End of Year Three Evaluation of the Access and Inclusion Model (AIM)

Research and Technical Report

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Full Research and Techncial Report: End of year Three Evaluation of the Access and Inclusion Model (AIM)

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The outcomes of this evaluation are also summarised in an Executive Summary, an Abridged Research Report, and an Easy Read Summary.

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Full Research and Technical Report: End of year Three Evaluation of the Access and Inclusion Model (AIM)

This section sets the scene for the end of year three evaluation of the Access and Inclusion Model (AIM). It begins with a summary introduction to AIM. Following this, the context for the evaluation, its governance and its methodological approach are described.

1.1: Introduction to AIM

This subsection provides a summary overview of AIM. A more detailed account of AIM's context and delivery structure is provided in Section 2 of this report.

AIM and the Early Childhood Care and Education (ECCE) Programme

The Department of Child and Youth Affairs (DCYA) now the Department of Children, Equality, Disability, Integration and Youth (DCEDIY), worked with a wide range of stakeholders to form an evidence-based, award-winning model for inclusion in the Early Childhood Care and Education (ECCE) programme in the form of AIM[1]. AIM was developed to support the inclusive practice of pre-school providers. The ECCE programme seeks to provide children with their first formal experience of early learning, and all children within the eligible age group are entitled to state-funded ECCE as part of the Irish Government's commitment to social inclusion and equity[2].

In Ireland, it is recognised that early years education is a powerful catalyst for greater social inclusion. In this context, AIM's purpose is to ensure that all children with disabilities in the eligible age group can access the ECCE programme available in their local communities. This is through a tiered model that moves from universal to targeted support.

The model is about supporting the access and inclusion of children with a disability which is defined as 'a long-term physical, mental, intellectual, or sensory impairment which, in interaction with various barriers may hinder a child's full and effective participation in society on an equal basis with others'[3]. This broad definition is active within the AIM model because it should ensure that those children with needs arising from long-term physical, mental, intellectual, or sensory impairment will be supported by the model, even where the specific area of need or difficulty is not traditionally recognised as a disability. In this context, AIM will support children who do not have a formal diagnosis, as well as those children who do. Within AIM, the focus is not on diagnosis.[4] There are indications that AIM's reach is growing with the total number of pre-schools receiving AIM support rising from 1,283 in 2016/17 (the first full programme year) to 2,048 in 2020/21, and a total of 3,871 since the programme

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[1] Government of Ireland (2020) *AIM programme wins global award for innovative policy.* [Online], Available at: https://www.gov.ie/en/press-release/f0f26a-aim-programme-wins-global-award-for-innovative-policy/. Accessed: 15/5/2020

[2] Government of Ireland (2019) *Roadmap for Social Inclusion, 2020-2025: Ambition, Goals, Commitments.* [Online], Available at: https://assets.gov.ie/46557/bf7011904ede4562b925f98b15c4f1b5.pdf (Accessed 20th January 2021)

[3] The definition is derived and adapted from *Supporting Access to the Early Childhood Care and Education (ECCE) Programme for Children with a Disability. Report of the Inter-Departmental Group*, September 2015

[4] DCYA (2016) *Access and Inclusion Model: policy on the operation of the Access and Inclusion Model*. [Online]. Available at: https://aim.gov.ie/app/uploads/2016/06/AIM-Policy.pdf. Accessed 05/04/2020

began. The total number of children receiving AIM support has risen from 2,486 to 18,521 over the same period, with a total of 40,603 AIM supports provided since the start of the programme.[5]

Introduction to AIM's purpose, principles, and structure

AIM defines its intended outcomes as the full inclusion and meaningful participation of all children in the ECCE programme[6]. AIM is about the belonging, engagement and learning of children with disabilities and additional needs in the context of the inclusion of *all* children. AIM sits within a developing ecosystem of policies (e.g., *First 5* and Early Start) designed to improve outcomes for young children and their families in the areas of health, economic wellbeing, and learning.

AIM is a 7-level model that builds as its foundation, a quality-first approach to inclusive practice. Levels 1-3 are designed to secure inclusion as a universal offer perpetuated by the development of:

- Level 1: An inclusive culture
- Level 2: Information for parents/carers and providers
- Level 3: A qualified and confident workforce

AIM Level 1 provides a €2 uplift in the weekly capitation rate per-child for pre-schools that have a qualified Inclusion Co-ordinator (INCO) on their staff team. It also includes funded Equality, Diversity and Inclusion (EDI) training for pre-school staff, AIM Inclusive Play resources and guides (provided to over 4,000 providers in 2018), and the Universal Design Guidelines (DCYA and CEUD-NDA, 2021).[7] A qualified INCO is a practitioner who is a graduate of the 'Leadership for Inclusion in Early Years' (LINC) programme – LINC is a level 6 special purpose award which was developed by a Consortium led by Mary Immaculate College, Limerick and comprising Early Childhood Ireland (ECI) and Maynooth University Froebel Department of Primary and Early Childhood Education (MU-Froebel Dept.). Mary Immaculate College is the lead agency in the Consortium and is responsible for the delivery and accreditation of the programme. The LINC+ programme provides further CPD for graduates of the LINC programme and commenced in 2021.

The INCO's role is to lead the development of inclusive practice and to mentor other staff[8]. Level 1 of AIM is also supported by the DCYA (now DCEDIY) the Diversity, Equality, and Inclusion (DEI) Charter and Guidelines for ECCE[9], a resource which promotes an anti-discriminatory approach and provides advice about inclusive practice.

AIM Level 2 provides national and local information for parents/carers and providers. The most substantive site for this information is DCEDIY's AIM website (aim.gov.ie) which was updated in 2021

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[5] Pobal monthly data sets for AIM (October 2021).
[6] [6] DCYA (2016) *Access and Inclusion Model: Policy on the operation of the Access and Inclusion Mode*l. [Online]. Available at: https://aim.gov.ie/app/uploads/2016/06/AIM-Policy.pdf. Accessed 05/04/2020
[7] DCYA and CEUD-NDA (2021) *Universal design guidelines for ELC settings.* [Online]. Available at: https://aim.gov.ie/app/uploads/2021/05/universal-design-guidelines-for-elc-settings-introduction-1.pdf. Accessed 10/03/2022
[8] Mary Immaculate College (February 2018) *The role of the Inclusion Co-ordinator explained.* [Online]. Available at: https://lincprogramme.ie/blog/the-role-of-inclusion-co-ordinator-explained. Accessed 03/12/21.
[9] Department of Children and Youth Affairs (2016) *Diversity, Equality and Inclusion Charter and Guidelines for Early Childhood and Care Education*. [Online]. Available at: https://assets.gov.ie/38186/c9e90d89d94b41d3bf00201c98b2ef6a.pdf. Accessed 05/12/2020

to be more accessible and user-friendly. This was in response to recommendations in the end of year one review of AIM.

AIM Level 3 supports are in the form of fully funded Continuing Professional Development (CPD) to support inclusive practice for children with specific needs. At the time of this evaluation, the CPD programmes available to pre-schools were Hanen (inclusive approaches to supporting children's interactions), Lámh (a manual sign system) and SPEL (Sensory Processing e-Learning). These programmes are delivered and hosted by Better Start.

AIM Levels 4-7 provide progressively targeted support:

- Level 4: Expert early years educational advice and support
- Level 5: Equipment, appliances, and minor alterations grants
- Level 6: Therapeutic intervention
- Level 7: Additional assistance in the pre-school room

AIM Level 4 is delivered by the Better Start Early Years Specialist Service (EYSS) in the context of the national practice frameworks - *Aistear* and *Síolta*. The EYSS aims to work collaboratively with parents/carers and pre-school providers to develop inclusion for all children in the ECCE programme. The Better Start EYSS supports pre-schools in developing an Access and Inclusion Plan for children with disabilities and additional needs where this is needed. The plan may lead to applications to Pobal[10] for Level 5 and/or Level 7 AIM supports. EYSS is also the link between the pre-school and the relevant HSE (Health Service Executive) contact for Level 6 who will advise on the best support for the child. Level 6 is accessed via a request for support from the EYSS.

AIM Level 5 funds minor building alterations (capital grants), appliances and specialist equipment (e.g., assistive technology for deaf and hard of hearing children) and are administered by Pobal with support from HSE, as necessary.

AIM Level 6 is in the form of information, advice and (in some cases) therapeutic support for children with disabilities/additional needs. This is to be supportive of full inclusion within the pre-school context. Level 6 is delivered by Ireland's Health Service Executive (HSE) and its funded service providers. HSE supports could be through a Children's Disability Network Team (CDNT), HSE Disability Service, HSE-funded Voluntary Organisation or HSE Primary Care Services.

AIM Level 7 provides additional funding to pre-schools that have a child whose needs warrant this kind of extra support. The funding can be used to reduce the child-to-adult ratio in the pre-school room or fund an additional member of staff to achieve the same. Level 7 is not imagined as 1:1 support but as a shared resource with other children to facilitate optimal participation for the child who has additional needs. More detail on AIM's purposes and delivery structure is provided in Section 2 of this report.

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[10] Pobal is an intermediary body sitting between Government and local partnerships/community-based structures. It works with over 4000 community and voluntary organisations. Pobal's main role in AIM is to appraise applications for AIM Level 1, 4, 5 and 7, make allocation decisions, manage payment/processing/reporting, and provide support and advice for families and pre-schools.

1.2: Context for the evaluation

This subsection explains the rationale, evaluation objectives and research questions for this end of year three evaluation of AIM.

The Department for Children, Equality, Disability, Integration and Youth (DCEDIY) commissioned this evaluation. Its purpose was to investigate the implementation and impact of the Access and Inclusion Model (AIM), from the perspective of multiple stakeholders. The findings of the evaluation would inform the continuous improvement of AIM within the contemporaneous policy context. The evaluation was led by the University of Derby (UoD) consortium and took place between December 2020 and December 2021.

Substantive evidence about the implementation and impact of AIM was gathered in this evaluation. Evidence is drawn from the participation of over 2,000 stakeholders and the analysis of over 140 documents. The sample for the study has comprised:

- 50 sources of documentary evidence (policy documents, agency reports, statistics, websites)
- 94 sources from the research and academic literature
- 1,157 parent/carers in an online survey
- 732 providers in an online survey
- 79 stakeholders (AIM delivery partners and agencies, disability sector, parent/carers and ELC practitioners)
- 14 children who are supported by AIM
- 14 pre-school settings that are engaged with AI

The rationale for the evaluation

The end of year three evaluation of AIM was commissioned to investigate the implementation and impact of the programme. This independent evaluation would inform policy and practice such that Ireland could continue to catalyse educational equity and social inclusion through a focus on Early Learning and Care (ELC) and School-Age Childcare (SAC).

This was in the context of the *First 5 strategy* for babies, young children, and their families (Government of Ireland, 2018[11]). AIM is regarded as central to strategic action 8.3., which seeks to:

> ‘Ensure that ELC provision promotes participation, strengthens social inclusion, and embraces diversity through the integration of additional supports and services for children and families with additional needs.’
>
> (Government of Ireland, 2018, p95)

To deliver on this, the *First 5 strategy* commits to, inter alia, ‘undertake an end of year three evaluation of AIM, and subject to evaluation findings and other relevant developments, consider enhancements to and/or extension of AIM to, for example, ELC services: all school aged childcare services (SAC) and/or to children with needs other than a disability.’

(Government of Ireland, 2018, p146)

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[11] Government of Ireland (2018) *First 5: A Whole-of-Government Strategy for Babies, Young Children, and their Families 2019-2028*. Government of Ireland. [Online]. Available at: https://first5.gov.ie/userfiles/pdf/5223_4966_DCYA_EarlyYears_INTERACTIVE_Booklet_280x215_v1.pdf#view=fit. Accessed 01/01/2021.

A further account of the objectives for this evaluation follows.

Evaluation objectives

This end of year three evaluation sought to describe the quality of AIM's processes, governance, impacts, and outcomes to identify elements that work well and/or need to be developed and/or improved. This was in support of policy review and development. The evaluation objectives and focusses are described in more detail in what follows.

Objective 1: Quality and Process
Evaluation of the relevance and effectiveness of AIM in terms of its approach, processes, and implementation.

This objective is achieved through the investigation of:

- The evidence-base, rationale, aims and objectives of AIM
- Development and evolution of the overall approach
- Implementation fidelity of the approach
- The extent to which AIM reaches the intended cohort
- Effectiveness of the overall approach, in respect of all levels of AIM, and from the perspective of all stakeholders
- Engagement with AIM over time by services, practitioners, children, and families
- Appropriateness and efficiency of application, assessment, and approval processes
- Role and value of the Early Years Specialists
- Reasons for non-participation of children, families, practitioners, and services in different levels of AIM, including barriers to participation
- Efficacy of the training provided, including, LINC, Hanen, Lámh and Sensory Processing training

Objective Two: Impacts and Outcomes
Evaluation of expected and achieved outcomes, contextual factors, and causality.

This objective is achieved through the investigation of:

- Impact on access to – and meaningful participation in – the ECCE Programme for children with disabilities/additional needs
- Outcomes across all levels of AIM, as perceived by all stakeholders
- Impact on the quality and inclusiveness of early learning and care provided; sustained learning and knowledge transfer among practitioners; strengthening of workforce capacity
- Embeddedness and sustainability of approach in settings
- Role of AIM in supporting positive transitions to primary school

Objective Three: Governance
Evaluation of leadership, co-ordination, communication, and accountability:

- Collaboration, communication, and knowledge-exchange among stakeholders
- Efficiency of the governance and leadership approach to AIM
- Engagement with other key agencies and partners

- Adequacy of available data and indicators for monitoring the effectiveness and efficiency of AIM
- Position of AIM in the delivery of related supports
- Adaptability, scalability, and sustainability of AIM
- Potential enhancements to, and/or extensions of AIM

Research questions

The objectives and investigations when combined, seek to answer four key questions for this evaluation:

- Is AIM effective and achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities?
- Has AIM influenced practice or capacity in the workforce?
- Is the current approach appropriate in the national context?
- To what extent can AIM be enhanced, and/or scaled up or out?

1.3: The evaluation team and governance of the end of year three evaluation of AIM

The next two subsections give an account of the governance, methodological approach, and ethical management of the end of year three evaluation of AIM. Further detail on methods is given in the relevant findings section of this report. The first proceeding subsection summarises the membership of the research team delivering the evaluation.

Research Team: The University of Derby Consortium

The research team comprised a consortium consisting of:

- Researchers from the *Institute of Education* at the *University of Derby (UoD)*. UoD were the lead organisation within the consortium. Key roles were project management, research design (including ethics), data collection, data analysis, report production and dissemination. The Project Director and Associate Director were Prof. Deborah Robinson and Dr Geraldene Codina, respectively. The research team were Dr Sophia Gowers, Dr Marco Antonio Delgado Fuentes, Dr Katherine Mycock, Jane Artess, Sarwat Qureshi and Dr Rosemary Shepherd.
- Researchers from *IFF Research* were responsible for leading the design, implementation and first-level analysis of the large-scale surveys used in the evaluation. The research director was Aoife Ni Luanaigh.
- In collaboration with researchers at the University of Derby, Dr Lisha O'Sullivan from *Mary Immaculate College* (MIC) and Dr Sophia Gowers (UoD) were responsible for designing and delivering training and support for the team of Practitioner Researchers who were deployed to case study development. This included quality assurance of data collection, analysis, and reporting.

The University of Derby consortium also included three expert advisors who provided impartial advice and critical friendship to the research team. The expert advisors were:

- Adam Harris: Founder and CEO of AsIAm, Ireland's National Autism Charity

- Prof. Emer Ring: Dean of Early Childhood and Teacher Education at Mary Immaculate College
- Prof. Mel Ainscow CBE. Professor of Education at the University of Manchester and UNESCO, and OECD advisor on educational equity.

Governance of the end of year three evaluation of AIM

To ensure that the research team were both supported in and accountable for the key deliverables for the end of year three evaluation of AIM, the DCEDIY assembled an Oversight Committee. This committee comprised DCEDIY policy leads, AIM delivery partners, members of the AIM Cross-Sectoral Implementation Group (CSIG) and representatives from the disability advocacy sector.

1.4: Methodological approach

This subsection summarises the methodological approach used in this evaluation. Five core methods of data capture were deployed, and these were designed into three research phases. Figure 1.1 summarises the phases, methods, sample sizes, and sequence of the research.

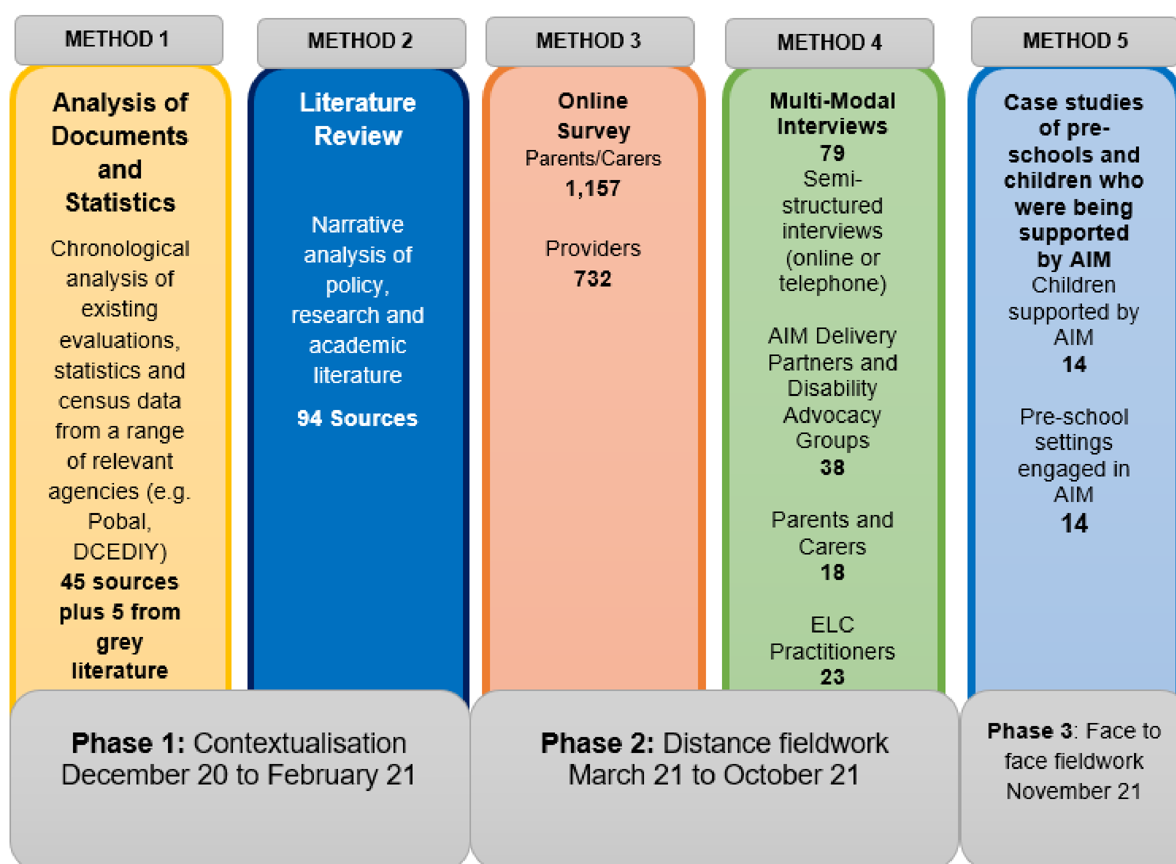

Figure 1.1: Summary of research design

Rationale

A mixed methods approach was adopted to reach as many stakeholders and pre-school settings as possible whilst ensuring a low burden for participants. Stakeholders included members of the AIM policy and delivery team (e.g., DCEDIY Principal Officers, representatives from relevant organisations

such as HSE and Better Start), parents/carers, pre-school providers and members of the disability advocacy sector (e.g., charities, non-government agencies). The methods combined to capture multiple perspectives on AIM's principles, processes, outcomes, and impacts at a general and individual level. This was important given the complex, cross-sectoral nature of the AIM delivery model, and the importance of narrating AIM at the national level, as well as at the level of individual children, families, and pre-schools.

Distance methods of data capture were planned for phases 1 and 2. Face-to-face fieldwork was delayed until October and November 2021. This was to manage the risks posed by the COVID 19 pandemic.

Methods

A summary of the five methods of data capture and analysis is summarised in what follows. Further technical detail on the implementation of these methods (sample selection, data capture, data analysis and limitations) are provided in the relevant findings sections of this report.

Phase 1: Contextualisation

During phase 1, the research focused on establishing a clear and evidence-based account of AIM in its national and international context. Phase 1 was designed to serve Objective One (Evaluation of the relevance and effectiveness of AIM in terms of its approach, processes, and implementation). Findings were also used to inform the design of research instruments and the interpretation of findings.

Method 1: Analysis of Documents and Statistics

Researchers collected and analysed 45 documentary sources and an additional 5 from the grey literature. The aim was to develop a chronological narration of AIM's development within its policy context. This would result in an accurate description of the programme's origins, rationale, evolution, changing reach (e.g., census data on the number of participating pre-schools and children who are supported by AIM), and current operational approach.

Method 2: Literature Review

Using Boolean searches of the international literature databases (e.g., the Education Resources Information Centre - ERIC), researchers identified, reviewed, and analysed: 16 government documents; 19 publications written by international/European organisations; 46 research papers; and 29 polemical publications (meaning publications which debate policy, practice and concepts but do not draw on original data) that were relevant to AIM. A matrix of search terms supported the identification of relevant sources for the literature review; this matrix is shown in Table 3.1 (Section 3). The analysis led to the identification of significant themes as they prevailed in national and international data and debate about inclusion in early education and models of progressive support. Findings from Phase 1 are reported in Sections 2 and 3 of this report.

Phase 2: Distance Fieldwork

Phase 2 employed distance fieldwork to gather data focused on perceptions of AIM from a wide range of stakeholders. Phase 2 was designed to serve all three evaluation objectives for the research.

Method 3: Online Survey

An online survey was used to capture perception data from a sample of 1,157 parent/carers and 739 practitioners. A large-scale survey was used to enable accurate predictions of the perceptions of the target populations, and sample sizes were large enough to be statistically representative to the 95% confidence level (see subsection 4.2). Z tests were used to identify significant differences in perception between sub-groups of the sample population (e.g., providers whose pre-schools are in rural areas compared to those in urban areas). Though it is noted that surveys provide limited explanatory insight, this was ameliorated by the evaluation's qualitative methods (interviews and case studies), which were combined with content analysis of the free text comments within the survey itself.

The survey was also used purposively to form lines of enquiry for integration into research instruments for Method 4 (interviews of parents/carers and providers), and Method 5 (case studies of children and pre-school settings). This was to increase the explanatory data in phases 2 and 3 of the evaluation.

Method 4: Multi-modal telephone/online Interviews

79 participants participated in semi-structured interviews with researchers. The sample included 18 parent/carers, 23 ELC practitioners, 32 participants from the AIM project team and AIM delivery agencies, and representatives of the disability advocacy sector.

Participants had the option of telephone interviews, video interviews or direct messaging to ensure accessibility and a reduction in participant burden. Transcripts and interview notes were analysed thematically, and findings were mapped to the evaluation objectives and foci.

Findings from Phase 2 are reported in Sections 4-11 of this report.

Phase 3: Field work

Phase 3 employed live or distance fieldwork to gather data which could illustrate how AIM was perceived, experienced, and applied on the ground. Data was collected by trained Practitioner Researchers (PRs) who had practice expertise. PRs were engaged as co-researchers in recognition of their practice expertise, and to ensure rich data, and interpretations that were as close to practice, and hence as authentic as possible. Phase 3 resulted in two types of case study. The first was a case study of a child to report their experience of full inclusion and meaningful participation in their pre-school. The second was a case study of the setting the child attended, and how AIM was perceived and applied within the setting.

Method 5: Case Studies of Children and Settings who are participating in AIM and receiving AIM support

With support from Early Childhood Ireland, the consortium recruited and trained 17 PRs from the ELC sector. The selection process was in two criterion-led phases to ensure it was objective, fair and robust.

Once recruited and trained, 13 PRs were deployed to at least one pre-school where they spent the equivalent of one full day collecting data, either online or face-to-face depending on circumstances. Data collection involved two foci. The first focussed on eliciting a child's perspective on their experience of *meaningful participation* and *full inclusion* at their pre-school. To make this task accessible and enjoyable a mapping method was used. Data arising from the mapping method was used by PRs to write a case study of the child's experience of inclusion. Each child was given the opportunity to create a map of their pre-

school setting, recording their interests and engagements within the contexts in which they occur.

Throughout the data collection, a flexible approach was used to foreground the child's strengths and preferences. Attention was paid to the range of communicative forms used by the child. Consequently, non-verbal forms of communication were noted including gesture, eye gaze, facial expression, and movement in addition to their verbal utterances and mark making within the mapping activity. Alternative methods for data collection were also provided to the PRs including walking tours, picture exchange activities and observation. Data arising from the mapping method was used by PRs to write a case study of the child's experience of inclusion, reported through the lens of the Diversity, Equality and Inclusion (DEI) Charter (DCYA, 2016)[12].

This helped researchers to evaluate how included children were in a way that privileged their individual experiences, their voice, and their perspectives. In this way, the method was in the spirit of AIM and its concern for the social inclusion of all children. Researchers at the University of Derby then analysed all the child case studies to report on the findings at the level of the individual child and the meta level. This level of analysis was also through the lens of the Diversity, Equality, and Inclusion (DEI) Charter (DCYA, 2016) to enable investigation of full inclusion as it was supported by or manifested in:

- Provision
- Practitioners
- Peer relationships
- Emotive responses
- The Physical environment
- Resources

The second focus was on how AIM support was used in the pre-school and how varied stakeholders, associated with the pre-school, perceived AIM, and its impacts. Through a face-to-face visit to the pre-school (or an online focus group), PRs interacted with stakeholders (lead practitioners, practitioners, parents/carers, Better Start Early Years Specialists, HSE staff) to collect data on their perceptions and engagement with AIM. This led to a case study of each pre-school setting which was analysed thematically to identify how individual pre-schools and the case study group as a whole, were implementing inclusive practice in the context of AIM. The child and setting case studies when combined, offered a close-to-practice account of how well AIM was working on the ground and what its strengths and weaknesses were from the perspective of its intended beneficiaries.

Findings from Phase 3 are reported in Section 12 of this report. Combined findings are reported in Section 13.

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[12] Department of Children, Equality, Disability, Integration and Youth (DCEDIY) (2016) *Diversity, Equality and Inclusion Charter and Guidelines for Early Childhood Care and Education*. Government Publications. Available at: https://www.gov.ie/en/publication/b1a475-diversity-equality-and-inclusion-charter-and-guidelines-for-early-ch/ Accessed: 10/12/21

Ethical Management and Children First

All recruitment, data collection and data management processes were reviewed and approved by the University of Derby's College of Arts, Humanities and Education (CAHE) Research Ethics Committee. Participant recruitment and data capture did not take place until approval was confirmed, and the process of research complied with the University's principles of Research Governance, Ethics, and Integrity (https://www.derby.ac.uk/research/about-our-research/ethics/). Underpinning this policy are the ethical imperatives of 'Do No Harm' (non-malfeasance) and 'Do Good' (beneficence). At each step, researchers ensured that participants were given the right to:

> **Fully informed voluntary consent.** Data collection only took place once participants had given their informed voluntary consent in the context of full, transparent information about the project they were participating in. Communications were adapted to support children in giving assent to their participation.
>
> **The right to withdraw.** Verbally and in writing, participants were informed of their right to withdraw from the process, including the closing date for withdrawal and how to withdraw. Researchers informed participants that they did not need to give any reason for their withdrawal.
>
> **The right to privacy.** Researchers informed participants of the measures we would take to protect them and their identity through confidentiality. Where it was not possible to assure anonymity, we made this clear. Researchers explained how personal data was stored, including an explanation of when and how it would be destroyed.
>
> **The right to protection from burden**. Researchers fully explained the time requirements for participation, taking measures to reduce participant burden.

The research team put children's safety and wellbeing first in the design and enactment of this evaluation. The evaluation was compliant with the Children First Act (Government of Ireland, 2015) and the research design adopted the principles of the Children First: National Guidance for the Protection and Welfare of Children (DCYA, 2011)[13], ensuring that all personnel are aware of these. Key principles are:

- To know and recognise signs of child abuse and neglect.
- To know who the designated person is in a setting so that, if there is a disclosure or if concerns arise, these can be referred to this designated person.
- To operate with the utmost respect for children's voice in the development and enactment of data capture involving them, including processes of consent that secure permission from parents/carers and secure children's consent in accessible ways (e.g. by asking, 'Is it still okay for me to ask you some questions?'

Practitioner Researchers engaged in fieldwork with children in pre-schools only when Garda Vetting was complete.

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[13] Department of C*hildren and Youth Affairs (2011)* Children First: National Guidance for the Protection and Welfare of children. [Online]. Available at: https://www.tusla.ie/uploads/content/Children_First_National_Guidance_2017.pdf. Accessed 20/05/20

Data storage and management

IFF Research Ltd. hold ISO/IEC 27001:2013 certification (the international standard for information security). The University of Derby and Mary Immaculate College had Information, Assurance and Security Policies to ensure the secure management of data. Important matters of regulation implemented in the project included:

- At the University of Derby, the Project Director was identified as the data owner during the evaluation.
- Personal Data related to participants (names, contact details, raw data) was stored on a central network in a location separate from data analysis. Personal data was protected with two layers of verification and only available to relevant members of the project team (as deemed by the project manager). Personal data was never stored on mobile devices or storage items (e.g. USB sticks) and included tables of respondent/participant identities matched to unique identifiers. All data analysis used this unique identifier to protect participant identity.
- The transfer of data by e-mail was prohibited unless it was with encryption. Transfer of data was by secure ftp services.
- Under GDPR, data privacy measures were explained to research participants, at the point of data collection. Their rights as a data subject were communicated in privacy statements that explained their right to see the personally identifiable data, we hold on them, to change this data, or to have it deleted.
- Participants were also signposted to further information on the consortium's webpages (e.g., www.iffresearch.com/gdpr and https://www.derby.ac.uk/about/data-governance/).
- At the end of the project, researchers transferred all data collected to the DCEDIY. Personal data was not transferred with this package since it was deleted in synchrony with this transfer.

Map of methods to themes for the evaluation

Appendix 1 presents a mapping of each method/participant group to the objectives and focusses for the evaluation. It demonstrates how the methods combined to provide a comprehensive evaluation of AIM in relation to the four research questions posed, which to reiterate were:

- Is AIM effective and achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities?
- Has AIM influenced practice, or increased capacity in the workforce?
- Is the current approach appropriate in the national context?
- Can AIM be enhanced, and/or scaled up or out?

2. The context, rationale and structure of the Access and Inclusion Model (AIM)

This section describes the context for AIM. The content was drawn from an analysis of documents/publications and statistics available in the public domain or in the form of grey literature. In total, 42 sources were identified for analysis, along with 5 items from the grey literature. In the main, the documentary analysis serves Objective one which is the evaluation of the relevance and effectiveness of AIM in terms of its approach, processes, and implementation, with reference to:

- AIM as one element within an improving ELC sector in Ireland.
- AIM as one element within an ecology of ELC programmes seeking quality and inclusion for all.
- The evidence-base, rationale, aims and objectives of AIM.
- AIM's implementation and whether it reaches the intended cohort.
- Current evidence of the effectiveness of the approach.
- Engagement in AIM over time by providers and other beneficiaries.
- The role of Early Years Specialists.
- The adequacy of available data for monitoring the effectiveness of AIM.

2.1: Introduction

The following subsections will describe the current context for AIM through situating it in Ireland's broader programmes and policies for Early Learning and Care (ELC). The first subsection offers an analysis of ELC in the context of the United Nation's Sustainable Development Goals (SDGs). Subsequent subsections describe national frameworks of Quality and Regulation for ELC in Ireland and DCEDIY's current ELC programmes. AIM as an additional strategy for the inclusion of children with disabilities and additional needs is also described in detail, this is at the level of its rationale and operation.

2.2: Equitable and Inclusive Education and Early Learning and Care in Ireland

Ireland's policy intention to develop inclusive and equitable education for all is manifested by domestic policy and legislature as well as in its engagement with international conventions and declarations. Ireland was a signatory to the UN Convention on the Rights of Persons of Disabilities (UNCRPD) in 2007 and enacted formal ratification in 2018. Article 24 of the UNCRPD requires state parties to provide inclusive, quality education for all with additional support for persons with disabilities in a manner consistent with the 'goal of full inclusion' (UN General Assembly, 2006, p17).

This commitment is reflected in Ireland's Education for Persons with Special Educational Needs (EPSEN) Act 2004 which promotes inclusive education for school aged learners with disabilities. In Section 2 of the EPSEN Act, 2004 mandates that 'a child with special educational needs shall be educated in an inclusive environment with children who do not have such needs' where this is in the best interests of the child and the children with whom he/she is to be educated. This commitment to inclusive education in primary, secondary, and tertiary education is echoed in Ireland's policies for ELC. There is evidence that Ireland has taken responsibility for following up and reviewing its own progress towards the United Nation's Sustainable Development Goals (SDGs) in the development of its SDG data hub (irelandsdg.geohive.ie). The SDG data hub monitors all 17 SDGs, including SDG4 which seeks to 'ensure inclusive and equitable quality education and promote life-long learning

opportunities for all by 2030' (UN General Assembly, 2015, p17). The data sets used to track Ireland's progress towards the SDGs for ELC are summarised in Table 2.1.

Table 2.1: Data sources used by Ireland to track progress towards SDG goals and targets for pre-school education

SDG target	Data Set	Related Publication	Headline Statistics
4.2.1: Proportion of Children Under 5 Years of Age who are Developmentally on Track in Health, Learning and Psychosocial Well-Being	Growing up in Ireland (GUI) Study. Longitudinal study of 11,000 families	Williams, J., Murray, A., McCrory, C. and McNally, S. (2013) *Growing up in Ireland: National Longitudinal Study of Children. Development from birth to three years: Infant Cohort.* Dublin: Department of Children and Youth Affairs	98% of children are described as healthy or very healthy by parents/carers. Just under 16% reported to have a long-standing illness, condition, or disability.
	Central Statistics Office (CSO), Table 1.17 – SDG 4.2.1 Percentage of 0–5-Year-Olds Experiencing Consistent Poverty.	Department of Children and Youth Affairs (2016) The state of the Nation's Children: Ireland 2016. Dublin: DCYA.	4.8% of children aged 0-5 years experienced consistent poverty.
	CSO, SCA05: Children and Young People having an Intellectual Disability (age group) and SCA06: Children and Young People having a Physical and/or Sensory Disability	Central Statistics Office (2017) SCA05 and SCA06 [Online]	Ages 0-4: 2.4/1,000 children (0.24%) Ages 5-9: 8/1,000 children (0.8%)
SDG 4.2.2: Participation Rate in Organised Learning (One Year Before the Official Primary Entry Age)	CSO: Report on Indicators for Goal 4: Participation rate in organised learning.	Department of Children and Youth Affairs (2020) *Annual Early Years Sector Profile Report 2018/19.* Dublin: DCYA	90.1% of 3 to 4 years and 84% of 4 to 5 years enrolled in the early years sector in the academic year 2018/2019 (note significant number enrolled in primary education aged 5). 96.8% of males and 96.5% of females in fulltime education at age 5.

Table 2.1 demonstrates that Ireland invests in data collection/analysis to compare ELC participation in relation to age, gender, region, and socio-economic group. This is with an intention to evaluate progress towards the SDGs and related strategic goals within domestic policy. Research has also been commissioned to investigate the impact of national programmes for ELC. An example of this is a study of the impact of taking up the Free Pre-School Year programme (FPSY, McGinnity Russell and Murray, 2015). The findings indicate marginal differences in cognitive outcomes where children attended a pre-school with a graduate leader. The study by McGinnity, Russell and Murray (2015) did not find evidence to undermine qualifications as a *proxy* for pre-school quality. This contributed to the evidence base for AIM's design and its investment in Continuing Professional Development (CPD) on inclusive practice for pre-school staff.

Ireland's data sets enable monitoring of participation rates in programmes funded by the Department of Childhood, Equality, Disability, Integration and Youth (DCEDIY) for ELC such as ECCE and AIM.

As yet, datasets enabling proportional comparison of participation among disabled and non-disabled children are underdeveloped, as are comparisons of outcome/impact. In part, this is because the population of young children identified as having a disability is small, being 0.24% of children who are 0-4 years and 0.8%, 5-8 years (CSO, SCA05 and SCA06, 2017), and disabilities may not be identified until later in the child's life. This makes it harder to assess whether AIM is reaching its intended cohort of children with disabilities, though studies by the ESRI (Whelan et al., 2021) indicate increases in the degree of participation by this group (see subsection 2.6). However, policies in Ireland have undergone significant development over the past twenty years in pursuit of quality ELC for all, including those with additional needs and disabilities from which thousands of children and families are benefiting. This is explored in what follows.

2.3: The context of Early Learning and Care in Ireland

AIM is one programme within an ecology of state-funded and state-subsidised programmes which seek to develop quality and equity of ELC for all. Drawing on the documentary record, this subsection will position AIM within this wider context through firstly, exploring the development of ELC in Ireland and secondly, mapping AIM's position in the current portfolio of programmes delivered by the DCEDIY and the Department of Education (DE)[14]. Section 3 of this report also provides a review of the literature that positions AIM within international data and debate.

An economic recession in the 1980s and early 1990s meant that there were limited opportunities for women to access paid employment. However, the economic boom between 1998 and 2007 led to almost 300,000 women joining the labour market. The participation rate of women with young children grew from 53.8% in 1998 to 60.2% in 2007 (Russell et al., 2009). This gave rise to the need for childcare arrangements, with private out-of-home services in demand (Devine et al., 2004; OECD 2006). At this time, there was no system of regulation of such services and their quality.

The Child Care Act of 1991 represented a sea change since it introduced a national regulation framework for the ELC sector for the first time. Ireland's ratification of the United Nations Convention on the Rights of the Child brought increasing focus on childcare and early education in the context of equal opportunities. For example, the Equal Opportunities Childcare Programme (EOCP 2000-2006) focussed on developing quality childcare services so that barriers to women's participation in the labour market were reduced. Between 2000 and 2010, the state had subsidised over 65,000 places in early childhood centres.

National Quality Frameworks for ELC in Ireland

In 2002, the Minister of Education and Science established a Cross-sectoral Implementation Group, with the Centre for Early Childhood Development and Education (CECDE), whose output was *Síolta* (meaning 'seeds'), a National Quality Framework for Early Childhood Education (CECDE, 2006). *Síolta*'s 16 quality standards reference the rights of the child, legislation and regulation. The Department for Education has policy responsibility for *Síolta*. In further pursuit of national quality standards, the National Council for Curriculum and Assessment (NCCA, an agency of the Department for Education) developed a Curriculum Framework for Early Childhood Education from birth to six years, *Aistear* (meaning 'journey'). *Aistear* holds 12 principles for Early Learning (many in common with *Síolta*) to expound children's rights as unique, capable citizens who have a right to an equitable, experiential, and playful early education in a context where they are connected with others (NCCA,

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[14] The Department of Education (DE) was named the Department of Education and Skills (DES) between 2010 and October 2020.

2009). These frameworks show how Ireland's conceptualisation of childcare developed to integrate care *and* education. The *Síolta* Quality Standards and Schedule 5 of the Early Years' Regulations 2016 are summarised in Figure 2.1.

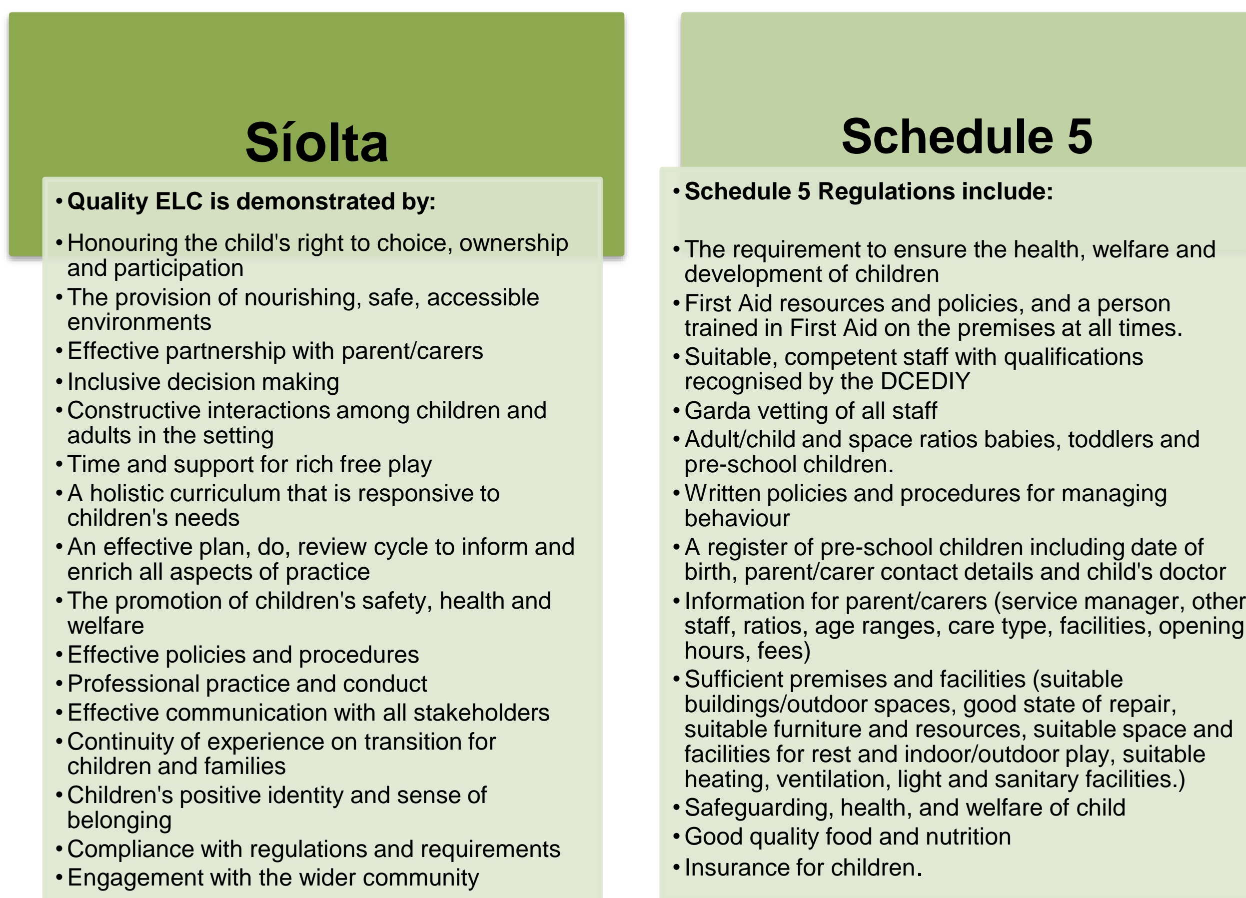


Figure 2.1: Key regulatory principles within Síolta, and statutory terms within Schedule 5 of the Early Years Regulations

Regulation of the ELC sector has continued to tighten with concomitant support from the state. Ireland's Child and Family Agency, Tusla was established in 2014 by the DCYA to serve as the agency responsible for wellbeing and outcomes for children (Tusla, 2014). Tusla operates under the Child and Family Agency Act 2013 which emphasises the responsibilities that services have to work beneficently, collaboratively, and seamlessly in pursuit of positive outcomes for children. Tusla was also formed as the regulatory agency for the inspection of Ireland's ELC providers in all their forms: crèches, playgroups, day-care services, and pre-schools that cater for children aged 0-6 years. Tusla's inspection framework focusses on providers' compliance with all regulations in the Child Care Act 1991 (Early Years Services) Regulations 2016, including Schedule 5 of the Early Years' Regulations 2016.

As Table 2.2 shows, the Department of Education (previously Department of Education and Skills – DES) Early Years' Education Inspectorate (EYEI) is responsible for evaluating the quality of educational provision in settings that provide ECCE provision. (DES, 2018). Recently, a consultation on a revised EYEI model was launched to include children from birth to six in Department of Education inspections (DE, 2021). This demonstrates that the ELC sector in Ireland has a system of dual inspection, with the EYEI focussing on educational quality, and Tusla focussing on regulatory compliance and care.

Table 2.2: Current National Frameworks for High Quality, Inclusive ELC for All.

National Frameworks for high quality, inclusive Early Learning and Childcare for all		
Universal Programme		**Administration Agency**
Síolta National Quality Regulatory Framework for Early Childhood Education CECDE, 2006	*Aistear* Early Childhood Curriculum Framework NCCA, 2009	The Department of Education Better Start Quality Development Service, 2015
Learning and Development National Síolta and *Aistear* Initiative (NSAI) 2016 AIM Level 3 2016		Better Start National Voluntary Childcare Organisations (NVCOs) City/County Childcare Committees (CCCs)
ELC Regulation, Quality Assurance and Compliance		Tusla Child and Family Agency and Tusla Early Years Inspectorate Department of Education Early Years Inspectorate
Tusla Early Years Inspectorate 2014	DES Early Years Inspectorate 2015	

Table 2.2 demonstrates that, as national quality frameworks have developed, so has support for providers. For example, the agency known as the Better Start Quality Development Service was founded by the DCYA (later the DCEDIY) in 2015 (European Commission, 2019). Its purpose is to promote quality and inclusion across the ELC sector for children aged 0-6. The Better Start Quality Development Service offers professional development, mentoring and coaching to providers to support them in the effective implementation of *Síolta* and *Aistear*. National Voluntary Childcare Organisations (NVCOs) and County/City Childcare Committees (CCCs) also contribute to the National Síolta and *Aistear* Imitative (NSAI). Better Start has a role in delivering Level 3 and Level 4 of AIM, as well as in bridging providers into Levels 5, 6 and 7 (see subsection 2.5). The quality and regulation frameworks, initiatives and inspection programmes shown in Figure 2.1 and Table 2.2 apply to all ELC providers and incorporate conditions for registration as an approved service. Compliance with regulations is also a condition for engagement with the funding programmes delivered by the DCEDIY and its agencies (DCYA, 2020). In 2018, there were a total of 4216 registered pre-school services with 2,687 of those services meeting the criteria for ECCE higher capitation rates (CSO SCA22, 2019).

Public funding for providers

Quality ELC provision is supported through state funding for providers and families, with funding schemes that include universal and targeted programmes. Table 2.3 provides some relatively recent examples of state support and subsidisation for providers.

Table 2.3: Examples of recent programmes of state subsidisation for providers of ELC

Examples of state subsidies for Providers
Programme Support Payment PSP, 2019/21 €19.4m programme of support for distribution to providers and calculated according to the number of registrations. The Programme Support Payment recognises the additional time required of providers of DCYA-funded ELC and school SAC, to complete the administrative work associated with funding schemes.
First 5 Core Funding (2022) €221m in full-year costs paid directly to providers (supply-side funding) alongside NCS and ECCE, to transform the sector and establish a new type of partnership between providers and the state to reflect the importance of ELC and SAC for the public good. Contingent on an Employment Regulation Order being agreed by the Joint Labour Committee. Designed to support several policy objectives – improved affordability

(protection against fees increasing), improved quality through better pay and conditions, employment of graduate staff, improved sustainability, and stability of services. Core funding is calculated according to the number/age of children, type/duration of services and staffing. Aims to incorporate funding to meet additional costs of the Workforce Development Plan (pay, conditions, development, progression), funding to support administration costs, funding to support the employment of graduate staff, and unlocking access to a package of support and resources.
ECCE Standard Capitation and ECCE Higher Capitation, 2016 Standard capitation where ECCE room leaders have a level 6 qualification that exceeds the regulatory minimum of Level 5. Where room leaders hold a degree qualification (level 7 or above) in Early Childhood Care and Education, a higher capitation is paid.
AIM Level 1 Additional Capitation Where providers employ a graduate of the Leadership in Inclusion (LINC) programme, they qualify for an increase of €2 per week, per approved registration over 38 weeks (as of 2020).
COVID 19 Reopening Funding Package (2020-21) €75m package of funding for reopening following the pandemic for childcare providers, to support providers to operate with less parental income without raising fear, and to support with any additional staffing, operating, capital or training costs implicated in re-opening.
Playing Outside Grant (2021) €5.5m to support services to facilitate greater outdoor facilities through improvements to existing facilities or the development of new facilities. Part of the Summer of Play Initiative.

Table 2.3 illustrates some of the funding measures available to providers to support affordable, high-quality childcare in Ireland. ELC providers can make funding applications through a single online platform (The Early Years Hive, active from 2020-21). Early Years Hive includes application portals for most of the AIM Levels (see subsection 2.5).

Funding allocations are designed, among other things, to support and enhance the quality of provision so that pre-schools can sustain their service to families, whilst not raising fees. For example, the COVID 19 Reopening Package sought to protect private sector providers from the financial impact of reduced numbers of children attending, as well as offering subsidies for the additional costs involved in re-opening (e.g., staffing, training, resource, and capital costs). The Core Funding Stream (to be made available in 2022) was to support private sector providers in recruiting and retaining better-qualified staff in a sector where traditionally pay has been relatively low and career development opportunities limited and would amount to over €200m per full funding year (DCEDIY, 2021).

Table 2.4 provides examples of the DCEDIY's current programmes of state-subsidised ELC for families and refers to universal and targeted schemes The *ECCE Programme* is a universal programme that provides up to two years of free pre-schooling for all children in the eligible age group (from a minimum entry age of 2 years 8 months). Families can avail of 15 hours per week over 38 weeks of the year for two programme years. The programme runs between September and June for two programme years. The number of children participating in ECCE since 2013 has been 610,031, and the number participating in 2019-2020 was 105,976 (Pobal, 2021)[15]. It is estimated that 96% of providers participate in the ECCE programme and up to 95% of children in the eligible age group are participating. (Government of Ireland, 2019b).

In 2020, it was reported that ELC providers were paid €69 per week per registered child. It is important to note that no additional fees are to be charged by ELC providers to parents for provision during the programme hours (Government of Ireland, 2019b). A maximum staff ratio of 11 children to 1 adult is set for ECCE. ECCE room leaders are required to have a minimum Level 6 qualification, and where room leaders are degree graduates in an area relevant to early education and care, a higher capitation rate is paid (€80.25 in 2020). It is estimated that approximately 53.5% of providers

[15] ECCE data is available from 2013 onwards when Pobal began making payments to Providers based on the number of children registered.

receive this higher capitation. Related to AIM, in 2020 €2 per child per week was paid to providers if a staff member has graduated from the Leadership in Inclusion (LINC) programme, and about 32% of providers avail of this additional capitation (Government of Ireland, 2019b).

Table 2.4: Examples of Public Funding Schemes in ELC and SAC for families in Ireland

State Subsidised Early Learning and Childcare for Families (DCEDIY)					
Universal Programme	Administrator	Application Platform	**Targeted Elements**	Administrator	Application Platform
ECCE programme, 2016	Pobal	Parental/carer application via a chosen provider. Provider ECCE registrations via Early Years Hive			
National Childcare Scheme (NCS), 2019 Subsidy for all children over 6 months to the ECCE qualifying age, and up to 15 years	Pobal	Parental/carer application via NCS Early Years Hive Provider NCS registrations via Early Years Hive	**National Childcare Scheme (NCS), 2019, Income Assessed Subsidies for children aged 6 months to 15 years**. Phased replacement of individual schemes: The Community Childcare Subvention Universal (CCSU) Programme The Community Childcare Subvention Plus Programme (CCSP) The CCSP programme also had some variants to support children in particular categories such as refugee children (CCSR), and homelessness children (CCSRT). For these two programmes, fees could not be charged to participating families The Training and Education Childcare (TEC) Programme	Pobal	Parental /carer application via Early Years Hive Provider NCS registrations via Early Years Hive

In Ireland, there are other public funding schemes designed to help parents to meet childcare costs. Following the passing of the 2018 Childcare Support Act, the National Childcare Scheme (NCS) was introduced which, when fully operative, delivers a streamlined scheme that integrates universal subsidies for families, and targeted ones for families in greater need (e.g., low-income). The Universal subsidy (which is paid directly to providers) is available to families who are in Tusla-registered childcare and when children are over 6 months old but under 15 years. At the time of writing, the subsidy amounted to €0.50c per hour and was subsidised for up to 45 hours a week (Citizens Information, 2021). The NCS also has an income-assessed subsidy (applying to the same age group and hours per week as NCS universal), which varies according to the family's reckonable income, the child's age, and their educational stage, with the highest maximum subsidy being over €5 per hour (Government of Ireland, 2019b).

The NCS targeted subsidies, when fully in place, will replace a range of established funding programmes. Some of these programmes are still running alongside the NCS in similar, or slightly altered form and are summarised below:

- The Community Childcare Subvention Universal (CCSU) Programme was a subsidy similar to that provided by the NCS and applied to ELC for children aged 6 months to age eligibility for ECCE. The NCS extended this entitlement to include SAC for children aged up to 15 in 2022.
- The Community Childcare Subvention Plus Programme (CCSP) provides enhanced funding on a sliding scale (according to income, age, and education phase) to ELC and SAC providers to offset the costs to parent/carers in a range of categories. The programme was extended to private and community providers in 2016 since it was only available to community up to that point. The CCSP programme also had some variants to support children in particular categories such as refugee children (CCSR), and homelessness children (CCSRT). For these two programmes, fees could not be charged to participating families.
- The Training and Education Childcare (TEC) Programme provides funding for ELC or SAC to support parent/carers who were attending eligible training programmes. It also supported some categories of parent/carers who were in a process of returning to work.

Department of Education programmes to support children with disabilities in ELC

In addition to the programmes provided by DCEDIY and illustrated in Table 2.4, the DE also has a role in pre-school provision for children with disabilities through the Early Start Programme, Early Intervention ASD Units, and the Home Tuition Grant scheme. The Early Start Programme is a one-year preventative programme offered in selected schools in areas that are identified as disadvantaged to meet the needs of children aged between 3 years and 5 years who are at risk of not reaching their potential within the school system. It involves an educational programme to enhance overall development, help prevent school failure and offset the effects of social disadvantage Early Start is run by fully qualified primary school teachers, supported by childcare workers, and sits under the auspices of the DE. Providers of Early Start follow the *Aistear* curriculum framework. Children can be enrolled in either Early Start or the ECCE scheme (DE, 2021).

The Department of Education, through its agency the National Council for Special Education, provides Early Intervention ASD classes for children with additional needs for whom there is no pre-school place available. In the 2021/22 school year 132 classes were providing pre-school education for 695 children. It is also true that children with disabilities can have a dual placement in a specialist pre-school and in a mainstream setting that delivers ECCE, spending part of the week in each. An additional option is provided by the *Home Tuition Grant Scheme* (DE, 2020), and a circular outlining the details of the scheme is published each year (DE, circular 38/21)[16]. This resource can be allocated to children between 2.5 and 3 years who are diagnosed with autism, and those aged 4 with autism who are recommended for an early intervention placement (e.g., in ECCE with AIM) but do not have access to one.

The Early Educational Intervention for children with Autism Spectrum Disorder strand of the Home Tuition Scheme provides early educational intervention for children with autism who meet the scheme's eligibility criteria. This scheme provides funding towards 10 hours tuition for children under 3 years of age and 20 hours per week for children over 3 years who cannot secure a placement in an early intervention class. In some circumstances, families can claim Home Tuition as a supplement to an ECCE placement. At the time of writing, if Home Tuition and ECCE are claimed together, the maximum total number of combined hours to be availed under both schemes is 10 hours per week for children between 2 and a half and 3 years, and 20 hours per week for children over 3. Statistics on how many children are enrolled on dual placements (i.e., ECCE/home tuition/specialist pre-school) were not available at the time of writing this report. It is fair to note that the range of support

programmes available for children with disabilities and additional needs is complex with each having its own detailed rules for qualification.

Following a review of the ELC model by the Partnership for the Public Good (2021) and campaigns by ELC advocacy groups (such as Early Childhood Ireland, ECI), the Irish Government's Budget 2022 included €716m for ELC, of which €207.3m (later revised to €221m) was for the new Core Funding Stream (see Table 2.3). This Funding Stream was to be contingent on the Employment Regulation Order that was under review by the Joint Labour Committee. Budget 2022 included significant increases for the ELC sector. This was in a context where OECD databases showed Ireland to be in the group of countries spending less than 0.5% of Gross Domestic Product (GDP) on ELC, lower than the OECD average of 0.7% (OECD, 2021). In 2021, the Minister for Children, Equality, Disability, Integration and Youth (CEDIY) also announced the Government's intention to increase state investment in ELC to €1 billion by 2028 (Government of Ireland, 2021a).

Commitment to increased state funding is also in the context of the whole-of-Government strategy, 'First 5'. *The First 5 2019-28 Strategy* identifies 5 'Big Steps' towards improving Ireland's capacity to 'create the conditions for the best start in life', as a reflection of children's right to 'a happy and fulfilled childhood' (Government of Ireland, 2019a, p3). The *First 5* Big Steps can be summarised as follows:

1. Access to a broader range of options for parents/carers to balance working and caring (parental leave scheme, family-friendly flexible working arrangements).
2. A new model of parenting/carer support (streamlining across departments/agencies, quality information and guidance – play and relationships, Parenting Unit established by the DCEDIY).
3. New developments in child health (dedicated child health workforce in areas most in need, National Healthy Childhood Programme, newly established Healthy Ireland Office – DoH, promotion of health for babies and young children).
4. Reform of the ELC system (continuing to improve affordability, accessibility, and quality, NCS, move to graduate-led ELC workforce, an extension of regulation and support, strengthened governance structure, the new funding model for ELC).
5. A package of measures to tackle early childhood poverty (free and subsidised ELC, ELC meals programme, adopting a Delivering Equality of Opportunity in Schools – DEIS model – with identification of levels of disadvantage and targeted support programmes).

In summary, AIM is situated within a range of policies, strategies and programmes which seek to strengthen the quality and inclusiveness of the ELC sector through universal and targeted support. The next subsection will focus on how AIM developed as a strategy for making the ECCE programme more accessible for children with disabilities and additional needs.

It is important to note that in 2019, 74% of ELC providers in Ireland were for-profit enterprises, with 26% being community (not-for-profit) providers. In Ireland, public funding programmes, quality frameworks, and support for providers (e.g., in the form of the Better Start Development Programme) have been important vehicles of state influence in the private ELC sector. Funding streams have been developed and grown to transform the relationship between providers and the state, such that the state could exert both more direction and support. The sustained intention has been to deliver quality, accessible and affordable childcare for all within an equitable framework.

2.4: AIM as a strategy for inclusive and equitable pre-school education for all

Table 2.5: The AIM Programme Universal and Targeted Elements

Access and Inclusion Model (AIM) for ECCE Implementation Development Group 2015, Cross-Sectoral Implementation Group, 2016					
Universal Programme	**Agency**	**Application Platform**	**Targeted Elements**	**Agency**	**Application Platform**
AIM Level 1: Funded LINC Training, 2016 and LINC+ Training, 2021	Mary Immaculate College (MIC)	MIC LINC Application Portal	**AIM Level 4:** Expert advice from Better Start Early Years Specialists	National Better Start Early Years Specialist Service (EYSS)	Early Years Hive
AIM Level 1: Funded Equality, Diversity and Inclusion Charter (2016) and Training, 2018	County/City Childcare Committees (CCCs)	CCC Application Portal/Form	**AIM Level 5:** Specialist equipment, appliances and minor building grants	POBAL	Early Years Hive
AIM Level 2: Information for Families and Providers, 2016, 2021	DCEDIY (aim.gov.ie)		**AIM Level 6:** Therapeutic Supports	Health Service Executive (HSE) and HSE partner agencies	Via referral from Level 4 EYSS to a relevant person on a HSE provided list of contacts. Website notes application for therapy services is via Early Years Hive using a full application form.
AIM Level 3: CPD (Hanen, Teacher Talk and Lámh), 2016	Better Start Learning and Development Unit	Better Start Training and Events Platform: MS form	**AIM Level 7:** Additional capitation (reduction of adult/child ratio)	Pobal	Early Years Hive

Like some other DCEDIY-funded programmes, AIM includes universal and targeted elements, delivered by a range of agencies within the DCEDIY and beyond it. Specifically, the Health Service Executive (HSE) and related delivery agencies/partners, and Pobal. Table 2.5 offers a summary of the AIM programme.

Table 2.5 illustrates how AIM is structured to deliver universal support for inclusive practice and outcomes (AIM Levels 1-3) through a range of agencies including the DCEDIY, Mary Immaculate College, the Better Start Learning and Development Unit and County/City Childcare Committees (CCCs). AIM Levels 4-7 are forms of targeted support for children whose disabilities or additional needs require them. Targeted support is also provided through the National Better Start Early Years Specialist Service (EYSS), Pobal and the Health Service Executive (HSE) and its partner agencies. As shown in Table 2.3, AIM provides additional capitation for providers who have a LINC graduate taking up the role of Inclusion Co-ordinator in a setting.

Applications for targeted support are through the Early Years Hive and must be made by providers in collaboration with parents/carers. More detail on each of these levels and their operation is given in subsection 2.5. AIM was introduced to enhance the quality and inclusiveness of the ECCE programme which introduces children within the eligible age range to a structured, play-based pre-

school experience in the two years preceding primary school. The entry point for ECCE is in September, with approximately 740,000 children benefitting from the programme since its launch in 2010 (in the form of the Free Pre-School Year).

In 2017, approximately 95% of eligible children were participating in ECCE and 95% of pre-school services were providing the programme. Up to the 12th of March 2020, 105,975 children were participating in the ECCE programme with 67% of these attending their first year of ECCE, and most registrations (77%) were in private services (Pobal, 2021). The OECD reports the child-to-adult ratio in pre-schools in Ireland is relatively low at 11:1 compared to the OECD average of 14:1 (OECD, 2017). Though uptake of ECCE was high and ratios favourable, there were variations in the support available for pre-school children with disabilities and/or additional needs. Stakeholders have perceived inconsistencies in access, with some regions having excellent provision, some with no services at all for this constituency of young children, and others having long waiting lists for registration in ELC services (DCYA, 2019)[17]. The National Disability Authority (2011) noted some evidence of providers turning away children with disabilities. The end of year one evaluation of the Access and Inclusion Model (DCYA, 2019) reported anecdotal evidence from stakeholders in the disability sector that pre-school leaders had been refusing to enrol children with disabilities because of resource shortages, and that some had suggested that another setting might be more appropriate. Evidence from a range of reports (NDA, 2011; DCYA, 2015; DESSA, 2007) identified the following factors as relevant to these exclusionary practices:

- Lack of policy attention to the inclusion of children with disabilities in the mainstream ELC sector
- Lack of infrastructure for supporting the ELC sector with inclusive practice
- Lack of training and support for providers in inclusive practice
- Lack of financial support for equipment, building alterations
- Lack of access to specialist advice and mentoring on inclusive practice for children with disabilities and additional needs
- An inconsistent policy message on expectations for inclusion in registered pre-schools

AIM development and governance

As a method for redressing deficits in training, support, and policy for inclusion in mainstream ECCE listed above, AIM was launched in 2016 by an Inter-Departmental Group (IDG) chaired by senior officials from the DCYA. It included representatives from the Department of Education and Skills (DES), the Department of Health (DoH), the Health Service Executive (HSE), the Tusla National Early Years Inspectorate, the Better Start Early Years' Specialist Service (EYSS), the National Council for Special Education (NCSE), the National Disability Authority (NDA) and the Dublin City Childcare Committee (CCC). Its purpose was to bring additional focus and support to providers of ECCE programmes so that children with disabilities and additional needs could be *fully included* and *meaningfully participate* in pre-school, and in so doing, reap the benefits of high-quality ELC. In 2015, AIM's vision was stated as follows:

> All children, including children with a disability, shall be able to meaningfully participate in the ECCE programme in mainstream pre-school settings (apart from exceptional situations where specialised provision is valid for reasons unavoidable).
>
> DCYA, 2015, p10

In 2016, the overall objective of the AIM was:

> To help service providers to deliver an inclusive pre-school experience, ensuring that children with a disability can fully participate in the Early Childhood Care and Education (ECCE) programme, thereby reaping the benefits of quality early years care and education and realising the opportunity to reach their full potential.
>
> DCYA, 2016, p.3-4

On its launch in June 2016, AIM's action objectives were stated as follows:

To promote and support an inclusive culture in pre-school settings by:

- Developing a new Inclusion Charter for the Early Years with strengthened EDI guidelines combined with nationwide training
- Providing up-to-date information for stakeholders on a website
- Funding LINC training for up to 900 practitioners over four years 2016-2020
- To fund multi-annual CPD for pre-school staff on disability and inclusion

To provide a system of targeted support for children and providers through:

- AIM Level 4 to Level 7
- A one-stop-shop for applications to targeted services (Levels 4-7) was also indicated, and CCCs were identified as important sources of support for providers in making these applications.

In 2016, governance and oversight of AIM were taken up by the AIM Cross-Sectoral Implementation Group (CSIG), which had the following membership:

- Department of Children Equality, Disability, Integration and Youth (Chair and Secretariat)
- Health Service Executive (HSE)
- National Council for Special Education (NCSE)
- National Disability Authority (NDA)
- Department of Education
- Department of Health
- Pobal
- Better Start (National Early Years Specialist Service)
- CCI (County/City Childcare Representative)
- Early Childhood Ireland (ECI)
- Tusla Child and Family Agency (National Early Years Inspectorate)
- Parents/carers Representative

The AIM CSIG has the remit 'to oversee and direct the operation and development of the Access and Inclusion Model (AIM). The Access and Inclusion Model was designed to support access to the Early Childhood Care and Education Programme (ECCE) for children with a disability' (DCEDIY, 2021). The AIM CSIG has three main responsibilities as follows:

1. Monitor the operation of AIM in line with DCEDIY policy and budget
2. Ensure adequate support is available to the AIM Project Team
3. Function as the final arbiter in issues which the AIM Project Team cannot agree

CSIG receives monitoring reports from AIM delivery services, including monthly data summaries and annual sector reports from Pobal which it uses to monitor take-up, engagement, and expenditure. However, routine reporting on the quality and impact of support (e.g., through inspection findings or stakeholder surveys) is not yet embedded, though this evaluation will cast light on this. The next

subsection provides a detailed analysis of AIM's conceptual and operational structure at the time of writing this report. This subsection will also refer to the most recent data on the take up of AIM supports to date, enabling some evaluation of progress against the IDG objectives listed above.

2.5: AIM's structure: universal provision and seven levels of support

The Access and Inclusion Model was designed to support access to the Early Childhood Care and Education Programme (ECCE) for children with a disability. Table 2.5 offers a summary of the AIM programme and demonstrates that it has a foundation of *universal design for quality* combined with *targeted support* over seven levels. AIM operates alongside national programmes that are also focused on quality and equity in ELC through universal and targeted elements (e.g., NCS).

AIM universal and targeted supports are not always interlinked. For example, Level 2 does not lead to Level 3, and Level 7 is not the ultimate goal or premised on progression through Level 5 and 6. At the time of writing, the DCEDIY were tending to move away from this graphic since it can be interpreted as a ladder of progressive support rather than a non-sequential range of provisions applied according to need.

Figure 2.2: DCYA's illustration of AIM as a Support Model for ECCE

AIM is delivered by a range of organisations including the HSE, MIC, Pobal, Tusla and Better Start. Figure 2.2 is the DCEDIY's illustration of AIM's structure (DCYA, 2016), and this illustration appears on the department's own AIM information site (aim.gov.ie) and those of its delivery organisations. Researchers note some small differences in the language used for each level on the figure and the descriptions of levels on the department's AIM website. The AIM model was developed to enable children with disabilities to access mainstream pre-school and experience inclusion. Within AIM's policy, disability is defined as 'a long-term physical, mental, intellectual or sensory impairment which in interaction with various barriers may hinder a child's full and effective participation in society on an equal basis with others.' (DCYA, 2016, p5). However, AIM is also intended to support children who do not have a diagnosis and 'where the particular impairment may not be traditionally recognised as a disability (DCYA, 2016, p5). The following describes the content and operation of each level of AIM with reference to any changes and developments that have occurred over time.

AIM Level 1: An Inclusive Culture

Level 1 comprises fully funded training and multi-annual CPD focussed on inclusive values and practice. The *Inclusion Co-ordinator Training* (LINC) is a level 6 special purpose award for Early Years educators which launched in 2016. It is hosted by the LINC consortium which is led by Mary Immaculate College (MIC) and includes MIC, ECI, and Maynooth University. The LINC consortium was awarded leadership of LINC through a competitive tendering process and its members are recognised nationally as leaders of education and training for the ELC sector. The LINC programme is a blended model involving online elements and onsite mentoring visits and comprises of 6 modules of between 6 and 12 European Credit Transfer System (ECTS) credits. The modules focus on the theory and practice of inclusion in the Early Years and the role of inclusion leaders. An interim evaluation of the LINC programme in 2019 demonstrated that the programme had been successful in bringing qualitative shifts to LINC graduates' knowledge and practice, of relevance to leadership for inclusive culture change. Participant satisfaction levels and completion rates were high, and the programme received several national awards for its quality, including the 2020 Education Awards for 'Best Online Learning Experience' and 'Best Marketing and Communications Team' (Mary Immaculate College, 2021). The interim evaluation (LINC Consortium, 2019) notes that 44% of enrolled students in 2018-19 were managers and 35% were team leaders and that this may serve to compromise distributed leadership for inclusion in ELC settings. It was recommended that more than one staff member in an ELC setting should participate in LINC and that the programme should continue beyond 2020.

Successful completion of the LINC award qualifies graduates to carry out the role of inclusion coordinator in their setting. AIM provides a role description for inclusion coordinators, and this emphasises the leadership of staff in the development of an inclusive culture (through the lens of the DEI charter), and in supporting practice and engagement with CPD. Inclusion coordinators also have a role in the implementation of AIM, specifically liaising with Early Years Specialists (EYSs), collaboration with parents/carers and external providers and preparing for the transition to primary school. Where a setting employs at least one inclusion coordinator, they can claim AIM Level 1 additional capitation (in 2020-21, this was an extra €2 per week for each ECCE registered child), and a setting can claim a one-off grant for a participant of LINC (€200). In 2018, the LINC award was also deemed one of the DCEDIY's *Early Years Recognised Qualifications* for ECCE standard capitation status, meaning that a LINC graduate could be a pre-school room leader. In recognition of the need for CPD for LINC graduates, the LINC+ programme was launched in 2020. The programme is free of charge to eligible participants and fully online. Its content centres on distributed leadership for inclusion and communities of practice (Mary Immaculate College, 2021).

Free of charge CPD for pre-schools is also delivered in the form of Equality, Diversity, and Inclusion (EDI) Training. This is supported by the *Diversity, Equality and Inclusion Charter and Guidelines for Early Childhood Care and Education*, (DCYA, 2016), and by training that is delivered by regional CCCs. Analysis of the charter shows it to be cohesive with the National Quality and Regulatory Standards for ELC since it emphasises protection from discrimination on the grounds of gender, civil status, family status, sexual orientation, religion, age, race, membership of the Traveller Community, and disability. Economic migrants, refugees, asylum seekers, speakers of Irish as an additional language, minority faiths and children of gay and lesbian parents/carers are also recognised in the charter as minorities who have the right to equal opportunities and inclusion in pre-schools. It provides guidance for pre-school providers on how to develop anti-bias policies and practices so that the right of every child to be 'welcomed and included on equal terms' with 'equality of participation' is upheld (DCYA, 2016, p.vi). The take up of LINC training and EDI training over time is summarised in Table 2.6 and shows that AIM's launch objectives for 900 LINC graduates by 2020 have been achieved. Over six thousand practitioners have completed EDI training to date (data provided by Pobal). This demonstrates that Level 1 has been implemented and taken up by providers, though the impact is not

discernible from these figures. Assuming 4,216 ECCE individual services (CSO SCA22, 2019) it is estimated that 83% of providers have engaged in this programme. Level 1 also includes AIM Inclusive Play resources and guides and the Universal Design Guidelines (DCYA and CEUD-NDA, 2021)

Table 2.6: Take of AIM Level 1 LINC and EDI training to 2020, and 2020-21

(n) graduates from LINC programme 2016-2020	(n) graduates from LINC programme in 2020-21	(n) EDI training participants 2016-2020	(n) Training participants 2020-21
3,504	585	6,500	30*

*EDI training has been paused since the first national lockdown on 12th March 2020

In essence, AIM Level 1 is about building capacity through CPD on inclusive practice since this is more effective in changing practice culture than legislation and regulations (CECDE, 2004). The state incentivises engagement in Level 1 through the higher capitation offered to pre-schools that employ at least 1 LINC graduate. AIM Level 1 is also supported by AIM Inclusive Play (AIP) pack and information guide (supplied to over 4,000 ELC settings in 2018).

AIM Level 2: Information for Parents/carers and Providers

Currently, the DCEDIY's AIM information site (aim.gov.ie) is the most substantive manifestation of AIM Level 2. Its content is echoed across AIM's delivery agencies including Better Start, Pobal and the City/County Childcare Committees (CCCs) and organisations that advocate for the ELC sector (such as Early Childhood Ireland – ECI). The research team note that AIM is not referred to on the HSE landing page for Children's Disability Advice for Parents and Carers, nor on most of the disability advocacy/support websites that HSE links to. The NCSE website also makes no mention of AIM. The DCEDIY updated its AIM Information Site in June 2021 to make it easier to navigate for parents/carers and providers. This was in response to user feedback and the recommendations of the end of year one review of AIM. The DCEDIY intend to develop the AIM Information Site through the use of videos, resource pages, and other accessible formats.

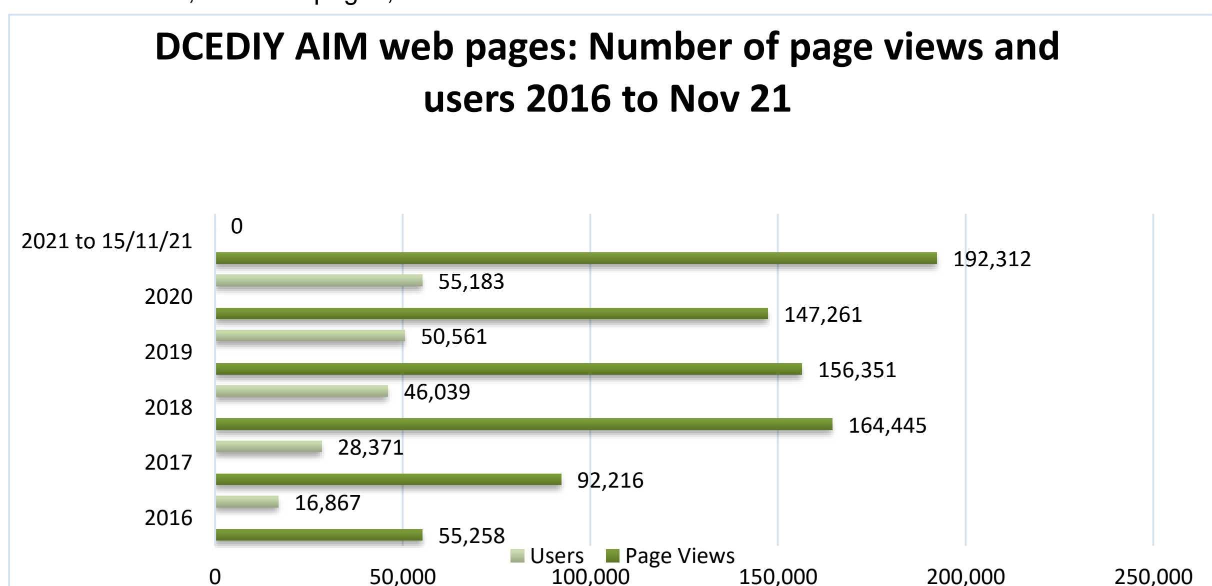


Figure 2.3: User counts and page views for DCEDIY AIM web pages from 2016 to November 2021

The AIM Information Site also provides visual assets that can be used by other agencies and organisations that are disseminating information about AIM (aim.gov.ie).

The website also includes contacts for parent/carers should they wish to make an enquiry or register an appeal complaint. These are also provided by CCCs, though all of the links are to DCEDIY AIM partners (Pobal, CCCs, Better Start) and do not include links to independent organisations that may also offer support and advocacy. For parent/carers, this may feel a little like a closed loop. Figure 2.3 shows the number of page views and the user count between 2016 to 2021, and demonstrates that over time, there has been a trend of increasing engagement with the AIM website; in 2021 the AIM website received 192,312 page views from 55,183 users between January 2021 and November 2021. The AIM website does not have a user feedback tool such as 'Did you find what you were looking for?' or 'How would you rate the usefulness of this website?' Researchers note that this could be a useful addition to the site to support routine monitoring of its usefulness and useability. It is also important to note that the AIM 'triangle' (shown in Figure 2.2) uses some different terms for levels of support than are on the website currently.

City/County Childcare Committees (CCCs) are responsible for disseminating information to providers and families in their areas, and all CCCs have information about AIM and additional links on their webpages. Researchers note that, at the time of writing, some information needs updating to reflect the introduction of the Early Years Hive as the registration and application platform for DCEDIY funding, including AIM. The AIM website and CCCs signpost a range of contacts that parent/carers can use should they have an AIM enquiry, a complaint or should they wish to appeal an application decision. These link to DCEDIY partners including Pobal and Better Start and may serve to loop parent/carers into communication routes that exist within the departmental space, rather than beyond it into independent/external sources of advice or advocacy.

AIM Level 3: A Qualified and Confident Workforce

Providers are supported through funded CPD focussed on inclusive practice and additional needs. CPD programmes are repeated yearly, twice yearly or termly. Currently, AIM provides the following CPD via applications on the Better Start website - only settings that are engaging in AIM support can apply for places on the programmes (Better Start, 2021):

> **Hanen 'Teacher Talk'** is an 18-hour course leading to a certificate of completion. Two of the three modules are available online. The training develops participants' understanding of how to support language development for all children, including those with language delays.
>
> **Lámh Module 1** develops participants' ability to support communication through the use of a manual sign system which is used by people with intellectual disabilities or communication needs in Ireland. It is limited to practitioners working in settings who have a Lámh user on their roll.
>
> **Sensory Processing in Early Learning (SPEL)** focusses on how to meet children's sensory needs and understand the importance of sensory integration in children's learning and development.

Table 2.7 shows the number of settings taking up Lámh and Hanen services to indicate that 34% of providers have enrolled onto at least one of these courses between September 2019 and July 2020 (DCEDIY, 2021).

Table 2.7: Take up of Lámh and/or Hanen Training during 2019-20

(n) Providers enrolled in AIM Lámh and/or Hanen Training to 2019-2020	(%) Providers enrolled in AIM funded Lámh and/or Hanen Training to 2019-2020
364	15%

AIM Level 4: Expert Early Years Educational Advice and Support

Better Start comprises a team of Early Years Specialists (EYSs) and Team Leaders who work directly with providers in a mentoring role to build their capacity to deliver high-quality, inclusive ECCE for children and their families. EYSs have a designated case load and work collaboratively with ELC staff to develop practices guided by the core elements of *Síolta* and *Aistear*.

EYSs also support settings in their implementation of AIM, and their role description includes a duty to 'provide advice and support to services in areas such as the inclusion of children with additional needs' and 'work co-operatively with other support services in the sector' (Pobal, 2018, p2). EYSs are required to have at least 3 years post qualification experience, have an in-depth understanding of ECCE and be skilled in mentoring and coaching. In relation to AIM, teams of EYSs are managed by a Better Start Team Leader with responsibility for oversight and deployment (Pobal, 2018).

Providers (with consent from and in collaboration with parents/carers) can apply for Level 4 support via the Early Years Hive (earlyyearshive.ncs.gov.ie). The application must include an *Access and Inclusion Plan* written by the setting. EYSs mentor and advise pre-school staff on the development of the Access and Inclusion Plan. This may include the identification of additional resources, and in some cases, an application for AIM Level 5 or 7, or an EYS Request for Support to the relevant HSE or HSE-funded service provider under Level 6. EYSs can also liaise with the National Council for Special Education to support the transition to primary school.

Table 2.7 summarises the number of providers that have received AIM Level 4 support following application, and shows that in 2019-20, 3,708 applications were approved, with 19,432 approved since AIM's launch in 2016-2017. 91% of Level 4 applications have been approved since 2016. This value is 95% for applications received in 2019-20 (data provided by Pobal). We also know that there had been a total of 55,154 Better Start Visits completed between the first full programme year of AIM (2016-17) and October 2021, and 3,347 HSE engagements with AIM Level 4 during the same period.

Table 2.8: Applications and Awards of AIM Level 4 over time and in 2019-20

Year	2019-2020 Applications made	2019-2020 Applications approved	2016 to October 21 Applications made	2016 to October 21 Applications Approved
Level 4	3,985	3,708	21,290	19,432

AIM Level 5: Equipment, appliances, and minor alterations grants

AIM Level 5 provides physical resources and alterations to make the pre-school more accessible for children with disabilities/additional needs. For example, building alterations might include the installation of a hoist, a wheelchair ramp or door widening. Equipment may include hearing loops, sound systems, specialised chairs, play equipment and standing frames, which are administered by Pobal, with support from HSE as necessary. Where settings are awarded a grant for equipment, training in the use of the equipment is provided free of charge, but single items costing less than €50 are not eligible under AIM Level 5.

An HSE, Better Start, DCYA (later DCEDIY) Joint Working Protocol published at the commencement of AIM implementation in 2017 and updated in 2020 (HSE, 2020) explains how HSE and HSE funded service providers integrate with Better Start within AIM.

In the case of AIM Level 5, the protocol notes that Level 5 awards will be made when a visiting teacher (for sensory or hearing difficulty) or a HSE clinician (e.g., Occupational Therapist) deems specific equipment appropriate, critical to participation and not already available to the pre-school. Designated professionals (architect, engineer, OT or other HSE professional) are also required to confirm that alterations are both needed and compliant with building regulations. Table 2.9 provides a summary of Level 5 applications and awards over time from 2016 up to 2020 and shows that a total of 1,874 have been approved since 2016, with 344 of these being in 2019-20. To date, 83% of Level 5 applications have been approved, with this figure being 78% in 2019-20.

Table 2.9: Applications and Awards of AIM Level 5 over time and in 2019-20

Year	2019-2020 Applications made	2019-2020 Applications approved	2016 to October 21 Applications made	2016 to October 21 Applications Approved
Level 5	344	269	2,253	1,874

AIM Level 6: Therapy Services

AIM Level 6 is provided by the Health Service Executive (HSE) and related agencies/partners which include the newly established Children's Disability Network Teams (CDNTs) and the HSE Primary Care Service. Additional resources were provided to the HSE to facilitate the provision of these supports under AIM. The HSE, Better Start, DCYA Joint Protocol (published in 2017 and updated in 2020) explains that Level 6 is accessed via an initial contact e-mail or phone call from Level 4 EYS to the relevant HSE service provider for support (HSE 2020 p15). Details of the health service provider where the child is currently receiving service (or is waitlisted) will be included by the parent/carer on the Access and Inclusion Profile. In addition, the HSE provided a 'Directory of Contacts' to Better Start for children who are not currently known to HSE.

Usually, Level 6 supports under AIM include universal strategies such as information and advice for the EYSS, and advice, leaflets and practical guidelines to assist groups of children, parent/carers and pre-school leaders with common areas of challenge for children with a disability generally, and in terms of specific diagnoses. Where this universal provision does not result in a child's meaningful participation in pre-school, targeted support can be requested through a referral. HSE provides targeted supports individual to the child such as individualised therapy interventions, pre-school plans, behaviour support plans, prescription of individualised equipment, professional advice over the phone and pre-school visits. The Joint Working Protocol (HSE 2021) is provided as a link within the HSE website (www.hse.ie/childdisability) along with the organisations it provides links to, such as *Informing Families*, (informingfamilies.ie), and AsIam (asiam.ie). Researchers were not able to find reference to AIM within the Childhood Disability pages of the HSE website (https://www2.hse.ie/childrens-disability/) or on the organisations it provides links to.

A key principle of Level 6 is that support should be integrated into the holistic programme provided in the pre-school, and service delivery within Level 6 was designed to enable 'prevention, early intervention, brief generic interventions and more individually tailored one-to-one intervention' (DCYA, 2016). The operational policy for AIM (DCYA, 2016, p24) also notes that in the context of parental consent, AIM Level 6 will require continuing interprofessional communication between Better Start EYSs and HSE professionals at a point where a referral for targeted support has been made:
The HSE will advise the Early Years Specialist of all supports delivered on foot of a referral. This will enable the Early Years Specialist to provide informed ongoing support to the child.

Universal and targeted support with Level 6

Level 6 is distinctive within the AIM structure of supports because it operates both universal and targeted support from HSE services. It also has different HSE/Better start engagement processes for children known and not known to HSE. Analysis of policy documents and web communications (aim.gov.ie) has identified the following descriptions of these supports and the process for applying for them.

Universal Level 6

- 'Universal services are the provision of leaflets or other supporting information' (aim.gov.ie).
- 'Universal strategies may include the provision of information, advice packs, leaflets, practical guidelines to assist groups of children, parent/carers, and pre-school leaders with common areas of challenge for children with a disability' (HSE, 2020, p14) and 'parent and pre-school leader training to understand and respond appropriately to the child's needs '(HSE, 2020, p4).
- In the case of a child **known** by the relevant health services a 'planned phone call with the EYS documented in the child's health record' (HSE, 2020, p15).
- In the case of a child **not known** by the relevant health service, 'the EYS will arrange a phone call with the relevant health service for support and advice (i.e., universal supports) over the phone' (HSE, 2020, p15).
- In the case of children not known by the HSE and where existing clinical information is not available 'health providers will address the child's needs through universal strategies such as the provision of information, advice packs, leaflets and practical guidelines, training of parent/carers or pre-school leaders to understand the child's needs and to respond appropriately, professional advice and support on the phone or by e-mail, access for staff to group therapeutic programmes or workshops and drop in consultation clinics' (DCYA, 2016, p24).
- 'Universal strategies should target themes that are specific to the needs of children in their specific ECCE setting' and benefit all children 'whether they have received an assessment or diagnosis' or not (HSE, 2020, p4).

Targeted Level 6

- 'Targeted services are individualised and could include behaviour support plans, classes, equipment, professional advice, or pre-school visits' (aim.gov.ie).
- In the case of a child **known** by the relevant health service, 'targeted interventions may include individualised intervention programmes, individualised pre-school plans, individualised behaviour support plans, the prescription of individualised equipment; professional advice on the phone regarding an individual child; pre-school visits to advise pre-school staff on their implementation' (HSE, 2020, p15).
- In the case of children **not known** to the relevant health service and where universal strategies are not working, 'this will need to be looked at on a case-by-case basis. In such cases, it is likely that individual assessment of the presenting needs will be required in order to provide individual, tailor-made interventions' (DCYA, 2016, p24).

Application for universal and targeted supports

- 'To apply for therapy services through AIM level 6 the entire application form on the early years hive including the My Inclusion Plan should be completed.' It is not clear what is being referred to by the 'entire application form' (aim.gov.ie) though researchers assume that this is the 'Age-Appropriate Additional Information form' referred to in the Joint Working Protocol

(HSE, 2020, p17) which parents/carers are asked to complete and sign. It is not entirely clear from this explanation on the website whether the application is for universal or targeted support.

- Where the child is **known** by the relevant health service and universal supports have not been sufficient 'the EYS will contact the healthcare professional again regarding the need to progress to targeted interventions' and 'forward a copy of the child's Access and Inclusion Profile including signed parental consent…by registered post to the healthcare professional who provided universal strategies' (HSE, 2020, p17).
- 'Where a service provider in conjunction with a parent/carer considers that a child may need therapeutic support, they can apply for this through Level 4 by completing an Access and Inclusion Profile' and 'where therapeutic input is likely to be required will initiate contact) 'a referral' to the HSE where necessary' (DCYA, 2016, p24).

In summary, from these examples of universal support, it can be deduced that Level 6 (universal) comprises an advice/training service, where HSE expertise is accessed to support the design of effective inclusive practices for children who are and are not known to HSE (and hence do or do not have a diagnosis).

Level 6 (targeted) is more individualised and bespoke in design. It may comprise a range of interventions which can be episodic or continuous. Level 6 (targeted) is applied for via a *referral* (which is the term used for *application* for targeted support in Level 6). Level 6 (targeted) may involve bespoke practice advice (e.g., visits to the pre-school) individualised planning (e.g., behaviour support plans) or other types of intervention. This is in a context where collaboration and continuous communication between the two services is expected as part of the process of reviewing the Access and Inclusion plan.

The operational approach to Level 6 delivery

The Joint Working Protocol (HSE, 2020) outlines the operational processes involving Level 6 delivery in the context of collaboration with EYSs. These processes are reported below with reference to children already known to HSE (who will usually have a diagnosis or be on a waitlist for assessment) and children not already known to HSE.

Where a child is already known to HSE providers (e.g., the Children's Disability Network Team (CDNT) or Primary Care), the Better Start EYS will liaise with the HSE contact identified on the Access and Inclusion Profile to discuss best practices. Where the child is not known to the HSE, the EYS will forward a completed Access and Inclusion Profile and referral forms (which are completed by the parent/carers) to the agreed HSE contact on the HSE's Directory of Contacts list provided. Level 6 support must commence within five weeks unless agreed otherwise with the EYS (e.g., a child is ill or a staff post is vacant) (HSE 2020 p17).

The AIM Joint Working Protocol (HSE, 2020) provides further detail on how Level 6 supports are accessed – the rationale behind the Protocol is to be fair to all children receiving and awaiting disability services, whilst supporting within 5 weeks a child's pre-school needs those with specific pre-school needs. **If a child is known to HSE** (i.e., is assessed and either awaiting or receiving a HSE intervention from the Children's Disability Network Team (CDNT) or Primary Care), then EYSs at Level 4 are responsible for contacting a lead practitioner within the relevant health service named on the Access and Inclusion Profile by the parent/carer. The Joint Working Protocol (HSE, 2020, p17) states that 'if no health service is named, [the] EYS will ask the parent/carer for health service contact details.' On contact with the HSE service, the EYS is expected to focus first on how universal support can be shaped to improve the child's inclusion and participation, and second on targeted supports

where the advice given by HSE professionals 'did not result in the child's access and participation in pre-school' (HSE, 2020, p17). At this point, the EYS makes follow-up contact with healthcare professionals and where the 'health service supports to be provided are critical to a child accessing and participating in ECCE' they must commence 'within a 5-week timeframe or as agreed with the EYS' (HSE, 2020, p17).

For children not already known to or waitlisted for HSE services, the EYS will contact the relevant health service as per the HSE's Directory of Contacts for universal supports based on an anonymised Access and Inclusion Profile. If it is deemed that targeted supports are required,the EYS must ask the parent/carer to complete and return to them, a completed 'National Access Policy Referral' and 'Age-Appropriate Additional Information' form. This is a referral. In addition to AIM Level 6 supports, this formally refers the child to the relevant health service, Primary Care or CDNT for assessment and intervention as appropriate. This is to be attached to the Access and Inclusion Profile and submitted to the relevant health service lead by the EYS. The implementation process for Level 6 targeted support is shown to have 11 steps in the Joint Working Protocol (HSE, 2020, p18), of which 3 are for the EYS, i.e., 1) contact the relevant health service, 2) support the parent/carers' completion of the Referral Form and Additional Information Form, and 3) submit the forms with a copy of the Access and Inclusion Profile and a review of the outcome of strategies applied to date. These are submitted via the Early Years Hive. The other 8 steps are HSE standardised processes i.e., acknowledgement receipt of request, checking whether information is complete, reviewing the child's needs to meaningfully participate in pre-school, contact with the parent/carer, commencement of support and provision of copies of targeted supports with family and pre-school. These steps are activated after the EYS is satisfied that universal strategies are not sufficient.

