care providers to include children with disabilities effectively. First, the video training approach is notable because it allows for training to occur anywhere people have access to video cassette players. Such training can be brought to child care providers rather than requiring them to go to a training site that is not their home or place of work. Accessibility to such training has been a problem historically because of time, transportation and other practical considerations and because of lack of motivation for some. Video training offers a convenient approach to ongoing education for after-school child care providers. With this convenience, providers' motivations can be enhanced to acquire training on inclusion of children with disabilities in their programs.

Secondly, the video program that was the focus of this study was of high quality in terms of production and content. The production qualities fit current commercial standards for video programs, which maximizes the program's credibility and marketability. Content was based on "best practices" having empirical validation in the special education and severe disability research literatures. After-school child care providers and their organizations typically lack the resources to assure this quality of content and presentation of educational programs.

Finally, the video program materials were specifically designed to engage and appeal to after-school child care providers. Depictions in the video program were taken from video footage of actual inclusion practices in after-school child care settings. Thus individuals, situations, interactions and communication were familiar to after-school child care providers.

The evaluation of the intervention focused on whether after-school child care providers learned and remembered principles and methods of including children with disabilities in their programs. The evaluation also focused on the extent to which providers' concerns about including children with disabilities were influenced by the video intervention. And, the evaluation was designed to determine whether providers perceived the principles and methods demonstrated in the video intervention program as important and acceptable, and if providers perceived the video intervention program as effective in facilitating their learning and reducing their concerns. The intervention was expected to increase providers' knowledge and ability to apply their knowledge, and to positively influence their concerns, about including children with disabilities in their after-school child care programs.

Findings supported the effectiveness of the video intervention in improving providers' knowledge and application of their knowledge. Providers who viewed the video program increased their knowledge about including children with disabilities in their after-school child care programs, and they increased their ability to apply their knowledge to novel situations. Increases in both of these types of knowledge (recognition/recall and application) also maintained at one-month post-intervention.

Findings also supported the effectiveness of the video intervention program in influencing the types and levels of concerns providers had about including children with disabilities in their after-school child care programs. As hypothesized, the video intervention group's Awareness, Personal and Management-related concerns about trying the techniques shown in the video program (for including children with disabilities in after-school child care programs) decreased significantly from pre- to immediate post-intervention (as did those of the workbook group), with a significantly greater drop on Personal concerns than that of the workbook group. The original hypothesis was based on the developmental nature of the construct of "concerns" (Hall et al., 1986). The initial concerns of users of an innovation are hypothesized to be those related to Awareness, Personal and Management considerations. Thus we would expect concerns such as "what is it?", "what will it be in my work?", and "how will I manage it?" to be the first concerns to be allayed by video-based educational interventions such as ours. And our findings demonstrated precisely that outcome.

Some evidence in the results can be interpreted to favor the video program over the workbook program. For Impact and Personal concerns, the video intervention group demonstrated a greater drop (approaching significance) than that of the workbook group from pre- to immediate post-intervention. For all four of the Awareness, Personal, Management and Impact concerns, the video program produced more reduction in raw "concerns" scores than did the workbook program. Only for the Personal ($p=.038$) and Impact ($p=.072$) concerns, however, was there a related group x time interaction where the video group demonstrated reduction in concerns immediately post-intervention and the workbook group's concerns were elevated slightly. Nonetheless, the trend favoring the video program can be interpreted as initial evidence of the relatively stronger impact of the video program on "concerns" than that of the workbook program. The verisimilitude of the video materials with real life situations and experiences provides a reasonable explanation for this, i.e., participants' concerns are more allayed when they see an innovation such as ours in action than when they simply read about it.

Interestingly, for both Impact and Collaboration related concerns, the video intervention group demonstrated a significantly higher level at one-month post-intervention than at immediate post-intervention. The workbook group did not demonstrate the same one-month post-intervention rise in Impact and Collaboration concerns. This finding, seemingly anomalous in its rise at one-month post-intervention for the video intervention group, can actually be interpreted as evidence of the

effectiveness of the video program in relation to concerns of staff who might potentially want to try to include more children with disabilities in their after-school child care programs. One interpretation of that rise in Impact and Collaboration concerns at one month post-intervention is that the video program may have served to sensitize viewers to their concerns. That is, video viewers might not have known intuitively at pre-intervention what to be concerned about regarding Impact and Collaboration, especially since these two concerns are theorized to be the “highest” level of concerns, developmentally, about innovations (Hall et al., 1986). The video program may well have made them aware of realistic concerns about Impact and Collaboration they could experience “down the road” with any inclusion efforts they attempt in the future. Because the workbook group did not also demonstrate this rise in these two types of concerns at one-month post-intervention, the verisimilitude of video and real life again seems a plausible explanation of this outcome.

The video intervention group also responded quite favorably regarding Importance, Acceptability and Effectiveness of the content and presentation of the video program. Viewer satisfaction is an important piece of information about the likely success of a media-based intervention. Ratings indicated that viewers regarded the content and presentation of the video program as highly important, acceptable and effective.

In summary, the video program received strong support in the evaluation study of the feasibility of continuing the approach. After viewing the video program, participants increased their recall/recognition and application knowledge regarding inclusion of children with disabilities in their after-school child care programs. And their concerns regarding such inclusion were favorably influenced as a result of their viewing of the video program. The use of video proved to be an effective and efficient training approach for facilitating inclusion of children with disabilities in after-school child care programs.

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Appendix A: (Video)

Including All Kids! Including Youth with Special Needs in School-Age Care.

Appendix B:

Leader's/Viewer's Manual

Appendix C:

Workbook (for the contrast group)

Appendix D:

Measures