Descriptions of step 9 indicate the HSE service will commence only when it is 'critical to the child's access and participation in ECCE' (HSE, 2020, p18) within a five-week timeline or beyond as agreed with the EYS such as where the child is ill or the staff post is vacant. This definition of 'critical to access and participate' was agreed to ensure that children requiring level 6 supports to access and fully participate in pre-school are not queue-jumping other children on a waiting list based on need for access to health services outside the child's pre-school needs. The Joint Working protocol includes a note about how support under AIM will be provided where children unknown to the health service can be formally referred to the CDNT under AIM. This is to receive Level 6 (targeted) supports, and this then waitlists the child for all other required assessments and interventions.

The Joint Working protocol includes a note about how support should be provided where children are to be on waiting lists for Assessments of Need:

> As a child's time in the ECCE Programme is relatively short, the relevant health service is required to respond within 5 weeks of receipt of the request for support in order to enable his/her access to and optimal participation in the ECCE Programme unless otherwise agreed between the healthcare professional and EYS. This is a formal referral to Early Intervention Services where the child will receive therapeutic supports critical to their participation in the ECCE programme while they remain on the waiting list for other health service supports (HSE, 2020, p16).

The rationale for the HSE Better Start and DCYA Joint Working Protocol is to be fair to all children receiving and awaiting disability services, whilst supporting a child's specific pre-school needs within five weeks of referral.

Therapeutic support from HSE services may be delivered at local health centres rather than at pre-school and it is noted that 'starting pre-school or school are very important steps in a child's life. The

team and the family will plan together to make this time as smooth as possible for you and your child' (HSE, 2021a, p.22). The Joint Protocol (HSE, 2020) indicates that this collaboration will arise in the development of an Access and inclusion Plan by the EYS in contact with the relevant health service. At the time of writing, HSE were implementing the *Progressing Disability Services for Children and Young People* (PDS) programme as part of the Sláintecare Strategy (Sláinte meaning 'health'). In March 2021 (HSE, 2021b), the Minister of State for Disabilities described the PDS programme as a 'significant reform of Children's Disability Services' to ensure that 'children with disabilities and their families have fairer access and clearer pathways to services.'

The PDS was developed cross-sectorally over several years and included consultation with families and voluntary services. One focus of the PDS programme was the development of a national system of 91 *Children's Disability Network Teams* (CDNTs), which are community services working under the auspices of Ireland's 9 Community Health Organisations (CHOs) to serve children with complex needs and their families. CDNTs are a pooling of the variety of HSE and HSE-funded agencies into multi-agency staffed teams (Finn, 2021). CDNTs provide for children from birth to 18.

The PDS programme is supported by the National Access Policy Joint Protocol between Primary Care, Child and Adolescent Mental Health Services (CAMHS) and Disability Services. It is also supported by the Joint Protocol between the HSE and Tusla toward 'breaking down silos and barriers, to signpost families to the right services at the right time' (HSE 2021a). In March 2021, almost all CDNT managers were in post and the PDS programme was being rolled out 'to build sustainable family-centred service models across the country' (HSE, 2021b). CDNTs each have a team of professionals with roles such as administrator, family support worker, nurse, occupational therapist, psychologist, social worker, speech and language therapist, and physiotherapist. Their work with families includes 'linking with pre-schools and schools' (East Cork City Children's Disability Network Team, 2021). A cyber-attack on the HSE and staff shortages led to delays in rolling out the PDS programme, this was reported in July 2021 (Finn, 2021).

The rationale for the transformation of Children's Disability Services through the PDS programme in Ireland is described as follows (HSE, 2021b):

- Children's disability services had originally been predicated on service to a type of disability or particular diagnosis, meaning wide variation across the country in service availability. Hence PDS was about 'equity of access and consistency across the country' and services 'based on the child's needs, not on their diagnosis' (HSE, 2021b).
- Families and referrers were finding it difficult to identify where services were and how to access them, and this needed to be transformed to meet the vision of Sláintecare which is to find the right service, at the right time, in the right place which is as close to home as possible.
- Service teams would need to work in partnership with families and with education services to achieve the best possible outcomes since these were considered to be key people in the child's life and development.
- The reconfiguration of children's disability services would achieve more efficient and equitable use of resources.

It is important to note that PDS is a transformative programme. It involves the reconfiguration of all children's disability services and staff (including those in HSE Primary Care and HSE Disabilities, Section 38, and Section 39 non-statutory organisations) into 91 CDNTs which was completed in 2021. Each CDNT provides services for children with complex needs within a given area. The CDNTs are expected to deliver the National Access Policy (HSE, 2019), adopt a family centred approach, and in line with the sector, focus its reporting on *outcomes* for

children and families rather than reporting on what *been provided* (e.g., number of therapy sessions). This might mean for example, reporting on the *impact* of speech and language therapy on their experience of inclusion and participation (Standards and Performance Reporting Working Group, 2013). The PDS also requires CDNTs to work collaboratively across HealthServices and Education. At the point of writing, a national forum has been established in line with the Framework for Collaborative Working between Education and Health (2013) comprising of the HSE, the National Council for Special Education (NCSE), and the National Educational Psychological Service (NEPS), though not yet with ELC representation. In addition, local Education and Health Forums will be established under this national structure as part of the Progressing Disability Services (PDS) programme). Forging links between HSE, CDNTs and education is identified as a priority for supporting children to achieve their optimal outcomes.

All CDNTs have been in place since 2021, and a National Access Policy is currently being implemented in CDNTs and primary care to signpost families to the right services. The National Access Policy is to be rolled out following pilots in 7 CDNTs. The information reported above is relevant to AIM and its evaluation because it illustrates how Level 6 is being delivered at a time of major national reform to children's disability services – the changes are structural and values-oriented, and so have implications for shifts in practice that are likely to work better for AIM (e.g., better links between services, pre-schools, schools, and families). Table 2.10 summarises available data on Level 6 to note that there have been 3,347 Level 4 HSE engagements since the programme began. This figure refers to the initiations of HSE universal supports by the EYS. There have been 133 Level 6 referrals for targeted support from HSE between 2016 and October 2021 (47 for children not known to HSE services and 86 for children known to HSE).

Table 2.10: Number of referrals for AIM Level 6 Targeted Support 2016-2020

Year	Number of applications
2019-20 L6 referrals for targeted support	22
2016 to October 21 L6 referrals for targeted HSE support	133
2019-20 L4 HSE Engagement	729
2016 to October 21 L4 HSE engagement	3,347

Table 2.10 shows that, per year, there were an average of 27 referrals for Level 6 (targeted), and 669 initiations from EYSs (Level 4) for Level 6 (universal). It is also important to note that the In-School and ELC Therapy Support Demonstration Project (Lynch et al., 2020), was developed to integrate a multi-tiered continuum of therapy services in the areas of speech and language and occupational therapy. The aim of the project was to explore models of interagency collaboration that could build capacity for inclusion. This indicates how interest in joined-up models of provision across education and HSE services has been growing in Ireland. AIM Level 4, Level 5 and Level 6 can be seen as strategies for enabling interprofessional work with the intention of achieving the full inclusion and meaningful participation of children with disabilities in the ECCE programme. In support of monitoring the added value of HSE support at Level 5 and 6 HSE Better Start and DCYA developed and launched 6 HSE Key Performance Indicators (KPIs) for a 1-year trial in January 2018. These KPIs are described in a HSE document '10th March 2017: HSE KPI Titles for AIM' as follows:

- **Number of requests received for health support made through the Access and Inclusion Model (AIM) at the end of a reporting month**
- The number of requests accepted for health supports that have been received through the Access and Inclusion Model (AIM), at the end of a reporting month
- Number of requests for health support that have been received through the Access and Inclusion Model (AIM) that have been re-directed to other services at the end of a reporting month.

- **Number of children in receipt of health supports following a request for support under the Access and Inclusion Model (AIM) at the end of a reporting month**
- The total number of children awaiting health supports, following an accepted request for health support through the Access and Inclusion Model (AIM) at the end of a reporting month.
- **Number of children awaiting health supports, longer than 5 weeks, following a request made through the Access and Inclusion Model (AIM) at the end of a reporting month.'**

At the time of writing, data describing the number of EYS HSE engagements, and the number of Level 6 (targeted) referrals was available for analysis, and this has been reported. Records on the type of Level 6 (universal) support provided, and the type of Level 6 (targeted support dispensed) was not available. Records on L6 referrals waitlisted longer than the 5-week timeline, and on how many children were waitlisted for other HSE interventions were also not available.

AIM Level 7: Additional Assistance in the pre-school room

AIM Level 7 was designed with the assumption that AIM Levels 1-6 were sufficient to meet the needs of most children with disabilities and additional needs. For some children whose needs were most complex, additional assistance would be required. This was originally estimated to be between 1 – 1.5% of the ECCE population but in 2020 it was reported that allocations for Level 7 had been over 3% (HSE, 2020). Oftentimes, Level 7 is shared to support more than one child.

The AIM Rules 2020-21 (Pobal, 2021, p26-27) outline permitted uses of Level 7 as follows:

- Where Pobal confirms approval, pre-schools can use the additional capitation granted through AIM Level 7 to reduce the child-to-adult ratio by enrolling fewer children.
- AIM Level 7 additional assistance staff is a shared resource for the pre-school, and 'does not fund Special Needs Assistants (SNAs)' and is 'a shared resource for all children in the pre-school room' (DCEDIY, 2021, p26).
- One additional staff member may be deemed to be sufficient to meet the needs of two or more children who have been granted Level 7, within the same session.
- Staff members providing the Level 7 additional assistance cannot be included in the child-to-adult-ratio (e.g., the presence of this additional staff member cannot lead to the enrolment of a further eleven children.

When recruiting staff for AIM-funded positions, providers tend to use the terms 'AIM Support Assistant' or 'AIM Support Worker' and often refer to the individual child being supported as the 'AIM Child'. Practitioners appointed to this role are usually expected to have a Level 5 qualification in Childcare as a minimum (or equivalent alternative) and are likely to be paid around €11.50 per hour. Analysis of job postings identified descriptions such as 'AIM is a strength-based model and not an SNA model, however, some children will require one-to-one care. Ideally, the child should not become dependent on their carer, and promoting the child's independence is essential' (Wicklow CCC, provider job posting for 'AIM Support Worker', 2021). The job posting makes it clear that this is not an SNA role but language such as 'their carer' reinforces the concept of a carer for a specific child. Table 2.11 shows current data for Level 7 applications and awards: a total of 19,354 applications were approved, with 5,186 of those occurring in 2019-2020. This represents a 77% approval rate for Level 7 funding and an 83% approval rate in 2019-20. Grounds for rejecting an application include where a second child with disabilities or additional needs joins a pre-school room for which Level 7 funding is already approved.

Table 2.11: Applications and Awards of AIM Level 7 to 2020*

Type of AIM support	2019-2020 Applications made	2019-2020 Applications approved	2016 to 2020 Applications made	2016 to 2020: Applications Approved
Level 7	5,582	4,659	25,278	19,354

Includes applications for second-year extension

In the IDG's original strategy formulation, regulation of the use of AIM Level 7 was to be a feature of AIM's implementation (DCYA, 2015). Though Level 7 awards cannot be made until an EYS has the view that 'a Level 7 support is critical to a child's participation in the pre-school setting' (Pobal, 2020, p6). Systems for monitoring the use and impact of Level 7 support were not in place at the time of this evaluation.

2.6: Developments to AIM

This subsection summarises the evolution of AIM since its launch in 2016. It begins with the analysis of developments in AIM's reach. Table 2.12 presents the most recent data on the number of children and providers who are being supported by AIM and shows that AIM's reach is growing with the total number of pre-schools receiving AIM support rising from 1,286 in 2016/17 (the first full year of AIM) to 3,871 since AIM began. The total number of children receiving AIM support has risen from 2,486 to 18,521 over the same period, with a total of 40,603 AIM supports provided since the start of the programme.[18]

Table 2.12: Providers and children benefiting from AIM over time (POBAL October 21 Report)

	AIM 2016/17 (Full Prog Yr.)	AIM 2017/18 (Full Prog Yr.)	AIM 2018/19 (Full Prog Yr.)	AIM 2019/20 (Full Prog Yr.)	AIM 2020/21 (Full Prog Yr.)	AIM 2021/22 (Year to date)	Since start of the programme up to 2020/21 call
Total no. of services benefiting*	1,286	1,956	2,397	2,427	2,048	2,059	**3,871**
Total no. of children benefiting[19]**	2,486	4,107	5,562	5,693	4,262	4,528	**18,521**
Total no. of AIM supports provided	4,087	6,618	8,003	8,879	6,184	6,832	**40,603**
Level 6 Referrals Unknown	7	12	16	8	4	0	**47**
Level 6 Referrals Known	39	7	20	14	5	1	**86**
Level 4 HSE Engagement	596	737	780	729	376	129	**3,347**
Better Start Visits Completed (2016/17 to 2021/22)***[20]**	7,900	12,035	3,274	5,727	16,541	9,677	**55,154**

It is fair to say that AIM has been developed and implemented both deliberatively and at speed to achieve its initial objectives. Since 2015, AIM has also been enhanced beyond its initial objectives

[18] Pobal monthly data sets for AIM (October 2021).
[19] includes level 7 initial and second year extensions, so a child may be counted in 2020/21 and then again in 2021/22 However, in the number of services benefiting since the start of the programme, each service is counted only once regardless of how many programme years they received supports for.
[20] **Total number of services benefiting by programme call: Each service that received supports under any of the AIM levels is counted once for that programme call. **Total number of children benefiting by programme call ***Better Start Visits Completed - Due to Covid-19 restrictions, 2020/21 & 2021/22 total figures are a combination of online meetings, phone calls, other communications, and priority on-site visits.

through the continuation of LINC training beyond four years and the addition of the LINC+. Applications for AIM have moved to the Early Years Hive which is a system for managing all funding schemes for Early Learning and Care Investment in AIM has also grown. A budget increase of 7% for each Level 7 fund awarded was also announced in 2020 (DCYA, 2020)but is only a small element in rising AIM investment. A spending 2021 spending review (Government of Ireland, 2021b) reports a movement from 2,486 children being supported by AIM in 2016 to 5,698 children in 2019/2020. This is a difference of 3,212 and represents a rise of 129%. For the number of providers, 1,283 were supported by AIM in 2016 compared to 2,427 in 220, a difference of 1,144, and an increase of 89%. This represents significant growth in expenditure during this period.

Table 2.13 summarises the budget spend on AIM between 2018 and 2021 and Figure 2.14 illustrates patterns of expenditure across Levels 4, 5, and 7 during this period. These data demonstrate that expenditure on AIM Level 4 has increased by 17% during this period, has decreased for Level 5 (by more than 50%), has decreased for Level 7 (by 26%) and decreased in total by 10%. Figure 2.4 shows that expenditure on Level 4 has been relatively stable, with Level 7 expenditure reaching a peak in 2019. This peak in Level 7 also explains the peak in overall expenditure in 2019. This was in a context where the spend on ELC is forecasted to increase to €1bn by 2028, in support of providers who will be managing an improving wage profile for the sector, and hence, increased delivery costs.

Table 2.13: AIM Budget Spend, Levels 4, 5 and 7[21]

	2018	2019	2020	2021	Difference between 2021 and 2018	% Increase or decrease by 2021
Level 4	€ 7,084,590	€ 7,669,000	€ 8,646,000	€ 8,514,375	€1,429,785	17%
Level 5	€ 795,539	€ 808,798	€ 574,727	€ 525,731	-€269,808	-51%
Level 6	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Level 7	€ 16,288,294	€ 21,560,000	€ 14,077,461	€ 12,975,000	-€3,313,294	-26%
Total	€ 24,168,423	€ 30,037,798	€ 23,298,188	€ 22,015,106	-€2,153,317	-10%

A general positive trend is evidenced in data provided by Pobal. Figure 2.5 provides a summary of these trends and includes counts of Level 4 Better Start visits completed and Level 6 (universal) EYS HSE engagements, along with Level 6 (targeted) referrals. It shows that expenditure dropped in 2020 and 2021, and a key influence was likely to be the COVID-19 pandemic and related lockdowns/restrictions. Figures from Pobal that there has been an overall positive trend in the number of services benefiting between the first full programme year 2016/17 (1,286) and 2020/21 (2,048), with the number of children benefitting (2,486 rising to 4,262) and the total number of AIM supports provided (4,087 rising 6,184).

The number of visits by Better Start EYSs has also and increased substantially during this period (7,900 rising to 16,541) with one drop to 3,247 in 2018/19. The number of engagements by EYSs for HSE Level 6 (universal support) peaked at 780 in 2018-19 and then fell to 376 in 2020/21. In the case of Level 6 targeted support, referrals were 46 in 2016/17 and show a decreasing trend with 9 referrals in 2020-21. Level 6 (targeted) referrals represent 0.33% of the total AIM supports provided between

[21] Provided by Pobal (November 2021)

2016/17 and 2020/21, and Level 6 (universal) supports 8%. The number of children referred for Level 6 (targeted) support is 0.6% of the total number of children supported by AIM.

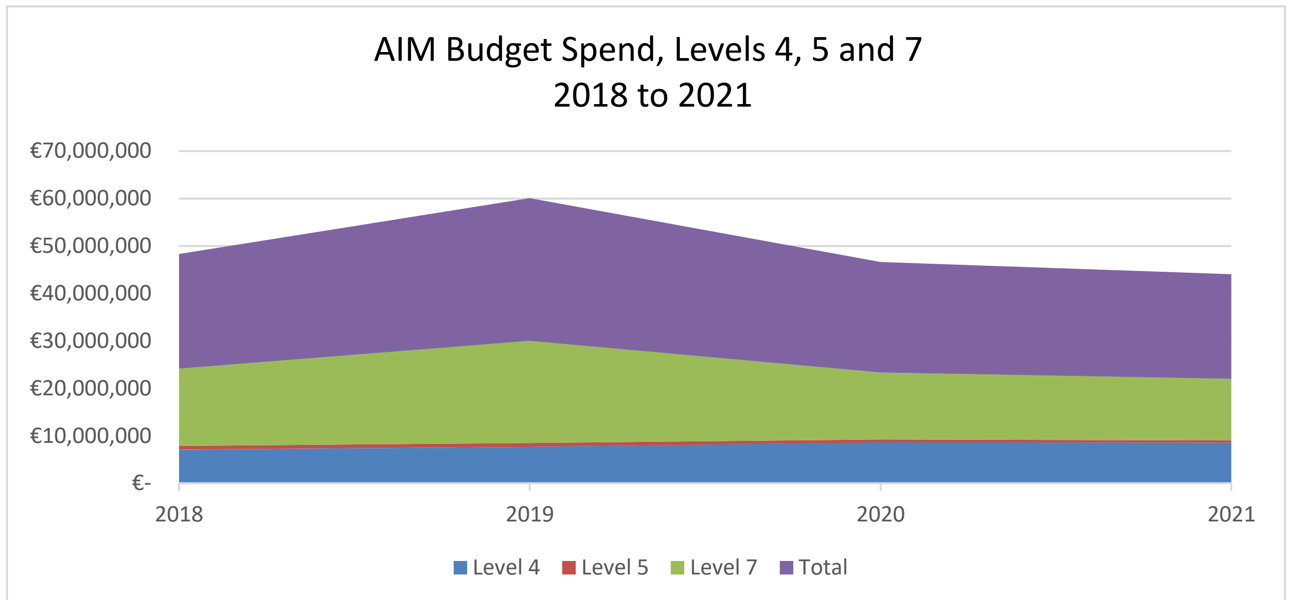
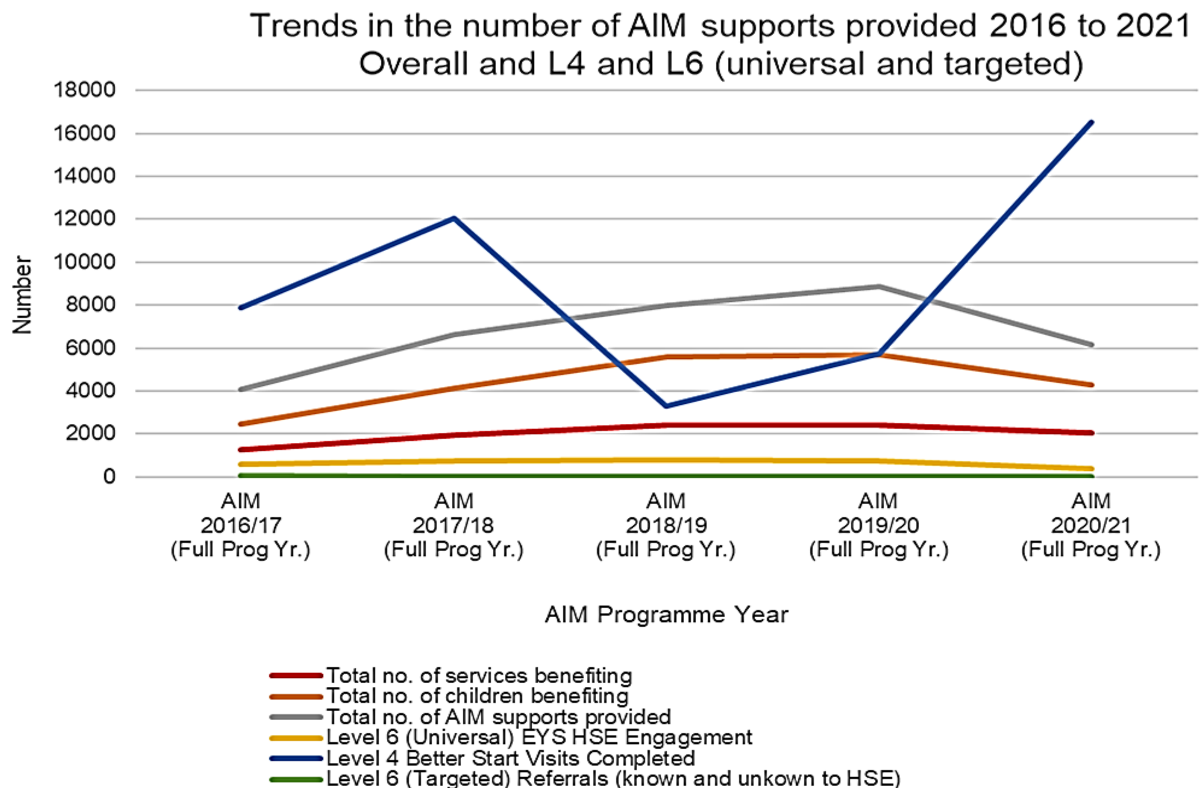


Figure 2.4: AIM Budget Spend on Levels 4, 5 and 7 between 2018 and 2021 22



22 Provided by Pobal (November 2021)

Figure 2.5: Trends in the number of AIM supports provided 2016-2021: Overall and for Levels 4 and 6 (Level 6 Universal and Level 6 Targeted).

A study by researchers at the Economic and Social Research Institute (Whelan et al., 2021) was commissioned by Pobal to investigate the incidence of childhood disability among 3–5-year-olds in Ireland. A key question posed was 'What is the current level of pre-school supports for children with disabilities provided by the Access and Inclusion Model and how are these evolving?' (Whelan et al., p1). The findings indicate that the number of AIM-supported children in proportion to the number of children with disabilities increased considerably between 2016 (where it was equated to be between 10 and 20 percent in each county) and 2019 where this figure was between 20 and 40%. Whelan et al., (2019, p65) conclude that 'this indicates a rapid expansion of both take-up over the period from the launch of the programmes in 2016 up to 2019.' In the context of this success, the *First 5 strategy* recognises the potential to extend AIM to a wider range of children with additional needs and age groups (pre-ECCE qualifying age and SAC).

In relation to the monitoring of AIM, the OECD report 'Strengthening Early Childhood Education and Care in Ireland: Review on Sector quality' (OECD, 2021) observes that AIM has been enthusiastically welcomed by the sector. It also observes some evidence of a need for additional specialised support and expertise (e.g., through multidisciplinary teams or improved cross-sectoral collaboration). The OECD recommendations foreground the integration of specialist expertise into pre-schools, as well as a more intersectional approach to inclusion (for children with disabilities and other types of need, such as the inclusion of children from Traveller and Roma communities) but does not propose that the AIM model should expand to accommodate groups of children whose needs are not definable as disabilities within AIM's policy.

2.7: The end of year one review of AIM

The end of year one review of AIM was published by the DCYA in 2019 (DCYA, 2019). The evaluation was delivered by RSM in collaboration with academics at Trinity College Dublin.

It implemented four methods; desk-based research; 32 semi-structured interviews with the AIM project team and disability sector organisations; online surveys with 170 providers and 90 parents/carers and 5 case study site visits.

The evaluation identified the following strengths from the perspective of participants.

Impact

AIM was having a positive impact on settings through:

- The development of more inclusive attitudes and cultures in pre-schools
- Increased confidence to support children with disabilities/additional needs
- Greater awareness of support and resources available
- Access to support (training, resources, reduced adult-to-child ratio)
- Professionalisation of ELC
- Improved wellbeing for pre-school staff
- Catalysing societal changes by laying a foundation.

AIM was having a positive impact on the children supported through it in the following ways:

- Access to ECCE provision for children who may otherwise have been excluded due to a disability
- Inclusion in and access to pre-schools in the local community and resulting positive impacts for parent/carers/families and other children
- Development of supported children's social skills and communication
- Improved participation and inclusion for children in their pre-schools
- Support for transition to primary school (e.g., sharing of the Access and Inclusion Plan)

AIM was having a positive impact on other children in pre-school settings who were experiencing:

- Enrichment of education through learning about acceptance and inclusion
- A more inclusive culture, better staffing levels and less disruption (in the context of support for a child with additional needs)

AIM was having a positive impact on stakeholders by offering a model of collaborative relationships across agencies, deemed by those agencies to be a model of good practice.

Impact: AIM Levels 1-3

AIM Levels 1-3 were impacting positively on inclusion because of improvements to professional knowledge and practice for inclusion, including improved communication between providers and families, improved understanding of inclusion, impact on policy and curriculum, and a higher quality learning environment (resources).

Impact AIM Levels 4-7

AIM Level 4 was impacting positively because it helped settings to link into additional funding and brought about more inclusive practice through advice and mentoring. The smaller amount of data relating to Level 5 did imply that additional resources provided safer and more accessible environments for the supported child and other children. The very small number of practitioner respondents in the survey who referred to Level 6, did note that it had brought benefits to the child and satisfaction among providers and parents/carers. AIM Level 7 was identified by participants as positive for the inclusion of the child with a disability/additional need, staff, parents/carers, and other children.

Areas that were working well

Overall, the AIM approach was found to be working well in the following areas:

- The overall conceptualisation and structure of the model were identified as a strength, specifically, the way that the AIM approach is accessible, equitable, child-centred, and non-diagnosis-led, and how AIM presents a model of progressive support to enable a tailored approach.
- AIM's development and implementation had been welcomed and embraced by stakeholders
- Provider satisfaction levels were high
- Where support had been received, there were reasonable to high levels of satisfaction with it
- Participants reported that application processes had sped up
- Generally, decision-making on applications for AIM support was deemed to be fair and transparent

- AIM had enriched knowledge in the sector, and participants noted that parents/carers had gained a good knowledge of AIM very quickly
- Financial investment from the Government had sent the right message about AIM
- Participants predicted that AIM would help with strategies for the transition to pre-school.

For AIM Levels 1-4 there was positive feedback from participants on:

- The quality of the LINC programme (Level 1)
- The value of the Inclusive Play Resource Packs (Level 1)
- Information and material (Level 2)
- CPD and training (Level 3)
- 64% of settings taking up EYS support, with 72% being satisfied with this (Level 4)
- The joint presentations on an area basis by HSE and Better Start EYS Co-ordinators were promising to build common understandings of AIM

For AIM Levels 4-7, the evaluation reported that systems of application were managed robustly and fairly, with well-developed systems of review and moderation.

Areas recommended for development

Content Management Systems for AIM
Development of a bespoke IT system for managing AIM applications and allocations
Communication in terms of:

- The stigma associated with the term 'disability' and a move towards 'additional needs'
- Streamlining of the AIM website to make it easier to navigate for parents/carers
- Managing expectations about the supports available and the eligibility for such supports
- Giving feedback on rejected applications

The reach of AIM in terms of:

- Broadening the reach of AIM to engage settings that may be fearful of change

The scope of AIM in terms of:

- The potential to include children with very complex needs in ECCE under AIM
- Expanding AIM beyond ECCE, and making it available for more hours/weeks in the year
- Introducing a family support element

Information about disability in terms of

- Accurate and detailed information on specific disabilities/additional needs

Application processes in terms of:

- Streamlining
- Response times (particularly from HSE and sometimes Pobal)
- Reducing bureaucracy

Supporting joint working through:

- Connecting AIM with wider services who are supporting children to ensure the efficient use of resources

AIM Levels 1-3 through:

Parent/carers

- More involvement of parents/carers in AIM briefing and processes (e.g., with EYSs)
- Training for pre-school staff on working with parents/carers
- Better information for parents/carers prior to pre-school enrolment
- More training of parents/carers on the needs of their child

Practitioners

- More ongoing training for practitioners
- More collaboration between ELC and Primary School Staff on transition

AIM Levels 4-7

Parent/carers

- More collaboration between EYSs and families
- Improving the connection between AIM and HSE so that families had a more joined-up experience of support

Pre-school

- More time with the EYSs
- Non-contact time for staff to support planning

HSE

- Accounting for the impact of AIM investment in HSE
- Key Performance Indicators for HSE contribution to AIM

Level 7

- Expansion of Level 7 Support beyond ECCE
- Improvement of pay and working conditions for staff who are appointed to deliver AIM Level 7
- Improvement of communication with parents/carers about how Level 7 support is used
- Continuing to improve staff knowledge through Levels 1-3 to reduce the need for Levels 6 and 7

This documentary analysis has evidenced where continuous improvement has been implemented for AIM following the end of year One Review, including the shifting of AIM applications to the Early Years hive applications and dispensations, and the commitments made to improving pay and conditions for the sector in Budget 2022. This evaluation will seek further evidence on improvements and impacts since the end of year one review, from the perspective of multiple stakeholders including the children themselves.

2.8: Summary

The documentary analysis has drawn on over 50 sources to illustrate the context for AIM, its operational approach, and its evolution over time. It demonstrates that AIM has emerged as one of a portfolio of state-funded programmes and initiatives focused on developing a high-quality, accessible, inclusive, and affordable system of childcare and early education in Ireland. AIM was constructed by the Inter-Departmental Group (IDG) in collaboration with multiple stakeholders and launched in 2016 with a vision to ensure that:

> All children, including children with a disability, shall be able to meaningfully participate in the ECCE Programme in mainstream pre-school settings (apart from exceptional situations where specialised provision is valid for reasons unavoidable) (DCYA, 2015, p10).

AIM is conceptualised and operationalised as a model of support comprising universal supports (Levels 1-3) and targeted supports (Levels 4-7). This analysis has showed the objectives set by the IDG in 2016 have been achieved in terms of Level 1 (take up of LINC and EDI training), Level 2 (availability of information about AIM) and Level 3 (roll out and take up of CPD on inclusion). In the case of AIM Levels 4-7, systems for the application and allocation of targeted support are now in place and being used. Though originally hosted on existing platforms, the move of AIM applications to the 'Early Years Hive' is likely to improve the user experience.

From the data provided by Pobal for Levels 1,3,4,5,7, and the DCEDIY for Level 2, it is clear that providers are taking up the offer of universal and targeted support, with Level 7 exceeding original

predictions on the number of likely applications and allocations. For Level 1 a total of 3,504 ELC practitioners had graduated from the LINC programme, and 6,500 had participated in EDI training. For Level 2, there had been about 197,000 users accumulating over 800,000 views of the DCEDIY's AIM information website. View numbers had increased steadily between 2016 (55,258) and 2021 (192,312), demonstrating clear growth in engagement. In 2019-20, 364 practitioners enrolled in Lámh and/or Hanen Training in the context of AIM Level 3.

Reporting from Pobal in October 2021 shows that the total number of pre-school services benefiting from the programme had increased from 1,283 to 3,871. The total number of children benefiting had also risen from 2,486 in 2016-17 to 18,521 up to the 2020-21 programme call. The total number of AIM supports provided had risen from 4,087 to 40,603 during this period. Reports by the ESRI ((Whelan et al., p1) suggest that the number of AIM-supported children in proportion to the number of children with disabilities increased considerably between 2016 (where it was equated to be between 10 and 20 percent in each county) and 2019 where this figure was between 20 and 40%. Whelan et al., (2019, p65) conclude that 'this indicates a rapid expansion of both take-up over the period from the launch of the programmes in 2016 up to 2019.'

In the end of year one review of AIM, stakeholders had positive things to say about AIM's philosophy, intentions, and impact. Areas for recommended action centred on the user-friendliness of application processes, increases in Level 7 funding, fuller involvement of parents/carers and stronger connections between AIM and HSE services.

Since the end of year one review, the documentary analysis reveals that continual improvement has been applied, including the development of the Early Years Hive which is now being used for all AIM applications. A further example was the 7% increase in direct funding for AIM Level 7 in 2020, and the allocation of a new *Core Funding Stream* in Budget 2022. This was to support private providers in pay improvements across the sector so that they could retain better-qualified staff in a sector where pay has been relatively low and career development opportunities limited with a consequence of high staff turnover (DCEDIY, 2021). It is likely that improvements to pay and conditions in the sector, will also benefit AIM, since settings will be able to recruit and retain well-qualified staff in support of universally inclusive practice, but also in the delivery of Level 7.

This analysis has referred to documentation produced and hosted by the DCEDIY and its providers (Better Start, Pobal, CCCs). It has also drawn on material from the agencies and Departments outside the DCEDIY which are involved in AIM delivery (HSE and HSE funded agencies) or who also run ELC programmes focussed on equity and inclusion, such as Early Start, the Early Intervention ASD Units, and the Home Tuition Scheme (DE). We observed that information about AIM is coherent and cohesive within the DCEDIY space. However, it is usually absent from online information for parents/carers hosted by the HSE, NCSE and DE. We also observed that beyond AIM, there were a range of funding programmes for providers and families, but the array combined with some complex rules and regulations, manifested in a complex landscape that may be challenging for parents/carers to navigate. We also observed that the process for AIM Level 6 (therapeutic services) was complex because it is based on a model of universal and targeted support based on need, with these supports being diverse in terms of intensity *and* duration. For example, delivery may be in the form of universal strategies (e.g., information sharing, advice packs, leaflets, training for parents/carers and/or practitioners, advice, and support on the phone or by e-mail, and access for staff to therapeutic programmes or drop-in clinics. At the targeted level a 'referral' to HSE is formalised to pursue individual assessment and more individual, tailor-made provisions which may be in the form of episodic or continuous therapeutic support (e.g., a visit to support the design of a behavioural plan). This complexity may make the contribution made by HSE difficult to measure or describe, and researchers note that current data on Level 4 HSE engagements (Level 6 Universal) and referrals

(Level 6 Targeted) currently show Level 6 to be the least prevalent type of support within AIM. HSE have informed researchers that this represents an under subscription.

In the case of Level 6, parent/carers may also assume that the term ‘Therapy Services’ refers to targeted needs assessments and continuous programmes of support (e.g., physiotherapy or speech and language therapy). In this case, they may not recognise Level 6 support in its universal form.

In terms of the sufficiency of monitoring data for AIM, the data available on Ireland’s journey toward SDG 4.2 (% of children receiving at least one year of a quality pre-primary education programme) is rich and serves an evaluation purpose in relation to equity for boys and girls, but not in relation to disability. However, an analysis by the Economic and Social Reseach Institute (Whelan et al., 2021) has noted the difficulties involved in estimating the prevalence of disability among young children but has also reported that the proportion of children with disabilities who are supported by AIM has increased considerably between 2016 (10 and 20 percent in each county) and 2019 (between 20 and 40%. Whelan et al., (2019, p65) conclude that ‘this indicates a rapid expansion of both take-up over the period from the launch of the programmes in 2016 up to 2019.’ More generally, data on the quality and outcomes of the AIM support provided for children with disabilities was not available at the time of writing. Statistical information was on the number of applications and dispensations of AIM support. This end of year three evaluation can provide more account of this, but there may be ways in which such outcomes can be measured more routinely and continuously in pursuit of system improvement.

We note that at the time of this evaluation, children’s disability services had been undergoing significant restructuring under the PDS programme, and this restructure was completed in 2021 in terms of the formation of CDNTs. Once rolled out, the changes in practice sought by the PDS are likely to be helpful for AIM since they include a commitment to improving the connection between health and education services. The principles of the PDS programme align with those of AIM since they emphasise services that are child-centred, family-centred, strength- based, needs focussed and equitable. The newly established CDNTs have the potential to forge better connections with the EYSS and with pre-schools in the regions they serve, and the focus on measuring the outcomes/impacts of support is a shift in accountability that could be emulated elsewhere in the ELC sector. As another example of the continuous improvement of the AIM programme, a Joint Working Protocol for the HSE, Better Start and the DCYA was written by the HSE, Better Start and DCYA in 2017 prior to commencement of AIM and updated in 2020 and accompanied by a programme of joint briefings delivered across the country for those agencies. Though there is some evidence of a continuing disconnect between HSE and AIM in the documentary evidence, it is important to note this difficulty may be assuaged by the roll out of the PDS programme, particularly if ELC as a sector, and AIM delivery teams could have an important role to play in the design and delivery of implementation plans.

Finally, though there are continuing debates about what comprises sufficient state funding and subsidisation for ELC, much has been achieved in the sector since the onset of the 21st Century. The Government has committed to investment in ELC to the level of €1bn by 2028, and there have been sustained efforts to improve the quality, accessibility, equity, and affordability of childcare in Ireland. AIM, along with the NCS and the PDS, is further evidence of the Irish Government’s commitment to creating a high quality ELC system through strategic policy making and budgetary allocations.

AIM emerges as one important programme within an ecology of state funded strategies, designed to make ECCE accessible for all families, including those with disabilities and/or additional needs.

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3. Review of the Literature: The Access and Inclusion Model (AIM) in an International Context

This section explores the key academic literature underpinning inclusion in the Early Years. The purpose and scope of the literature review, and methods used for sourcing literature, are described in subsections 3.1 and 3.2, respectively. The themes defined in the literature review are outlined in subsection 3.3 and critically analysed in subsection 3.4. This section ends with a summarisation of the key literature and an outlining of six key implications for AIM as identified in relation to this review of the literature.

3.1: Purpose and scope of the literature review

This literature review draws on 110 sources; it is included in this end of year three Evaluation to provide an international research-based context for AIM. Whilst AIM is an Irish approach to promoting and removing barriers to inclusion in the Early Years, it is important to situate this model within the wider international literature. Therefore, the purpose of this literature review is to provide the readers of this evaluation report with a contextualised analysis of some of the key facets of AIM in relation to the wider international literature. This serves the Objective 1 of the end of year three evaluation, and its particular focus on 'The evidence-base, rationale, aims and objectives of AIM,' (Subsection 1.2).

3.2: Method

Using Boolean searches of the international literature databases (e.g., the Education Resources Information Centre - ERIC), researchers identified, reviewed, and analysed: 16 government-funded documents; 19 publications written by international/European organisations; 46 research papers; and 29 polemical publications that were relevant to AIM. A matrix of search terms supported the identification of relevant sources for the literature review; this matrix is shown in Table 3.1. The analysis led to the identification of significant themes as they prevailed in national and international data and debate about inclusion in early education and models of progressive support.

Table 3.1: Matrix of search terms supported the identification of relevant sources for the literature review

Policy and Provision	Constituency	Age Group	Overarching Concepts
Access and Inclusion Model	Disability	Early Years	Inclusion
Better Start	Special Educational Needs	Early Education	Equity
First 5	Special Needs	Pre-School	Equal opportunities
Early Childhood Care and Education	Learning Difficulties	Young children	Access
Early Learning and Care	Learning Disabilities	Under Fives	Accessibility
LINC training	Additional Needs		Inclusive
Universal	Additional Educational Needs		Social justice
Targeted	Visible disability		
Specialist	Invisible disability		
Special			
Therapeutic			
Graduated			
Welfare			
Mainstream			
Ordinary			
Special			
Funding			
Aistear			
***Síolta*,**			
Transition to primary			
Childcare markets			

3.3: Review of themes relevant to AIM and its evaluation

Following the initial Boolean literature search and analysis of the data, a number of key themes were selected for critical analysis:

3.4.1 Inclusion in Early Years education
3.4.2 The Irish Early Years context
3.4.3 Funding Inclusion: Resourcing dilemmas and implications
3.4.4 Funding inclusion: An analysis of AIM
3.4.5 Inclusive policy for the Early Years and reliance on the private sector
3.4.6 Intersectionality and vulnerability to exclusion: cross-departmental working and the team around the child
3.4.7 Parental communication, participation, and co-production
3.4.8 Transitions to the next stage of education

These themes were selected based on their prominence within the literature and their correlation with the key facets of AIM emerging in this end of year three evaluation. Thus, Section 3 provides an international literary context for some of the significant and intractable challenges currently prevalent in the Early Years sector.

3.4: AIM in the context of the international debate on policy and practices for inclusion in pre-school

This subsection draws on 36 sources, including documents published by UNESCO and UNICEF, research papers, and polemical publications. The purpose of this subsection is to: identify key literature which sets out the frameworks for inclusive Early Years education; define the nature of Early Years pedagogy; and identify the correlation between inclusion and child-centred education, including a consideration of the challenges and tensions associated with inclusive child-centred education.

3.4.1: Inclusion in Early Years Education

Building on the Salamanca Statement (UNESCO, 1994), which established the rights of children with special educational needs (SEN) to have access to regular schools, the Human Rights (HR) framework has been crucial globally in the development of services for children with disabilities. The framework is conceived as an aspiration to build up just societies committed to meeting everyone's rights. The approach has four fundamental principles: Universality, Accountability, Indivisibility and Participation (UNICEF, 2009). The combined principles mean that governments should make sure HR is for everyone, emphasising those described as 'vulnerable minorities' (UNICEF, 2009, p22). A system that registers the progression and success of services must be in place to make this happen. Those services must maintain a holistic approach addressing all rights, not just some of them, for example, protection, care, and education in early childhood services. Finally, children, families and communities participate in the formulation, delivery, and assessment of services that affect their rights.

Although HR are the same for everybody in all circumstances, the principles have been adapted to focus on particular groups (De Beco, 2010). In the case of children, according to the *Convention on the Rights of the Child* (UNICEF, 1989), the particularity is that they are not considered citizens until they are eighteen years of age. Consequently, their rights have to be watched by their families, carers, and the State. This is crucial in the case of early childhood education, where there is an acknowledgement of children's rights and agency, but they still need the protection and care of all

involved (Wharton et al., 2019). The case of people with disabilities has a history that cannot be understood without recognition of political engagement and activism by disabled people themselves (see, for example, Charlton, 2000; Werner, 1987). This activism led to the formulation of *The Convention on the Rights of Persons with Disabilities* (United Nations, 2006). Additionally, the UN has developed the *Disability Inclusion Strategy* (United Nations, 2018) and has formulated specific aims related to disability as part of the *Sustainable Development Goals* (UNESCO, 2016; United Nations, 2018) to 'ensure inclusive and equitable quality education and promote lifelong learning opportunities for persons with disabilities.' This goal is part of Sustainable Development Goal (SDG) 4 (UNDESA, 2018, p75). Inclusion and equity are also emphasised and defined by UNESCO (2017, p13; 2020, p25):

- **Inclusion** is a process that helps overcome barriers limiting the presence, participation, and achievement of learners.
- **Equity** is about ensuring that there is a concern with fairness, such that the education of all learners is seen as having equal importance**.**

Since the conference *Education for All* and the *Dakar Framework for Action* (UNESCO, 2000), early childhood education and special educational needs have received more attention, resources, and expansion in various countries worldwide. This means that early detection of special needs is more likely to be addressed collaboratively by schools, social and health services, families, and communities. Globally, there has been an increasing commitment to models of equitable education. The HR principles align with the concept of Learner Centred Education (LCE) also referred to as child-centred education and care. The strategy changes the emphasis on curriculum and attainment to concentrate on the learner and their needs (Schweisfurth, 2019). In a way, this means the curriculum should be responsive to learners' current needs, and the process tends to be understood from a constructivist point of view (Mendenhall et al., 2015). Even further, the learners' needs are not established by experts solely but with the participation of the children with disabilities and their parents or carers.

Child-centred education and care can be viewed as the historical golden thread that traditionally runs through Early Years provision. Rousseau (1762/1921) emphasised the importance of adults observing children (rather than adults directing children), and Pestalozzi (1746-1827/1977) promoted the idea that adults should follow children's interests. The enduring popularity of child-centred pedagogy is evident in the more recent work of Bruce (1993), who constructed the free-flow play environment in which children's learning centres around their own play choices. Described by Bruce (2010) as an active process without a product, in the free-flow play environment, children set the rules of the play and choose when to join/leave. In contrast to 'free-play' where Early Years professionals may timetable free slots, perhaps hastily putting out and/or packing away play resources and using the time to catch up on paperwork (Thompson, 2012), Bruce (2010) stresses that children cannot be made to play, it is intrinsically motivated and requires time for children to sufficiently develop their ideas (Bruce, 2010).

Naturally, the implementation of LCE brings about challenges. For example, Schweisfurth (2019) elaborates on a metanalysis he conducted in the past on LCE in various educational levels and identifies common implementation problems: unrealistic expectations, minimal training and monitoring, low teacher capacity, lack of materials, large classes, unsupportive management and inspection regimes and some cultural barriers when exporting LCE or dealing with cultural minorities. Among the conditions that make LCE more likely to work are students' motivation, respect between participants, consideration of prior knowledge, and cultural relevance.

Child-centred education is, however, generally perceived to possess naturally inclusive attributes (Scott, 2021). For example, the way child-centred education embeds children’s autonomous organisation of their environment (Malaguzzi, 1996) promoting the idea that children are given space and time to look, learn and understand their day, avoiding feelings of being hurried to keep up with other children (Macintyre, 2010). Child-centred pedagogy also aligns with different inclusive approaches such as Norwich and Lewis' (2007) construction of the 'unique differences position', which stresses that all students have both unique learning needs and needs common to all learners. This pedagogy contrasts with the 'general differences position' (Norwich and Lewis, 2007), which encompasses both unique and common learner needs and emphasises the need for a 'special pedagogy' relevant to a specific group; see Figure 3.1 below.

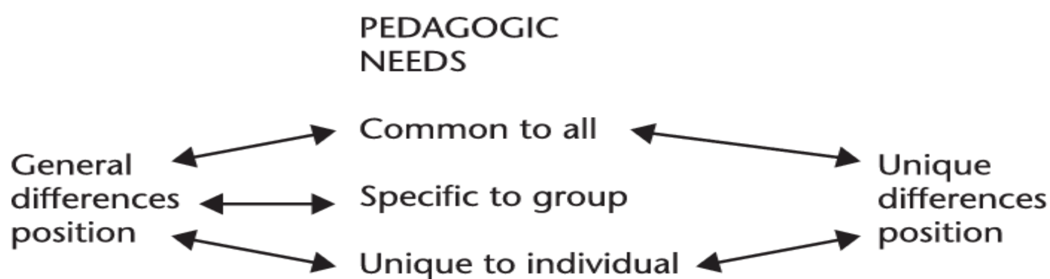


Figure 3.1: Norwich and Lewis’ (2007) depiction of the ‘general’ and ‘unique’ differences positions

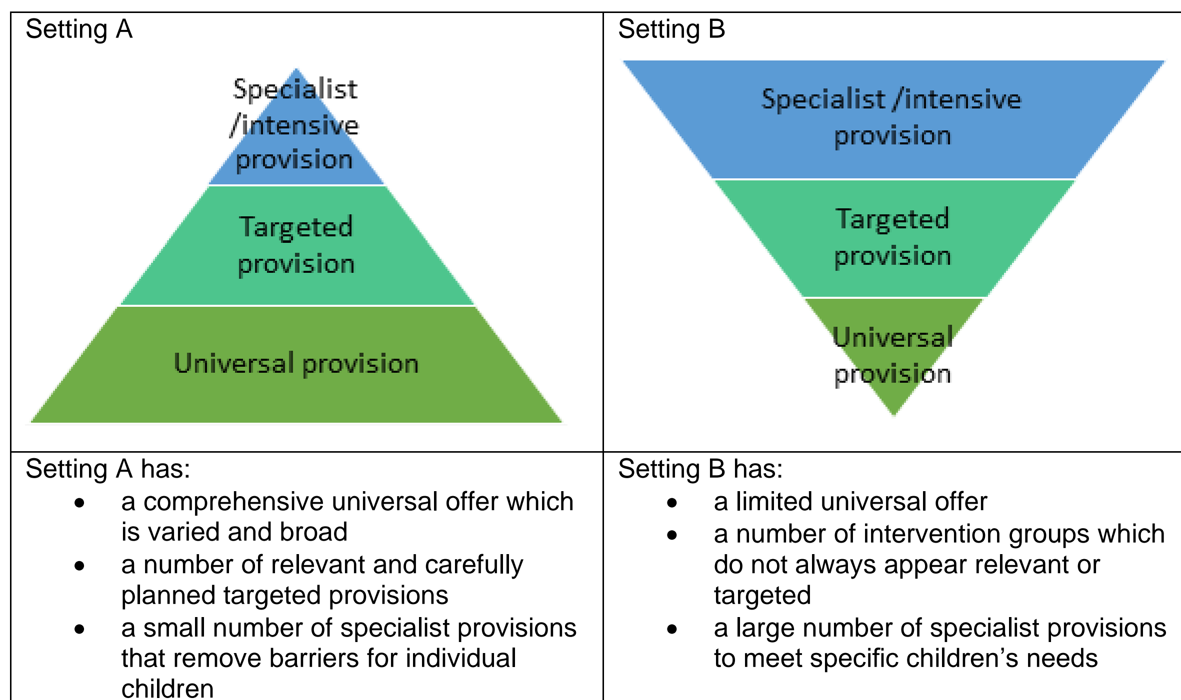
When child-centred education is driven by a strong pedagogical understanding of the ‘culturally relevant’ (Schweisfurth, 2019) needs common to all children and concentrates on the learner and their unique needs (UNESCO, 2020), there is a strong alignment between the properties of child-centred pedagogy and the ‘unique differences perspective’ (Norwich and Lewis, 2007). Nutbrown (1998) also describes Early Years education as 'at its best' inclusive education, when it includes:

> Developmentally appropriate practice, observation-based pedagogy, and assessment; close parental involvement; equality of access to a differentiated curriculum and a multi-professional, cross-agency approach to provision (Nutbrown et al., 2013, p19).

Despite its inclusive learner-centred pedagogy, the Early Years’ environment is not exempt from the struggles ever-present in the inclusion literature (Nutbrown et al., 2013). For example, Bremner’s (2019) research suggests that LCE may be more useful when considered as one more teaching strategy (part of a hybrid pedagogy) but not a unique possibility when working with children who have special educational needs. Scott (2021) also points to the influence of maturation stage theorists like Locke (1824) and Piaget (1957), whose construction of developmental milestones permeates worldwide Early Years practice. When Early Years’ assessment and curricula heavily inlay a developmental milestones approach which describes children as having met or not met the expected progress, analysis takes on a ‘norms led’ (Trussler and Robinson, 2015) positivistic tone which embeds ‘measuring grading and ranking’ (James, Jenkins and Prout, 2004) into EY practice and pedagogy (Scott, 2021). The ontological challenge of implementing a constructivist EY pedagogy alongside a positivistic stance on childhood development can draw practitioners away from the naturally inclusive attributes of LCE (Scott, 2021). For example, if the inclusive nature of a child-centred pedagogy is replaced by adult autonomy, and the rhythm, timing, and structure of the day are driven by factors external to the child, there is a greater likelihood that a 'special pedagogy' (Norwich and Lewis, 2007) will then also be required.

A similar point is also made by Wharton et al., (2020) who explain that if the breadth and depth of the inclusive universal offer decreases, this will conversely increase the need for targeted and specialist

provision ('specialist provision' in the USA being referred to as ‘intensive provision’ (Van Geel et al., 2019)). This is a point illustrated in Figure 3.2.



Setting A has:	Setting B has:
• a comprehensive universal offer which is varied and broad • a number of relevant and carefully planned targeted provisions • a small number of specialist provisions that remove barriers for individual children	• a limited universal offer • a number of intervention groups which do not always appear relevant or targeted • a large number of specialist provisions to meet specific children’s needs

Figure 3.2: Levels of Provision (adapted from Wharton et al., 2020)

In summary, within a Human Rights framework, inclusion is argued to be a golden thread that runs through child-centred practice in the Early Years (Scott, 2020). The properties of Early Years provision (developmentally appropriate practice, observation-based pedagogy, partnership with parents/carers, equity, and a multi-agency approach) when ‘at their best’, comprise of inclusive education (Nutbrown et al., 2013).

Despite its inclusive learner-centred pedagogy, the Early Years environment is not exempt from the struggles ever-present in the inclusion literature (Nutbrown et al., 2013). For example, the measurement of children’s progress against developmental milestones, and adherence to adult autonomy which dictates the rhythm, timing and structure of the day, can draw practitioners away from the naturally inclusive attributes of a child-centred pedagogy (Macintyre, 2010; Malaguzzi, 1996; Scott, 2021).

Such changes will likely lead to an increased need for a ‘special pedagogy’ (Norwich and Lewis, 2007) that is more likely to involve the provision of specialist provision. The breadth and depth of the specialist provision is argued by Wharton et al., (2019) to be proportionally related to the decreasing availability of the universally inclusive offer.

3.4.2: The Irish Early Learning and Care Context

This subsection draws on 8 sources of literature to outline both the recent historical context for Irish Early Years’ policy and the key facets of AIM. This subsection is subsequently utilised in other parts of

this review as the literary starting point for the analysis of AIM in relation to different key themes, such as funding (subsection 3.4.4).

The history of pre-school education can be understood as relatively recent in the Irish context. Flood and Hardy (2013) report that apart from some exceptions, the pre-school service started a relevant expansion between the 1980s and 1990s. Such growth was related to the number of women participating in the labour market. Consequently, the service was created more to address adults' needs; later, children's needs were addressed.

In 1992, Ireland ratified the *Convention on the Rights of the Child*, and in 2000, the *National Children's Strategy* was published (Department of Health and Children, 2000).

Later, the Centre for Early Childhood Development and Education worked from 2002-2008 and formulated a policy on early childhood quality education, *Síolta,* with a reformulated manual in 2017 (Early Years Education Policy Unit, 2017) and a website with various resources. The Framework establishes sixteen quality standards that guide the provision and development of early childhood education and includes a consideration of the rights of the child and other legislation. Later, *Aistear*, the *Early Childhood Curriculum Framework* was launched by the National Council for Curriculum and Assessment (NCCA, n.d.).

Aistear provides information for adults to plan enjoyable and challenging educational activities for children from birth-six years of age. An audit reviewing *Síolta,* and *Aistear* was enacted (NCAA, 2009), resulting in a series of recommendations to work with the two papers together; the audit is available on *Síolta's webpage (Early Years Education Policy Unit, 2017)*. The site also contains a collection of publications referring to the Principles and Themes, Guidelines for Good Practice, and Support Materials for Early Childhood and Primary School levels. Complementarily, specific guidelines to promote inclusion are developed in the document Diversity, Equality and Inclusion Charter and Guidelines for Early Childhood Care and Education (DCEDIY, 2016) Ireland has ratified the legislation around people living with disabilities and aligns with SDG 4.

Notably, for early childhood education, the 'Access and Inclusion Model' (AIM) was launched in June 2016 to ensure that children with disabilities can fully participate in the Early Childhood Care and Education (ECCE) Programme (Government of Ireland, 2021). AIM is a child-centred strategy that includes parent/carers, and its formulation attempts to implement the HR Framework as discussed above. It was designed to ensure that children with disabilities can fully participate in Early Childhood Care and Education (ECCE) and has been developed to include 7 levels of progressive support (Government of Ireland, 2021).

Levels 1-3 are described as 'universal supports' and comprise inclusion training, information for parents/carers and providers and continuing professional development. Levels 4-7 are described as 'targeted supports' and incorporate expert advice, specialist equipment and minor alterations, therapy services and additional funding to reduce capitation. AIM (Government of Ireland, 2021) also embeds inclusive play guidelines and universal design guidelines (UDG). These were developed and competed by the Centre for Excellence in Universal Design (CEUD) at the National Disability Authority in 2019 (CEUD, 2019) Developed by the Centre for Applied Special Technology (CAST), UDL is described as providing multiple representations so everyone can access and engage with the learning environment (CAST, 2018).

UDL in the context of AIM is defined as 'the design and composition of an environment so it can be accessed, understood and used to the greatest extent possible by all people, regardless of their age, size, ability or disability' (Ring et al., 2019, p4).

In summary, in Ireland, the ELC sector developed substantially during the last two decades of the 20th century, and this occurred at the time when the government had ratified the *Convention of the Rights of the Child* and *The Convention on the Rights of Persons with Disabilities* (Flood and Hardy, 2013). Consequently, the development of services was decidedly influenced by the global policy context and various other Human Rights legislation that the country subscribed to.

Currently, the work of the sector is guided by three key documents, *Aistear* (NCCA, 2009.), Síolta (CECDE, 2006), and the *Diversity, Equality and Inclusion Charter and Guidelines for Early Childhood Care and Education* (DCEDIY, 2016), all of which emphasise learner centred, anti biased and quality ELC for all (including those from minority groups). AIM also provides guidance on the use of inclusive play and universal design guidelines for effective ELCs (Government of Ireland, 2021).

This background gives AIM a robust basis to provide for children with disabilities/additional needs in the first years of their lives, since it is designed to distribute investment and resources across universal provision (universal design for learning) and targeted provision within the milieu of an inclusive culture within pre-schools.

3.4.3: Funding Inclusion: Resourcing dilemmas and implications

This subsection draws on 28 sources of literature; this literature comprise of international research papers and research conducted by the European Union and UNESCO. Specific reference is made to research conducted in the European Union, the United States of America, and England/Wales. Attention is directed towards two distinct kinds of funding for inclusive education: throughput funding and input funding (Meijer, 1999). The purpose of this subsection is to draw together some of the international literature on the topic of funding inclusion, unpicking the dilemmas and implications associated with different funding models. In the following subsection 3.4.4, this literature is then synthesised as the basis for critically analysing the funding components of AIM's 7 Levels.

The allocation of funding for inclusion is described as one of the most significant factors determining inclusion (Meijer, 1999) – the mechanisms for financing inclusion are central to explaining the 'discrepancies between general policies, practical organisation, and implementation' (Meijer, 1999, p11). Post the publication of the Salamanca Statement (UNESCO, 1994), much of the research into the funding of inclusion draws on a report published by the European Agency for the Development in Special Needs Education[23] by Meijer (1999). Researching the financing of special needs education in seventeen European countries (including Ireland), Meijer (1999) draws on a publication he wrote in Dutch with Peschar and Scheerens (1995), to identify the parameters for funding inclusion. Arguing that every existing or newly developed funding model for education, health and care can be described within a set of parameters, Mejer et al. (1995 cited in Meijer, 1999) set these out as follows:

- type of resource (time, money, materials, training facilities, etc.)
- the destination for the resource (parent/carers/pupils, schools, communities, regional institutions)

[23] In 2014, to reflect a paradigm shift in member countries thinking towards a rights based approach (Meier and Watkins, 2019) the *European Agency for the Development in Special Needs Education* was renamed as the *European Agency for Special Needs and Inclusive Education*).

- earmarking (referred to in the UK as ringfencing) of the resource (yes or no)
- group or individual based funding
- conditions for funding (input, throughput, or output)
- degrees of freedom in expenditure (advanced budget or declaration based)

Combined, these parameters result in more than a thousand possible funding models (Meijer, 1999). Focusing specifically on destination (who gets the funding) and the conditions for the allocation of funding, Meijer (1999) proposed that all funding for special education needs is essentially input (needs) or throughput (tasks) funding:

- input funding is based on expressed or measured needs, such as the number of special needs pupils in a school, municipality or region, referral rates, low achievement scores, number of disadvantaged children and so on.

whereas

- throughput funding is based on the functions or tasks that have to be undertaken or developed. Not based on the financing of needs, throughput funding concerns the supply of services provided by a school, municipality, or region. Finances are allocated according to the development or maintaining of services. In this model, schools, municipalities, or regions are equally treated: funds are based on total enrolment or other population indicators. In this model, certain *output* conditions can be put in place, but the funding itself is not based on outputs (or inputs). When funding is based on *outputs*, it is allocated according to the measured outcomes of a system; for example, achievement or added value scores (Meijer, 1999).

Illustrative of the multiple ways that funding for special education can be distributed, Ahearn (2010) analyses the funding formulas used in the United States of America (USA). Ahearn's (2010) analyses reveals eight funding formulas; however, synthesis with Meijer's (1999) description of input and throughput funding suggests that within these eight formulas exist multiple funding parameters:

- *Multiple Student Weight* funding was found in twelve States. This input model allocates tiered financing to students with special educational needs. The amount of funding varies by disability, placement, or student need.
- *Census-based* funding was found in seven States. This is a throughput model which allocates funding based on enrolled students. It is argued to operate on the assumption that students with special educational needs are uniformly distributed across districts (Dhuey and Lipscomb, 2013).
- *Single Student Weight* funding was found in seven States. This input model allocates funding per student (either a single multiple of the general education amount or a fixed dollar amount).
- *No separate special education funding* was found in 7 States. This is a throughput model of grant where funding to support special education is rolled into the overall funding levels.
- *Combination* funding was found in five States. This is a combination of formula types and could be either an input or throughput model or both dependent upon assemblage.
- *Percentage Reimbursement* funding found in five States. This model allocates funds based on a predetermined percentage of actual expenditures and thus could be throughput, input or both dependent on what is measured (i.e., actual spending on services or needs).
- *Block grant* funding found in one State. This model allocates funds based on initial allocations and thus could be throughput, input or both dependent on what is measured (i.e., expenditure on services or needs).

It is important to note that whilst there are differences in the funding formulas across the USA, all States are enacting the same national (i.e., federal) law, known as the *Individuals with Disabilities Act* (IDEA) 2004. Amended in 1997 and 2004, the law requires States 'to establish placement neutral

funding formulas' (Ahern, 2010, p1). A placement neutral funding formula does not provide fiscal incentives for placing students with disabilities in separate settings (Ahearn, 2010).

The fiscal incentivising of special needs practices is a widely reported, international phenomenon (for example, European Agency for Special Needs and Inclusive Education, 2016; Graham, 2015; Meijer, 1999; Pijl and Dyson, 1998; Sansour and Bernhard, 2018). As Meijer (1999) points out, the three main funding approaches (input, throughput, and output) embed three distinct and different incentives:

- an output model may reinforce the referral of pupils with expected low gains in achievement scores to other parts of the system.
- on the other hand, input funding based on low achievement reinforces low achievement itself: more funds can then be expected.
- throughput funding may reinforce inactivity and inertia - whether anything is done or not, funds will be available (Meijer, 1999, p153).

Drawing together Meijer's (1999) research and a later publication written by the European Agency for Special Needs and Inclusive Education (2016) (here after referred to as EASNIE), Meijer and Watkins (2019, p715) concur that input funding models 'risk promoting strategic behaviours that work against the principles of inclusive education, as well as lead[ing] to increased costs.' Although throughput funding seems to be the most successful option for inclusive education, accountability and governance are critical issues (Meijer, 1999; EASNIE, 2016, Meijer and Watkins, 2019). Regarding current practice in Europe, EASNIE (2016, p26) reported 'that nearly all countries link resource allocation to an official decision of SEN. For these learners, resource allocation follows an input model of funding (also sometimes referred to as a demand-side approach).' It should be noted, however, that throughput and input funding models are not necessarily separate as shown on Figure 3.3.

For those countries that strongly connect eligibility for support in education with an official decision regarding the nature of a child's special educational need, the primary way of implementing inclusion is a demand-side approach (input funding) (EASNIE, 2016).

Of the numerous available parameters (Meijer, 1999) for implementing an input funding model, one specific type is the 'pupil-bound budget' (Meijer and Watkins, 2019). These budgets have proved popular with parent/carers and are readily accepted by the education community (Meijer, 1999). Often enabling parent/carers to opt for a mainstream school, the effectiveness of this funding system could be seen as making inclusion possible (Meijer, 1999), as defined in the Salamanca Statement (UNESCO, 1994). There are, however, some clear disadvantages to this model. Schools are generally motivated to have pupils with budgets who do not cause them too much additional work. Pupils with more complex needs being perceived as less advantageous for a school (EASNIE, 2016). In addition, parent/carers (sometimes advised by schools and other professionals) 'will always attempt to get the best for their child, and as a result, will try to get the 'highest' amounts of special needs funding' (Meijer, 1999, p12). As such, the learner-bound budget funding model is described as provoking costly bureaucratic procedures (i.e., complex diagnostic processes, categorisation and appeals and litigation) (Meijer, 1999). Twenty-one years after Meijer (1999) identified this kind of parent/carer behaviour, Lamb (2009) conducted an inquiry into parental confidence in special educational needs in England and Wales (England and Wales utilise input funding in the form of a pupil-bound budget for those assessed to have the most complex needs).

Describing the experiences of parent/carers who have children with special educational needs, Lamb (2009) referred to the funding system as creating 'warrior parents' who, at odds with the school, feel they have to fight for what should be their children's by right; thus, creating conflict where there should be trust (Lamb, 2009, p2). In addition, 'parents [and carers] who have fought to acquire additional support for their children may be concerned that moves towards inclusion may see such support disappear' (UNESCO, 2020, p33). A paradigm shift towards inclusion can also be seen as a

disinvestment in special education, and a devaluation of special education teachers (Alves et al., 2020). In a recent review by the UK House of Commons Education Committee (HoCEC, 2019, p106), the current system of personal budgets was called into question by respondents who noted 'there was no accountability of where an individual's budget was being spent in a school and that the SEND provision was often shared with other students and was not ringfenced.' How parent/carers are informed about special needs provision in educational settings and its results is described in 1999 as one of the vital accountability issues (Meijer, 1999). Synthesising the research points presented above, it seems the lessons about accountability and how it affects parental confidence have not been learnt in the UK.

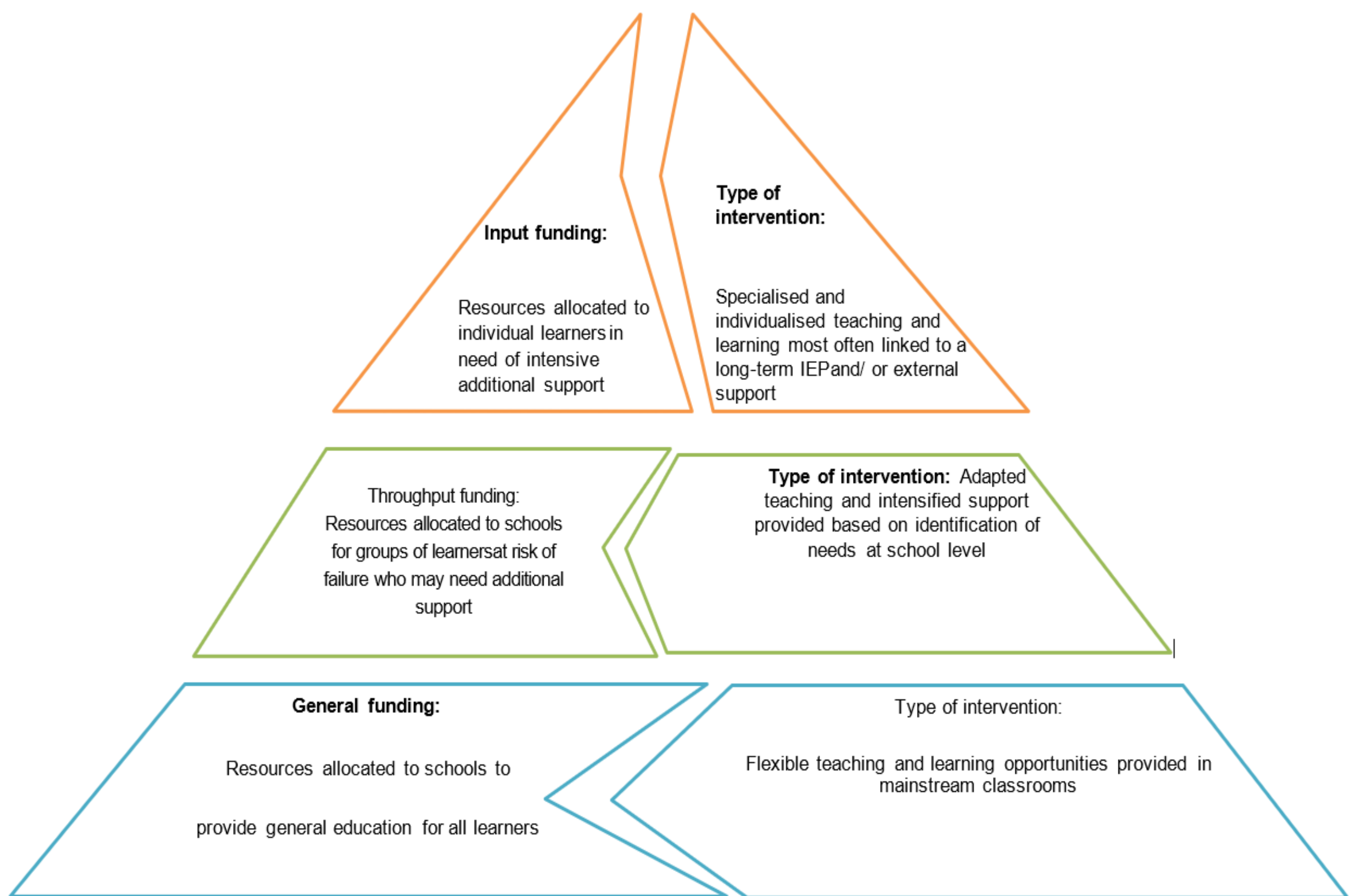


Figure 3.3: Resource allocation mechanism for supporting learners (EASNIE, 2016, p24)

In the Netherlands, where there is no significant tradition of parent/carer pressure groups and substantial numbers of teachers and parent/carers questioning inclusion, the *Together to School Again* policy aimed to reduce the country's reliance on special schools and address a feeling that children with SEN are better off educated in segregated settings (Pijl, 2010). The *Together to School Again* policy intertwines with the *Backpack* fund, which Pijl (2016) argues has affected the efficacy of the Dutch approach to inclusion. Whilst the *Together to School Again* policy initiated a throughput funding model not based on enrolled numbers of children with special needs in a school, but rather the total number of students on-roll, this policy only relates to those children who have: no special needs, mild learning disabilities and intellectual disabilities. A demand-orientated input funding system was introduced for children with other special needs (such as sensory, physical, and/or mental disabilities). This additional funding is referred to as the *Backpack* fund. Aware of the risks of an input

funding system, Dutch policymakers introduced defined criteria (Pijl 2016). To qualify for the demand-orientated *Backpack* funding, positivistic measures assess whether children's:

- hearing and vision fall below an identified level
- intellectual disabilities are below an IQ of 60
- medical data details sufficient need for those with a physical disability or who are chronically ill
- Diagnostic and Statistical Manual of Mental Disorders (DMS) categorisation registers a 'behavioural disorder'

The simultaneous operation of two different special needs funding models is argued by Pijl (2016, p561) as 'not a good idea', and the development of strict criteria to control the numbers eligible for *Backpack* funding has proved difficult. Since the introduction of the *Backpack* fund, the percentage of students labelled with special needs has increased steeply, and there has been no decrease in the proportion of pupils attending special schools (which is around 4.7%). Those children who now attract *Backpack* funding in regular education schools are described by Pijl (2016, p561) as students who 'were already in regular schools and under the new policy acquired both a label and additional funding emphasising their difference.' As Pijl (2016, p561) states, 'governments should be aware of the dangers of putting in place systems intended to promote inclusive education, but in practice have the opposite effect.'

Another key finding by EASNIE (2016), is the trend for countries to move towards more decentralised funding systems where the region or municipality has the primary responsibility for the organisation of special education (Meijer and Watkins, 2019). In some countries, implementation has involved local authorities gaining the possibility to define resource allocation mechanisms according to local needs, whereas, in other countries, national funding criteria combine pupil-weighted funding with a regional needs-based approach (EASNIE, 2016). As decentralised funding is argued to create more significant opportunities for developing innovative forms of inclusive education (Stubbs, 2008; NESSE, 2012) and to support throughput funding models (Meijer and Watkins, 2019), it is important to critically analyse the nature of this funding approach. The correlation between throughput funding and decentralised funding occurs at the point where decentralised and flexible education, aims to increase 'the need for capacity-building and support at local and at school levels' (EASNIE, 2016, p54). Thus, the efficacy of decentralised funding requires a commitment to throughput funding and the mechanisms of governance and accountability that address effectiveness, equity, and accountability. Problematically:

> Existing governance mechanisms seem to hamper the implementation of high-quality, cost-effective inclusive education [… and] lack of data makes it challenging to monitor existing policies. This prevents policymakers from identifying the academic and social outcomes of inclusive education and its strengths and weaknesses. Consequently, it impedes them from improving its implementation quality (EASNIE, 2016, p63).

Thus, decentralised funding expenditure trends can derive from weaknesses in governance; for example, flaws that fail to generate synergies among stakeholders and embed integrated frameworks that allow for inter-institutional cooperation and coordinated provision (EASNIE, 2016). The challenges should, however, not detract from the overall aim to develop inter-institutional cooperation; for it is argued that policies for reform should seek to influence as many stakeholders as possible, working with them to ensure they are convinced about the value of the proposed changes, and drawing on their knowledge to inform the planning process (UNESCO, 2020).Regarding the nature of the synergy required for inter-institutional partnerships, Frost's (2005) model of multi-agency working (see Table 3.2) points to the variety of practice that can exist, from 'cooperation' which involves the sharing of information between services, to 'integration' that embeds services merging.

Table 3.2: Frost's (2005) model of multiagency working adapted by Wharton et al. (2019)

No partnership	Uncoordinated, free-standing services.
Level 1: Co-operation	At this first level of joined up working there is an aim to achieve **co-operation** between services. In contrast to 'no partnership' information is now shared between services, but each service maintains its full independence.
Level 2 Collaboration	At the second level there is an emphasis placed on **collaboration** between services. Like the **co-operative** stage services retain their independence and share information, but there is an emphasis on planning together with other services to address issues which overlap (thus aiming to avoid duplication and also conflicting approaches).
Level 3 Co-ordination	At the third level an emphasis is placed on systematic working between services. At this level of joined up working, services are now **co-ordinated** at a strategic level; goals are shared and understood, and crucially different services consider one another's values, finances, and expectations.
Level 4 Integration	At the fourth level there is **integration** of services, this means different services now become one organisation in order to enhance service delivery.

When interpreting Frost's (2005) model, it is important not to view it as a hierarchy (with integration at the top). In some cases, integration may not be possible or desirable and can lead to viewing integration as an end in itself (Stone and Foley, 2014). For as Griffin and Carpenter (2007) point out, the picture is arguably more complex than Frost's (2005) model depicts; for example, a merger at the strategic level does not guarantee integration at the frontline (Griffin and Carpenter, 2007), or ensure improved outcomes for children/young people will be delivered. The challenge of avoiding fragmented systems and missed opportunities for collaboration can at times require a significant shift towards forms of co-operative engagement that embed the following cultures:

- being prepared to re-visit and challenge existing practice, setting assumptions and preconceived ideas to one side
- being open to innovative ideas and being ready to think differently
- being able to learn from one another, listening to other's perspectives and valuing other's attributes
- being able to evaluate current thinking and practice and plan to create functional new groups
- being able to recognise relationships and see connections between potentially disparate ideas and approaches. This will involve keeping the 'big picture' in mind as well as attending to the specific details.
- through ongoing dialogue and partnership, establishing a shared purpose, goal/aim

(Stoll, Fink, and Earl, 2003, adapted by Wharton et al., 2019)

Synthesised, without efficacious governance (EASNIE, 2016), an agreed understanding of the desired level of inter-institutional co-operation (Frost, 2005), and a critical analysis of inter-institutional co-operative working (Stoll, Fink, and Earl, 2003; Wharton et al., 2019), decentralised funding risks compartmentalisation between stakeholders (EASNIE, 2016), inertia and inactivity (Meijer and Watkins, 2019). In subsection 3.4.6, this discussion is extended to include a specific focus on cross-departmental working and the team around the child in the Early Years. Drawing this subsection to a close, the most recent and robust research into the financing of inclusion by EASNIE (2016, pp10-11) reported the following key points:

- modes of funding in countries incentivise the labelling of learners
- modes of funding prevent special schools from acting efficiently as resource centres
- flexibility in financing learning needs must be linked to an inclusive design approach to educational accessibility. This approach adequately combines universal design for accessible learning with extra support when needed.
- despite various country efforts, governance mechanisms promote fragmented systems for inclusive education by failing to embed means and resources in an integrated framework that allows for inter-institutional co-operation and co-ordinated provision.
- the difficulties that stakeholders encounter in implementing inclusive education may be related to weaknesses in existing governance mechanisms.

Despite the challenges associated with financing inclusion, academics (for example, Slee, 2018; Meijer and Watkins, 2019), UNICEF (2015) and Members of the European Petition Committee (Fontaine, 2019) have all stressed that an effective inclusive education system requires investment and adequate support. Whilst, it might have been anticipated that the recent financial crisis in 2008 would have reduced expenditure on inclusive education, EASNIE (2016) reported that this has not always been the case. On the contrary, several countries said they had 'reduced expenditure on their education system because of the financial crisis, along with increased spending on the education of learners with SEN in need of additional support' (EASNIE, 2016, p20).

> However, far from being an indicator of a positive move towards inclusive education, the European Agency Study (2016) suggests that increased spending may be an indication of: 'schools' need to label learners as having SEN that require additional support' (Meijer and Watkins, 2019, p711).

As Campbell et al., (2003) point out, it takes more than redirecting cash flow to make inclusion a reality. It is also worth remembering that building a fiscally effective inclusive education system is not an end in itself. Rather it is a means to support the development of active citizens with equal citizenship opportunities (Fontaine, 2019).

In summary, it is argued by Meijer (1999) that all funding for inclusion and special education is essentially input (needs) or throughput (tasks) funding. Input funding is based on an individual's measured needs, whereas throughput funding is based on the development or maintenance of services. Both funding models embed distinct and different incentives: an input funding model based on low achievement reinforces low achievement itself - more low achievement, more funds; whereas, throughput funding may reinforce inactivity and inertia - whether anything is done or not, funds will be available (Meijer, 1999). Thus, input funding models 'risk promoting strategic behaviours that work against the principles of inclusive education, as well as lead[ing] to increased costs' (Meijer and Watkins, 2019). Whilst throughput funding seems to be the most successful option for inclusive education, accountability and governance are critical issues (EASNIE, 2016; Meijer, 1999; Meijer and Watkins, 2019). It should be noted, however, that throughput and input funding models are not necessarily discreet and disaggregated from one another (EASNIE, 2016). Pijl (2016) warns that the simultaneous operation of two different special needs funding models may not be a good idea. There is a correlation between throughput funding and the decentralisation of funding systems, where the region or municipality has the primary responsibility for the organisation of special education (Meijer and Watkins, 2019). Decentralised funding systems are argued to create more significant opportunities for developing innovative forms of inclusive education (Stubbs, 2008; NESSE, 2012) and support throughput funding models (Meijer and Watkins, 2019). Regarding the synergy required for inter-institutional partnerships, it should be noted that this way of working can operate on multiple levels, from service co-operation right through to service integration (Frost, 2005). In addition to which, a move towards increased inter-institutional partnerships is likely to require a culture shift that necessitates shared understandings, a willingness to develop new practices and respect between institutions (Stoll, Fink and Earl, 2003).

Whilst it is acknowledged that inclusive education requires funding (Fontaine, 2019; Meijer and Watkins 2019; Slee, 2018), it is also understood that increased funding may be indicative of a need to label learners as having SEN that require additional support (Meijer and Watkins, 2019).

3.4.4: Funding inclusion: An analysis of AIM

This subsection draws on 10 sources which are predominantly (although not exclusively) a synthesis of the literature featured in subsection 3.4.3. This subsection aims to view the funding approach utilised by AIM through the lens of the international literature on the topic of financing inclusion. Literature specific to the Irish context is introduced as part of this critical synthesis.

Like most European models for funding inclusion (EASNIE, 2016), AIM contains both 'throughput' and 'input' elements; AIM does not incorporate 'output' funding (Maijer,1999). Levels 1-3 of the AIM model are clearly described as 'universal' and thus part of a throughput funding approach to inclusion, focusing on service development through continued professional development for Early Years educators and information for parent/carers and providers. Regarding the Leadership for INClusion in the Early Years programme (LINC) (Level 1), Ring and O'Sullivan's (2019) critical analysis of LINC describes it as both cost effective and suitable; cost-effective when compared to degree level education; and suitable because of the relevance of the programme to the sector in terms of curricula and accessibility to those already working in early childhood education. In addition to which, AIM's commitment to 'Inclusive Play' (Government of Ireland, 2021) clearly embeds an 'inclusive design approach to educational accessibility' (EASNIE, 2016). The throughput elements of the offer are also present in AIMs 'targeted' supports; this is particularly true of Level 4, which comprises of collaborative work between Early Years Specialists, parent/carers, and pre-service providers. Level 5 could be described as having both throughput and input funding elements:

- *throughput* when Level 5 funding is used for minor alterations to a building that enhance the accessibility of an EY setting
- *input* when Level 5 funding is used to purchase specialist equipment for a specific child, which can be taken with them to another setting

Regarding Level 6, as defined on the AIM website (Government of Ireland, 2021), it is both a universal and targeted offer and thus has both throughput and input funding elements. The throughput (universal) elements comprise of the offer to provide information and Health Service advice and, the upskilling of Early Years staff to develop resources like behaviour support plans. The input (targeted) funding elements of the Level 6 offer comprise of: therapies provided to individual children.

AIM Level 7 is a form of input funding, and like the Netherlands '*Backpack*' fund (Pilj, 2016), it will transfer with a child to another Early Years setting should they move. As a *Backpack* fund, Level 7 is arguably vulnerable to valorisation by parents/carers and professionals who will try to get the 'highest' amounts of targeted funding (Meijer, 1999, p12). This situation could be exacerbated if parent/carers/professionals are unsure about funding accountability (Meijer, 1999) or feel that conflict is present rather than trust (Lamb, 2009). That said, the Level 7 input fund features are distinguishable from other pupil-bound budgets in two essential ways. First and foremost, unlike the *Backpack* offer (Pijl, 2016), Level 7 does not, in theory, require pupil diagnosis, thus avoiding some of the frequently found problems with learner-bound budgets, such as: costly bureaucratic procedures and the incentivisation of low pupil achievement (Meijer 1999) and, removal of the need to categorise to intervene (Alves et al., 2020). Secondly, Level 7 funding is designed to 'reduce the child-to-adult ratio in the pre-school room or fund an extra staff member as a shared resource with other children in the ECCE setting' (Government of Ireland, 2021, online). So, whilst Level 7 input funding will *Backpack* with a child, it is also explicitly designed to be a shared resource that enhances the environment for all children in the room/setting, thus inserting a throughput element into this input approach to funding. In addition, Roberts, and Callaghan (2021, p791) have suggested that the 'AIM training available at Level 1 and 3 should become a prerequisite of recruitment of the AIM Support worker and named specifically within the job specification.' Should AIM Level 7 be developed in the

way suggested by Roberts and Callaghan (2021), the provision of CPD (such as LINC) will further enhance the throughput funding properties of this input fund. This is a significant finding, as funding systems that do not require diagnosis necessitate substantial investment in the development of teachers' agency (Alves, 2020), and bypassing labels to access support is argued to require enhanced practitioner knowledge of inclusive pedagogy (Black-Hawkins and Florian, 2012; Rouse, 2008).

To summarise, the throughput funding properties of AIM (the child-centred pedagogy, inclusive play and, embedding of a universal design for learners with extra support when needed) are all factors associated with the establishment of an inclusive learning environment (EASNIE, 2016; Meijer and Watkins, 1998; Scott, 2021). That said, models which embed throughput funding are vulnerable to 'inactivity and inertia' (Meijer, 1999) and weaknesses in accountability and effectiveness between stakeholders potentially lead to an expenditure trend (EASNIE, 2016).

Whilst throughput models are generally understood to embed decentralised collaborative working, Frost's (2005) model of multi-agency working is a salient reminder that partnerships can operate at a superficial or deeply embedded level. Successful partnership working requires a commitment to ongoing dialogue and the development of a shared purpose (Stoll, Fink and Earl, 2003, adapted by Wharton et al., 2019).

3.4.5: Inclusive policy for the early years and reliance on the private sector

This subsection draws on 11 sources as the basis for critically analysing some of the facets associated with the establishment of partnership working between the public and the private sector. This topic is crucial for managing the expansion and consolidation of the industry. At the time of writing, changes were taking place in funding mechanisms, so every analysis should consider recent developments.

The HR framework establishes that governments are responsible for ensuring that strategies and services address the rights of so called 'vulnerable and excluded' communities. This means the State is responsible for implementing the HR framework either on its own or with the joint effort of the government, families, communities, charities, and the private sector (De Beco, 2010). The arrangements are diverse, and it is up to each country to determine the nature of such agreements. Naturally, a government's role consists of formulating the framework for supporting participation and engagement with the service of HR frameworks in the ELC sector.

Overall, the international literature points out some contradictions in implementing services when the profit-making drive does not meet the HR framework entirely. In two historical analyses, Haddad (2002) and Meyers and Gornick (2003) discuss how societies with neoliberal, free-market ideas tended to create fragmented systems differentiating childcare from education. Such conditions were found to favour quality services for wealthy populations in urban areas where families were able to pay, leaving the state with a responsibility to subsidise quality childcare for families 'in need'. On the other hand, countries with more community-led and government-controlled policies created more widespread and integrated services. Penn (2011) discusses the complex relationship between the market and the government regarding Early Childhood Care and Education (ECCE) provision, mainly in the UK and identifies various risks related to economic change. For example, the change of ownership of large companies providing several services and changing its policies; the competitive nature of the market and its repercussion on the workforce salary; and the relatively high price of services that end up not making families choices real. Haug (2014) discusses the case of Norway,

where, for several years, the relationship between the government and private nurseries seemed to work well as the latter received public money. Later struggles emerged, and the private sector wanted to increase its profits; the discussion focused on the aim of the services, which were to promote social justice and wellbeing and how a purely economic rationale was insufficient to achieve this. Later, significant public opposition was shown when some public nurseries were privatised.

In a comparative study between England, France and Germany, West et al., (2020) discuss how the private sector in the UK is characterised by lower quality skills due partially to the low paid workforce in the private sector, while the other countries benefited from a government-led provision with better salaries. Critically, evidence from the OECD suggests that 'countries where teachers believe their profession is valued show higher levels of equity in learning outcomes (Schleicher, 2015). Equity, in this instance, refers to 'ensuring fairness, where the education of all learners is seen as having equal importance (UNESCO, 2020, p.25). Perhaps one of the most decisive discussions is taking place in the US after COVID-19 caused the closure of several nurseries and a considerable number of staff did not return to work in the low paid private sector. Many parent/carers cannot afford private Early Childhood Education and Care (ECEC) provision making it difficult, mainly for women, to return to work, so the government is considering investing four billion dollars in creating a universal system for children three-four years of age (The Hunt Institute, 2021). It is important to note that when using the term ECEC, we are referring to the global term given to early childhood care and education, whereas the term ECCE refers to the specific programme of subsidised childcare provided in Ireland (see subsection 2.3). The US has been considered the prominent example of the free market ECCE provision. It seems that it could not deal with the pandemic's disruption as well as the government-led provision could elsewhere. At the time of authoring this report, the Government of Ireland commissioned an expert group to review funding for ELC and School-Age Childcare (SAC). In the report *A New Funding Model for Early Learning and Care and School-Age Childcare (*Partnership for Public Good, 2021) the expert group concluded that Ireland faced some of the same problems reported in other countries:

- the limiting impact of low pay on the recruitment and retention of high-quality staff, and hence on the quality of provision
- reliance on a large private sector causing challenges to sustainability and the match between supply and demand
- challenges for provider sustainability
- the high cost of ELC for families, and variable quality.

Amongst the recommendations was one to increase public funding to the sector so that this could support the employment of graduate staff and improve pay and conditions.

In summary, the literature examining Ireland coincides with the international research highlighting some issues on the complex relationship between the public and the private sectors in the ECCE. When left to the market alone, services tend to concentrate in urban areas where families can afford them (Meyers and Gornick, 2003; Penn, 2011); sometimes, this causes a double tier where the government has to implement a different service for excluded children and their families (Haddad, 2002). Profit-making strategies usually employ a low-paid workforce with a high turnaround rate that results in provision with low quality that is expensive for families (West et al., 2020). Governments, therefore, should intervene by providing a clear quality framework, an adequate initial training system and an accessible ongoing continuous professional development scheme. Public funding should still secure affordable coverage in disadvantaged areas and, ideally, as part of a broader strategy to tackle poverty. Recent studies on the Irish circumstances report similar conditions, with evidence of growing public investment and state intervention, though funds allocated to ELC compared to Gross Domestic Product (GDP) are low compared to other comparable countries (OECD, 2021; PPG, 2021).

3.4.6: Intersectionality and Vulnerability to exclusion: Cross-departmental working and the team around the child

This subsection draws on 7 literary sources as the basis for critically analysing some facets of the cross-departmental work provided by ECCE. This topic is crucial for managing the coordination of services and the initial training of the specialised workforce.

As mentioned above, the historical development of early childhood services had tended to create fragmented provision that left out the proportion of the population who could not afford them (Haddad, 2002). This has been the case internationally, and in Ireland (PPG, 2021). In the evolution of ELC, there has been a continuing tendency for adult-centric (rather than child-centric) discourse to dominate. For example, in the setting of timetables, curricula, favoured philosophies, and workforce needs. However, the human rights approach to ELC requires a holistic approach to services, where childcare is synthesised with education, and where children's needs drive reforms. One of the first major comparative studies (Kaga et al., 2010) analysed ELC in six countries (Jamaica, Brazil, New Zealand, Slovenia, Sweden, and Belgium). Kaga et al., (2010) concluded that where ELC was firmly positioned within educational services, staff retention, quality and service sustainability were likely to be more positive. Hence, the integration of education and care was crucial, though Kaga et al., (2010) point out that there are many ways to achieve such integration. However, political commitment from all parties was found to be necessary, along with reformulations of funding and governance such that education was made equal to care. Integration, however, is not a solution in its own right; integrations should be considered a means to achieve broader aims. Snider et al., (2020) identify integrated services as particularly effective with refugees and other so called 'vulnerable' populations. This correlates with Stone and Foley's (2014) analysis of Frost's (2005) depiction of the levels of multi-agency working (see subsection 3.4.3, Table 3.2). *Aistear* and *Síolta* were formulated to develop integrated solutions to an ELC ecosystem based on a quality Framework and a straightforward pedagogical approach that allowed for the training of a new workforce knowledgeable of the new system. Recently, the OECD (2021) highlighted that reinforcing leadership should be a key strategy to improve quality in the Irish context, a situation already addressed with creating a new workforce knowledgeable of *Síolta, Aistear* and the DEI charter. According to the same source, the quality assurance brought about by these documents will expand towards other types of provision, including home-based provision. A challenge, however, is that guidance remains patchy and independent providers find it challenging to access.

In summary, integrating services is a process shared by many western countries that started with fragmented ECCE services (Haddad, 2002). This facilitates a holistic approach, and potentially, better use of resources as shared information reduces duplicated efforts. However, there are many challenges, such as the terminology used, the focus of the services and the lack of specialised knowledge that can derive from overseeing crucial information (Kaga et al., 2010). Creating a new workforce knowledgeable of the quality framework and other recent policy development makes this more likely (OECD, 2004; 2021).

3.4.7: Parental/Carer Communication, Participation, and Co-production

This subsection has drawn on 15 sources as the basis for critically analysing some facets of parental/carer engagement. This topic is much researched and written about, both outside and inside the inclusion/special education fields. Therefore, the issues highlighted are only those most relevant to the findings of this end of year three evaluation of AIM.

> What occurs within the family, whatever its composition, has more impact on a child's learning, development, and well-being than any other single factor. What families do is far more important than the structure of the family, particularly as they are the first prime educators of their children. […] Parents [and carers] are usually the best judges of what children need. They understand their children better than anyone else and have important insights into what children want (Cheminais, 2015, p111).

The HR approach, specifically the Right to Education, contemplate the right to participate. Parent/carers' community participation make it likely to be culturally relevant and meet their needs. Furthermore, the HR approach requires the rights of all involved in education, that is, children, families, communities, and workers, to be respected and promoted (De Beco, 2010). Particularly in the case of young children with special needs, a close relationship between the school and the family is needed (Cheminais, 2015). In the history of services, at times, the relationship between families and specialists has been complex as represented by the medical model (Werner, 1987), where families were expected to do as specialists told them, and the disabilities, not the whole person, were seen as a condition to be dealt with medically. As the approach evolved into the HR framework where it was necessary to consider the children's environment, particularly families and communities. This is because many of the problems faced by people with special educational needs have their origins in discrimination and exclusion. In a way, holistic services refer to the need to include families and communities in understanding the HR framework, promoting inclusion across all levels of society, and including children and families in the formulation of strategies to address the situations they face (Werner, 1987). This is sometimes referred to as a family-centred approach (Cheminais, 2015).

Family-centred and child-centred approaches that recognise parent/carers unique understanding of their child and how barriers can be removed are described as being of great importance to all families of children with hidden and visible disabilities (Porter et al., 2013). Hidden disabilities are understood to be those that 'do not manifest themselves physically' (Houston, 2020); 'unlike a visible disability, where an access ramp might be obvious, or visual cues for, say, a hearing difficulty, hidden disability adjustments can be less obvious' (Xmlrpcuser, 2019, p2). The challenge for families of children with hidden disabilities can be the seeming invisibility of their child's needs to a setting (Porter et al., 2013). For example, when researching the experiences of parent/carers accessing leisure facilities and short break respite care, a common observation was that:

> Their son or daughter possessed a 'hidden disability' rather than any physical manifestation that leisure staff could immediately pick up on. Consequently, people viewed these children as 'just naughty'. Instead, it was felt that people involved in provision need to know how to manage these children and therefore required more training in order to do so (Thompson and Emira, 2011, p71).

Parent/carers also described assumptions being made about children, which were based upon unrealistic expectations derived from an assessment of appearance that overlooked the hidden nature of a disability (Thompson and Emira, 2011). One parent/carer described her child's disability as: 'it's very hidden until it manifests itself and then it's very dramatic' (Thompson and Emira, 2011, p72). In a separate study into the reasonable adjustments parent/carers want for their children, Porter et al., (2013) suggested that parent/carers felt adjustments were limited to the physical layout or the provision of aids and equipment. Instead, parent/carers reinforced the need for schools to retain flexibility in their provision for children, arguing that above all:

> Schools need to have in place the two-way communication process that supports them in 'knowing' about the visible and invisible challenges that pupils with difficulties and disabilities face in participating in school life, processes that go beyond simply having data on file (Porter et al., 2013, p16).

In 2009, Lamb's inquiry into special educational needs and parental confidence revealed that few parent/carers 'seemed to have been encouraged to discuss the outcomes they expected, or aspired to, for their child or how best these outcomes might be achieved' (Lamb, 2009, p20). Since then, a systematic review by Boonk et al. (2018) identified types of parental engagement that led to improved academic achievement: high expectations or aspirations, communication between parent/carers and school, and parental encouragement for learning and reading at home. In addition, evidence by Higgins and Katisipataki (2015) and Axford et al. (2019) showed that where school, family and community partnerships are developed, there is consistent evidence of the beneficial impact on children's academic attainment.

Parental/carer involvement, however, is not straightforward. In formulating an index of satisfaction of service users of Mexico's nurseries, Lobato Calleros et al., (2012) identified several key issues. Families from the most excluded groups of society who feel intimidated dealing with service staff thought they had little to contribute and would manifest satisfaction even with low-quality services. It seems that part of the nurseries' work is also to help parent/carers understand what to expect from services and identify the quality components of the services. It is also worth noting that just because a partnership with a parent/carer begins with discord, it will not always remain on this trajectory. Suppose a parent/carer articulates their dissatisfaction, in this case, this can become the platform for an open and honest building of trust and a more positive relationship comprising of mutual respect and understanding (Laluvein, 2010). Similarly, a partnership that seems on the surface very harmonious may, in reality, hold several suppressed tensions (Laluvein, 2010). Thus, parent/carers need an opportunity to express both their satisfaction and dissatisfaction. A structured conversation can be a helpful way to address parental/carer dissatisfaction and move toward more positive actions which should ultimately benefit the child/young person (Lendrum et al., 2015). Defined by the Department for Children Families and Schools (DCFS, 2009, p4), 'the structured conversation is intended to support the greater engagement of parent/carers by enabling them to make their contribution heard and understood by teachers and the wider school.' The critical components of this conversation are an opportunity for parent/carers and practitioners to *explore* key issues; collaboratively *focus* on the ways key adults can identify priorities and clarify key issues; *plan* and agree on targets and actions; *review* and summarise key points from the meeting and establish the timeframe for achieving the agreed actions (DCFS, 2009).

In summary, this subsection reiterates the Human Rights context for families' engagement in their child's education (De Beco, 2010). This is a point repeatedly emphasised as pedagogically and academically significant for the families of children with additional needs (Axford et al., 2019; Boonk et al., 2018; Cheminais, 2015; Higgins and Katisipataki, 2015; and Lamb, 2009) and critical to the establishment of an inclusive environment (UNESCO, 2020). The literature suggests that families with children with so-called 'hidden disabilities' may find it more challenging to secure appropriate provision for their child than those whose children have a so-called 'visible' disability (Porter et al., 2013; Thompson and Emira, 2011). This is because a 'hidden disability' can produce the effect of making invisible a child's unique needs (Porter et al., 2013; Thompson and Emira, 2011). Central to the removal of those barriers, and aligned with the Human Rights for family engagement, is a need for a two-way communication process which engages professionals and families in meaningful conversations (Lamb, 2009; Porter et al., 2013). However, family engagement is not without its challenges (Lobato Calleros et al., 2012); approaches such as structured conversations are one strategy that can address such challenges (DCFS; 2009; Lendrum et al., 2015).

3.4.7: Transitions to the next stage of education

This subsection draws on 16 sources as the basis for critically analysing some facets of the transition from pre-school to primary school. This topic is crucial for managing the sustained support children receive when enrolling on a new setting and changing all support funding arrangements, staff, and routines.

The transitions from pre-school to primary school are challenging for every child and family. The nature of the activities of each educational level, the pedagogical origin of their approach and the conceived role of the learner are not necessarily coherent and sometimes are openly contradictory between these levels (Ahtola et al., 2016; Babić, 2017; Brooker, 2008; Taggart et al., 2006). Children would experience a new physical and cultural environment, and some would experience fear and find it challenging to understand their new role. Pre-school tends to rely on participative pedagogies; children are involved in planning, implementing, and assessing their learning; autonomy and child-centred methods are widespread. Free play and choice are frequent too. In contrast, primary school tends to promote obedience and focus on attainment. Children with special needs, particularly boys, are likely to be in vulnerable groups making LCE potentially more challenging to implement. At the same time, more directive pedagogies are more common in primary schools.

Various strategies have been trialled and recommended, from visiting schools before transition (Ackesjö, 2013; Babić, 2017; Carr, 1998) to preparing families to support their children (Ahtola et al., 2016; Bérubé et al., 2018; Burriss, 2003). Particular emphasis has been put into building up children's emotional resilience and self-esteem (Alatalo et al., 2016; Beers, 2018; Carr, 1998). The use of play has also been identified as an effective strategy to make the transition easier (Melhuish et al., 2015; O'Sullivan and Ring, 2018). Van Laere et al., (2012) alert on the potential risk of schoolifying pre-school while focusing on attainment and reducing emphasis on wellbeing and inclusion. Such a process can be identified by lesser importance and time dedicated to playing and free play and more prescriptive pedagogies, together with early attempts to assess attainment. There are, however, critical views that question whether we may need to change primary school to support children's emotional development, autonomy, and active learning (Brooker, 2008).

In Ireland, primary school commences at six years of age, although children traditionally have started primary school at four years of age in infant classes. Ring et al. (2016) report that all five-year-old and half of the population of four-year-old children attend primary school for historical reasons unrelated to the Human Rights framework; consequently, Irish children experience transition earlier than other European children. The adult ratio is one of the main differences, as in pre-school, this is 1:11 while it is 1:28 in primary school.

Smyth (2018) conducted an extensive study about the transition from pre-school to primary education. Similar to the international literature, this report found that children with SEN, particularly males, were more likely to show transitional difficulties. Bigger groups make directive pedagogies more likely and, therefore, LCE more challenging. Inequalities affect disadvantaged groups such as children with low-income backgrounds and children with SEN. The report recommends working with parent/carers to make the transition smoother and reformulate the nature of the primary school, or at least its first years. Race, income, gender, family structure and parenting have also been identified as essential backgrounds impacting transition (Ring et al., 2016). Interventions, therefore, should acknowledge these components in a holistic approach considering children, families, and schools. In line with current international literature, Ring and O'Sullivan (2018) distinguish two perspectives regarding the transition from pre-school to primary school in the form of school readiness; either as a schoolification of pre-school or a gradual extension of LCE and play-based learning, advocating for the latter as it would benefit children particularly those who might be described as disadvantaged, and making it

easier for AIM. Ring and O'Sullivan (2016) make a case to consider the voice of the children during the transition to primary school, as this is in line with the rights of the child.

In summary, the transition from pre-school to primary school can be challenging for some children, particularly for so called 'vulnerable' children, for reasons of income, family structure, excluded groups, or disability (Brooker, 2008; Melhuish et al., 2015). Usually, pre-school tends to use play and other child-centred approaches, while a more directive way is widespread in primary school (Taggart et al., 2006). For historical reasons, in Ireland, infant groups with children of four and five years of age are common, so transition tends to be earlier (Ring et al., 2016). Infant groups have 28:1 children and adult ratio, while in pre-school, this is 11.1. AIM support could ameliorate this transition (Smyth, 2018).

3.5: Summary and implications for the end of year three evaluation of AIM

The complex and sophisticated nature of the AIM model means it is not practicably possible or desirable to draw on every piece of available literature to critically analyse all the aspects of AIM. Thus, Section 3 of this end of year three evaluation provides a literary context for some of the most pertinent facets of the programme. In this concluding subsection, the following is thus presented:

3.5.1 a summary of the key literature.
3.5.2 a synthesised analysis of AIM through the lens of the key literature.
3.5.3 an outlining of six key implications for AIM as identified in relation to this literature review.

Summary of the key literature

Situated within a Human Rights framework, inclusion is argued to be inherent within 'the best' Early Years child-centred practice (Nutbrown et al., 2013; Scott, 2020). The major facets of AIM (Government of Ireland, 2021), such as: inclusive play, universal design for learning, multi-agency working, a strong focus on CPD, funding without diagnosis, and partnership with parent/carers are all referred to in the research literature as central to the development of inclusive education (Alves, 2020; Alves, et al., 2020; Black-Hawkins and Florian, 2012; EASNIE, 2016; Meijer and Watkins, 2019; Lamb, 2009; Rouse, 2008; PPG, 2021; UNESCO, 2020). Norwich and Lewis' (2007) presentation of the general and unique differences perspective is, however, a salient reminder that the properties pertaining to a 'unique differences perspective' are also evident to some degree in the 'general differences perspective' which includes a 'special pedagogy' (Figure 3.1). Similarly, both Figures 3.2 and 3.3 also highlight how some of the properties of inclusion can be present, to an extent, in settings where practice is less inclusive than it might be.

Regarding the funding of inclusion, it is clear from multiple sources (for example, Fontaine, 2019; Meijer and Watkins, 2019; Slee, 2018; UNICEF, 2015) that an effective inclusive education system requires investments and adequate support. That said, increased funding may not always be a marker of greater inclusivity, for it can indicate an increasing need to label learners as having SEN that require additional support (Meijer and Watkins, 2019). Whilst the various properties of inclusion funding models are numerous, it is argued by Meijer (1999) that all funding for inclusion/special educational needs is essentially input (needs) or throughput (tasks) funding. It is also widely acknowledged within the literature that whichever funding model is in place, the fiscal incentivising of special needs drives behaviours (positive or negative) within education settings (EASNIE, 2016; Graham, 2015; Meijer, 1999; Pijl and Dyson, 1998; Sansour and Bernhard, 2018).

Of the two-funding approaches, input funding is generally considered to be the less inclusive option (Meijer and Watkins, 2019). This is because input funding is argued to reinforce low achievement - the lower children's achievements, the more funds can be expected (Meijer, 1999). Aware of the challenges associated with input funding, policymakers have found that the funding model necessitates complex diagnostic processes and categorisation, leading to appeals and litigation (Meijer, 1999; Pilj, 2016). Input funding that does not require categorisation for intervention is thus considered a more inclusive option (Alves et al., 2020). Input funding has, however, proved popular with parent/carers but is argued to have led to settings and parent/carers valorising the 'highest' amounts of SEN funding (Meijer, 1999). The litigious consequences of this form of funding valorisation have created conflict for parent/carers where there should be trust (Lamb, 2009). Parent/carers of children with special educational needs and disabilities have also reported levels of concern about inclusive education, fearing that inclusion correlates with the potential dissolution of funding they have fought to get (Pijl and Dyson, 1998; UNESCO, 2020).

Throughput funding (which can be aligned with a decentralised budget) is argued to be the more inclusive of the two funding options (Meijer and Watkins, 2019) because it seeks to develop and improve services and is more likely to avoid the labelling of pupils (Meijer, 1999). In order to bypass labels to access support, throughput funding requires practitioners' engagement in efficacious CPD which facilitates the development of knowledge about inclusive pedagogy (Alves, 2020; Black-Hawkins and Florian, 2012; Rouse, 2008). A specific challenge here for the Early Years sector is the low paid nature of the workforce, which can lead to high levels of staff attrition. This issue can be further compounded by the sector's reliance on the marketised private industry, which can necessitate profit-making, thus further embedding issues related to low-pay and staff attrition (West et al., 2020). Critically, evidence from the OECD suggests that 'countries where teachers believe their profession is valued show higher levels of equity in learning outcomes (Schleicher, 2015).

Decentralised throughput funding expenditure trends are also argued to derive from weaknesses in the governance of services, including the effectiveness of inter-institutional partnership working. Flaws in governance mechanisms have also been found to hamper the collection of data that makes possible the monitoring of existing policies, which impedes future developments (EASNIE, 2016). Regarding the synergy required for inter-institutional working, it should be noted that this can operate on multiple levels (Frost, 2005); thus, a shared understanding between services of the desired level of inter-institutional partnership is essential (Kagan et al., 2010). However, a merger at the strategic level does not guarantee integration at the frontline (Griffin and Carpenter, 2007), and issues can arise when fragmented services begin to integrate. From a family engagement human rights perspective (De Beco, 2010), successful partnership working necessitates a commitment to ongoing two-way dialogue and the development of a shared purpose (Porter et al., 2013; Stoll, Fink, and Earl, 2003). Service continuity, inter-institutional partnership working, and two-way communication are also issues central to the successful transition of children from pre-school to primary school (Brooker, 2008; Melhuish et al., 2015, Taggart et al., 2006). Described as a potentially difficult time for all families, the contrast between the participative child-centred pedagogies of the Early Years and the more formal structures of the primary school can mean that this first transition is demarcated by a move away from an inclusive education culture. Furthermore, the transition from pre-school to primary school has raised questions about children's school readiness, either as a schoolification of pre-school or a gradual extension of child-centred play-based learning (Ring and O'Sullivan, 2018; Van Laere et al., 2012). The inclusive properties of child-centred play-based learning make the latter the more inclusive option.

Synthesised analysis of AIM through the lens of the key literature

- Like most European models for funding inclusion (EASNIE, 2016) the Access Inclusion Model (AIM) contains both 'throughput' and 'input' elements; AIM does not incorporate 'output' funding (Maijer, 1999).
- The throughput funding properties of AIM: CPD focussed on inclusion and child-centred learning, partnership with parent/carers, the embedding of universal design for learners with extra support when needed, are all factors associated with the establishment of an inclusive learning environment (EASNIE, 2016; Meijer and Watkins, 1998; Nutbrown et al., 2013; Scott, 2021). The throughput nature of the funding model does therefore present challenges regarding mechanisms of governance concerning effectiveness, equity, and accountability.
- AIM does require inter-institutional co-operation and stakeholder collaboration; the desired level of these partnerships from co-operation through to service integration (Frost, 2005) does therefore require consideration.
- Avoidance of a diagnosis led input fund and the focus on reducing the child-adult ratio in the pre-school room, are potentially significant factors that sidestep some of the critical challenges associated with the simultaneous operation of throughput and input funding models, including bureaucratic assessment processes, categorisation, and litigation. However, it is argued the efficacy of such an approach is dependent upon investment in the development of teachers' agency (Alves, 2020), and enhanced practitioner knowledge of inclusive pedagogy (Black-Hawkins and Florian, 2012; Rouse, 2008). This is a pertinent challenge for the Early Years sector with a lower-paid workforce resulting in staff attrition. In addition to which, the so-called highest Level of AIM (Level 7) embeds an input funding model (all be it with a throughput element due to the shared nature of the resource), which is open to valorisation by parent/carers and settings. Moreover, the families of children whose needs are not met by Level 7 funding may be concerned that moves towards further inclusion will initiate the dissolution of funds they have fought to secure (UNESCO, 2020).
- For historical reasons, in Ireland, primary school infant groups with children of four and five years of age are common; such groups have 28:1 children and adult ratio, while in pre-school, this is 11.1 (Ring et al., 2016). It is important to note that average ratios are reducing as a result of AIM. AIM support could ameliorate this transition; a gradual change towards using LCE in primary school could benefit all children.
- The literature examining Ireland coincides with the international research highlighting some issues on the complex relationship between the public and the private sectors in the ECCE (Kagan et al., 2010; PPG, 2021). Profit-making strategies in the EY sector have tended to cohabit with employment in a low-paid workforce, which can stimulate staff attrition and EY provision which is both low quality and high cost for families.

Implications

In the context of the international literature, the key implications for AIM, and relevant focusses for the evaluation are as follows:

1. Mechanisms of governance are required to evaluate the effectiveness, equity and accountability of AIM.
2. The level of inter-institutional partnership needs to be clearly understood by all parties and efficacious on the frontline (i.e., for settings and families).
3. CPD needs to be utilised effectively to develop the professionalism, agency and pedagogic knowledge of Early Years staff who are brought in to 'reduce the child-to-adult ratio in the pre-school room and support the inclusion of all children.
4. In relation to point 2, AIM funding (throughput and input) needs to avoid a CPD expenditure trend which is unnecessarily high due to staff attrition.
5. Families' human right to actively engage in their child's education needs to build trust through two-way communications, which enable every unique child's equitable participation in an inclusive environment.
6. Families need to have confidence that the parameters of the AIM funding model will:
   a) meet their child's needs;
   b) prepare them for the next phase of their education (i.e., transition into primary school).

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4. Surveys of parent/carers and providers: Method

This section describes the methodology for the large-scale surveys of parent/carers and providers of Early Childhood Care and Education (ECCE) who are engaged in the Access and Inclusion Model (AIM) and receiving support from it. This section begins with a description of the objectives for the survey. This is followed by a description of the methods used for design, recruitment, and analysis.

4.1: Survey objectives

The purpose of the survey was to investigate how AIM had been experienced and perceived by its key beneficiaries: families, children, and providers. The main evaluation objectives served by the survey (in combination with qualitative methods) were as follows:

Objective 1: Quality and Process
Evaluation of the relevance and effectiveness of AIM in terms of its approach, processes, and implementation. Investigation of:

- Effectiveness of the overall approach, in respect of all levels of AIM, and from the perspective of all stakeholders
- Engagement with AIM over time by services, practitioners, children, and families
- Appropriateness and efficiency of application, assessment, and approval processes
- Role and value of the Early Years Specialists
- Reasons for non-participation of children, families, practitioners, and services in different levels of AIM, including barriers to participation
- Efficacy of training provided, including ECI, LINC, Hanen, Lámh and Sensory Processing training.

Objective Two: Impacts and Outcomes
Evaluation of expected and achieved outcomes, contextual factors, and causality. Investigation of:

- Impact on access to – and meaningful participation in – the ECCE Programme for children with disabilities/additional needs
- Outcomes across all levels of AIM, as perceived by all stakeholders
- Impact on the quality and inclusiveness of early learning and care provided; sustained learning and knowledge transfer among practitioners; strengthening of workforce capacity
- Sustainability of approach in settings
- Role of AIM in supporting positive transitions to Primary School

The survey for providers also sought to gather stakeholder views on:

- Adaptability, scalability, and sustainability of AIM
- Potential enhancements to, and/or extensions of AIM

The survey would provide a generalisable account of the experiences and perceptions of the target population. Though surveys have limited explanatory power, this has been ameliorated by the integration of qualitative approaches within the methodological design (see subsection 1.4), and the application of content analysis to free-text items within the questionnaire itself.

4.2: Methodology for survey

This subsection summarises methods of design, recruitment, and analysis.

Survey design and cognitive testing

Through collaboration with the Department of Children, Education, Disability, Integration and Youth (DCEDIY), researchers at IFF Research developed two questionnaires. One for parent/carers, and another for providers of the Early Childhood Care and Education (ECCE) Programme.

Each survey was subjected to cognitive testing with five parent/carers and five providers. Cognitive testing involved an observation of respondents as they completed the questionnaires so that areas of ambiguity or confusion could be identified and resolved. Respondents were also asked to feedback on their experiences of the questionnaire in terms of accessibility, ease of use and relevance. The time taken by respondents to complete the survey was also observed to ensure it was not too burdensome and close to the fifteen-minute completion time intended. Revisions were made in light of the findings so that its effectiveness was improved. The survey was online and GDPR compliant.

The questionnaire for parent/carers covered:

- Details about the child's disability/additional needs
- Choice of pre-school
- Awareness of the AIM programme
- Experience of AIM support
- Views on AIM and its impact on the child and family

The questionnaire for providers covered:

- Information about the setting
- Pre-2016 experiences of enrolling and seeking information on how best to support children with additional needs
- Awareness of, and participation in, AIM programme
- LINC programme and INCO
- Advice/support/mentoring from Early Years Specialists
- Satisfaction with/impact of interventions
- Overall impact of AIM

Recruitment

Parent/Carers Survey

Better Start sent out an email on behalf of the University of Derby Consortium, inviting the parent/carers of children who had applied for or received support from AIM to take part in the survey. The email included a link to the survey, which was open from 26 April 2021 to 22 May 2021. In total, 18,449 parent/carers were emailed (excluding undeliverable emails/refusals). However, there are likely to be some duplicates – i.e., parent/carers who received more than one email (where more than one child in a family received support from AIM, for example). In addition, several parent/carers contacted IFF Research to note their child had not applied for/been supported by AIM.

As a very cautious estimate, we assume that the response covers at least 9% of the target population (1,157 responses/13,320 AIM supported families, allowing for 10% of AIM-supported children to be younger siblings/twins). Each respondent was asked to answer about one child only, though it is

noted that 6% of respondents had more than one child who was being supported by AIM. For these reasons we can assume that our sample size is large enough to be statistically representative to a 95% confidence level.

Provider Survey

Better Start sent an e-mail to all pre-schools which had received support from AIM. The email included a link to the survey, which was open from 30 April 2021 to 30 May 2021, with one reminder email sent to the same providers. In total, 2,790 providers were emailed (excluding undeliverable emails). There were 739 responses to the provider survey: a response rate of 26% which is sufficient for the sample to be statistically representative to the 95% confidence level.

Tools used for statistical analysis

Survey responses were checked and anonymised. Tables for each question were produced, comparing responses by key cross breaks. For providers, these were: size of ELC setting; type (community/private); pre-school location; year started participating in AIM; and respondent's job role).

For both surveys, two-tailed z-tests were used to identify where responses from specific groups within the population were statistically significantly different to the others. Details of the full population profile were not available, so the survey data was not weighted. The two-tailed Z test factors in differences in the size of sub-groups being compared. Given the absence of weighting, statistically significant differences are only reported as such, when the base sizes being compared are at least n=30.

The survey included opportunities for respondents to make free-text responses to add detail or explanation to the selections they had made in Likert scales. For each free-text item, researchers used content analysis to enumerate the prevalence of phenomena within these responses. For example, the reasons parent/carers gave for not enrolling their child in the first choice of ELC setting were analysed to identify how many described 'negative attitudes to disability' or 'the setting did not have capacity' as the cause.

Limitations and mitigations

It is noted that responses from providers may have shown some positive bias given that this group are likely to be those that are engaged in AIM, and hence recipients of DCEDIY funding with a responsibility to deploy it effectively. It may also be true that the parent/carers most motivated to respond, will be those who have had negative experiences that they wanted to report. This indicates the value of capturing parental and provider voices in the survey.

Given the potential for positive and negative biases in each constituency of participants (parent/carers and providers), this report refers to statistically significant differences only where the base sizes of groups within the population are equal or greater than n=30.

If there are interesting differences that are not statistically significant, these are also reported where appropriate but with base numbers noted (n=x). Major conclusions and headline findings are drawn only when a phenomenon emerges through multiple cross-tab analyses, and/or large group sizes.

5. Parent/carer survey: Findings

This section reports the findings of the large-scale surveys of parent/carers whose children have participated in Early Childhood Care and Education (ECCE) and have received support through the Access and Inclusion Model (AIM).

5.1: Introduction: presentation of findings

Findings are presented in the following way. Firstly, the characteristics of the sample will be summarised in terms of demographics. Then, findings on parent/carers choices of setting, awareness of AIM, and perceptions of its impact are reported. These will include impacts on their child, family, full inclusion, meaningful participation, and transition to schools. Following this, findings related to each level of AIM (1-7) will be reported. Findings will be reported graphically (through summary tables, cross-break tables, and charts), with narrations of content and interpretation beneath. Findings from the analysis of the surveys' qualitative content will also be reported. Section 5 ends with a summary of the findings as these relate to the four evaluation questions, which to reiterate, are:

- Is AIM effective and achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities?
- Has AIM influenced practice, or increased capacity in the workforce?
- Is the current approach appropriate in the national context?
- Can AIM be enhanced, and/or scaled up or out?

Each subsection includes a summary of key findings in a text box. Finally, headline findings are summarised in an infographic.

5.2: Characteristics of the respondent sample

The following subsection reports on the demographic characteristics of the respondent sample.

Table 1a: Respondent total and number of children in AIM

		Year first started				
Number of Children in AIM		**2016**	**2017**	**2018**	**2019**	**2020 or later**
Total	**1157**	159	179	257	324	238
One	1091	149	166	246	305	225
	94%	94%	93%	96%	94%	95%
Two	59	8	12	10	18	11
	5%	5%	7%	4%	6%	5%
Three or more	7	2	1	1	1	2
	1%	1%	1%	%	%	1%
ONE	1091	149	166	246	305	225
	94%	94%	93%	96%	94%	95%
MORE THAN ONE	66	10	13	11	19	13
	6%	6%	7%	4%	6%	5%

- Table 1a summarises that there were 1157 responses to the parent/carer survey. The majority of parent/carers (94%) had one child supported by AIM with 6% having more than one. Each respondent was asked to answer about one child only.
- In terms of the year that children first attended pre-school in this respondent population, the total numbers show a rising trend between 2016 (n=159) to 2019 (n=238).

Table 1b: Type of pre-school and setting of pre-school

		Type of Setting		
Type of pe-school	**Total**	**City or large urban area**	**Town**	**Rural**
Total	**1157**	323	481	350
		27%	42%	30%
Community	519	117	219	180
	45%	36%	46%	51%
Private	550	177	229	144
	48%	55%	48%	41%
Other	36	15	12	9
	3%	5%	2%	3%

- As shown in Table 1b, 45% of children attended a community ELC setting, 48% private, and 3% other (such as a special pre-school). 27% of children attended an ELC setting in a city/large urban area, 42% in a town, and 30% in a rural area. It is important to note that nationally, 75% of services are private and 25% community and this data implies that community schools are more likely to engage in AIM.
- We also know from cross-break analysis that in the case of community pre-schools, there is a statistically significant difference between the number of children supported by AIM in city/large urban areas (36%) and rural areas (51%). This is also true of

private pre-schools though the balance is reversed with more children supported by AIM in city/large urban areas than in rural ones (55% city/large urban and 41% rural). Overall, there is sufficient balance in the sample, though it is noted that the sample contains more private pre-schools supported by AIM than community ones.

Table 1: Type of disability/additional needs and current setting

	Type of disability/additional need					
Current Setting attended by the child	**Physical or sensory disability**	**Emotional Disturbance or Severe Emotional Disturbance (emotional and behavioural disorders)**	**Learning disabilities**	**Autism / Autistic Spectrum Disorders**	**Specific Speech and Language Disorder**	**Multiple main disabilities**
Total	92	36	54	495	96	124
	8%	3%	5%	43%	8%	11%
Community pre-school	27	11	18	118	34	36
	29%	31%	33%	24%	35%	29%
Private pre-school	21	9	13	115	17	29
	23%	25%	24%	23%	18%	23%
Other	0	1	0	28	1	2
	0%	3%	0%	6%	1%	2%
Mainstream primary school	40	15	13	135	31	37
	43%	42%	24%	27%	32%	30%
Special class in mainstream primary school	0	0	3	82	8	7
	0%	0%	6%	17%	8%	6%
Special education primary school	3	0	6	11	2	11
	3%	0%	11%	2%	2%	9%
Home education	0	0	0	0	1	0
	0%	0%	0%	0%	1%	0%

- In the survey, almost all respondents (99%, n=1143/1157) assented to a survey question about their child's additional needs. Table 3 shows that parent/carers identified these as follows: 43% of children had a main diagnosis of autism / autistic spectrum disorders; 8% had a physical or sensory disability; 8% a specific speech and language disorder; 5% learning disabilities; and 3% emotional and behavioural disorders. 11% had multiple main disabilities.
- Though the table does not include reference to this, it is important to note that 13% of parent/carers reported that their child had another type of disability not listed, and 7% had no diagnosis. This demonstrates that AIM support is reaching some children without the requirement of a diagnosis but that for the majority, a diagnosis is in place. The majority of children (over 70%) had more than one type of disability, but it

is reasonable to assume that where parent/carers are identifying a type of disability, it refers to the primary area of need.

- In relation to type of disability/additional need, there were statistically significant differences in reported attendance of a mainstream school. For example, 43% of children with physical disabilities (n=40) were attending a mainstream primary school compared to 27% with autism/autistic spectrum disorder (n=135). 17% of children (n=82) with autism were attending special classes in mainstream primary schools.

Table 2: County of pre-school and (% of open services with an ECCE contract)[24]

Total	**1157**				
Co Carlow	15		**Co Leitrim**	2	
	1%	(1.1%)		*%	(0.7%)
Co Cavan	25		**Co Limerick**	59	
	2%	(1.6%)		5%	(4.2%)
Co Clare	30		**Co Longford**	6	
	3%	(3.1%)		1%	(0.8%)
Co Cork	169		**Co Louth**	46	
	15%	(10.7%)		4%	(2.7%)
Co Donegal	39		**Co Mayo**	31	
	3%	(3.6%)		3%	(3%)
Co Dublin - Dublin City	85		**Co Meath**	52	
	7%	(9.2%)		4%	(4.4%)
Co Dublin - Dun Laoghaire Rathdown	29		**Co Monaghan**	13	
	3%	(4.2%)		1%	(1.5%)
Co Dublin - South County Dublin	85		**Co Offaly**	26	
	7%	(5.1%)		2%	(1.5%)
Co Dublin - Fingal	70		**Co Roscommon**	11	
	6%	(6.8%)		1%	(1.4%)
Co Galway	44		**Co Sligo**	11	
	4%	(6.4%		1%	(1.7%)
Co Kerry	42		**Co Tipperary**	37	
	4%	(3%)		3%	(3.9%)
Co Kildare	50		**Co Waterford**	28	
	4%	(4.3%)		2%	(2.3%)
Co Kilkenny	28		**Co Westmeath**	13	
	2%	(1.9%)		1%	(1.8%)
Co Laois	33		**Co Wexford**	51	
	3%	(1.9%)		4%	(3.1%)
Prefer not to say	2		**Co Wicklow**	25	
	*%			2%	(3.6%)

[24] Figures acquired from Pobal, November 2021

- As Table 3 shows, in relation to geographical distribution, all 29 counties were represented in the sample though there were variations in the respondent count for each, in most cases, relative to the % of services with an ECCE contract

5.3: Findings: Parent/carer perspectives on AIM overall

This subsection reports findings on parent/carers' experiences of AIM in terms of access, awareness, and impacts.

Parent/carer perspectives on access to their first choice of setting

Table 3: Whether the pre-school was parent/carers' first choice and type and setting of pre-schools

		Type of pre-school			Setting of pre-schools		
Whether pre-school was first choice	**Total**	**Community**	**Private**	**Other**	**City or large urban area**	**Town**	**Rural**
Total	1157	519	550	36	323	481	350
Yes	1024	458	488	34	288	413	320
	89%	88%	89%	94%	89%	86%	91%
No	118	55	57	2	31	61	26
	10%	11%	10%	6%	10%	13%	7%

- As shown in Table 4, children generally attended parent/carers' first choice of setting (89%) though this was more likely to occur in a rural setting (91%) than in a town (86%) with this difference being statistically significant.

Table 4: Whether the pre-school was parent/carers' first choice and main type of disability/additional need

	Main type of disability/additional need						
First choice, Yes/No	**Total**	**Physical or sensory disability**	**Emotional Disturbance or Severe Emotional Disturbance (emotional and behavioural disorders)**	**Learning disabilities**	**Autism / Autistic Spectrum Disorders**	**Specific Speech and Language Disorder**	**Multiple main disabilities**
Total	1157	92	36	54	495	96	124
Yes	1024	87	33	49	421	91	106
	89%	95%	92%	91%	85%	95%	85%
No	118	5	3	5	66	4	13
	10%	5%	8%	9%	13%	4%	10%

- As Table 6 shows, there were some statistically significant differences in terms of main type of disability/additional need and whether the setting was the parent/carers' first choice. Parent/carers of children with autism/autistic spectrum disorders were more likely to report that their child did not attend their first choice of ELC setting

(13%). Parent/carers of children with specific speech and language disorders (95%) were more likely to report that their child attended their first choice of setting than was the case with autism/autistic spectrum disorder (85%).

Free text comments by parent/carers on why their child was not enrolled in their first choice of pre-school

Common reasons for not enrolling their child at their first choice of pre-school included the pre-school's refusal because the child was not toilet trained, the preferred school having closed down, discontinuation of the placement by the pre-school, unsuitability of the environment for the child and hence a decision to change pre-schools by the parent/carer, non-engagement in AIM by the pre-school, no further capacity for an additional adult in the pre-school, no available places in autism specialist pre-school and negative attitudes to disability by pre-school staff.

- The pre-school refused to take the child because they were not toilet trained.

> 'As my child was in nappies, a number of the providers refused to take him even with AIM support. They stated various reasons including TUSLA guidelines'

- The pre-school setting was full or had closed down, sometimes due to COVID.

> 'All booked up.'
>
> 'My first choice was a creche up the road from me and the girl who runs it said they had no place available.'
>
> 'It closed down due to the COVID-19 pandemic.'

- The child had started at the parent/carer's first choice of provider, but the provider discontinued the placement.

> 'He had already been excluded from a previous creche setting and there were no spaces available locally - as such he spent months with no ECCE or pre-school place available - we were lucky to get him in anywhere.'
>
> 'My son was in [SETTING A] for his first year but they refused to take him for the second year because he has a chronic illness and wanted his teacher for another class. The Management were awful and just in it for the money. We went to [SETTING B] then. They were wonderful and so inclusive. I didn't send my son to [SETTING B] the first year because they only had an afternoon class available, and my son still had a nap at the end of the day.'
>
> 'Failed trial - they could not meet his needs and did not have AIM support programme.'
>
> 'We did and he was asked to leave so we went to the place he is now.'

- The child had started at the parent/carer's first choice of provider, but the setting turned out to be unsuitable in the parent/carer's view.

> 'Did enrol in first choice but it was indoors and too many children per child ratio at that age and not enough individual support, so he became destructive in class and had to pull out. The next pre-school was outdoors and was more suited to his sensory needs although he really needed an SNA then and did not get one till National School.'
>
> 'He was in a pre-school, and it didn't work out as he wasn't getting the support he needed, so I changed pre-school and he got all the proper support he needed.'

'At the time we were looking for autism-specific pre-schools and there were very few spaces available to us. We accepted a place in a school that was outside our community, on advice that no other similar space would be available in the area. We had misgivings about this school and were subsequently told it was not a good environment. Because we had accepted this place, we could no longer avail of government supports to fund an alternative place (if any became available). It was after this we learned about AIM. The pre-school we chose was a mainstream pre-school within our community and was, as it transpired, a better fit ultimately.'

'My child, who had an autism diagnosis, was denied AIM support at our pre-school of choice (a mainstream pre-school) as the assessor did not determine he was sufficiently impacted by his autism to require AIM support. This was despite him being non-verbal and heavily attached to a single teacher who could not move from the Montessori to the pre-school room with him. So, we had to remove him from this location and enrol him in a special school, operated using ABA principles, to gain AIM support there, as all enrolled children automatically receive this support.'

'We did but were not satisfied our child's needs were being met. I Felt my child was neglected. Had no support from aims or Pobal in that setting and so moved pre-school at year end. Very distressing time'

- The parent/carer wanted the child to attend a specialist pre-school for autism but there were no places available, or the child was not yet diagnosed.

'I would have liked an autism-specific pre-school who had experience in toilet training, PECS etc.'

'My son was suspected autism, but waiting for assessment and without a diagnosis was unable to get into an autism pre-school unit.' 'No places available in an autism pre-school at the time'

'There are no places available for children with Autism in most of the schools and pre-schools in Dublin Ireland'

- The pre-school refused/were unwilling to engage in AIM or knew little about it.

'The first-choice pre-school in our locality was not interested in applying for additional supports or AIM to help our child. They felt they could manage without extra help. We did not agree with this.'

'They made it very difficult and gave the impression they were not interested in supporting our child. It was the first year of AIM so they may not have been aware of what was involved but it was very disappointing at the time.'

'They were very reluctant to take my child, put up a lot of obstacles and were unaware of the AIM model.'

- The pre-school could not fit another additional adult in the pre-school room

'They refused to accept her as soon as they realised, she would require AIM support as they apparently could not fit another adult in their room. All other pre-schools were full.'

- Negative attitudes in pre-school

'It was a private pure Montessori school which would've been a perfect fit for my son who because of his ASD traits responded very well to pure Montessori - not a play-

based setting. The introduction appointment could not have gone worse with the teacher visibly uncomfortable by my son's balance impairment. In the end she said to another teacher: go and sit with that child before he stabs himself with a triangle. We promptly left and never heard from them again - not even to inform us that the school is not the right place for him. The second school I tried could not have been more welcoming, warm, open, and accepting - getting AIM support in place etc.'

'I had enrolled him in my first choice but due to the negative attitude towards my son and his challenges I moved him to another pre-school.'

'The previous provider I approached was not able to accommodate me when I informed them my son was autistic. They didn't say that was the reason, but it was obvious to me it was the reason'

Parent/carer awareness of AIM

Table 5: Whether parent/carers had heard of AIM before child started pre-school and Year first started

		Year first started				
Whether parent/carers had heard of AIM before child started pre-school	**Total**	**2016**	**2017**	**2018**	**2019**	**2020 or later**
Total	1157	159	179	257	324	238
Heard of but didn't know much about it	228	26	22	41	73	66
	20%	16%	12%	16%	23%	28%
Heard of and knew a bit about it	121	12	13	21	38	37
	10%	8%	7%	8%	12%	16%
Heard of and understood the offer	104	12	12	17	31	32
	9%	8%	7%	7%	10%	13%
No	693	105	131	177	178	102
	60%	66%	73%	69%	55%	43%
HAD HEARD OF AIM	453	50	47	79	142	135
	39%	31%	26%	31%	44%	57%
HAD NOT HEARD OF AIM	693	105	131	177	178	102
	60%	66%	73%	69%	55%	43%

- Table 6 shows that most parent/carers (60%) had not heard of AIM before their child started pre-school, but the general trend has been towards greater awareness of AIM. An example of this is the statistically significant differences between awareness in 2017 and 2020 onwards: In 2017, 73% (n=131) had not heard of AIM before their child started pre-school, compared to 43% (n=102) in 2020 or later, a statistically significant difference.
- The number of parent/carers who had heard of AIM and understood its offer before their child started pre-school was 8% in 2016 compared to 13% in 2020 or later where the difference is statistically significant when compared to the average of all other years (9%). This is more evidence of a positive trend in awareness, in a context where awareness is still low overall.

Table 6: Whether parent/carers had heard of AIM before starting pre-school and type of disability

Whether parent/carers had heard of AIM before starting pre-school	Main type of disability/additional need						
	Total	**Physical or sensory disability**	**Emotional Disturbance or Severe Emotional Disturbance (emotional and behavioural disorders)**	**Learning disabilities**	**Autism / Autistic Spectrum Disorders**	**Specific Speech and Language Disorder**	**Multiple main disabilities**
HAD HEARD OF AIM	453	44	9	24	167	36	62
	39%	48%	25%	44%	34%	38%	50%
HAD NOT HEARD OF AIM	693	48	27	29	323	58	61
	60%	52%	75%	54%	65%	60%	49%

- As Table 7 shows, when considering the main type of disability/additional need, parent/carers of children with autism/autistic spectrum disorders are significantly more likely not to have heard of AIM before starting pre-school (65%) than those with physical or sensory difficulties (52%) and multiple main disabilities (49%). Those parent/carers of children with multiple main disabilities (50%) (n=62) were significantly more likely to have heard of AIM before starting pre-school when compared to those with autism/autistic spectrum disorder (34%) (n=167).

Table 7: Whether parent/carers had heard of AIM before the child started pre-school and current setting

Whether parent/carer had heard of AIM before start at pre-school	Current Setting					
	Community pre-school	**Private pre-school**	**Other**	**Mainstream primary school**	**Special class in mainstream primary school**	**Special education primary school**
Total	319	280	33	363	105	41
HAD HEARD OF AIM	141	127	14	111	31	18
	44%	45%	42%	31%	30%	44%
HAD NOT HEARD OF AIM	174	151	19	250	71	23
	55%	54%	58%	69%	68%	56%

- Table 8 shows that, in relation to the child's current setting parent/carers were significantly more likely to report that they had heard of AIM before their child started pre-school if they were currently attending a community pre-school (44%) or private pre-school (45%) than if they were currently attending a mainstream primary school (31%) or a special class in a mainstream primary school (30%).

- We also know that there are no statistically significant differences in responses when considering the type of region that the pre-school is in (i.e., urban, town, rural).

Table 8: How parent/carers had heard about AIM before their child started pre-school and type/setting of pre-school

How parent/carers had heard about AIM before their child started pre-school	Type of pre-school				Setting of pre-school		
	Total	Community	Private	Other	City or large urban area	Town	Rural
Total	453	217	203	18	127	183	142
Another child in the family had been supported by AIM	31	16	12	1	4	13	14
	7%	7%	6%	6%	3%	7%	10%
Through friends/family	83	39	36	4	23	38	22
	18%	18%	18%	22%	18%	21%	15%
Through a support organisation	84	42	36	3	26	30	28
	19%	19%	18%	17%	20%	16%	20%
From a medical or care professional	107	53	47	6	31	39	37
	24%	24%	23%	33%	24%	21%	26%
From Government publications/adverts/websites	43	18	23	2	6	26	11
	9%	8%	11%	11%	5%	14%	8%
Social media / online support forums	54	21	29	1	15	26	13
	12%	10%	14%	6%	12%	14%	9%
Other	115	49	60	3	31	47	36
	25%	23%	30%	17%	24%	26%	25%

- As shown in Table 9, where parent/carers had heard of AIM before their child started pre-school, this was most commonly from a source named as ‘other’. Analysis of the ‘other’ sources of support shows that these were often visiting teachers, members of the early intervention team, therapists (e.g., speech and language, Occupational Therapy) and psychologists. Table 10 also shows that parent/carers were also accessing information about AIM from medical or care professionals (24%), support organisations (19%), family/friends (18%), social media/support forums (12%). A smaller number were accessing information via Government publications/adverts/websites (9%) or knew about AIM because another child had been supported by it (7%). There were differences in terms of type and setting of pre-school but generally, these were not statistically significant.

Table 9: How parent/carers who had not heard of AIM heard about it after their child started pre-school and year first started

Base: Had not heard of AIM	Year first started Total	2016	2017	2018	2019	2020 or later
Total	693	105	131	177	178	102
From pre-school staff/manager	526	77	95	143	144	67
	76%	73%	73%	81%	81%	66%
From another parent/carer	25	5	4	5	6	5
	4%	5%	3%	3%	3%	5%
From a support organisation	49	5	9	16	8	11
	7%	5%	7%	9%	4%	11%
From a medical or care professional	97	10	20	22	25	20
	14%	10%	15%	12%	14%	20%
From Government publications/adverts/websites	2	1	0	1	0	0
	%	1%	0%	1%	0%	0%
Social media / online support forums	9	2	1	2	1	3
	1%	2%	1%	1%	1%	3%
Other	22	7	8	0	4	3
	3%	7%	6%	0%	2%	3%

- Table 10 shows that where parent/carers first heard of AIM when their child started pre-school, this was generally from pre-school staff/manager (76%) or from a medical or care professional (14%). There is a rising trend in the identification of the pre-school staff/manager as the source of information about AIM (73% in 2016 to 81% in 2019) but with a statistically significant decrease if the child started pre-school in 2020 or later (66%). This is likely to be a consequence of COVID-19 and periods of closure in the sector during that time, though this cannot be confirmed by this data

Table 10: Awareness of disability prior to staring pre-school and year first started

Awareness of the child's disability prior to starting pre-school	**Total**	Year first started **2016**	**2017**	**2018**	**2019**	**2020 or later**
Total	1157	159	179	257	324	238
Yes	833	103	126	175	236	193
	72%	65%	70%	68%	73%	81%
No	264	47	42	65	75	35
	23%	30%	23%	25%	23%	15%

- Table 11 shows that most (72%) parent/carers who completed the survey were aware of their child's disability prior to the child starting pre-school, though this does not necessarily mean that there had been a formal diagnosis.
- Parent/carers of children with a diagnosis prior to entering pre-school, were more likely to know about AIM than those whose children did not have a diagnosis.

- This increased slightly where the child had started pre-school more recently, but changes were not generally statistically significant except in the case of 2020 or later (81% compared to 65% in 2016).

Table 11: Awareness of disability prior to starting pre-school and type of pre-school and setting

Awareness of child's disability prior to starting pre-school	Total	Type of pre-school			Setting of pre-school		
		Commu-nity	Private	Other[25]	City or large urban area	Town	Rural
Total	1157	519	550	36	323	481	350
Yes	833	392	384	26	215	338	278
	72%	76%	70%	72%	67%	70%	79%
No	264	104	135	8	94	113	57
	23%	20%	25%	22%	29%	23%	16%

Table 12: Awareness of disability prior to starting pre-school and type of disability/additional need

Awareness of disability prior to starting pre-school	Total	Main type of disability/additional need					
		Physical or sensory disability	Emotional Disturbance or Severe Emotional Disturbance (emotional and behavioural disorders)	Learning disabilities	Autism / Autistic Spectrum Disorders	Specific Speech and Language Disorder	Multiple main disabilities
Total	1157	92	36	54	495	96	124
Yes	833	84	16	44	334	60	114
	72%	91%	44%	81%	67%	63%	92%
No	264	8	16	6	135	28	8
	23%	9%	44%	11%	27%	29%	6%
Not sure	58	0	4	4	25	8	2
	5%	0%	11%	7%	5%	8%	2%
Can't remember	2	0	0	0	1	0	0
	%	0%	0%	0%	%	0%	0%

- Table 12 shows that there were few differences between awareness of their child's disability prior to pre-school and the type or location of the setting.
- As shown in Table 13, there were statistically significant differences by main type of disability with parent/carers of children with physical/sensory disability (91%) and multiple main disabilities (92%) being significantly more likely to be aware of their child's disability than those of children with other types of need (except for learning disabilities). This may be related to the age at which disabilities or additional needs are identified, and the way in which children with visible and/or complex disabilities may come under the auspices of HSE services at an earlier point.

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[25] Where the term 'other' is used to identify the type of pre-school that the child currently attends, where this is not a community or private provider. For example, children might attend HSE specialist pre-schools following a period of placement in AIM supported ECCE.

Parent/carers' awareness of AIM's universal and targeted supports

Table 15: Parent/carers' awareness of types of AIM support provided by the pre-school that the child attends/attended [26]

	AIM Levels[27]						
Whether aware/unaware of types of AIM Support in Pre-School	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Total	1157	1157	1157	1157	1157	1157	1157
Yes, to my child	500	415	427	403	292	150	745
	43%	36%	37%	35%	25%	13%	64%
Yes, but not to my child	47	43	55	38	82	52	66
	4%	4%	5%	3%	7%	4%	6%
NO	78	186	101	142	287	351	114
	7%	16%	9%	12%	25%	30%	10%
YES	547	458	482	441	374	202	811
	47%	40%	42%	38%	32%	17%	70%

- Table 15 shows that parent/carers' awareness of the types/levels of AIM support available at their pre-school was relatively low. For most levels, 40-50% of respondents answered that they did not know if that type of support was available for their own child, awareness of AIM support for children other than their own child was around 5-6% with awareness of L5 highest at 7%. Awareness of L6 was lowest for 'yes to my child' (4%), and for 'yes, but not to my child' (4%).
- The exception was for Level 7 support where 70% knew that this was provided at their child's setting (64% for own child and 6% for other children) which suggests either that the majority of responses were from parent/carers whose child received Level 7 support and/or that AIM support as a concept is synonymous with L7 support in respondents' general view. These findings may also indicate that parent/carers are most aware of those supports that are tangible and visible (such as additional adults and equipment/building alterations).
- From analysis of other cross-breaks, we also know the following about differences in parent/carer awareness between year first started, types of pre-schools, current setting, and main type of disability/additional need:

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[26] 'Don't know' responses removed.
[27] Key:
Level 1: Awareness of whether the pre-school provides an inclusion policy/named Inclusion co-ordinator.
Level 2: Awareness of whether the pre-school provides signposting of relevant information to parent/carers (on www.aim.gov.ie)
Level 3: Awareness of whether the pre-school have received disability and inclusion training.
Level 4: Awareness of whether the pre-school have access to expert educational advice from Early Years Specialists.
Level 5: Awareness of whether the pre-school have additional equipment or building alterations.
Level 6: Awareness of whether the pre-school have additional therapeutic/health interventions
Level 7: Awareness of whether the pre-school have an additional staff member to support a child.

- AIM Level 1. Awareness overall, 47%. Parent/carer awareness of Level 1 was highest in ‘other’ types of pre-schools (61%). Awareness of the presence of Level 1 as a support for own child was significantly higher in ‘other’ types of pre-school (61%) than in community and private pre-schools (42% and 44% respectively). Parent/carers were statistically significantly less likely to choose ‘don’t know’ when the setting was in a town (42%) rather than a rural location (49%). There were no statistically significant differences in terms of year first started, current location and main type of disability/additional need.
- Level 2: Awareness overall, 40%. In general, awareness of AIM Level 2 support was significantly lower in 2020 (34%) than it was for the average of all years (40%). Awareness of L2 support provided for own child was significantly higher in private pre-schools (39%) than in community pre-schools (32%) and a similar pattern was visible when aggregating ‘yes’ type responses (36% community pre-schools compared to 43% in private pre-schools). Generally, in city/large urban areas, awareness is significantly lower (35%) than in the case of settings in towns (42%). General awareness was similar across all types of disability/additional need (between 34-44%) and was lowest from parent/carers with children who had physical or sensory disabilities (34%) and autism/autistic spectrum disorders (38%). Responses to question B3 in the survey (for parent/carers who knew about AIM before they started pre-school), ‘How did you hear about AIM when your child started pre-school’ offers an insight into why this might be since 38% (n=18) of parent/carers of children with physical/sensory disabilities had heard about AIM from a medical or care professional compared to between 3% and 16% of children with other types of need.
- Level 3: Awareness overall, 42%. In relation to the year first started, parent/carers were significantly more likely to be aware of L3 in 2016 (50%) than in 2019 (41%) and 2020 or later (33%). The 2020 or later value is likely to be a result of COVID-19. There was a notable difference in the likelihood of responding with a ‘No’ type response to ‘Does your pre-school have/provide training on disability and inclusion’ if the pre-school was in a city/large urban area (12%) than if it was in a town (9%) or rural area (6%, n=21). When considering the current setting, the likelihood of choosing a ‘Yes’ type response was significantly higher if children were currently attending a mainstream primary school (46%) than if they were attending a community or private pre-school (37% and 38% respectively). Parent/carers of children with multiple main disabilities (46%) were more likely than those with autism/autistic spectrum disorders (36%) and those with emotional disturbance or severe emotional disturbance (22%) to be aware that the setting was providing this support for their child.
- Level 4: Awareness overall, 38%. The likelihood of responding with a ‘Yes’ type response to the question ‘Does your pre-school have/provide access to expert educational advice from an Early Years Specialist?’ was significantly more likely in 2016 (46%) than in 2020 or later (29%). The likelihood of being aware that the pre-school was getting support from an Early Years Specialist was significantly lower in city/large urban areas (30%) than in town ones (37%). Noting that there are low base numbers, there were indications that parent/carers of children currently attending pre-schools defined as ‘other’ were more likely not to know about L4 (12%, n=4) than those attending private (52%) or community (51%) pre-schools. Parent/carers of children with autism/autistic spectrum disorders, were most likely to answer ‘No’ to this question (17%) than all other categories but low base numbers in other categories meant that the significance of this difference was less discernible.

- Level 5: Awareness overall, 32%. The likeliness of knowing that AIM support was being provided for own child or another child was significantly higher if the year first started was 2017 (38% and respectively 47%) than in all other years. In 2017, the likelihood of choosing a 'yes' type answer to the question 'Does your pre-school provide have/provide equipment or building alterations?' was 47% in 2017 which was significantly higher than all other years. This value was significantly lower at 25% if the year first started was 2020 or later. This may be a result of COVID-19. Parent/carers in a community pre-school were significantly more likely to choose 'Don't know' (48%) for this survey question if their child was currently attending a community pre-school than if they were attending an 'other' pre-school, special class in a mainstream school (30%) or a special educational primary school (29%, n=12). Parent/carers of children with physical or sensory disabilities were significantly more likely to be aware that this support was being provided for their child (54%) than all other groups which is unsurprising since this is the group who have needs that are most tuned to what Level 5 provides. Parent/carers of children with autism/autistic spectrum disorder were more likely to answer 'no' to this question than all other groups.
- Level 6: Awareness overall, 17%. Where children's first year started was 2017, parent/carers were more likely to respond, 'don't know' to the question 'Does your pre-school have/provide additional therapeutic/health interventions?' than in all other years (45%). If the first year started was 2018, they were significantly more likely to answer 'No' (35%) than if the year of starting was 2020 or later (27%). Where the child currently attended a community pre-school, they were significantly less likely to answer 'No' (24%) than in the case of a private pre-school (32%) or 'other' type of pre-school. Parent/carers of children attending a special class in a mainstream primary school were significantly more likely to answer 'No' (41%) than parent/carers of children in community pre-school or 'other' types of pre-schools. Parent/carers of children currently attending a special class in a primary school were more likely to respond 'no' (41%) than parent/carers of children in a mainstream primary school (29%) or a community pre-school. It was also true that parent/carers of children in special classes in mainstream primary school were significantly more likely to answer 'don't know' to this question (43%).
- Level 7: Awareness overall: 70%. When responding to the question 'Does your pre-school have/provide additional staff member to support a child?' 64% of parent/carers responded 'yes, to my child' and 6% 'yes, but not to my child. Parent/carers whose children's year first started was 2020 or later, were significantly more likely to answer 'Yes, to my child' (71%) than those whose children's year first started was 2016 (58%) and 2018 (60%). The likelihood of selecting 'yes, to my child' was significantly greater in private pre-schools (68%) than it was in community pre-schools (61%) or 'other' pre-schools (61%). Parent/carers of children attending schools in city/large urban areas are significantly more likely to respond 'No' than those in town or rural areas. In relation to current setting parent/carers of children attending private pre-schools are significantly more likely to respond 'yes, to my child' than parent/carers of children attending community pre-schools (60%) or mainstream primary schools (62%). In terms of main type of disability/additional need and the response 'yes, to my child' there are differences as follows:
    - Physical or sensory disability: 91%, n=56
    - Emotional Disturbance or Severe Emotional Disturbance (emotional and behavioural disorders): 56%, n=20.

- Learning disabilities: 61%, n=33.
- Autism/autistic spectrum disorders: 66%, n=328.
- Specific speech and language disorder: 52%, n=50
- Multiple main disabilities: 73%, n=90

- From the above, it is notable that the parent/carers of children with multiple main disabilities are significantly more likely to answer ‘yes, to my child’ (73%) than parent/carers of children with specific speech and language disorders (52%) who are also less likely to answer ‘yes, to my child’ than all other groups.

To summarise, **parent/carers awareness of AIM before pre-school**

Most parent/carers (60%) had not heard of AIM before their child started pre-school, but the general trend has been towards greater awareness of AIM. An example of this is the statistically significant differences between awareness in 2017 and 2020 onwards: In 2017, 73% (n=131) had not heard of AIM before their child started pre-school, compared to 43% (n=102) in 2020 or later, a statistically significant difference.

The data suggests that awareness is higher when children enter AIM with a diagnosis since this is more likely to be in place where needs are visible (e.g., physical, or sensory) and/or complex. Indicative of this is the finding that parent/carers of children with autism/autistic spectrum disorders are significantly more likely not to have heard of AIM before starting pre-school (65%) than those with physical or sensory difficulties (52%) and multiple main disabilities (49%). Those parent/carers of children with multiple main disabilities (50%) (n=62) were significantly more likely to have heard of AIM before starting pre-school when compared to those with autism/autistic spectrum disorder (34%) (n=167). Responses to the question 'How did you hear about AIM when your child started pre-school' offer an insight into why this might be since 38% (n=18) of parent/carers of children with physical/sensory disabilities had heard about AIM from a medical or care professional compared to between 3% and 16% of children with other types of need.

The number of parent/carers who had heard of AIM and understood its offer before their child started pre-school was 8% in 2016 compared to 13% in 2020 or later where the difference is statistically significant when compared to the average of all other years (9%). This is more evidence of a positive trend in awareness, in a context where awareness is still low overall. Generally, parent/carers are reliant on the information and advice they receive from professionals they are already connected with, either through HSE services or within the pre-school when their child is enrolled and/or has begun to attend.

To summarise, **parent/carers awareness of AIM Levels 1-7**

- Level 1. Awareness overall, 47%
- Level 2: Awareness overall, 40%
- Level 3: Awareness overall, 42%.
- Level 4: Awareness overall, 38%.
- Level 5: Awareness overall, 32%
- Level 6: Awareness overall, 17%
- Level 7: Awareness overall: 70%.

Parent/carer awareness of AIM Level 7 was highest (70%) and generally low for other levels (1-5 around 40%). Awareness was lowest for AIM Level 6 (17%). It is notable that parent/carers of children with physical and sensory difficulties and multiple main disabilities were most likely to report that Level 7 support had been provided for their child (91%) when compared to other types of disability (73% to 52%) which may, in part, explain higher overall levels of satisfaction among this group.

Parent/carer perceptions of the impacts of AIM

Table 16: The extent to which parents/carers reported that AIM benefited their child and type of disability [28]

		Main type of disability/additional need					
Extent to which AIM benefited their child	**Total**	**Physical or sensory disability**	**Emotional Disturbance or Severe Emotional Disturbance (emotional and behavioural disorders)**	**Learning disabilities**	**Autism / Autistic Spectrum Disorders**	**Specific Speech and Language Disorder**	**Multiple main disabilities**
Total	1157	92	36	54	495	96	124
To a great extent	602	67	16	27	241	40	66
	52%	73%	44%	50%	49%	42%	53%
To some extent	230	18	6	13	99	20	23
	20%	20%	17%	24%	20%	21%	19%
To a small extent	120	4	3	7	58	12	14
	10%	4%	8%	13%	12%	13%	11%
Not at all	130	3	7	4	62	15	18
	11%	3%	19%	7%	13%	16%	15%
TO AN EXTENT	952	89	25	47	398	72	103
	82%	97%	69%	87%	80%	75%	83%
NOT AT ALL	130	3	7	4	62	15	18
	11%	3%	19%	7%	13%	16%	15%

- Table 16 shows that the majority (82%) of parent/carers felt participation in AIM had benefitted their child. In relation to benefits for the child, parent/carers of children who had physical or sensory disabilities (97%) were significantly more likely to report that AIM had benefited their child than parent/carers of children with emotional disturbance or severe emotional disturbance (69%). We also know that 73% believed that AIM support had also benefitted them/their partner, and 46% said it had benefitted other children in the family (although some respondents noted their child was an only child). Generally, there were no statistically significant differences in responses across types of pre-school (community, private, other) or setting for the pre-school (city-urban/town/rural) or type current setting (pre-school, mainstream primary school, special primary school).
- There were some statistically significant differences in terms of main type of disability/additional need. In relation to benefits to the child, parent/carers of children with physical or sensory disabilities were significantly more likely to choose the rating descriptor 'a great extent' when considering benefits (73%) when compared to all other types of additional need. Parent/carers of children with autism/autistic spectrum disorders (49%) and specific speech and language disorders (42%) were significantly less likely to choose the rating descriptor 'a great extent' than parent/carers of children with other types of need.

[28] The category 'Don't know' is removed because of small base size and the need to protect anonymity.

Free text comments for survey question: In what way has AIM benefited your child?

725 respondents (63%) provided answers to this question. Parent/carers were positive and often effusive about the benefits of AIM to their child. The following summarises and exemplifies the predominant themes which were mainly focussed on inclusion, participation, improved confidence and interaction, progress and development, quality of life and improved transition (in day-to-day life and in terms of the next stage of education).

- The child is included and can participate.

  > 'AIM meant he can go to pre-school'
  >
  > 'Without the AIM support he would not have been able to attend our local pre-school'
  >
  > '[NAME] has always been included in every aspect of his pre-school experience staff were released from pre-school when courses, training and observation sessions were offered - they always attended.'
  >
  > She was able to access the same early education as other children her age and the pre-school were hugely supportive in providing her with whatever scaffolding she needed to fully take part. Our experience was amazing.'
  >
  > 'By enabling my child to attend a mainstream playschool he is able to engage with neuro typical children and his play skills, concentration, focus and attention have all greatly improved, and he is just able to be a child and learn in a natural environment with additional support.'
  >
  > 'Aims has meant that my child can access pre-school along with his peers. He is supported when needed'
  >
  > '[NAME] has been able to participate in all activities and has been included in everything'
  >
  > 'A happier child and a child who feels included'
  >
  > 'Able to fit in more and be part of the overall group, especially during group activities. Extra pair of hands to calm him down when he gets upset. Try to help him regulate his emotions a bit more.'
  >
  > 'Able to go to his local pre-school with supports rather than a special pre-school.'
  >
  > 'AIMS has given my daughter a chance to attend pre-school like her peers even though she has obstacles in her way she is over coming these and hitting new milestones every day. Aims was the best thing to happen to us we couldn't have asked for a better person to mind our baby and be so hands on and in touch with her needs. We are blessed!! Thank you all.'
  >
  > 'Before she had AIM, she had severe anxiety around pre-school and would refuse to go, when I enforced it, she would wet herself or bite herself on the journey and would be very upset during the school morning, she didn't integrate with her peers and never said a spoken word in pre-school'

- AIM helped to improve the child's wellbeing and quality of life

  > 'My child may suffer from a condition where her bones are fragile until she is past the age of puberty, she is now 4.7 years old, up to the age of three she had seven fractures. I as her parent suffer the same condition and had sixty fractures by the age

of 14. Since the age of three my daughter has had no fractures. She played with all the other kids and is unaware of the difficulty. We keep her away from contact sports and direct her towards ballet, swimming, running, we are observant of her when playing with other kids, so as to be fully aware of any difficulty she may in counter. The AIM assistant has been great, I hope that she will not need it any longer as her ability to ambulate is very good now and the intervention was relieving as a parent. Thanks'

'The AIM supports my son received at pre-school has been invaluable. I strongly believe it gave him the best possible start to his educational journey and made a hugely positive impact to his life as a whole. He changed from a very anxious, socially distant child to one who can communicate with teachers and pupils in mainstream school. He enjoys his time there and feedback has been extremely positive regarding his behaviour. For instance, he has never been taken to the sensory room at primary school due to a melt down or outburst, he stays at his table and follows instruction from his teacher and plays independently in the school yard. He has been allocated an SNA at primary school but has shown himself to be self-sufficient in most things. The effort made by his AIM support teacher has changed his life and the lives of our whole family and I will be forever grateful.'

- The child has progressed in important areas, sometimes profoundly

'He has started speaking again. He is getting more involved playing with my other children. I can understand his needs now and his cues pre-meltdown and try and avoid if possible. He has become much more confident. He used to pull my finger and walk me to what he wanted and mutter or scream, now he speaks slowly, and I understand almost always what he wants. He has come on such an incredible amount thanks to his AIMS worker and the help and support she gives him in school. He is also counting and learning how to mix with his peers.'

'[NAME] was non-verbal. His speech improved immensely with the help he received during his ECCE years. His ability to communicate also improve his behaviour - with less frustration there was a great reduction in "meltdowns'.'

'1. This program has helped my child communicate and understand his transitioning from one subject to another by using visual aids at first and with one-on-one work and teachers' work he now has his few words and confidence to ask or tell you what he wants or needs. 2. He now understands how to understand, follow, and abide by the rules.'

'Additional 1:1 attention and time to enable my child to participate in activities like her peers. Giving my child the time to reach milestones at own pace while being encouraging and recognising where my child needs something else.'

'As she is non-verbal the extra support through AIM helped her be included and grow/develop. The pre-school not only was inclusive from the perspective of staff, but they instilled this in the children as well and they all looked after her and made sure she was able to take part in some small way. In turn this has really helped her grow/develop.'

- The child enjoys pre-school and is happy because people are responsive to individual needs

'[NAME] loves the swings & his additional worker takes him out to them or another room if he seems distressed overwhelmed in the room. Though he wouldn't be into

painting - he does tolerate paint in his hands & they try this to include him in a group activity.'

'Extremely happy in pre-school & coming on really well & loves his teachers.'

- Additional adult support made inclusion possible

'It benefited my child greatly. He received exceptional help and care from the staff in his pre-school. The staff were very observant and quick to identify areas that he needed extra help with and attention. Having the extra staff member appointed through AIM meant my son was able to participate and feel comfortable in the learning environment, without causing extra strain on the other staff members too. It meant that he received the extra attention that he required to learn, and I am very grateful to his pre-school staff for their early intervention and their observation skills.'

'My child needs 1:1 support to help him with his communication and overall safety. Without an Aims worker his development would have been limited. He has been able to achieve so much more with the support of the Aims worker which wouldn't' have been possible otherwise.'

- The child was able to attend mainstream school

'[NAME] was able to attend mainstream school with additional supports primarily because we were able to access supports at such an early age of her educational development through AIM.'

- The child was accepted and valued

'[NAME] was accepted for who she was, the staff didn't try to change her but enhance her strengths and encouraged her to overcome her weakness.'

'It made my child feel valued and included and that their needs were met.'

- Support from the pre-school regarding information and application for AIM

'AIM was a very new service when I applied for it through my son's pre-school. The manager of the pre-school informed me about AIM and encourage me to complete an application form with her help to apply for the service.'

- AIM meant that the school received specialist advice on how to support the child

'She was able to attend pre-school and they made a little sensory area for her to take time away from the class when she became overwhelmed. They sought advice from speech and language therapist to help improve communication.'

'My child can enter a class that is not full up with children, meaning it's not overwhelming. The noise level is low. There is plenty of choice for my child to choose what he wants to do. There are quiet areas for him to go to and special trained staff to deal with melt downs. My child has an intellectual disability and the pre-school hired higher level degree staff who have experience with ASD children. They provided more than AIM funded for. Specialists from *AsIAm* trained all staff and the class was changed to suit my child.'

- Early intervention without a diagnosis made a big difference

'Early intervention was key. We did not have to wait long for diagnosis and while waiting AIMS assessment was quick, so my child had to benefit of extra support while waiting for diagnosis.'

‘Early intervention was vital for my son and even though he still struggles he has come on so much due to the fact he was helped at such a young age.’

- Supported transitions

‘Eased transitions. Reduced staff-children ratio which made environment easier on my child. Increased inclusion for activities.’

‘It highlighted our child’s additional needs helping us to prepare for primary school and allowing us to get assessments done by an OT and educational psychologist early, helping to settle our child into school and to achieve his potential. In our case the pre-school, with our permission was able to highlight areas of concern with his junior infant teacher allowing for a co-ordinated and supportive transition to school.’

‘I will forever be grateful for the hard work and support from my child's pre-school. For their sensitivity and professionalism during the assessment process. The speedy nature in which they responded to ensuring my child was fully supported in a private mainstream pre-school setting. Having an AIM worker in place has changed my child's life. Early Intervention is so important and having an AIM worker in place ensured that all professionals involved could link in with them and provide a multidisciplinary approach to supporting my child. Prior to starting pre-school my child was preverbal and has recently started speaking, I put this down to the hard work of his AIM worker and their keenness to learn.’

‘It really helped my son to prepare for primary school and also prompted me to contact his primary school before he started, they then provided extra support with one-on-one lessons with a teacher who helps his speech. Also, the help he received in pre-school really helped his confidence in general’

Free text comments for survey question: In what way has AIM benefited you and your partner?

583 (50%) parents/carers responded to this question. The most common themes were reductions in anxiety, a trusting relationship with pre-school staff, support, and advice from the pre-school, knowing that support didn’t need to be fought for, seeing their child thrive, and seeing their child valued and accepted. Below, the predominant themes are summarised and exemplified.

- Peace of mind and less worry

‘The anxiety of being a parent of a child with needs is lessened when you feel your child is getting the chance to enjoy life as other kids their age is, to be happy and to reach their potential. These are such crucial years and set the scene for their future. Getting services for kids with special needs is so challenging - the AIM Process was a breath of fresh air in how efficient and effective it is. ‘

‘Worry free for parent, didn't have to constantly worry if he had a toilet accident and that if any problem arose, he was taken care of.’

‘When your child is happy and content it makes things much easier. Also, good to know that he is in a safe environment and is being looked after so well.’

‘When [NAME] is happier and safer and pre-school it gives us peace of mind.’

‘We were worried and stressed over a number of things and the pre-school staff eased a lot of worries we had, and also taught us different ways to approach things and to help our son acclimatise to pre-school. It also meant we felt very comfortable

that our son was receiving fantastic care by people who had a genuine interest in him being included in every-day pre-school activities.'

'We don't worry as much about him throughout the day. Previously we worried that his behaviour may harm him or another child but with the full attention of a staff member we know this can't happen. We are more relaxed, and happy because he is happier now.'

- Staff knowledge and expertise was reassuring and there was a trusting relationship with staff in the pre-school

  'We were reassured by the skills the staff had in dealing with my child's needs'

  'We were very familiar with the staff and a very good relationship of friendship and trust. They cared for [NAME] like family.'

- Parent/carers felt supported by staff in the pre-school and benefited from their communication and advice.

  'We were supported and informed about our child allowing us to get early interventions.'

  'We learned how to deal with [NAME] and how to avoid "triggers". For example, never saying no as this would generally lead to a meltdown.'

  'Without the support of the staff we would not have received the help we needed to get our son through, to have him assessed and to give him the best chance he deserved.'

  'We have a better understanding of my child's needs. The aims support worker gives us regular updates on how he's doing and what works for his behaviour at school, and then we feel more at ease that they know how to care for him. They include him in everything. We feel we wouldn't have got a diagnosis so quick if not for the aims support worker and the other staff.'

  'The staff in the school are very good and regularly keep us updated on our child's progress. They regularly give us ideas and tips to do at home with our child, so we are all working together in the same area of learning.'

- It felt positive to know that support didn't need to be fought for.

  'We were comfortable knowing that our son had all the extra supports he needed in pre-school. Our son has a very positive bond with his aims worker. It is very reassuring to know he has one-to-one support in pre-school when needed.'

  'We were worried and stressed over a number of things and the pre-school staff eased a lot of worries we had, and also taught us different ways to approach things and to help our son acclimatise to pre-school.'

- Seeing children's progress is very positive for parent/carers

  'We see a remarkable difference in our son. His understanding is increasing, and he is learning so much at school due to AIM support. Without it, he wouldn't have been able to stay in a pre-school setting.'

- Seeing their child being valued and accepted is very positive for parent/carers

We have seen our son being accepted, supported, and understood. AIM allowed us the flexibility to choose a pre-school in our community where our son could meet the children, he would eventually attend school with (and maybe make friends too!) It removed the feeling (somewhat!) of unrelenting pressure you have once the diagnosis is received, and thoughts of your child's education come to the fore. Allowing us to remain in our community in this way on a very practical level allows us a much more manageable routine which eases pressure on all of us.

- Knowing their child was being included is very positive for parent/carers

‘We had peace of mind that our daughter was included in all activities.’

‘Peace of mind knowing we sent her to the right place, we had an offer of an ASD specific pre-school but felt that her need would have been overshadowed by more profoundly autistic peers who also might have physical issues. The pre-school really stepped up and created an environment she could grow and learn’

- Seeing their child’s independence develop is very positive for parent/carers

‘We have a happy confident head strong child who does his own homework in second class and rely less and less on his SNA because of his starting off in the pre-school.’

Free text comments for survey question: In what ways has AIM benefited other children in your family?

339 (30%) parents/carers provided responses to this question though for some this was to note they only had one child. Below, the predominant themes are summarised and exemplified, and they focus on how AIM support has helped their other children to relate to their siblings, be in the same community spaces as their siblings, and experience a calmer, happier life at home. An important theme was to know how AIM had helped siblings develop more positive views on disability and how it had allowed parent/carers more time to spend with their other children.

- Home is calmer and happy for the family

‘A calmer and happier home’

‘That happiness to go to school in the morning makes life easier for his siblings trying to get out of the door at the same time.’

‘Because our son is happier going into school, the whole morning is easier and the atmosphere in the home is better and less tense than previously.’

‘{NAME] is learning new skills including play skills. He has the same routine as his sibling in morning, getting out to pre-school which is good for everyone.’

‘A less stressed parent makes a difference to everyone. It was the respite and knowing that I had 3 hours where he was happy, engaged and stimulated. I didn't have to feel guilty about getting my own errands done. I was able to shop and do the outside jobs that were so stressful when he was with me.’

- Siblings can attend the same setting

‘Allowed both my children to attend the same setting together and her SNA often did skills with both to build their relationship.’

‘As twins, they can attend the same setting.’

> ‘He has a little sister now and I know if he didn't have the support he had, he probably wouldn't have been able to handle a new baby, she will also be going to the same pre-school.’
>
> ‘His brother is now in the same room as him and she involves him too which is great for them both.’

- Siblings can have a better relationship with their brother/sister

> ‘Helped them to have a better relationship with him because AIM has taught him to interact.’
>
> ‘Since my child has been given assistance for ASD his engagement with his sibling and extended family has been enhanced. He has become more aware of his own emotional state and how to engage with others. Basically, his engagement with the overall world has been enhanced.’

- Siblings learning to see disability positively and to understand their sibling better

> ‘Allowed his brothers the chance to see him as part of their community, attending school like they did - despite his difficulties.’
>
> ‘Allowed his sibling to see that it's ok to have a disability.’
>
> ‘Better understanding of their sibling.’
>
> ‘His sister sees how strong-willed and determined he is, and she looks up to him now she’s moving out of pre-school in Sept.’
>
> ‘It has shown them that all children are and should be seen on their abilities as opposed to their disabilities.’

- More time to give other children

> ‘I guess we became more relaxed parents and had time to spend with my daughter. She had become slightly neglected during the diagnosis and trying to put therapies and appointments in place. We felt we had time to think of her again.’
>
> ‘It gave us some time to spend with our other child and it was lovely for them to see their brother having so much fun and enjoying pre-school.’

Free text comments for survey question: Why do you feel there was limited benefit?

Parent/carers who had reported little or no benefit from AIM, provided some explanations of why this was. Below, the predominant themes are summarised and exemplified, and they focus on how a lack of staff-training/expertise, poor communication and follow through, reluctance in pre-schools to engage with AIM, ineffective use of AIM support in the setting, and a difficult application process impacted negatively on potential benefits.

- Level 7 support was not provided and if it was, it made little difference because the individual was not well trained OR they were a shared resource rather than one to on.

> ‘[NAME] needed an aims assistant but it was explained to me that her pre-school already had their maximum of aims assistants, these girls were assigned to other children. They tried to help [NAME] but not specifically.’
>
> ‘Aim just provided an extra staff member in the pre-school room. The extra person had no specific special needs training. They were literally an extra body in the room.

It was a lucky co-incidence that one of the staff members who was in the room originally had experience in this area and took an interest in my child as she was a special needs teacher in [another country].'

'Because my child was granted AIM, but the pre-school could not fulfil the role during the school year, therefore my daughter without AIM support. There was an AIM support in the class supporting another child, so my daughter benefited a little from having a greater staff-student ratio however the other child required a high degree of care so essentially had the attention of his Aim worker most of the time.'

'His disability was largely speech-related and as such no support was offered to develop his significant speech disorder - also the additional member of staff was not directly allocated to our child, so we had to fight to get 15mins one on one speech development plans per day from the management of the setting. It prob[ably] benefited the other children more.'

- The setting did not understand inclusion and participation

'I don't feel they fully understood inclusion and the importance of including my child in play with other children. My child plays happily on her own but was not really encouraged to develop her play skills with other children - she has delayed speech and I don't feel attempts were made to overcome/work around this and help her develop these skills.'

'I feel that the resource employed was not special needs trained and neither are any of the other staff. COVID obviously added a complication as there may have been face-to-face meetings in normal circumstances which may have helped. There was no structure to the support, no template to follow, no agreed goals to aim for so I don't think we got what we hoped for out of this. The pre-school drove the application process but then did not take any responsibility for implementing support for [NAME].'

- The provider did not understand the principles of AIM and AIM resources are not being utilised well by the provider.

'[The} Creche has no understanding of how the AIM model should be implemented. They use it as a 1-1 with my son which limits his time with his peers and therefore limits his inclusion.'

'The resource is not being used to [its] full potential'

'Our child was paired with another child who was receiving AIM support thus I felt he was segregated from the others in the class. The other child had more complex needs than our child, e.g., our child was brought to a sensory room because the other child under the AIMs caring needed to go, so the girl assigned under AIMs in the class brought our child all the time too, and there was not a need.'

- The provider put up obstacles and their practices marginalised the child.

'He was completed excluded. Only allowed to attend pre-school for 1 hour, once a week, even though level 7 Aim support was in place for him. 'He was singled out.'

'My kids are no longer in the pre-school where we were offered AIM support, there was absolutely no support from staff or the pre-school organisers when it came to my kids (not blaming the staff, wasn't their fault, they didn't have the right training) not once did I meet with someone regarding the needs of my kids, the only difference was that they brought a member of staff from a different room (pre-school also had a

creche in the building, she also didn't have the correct training) and not once did I see her with either of my kids. The pre-school organisers avoided me throughout the time that my kids attended.'

- The application process was difficult and there were delays

> 'Support was awarded after several months of appeals and interaction with AIM CEO and Complaints Dept. As a result, Level 7 funding was awarded when my child was in Year 2 of ECCE and several months into the school year. This made it extremely difficult for the school to source an appropriately qualified person to fulfil the AIM role. My child benefitted from community disability services funding beginning in 2016. AIM was a gruelling and disheartening process.'

> 'We were awarded some equipment, took too long to get approved and then very slow to actually receive the equipment. Think it was March / April, so only had it for 2-3 months.'

> 'As stated, we had several months of debate with AIM involving The Ombudsman for Children and several local TDs. Thus, resulting in untold stress for myself and my husband.'

- There was not enough specialist advice or support

> 'There was not any assistance for my autistic son. The ECCE and AIM didn't send any specialised person to my son's school. There was a lady that came to evaluate him, and she was full of promises that [NAME] will receive support and then she said on the phone that we are not the only parents in Ireland and that the resources are limited so we are by ourselves.'

- COVID had an impact

> 'Due to Covid, the AIM rep was unable to visit / observe my child at community playschool. Therefore, he never received any support other than the support he receives from the staff at his community playschool on Level 4, no extra staffing was allocated for him to the pre-school which isn't good enough.'

- There is not enough feedback or communication from the pre-school or AIM, things are not always followed up and there are confusing mixed messages.

> 'Had no idea what this scheme was going to do for our little child. No information or feedback. He still came home every day with nothing extra gained from it.'

> 'Initially in [PLACE] it had a negative impact. We were constantly being involved in a battle between early intervention the creche and the AIMS coordinator to such an extent we didn't know who was telling us the truth and who was lying.'

> 'No feedback from AIM regarding how his schooling went week to week or end of year.'

> 'Very bad communication between AIMS and pre-school.'

- It was clear that the provider did not want the child there.

> 'They disliked my child and made it aware to me.'

> 'They complained about my son's behaviour almost every day after pre-school.'

To summarise, **parent/carers perceptions of AIM's overall benefits** were found to be as follows

Benefit of AIM to their child

- 82% of parent/carers reported that AIM benefited their child, with 52% reporting this to be to a great extent and 10% to a small extent. 11% reported no positive impact from AIM.
- There were some statistically significant differences in terms of main type of disability/additional need. In relation to benefits for the child, parent/carers of children who had physical or sensory disabilities (97%) were significantly more likely to report that AIM had benefited their child than parents of children with emotional disturbance or severe emotional distrurbance (69%).
- Parent/carers of children whose main type of need was a physical or sensory disability were significantly more likely to choose the rating descriptor 'a great extent' when considering benefits (73%) when compared to all other types of additional need. Parent/carers of children with autism/autistic spectrum disorders (49%) and specific speech and language disorder (42%) were statistically significantly less likely to choose the rating descriptor 'a great extent' than parent/carers of children with other types of need (average 52%).
- 725 respondents (63%) provided answers to the question, 'in what way has AIM benefited your child?' Parent/carers were positive and often effusive about the benefits of AIM to their child. Benefits described focussed on inclusion, participation, improved confidence and interaction, progress and development, quality of life and improved transition (in day-to-day life and in terms of the next stage of education).

Benefits of AIM to themselves and their partner, and to their other children

- 73% of parent/carers reported that AIM support had also benefited them and their partner, and 46% that it had benefited their other child/children.
- 583 (50%) parent/carers provided responses to the question, 'in what way has AIM benefited you or your partner?' Answers focussed on reductions in anxiety, a trusting relationship with pre-school staff, support, and advice from the pre-school, knowing that support didn't need to be fought for, seeing their child thrive, and seeing their child valued and accepted. Below, the predominant themes are summarised and exemplified.
- 339 (30%) parent/carers provided responses to this question though for some this was to note they only had one child. Answers focussed on how AIM support has helped their other children to relate to their sibling, be in the same community spaces as their sibling, and experience a calmer, happier life at home. An important theme was to know how AIM had helped siblings develop more positive views on disability and how it had allowed parent/carers more time to spend with their other children.

Parent/carers views on the impact of AIM on meaningful participation and inclusion

Table 17: Extent to which parent/carers agree with positive statements about their child's meaningful participation and inclusion.

Extent to which parent/carer agrees with statement about meaningful participation and Inclusion	**As a result of AIM, my child was able to interact socially more frequently with other children**	**As a result of AIM, my child was able to participate more meaningfully in pre-school activities**	**As a result of AIM, my child is more confident in educational settings**	**As a result of AIM, my child is more confident in interacting with peers**	**As a result of AIM, my child was able to attend a mainstream school**
	Total		Total	Total	Total
Total	1157	1157	1157	1157	1157
Strongly agree	562	562	470	412	415
	49%	49%	41%	36%	36%
Tend to agree	236	236	242	253	167
	20%	20%	21%	22%	14%
Neither agree nor disagree	121	121	169	201	183
	10%	10%	15%	17%	16%
Tend to disagree	64	64	70	87	74
	6%	6%	6%	8%	6%
Strongly disagree	107	107	113	116	144
	9%	9%	10%	10%	12%
AGREE	798	798	712	665	582
	69%	69%	62%	57%	50%
DISAGREE	171	171	183	203	218
	15%	15%	16%	18%	19%

- As Table 17 shows, the majority of parent/carers agreed with the following statements: as a result of AIM, my child was able to interact socially more frequently with other children (69%), as a result of AIM, my child was able to participate meaningfully in pre-school activities (69%), as a result of AIM, my child is more confident in educational settings (62%), as a result of AIM my child is more confident in interacting with peers (57%), as a result of AIM, my child was able to attend a mainstream primary school (50%).
- The two benefits reported most positively are related to social interaction (strongly agree, 49%) and meaningful participation (strongly agree, 43%).
- We also know that when categorising responses according to year of entry into AIM support, in the case of the statement, 'As a result of AIM, my child was able to participate meaningfully in pre-school activities', the tendency to disagree was significantly higher in 2016 (21%) compared to 2019 (11%).
- Disagreement with the statement 'As a result of AIM, my child was able to participate meaningfully in pre-school activities' was expressed by a minority of respondents overall (64% agree, 15% disagree) but disagreement was significantly more likely when children attended an ELC setting in a city or large urban area (19%) than when the setting was in a rural location (12%).

- Agreement with the statement 'As a result of AIM, my child was able to participate meaningfully in pre-school activities' was significantly more likely when the child had a physical or sensory disability (85%) when compared with all other types of additional need. It was significantly less likely for parents/carers to agree with this statement if children had autism/autistic spectrum disorder (66%).
- In the case of the statement, 'As a result of AIM, my child was able to attend a mainstream school', parent/carers were significantly less likely to agree in 2020 or later than in all other years (13% compared to an average of 19%). COVID 19 is likely to have had an impact here, given pre-school closures and possible disruption to services during a period of lockdown, but this is not clear from the data. Parent/carers of children attending an ELC setting in a city or large urban area (46%) were significantly less likely to agree with this statement than those whose children attended town (52%) or rural settings (53%).
- Agreement with the statement, 'As a result of AIM, my child was able to attend a mainstream school' was significantly more likely if children had physical and sensory disabilities (66%) than in the case of all other types of disability.

To summarise, parent/carers **perceptions of AIM's impact on full inclusion and meaningful participation**

- The majority of parent/carers agreed with the following statements: as a result of AIM, my child was able to interact socially more frequently with other children (69%), as a result of AIM, my child was able to participate meaningfully in pre-school activities (69%), as a result of AIM, my child was able to interact socially more frequently with other children (64%). as a result of AIM, my child is more confident in educational settings (62%), as a result of AIM my child is more confident in interacting with peers (57%), as a result of AIM, my child was able to attend a mainstream primary school (50%).
- The two benefits reported most positively are related to social interaction (strongly agree, 49%) and meaningful participation (strongly agree, 43%).
- Disagreement with the statement 'As a result of AIM, my child was able to participate meaningfully in pre-school activities' was expressed by a minority of respondents overall (64% agree, 15% disagree) but disagreement was significantly more likely when children attended an ELC setting in a city or large urban area (19%) than when the setting was in a rural location (12%).
- Agreement with the statement 'As a result of AIM, my child was able to participate meaningfully in pre-school activities' was significantly more likely when the child had a physical or sensory disability (85%) when compared with all other types of additional need. It was significantly less likely for parent/carers to agree with this statement if children had autism/autistic spectrum disorder (66%).
- In the case of the statement, 'As a result of AIM, my child was able to attend a mainstream school', parent/carers were significantly less likely to agree in 2020 or later than in all other years (13% compared to an average of 19%). COVID 19 is likely to have had an impact here, given school closures and possible disruption to services during a period of lockdown, but this is not clear from the data. Parent/carers of children attending an ELC setting in a city or large urban area (46%) were significantly less likely to agree with this statement than those whose children attended town (52%) or rural settings (53%).

Parent/carers views on the impact of AIM on their child's preparedness for school

Table 18: Parent/Carer views on the impact of AIM on their child's transition to school

Base: Parent/carers whose child has started school

Parent/carer views on how well prepared child was for learning on transition to school	**Total**
Total	509
Yes - my child was better prepared for the learning side of school because of AIM support	230
	45%
Yes - my child was better prepared for the social side of school because of AIM support	192
	38%
My child was less well prepared for school as a result of AIM support	20
	4%
AIM support did not make any difference to my child's transition to school	133
	26%
WELL PREPARED	318
	62%
NO DIFFERENCE/DON'T KNOW	180
	35%

- As Table 18 shows, the majority of parent/carers whose children had started school believed that AIM had supported their child's preparation for school (62%, n=318) though 26% (n=133) believed it had made no difference and 4% (n=20) believed AIM support had led to them being less prepared.
- When analysing cross-breaks, we also know that parent/carers of children attending a mainstream school are significantly more likely to report that AIM had a positive impact on transition to school (66%, n=239) when compared to those attending special classes in mainstream schools (58%, n=58).
- In the case of children with physical or sensory disabilities, parent/carers were significantly more likely to report that AIM had a positive impact on the transition to school (77%, n=33), than in the case of children with autism/autistic spectrum disorder (60%) and specific speech and language disorder (51%).

Table 19: Parent/carer views on how well prepared their children are for learning on transition to school <u>and</u> year first started in relation to AIM's impact

Base: Parent/carers whose child has started school[29]

Parent/carer views on how well-prepared child is for learning on transition to school		**Year first started**				
	Total	**2016**	**2017**	**2018**	**2019**	**2020 or later**
Total	509	135	149	173	45	7
Very well prepared for the learning aspects of school	175	55	57	48	14	1
	34%	41%	38%	28%	31%	14%
Fairly well prepared for the learning aspects of school	208	57	54	79	14	4
	41%	42%	36%	46%	31%	57%
Not very prepared for the learning aspects of school	67	13	21	24	8	1
	13%	10%	14%	14%	18%	14%
Not at all prepared for the learning aspects of school	43	6	12	18	6	1
	8%	4%	8%	10%	13%	14%
WELL PREPARED	383	112	111	127	28	5
	75%	83%	74%	73%	62%	71%
LESS WELL PREPARED	110	19	33	42	14	2
	22%	14%	22%	24%	31%	29%

- Table 19 demonstrates that parent/carers whose child had started school generally felt they were well prepared for learning (75% agree) though the indicator 'well prepared' is significantly more likely in 2016 (83%) than it is in 2018 (73%) and 2019 (62%).

[29] 'Don't know category removed because of low base numbers

Table 12: Parent/carer views on how well prepared their child was for starting school in relation to AIM's impact[30]

Base: Parent/carers whose child has started school				
Parent/carer views on how well prepared child was for learning on transition to school	**Total**	**Current Setting**		
		Mainstream primary school	**Special class in mainstream primary school**	**Special education primary school**
Total	509	363	105	41
Very well prepared for the learning aspects of school	175	141	25	9
	34%	39%	24%	22%
Fairly well prepared for the learning aspects of school	208	148	43	17
	41%	41%	41%	41%
Not very prepared for the learning aspects of school	67	44	17	6
	13%	12%	16%	15%
Not at all prepared for the learning aspects of school	43	21	15	7
	8%	6%	14%	17%
WELL PREPARED	383	289	68	26
	75%	80%	65%	63%
LESS WELL PREPARED	110	65	32	13
	22%	18%	30%	32%

- Table 20 shows that parent/carers of children who are currently attending a mainstream school are significantly more likely to agree that their children are well prepared for learning in school (80%, n=289) compared to those in special classes in mainstream schools (65%, n=32). Where children attend special education primary schools, parent/carers are also less likely to report that their children are well prepared for primary school (63%, n=26), though we note that base numbers are low.
- This group are also more likely to describe their children as 'very well prepared' (39%, n=141) than those attending special classes in mainstream schools (24%, n=25) and special educational primary schools (22%, n=9) but it is noted that base numbers for these two groups are low and hence conclusions must be drawn tentatively.

[30] 'Don't Know' responses removed

Table 21: Parent/carer views on how well prepared their child was for learning on transition to school and type of disability/additional need[31]

Base: Parent/carers whose child has started school								
Parent/carer views on how well prepared child was for learning on transition	**Total**	**Main type of disability/additional need**						
		Physical or sensory disability	**Emotional Disturbance or Severe Emotional Disturbance (emotional and behavioural disorders)**	**Learning disabilities**	**Autism / Autistic Spectrum Disorders**	**Specific Speech and Language Disorder**	**Multiple main disabilities**	
Total	509	43	15	22	228	41	55	
Very well prepared for the learning aspects of school	175	29	4	10	65	18	9	
	34%	67%	27%	45%	29%	44%	16%	
Fairly well prepared for the learning aspects of school	208	12	8	4	101	14	29	
	41%	28%	53%	18%	44%	34%	53%	
Not very prepared for the learning aspects of school	67	1	2	7	31	5	9	
	13%	2%	13%	32%	14%	12%	16%	
Not at all prepared for the learning aspects of school	43	0	1	1	21	3	7	
	8%	0%	7%	5%	9%	7%	13%	
WELL PREPARED	383	41	12	14	166	32	38	
	75%	95%	80%	64%	73%	78%	69%	
LESS WELL PREPARED	110	1	3	8	52	8	16	
	22%	2%	20%	36%	23%	20%	29%	

- Generally, parent/carers felt that their children were well prepared for learning in school as one of the impacts of AIM. Table 20 shows that parent/carers of children with physical or sensory disabilities were significantly more likely (95%, n=41) to report that their children were well prepared than in the case of all other types. We know that 67% (n= 29) of parent/carers of children with physical or sensory difficulties also selected this description and this was higher than those with autism spectrum

[31] Don't know responses removed

disorder (29%, n=65) and multiple main disabilities (16%, n=9) but cannot be reported as significant because of low base numbers in one of these groups.

- Those parent/carers of children with autism/autistic spectrum disorder were significantly less likely to choose this descriptor, ‘very well prepared for the learning aspects of school’ than was the average for this item (34%).

To summarise, parent/carers **perceptions of AIM’s impact on transition to primary school**

- The majority of parent/carers whose children had started school believed that AIM had supported the child’s preparation for school (62%, n=318) though 26% (n=133) believed it had made no difference and 4% (n=20) believed AIM support had led to them being less prepared.

- Parent/carers of children attending a mainstream school are significantly more likely to report that AIM had a positive impact on transition to school (66%, n=239) when compared to those attending special classes in mainstream schools (58%, n=58).

- Agreement with the statement, ‘As a result of AIM, my child was able to attend a mainstream school’ was significantly more likely if children had physical and sensory disabilities (66%) than in the case of all other types of disability.

- In the case of children with physical or sensory disabilities, parent/carers were significantly more likely to report that AIM had a positive impact on transition to school (77%, n=33), than in the case of children with autism/autistic spectrum disorder (60%) and specific speech and language disorder (51%).

- Parent/carers of children who are currently attending a mainstream school are significantly more likely to agree that their children are well prepared for learning in school (80%, n=289) compared to those in special classes in mainstream schools (65%, n=32).

- Where children attend special education primary schools, parent/carers are also less likely to report that their children are well prepared for primary school (63%, n=26), though we note that base numbers are low and cannot be claimed as statistically significant.

These data indicate that AIM is perceived by most parent/carers (62%) as having a positive impact on transition to school. For children with ‘visible’ disabilities (physical/sensory), these positive impacts are more prevalent than for those with ‘invisible’ disabilities (autism, speech and language disorder). They are also more prevalent where children are attending mainstream settings rather than special school settings.

This may indicate that for parent/carers, successfully accessing mainstream schools is one of their hopes for AIM support, though this needs further exploration in the wider evaluation.

Parent/carers views on the aspects of AIM that were most impactful

Table 22: Parent/carer views on the aspects of AIM that were most impactful, and year first started AIM[32]

Aspects of AIM that were most impactful	Total	2016	2017	2018	2019
Total	1157	159	179	257	324
Information or advice provided to pre-school staff on inclusion	299	47	52	76	74
	26%	30%	29%	30%	23%
Additional equipment so my child could participate fully in pre-school	167	33	35	29	42
	14%	21%	20%	11%	13%
Building alterations so my child could access pre-school	33	6	3	8	9
	3%	4%	2%	3%	3%
Therapeutic/health support so my child could access pre-school	58	14	8	17	11
	5%	9%	4%	7%	3%
Additional assistance (staff member)	722	86	111	168	201
	62%	54%	62%	65%	62%
Working in partnership with pre-school staff to support my child's inclusion	388	62	49	96	102
	34%	39%	27%	37%	31%
Other	30	2	7	7	9
	3%	1%	4%	3%	3%
A negative outcome	41	9	6	5	12
	4%	6%	3%	2%	4%
Made no difference to my child	120	20	18	31	34
	10%	13%	10%	12%	10%
A positive impact	914	119	150	209	249
	79%	75%	84%	81%	77%
No/negative/unknown impact	231	36	28	48	70
	20%	23%	16%	19%	22%

- Table 22 shows that the aspects of AIM that parent/carers felt had made the greatest difference to their child were: additional assistance (staff member) (62%); working in partnership with pre-school staff (34%); and the information or advice provided to pre-school staff on inclusion (26%). Numbers of parent/carers selecting L6 (therapeutic support) as having been most impactful are relatively low but similar to the numbers who had identified it as an AIM support that their children were receiving, which

[32] Don't know responses removed.

implies that when L6 is provided either within or outside AIM, it is deemed impactful by parent/carers.

- The number of parent/carers reporting that additional equipment had made the most difference was significantly higher in 2016 (21%, n=33) and 2017 (20%, n=35) than in later years.
- The number of parent/carers reporting that additional assistance had made the most difference was significantly lower in 2016 (54%) in comparison to the average for all years (62%) and this may be because of the growing number of dispensations made for Level 7 post 2016 (see subsection 2.5).

5.4: AIM Level 1: Universal supports and inclusive cultures in the pre-school

The following subsections (5.4 to 5.11) report findings related to each of the seven levels of AIM.

Table 23: Parent/carer views on the extent to which pre-school staff supported their child's full inclusion in pre-school activities and setting of pre-school

Pre-school staff support of full inclusion		Setting of pre-school		
	Total	**City or large urban area**	**Town**	**Rural**
Total	1157	323	481	350
To a great extent	712	182	293	234
	62%	56%	61%	67%
To some extent	251	78	103	70
	22%	24%	21%	20%
To a small extent	120	38	51	31
	10%	12%	11%	9%
Not at all	41	14	20	7
	4%	4%	4%	2%
Don't know	28	9	11	8
	2%	3%	2%	2%
Too early to say	5	2	3	0
	%	1%	1%	0%
TO AN EXTENT	1083	298	447	335
	94%	92%	93%	96%
NOT AT ALL	41	14	20	7
	4%	4%	4%	2%

- Table 23 shows that the majority of parent/carers (94%) believed that the staff in their child's pre-school setting supported their child's full inclusion. Where children attended a setting in a large city/urban area, parent/carers were less likely to agree that this was to 'a great extent' (56%) than if their children attended a setting in a rural area (96%).
- We also know that parent/carers of children currently attending a mainstream primary school chose the descriptor 'to a great extent' (66%) when considering how well staff supported their children's full inclusion at pre-school. This is more than those who had children who were currently in special classes in mainstream schools (50%) or in 'other' types of pre-school than private or community. Parent/carers of children with physical or sensory disabilities were significantly more likely to choose 'to a great extent' (73%) than if their children had emotional and behavioural disorders (53%) or autism/autistic spectrum disorders (57%).

Table 24: Parent/carer views on the extent to which pre-school staff supported their child's meaningful participation in pre-school activities and year first started and setting of pre-school[33]

		Year first started				Setting of pre-school		
Staff support for meaningful participation	**Total**	**2016**	**2017**	**2018**	**2019**	**City or large urban area**	**Town**	**Rural**
Total	1157	159	179	257	324	323	481	350
To a great extent	719	105	107	154	207	187	293	236
	62%	66%	60%	60%	64%	58%	61%	67%
To some extent	254	32	40	65	68	71	110	73
	22%	20%	22%	25%	21%	22%	23%	21%
To a small extent	116	19	19	22	32	37	50	29
	10%	12%	11%	9%	10%	11%	10%	8%
Not at all	38	2	9	14	7	16	18	4
	3%	1%	5%	5%	2%	5%	4%	1%
TO AN EXTENT	1089	156	166	241	307	295	453	338
	94%	98%	93%	94%	95%	91%	94%	97%
NOT AT ALL	38	2	N=	14	7	16	18	4
	3%	1%	5%	5%	2%	5%	4%	1%

- As Table 24 shows, the majority of parent/carers (94%) believe that the staff in their child's pre-school setting have supported their child's meaningful participation in pre-school activities, with 22% believing this to be to 'some extent', 10% to 'a small extent' and 3% not at all.
- Parent/carers of children attending settings in rural areas are significantly more likely to choose the descriptor 'to a great extent' (67%) than in the case of city/large urban areas (58%).
- We also know that where the child's current setting is a mainstream primary school, parent/carers are significantly more likely to report that staff in the pre-school supported the child's meaningful participation to an extent (96%) than in the case of an 'other' type of pre-school (85%, n=28) and a special class in a mainstream primary school (90%). Parent/carers of children with sensory or physical disabilities are significantly more likely to choose the descriptor 'to a great extent' (73%) than those with emotional and behavioural disorders (47%) and autism/autistic spectrum disorder (57%)

Table 25: The extent to which parent/carers agreed with positive statements about the inclusive culture at their child's pre-school[34]

[33] 'Don't know' and 'too early to say' removed.

[34] 'Don't know' responses removed.

Extent of agreement with statements about the inclusive culture at the pre-school	**I know who I should talk to at my child's pre-school about access and inclusion**	**Staff at my child's pre-school work with me as a parent/carer of a child with disabilities**	**Conversations with staff about my child's disability/ additional needs are handled sensitively**	**Conversations with staff about my child's disability/ additional needs take place quickly when needed**	**Staff at my child's pre-school recognise when my child requires additional support (e.g., from other professionals) and seek it.**	**Staff at my child's pre-school take the lead in making sure my child gets the most out of early childhood and care (ECCE) provision**	**There is an inclusive culture at my child's pre-school (this means my child is included in learning and socialising alongside other children)**
	Total						
Total	1157	1157	1157	1157	1157	1157	1157
Strongly agree	747	655	686	676	550	626	699
	65%	57%	59%	58%	48%	54%	60%
Tend to agree	208	252	251	255	257	238	270
	18%	22%	22%	22%	22%	21%	23%
Neither agree nor disagree	78	106	92	118	138	127	73
	7%	9%	8%	10%	12%	11%	6%
Tend to disagree	50	63	64	48	91	60	42
	4%	5%	6%	4%	8%	5%	4%
Strongly disagree	37	67	51	46	74	70	51
	3%	6%	4%	4%	6%	6%	4%
AGREE	955	907	937	931	807	864	969
	83%	78%	81%	80%	70%	75%	84%
DISAGREE	87	130	115	94	165	130	93
	8%	11%	10%	8%	14%	11%	8%

- As Table 25 shows, the majority of parent/carers agreed with the following statements: I know who to talk to at my child's pre-school about access and inclusion (83%); pre-school staff work with me (78%); conversations with staff about my child's disability/ additional needs are handled sensitively (81%) and take place quickly (80%); pre-school staff recognise when my child requires additional support and seek it (70%); pre-school staff take the lead in making sure my child gets the most out of ECCE provision (75%); and there is an inclusive culture at my child's pre-school (84%).

- We also know that parent/carers are less likely to agree with the statement 'There is an inclusive culture at my child's pre-school (this means my child is included in learning)' if their child attends a setting in an urban area (56%) compared to a town (60%) or a rural area (64%). This difference is statistically significant. Parent/carers also less likely to agree with this statement if their child attends an 'other' type of pre-school (64%) when compared to a community pre-school (88%) or a private pre-school (83%).

- When considering types of disability/additional need, most parent/carers agree with the statement (80-85%) though those with children who have physical and sensory difficulties are significantly more likely to agree (93%) than those with emotional disturbance (81%), learning disabilities (85%), autistic spectrum disorders (82%), specific speech and language disorder

(83%) and multiple main disabilities (85%). Parent/carers of children with autism/autistic spectrum disorders are significantly more likely to disagree with the statement (10%) than those with physical and sensory difficulties.

Table 26: Parent/carer awareness of staff in the setting who support inclusion (Inclusion Co-ordinator) and year first started and setting of pre-school

Parent/carer awareness of INCO	Year first started						Setting of pre-school		
	Total	**2016**	**2017**	**2018**	**2019**	**2020 or later**	**City or large urban area**	**Town**	**Rural**
Total	1157	159	179	257	324	238	323	481	350
Yes	178	26	24	46	48	34	43	87	48
	15%	16%	13%	18%	15%	14%	13%	18%	14%
No	171	27	26	45	46	27	55	63	53
	15%	17%	15%	18%	14%	11%	17%	13%	15%
Don't Know	808	106	129	166	230	177	225	331	249
	70%	67%	72%	65%	71%	74%	70%	69%	71%

- As shown in Table 26, awareness of the employment of an Inclusion co-ordinator (INCO) in the pre-school was relatively low among parent/carers with most (70%) being unsure.
- We also know that parent/carers of children whose pre-schools were in towns were significantly more likely to know about the INCO (18%) than those in city/large urban areas (13%) or rural areas (14%).

Associations between AIM Level 1 (inclusive culture) and parent/carer perceptions of AIM

Chi-Squared tests were used to further investigate the relationship between parent/carer experiences of communication and partnership and overall perception of AIM's impact.

- There is very strong evidence of an association between the perception that working in partnership has been beneficial and an overall positive view of the impact of AIM on the child. $p < .001$. The major departure from independence[35] is due to parent/carers who did not perceive partnership working as being a beneficial aspect of AIM were less likely to have a positive view of the impact of AIM on their child.

We conclude that where parent/carers experience partnership working, they are more likely to perceive AIM's impacts positively.

[35] When using the phrase 'departure from independence' we are referring to evidence of a relationship between one factor and another. This means that we cannot be absolutely certain that two factors are independent of one another, and that they have no influence over one another. In this case, there is a relationship between a perception of working in partnership with pre-school staff, and a positive perception of AIM overall.

5.5: AIM Level 2: Information for parents and carers

- As was shown in Table 15, 40% of parent/carers selected 'yes, to my child' when answering the survey question 'As far as you're aware, does your pre-school provide signposting to parent/carers about relevant information (on aim.gov.ie)? Statistically significant differences according to year started, type of setting and type of disability/additional need are considered under Table 22.
- It is important to restate the information or advice provided to pre-school staff on inclusion (26%) was one of the aspects of AIM support believed to be most impactful by parent/carers.

Associations between AIM Level 2 (information for parents and providers) and parent/carer perceptions of AIM

Chi-Squared tests were used to further investigate the relationship between parent/carer experiences of communication and partnership and overall perception of AIM's impact.

- There is very strong evidence of an association between the perception that AIM information or advice has been beneficial and an overall positive view of the impact of AIM on the child. $p = 0.167$. The major departure from independence is due to parent/carers who have perceived information or advice provided to/from pre-school staff as beneficial and having a positive perception of the impact of AIM on their child compared to those parent/carers who did not identify information to settings as a beneficial aspect of AIM.

This suggests that those who do not feel that a benefit of AIM was information for parents and providers (or did not select this as a beneficial aspect in the survey) were more likely to report that AIM had no positive impact on their child overall. These data provide support for the important role of AIM Level 2 in achieving the intentions of the policy.

5.6: AIM Level 3: A qualified and confident workforce

Table 27: Parent/carer views on how well-trained the staff in the pre-school setting are <u>and</u> setting of pre-school <u>and</u> current setting

Parent/carer views on how well-trained staff in pre-school settings are	**Total**	**Setting of pre-school**					**Current Setting**				
		City or large urban area	Town	Rural	Community pre-school	Private pre-school	Other	Mainstream primary school	Special class in mainstream primary school	Special education primary school	Home education
Total	1157	323	481	350	319	280	33	363	105	41	1
Very well	565	147	228	187	165	136	10	187	40	19	0
	49%	46%	47%	53%	52%	49%	30%	52%	38%	46%	0%
Well	337	88	159	90	90	78	5	113	35	12	0
	29%	27%	33%	26%	28%	28%	15%	31%	33%	29%	0%
Neither well nor poorly	113	39	38	36	27	26	10	29	15	5	1
	10%	12%	8%	10%	8%	9%	30%	8%	14%	12%	100%
Poorly	65	26	24	15	11	24	6	14	6	3	0
	6%	8%	5%	4%	3%	9%	18%	4%	6%	7%	0%
Very poorly	41	12	21	8	13	5	2	12	6	2	0
	4%	4%	4%	2%	4%	2%	6%	3%	6%	5%	0%
Don't know	36	11	11	14	13	11	0	8	3	0	0
	3%	3%	2%	4%	4%	4%	0%	2%	3%	0%	0%
WELL	902	235	387	277	255	214	15	300	75	31	0
	78%	73%	80%	79%	80%	76%	45%	83%	71%	76%	0%
POORLY	106	38	45	23	24	29	8	26	12	5	0
	9%	12%	9%	7%	8%	10%	24%	7%	11%	12%	0%

- Table 27 shows that most parent/carers (78%) believe staff at their child's pre-school are well-trained. This is lower in urban areas (73%) than in town (80%) or rural (79%) areas. Where children were currently attending a mainstream setting, parent/carers were more likely to describe pre-school staff as well trained (83%) than in other types of current setting. Pre-school settings described as 'other' achieved lower ratings (43%) compared to other types of current settings. All of these differences are statistically significant.

  We also know that parent/carers of children with autism/autistic spectrum disorder were least likely to describe pre-school staff as well-trained than all other types of disability/learning difficulty (73%). Parent/carers of children with physical and sensory difficulties were the most likely to describe pre-school staff as well-trained (87%) when compared to autism/autistic spectrum disorder (73%) and emotional and behavioural disorders (72%, n=26).

Associations between AIM Level 3 (staff development) and parent/carer perceptions of AIM

Chi-Squared tests were used to further investigate the relationship between parent/carer experiences of communication and partnership and overall perception of AIM's impact.

- There is very strong evidence of an association between the perception of staff being well trained and an overall positive view of the impact of AIM on the child. $p < .001$
- There is strong evidence of an association between the perception that staff are well trained and the reported main areas for disability. $p = 0.037$. The major departure from independence is due to parent/carers of children with ASD being more likely to report that the practitioners in the setting are poorly trained than parent/carers of children with other main types of disability. (Observed number = 64, expected 50.8)
- There is very strong evidence of an association between the perception that staff are well trained, and the following being perceived as being beneficial:
    - Information or advice provided to pre-school staff on inclusion
        - $p < 0.001$
        - 98% of parent/carers who perceived information to staff as being a beneficial aspect of AIM felt that staff were well trained.
    - Additional equipment so my child could participate fully in pre-school
        - $p = 0.009$
        - 95% of parent/carers who perceived equipment as being a beneficial aspect of AIM felt that staff were well trained. (It is important to note that 75% of the total surveyed did not identify equipment, but still felt staff were well trained)
    - Additional assistance (adult in the room)
        - $p < 0.001$
        - 62% of all who completed the survey felt that additional assistance was beneficial, and that staff were well trained, whilst 96% of those who felt that additional assistance was a beneficial aspect felt that staff were well trained.
    - Working in partnership with pre-school staff to support my child's inclusion
        - $p < 0.001$
        - 36% of all who completed the survey felt that additional assistance was beneficial, and that staff were well trained, whilst 98% of those who felt that additional assistance was a beneficial aspect also felt that staff were well trained.
    - Other, $p=0.6$ not significant
    - Negative outcome
        - $p < 0.001$
        - Only 1.6% of all who completed the survey felt that AIM support had a negative outcome, and that staff were poorly trained, whilst 48% of those who felt that AIM support had a negative outcome also felt that staff were poorly trained (the exact count is much higher than statistically expected) (nb 52% felt they were well trained)
    - Made no difference to my child
        - $p < 0.001$
        - Only 4% of all who completed the survey felt that AIM support made no difference to their child and that staff were poorly trained, whilst 52% of those who felt that AIM support made no difference to their child also felt that staff were poorly trained, this is a higher count than would be expected(It is important to note that 48% felt they were well trained).

These data demonstrate that from the perspective of parent/carers, AIM is regarded as more impactful when they perceive that pre-school staff are well-trained. Where the observation is that practitioners are poorly trained, parent/carers are more likely to perceive that AIM had made no difference. This supports the importance of integrating continuous professional development into AIM, since it emerges that having the supports in place is not a guarantee of impact since much may rely on how well practitioners can make use of those supports to achieve inclusive outcomes.

To summarise, **parent/carers perceptions of AIM** for each level of its universal supports were found to be as follows:

AIM Level 1:

- The majority of parent/carers (94%) believed that the staff in their child's pre-school setting supported their child's full inclusion. Where children attended a setting in a large city/urban area, parent/carers were less likely to agree that this was to 'a great extent' (56%) than if their children attended a setting in a rural area (97%).
- Parent/carers of children currently attending a mainstream primary school chose the descriptor 'to a great extent' (66%) when considering how well staff supported their children's full inclusion at pre-school. This is more than those who had children who were currently in special classes in mainstream schools (50%) or in 'other' types of pre-school than private or community.
- Parent/carers of children with physical or sensory disabilities were significantly more likely to choose 'to a great extent' when describing how well staff supported their child's inclusion (73%) than if their children had emotional and behavioural disorders (53%) or autism/autistic spectrum disorders (57%).
- Parent/carers of children attending settings in rural areas are significantly more likely to choose the descriptor 'to a great extent' (67%) than in the case of city/large urban areas (58%). Parents/carers are less likely to agree with the statement 'There is an inclusive culture at my child's pre-school (this means my child is included in learning' if their child attends a setting in an urban area (56%) compared to a town (60%) or a rural area (64%). This difference is statistically significant.
- When asked to agree/disagree with positive statements about the inclusive culture at their child's pre-school, 83% agreed. Parents/carers are less likely to agree with the statement 'There is an inclusive culture at my child's pre-school (this means my child is included in learning' if their child attends a setting in an urban area (56%) compared to a town (60%) or a rural area (64%). This difference is statistically significant. Those with children who have physical and sensory difficulties are significantly more likely to agree (93%) than those with emotional and behavioural disorders (81%), learning disabilities (85%), autistic spectrum disorders (82%), specific speech and language disorder (83%) and multiple main disabilities (85%). Parent/carers of children with autism/autistic spectrum disorders are significantly more likely to disagree with the statement (10%) than those with physical and sensory difficulties.
- Where parent/carers had experienced partnership working, they were more likely to perceive AIM's overall impacts positively.

AIM Level 2:

- 40% of parent/carers selected 'yes, to my child' when answering the survey question 'As far as you're aware, does your pre-school provide signposting to parents about relevant information (on aim.gov.ie)?
- Where parent/carers did not select AIM Level 2 as an aspect of AIM that was beneficial, they were more likely to report that AIM had no positive impact on their child overall. This illustrates that AIM Level 2 makes an important contribution to positive perceptions of impact.

AIM Level 3:

- Most parent/carers (78%) believe staff at their child's pre-school are well-trained, although this is lower in urban areas (73%) than in town (80%) or rural (79%) areas. Where children were currently attending a mainstream setting, parent/carers were more likely to describe pre-school staff as well trained (83%) than in other types of current setting
- We also know that parent/carers of children with autism/autistic spectrum disorder were least likely to describe pre-school staff as well trained than all other types of disability/learning difficulty (73%). Parent/carers of children with physical and sensory difficulties were the most likely to describe pre-school staff as well trained (87%) when compared to autism/autistic spectrum disorder (73%) and emotional and behavioural disorders (72%, n=26).
- From the perspective of parent/carers, AIM is regarded as more impactful when they perceive that pre-school staff are well trained. Where the observation is that practitioners are poorly trained, parent/carers are more likely to perceive that AIM had made no difference. This supports the importance of integrating continuous professional development into AIM, since it emerges that having the supports in place is not a guarantee of impact since much may rely on how well practitioners can make use of those supports to achieve inclusive outcomes.

5.7: AIM Level 4: Expert early years educational advice and support

Table 13: Contact with Better Start Early Years Specialists among parent/carers who had heard of AIM before starting pre-school.

Base: Heard of AIM *Contact with Better Start Early Years Specialist*	**Did you and/or your pre-school have any contact with Better Start Early Years Specialists when applying for a pre-school place for your child?**	**Did your child's pre-school access information/advice from an Early Years Specialist for your child?**
	Total	
Total	453	453
Yes	108	190
	24%	42%
No	178	68
	39%	15%
Don't know	167	195
	37%	43%

- Table 28 shows that, for those parent/carers who had heard of AIM before starting pre-school, just under a quarter (24%) of parent/carers said they/the pre-school had had contact with a Better Start Early Years Specialist when applying for a pre-school place (39% had not, and 37% said they did not know). Differences between types of pre-school, type of setting, current setting and type of disability were small and not statistically significant.

- Two-fifths of parent/carers (42%) said the pre-school had accessed information/advice from an Early Years Specialist.

Table 14: Main reasons for seeking additional support (Levels 4-7)

Base: Contacted Better Start or pre-school accessed support from an Early Years Specialist

Main reasons given for seeking additional support through AIM	**Total**
Total	213
My child needed additional classroom support (e.g., an additional staff member to support him/her)	144
	68%
I felt my child needed additional support	132
	62%
Staff at the pre-school suggested contacting Early Years Specialists	64
	30%
My child needed additional therapy or health support to access pre-school	28
	13%
My child needed additional equipment to access pre-school	27
	13%
I wanted more information/advice on inclusion	17
	8%
Other	8
	4%

- Table 29 shows that for those parent/carers who had indicated that they or the pre-school had accessed support from an Early Year Specialist (EYS) (base size n=213) the main drivers were: parent/carers feeling their child needed additional support (62%); staff at the pre-school suggesting contacting Early Years Specialists (30%), and the child needing additional classroom support (68%).
- There were no statistically significant differences between groups according to the first year started, type of pre-school, location, or type of disability but it is notable that 41% (n=22) of parent/carers of children attending mainstream school were more likely to indicate that the pre-school suggested contacting an Early Years Specialist than other groups.

Table 30: Whether parent/carers had heard of the Access and Inclusion Profile and if so, whether they were involved in completing one

Whether Parent/carers had heard of an Access and Inclusion Profile and if they were involved in completing one	**Have you heard of the Access and Inclusion Profile**	**When 'yes', were you involved in completing an Access and Inclusion Profile,**
	Total	**Total**
Total	1157	1157
Yes	558	655
	48%	57%
No	492	241
	43%	21%
Don't know	107	261
	9%	23%

- As Table 30 shows, there was relatively low awareness of the Access and Inclusion Profile. 48% of parent/carers had heard of an Access and Inclusion Profile and of those 57% were involved in completing one for their child and 43% were not, with 9% answering 'don't know. This was surprising since the Access and Inclusion Profile is the primary mechanism by which parent/carers are routinely involved in identifying their child's needs for support and for giving consent for application for additional support or for information sharing between the EYS and HSE. Applications cannot be processed until parental consent (as recorded on the Access and Inclusion Profile) is confirmed.
- We also know that parent/carers of children with autism/autistic spectrum disorder were less likely than parent/carers of children with other types of disability/additional need to answer 'yes' when asked if they were involved in completing an Access and Inclusion Profile (26%). Parent/carers in community pre-schools (51%) were less likely than parent/carers in private pre-schools (61%) to answer 'yes' to this question.

Table 31: Parent/carers experiences of support from early years specialists

Base: Were involved in completing an Access and Inclusion profile for their child

The extent to which parent/carers agree with Statements about their experience of EYS support	**The process of accessing support from EYS was straightforward**	**I did not have to wait a long time for support**	**The advice was relevant to my child's needs**	**Staff at my child's pre-school supported me through the process**	**My child was treated like an individual**	**My child was allocated the equipment he /she needed to access learning at pre-school**
	Total					
Total	655	655	655	655	655	655
Strongly agree	290	290	363	462	411	278
	44%	44%	55%	71%	63%	42%
Tend to agree	201	201	160	110	133	113
	31%	31%	24%	17%	20%	17%
Neither agree nor disagree	54	54	57	41	43	115
	8%	8%	9%	6%	7%	18%
Tend to disagree	48	48	23	17	21	33
	7%	7%	4%	3%	3%	5%
Strongly disagree	46	46	43	22	31	44
	7%	7%	7%	3%	5%	7%
Don't Know	14	14	8	2	14	63
	2%	2%	1%	%	2%	10%
Too early to say	2	2	1	1	2	9
	%	%	%	%	%	1%
AGREE	491	491	523	572	544	391
	75%	75%	80%	87%	83%	60%
DISAGREE	94	94	94	39	52	77
	14%	14%	14%	6%	8%	12%

- As Table 31 shows, the majority of parent/carers agreed that the process of accessing support from an Early Years Specialist was positive (between 75% and 85%). Most parent/carers also indicated that their child was treated like an individual (83%) and that they were well supported by the pre-school staff in the process of engaging with the EYS (87%).
- In relation to L5 support gained through support from the EYS, 60% of parent/carers report that their child was allocated the equipment they needed with 12% noting that this was not the case.

- We also know that in terms of experiencing the process as straightforward, respondents were more likely to choose the descriptor ‘strongly agree’ (54%) in 2020 or later than they were in previous years. Parent/carers of children with specific speech and language disorders were the most likely to agree that the process was straightforward overall and there was a statistically significant difference between this group (86%) and those with multiple main disabilities (64%) who were also most likely to disagree that the process of accessing EYS support was straightforward (64%).

- In relation to the waiting time for support, parent/carers were significantly more likely to agree with the statement ‘I did not have to wait a long time for support’ in 2020 or later (80%) when compared to previous years.

- In relation to the statement ‘staff at my child’s pre-school supported me through the process’, 89% of parent/carers agreed. Parent/carers of children with physical or sensory difficulties are significantly more likely to agree with this statement (98%) than those with autistic spectrum disorders (87%), speech and language disorder (89%) or multiple main difficulties (86%) but overall, the picture is of a positive experience.

- In relation to the statement, ‘The advice and support was relevant to my needs’, parent/carers of children attending pre-schools in city/large urban areas were significantly less likely to agree (73%) than those in towns (83%) or rural settings (82%). This was also the case if children were currently attending a mainstream primary school (84%) compared to all other types of current setting.

- For the statement, ‘My child was treated as an individual’, the picture is positive across categories and groups. However, parent/carers of children with multiple main disabilities were more likely to disagree with this statement (15%, n=11) than parent/carers of children with physical and sensory difficulties (3%, n=2) and all other types of disability/additional need.

- When considering the statement, ‘my child was allocated the equipment he/she needed to access learning at pre-school’, 60% of parent/carers agreed. Parent/carers of children currently attending mainstream school were more likely to agree with this statement (67%) than was the case with all other types of current setting. Parent/carers of children with physical/sensory disabilities were more likely to agree with this statement (80%) than those with autism/autistic spectrum disorders (56%), specific speech and language disorders (63%) and multiple main disabilities (57%). Parent/carers of children with autism/autistic spectrum disorder were significantly less likely to agree with this statement (15%) than those with physical and sensory disabilities (3%, n=2). This may be because children with physical/sensory difficulties are most likely to have needs that are served by Level 5 type support.

Table 32: Types of AIM support applied for by parent/carers/pre-school for their child and year first started and type of pre-school

	Year first started						Type of pre-school		
	Total	2016	2017	2018	2019	2020 or later	Community	Private	Other
Total	1157	159	179	257	324	238	519	550	36
Additional equipment so my child could participate fully in pre-school	220	43	50	41	49	37	94	113	6
	19%	27%	28%	16%	15%	16%	18%	21%	17%
Alterations to the pre-school building so my child could access learning/play at pre-school	45	7	7	10	15	6	17	24	3
	4%	4%	4%	4%	5%	3%	3%	4%	8%
Alterations to the toilet/changing area so my child could access pre-school	69	10	12	21	15	11	35	30	1
	6%	6%	7%	8%	5%	5%	7%	5%	3%
Therapeutic support so my child could access pre-school	63	15	10	15	13	10	26	33	3
	5%	9%	6%	6%	4%	4%	5%	6%	8%
Additional assistance in pre-school for my child (an additional staff member or reduced staffing	958	120	157	210	262	209	415	477	28
	83%	75%	88%	82%	81%	88%	80%	87%	78%
Don't know / can't remember	95	21	8	20	31	15	59	26	3
	8%	13%	4%	8%	10%	6%	11%	5%	8%

- Table 32 shows that from the perspective of parent/carers, most applications had been for additional assistance (L7) in the pre-school (83%) followed by additional equipment (L5) (19%).
- Applications for additional equipment were significantly higher if the year first started was 2016 (27%) and 2017 (28%) than they were in subsequent years.
- Applications for additional assistance were significantly higher in 2020 or later than in 2016 (75%) and 2019 (81%).
- We also know that applications for Level 7 were highest in private pre-schools (87%) when compared to community pre-schools (80%). This was also true when children were currently attending special classes in mainstream primary schools. (90%) when compared to community pre-schools (80%) and mainstream primary schools (81%).
- The likelihood of application for L5 support was highest for children with physical and sensory difficulties (additional equipment, 63%, alterations to building, 20% (n=18), alterations to toilet changing room, 18%, n=17). For children with sensory and physical difficulties and specific speech and language difficulties, there was less likelihood that the applications would be for Level 7 (72%, n=66 and 70%, n=67 respectively).

Table 33: Parent/carer reports on the outcome of applications for AIM support (Level 4-7) and year first started and type of pre-school

	Total outcomes of application	2016	2017	2018	2019	2020 or later
Total	1157	159	179	257	324	238
The Early Years Specialists provided information or advice to pre-school staff on inclusion (L4)	235	47	45	50	62	31
	20%	30%	25%	19%	19%	13%
My child was allocated additional equipment so they could take part fully in pre-school (L5)	145	31	34	21	35	24
	13%	19%	19%	8%	11%	10%
Alterations were made to the pre-school building so my child could access learning/play at pre-school	35	7	4	7	13	4
	3%	4%	2%	3%	4%	2%
Alterations were made to the toilet/changing area so my child could access pre-school (L5)	50	10	7	16	11	6
	4%	6%	4%	6%	3%	3%
Therapeutic/health support was provided to my child access pre-school (L6)	32	10	3	10	6	3
	3%	6%	2%	4%	2%	1%
Additional assistance was provided in pre-school to my child (an additional staff member or reduced (L7)	807	97	135	181	222	172
	70%	61%	75%	70%	69%	72%
Other	77	8	13	22	19	15
	7%	5%	7%	9%	6%	6%
No outcome yet	45	4	1	10	16	14
	4%	3%	1%	4%	5%	6%
Don't know/ can't remember	81	14	8	24	21	14
	7%	9%	4%	9%	6%	6%
OUTCOME	972	135	159	208	271	199
	84%	85%	89%	81%	84%	84%

- Table 33 shows that from the parent/carer perspective, the provision of additional assistance was the most frequent type of outcome after an application (70%) followed by EYS information and advice (20%) and allocation of additional equipment (20%). Receipt of L5 supports (additional equipment and building alterations) was significantly more likely in the 2016 (19%) and in 2017 (21%) than in later years which may explain why parent/carer awareness is higher in 2016. L6 support (therapeutic/health), was reported as being an outcome of an application in 3% to 6% of cases though there were no significant differences according to the year of application and it has been noted that parent/carers may be reflecting on referrals they have made themselves or through a health professional rather than an EYS supported referral in AIM.

- The majority of parents/carers reported that applications have resulted in an outcome (84%) though 7% are not sure and 4% are awaiting an outcome.

- We also know that there are small differences among types of disability, but the statistically significant differences indicate that children with physical and sensory difficulties are more likely to receive Level 5 supports than is the case with other types of disability and least likely to have additional assistance (60% compared to an average of 70%). For this group it is also more likely for parent/carers to report that their application has resulted in provision of AIM support (91%) than those whose children have autism/autistic spectrum disorder (83%), and this is not surprising given that this group are the most likely to have needs related to what Level 5 offers.

Free text responses from parent/carers to the question, 'What additional support needs to be put in place for staff to support meaningful participation in pre-school activities?'

137 (12%) of respondents responded to this question.

The predominant themes in response to this question are summarised and exemplified below and include reference to the need for additional support in the form of 1:1 or SNA support, more principled engagement with L7 support by providers, better pay and working conditions for additional staff, more training on specific disabilities (particularly ASD) and better communication/collaboration between providers, parent/carers, and other agencies.

- The need for 1:1 or SNA support and a preference for this over reduction in the child-to-adult ratio.

> 'She needs a one-on-one support not shared support as she is very quiet has SPD and gets stressed in noisy, over stimulating environments seeking quiet and will be left behind very easily without extra supports to calm and refocus.'
>
> 'Member of staff to support her on her own.'
>
> 'More 1:1 support.'

- A perception that settings were cynically using Level 7 support to benefit the pre-school rather than the child and that this needed to be monitored more effectively.

> 'Pre-schools make use of AIM just to employ one more staff. My child had no benefit from the scheme. It's just a waste of tax money.'
>
> 'AIM approved funding for an extra staff member for my son. Once I had left the building after drop-off, they would move the staff member to a different room to work as a member of staff. My son was left without his resource for months. The manager blamed her staffing issues and said there was nothing she could do.'
>
> 'I tried to communicate with AIM that the service was not applying the additional member of staff to assisting my child integrate in the setting. Instead, it was used to lower ratios / enrol more children. The manager/owner of the service spent 40 minutes explaining to me that my child could not have a dedicated staff member whom they knew to approach for help or whom I could speak with. Instead, it was whoever was around on the day. After I complained to AIM and explained I was very unhappy with the service, the manager told a blatant lie to AIM and said he had a dedicated staff member.'
>
> 'The AIMS support person for my son was used to have more favourable ratios in pre-school rooms, unacceptable considering they were only there because of him, and his significant needs meant he needed them for the hours involved. e.g., 3 pre-school rooms, 2 full to capacity and one with 9 students and none of them special needs, my son is put into the full room to take advantage of his AIMS worker. Tried to report this and couldn't get anywhere, nobody would even give me the contact number of the better start person, no matter what agency I rang, pulled him from the school in the end as I felt it unsafe and detrimental to his mindset.'

- The view that higher pay and more substantial hours would improve recruitment of staff for provision of additional support and improve their quality.

  ‘The money provided is minimum wage and only on half day basis. The pre-school finds it hard to employ staff with the money provided.’

  ‘Aim is not fit for purpose, crèches got no support, giving hours does not work as you can’t employ people for 3 - 4 hours. It was a complete waste of time and money, so disappointing another example of paperwork and nothing.’

  ‘As I mentioned before, AIM was approved for my child, but the person was never hired to work. As a result, my child was excluded from pre-school.’

- More training on specific disabilities, particularly ASD.

  ‘An understanding of my child’s sensory issues as to what he will or will not eat and the ASD aspect of things too.’

  ‘Autism awareness course/ladybird course/NAS course for insight on how to identify a child’s sensory needs and how to teach them appropriately.’

  ‘More training with children with autism and how to teach a child with autism.’

  ‘Staff fully trained in the needs of an autistic child and since autism so different it has to be geared towards individual’s needs.’

  ‘The AIM programme is great and the extra member of staff to support children with SEN is invaluable. Unfortunately, the staff had no idea of autism, no understanding, no communication between home and pre-school, and lacked empathy, education and understanding. It should be a condition that staff are trained in SEN and understand the child’s needs, abilities and limitations and behaviours.’

  ‘An iota of training in autism, speech delay, alternative communication, sensory overload.’

- Better collaboration and communication between parent/carers, providers and in some cases, other agencies.

  ‘The Aims report that was written by the early years specialist to support my child was too generic and did not provide goals specific to my child's needs despite having input from a Speech and language therapist.’

  ‘I would really appreciate it if there was more communication. My child has issues with fatigue and if he isn't supported to take regular breaks it impacts his behaviour and his socialisation with others. He has an invisible disability, but he does not want to feel different so will not ask for help when he needs a break. He will often be sad and ask why he finds it so tiring when others don't. It is hard for others to understand what the signals are that he needs a break before he has a meltdown,’

  ‘More communication between staff and parents.’

  ‘A direct line of communication between staff in ECCE and the child's therapists who would give advice on site to staff to ensure the best learning opportunities.’

  ‘Feedback, to know how he is doing and how much support he is requiring.’

5.8: AIM Level 5: Equipment, appliances, and minor alterations grants

Table 34: Types of additional equipment applied for by parent/carer or setting and year first started and type of pre-school and setting of pre-school

Base: Applied for additional equipment

		Year first started					Type of pre-school				Setting of pre-school	
	Total	**2016**	**2017**	**2018**	**2019**	**2020 or later**	**Community**	**Private**	**Other**	**City or large urban area**	**Town**	**Rural**
Total	220	43	50	41	49	37	94	113	6	64	83	73
Play & Learning Material Toys and books	94	19	29	18	16	12	33	53	4	31	34	29
	43%	44%	58%	44%	33%	32%	35%	47%	67%	48%	41%	40%
Specialised Chairs Adjustable chairs with accessories - i.e., footrests, armrests, backrests, pommel	90	18	17	18	19	18	33	52	4	24	31	35
	41%	42%	34%	44%	39%	49%	35%	46%	67%	38%	37%	48%
Health service support (e.g., therapy and nursing support) Items Therapy mats / Items to develop	46	8	14	9	11	4	21	22	2	17	18	11
	21%	19%	28%	22%	22%	11%	22%	19%	33%	27%	22%	15%
Changing Table/Nursing Bench Height-adjustable changing table or nursing bench.	33	6	5	8	8	6	14	18	1	8	10	15
	15%	14%	10%	20%	16%	16%	15%	16%	17%	13%	12%	21%
Toileting Supports Toileting supports, such as: adapted toilet seats, toilet support cushions,	30	7	5	8	6	4	10	17	3	10	10	10
	14%	16%	10%	20%	12%	11%	11%	15%	50%	16%	12%	14%
Assistive Technology & Equipment for children who are deaf/hard of hearing or blind/visually	30	5	8	5	5	7	18	10	1	8	14	8
	14%	12%	16%	12%	10%	19%	19%	9%	17%	13%	17%	11%
Positioning Supports Corner chairs, wedges, rolls, move-n-sit cushions.	28	7	9	3	5	4	10	15	3	8	10	10
	13%	16%	18%	7%	10%	11%	11%	13%	50%	13%	12%	14%
Gait trainers, standers and standing frames Gait trainers designed to develop balance and help	17	2	1	5	8	1	8	5	3	5	7	5
	8%	5%	2%	12%	16%	3%	9%	4%	50%	8%	8%	7%
Duplicate Items i.e., items which cannot be transported from home.	15	5	3	3	2	2	8	6	1	5	6	4
	7%	12%	6%	7%	4%	5%	9%	5%	17%	8%	7%	5%

Hoists and Slings Mobile hoists and slings for transferring children.	1	0	1	0	0	0	0	0	1	0	1	0
	%	0%	2%	0%	0%	0%	0%	0%	17 %	0%	1%	0%

- Table 34 shows that 220 (19%) of parents/carers indicated that they or their pre-school had applied for equipment, appliances, and minor alteration grants (Level 5).
- The types of specialist equipment applied for most frequently was play and learning material, toys and books with applications being highest in 2017 (58%, n=29). Applications were significantly more likely from community pre-schools (35%) than private pre-schools (47%). Second and third most frequently applied for were specialised chairs (41%) and health service support items (21%).
- We also know that applications for Level 5 support were more common for those with physical or sensory difficulties (n=58) and autism/autistic spectrum disorder (n=67). Toileting supports (26%, n=15) and assistive technology (41%, n=24) were applied for more frequently for this group also. For those with autism, autistic spectrum disorder (n=67), play and learning materials (72%) and health service support items (36%, n=24) were applied for more frequently than was the case for physical and sensory disabilities (5%, n=3; 10%, n=6)) or multiple main disabilities (39%, n=15; 16%, n=6). In the case of children with multiple main disabilities (n=38), it was most likely that applications would be for specialised chairs (61%, n=23) and changing tables (34%, n=13) when compared to those with physical and sensory disabilities and autism/autistic spectrum disorder.

Associations between receipt of Level 5 support and parental perceptions of AIM's impact

Researchers implemented additional significance tests to explore associations between receiving/not receiving Level 5 support following an application, and parent/carers' perceptions of AIM's impact. Chi-Squared tests were used since they enabled the analysis of significant differences where base sizes smaller than 30.

The relationship between receiving or not receiving an outcome of support following an application and parent/carer perceptions.

- There is very strong evidence of an association between the perception that additional equipment has been beneficial and an overall positive view of the impact of AIM on the child. $p < .001$. The major departure from independence is due to parent/carers who have perceived additional equipment as beneficial being less likely to have a negative view of the impact of AIM on their child.
- There is no evidence that a negative outcome of AIM support was associated with the presence (or absence) of building alterations. $p = .285$
- There is very strong evidence of an association between not receiving AIM targeted support following application for L5 supports and a perceived negative outcome of AIM support. $p < .001$. The major departure from independence is due to parent/carers of children who did not receive AIM targeted support following an application for L5 support being more likely to have a negative view of the impact of AIM on their child. $p < .001$
- There is very strong evidence of an association between receiving an outcome following an application for AIM L5 support and parental perception that it is easy to access the support

their child needed from AIM. p < .001. The major departure from independence is due to parent/carers who did not receive an outcome from their application for AIM support being more likely to disagree that it was easy to access the support their child needed.

- There is very strong evidence of an association between receiving an outcome following an application for AIM L5 support and parental perception that as a result of AIM, their child was able to participate more meaningfully in pre-school activities. p < .001. The major departure from independence is due to parent/carers who did not receive an outcome from their application for AIM support being more likely to disagree that, as a result of AIM their child was able to participate more meaningfully in pre-school activities.

- There is very strong evidence of an association between receiving an outcome following an application for AIM Level 5 support and parental perception that as a result of AIM, their child was able to participate more meaningfully in pre-school activities. p < .001. The major departure from independence is due to parent/carers who did not receive an outcome from their application for AIM support being more likely to disagree that, as a result of AIM their child was able to participate more meaningfully in pre-school activities.

- No Associations (p < .001) were observed between receiving an outcome following an application for AIM Level 5 and:

    Agreeing/disagreeing that their child was able to interact socially more frequently with other children
    Agreeing/disagreeing that their child was more confident in educational settings
    Agreeing/disagreeing that their child was more confident interacting with peers
    Agreeing/disagreeing that their child was able to attend a mainstream pre-school

We conclude that the receipt of Level 5 support is associated with positive perceptions of an impact on meaningful participation, and the view that support was easy to access. Receipt of Level 5 support is also associated with a positive view of AIM overall, among parent/carers who are reporting that an application was successful.

5.9: AIM Level 6: Therapy Services

Table 35: Types of therapeutic/health support applied for by parent/carers or pre-school settings

Base: Applied for therapeutic/health support

Type of L6 support applied for	Total
Total	63
Speech and Language Therapy intervention	39
	62%
Occupational Therapy	34
	54%
Psychology intervention	19
	30%
Physiotherapy	15
	24%
Paediatrician	9
	14%
Nursing	3
	5%
Other	5
	8%
Don't know/can't remember	14
	22%

- As Table 35 shows, 63 parent/carers indicated that they or their pre-school had applied for therapeutic/health support. The most common type of support applied for was speech and language therapy (62%), occupational therapy (54%), psychology intervention, (30%, n=19) and physiotherapy (24%, n=15).
- There were no discernible statistically significant differences between groups.
- It is important to note that applications for Level 6 targeted supports are made by a referral that Better Start Early Years Specialists make on Early Years Hive (the applications portal for DCEDIY subsidies to pre-schools) with the involvement/consent of parents/carers. Though the survey question was cognitively tested to ensure that it was comprehensible and unambiguous, it is likely that some respondents were referring to applications for HSE supports outside of AIM (through making a referral themselves or via their GP or Public Health Nurse). This is likely given that the generic survey questions refers to applications made by 'you or staff at the pre-school' and we know from Pobal that there were a total of 133 AIM Level 6 (targeted support) referrals between 2016 and 2021[36]. The total number of applications (referrals) among the survey population (n=124) is higher than would be expected in a survey sample of 1,157 (representing just under 10% of the target population) and a value between n=9 and n=14 would be more likely.
- This indicates that respondents are very likely to be conflating their experiences of HSE intervention outside AIM (e.g., where they or a health professional has completed a referral leading to an intervention, and where the child may have a diagnosis prior to pre-

[36] Pobal Monthly Report (October 2021)

school) with AIM Level 6 (where universal support may also be conflated with targeted support). This suggests some need to clarify with parent/carers what the actual purpose and content of AIM Level 6 is since some qualitative data in the survey demonstrates that parent/carers conceptualise AIM Level 6 as the provision of a continuous programme of, for example, physiotherapy or speech therapy.

Associations between HSE intervention (including AIM Level 6) and parental perceptions of AIM's impact

Researchers implemented additional significance tests to explore associations between receiving Level 6 support (or not) and parent/carers perceptions of AIM's impact. Chi-Squared tests were used since they enable analysis of significance in base sizes smaller than 30.

Limitations

Limitations are in the uncertainty about whether parent/carers identify Level 6 support as therapeutic support accessed through referral routes outside AIM or whether these are accessed inside AIM (through the EYS) and comprise Level 6 support as it is constructed in policy. Nonetheless, these analyses will provide some insight into how parent/carers perceptions of AIM are associated with engagement from HSE during their child's pre-school years.

Key findings are as follows

The analyses here acknowledge that parent/carer responses to questions about Level 6 are not specific to Level 6 but also refer to perceptions of having HSE support outside of AIM (and not because of it). For this reason, the term 'AIM Level 6 support/HSE outside AIM' is used to describe this support.

- There is strong evidence that parent/carers' positive perception of the impact of AIM on their child was associated with the presence of therapeutic / health support. $p = 0.016$. The major departure from independence is due to parent/carers who have perceived'AIM Level 6 support/HSE outside AIM' as beneficial having a positive perception of the impact of AIM on their child (conversely those who had a positive experience of therapeutic support were less likely to have a negative view of AIM).
- There is very strong evidence of an association between receiving an outcome following a referral for AIM Level 6 support/HSE support outside AIM and parental perception that it is easy to access the support their child needed from AIM. $p = 0.006$. The major departure from independence is due to parent/carers who did not receive an outcome from their application for Level 6 AIM support being more likely to disagree that it was easy to access the support their child needed.
- There is strong evidence of an association between receiving an outcome following referral for AIM Level 6 support/HSE support outside AIM and parental perception that as a result of AIM, their child was able to participate more meaningfully in pre-school activities. $p = 0.016$. The major departure from independence is due to parent/carers who did not receive an outcome from their application for Level 6 AIM support being more likely to disagree that, as a result of AIM their child was able to participate more meaningfully in pre-school activities.
- There is strong evidence of an association between receiving an outcome following a referral n for AIM Level 6 support/HSE support outside AIM and parental perception that as a result of AIM, their child was able to interact socially more frequently with other children. $p = 0.019$.

- There is strong evidence of an association between receiving an outcome following a referral for AIM Level 6 support/HSE support outside AIM and parental perception that as a result of AIM, their child was more confident in educational settings. p = 0.013.
- There is strong evidence of an association between receiving an outcome following a referral for AIM Level 6 support/HSE support outside AIM and parental perception that as a result of AIM, their child was able to attend a mainstream pre-school. p = 0.029. 12 out of 13 who responded to this question (and received Level 6 AIM support) felt that their child was able to attend a mainstream pre-school as a result of AIM. Whereas 17 out of 29 who applied for, but did not receive Level 6 support, felt that as a result of AIM, their child was able to attend a mainstream pre-school.
- There is strong evidence of an association between receiving an outcome following a referral for AIM Level 6 support/HSE support outside AIM and parental perception that as a result of AIM, their child was more confident in interacting with peers. p = 0.013.

To summarise, where children have been referred for HSE intervention (either through Level 6 within AIM or outside it, via a self-referral or referral by a GP or Public Health Nurse, PHN), there is strong evidence of an association between the presence of HSE engagement during their child's pre-school years and positive perceptions of AIM's impact (e.g., meaningful participation, social interaction, attendance of mainstream pre-school). This indicates that for the parent/carers surveyed, HSE engagement seemed to have enhanced AIM's effectiveness. It is also important to note that not getting Level 6 targeted support /HSE support following a referral was not associated with parent/carers feeling that AIM had made no difference. Rather, from the perspective of parent/carers, HSE engagement deepened AIM's impact on full inclusion and meaningful participation)

5.10: AIM Level 7: Additional assistance in the pre-school room

Table 36: Parent/carer awareness of staff employed to provide additional assistance in the pre-school

		Year first started					Type of pre-school		
Parent/carers awareness of staff employed for L7	**Total**	**2016**	**2017**	**2018**	**2019**	**2020 or later**	**Comm unity**	**Private**	**Other**
Total	1157	159	179	257	324	238	519	550	36
Yes	846	103	134	185	243	181	371	418	24
	73%	65%	75%	72%	75%	76%	71%	76%	67%
No	149	32	18	37	37	25	68	68	5
	13%	20%	10%	14%	11%	11%	13%	12%	14%
Don't Know	162	24	27	35	44	32	80	64	7
	14%	15%	15%	14%	14%	13%	15%	12%	19%

- Table 36 shows that where parent/carers were asked, 'Does your child's pre-school employ an additional member of staff to support your child?' most responded with 'yes' (73%). 'Yes' responses were least likely in 2016 (65%) or before compared to all other years. 'Yes' was also more likely when children attended private pre-schools (76%) than when they attended community (71%) or 'other' pre-schools (n=24). This is more evidence that parents/carers were more aware of AIM support when it was in the form of additional adult assistance. It is also important to re-state that 64% of parent/carers had indicated that the pre-school provided additional adult assistance (Level 7) for their child.

- We also know that for parents/carers of children with specific speech and language disorders were significantly less likely to answer ‘yes’ (65%) to the question ‘Does your child’s pre-school employ an additional member of staff to support your child?’ than was the case for all other types of disability/additional need.

- When parent/carers were asked if their child’s pre-school employed a Special Needs Assistant, awareness was also relatively low (42% choosing ‘don’t know’ and 27% choosing ‘yes’). Parent/carers of children in community pre-schools were more likely to select ‘yes’ than those in private (21%) or ‘other’ (36%, n=13). Parent/carers of children in city/large urban areas were less likely to respond with ‘yes’ than those in town (30%) or rural (30%) areas.

- It is important to restate that, in terms of the most beneficial elements of AIM, 62% of parent/carers noted that additional support in the pre-school room was the most beneficial aspect.

Associations between receipt of AIM Level 7 and parent/carers’ perception of AIM

Researchers carried out additional significance testing (using the Chi Squared method) to investigate the interaction between Level 7 support being awarded and parent/carer perception of impact.

- There is very strong evidence of an association between the perception that additional assistance has been beneficial and an overall positive view of the impact of AIM on the child. $p < .001$. The major departure from independence is due to parent/carers who have perceived additional assistance as beneficial being less likely to have a negative view of the impact of AIM on their child than those who did not select assistance as beneficial.
- There is a very strong association between receiving L7 support and parent/carers perceiving that additional assistance made a difference to their child. The major departure from independence is due to parent/carers who did not receive L7 support being less likely to perceive additional assistance (staff member) as making a great difference.
- The major departure from independence is due to parent/carers who did not receive L7 support being less likely to perceive additional assistance (staff member) as making a great difference
- There is a very strong association between receiving L7 support and parent/carers perceiving that working in partnership made a difference to their child. However- looking at the responses, the majority of parent/ carers who did receive L7 support did not select working in partnership as making a great difference. The question was set up that they selected or did not, so not selecting it does not necessarily mean that they did not value partnership working but does suggest that it was not perceived as being the most valuable/important.
- There is a very strong association between not receiving L7 support and parent/carers perceiving that AIM support had a negative outcome. $p < 0.001$. The major departure from independence is due to parent/carers who did not receive L7 support being more likely to perceive that AIM had a negative outcome for their child. It is important to note that relatively small numbers of respondents perceive a negative outcome of AIM. Only 34 out of 958 of those who applied for L7 felt it had a negative outcome (irrespective of outcome).
- There is a very strong association between not receiving L7 support and parent/carers perceiving that AIM made no difference to their child. $p < 0.001$. The major departure from independence is due to parent/carers who did not receive L7 support being more likely to perceive that AIM had a negative outcome for their child
- There is very strong evidence of an association between receiving an outcome following an application for AIM L7 support and parental perception that it is easy to access the support their child needed from AIM. $p < 0.001$.

- There is strong evidence of an association between receiving an outcome following an application for AIM L7 support and parental perception that as a result of AIM, their child was able to participate more meaningfully in pre-school activities. $p < 0.001$.
- There is strong evidence of an association between receiving an outcome following an application for AIM L7 support and parental perception that as a result of AIM, their child was able to interact socially more frequently with other children. $p < 0.001$.
- There is strong evidence of an association between receiving an outcome following an application for AIM L7 support and parental perception that as a result of AIM, their child was more confident in educational settings. $p < 0.001$.
- There is very strong evidence of an association between receiving an outcome following an application for AIM L7 support and parental perception that as a result of AIM, their child was more confident in interacting with peers. $p < 0.001$.
- There is very strong evidence of an association between receiving an outcome following an application for AIM L7 support and parental perception that as a result of AIM, their child was able to attend a mainstream pre-school. $p < 0.001$.

To summarise, we conclude that receipt of Level 7 support is associated with positive perceptions of AIM and its impact on children's development, inclusion, and participation. Where applications are declined, this is associated with negative perceptions of AIM and its impact. However, these data have also illustrated that parent/carers have strong belief in Level 7 as a route to inclusion for their children, since only 34/958 who had been involved in an application for Level 7 support described it as bringing a negative outcome, even where it had not been awarded.

To summarise, findings on **parent/carers' experiences of the AIM support application process**

Outcomes from applications

- The majority of parents/carers report that applications have resulted in an outcome (84%) though 7% are not sure and 4% are awaiting an outcome.
- Statistically significant differences indicate that children with physical and sensory difficulties are more likely to receive Level 5 supports than is the case with other types of disability and least likely to have additional assistance (60% compared to an average of 70%). For this group it is also more likely for parent/carers to report that their application has resulted in provision of AIM support (91%) than those whose children have autism/autistic spectrum disorder (83%). This is unsurprising since the needs of children with physical and sensory difficulties is likely to be more matched to what Level 5 supports can provide.

Views on additional support that needs to be put in place

137 (12%) of respondents provided responses to the question, 'what additional support needs to be put in place for staff to support meaningful participation in pre-school activities? Answers focussed on the need for additional staff to provide 1:1 (or SNA) support, more effective and ethical use of Level 7 support by Providers, better pay and working conditions for Level 7 staff, more training on specific disabilities (particularly ASD) and better communication/collaboration between Providers, parents, and other agencies, including therapists and HSE staff.

To summarise, **parent/carers' perceptions of AIM** for each level of its targeted supports were found to be as follows

AIM Level 4:

- For parent/carers who had heard of AIM before starting pre-school, just under a quarter (24%) of parent/carers said they/the pre-school had had contact with a Better Start Early Years professional when applying for a pre-school place (39% had not, and 37% said they did not know).
- Two-fifths of parent/carers (42%) said the pre-school had accessed information/advice from an early years specialist, but overall, awareness of Level 4 is relatively low.
- There was relatively low awareness of the Access and Inclusion Profile. 48% of parent/carers had heard of an Access and Inclusion Profile and of those 57% were involved in completing one for their child and 43% were not, with 9% answering 'don't know.
- We also know that parent/carers of children with autism/autistic spectrum disorder were less likely than parent/carers of children with other types of disability/additional need to answer 'yes' when asked if they were involved in completing an Access and Inclusion Profile (26%).
- The majority of parent/carers who said that they were involved in writing an Access and Inclusion Profile agreed that the process of accessing support from an Early Years Specialist was positive (between 75% and 85%). Most parents/carers also indicated that their child was treated like an individual (83%) and that they were well supported by the pre-school staff in the process of engaging with the EYS (87%).

AIM Level 5

- When considering the statement, 'my child was allocated the equipment he/she needed to access learning at pre-school', 60% of parent/carers agreed. Parent/carers of children currently attending mainstream school were more likely to agree with this statement (67%) than was the case with all other types of current setting. Parent/carers of children with physical/sensory disabilities were more likely to agree with this statement (80%) than those with autism/autistic spectrum disorders (56%), specific speech and language disorder (63%) and multiple main disabilities (57%). Parent/carers of children with autism/autistic spectrum disorder were significantly less likely to agree with this statement (15%) than those with physical and sensory disabilities (3%, n=2).
- Receipt of Level 5 support is associated with parent/carer perceptions of positive impact in relation to participation, and ease of access in securing support. It was not associated with parent/carer perceptions of increased social confidence or ability to attend a mainstream pre-school.

AIM Level 6:

- 63 (5%) of parent/carers indicated that they had applied for therapeutic/health support. The most common type of support applied for was speech and language therapy (39%), occupational therapy (34%), psychology intervention, (30%, n=19) and physiotherapy (24%, n=15) though there is evidence to suggest that most of these applications were made outside AIM. Awareness of AIM Level 6 was lowest at 6% 'for my child' and 4% for 'children other than my child' compared to an average of 40-50% for other levels.
- Where children have been referred for HSE intervention and received it (either through Level 6 within AIM or outside it, via a self-referral or referral by a GP or Public Health Nurse, PHN), there is strong evidence of an association between the presence of HSE engagement during their child's pre-school years and positive perceptions of AIM's impact (e.g., meaningful participation, social interaction, attendance of mainstream pre-school). This indicates that for the parent/carers surveyed, HSE engagement seemed to have enhanced AIM's effectiveness. It is also important to note that not getting Level 6 targeted support /HSE support following a referral was not associated with parent/carers feeling that AIM had made no difference. Rather, HSE engagement deepened AIM's impact in relation to its key goals (full inclusion and meaningful participation).

AIM Level 7

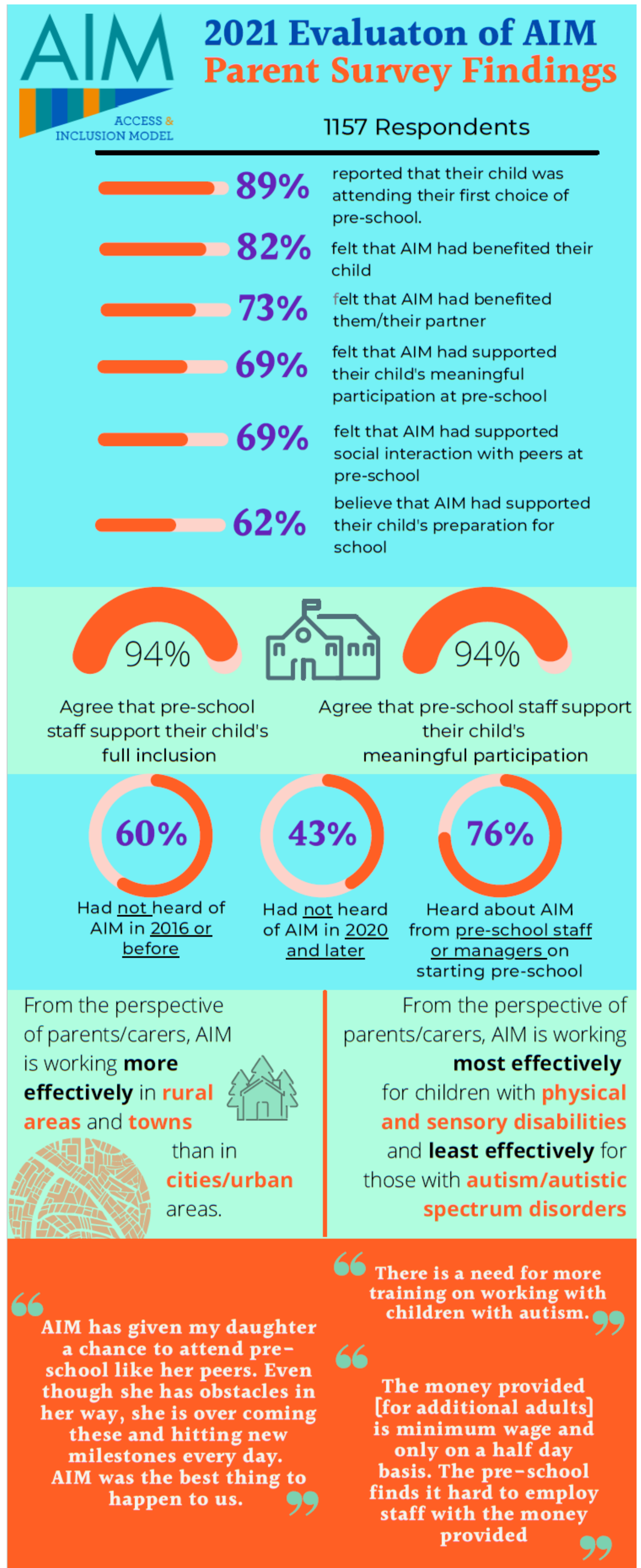
- Awareness of Level 7 support as an aspect of AIM was relatively very high compared to other AIM Levels (73% of parents/carers were able to identify when an additional member of staff was appointed to support their child).
- It is important to restate that, in terms of the most beneficial elements of AIM, 62% of parent/carers noted that additional support in the pre-school room was the most beneficial aspect.
- To summarise, we conclude that receipt of Level 7 support is associated with positive perceptions of AIM and its impact on children's development, inclusion, and participation. Where applications are declined, this is associated with negative perceptions of AIM and its impact. However, these data have also illustrated that parent/carers have strong belief in Level 7 as a route to inclusion for their children, since only 34/958 who had been involved in an application for Level 7 support described it as having a negative outcome, even where it had not been awarded.

These data indicate that parent/carers are most aware of Level 5 and Level 7, perhaps because they are the most visible, tangible elements of AIM support. Where parent/carers perceive their involvement the development of Access and Inclusion Profiles, their perceptions of Level 4 are more positive, though it is noted that parent/carer signatures on this

Headlines Infographic

The infographic summarises the headline findings from the survey of parent/carers.

The next subsection applies qualitative analysis to investigate statistically significant differences between groups in relation to rural areas and towns/urban areas, and autistic spectrum disorder/other types of additional need. The analysis will also explore whether parent/carers whose children attended special pre-schools or primary schools at the time of completing the survey, had particular issues to raise when reflecting on the impact of AIM and how it could be improved. Subsection 5.11 reports on further analysis of the quantitative and qualitative data to investigate the differences in parent/carer satisfaction according to the reported type of disability and pre-school location, along with some other significant differences of interest.



5.11: Further Analysis of significant differences in parent/carer satisfaction with AIM across groups

This subsection presents further quantitative and qualitative analysis of the survey data, in order to better understand the significant differences in parent/carer satisfaction with AIM in relation to the reported type of disability and the location of the pre-school (city, town and rural). It begins with the findings from quantitative analysis. It then reports findings from the qualitative analysis of the free text comments in the survey.

Quantitative Analysis

Investigating statistically significant differences between parent/carer perceptions and reported main type of disability

Collation of significant differences across types of disability

First, significant differences in perception among parent/carers of children with particular types of reported main disability were collated from the reported hypothesis testing in subsections 5.3 to 5.10. This was done where there were more than two incidences of statistically significant differences between types of disability.

Physical and Sensory Disabilities
Compared to other types of disability, parent/carers were significantly more likely to:

- Have heard of AIM before their child started pre-school
- Report that AIM had benefited their child
- Choose the rating descriptor 'a great extent' when considering the benefits of AIM
- Agree with the statement 'As a result of AIM, my child was able to participate meaningful in pre-school activities'
- Report that AIM had a positive impact on the transition to school
- Choose 'to a great extent' to describe their view of the extent to which pre-school staff supported their child's full inclusion
- Agree that 'there is an inclusive culture at my child's pre-school'
- Choose the rating descriptor 'to a great extent' when reporting on the extent to which pre-school staff supported their child's full inclusion
- Agree that 'staff at my pre-school supported me through the [application] process
- Agree that 'my child was allocated the equipment he/she needed to access learning at pre-school'
- Agree that 'as a result of AIM my child was able to attend a mainstream school'

Parent/carers significantly less likely to:

- Report that applications were for Level 7 support

Autistic Spectrum Disorder
Compared to other types of disability, parent/carers were significantly less likely to:

- Choose the rating descriptor 'a great extent when considering the benefits of AIM'
- Agree with the statement 'As a result of AIM, my child was able to participate meaningfully in pre-school activities'
- Choose the descriptor 'very well prepared for the learning aspects of school'
- Report that AIM had a positive impact on the transition to school

- Choose the descriptor ‘to a great extent’ when reporting the extent to which pre-school staff supported their child
- Agree with the statement ‘there is an inclusive culture at my child’s pre-school’
- Answer ‘yes’ when asked whether they were involved in completing an Access and Inclusion Profile
- Agree with the statement ‘My child was allocated the equipment he/she needed to access learning at pre-school’
- Report that pre-school staff supported them through applications for AIM
- Be aware that Level 3 (training on disability) was a support available in their child’s pre-school
- Be aware that Level 4 (Early Years Specialist Support) was a support available in their child’s pre-school

Parent/carers were significantly more likely to:

- Disagree with the statement ‘there is an inclusive culture at my child’s pre-school’
- Report that their child did not attend their first choice of ELC setting

Emotional Disturbance

Compared to other types of disability, parent/carers are significantly less likely to:

- Report that participation in AIM had benefited their child
- Choose the rating descriptor ‘to a great extent’ when reporting the degree to which pre-school staff supported their child’s full inclusion
- Agree that ‘there is an inclusive culture at my children’s pre-school’
- Be aware that Level 3 (training on disability) was a support available in their child’s setting

Specific Speech and Language Disorder

Compared to other types of disability, parent/carers are significantly less likely to:

- Choose the rating descriptor ‘a great extent’ when describing AIM’s benefits
- Report that AIM had a positive impact on the transition to school
- Agree that ‘there is an inclusive culture in my child’s pre-school
- Agree that ‘my child was allocated the equipment they need’

The collation of evidence above demonstrates that children with physical and sensory disabilities are gaining most from AIM from the perspective of their parent/carers. It is also clear that parent/carers of children with ASD perceive AIM to be serving their children’s needs least effectively and report an experience of being less well supported. To a lesser extent, this is also true of children with specific speech and language difficulties. Though these data cannot explain these differences in perception, they may arise because children with physical and sensory needs are more likely to enter AIM with a diagnosis and less likely to have learning, emotional and behavioural difficulties. This may also arise from differences in attitudes to children with emotional and behavioural needs, and how these may challenge pre-school staff’s capacity to practice inclusively. It may also be because diagnosis of psychosocial disabilities tends to come later in the child’s life. We note that parent/carers of children with a diagnosis prior to entering pre-school, were more likely to know about AIM than those whose children who did not have a diagnosis, and this is likely to impact on the speed at which the child’s needs become known to pre-school staff (through observation and assessment), on the length of time support has been in place, and consequently on the degree of impact experienced.

Results of Chi-Square Tests

Next, some further hypothesis tests were carried out to investigate whether there were associations between factors (e.g., type of disability and parent/carer perceptions of the ability of pre-school staff to include their children). Chi-Square tests were used to a) allow testing where base numbers were less

than 30, and b) compare observed results with expected results in order to confirm the significance of the difference.

The relationship between reported main type of disability and parent/carers' perceptions of the ability of staff to include their child and the inclusive culture in the pre-school

- There is strong evidence of an association between the perception that staff support children's full inclusion in pre-school activities and the reported main areas for disability. p= 0.037. The major departure from independence is due to parent/carers of children with emotional disturbances and multiple main disabilities being more likely to report that the practitioners are not able to support their child's full inclusion than other main types of disability. (Observed number = 64, expected 50.8)
- There is a very strong association between the child's main type of disability and parental agreement that staff at their child's pre-school recognise when their child requires additional support and seek it. p= 0.007. The major departure from independence is due to parent/carers of children with physical disabilities being more likely to feel the pre-school recognises when the child needs additional support whilst parent/carers of children with emotional disturbances and those with ASD were less likely to feel staff recognise when their child requires additional support than other main types of disability.
- There is a strong association between the child's main type of disability and parental agreement that staff at their child's pre-school take the lead in making sure their child gets the most out of ECCE provision. p= 0.016. The major departure from independence is due to parent/carers of children with physical disabilities being more likely to feel that staff at the pre-school take the lead in making sure children get the most out of ECCE provision whilst parent/carers of children with emotional disturbances and those with ASD were less likely to feel staff take the lead than other main types of disability.
- There is a strong association between the reported main type of disability and parent/carers agreeing that there is an inclusive culture in their child's pre-school. p= 0.033. The major departure from independence is due to parent/carers of children with physical disabilities being more likely to feel that there is an inclusive culture whilst parent/carers of children with emotional disturbances and those with ASD were less likely to feel that there is an inclusive culture than other main types of disability. It is important to note that all parent/carers of children with a physical disability felt that there was an inclusive culture in the setting.

The relationship between the reported main type of disability and parent/carers' experience of relationships with staff in the pre-school.

- There is strong evidence of an association between parent/carers agreeing that they know who to talk to and the reported main areas for disability. p= 0.02. The major departure from independence is due to parent/carers of children with physical disabilities being more likely to know who to talk to whilst parent/carers of children with emotional disturbances were less likely to know who to talk to than other main types of disability. *No significant differences were observed from those expected for children with ASD.
- There is strong evidence of an association between parent/carers agreeing that staff worked in partnership with them and the reported main areas for disability. p= 0.007. The major departure from independence is due to parent/carers of children with physical disabilities being more likely to feel staff work in partnership with them whilst parent/carers of children with emotional disturbances were less likely to feel parent/carers work in partnership with them than other main types of disability. *No significant differences were observed from those expected for children with ASD.
- There is very strong evidence of an association between parent/carers agreeing that conversations with staff about their child's disability are handled sensitively and the reported main areas for disability. $p < 0.001$. The major departure from independence is due to parent/carers of children with physical disabilities being more likely to feel that conversations

are handled sensitively, whilst parent/carers of children with emotional disturbances were less likely to feel that conversations were handled sensitively than other main types of disability. *No significant differences were observed from those expected for children with ASD.

Relationship between reported main type of disability and the ease of applying for support through AIM

- There is very strong evidence of an association between parent/carers agreeing that it was easy to apply for support and the reported main areas of disability. $p < 0.001$. The major departure from independence is due to parent/carers of children with physical disabilities and those with speech and language disorders being more likely to feel that it was easy to apply for support, whilst parent/carers of children with multiple main disabilities were less likely to feel that it was easy to apply for support than other main types of disability.

Relationship between reported main type of disability and views of the benefits that specific levels of AIM support brought

- There is very strong evidence of an association between type of disability and additional equipment being viewed as beneficial. $p < .001$. The major departure from independence is due ot parents/carers of children with physical disabilities and those with speech and language disorders being more likely to describe these as beneficial.
- There is very strong evidence of an association between type of disability and building alterations being viewed as beneficial. $p < .001$. The major departure from independence is due ot parents/carers of children with physical disabilities being more likely to describe these as beneficial.
- There is no evidence that the perceived benefits of information or advice provided to pre-school or staff on inclusion was associated with a particular type of disability. $p = 0.07$.
- There is no evidence that the perceived benefits of therapeutic/health support were associated with a particular type of disability. $p = 0.091$.
- There is no evidence that the perceived benefits of additional assistance (staff member) were associated with a particular type of disability. $p = 0.014$.
- There is no evidence that the perceived benefits of working in partnership was associated with a particular type of disability. $p = 0.192$.

Relationship between reported main type of disability and parent/carer perceptions of the impact of AIM on inclusion and participation

- There is very strong evidence of an association between parent/carers agreeing that their child was able to participate more meaningfully in pre-school activities and the reported main areas of disability $p =0.003$. The major departure from independence is due to parent/carers of children with physical disabilities and those with learning disabilities being more likely to feel that their child was able to participate meaningfully, whilst parent/carers of children with ASD were less likely to feel that their child was able to participate meaningfully than other main types of disability.
- There is strong evidence of an association between parent/carers agreeing that their child is more confident in educational settings and the reported main areas of disability. $p =0.014$. The major departure from independence is due to parent/carers of children with physical disabilities being more likely to feel that their child is more confident in educational settings, whilst parent/carers of children with ASD and those with speech and language disorders were less likely to feel that their child was more confident in educational settings than other main disability groups.
- There was no observable, significant association between parent/carer agreement with the statement “As a result of AIM, my child is more confident in interacting with peers” and the type of disability ($p= 0.073$).

- There was no observable, significant association between parent/carer agreement with the statement “As a result of AIM, my child was able to attend a mainstream pre-school” and the type of disability (p= 0.076)

In summary, these data indicate parent/carers of children with physical and sensory disabilities are experiencing and perceiving AIM more positively that parent/carers with other types of difficulties. This is in terms of the inclusiveness of the culture of pre-schools, staff capacities to deliver inclusive practice, and relationships with pre-school staff (e.g., communication and working in partnership). Parent/carers of children with physical and sensory difficulties are also more likely to perceive AIM as having a positive impact. For this group, both the experience of AIM and the impact of AIM is most positive.

Though it is noted that there are some aspects where there are no significant differences (AIM’s impact on confidence for peer interaction or child’s ability to attend a mainstream pre-school), parent/carers of children with ASD (and to a lesser extent children with Emotional Disturbance (ED), Specific Speech and Language Difficulties (SSLD), and Multiple Main Disabilities (MMD) report a more variable experience and are less likely to perceive staff as well trained (ASD, ED), able to practice inclusively (ASD, ED), or working in partnership with them (ED).

Across all of these analyses, it emerges that parent/carers of children with PDs are significantly more likely to experience AIM positively, and parent/carers of children with ASD are significantly less likely to do so. However, in the case of ED, PD and MMD, there are also differences. This may demonstrate that pre-school’s providers need continued professional development in how to support children with psychosocial difficulties and complex needs (including challenging behaviour), as well as training in how to work effectively with parent/carers of children with such needs.

Investigating statistically significant differences in parent/carer perceptions of AIM and the location of settings (urban, town, rural)

The results of hypothesis testing reported in subsections 5.2 to 5.10 had revealed statistically significant differences in parent/carer perception according to location (city/large urban, town and rural), and these are summarised below:

Rural Areas

- Less likely to know about AIM Level 1

Towns

- More likely to know about the INCO and AIM Level 1 within the pre-school

Cities and large urban areas (compared to Rural and Towns)

- Less likely to agree that pre-school staff supported their child’s full exclusion ‘to a great extent’
- More likely to reply ‘no’ to the question ‘Does your pre-school have/provide training on disability and inclusion?’
- Less likely to agree with the statement ‘there is an inclusive culture at my child’s pre-school’ (Level 1)
- Less likely to agree that ‘the advice and support was relevant to my needs’ (Level 2)
- Less likely to agree that staff at the pre-school are well trained (Level 3)

- Less likely to be aware that the pre-school was getting support from an Early Years Specialist (Level 4)
- Less likely to be aware of Level 7 support being available with the pre-school

Chi-Square tests were used to further investigate statistically significant differences in perception according to location. Results are presented below:

Prevalence of types of disability and location of setting

- There is strong evidence of an association between geographical location and main type of disability. p = 0.031. The major departure from independence is due to families living in rural locations being more likely to report a physical or sensory disability or a multiple main disability as their child's main type of disability. On the other hand, families living in urban locations being more likely to report ASD as their child's main type of disability. This may explain the lower levels of satisfaction reported by parent/carers of children who attend settings in urban areas.

Geographical location of the pre-school and parent/carer perceptions of AIM's impact

- There is strong to very strong evidence of an association between the geographical location of the pre-school and parental perception that pre-school staff support their child's meaningful participation in pre-school activities. (P= 0.007 urban or rural, p=0.037 city, town or rural). The major departure from independence is due to families living in rural locations being less likely to report that staff do not support meaningful participation. This suggest that parent/carers of children attending pre-schools in settings and towns have a more variable experience of staff's engagement in helping their child to participate.
- No significant association between geographical location and parent/carer perceptions on how well staff in the child's setting are trained (p=0.53 urban or rural, P=0.098 city, town or rural).
- No significant association between geographical location and parent/carer perceptions of how well staff support the child's full inclusion. (p=0.57 urban or rural, p=0.288 city, town or rural).
- No significant associations between the perception of benefits of AIM and geographical location (city or urban, p=0.170).
- There is no significant association between parent/carers reporting on the aspects of AIM which have made the greatest difference to their child and geographical location (e.g., Level 7 additional assistance, p=0.476 urban vs rural, Level 5 building alterations, p=0.444 urban vs rural).
- There is no significant association between geographical location and perceptions of participation (p=0.050 urban vs rural), social confidence and interaction (p=0.188) and being able to attend mainstream school (p=0.347).

These results demonstrate that ASD is more prevalent in pre-schools located in urban areas, and this may have a skewing effect on the data in the light of the associations between *perceptions of AIM* and main *reported type of disability* (see previous section to review less positive perceptions of AIM among parent/carers of children with ASD). In cities, parent/carers are less positive about the impact of AIM on full inclusion and meaningful participation and tend to have lower awareness of the range of supports that are active within their child's pre-school.

Though the significant differences are visible in these data, it is reasonable to assume that they are due to some skewing in the data in combination with lower awareness of AIM supports in pre-school that are located in city and large urban areas. This indicates a need to consider how communication about AIM (including communication from the pre-school to parent/carers) might need to differ in urban contexts where there are likely to be higher levels of mobility and more complex intersections of need (including disadvantage and language barriers).

To summarise, the findings from **further quantitative analysis of significant differences between groups.**

Parent/carers perceptions of AIM (experience and impact) and reported main type of disability

- In summary, these data indicate parent/carers of children with physical and sensory disabilities are experiencing and perceiving AIM more positively that parent/carers with other types of difficulties. This is in terms of the inclusiveness of the culture of pre-schools, staff capacities to deliver inclusive practice, and relationships with pre-school staff (e.g., communication and working in partnership). Parent/carers of children with physical and sensory difficulties are also more likely to perceive AIM as having a positive impact. For this group, both the experience of AIM and the impact of AIM is most positive.
- Though it is noted that there are some aspects where there are no significant differences (AIM's impact on confidence for peer interaction or child's ability to attend a mainstream pre-school), parent/carers of children with ASD (and to a lesser extent children with emotional disturbance (ED), specific speech and language difficulties (SSLD), and multiple main disabilities (MMD) report a more variable experience and are less likely to perceive staff as well trained (ASD, ED), able to practice inclusively (ASD, ED), or able to work in partnership with them (ED).
- Across all of these analyses it emerges that parent/carers of children with PDs are significantly more likely to experience AIM positively, and parent/carers of children with ASD significantly less likely to do so. However, in the case of ED, PD and MMD, there are also differences. This may demonstrate that pre-schools providers need continued professional development in how to support children with psychosocial difficulties and complex needs (including challenging behaviour), as well as training and support in how to work effectively with parent/carers of children with such needs.

Parent/Carers perception of AIM (impact and awareness) and location of the pre-school.

- It was found that ASD was more prevalent in pre-schools located in urban areas, and this may have a skewing effect on the data in the light of the associations between *perceptions of AIM* and main *reported type of disability* (see previous section to review less positive perceptions of AIM among parent/carers of children with ASD). In cities, parent/carers are less positive about the impact of AIM on full inclusion and meaningful participation and tend to have lower awareness of the range of supports that are active within their child's pre-school. Though the significant differences are visible in these data, it is reasonable to assume that they are due to some skewing in the data in combination with lower awareness of AIM supports within the pre-school. This indicates a need to consider how communication about AIM (including communication from the pre-school to parent/carers) might need to differ in urban contexts where there are likely to be higher levels of mobility and more complex intersections of need (including, for example, disadvantage, language diversity and socioeconomic disadvantage).

Qualitative analysis of data in the survey.

This subsection presents the findings of analysis of the qualitative data from the survey of parent/carers. There were two purposes. The first was to provide an enumerated analysis of the most prevalent *categories of response* in the free text comments written by respondents. The second purpose was to seek explanations for the statistically significant differences/ differences of interest between respondent sub-groups and their perception of AIM.

To serve the second purpose, content analysis was used to investigate what explanations, if any, free text comments provide about why:

- parents/carers' perceptions of AIM are statistically significantly different in *towns and rural areas* than they are in *cities and large urban* areas, with the latter reporting fewer positive perceptions
- parent/carers' perceptions of AIM are statistically significantly less positive if their children have a diagnosis of autism/autistic spectrum disorder compared to other types of additional needs/disabilities
- parent/carers' perceptions of AIM are less positive if their children are attending a special pre-school, special class in a primary school or primary school.

Coding was done question by question, and coders used agreement trialling processes to ensure accuracy and consistency across the team. Using a workbook, coders recorded total counts for text coded to a single category (e.g., *Level 7 support not used effectively*). These per-category totals were also broken down into counts for each group of interest. The groups, their base sizes and their proportion of the total respondent population are as follows:

- City and Large Urban (n=323, 0.28) settings compared to Rural and Town (n=650, 0.57) settings
- Autism/autistic spectrum disorder (n= 493, 0.43) compared to all other disabilities/additional needs (n=650, 0.57)[37]
- Mainstream school or pre-school placement (n=1067, 0.93), compared to special school or special pre-school placement (n=74, 0.06)[38]. A mainstream school placement was identified when parent/carers noted their child's current placement as 'mainstream primary school'

Given that base sizes within groups in the survey were often very different, weighting algorithms were used to ensure that sample bias was minimised.

Using the example of groups rural and town/city and large urban, and survey question 5, 'Why did you not enrol your child in your first choice?' This question was asked when parent/carers indicated that their child was not attending their first choice of pre-school. The enumeration process involved the following steps:

- Calculating the total responses matched to the category (n=43) (column 1)
- Calculating the total survey population and proportion of each group (respondents identifying the setting their child attends as located in a *rural area or town*, n=831, 0.72 or a *city and large urban area*, n=323, 0.28) (columns 2 and 3)
- Noting the total instances where text was coded to the category for respondents in *rural area and town* (n=15) or *city and large urban area* (n=28)

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[37] Does not include 'Don't know' or 'Don't wish to disclose'
[38] Does not include 'other' (e.g., home tuition)

- Calculating the proportion of text coded to the category for each group/total (category count for rural and town, 15/43 =0.35 and city and large urban, 28/43 = 0.65) (columns 5 and 10)
- Calculating the weighted proportions as the product of columns 6 and 3 (for rural and town) and the production of columns 11 and 8 (for city and large urban)
- Calculating the difference between the weighted proportions (column 13)

Where weighted differences between one group and another are calculated, conditional formatting is used to identify magnitudes as follows:

<u>Between +0.5 to +1.0 = Red cell with red text</u>
This indicates that the difference between the groups for the category is relatively large and in the direction of the group of interest (i.e., groups that were less positive about AIM: *city and large urban, ASD, special setting*). For example, a difference of +0.65 would indicate a relatively large difference between the frequency of a category within the group *ASD* and *non-ASD*, with the higher frequency being within the group *ASD.*

<u>+0.4999 and 0 = Green cell with green text</u>
This indicates that the difference between the groups for the category is relatively small and in the direction of the group of interest.

<u>-0.01 and -0.4999 = Yellow cell</u>
This indicates that the difference between the groups for the category is relatively small and is not in the direction of the group of interest.

For example, a difference of -0.35 would indicate a relatively small difference between the frequency of a category within the group *city and large urban area,* and *rural area and town,* with the higher frequency being in the group rural area and town.

<u>-0.50 and -1.00 = Orange Cell</u>
This indicates that the difference between the groups for the category is relatively large in not in the direction of the group of interest.

This process was used to enumerate the frequency of categories within the qualitative data, so as to minimise the distorting impact of different base sizes within groups.

Limitations

Though it has been possible to minimise the effect of sample size biases, category counts from content analysis cannot be compared to find statistically significant differences. It is also important to note that the split of groups into 'autism/ASD' and all 'other additional needs' has been necessary to support meaningful analysis but is not without problems since the group 'other additional needs' contains children who may have autism/ASD but have not yet been diagnosed, and children who have ASD along with other areas of need (e.g., as part of a complex profile of learning disability and sensory disability). However, the analysis allows us to identify whether are any large differences in the accounts that respondents write about their experience of AIM in the survey. The results of the qualitative analysis of respondent texts are presented in the tables that follow. Prevalence counts higher than n= 9 are shaded to indicate those categories that were most prevalent across the qualitative data in the survey.

Table 5.11.1: Survey Question 5: Why did you not enrol your child in your first choice? Weighted differences between prevalence for categories across groups

Category	(n) Total responses matched to this category	(n) Category count Rural & Town	(n) Category count City & Large Urban	Weighted Difference City and Large Urban - Rural and Town	(n) Category Count Autism and ASD	(n) Physical and/or Sensory Disability category count	(n) Category count not ASD	Weighted Difference ASD - not ASD	Category Count mainstream	Category count special setting	Weighted difference special setting - mainstream setting
Q5 Why did you not enrol your child in your first choice?											
Pre-school full closed or with limited space	185[39]	100	57	-0.30	55	4	53	-0.16	1	0	-0.02
Better offer made by another pre-school (e.g., more hours)	26	18	8	-0.41	8	1	15	-0.19	9	4	-0.31
Setting unsuitable for my child and their needs	24	15	4	-0.40	8	1	9	-0.07	6	5	-0.22
Negative attitudes to disability and/or my child at pre-school	19	9	9	-0.21	5		13	-0.28	7	6	-0.32
Pre-school would only accept child if toilet trained or verbal	18	7	2	-0.25	7			0.17	0	1	0.00
Pre-school ended placement	16	8	2	-0.32	3		7	-0.17	2	4	-0.10
A more inclusive culture	12	7	5	-0.30	5		7	-0.15	3	3	-0.22
AIM not available	4	3	1	-0.47	2		2	-0.07	2	2	-0.43
Parent/carer removed child because unhappy with support	4	1	1	-0.11	2			0.22	1	0	-0.23
Pre-school refused child because of need	4	2		-0.36	2			0.22	0	2	0.03
Setting would not access AIM	3	1		-0.24			1	-0.19	0	1	0.02
Specialist pre-school would not accept without diagnosis	2	2		-0.72	1		1	-0.07	1	1	-0.43
Too far from home	2	2		-0.72	1	1		0.22	1	0	-0.47
Another setting more suitable	1	1		-0.72		1		0.00	1	0	-0.93
Choice changed once disability diagnosed	1	1		-0.72	1			0.43	0	1	0.06
Did not get AIM support awarded	1	1		-0.72	1			0.43	1	0	-0.93
Inadequate staffing	1	1		-0.72	1			0.43	0	1	0.06
Keeping siblings together	1	1		-0.72	1			0.43	1	0	-0.93
Level 7 not provided	1	1		-0.72	1			0.43	0	1	0.06
No choice	1	1		-0.72	1			0.43	1	0	-0.93
Opted for home tuition	1	1		-0.72	1			0.43	1	0	-0.93
Setting identified additional needs	1	1		-0.72	1			0.43	1	0	-0.93
Staff low paid	1	1		-0.72			1	-0.57	1	0	-0.93
Unregistered setting	1	1		-0.72	1			0.43	1	0	-0.93

Table 5.11.1 demonstrates that the most prevalent reasons for parent/carers not enrolling their children in their first choice of pre-school were:

- The pre-school was full, closed or with limited space (185)
- An offer of better hours and/or support was given by another pre-school (26)
- The setting was considered to be unsuitable for the child and their needs, either following an enquiry by the parent/carer or after a period in the pre-school (24)
- Staff in the pre-school had negative attitudes to disability and/or the child (19)
- The pre-school would not accept the child because of the requirement for them to be toilet trained or verbal (18)
- The pre-school ended the placement (16)
- That they wanted a pre-school with a more inclusive culture (12)

These data indicate that parent/carers do encounter negative attitudes or resistance from settings, and that these are important reasons for seeking alternative placements. This is sometimes triggered by parental concerns or by pre-schools' resistance/refusal to accept children with

[39] (n) total responses matched to a category do not always match totals per group due to varied combinations of demographic characteristics per respondent.

disabilities/additional needs. For these categories, the differences between groups were small (less than 0.49 or -0.49). Group differences of note are as follows:

- In the case of the rural and town/city and large urban groups, reasons for not enrolling children at parent/carers' first choice of pre-school were more prevalent in the rural and town group, but only to a small degree. The largest difference in categories with counts above (n=10) was for t *better offer made by another pre-school* (-0.41) *and setting unsuitable for my child and their needs* (-40).
- Parent/carers of children with autism/ASD report a range of reasons for not enrolling the child at their first choice of pre-school and the categories when combined describe a situation where settings were considered unsuitable (e.g., *parent/carer removed the child because parent/carer unhappy with support*) or unwelcoming (*pre-school refused child because of need*). Prevalence counts for ASD tend to be higher in these cases, but differences are still small (0.12 to 0.43). The category *Negative attitudes to disability and/or my child at pre-school* is also of interest since it was cited by 19 parent/carers. However, most of these had children who were in groups other than ASD (-0.28), suggesting that negative attitudes are not exclusive to this group.
- When comparing the groups special/mainstream, differences are small, though the category *pre-school full, closed or with limited space* arises less often among the special group than the mainstream group (-0.20).

Table 5.11.2: Survey Question 6: What additional supports do you think would need to be put in place for staff to support your child's meaningful participation in pre-school activities? Weighted differences between prevalence for categories across groups

Category	(n) Total responses mached to this category	(n) Category count Rural & Town	(n) Category count City & Large Urban	Weighted Difference City and Large Urban - Rural and Town	(n) Category Count Autism and ASD	(n) Physical and/or Sensory Disability category count	(n) Category count not ASD	Weighted Difference ASD - not ASD	Category Count mainstream	Category count special setting	Weighted difference special setting - mainstream setting
Q6 What additional supports do you think would need to be put in place for staff to support your child's meaningful participation in pre-school activities?											
Training in how to identify and support children with disabilities/additional needs	88	61	27	-0.41	28	4	28	-0.04	23	20	-0.23
Additional staff to support child	49	31	18	-0.35	27		22	-0.02	6	13	-0.10
Training in how to support autism	36	23	13	-0.36	31	0	5	-0.24	7	8	-0.17
Ensure Level 7 is being used effectively to support my child	16	9	7	-0.28	6	1	10	-0.19	10	4	-0.57
Working with and communicating with parent/carers	15	9	6	-0.32	10	0	5	-0.39	5	3	-0.30
Specialist equipment (e.g., sensory room)	12	7	5	-0.30	7	0	5	0.02	2	3	-0.14
Ensure AIM support is being used to effectively support my child	9	7	2	-0.50	4	1	4	-0.06	2	0	-0.21
Communication and collaboration between pre-school and HSE	6	4	2	-0.39	5			0.36	3	3	-0.43
Getting AIM support approved	5	2	3	-0.12	2		3	-0.17	1	3	-0.15
Safety management and training in medical needs	5	3	2	-0.32	2	2	1	0.06	3	1	-0.55
Making L6 support available	4	1	3	0.03	4		2	0.15	1	3	-0.19
Making recruitment to Level 7 possible	4	1	1	-0.11	3		1	0.18	0	2	0.03
Being positive with and about the child	3	2	1	-0.39	3			0.43	1	0	-0.31
Support for parent/carers in completing AIM applications	3	0	3	0.28	1	0	2	-0.23	1	2	-0.27
Extend hours for child	2	1	1	-0.22			2	-0.57	0	1	0.03
Improve pay and conditions	2		2	0.28	2			0.43	1	1	-0.43
Supporting smoother transition from pre-school to school	2	1	1	-0.22	2			0.43	1	1	-0.43
Ensure INCO is in place	1	1		-0.72	1			0.43	0	1	0.06
Fund increased number of pre-school rooms	1		1	0.28	1			0.43	1	1	-0.87
Reduce ratios	1	1		-0.72	1			0.43	0	1	0.06
Training in how to support second language	1		1	0.28			1	-0.57	1	0	-0.93
Training in positive behaviour management	1	1		-0.72			1	-0.57	0	0	0.00

Table 5.11.2 shows that the most prevalent additional supports called for by parent/carers for their child's meaningful participation are as follows:

- Providing staff with more training on how to identify and support children with disabilities/additional needs (88)
- Providing additional staff to support their child (49)
- Providing pre-school staff with more training on autism/ASD (36)
- Finding ways to ensure that Level 7 support is used effectively (e.g., through using a 1:1 model, recruiting better-trained staff or placing Level 7 support within an inclusive general culture) (16)

- Developing deeper partnership with parent/carers (working with them and communicating) (15)
- Developing the range and quality of specialist equipment (e.g., sensory rooms, hearing equipment) (12)

Generally, differences between groups are small and categories are more prevalent in the ‘rural/towns’, ‘not ASD’ and ‘mainstream groups’. This implies that these proposals for additional support prevail across contexts and are not specific to ASD, nor more necessary in pre-schools in ‘rural and towns/city large urban’ locations. However, prevalence does lean toward rural and towns overall, suggesting that training needs in those locations are higher when compared to city and large urban contexts. Finally, there is more call from parent/carers of children in the ‘ASD’ group for improvements in communication between pre-schools and HSE (weighted difference 0.36).

Table 5.11.3: Survey Question 7: In what way has the support provided by AIM benefited your child? Weighted differences between prevalence for categories across groups

Category	(n) Total responses matched to this category	(n) Category count Rural & Town	(n) Category count City & Large Urban	Weighted Difference City and Large Urban - Rural and Town	(n) Category Count Autism and ASD	(n) Physical and/or Sensory Disability category count	(n) Category count not ASD	Weighted Difference ASD - not ASD	Category Count mainstream	Category count special setting	Weighted difference special setting - mainstream setting
Q7 In what way has the support provided by AIM benefited your child?											
Developments - communication and social skills/confidence	461	337	124	-0.45	170	33	252	-0.15	153	146	-0.29
AIM supported child's inclusion and participation	281	200	72	-0.44	96	19	153	-0.16	85	89	-0.26
AIM brought 1:1 support	211	156	55	-0.46	92	16	104	-0.09	69	52	-0.29
AIM support meant my child's needs were met and understood	199	139	54	-0.43	72	18	101	-0.13	79	68	-0.35
Developments - emotions and behaviour	86	67	19	-0.50	47	0	39	-0.02	29	25	-0.30
Developments - practical skills	70	47	23	-0.39	20	4	41	-0.21	32	22	-0.41
Developments - confidence	60	44	16	-0.45	8	8	33	-0.26	26	20	-0.38
Transition - readiness for school	52	30	22	-0.30	20	4	32	-0.18	16	20	-0.26
Developments - general	50	36	13	-0.44	24	4	25	-0.08	13	15	-0.22
Resources and equipment supported child's inclusion	29	19	10	-0.37	5	1	10	-0.12	9	7	-0.27
AIM support reduced adult to child ratio	25	20	5	-0.52	12		13	-0.09	11	8	-0.39
Parent/carers were supported	24	15	9	-0.34	8	1	15	-0.21	8	11	-0.28
No benefit	22	17	5	-0.49	2	2	9	-0.19	10	8	-0.40
Improvements at home	12	7	5	-0.30	3		1	0.06	5	1	-0.38
AIM support meant access to additional hours in pre-school	5	2	3	-0.12	2		3	-0.17	1	3	-0.15
Developments - practical skills (physical)	5	2	3	-0.12	3		2	0.03	1	2	-0.16
My child's additional needs were identified	4	2	2	-0.22			4	-0.57	2	0	-0.47
Staff training	4	2	2	-0.22	2		2	-0.07	0	3	0.05
Communication with parent/carers (feedback)	2	1	1	-0.22		1	2	-0.57	0	1	0.03
Development - practical (physical)	1	1		-0.72			1	-0.57	0	1	0.06
Developments - sensory	1			0.00				0.00	1	0	-0.93
Developments - emotions and behaviour	1	1		-0.72	1			0.43	0	0	0.00
Parent/carer supported in applying for AIM	1	1		-0.72	1			0.43	0	1	0.06
Provided information for family	1		1	0.28	1			0.43	0	0	0.00

Referring to table 5.11.3, the following categories are most prevalent among the text entries written by respondents in response to the question, 'In what way has the support provided by AIM benefited your child?

- Parent/carers write about the way that their child has developed at pre-school in the context of AIM support
    - Developments in communication, social skills and social confidence (461)
    - Developments in the emotional and behavioural domain (86)
    - Developments in practical skills that are important to independence (70)
    - Developments to general confidence (60)
    - Development in general (50)
- Perceiving benefits to inclusion and participation (281)
- Perceiving benefits to the extent to which their child's needs were understood and met (199)
- The child being more ready for school (52)
- Resources supporting the child's inclusion (29)
- Reductions to the adult-to-child ratio that was key to bringing benefits (25)

- Parent/carers feeling supported (24)
- Improvements to home life (12)

22 parent/carers report no benefits when answering survey question 7, with a proportion difference of 0.10 for the group ‘ASD’. This is a small difference but important to note since it is one of the only weighted differences that lies in the direction of ASD.

When considering differences in prevalence between groups, differences are generally small, though weighted towards city and large urban settings. This is also the case with the group ‘ASD’ and ‘special’. In summary, qualitative analysis for this survey question cannot explain statistically significant differences between groups. Instead, we see that the type of benefits from AIM, as perceived by parent/carers, are similar across types of disability/additional need and context.

Table 5.11.4: Survey Question 8: In what ways has AIM support benefited you/your partner? Weighted differences between prevalence for categories across groups

Category	(n) Total responses matched to this category	(n) Category count Rural & Town	(n) Category count City & Large Urban	Weighted Difference City and Large Urban - Rural and Town	(n) Category Count Autism and ASD	(n) Physical and/or Sensory Disability category count	(n) Category count not ASD	Weighted Difference ASD - not ASD	Category Count mainstream	Category count special setting	Weighted difference special setting - mainstream setting
Q8 In what ways has AIM support benefited you/your partner?											
Reassured right support is in place	286	182	76	-0.38	82	22	143	-0.16	106	113	-0.32
Lessened anxiety and feelings of isolation	285	199	86	-0.42	110	29	174	-0.18	104	124	-0.31
Seeing progress	102	64	38	-0.35	38	10	54	-0.14	34	40	-0.29
Child is happier and more content	61	48	13	-0.51	28	8	32	-0.10	22	22	-0.31
Parent/carers are happier and more content	55	39	16	-0.43	22	6	33	-0.17	14	19	-0.22
Learning about own child's needs and how to support	36	29	7	-0.52	18	2	16	-0.04	13	12	-0.32
Support for parent/carers reduced stress	36	30	6	-0.55	12	4	24	-0.23	15	14	-0.36
Child can go to pre-school in own community (with siblings)	31	23	8	-0.46	10	2	21	-0.25	7	12	-0.19
Being informed	22	15	7	-0.40	10	3	12	-0.11	2	16	-0.04
Being able to access staff	21	15	6	-0.43	9	2	11	-0.11	8	6	-0.34
Preparation for school	11	9	2	-0.54	4	1	7	-0.20	4	5	-0.31
Improvements at home	5	4	1	-0.52	2		3	-0.17	2	2	-0.35
Time for other children	2	2		-0.72	1	1	1	-0.07	0	1	0.03
Parent/carers can work	1	1		-0.72		1	1	-0.57	0	1	0.06
Support with toilet training	1	1		-0.72			1	-0.57	0	1	0.06

Table 5.11.4 shows that when answering survey question 8, ‘in what ways has AIM support benefited you/your partner’ (table 5.11.4), the following categories are present in the texts written by parent/carers:

- Being reassured that the right support is in place (286)
- Feeling less isolated and anxious (285)
- Seeing their children’s progress (102)
- Seeing that their child is happier and more content (55)
- Learning about their child’s needs and how to support them from pre-school staff and other professionals (36)
- Experiencing support that reduces their stress levels (36)
- Their child can go to the local pre-school with their siblings (31)

- Feeling informed (22) and able to access pre-school staff and other professionals (21)
- Their child being prepared for school (11)

These data demonstrate how important AIM support in pre-school has been to parent/carers, particularly in terms of its impact on their child's wellbeing and reductions in their own anxiety. In this sense, reductions of stress and worry are important outcomes.

When exploring differences in prevalence between groups, the following is of interest:

For the groups 'city and large urban/rural and town', we see that the parent/carers in the 'rural and town' group' report the following benefits at higher prevalence:

- Child is happier and more content (-0.51)
- Learning about child's needs and how to support them (-0.52)
- Support for parent/carers brings a reduction in stress (-0.55)
- The child is ready for school (-0.54)

This means that the parent/carers of children who attend pre-schools in the city or a large town report reductions in stress less often. This may indicate that the outcomes of AIM are impacted by a range of factors. Families living in cities and large urban areas may be subject to more complex stresses than those in rural/town areas. Though the data cannot confirm this theory, it is important to note this intersectionality since AIM's success will depend on the extent to which parent/carers experience support in a tangible way, and in a way that is responsive to their circumstances and the additional obstacles this might create.

Differences between the groups 'ASD/not ASD' are very small, and this is also the case for the groups 'special/mainstream', adding evidence to the claim that benefits are not particular to groups but ubiquitous across types of additional needs and context.

Table 5.11.5: Survey Question 9: In what ways has AIM support benefited other children in your family? Weighted differences between prevalence for categories across groups

Category	(n) Total responses matched to this category	(n) Category count Rural & Town	(n) Category count City & Large Urban	Weighted Difference City and Large Urban - Rural and Town	(n) Category Count Autism and ASD	(n) Physical and/or Sensory Disability category count	(n) Category count not ASD	Weighted Difference ASD - not ASD	Category Count mainstream	Category count special setting	Weighted difference special setting - mainstream setting
Q9 In what ways has AIM support benefited other children in your family?											
Developments to child's social skills and emotional wellbeing makes home life happier	179	124	54	-0.41	57	8	96	-0.17	64	67	-0.31
Happy for sibling	47	30	17	-0.36	17	6	30	-0.21	20	14	-0.38
Positive sibling relationship	33	23	10	-0.42	15	1	12	-0.01	8	18	-0.19
Child included (not seen as different)	31	24	7	-0.49	8	4	23	-0.31	10	15	-0.27
Time for other children	0	20	10	-0.39	13	3	17	-0.13	11	11	-0.32
Child can go to pre-school in own community (with sibling-s)	24	18	6	-0.47	7	2	17	-0.28	5	11	-0.17
Improvements at home (less stress)	18	12	6	-0.39	6	2	12	-0.23	7	5	-0.35
Siblings can have a break	6	4	2	-0.39	2	2	4	-0.23	2	0	-0.31
Able to go out together as a family	1	1		-0.72			1	-0.57	0	0	0.00
Positive changes to attitudes about disability among siblings	1	1		-0.72		1		0.00	0	0	0.00
Preparation for school	1		1	0.28	1			0.43	0	0	0.00

Table 5.11.5 summarises the qualitative analysis of text under the question 'In what ways has AIM benefited other children in your family?

The most prevalent categories are similar to those reported under Table 5.11.4, and in Table 5.11.5 and comprise the following:

- The child's social skills and emotional wellbeing has improved bringing benefits to home life (179)
- The child's sibling is happy to see their child at the local pre-school, and doing well there (47)
- The relationship between siblings is more positive (33)
- The child is included and not seen as different bringing benefits to the family (31)
- The parent/carers have more time to share with their other children (30)
- The child can attend the pre-school with their siblings, making things simpler (24)
- Stress levels at home are reduced (18)

Where parent/carers report benefits at home, to their other children, they describe a calmer, happier, simpler life at home which all members of the family gain from. Improved relationships and a feeling that the child is accepted within the local community are also important. Differences between groups are small, with parent/carers in rural and town areas being a little more likely to report benefits than those in city and urban areas. It is important to note that parent/carers are more likely to report benefits arising from their child being included and accepted in the local community in rural and town areas than in large urban and city ones (related weighted differences -0.42, -0.49, -0.47). The reason for this is unclear from these data. For the groups ASD/not ASD, benefits are broadly similar, with very small differences in prevalence.

Table 5.11.6: Survey Question 10: Why do you feel there was no benefit from AIM for your child? Weighted differences between prevalence for categories across groups

Category	(n) Total responses matched to this category		(n) Category count Rural & Town	(n) Category count City & Large Urban	Weighted Difference City and Large Urban - Rural and Town	(n) Category Count Autism and ASD	(n) Physical and/or Sensory Disability category count	(n) Category count not ASD	Weighted Difference ASD - not ASD	Category Count mainstream	Category count special setting	Weighted difference special setting - mainstream setting
Q10 Why do you feel there was no benefit from AIM for your child?												
Did not get AIM support applied for	115		73	31	-0.38	36	4	58	-0.15	39	41	-0.29
Staff in pre-school poorly trained	74		51	23	-0.41	41	3	33	-0.01	22	31	-0.25
Level 7 support not used effectively	59		38	21	-0.36	29	0	30	-0.08	18	30	-0.25
Did not get sufficient support in pre-school	34		22	12	-0.37	22		12	0.08	12	15	-0.30
Poor communication and feedback from AIM/pre-school	29		9	10	-0.13	11	1	18	-0.19	11	11	-0.33
Took too long to get AIM support in place	27		18	10	-0.38	11		16	-0.16	12	10	-0.39
Level 7 support not used effectively (not 1-1)	22		13	9	-0.31	12		10	-0.02	6	13	-0.22
Did not get AIM support applied for	16		11	5	-0.41	6		10	-0.19	5	6	-0.27
Unaware that there was any support	15		7	8	-0.19	6			0.17	8	4	-0.48
Found alternative setting	9		5	4	-0.27	6		3	0.10	3	4	-0.28
Child's needs not met	7		4	3	-0.29	2		5	-0.28	1	4	-0.10
Equipment child needed not available	6		4	2	-0.39	4	1	2	0.10	1	1	-0.14
Level 7 support not used effectively	5		4	1	-0.52	2		3	-0.17	0	3	0.04
Level 7 support too difficult to recruit	5		1	4	0.08	3		2	0.03	1	4	-0.14
AIM waste of time	4		3	1	-0.47	3		1	0.18	1	2	-0.20
Did not get AIM support applied for	4		4		-0.72	2		2	-0.07	2	2	-0.43
Impact of COVID	4		2	2	-0.22	1		1	-0.03	1	3	-0.19
Need more information	4		3	1	-0.47	1	2	2	-0.18	2	1	-0.45
Lack of consistency in routines and staff for child	3		1	2	-0.05	3			0.43	0	0	0.00
Level 7 support not used effectively	3		2	1	-0.39	2		1	0.10	1	1	-0.29
Child non-verbal	2		2		-0.72	1		1	-0.07	1	0	-0.47
Child singled out and stigmatised	2		2		-0.72			2	-0.57	1	1	-0.43

Table 5.11.6 offers insights into why parent/carers report that there was no benefit from AIM for their children. The most prevalent categories centre on the absence of needed support, either because Level 7 was not awarded, delayed, or not used effectively, or because staff (particularly at Level 7) were poorly trained. The following categories were most prevalent

- Did not get AIM support applied for (115)
- Staff in pre-school poorly trained (74)
- Level 7 support not used effectively (59)
- Did not get sufficient support in pre-school (34)
- Poor communication and feedback from AIM/pre-school (29)
- Took too long to get AIM support in place (27)
- Level 7 support not used effectively (not 1-1) (22)
- Did not get AIM support applied for (16)
- Unaware that there was any support(15)

These experiences were reported at slightly higher prevalence among parent/carers whose children attended pre-schools in rural and town areas, with the weighted differences between groups being higher for the following categories:

- Staff in the pre-school being poorly trained (-0.41)
- Not getting AIM support applied for (-0.41)
-

Differences between the groups 'ASD/not ASD' and 'special/mainstream' are small though parent/carers of children in mainstream settings reported that they were unaware that there was any support being provided in the pre-school (-0.48). Overall, these data indicate that the reasons for being dissatisfied with AIM's impact are similar across contexts and types of disability/additional need. In total, the reasons that parent/carers give for dissatisfaction are a guide to what makes AIM less effective from parent/carers' perspectives. These centre on the absence of needed support and poor communication between the pre-school, AIM agencies and the family.

Table 5.11.7: Survey Question 11: Why do you feel there was no benefit from AIM for you/your partner? Weighted differences between prevalence for categories across groups

Category	(n) Total responses matched to this category	(n) Category count Rural & Town	(n) Category count City & Large Urban	Weighted Difference City and Large Urban - Rural and Town	(n) Category Count Autism and ASD	(n) Physical and/or Sensory Disability category count	(n) Category count not ASD	Weighted Difference ASD - not ASD	Category Count mainstream	Category count special setting	Weighted difference special setting - mainstream setting
Q11 Why do you feel there was no benefit from AIM for you/your partner?											
Pressure on parent/carers to lead support and handle challenges (e.g., transport)	183	88	38	-0.29	47	11	63	-0.08	39	55	-0.18
Not applicable	133	86	37	-0.39	49	8	84	-0.20	42	61	-0.27
Poor feedback and reciprocal communication	102	75	27	-0.45	30	5	51	-0.16	38	36	-0.33
No support provided by AIM	93	60	33	-0.36	39	1	39	-0.06	41	32	-0.39
Negative attitudes and practices from staff	19	15	4	-0.51	10	6	4	-0.49	7	9	-0.31
Support insufficient	15	12	3	-0.52	1	1	7	-0.24	4	6	-0.22
AIM support took too long too arrive	10	5	5	-0.22	5	1	5	-0.07	2	6	-0.15
Child unhappy	9	7		-0.56	5		4	-0.01	1	7	-0.05
No benefit	9	8	1	-0.61	4	1	5	-0.12	4	4	-0.39
The focus was on the child rather than supporting parent/carers	8	6	2	-0.47	5		4	-0.01	0	6	0.05
Child has not progressed	6	5	1	-0.55	2		4	-0.23	0	3	0.03
Limited hours and time in pre-school	4	2	2	-0.22	2		2	-0.07	1	2	-0.20
AIM jargon	2		2	0.28			2	-0.57	0	0	0.00
Had to change pre-school	2	1	1	-0.22	2			0.43	1	1	-0.43
Impact of COVID	2	2		-0.72			2	-0.57	1	1	-0.43
A battle to get AIM support	1	1		-0.72	1			0.43	1	0	-0.93
Awaiting diagnosis	1	1		-0.72	1			0.43	0	1	0.06
Impact of COVID	1	1		-0.72			1	-0.57	0	1	0.06
No accountability	1	1		-0.72				0.00	1	0	-0.93
Rural area	1	1		-0.72			1	-0.57	0	1	0.06

Table 5.11.8: Survey Question 12: Why do you feel that there was no benefit from AIM for other children in your family? Weighted differences between prevalence for categories across groups

Category	(n) Total responses matched to this category	(n) Category count Rural & Town	(n) Category count City & Large Urban	Weighted Difference City and Large Urban - Rural and Town	(n) Category Count Autism and ASD	(n) Physical and/or Sensory Disability category count	(n) Category count not ASD	Weighted Difference ASD - not ASD	Category Count mainstream	Category count special setting	Weighted difference special setting - mainstream setting
Q12 Why do you feel that there was no benefit from AIM for other children in your family?											
No support provided	69	47	22	-0.40	34	4	35	-0.08	26	30	-0.32
Child did not improve	22	17	5	-0.49	11	1	11	-0.07	7	9	-0.27
They are already supportive	7	6	1	-0.58	4		4	0.00	4	2	-0.52
Did not know AIM could benefit other children	5	2	2	-0.18	2	1	3	-0.17	1	2	-0.16
Did not reduce pressure on parent/carers (other siblings have additional needs)	3	2	1	-0.39	3			0.43	1	1	-0.29
Sibling did not understand	3	3		-0.72	1		2	-0.23	1	1	-0.29
Lack of space or resources at home	2	1	1	-0.22	1	1	1	-0.07	0	2	0.06
Child still struggling (behaviour, emotions)	1		1	0.28	1			0.43	0	0	0.00
Did not impact positively on financial pressures at home	1	1		-0.72			1	-0.57	1	0	-0.93
Did not know AIM could benefit other children	1		1	0.28			1	-0.57	1	0	-0.93
Siblings already understood child's needs	1		1	0.28			1	-0.57	1	0	-0.93
Siblings attend different setting	1	1		-0.72			1	-0.57	0	1	0.06
Siblings had witnessed abuse	1	1		-0.72			1	-0.57	0	0	0.00
Still separated from sibling	1	1		-0.72			1	-0.57	0	0	0.00
Twins sent home together (when poor behaviour from child)	1	1		-0.72	1			0.43	0	0	0.00
Younger child negatively impacted	1	1		-0.72			1	-0.57	1	0	-0.93

Table 5.11.9: Survey Question 13: What was the negative outcome from AIM (where negative outcome chosen as response)? Weighted differences between prevalence for categories across groups

Category	(n) Total responses matched to this category	(n) Category count Rural & Town	(n) Category count City & Large Urban	Weighted Difference City and Large Urban - Rural and Town	(n) Category Count Autism and ASD	(n) Physical and/or Sensory Disability category count	(n) Category count not ASD	Weighted Difference ASD - not ASD	Category Count mainstream	Category count special setting	Weighted difference special setting - mainstream setting
Q13 What was the negative outcome from AIM (where negative outcome chosen as response)											
The absence of needed support	38	26	12	-0.40	20	3	20	-0.07	13	12	-0.30
Absence of inclusive culture	5	5		-0.72	2	1	3	-0.17	3	0	-0.56
Stress and anxiety from not getting needed support	3	2	1	-0.39			3	-0.57	0	1	0.02
The absence of needed support (could not recruit L7)	3	3		-0.72	2	1	1	0.10	1	1	-0.29
The absence of needed support (poorly trained staff)	3	2	1	-0.39			3	-0.57	0	1	0.02
Child stigmatised	2	1	1	-0.22	2			0.43	1	0	-0.47
The absence of needed support (pre-school did not use L7 support effectively)	2	2		-0.72	2		2	-0.14	2	0	-0.93
The absence of needed support (process too long)	2		2	0.28	2			0.43	2	0	-0.93
Absence of inclusive culture/asked to leave	1	1		-0.72	1			0.43	1	0	-0.93
Feeling we weren't listened to	1	1		-0.72	1			0.43	1	0	-0.93
No development in child	1	1		-0.72		1	1	-0.57	0	1	0.06
Not applicable	1	1		-0.72			1	-0.57	1	0	-0.93
Poor communication/not listening to us	1		1	0.28	1			0.43	1	0	-0.93
Stress and anxiety from not getting needed support (not being able to go to work)	1		1	0.28			1	-0.57	1	0	-0.93
The absence of needed support (L5)	1		1	0.28	1			0.43	0	0	0.00
The absence of needed support (L7 shared)	1		1	0.28			1	-0.57	0	0	0.00
The absence of needed support (safety)	1	1		-0.72	1			0.43	0	1	0.06
We had to change pre-school	1	1		-0.72			1	-0.57	1	0	-0.93

Tables 5.11.7, 5.11.8, and 5.11.9 show that when parent/carers are writing about no benefits from AIM for themselves, their partner and their other children, they give similar reasons to those identified in Table 5.11.6. These centre on support not being in place, their child not improving or developing, and feeling in the dark because of an absence of communication. There are some weighted differences between groups of interest as follows:

Parent/carers of children in the group 'ASD, report that AIM support has not reduced pressure at home (n=3, 0.43), suggesting that in this group, reduction in stress is a benefit from AIM that parent/carers need and hope for. Parent/carers of children in the group 'not ASD' also mention the lack of reduction in stress as a negative outcome of AIM (-0.57) implying that where parent/carers' hope for support and the benefits of it are not fulfilled, it leaves them feeling particularly disappointed by AIM. There are indications here of the importance of communication between parent/carers, pre-schools, and AIM agencies. Parent/carers report not being listened to as a negative outcome of AIM (n=102). It is important to acknowledge that where AIM supports parent/carers as well as children, it is likely to be perceived more positively.

To summarise, findings from **qualitative analysis of text entries by parent/carers** identified the following differences between groups

Groups 'city and large urban' compared to 'rural and town'
Though the survey found that AIM was working more effectively in rural and town areas compared to city and large urban areas from the perspective of parent/carers, the qualitative analysis found few differences between these groups in the category counts for groups. The frequency of categories arising in the text content of the surveys was broadly similar for responses focussing on why the child was not enrolled in parent/carers' first choice of pre-school, additional supports needed for meaningful participation, benefits that AIM brought to the child and family, and reasons for AIM having no benefit or a negative impact. However, there was slightly higher tendency for respondents in the group 'rural and town' to identify the need for more training in additional needs among pre-school staff. Where parent/carers write about benefits, categories are slightly more prevalent in the city and large urban group. Parent/carers of children who attend pre-schools in city and large towns report reductions in stress (-0.55), their child being happier and more confident less often (-0.54), and their child being ready for school (-0.54) less often. This may indicate that the outcomes of AIM are impacted by a range of factors. Families living in cities and large urban areas may be subject to more complex stresses than those in rural/town areas. Though the data cannot confirm this suggestion, it is important to note this intersectionality since AIM's success will depend on the extent to which parent/carers experience support in a tangible way, and in a way that is responsive to their circumstances and the additional obstacles this may pose. We conclude that the survey's qualitative data cannot explain the statistically significant differences between these groups.

Groups 'ASD' compared to 'not ASD'
Though the frequency counts for categories are broadly similar across these groups, there are small but interesting differences between them

- Parent/carers of children with autism/ASD report a range of reasons for not enrolling the child at their first choice of pre-school and the categories when combined, describe a situation where settings were considered unsuitable (e.g., parent/carer removed child because parent/carer unhappy with support) or unwelcoming (pre-school refused child because of need). Prevalence counts for ASD tend to be higher in these cases, but differences are small (0.12 to 0.43).
- The category 'negative attitudes to disability and/or my child at pre-school' is also of interest since it was cited by 19 parent/carers. However, most of these had children who were in groups other than ASD (-0.28), suggesting that negative attitudes are not ASD specific. Evidence from Chi-Square testing tends to support this and provides further evidence that parent/carer perceptions of AIM's impact and inclusive cultures are less positive when their child has ASD or Emotional Disturbance. There is more call from parent/carers of children in the 'ASD' group for improvements in communication between pre-schools and HSE (weighted difference 0.36).

Groups 'special' compared to 'mainstream':
Differences between these groups were small, with category counts being broadly similar.

Generally, parent/carers provide accounts of their experiences of AIM's benefits, strengths and shortcomings that are similar across groups. This indicates that the factors that make AIM work well or poorly are the same no matter the context or disability. The next text box summarises these factors as they are described by parent/carers.

To summarise, the findings from the **qualitative analysis of parent/carers positive experiences of AIM:**

Parent/carers feel **positive about AIM's benefits to their child** when they see the following outcomes:

- Their child has developed at pre-school in the context of AIM support
    - Developments to communication, social skills and social confidence (461)
    - Developments in the emotional and behavioural domain (86)
    - Developments in practical skills that are important to independence (70)
    - Developments to general confidence (60)
    - Development in general (50)
- Improved inclusion and participation (281)
- Their child's needs were understood and met (199)
- The child was more ready for school (52)
- Resources supporting the child's inclusion were in place(29)
- There were reductions to the adult to child ratio that were key to bringing benefits (25)
- Parent/carers were feeling supported (24)
- There were improvements to home life (12)

Parent/carers feel **positive about AIM's benefits to their family** when they see the following outcomes:

- A feeling of being reassured that the right support is in place (286)
- Feeling less isolated and anxious (285)
- Seeing that their child is happier and more content (55)
- Learning about their child's needs and how to support them from pre-school staff and other professionals (36)
- Experiencing support that reduces their stress levels (36)
- Their child can go to the local pre-school with their siblings (31)
- Feeling informed (22) and able to access pre-school staff and other professionals (21)
- Their child being prepared for school (11)
- The child's social skills and emotional wellbeing has improved bringing benefits to home life (179)
- The child's sibling is happy to see their child at the local pre-school, and doing well there (47)

To summarise, the findings from the **qualitative analysis of parent/carers negative experiences of AIM:**

Parent/carers **experience AIM negatively** when they encounter the following:

- The pre school they want to send their child to is full, closed or with limited space (185)
- They experience settings to be unsuitable for the child and their needs, either following an enquiry or after a period in the pre-school (24)
- Staff in the pre-school had negative attitudes to disability and/or the child (19)
- Pre-schools will not accept their child because of the requirement for them to be toilet trained or verbal (8)
- The pre-school ended the placement because they could not cope with the level of need (16)
- They need to seek alternative placements because a pre-school does not have an inclusive culture (12)

Parent/carers **would feel more positive about AIM** if the following additional supports were in place for their children:

- Providing staff with more training on how to identify and support children with disabilities/additional needs (88)
- Providing additional staff to support their child (49)
- Providing pre-school staff with more training on autism/ASD (36)
- Finding ways to ensure that Level 7 support is used effectively (e.g., through using a 1:1 model, recruiting better trained staff or placing Level 7 support within an inclusive general culture) (16)
- Developing more partnership with parent/carers (working with them and communicating)(15)
- Developing the range and quality of specialist equipment (e.g., sensory rooms, hearing equipment)(12)

Though quantitative analysis has demonstrated that parent/carers of children with ASD particularly, and to a lesser extent emotional disturbance, speech and language difficulty and multiple main disability are significantly less likely to perceive AIM positively and experience it as such (when compared to parent/carers of children with physical and sensory Disabilities), the reasons for the difference are not specific to the type of disability but relate to universal aspects of best practice (AIM levels 1-3)

5.12: Summary of findings: Survey of parent/carers

This subsection summarises the main findings from the parent/carer survey with 1,157 respondents. The summary is structured around three core research questions posed for this end of year three evaluation of the Access and Inclusion Model.

Is AIM effective and achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities and additional needs?

The survey findings show that, for the majority of parent/carers, AIM is perceived to have a **positive impact on full inclusion and meaningful participation**.

- The majority of parent/carers agreed with the following statements: as a result of AIM, my child was able to interact socially more frequently with other children (69%), as a result of AIM, my child was able to participate meaningfully in pre-school activities (69%), as a result of AIM, my child was able to interact socially more frequently with other children (69%). as a result of AIM, my child is more confident in educational settings (62%), as a result of AIM my child is more confident in interacting with peers (57%), as a result of AIM, my child was able to attend a mainstream primary school (50%).
- The two benefits reported most positively are related to social interaction (strongly agree, 49%) and meaningful participation (strongly agree, 43%).
- Disagreement with the statement 'As a result of AIM, my child was able to participate meaningfully in pre-school activities' was expressed by a minority of respondents overall (64% agree, 15% disagree) but disagreement was statistically significantly more likely when children attended an ELC setting in a city or large urban area (19%) than when the setting was in a rural location (12%).
- Agreement with the statement 'As a result of AIM, my child was able to participate meaningfully in pre-school activities' was statistically significantly more likely when the child had a physical or sensory disability (85%) when compared with all other types of additional need. It was significantly less likely for parents/carers to agree with this statement if children had autism/autistic spectrum disorder (66%).
- In the case of the statement, 'As a result of AIM, my child was able to attend a mainstream school', parent/carers were statistically significantly less likely to agree in 2020 or later than in all other years (13% compared to an average of 19%). COVID 19 is likely to have had an impact here, given school closures and possible disruption to services during a period of lockdown, but this is not clear from the data. Parent/carers of children attending an ELC setting in a city or large urban area (46%) were statistically significantly less likely to agree with this statement than those whose children attended town (52%) or rural settings (53%).

Parent/carers perceptions of the overall impact of AIM on their child, themselves and the family

In relation to **AIM's overall benefits to their child, themselves, their partner and their other children**, the majority of parent/carers reported positive perceptions of this.

- The majority of parent/carers (82%) reported that AIM benefited their child, with most (52%) reporting this to be to a great extent and 10% to a small extent. A minority (11%) reported no positive impact from AIM, and 4%, a negative impact.
- There were some statistically significant differences in terms of main type of disability/additional need. In relation to benefits for the child, parent/carers of children who

had physical or sensory disabilities (97%) were significantly more likely to report that AIM had benefited their child than parent/carers of children with emotional disturbance or severe emotional distrurbance (69%).

- Parent/carers of children whose main type of need was a physical or sensory disability were significantly more likely to choose the rating descriptor 'a great extent' when considering benefits (73%) when compared to all other types of additional need. Parent/carers of children with autism/autistic spectrum disorders (49%) and specific speech and language disorders (42%) were statistically significantly less likely to choose the rating descriptor 'a great extent' than parent/carers of children with other types of need (average 52%).
- 725 respondents (63%) provided answers to the question, 'how has AIM support benefited your child?'. Parent/carers were positive and often effusive about the benefits of AIM to their child.
- 73% of parent/carers reported that AIM support had also benefited them and their partner, and 46% that it had benefited their other child/children.
- 583 (50%) parents/carers responded to the question, 'how has AIM support benefited you/your partner? The most common themes were reductions in anxiety, a trusting relationship with pre-school staff, support, and advice from the pre-school, knowing that support didn't need to be fought for, seeing their child thrive, and seeing their child valued and accepted. Below, the predominant themes are summarised and exemplified.
- 339 (30%) parents/carers responded to the question, 'how has AIM support benefited your other children?' though for some this was to note they only had one child. Below, the predominant themes are summarised and exemplified, and they focus on how AIM support has helped their other children to relate to their siblings, to be in the same community spaces as their siblings, and experience a calmer, happier life at home. An important theme was to know how AIM had helped siblings develop more positive views on disability and how it had allowed parent/carers more time to spend with their other children.

Access to the first choice of pre-school

- In terms of full inclusion, and meaningful participation, respondents' experiences of being able to send their child to their first choice of pre-school are also relevant, since this has a connection with how accessible they found the sector to be. The majority (89%) reported that they were able to send their child to their first choice of pre-school though this was more likely to occur in a rural setting (91%) than in a town (86%) with this difference being statistically significant. Parents/carers of children with specific speech and language disorders (95%) were more likely to report that their child attended their first choice of setting than was the case with autism/autistic spectrum disorder (85%).
- Common reasons for not enrolling their child at their first choice of pre-school included the pre-school's refusal because the child was not toilet trained, the preferred school having closed down, discontinuation of the placement by the pre-school, unsuitability of the environment for the child and hence a decision to change pre-schools by the parent/carer, non-engagement in AIM by the pre-school, no further capacity for an additional adult in the pre-school, no available places in autism specialist pre-school and negative attitudes to disability by pre-school staff.

Awareness of AIM

- Most parents/carers (60%) had not heard of AIM before their child started pre-school, but the general trend has been towards greater awareness of AIM. An example of this is the statistically significant differences between awareness in 2017 and 2020 onwards: In 2017, 73% (n=131) had not heard of AIM before their child started pre-school, compared to 43% (n=102) in 2020 or later, a statistically significant difference.

- The number of parents/carers who had heard of AIM and understood its offer before their child started pre-school was 8% in 2016 compared to 13% in 2020 or later where the difference is statistically significant when compared to the average of all other years (9%). This is more evidence of a positive trend in awareness, in a context where awareness is still low overall. Generally, parent/carers are reliant on the information and advice they receive from professionals they are already connected with, either through HSE services or within the pre-school when their child is enrolled and/or has begun to attend.

Transition to primary school

- The majority of parent/carers whose children had started school believed that AIM had supported the child's preparation for school (62%, n=318) though 26% (n=133) believed it had made no difference and 4% (n=20) believed AIM support had led to them being less prepared.
- Parent/carers of children attending a mainstream school are significantly more likely to report that AIM had a positive impact on transition to school (66%, n=239) when compared to those attending special classes in mainstream schools (58%, n=58).
- Agreement with the statement, 'As a result of AIM, my child was able to attend a mainstream school' was significantly more likely if children had physical and sensory disabilities (66%) than in the case of all other types of disability.
- In the case of children with physical or sensory disabilities, parent/carers were significantly more likely to report that AIM had a positive impact on transition to school (77%, n=33), than in the case of children with autism/autistic spectrum disorder (60%) and specific speech and language disorder (51%).
- Parent/carers of children who are currently attending a mainstream school are significantly more likely to agree that their children are well prepared for learning in school (80%, n=289) compared to those in special classes in mainstream schools (65%, n=32).
- Where children attend special education primary schools, parent/carers are also less likely to report that their children are well prepared for primary school (63%, n=26), though we note that base numbers are low and cannot be claimed as statistically significant.

These data indicate that AIM is perceived by most parent/carers to have brought positive benefits to their child because (89%) indicate some benefit, 10% no benefit and 4% negative impact This shows that there is some variability in parent/carers perceptions of how included their child was in the pre-school. 69% of parents agreed that AIM had an impact on meaningful participation, and 62% of parent/carers believed that AIM support had supported the transition to school. This may indicate that for parent/carers, successfully accessing mainstream schools is one of their hopes for AIM support, though this needs further exploration in the wider evaluation.

Further quantitative investigation of these differences has confirmed the following findings

Within an overall positive picture where the majority of parent/carers are positive about AIM's impact, there is further evidence that:

- Parent/carers perceive AIM and the inclusiveness of their child's pre-school less positively where their child's reported main disability is ASD.
- Parent/carers of children with emotional disturbance are also less likely to perceive AIM positively, along with those with multiple main disabilities and speech and language difficulties but for these latter two groups, significant differences are less prevalent.

The clearest and most prevalent significant difference is for children with ASD (less positive perceptions of AIM) and children with physical and sensory disabilities (more positive perceptions of AIM).

In summary, for most parent/carers, and in some cases for the majority, AIM is achieving its goal of enabling inclusion and participation, but experiences and the extent of impact is generally varied, with statistically significant differences between some groups (autism/ASD, rural areas and towns/urban areas). There were statistically significant differences in parent/carers perceptions of AIM's positive impact, with parent/carers of children with visible disabilities (physical and sensory) more likely to report positive benefits than those with invisible disabilities (emotional disturbance, autism/ASD, speech and language disorder). Those with autism/ASD seem more likely to have negative experiences overall from the perspective of parent/carers. Analysis of quanitative data in the survey was used to further investigate the reasons for these differences and the key findings were:

Parent/carers perceptions of AIM (experience and impact) and reported main type of disability

- In summary, these data indicate parent/carers of children with physical and sensory disabilities are experiencing and perceiving AIM more positively that parent/carers with other types of difficulties. This is in terms of the inclusiveness of the culture of pre-schools, staff capacities to deliver inclusive practice, and relationships with pre-school staff (e.g., communication and working in partnership). Parent/carers of children with physical and sensory difficulties are also more likely to perceive AIM as having a positive impact. For this group, both the experience of AIM and the impact of AIM is most positive.
- Though it is noted that there are some aspects where there are no significant differences (AIM's impact on confidence for peer interaction or child's ability to attend a mainstream pre-school), parent/carers of children with ASD (and to a lesser extent children with emotional disturbance (ED), specific speech and language difficulties (SSLD), and multiple main disabilities (MMD) report a more variable experience and are less likely to perceive staff as well trained (ASD, ED), able to practice inclusively (ASD, ED), or working in partnership with them (ED).
- Across all of these analyses, it emerges that parent/carers of children with PDs are significantly more likely to experience AIM positively, and parent/carers of children with ASD significantly less likely to do so. However, in the case of ED, PD and MMD, there are also differences. This may demonstrate that pre-schools providers need continued professional development in how to support children with psychosocial difficulties and complex needs (including challenging behaviour), as well as training in how to work effectively with parent/carers of children with such needs.

Parent/Carers perception of AIM (impact and awareness) and location of the pre-school.

- It was found that ASD was more prevalent in pre-schools located in urban areas, and this may have a skewing effect on the data in the light of the associations between *perceptions of AIM* and main *reported type of disability* (see previous section to review less positive perceptions of AIM among parent/carers of children with ASD). In cities, parent/carers are less positive about the impact of AIM on full inclusion and meaningful participation and tend to have lower awareness of the range of supports that are active within their child's pre-school.
- Though significant differences are visible in these data, it is reasonable to assume that they are due to some skewing in the sample combined with lower awareness of AIM supports within pre-schools in urban areas. This indicates a need to consider how communication about AIM (including communication from the pre-school to parent/carers) might need to differ in urban contexts where there are likely to be higher levels of mobility and more complex

intersections of need (including, for example, disadvantage, language diversity and socioeconomic disadvantage).

Has AIM influenced practice, or increased capacity in the workforce?

Indicating positive perceptions of the workforce's capacity for inclusive practice, data from the survey demonstrates the following:

- The majority of parent/carers (94%) believed that the staff in their child's pre-school setting supported their child's full inclusion. Where children attended a setting in a large city/urban area, parent/carers were less likely to agree that this was to 'a great extent' (56%) than if their children attended a setting in a rural area (97%).
- Parent/carers of children currently attending a mainstream primary school chose the descriptor 'to a great extent' (66%) when considering how well staff supported their children's full inclusion at pre-school. This is more than those who had children who were currently in special classes in mainstream schools (50%) or in 'other' types of pre-school than private or community.
- Parent/carers of children with physical or sensory disabilities were significantly more likely to choose 'to a great extent' when describing how well staff supported their child's inclusion (73%) than if their children had emotional and behavioural disorders (53%) or autism/autistic spectrum disorders (57%).
- Parent/carers of children attending settings in rural areas are significantly more likely to choose the descriptor 'to a great extent' (67%) than in the case of city/large urban areas (58%). Parents/carers are less likely to agree with the statement 'There is an inclusive culture at my child's pre-school (this means my child is included in learning' if their child attends a setting in an urban area (56%) compared to a town (60%) or a rural area (64%). This difference is statistically significant.

Overall, the findings demonstrate that the majority of parent/carers perceive pre-school staff and their capacity for inclusive practice positively, though this is more likely when their children have visible disabilities (physical and sensory) than less visible ones (ASD, emotional disturbance, speech and language difficulties); and less likely when the pre-school is in a large urban/city location than other types of location.

Is the current approach appropriate in the National Context?

Parent/carers are generally positive about AIM's positive effects on the inclusion of their child. Generally, parent/carers had relatively low awareness of AIM Levels 1-3, and higher awareness of AIM Levels 4-7, particularly AIM Levels 5 and 7, as demonstrated in the aspects of AIM they identified as being most impactful (as below).

Aspects of AIM making the biggest positive difference

- The aspects of AIM that parent/carers felt had made the greatest difference to their child were: additional assistance (Level 7, staff member) (62%); working in partnership with pre-school staff (34%); and the information or advice provided to pre-school staff on inclusion (Level 2, Level 4, Level 626%). Numbers of parent/carers selecting L6 (therapeutic support) as having been most impactful are relatively low but similar to the numbers who had identified it as an AIM support that their children were receiving. This is notable because it implies that when HSE support is provided either within or outside AIM, it is deemed impactful by parent/carers.

- The number of parent/carers reporting that additional equipment had made the most difference was significantly higher in 2016 (21%, n=33) and 2017 (20%, n=35) than in later years, but the reasons for this are unclear.
- The number of parent/carers reporting that additional assistance had made the most difference was significantly lower in 2016 (54%) in comparison to the average for all years (62%).

This demonstrates that parent/carers tend to identify AIM's most tangible targeted supports as the most impactful elements of AIM. There is evidence in the survey that parent/carers perceive 'AIM support' to be synonymous with Level 7 support. Parent/carers' awareness and perceptions of each Level of AIM are summarised in what follows, beginning with AIM Levels 1-3 (universal supports) and moving to AIM Levels 4-7 (targeted supports)

<u>AIM universal supports</u>

Awareness of AIM's universal supports

- Parent/carers' awareness of the types/levels of AIM support available at their pre-school was relatively low. For AIM Levels 1-3, 40-50% of respondents answered that they didn't know if this type of support was available for their own child, awareness of AIM support for children other than their own child was around 5-6%.

AIM Level 1:

- When asked to agree/disagree with positive statements about the inclusive culture at their child's pre-school, 83% agreed. Parents/carers are less likely to agree with the statement 'There is an inclusive culture at my child's pre-school (this means my child is included in learning' if their child attends a setting in an urban area (56%) compared to a town (60%) or a rural area (64%). This difference is statistically significant. those with children who have physical and sensory difficulties are significantly more likely to agree (93%) than those with emotional and behavioural disorders (81%), learning disabilities (85%), autistic spectrum disorders (82%), specific speech and language disorder (83%) and multiple main disabilities (85%).
- Parent/carers of children with autism/autistic spectrum disorders are significantly more likely to disagree with the statement (10%) than those with physical and sensory difficulties.

AIM Level 2:

- 40% of parent/carers selected 'yes, to my child' when answering the survey question 'As far as you're aware, does your pre-school provide signposting to parent/carers about relevant information (on aim.gov.ie)? Hence awareness of AIM Level 2 is relatively low but is implicated in more positive perceptions of AIM overall.

AIM Level 3:

- Most parent/carers (78%) believe the staff at their child's pre-school are well-trained, although this is lower in urban areas (73%) than in town (80%) or rural (79%) areas. Where children were currently attending a mainstream setting, parent/carers were more likely to describe the pre-school staff as well trained (83%) than in other types of current setting
- We also know that parent/carers of children with autism/autistic spectrum disorder were least likely to describe pre-school staff as well-trained than all other types of disability/learning difficulty (73%). Parent/carers of children with physical and sensory difficulties were the most likely to describe pre-school staff as well trained (87%) when compared to autism/autistic spectrum disorder (73%), learning disabilities,speech and language disorder, and emotional and behavioural disorders (72%, n=26). Parent/carers of children with autism/ASD are the

most likely to hold negative perceptions of inclusiveness in the setting and how well-trained staff are.

Overall, most parent/carers are positive about the inclusive culture of their child's pre-school, and the majority report that pre-school staff are well trained. Again, parent/carers of children with sensory and physical disabilities are more positive than those of parent/carers with less visible disabilities (autism/ASD, emotional disturbance, speech, and language disorder), with parent/carers of children with autism/ASD being more likely to be dissatisfied with AIM level 1 and 3. Experiences also emerge to be less positive when a child is attending a pre-school in a city or large urban area and a mainstream setting.

Findings from further quantitative analysis using Chi-Squared tests, shed light on the relationship between key aspects of AIM's universal supports and parent/carer perceptions of AIM's overall impact. These findings are as follows:

- Level 1: Where parent/carers experience partnership working, they are more likely to perceive AIM's impacts positively.
- Level 2: Where parent/carers do not perceive information to/from pre-school staff as beneficial, they are more likely to report that AIM had no positive impact on their child overall. These data provide support for the important role of AIM Level 2 in achieving the intentions of the policy.
- Level 3: From the perspective of parent/carers, AIM is regarded as more impactful when parent/carers perceive that pre-school staff are well trained. Where the observation is that practitioners are poorly trained, parent/carers are more likely to perceive that AIM had made no difference to their child's inclusion. This supports the importance of integrating continuous professional development into AIM since it emerges that having the supports in place is not a guarantee of impact since much may rely on how well practitioners can make use of those supports to achieve inclusive outcomes.

AIM targeted supports

Awareness of AIM targeted supports

- 40-50% of respondents answered that they did not know if that type of support was available for their own child, awareness of AIM support for children other than their own child was around 5-6% with awareness of L5 highest at 7%. Awareness of L6 was lowest for 'yes to my child' (4%), and for 'yes, but not to my child' (4%).
- The exception was for Level 7 support where 70% knew that this was provided at their child's setting (64% for own child and 6% for other children) which suggests either that the majority of responses were from parent/carers whose child received Level 7 support and/or that AIM support as a concept is synonymous with L7 support in respondents' general view. These findings may also indicate that parent/carers are most aware of those supports that are tangible and visible (such as additional adults and equipment/building alterations).

To summarise, **parent/carers' perceptions of AIM** for each level of its targeted supports were found to be as follows.

AIM Level 4:

- For parent/carers who had heard of AIM before starting pre-school, just under a quarter (24%) of parent/carers said they/the pre-school had had contact with a Better Start Early Years professional when applying for a pre-school place (39% had not, and 37% said they did not know).

- Two-fifths of parent/carers (42%) said the pre-school had accessed information/advice from an early years specialist, but overall, awareness of Level 4 is relatively low.
- There was relatively low awareness of the Access and Inclusion Profile. 48% of parent/carers had heard of an Access and Inclusion Profile and of those 57% were involved in completing one for their child and 43% were not, with 9% answering 'don't know. This was surprising given that parental assent on the Access and Inclusion Profile must be in evidence before an application can be made and again may indicate that parent/carers are less aware of the nomenclature of AIM as it exists in policy than they are of the engagement they experienced.
- We also know that parent/carers of children with autism/autistic spectrum disorder were less likely than parent/carers of children with other types of disability/additional need to answer 'yes' when asked if they were involved in completing an Access and Inclusion Profile (26%).
- The majority of parent/carers who said that they were involved in writing an Access and Inclusion Profile agreed that the process of accessing support from an Early Years Specialist was positive (between 75% and 85%). Most parents/carers also indicated that their child was treated like an individual (83%) and that they were well supported by the pre-school staff in the process of engaging with the EYS (87%).

AIM Level 5

- When considering the statement, 'my child was allocated the equipment he/she needed to access learning at pre-school', 60% of parent/carers agreed. Parent/carers of children currently attending mainstream school were more likely to agree with this statement (67%) than was the case with all other types of current settings.
- Parent/carers of children with physical/sensory disabilities were more likely to agree with this statement (80%) than those with autism/autistic spectrum disorders (56%), specific speech and language disorders (63%) and multiple main disabilities (57%). Parent/carers of children with autism/autistic spectrum disorder were significantly less likely to agree with this statement (15%) than those with physical and sensory disabilities (3%, n=2).
- Analytic statistics showed that there is very strong evidence of an association between receiving an outcome following an application for AIM Level 5 support and parental perception that as a result of AIM, their child was able to participate more meaningfully in pre-school activities. We conclude that the receipt of Level 5 support is associated with parent/carer perceptions of positive impact in relation to participation, and ease of access in securing support. It was not associated with parent/carer perceptions of increased social confidence or ability to attend a mainstream pre-school.

AIM Level 6:

- 63 (5%) of parent/carers indicated that they had applied for therapeutic/health support. The most common type of support applied for was speech and language therapy (39%), occupational therapy (34%), psychology intervention, (30%, n=19) and physiotherapy (24%, n=15).
- Awareness of AIM Level 6 was lowest at 6% 'for my child' and 4% for 'children other than my child' compared to an average of 40-50% for other levels.
- A key finding was that parent/carers were likely to be conflating their experiences of HSE intervention outside AIM (e.g., where they or a health professional has completed a referral leading to an intervention, and where the child may have a diagnosis prior to pre-school) with AIM Level 6 (where universal support may also be conflated with targeted support). This suggests some need to clarify with

parent/carers what the actual purpose and content of AIM Level 6 is since some qualitative data in the survey demonstrates that parent/carers conceptualise AIM Level 6 as the provision of a continuous programme of, for example, physiotherapy or speech therapy. Though this may happen as a result of referral through AIM, it is not the only or most likely type of Level 6 support.

- Where parent/carers have experienced a referral with follow-up intervention from HSE (within or outside AIM), their perceptions of AIM are more positive. This association is evidenced very clearly and suggests that growth in Level 6 (targeted and universal) may also result in growth in positive perceptions of AIM. However, it is also important to note that not getting Level 6 support was not associated with parent/carers feeling that AIM had made no difference. Rather, Level 6 targeted/HSE support deepened the impact of AIM for children in parent/carers' view. We conclude that there is a relationship between the presence of Level 6 targeted/HSE support (inside or outside AIM) and parent/carers' perception of AIM's positive impact.

AIM Level 7

- Awareness of Level 7 support as an aspect of AIM was relatively very high compared to other AIM Levels (73% of parents/carers were able to identify when an additional member of staff was appointed to support their child in the pre-school context).
- It is important to restate that, in terms of the most beneficial elements of AIM, 62% of parent/carers noted that additional support in the pre-school room was the most beneficial aspect.

These data indicate that parent/carers are most aware of Level 5 and Level 7, perhaps because they are the most visible, tangible elements of AIM support. Where parent/carers were involved in the development of Access and Inclusion Profiles, perceptions of Level 4 are more positive. Evidence of statistically significant differences between parent/carers' satisfaction with AIM where their children have autism/ASD when compared to physical and sensory disabilities continues to emerge. It is also notable that satisfaction with AIM Level 5 is higher when children attend mainstream school.

Further statistical analysis has also found the following relationships between AIM's targeted supports and parent/carer perceptions as follows:

- Level 5: The receipt of Level 5 support is associated with positive perceptions of the impact on meaningful participation, and the view that support was easy to access. Receipt of Level 5 support is also associated with a positive view of AIM overall, among parent/carers who are reporting that an application was successful.
- Level 6: Where children are reported to have been referred for HSE intervention (either through AIM Level 6 or via a self-referral or referral by a GP or Public Health Nurse outside AIM) there is strong evidence of an association between the presence of HSE engagement during their child's pre-school years and positive perceptions of AIM's impact (e.g., meaningful participation, social interaction, attendance of mainstream pre-school). This indicates that for the parent/carers surveyed, HSE engagement seemed to have enhanced AIM's effectiveness. It is also important to note that <u>not</u> getting Level 6 targeted support /HSE support following a referral was <u>not</u> associated with parent/carers feeling that AIM had made no difference. Rather, HSE engagement deepened AIM's impact in relation to its key goals (full inclusion and meaningful participation)
- Level 7: The receipt of Level 7 support is associated with positive parent/carer perceptions of AIM and its impact on children's development, inclusion, and participation. Where applications are declined, this is associated with negative perceptions of AIM and its impact. However, these data have also illustrated that parent/carers have strong belief in Level 7 as a route to

inclusion for their children, since only 34/958 who had been involved in an application for Level 7 support described it as having a negative outcome, even where it had not been awarded

Overall, for most parent/carers, AIM is perceived to be working, though there is variability in the extent of its impact, suggesting that there is work still to do to ensure that AIM is working effectively for all.

Areas that are working well

Generally, most, and sometimes the majority of parent/carers perceive AIM's impact and the inclusiveness of their child's pre-school positively. Content analysis of the survey's qualitative data found the following when exploring why parent/carers' hold these positive perceptions, and these factors were common across types of disability and location of the pre-school (urban, town, city), demonstrating that universal, effective practice is relevant no matter what the context.

Qualitative analysis of text responses in the survey showed that parent/carers feel positive about AIM's benefits to their child when they see the following outcomes:

- Their child has developed at pre-school in the context of AIM support
    - Developments in communication, social skills, and social confidence (461)[40]
    - Developments in the emotional and behavioural domain (86)
    - Developments in practical skills that are important to independence (70)
    - Developments to general confidence (60)
    - Development in general (50)
- They perceive improved inclusion and participation (281)
- Their child's needs were understood and met (199)
- The child was more ready for school (52)
- Resources supporting the child's inclusion were in place(29)
- There were reductions to the adult-to-child ratio that was key to bringing benefits (25)
- Parent/carers were feeling supported (24)
- There were improvements to home life (12)

Parent/carers feel positive about AIM's benefits to their family when they see the following outcomes:

- A feeling of being reassured that the right support is in place (286)
- Feeling less isolated and anxious (285)
- Seeing that their child is happier and more content (55)
- Learning about their child's needs and how to support them from pre-school staff and other professionals (36)
- Experiencing support that reduces their stress levels (36)
- Their child can go to the local pre-school with their siblings (31)
- Feeling informed (22) and able to access pre-school staff and other professionals (21)
- Their child is prepared for school (11)
- The child's social skills and emotional wellbeing have improved bringing benefits to home life (179)
- The child's sibling is happy to see their child at the local pre-school, and doing well there (47)

[40] Value in brackets is the prevalence count for this category of reason. It denotes how many respondents raised this point in free -text comments

It can be noted that when AIM is working well for parent/carers it is because their child is developing and understood, because their child is being included, and because resources for support were in place. Reductions in stress at home were also important, as was the child being prepared for school, and the experience of the child being accepted in the local community.

Areas that need development

- 137 (12%) of respondents answered the question, 'What additional support needs to be put in place for staff to support meaningful participation in pre-school activities? Answers focussed on the need for additional staff to provide 1:1 (or SNA) support, more effective and ethical use of Level 7 support by providers, better pay and working conditions for Level 7 staff, more training on specific disabilities (particularly ASD) and better communication/collaboration between providers, parent/carers, and other agencies.

To summarise, the findings from **the qualitative analysis of parent/carers about parent/carers' negative experiences of AIM: Parent/carers experience AIM negatively when they encounter the following:**

- The pre school they want to send their child to is full, closed or with limited space (185)
- They experience settings to be unsuitable for the child and their needs, either following an enquiry or after a period in the pre-school (24)
- Staff in the pre-school had negative attitudes to disability and/or the child (19)
- Pre-schools will not accept their child because of the requirement for them to be toilet-trained or verbal (8)
- The pre-school ended the placement because they could not cope with the level of need (16)
- They need to seek alternative placements because a pre-school does not have an inclusive culture (12)

Parent/carers would feel more positive about AIM if the following additional supports were in place for their children:

- Providing staff with more training on how to identify and support children with disabilities/additional needs (88)
- Providing additional staff to support their child (49)
- Providing pre-school staff with more training on autism/ASD (36)
- Finding ways to ensure that Level 7 support is used effectively (e.g., through using a 1:1 model, recruiting better-trained staff or placing Level 7 support within an inclusive general culture) (16)
- Developing deeper partnerships with parent/carers (working with them and communicating) (15)
- Developing the range and quality of specialist equipment (e.g., sensory rooms, hearing equipment) (12)

Generally, these findings indicate that the shortages of available places, negative attitudes in the pre-school, or pre-school refusal on the basis of the child's additional needs are reasons for dissatisfaction. In relation to routes for an improved experience, parent/carers focus on the need for more training (in additional needs generally, and autism), additional support, making Level 7 more effective and having more of a partnership experience with pre-schools and AIM agencies.

Analysis of these data for differences between groups of respondents whose perceptions tended to be less positive to a statistically significant degree (Autism/ASD, special setting, city/large urban), found the reasons for a positive or negative experience were similar across these groups. This indicates that the factors that make AIM work well or poorly are the same no matter the context or

disability. Quantitative analysis has also cast light on the importance of an inclusive culture to parent/carer perceptions of AIM and its impact.

We conclude that the survey's qualitative data cannot explain the statistically significant differences between these groups, but do offer an insight into the generally effective practices that are fundamental to the effective inclusion of all children from the perspective of parent/carers. Quantitative analysis has indicated that an experience of partnership working, information about AIM to staff, perceptions that staff are well trained, and receipt of Level 5 and Level 7 support, are associated with more positive perceptions about AIM's impact on children.

Another key finding from the survey of parent/carers was confusion over the purpose and content of Level 6 HSE support. Though it is true to say that parent/carers have very low awareness of Level 6 support, and in general it is the least prevalent type of support provided through AIM, quantitative analysis has identified a clear association between the presence of HSE engagement in children's pre-school years (whether inside or outside of AIM Level 6) and parent/carers perception of AIM as being effective in the full inclusion and meaningful participation of their child.

To what extent can/should AIM be scaled up and out?

This question was explored in interviews with parent/carers and in the case studies.

6. Early Learning and Care Providers Survey: Findings

This section reports the findings of the survey of providers of Early Childhood Care and Education (ECCE), who participated in the Access and Inclusion Model (AIM).

6.1: Introduction: Presentation of findings

Findings are presented in the following way. Firstly, the characteristics of the sample will be summarised in terms of its demographics. Then, findings on participation and providers' views on the impact of AIM will be reported. These will include impacts on the pre-school (knowledge, practice, and capacities), and children and families. Following this, findings related to each level of AIM (1-7) will be reported. Findings are presented graphically (through summary tables, cross-break tables, and charts), with narrations of content and interpretation beneath. Findings from the analysis of the surveys' qualitative content will also be reported. The section ends with a summary of the findings as these relate to the four evaluation questions, which to reiterate, were:

- Is AIM effective and achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities?
- Has AIM influenced practice, or increased capacity in the workforce?
- Is the current approach appropriate in the national context?
- Can AIM be enhanced, and/or scaled up or out?

Finally, headline findings are summarised in an infographic.

6.2: Characteristics of the sample

Table 1: Size and type and setting of pre-school

	Total
Total	732
Up to 29 children	290
	40%
30 children or more	442
	60%
Type of pre-school	
Community	203
	28%
Private	362
	49%
Setting of pre-school	
City or large urban area	182
	25%
Town	273
	37%
Rural	276
	38%

- As Table 1 shows, there were a total of 732 respondents in the survey of ELC providers.

- 28% of respondents were from a community ELC setting and 49% were from a private ELC setting. 25% of settings were in a city/large urban area, 37% in a town, and 38% in a rural area.

Table 2: Year setting opened and job role

Job Role	
Owner	339
	46%
Manager	309
	42%
Inclusion coordinator (INCO)	71
	10%
Other staff member	13
	2%
Year ELC setting opened	732
2020	6
	1%
2019	11
	2%
2018	13
	2%
2017	9
	1%
2016	20
	3%
Prior to 2016	673
	92%
2016 or later	59
	8%

- As Table 2 shows, when asked to select one option in response to the question 'What was your job role? 46% of respondents communicated that they were setting owners, 42% managers, 10% Inclusion co-ordinators (INCOs), and 2% other staff members. It can be assumed that most respondents were in the role of manager and INCO co-ordinator given that in another section of the survey, the majority (88%) noted that there is a named inclusion co-ordinator among the staff at their setting.
- 92% of the settings represented in the survey had opened prior to 2016 (the year AIM was launched).

Table 3: Number of children and type of pre-school

Number of children enrolled in pre-school	Type of pre-school: Total	Community	Private
Total	732	203	362
1-9	21	5	9
	3%	2%	2%
10-19	115	25	56
	16%	12%	15%
20-29	154	35	91
	21%	17%	25%
30-39	113	23	66
	15%	11%	18%
40 or more	329	115	140
	45%	57%	39%
Up to 29	290	65	156
	40%	32%	43%
30 or over	442	138	206
	60%	68%	57%

- As Table 3 shows, 3% (n=21) of settings had 1-9 children on roll, 16% had 10-19, 21% had 20-29, 15% had 30-39, and 45% had 40 or over.
- Statistically significant differences were found between the type of pre-school and the number of children on roll. For example, community pre-schools were significantly more likely to enrol 40 or more children (57%) when compared to private pre-schools (39%). It is notable that 68% of community settings (n=138) had 30 or over children on roll and 32% (n=65) had up to 29. In contrast, 25% of private pre-schools (n=91) had 20-29 children on roll and 18% (n=66) had 30-39, meaning that private pre-schools were significantly more likely to be smaller.

Table 4: County of pre-school for providers and (% of open services with an ECCE contract)[41]

Total	**732**		
Co Carlow	7	**Co Leitrim**	5
	1% (1.1%)		1% (0.7%)
Co Cavan	16	**Co Limerick**	25
	2% (1.6%)		3% (4.2%)
Co Clare	29	**Co Longford**	9
	4% (3.1%)		1% (0.8%)
Co Cork	77	**Co Louth**	15
	11% (10.7%)		2% (2.7%)
Co Donegal	22	**Co Mayo**	21
	3% (3.6%)		3% (3.0%)
Co Dublin - Dublin City	61	**Co Meath**	40
	8% (9.2%)		5% (4.4%)
Co Dublin - Dun Laoghaire Rathdown	21	**Co Monaghan**	6
	3% (4.2%)		1% (1.5%)
Co Dublin - South County Dublin	48	**Co Offaly**	16
	7% (5.1%)		2% (1.5%)
Co Dublin - Fingal	33	**Co Roscommon**	7
	5% (6.8%)		1% (1.4%)
Co Galway	39	**Co Sligo**	11
	5% (6.4%)		2% (1.7%)
Co Kerry	28	**Co Tipperary**	27
	4% (3.0%)		4% (3.9%)
Co Kildare	43	**Co Waterford**	19
	6% (4.3%)		3% (2.3%)
Co Kilkenny	14	**Co Westmeath**	9
	2% (2.2%)		1% (1.8%)
Co Laois	22	**Co Wexford**	35
	3% (1.9%)		5% (3.1%)
Prefer not to say	2	**Co Wicklow**	25
	*%		3% (3.6%)

- Table 4 shows that all 29 counties were represented in the survey, though there were variations in the respondent count for each, in most cases related to the number of services with an ECCE contract. For example, the counties with the highest representation were Cork (11%), followed by Dublin City (8%) and South County of Dublin (7%). In comparison, those with the lowest representation of 1% were Carlow, Leitrim, Longford, and Westmeath.6.3:

AIM overall

This section reports on providers' perceptions of AIM overall. Sections 6.4 to 6.10 will report on findings related to each level of AIM.

[41] Figures acquired from Pobal, November 2021

Pre-school participation in AIM

Table 5: Year that ELC setting first participated in AIM and size and type and setting of pre-school

Year first started AIM	Size of ELC			Type of pre-school			Setting of pre-school	
	Total	**Up to 29 children**	**30 children or more**	**Community**	**Private**	**City or large urban area**	**Town**	**Rural**
Total	732	290	442	203	362	182	273	276
2021	6	2	4	2	4	3	2	1
	1%	1%	1%	1%	1%	2%	1%	%
2020	52	31	21	12	26	12	22	18
	7%	11%	5%	6%	7%	7%	8%	7%
2019	81	56	25	17	41	19	27	35
	11%	19%	6%	8%	11%	10%	10%	13%
2018	110	53	57	28	58	34	37	38
	15%	18%	13%	14%	16%	19%	14%	14%
2017	132	58	74	38	61	33	50	49
	18%	20%	17%	19%	17%	18%	18%	18%
2016 - when AIM first started	321	82	239	95	161	75	123	123
	44%	28%	54%	47%	44%	41%	45%	45%
2017 or later	381	200	181	97	190	101	138	141
	52%	69%	41%	48%	52%	55%	51%	51%

- Table 5 shows that 44% of pre-schools began participating in AIM in 2016 (when AIM first started). 52% participated from 2017 onwards.
- Participation in 2016 was significantly more likely in settings with 30 children or more (54%, n=239) when compared to settings with up to 29 children (28%, n=82). When pre-schools first participated in AIM from 2017 onwards, there was a statistically significant difference between larger and smaller pre-schools. For example, respondents in smaller pre-schools were significantly more likely to report that 2018 was the year when they first participated in AIM (18%, n=53) than larger pre-schools (13%, n=57). This implied that AIM's scope has developed to encompass smaller ELC settings.

Table 6: For settings open prior to 2016, approximate number of children with disabilities/additional needs on roll prior to 2016 and at the end of 2020

If the setting has children with disabilities at the end of 2020	**Prior to 2016**	**At the end of 2020**
Total	673	732
Yes	571	647
	85%	88%
No	55	76
	8%	10%
Mean Score	3.1	3.4

- As shown in Table 6, 88% of respondents reported that their settings had children with disabilities/additional needs on roll at the end of 2020 with the mean being 3.4 compared to 3.1 before 2016 though this difference is not statistically significant.
- From further cross-break analyses, we also know that the mean score for the approximate number of children with disabilities in an ELC setting in 2016 was 3.9 in city/large urban areas, 3.2 in towns and 2.5 in rural areas. However, these differences are not statistically significant.

Table 7: Approximate number of children with disabilities/additional needs on roll at the end of 2020 and size/type/setting of pre-school

Base: Providers who had children with disabilities/additional needs at the end of December 2020

Number of children with disabilities/additional needs on roll		**Size of ELC**		**Type of pre-school**		**Setting of pre-school**		
	Total	**Up to 29 children**	**30 children or more**	**Community**	**Private**	**City or large urban area**	**Town**	**Rural**
Total	647	238	409	183	320	168	247	232
Mean Score	3.4	2.5	4.0	4.2	3.1	4.4	3.4	2.7

- As shown in Table 7, at the end of 2020, no statistically significant differences were found in the profile of children with disabilities/additional needs on roll at the end of 2020 in terms of size of ELC, type and setting of pre-school, and year started AIM.
- However, there are some notable differences as follows:
  - The mean number of children with disabilities/additional needs is highest in pre-schools with 30 children or more (4.0) compared to those with 29 or fewer (2.5).
  - The mean is also higher in community pre-schools (4.2) than it is in private pre-schools (3.1).
  - The mean in rural (2.7) and town (3.4) areas is lower than in city/large urban areas (4.4).

Table 8: Approximate number of children with disabilities/additional needs on roll at the end of 2020 and year participation in AIM started

Base: Providers who had children with disabilities/additional needs at the end of December 2020

		Year started AIM				
	Total	**2020-2021**	**2019**	**2018**	**2017**	**2016**
Total	647	52	68	86	116	298
Mean Score	3.4	2.6	2.9	2.8	3.3	3.9

- As Table 8 shows, when considering the year that ELC settings started participating in AIM, the mean score for the number of children on roll with disabilities at the end of 2020 is higher for ELC settings which started AIM in 2016 than it is for those which started in 2020-21.
- These differences were not found to be statistically significant.

6.3: Provider perspectives on AIM overall

Table 9: Providers' view on how much impact AIM has made to inclusion in their ELC setting overall and size of ELC, and type of pre-school and first year of participation in AIM

		Size of ELC		Type of pre-school		Year started AIM				
The Impact of AIM on the setting overall	**Total**	**Up to 29 children**	**30 children or more**	**Commun-ity**	**Private**	**2020-2021**	**2019**	**2018**	**2017**	**2016**
Total	732	290	442	203	362	58	81	110	132	321
A large positive impact	580	237	343	172	299	35	62	88	116	257
	79 %	82%	78%	85%	83%	60%	77%	80%	88%	80%
A small positive impact	120	37	83	25	56	19	15	16	16	49
	16 %	13%	19%	12%	15%	33%	19%	15%	12%	15%
No impact	18	12	6	3	3	3	3	1	0	10
	2%	4%	1%	1%	1%	5%	4%	1%	0%	3%
A small negative impact	3	0	3	0	1	0	0	2	0	1
	%	0%	1%	0%	%	0%	0%	2%	0%	%
A large negative impact	1	0	1	0	0	0	0	1	0	0
	%	0%	%	0%	0%	0%	0%	1%	0%	0%
Too early to say	8	3	5	3	2	1	0	2	0	3
	1%	1%	1%	1%	1%	2%	0%	2%	0%	1%
Don't know	2	1	1	0	1	0	1	0	0	1
	%	%	%	0%	%	0%	1%	0%	0%	%
POSITIVE IMPACT	700	274	426	197	355	54	77	104	132	306
	96 %	94%	96%	97%	98%	93%	95%	95%	100%	95%
NEGATIVE IMPACT	4	0	4	0	1	0	0	3	0	1
	1%	0%	1%	0%	%	0%	0%	3%	0%	%

- As Table 9 shows, 96% of respondents reported that AIM had a positive impact in their ELC setting with a significant difference in the responses of those whose settings started with AIM in 2017 (100%) compared to all other years.
- Respondents from private settings were significantly more likely to report this (98%) than those from community settings (97%). Positive impacts described as 'large' were most likely to be reported in cases where the setting had begun to engage with AIM in 2017 (88%) compared to 2019 (77%) and 2020-21 (60%) and these differences were statistically significant.

- For providers whose ELC settings began to engage with AIM in 2020-21 (60%), respondents were significantly more likely to report that the impact was 'small' (33%) or that there was little or no benefit (10%) than in the case of all other years. This may be a result of COVID 19 and closures/limitations in ELC and other (HSE) services. It is reasonable to assume that this may also be an indication that AIM needs to bed in and for inclusive practice to be embedded.

Free text comments related to the survey question 'Why do you say that?' in the context of impacts of AIM

645 (88%) of respondents answered the question 'why do you say that?' following their rating on the impact of AIM. Their responses provide explanations for why respondents perceive positive impact and little/no or negative impact.

Comments provided by respondents who reported positive impacts

The most common themes related to positive impacts are summarised and exemplified below. The content of comments generally focusses on the way that AIM has; made inclusion possible; enabled better provision for children; secured enough support to enable children to develop and progress; reduced the teacher-to-pupil ratio; supported access to different specialists, and enabled mentorship from Early Years Specialists.

- AIM has made inclusion more possible.

> 'I have operated a pre-school service since 1990, and lived through all the Acts, regulations and changes and every aspect of change has been a very welcomed one. Ireland is now catching up with other countries in providing inclusive settings for children and families and has made working with children less stressful as the support is there to ensure that a service can achieve their goal.'
>
> 'AIM has been such a positive fundamental resource for our service. It has enabled us to include all children within our pre-school. The advice and support have always been there with our mentors.'
>
> 'The provision of AIM has benefitted children attending our service who have additional needs and require extra supports massively. It has ensured that our service is accessible to all children and their individual care needs are met by way of an extra member of staff.'

- AIM has enabled better provision for all children

> 'We have been able to do so much more for the children in our pre-school than we would have been able to if we did not have access to the training, early years specialist support or the higher capitation that AIM provides.'
>
> 'It has provided funding and support for including all children having an extra staff member allows practitioners time to meet the needs of the child in an inclusive environment with their peers.'
>
> 'AIM is very important for services to deliver the proper care for all children. Staff need to be supported to deliver this.'

- AIM has secured the additional support needed to help children to progress and develop.

> 'With the additional support of a staff member, it has ensured the children and team feel supported. The additional support has allowed children to access the curriculum at their own pace and allowed for specific, individualised planning.'

‘We have seen the benefits first-hand of how time and support given to a child can help them reach their full potential. By assisting and encouraging them to participate fully in the early years setting, they can go on to mainstream school.’

‘It has given children with additional needs a better opportunity to develop and learn in their time frame, and has aided them when they need extra supports, when they might be typically with big groups in pre-school.’

- AIM has supported a reduction of the teacher-to-pupil ratio, and has improved the experiences of staff and children, as well as improving the quality of provision overall.

‘It enables more staff to be hired to allow lower ratios and in turn, give more time to the children who need assistance as well as ensuring the other children in the room receive enough attention.’

‘It was wonderful to have support for the staff and the child in question by reducing the child-adult ratio and bringing in an extra member to the team adds to the team experience.’

‘Because the ratios are high to provide quality care to all children, therefore by being able to receive AIM supports allows us to lower our ratios somewhat allowing us to spend more quality time with each child. I personally feel the ratio 1-11 is very high in the ECCE service as most children would benefit from more one-to-one time with an adult.’

‘Funding to employ additional staff or reduce numbers makes a huge difference to quality of care for all the children.’

- AIM has provided access to specialist advice and support, and this has been beneficial.

’Support from AIM early years specialist was helpful to ensure we are on the right track, brings new ideas and strategies.’

‘Support and advice from early years specialists, funding assistance for staff for child with inclusion.’

- AIM has provided funding for extra staff

‘We have support from our mentor if we need it. We have additional staff, bringing our child/adult ratios down, offering support to children. We have become more knowledgeable ourselves around the ethos of inclusion and the benefits for all involved.’

- AIM has provided advice and mentoring from Early Years Specialists, which has been supportive to inclusion

‘The mentoring and advice from the early years specialist has been invaluable to us in adopting inclusion in our service. The capitation to employ additional staff members has truly made a huge impact on the inclusion of all children and ensuring full participation of all children.’

‘The knowledge we continue to learn from the EYS (each child and each year brings new challenges and need new strategies, advice, and emotional support) and the benefit and knowledge gained by having an extra educator bringing their knowledge and experience has been and continues to be hugely beneficial to all the children who use our service.’

'Having extra staff has made a difference. Support and information received from our early years specialist was excellent.'

Comments from respondents who reported little/no or negative impact.

When reporting why there had been little or no impact, respondents focussed on issues related to low pay and poor working conditions for additional staff in the context of Level 7; the need for more detailed and regular assessment/reviews from specialists for children with diagnoses, and the need to deliver Level 6 support within the setting. Examples are provided below.

'There are so many problems with AIM. - Why can a primary school employ an SNA, but a pre-school must have a full level 5? SNA courses can be completed in 12 weeks!!! - How do you employ someone for 38 weeks of the year and expect them to work for minimum wage?? Why have AIM a reluctance to reduce ratios? From my experience, AIM do not want to give level 7 to reduce ratios and push for additional staff when it's virtually impossible to hire a staff member with the conditions I've mentioned above.'

'I feel the specialists need to liaise more with services in order to for constant reviews to be completed and provide more detailed and specialist information if a child has a diagnosis. Any children to date within our service have already availed of additional supports from external sources before applying for the aim assistance.'

'Level 4 support has always been great; however, I think that in a lot of ways speech and language/occupational therapy services should be maybe a pathologist calling into a service working with children within the setting that the children are already familiar with rather than parent/carers having to take them out of services to attend elsewhere. Level 7 support is too low it needs to be raised to at least €18.00 per hour for the extra member of staff to earn a decent enough wage.'

Table 10: Providers' views on the extent to which AIM support has benefitted children, families, and staff within their setting

Providers' views on AIM's impact on children, families, and staff	**Benefits to children with disabilities/additional needs**	**Benefits to other children in the setting**	**Benefits to parents/ carers of children with disabilities/ additional needs**	**Benefits to other parents/ carers**	**Benefits to ELC practitioners**	**Benefits to other staff**
Total	732	732	732	732	732	732
To a great extent	561	425	483	263	526	370
	77%	58%	66%	36%	72%	51%
To some extent	127	218	170	229	146	181
	17%	30%	23%	31%	20%	25%
To a small extent	30	50	52	110	47	70
	4%	7%	7%	15%	6%	10%
Not at all	4	29	11	80	7	42
	1%	4%	2%	11%	1%	6%
Too early to say	7	4	7	10	5	14
	1%	1%	1%	1%	1%	2%
Benefits	688	643	653	492	672	551
	94%	88%	89%	67%	92%	75%
Little or no benefits	34	79	63	190	54	112
	5%	11%	9%	26%	7%	15%

- In relation to the benefits of AIM on children, parents/carers and staff, providers were generally very positive when reporting their experiences.
- Key findings are as follows:
  - As shown in Table 10, 94% of providers reported that AIM had benefited children with disabilities/additional needs with 77% reporting that the magnitude of the benefit had been to ‘a great extent, and 4% ‘to a small extent. From analysis of cross-breaks in data tables, we also know that providers were statistically significantly less likely to report this if their year of starting AIM was 2020-2021 (62%) compared to 2017 (80%) and 2016 (78%).
  - 88% of providers reported that AIM had benefited other children in the setting. From analysis of cross-breaks in data tables we also know that benefits were more likely to be reported by respondents working in private settings (91%) when compared to community settings (89%).
  - 89% reported that AIM had benefited parent/carers of children with disabilities/additional needs. We also know that there was a significant difference between respondents whose settings had started AIM in 2021 (76%) compared to 2018 (90%), 2017 (91%) and 2016 (98%). 67% of respondents reported that the support provided by AIM benefited parent/carers who did not have children with disabilities/additional needs.
  - 92% reported benefits to staff in the ELC setting, with 75% reporting benefits to other staff. From analyses of cross-breaks in data tables, we also know that private pre-schools are more likely to report benefits (94%) than community pre-schools (93%). This difference is statistically significant.
  - When analysing responses by type of disability/additional need, there are no statistically significant differences between groups, with 77%-79% of providers describing AIM’s benefit to children to the level of ‘a great extent, 13% to 18% selecting ‘to some extent, and 2-9% selecting ‘to a small extent. Figures for autism/ASD are 79% (great extent), 17% (some extent) 3% (a small extent), and 4% (no extent).

When viewing the data from this Likert scale as a whole, it is clear that providers who started to participate in AIM in 2021-21 are less likely to report benefits for children, staff, and parents/carers than those whose participation began earlier. This is probably because the benefits are not yet embedded/visible and because of the impact of COVID 19.

To summarise, **providers' views on the impact and benefits of AIM** were found to be as follows

Impact on inclusion in the setting

- 96% of respondents reported that AIM had a positive impact at their ELC setting with a significant difference in the responses of those whose settings started with AIM in 2017 (100%) compared to all other years. Positive impacts described as 'large' were most likely to be reported in cases where the setting had begun to engage with AIM in 2017 (88%) compared 2019 (77%) to 2020-21 (60%) or and these differences were statistically significant. For providers whose ELC settings began to engage with AIM in 2020-21 (60%), respondents were significantly more likely to report that the impact was 'small' (33%) or that there was little or no benefit (10%) than in the case of all other years. This may be a result of COVID 19 and closures/limitations in ELC and other (HSE) services.
- 645 (88%) of respondents provided free-text comments explaining AIM's benefits. Responses focus on AIM enabling inclusion for children with additional needs, better provision and support, children's development, and progress, a reduced teacher-to-pupil ratio, supported access to different specialists and mentorship from Early Years Specialists.
- When reporting why there had been little or no impact, respondents focussed on low pay and poor working conditions for additional staff in the context of Level 7, the need for more detailed and regular assessment/reviews from specialists for children with diagnoses, and the need to integrate Level 6 support with pre-school provision.

Impact on children, families and staff

- In relation to the benefits of AIM on children, parents/carers and staff, providers were generally very positive when reporting their experiences. Providers reported that AIM had benefited children with disabilities/additional needs with 77% reporting that the magnitude of the benefit had been to 'a great extent, and 4% 'to a small extent.
- 89% reported that AIM had benefited parent/carers of children with disabilities/additional needs. We also know that there was a significant difference between respondents whose settings had started AIM in 2021 (76%) compared to 2018 (90%), 2017 (91%) and 2016 (98%).
- 92% reported benefits to staff in the ELC setting, with 75% reporting benefits to other staff.

Provider views on the sustainability of AIM

Table 11: Providers' views on the sustainability of changes made in their ELC setting as a result of AIM support

		Type of pre-school			Setting of pre-school		Year started AIM				
	Total	Community	Private	City or large urban area	Town	Rural	2020-2021	2019	2018	2017	2016
Total	732	203	362	182	273	276	58	81	110	132	321
Very sustainable	204	63	112	43	74	87	9	24	31	38	93
	28%	31%	31%	24%	27%	32%	16%	30%	28%	29%	29%
											a
Fairly sustainable	284	89	135	69	111	103	21	30	44	64	114
	39%	44%	37%	38%	41%	37%	36%	37%	40%	48%	36%
Not very sustainable	89	26	46	30	33	26	8	9	14	14	39
	12%	13%	13%	16%	12%	9%	14%	11%	13%	11%	12%
				c							
Not sustainable at all	49	8	28	21	15	13	5	4	6	5	28
	7%	4%	8%	12%	5%	5%	9%	5%	5%	4%	9%
Not applicable - AIM has not resulted in any changes in our early learning and care (ELC) setting	44	5	17	12	18	14	7	8	4	5	19
	6%	2%	5%	7%	7%	5%	12%	10%	4%	4%	6%
Too early to say	22	6	7	3	9	10	5	1	3	3	9
	3%	3%	2%	2%	3%	4%	9%	1%	3%	2%	3%
Don't know	40	6	17	4	13	23	3	5	8	3	19
	5%	3%	5%	2%	5%	8%	5%	6%	7%	2%	6%
Doubt sustainability	138	34	74	51	48	39	13	13	20	19	67
	19%	17%	20%	28%	18%	14%	22%	16%	18%	14%	21%
Believe in sustainability	488	152	247	112	185	190	30	54	75	102	207
	67%	75%	68%	62%	68%	69%	52%	67%	68%	77%	64%

- As Table 11 shows, two-thirds (67%) of respondents felt that the changes made in their setting as a result of AIM were sustainable, with 19% feeling they were not sustainable and 6% saying AIM had not resulted in any changes in their setting. Pre-schools in city/large urban areas were significantly more likely to doubt sustainability (28%) than those in towns (18%) and rural areas (14%).
- Respondents whose settings started with AIM in 2021, were significantly less likely to believe in sustainability (52%) than those whose settings started in other years. Those providers who started in 2017 were most likely to see the changes made to their setting as a result of AIM as sustainable (77%) when compared to 2020-21(52%) and 2016 (64%).

To summarise, **providers' views on the sustainability of AIM** were found to be as follows:

- Two thirds (67%) of respondents felt that the changes made in their setting as a result of AIM were sustainable, with 19% feeling they were not sustainable and 6% saying AIM had not resulted in any changes in their setting. Pre-schools in city/large urban areas were significantly more likely to doubt sustainability (28%) than those in towns (18%) and rural areas (14%).
- Respondents whose settings started with AIM in 2021, were significantly less likely to believe in sustainability (52%) than those whose settings started in other years. Those providers who started in 2017 were most likely to see the changes made to their setting as a result of AIM as sustainable (77%) when compared to 2020-21(52%) and 2016 (64%). This may be more evidence of the importance of longevity of engagement in AIM.
- Further qualitative and quantitative analyses are reported in subsection 6.11.

Provider views on how AIM could be improved

112 (15%) respondents chose the option 'no improvement needed' in the options menu for this survey item. When asked to share their views on how AIM could be improved, 508 (69%) of respondents provided free text comments.

Free text comments for survey question: What suggestions do you have for how AIM could be improved?

The most common themes arising in response to the question, 'What suggestions do you have for how AIM should be improved' are exemplified below. These comments commonly focus on; the need to increase the financial support/funding provided for Level 7, the development of a database for additional staff available for Level 7; enhancing the pre-school's access to specialist professionals; a call form providing AIM support from an earlier age, and the need for continuing training for ELC staff in inclusive practice. In relation to specific needs (particularly autism, emotional disturbance, sensory issues); reviewing the quality and appropriateness of advice offered by Early Years Specialists and other specialists and speeding up the application process for funding; reviewing the language of disability on AIM application forms.

- Increase in the financial support/funding provided for the ELC sector.

> 'Better funding for level 7 support to pay someone to come in to support in the setting. The funding is way too low making it impossible to recruit without providers topping up. An SNA model should be adopted in pre-school. Parent/carers applying for level 7 support believe the additional person is there to support their child, not just act as an extra pair of hands in the room and don't see why they should be the ones to fill out the forms if the support is not specific to their child. They think an SNA model is what they are getting and are disappointed.'

> 'AIM should be disbanded and ELC settings should be properly funded so all children can reap the rewards instead of the government ticking boxes and giving themselves pats on the back!! Peace meal is all that comes to mind!!'

- Database of additional staff available for Level 7

> 'Have a panel of AIM support workers. It's extremely difficult to find a level 5 AIM support work. SNA's should be allowed to work as an AIM support worker like they do

in primary school. It’s crazy that we need a full level 5 childcare worker to be an aim support person.’

‘Each county should have a list of aim support workers for a pre-school. It is very hard to get one to come into school for 15 hrs a week. It can be very hard to get staff for AIM.’

- Enhance access to specialist professionals through Level 6

‘While level 7 has made a huge difference to us. I feel Level 6 has not had the same impact. The parent/carers would like more support with services like Occupational Therapist and Speech Therapists.’

‘In an ideal world an OT, and a S&L therapist would be shared between 5 pre-schools in an area and spend 1 day per week in each. They would identify children who required intervention and work with them in the pre-school, so all pre-school children receive the early intervention they need. Failing that INCO's should be able to call in an ST or OT to the pre-school with the consent of the parent/carer if they feel there is a concern over a child's development.’

- Provide AIM support at a younger age.

‘We are full day care and some of our children have been identified at a much younger age than ECCE. There is an immediate need to support services with children with additional needs at a younger age.’

‘By allowing children with needs before the age of 3 years to have an aims worker. Children at 2 years need help as well.’

- Regular and updated continuing professional development and training.

‘I think all childcare practitioners should be regularly trained, offered workshops, practice conflict resolution. Real strategies that staff can use.’

‘Extra training for staff in Lámh/ Pecs/ Hanen etc plus training in supporting children on a daily basis with their particular needs. For example, helping a child with sensory needs, understanding autism/managing challenging behaviour associated with various needs such as oppositional defiance disorder / ADHD etc.’

- Increasing the time that Early Years Specialists spend in settings

‘Review of the position of the early years specialist. We found this the biggest challenge (the visits were not always supportive). A review of how a child is deemed eligible for level 7. A generic tick chart and an hours observation by a stranger (early years specialist) does not allow for sufficient profiling of a child's needs or suitability to require additional staffing supports. Professionals understanding of the pre-school regulations need to be addressed. (We had an OT strongly suggested that we removed access to one of the pre-school toilets to fit a mechanical changing table.’

- Speeding up the application process for funding

‘The application process must be speeded up to allow inclusion. We have had children who have come to us with already assessed additional needs, but applications not processed, and funding not provided until November or December. This has resulted in great stress for staff, larger adult-child ratios for the rest of the class or the pre-school losing money by having to employ additional staff.’

> 'To speed up the process of applications for funding.'

- Improving the application forms

> 'I believe that the forms could be better designed. I would like a space to write about the child at each question rather than simply tick boxes in relation to them. I don't believe all the answers are black and white and I would like to be able to have somewhere to communicate this.'

- Rewording the language used to describe children with additional needs

> 'I would like to see AIM re-evaluate their application form. It has put some parents off applying for support when they see disability written all over the form. Some children may not have a diagnosis at the time of application, and it has upset them.'

> 'Could the word "disability" be removed from the aim flyer/information that is provided to parents as I have found that word is off putting to parents. When our service wants to bring parents onboard & introduce them to the aim programme, this word can be a stumbling block.'

Free Text comments: Providers' views on the aspects of AIM support that have the most impact

455 (62%) of respondents provided comments in response the survey question 'What aspects of AIM Levels 1-3 have had the most impact on how your setting delivers early learning and care?' Responses were varied but included to approximately equal degrees; training (e.g., Diversity, Equality, and Inclusion Training; Hanen, Lámh), resources (inclusive play materials), the INCO role, the AIM website, and the LINC programme. This implies that all aspects of Level 1-3 are experienced as having a positive impact but in varying ways in different settings. Providers' views on the aspects of Level 4-7 AIM support that have the most impact 537 respondents (73%) provided free text comments in response to the survey question 'What aspects of AIM Levels 4-7 have had the most impact on how your setting delivers early learning and care?' This data demonstrates that additional capitation is the type of AIM support that providers believe has the most impact on their capacity to be inclusive though many note that Level 4 and Level 7 run in parallel. Hence Level 4 and 7 are identified as the AIM aspects having the most impact in the targeted support range

To summarise, **providers' views on how AIM could be improved** were found to be as follows

112 (15%) respondents chose the option 'no improvement needed' in the options menu for this survey item. When asked to share their views on how AIM could be improved, 508 (69%) respondents provided free text comments. Responses focussed on the following:

- Increase in the financial support/funding provided for the ELC sector (for Level 7 and the sector as a whole)
- Developing a database of staff available for Level 7 Support
- Enhance access to specialist professionals through Level 6.
- Provide AIM support to children at younger ages
- Provide continuous professional development, regularly repeated, and updated
- Increase the time that Early Years Specialists spend in settings
- Reduce delays in applications and award processes
- Redesign AIM forms for more detail on the child's uniqueness, and lessened used of the word 'disability'

6.4: AIM Level 1: Universal supports in the pre-school

Participation in AIM Level 1: The Diversity, Equality and Inclusion Guidelines and Charter

- 99% of settings had adopted Diversity, Equality, and Inclusion Guidelines (no significant differences by size, type, or location of setting)
- 94% of settings had adopted the Inclusion Charter (no significant differences by size, type, or location of setting; lower for settings who started AIM in 2020-21).
- 83% of respondents had attended Diversity, Equality and Inclusion training offered by County Childcare Committees (CCCs) and 76% had sent other staff members on such training

Participation in AIM Level 1: The Leadership for Inclusion (LINC) programme and Inclusion Coordinators (INCO's)

- 78% of settings had a member of staff who had completed the LINC programme. There were statistically significant differences by size and year settings started AIM. For example, ELC settings with up to 29 children (91%) on roll were more likely to have one member of staff who completed the LINC programme than those having 30 children or more (71%).
- This was the case for settings whose engagement with AIM started in 2018 (87%) compared to those with onset in 2016 (71%).
- 97% of staff were reported to have completed the LINC training while working at the responding provider's setting and 13% at a different ELC setting.

Table 12: Settings with a named INCO by type and size of setting

		Size of ELC		Type of pre-school	
	Total	**Up to 29 children**	**30 children or more**	**Community**	**Private**
Total	732	290	442	203	362
With an INCO	625	233	392	164	320
	85%	80%	89%	81%	88%
No INCO	103	55	48	39	41
	14%	19%	11%	19%	11%

- As Table 12 shows, 85% of settings had a named Inclusion Coordinator (INCO) though this was more likely to occur to private pre-schools (88%) compared to community pre-schools (81%). Besides type of setting, statistically significant differences were also found in the size of settings, with ELC Providers with 30 children or more (89%) being more likely to have an INCO among their staff than those having up to 29 on roll (80%).
- Of the 87% of settings that had a member of staff who had completed the LINC programme, most (78%) had one such staff member; 18% had two; and 3% had three.

Table 13: Main reasons for staff enrolling on the LINC Programme

	Total
Total	634
Continuing professional development/ career development for staff	551
	87%
To be in a better position to support parents/carers of children with disabilities/additional needs	531
	84%
To improve inclusive practice in the early learning and care (ELC) setting	499
	79%
To improve inclusive culture at the early learning and care (ELC) setting	473
	75%
To provide staff with inclusive pedagogical (teaching) strategies	449
	71%
Additional funding available (capitation/ staff funding)	373
	59%
To find out more about inclusion	373
	59%
Child(ren) with disabilities/additional needs already enrolled at the early learning and care (ELC)	374
	59%
Formal qualification - Special Purpose Level 6 Award	252
	40%
Child(ren) with disabilities/additional needs due to start at the early learning and care (ELC)	200
	32%

- As can be seen in Table 13, the main reasons for staff enrolling on the LINC programme were for; continuing professional development/career development for staff (87%), to be in a better position to support parents/carers of children with disabilities/additional needs (84%), to improve inclusive practice in the early learning and care (ELC) setting (79%), to improve inclusive culture at the early learning and care (ELC) setting (75%), and to provide staff with inclusive pedagogical (teaching) strategies (71%).
- 59% of the respondents noted that the reasons for enrolling on the LINC programme were to find out more about additional funding available (capitation/staff funding), to find out more about inclusion, as well as about child(ren) with disabilities/additional needs already enrolled at the early learning and care (ELC).
- In general, the reasons lean towards a desire to develop more skills and knowledge in how to implement inclusive strategies at the universal level.

Quality and impact of the LINC programme

Three-quarters (76%) of settings were satisfied or very satisfied with the LINC programme.

Examples of main themes arising in the free-text comments for survey question: Why did you give this score (for satisfaction with the LINC programme)?

The predominant themes arising in response to this question are summarised and exemplified below. The text context generally focusses on praise for the LINC experience, the relevance and quality of information/content, accessibility, knowledge obtained, support provided by tutors, networking

opportunities, flexibility in online training, feeling better equipped to deliver inclusion, the transferability of skills learned, learning about relevant practical strategies, and the need for training to be open to everyone.

- Praise for LINC training experience

> 'I found the Linc programme excellent. Accessing the course, the content of training and the support given throughout the programme was amazing. I have found doing the Linc has benefitted all the stakeholders in the service. It also gave me the confidence and courage to return to formal education and complete my degree.'

> 'I found the whole experience really informative, well organised and the information that I gained from doing the course was and is invaluable. I really loved it. I think all the children in the setting benefited from the training.'

- Information-rich course content

> 'Thought the course was excellent and well delivered by an excellent tutor, it deserves a higher award than level 6. Superb course content a lot of what is used every day in my service.'

> 'The content of the training was outstanding.'

> 'The content is excellent and so relevant to today's early years setting and all the problems we come across, tutors' knowledge they were people that worked on the ground knew exactly what they were talking about!'

- Accessibility and quality of information

> 'I found the course extremely useful for practise and the content was manageable. The mentor was extremely supportive and was always on the other end of the phone or email if we needed anything.'

> 'The course was enjoyable, relevant, and informative. The course content expanded and supported my understanding of how to support children with additional needs in my setting.'

> 'Full of useful information and very good at guiding you in the right direction.'

- Support provided by tutor(s)

> 'I absolutely loved the LINC training. The tutors were fantastic and very knowledgeable. Personally, I felt I learned more from the LINC training, than I did at level 7 degree. I really enjoyed the LINC course and will consider doing a refresher course maybe next year.'

> 'The tutor was excellent, always at hand to give advice on completing assignments or there to answer any questions that I might have...'

- Networking opportunities

> 'The content of the training was clear, the content was relative at the time, blending learning was good, and a classroom setting for some of the modules was an opportunity to consult with other practitioners.'

> 'Content, of course. Support received. Meeting other people working in the sector and brainstorming.'

- Online training flexibility

  ‘The ease of accessing the course online, especially when working.’

  ‘Ease of accessing the course - online; teachers’ knowledge.’

  ‘The LINC course was a beautiful, blended learning course which informed our setting greatly about inclusion. The coursework was very manageable, coinciding with working full time and we met some really wonderful people who we were inspired by.’

- Feeling better equipped to deliver inclusion

  ‘I felt it was very beneficial for my service all round and gave me a lot of information on how to be an effective leader and make my service inclusive to all users.’

  ‘My colleagues who completed the course were able to help with a self-evaluation of our school and practices. We were then able to put in place new approaches to our education and care of the children.’

  ‘Learnt new material and felt better equipped to deal with parents and to help and support parents.’

  ‘I learned so much about supporting families, children, and inclusion in this course. The content, delivery, and support were fantastic. Our tutor was very supportive and so down-to-earth. I couldn't recommend the LINC enough; I think every childcare practitioner should complete this course.’

- Transferability of skills to settings

  ‘My colleagues who completed the course were able to help with a self-evaluation of our school and practices. We were then able to put in place new approaches to our education and care of the children.’

  ‘I learned a lot and was able to bring that learning back to my staff and families using the service.’

  ‘All of the above plus the staff member who undertook the course bought wonderful materials and knowledge back to the rest of the staff. She was very impressed with the course overall.’

- Opportunities to learn practical strategies

  ‘I thought it was a brilliant course and found I learnt so much, after completing a degree course the year previous, I actually felt I learnt as much if not more practical advice and knowledge than the degree programme. Everything I learnt I could apply daily to my work.’

  ‘It was interesting in part. I enjoyed the classroom sessions. Some was repetitive and common sense; I had hoped it would offer strategies to support in practical terms. I felt it was lacking in that area.’

- Need for training to be open to everyone so that training can happen as needed

  ‘It is the accessing of the course that lowers the score - it is so difficult to access same. If your LINC worker leaves, you have to wait for another to be trained, it should be an ongoing module that ALL childcare practitioners have access to and are facilitated to complete as good practice.’

> ‘LINC has been fabulous in enabling more supports for our children attending that present with additional or special needs. The only downside is more staff want to do it and they can't due to us already having a LINC Co-Ordinator on staff. We would hope to have more staff trained in AIM asap!’

- However, some respondents felt that the course did not meet their expectations for various reasons. Examples of their responses are given below and these focus on the need to learn how to include Traveller families and the need to learn about specific AIM processes such as how to complete an Inclusion Profile and an Inclusion Plan.

> ‘It's an accessible course, and not too intense but I felt it was lacking in some areas. In particular inclusion of minority groups. I completed LINC the first year it was offered. I have a staff member completing it at the moment. I felt with Traveller ethnicity having been recognised in between, that there would have been more of a focus, but there hasn't. I have Traveller children attending my service, one with AIM support level 7, and I really could have done with knowledge and training to support this family in terms of encouraging them to seek a diagnosis and accessing supports.’

> ‘Content of the training was very good. I felt that the training didn't really offer a good insight into the role of Inclusion Co-ordinator. I felt that more of the training should have included information on the AIM Inclusion Profile and the AIM Inclusion Plan.’

Table 14: Providers view of the impact of the LINC training on settings

Base: Providers who gave a score rating satisfaction with LINC

Providers view on the level of impact of LINC on settings	Impact on staff members practice	Learning has been effectively shared within the setting	The programme helped the setting to include a child/children with disabilities/additional needs	The programmed helped a child/children with disabilities/additional needs to get the most form their ECCE provision	The programme improved the way staff communicate with parents/carers about disabilities/additional needs	Learning from the programme has contributed to a culture change in making us more inclusive
Total	634	634	634	634	634	634
1 - No impact	33	18	56	30	32	48
	5%	3%	9%	5%	5%	8%
2 - Little impact	43	37	24	31	33	34
	7%	6%	4%	5%	5%	5%
3 - Some impact	91	92	81	71	76	75
	14%	15%	13%	11%	12%	12%
4 - Notable impact	164	166	125	130	138	136
	26%	26%	20%	21%	22%	21%
5 - Significant impact	297	317	341	364	346	331
	47%	50%	54%	57%	55%	52%
No or little impact	82	59	87	69	74	92
	13%	9%	14%	11%	12%	15%
Notable or Significant impact	461	483	466	494	484	467
	73%	76%	74%	78%	76%	74%

- Table 14 shows that overall, providers were positive about the impact of LINC training on their setting with between 73% and 78% reporting notable or significant impact on sharing of learning, including a child/children with disabilities/additional needs, helping a child/ren with disabilities/additional needs to get the best out of the ECCE provision, communication with parent/carers and inclusive culture change.
- Generally, a positive impact was more likely to be reported in rural areas or towns than in city/large urban areas. In the case of the LINC programme's impact on the capacity of staff to include a child/children with additional needs, respondents in settings in rural areas (63%) were significantly more likely to report notable or significant impact (83%) than was the case in towns (73%) or city/large urban areas (60%).
- There were similar statistically significant differences in the case of LINC's impact on helping a child/children with disabilities to get the most out of their ECCE provision. In rural areas, 85% of respondents reported this to be notable or significant compared to 69% in city/large urban areas and 76% in towns.
- In the case of the LINC programme's impact on inclusive culture change, 79% of respondents working in settings in rural areas chose to describe the impact as notable or significant compared to 65% in city/large urban areas and 74% in towns.

Providers' views on the impact of the INCO role and how it was used

- 91% of settings with an INCO felt that the role had made a positive difference to their setting with 45% describing this as a difference as 'big' and 8% noting that the role had made 'no' difference. When analysing cross-breaks in the data tables, a statistically significant difference is evident with 89% of providers reporting that the INCO role had made some

difference if the setting began engaging with AIM in 2016 compared to all other years (average, 91%).

- INCO funding was most commonly used to fund salary increases for role holders (62%) and to purchase additional equipment (39%), with significant differences by group. For example, salary increases were less likely in ELC settings with up to 29 children on roll (53%) compared to those with 30 children or more (68%). This was also true when considering the year that settings first engaged with AIM. For those that started AIM in 2020-2021, using INCO funding for salary increases was less likely (47%) than for those settings who began with AIM in 2019 (50%). Also, 32% of community settings used INCO funding to purchase additional equipment compared to private pre-schools (41%).

6.5: AIM Level 2: Information for parents and carers

Use and dissemination of information about AIM

- Providers responded 'yes' to having accessed the information they needed about support for inclusion in ELC settings from the following sources:
    - 76% the AIM website (www.aim.gov.ie)
    - 63% the manager at the early learning and care (ELC) setting
    - 61% via the Inclusion Coordinator
    - 60% City/County Committees (CCCs),
    - 40% Better Start
    - 39% Co-workers at the ELC setting
    - 39% LINC programme team/LINC website
    - 30% HSE and/or Disability Voluntary Agency
    - 17% Pobal
    - 7%, an ECCE Contact.

- 86% of respondents reported that when they had sought information, they did find information that met their needs. This was significantly more likely in rural settings (89%) than in towns (85%) or city/large urban areas (83%).

- 96% of providers agreed that they have signposted parents/carers to the following sources of information:
    - 83% AIM website
    - 48% Better Start
    - 42% City/county childcare committees
    - 40% via the Inclusion Co-ordinator
    - 39% managers at the ELC setting
    - 35% HSE and/or disability/voluntary association
    - 19% LINC Programme team/Link website
    - 15% co-workers at the ELC setting
    - 10% Pobal
    - 4% an ECCE contact (n=28)

6.6: AIM Level 3: A qualified and confident workforce

Table 15: Providers' reporting of training that staff at the ELC setting have taken part in and size of ELC and type of pre-school

		Size of ELC		Type of pre-school	
Training taken part in	**Total**	**Up to 29 children**	**30 children or more**	**Community**	**Private**
Total	732	290	442	203	362
Lámh training	398	126	272	114	193
	54%	43%	62%	56%	53%
Sensory processing training	359	131	228	105	173
	49%	45%	52%	52%	48%
Learning Language and Loving It and Teacher Talk - The Hanen Programmes for Early Childhood	363	128	235	112	173
	50%	44%	53%	55%	48%
None of the above	130	64	66	29	71
	18%	22%	15%	14%	20%

- As Table 16 shows, respondents reported that the staff in their ELC setting had taken part in training as follows:
  - Lámh training (54%)
  - Learning Language and Loving It and Teacher Talk- The Hanen Programmes for Early Childhood (50%)
  - Sensory processing training (49%)
  - None of the above (18%)
- Providers from larger settings were significantly more likely to select 'none of the above' (22%) than those in smaller settings (15%). Providers who started participating in AIM in 2016 were significantly less likely to select 'none of the above' than those who started in later years.
- 94% of settings had provided staff members with training materials on inclusion, though it is notable that this was less likely among settings that started AIM in 2020-21 (81%).

To summarise, **providers' views on AIM's universal supports (Levels 1-3) were found to be as follows:**

455 (62%) of respondents provided comments in response the survey question 'What aspects of AIM Levels 1-3 have had the most impact on how your setting delivers early learning and care? Responses were varied but included to approximately equal degrees; training (e.g., Diversity, Equality, and Inclusion Training; Hanen, Lámh), resources (inclusive play materials), the INCO role, the AIM website, and the LINC programme. This implies that all aspects of Level 1-3 are experienced as having impact but settings vary in the aspect they select as most impactful.

AIM Level 1:

- 99% of settings had adopted Diversity, Equality, and Inclusion Guidelines (no significant differences by size, type, or location of setting)
- 94% of settings had adopted the Inclusion Charter (no significant differences by size, type, or location of setting; lower for settings who started AIM in 2020-21).
- 83% of respondents had attended Diversity, Equality and Inclusion training offered by County Childcare Committees (CCCs) and 76% had sent other staff members on such training
- 97% of staff were reported to have completed the LINC training while working at the responding provider's setting and 13% at a different ELC setting.
- Three quarters (76%) of settings were satisfied or very satisfied with the LINC programme.
- In general, the reasons given for undertaking LINC lean towards a desire to develop more skill and knowledge in how to implement inclusive strategies at the universal level.
- Overall, providers were positive about the impact of LINC training on their setting with between 73% and 78% reporting notable or significant impact on sharing of learning, including a child/children with disabilities/additional needs, helping a child/ren with disabilities/additional needs to get the best out of the ECCE provision, communication with parents and inclusive culture change.
- In the case of the LINC programme's impact on the capacity of staff to include a child/children with additional needs, respondents in settings in rural areas (63%) were significantly more likely to report notable or significant impact (83%) than was the case in towns (73%) or city/large urban areas (60%).
- 91% of settings with an INCO felt it that the role had made a positive difference to their setting with 45% describing this as a 'big' difference and 8% noting that the role had made 'no' difference.

AIM Level 2:

- 86% of respondents reported that when they had sought information, they did find information that met their needs. This was significantly more likely in rural settings (89%) than in towns (85%) or city/large urban areas (83%).

AIM Level 3:

- Respondents reported that the staff in their ELC setting had taken part in training as follows:
    - Lámh training (54%)
    - Learning Language and Loving It and Teacher Talk- The Hanen Programmes for Early Childhood (50%)
    - Sensory processing training (49%)
    - None of the above (18%)

Generally, respondents were positive about their engagement and satisfaction with AIM Level 3, with this being more positive for settings who joined AIM in 2017-18 and 2019-20.

6.7: AIM Level 4: Expert early years educational advice and support

Participation in AIM Level 4

- 95% of settings had sought advice and mentoring from Early Years Specialists (the proportion being higher for community pre-schools at 98%), and 87% had signposted parent/carers to advice and mentoring from Early Years Specialists.
- 95% of settings had supported parent/carers to complete an access and inclusion profile (98% for community settings) [note: in practice, this often seems to be done by ELC staff rather than a parent/carer].

Reasons for accessing AIM Level 4

Table 17: Main reasons for accessing the Early Years Specialist and size of ELC

		Size of ELC	
	Total	**Up to 29 children**	**30 children or more**
Total	715	283	432
To get information and advice on access and inclusion	426	154	272
	60%	54%	63%
To get access to health support or therapy	202	65	137
	28%	23%	32%
To get access to additional support within the ELC setting	633	240	393
	89%	85%	91%

- As Table 17 demonstrates, where settings had sought advice from Early Years Specialists, this was to get: access to additional support within the ELC setting (89%); information and advice on access and inclusion (60%); access to health support or therapy (28%).
- There were significant differences by setting size. In particular, the respondents who work in ELC settings with 30 children or more were significantly more likely to report that they accessed the Early Years Specialist to get information and advice on access and inclusion (63%) than those working in pre-schools with up to 29 children (54%). Larger settings were also more likely to engage with Early Years Specialists to access health support or therapy (32%) and additional support within the ELC setting (91%) when compared to smaller settings (23% and 85%, respectively).

Quality and impact of AIM Level 4

Table 18: Providers' views on the quality of support received from Early Years Specialists and size/type/setting of pre-school

	Size of ELC setting			Type of pre-school			Setting of pre-school		
	Up to 29 children	30 children or more	Community	Private	City or large urban area	Town	Rural	2020-2021	2019
Total	283	432	201	354	178	267	270	56	81
Very dissatisfied	20	27	17	22	15	14	18	2	6
	7%	6%	8%	6%	8%	5%	7%	4%	7%
Somewhat dissatisfied	10	17	5	8	6	12	9	5	5
	4%	4%	2%	2%	3%	4%	3%	9%	6%
Neither satisfied nor dissatisfied	16	14	3	14	12	11	7	2	3
	6%	3%	1%	4%	7%	4%	3%	4%	4%
Somewhat satisfied	33	103	37	59	29	61	46	11	14
	12%	24%	18%	17%	16%	23%	17%	20%	17%
Very satisfied	201	268	138	248	114	167	188	34	53
	71%	62%	69%	70%	64%	63%	70%	61%	65%
Dissatisfied	46	58	25	44	33	37	34	9	14
	16%	13%	12%	12%	19%	14%	13%	16%	17%
Satisfied	234	371	175	307	143	228	234	45	67
	83%	86%	87%	87%	80%	85%	87%	80%	83%

- Table 18 demonstrates that providers were generally satisfied with the advice/mentoring received from Early Years Specialists. We also know that on average 85% were satisfied with 66% noting that they were very satisfied. Table 18 shows that smaller settings were significantly more likely to choose the descriptor 'very satisfied' (71%) than larger ones (62%).
- We also know that in relation to specific types of support from Early Years Specialists, providers' view on quality of support was as follows:
    - Satisfied with the quality of mentoring and coaching strategies (81%)
    - Satisfied with support provided in enhancing parent/carer partnerships (71%)
    - Satisfied with the support provided for implementing practices and strategies to support inclusion (80%)
    - Satisfied with the liaison with HSE and other professionals in providing advice on goals for programmes for the child (56%)
    - Access to health service supports to enable the child to access the ELC setting (49%)

- In general, providers were satisfied with specific types of support from Early Years Specialists. In the case of liaison with HSE support, they communicated relatively low levels of satisfaction.

Table 19: Providers' views on the impact of receiving advice and mentoring from Early Years Specialists.[42]

Base: Providers that sought advice and mentoring from Early Year Specialists

	Impact on the inclusion of a child/children in the setting	Impact on effective sharing of learning from advice/mentoring within the setting	Impact on child/children with disabilities/additional needs getting the most out of their ECCE provision	Impact on helping a child to access specialist equipment or appliances (Level 5)	Impact is that minor alterations have been accessed to help a child' s/children' s inclusion.	Impact on developing more inclusive pedagogy	Impact on more inclusive practice	Impact on staff ability to support parent/carers of children with disabilities/additional needs
Total	715	715	715	715	715	715	715	715
1 - No impact				151	180	60	41	33
	6%	5%	5%	21%	25%	8%	10%	8%
2 - Little impact	31	28	26	29	32	25	34	28
	4%	4%	4%	4%	4%	3%	5%	4%
3 - Some impact	79	71	73	69	62	89	82	88
	11%	10%	10%	10%	9%	12%	11%	12%
4 - Clear impact	171	198	181	109	115	176	186	159
	24%	28%	25%	15%	16%	25%	26%	22%
5 - Significant impact	386	381	393	256	227	349	321	372
	54%	53%	55%	36%	32%	49%	45%	52%
Impact	557	579	574	365	342	525	507	531
	78%	81%	80%	51%	48%	73%	71%	74%
No impact	72	61	59	180	212	85	106	83
	10%	9%	8%	25%	30%	12%	15%	12%

- As Table 19 shows, providers are generally positive about the impact of receiving advice and mentoring from Early Years Specialists, particularly when describing impact on inclusive practice in the setting. With reference to specific impacts, the following can be noted from Table 19 and when analysing cross breaks in data tables.
    - 78% reported a positive impact on the inclusion of a child/children in a setting. In 2020/21 this was significantly lower at 66%.
    - 81% report that there was a positive impact on the sharing advice from the Early Years Specialist across the setting. This was also significantly lower in 2020-21 (70%).

[42] 'Don't know' responses removed.

    - 80% report that a child/children with disabilities/additional needs were getting the most out of their ECCE experience because of advice and mentoring. This was significantly lower in 2021 (70%) compared to all other years.
    - 73% perceived that advice and mentoring from the Early Years Specialist had impacted positively on the development of more inclusive pedagogy. The likelihood of this was significantly lower in 2016 (69%) than it was for all other years.
    - 71% noted that there was a positive impact on the development of more inclusive practice.
    - 74% reported that advice from Early Years Specialists had supported pre-school staff in supporting the parent/carers of children with disabilities/additional needs.
- Overall, providers were positive about the impact of Early Years Specialist Advice on inclusion for all children and for children with disabilities/additional needs. Often, the impact was rated lower in 2021-22 than other years.
- As Table 19 shows, providers gave relatively low ratings for impact when considering Level 5 supports such as access to equipment (51%) and building alterations (48%). Analysis of cross breaks in the data tables also showed that:
    - In the case of access to equipment, pre-schools in city/large urban areas were more likely to report that there was 'no impact' (31%) than rural areas (22%). This response was also significantly more likely in 2020-21 (43%) than in other years.
    - In the case of access to building alterations, pre-schools in large city/urban areas were also more likely to report that there was 'no impact' (37%) than pre-schools in rural areas (24%).

6.8: AIM Level 5: Equipment, appliances, and minor alterations grants

Participation in AIM Level 5

- 38% of settings had applied for specialist equipment, appliances, and alterations and of those, 34% of settings had been awarded specialist equipment, appliances, and alterations.
- Among those who had applied for AIM Level 5, 68% were satisfied with the ease of applying for Level 5 support and 69% were satisfied with the decision-making process. 57% were satisfied with the timeframe from application to payment (27% were dissatisfied).
- 50% were satisfied with ongoing support in using the equipment and 28% were dissatisfied.
- 70% were satisfied with the appropriateness of the equipment.

Quality and impact of AIM Level 5

- The majority of providers who had been awarded specialist equipment, appliances and alterations for a child were satisfied with these and felt there had been a positive impact on the setting, particularly on children and their inclusion. For example, 77% agreed that the Level 5 support had helped the setting to include a child/children with disabilities and additional needs so that they could get the most out of their ECCE provision (7% disagreed). Generally, there were no significant differences by group.

To summarise **providers' views on AIM's Level 4 and Level 5 targeted supports were found to be as follows:**

AIM Level 4:
In general, providers were satisfied with specific types of support from Early Years Specialists and its impact on inclusion.

- 78% reported a positive impact on the inclusion of a child/children in a setting. In 2020/21 this was significantly lower at 66%.
- 95% of settings had sought advice and mentoring from Early Years Specialists (the proportion being higher for community pre-schools at 98%), and 87% had signposted parent/carers to advice and mentoring from Early Years Specialists.
- 95% of settings had supported parent/carers to complete an access and inclusion profile (98% for community settings) [note: in practice this often seems to be done by ELC staff rather than a parent/carer]
- Providers views on the quality of EYS support was as follows
    - Satisfied with the quality of mentoring and coaching strategies (81%)
    - Satisfied with support provided in enhancing parent/carer partnerships (71%)
    - Satisfied with the support provided for implementing practices and strategies to support inclusion (80%)
    - Satisfied with the liaison with HSE and other professionals in providing advice on goals for programmes for the child (56%)
    - Access to health service supports to enable the child to access the ELC setting (49%)

AIM Level 5:

- 38% of settings had applied for specialist equipment, appliances, and alterations and of those, 34% of settings had been awarded specialist equipment, appliances, and alterations.
- Among those who had applied for AIM Level 5, 68% were satisfied with the ease of applying for Level 5 support and 69% were satisfied with the decision-making process. 57% were satisfied with the timeframe from application to payment (27% were dissatisfied).
- 50% were satisfied with ongoing support in using the equipment and 28% were dissatisfied.
- 70% were satisfied with the appropriateness of the equipment.
- For example, 77% agreed that the Level 5 support had helped the setting to include a child/children with disabilities and additional needs so that they could get the most out of their ECCE provision (7% disagreed).

6.9: AIM Level 6: Therapy Services

Participation in AIM Level 6

- In response to the survey item, *'The following questions about your early learning and care (ELC) setting's involvement with AIM to date. Have you: -16 (child in setting has) applied for therapeutic and/or health intervention to enable them to access and participate in early learning and care, - 17 (child in setting has) been awarded therapeutic and/or health intervention to enable them to access and participate in early learning and care'* 30% of providers reported that there had been an application for therapeutic/health interventions, and of those, 24% of settings had been awarded therapeutic/health interventions (described in the survey as therapy and nursing support). This represents 7.2% of the survey population.
- Reasons given for accessing health interventions included 'a need for therapeutic and/or health interventions for a child' which had been suggested by 'the pre-school' (425) by 'an Early Years Specialist' (42%), and 40% by the respondent "I".
- When asked to report on how many children had been referred to Level 6 support since September 2016 through AIM by Early Years Specialists:
    - 79 providers (11%) responded with an exact number. In this case, the mean was 1.9. (10%) There were no significant differences across sub-categories.
    - 70 providers responded with an estimated figure. The mean was 5.4 with no statistically significant differences across subcategories.
- When asked to report on how many children had received therapeutic and/or health interventions since September 2016 as a result of AIM findings were as follows:
    - The mean of the exact figure given by 70 (10%) respondents was 2.2 with no statistically significant differences across subcategories.
    - When respondents gave an estimated figure (n=59), the mean was 4.9 with no statistically significant differences between subcategories.
- Providers who responded with the exact and estimated number of children who 'received as a result of the AIM, referral health service supports' (i.e., therapy and nursing support) by HSE/Disability Voluntary Organisations.175 providers reported that the type of interventions provided were:

  81% Speech and language therapy (n=141)
  66% Occupational therapy (n=115)
  31% Psychology intervention (n=55)
  23% Paediatrician (n=40)
  3% Nursing (n=17)
  6% Other (n=10)

Limitations in these data

It is important to note that there are challenges in interpreting the data listed above because:

- Level 6 has both universal and targeted interventions. Pobal figures for October 2021 indicate that there have been 3,347 Level 6 (universal) HSE engagements via EYSs, and 133 Level 6 (targeted) referrals to HSE between 2016 and 2021.
- The total number of Level 6 targeted HSE interventions listed by survey respondents is n=378. Though respondents may have chosen more than one type of intervention to a) cover all children in their setting, and b) capture where children may receive support from more than one service, the number of interventions reported (n=378) is much higher than would be expected from a sample representing 26% of the target population (n=732). In

a sample of 732, the expected number of AIM Level 6 targeted referrals would be closer to n=34 (+/- 1.6). This means that in their responses, participants may be:
    - Conflating HSE support accessed outside AIM with Level 6 support
    - Conflating AIM Level 6 (universal) with Level 6 (targeted) supported
- This phenomenon was also observed in the analysis of the survey data for parent/carers, and further supports the suggestion that service users (providers and parent/carers) are not clear about what is meant by AIM Level 6. This suggests a need to clarify the purpose and content of AIM Level 6 in the information provided at a universal and individual level.

Quality of AIM Level 6

- Satisfaction with therapeutic/health interventions was generally between 70-85% as follows:
    - Speech and language therapy: satisfied 76%, dissatisfied, 23%
    - Occupational Therapy: satisfied 77%, dissatisfied, 21%
    - Psychology intervention: satisfied 75%, dissatisfied, 20%
    - Psychotherapy; satisfied, 83%, dissatisfied; 13%
    - Paediatrician; 88% satisfied, dissatisfied; 0%.
    - Nursing: 50% satisfied, dissatisfied, 50%.

- As for the impact of the health services interventions, the majority of respondents agreed that health services assisted them to: include a child/children with disabilities/additional needs (55% agree, 17% disagree); help a child/children with disabilities/additional needs get the most out of their ECCE provision (62% agree, 15% disagree); change their practice in how they include children (50% agree, 24% disagree); improve the way that staff communicate with parents/carers about inclusion and disability/additional needs (55% agree, 23% disagree); contributed to a culture of change, so they are more inclusive (53% agree, 25% disagree); implement an inclusive pedagogy (57% agree, 21% disagree). There were no significant differences between subcategories. As indicated above,

- In the context of advice/mentoring from EYSs, providers also communicate the following perceptions:
    - Satisfied with the liaison with HSE and other professionals in providing advice on goals for programmes for the child (56%)
    - Access to health service supports to enable the child to access the ELC setting (49%)

Limitations in the data

As noted previously, there is evidence that perceptions of satisfaction and impact for Level 6 (targeted) are drawn from respondents' encounters with HSE interventions outside of AIM (through prior diagnosis and existing interventions before pre-school), as well as receipt of Level 6 (universal) supports It emerges that there is a need to clarify the purpose and content of Level 6 support in communications with parent/carers and providers, particularly since this same phenomenon was observed in the parent/carer survey. It is perhaps, unsurprising that service users are not as concerned with the nomenclature of AIM Levels as they are with the experience they have had of support, and from who they have received it from. It is also unclear from these data whether respondents' perceptions of the impact of Level 6 were a result of its lower level of visibility/prevalence compared to other AIM

levels[43] or its quality, though where their child is in receipt of HSE support during pre-school, the majority are satisfied with its quality.

6.10: AIM Level 7: Additional assistance in the pre-school room

Participation in AIM Level 7

- 87% of settings had applied for additional capitation for additional assistance. Statistically significant differences were found by size and the year that settings started AIM. In particular, settings with 30 children or more on roll (90%) were more likely to apply for additional capitation than those with up to 29 children on roll (83%) and the settings that started AIM in 2016 (90%) were significantly more likely to apply for Level 7 support than those with onset in 2020-2021 (76%).
- Of all the settings (n= 638) who applied for additional capitation, 88% had been awarded it while 11% (n= 81) had not.
- Of those that had applied for additional capitation, 79% (n= 519) were satisfied with the application process. Providers with settings in city/large urban areas were significantly more likely to be dissatisfied (25%) than those in towns or rural areas. For settings that first participated in AIM in 2020-2021, there was a significantly higher likelihood of being satisfied with the application process (91%) than in 2016 (78%).
- Additional capitation was most commonly used by settings to recruit additional staff (80%). 7% (n=47) used the funding to enrol fewer children without financial loss and 17% used the funding to achieve both recruitment of additional staff and the enrolment of fewer children without financial loss.

Use and impact of AIM Level 7

Table 20: Providers' perceptions of the impact of additional capitation funding

Base: Providers who received additional capitation

	It helped include a child/children with disabilities/additional needs into the ELC setting	It helped a child/children with disabilities get the most out of their ECCE provision	It changed practice in including children with disabilities/additional needs in the setting	It improved the way that staff communicate with parent/carers about inclusion and disability/ additional needs	It contributed to culture change at our ELC setting	It contributed to staff capacity to implement an inclusive pedagogy
Total	643	643	643	643	643	643
1 - Strongly disagree	20	16	63	46	56	24
	3%	2%	10%	7%	9%	4%
2 - Disagree	8	12	34	36	36	20
	1%	2%	5%	6%	6%	3%
3 - Neither agree nor disagree	29	23	57	63	63	42
	5%	4%	9%	10%	10%	7%
4 - Agree	67	73	90	134	117	99
	10%	11%	14%	21%	18%	15%
5 - Strongly agree	506	505	383	349	356	441
	79%	79%	60%	54%	55%	69%
Too early to say	8	8	5	6	6	6

[43] 8% of the total AIM supports allocated are Level 6 (universal – EYS engagement with HSE), and 0.33% are Level 6 (targeted - referrals) according to data provided by Pobal (Monthly Report, October 21). HSE have reported to researchers that this represents undersubscription rather than a shortage of resource.

	1%	1%	1%	1%	1%	1%
Disagree	28	28	97	82	92	44
	4%	4%	15%	13%	14%	7%
Agree	573	578	473	483	473	540
	89%	90%	74%	75%	74%	84%

- As shown in Table 20, providers were positive about the impact of additional capitation funding. 90% agreed that additional capitation had helped children with disabilities to get the most out of their ECCE provision. 89% agreed that additional capitation had helped the setting to include a child/children with disabilities/additional needs. 84% reported that it had increased ELC staff capacity to implement inclusive pedagogy.
- In relation to the impact on inclusive practice and culture, 74-75% of providers reported benefits from additional capitation.
- When considering the way that staff communicate with parents/carers about the inclusion and disability/additional needs, 75% reported that additional capitation had led to improvements.

To summarise **providers' views on AIM's Level 6 and Level 7 targeted supports were found to be as follows:**

AIM Level 6:

In general, fewer providers were satisfied with liaison with health specialists (49%), and access to health service supports to enable children to access the ELC setting than with other AIM supports. Satisfaction with therapeutic/health interventions was generally between 70-85%. On the impact of health service interventions, respondents agreed that health services assisted them to:

- include a child/children with disabilities/additional needs (55% agree, 17% disagree)
- help a child/children with disabilities/additional needs get the most out of their ECCE provision (62% agree, 15% disagree)
- change their practice in how they include children (50% agree, 24% disagree)
- improve the way that staff communicate with parents/carers about inclusion and disability/additional needs (55% agree, 23% disagree)
- bring about culture change, so they are more inclusive (53% agree, 25% disagree)
- implement an inclusive pedagogy (57% agree, 21% disagree).

In general, ratings of the magnitude of impact from Level 6 are lower than for other AIM Levels. However, interpretation of these findings is made complex because there is evidence that respondents conflate HSE support generally (where accessed outside AIM via parent/carer self-referral or referral by health practitioner) with Level 6 support within AIM, and that AIM Level 6 (universal) is conflated with AIM Level 6 (targeted). This indicates some need to clarify the purpose and content of Level 6 support, particularly since this same phenomenon was observed in the parent/carer survey. It is also unclear whether respondents' perceptions of Level 6 were a result of its lower level of visibility/prevalence in ELC settings compared to other AIM levels.

AIM Level 7:

ELC providers were positive about the impact of additional capitation funding.

- 90% agreed: that additional capitation had helped children with disabilities to get the most out of their ECCE provision.
- 89% agreed that additional capitation had helped the setting to include a child/children with disabilities/additional needs. 84% reported that it had increased ELC staff capacity to implement inclusive pedagogy.
- In relation to the impact on inclusive practice and culture, 74-75% of providers reported benefits from additional capitation.
- When considering the way that staff communicate with parents/carers about the inclusion and disability/additional needs, 75% reported that additional capitation had led to improvements.
- Of all the settings (n= 638) who applied for additional capitation, 88% had been awarded it while 11% (n= 81) had not.
- Of those that had applied for additional capitation, 79% (n= 519) were satisfied with the application process. Providers with settings in city/large urban areas were significantly more likely to be dissatisfied (25%) than those in towns or rural areas. For settings that first participated in AIM in 2020-2021, there was a significantly higher likelihood of being satisfied with the application process (91%) than in 2016 (78%).
- Additional capitation was most commonly used by settings to recruit additional staff (80%). 7% (n=47) used the funding to enrol fewer children without financial loss and 17% used the funding to achieve both.

Headlines Infographic

The infographic summarises the headline findings from the survey of providers. It is noted that less positive perceptions of how AIM is working among providers joining in 20-21 are likely to be due to COVID-19, as well as the need for AIM to become embedded.

The next subsection applies further quantitative and qualitative analysis. This is to investigate statistically significant differences between groups.

2021 Evaluaton of AIM
Provider Survey Findings

732 Respondents

96% reported that AIM was having a positive impact in their setting

94% believed that AIM was having a positive impact on children with disabilities/additional needs

96% believed that AIM was having a positive impact on inclusion in their setting.

99% have adopted the Diversity, Equality and inclusion Guidelines

93% have attended the Diversity, Equality and Inclusion Training provided by County Childcare commitees

85% have a named inclusion co-ordinator

91% Having a named **inclusion Co-ordinator** impacts positively on **inclusive culture, pedagogy and practice.**

78% The **LINC programme** impacts positively on their setting's ability to **include children with disabilities/additional needs.**

80% Support from **Better Start Early Years Specialists** helps children with disabilities/additional needs to get the best from their ECCE provision.

77% Specialist **equipment/appliances and minor building alterations** are having a positive impact on **children and staff** in the ELC setting.

62% **HSE support** is helping a **children with disabilities/additional needs** to get the best out of their ECCE provision

89% **Additional capitation funding for extra staffing** is helping the setting to include children with disabilities/additional needs

From the perspective of providers, AIM worked **most well** if their setting had joined the programme in 2017-18 or 2018-19. It worked **least well** if they had joined in 2020-2021

Providers from settings in cities and urban areas are **less likely** to believe that the improvements in their setting's inclusive practices supported through AIM are **sustainable** than those in rural areas or towns

"AIM has been such a positive fundamental resource for our service. It has enabled us to include all children within our pre-school."

"We have been able to do so much more for the children in our pre-school than we would have been able to if we did not have access to the training, early years specialist support or the higher capitation that AIM provides."

"I would like to see AIM re-evaluate their application form. It has put some parents off applying for support when they see disability written all over the form."

"[We need] better funding for level 7 support to pay someone to come in to support in the setting. The funding is way too low making it impossible to recruit without providers topping up the pay."

6.11: Further Analysis of significant differences between groups

This subsection investigates significant differences between groups in order to cast more lights on association between factors and identify potential explanations. It begins with further analysis of the quantitative data before proceeding to analysis of the qualitative data (respondents' responses to free-text questions).

Quantitative Analysis

Investigating statistically significant differences between providers' perceptions of AIM and the year that their setting began participating in AIM.

Collation of significant differences across Year Started in AIM

Year started in AIM 2020-21

- More likely to report that the impact of AIM was 'small' or brought 'little or no benefit'
- Less likely to report that AIM had benefitted parent/carers of children whose children did not have disabilities
- Less likely to report that AIM had benefited children, staff, parents, and carers
- Less likely to report that the benefit of AIM to children with disabilities/additional needs was 'a great extent'
- Less likely to believe in sustainability
- Less likely to rate the impact of Early Years Specialist Advice highly.
- More likely to be satisfied with the application process

Year started in AIM 2016

- More likely to report that the INCO role had made a positive difference to their setting.
- Less likely to select 'none of the above' when reporting whether children with disabilities/additional needs were getting the most out of their ECCE programme because of Level 4 (EYS advice and mentoring)
- Less likely to report that advice and mentoring from the EYS (Level 4) had impacted positively on development of inclusive pedagogy.

Year AIM started between 2017-18 and 2018-19

- More likely to report that AIM had benefited parent/carers of children with additional needs, and parent/carers of children who did not have disabilities.
- More likely to report that AIM had benefited children with disabilities/additional needs
- More likely to see the changes made to their setting as sustainable
- More likely to rate the impact of the Early Years Specialist Service highly.

A correlation test has also been implemented to test the strength and direction of the relationship between the year providers started in AIM and their perceptions of AIM, but no directional correlation has been found.

These data demonstrate that providers are most likely to report positive outcomes and beliefs about sustainability if they started the AIM programme between 2017-18 and 2018-19. Perceptions of the

ease of applications were most positive among providers who began to participate in 2020-21 and this is when the Early Years Hive became the platform for all AIM applications. The relationship between the year that the setting began to participant in AIM and providers' perception of impact has been confirmed, but a linear relationship has not. It is reasonable to assume that as experience of AIM's implementation grows and evidence of impact grows, so do positive perceptions. This is because inclusive culture and practices take time to build. The more negative perceptions among providers who joined in 2020-21 are likely to be associated with COVID 19 and related disruptions, in addition to the need to embed inclusive practices in the setting. This is evidence of the importance of longevity in a provider's engagement with AIM.

Investigating statistically significant differences between providers' perceptions of the sustainability of AIM and the location of their setting (rural, urban, town)

Collation of significant differences across Year Started in AIM

- Pre-schools in city/large urban areas were significantly more likely to doubt sustainability (28%) than those in towns (18%) and rural areas (14%).
- Pre-schools in city/large urban areas were significantly more likely to doubt sustainability (28%) than those in towns (18%) and rural areas (14%).

Chi-Squared Tests were used to investigate the question of sustainability further, with findings as follows:

Relationship between length of time in AIM and belief in sustainability in AIM among

- There is very strong evidence of an association between the geographical location of the pre-school setting and practitioners' belief in the sustainability of AIM. p= 0.002. The major departure from independence is due to practitioners working in city pre-school setting being less likely to believe AIM is sustainable than those working in either town or rural settings
- *Relationship between length of time in AIM and belief in sustainability in AIM among providers.*

Relationship between size of setting and belief in the sustainability of AIM among providers

- No significant relationship between the size of the setting (under 29/0ver 30 vs belief in sustainability Y/N)

Relationship between geographical location (urban, town or rural) and perceptions of the impact of AIM on inclusion among providers

- No significant association between the geographical location of the setting and the perceived impact of AIM on inclusion, p=0.6 (Note: Only 4 practitioners in total felt AIM had a negative impact on inclusion).
- No significant association observed between the geographical location of the pre-school setting and practitioner perceptions of the benefits of AIM on children, families or staff in the pre-school setting.

Relationship between geographical location (urban, rural or town) and main type of disability

- There is strong evidence of an association between geographical location and the main type of disability. p = 0.031. The major departure from independence is due to families living in

rural locations being more likely to report a physical or sensory disability or a multiple main disability as their child's main type of disability. On the other hand, families living in urban locations are more likely to report ASD as their child's main type of disability.

Relationship between size of pre-school and location (city/large urban, town, rural)

- There is very strong evidence of an association between the number of children in the pre-school and the geographical location. p <0.001. The major departure from independence is due to rural settings being more likely to have 29 or fewer children than either town or city settings.

Relationship between size of setting and perceived impact of AIM on inclusion among providers

- No significant association between the size of the setting and the perceived impact of AIM on inclusion, p=0.106
- No significant association was observed between the size of the setting and perceptions of the benefits of AIM on children, families, or staff in setting

The findings confirm that providers in urban settings are less likely to believe in the sustainability of AIM, and this does not appear to be because AIM is perceived to be less impactful or beneficial by providers in city locations, or because the sizes of settings are generally larger in cities. These data perceptions may be related to the higher number of children with ASD in pre-schools in cities. We do not assume the problem to be within this group of children, and do not identify this group of children to have deficits. Instead, we apply a social model and draw from the wider evidence (parent/carer surveys, interviews with stakeholders, case studies) clear signs of a continuing need for training and development (including mentoring and coaching) focussed on inclusive practice for children with less visible, psychosocial disabilities. Children with physical and sensory disabilities were more prevalent in the sampled population of parent/carers whose children attended pre-schools in rural areas (the group who were more likely to report positive experiences of AIM).

To summarise findings from **quantitative analysis of differences between groups**

Year providers stated in the AIM programme

- Providers are most likely to report positive outcomes and beliefs about sustainability if they started the AIM programme in 2017-18 or 2018-19.
- Perceptions of the ease of applications were most positive among providers who began to participate in 2020-21 and this is when the Early Years Hive became the platform for these.
- The relationship between the year that the setting began to participant in AIM and providers' perception of impact has been confirmed, but a clear linear relationship between year started in AIM and perceptions has not. However, it is reasonable to assume that as experience of AIM's implementation grows and evidence of impact grows, so do positive perceptions. This is because inclusive culture and practices are likely to take time to build.
- The more negative perceptions among providers who joined in 2020-21 are likely to be associated with COVID-19 and related disruptions, as well as the need to engage with and embed inclusive practice in the setting.

Sustainability

- The findings confirm that providers in urban settings are less likely to believe in the sustainability of AIM, and this does not appear to be because AIM is perceived to be less positively impactful by providers in city locations, or because the sizes of settings are generally larger in cities.

- These data do indicate that these perceptions may be related to the higher number of children with ASD in pre-schools in cities. We do not assume the problem to be within this group of children, and do not identify this group of children to have deficits. Instead, we apply a social model and draw from the wider evidence (parent/carer surveys, interviews with stakeholders, case studies) indications of a continuing need for training and development (including mentoring and coaching) focussed on inclusive practice for children with less visible. psychosocial disabilities. Children with physical and sensory disabilities, were more prevalent in the sampled population of parent/carers whose children attended pre-schools in rural areas (the group who were more likely to report positive experiences of AIM).

Analysis of qualitative data in the survey.

This section presents the findings of an analysis of the qualitative data from the survey of ELC providers. There were two purposes. The first was to provide an enumerated analysis of the most prevalent themes (broadly summarised and illustrated in subsections 6.3 and 6.4). The second purpose was to seek potential explanations for the statistically significant differences between respondent sub-groups and their perception of AIM.

To serve the second purpose, content analysis was used to explore whether the qualitative data could offer explanations for:

- why ELC providers from settings in *cities and large urban areas* were less likely to believe that the improvements they have made to inclusive practice supported through AIM are sustainable
- why AIM is perceived to work more effectively in settings that have been *engaging with AIM for at least 3 years*
- why parent/carer perceptions of AIM when their child has ASD are less positive than for other types of additional need/disability.
- why settings who have been engaging in AIM since 2019 are less positive about AIM than those who started in 2017-18 and 2018-19

The process for calculating weighted differences in the frequency of text coded to categories between groups was described in detail in subsection 5.11.

The following tables summarise the results of the content analysis. Counts higher than n=9 are shaded in grey to indicate the most prevalent categories across the sample.

Content Analysis: Weighted differences between prevalence for categories across groups

Table 6.11.1: Survey Question C4: How satisfied were you with the LINC programme? Weighted differences between prevalence for categories across groups

Category	(N) Total Matched To Category	Weighted Difference Category City & Large Urban - Rural & Town	Weighted Difference Category 30 Or Over On Roll - Up To 29 On Roll	Weighted Difference Autism/ASD - Disability Other Than Autism/ASD	Weighted Difference
LINC Course was effective and well managed	425	-0.54	0.22	0.34	-0.34
LINC Course was easily accessible	55	-0.16	-0.05	0.37	-0.34
Ineffective LINC Course	49	-0.13	0.14	0.37	-0.36
LINC Course was repetitive	16	-0.09	0.35	0.26	-0.28
LINC Course challenging due to heavy workload	13	-0.16	0.45	0.48	-0.31
LINC Course was challenging	10	-0.10	0.40	0.31	-0.29
LINC knowledgeable, exceptional tutor	9	-0.17	0.27	0.35	-0.32
LINC Course availability was restricted/ limited	7	-0.22	0.32	0.48	-0.22
LINC Tutor was unsupportive	6	0.00	-0.06	0.42	-0.17
LINC Course was challenging due to COVID	3	-0.17	0.27	0.29	-0.44

Table 6.11.2: Survey Question D4-10 What if anything was the impact of receiving advice/mentoring from Early Years Specialists (Access and Inclusion)? (When 'other' is response) Weighted differences between prevalence for categories across groups

Category	(n) Total matched to category	Weighted Difference category City & Large Urban - Rural & Town	Weighted Difference category 30 or over on roll - Up to 29 on roll	Weighted Difference Autism/ASD - Disability other than autism/ASD	Weighted Difference *'Started AIM in 2019 or later' compared to 'started AIM in 2017-18 and 2018-19'*
AIM support for children with special needs, families	67	-0.12	0.22	0.34	-0.34
Insufficient AIM support	12	-0.17	0.27	0.44	-0.35
NO AIM support received	9	-0.11	0.27	0.62	-0.27
AIM funding for additional staff and equipment	7	-0.14	0.03	0.18	-0.28

Table 6.11.3: Survey Question D16: What aspects of AIM Levels 4-7 have had the most impact on how your setting delivers early learning and care provision (When 'Other' selected as response) Weighted differences between prevalence for categories across groups

Category	(n) Total matched to category	Weighted Difference category City & Large Urban - Rural & Town	Weighted Difference category 30 or over on roll - Up to 29 on roll	Weighted Difference Autism/ASD - Disability other than autism/ASD	Weighted Difference *'Started AIM in 2019 or later' compared to 'started AIM in 2017-18 and 2018-19'*
AIM level -7 Additional capitation	403	-0.14	0.23	0.40	-0.34
AIM level- 4 Advice & mentoring	98	-0.16	0.22	0.34	-0.32
AIM levels providing support for children with special needs	27	-0.07	0.20	0.36	-0.32
AIM level -5 additional equipment	22	-0.11	-0.08	0.21	-0.32
AIM level support 5,6,7	10	0.00	0.10	0.26	-0.22
AIM support level 4-7	9	-0.17	0.16	0.33	-0.33
AIM support level 4, 5, 7	8	0.00	0.23	0.34	-0.44
AIM support has no impact	6	-0.08	-0.06	0.31	-0.26
AIM level support 4,6,7	4	0.00	0.35	0.31	-0.17
AIM support level 4.6	3	0.00	-0.06	0.42	-0.44

Table 6.11.4: Survey Question E1-2 How much impact, if any, has AIM made to inclusion at your early learning and care (ELC) setting? Why do you say that? Weighted differences between prevalence for categories across groups

Category	(n) Total matched to category	Weighted Difference category City & Large Urban - Rural & Town	Weighted Difference category 30 or over on roll - Up to 29 on roll	Weighted Difference Autism/ ASD - Disability other than autism/ ASD	Weighted Difference *'Started AIM in 2019 or later' compared to 'started AIM in 2017-18 and 2018-19'*
AIM support has positive impact on children with additional needs	412	-0.12	0.19	0.34	-0.33
AIM support in funding for extra staff who can give children the support and attention they need	162	-0.15	0.31	0.37	-0.30
Improvements to communication with parent/carers and settings about assessment of needs (HSE, Pobal and EYSS)	153	-0.15	0.23	0.37	-0.34
AIM support ineffective because (poor pay for L7, delays in funding, limitations in HSE support)	44	-0.14	0.22	0.30	-0.38
AIM Early Years Specialist support & advice	24	-0.11	0.27	0.37	-0.33

Table 6.11.4: Survey Question E1-2 How much impact, if any, has AIM made to inclusion at your early learning and care (ELC) setting? Why do you say that? Weighted differences between prevalence for categories across groups

Category	(n) Total matched to category	Weighted Difference category City & Large Urban - Rural & Town	Weighted Difference category 30 or over on roll - Up to 29 on roll	Weighted Difference Autism/ ASD - Disability other than autism/ ASD	Weighted Difference 'Started AIM in 2019 or later' compared to 'started AIM in 2017-18 and 2018-19'
AIM support has positive impact on children with additional needs	412	-0.12	0.19	0.34	-0.33
AIM support in funding for extra staff who can give children the support and attention they need	162	-0.15	0.31	0.37	-0.30
Improvements to communication with parent/carers and settings about assessment of needs (HSE, Pobal and EYSS)	153	-0.15	0.23	0.37	-0.34
AIM support ineffective because (poor pay for L7, delays in funding, limitations in HSE support)	44	-0.14	0.22	0.30	-0.38
AIM Early Years Specialist support & advice	24	-0.11	0.27	0.37	-0.33

Table 6.11.5: Survey Question E5: What if any suggestions do you have for how AIM could be improved? Why do you say that? Weighted differences between prevalence for categories across groups

Category	(n) Total matched to category	Weighted Difference category City & Large Urban - Rural & Town	Weighted Difference category 30 or over on roll - Up to 29 on roll	Weighted Difference Autism/ ASD - Disability other than autism/ ASD	Weighted Difference Started AIM in 2019 or later - Started AIM in 2016
AIM Funding needs to improve, including higher pay for staff	141	-0.14	0.24	0.38	-0.33
No Improvements needed	112	-0.12	0.05	0.31	-0.29
Extension of AIM Program beyond ECCE age bracket and 3 hours per day	73	-0.17	0.38	0.39	-0.31
AIM Application format & process needs improvement	43	-0.09	0.13	0.33	-0.32
LINC training for more staff members	33	-0.11	0.24	0.37	-0.31
AIM Program positive impact	24	-0.04	0.10	0.31	-0.35
More visits from Early Year Specialist needed	24	-0.11	0.31	0.39	-0.33

Table 6.11.5: Survey Question E5: What if any suggestions do you have for how AIM could be improved? Why do you say that? Weighted differences between prevalence for categories across groups

Category	(n) Total matched to category	Weighted Difference category City & Large Urban - Rural & Town	Weighted Difference category 30 or over on roll - Up to 29 on roll	Weighted Difference Autism/ ASD - Disability other than autism/ ASD	Weighted Difference Started AIM in 2019 or later - Started AIM in 2016
AIM Funding needs to improve, including higher pay for staff	141	-0.14	0.24	0.38	-0.33
No Improvements needed	112	-0.12	0.05	0.31	-0.29
Extension of AIM Program beyond ECCE age bracket and 3 hours per day	73	-0.17	0.38	0.39	-0.31
AIM Application format & process needs improvement	43	-0.09	0.13	0.33	-0.32
LINC training for more staff members	33	-0.11	0.24	0.37	-0.31
AIM Program positive impact	24	-0.04	0.10	0.31	-0.35
More visits from Early Year Specialist needed	24	-0.11	0.31	0.39	-0.33
AIM Database for qualified staff (level 7)	16	-0.13	0.35	0.36	-0.31

In a context where 78% of respondents perceived positive impacts from the LINC programme on their inclusive practice, table 6.1.11 reports on the text under Survey Question C4. For this item, respondents were invited to explain the reasons for their satisfaction rating of the LINC programme as indicated on Likert items and scales. The most prevalent categories for the coded text were as follows:

Positive perspectives on LINC
The LINC programme was effective and managed/delivered well (425)
The programme was easy to access (materials and the fact that it was online) (55)

The course was challenging (10)

Negative perspectives on LINC
The course was ineffective (49)
The course was repetitive since it covered things already known by respondents (16)
A heavy workload impacted on engagement with the programme (13)

Differences between the groups ‘City and Large Urban/Rural and Town’ were small, though respondents working in settings located in towns wrote text coded to the category *LINC course was effective and well managed’* more frequently. Settings with higher numbers of children on role reported that the course was challenging and that it was impacted by workload more frequently than those in smaller settings (0.45 and 0.40 respectively). This implies that workload pressures for LINC enrolees are greater in larger settings. There were only small differences in the groups ‘started AIM 2019 or later/started AIM 2017 or earlier’.

In a context where 80% of providers agreed that support from Early Years Specialists (AIM Level 4) had helped children with disabilities/additional needs to get the best out of their ECCE provision, Table 6.11.2 shows that weighted differences between groups were small. Of interest is the higher frequency of respondents who have children on roll with autism/ASD reporting that no AIM support had been received (0.62) but the count is relatively low for this category (n=9). However, this experience is also communicated in the category of *insufficient AIM support* (n=12), with a higher frequency for the group ‘ASD’ (0.44). This implies that providers experience less impact from AIM Level 4 when impact is conceived as successful applications for AIM support.

It is clear from Table 6.11.3, that the category *AIM Level 7 – additional capitation* was perceived as the most impactful AIM targeted support (403). This was followed by AIM Level 4 (98), a more general category *AIM levels providing support for children with special needs* (27), AIM Level 5 (22) and a grouping of AIM Levels 5, 6 and 7 (10).

There are very small, weighted differences between groups, implying that these AIM supports are prized across types of disabilities/additional needs and contexts. Settings that started AIM in 2017 or earlier, tend to report these beneficial elements more frequently than settings that joined the programme later.

Table 6.11.4 shows that, in a context where 96% of respondents agreed that AIM support was having a positive impact on inclusion in their setting, respondents recorded the following reasons for their rating most frequently:

- AIM support has a positive impact on children with additional needs (412)
- AIM support in funding for extra staff (referring to Level 7) (162)
- Improvements in communication between pre-school, services, and families (153)
- AIM Level 4 support and advice (24)

44 respondents commented that AIM support had not been effective for several reasons including poor pay for L7 staff, delays in funding and shortfalls/limitations in support from HSE services. Weighted differences between groups were usually very small, though settings who had children in the group ‘ASD’ reported both positive impacts more frequently (0.34 to 0.37), and negative ones too (0.30), implying that for this group, impacts are a little more variable than for other groups. Table 6.11.3 contains more evidence of providers’ tendency to value targeted support more highly than

universal support since this is used to explain positive impact or reasons for a lack of impact. The need for more training in ASD, complex and medical needs was also raised by 12 participants.

Table 6.11.5 demonstrates that there is consensus across providers about how AIM could improve. There are only small differences across subcategories, though we can note that respondents in ‘rural and town’, ‘’30 or over on roll’, ‘ASD’ and ‘Started AIM in 2016 or later’ groups provide text responses more frequently than those in their paired groups. Proposals for improvements are as follows in order of prevalence:

- The improvement of capitation for Level 7 to allow recruitment of high-quality staff (141)
- The extension of AIM to younger children and beyond 3 hours a day (73)
- Improvement of the application process including the quicker turnaround of decisions and a review of the language of ‘disability’ on forms (43)
- Allowing more than one member of staff in each setting to enrol in the LINC training (33)
- More visits and intensive support from Early Years Specialists (Level 4) (24)
- Developing a database of qualified staff for Level 7 (16)

112 Providers noted that no improvements were needed and 24 described the AIM programme as very well formed and essential as a model of support for inclusion. There were only small differences across groups, implying that these proposals for improvement are relevant across contexts and types of additional needs/disabilities.

To summarise findings from **qualitative analysis** identified the following differences between groups

Groups 'city and large urban' compared to 'rural and town'

- Differences between these groups were very small though respondents working in settings located in towns and rural areas wrote text coded to the category *LINC course was effective and well managed'* more frequently, implying that the programme is a better fit with their needs than it is for providers in cities and large urban areas, since they may have more access to CPD opportunities.

Groups 'more than 30 on roll' compared to '29 or less on roll''

- Settings with higher numbers of children on role reported that the LINC course was challenging, and that it was impacted by workload more frequently than those in smaller settings (0.45 and 0.40 respectively). This implies that workload pressures for LINC enrolees are greater in larger settings.

Groups 'ASD' compared to 'non ASD''

- A higher frequency of respondents who have children on roll with autism/ASD reported that no AIM support had been received (0.62) but we note the count is relatively low for this category (n=9). However, this experience is also communicated in the category *insufficient AIM support* (n=12), with a higher frequency for the group 'ASD' (0.44). This implies that providers experience less impact from AIM Level 4 for this group when impact is measured by the success of failure of applications for additional support.
- Weighted differences between groups were usually very small, though settings who had children in the group 'ASD' reported both positive impacts more frequently (0.34 to 0.37), and negative ones too (0.30), implying that for this group, impacts are a little more variable than for other groups

Groups 'Started AIM in 2019 or later' compared to 'started AIM in 2017-18 and 2018-19'

Settings that started AIM in 2017 or earlier, tend to report the benefits of AIM Levels 4-7 more frequently that settings that joined the programme later, implying that it meets their needs more fully. AIM since 2019 are less positive about AIM than those who started in 2017-18 and 2018-19

Generally, differences between groups were small, though lower levels of success in gaining support for children with ASD may offer some explanation of why parent/carer satisfaction levels are lower. It emerges that parent/carers and providers measure impact, at least in part, by how successful applications for additional support has been. For the group 'ASD' the chances to gain support through AIM seem to be a little more variable.

To summarise findings from **qualitative analysis of text entries by providers** on quality and impact (positive and negative)

Positive perspectives on LINC
The LINC programme was effective and managed/delivered well (425)
The programme was easy to access (materials and the fact that it was online)(55)
The course was challenging (10)
Negative perspectives on LINC
The course was ineffective (49)
The course was repetitive since it covered things already known by respondents (16)
A heavy workload impacted on engagement with the programme (13)

Impacts of Level 4
Positive perspectives on AIM Level 4
Results in targeted AIM support for children and families (67)
Negative perspectives on AIM Level 4
Does not deliver sufficient support (12)

The most impactful targeted supports
Level 7 is perceived to be the most impactful AIM targeted support (403), followed by Level 4 (98), and Level 5 (22)
Some participants grouped Levels 5, 6 and 7 to describe support with the most impact (10)

Positive impacts of AIM support
- AIM support has a positive impact on children with additional needs (412)
- AIM support in funding for extra staff (referring to Level 7) (162)
- Improvements in communication between pre-school, services, and families (153)

Reasons for little or no impact from AIM support
- AIM support ineffective because of poor pay for L7, delays in funding allocations and limitations in HSE support (44)

Generally, providers are satisfied when AIM results in additional support being in place. Where AIM has not resulted in additional support or the child (in targeted form), providers are less positive about its impact. In this way, providers tend to equate impact with the successful garnering of additional resources.

To summarise findings from **qualitative analysis of text entries by providers on proposals for improvement of AIM** identified the following categories as most prevalent

Suggestions for how AIM could be improved by providers in free text comments

- The improvement of capitation for Level 7 to allow recruitment of high-quality staff (141)
- The extension of AIM to younger children and beyond 3 hours a day. (73)
- Improvement of the application process including quicker turnaround of decisions and a review of the language of 'disability' on forms (43)
- Allowing more than one member of staff in each setting to enrol in the LINC training (33)
- More visits and intensive support from Early Years Specialists (Level 4) (24)
- Developing a database of qualified staff for Level 7 (16)

112 Providers noted that no improvements were needed and 24 described the AIM programme as very well formed and essential as a model of support for inclusion.

6.12: Summary of findings: ELC provider survey

This subsection reports the overall findings from the survey of ELC providers. The reporting of findings is structured to the four key questions posed for this end of year three evaluation of AIM.

Is AIM effective and achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities and additional needs?

Participation in AIM by providers

- 44% of pre-schools began participating in AIM in 2016 (when AIM first started). 52% participated from 2017 onwards.
- Participation in 2016 was significantly more likely in settings with 30 children or more (54%, n=239) when compared to settings with up to 29 children (28%, n=82). When pre-schools first participated in AIM from 2017 onwards, there was a statistically significant difference between larger and smaller pre-schools. For example, respondents in smaller pre-schools were significantly more likely to report that 2018 was the year when they first participated in AIM (18%, n=53) than larger pre-schools (13%, n=57). This implied that AIM's scope has developed to encompass smaller ELC settings.
- At the end of 2020, no statistically significant differences were found in the profile of children with disabilities/additional needs on roll at the end of 2020 in terms of size of ELC, type and setting of pre-school, and year started AIM.
- However, there are some notable differences as follows, but these differences were not found to be statistically significant:
  - The mean number of children with disabilities/additional needs is highest in pre-schools with 30 children or more (4.0) compared to those with 29 or fewer (2.5).
  - The mean is also higher in community pre-schools (4.2) than it is in private pre-schools (3.1).
  - The mean in rural (2.7) and town (3.4) areas is lower than in city/large urban areas (4.4).

Benefits of AIM to children, parent/carers, and families

- In relation to the benefits of AIM on children, parents/carers and staff, providers were generally very positive when reporting their experiences.

- Key findings are as follows:
  - 94% of providers reported that AIM had benefited children with disabilities/additional needs with 77% reporting that the magnitude of the benefit had been to 'a great extent, and 4% 'to a small extent. From analyses of cross-breaks in data tables, we also know that providers were statistically significantly less likely to report this if their year of starting AIM was 2020-2021 (62%) compared to 2017 (80%) and 2016 (78%).
  - 88% of providers reported that AIM had benefited other children in the setting. From analyses of cross-breaks in data tables we also know that benefits were more likely to be reported by respondents working in private settings (91%) when compared to community settings (89%).
  - 89% reported that AIM had benefited parents/carers of children with disabilities/additional needs. We also know that there was a significant difference between respondents whose settings had started AIM in 2021 (76%) compared to 2018 (90%), 2017 (91%) and 2016 (98%). 67% of respondents reported that the support provided by AIM benefited parents/carers who did not have children with disabilities/additional needs.
  - 92% reported benefits to staff in the ELC setting, with 75% reporting benefits to other staff. From analyses of cross-breaks in data tables, we also know that private pre-schools

are more likely to report benefits (94%) than community pre-schools (93%). This difference is statistically significant.

- When analysing responses by type of disability/additional need, there are no statistically significant differences between groups, with 77%-79% of providers describing AIM's benefit to children to the level of 'a great extent, 13% to 18% selecting 'to some extent, and 2-9% selecting 'to a small extent. Figures for autism/ASD are 79% (great extent), 17% (some extent) 3% (a small extent), and 4% (no extent). However, when viewing the data from this Likert scale as a whole, it is clear that providers who started to participate in AIM in 2021-21 are less likely to report benefits for children, staff, and parents/carers than those whose participation began earlier. This is probably because the benefits are not yet embedded/visible and because of the impact of COVID 19, although the data cannot confirm this.

Further quantitative analysis has led to the following findings:

- Providers are most likely to report positive outcomes and beliefs about sustainability if they started the AIM programme in 2017-18 or 2018-19.
- The relationship between the year that the setting began to participate in AIM and providers' perception of impact has been confirmed, but a clear linear relationship between year started in AIM and perceptions has not. However, it is reasonable to assume that as experience of AIM's implementation and impact grows, so do positive perceptions. This is because inclusive culture and practices are likely to take time to build.
- The more negative perceptions among providers who joined in 2020-21 are likely to be associated with COVID-19 and related disruptions, as well as the need to engage with and embed inclusive practices in the setting.
- Perceptions of the ease of applications were most positive among providers who began to participate in 2020-21 and this is when the Early Years Hive became the platform for these.

Qualitative analysis was used to investigate whether the greater likelihood of a negative perception of the AIM for parent/carers with ASD could be seen or explained by the free text data written by respondents in the provider survey. It was also used to investigate whether the qualitative data might explain perception differences across locations, time in AIM and size of setting. The findings were as follows

Groups 'city and large urban' compared to 'rural and town'

- Differences between these groups were very small though respondents working in settings located in towns wrote text coded to the category *LINC course was effective and well managed'* more frequently, implying that the programme is a better fit with their needs than it is for providers in cities and large urban areas, since they may have more access to CPD opportunities.

Groups 'more than 30 on roll' compared to '29 or less on roll''

- Settings with higher numbers of children on role reported that the LINC course was challenging and that it was impacted by workload more frequently than those in smaller settings (0.45 and 0.40 respectively). This implies that workload pressures for LINC enrolees are greater in larger settings.

Groups 'ASD' compared to 'non ASD''

- A higher frequency of respondents who have children on roll with autism/ASD reported that no AIM support had been received (0.62) but we note the count is relatively low for this category (n=9). However, this experience is also communicated in the category *insufficient AIM support* (n=12), with a higher frequency for the group 'ASD' (0.44). This implies that

providers experience less impact from AIM Level 4 for this group when impact is measured by the success or failure of applications for targeted support.

- Weighted differences between groups were usually very small, though settings who had children in the group 'ASD' reported both positive impacts more frequently (0.34 to 0.37), and negative ones too (0.30), implying that for this group, impacts are a little more variable than for other groups

Groups 'Started AIM in 2019 or later' compared to 'started AIM in 2017-18 and 2018-20.

- Settings that started AIM in 2017 or after were tending to report the benefits of AIM Levels 4-7 more frequently than settings that joined the programme later, implying that it meets their needs more fully.

Generally, differences between groups were small, though perceived lower levels of success in gaining AIM support for children with ASD among providers may offer some explanation of why parental satisfaction levels are lower. It emerges that parent/carers and providers measure impact, at least in part, by how successful applications for additional support has been. For the group 'ASD' the chances to gain support through AIM seem to be a little more variable.

Has AIM influenced practice, or increased capacity in the workforce?

Impact on inclusion in the setting

Generally, respondents were very positive about the impact that AIM had on inclusive practice in their settings

- 96% of respondents reported that AIM had a positive impact on inclusive practice at their ELC setting with a significant difference in the responses of those whose settings started with AIM in 2017 (100%) compared to all other years.
- Respondents from private settings were significantly more likely to report this (98%) than those from community settings (97%). Positive impacts described as 'large' were most likely to be reported in cases where the setting had begun to engage with AIM in 2017 (88%) compared to 2019 (77%) and 2020-21 (60%) or and these differences were statistically significant.
- For providers whose ELC settings began to engage with AIM in 2020-21 (60%), respondents were significantly more likely to report that the impact was 'small' (33%) or that there was little or no benefit (10%) than in the case of all other years. This may be a result of COVID 19 and closures/limitations in ELC and other (HSE) services. It may also be because AIM requires time for bedding in, and that confidence in its potential grows as engagement with it lengthens. 645 (88%) of respondents provided answers to the survey question 'why do you say that?' following their rating on the impact of AIM. Their responses provide explanations for why respondents perceive positive impact and little/no or negative impact. The content of comments generally focuses on the way that AIM has; made inclusion possible; enabled better provision for children; secured enough support to enable children to develop and progress; reduced the teacher-to-pupil ratio; supported access to different specialists, and enabled mentorship from Early Years Specialists.
- When reporting why there had been little or no impact, respondents focused on issues related to low pay and poor working conditions for additional staff in the context of Level 7; the need for more detailed and regular assessment/reviews from specialists for children with diagnoses, and the need to deliver Level 6 support within the setting.

Sustainability of changes made to the setting as a result of AIM

- Two-thirds (67%) of respondents felt that the changes made in their setting as a result of AIM were sustainable, with 19% feeling they were not sustainable and 6% were saying AIM had not resulted in any changes in their setting. Pre-schools in city/large urban areas were significantly more likely to doubt sustainability (28%) than those in towns (18%) and rural areas (14%).
- Respondents whose settings started with AIM in 2021, were significantly less likely to believe in sustainability (52%) than those whose settings started in other years. Those providers who started in 2017 were most likely to see the changes made to their setting as a result of AIM as sustainable (77%) when compared to 2020-21(52%) and 2016 (64%). This may be more evidence of the importance of longevity of engagement in AIM.
- Further quantitative analyses confirm that providers in urban settings are less likely to believe in the sustainability of AIM, and this does not appear to be because AIM is perceived to be less positively impactful by providers in city locations, or because the sizes of settings are generally larger in cities.
- These data do indicate that these perceptions may be related to the higher number of children with ASD in pre-schools in cities. We do not assume the problem to be within this group of children, and do not identify this group of children to have deficits. Instead, we apply a social model and draw from the wider evidence (parent/carer surveys, interviews with stakeholders, case studies) indications of a continuing need for training and development (including mentoring and coaching) focussed on inclusive practice for children with less visible disabilities. In addition, there are significantly higher numbers of parent/carers whose children attend pre-schools in rural areas reporting physical and sensory disabilities as their child's main type of disability. Again, this may be skewing the data in favour of rural settings.

Is the current approach appropriate in the National Context?

Overall, providers are positive about AIM's operation and impact, indicating that the current approach is working for them, though with some variabilities.

Areas that are working well

AIM Levels 1-3

To summarise, **providers' views on AIM's universal supports (Levels 1-3) were generally positive and found to be as follows:**

- 455 (62%) of respondents provided comments in response the survey question 'What aspects of AIM Levels 1-3 have had the most impact on how your setting delivers early learning and care?' Responses were varied but included to approximately equal degrees; training (e.g., Diversity, Equality, and Inclusion Training; Hanen, Lámh), resources (inclusive play materials), the INCO role, the AIM website, and the LINC programme. This implies that all aspects of Level 1-3 are experienced as having a positive impact but settings vary in the aspect they select as most impactful.

AIM Level 1:

- 99% of settings had adopted Diversity, Equality, and Inclusion Guidelines (no significant differences by size, type, or location of setting)
- 94% of settings had adopted the Inclusion Charter (no significant differences by size, type, or location of setting; lower for settings who started AIM in 2020-21).

- 83% of respondents had attended Diversity, Equality and Inclusion training offered by County Childcare Committees (CCCs) and 76% had sent other staff members on such training
- 97% of staff were reported to have completed the LINC training while working at the responding provider's setting and 13% at a different ELC setting.
- Three-quarters (76%) of settings were satisfied or very satisfied with the LINC programme.
- In general, the reasons given for undertaking LINC lean towards a desire to develop more skills and knowledge in how to implement inclusive strategies at the universal level.
- Overall, providers were positive about the impact of LINC training on their setting with between 73% and 78% reporting notable or significant impact on sharing of learning, including a child/children with disabilities/additional needs, helping a child/ren with disabilities/additional needs to get the best out of the ECCE provision, communication with parent/carers and inclusive culture change.
- In the case of the LINC programme's impact on the capacity of staff to include a child/children with additional needs, respondents in settings in rural areas (63%) were significantly more likely to report notable or significant impact (83%) than was the case in towns (73%) or city/large urban areas (60%).
- 91% of settings with an INCO felt it that the role had made a positive difference to their setting with 45% describing this as a 'big' difference and 8% noting that the role had made 'no' difference.

AIM Level 2:

- 86% of respondents reported that when they had sought information, they did find information that met their needs. This was significantly more likely in rural settings (89%) than in towns (85%) or city/large urban areas (83%).

AIM Level 3:

- Respondents reported that the staff in their ELC setting had taken part in training as follows, and it is noted that participation in these opportunities seems relatively low, though reasons for non-participation are unclear.
    - Lámh training (54%)
    - Learning Language and Loving It and Teacher Talk- The Hanen Programmes for Early Childhood (50%)
    - Sensory processing training (49%)
    - None of the above (18%)

Generally, respondents were positive about their engagement and satisfaction with AIM Level 3, with this being more positive for settings who joined AIM three or more years ago (2017 or earlier) than between 2019 and 2021. The training offer appears to be more relevant to those providers in rural areas than in town or city ones.

Levels 4-7

- 537 respondents (73%) provided free text comments in response to the survey question 'What aspects of AIM Levels 4-7 have had the most impact on how your setting delivers early learning and care?' This data demonstrates that additional capitation is the type of AIM support that providers believe has the most impact on their capacity to be inclusive though many note that Level 4 and Level 7 run in parallel. Hence Level 4 and 7 are identified as the AIM aspects having the most impact in the targeted support range

To summarise **providers' views on AIM's Level 4 and Level 5 targeted supports were generally positive and found to be as follows**

AIM Level 4:

In general, providers were satisfied with the specific types of support provided by Early Years Specialists and its impact on inclusion.

- 78% reported a positive impact on the inclusion of a child/children in a setting. In 2020/21 this was significantly lower at 66%.
- 95% of settings had sought advice and mentoring from Early Years Specialists (the proportion being higher for community pre-schools at 98%), and 87% had signposted parent/carers to advice and mentoring from Early Years Specialists.
- 95% of settings had supported parent/carers to complete an access and inclusion profile (98% for community settings) [note: in practice this often seems to be done by ELC staff rather than a parent/carer]
- Providers' views on the quality of EYS support were as follows
  - Satisfied with the quality of mentoring and coaching strategies (81%)
  - Satisfied with support provided in enhancing parent/carer partnerships (71%)
  - Satisfied with the support provided for implementing practices and strategies to support inclusion (80%)
  - Satisfied with the liaison with HSE and other professionals in providing advice on goals for programmes for the child (56%)
  - Access to health service supports to enable the child to access the ELC setting (49%)

AIM Level 5:

- 38% of settings had applied for specialist equipment, appliances, and alterations and of those, 34% of settings had been awarded specialist equipment, appliances, and alterations.
- Among those who had applied for AIM Level 5, most (68%) were satisfied with the ease of applying for Level 5 support and 69% were satisfied with the decision-making process. 57% were satisfied with the timeframe from application to payment (27% were dissatisfied).
- 50% were satisfied with ongoing support in using the equipment and 28% were dissatisfied.
- 70% were satisfied with the appropriateness of the equipment.
- For example, 77% agreed that the Level 5 support had helped the setting to include a child/children with disabilities and additional needs so that they could get the most out of their ECCE provision (7% disagreed).

AIM Level 6:

In general, fewer providers were satisfied with liaison with health specialists (49%) than with other AIM supports. Where they were positive, respondents agreed that health services assisted them to:

- include a child/children with disabilities/additional needs (55% agree, 17% disagree)
- help a child/children with disabilities/additional needs get the most out of their ECCE provision (62% agree, 15% disagree)
- change their practice in how they include children (50% agree, 24% disagree)
- improve the way that staff communicate with parents/carers about inclusion and disability/additional needs (55% agree, 23% disagree)
- bring about culture change, so they are more inclusive (53% agree, 25% disagree)
- implement an inclusive pedagogy (57% agree, 21% disagree).

In the context of the interplay between Level 4 and Level 6 providers were also:

- Satisfied with the liaison with HSE and other professionals in providing advice on goals for programmes for the child (56%)
- Access to health service supports to enable the child to access the ELC setting (49%)

Evidence from the survey of providers also indicates that perceptions of satisfaction and impact for Level 6 are drawn from respondents' encounters with HSE interventions accessed by families outside of AIM (through prior diagnosis and existing interventions before pre-school) as well as Level 6 (universal and targeted) supports accessed within AIM. This implies that respondents are conflating these elements under the concept of 'Therapeutic Support' as was the case in the parent/carer survey. This is not surprising since providers and parent/carers may be less concerned with precision around the nomenclature of AIM than they are with their lived experience of AIM support, and the people they have/expect to receive that support from.

This indicates a need to clarify the purpose and content of Level 6 support in general and individual communications with parent/carers and providers, particularly since this same phenomenon was observed in the parent/carer survey. It is also unclear whether respondents' perceptions of Level 6 were a result of its lower level of visibility/prevalence in ELC settings compared to other AIM levels[44] or its quality overall.

AIM Level 7:
ELC providers were generally positive about the impact of additional capitation funding.

- The majority of providers (90%) agreed: that additional capitation had helped children with disabilities to get the most out of their ECCE provision.
- 89% agreed that additional capitation had helped the setting to include a child/children with disabilities/additional needs. 84% reported that it had increased ELC staff capacity to implement inclusive pedagogy.
- In relation to the impact on inclusive practice and culture, 74-75% of providers reported benefits from additional capitation.
- When considering the way that staff communicate with parents/carers about the inclusion and disability/additional needs, 75% reported that additional capitation had led to improvements.
- Of all the settings (n= 638) who applied for additional capitation, 88% had been awarded it while 11% (n= 81) had not.
- Of those that had applied for additional capitation, 79% (n= 519) were satisfied with the application process. Providers with settings in city/large urban areas were significantly more likely to be dissatisfied (25%) than those in towns or rural areas. For settings that first participated in AIM in 2020-2021, there was a significantly higher likelihood of being satisfied with the application process (91%) than in 2016 (78%), and this may be due to the introduction of the new application portal (Early Years Hive).
- Additional capitation was most commonly used by settings to recruit additional staff (80%). 7% (n=47) used the funding to enrol fewer children without financial loss and 17% used the funding to achieve both.
- Generally, Levels 4, 5 and 7 achieved higher levels of satisfaction for their impact than Level 6.

Positive perspectives on AIM Level 4

- Results in targeted AIM support for children and families (67)

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[44] 8% of the total AIM supports allocated are Level 6 (universal – EYS engagement with HSE), and 0.33% are Level 6 (targeted - referrals) according to data provided by Pobal (Monthly Report, October 21). It has been reported by HSE that these counts represent undersubscription to Level 6 rather than a lack of resource availability

The most impactful targeted supports

- Level 7 is perceived to be the most impactful AIM targeted support (403), followed by Level 4 (98), and Level 5 (22)
- Some participants grouped Levels 5, 6 and 7 to describe support with the most impact (10)

Positive impacts of AIM support

- AIM support has a positive impact on children with additional needs (412)
- AIM support in funding for extra staff (referring to Level 7) (162)
- Improvements in communication between pre-school, services, and families (153)

These data demonstrate that providers are generally more satisfied when AIM results in additional support being in place, and where communication between the pre-school, AIM agencies/services and families are good.

Areas that need development

112 (15%) respondents chose the option 'no improvement needed' in the options menu for this survey item. When asked to share their views on how AIM could be improved, 508 (69%) respondents provided free text comments. Responses focused on the following:

Suggestions for how AIM could be improved

- The improvement of capitation for Level 7 to allow recruitment of high-quality staff (141)[45]
- The extension of AIM to younger children and beyond 3 hours a day. (73)
- Improvement of the application process including a quicker turnaround of decisions and a review of the language of 'disability' on forms (43)
- Allowing more than one member of staff in each setting to enrol in the LINC training (33)
- More visits and intensive support from Early Years Specialists (Level 4) (24)
- Developing a database of qualified staff for Level 7 (16)

24 respondents described the AIM programme as very well formed and essential as a model of support for inclusion. The proposals for improvement focus on improvements to Level 7, the extension of AIM beyond the ECCE programme, a review of the term 'disability' in the application process and increases in the intensity and frequency of training and mentoring. The availability of Level 6 support was also indicated as an area for development. Other findings were as follows:

Negative perspectives on AIM Level 4

- Does not deliver sufficient support (12)

Reasons for little or no impact from AIM support

- AIM support was ineffective because of poor pay for L7, delays in funding allocations and limitations in HSE support (44)

These findings indicate that where AIM has not resulted in additional support for the child (in the form of targeted funding), providers are less positive about its impact. In this way, providers tend to equate impact with the successful garnering of additional resources. Limitations in resources for HSE support

[45] Value is the prevalence of the category indicating how many respondents made this point.

are also identified as barriers to AIM's impact from the perspective of providers, but we note that HSE had informed researchers that Level 6 is undersubscribed rather than under resourced. This is more evidence of confusion among survey respondents about the purpose and content of AIM Level 6, signaling a need for better communication at all levels.

Differences in groups

To summarise findings from **qualitative analysis of text entries by providers** identified the following differences between groups

Groups 'city and large urban' compared to 'rural and town'

- Differences between these to groups were very small though respondents working in settings located in towns wrote text coded to the category *LINC course was effective and well managed'* more frequently, implying that the programme is a better fit with their needs than it is for providers in cities and large urban areas, since they may have more access to CPD opportunities.

Groups 'more than 30 on roll' compared to '29 or less on roll''

- Settings with higher numbers of children on role reported that the LINC course was challenging, and that it was impacted by workload more frequently than those in smaller settings (0.45 and 0.40 respectively). This implies that workload pressures for LINC enrolees are greater in larger settings.

Groups 'ASD' compared to 'non ASD''

- A higher frequency of respondents who have children on roll with autism/ASD reported that no AIM support had been received (0.62) but we note the count is relatively low for this category (n=9). However, this experience is also communicated in the category *insufficient AIM support* (n=12), with a higher frequency for the group 'ASD' (0.44). This implies that providers experience less impact from AIM Level 4 for this group when impact is measured by the success or failure of applications for additional support, perhaps indicating that some providers view/have experienced support from an EYS as a gateway to additional resources rather than a mentoring service.
- Weighted differences between groups were usually very small, though settings who had children in the group 'ASD' reported both positive impacts more frequently (0.34 to 0.37), and negative ones too (0.30), implying that for this group, impacts are a little more variable than for other groups

Groups 'Started AIM in 2019 or later' compared to 'started AIM in 2017 or earlier'

- Settings that started AIM in 2017 or earlier, tended to report the benefits of AIM Levels 4-7 more frequently than settings that joined the programme later, implying that it meets their needs more fully.

Generally, differences between groups were small, though lower levels of success in gaining support for children with ASD as reported by providers (who may have more of an overview) may offer some explanation of why parental satisfaction levels are lower for this group too.

It emerges that parent/carers and providers measure impact, at least in part, by how successful applications for additional support has been. For the group 'ASD' the chances to gain support through AIM seem to be a little more variable, perhaps because of later diagnosis or the nature of ASD as a less visible disability, The data cannot confirm this, however, and it is important to note that in the parent/carer survey, parent/carers of children with other types of less visible disability also tended to be less satisfied with the impact of AIM.

To what extent can/should AIM be scaled up and out?

This question was explored with providers and practitioners in interviews and case study visits.

7. Interviews with stakeholders: Methods and Sample

This section describes the methods used for data capture from semi-structured interviews of AIM stakeholders. In summary, the sample consisted of the following participants:

- 32 participants from the Access and Inclusion Model (AIM) Project Team and Agencies, including members of the AIM Cross-Sectoral Implementation Group (CSIG)
- 7 representatives from the Disability Sector
- 23 Early Learning and Care (ELC) practitioners
- 18 parent/carers of children with disabilities or additional needs.

The objectives, methods, and sample for the interviews with stakeholders will be described in more detail in what follows.

Objectives

The purpose of the interviews was to explore the implementation and impact of AIM from the perspective of parent/carers and practitioners and those who designed and are responsible for delivering AIM. The instrumentation for semi-structured interviews was designed to collect data relevant to the following objectives for the end of year three Evaluation of AIM.

Objective 1: Quality and Process

Evaluation of the relevance and effectiveness of AIM in terms of its approach, processes, and implementation

- The evidence-based rationale, aims and objectives of AIM *(and how stakeholders understand this)*
- Development and evolution of the overall approach
- Implementation fidelity of the approach
- The extent to which AIM reaches the intended cohort
- Effectiveness of the overall approach, in respect of all levels of AIM, and from the perspective of all stakeholders
- Engagement with AIM over time by services, practitioners, children, and families
- Appropriateness and efficiency of application, assessment, and approval processes
- Role and value of the Early Years Specialists
- Reasons for non-participation of children, families, practitioners, and services in different levels of AIM, including barriers to participation
- Efficacy of training provided, including ECI, LINC, Hanen, Lámh and Sensory Processing training.

Objective Two: Impacts and Outcomes

Evaluation of expected and achieved outcomes, contextual factors, and causality

- Impact on access to – and meaningful participation in – the ECCE Programme for children with disabilities/additional needs
- Outcomes across all levels of AIM, as perceived by all stakeholders
- Impact on the quality and inclusiveness of early learning and care provided; sustained learning and knowledge transfer among practitioners; strengthening of workforce capacity
- Embeddedness and sustainability of approach in settings
- Role of AIM in supporting positive transitions to Primary School

Objective Three: Governance:
Evaluation of leadership, coordination, communication, and accountability

- Collaboration, communication, and knowledge-exchange among stakeholders
- The efficiency of the governance and leadership approach to AIM
- Engagement with other key agencies and partners
- Position of AIM in the delivery of related supports
- Adaptability, scalability, and sustainability of AIM
- Potential enhancements to and/or extensions of AIM

Method

Processes of recruitment and instrument design were done in consultation with the AIM Evaluation Oversight Committee and our Expert Panel. This subsection describes methods of data collection, data analysis and recruitment.

Data collection

Semi-structured interviews were used to collect the data. Interview schedules were piloted with one member of each constituent stakeholder group prior to formal data collection and revised following review. Data collection was multimodal, and participants could choose to be interviewed by telephone, via video call or through live chat/e-mail, depending on their needs. To ensure data quality consistency across these modes, researchers used the same interview schedules to support these exchanges and mapped data into spreadsheets based on the interview schedule itself. Interviews used an active listening approach, allowing the participant to take the lead whilst guiding the participant in ways that enabled relevant details to be captured. Researchers used reflection and summarising to clarify and ensure that participants felt heard and supported. This was particularly important for parent/carers, whose stories were often very personal. The interview schedule for the AIM project team, delivery services and the disability sector explored stakeholder perspectives on:

- AIM's rationale purposes and principles
- How AIM has evolved over time
- The sustainability of AIM
- The expansion of AIM
- Cross-departmental working and AIM
- The impact of AIM on related services
- The impact of AIM on children, parent/carers and ELC settings
- Factors that have helped and/or hindered AIM's impact
- Non-participation in AIM
- The implementation and impact of each of the AIM Levels (1-7)

The interview schedule for ELC practitioners covered the following themes:

- AIM's rationale, purposes, and principles
- Engagement with AIM and how AIM support is used in the setting
- The impact of AIM on children, parent/carers, and the setting
- What is working well and what needs to be developed
- What factors have helped and/or hindered AIM's impact

- The sustainability of AIM
- The expansion of AIM
- The implementation and impact of each of the AIM Levels (1-7)

The interview schedule for parent/carers covered the following themes

- Accounts of their child's strengths, preferences, and needs
- Choice of setting rationale
- Experiences of inclusion for their child in the pre-school
- Experiences of support from pre-school staff for them and their child
- What is working well
- What needs to be improved
- The expansion of AIM
- Their knowledge and experience of each of the AIM Levels (1-7)

Interview schedules were also designed to give participants space to voice their perspectives on any other issues that they believed to be relevant to the evaluation of AIM. Though interviews were anticipated to be no longer than 45 minutes, interviewers spent longer with participants if that was desired. All practitioners and parent/carers who participated in interviews were offered a €15 gift voucher as compensation for their time.

Lines of inquiry for parent/carer and practitioner interviews arising from the survey findings

The survey revealed statistically significant differences between groups. For example, satisfaction with AIM among parent/carers of children with autism/autistic spectrum disorder (ASD), compared to parent/carers whose children had other types of additional needs, and differences in how positive providers were about the sustainability of AIM in rural/town compared to large urban settings. Since interviews with parent/carers and practitioners took place after these results were in, the instrumentation was developed to further inquire into why these phenomena arose.

In summary, the lines of inquiry integrated into the instrumentation were as follows.

- What factors explain positive and negative experiences of AIM
- Whether and why AIM is more effective for children with some types of additional needs than others.
- Whether and why AIM is more effective or less effective or equally effective for children with additional needs/disabilities that are described as 'autism' or 'autistic spectrum disorder'?
- Whether and why AIM works better for children who have an earlier identification/diagnosis than a later one.
- What experiences do pre-schools/parent/carers have of Level 7 support, and do they understand/use it as a 1:1 or distributed model?
- Pre-schools'/parent/carers' views on whether and why the geography or location of the pre-school has an impact on how successful and/or sustainable AIM is (i.e., in city/large urban areas vs rural areas).

These lines of inquiry also had implications for the selection of the sample for semi-structured interviews, as explained further below.

Data analysis

Workbooks were used to map transcribed data to themes of relevance to the investigation. Columns were for individual participants (identified using a ledger code), and rows contained data related to a specific theme (e.g., 'Views on expansion of AIM', 'AIM impact on children'). This enabled researchers to see perceptions about AIM down a single case, and the participant group as a whole, along a single theme. The research team met to check and refine the consistency of coding and to debate key findings, with one researcher taking the lead in examining and cleaning the data. Figure 7.1 is an extract of a workbook and illustrates the process, showing analysis of conceptualisations of AIM's purposes among participants.

Evaluation focus: Participant perspectives on AIM Rationale and Purposes	**Ledger code and interviewer**			
	ADT 1 (DR)	ADT2 (DR)	ADT3(SG)	ADT (GC)
Participants' conceptualisation of AIM: relevant data	Its very fundamentally an approach for inclusion and inclusion in the mainstream – building capacity in the mainstream – progressive universalism. Universal ambition to make it meaningful. Tiered approach, embedded. Another fundamental thing is interagency approach – developing ad designing and through all our structures we work collaboratively – brining together health services. Progressive universalism. – in order to make public services good – services that work for everyone – have to add targeted support. Graduated, tiered. ***(Key terms: mainstream capacity, progressive universalism, tiered, public good, all means all, interagency)***	It was that it was developed to provide. Access to mainstream ECCE programme for children with a disability. Back in 2016 it was inconsistent across the county whether they got to mainstream pre-school, whether they got to a special school, but have the special schools. There were very different models because there was no national policy around. There was no consistency. And, you know, some children got into mainstream pre-school with complex needs as a result of their disabilities. So, this programme was to support all children with disabilities, have access to their ECCE programme, the same as a child without a discussion. ***(Key terms: mainstream, access, all means all, disabilities, unambiguous)***	I look at it through the lens of the Department of Education's interest, "the way I'd look at it from our point of view, it's about maximising the extent to which Children, regardless, if you like, of their circumstance or background, can access education in an integrated way on a par with their peers." We look at it in terms of transition to primary school, of course, in order for that to happen, it means that there can be access to the support that they get through their two years ECCE It's about giving each and every chance (for children) to be screened, ready as they can be when they hit five (and start primary school) ***Key terms: mainstream, transition to primary school, alongside peers, all means all, opportunity, preparation for school, disabilities)***	Why AIM developed? "Okay. I think it was developed because I thought the children, local children, ought to go to their local playschool, and go regardless of their siblings, neighbours, friends. I think I think go regardless. And then the local pre-school are able to open the doors to all children in their community" That's very simple way of looking at it. I know it is likely to promote meaningful participation of children with disabilities (paraphrase) ***Key terms: unambiguous, mainstream, all means all, alongside peers, meaningful participation of children with disabilities, disabilities, inclusive schools)***

Figure 7.1: illustration of workbook approach to analysis

Recruitment of AIM project team and service providers

Recruitment and data collection methods were GDPR compliant and enacted the principles of voluntary informed consent (see subsection 1.4). Members of the AIM Project Team, AIM Services, and the Disability Sector were recruited via the Department of Childhood, Education, Disability, Integration and Youth (DCEDIY), using existing contacts within its network. Contact details were only shared with researchers at the University of Derby when participants confirmed consent.

Recruitment of parent/carers and practitioners

The sample of parent/carers and practitioners was purposive, meaning that it was shaped around the lines of inquiry arising from the survey findings. The purposive sample was recruited using two methods. Firstly, via the survey, which included respondent consent to further contact, along with demographic and satisfaction indicators to support purposive sampling. Secondly, the evaluation team's accumulating contacts and networks (e.g., DCEDIY Agencies, Disability Sector and Practitioner Researchers). Once the recruited sample contained the demographic and satisfaction range needed for the purposive investigation, social media was used as the third recruitment method to vary the sample further. The following subsection summarises the characteristics of the sample for each group.

Characteristics of the Sample

In total, there were 79 interview participants as follows.

AIM Project Team and Delivery Agencies

Table 7.1 summarises agencies and roles in the interview sample to show that 32 participants represented ten organisations/agencies.

Table 7.1: Sample of AIM Project Team and Delivery Agencies

Department or Agency	**Role**
County Childcare Committee (CCC)	CCC Manager
County Childcare Committee	CCC Manager
County Childcare Committee	CEO of CCC
County Childcare Committee	EDI trainer
County Childcare Committee	EDI trainer
County Childcare Committee	EDI trainer
County Childcare Committee	EDI trainer
Cross-Sectoral Implementation Group CSIG	Parent/carer advisor on
Department of Childhood, Education, Disability and Youth (DCEDIY)	Principal Officer, Early Years Quality
DCEDIY	Head of Division for ELC and SAC
DCEDIY	Assistant Principal, Early Years Quality
Department of Education	Inspector
Department of Education and Skills	DES Officer
Early Childhood Ireland	CEO
Early Childhood Ireland	Director of Research and Professional Learning
Health Service Executive (HSE)	Children's Disability Network Team Manager
HSE	Children's Disability Network Team Manager
HSE	Member of National Children's Services Team (National Disability Specialist)
National Council for Special Education (NCSE)	CEO of NCSE
Pobal Better Start	Better Start AIM National Team Lead
Pobal Better Start	Early Years Specialist
Pobal Better Start	Early Years Specialist
Pobal Better Start	Early Years Specialist
Pobal Better Start	Early Years Specialist
Pobal Better Start	EYSS Team Leader
Pobal Better Start	EYSS Team Leader
Pobal Better Start	EYSS Team Leader
Pobal Better Start	Better Start and Early Years Development Programme
Pobal Better Start	Director of Early Years Operations
Pobal Better Start	Lámh applications and allocations
Tusla	EY inspector, DES, Professional Development Lead
Tusla	Professional Development Lead for EY inspectorate

Disability Sector

Table 7.2 summarises the organisation and roles represented in the interview sample to show that 6 participants represented four organisations in this group.

Table 7.2: Sample from the Disability Sector

Organisation	**Role**
National Disability Authority	Senior Policy and Public Affairs Advisor
Equality, Diversity in Early Childhood Network (EDeNn)	Network Co-ordinator
Inclusion Ireland	CEO
Disability Federation Ireland (DFI)	Director
Disability Federation Ireland	Policy and Research Officer
Disability Federation Ireland	Policy Advisor for DFI

Practitioners

Table 7.3 summarises the characteristics of the practitioner sample to show that 23 participants were interviewed. Most were managers or assistant managers, but one participant was an AIM support worker and one a pre-school room leader.

Table 7.3 Practitioner Sample[46]

Role	Participant also INCO?	Capitation Level	Number on Roll	Setting Opened	Started with AIM	No. children supported by AIM	AIM Levels
Assistant Manager/Team Leader	No	Higher	51	1986	2016	11	4, 10
Pre-school room leader	Yes	Higher	50	2001	2016	1	7, 4
Leader/Manager	No	Higher	66	1985	2016	8	L1-7 (applied for L6 but not received)
Level 7 AIM worker	No	Unsure	9	1991	2016	1	4, 7
Manager	Yes	Higher	44	1975	2016	7	4, 7
Manager	Yes	Higher			2016	4	3,5,7
Manager	No	Higher	12	2002	2016	3	HSE support (not through AIM)
Manager	Yes	Higher	22	1995	2016	0	1,2,3,4,7
Manager	Yes	Not noted	160	2009	2016	4	1-7 (not 6)
Manager/owner	No	Higher	43	1998	2018	1	4, 7
Manager/owner	Yes	Higher	44	2007	2016	3	4, 8
Manager/Owner	No	Higher	25	2016	2016	2	4, 9
Owner/Director	Yes	Higher	360	1980	2016	7	4, 5, 7
Owner/Director	Yes	Higher	26	2009	2016	1	4, 7, 5
Owner/manager	Yes	Standard	13	2000	2019	0	1,2,3, 4,5,7
Owner/manager/room leader	No	Standard	20	2004	2018	1	2, 4, 7,5
Owner/manager/room leader	Yes	Higher	55	2009	2016	3	1, 3, 4, 5,7
Owner/manager/room leader	Yes	Higher	44	2015	2016	4	1, 3, 4, 5, 7
Owner/manager/room leader	No	Higher	27	2015	2017	2	1,4,5,7
Owner/manager/room leader	No	Higher	27	2015	2017	2	L4, L5, L7 (HSE but not through AIM)
Owner/manager/room leader	Yes	Higher	32	1986	2016	2	1,4,7
Setting Manager	No	Higher	40	2005	2016	4	4, 7

Participants represented 11 counties, including County Clare, Cork, Kildare, Leitrim, Mayo, Offaly, Roscommon, Tipperary, West Meath, and Dublin. 5 were community settings, and 15 were private. Most were in urban areas (16), with 3 in small towns and 1 in a rural area.

[46] Some details removed to protect anonymity

Parent/carers
Table 7.4 summarises the characteristics of the parent/carer sample to show that 18 parent/carers were interviewed.

Table 7.4: Parent/carers sample[47]

Role	Time in pre-school	Age	Type of AIM support provided (as identified by a parent/carer)
Pre-school attached to a school	2 years	6	Level 4, Level 7, mainly 1:1,
Private, then special pre-school	More than 2 years	4	Level 4, Level 7, not 1:1
Private Montessori	2 years	6	Level 4, L7 not discussed as an option
Private creche, private pre-school	2 years	7	L7 (not 1:1 but parent/carers not happy) HSE support but not through AIM
Urban	2 years	5	First pre-school, L4 Second pre-school, L4 and L7
Rural		3	L4, L7 (cannot find someone to do the work)
Rural	2 years	8	L4. L6 (Yoga via HSE, not AIM)
Urban	2 years	7	Didn't need AIM (Early Intervention)
Urban	2 years	8	L7 Doesn't remember L4
Urban	2 years	6	L4, L5, L7
Urban	2 years	7	L7 (1-1 in the first setting, not in second) HSE support (but not through AIM)
Rural	3 years (with AIM)	6	L7
Rural	Just started	4	Applying for L7
Urban	2 years	3 and a half	L7
Rural	2 years	6	L5 (hearing equipment for teacher)
Town	2 years	5	L7 (but provided by pre-school room leader rather than additional staff member)
Town	2 years	5	L4, L7
Town	2 years		L4

The parent/carer sample included eight parent/carers who had a positive experience of AIM, five had a mixed background (usually because they had moved their child to a setting that was doing better with AIM), and 2 had a negative experience. The sample included parent/carers of children with a diagnosis of ASD (9), no diagnosis (3), complex medical needs (1), learning disability and hearing difficulty (1), learning disability (1) hearing difficulty (1), visual difficulty and medical needs (1) and

[47] Some details removed to protect anonymity of participants

speech and language difficulties (1). Ten counties were represented in the sample, including West Meath, Tipperary, Meath, Mayo, Limerick, Kildare, Dublin, Cork, Clare, and Carlow.

A mixture of private, community, creche and special-education settings were attended by children of the parents/carers interviewed. Nine parent/carers described their child's pre-school as being in an urban area, six were rural, and three were in towns. In 12 cases, children were currently attending school, with ten being in mainstream school (most with a Special Needs Assistant – SNA), 1 attending a special class within a mainstream school, and 1 attending a special school.

8. Interviews with AIM project team and services: Findings

This section reports on the findings from interviews with 32 AIM project team members and service delivery partners. The reporting begins with a focus on the *overall* implementation and impact of AIM from the perspective of AIM project team members and service delivery partners. This is followed by the reporting of findings that are pertinent to *each level of AIM* (Levels 1-7). The section ends with a summary of key findings overall, and for each level of AIM in the context of the evaluation's four research questions. The characteristics of the sample for AIM project team and service delivery partner interviews was described in Section 7, along with a description of the methods used to recruit, collect and analyse data.

Introduction: Approach to presenting the findings

Findings are presented under each of the key lines of enquiry constructed for this evaluation (see subsection 1.2). Summarily, these comprise AIM project team members and service delivery partners' views on AIM's implementation, AIM's impact, aspects of AIM that are working well, and aspects of AIM that need to be improved. Findings are described, and where relevant, direct quotations are used to illustrate a key theme arising from analysis of the data. The following approach has been adopted to provide a guide as to the strength of responses:

- All – all participants
- Most – at least three quarters but not all participants
- Majority – between half and three quarters of participants
- Some – between a quarter and a half of participants
- A minority – less than a quarter of participants
- Very few – one or two participants only

For each subsection, findings are summarised in a coloured text box.

The next subsection explores AIM project team and service deliverers' perspectives on AIM overall, beginning with their view of AIM's rationale, purposes and principles. Participants were aware that researchers would report findings confidentially, but could not guarantee anonymity in all cases, given the specificity of the professional roles within this group.

8.1 AIM overall

The interview sample included 32 participants representing 10 organisations/agencies. A range of organisational roles were represented. The roles of participants are described in subsection 7.1. Overall, 25 participants had a positive view of AIM, whilst 7 participants held a mixed view. No participants held a solely negative view of AIM.

Where views were mixed, this was reported to be due to challenges in communication and collaboration between organisations such as HSE and Better Start), difficulties associated with the training, recruitment and retention of Early Learning and Care (ELC) practitioners resulting in perceived gaps in the coverage of AIM. Participants suggested clear and focussed areas where they felt developments could be made to enhance the impact and reach of AIM.

AIM team and service deliverers' perspectives on AIM's rationale, purposes, and principles

The findings indicate that participants had a clear understanding of AIM's rationale, purposes, and principles.

In describing the rationale for AIM, participants reflected upon the pivotal role of the introduction of the Early Childhood Care and Education (ECCE) Scheme in 2010. This was described as a "game-changer" in the lives of young children and the sector:

> 'It led to very quickly the pre-school programme being seen as an important rite of passage for children from the ages of three or four.'
>
> [CEO Early Childhood Ireland]

Participants felt that AIM responded to the increase in demand from parent/carers to have access to pre-school settings, including families of children with additional needs. Some participants spoke of all young children now having an entitlement to access the ECCE programme through pre-school settings, alongside their peer group. However, it was recognised that at the time the ECCE scheme was first introduced, services may not have had the expertise or staff to be able to include all children.

Participants expressed that the overarching goal of AIM was to ensure that ECCE is accessible for all children and that they can take up their free pre-school entitlement. In achieving this goal, the majority of participants identified that a key purpose of AIM was to support settings to include all children. One participant summarised that a fundamental approach to increasing inclusion in mainstream settings was to "build capacity in the mainstream." It was felt by some participants that the universal and targeted Levels of AIM worked together to develop this capacity. The universal Levels of AIM (Levels 1-3) were recognised as raising awareness, providing information, and offering training, some participants felt strongly that Levels 1-3 were fundamental and formed the basis of AIM. In addition to this, the targeted Levels of AIM (Levels 4-7) were seen as providing specific, tailored supports to complement and extend existing practice and provision within pre-school settings.

A number of interrelated core principles were identified by participants:

- AIM is primarily child-led, with decisions made in the best interests of the child (5)
- AIM is needs-based rather than diagnosis-led (5)
- Every child is unique, and their strengths are celebrated (7)
- There is equity of access for all children, irrespective of their geographical location, socio-economic circumstances, or ethnicity (6)
- AIM enables children to attend pre-school with their peer group, and fosters positive relationships for all children (9)

With inclusivity at its core, AIM was deemed to promote meaningful participation and full inclusion. Most participants noted the subtle difference between the two concepts.

Meaningful participation was typified by children having a range of opportunities to engage in the pre-school setting alongside their peers, with contingent support offered which responds to the strengths, interests, and needs of the child. In addition, the presence of positive relationships with pre-school staff and peers was referred to frequently as a feature of meaningful participation. It was noted that by one participant that:

> 'It's really important that everybody in the setting is afforded an opportunity to form relationships… and you can only do that by participating.'
>
> [CEO Early Childhood Ireland]

Some participants reflected that they had initially held concerns that whilst AIM supported pre-schools to provide places for children with disabilities, there was a risk that the children would be present but not able to participate fully. In spite of this, most participants identified that within AIM there was a commitment to ensuring that all children are able to participate fully in their two years of pre-school. In order for this participation to be meaningful, the uniqueness of the child must be recognised and responded to, "just being in the room is not enough."

Full inclusion on the other hand was viewed as positively promoting and celebrating the strengths of the entire setting. Interestingly, some participants noted that full inclusion was not tied to a particular physical setting or environment but was observed within a "core ethos" or approach that includes all children and enables all children to grow. In doing so, children have opportunities to pursue their interests and engagements, whilst pro-active action is taken to remove barriers.

Although most participants were able to give clear examples of meaningful participation and full inclusion, they were not able to describe ways in which evidence of this was present in pre-school settings or collected. Some participants referred to anecdotal evidence, or a sense that this was happening in the field but could not point to how this currently is or could be recorded and monitored going forward.

AIM team and service deliverers' understanding of the rationale, purposes and principles was sometimes at a very nuanced level. Some participants noted the positive consequences of AIM for inclusion beyond the pre-school setting. It was identified that through attending local pre-school settings, children could form relationships with their peer group and wider community that were supportive of their ongoing inclusion. In addition, some participants recognised the potential positive impact AIM could have on families as well as the wider community.

Participants placed different degrees of emphasis on the extent to which AIM was intended as a model for children with a disability. Some participants stressed the focus on inclusivity for all children present through the universal supports provided within AIM Levels 1-3, followed by needs-based supports offered within Levels 4-7. On the other hand, some participants described AIM as being a model designed to support children with a disability and referred to the language used on the AIM website. Further clarity is therefore required regarding who can avail AIM supports, including those children who may speak English and/or Irish as an Additional Language, live in areas of social deprivation or belong to a minority group.

AIM team and service deliverers reported instances of the purpose and principles of AIM being distorted in the field. Some participants reported heightened awareness of AIM Level 7 amongst pre-school settings, and there were concerns this could be at the cost of promoting the principles of equality, diversity and inclusivity associated with the universal Levels of AIM.

Most participants described misunderstandings held by parent/carers and some pre-school settings regarding the use of AIM Level 7 supports and the role of the additional adult. It was reported that Level 7 was often seen as 1:1 support for a child with a disability, which was in opposition to the core ethos of creating a room that is inclusive and supports all children to participate. A minority of participants suggested that these misconceptions stemmed from media reports, whilst the majority felt that there was an assumption amongst parent/carers that Level 7 of AIM was similar to the SNA supports offered in primary school settings. These observations are expanded upon further in

subsection 8.8. Some participants acknowledged that the AIM policy is just four years old and that whilst some families were deeply knowledgeable regarding AIM it was “understandable if parent/carers don’t understand the core principles.” Similarly, some participants felt that families were aware of AIM but focused primarily on the availability of supports and the opportunities this afforded their children to attend pre-school. It was felt by the majority of participants that there is a need to consider how information about AIM is communicated so that all parent/carers have clear information on the range of supports available. The communication of AIM to parent/carers is expanded upon further within subsection 8.3 which addresses Level 2 of AIM.

Limitations in ELC workforce capacity

Workforce capacity development was viewed as an essential principle of AIM. Collectively, participants recognised that this responded to two interconnected issues.

Firstly, for young children to be included in pre-school settings it is necessary to have skilled and knowledgeable staff. All participants recognised the importance of providing training to pre-school staff. Participants were familiar with the range of funded training opportunities that were offered to pre-school staff through AIM. These are examined in greater detail in subsection 8.2 regarding ‘AIM Level 1: universal supports in the pre-school’ and subsection 8.4 ‘AIM Level 3: A qualified and confident workforce.’ Additionally, some participants referred to the role of the Early Years Specialist as being an important part in developing the workforce capacity in the sector as they also provided support and training to pre-school settings. The role of the EYS is explored in greater detail in subsection 8.5. the ongoing presence of training and support for pre-school services, it was felt by the majority of participants that there remained a chronic shortage of qualified staff in the sector. A focus for future workforce capacity development lies in keeping and maintaining skilled and qualified staff.

The second key issue participants identified was that workforce capacity development is also central to the cultural shift taking place through AIM. Some participants proposed that building the capacity within the pre-school sector (through increasing ELC practitioner knowledge, skills, and confidence to support young children), would facilitate the shift away from inclusion requiring specialist provision towards inclusive practice being a universal standard across pre-school settings. A minority of participants highlighted the history of segregated services and signaled that these reflected the sector’s relative inaccessibility at the time, rather than children’s ability or desire to participate. Consequently, increasing the capacity of the workforce was seen as a way of securing the future of inclusive mainstream services.

> ‘If you don’t have the culture in your setting within the whole service, you know, there's no point in one or two people being trained. If you're not embedding the culture within the whole service. So that takes a significant amount of time and effort and work.’
>
> [CEO Waterford CCC]

Participants from the AIM project team and service delivery partners had a clear and sometimes nuanced understanding of the rationale, purposes, and principles of AIM.

In relation to the fidelity of AIM, these data imply that participants hold a cohesive and collective conception of AIM, in keeping with the model's core purposes and principles. With inclusivity at its core, AIM was deemed to promote meaningful participation and full inclusion. Workforce capacity development was viewed by most participants as an essential principle of AIM:

- For children to be included within pre-school settings, it is imperative that ELC practitioners have the skills and knowledge required to respond to their needs.
- Increasing ELC practitioner confidence contributes towards a cultural shift towards inclusive practice.

Further clarity is required within the AIM project team and service delivery partners regarding who can avail of AIM supports for clear messaging and communication to be disseminated to services and stakeholders. Across the interviews conducted, participants placed different degrees of emphasis on AIM being a model for children with a disability:

- Some participants stressed the focus on inclusivity for all children present through the universal supports provided within AIM Levels 1-3 followed by needs-based supports offered within Levels 4-7.
- On the other hand, some participants described AIM as being a model designed solely to support children with a disability and referred to the language used on the AIM website.

The next step for the AIM project team and service delivery partners lies in being able to measure impact. This will require the collection of evidence to enable identification of where the implementation of AIM reflects its core principles and also highlight gaps where the implementation may not fully reflect these.

AIM team and service deliverers' accounts of how AIM has evolved over time.

Participants described their pride at the rapid speed of the rollout and implementation of AIM. This was facilitated from the initial inception of AIM through to implementation in 2016 by the commitment and engagement across different departments and organisations "at a level that was unprecedented".

The scale of the task in getting AIM "off the ground and all the workforce in place" was acknowledged by most participants. They spoke of the pressure placed upon different agencies, including HSE, MIC, Pobal, Tusla and Better Start, to contribute, collaborate and meet key deadlines. Strong leadership was felt by the majority of participants to have played a key role in securing the rapid implementation of AIM. Consequently, some participants felt that the implementation of AIM serves as a model for delivering a national programme of support, at speed.

The AIM project team and service delivery partners described several key dates within the evolution ECCE scheme and subsequently AIM over time:

- 2010 - The Early Childhood Care and Education (ECCE) Scheme was introduced. This marked for the first time that there had been state funding for pre-school education outside of the primary school structure in Ireland

- 2016 - AIM was introduced as a universal, inclusive model so that all children within the age range could participate in one year of ECCE.
- 2017- the age eligibility for the ECCE scheme was broadened
- 2018 - the ECCE Scheme was made into a full two-year programme.

AIM was introduced in 2016 as a tiered model of universal and targeted supports to ensure that all children within the eligible age range could participate in ECCE. As the age range eligible for ECCE broadened over time, first in 2017 and subsequently 2018 to create a two-year pre-school programme, AIM was also extended to allow children to receive universal and targeted supports during this time.

All participants reported there had been an increase in the uptake of AIM year on year since 2016, firstly in the number of settings making applications for AIM supports, and secondly as well as the numbers of children availing of AIM. This increase in demand for AIM supports occurred within the context of increasing numbers of children attending pre-school as part of the ECCE scheme. There was a general sense amongst participants that AIM has embedded itself within the pre-school sector with increased awareness year-on-year of the AIM programme. It was observed by some participants that AIM was now well-known and recognised by pre-school settings, with one participant likening it to a "brand."

When reflecting upon the uptake of AIM since 2016 all participants acknowledged the prevalence of children availing of targeted AIM supports had been substantially underestimated, particularly at Level 7. Most participants were aware that whilst the estimated uptake of AIM Level was 1.5%, the actual uptake has risen to around 4.5% of children in the ECCE Scheme. It is not yet known if this figure has reached its peak or will continue to grow. Identifying the future demand for AIM supports year-on-year will be a crucial part in determining future plans and making key decisions regarding the sustainability and scalability of AIM. Consequently, it is recommended that a working group convene to examine trends in the data, with a particular focus on the uptake of AIM Level 7 supports.

> 'We probably would have been much more terrified starting off this journey if we had had a more accurate understanding or a more thorough understanding of the prevalence and uptake of AIM supports. Applications went from, you know, maybe fourteen or fifteen hundred in the first year to now over 5000 annually.'
>
> [Better Start Early Years Development Programme Manager]

In the first year of AIM, it was identified by some participants that the focus was on supporting services to apply for and secure funding for AIM Level 7. EYS employed by Better Start played an important role here during this time in supporting pre-schools to make applications. However, a few participants likened their response as the time to "firefighting" due to the very high caseloads which limited their ability to provide support and mentoring. As time has gone on it was felt that the EYS have been more able to provide mentoring, advice, and support within AIM Level 4. This has been aided by measures taken to reduce caseloads, including employing additional Early Years staff. In addition, it was acknowledged that the initial support provided to pre-school settings in making applications for targeted AIM supports had been beneficial. This was because most were now familiar with the application process and subsequently required less support when making an application.

Participants felt that efforts had been made to consult the pre-school sector continuously, leading to changes in AIM. One example provided by some participants was the changes made in relation to AIM Level 5 'Equipment, appliances, and minor alterations grants.' In the first two years of implementation, it was noted that pre-school settings made applications for small pieces of equipment, including sensory toys or adaptions. It was identified that the cost of the items was lower than the costs associated with processing the application. This led to the piloting and subsequent

distribution in 2018 of the AIM Inclusive Play pack and guide to over 4000 pre-school settings. The associated training materials and guide continue to be available to all pre-school settings on the AIM website.

The reach of AIM was remarked upon by most of the participants, with uptake by pre-school settings across Ireland being recognised. It was reported that 80% of registered services to date have availed of AIM support. Participants were able to add further insight into this reported figure, identifying that this did not necessarily mean that services needed to access targeted AIM supports every year. In many instances it was identified that pre-school services had developed the capacity to support children's additional needs or disabilities within the setting, through their universal provision. A few participants felt that the longer a service engaged in AIM, the better their understanding of how to support young children became. This marked a shift from the provision available within the sector previously, summarised by one participant as:

> '…it was a bit of a geographic luxury as to where a child might be and what services they would have access to.'
>
> [Better Start Manager]

The inconsistency of pre-school availability across different geographical regions within Ireland was recognised within the end of year one review. However, most participants felt that such marked variations no longer existed and that most families were now able to access AIM support within a local pre-school setting. A few exceptions to this were reported by a minority of participants. It was identified that in some urban City areas of Dublin, there was a general shortage of ECCE places available to children. It was also suggested by a few participants that in rural areas with a low population there may be single-provider settings, and this may limit the availability of AIM supports due to limits on the number of places available within the ratio for the room.

Responses to the COVID 19 pandemic

Since early 2020 several changes have been made to the delivery of training and support provided to pre-school settings due to the Covid-19 pandemic with participants speaking of the challenges and opportunities this brought to future ways of working.

A number of key challenges are associated with the irregular attendance of young children in pre-school settings due to Covid-19. Firstly, whilst applications for targeted AIM support appear to be plateauing in some areas it is not possible to determine whether this is the case. The majority of participants spoke of their previous hope of being able to identify the prevalence of the uptake of AIM targeted supports by the end of the third year of implementation but acknowledged that this was currently not possible. Coupled with the challenge in predicting the future uptake of AIM, a few participants spoke of their concern that there may be a surge in demand for targeted AIM supports once pre-school settings are able to return to their normal working patterns. The impact of social distancing and the lack of access to the ECCE scheme was identified as having a potentially significant impact on young children's lives. In addition, a few participants anticipated that the lack of consistency will have a negative impact on young children's transitions both within pre-school and to primary school, for which they would require support.

New ways of working have arisen as a result of the Covid-19 pandemic, and it was felt by some participants that they offered opportunities to take a more blended approach to communication and support. It was felt by a few participants that these changes to the delivery of support to pre-school settings by EYS may have happened eventually, but that Covid-19 had necessitated the rapid implementation. Advantages of the blended model included the reduced time spent on travel to

settings, making high caseloads more manageable. The use of video or phone calls, rather than in-person meetings, increased the informal nature of such interactions and it was felt by a few participants that this made pre-school settings feel more at ease and open to discussion. It also increased the availability for pre-school settings to make a quick call to check-in and access information and supports as needed, rather than waiting for an in-person meeting.

The Covid-19 pandemic has also resulted in temporary changes to the application process for AIM Level 7. In previous years, the pre-school setting would send in a profile for the child completed in conjunction with the parent/carer, before organising a time for the EYS to observe the child in the setting. During 2020 and 2021, EYS have been less able to visit settings in person. This has led to greater communication with families through video or phone call to assess children's needs. It was felt by a few participants that this should be continued as it gave parent/carers greater opportunity to express their perspectives regarding their child's strengths and needs. However, other participants identified that increasing the level of engagement between the EYS and families needed to be carefully balanced in order to support and maintain the existing relationship between the family and pre-school setting.

Implementation and monitoring of AIM

Given that AIM appears to be embedded in the pre-school sector, it was suggested by some participants that the focus going forward should shift to implementation and monitoring.

A number of pilot studies are taking place to refine the implementation of AIM. The outcomes of these can offer insight into the future implementation of AIM. These include:

- Complex healthcare needs pilot study - according to current policy, all children can access the ECCE Scheme in a mainstream pre-school setting. However, it was identified that a small cohort of children with complex medical needs were not attending. A pilot study was conducted with a small number of families who were already availing of the HSE paediatric home care package to provide nursing support in the pre-school setting.
- Demonstration Project for In School and In Early Years Therapies - this pilot, developed by the Department of Education (DES), Department of Children and Youth Affairs (DCYA) and Department of Health (DoH) is coordinated by the National Council for Special Education (NCSE). Although still in progress, it illustrates the potential for greater collaboration between ELC practitioners, therapists, and parent/carers in many pre-school settings.

Participants who referred to the pilot studies noted their interagency approach was key to the philosophy of AIM. A few participants felt strongly that embedding health services into the pre-school sector, was a critical area to develop within the future implementation of AIM.

Developing the AIM training portfolio

Training for ELC practitioners was also identified as an area which would continue to support the future implementation of AIM. Within AIM Level 1, fully funded training and multi-annual CPD is offered which focuses on inclusive values and practice. A review of the equality, diversity, and inclusion (EDI) training took place in the last year. Participants are currently awaiting the outcomes of this review. Some participants felt the addition of further specialist training modules would be beneficial for pre-school practitioners. It was felt that now there was a greater awareness of the range of needs present within the pre-school population, that responsive training could now be offered.

Training is discussed in greater detail in subsection 8.4. Areas identified by participants for future training included:

- Support for young children on the autistic spectrum diagnostic (ASD) pathway. Whilst it was recognised that AIM is not a diagnosis-led model, participants felt that a sizable number of young children attending pre-school settings had or were awaiting diagnosis for an autistic spectrum condition. Therefore, specialist training and support for practitioners would facilitate high quality provision for this group of learners. (5)
- Support for young children with complex medical needs. This area of training would allow practitioners to fulfill their responsibility for children in their care. (8)
- Competency development. At the time of writing, a tender had been re-issued to provide a blended learning programme for practitioners. (2)

AIM was identified by the majority of participants as the only programme within the ECCE Scheme that was consistent throughout Ireland. Despite this, some participants felt the roll out of AIM came at a time when there were many policy changes happening in Ireland. Therefore, it was suggested a clearer "roadmap" was required to ensure consistency and coherence across all seven levels of AIM. Most participants felt there were many positive outcomes associated with AIM, but not all areas were operating in the same way.

Participants reported that a piece of work had been completed on the communication strategy and communication guidelines for AIM. This revised approach was seen in the launch of the new public-facing AIM website in the summer of 2021. Some participants felt this would be beneficial to parent/carers and ELC practitioners as a 'one-stop shop' for AIM information. It is hoped this will further increase awareness of AIM, particularly amongst parent/carers, and provide greater clarity regarding the seven levels of AIM as a progressive support model for ECCE.

Participants spoke of the need to focus on monitoring "how well AIM is implementing its philosophy." Collectively, participants felt that monitoring is required in two overlapping areas. Firstly, to ensure that AIM's philosophy of engagement (a foundation of universal design for quality, through to targeted supports) is upheld. It was acknowledged that KPI numbers alone do not provide a clear picture regarding how meaningful participation and full inclusion are experienced by young children and their families. For example, whilst it is possible to record the number of ELC practitioners who have attended the EDI training offered within AIM Level 1, it is much harder to gauge the subsequent impact this knowledge and awareness has within the pre-school setting. Tuning in to the child's voice and those of the parent/carer could offer valuable insight here and would align with AIM's grounding within the Child Rights movement. It is therefore important to consider how the reach and impact of the universal levels of AIM (1-3) can be recorded and monitored.

> 'We know that AIM is good and broadly well received but we need to know more about how it is being applied on the ground and whether Level 7 is being applied with fidelity.'
>
> [DCEDIY Assistant Principal]

The second area of focus for monitoring lies in the uptake AIM supports, including Level 7. All participants felt confident that pre-school settings were aware of, and able to access AIM Level 7 support, however, most felt unsure whether pre-school settings were also drawing upon the other six levels of AIM. In addition, it was felt by most participants that Level 7 support was being used in diverse ways within pre-school settings and that ELC practitioners had a range of different interpretations regarding how the 'additional assistance in the pre-school room' should be used. Participants agreed that clear guidance and support to implement Level 7 with fidelity was required, with a few participants noting that fidelity is not just the responsibility of the setting, in how they carry

out AIM, but also those supporting settings. Interestingly, amongst the AIM team and service deliverers, there were also different interpretations of how AIM Level 7 should be used. Some participants were aware that additional capitation could be used either to reduce the child-to-adult ratio in the pre-school room or to fund an extra staff member as a shared resource with other children in the ECCE setting. Other participants asserted strongly that AIM Level 7 could only be used to employ an additional member of staff and that it was not possible to reduce the ratios in the room. Whilst both groups of participants are correct to some extent, their explanations do not fully reflect the AIM funding rules (Pobal, 2020[48]). This indicates there are a range of misunderstandings inherent in AIM Level 7, and that a renewed clarity of purpose is required.

In summary, participants spoke of the rapid evolution and implementation of AIM. There was a keen sense of pride that the programme had quickly become embedded within the pre-school sector and expanded rapidly. AIM was viewed as key to facilitating the high numbers of children who have participated in the ECCE scheme. The AIM team and service deliverers' viewed this evaluation 'as a key moment' which marks the next phase of policy development. It was identified that the future development of AIM would focus on refining the implementation of AIM across all seven levels. A renewed focus on monitoring would allow the impact of AIM 'on the ground' to be captured whilst ensuring greater fidelity in the delivery of the seven levels of AIM.

Participants from across the AIM project team and service delivery partners provided a thorough account of key changes that have taken place in the development of AIM since 2016. Most participants spoke of their pride in securing the roll out of an ambitious national programme at significant speed. The findings provided evidence of the development and evolution of the overall approach of AIM:

- The age eligibility for the ECCE scheme was broadened in 2017
- The ECCE Scheme was made into a full two-year programme in 2018, with AIM support available throughout.
- The initial focus in the first two years of AIM was felt by the majority of participants to be dissemination and support for settings to engage with the AIM application process.
- Pilot studies have been initiated to refine the implementation of AIM for children with complex medical needs and/or in receipt of therapeutic supports.
- Fully funded training and multi-annual CPD is offered within the context of AIM Level 1 and 3. This is now subject to review (EDI training was reviewed in 2020) and potential expansion in response to the needs of children and the ELC sector.
- The impact of COVID 19 presented a significant disruption in 2020 and 2021. However, some participants felt that ongoing opportunities have arisen through the shift in working practices.

The developments have taken place against a backdrop of increased demand for AIM, particularly Level 7 support. The interview findings suggest that the majority of participants feel AIM is embedded across the ECCE sector, with good levels of ELC practitioner knowledge and awareness. A shift in focus is now required to examine in greater detail the implementation and the monitoring of AIM to ensure fidelity.

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[48] Pobal (2020) *AIM Rules 2021/2022*. [Online] Available at: https://www.pobal.ie/app/uploads/2020/06/19-07-31-aim-rules-for-publication-july-2019.pdf. Accessed 10/11/2021

AIM team and service deliverers' views on the sustainability of AIM.

AIM is viewed as an important national programme which complements the ECCE scheme. Participants perceived that it played a vital role in raising awareness of inclusion and facilitating access to pre-school settings. All participants expressed a hope that AIM is sustainable, and could continue to be, for future young children and their families.

Participants described several positive factors which were supportive to the sustainability of AIM.

- A high level of public interest and support for AIM is perceived (5)
- There are clearly defined roles and responsibilities across the organisations involved in the implementation of AIM (3)
- There are good levels of awareness of AIM in pre-school settings, ELC practitioners are confident in accessing AIM supports (2)
- There is high demand for training CPD offered as part of AIM Level 3. However, the retention of qualified and experienced staff was reported by a few participants to be an area of difficulty. This is key to securing a qualified and confident workforce and is discussed further in subsection 8.4 (4)
- The universal Levels of AIM (1-3) were deemed to be a cost-effective means for raising the quality of provision across the pre-school sector. This positive impact was felt to extend beyond the pre-school room, to include all children within the pre-school setting (3)

Though there were positive developments and impacts, participants were concerned about the rising cost of delivering AIM:

- A few participants felt that, although high, this initial investment in the ECCE Scheme through AIM would have a positive impact in the education system, particularly in the primary years (2)
- It was acknowledged there is a level of cost associated with providing a high-quality public service. A minority of participants felt the unit cost associated with AIM Level 7 could be spread as the adult contributed to provision across the pre-school room, rather than solely for one child (4)
- As AIM is not a diagnosis-led model, it is difficult to impose limits on the number of applications for AIM Level 7 (2)
- Across the pre-school sector there are difficulties in recruiting and retaining qualified staff, even where Level 7 funding is awarded. Some participants felt that the pay and working conditions associated with the role contributed to this. This is expanded upon further in subsection 8.8 (6)

Some participants felt there was 'scope for streamlining' the supports that are available within AIM. It was felt that this would help to secure the sustainability of the AIM programme. Some participants reported that settings were using AIM Level 7 as a way to staff the setting and maintain quality. Consequently, it was proposed that an alternative to funding Level 7 could be achieved through reducing the ratios in the pre-school room. Reduction of ratios in the room, from the current Tusla regulations of 11:1, has the potential to:

- Reduce the number of applications for Level 7 supports focused on behavioural needs (2)
- Allow pre-school settings greater choice and flexibility in how supports are provided (4)
- Reduce costs to settings associated with recruitment (3)
- Provide greater stability to settings. Currently settings are only able to offer fixed term contracts to staff employed in the Level 7 role. This causes unnecessary instability,

particularly for young children progressing from their first to second year in the ECCE scheme (5)
- The current focus within the pre-school sector on acquiring Level 7 supports is potentially at the cost of inclusion. There is a risk this will encourage the adoption of the former SNA model used in primary schools of 1:1 supports for the child (4)

Transition poses a significant challenge to the sustainability of AIM. In particular, the challenges associated with the transition from pre-school to primary school are significant barriers to the sustainability of AIM as they place undue pressure and focus on securing AIM Level 7 in order to secure later support in primary school. This is referred to within the wider inclusion literature as the 'valorisation' of the most intensive forms of support.

A minority of participants felt that it is currently difficult for families to navigate the current system, moving from the ECCE scheme to the primary school system which provides support for children in a markedly different manner. Whilst AIM places great focus on inclusive practice, with universal and targeted support offered in the wider context of the pre-school, the SNA model used within primary schools was historically typified by the provision of 1:1 support for children with high or complex needs. Only a minority of participants acknowledged that changes had taken place within primary education to provide supports outside of the SNA model, including the introduction in 2019 of the revised Resource Allocation Model. A minority of participants acknowledged that the SNA model was beginning to move towards being a model of classroom support, rather than support for an individual or pair of pupils. However, they did not feel that parent/carers of children in the ECCE programme were aware of the developments that have taken place in primary education. This finding further demonstrates the challenges families are believed to experience in negotiating two quite different education systems.

Whilst the provision of AIM supports is needs-led, a minority of participants believed that supports available in the primary education system are diagnosis-led, a distinction which parent/carers are observed to be extremely sensitive to. Consequently, it was proposed that the lack of coordination between primary school and the pre-school sector was actively driving the behaviours observed in the high uptake of Level 7 supports in AIM and the high demands for assessment observed in healthcare.

There is recognition with the *First 5 strategy* that a better approach is needed to support transitions to primary school. Participants identified that improving the transition from the ECCE Scheme to primary school for children availing of AIM support has the potential to:

- Reduce the number of requests for over-age exemptions, thus enabling more children to start school alongside their peer group (3)
- Increase parental confidence in choosing a mainstream education setting for their child (7)
- Ensure continuity of support, at the level that currently works well for the child (2)

Some participants reported that pre-school settings did not feel that primary schools took account of the successful strategies and good practice put in place in the pre-school to support the child. Participants also felt that the reason for this could lie in primary school staff lacking awareness of which information to request, or which was most relevant to consider for the individual child on entering primary school. It was therefore felt that enhanced transition supports were needed, particularly for children availing of AIM supports, which took place between key stakeholders including: the primary school, the pre-school, intervention services, parent/carers, and the child.

In summary, participants believed AIM has the potential to be a sustainable programme of support for children within the ECCE scheme. The findings suggest that the current approach of AIM is broadly appropriate in the national context. The high levels of engagement by ELC practitioners, coupled with positive public awareness were both deemed to be supportive of the future sustainability of AIM.

Whilst the universal Levels (1-3) of AIM were felt to provide cost-effective support, there are higher than forecast costs associated with Level 7 due to rising demand. Transition to primary school was identified as an area which poses a significant challenge to the sustainability of AIM. This is due to the lack of alignment between the needs-based model adopted within the pre-school sector and the SNA model utilised within primary education. This places increased pressure on parent/carers and pre-school settings to obtain the maximum level of targeted support through AIM as it is perceived that this will secure access to ongoing support on entry to primary school.

AIM team and service deliverers' views on the scalability of AIM

There were mixed views amongst the AIM team and service deliverers regarding the scalability of AIM. Most participants expressed a desire to extend AIM to allow the positive impacts to be experienced by a wider range of children and families. However, it was acknowledged that there were significant costs associated with each proposed area of scalability. One participant summarised that 'there is a sense that you need to balance wants and needs.' A minority of participants questioned whether the scaling up of AIM would be cost-effective or have a significant impact beyond the high-quality provision that was already available within pre-school settings. The presence of other funding for the sector including the National Childcare Scheme (NCS) and the After-School Child Care Scheme (ASCC) was referred to by a minority of participants as providing support for some children to attend sessions outside of AIM.

Examining the scalability of AIM presents the opportunity to reflect and learn from the implementation of AIM to date. It was suggested by a minority of participants that whilst the current model of AIM is good, there remained some gaps in the coverage and reach which have been made apparent over time.

Participant views on scaling up and extending AIM can be grouped into the following areas:

- Increasing the availability of AIM for children within the current ECCE Scheme
- Broadening the scope of AIM within the current ECCE Scheme to respond to a wider range of needs
- Making AIM universal (Levels 1-3) and targeted (Levels 4-7) support available to younger children in pre-school settings, before they start the ECCE Scheme
- Making AIM universal (Levels 1-3) and targeted (Levels 4-7) support available to older children in pre-school settings, including after-school care
- Making AIM universal (Levels 1-3) and targeted (Levels 4-7) support available to older children in primary school settings

Perspectives on increasing the availability of AIM support for children in the ECCE Scheme

Increasing the availability of AIM support for children in the current ECCE scheme would allow access to needs-based support throughout the pre-school day. Although universal supports should be provided throughout the pre-school opening hours, currently AIM Level 7 provides funding for a

maximum of 3 hours per day. This reflects the number of daily hours in an ECCE Scheme session. Scaling AIM up in this way would allow targeted supports to be accessed throughout the time children aged 3 to 5 years are attending the pre-school setting, increasing availability to those who attend full day sessions.

It was expressed that whilst the current provision of targeted support reflects the hours provided within the ECCE Scheme (3 hours per day for up to 38 weeks of the year), many children attend pre-school for longer than this. Some participants, including those representing Early Childhood Ireland (ECI) and Better Start, felt very strongly that if a child had needs that were deemed to require targeted support, this should be available whenever the child was in the setting. Several points were raised in support of this proposal:

- Consistency and routine are important when supporting the needs of young children. A few participants felt that the withdrawal of targeted support once the ECCE session had finished meant that the pre-school setting was not able to use the same strategies throughout the day, reducing their efficacy (2)
- Providing support throughout the full day would enable more effective transitions within the setting. A minority of participants reported that both the child and setting struggle if the same level of support is not maintained throughout the day. This can be a particular challenge during mealtimes and when transitioning from the morning session to the afternoon (4)

Participants held mixed views regarding the use of the NCS to provide support for children. The NCS currently provides funding for some children to attend additional hours outside of the ECCE Scheme. Entitlement is dependent on individual family circumstances, including hours of employment and income. Some participants felt that this additional funding, provided separately to AIM, was sufficient to allow children to access additional hours in the setting. In contrast, some participants felt strongly the two schemes had wholly different purposes. Whilst NCS allowed children to be present within the setting, AIM is intended to ensure that children experience full inclusion and meaningful participation whilst they attend. For most children, the universal levels of AIM are sufficient and are well aligned to the use of the NCS to support attendance outside of the ECCE Scheme. However, some participants felt that a minority of children have higher needs requiring AIM targeted support during the hours funded by the NCS in order to secure full inclusion and meaningful participation.

Transition between pre-school and primary school was identified by a minority of participants as a further area where children within the current ECCE Scheme would benefit from extended support. Currently, AIM supports are available for around 38 weeks of the year leaving a gap during the summer holiday period. Many children who avail of AIM were deemed to benefit from the consistency and routine of the pre-school setting. Although some pre-school settings close for a period of time during the summer, many offer holiday clubs for children, and families can access the NCS to fund these sessions. A minority of participants felt that removing AIM support over the summer period can cause unnecessary disruption and make it more challenging for children to be included in the summer holiday provision that is generally available to their peers. This presents a barrier to full inclusion. A further minority of participants felt that the time over the summer could be used productively to prepare children for school and to support a smooth transition from one setting to the next. The expertise of the EYS could be drawn upon during this time as part of their broader role in supporting the transition from the ECCE Scheme to school.

Perspectives on broadening the scope of AIM within the current ECCE Scheme to respond to a wider range of needs

Broadening the scope of AIM would allow access to universal and targeted supports for children with a much wider range of needs. Whilst AIM has needs-based elements within its model, some participants felt that it was focused predominantly on the needs of children with a disability, particularly in the allocation of targeted supports. Whilst all participants felt that it was right that children with a disability were supported by AIM, some questioned whether AIM could look more broadly at the needs of children in order to secure further positive outcomes. Scaling AIM up to meet a wider range of needs would allow a more diverse group of children aged 3 to 5 years to access supports in the ECCE Scheme.

Across the interviews conducted, participants identified groups of children who could benefit from the availing of universal or targeted AIM supports. It was acknowledged that some children could be identified as fitting into more than one group, depending on their individual circumstances. Although not an exhaustive list, this included:

- Children with a disability
- Children with additional needs
- Children who speak English and/or Irish as an Additional Language
- Refugee and migrant children
- Children from Irish Traveler and Roma communities
- Children in communities at risk of disadvantage and social exclusion

As noted within the preceding section which explored the AIM project team and service deliverers' perspectives on the principles and purposes of AIM, there remain some entrenched misconceptions regarding who can avail of AIM support. This is further observed in opposing perspectives regarding scaling up AIM to support the needs of a wider range of children.

Some participants felt that there is no need to scale up the AIM model as it includes a needs-based approach. Consequently, if barriers to meaningful participation and full inclusion were identified, universal or targeted supports from across the seven levels of AIM could be implemented to support the child. Children in communities at risk of disadvantage and social exclusion were recognised by some participants as having needs that can be supported in pre-school settings. However, it was recognised that AIM is not the solution to these systemic issues. The participants who referred to disadvantage and social exclusion identified AIM as being part of a collective solution, including the *First 5 strategy*, which is part of "a suite of activities that help to provide equity":

> 'So, we know the children, for instance, who have come from a very poor home learning background or early childhood adverse experiences that they are going to need, you know, stability. They're going to benefit from highly qualified staff. They're going to benefit from particular forms of pedagogy. We would hope that those would be readily available to all children in most pre-schools.'
>
> [Better Start Early Years Development Programme Manager]

Despite this, a minority of participants felt this approach was not being taken consistently within pre-school settings. Participants felt that there was a sense within the ECCE sector that AIM was intended to support children with a disability. It is possible that there are underlying misconceptions within the ECCE Sector regarding the purposes of the universal supports offered through AIM (Levels 1-3). However, participants were unable to offer evidence that demonstrates that this is the case nor the scale of this observation. A few participants identified that the pre-school INCO could play a significant role in promoting inclusion for all children. It was identified that they have a key role in facilitating communication between parent/carers and the pre-school setting, therefore bridging the

gap between home, and setting. Participants felt developing this relationship was critical in supporting children and families.

In contrast, some participants felt that AIM was solely a model of support for young children with a disability. Consequently, a broader range of children with diverse needs, including those from communities at risk of disadvantage and social exclusion were not viewed as eligible for AIM support. A further minority of participants felt that whilst a broad range of children with diverse needs could be supported through AIM's universal levels of support, targeted AIM support was only available for children with a disability. Participants suggested that this is reflected in the wording used in application forms, leaflets, and information distributed by the DCEDIY.

Collectively, the varying views expressed demonstrate a clear need to revisit the rationale, principles, and purposes of AIM to ensure that there is consensus amongst the AIM project team and service delivery partners. A key area for exploration is the underlying philosophy which permeates AIM. Following this it is imperative that these underpinning concepts are reinforced within teams before being cascaded and communicated outwardly to pre-school settings and partners. Taking these actions are important to ensure fidelity in the information and support provided and have a subsequent impact in how AIM is implemented and experienced in the ECCE sector.

Perspectives on making AIM supports available to younger children in pre-school settings

Making AIM supports available to younger children would allow infants and young children aged 0 to 3 years to access universal and targeted support. This would include those currently cared for in ELC settings within baby and toddler rooms.

Some participants felt strongly that AIM supports should be available from the point at which a child starts attending a setting. In common with perspectives expressed regarding the increased availability of AIM support for children within the ECCE Scheme, it was felt that all children should have access to needs-based supports throughout their time in ELC settings. Several reasons were provided within the rationale for making AIM supports available to younger children:

- There is substantial interdisciplinary research evidence regarding the benefits of early identification and early intervention. ELC practitioners are well positioned to contribute positively to this (1)
- Currently, pre-school settings may be aware of younger children who have needs, but are not able to access the targeted supports they feel the child would benefit from until they enter the ECCE Scheme (3)
- Adopting AIM throughout the setting would support transition from the baby and toddler room into the ECCE Scheme (2)
- Making AIM supports available from an earlier age would go some way to enabling greater parental choice. Parent/carers of children with additional needs or a disability would have more freedom to decide the age their child starts attending an ELC setting and which type of setting is best suited to meet their needs if AIM supports are made available prior to the child starting the ECCE Scheme (3)

In contrast, a minority of participants felt that extending AIM to support the needs of younger children was a diversion from the original purpose of AIM as a model of supports for the pre-school ECCE Scheme. Participants suggested there were a number of risks inherent in scaling AIM up to include younger children. This included the financial costs associated with providing supports for an additional 2-3 years as well as the risk that no significant impact would be seen as a result of this investment. In

addition, a minority of participants felt that families had existing access to support through baby groups and health services that were better positioned to meet their needs.

Several challenges were identified by a minority of participants in response to providing AIM supports to younger children:

- It was felt that the impact of targeted supports, including AIM Level 7, would not be significant in baby and toddler rooms given the existing low adult to child ratios. An adult to child ratio of 1:3 applies for babies up to one year of age, rising to 1:6 for children aged 2 to 3 years. In contrast, a 1:11 ratio must be maintained in the pre-school room (3)
- Participants did not want AIM to be seen as a staffing model. This does not reflect the core principles of AIM (2)
- A minority of participants questioned what the role of an additional adult in the baby or toddler room would look like and whether this would present too much adult intervention (6)
- It was questioned how targeted supports could be provided equitably to younger children within the needs-based model of AIM. A minority of participants felt that it would be difficult to determine which babies and toddlers had high levels of need. Equally, participants did not want to introduce additional application criteria for younger children, such as the requirement of a diagnosis in order to receive support, as this did not reflect the principles of AIM (4)
- It was observed that as eligibility for AIM increased in 2018 to provide supports across the two year ECCE Scheme, the number of applications for Level 7 supports increased significantly. A few participants suggested this was due to applications being made to support the personal care needs of young children. There were concerns that extending AIM further for younger children would continue this perceived pattern of uptake (2)
- A minority of participants felt that the presence of the NCS already provided some funding for childcare outside of the ECCE Scheme (3)

Whilst there were conflicting views regarding the provision of targeted supports for younger children, the majority of participants felt the provision of universal supports in ELC settings would be beneficial. This would reinforce the commitment to full inclusion and meaningful participation for young children and infants already observed within the ECCE Scheme. However, the majority of participants agreed that an assessment of the training and development needs of ELC practitioners supporting younger children could be conducted as a supportive measure for settings. This would help to maintain high-quality provision in ELC settings and could feed into existing plans to enhance the training and development offered within AIM Level 1 and 3.

It was proposed by a minority of participants that the role of the EYS could be broadened in order to provide ongoing supports for settings who care for younger children. A few participants felt that aspects of this role were already being undertaken by the EYS within their existing relationships with pre-school settings. Advice is provided as well as recommendations for strategies and resources which may support the needs of the child. Additional support for ELC practitioners and settings could be provided either within the general scaling up of AIM to meet the needs of younger children, or in a truncated version of AIM which sought to embed universal support throughout ELC settings rather than providing additional targeted supports. This would be a lower-cost model; however, further exploration is required regarding the potential training needs of the EYS in fulfilling this extended role.

Perspectives on making AIM supports available to older children in School Aged Childcare (SAC) settings

Currently children who attend primary school are able to access private SAC during the afternoon. There is also funding and some local subsidies available outside of the remit of AIM, including the

NCS. Making AIM available in after-school care settings would allow children aged 5 to 12 years to access needs-based universal and targeted supports.

Some participants felt the lack of support available for children who returned to pre-school settings to attend SAC, or were accessing SAC in another type of setting, represented a significant gap in support. Participants questioned the rationale and logic behind the withdrawal of supports for children over the age of 5 years in pre-school settings. Several examples were provided by participants to illustrate this perceived gap in supports:

- A child may receive AIM Level 7 support in the pre-school setting between the ages of 3 to 5 years. Upon return to the same setting for after-school care as a 5- or 6-year-old child, they would receive no further targeted support.
- A child may receive SNA support throughout the school day. When attending a pre-school setting for after-school care no AIM or SNA support is available.

Participants expressed a range of challenges this gap in support presented for older children, particularly in relation to transitions throughout the day. A minority of participants felt that children found the transition from primary school to after-school care challenging and required further support. Participants believed that the current lack of funded support available during after-school care results in a lack of consistency and lack of continuity in the use of positive strategies. Transitions from between the two settings are also subject to gaps in collaboration and communication. As one participant identified, even if a child were to have support provided in after-school care, there is currently no system in place to ensure that information regarding the child, their strengths, needs, and strategies used to support them are shared on an ongoing basis. This mirrors the lack of support for transition observed when children move from pre-school to primary school. Consequently, the minority of participants who raised the issue of transitions felt that this had a negative impact on children and did not represent child-centred practice.

Some of the participants questioned what the provision of AIM supports should look like when meeting the needs of older children. There appeared to be tensions around the perceived purposes of School Aged Childcare (SAC) in comparison to pre-school, leading to a different focus on the intended outcomes for support. For example, a few participants felt that School Aged Childcare (SAC) support should centre around educational outcomes and the provision of support for homework, rather than play-based learning. It was felt that an hour of support may be sufficient to allow homework or educational tasks to be completed with support. However, the tensions between pre-school and primary school education were further observed in the expression by a minority of participants that ELC practitioners were not suitably qualified or experienced to provide educational support to older children.

The perceived distinction between 'education' and 'play' was raised by a few participants as a reason not to provide AIM in School Aged Childcare (SAC). They expressed that they did not wish AIM to be used to extend the formal school day for older children. Concerns were expressed that this would lead to children with additional needs or disabilities being subject to further interventions and formal teaching beyond school hours. In contrast, it was felt that attendance at a School Aged Childcare setting should provide older children with different experiences and an opportunity to engage in activities which reflected their strengths and interests. These perspectives reflect a more holistic view of children and their engagements. Given the opposing perspectives, further consideration is required regarding the scope and purposes of AIM in order to inform decision making regarding scaling AIM up to support older children in School Aged Childcare.

It was acknowledged that there were significant costs involved in extending AIM to meet the needs of primary school pupils when they attend School Aged Childcare. In common with proposals made to provide AIM support to much younger children, it was suggested that the universal levels of AIM support (1-3) could be provided in School Aged Childcare, rather than targeted support. This would allow pre-school settings to continue to follow the inclusive principles of AIM. It was also proposed by a minority of participants that the role of the EYS within Level 4 could be broadened in order to provide ongoing supports for settings who deliver School Aged Childcare for children. If this approach were to be taken, it is important that communication is maintained between the pre-school setting, the primary school setting, and families. This would ensure that an accurate picture of the child and their needs over time are maintained. In addition, strategies and approaches used when supporting the child should be shared to ensure consistency and aid smooth transitions from one setting to the other.

Perspectives on making AIM supports available to older children in primary school settings

Most participants felt that it would not be possible to scale up AIM to support the needs of children in primary schools. Although it was felt strongly that if children required support in pre-school, they would also require support in primary school, participants cited the segregation between the DCEDIY and Department of Education as a fundamental reason why AIM could not successfully be scaled up to support the needs of older children in primary school settings. A few participants referred to the challenge and resistance to implementing *Aistear* within primary school settings as evidential of the difficulties that would be faced, should attempts be made to scale AIM up into primary school settings. Some participants observed the lack of joint working and collaboration between departments was mirrored in the lack of joint working and collaboration observed between the pre-school and primary education sectors.

This presents a significant challenge to the ongoing successful implementation of AIM. Participants explained that a key difference between support offered through AIM in pre-schools and the support offered in schools lies in the model of inclusion adopted. AIM provides a tiered model of needs-based support, across universal and targeted levels. In contrast, in primary school settings some children may receive 1:1 support from a special needs assistant (SNA). Whilst there have been significant recent changes made to the SNA model, which allocates SNAs to school in response to previous levels of need, some participants still referred to the SNA model as “diagnosis-led.” For example, they highlighted that unlike AIM, a child may be deemed eligible for SNA support if they have a medical condition or a letter from a professional detailing assessment that had been undertaken to identify their needs. As a result, the concept of universal support or incremental supports provided across a continuum of need seen within AIM was not perceived to readily transfer into primary education. This is believed to have a knock-on effect on parental perspectives and confidence:

> ‘Parents are concerned about what happens after AIM stops.’
>
> [Early Years Specialist]

The influence of the SNA model of support adopted in primary schools can be seen within the ‘valorisation’ of AIM Level 7 in pre-school settings. This reflects a privileging of the most intensive level of support available:

- The majority of participants felt that parent/carers and pre-school settings sought to obtain Level 7 supports, in order to feel that they were receiving AIM (16)

- Some participants felt that parent/carers and settings look to the 1:1 SNA model of support they believed was provided in primary school settings and sought to replicate this in pre-school settings (8)
- The focus on diagnosis and professional assessment in order to unlock 1:1 support in primary school may be observed in the high uptake of Level 7 support. A minority of participants felt that settings applied for the highest level of support as a means of evidencing the needs of the child and subsequently secure later, ongoing support for children on entry to primary school (3)

A minority of participants acknowledged that changes were taking place within primary education to provide supports outside of the SNA model. This includes the revised Resource Allocation Model, introduced in 2019, which can provide support to pupils without the requirement of a diagnosis. Equally, it was felt by a minority of participants that the SNA model was beginning to move towards being a model of classroom support, rather than support for an individual or pair of pupils.

This is more aligned to the Level 7 support available within AIM. However, given the long-standing awareness of the SNA model in primary schools, it will take time for any changes in public perception of the nature of supports to become embedded. As a result, demand for Level 7 supports as a pathway to 'unlock' later support in primary school education may continue to be observed.

Most participants identified that children and families would benefit from a smoother transition from pre-school to primary school. It was felt that families received good support from the pre-school INCO and were supported to make applications for targeted AIM supports when required. The EYS also provides support to parent/carers when applying for a primary school place for their child. However, most participants felt that families had to 'start from scratch' when their child begins primary school.

> 'For school age children, from a parent's perspective it would simplify things if they knew that the path their child commences on for pre-school continues for primary school.'
>
> [HSE National Disability Specialist]

Despite this, most participants identified areas where transition could be developed further under the current remit of AIM. Changes have already taken place within the organisation of health care which are supportive of the transition of children into primary school. A few participants explained that teams are no longer organised into early years and school age teams, and that a single team structure had been adopted since 2020 for children from birth to 18 years of age. In addition, during the Summer 2021 a new set of regional teams were to be implemented[49]. Consequently, representatives of the HSE felt they were 'in a very good position to support' transitions within an extended AIM model should these be introduced. It was proposed by a minority of participants that the role of the EYS could be also extended to bridge the transition into primary school. Currently, the EYS supports the preparation of a transition plan in conjunction with the child's parent/carers and the pre-school setting.

The parent/carers are then responsible for providing this to the school setting. However, it was reported that the EYS have no further contact with the family beyond this point, nor do they have any substantial contact with the school or class teacher. As a result, it was suggested by a minority of participants that contact between the family and EYS could continue for a short period of time,

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[49] HSE informed researchers that the remaining of the 91 Children's Disability Network Teams (CDNTs) (birth to 18) were implemented in 2021 and are not 'regional teams' as described here. Also, local Education and Health Forums are in place to support, amongst other purposes, transition planning from pre-school to primary school (and primary to post primary).

drawing in the class teacher or primary school representative, to support the transition into primary school for children who had previously availed of targeted supports (Levels 4-7).

Participants held mixed views regarding AIM's ability to be enhanced through scaling up or out. The findings suggest that opposing views regarding which children are able to avail of AIM influenced participant perspectives regarding the scaling up and out of AIM. There was debate regarding whether AIM is solely for children with a disability or provided in response to need. Participants views regarding the scalability of AIM are as follows:

- Most participants felt that AIM should be scaled up to provide support beyond the ECCE Scheme hours to provide support for children attending full day sessions and aid transitions throughout the day.
- There were mixed views regarding the provision of AIM targeted support to younger children. Some participants questioned how a needs-based assessment could be conducted equitably in the 0-3 years age range, whilst the existing lower ratios were felt to limit the impact of provision of an additional adult within the context of AIM Level 7.
- Amongst some participants there was a strong feeling that where children had needs, these should be supported for the duration that they are in setting. Therefore, when older children who return for after-school care they should receive needs-based support.
- Whilst it was acknowledged that there were a number of barriers to scaling AIM up to meet the needs of children within primary education, participants felt the philosophy of AIM had potential for successful application within School Aged Childcare (SAC).
- Supporting effective transitions between and within settings was identified as a potentially positive outcome for scaling AIM up and out, across the different age groups.

It was questioned by some participants whether existing financial support, including the NCS, could be used by ELC settings to cover staffing costs and therefore render the scaling up of AIM unnecessary. Participants agreed that AIM should not become a staffing model and that this was a risk of scaling up or out. However, it is noted that NCS are subsidies to offset fees and do not increase overall income per child.

AIM team and service deliverers' experience and view of cross-departmental working in the context of AIM

Cross-departmental working and collaboration was at the core of the inception, development, and implementation of AIM. It was remarked that there was an energy and 'spirit of collaboration' in the initial design phase, which has continued to be fueled between project partners throughout the project. All participants perceived this collaborative approach, viewed by some as an 'AIM expectation,' as a strength of the project as it brought together expertise from a range of stakeholders from across early years, health, and education. This collaboration was viewed as essential given the complexity and scale of AIM. Most participants felt that AIM would not have been possible had one Government department tried to deliver the programme alone:

> 'So, one of the key principles within it, was a commitment to be different to do this work differently.'
>
> [CEO Early Childhood Ireland]

The Cross-sectoral Implementation Group (CSIG) brought together important stakeholders, including the Health Services Executive (HSE), Pobal, Better Start and the National Disability Authority (NDA). It was recognised by most participants that the different organisational stakeholders had previously

operated individually in different ways and that involvement in AIM required them not only to work differently, but to work differently in a collaborative manner. Although a minority of participants felt that they initially held reservations about the potential overlapping of roles between organisations, these were resolved over time as a shared understanding was achieved. A minority of participants viewed the open, collaborative way of working as “innovative.” It was remarked that although each organisation had their own focus, there was “one vision” within AIM to ensure that children with disabilities are included in ECCE.

A key factor that most participants felt was supportive to interagency working and collaboration was the clear leadership within the DCEDIY and the assignment of clear roles and responsibilities. Organisational stakeholders participated in different project groups, training groups as well as an overall consultation group. Most participants reported leadership of this to have been strong from the start of the project. This helped to ensure openness and collegiality between the range of organisational stakeholders. A minority of participants described that they found collaboration within AIM to be easy and that it was something that came naturally as a result of the ways that working together had been organised. Over time there has been a reduced need to meet with the same level of frequency as at the inception of AIM, and this has been attributed to the achievement of big targets at the initial AIM implementation stage. A few participants identified that in order to keep the energy and commitment to AIM going forward, there now needs to be a renewed focus on a specific purpose:

> ‘It is probably one of the top policy implementation projects that I have been involved in in my entire career. Government projects are often challenging because of the different ways that different departments work. And this is an example of how to do things well.’
>
> [HSE National Disability Specialist]

The governance and leadership of AIM has set the tone for those involved in supporting the delivery of AIM. A minority of participants described how the leadership approach adopted within AIM had filtered down and influenced leadership within their own organisation in a positive way. For example, within Better Start the EYS managers hold ‘mini meetings in peer groups’ each month in order to facilitate discussions at team level. A few participants felt that these were highly ‘solutions-focused,’ echoing the approach taken within the CSIG. Meanwhile, at the time of writing, HSE were enacting the Progressing Disability Services for Children and Young People (PDS) programme as part of the Sláintecare Strategy (Sláinte meaning ‘health’). This marks a significant reform of Children’s Disability Services to ensure fairer access and clearer pathways to services for children with disabilities and their families. The PDS was developed cross-sectionally over several years and included consultation with families and voluntary services. The first focus of the PDS programme was the development of a national system of 91 Children’s Disability Network Teams (CDNTs),which are community services working under the auspices of Ireland’s 9 Community HealthOrganisations (CHOs) to serve children with complex needs and their families. The remainder of the 91 CDNTs were set up and operational in 2021.

Collaboration and communication between stakeholders

All participants recognised that AIM is bigger than just one organisation and felt that this was evident across the universal and targeted Levels 1-7. It was felt that the organisational stakeholders that the DCEDIY had brought on board were the ‘right mix.’ Most participants felt that the other organisational stakeholders they engaged with brought valuable expertise and this provided an opportunity to learn from each other. This was deemed particularly helpful in providing a greater understanding of the work of different departments and organisations, the roles held within these and the strengths they had to offer.

> 'I think it has done quite a bit to improve the kind of understanding and maybe and recognition of the value of early learning and care and of early learning and care specialists.'
> [Better Start Early Years Development Programme Manager]

Participants identified a number of examples where collaborative working on specific projects associated with AIM had resulted in a positive outcome. A minority of participants described the development of the universal Design Guidelines, in conjunction with Trinity College Dublin. It was remarked that working with design and architecture specialists had shaped the participants own thinking and allowed identification of issues that they would not have considered themselves. Some participants referred to the training materials produced through collaboration between Early Childhood Ireland and Mary Immaculate College, Limerick. It was felt that this co-working brought together the expertise and research evidence regarding inclusive pedagogy with a nuanced and current knowledge of what is happening within ELC settings. It was felt by a few participants that the two organisations were able to influence the work of each other in a positive and highly productive manner, leading to the production of the high-quality, award-winning Leadership for INClusion in the Early Years (LINC) Programme.

Despite these positive outcomes, some participants identified barriers to collaborative working associated with communication between service delivery partners in the field. This was reported as being particularly problematic where several organisations were supporting the same pre-school setting. For example, a minority of participants reported that there was very little contact between the EDI trainers working for the County Childcare Committees (CCCs) and the Better Start EYS. The requirements of GDPR were cited by a few participants as one reason why they were unable to share information with another organisation. However, it was noted that there were wide regional variations reported in the degree of communication between the two organisations. Similarly, it was reported by a few participants that there was no expectation that the CCCs communicate or engage in collaborative projects with each other across county borders. As a result, further guidance regarding communication and collaboration between service delivery partners is required as part of a distributed leadership model. It is also suggested that a more streamlined approach to information sharing between organisations is identified to support collaborative working in the field for those supporting pre-school settings.

> 'There is room for better communication for better collaboration. Hearing the issues in the implementation of AIM, it is frustrating for services.'
> [CCC Manager]

Communication and collaborative working between the HSE, and Better Start was identified by some participants as posing a challenge. Whilst there was praise and respect for the chair of the HSE working group, there were criticisms of the working relationship between the two organisations[50]. A minority of participants felt that this was connected with wider, systemic challenges associated with bringing health and social care and education together. It was noted that the two operated quite different systems, with a different hierarchical structure.

- Collaborative work with the HSE was reported by a minority of participants to be slow due to the organisational structure of the HSE (5)
- A few participants felt that there was initially a sense of suspicion regarding the qualification profile of those working in the ELC sector and questions raised regarding the suitability and expertise of the EYS to offer support and information to pre-school settings (2)

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[50] There is a Better Start and HSE Forum in place to address such issues, but participants did not refer to this.

- The impact of the CHOs is reported by a few participants to be variable across regions (2).[51]
- Parental leave or loss of postholders in both organisations was reported to be a challenge. Participants working for both organisations identified that where staff were not in post, these roles were not covered (5)
- The challenges and barriers to children receiving AIM Level 6 support (see subsection 8.7) puts pressure on other targeted supports, especially Levels 4 and 7. There was a feeling expressed amongst a minority of participants that health and social care are not fulfilling their responsibilities within AIM. This has had a negative impact on collaborative working relationships (4)

Despite the challenges identified, it was felt by some participants that over time a greater understanding of the structure, roles, and responsibilities within the two organisations has been achieved. It was also acknowledged that the implementing of new organisational structures by the HSE would take time to embed before the positive impacts of these were felt by collaborative partners. Some participants also felt that there were future positive opportunities for collaboration. This included the important contribution that the HSE can make to the rolling out of the nursing supports pilot study. In addition, joint working towards workforce capacity development, including the development of specialised training modules, would be of great benefit as it would allow the expertise from across health, social care and the ELC sector to be brought together in line with the underpinning philosophy of collaborative working within AIM. In order to secure these positive outcomes, it is imperative that the open communication and solutions-focused approach seen in the leadership and governance of AIM is embedded across organisations in their collaborative working.

Consultancy and engagement

Some participants expressed that there was an ‘openness’ to hearing from a range of parties in relation to developing and implementing AIM. A minority of participants noted that this included hearing from parent/carers, children, and pre-school settings in order to identify the design of AIM that would work for them and to secure meaningful participation and full inclusion. A few participants felt that this reflected the leadership of the CSIG, which emphasised the collecting of evidence rather than making “knee jerk reactions” to issues as they arose:

> ‘I think there was a real openness to hearing from all of the parties in that regard as to what kind of system would work. So hearing from parents, hearing from children, hearing from the operators of settings you know, what was it going to take to really meaningfully include those children.’
>
> [CEO, Early Childhood Ireland]

Whilst most participants felt that the leadership of the AIM project had been inclusive, a minority of participants noted that the work of the CSIG was ‘very agency led.’ Whilst it was acknowledged that members of the CSIG valued the vast professional experience and personal knowledge of the parent/carer representative, the development of AIM may have benefited from greater parental involvement and broader range of opinions. It was noted by a minority of participants that there was a lack of direct engagement with families in the governance of AIM, leading to a perceived gap in parental voice. For example, the parent/carers of children with Down Syndrome are represented by

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[51] The CDNTs were not in place at the time of interviews.

Down Syndrome Ireland, rather than having direct involvement or input. Equally, it was felt that there was a lack of disability representation across the members of the CSIG itself.

> 'There isn't representation of individuals with a disability. Although children aged 3 to 5 may be too young, there also isn't an adult representative with lived experience of disability. It's an important perspective to be included… there isn't an individual with epilepsy, autism or a physical disability who will have a lived experience.'
>
> [Better Start Early Years Development Programme Manager]

It was also felt that more could be done by engaging individuals from marginalised or minority groups. For example, a few participants also identified that there was a lack of engagement with members of the Irish Traveller and Roma communities. This is significant as a minority of participants expressed their concern that minority groups and those from communities at risk of disadvantage and social exclusion were less likely to avail of AIM. This is discussed in greater detail in the subsection which discusses AIM project team and service deliverers' perspectives on non-participation in AIM. From a governance perspective, developing parental forums within communities and bringing in the perspectives of those individuals with lived experience could help to provide answers and solutions to unanswered questions, including those surrounding the lack of engagement and uptake of AIM.

Learning from previous work and pilot studies

Some participants felt there had been limited learning from previous work that had been conducted since the inception of AIM.

Some participants expressed frustration that although a number of pilot studies had been conducted, there had been no further outcomes or decisions communicated regarding next steps. In addition, some short-term projects had also been conducted but discontinued. These included:

- Nursing supports pilot study - According to current policy, all children can access the ECCE Scheme in a mainstream pre-school setting. However, it was identified that a very small cohort of children with complex medical needs were not attending. A pilot study was conducted with a small number of families who were already availing of the HSE paediatric home care package to provide nursing support in the pre-school setting (5)[52]
- Demonstration Project for ELC and in-school Therapies - This pilot, developed by the DES, DCYA and Department of Health (DoH) is coordinated by the National Council for Special Education (NCSE) (1)[53]
- Universal Design Guidelines - Early Childhood Ireland led a consortium that wrote a set of guidelines for the National Disability Authority. These provided guidance on using a universal design approach to develop the ELC setting. Although the guidelines have been developed, it was felt that no further activity has taken place to finalise and disseminate the guidelines publicly; for example, through a website with pictures and examples of an inclusive setting (2)[54]

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[52] This pilot was ongoing at the time of writing
[53] This pilot was ongoing at the time of writing and has a publication in the form of Lynch, H., Ring, E., Boyle, B., Moore, A., O'Toole, C., O'Sullivan, L., Brophy, T., Frizelle, P., Horgan, D., and O'Sullivan, D. (2020) Evaluation *of early learning and care and in-school therapy support demonstration project*, National Council for Special Education. [Online}. Available at: https://ncse.ie/wp-content/uploads/2020/11/Demo-project-evaluation-fInal-for-web-upload.pdf
[54] The publication referred to is: DCYA and CEUD-NDA (2021) *Universal design guidelines for ELC settings.* [Online]. Available at: https://aim.gov.ie/app/uploads/2021/05/universal-design-guidelines-for-elc-settings-introduction-1.pdf. Accessed 10/03/2022

- Over age exemption for the ECCE programme. This project started but did not progress as the Minister for the DCEDIY changed (2)
- The CCC and EDeNn developed training from 2011-2012 as part of the national project, "Pre-school Education Initiative for Children from Minority Groups". This was delivered in 26 counties and was reported to have achieved good outcomes. However, a few participants felt that the learning gained had been incorporated into Level 1 of AIM (2)

Whilst participants acknowledged that by their very nature not all pilot studies would continue to the implementation stage, they would benefit from this information being communicated to them. They remain unsure as to whether the outcomes of the pilot study have not been published because the pilot will not continue, or whether there is simply a delay in rolling out any planned actions resulting from the pilot. As a result, it is important that the updates and outcomes relating to pilot studies and projects are shared and disseminated.

All participants perceived the collaborative approach as a strength of the project as it brought together expertise from a range of stakeholders.

This was viewed by some as an "AIM expectation." The findings demonstrate that collaboration, communication, and knowledge-exchange was viewed positively amongst participants and essential to the complexity and scale of AIM. Most participants felt that AIM would not have been possible had one Government department tried to deliver the programme alone.

Whilst most participants reported that engagement with other key agencies and partners was good and had led to some positive developments, including training, there remained some areas for further development:

- Greater understanding of the roles and responsibilities within contributing organisations (particularly HSE, Better Start and DCEDIY) would enhance communication and collaboration.
- Whilst some participants expressed that there was an 'openness' to hearing from a range of parties in developing and implementing AIM more could be done to engage with families as the leadership and governance of AIM is largely agency-led.
- Some participants felt that there had been limited learning from work conducted since the inception of AIM, including several completed projects and pilot studies. Whilst participants acknowledged that by their very nature not all pilot studies would continue to the implementation stage, they would benefit from clear updates being communicated to them.

AIM team and service deliverers' view of the impact of AIM on related services

Participants from the AIM team and service delivery partners held mixed views regarding the impact of AIM on related services. Within the ELC sector, parent/carers of children with disabilities or additional needs currently have some choice regarding the placement of their child; children may attend a specialist pre-school, a mainstream pre-school setting or take up a dual placement across the two settings. In some circumstances, families are able to access the Home Tuition Grant Scheme. The range of support programmes available is complex with each having its own detailed rules for qualification (see subsection 2.3). Whilst some participants felt that AIM had increased the availability and opportunity for children to attend a local mainstream pre-school setting, others felt that the situation was less clear cut. In addition, participants were divided regarding the future role of specialist

pre-school settings and the extent to which these were required in addition to the provision of AIM in mainstream pre-school settings.

During interview, some participants spoke of the difficulty of establishing trends or patterns in the existing data they had access to, which could establish the impact of AIM on related services. This had a direct impact on participants' ability to identify the nature of the relationship between AIM and the uptake of mainstream and specialist pre-setting places by children.

- Participants were not able to establish reliable trends to suggest that families were choosing for their child to attend a mainstream pre-school setting rather than a specialist pre-school setting.
- No reliable trends were established to suggest that children were moving from specialist pre-schools to mainstream pre-school settings during the two year ECCE programme.
- There were conflicting anecdotal reports across the participants interviewed suggesting that the numbers of children in specialist settings were either unchanged or growing. A minority of participants reported huge demand for places and long waiting lists in their local area.
- Large regional variations were reported, with a minority of participants reporting that their local specialist settings had falling numbers and were at risk of closure.

Parental choice through AIM

Most participants spoke of the benefits that increased choice facilitated by AIM presented to families. Collectively, participants remarked that AIM played a role in enabling:

- Dual placements, in which children may attend a mainstream pre-school setting for two days a week and a specialist setting for three days a week when taking up their ECCE entitlement. This places less focus on the medical model of disability and promotes inclusion within a social model which takes a holistic view of the child, their strengths, and needs.
- In a minority of cases, children avail of AIM in a mainstream setting whilst on the waiting list for specialist provision. In some cases, children may remain in mainstream if parent/carers feel this meets the child's needs.

Although the provision of AIM support in mainstream pre-school settings provided families with greater choice, the range of different services available can be difficult to navigate. Some participants felt that the different rules and systems in place for children under the age of five was overly complex, particularly as parent/carers have to renavigate another system again on entry to primary school age provision. This issue reflects the wider need to enhance the communication of AIM to families, including the signposting of the diverse levels of support that children may avail of. A minority of participants felt that it was not sufficient to simply advertise these on the Departmental website, as this was only beneficial to those parent/carers who had some initial knowledge or understanding of AIM and therefore knew to look on the website. As a result, it is suggested that other organisations or professionals who come into contact with families provide some initial information regarding the availability of AIM supports within the ECCE Scheme.

> 'I try not to predict where the child will be in a year and try to set goals to help them make progress, I think it's great that they have chance to attend mainstream and be supported.'
>
> [Early Years Specialist]

A further issue associated with having a choice in placement was identified as parent/carers feeling unsure or fearful of making the wrong decision for their child. A minority of participants identified that parent/carers did not feel that they would later be able to change their minds, particularly if they did

not take up a specialist placement when offered to them. Participants described this issue as being compounded by the relative scarcity of specialist setting places, and the existence of waiting lists in many areas. Whilst enhancing the opportunity to transition between the two setting types may support parent/carers to feel freer to make decisions in response to their child's needs at the time, this may not always be possible to facilitate if the alternate placement is simply not available. In addition, it should be noted that the views expressed by participants within the AIM project team and service delivery partners reflect their own observations and anecdotal evidence. There is currently no data available to indicate which are the most significant factors that influence parent/carer choice, nor their feelings regarding these decisions once their child starts attending pre-school. It is also unknown how many children transfer between mainstream and specialist pre-school settings, in either direction, during the two year ECCE programme.

AIM in context

As a result of a reported lack of impact data, participants were reliant on their own observations and anecdotal evidence regarding the impact of AIM on related services. A key difficulty is that when a parent/carer chooses to send their child to a mainstream pre-school setting and they avail of AIM, there understandably is no record kept of whether or not the child would otherwise have been eligible for or attended a specialist setting. A potential way of gathering data to establish trends or changes in attitude to mainstream and specialist pre-school provision could be to conduct interviews or surveys with parent/carers at the start of the ECCE programme. This would allow parent/carers to identify which services they had considered for their child and ultimately which they had chosen to meet the needs of their child during their pre-school education.

Despite the increased choice offered to parent/carers, some participants strongly felt that for a number of children with complex needs, specialist provision was required through either a specialist pre-school setting, home tuition or early intervention. The largest criticism of AIM's ability to replace or reduce the need for related services was that it is not a specialist model. A minority of participants felt strongly that whilst AIM was good at supporting mild or moderate needs, it was not designed or able to meet complex and/or medical needs.

Some participants expressed that they held a number of concerns regarding the potential reduction or closure of specialist pre-schools in favour of children being supported through AIM in mainstream pre-school settings. Firstly, a minority of participants felt that the high demand for specialist pre-schools in their local area demonstrated that there remained a need for this type of specialist provision. Secondly, a further minority of participants identified that there are instances where a placement in a pre-school setting can break down and no longer be sustainable. This can be the case even when the highest level of AIM support, at Level 7, has been provided. Combined, the two views suggest that some participants are concerned that encouraging all children to attend a mainstream pre-school setting could be at odds with inclusive practice as children may be placed in settings that are either unable or unavailable to meet their needs. The ultimate fear is that removing specialist provision may result in some children being unable to attend pre-school and therefore unable to afford of their right to engage in the two year ECCE Scheme. A minority of participants therefore questioned where children could be placed should the provision of specialist pre-school settings be reduced or removed.

On the other hand, a minority of participants felt that the existence of specialist provision presented a fundamental challenge to AIM. For example, a child with an autistic spectrum disorder (ASD) could be supported through AIM to attend a mainstream pre-school setting but, in many cases, families choose to avail of early intervention or place their child in a specialist pre-school setting. It was questioned whether the current system, where children who have an additional need or disability are placed elsewhere from their peer group, was at odds with the concept of progressive universalism. However,

it was acknowledged that there were a number of challenges and risks associated with attempting to bring all children into the mainstream pre-school setting. A few participants noted that were AIM unsuccessful in meeting the needs of children, there is an inherent risk that this would drive families back to specialist settings and foster a lasting mistrust in the suitability of mainstream settings. As a result, it is necessary to develop and build the capacity within AIM to meet more complex needs first, before considering whether AIM alone is sufficient as a model of inclusion to support the needs of all children in the ECCE programme. It was identified that the development of additional supports for children with complex needs or medical conditions is required if AIM is to provide more specialist support. A few participants identified that there is a perception amongst families that attending specialist pre-schools provides greater access to therapeutic supports. One possible solution to challenge this perception is to offer specialist training modules to ELC practitioners. Training could be developed through collaboration between health and social care and the ELC sector in order to increase workforce capacity. It is anticipated that this could increase both practitioner and parent/carer confidence in the ability of mainstream pre-school settings to meet the needs of children during sessions (see subsection 8.4). In addition, the expansion and increased availability of AIM Level 6 support, which is intended to provide therapeutic supports (see subsection 8.7), is needed in order to reassure parent/carers and ELC practitioners that children will be eligible for and receive needs-based therapeutic supports should they attend a mainstream pre-school setting.

A further element of specialist support currently under development is the complex health care needs pilot study which seeks to provide nursing support in the pre-school settings. The pilot was limited to a small number of families who were already availing of the HSE paediatric home care package. However, it was felt by a minority of participants that a number of other children would benefit from this approach but would not be awarded this as they are not currently eligible for a home care package. It was identified that some children who have healthcare needs are only able to access their pre-school setting for limited periods of time and were not currently able to avail of their full ECCE entitlement due to a lack of support for their medical needs. Children who are peg-fed were provided as an example of those who may not have high enough medical needs to receive a homecare package but would benefit from having some nursing supports in the setting to allow them to access a full three-hour ECCE Session without being limited by the timing of their feed. Consequently, when evaluating the pilot, it is suggested that the profile of children who could be included is fully explored and expansion to children outside of the home care package given consideration.

Participants from the AIM project team and service agencies held mixed views regarding the impact of AIM on related services. During interview, participants spoke of the difficulty of establishing trends or patterns in the existing data they had access to which could establish the impact of AIM on related services. This had a direct impact on participants' ability to identify the nature of the relationship between AIM and the uptake of mainstream and specialist pre-setting places by children. However, most participants spoke of the benefits that increased choice facilitated by the introduction of AIM brought to families. Despite the increased choice offered to parent/carers, some participants strongly felt that for a number of children with complex needs, specialist provision was required through either a specialist pre-school setting, home tuition or early intervention. The largest criticism of AIM's ability to replace or reduce the need for related services was that it is not a specialist model. A minority of participants felt strongly that whilst AIM was good at supporting mild or moderate needs, it was not designed or able to meet complex or medical needs. It was identified that the development of additional supports for children with complex needs and/or medical conditions is required if AIM is to provide more specialist support in the context of mainstream pre-schools.

AIM team and service deliverers' views on the impact of AIM on children, parent/carers, and pre-school settings

Participants felt that AIM responds to the commonly held expectation amongst families and ELC settings that all children have a right to access the two year ECCE programme. Most participants felt that it was important that children were able to access their local pre-school setting, alongside their peers and that AIM's commitment to inclusion facilitated this.

Most participants spoke of AIM's structure as aiding pre-school settings, which in turn helped them to provide support to children and their families. It is not just the policy of AIM that has secured positive impacts for children and families, but the way that this has been implemented in pre-school settings. This has been instrumental to embedding the core principles of AIM: meaningful participation and full inclusion. As a result, this section begins by reporting AIM team and service deliverers' views on the impact of AIM on pre-school settings, before discussing their views on the subsequent impact on children and their families. An identification is made of the areas where a positive impact has been made, whilst illuminating those areas where additional work could be done to secure further positive impacts.

The impact of AIM on pre-school settings

Participants felt that AIM is having a positive impact on pre-school settings, including their confidence and willingness to be inclusive. The change in attitudes and approaches in settings was observed by some participants to have taken place quickly and to have had a profound impact. This 'incremental confidence' which had been achieved in a short space of time was reported by some participants to be growing - as pre-school settings and practitioners completed the ECCE programme with one child and then replicated this experience with subsequent children in subsequent years. The EYS who took part in the interviews described pre-school settings as having great pride in their role in supporting children, 'leading to confidence to do it again'.

Most participants felt that there was an increased willingness and confidence within pre-school settings to offer places and provide ongoing support to children with additional needs or a disability. A minority of participants felt that whilst pre-school settings may have historically wanted to be inclusive of all children, they did not previously have the support or resources they felt they needed in order to facilitate this. The majority of participants felt that pre-school settings were more open as a result of AIM. This was deemed to have the overriding benefit of allowing local children to attend a local pre-school setting alongside their peers. Participants felt that word of mouth had played a role in spreading awareness between pre-school settings regarding the availability and benefits of AIM.

Participants also felt that the impact of AIM on pre-school settings could be observed in the increased quality of provision. Some participants felt that this was related to the increased training available to ELC practitioners through AIM Level 1 and 3 (see subsection 8.2 and 8.4). Most participants spoke highly of the LINC programme offered within AIM Level 1 which allowed a member of staff from the pre-school to undertake the INCO role. Having a trained INCO in the setting was viewed by most participants as having a positive impact on a setting's wider workforce, as they had access to a member of staff who had engaged in the training and could offer advice and support internally within the setting. This reflects a throughput approach to training, where knowledge and expertise can be shared in their field by those who receive the training first-hand.

> 'There's a sense that settings and practitioners want to get better, they want to train and develop skills so they can support and be open to children.'
>
> [DES Early Years Inspector]

It was identified that a training course alone would not have been sufficient to secure the increased workforce capacity that was required to implement and maintain high quality provision. The role of the EYS was recognised by most participants as being supportive of ongoing high-quality practice in the ELC sector. Their role of the EYS includes elements of training, mentoring and the provision of ongoing support to settings as part of AIM Level 4 (see subsection 8.5). In combination, the investment in training and ongoing professional development and support was felt by most participants to have had a positive impact on pre-school settings as it continues to build up the knowledge and expertise of ELC practitioners:

- Settings are reported to be more confident in applying for targeted support across AIM Levels 4-7 (8)
- Settings are aware of the resources available to them in supporting children through AIM (8)
- A minority of participants observed that some settings who had accessed AIM in earlier years had a reduced need to apply for targeted support in subsequent years. This was attributed to the increased workforce capacity that had developed over time through engagement in training and mentoring coupled with practical experience of supporting children with additional needs or disability that could be applied to future contexts (3)
- Professional growth and learning have been facilitated through access to training, mentoring and support (10)
- Where children are in receipt of therapeutic supports, participants from health and social care felt that the child's individual programme was more likely to be implemented within settings who had engaged in AIM training and development opportunities (2)

> 'There is a big upskill in what staff understand about disability.'
>
> [Children's Disability Network Manager]

Some participants felt that the opportunity for pre-school settings to reduce their ratios through AIM Level 7 was an important factor in increasing the quality of ELC provision. Having an increased adult to child ratio was identified as allowing greater time for engagement between ELC practitioners and children. Some participants felt that the positive impact of reduced ratios extended beyond the child to whom AIM Level 7 was awarded to: ELC practitioners would be more able and equipped to undertake their roles to a high standard which in turn enabled other children in the room to benefit. Consequently, a minority of participants advocated for the reduction of adult-child ratios in pre-school settings, irrespective of whether Level 7 had been awarded to the room. It was proposed that the ECCE Scheme ratio should be reduced down from 11:1 to 1:8, which is the standard ratio for children aged 3 to 6 years in full day care outside of the ECCE Scheme hours.

The impact of AIM on parent/carers

Participants believed that AIM provided an acknowledgement to parent/carers that the Government are willing to support their child in the early years. Participants spoke of the reassurance that they hoped AIM brought to families in feeling that the Government and policy were on their side. Some participants acknowledged that many parent/carers had experience of advocating for their child and expressed a desire for AIM to be a positive example where families did not need to fight to receive the access and support that they were entitled to in order to participate in the ECCE Scheme.

> 'There is an expectation or a feeling that if a child has a disability – they have an entitlement. AIM responds to this.'
>
> [Early Years Quality Unit- Principal Officer]

Participants felt AIM provided reassurance to families that their child is wanted and welcome in their local pre-school setting. Some participants reflected upon the change in availability of places since the introduction of AIM. For example, an Early Years Team leader described that prior to AIM parent/carers may have been limited to a small number of pre-schools who were able to offer a place to their child, whereas under AIM parent/carers are able to approach the local pre-school setting of their choice and apply for a place for their child. This application is facilitated in part by the fact that pre-school settings are aware that they can apply for AIM supports to meet the needs of the child should this be required. This reflects the description of AIM as enabling pre-school settings to provide support for children and families.

The strengths-based approach adopted within AIM was suggested to have a positive impact on parent/carers. A few participants identified that for some parent/carers, AIM could represent the first time they had seen their child participating in a setting which is non-medicalised. It could also represent the first time, outside of the wider family context, that children are seen to be included within their peer group. It was identified that for some families the focus may previously have been on the child's deficits or a medical condition, whereas participants from Better Start remarked that the parent/carers they had contact with found the 'the shift in focus to consider the child's strengths, interests and abilities quite energising for themselves to think of their child in that way'.

Participants also felt that AIM had a positive impact on parental confidence in mainstream pre-school settings. Although reliant on their own experiences or anecdotal evidence, some participants identified that parental confidence had increased by virtue of the pre-school settings they were now able to access being part of their local community. It was felt that word of mouth played a powerful role in supporting families to choose the pre-school setting. If they had a recommendation or knew of another parent/carer of a child with a disability, this reinforced the message that the mainstream pre-school settings were open to them and able to meet the needs of their child. As discussed in the previous section regarding the impact of AIM on related services, participants did not have data to evidence the perceived increase in parental confidence. However, most felt that this was reflected in the increased uptake of both ECCE Scheme places and increased uptake of targeted AIM support which collectively suggest that more children with additional needs and disabilities are attending mainstream pre-school settings. Some participants suggested that AIM Level 7 provided peace of mind for parent/carers. The provision of an additional adult in the room provided reassurance that their child would not be "lost in a room with 22 other children".

The collaboration between organisations within AIM was deemed beneficial to families. This was expressed by a minority of participants as providing reassurance or security in knowing that the range of professionals engaged in their child's life were communicating with one another, and collectively held the child's best interests in mind. This was perceived to take pressure off the parent/carer and remove the need for them to act as the 'the conduit' between services. In an ideal situation it was expressed that different service delivery partners would offer a coordinated approach in providing needs-based support to the child. For example, a therapist could engage with the setting and share information regarding the child's needs and the intervention and approaches that would be of benefit, allowing ELC practitioners in the setting to act upon these. However, it was noted by a minority of participants that in practice this communication and coordination could be smoother. Consequently, further collaborative work within the remit of AIM, such as creating stronger links between ELC, health and social care, will be of further benefit to families.

The impact of AIM on children

Participants felt the greatest impact of AIM was that it allowed children to attend a local mainstream pre-school setting whom may not otherwise have been able to do so. Most participants attributed this

to the provision of targeted support across AIM Levels 4-7 whilst AIM Level 7 was singled out as being the most significant contributor to facilitating children's access to the ECCE programme.

Participants noted that AIM's needs-based model of support, which does not require a child to have a formal diagnosis, had a significant impact as children's needs were identified earlier and supports were subsequently made available quickly. Most participants felt that the increased availability of adult support, either through the reduction in ratios or through the employment of an additional member of staff, was key to the child experiencing full inclusion and meaningful participation.

Within the pre-school setting, participants identified that AIM had a number of positive impacts on children with additional needs or a disability. Collectively, this included:

- Having the opportunity and the supports necessary for them to participate in their local ELC setting. Most participants noted that impact came not just through the availability of the placement, but in the placement being accompanied by needs-based support. This was seen as fundamental to meaningful participation and full inclusion of children (25)
- Having access to trained and knowledgeable ELC practitioners. A minority of participants felt that the impact on children was greater where the setting had been able to engage in training and mentoring. This led to settings being more responsive to the child and able to plan for and support 'small steps' progress (6)
- Having learning opportunities to support the development of social skills and foster meaningful relationships with other children and adults in the local pre-school setting. Some participants felt that the holistic view of the child and their wider needs had a positive impact on children's inclusion within their peer group (10)
- A minority of participants felt that increased ELC practitioner knowledge and use of different forms of communication, including the use of visuals, picture exchange and Lámh, was viewed as having a positive impact on children's ability to express themselves and communicate their needs in pre-school settings (6)

Whilst all participants agreed that AIM benefited children with additional needs or a disability, they also agreed that AIM was of benefit to all children in the pre-school setting. Some participants identified that all children benefited from the increased capacity of the ELC workforce and the increased quality of provision this brought.

The learning that ELC practitioners engaged in through completing AIM funded training and qualifications was deemed to have a positive impact on all children. Furthermore, most participants felt that AIM contributed positively to children's understanding and exposure to peers with a diverse range of strengths and needs within the local ELC setting. The positive impacts on children across the pre-school setting reflect the underpinning universal supports across AIM Levels 1-3.

> 'A service that's accessible to a child with a disability is accessible inclusion of all children.'
> [Better Start Programme Manager]

Overarching benefits of AIM

When discussing the impact of AIM on children, families and pre-school settings, participants expressed that together AIM was starting to have an overarching impact on societal attitudes toward disability and additional needs.

- Some participants felt that AIM is having a positive impact on reducing the taboo of disability. This is aided by the visibility of children with a range of needs being in a local pre-school setting alongside their peer group. (8)
- All participants felt that it was beneficial for all children to engage and form relationships in their pre-school setting with other children, including those who may have complex needs. Some participants expressed that children themselves saw the child first, and not the need (8)
- Changing attitudes towards disability are observable in the increased openness of pre-school settings. Most participants felt that pre-school settings feel more confident and better equipped to meet a diverse range of needs, due to the increased availability of training, support, and resources (16)
- Word of mouth has helped to spread awareness amongst parent/carers and pre-school settings. Some participants felt that this was seen in the increased uptake of the ECCE Scheme and AIM supports, as both families and pre-school settings are aware of the child's right to attend and the supports that are available to facilitate this (10)
- Seeing other children with a disability in mainstream pre-settings was viewed as a positive experience for parent/carers of a child with an additional need or disability (3)
- A minority of participants felt that the EDI training offered within AIM Level 1 had contributed positively to inclusive practice in settings (3)

However, participants felt that this cultural shift toward inclusivity was just the beginning and there remained some way to go before the impact could be felt in wider society:

- Some participants felt that not all disabilities were viewed equally. For example, participants felt that children with a physical disability were more widely accepted within society than those children with less visible disabilities (8)
- The visibility of children with disability and additional needs is important to increasing societal awareness of diversity (5)
- A minority of participants were concerned that negative societal views regarding disability presented a barrier to parent/carers in accessing mainstream pre-school and availing of AIM support (3)

A final area reported that relates to the ongoing impact of AIM was the access to children and their families the programme provides to the state. The two-year ECCE Scheme is accessed by the vast majority of children in Ireland from the age of 2 years and 8 months. This was described by a few participants as presenting itself as an opportunity should the state wish to engage families, including those of children with additional needs or disabilities. For example, should a new early learning initiative or strategy be devised, whether at a universal or targeted Level, disseminating and implementing this through AIM would ensure it reached the vast majority of children through pre-school settings. In addition, in evaluating the implementation and impact of AIM, a key opportunity lies in the mechanism this provides for capturing ongoing feedback from parent/carers. The pre-school setting children attend, and the contact details for their family are known as they are provided within the AIM application form. Whilst it is believed that AIM has a positive impact on pre-school settings, families, and children there is a need to move towards the identification of impact measures. Subsequently, engaging with families and pre-school settings using information provided through the AIM application process has the potential to contribute important information to support the measurement of impact.

Participants considered that AIM responds to the commonly held expectation that all children have a right to access the two year ECCE programme. The findings strongly suggest that AIM has influenced practice and increased capacity in the workforce. Most participants spoke of the AIM structures as providing support to pre-school settings, which in turn allows them to support children and their families. It is not just the policy of AIM that has secured positive impacts for children and families, but the way that this has been implemented in pre-school settings. This has been instrumental to embedding the core principles of AIM: *meaningful participation* and *full inclusion*.

Participants perceived the following positive impacts of AIM:

- Pre-school settings have increased confidence and willingness to be inclusive. This has been secured through access to training and CPD within Levels 1 and 3, alongside ongoing support and mentoring from the EYS within AIM Level 4.
- The openness of pre-school settings has a subsequent positive impact on families who are believed to have greater confidence in the ability of mainstream pre-school settings to meet the needs of their child.
- The increased visibility of children with additional needs and/or disability is believed to be supportive of families feeling included and welcome within the ELC sector.
- The majority of participants proposed that facilitating children to attend a local pre-school setting alongside their peer group was a significant achievement of AIM.

A limitation of the views expressed during the interviews was that they relied on participants' anecdotal knowledge. There is currently no impact data captured by the AIM project team or agencies which explores ELC practitioner, family, or children's views. Whilst it is firmly believed that AIM has a positive impact on pre-school settings, families, and children there is a need to move towards the identification of impact measures. Subsequently, engaging with families and pre-school settings using information provided through the AIM application process as a starting point has the potential to contribute important information to support the measurement of impact.

AIM team and service deliverers' views on the factors that have helped and hindered impact in the context of AIM

Participants referred to the benefits of widening focus from diagnosis to need within AIM as being a key factor in securing impact. Most participants felt that AIM was responsive to the needs of the individual and that there was flexibility within AIM to provide tailored supports. For example, one participant described how two children with the same diagnosis could have two quite different sets of needs and would therefore need to be supported differently. The flexibility within AIM was also observed in other areas:

- Within health and social care there is a shift away from providing dedicated therapeutic supports to certain pre-schools and a move towards providing these through Children's Disability Network Teams (2)
- Pre-school settings are able to apply for AIM targeted support throughout the year. This allows them to respond quickly to emergent needs (4)
- The supports that are provided to the child can be changed over time in response to need and as they arise. Pre-school settings are able to reapply for additional support should this be required (4)

- There is no limit on the number of times a pre-school setting can apply for AIM support as it is provided in response to the needs of the child. If required, an application can be made every year. Equally if the pre-school setting does not apply, they do not lose their entitlement to apply in future (4)
- The strengths-based approach used when applying for AIM involves engagement with families and talking to them about what they want for their child (8)

Building capacity in settings through CPD on inclusive practice has been found to be more effective in changing practice culture than legislation and regulations. Consequently, several training and development opportunities have been made available to pre-school settings in order to enable them to support children and families. It was noted that for AIM to work well, it was not just children who would benefit from support, and that the ELC practitioners who implement AIM also benefitted from ongoing support. All participants viewed the provision of training, development opportunities and support through AIM as being a positive factor which contributed to impact. Collectively, a number of examples were provided by participants:

- Pre-school settings have increased access to supports and information, they no longer have to rely upon local knowledge (12)
- The EYS was noted as providing ongoing support to pre-school settings and practitioners through training and mentoring. However, it was noted by a minority of participants that relationship with the EYS builds over time and that not all pre-school settings engaged fully with the support offered within AIM Level 4 (see subsection 8.5). (4)
- Where ELC practitioners have engaged in funded AIM Level 3 training, such as Hanen (inclusive talk), Lámh (manual sign system) and SPEL (focussed on sensory processing) it was noted by HSE representatives that the pre-school setting was more able to implement the strategies recommended by the therapeutic team (2)
- As ELC practitioners engage in training alongside mentoring and support, this has a cumulative effect in increasing their knowledge and skills in supporting children across the universal and targeted levels of AIM (5)
- The funded LINC programme offered within AIM Level 1 was identified as being beneficial as it provides training for one member of staff to become an INCO. Once trained, the INCO is able to offer support within their setting to other ELC practitioners and may cascade information and provide internal training to staff (8)

Participants noted that financial incentives had been offered which encouraged settings to engage in AIM training and CPD. Some participants felt that the funding was a significant factor which incentivised pre-school settings to undertake training beyond their initial qualification. This has contributed positively to the upskilling of the ELC workforce. Some participants also referred to the financial reward that was provided following completion of the LINC programme; the state incentivises engagement in Level 1 through the higher capitation offered to pre-schools that employ at least 1 LINC graduate.

The costs to settings associated with providing targeted support at AIM Levels 5 and 7 are also covered to ensure that inclusive pre-school settings are not at a financial disadvantage. Within AIM Level 5, pre-school settings may apply for a grant to cover the costs of providing physical resources and alterations to make the ECCE learning environment more accessible whilst specialist equipment can also be applied for to meet the needs of children with disabilities/additional needs (see subsection 8.6). Meanwhile, AIM Level 7 provides funding to cover the cost of employing an additional adult for up to 15 hours per week for 38 weeks of the year (see subsection 8.8). Some participants expressed concern that the current implementation of AIM Level 7 risked it becoming seen as a staffing model. AIM Level 7 is not intended as a means for pre-school settings to cover day-to-day staffing costs.

Consequently, it was suggested that greater compliance and governance is required to ensure that funding and subsidy is used in appropriate ways and with fidelity to the AIM programme. Together, the funding available within AIM Level 5 and 7 provides recognition of the cost to pre-school settings of providing targeted support and is a positive factor in ensuring that pre-school settings feel that they are financially able to meet the needs of children with additional needs or disability.

Factors which limit the impact of AIM

The single biggest barrier to AIM was reported by the majority of participants as being the lack of availability of therapeutic services for children with disabilities. In relation to services for children with disabilities beyond AIM, participants reported wide regional variations in waitlists. Participants reported the length of waitlists for therapeutic services to be as high as three years. This means that some children would never reach the top of the waitlist or receive any therapeutic support for the duration of time that they are in the ECCE Scheme. Though this is an issue outside AIM, it is perceived to impact on children accessing mainstream ECCE and AIM.[55] It emerged that there are two views on this situation. One is that Level 6 (targeted with referral to HSE), does have capacity and is simply undersubscribed due to a shortage of referrals, and the other is that Level 6 is impacted by wider challenges in the capacity of HSE disability services.

Where interviewees perceived a lack of availability in AIM Level 6 (and it has been noted that there were different views on this) they had observed this placing undue pressure on AIM Level 7. Some participants identified that because pre-school settings believe that they will not be able to avail of AIM Level 6 (because of the waitlist challenges), they no longer apply for this level and apply straight for AIM Level 7 (we note here that it is the role of EYSs to apply for Level 6 supports). This observation could explain the pattern of increased applications for Level 7 year on year whilst applications for AIM Level 6 (targeted) remain relatively low. Though this context is situated beyond AIM, participants were describing its impact on AIM.

It was also identified by a minority of participants that the challenge of securing therapeutic supports was preventing parent/carers from choosing a mainstream setting for their child. Participants had observed that parent/carers were making the pragmatic decision to send their child to specialist settings because they could be more certain that HSE interventions would be offered there. This was in spite of the parent/carers' preference for mainstream AIM-supported ECCE. This was reported as having a subsequent impact when families come to apply for a primary school place for their child. As the family have no prior experience or engagement with mainstream provision, they do not have the opportunity to build up confidence in mainstream or gain insight into how their child could be included. As a result, the same families who experience barriers to accessing mainstream pre-schools are further excluded from accessing a mainstream primary school setting. Participants argued that the parent/carers they had met, were experiencing the absence of therapeutic supports in pre-schools (or at least the difficulty of securing them, and of having them delivered in the setting). This presented a significant barrier to inclusion for children and families. This was another example of how participants viewed the interaction of the wider waitlist issue with AIM's success in achieving its intentions.

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[55] HSE provided researchers with further context on this phenomenon to note that participants may be conflating access to 'regular' health service where those waitlisted are prioritised based on need with
AIM Level 5 and 6 supports provided by HSE where under the Joint Protocol, an EYS submits 'Request for Support' where deemed critical to access and participation in pre-school and this must be provided by HSE/HSE funded agencies within 5 weeks. This protocol includes an escalation pathway for resolution where the 5 weeks has been breached, in recognition of child's short time in pre-school. It was reported that 5 cases have been raised in the past 3 years to national level to resolve.

It was acknowledged that at the time of writing several changes within the HSE were due to be implemented. Firstly, a large-scale reorganisation was taking place which would result in a new national system of 91 CDNT's which were community services working under the auspices of Ireland's 9 Community Health Organisations[56].

The AIM project team and service delivery partners offered a range of factors that affect the impact of AIM. The findings demonstrate that the impact of AIM on access to – and meaningful participation in – the ECCE Programme for children with disabilities/additional needs is contingent on increasing the capacity of the ELC workforce

Significant amongst the factors that help AIM to have impact are:

- ELC settings can respond flexibly to children's needs and make applications in response to emergent needs.
- AIM responds positively to the training and development needs of ELC practitioners.
- The range of funded training, CPD and mentoring opportunities across Levels 1, 3 and 4 build confidence and strengthening ELC workforce.
- Funding is available to pre-school settings to cover costs associated with AIM Level 5 and 7. However, some participants expressed concern that AIM Level 7 could be seen primarily as a staffing model and required greater compliance and governance to ensure fidelity.

Participants proposed that a key contextual factor that was impeding achievement of AIM's intentions was the need for greater HSE engagement during children's pre-school years. The reasons by participants were:

- Significant barriers are presented to children accessing mainstream pre-school settings as they parent/carers believe that they cannot avail of the support that they require to meet their needs.
- Lack of availability and uptake of AIM Level 6 (targeted) is identified as having a subsequent impact on the increased uptake of AIM Level 7. It is noted that this is perceived by HSE as undersubscription rather than a shortage of resource.
- Some participants felt that pre-school settings did not attempt to apply for AIM Level 6 (targeted) as they perceived it to be unavailable, and complex. In this way, the wider context of HSE waitlists interact with the behaviour of key stakeholders around AIM Level 6.
- A minority of participants reported that parent/carers were making a pragmatic choice to enroll their children in specialist pre-schools because HSE therapeutic support was provided there, and hence was easier to access than it was in AIM supported mainstream ECCE.

Participants anticipated that the implementation of new national Children's Disability Network Teams coupled with a new HSE waitlist system may catalyse more referrals for AIM Level 6 (targeted).

[56] All teams are now in place.

AIM team and service deliverers' views on non-participation in AIM.

Participants believed that non-participation in AIM could be divided into two strands: pre-school settings who did not participate in AIM, and families who did not participate in AIM. Throughout the interviews, most participants described that a challenge in identifying and understanding non-participation was that there was no record of who could be eligible for AIM but was subsequently not engaging. This statement applies to both pre-school settings and families and reflects the non-diagnosis led nature of the model. There is no potential list of families who could be eligible, nor of settings attended by a child who could be eligible. In common with other areas explored across the interviews, a lack of recorded data presents a key challenge in identifying patterns in the uptake and implementation of AIM, in this instance in ascertaining trends in relation to non-participation.

Non-participation of families in AIM

Most participants felt that the biggest barrier to participation in AIM was the use of the term 'disability' throughout the information and application forms provided to families. Whilst most participants felt that pre-school settings had a secure understanding of which children may be eligible for AIM, and may benefit from additional targeted support, participants recognised that families may be at a different stage of understanding of the needs of their child:

- Many children who are eligible for AIM do not have a diagnosis and may not previously have engaged with professionals in relation to their needs (4)
- Families may not be aware of their child's emerging areas of need, the ELC practitioner may be the first person to discuss this with them (4)
- Most participants recognised that the term disability was viewed negatively by many parent/carers or was not a term they associated with their child (25)
- Parent/carers are concerned that their child is being 'labelled' and are worried about the future implications of this (4)
- Some participants felt that parent/carer responses reflected wider societal views and stigma associated with 'disability' (12)

In spite of the perceived negative reception of the term 'disability' participant views were mixed regarding whether the language used should be revised. A minority of participants felt the use of the term 'disability' was important as it signaled that targeted AIM support was intended for children with complex needs. In addition, a minority of participants felt that it was right that the term be used as this helped to counteract some of the negative stereotypes and stigma associated with disability; failure to use the term reduces visibility and positions children with disabilities as outside accepted society. On the other hand, a minority of participants felt that the rephrasing of the communication of AIM around children's needs could be more acceptable to families and would still reflect the needs-based approach of AIM. This would represent a gentler way to communicate with families and would also recognise that for some children their needs may be acute and not constitute a disability:

> 'Parents are put off by the term disability, some choose not to apply for AIM when filling in the forms as they do not identify their child as disabled.'
>
> [Early Years Specialist]

In contrast, families of children with more complex needs were identified as not participating in AIM due to a limit on the level of support offered. Some participants felt that there remained concerns amongst parent/carers regarding the suitability of a mainstream pre-school setting for their child. In addition, for some children the access to the specialist support that they require is not yet available

within AIM. Participants who worked in direct contact with families identified a number of examples which led to non-participation in AIM by families:

- There were broad concerns held that mainstream pre-school settings do not provide enough support for children with complex needs (3)
- Parent/carers fear they will lose access to the therapeutic supports that are provided in specialist pre-schools[57]. The perceived lack of availability of therapeutic support further compounds this issue if mainstream pre-school settings are not offering assurance that therapy will be provided in the way that specialist pre-schools can (4)
- Families of autistic children may choose to attend a specialist setting with expertise in ASD that is not currently present in mainstream pre-school settings (2)
- Where families have wanted to attend a mainstream pre-school setting, in some cases they have been unable to as the nursing support that they require to meet their medical needs was not made available through AIM. Although a pilot study has been conducted in 2021 to provide nursing support in pre-school settings, at the time of writing this had not been evaluated or rolled out more widely (5)
- When applying for AIM support, families are asked to complete a strengths profile. Due to the format and questions asked, the parent/carers of some children with complex needs are only able to select the option ‘never’ when responding to the statements describing what their child can do. This was felt to further reinforce the fact that the child could not participate meaningfully in mainstream pre-school as they did not have any of the strengths identified. The impact of completing this profile on families of children with complex needs and the message that it communicates about their child should not be overlooked (4)

The findings suggest that revisiting the communication strategy of AIM presents a solution to non-participation in AIM. Most participants felt that families needed to hear more reassuring messages, in a softer way. For some parent/carers, the identification that their child requires targeted support can be unexpected and provoke fear as there are so many unknown factors. The clear message that needs to be communicated is that there are supports available which respond to the individual needs of the child. Focusing on personalisation and tailored support, rather than labelling is proposed to make AIM more widely acceptable to parent/carers who may be at the beginning of understanding their child’s needs. For families of children with more complex needs, further messages are needed regarding the availability of AIM support.

These messages would not be in contradiction to those communicated to other parents as again the focus should be on providing highly personalised, tailored support in response to the needs of the child. Greater clarity is also required regarding the availability of therapeutic supports for children attending mainstream pre-school settings. It was recognised that parental choice should be respected, but it is important that parent/carers have clear information made available to them to help them reach decisions about the placement of their child. For families, it is important the information communicated to them helps them to picture their child within the context of AIM in order to ascertain what benefits participation could provide to them.

Non-participation of settings in AIM

[57] Under the Progressing Disability Services (PDS) programme, a Health Care Professionals (HCP) service is to be provided based on need rather than diagnosis, with the intention that this service is to be delivered where the child lives or goes to school.

When discussing the non-participation of settings in AIM, participants referred to the lack of uptake of targeted supports across Levels 4-7. Whilst participants did not feel that there were regional variations regarding the uptake of AIM support, they did feel that there were some types of settings which were less likely to avail of AIM. Throughout the interviews it was noted that participation in AIM was discussed in relation to availing of AIM support, rather than not adopting an inclusive ethos or failure to offer places to children with additional needs or a disability.

Single provider settings were identified by the majority of participants as one type of setting who may choose not to avail of AIM, particularly in relation to hiring an additional adult through AIM Level 7. These ELC settings were typically those run by childminders from their own home or small providers with just one member of staff. A key reason identified for these settings not availing of AIM was that they do not want to become employers or become a registered business. It was identified that this additional responsibility came with significant costs, tax implications and the need to be additionally aware of employment law. As a result, small settings may not feel that accessing AIM Level 7 would be of significant benefit to them. Most participants were keen to recognise that the lack of engagement with AIM Level 7 did not reflect a lack of quality. It was identified that many small ELC settings were embedded within the local community and were well attuned to the needs of the children. It is not possible to ascertain the exact numbers of small ELC settings who could apply for AIM Level 7 but choose not to as the numbers of eligible children are unknown. However, some participants reported that single providers were inclusive and supported children with additional needs but simply felt that AIM Level 7 was not something they wanted or required. In theory, small ELC settings could apply instead to reduce the ratio in the room from 1:11 to 1:8 however, participants were not able to identify reliable trends to ascertain whether or not single provider ELC settings were choosing to do this.

Some participants reported that the lack of availability of qualified staff presented a barrier to engagement in AIM Level 7. Whilst pre-school settings may be successful in their application for AIM Level 7, this does not guarantee that supports will be made available to the child if a member of staff cannot be recruited. It was identified that there is a chronic shortage across the ELC workforce, and that retention of skilled and experienced staff is highly challenging. The pay and working conditions for ELC practitioners was referred to by most participants as a significant contributor to the challenge of recruiting and keeping staff. Participants explained that the fixed term contract offered to ELC practitioners who undertake the additional adult role within AIM Level 7 lacked job security and were not adequately rewarded financially for undertaking the role. Pre-school settings are only able to offer an additional adult the maximum of a 15-hour contract for 38 weeks of the year through AIM Level 7. It was noted by some participants that the pay for ELC practitioners was only marginally above minimum wage and that often they would be better off financially if they were to seek employment in a primary school or in the retail sector. Urgent action is required to secure the retention of skilled and qualified ELC practitioners through enhanced pay and working conditions. Failure to do so risks limiting the support available to children through AIM as pre-school settings are unable to recruit the staff, they need in order to provide AIM Level 7 support.

Some participants noted that they had observed patterns in the uptake of AIM Level 4. It was identified that a high number of pre-school settings will apply for AIM Level 4 and 7 in combination with one another. On the other hand, a minority of pre-school settings choose to apply for just AIM Level 4. It was suggested that Level 7 was being prioritised and targeted by pre-school settings and that applications for Level 4 were viewed only as being a pathway to securing the highest level of support. In addition, the EYS felt that some ELC settings do not want external services coming into their setting so may avoid applying for AIM Level 4. This was attributed to the potential lack of relationship between the EYS and the setting or a lack of understanding of the support and mentoring that the EYS are able to provide.

Whilst AIM Level 7 presented a challenge to engagement in AIM for some pre-school settings, the participants felt that the reasons for non-participation in AIM were often less clear cut. There remain a small number of ELC settings who have never applied for AIM. The EYS questioned whether this was due to the pre-school setting managing to meet the needs of children without needing to draw upon additional AIM support, or whether no children with additional needs or a disability had attended. As the EYS have no contact with ELC settings who choose not to participate in AIM, there is currently no mechanism for approaching these remaining ELC settings and making such enquiries. This is potentially problematic if the ELC setting is also choosing not to implement AIM universal support or adopt the inclusive practices associated with AIM Level 1. As discussed further within subsection 8.2, there is currently no mandatory requirement for an ELC practitioner to undertake basic EDI training. Therefore, non-participation in the universal levels of AIM has the potential to have a negative impact on inclusion. Most participants expressed that they were interested to uncover the reasons behind non-participation, and this could help to inform the future developments of AIM, ensuring that no ELC settings or children are overlooked.

In summary, participants perceived that non-participation in AIM affected both families and pre-school settings. The findings revealed that non-participation in AIM by families was associated with the extent to which families have previously engaged with other services and professionals:

- For families who had no prior engagement, the communication of AIM and the use of the term 'disability' was perceived to be a barrier.
- Families at an early stage of understanding of the needs of their child use of the term "disability" does not reflect how they themselves view their child, and in some cases where children have acute needs, it is not the appropriate term to be used.
- In contrast, for families who have prior engagement with services there may be concern regarding the extent to which AIM can provide the specialist support their child needs.
- There was a high degree of uncertainty reported regarding the ongoing provision of therapeutic supports for families who chose to attend mainstream pre-school settings.

Families would benefit from clearer communication and carefully balanced information to allow them to picture their child in the context of AIM. It is proposed that the focus should be on the provision of personalised supports to meet the needs of the individual child. Non-participation in AIM by pre-school settings was discussed in relation to the uptake of AIM Level 7:

- Applications for AIM Level 4 were identified as being linked to applications for AIM Level 7. Only a minority of pre-school settings apply for AIM Level 4 in isolation. Participants perceived this to be part of the ongoing valorisation of AIM Level 7 across the ELC sector.
- For small, single provider ELC settings the lack of uptake of AIM Level 7 was perceived to be due to the owners not wishing to become employers. The costs and additional responsibility associated with becoming an employer did not outweigh the benefit of hiring an additional member of staff.
- For pre-school settings who did wish to recruit a member of staff as an additional adult within the context of AIM Level 7, the chronic shortages present within the ELC workforce presented a barrier. This was attributed to the poor pay and conditions within the ELC sector.
- Finally, it was noted that a small number of pre-school settings had never engaged in AIM. The reasons for this are unclear however this raised concern as there is no way of ascertaining whether this also reflects a lack of engagement in AIM universal support.

8.2: AIM Level 1: Universal supports in the pre-school

The following subsections explore participants' perceptions of AIM's implementation and impact across each of its levels (1-7). A summary of AIM's levels is provided in subsection 2.5.

Some participants observed that whilst much of the focus on AIM is often on securing targeted supports, it is AIM Level 1 which underpins the attitude and culture within ELC settings. In 2018 the AIM Inclusive Play pack and guide was distributed to over 4000 pre-school settings. Most participants reported these as being very well-received. Some participants described the pack as encouraging ELC practitioners to experiment and try out different resources or strategies with children that they may not have previously considered. The associated training materials and guide continue to be available to all pre-school settings on the AIM website.

Leadership for INClusion in the Early Years (LINC) Programme

There was widespread praise for the LINC programme. Most participants felt that the high-quality nature of the course was reflected in the numerous awards that it had won. The LINC programme was also deemed by the majority of participants to be well received within the ELC sector, with high annual demand for places. A minority of participants praised the fact that there is no requirement for there to already be a child within the pre-school setting with a disability or additional needs in order for an ELC practitioner to participate in the course. This was identified as reflecting that AIM is not diagnosis-led. Participants view this as a commitment to building capacity and preparing pre-school settings to be open to supporting the needs of all children.

Some participants criticised LINC as a conferment of a Level 6 Special Purpose Award. Completion of the LINC programme currently allows ELC practitioners to undertake room leadership responsibility. Some participants voiced the following concerns:

- Some participants observed that completion of the LINC programme was being used as a "short-cut" route to acquire a fully funded level 6 qualification (5)
- A minority of participants felt that the LINC programme did not contain the same volume or breadth of content as other equivalent ELC level 6 qualifications (4)
- A minority of participants felt that the minimum qualification requirements for room leadership responsibility should be raised to QQI Level 8. It was suggested that there were clear benefits to having a member of staff in the pre-school setting with a degree level qualification. However, it was acknowledged that the pay and conditions would need to be increased in order to secure recruitment of highly qualified staff (3)

In spite of the praise for the LINC programme, some participants voiced concerns regarding the difficulty of retaining ELC practitioners after they had completed training. The LINC programme itself was reported to have a high retention rate from registration to graduation; around 90% of those who start the course complete the training successfully. However, there is observed to be a significant "leakage" from graduation to undertaking the INCO role. It was suggested by one participant that between 30 and 42% of those who graduate from the LINC programme do not go on to be recorded as undertaking an INCO role within a pre-school setting. The exact figures and year on year trends could be identified through examining the uptake of higher capitation within pre-school settings. It was suggested by some participants that ELC practitioners leave the sector once they have achieved the Level 6 Special Purpose Award as they are able to obtain better pay and working conditions elsewhere. Consequently, a key challenge for the long-term implementation of AIM lies in retaining trained and qualified staff. Meanwhile, in the shorter term there will be a continued need to fund LINC programme on an annual basis to replace those who leave the profession.

The INCO role was recognised as being a valuable part of AIM Level 1. Some participants felt that the strength of the INCO role was that it brought a leadership role into pre-school settings. This meant that there was a single point of contact within settings for families and other ELC practitioners for advice and support regarding additional needs and disability. Participants also identified that the enhanced knowledge and skills gained through completing the LINC programme could be cascaded within pre-school settings amongst staff. Consequently, participants felt that the INCO role had a positive impact on increasing quality and inclusive practice within pre-school settings.

However, a minority of participants noted that having the qualification awarded did not mean the role was being undertaken with fidelity in the pre-school setting. A number of barriers to the INCO role were identified by participants:

- The INCO role carries responsibility, however, pre-school staff undertaking the role do not get paid cover or release time to undertake the tasks associated with the role, such as, conducting observations, completing administrative tasks, and undertaking meetings with parent/carers or other service providers (3)
- The INCO role was identified to work well when an ELC practitioner had time to act as a 'floating' member of staff in addition to the room ratios. However, it was noted that the higher capitation provided to many pre-school settings, of two euros per child per week, was insufficient to allow this to take place (4)
- The EYS interviewees felt that the INCO role had greatest impact when undertaken by a designated member of pre-school staff with no other responsibilities (4)
- In many pre-school settings, the INCO role is undertaken by the owner or manager of the service. This represents an unequal distribution of training and responsibility. Owner/managers have significant responsibilities and commitments outside of the INCO role (3)
- Most pre-school settings are only able to send one member of staff on the LINC programme. A minority of participants felt that this contributes to training being undertaken by the owner/manager of the ELC setting as it is more likely that this member of staff will be retained following graduation. In response to high demand from pre-school settings, there are some instances when an additional member of staff may apply for a funded training place (3)

EDI Training

Free-of-charge CPD for pre-schools is also delivered in the form of Equality, Diversity, and Inclusion (EDI) Training. This is supported by the Diversity, Equality and Inclusion Charter and Guidelines for Early Childhood Care and Education, (DCYA, 2016[58]), and by training that is delivered by regional CCCs. Some participants felt that there is an initial misconception where people think they already know what EDI training is about, but once they start the course, they are able to reflect upon their experiences, learn and benefit from taking part.

> 'It's based on the anti-bias approach, it's so important for staff to have the time to reflect on their experiences, their own values, you know, and the experiences and values of their co-workers.'
>
> [CEO Waterford CCC]

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[58] Department of Children and Youth Affairs (2016) *Diversity, Equality and Inclusion Charter and Guidelines for Early Childhood and Care Education.* [Online]. Available at: https://assets.gov.ie/38186/c9e90d89d94b41d3bf00201c98b2ef6a.pdf. Accessed 05/12/2020

Participants perceived mixed responses to the EDI training within the ELC sector. These were summarised as:

- Large regional variations were reported in the uptake of EDI Training sessions. Whilst some areas are able to fill course places, other areas report there being no demand (4)
- During interview, EDI trainers reported that in some rural areas uptake of training was low as pre-school settings did not consider themselves to be in an area of diversity and therefore did not require training. The EDI trainers confirmed that these were the types of misconceptions that the training sought to address in order to promote inclusive practice (4)
- A few participants identified that although online materials and resources are offered in both the English and Irish language, the EDI training itself was only delivered in English. This was identified as a potential barrier to engagement by Irish Medium settings whose funding stipulates that they may only attend training delivered in Irish. It was also felt that this lacked respect for the first language of many ELC practitioners (1)
- Some participants felt that the length of the course was too long. The course duration comprises one whole day and three evening sessions. It was felt that this commitment was off-putting to ELC practitioners (10)
- Whilst EDI training itself is funded, the time ELC practitioners spend completing the training is not reimbursed. In contrast, the LINC programme includes reimbursement for time spent during training. Some participants felt strongly that this was why EDI training was overlooked or seen as less important within pre-school settings (8)
- EDI training is not compulsory and there is no requirement for pre-school settings to send any staff on the course. A minority of participants felt that EDI training should be a mandatory requirement and monitored by Tusla (3)

Going forward, participants believed that the revision and updating of EDI training should be prioritised. A review of the current EDI training was conducted in 2020, however, subsequent actions are yet to be taken. It is understood that this is in part related to the COVID 19 pandemic which saw all EDI training suspended in March 2020. During interviews, participants made the following recommendations for revising the EDI training:

- A blended delivery approach was identified as offering participants greater flexibility in their participation, whilst also ensuring that they have opportunities for discussion and engagement with other ELC practitioners (5)
- Some participants felt that the length of the EDI training could be reduced, or the timings changed from weekend and evening delivery (10)
- Some participants felt that the issues and topics covered within the EDI training could be brought up to date. It was noted that there had been significant societal changes since 2016 and that training should be refreshed to take account of these (4)
- A 'Communities of Practice' approach was suggested as a potential model that could be adopted within training (2)

Some participants observed gaps between the EDI training and the LINC programme offered within the context of AIM Level 1. Whilst EDI focuses on the broad nature of equality, diversity and inclusion, participants believed the LINC programme is focused primarily on disability. Participants suggested that this presents a challenge where a member of pre-school staff completes just one of the pieces of training and not both as there may be gaps in their knowledge and understanding. In addition, it was suggested that this further reinforces the idea that AIM is primarily for children with a disability and overlooks the importance of universal support.

This apparent prioritising of targeted support within AIM Level 1 training was felt to be further reflected in the financial incentives offered for those who complete the LINC programme rather than EDI training. Once complete, pre-school settings whose staff complete the LINC programme are eligible for higher capitation, whereas there is no financial reward or recognition for those whose staff only complete the EDI training. Whilst participants understood that the LINC programme constituted a level 6 qualification, and required a higher level of ongoing commitment, it was suggested that the incentives for engaging in training and CPD be revisited as they were currently deemed to be sending the message that inclusive practice and AIM universal support was of less importance than targeted support. The tensions between the CPD and training offered within AIM Level 1 relate to wider issues related to the professionalisation of the ELC sector.

Whilst the introduction of additional roles, including the INCO as a leadership role, was largely seen as a positive move by the majority of participants it was also noted that greater clarity was required regarding the scope and expectations associated with these. The INCO role carries with it a title and level of professional status that other roles within the ELC do not. The role of the additional adult employed through AIM Level 7 currently has no official title and was referred to throughout interviews interchangeably as the “AIM worker”, the “AIM support” or the “additional adult” (see also subsection 8.8). The lack of an official title for those ELC practitioners carrying out a highly important role with children with the highest level of need signifies a lack of respect for the role. Additionally, it risks leading to children who are supported within AIM Level 7 as being marginalised as “the AIM child”, which is in direct opposition to the inclusive values of AIM.

Despite carrying an official title and significant responsibility within the pre-school setting, participants were unsure how to ascertain that the INCO role was being carried out with fidelity to AIM or the LINC programme. Furthermore, as training opportunities are offered, and sections of the ELC workforce are increasingly professionalised, there is a risk that highly trained and qualified staff will be lost due to current challenges associated with pay and working conditions. Consequently, there is a need for wider recognition of the range of roles within the ELC sector.

Participants viewed AIM Level 1 as foundational to inclusive practice in pre-school settings. The findings suggest that the LINC programme has increased capacity in the ELC workforce. However, participants expressed mixed views regarding the outcomes and impact of the LINC programme:

- The LINC programme was perceived to be high quality and well received within the ELC sector.
- Some participants voiced concern over the retention of graduates beyond the LINC programme; the Level 6 Special Purpose Award allows practitioners to secure work outside of the ELC sector in other professions with better pay and working conditions. As a result, there is an ongoing need to fund places on a rolling basis until the underlying causes of attrition are addressed.
- Successful completion of the LINC programme allows ELC practitioners to undertake the INCO role. This role was viewed as providing leadership and expertise on disability within ELC settings.
- Some participants raised questions regarding the fidelity of the INCO role across pre-school settings.
- The INCO role was observed to have most impact when undertaken by a dedicated member of staff, awarded the time to fulfill the responsibilities of the post.

Participants held mixed views regarding the EDI training:

- The content of the course sought to broaden knowledge and understanding of inclusion.
- There are regional variations in the uptake of the course.
- Participants felt that difference in financial reward between the EDI training and the LINC programme contributed to the diverse levels of uptake observed.
- A minority of participants proposed EDI training should be mandatory in order to secure a commitment to inclusive practice across the ELC sector.

The challenges associated with the training and retention of ELC practitioners are situated within wider issues related to the professionalisation of the ELC sector. Whilst the introduction of the INCO role is believed to have a positive impact on quality, greater clarity is required regarding the scope and expectations of other practitioner roles within the setting.

8.3: AIM Level 2: Information for parents and carers

The purpose of AIM Level 2 is to provide information to families. Participants identified that the DCEDIY had updated its AIM Information Site in 2021 to make it easier to navigate for parent/carers and ELC practitioners. This was in response to user feedback and the recommendations of the end of year one review of AIM (DCYA, 2020[59]). Some participants felt that the previous website was difficult to navigate and lacked step-by-step information regarding the application process. In contrast, most participants felt that the updated website had a greater balance of visual content and was more engaging and user-friendly. However, a minority of participants were mindful of the fact that not all families have access to the internet. As a result, the enhanced website may be seen as just one

[59] Department of Childhood and Youth Affairs (2020) *End of year one Review of the Access and Inclusion Model.* Dublin: DCYA

method for providing information within a wider communication strategy. Interagency collaborative working was seen as essential in ensuring that information about AIM was disseminated widely amongst families. The CCC were identified by most participants as key project partners in providing information at a local level:

- The role of the CCC was described as including the delivery of workshops, engagement with families, toddler groups and ELC providers. Funding is provided to the CCCs to commit to 3.5 hours of communication, per pre-school setting (5)
- A few participants referred to the CCC as the 'neutral' party in promoting the AIM programme (2)
- The CCC were viewed as delivering a consistent message regarding AIM, in line with the communication guidelines. A minority of participants suggested this demonstrated that the CCC were well equipped to roll out information nationally in a consistent manner (5)

It was identified that parent/carers were at different stages of knowledge and understanding regarding AIM. Communicating sensitively and providing clear information was identified as important to ensuring that families are able to participate in AIM:

- Most participants felt that parent/carers had very little knowledge or understanding of AIM prior to their child starting pre-school. Consequently, when parent/carers are initially approached regarding applying for AIM support this can be met with confusion and sometimes distress as families are informed for the first time that their child may have additional needs or a disability (25)
- Communication was identified as a key solution to non-engagement in AIM by most participants. For families who are learning about their child's emergent needs for the first time, it was identified that gentle communication and reassurance is needed. It is not possible to make an application for targeted AIM support (Levels 4-7) without parental consent (4)
- Most parent/carers do not like the use of the term "disability" within the information leaflets and application forms for AIM. For many, this does not reflect how they see their child and they find this off-putting (25)
- When interviewed, the EYS identified that some ELC practitioners used terms such as "extra support" or "a bit of extra help" when communicating to parent/carers about AIM in order to reduce the focus on the term "disability" and encourage parent/carers to consider applying for AIM (4)
- Some parent/carers are very proactive in seeking out supports for their child. The biggest challenge for them lies in navigating through the system and understanding how to apply for different types of support. For some parent/carers, having clear information can make the difference between applying for a mainstream or specialist pre-school setting (6)
- A minority of participants identified that there is a lack of side-by-side information which allows families to compare the different provision available to them. In addition, it is not always clear to parent/carers which services they will "lose" if they attend a mainstream pre-school setting and avail of AIM, rather than attending a specialist setting (3)
- A minority of participants felt the current communication regarding AIM focused primarily on targeted support (Levels 4-7), rather than the universal support (Levels 1-3) (3)

Future developments for AIM Level 2

Given the large number of families who appear to lack knowledge of AIM prior to starting the ECCE Scheme, it was proposed by most participants that other services and organisations could play a role in sharing information. Communication and different forms of engagement are needed from a range of professionals that the parent/carer encounters. Within primary healthcare this could include the GP

and public health nurse. Equally, it was recognised that for some families who do not have internet access at home, the library service can provide a valuable resource so it would be beneficial to have information regarding AIM available in this environment too. Making families aware of AIM prior to starting the ECCE Scheme, irrespective of the needs of the child would help to increase awareness of the programme's universal and targeted supports. Should a family later need to avail of AIM, their existing awareness would play a supportive role. A recommendation is made that all organisations, services, and professionals who have contact with families from birth are appropriately briefed regarding AIM's universal and targeted supports. This will ensure those who engage with families have accurate and up-to-date information about AIM that can be shared.

The findings demonstrate that communication plays a key role in ensuring AIM reaches the intended cohort. Participants held the following views regarding the information provided to parent/carers:

- The revised AIM website adopts a more user-friendly interface. This now includes greater information for parent/carers and ELC practitioners regarding universal and targeted support and the application process.
- Interagency collaborative working was seen as essential in ensuring that information about AIM was disseminated widely amongst families.
- The CCC were identified by most participants as key project partners in providing information at a local level.

Participants identified the following barriers to communication:

- Parent/carers were often at different stages of understanding regarding the needs of their child.
- For some families, the use of the term "disability", was not well received and contributes to non-participation in AIM.
- Clearer side-by-side information is needed to allow families to make informed decisions regarding placement of their child in a pre-school setting.

Most participants perceived that parent/carers did not have knowledge or understanding of AIM prior to their child starting in a pre-school setting. It was recommended that all organisations, services, and professionals who have contact with families from birth are briefed regarding AIM's universal and targeted supports. This will ensure that those who engage with families are able to contribute to sharing information about AIM.

8.4: AIM Level 3: A qualified and confident workforce

Participants felt that there was a 'hunger to learn' within the ELC sector. This was observed in the strong uptake of CPD training by ELC practitioners. Participants identified that the introduction of AIM Level 3 marked the first time that ELC practitioners have been paid to do CPD and this communicated a level of professional respect for their role. Collectively, participants identified that engagement with funded AIM Level 3 training had a positive impact in the following areas:

- Practitioner knowledge and confidence is increased (16)
- Pre-school settings are more open to children with a disability (16)
- The training on early language development was noted as being integrated into practice. Where ELC practitioners had engaged in Hanen, HSE representatives noted that they were more likely to implement the strategies recommended by therapists within the pre-school setting (2)
- A minority of participants felt the content of the CPD offered within AIM Level 3 was of great support to all children in the pre-school setting (4)

- Some participants perceived that the CPD increased practitioner awareness and understanding of inclusive practice (8)

Whilst the existing training available within AIM Level 3 was well received, it was identified that a rolling programme of training is required to allow staff to upskill and develop over time. For example, staff may have completed Lámh previously but not used this in the past year so may wish to refresh their knowledge and skills. Equally, given the high attrition rate within the ELC workforce it is important that pre-school settings are able to maintain training levels across their staff.

Future developments for AIM Level 3

It was also proposed that more specialist CPD be offered to settings across a greater range of areas. Some participants identified that a training bursary could be awarded to pre-school settings to allow them to select from a range of courses, choosing which opportunities they would like to apply their bursary funding towards. The benefit of this approach is that it would allow CPD engagement to be responsive to the needs of the children within the pre-school setting. Collectively, participants identified that the following areas could be addressed through a broader catalogue of CPD:

- **Autism specific training:** Most participants identified that there was a great demand for specialist training to support the needs of children awaiting assessment or in receipt of diagnosis of autistic spectrum disorders. The four EYS who participated in interviews indicated that this reflected the single biggest group of children on their caseload.
- **Medical needs training:** Participants felt that there was a need to balance out training with responsibility. It was recognised that as part of the commitment to inclusive practice there were more likely to be children within mainstream pre-school settings with medical needs which would require practitioners to have additional skills and expertise. Due to the diverse range of different medical needs, this block of training could contain different training components including epilepsy, allergies, diabetes, and peg feeding.

It was identified that the AIM project team are reconvening a working group in order to further identify where gaps in CPD exist and how these might be addressed. Interagency working was recognised as being key to this due to the different areas of expertise held by those working across different sectors. For example, it was suggested by some participants that the HSE could play a role in informing the development of workforce competencies related to the therapeutic needs of children.

Participants identified that AIM Level 3 responded to the ‘hunger to learn’ within the ELC sector. The findings demonstrate that CPD contributes positively to workforce capacity development. Participants made the following observations regarding CPD:

- Practitioners are currently able to engage in CPD opportunities including Hanen, Lámh and SPEL. The courses are reported to have high levels of uptake.
- Participants identified that the impact of CPD could be seen in increased levels of ELC practitioner confidence, knowledge, and skills.
- CPD was perceived to increase the openness of pre-school settings to children with additional needs and/or disability.
- CPD strengthens the quality of universal provision for all children.
- Training regarding ASD and complex medical needs were priortised as further areas that would benefit the ELC sector.

Some participants suggested that an annual training bursary could be awarded to pre-school settings to enable them to pursue the areas of training which responded to the needs of the children in their setting. When the training working group reconvenes an evaluation is required of where the current gaps in training lie. It is proposed that further interagency working, which is central to the philosophy of AIM, could generate further high quality CPD opportunities for the ELC sector.

8.5: AIM Level 4: Expert early years educational advice and support

Better Start comprises of a team of EYS and Team Leaders who work directly with providers in a mentoring role to build their capacity to deliver high quality, inclusive ECCE for children and their families. EYS have a designated caseload and work collaboratively with ELC practitioners to develop practice guided by the core elements of *Síolta* and *Aistear*. EYS also support settings in their implementation of AIM and plays a role within the application process for targeted supports. Participants felt that AIM Level 4 runs alongside and complements the workforce development and training offered within AIM Level 3, with one participant describing AIM Level 4 as putting 'theory into practice'.

> 'You know, the longer the services are with you that they start to generalise the skills, learning, education, the training, strategies… It's all about building culture.'
>
> [Early Years Specialist]

EYS have a key role in building capacity within the ELC sector. A central part of this is achieved through the development of positive relationships with pre-school settings. Participants described that as part of this relationship ELC practitioners may experience coaching, mentoring or demonstrations with the EYS to increase their knowledge and experience. During interviews with EYS and Team Leaders, it was identified that over time pre-school settings require less support as their own capacity grows and strategies become embedded within practice. Whilst every ELC service has a different starting point the goal of the work of the EYS was described as providing support to create a confident and capable workforce. The support role of the EYS was viewed as fundamental to AIM.

The EYS also have a role in assessment when pre-school settings make an application for targeted support at Levels 5, 6 or 7. In initial contact with settings, the EYS will explain the different levels of support and what is available to pre-school settings. It was identified that a key component of this work is intended to clarify any misconceptions, particularly around the provision of Level 7 as an additional adult for the room rather than as a 1:1 support for the child. Following application for targeted support, the EYS will visit the pre-school setting and observe the child in order to understand the child's needs in the context of the setting:

> 'The assessment process is key to ensuring that we are responding to need – not diagnosis driven. They understand practice and ELC and assessing need for additional support.'
>
> [Principal Officer EY Quality Unit]

In the past year, changes have been made to the assessment process where observations have not been possible due to the COVID 19 pandemic. This has led to the EYS being in direct contact with parent/carers regarding their child's needs rather than conducting observations in person. Contact with parent/carers has typically taken place through phone or video call. Whilst the central purpose of assessing the needs of the child has not changed, previously contact would take place through the pre-school setting. When interviewed, the EYS and EYS Team Leads had mixed views regarding this change in practice and whether this should continue in the future:

- A few felt that this was a positive change as it allowed parent/carers to share their views more openly. This helped to build a clearer and more holistic picture of the child (2)
- A few EYS felt that they heard a greater range of the child's strengths and interests from parent/carers. This was deemed useful as the EYS could then share this information with the ELC setting, using it to provide support and suggest strategies (2)
- A minority of participants suggested that challenges could occur when parent/carers bypass the pre-school setting and seek support and advice directly from the EYS. They identified that

the EYS is not a permanent source of support for the family and that the relationship between the family and the pre-school setting is important to preserve (3)
- Should direct contact with parent/carers continue it is necessary to consider the training needs of the EYS in managing the expectations of parent/carers and strategies for delivering clear information regarding AIM (3)
- If the contact between families and the EYS were to continue, this provides an opportunity to clarify misconceptions and outline the support AIM can offer (4)

Challenges to the EYS role

During interviews, a number of challenges were identified which limited the impact of the EYS role. It was identified that there remained a number of pre-school settings who did not wish to engage in AIM Level 4. Participants did not feel that this reflected regional variations or that there were trends associated with the type or size of pre-school setting. However, it was questioned whether this lack of engagement may have a negative impact on quality and inclusive practice if some settings did not access advice and support. Participants observed that:

- A high number of pre-school settings will apply for AIM Level 4 and 7 in combination with one another (4)
- A minority of pre-school settings choose to apply for AIM Level 4 in isolation (4)
- Level 7 appeared to be prioritised and targeted by pre-school settings, with applications for Level 4 viewed as being a pathway to securing a higher level of support (4)
- The EYS felt that some ELC settings do not want people coming into their setting so may avoid applying for AIM Level 4. This was attributed to the potential lack of relationships between the EYS and the setting or a lack of understanding of the support and mentoring that the EYS are able to provide (3)
- Some pre-school settings were described as “evasive” once they receive Level 7 funding, no longer wishing to engage with the EYS (3)

It was noted that throughout 2021 Better Start had adopted a blended (online and face-to-face) approach to training and coaching and this had signs of being well received. As a result, it was suggested that developing this approach further may increase engagement in AIM Level 4. One of the reasons engagement in Level 4 is deemed to be important is due to the potentially key role the EYS can play in ensuring the fidelity of the implementation of AIM in pre-school settings. Currently there are very high numbers of AIM Level 7 awarded to children; however, concerns exist that the implementation of support does not reflect the underlying principles and purposes of AIM (see subsection 8.8). Equally, pre-school settings may benefit from support and mentoring in order to maximise the impact of the additional adult in the setting, a role that the EYS could fulfil after AIM Level 7 has been awarded. It is therefore identified that maintaining ongoing contact with pre-school settings through a series of follow-up visits subsequent to the awarding of AIM Level 7 could be worthy of consideration.

A further challenge to the role of the EYS was identified as the high caseload numbers and peaks in applications at key points in the year. It was identified that this was in part due to the much higher uptake of targeted supports than initially predicted. This can have a negative impact on their ability to respond to applications and enquiries from pre-school settings at times. Some of the EYS identified that the large geographical areas they covered reduced the amount of time they had available to spend in pre-school settings, however, the shift to blended supports through phone or video call has been beneficial in helping them to manage their caseload. It was recognised that steps had been taken to recruit additional staff that would enable caseloads to be reduced. The EYS felt that mentoring was an important aspect of their role and that it was important that sufficient time was

allocated to enable them to carry this out in pre-school settings to maximise the impact of their support.

Future developments for AIM Level 4

The role of the EYS within AIM Level 4 has developed since the introduction of AIM in 2016. In the first few years of AIM, the focus was primarily on sharing information and supporting applications for targeted support. The AIM National Team Lead for Better Start described this as akin to firefighting due to high caseloads and intensive support for making AIM Level 7 applications. This work has ensured that AIM is embedded within pre-school settings and the EYS who participated in interview confirmed the majority of pre-school settings understand the AIM application process for targeted support. More recently, the role of the EYS has taken greater focus on supporting the implementation of inclusive practice. The focus for the EYS and Team Leaders going forward will be on providing mentoring to ELC settings and practitioners to enhance inclusive practice.

As the future role of the EYS relates to developing the practice of others, it was also noted by some participants that there should also be support for the EYS to carry out their role effectively. It was suggested that they themselves may require support and development opportunities as reflective practitioners to deliver high quality coaching and mentoring to others. If their future role were to continue to involve engagement with families, this could also be an area for development. A few participants suggested that there remains a future piece of work to be completed in collaboration with the HSE to increase the knowledge of the EYS in therapeutic supports and medical needs. This has potential to enhance the breadth and quality of the support and advice that is provided to pre-school settings. Representatives from the HSE identified that the EYS were the first to meet the child and it was suggested that they could play a key role in early identification of need.

The findings demonstrate the key role the EYS play in building capacity within the ELC sector. Whilst participants identified the value of the EYS, they perceived limitations in the uptake of AIM Level 4:

- The provision of coaching, mentoring and support to pre-school settings facilitates the inclusion of children.
- The EYS develop positive relationships with pre-school settings.
- However, there is a tendency for AIM Level 4 to be overlooked in favour of higher levels of targeted support, in particular AIM Level 7. This presents a challenge if AIM is not implemented with fidelity.
- It was proposed that the EYS could have a continuing role in monitoring and supporting the implementation of AIM targeted supports beyond the point at which AIM Level 7 is awarded.

Recent changes due to the COVID 19 pandemic have seen the EYS take a more blended approach to support including the use of phone and video calls to pre-school settings. EYS have also had greater contact with parent/carers during the application process for targeted supports. Whilst this is reported to have benefits in building a holistic picture of the child, the EYS did not wish this to be at the expense of existing relationships between families and the pre-school setting.

8.6: AIM Level 5: Equipment, appliances, and minor alterations grants

Participants viewed AIM Level 5 as fundamental to building an inclusive environment. Applications can be made for physical resources and alterations to make the ECCE learning environment more accessible for children with disabilities/additional needs. For example, building alterations might include the installation of a hoist, a wheelchair ramp or door widening. Additionally, applications for equipment may include hearing loops, sound systems, specialised chairs, play equipment and standing frames. Where settings are awarded a grant for equipment, training in the use of the equipment is provided free of charge, but single items costing less than €50 are not eligible under AIM Level 5.

Since the introduction of AIM in 2016, applications for AIM Level 5 have been lower than predicted. Some participants were surprised by this trend as research had suggested that not all ELC services are suitably accessible for children. In addition, it was felt the Universal Design guidelines issued do support ELC providers to think about accessibility in this way and do include prompts which settings can utilise to evaluate their setting's accessibility. Participants suggested several different explanations for the lack of demand for AIM Level 5:

- Declining numbers of requests for capital grants may be due to the required changes to the learning environment being completed. For example, once a ramp is in place within a pre-school setting there is not subsequent need for a further application (5)
- A minority of participants felt that some pre-school settings may not wish to engage in large building works if the child is only attending for one year (3)
- Further applications for capital grants were predicted by a few participants to continue to remain low due to the introduction of new Tusla regulations for the physical environment of new pre-school settings (2)
- Participants identified that there were barriers to ELC settings in the application process as they were required to provide proof from a medical professional, letters of recommendations, and information regarding the child's needs. This places a burden on ELC settings to source and organise information (6)

Despite the low demand, participants agreed that pre-school settings had a very good understanding of the purposes of AIM Level 5. Some participants felt that the application process itself was clear and easy to follow. However, it was noted that a significant degree of responsibility was placed on the ELC service to coordinate with other external services in order to complete the assessment process. Some participants felt that AIM Level 5 constituted an example of underpinning principles of AIM working well and with fidelity as pre-school settings were able to apply for specific support in response to the needs of the child. Participants provided examples of positive outcomes for children including the installation of ramps, the installation of an audio loop and the provision of a specialist feeding chair to meet the needs of the child.

Significant delays were reported by participants to exist within the application process for AIM Level 5 support. This led to pre-school settings expressing frustration that they were not able to obtain the equipment or resources they needed to support the child. Although ELC settings are able to make applications and understand the requirements placed upon them, once this application is submitted there are long waits associated with having the environment assessed and a report being issued to confirm the suitability of the equipment. Following this there are reported to be further delays in waiting for the equipment to arrive. A representative from Pobal suggested that the process of assessment and procurement can take around 12 weeks to complete following application.

Participants therefore expressed concern about the delays within the application process and the barriers to inclusion this presents:

- The child may not be able to access the same areas within the ELC environment as their peers. This reduces their opportunity to meaningfully participate and experience full inclusion (6)
- A minority of participants expressed concerns regarding unsafe practices whilst the ELC setting wait for equipment to arrive, with both the safety of the ELC practitioner and child being put at risk. This is a particular concern due to the aspects of manual handling involved in the personal care of young children (3)
- Delays can lead to equipment being the incorrect size by the time it is delivered. The example of a made to measure chair was provided by one participant; however, this observation was reported to be widespread by a number of other participants (6)

A few solutions were suggested by participants to speed up the application process. The EYS identified that the EYS Team Lead can act as a link to AIM Level 5 and can be contacted to investigate delays. It was also suggested that pre-school settings were advised to apply for equipment in the summer prior to the child starting in September to avoid delays. However, a challenge of this proposal is that as assessment is required of both the child and the physical environment, this can be challenging to organise if the child is not physically attending the ELC setting. In addition, applying before September for made to measure pieces will not remove the challenges associated with the child growing and the equipment not being the correct size.

A further barrier associated with AIM Level 5 is the ownership of the equipment. All pieces of equipment or resources that are not ‘fixed’ are not viewed as belonging to the pre-school setting. This means that they must be returned or sent on to the next setting the child attends once they leave the ELC service. Some participants questioned whether this was a cost-effective approach. Furthermore, some participants suggested that this could be off-putting to pre-school settings as they commit to making the application and going through the application process, but do not receive any long-term benefits as a result. It was also identified that some pieces of equipment, such as a height adjustable changing table, could reasonably be reused in subsequent years by other children in the pre-school setting. However, pre-school settings are not permitted to keep the equipment and re-use this. In some cases, this can lead to a pre-school setting returning the equipment that they have in the summer and reapplying for the same piece for another child in September.

> ‘The equipment remains the property of the department, rather than the setting and there is a cost associated with the transport, storage, collection of equipment. May it be more cost effective to leave it in setting for future children to use as required?’
> [Pobal- Lámh applications and allocations]

Future developments for AIM Level 5

Participants felt that AIM Level 5 had been fairly successful in allowing changes to be made to the physical environments of pre-school settings. The low level of demand, however, suggested that a change in focus was required to ensure that support was available to pre-school settings to increase the accessibility of their learning environments to all children. It was therefore questioned what the future focus or goal of AIM Level 5 should be in order to support inclusion.

The AIM Inclusive Play pack and guide was issued in 2018 to over 4000 pre-school settings to provide a set of relatively low-value sensory resources. At the time, it was noted that pre-school

settings made applications for small pieces of equipment, including sensory toys or adaptions where the actual cost of the items was lower than the costs associated with processing the application. Whilst the pack is no longer issued to pre-school settings, a few participants felt that there was scope to adopt a similar approach through providing a universal contribution toward small pieces of equipment or resources directly to pre-school settings. This could take the form of a fixed value annual grant.

A further suggestion was to allow pre-school settings to make further use of the Universal Design Guidelines to create a better environment for all children. Again, a grant system could be adopted to enable to pre-school settings to pay for alterations or resources for a specific area of the environment. It was proposed that this could lead to the creation of sensory garden spaces, acoustic treatment to walls or the provision of inclusive playground equipment.

In summary, participants identified that the uptake for AIM Level 5 had been lower than initially predicted. Whilst this can be explained in part by the reduced need over time for capital grants to conduct alterations to the physical environment, there remain areas within the application process which may contribute to the lack of uptake:

- The current need to coordinate external services, reports and letters of support place undue pressure and responsibility on the ELC setting.
- Whilst ELC practitioners are believed to have a good understanding of AIM Level 5 and the application process, this was felt to take far too long.
- The delays experienced by ELC settings were identified as unnecessarily presenting barriers to inclusion and have the potential to result in unsafe practices.

Despite this, some participants felt that AIM Level 5 provided an example of the principles of AIM working well: where equipment and resources have been provided, they are in response to individual need and facilitate *meaningful participation* and *full inclusion*. Ideas for the future development of AIM Level 5 were suggested by participants. This included the provision of a fixed annual grant to provide small resources similar to those previously supplied in the AIM inclusive play pack. A further suggestion was to revisit the Universal Design guidelines and allow pre-school settings to pursue projects to enhance areas within the learning environment.

8.7: AIM Level 6: Therapy Services

Participants' view was that AIM Level 6 currently provides support to a very small number of children. Representatives from Better Start identified that where children have particularly complex needs, or it is felt that professional advice is required, a request can be made to the HSE Children's Disability Network Teams (CDNTs). It was explained that the EYS being able to make the referral directly rather than going through the GP or primary health care was an innovation to AIM. However, in the majority of cases it was identified that the child was already known to the HSE and will have received some form of therapeutic support previously.

Some participants spoke highly of collaboration with the HSE. It was identified that they had been involved with AIM from the beginning. The HSE are represented within the CSIG by the National Disability Specialist who is viewed as a respected and highly experienced leader.

Ongoing collaborative work and positive relationships between therapists and the EYS are viewed as important to the implementation of the universal element of support provided by therapists. Some participants identified that this allows advice to be given and strategies to be devised to support the individual needs of children within pre-school settings. One of the Children's Disability Network Managers identified that during such communication it is important that they are made aware of any existing programmes the child has engaged in, such as speech and language therapy, so that recommendations for future strategies to be used within the pre-school setting can be made. It was identified that the overarching goal of AIM Level 6, from the perspective of those working for the HSE was: 'that the child is getting the right support so they can access pre-school and the ECCE programme; that they are involved'.

Despite this, the majority of those working within the AIM project team as delivery agents felt that there was little or no awareness of how children were being supported by AIM Level 6. The views expressed during interview included:

- Some participants who have no direct contact with ELC settings expressed that they were not sure how AIM Level 6 was being implemented but assumed that others who worked more closely with ELC settings would know. These views were also expressed by the Head of the Early Learning and Care and School Age Childcare division for the DCEDIY (16)
- Some participants who work more closely with ELC settings, including those working for the CCC, expressed that AIM Level 6 was the one level that they "heard little about" and that they did not feel that ELC settings were getting any support (10)
- The EYS feel they have very little to do with AIM Level 6. They explained that for a pre-school setting to make referral for targeted HSE interventions (which occurs when the universal HSE supports offered through Level 6 have not been sufficient) substantial form filling was expected from both the pre-school setting and family which often led to no outcome or support. Consequently, they felt that ELC settings' negative previous experiences put them off applying (4). This may explain why applications to Level 6 (targeted) have been undersubscribed and may point to the complexity of the operational process for making referrals (though it is also noted that the protocol for referral includes standard HSE processes designed to ensure fairness in waitlisting).
- Where AIM Level 6 is implemented, a minority of participants felt that the 'output was so small it is negligible' (3)
- Some participants felt that as AIM Level 6 was not very visible or active in AIM, the level should be removed from AIM altogether (10)

Taken together, the views expressed during interview suggest that there was a lack of oversight regarding the implementation of AIM Level 6. It also appeared that there was an incorrect assumption that others had a greater understanding of the implementation and impact of AIM Level 6 and that insufficient questions were asked to challenge this.

> 'Gaps in the AIM model are highlighted and they mostly appear in Level 6 would be my view. Level 6 is access to speech and language therapists and other therapists and so on, which hasn't happened and is a commitment of AIM.'[60]

[CEO Early Childhood Ireland][61]

It was identified that a challenge to implementing AIM Level 6 was that it relies on the wider capacity of the HSE. Participants tended not to see the lack of engagement with Level 6 (targeted) as a matter of undersubscription, but as an outcome of waitlist challenges elsewhere that were impacting on service users engagement with this aspect of AIM.[62]

Additionally, it was explained that there were challenges experienced when children do see a therapist through AIM Level 6. The therapists would only be involved with the child and their family for a short period of time, often whilst they are on the waiting list for other health care services or assessments. The Children's Disability Network manager explained that this presented a challenge as the professional has a duty of care for the child during this time and may subsequently identify other areas of need outside of pre-school that require further support. Thus, in providing AIM Level 6 support, the professional is then bound by duty of care to take wider responsibility for the needs of a child not already known to HSE, should they be identified as requiring further interventions. This had implications for caseloads.[63]

During the interview, the EYS explained that they had encountered several parent/carers who had made the decision to seek private assessments and therapies in order to gain the support they felt their child needed, including private speech and language therapy and psychological assessment. However, because private services operate outside of the HSE the EYSs are not able to contact the therapist. If the parent/carer is provided with a physical copy of a report made by the private therapists, they may choose to share this with the pre-school setting and EYS. Participants explained that this limits collaboration between the EYS and the therapist as it would ordinarily occur if the therapist were working under the remit of the HSE (and hence contacted by the EYS during the universal support stage of Level 6). Equally where a private report or psychological assessment is conducted this cannot be used by the EYS or HSE (unless when commissioned by HSE) and is not permitted to contribute to the work completed by the HSE. Even where families seek to address their child's needs themselves at significant personal expense and do so with their best interests in mind, there remain significant barriers as private therapeutic services do not interface with the existing model of AIM Level 6. Participants shared the view that this limits EYSs liaison with therapists for advice during the writing of the Access and Inclusion Profile in AIM Level 6 (universal) with the consequence that the process for accessing AIM Level 6 (targeted) is lengthened because the Universal stage is deemed incomplete.[64]

The <u>perceived</u> lack of availability of AIM Level 6, and reluctance to engage with a complex process of application for AIM Level 6 (targeted) is viewed by participants to interact with other AIM levels of targeted support, particularly AIM Level 7. Some participants identified that as pre-school settings prioritise Level 7 since an award is more likely and the process less complex. This observation could

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[61] The Joint Working Protocol (HSE, 2020) notes that some form of therapeutic intervention (which may be episodic, continuous, intensive, or less intensive) has to take place within five weeks unless the EYS agrees that this period can be/should be extended. Level 6 does not often (or necessarily) lead to continuous therapies such as speech and language therapy and may come in a range of forms (e.g., visits to the pre-school to design behaviour support plans, ongoing review of the Access and Inclusion Plan. HSE observe this to be an example of misunderstanding about what Level 6 (targeted) provides.

[63] HSE note that the purpose of the Level 6 referral for children not already known to HSE is to ensure the child is appropriately prioritised on the CDNT's waitlist, as well as to put interventions in place within a five-week time frame.

explain the pattern of increased applications for Level 7 year on year whilst applications for AIM Level 6 (targeted) remain low. It was also identified by a minority of participants that the lack of therapeutic supports presented a barrier to parent/carers choosing a mainstream setting for their child. Parent/carers reported to the participants that they chose to send their child to specialist pre-schools purely because they were provided by healthcare rather than the ELC sector, with therapeutic support provided onsite where needed, without the need for AIM applications. This was reported as having a subsequent impact when families come to apply for a primary school place for their child. As the family have no prior experience or engagement with mainstream provision, they do not have the opportunity to build up confidence in mainstream or gain insight into how their child could be included. As a result, the same families who experience barriers to accessing mainstream pre-schools are further excluded from accessing a mainstream primary school setting. The gap in therapeutic supports therefore presents a significant barrier to inclusion for children and families.

A specialist from a disability advisory group to the government, explained that the number of requests received for AIM Level 6 (targeted) support have been examined as well as the number of referrals. Subsequently, the number of children who receive a) therapeutic supports within the 5-week timeline and b) those who are waitlisted are recorded. However, challenges arose as the numbers of children are very small and appear to be far lower than those that could reasonably be expected to require therapeutic support. Subsequently, meetings have been conducted with Better Start in order to identify the number of requests being made by ELC settings via their EYS.

Additionally, the Children's Disability Network Manager explained that much pre-school support is informal and takes place outside of the AIM Level 6 engagement and referral route. Though in essence this represents Level 6 type activity, it is not recorded under AIM KPI's. Hence, there is no impact or quality impact associated with this role. The scale of HSE engagement or level of uptake of universal support is not known. Consequently, it was acknowledged that the existing data and approach to measurement is neither "robust, valid or useful".

Future developments for AIM Level 6

At the time of writing several changes within the HSE are due to be implemented which are anticipated to have a positive impact on AIM Level 6. Firstly, a large-scale reorganisation is taking place which will result in a new national system of 91 Children's Disability Network Teams (CDNTs), each led by their own area manager[65]. These are community services working under the auspices of Ireland's 9 Community Health Organisations. The HSE National Disability Specialist explained that, in her view, this would provide a clearer reporting structure and allow issues to be escalated firstly to one of the nine operations managers and subsequently to the National Disability Specialist herself if urgent attention is required. This does signal the participants' attention to revising protocols in the context new CDNT structures, and the same participant explained how new waitlist systems may be helpful in changing attitudes to Level 6 applications.

A further area that requires attention is the greater monitoring and measurement of the impact of HSE on AIM and the contribution this makes to securing meaningful participation and full inclusion of children within the ECCE programme.

Participants suggested that further monitoring focuses on the following areas:

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[65] This process is now complete.

- To monitor the number of children awaiting therapeutic support in order to gain a true picture of the scale of waitlists.
- To monitor the volume of support requests and responses made as part of the universal element of HSE support to pre-school settings. This should record the number of pre-school settings, the number of children and the frequency of support requests.
- To identify why seemingly few children are referred for AIM Level 6 support.
- To develop KPIs to allow measurement of a) the impact of HSE on AIM Level 6 and b) the impact of HSE engagement across AIM's universal and targeted Levels of support (Levels 1-7).
- To include a KPI which relates directly to the experiences and perspectives of ELC providers and families who request AIM Level 6 support (i.e., to evaluate experiences and impacts).

In summary, participants argued that an important future development is in the development of valid and comprehensive approaches to measuring both a) the number and type of HSE engagements at Level 6 at both the universal and/or targeted levels and b) progression through the 5-week limit on Level 6 (targeted) intervention, and c) accounts of progression through CDNT waitlists once the Level 6 referral has been made. The results of this improved oversight will support the future development of AIM Level 6.

In summary, participants felt that AIM Level 6 in its current form was not meeting the needs of children and families. The following challenges were associated with the implementation of AIM Level 6:

- Whilst participants felt the concept of AIM Level 6 could be supportive of the needs of children and should enable meaningful participation and full engagement, the majority could give no clear example of where this was happening in practice.
- The perceived lack of availability of AIM Level 6 was identified as having a subsequent impact on the increased number of applications for AIM Level 7. Though it is clear that Level 6 (targeted) is undersubscribed and perceptions of lack of availability may be catalysed by wider issues in the system (e.g., HSE waitlists), rather than the actual capacities, the operational complexity of Level 6 (targeted) was identified by participants as a disincentive for applying.
- Families were reported to have sought private therapeutic supports because of the wider waitlists issue, however, these do not readily interface with the current AIM model at Level 6.
- A minority of participants had observed that parent/carers were not able to access mainstream pre-schools and subsequently mainstream primary schools due to the challenges involved in securing therapeutic supports. Though this issue does not sit inside AIM or Level 6, it may limit parent/carers choice of mainstream, AIM supported ECCE.

A number of changes were underway within the HSE at the time of writing which could offer some solutions; these include the implementation of new national Children's Disability Network Teams coupled with a new waitlist system. It is hoped that these changes will offer a clearer structure. However, there is currently a lack of valid and robust data related to the scale and impact of AIM Level 6.

The true numbers of children supported by HSE engagement (Level 6 universal, Level 6 targeted and informally outside AIM) are reported as unknown, as are the number of children waitlisted for therapeutic support following a Level 6 (targeted) referral. Also unknown are the number of children served within the five-week time limit and the type of support offered.

In the case of AIM Level 6, the type or outcome of liaison with HSE at the Level 6 (universal) stage is also unknown. Participants suggested that new measures be sought to collate and measure these crucial issues. Some participants suggested that new KPIs be developed to allow measurement of the impact of health on AIM Level 6 and the contribution of health across AIM's universal and targeted Levels of support (Levels 1-7).

8.8: AIM Level 7: Additional assistance in the pre-school room

All participants spoke highly of the positive impact of AIM Level 7 on children's meaningful participation and full inclusion. It was felt that for many children, having support available made the difference to whether they could attend a mainstream pre-school setting or not. Participants expressed pride in the support being needs-based rather than diagnosis led as it allowed support to be provided quickly in response to emergent need. Collectively, participants were able to list a number of positive features associated with AIM Level 7:

- Contingent support and guidance are provided in response to the needs of the child (8)
- Support is provided to the existing staff within the pre-school room. Having an additional person can provide the extra capacity needed to carry out strategies and interventions (6)
- Higher quality interactions are enabled throughout the pre-school room due to the reduced adult to child ratio (2)
- Greater access to mainstream pre-school settings has been secured for children with additional needs and/or disability (16)
- Some participants perceived that the presence of AIM Level 7 increased parental confidence in mainstream pre-school settings (5)

Overall, participants viewed AIM Level 7 positively and felt that it was needed to provide support to both ELC settings and children during the ECCE programme. However, there were concerns regarding the extent to which AIM Level 7 was seen as the most desirable Level of AIM. Some participants felt that pre-school settings view it as a failure if they do not get AIM Level 7 support. Participants therefore wondered whether AIM Level 7 in itself had 'become the definition of AIM' and questioned whether this had become a crutch which prevented deeper engagement across AIMs universal and targeted Levels 1-7.

The demand for AIM Level 7 has exceeded initial predictions and some participants expressed concern regarding the increasing cost. Most participants were aware that whilst the estimated uptake of AIM Level 7 was 1.5%, the actual uptake has risen to around 4.5% of children in the ECCE Scheme. It is not yet known if this figure has reached its peak or will continue to grow, and this has been hindered in part by the Covid-19 pandemic. Some participants felt that a positive feature of AIM Level 7 was that there were no limits placed on the number of applications awarded each year, allowing AIM to be highly responsive to emergent need. However, participants identified that it is not fully understood why the number of applications year-on-year exceed expectation. Whilst participants from the AIM project team identified that they currently have the budget available to meet the level of demand for AIM Level 7, this may not always be the case should numbers continue to grow.

Participants had a clear understanding of the application process for AIM Level 7 and the role the EYS plays within this. Pre-school settings must first make an application for AIM Level 4 before they are able to make a subsequent application for AIM Level 7. A few participants identified that there is a balance to be struck between making the application process accessible and also not making it too easy and requiring thought to be put into the underlying reasons why the highest level of support is required to meet the needs of the child.

Participants, including the EYS and Team Lead explained that the application process for AIM Level 7 consists of the following steps:

- The pre-school setting completes an application. This includes a section for parent/carers to complete which helps to build a picture of the child's relative strengths and needs. The EYS may provide support to the pre-school setting when completing the initial application form.
- The EYS conducts a visit to the pre-school setting to observe the child in the context of the ELC setting environment. The response of the ELC setting to the child's needs is noted. Where in-person visits have not been possible due to the Covid-19 pandemic the EYS conduct a phone or video call with the parent/carer of the child.
- An appraisal is made of the application which brings together evidence from the application form and observations. During interview, an EYS Team Lead identified that the unique situation of each child and pre-school setting is considered.
- A recommendation is made by the EYS Team Lead regarding whether the AIM Level 7 should be awarded. This is communicated to Pobal who make the final decision about funding.

It was identified that a new online application system is due to be introduced at the time of writing. Applications will now be made using the Hive system, which the CCC and pre-school settings already use for other applications[66]. It is anticipated that this will be more user-friendly than the previous PIP system. Whilst pre-school settings have previously required support to make the application, it was identified by some participants that after making the first few applications pre-school settings are confident and able to make their subsequent applications independently.

The majority of participants felt that the application process for AIM Level 7 was fair and equitable. Participants felt that EYS and Pobal have a very fair way of reviewing applications, and this is enhanced by the fact that they go through a number of different stages as the application is escalated before a final decision is made. Participants also felt that a strength was that all applications were treated identically, with every child and family receiving the same application process to determine the child's needs.

Whilst the application process was deemed to have high levels of fidelity, it was identified that greater account could be taken of parent/carer's perspectives. Currently parent/carer's views are captured through a tick box system. A few participants expressed that the provision of open text boxes would allow greater parental voice to be incorporated into the assessment process. The EYS identified that during the Covid-19 pandemic they had greater direct contact with families and gained a more detailed picture of children's needs. This was identified as being particularly beneficial where parent/carers chose the 'almost never' box to describe what their child could do, as they were able to explain in greater detail the individual strengths of their child, thus achieving a more person-centred approach. This information about children could also be captured at an initial stage through altering the application form families are asked to complete. This would be a relatively straightforward change to make and would have the benefit of offering families greater input into the application process and also provide EYS with a more holistic view of the child's relative strengths and needs.

Perspectives on the interpretation and implementation of AIM Level 7

AIM Level 7 is intended to provide funding for an additional adult during ECCE sessions for up to 15 hours per week. Alternatively, pre-school settings may make an application to reduce the adult-to-child ratio by enrolling fewer children from the regulated ratio of 1:11 down to 1:8.

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[66] Early Years Hive is now established as the application and referral portal for AIM.

Despite AIM being embedded across the ELC sector, most participants felt that there remained misconceptions regarding the implementation of AIM Level 7. The most common of these was the belief that the role of the additional adult funded through AIM Level 7 was to provide 1:1 support to an individual child. Participants observed that:

- The desire to provide 1:1 support reflects an existing awareness of the SNA role within primary education and an apparent desire to replicate this within the ELC setting.
- Parent/carers' understandings of AIM Level 7 mirrors that of pre-school settings; the EYS reported that they often have to clarify the role of the additional adult during phone calls with parent/carers.
- The information provided to the pre-school setting perpetuates the misconception of 1:1 support as it states that AIM Level 7 support has been awarded to the named child, rather than to the room as a whole.
- Participants explained that the adoption of a 1:1 support model is in opposition to the underlying principles of AIM as it can present a barrier to children's meaningful engagement and full inclusion within their peer group.
- There is a gap in terminology to refer to adult support within AIM Level 7. Whilst AIM has created the title 'Inclusion Co-ordinator' (INCO) no title was created for the ELC practitioner who undertakes the role of the additional adult. This leads to the individual being referred to as the 'the AIM worker' or the 'AIM person' who works with the 'AIM child'. This discourse further reinforces the idea of 1:1 support.

It was identified that the EYS can play a key role in shifting perspectives and directing positive use of AIM Level 7. During interview, the EYS explained that they often speak to pre-school settings during the application process and ask them how they envisage using the additional adult within the setting environment. This can stimulate conversation around the impact that AIM Level 7 can have on the child and the wider context of the pre-school setting. A minority of participants suggested that the EYS role could be extended to include the monitoring of implementation of AIM Level 7 after this has been awarded to a pre-school setting. Whilst this could help to enhance fidelity it is recommended that this takes the form of professional conversation, coaching and modelling rather than scrutinising and critiquing practice. This will ensure that the underlying approach across AIM of supporting ELC settings to support the needs of children is continued.

Some participants expressed concern that AIM Level 7 was being viewed as a staffing model to enable pre-school settings to cover the costs associated with employing members of staff. This is enabled in part by the fact that the additional adult is for the room rather than a named individual child. However, it was noted that the underpinning reason behind this could be that pre-school settings want to provide greater quality. For example, some pre-school settings choose to use their funding to staff the room over ratio 'because it wants to do that for staff well-being or because it wants to do it for quality'. Another participant suggested that smaller pre-school settings may apply for and use AIM Level 7 annually in order to employ an extra member of staff annually. Given that these are both anecdotal examples, analysis of trends and patterns of AIM Level 7 may provide further insight.

Equally, questions can be posed regarding why pre-school settings may feel the need to take such steps to use AIM Level 7 purely to ensure they have sufficient staff within the pre-school to support the needs of children. Some participants felt that it would be more beneficial to remove AIM Level 7 altogether and reduce the adult to child ratio within the pre-school from 1:11 to 1:8, which is the standard ratio for children aged 3 to 6 years in full day care outside of the ECCE Scheme hours. An advantage of this approach would be that it would remove the focus from 1:1 support for an individual child, to considering the quality of provision across the room where inclusion is a feature of high-quality practice.

Some participants questioned whether AIM Level 7 is currently able to provide enough specialist support to meet the needs of all children. It was felt that the development of additional supports for children with complex needs or medical conditions is required if AIM is to provide more specialist support. The following suggestions were made during interview to broaden the scope of AIM Level 7:

- Offer specialist training modules to ELC practitioners. Training could be developed through collaboration between health and social care and the ELC sector in order to increase workforce capacity. It is anticipated that this could increase both practitioner and parent/carers' confidence in the ability of mainstream pre-school settings to meet the needs of children during ECCE sessions (see subsection 8.4) (4)
- The expansion and increased availability of AIM Level 6 support, which is intended to provide therapeutic supports (see subsection 8.7), is needed in order to reassure parent/carers and ELC practitioners that children will be eligible for and receive needs-based therapeutic supports should they attend a mainstream pre-school setting (6)
- The complex health care needs pilot study seeks to provide nursing support in pre-school settings. Although the pilot study was limited to a small number of families who were already availing of the HSE paediatric home care package, rolling this out as a national programme could increase access to mainstream pre-school settings for children with complex medical needs (8)

Barriers to AIM Level 7

The majority of participants felt that the biggest barrier to AIM Level 7 was the difficulty ELC providers faced in recruiting and retaining staff. Whilst pre-school settings were able to make successful applications for AIM Level 7 support, a lack of ELC practitioners meant that many vacancies go unfilled, and children do not receive the support they are eligible for. Participants felt there were a number of factors which contributed to the staffing challenges experienced in the ELC sector:

- The contract for the additional adult is based on 15 hours per week, for 38 weeks. This is dependent on funding, so if the child leaves the setting the contract is terminated (6)
- Keeping experienced and skilled members of staff from one year to the next can be challenging. Some reassurances are made in the form of a 'second-year extension' to enable funding to be continued for a child moving to their second year of the ECCE programme. However, no such reassurance is made where a child with AIM Level 7 leaves the pre-school setting and a new child with high needs is due to start the following September (3)
- The low pay and poor working conditions put suitably experienced and qualified ELC practitioners off applying for the AIM Level 7 posts. There is no job security, and the fractional contracts are undesirable (6)
- There is a high turnover of staff in the AIM Level 7 role. This can be due to the demanding nature of the job as well as the fixed term contract awarded (6)
- A few participants identified that there are minimal development and progression opportunities for a member of staff undertaking the AIM Level 7 role. As the pre-school setting are aware that they are only employed for a fixed period of time, they may not be prioritised for training and CPD. Equally, it is reported to be difficult to find cover to release the member of staff to attend training as they are required to support the child (2).

Some participants proposed that a possible solution to address staffing challenges would be to widen the qualification criteria for the AIM Level 7 post and enable greater flexibility to pre-school settings in recruitment. Currently ELC practitioners appointed to this role are expected to have a QQI Level 5 qualification in Childcare as a minimum. However, some participants felt that a positive move could be to allow pre-school settings to employ someone with expertise outside of Childcare. For example, a

pre-school setting may wish to employ an individual with a degree in a related subject area such as Psychology or Health. Their knowledge and skills could be a valuable addition to the pre-school setting and respond directly to the needs of the child. Equally the pre-school setting may wish to employ someone with an SNA qualification. This has the advantage of increasing the number of potential applicants. Such candidates may also have additional experience and expertise which could complement the expertise and Childcare qualifications already held by those already working in the pre-school setting. Currently this approach to recruitment is not permitted within AIM Level 7.

Future developments for AIM Level 7

The future of AIM Level 7 will be highly dependent on establishing the true level of uptake. It is currently unknown whether demand for AIM Level 7 will continue to grow or has plateaued at 4.5% of the ECCE population. Whilst AIM Level 7 is generally viewed by participants to be sustainable, it is entirely dependent on funding continuing to be available year-on-year.

There are tensions in the discussion around the uptake of AIM Level 7. On one hand, the majority of participants felt that the application process used to assess and award the highest level of support was fair and equitable; the applications made so far have been awarded to those children whose needs were deemed to require support. However, there remains a feeling amongst participants that AIM Level 7 is not being implemented in the way it is intended and that the number of applications is too high. If future sustainability relies upon there being fewer applications for AIM Level 7, this presents a significant challenge to future developments for AIM Level 7. Should the assessment system need to be revised to increase the threshold at which AIM Level 7 is awarded, this runs the risk of moving toward a diagnosis-led model or poses difficult questions regarding whose needs are deemed more worthy of additional support. Alternatively, a cap could be placed on the numbers of awards made for targeted support. Neither approach is recommended within the context of this evaluation given the commitment expressed by all participants for AIM to continue to be a needs-based model of support.

Currently AIM Level 7 is awarded in the vast majority of applications. This raises further questions regarding the application process and the level of professional respect given to ELC providers and practitioners. If it is acknowledged that: a) the majority of applications are successful and, b) the application process is fair and equitable, this suggests the ELC providers who submit applications for AIM Level 7 are making appropriate practitioner judgements regarding which children will benefit from the highest level of targeted support. Consequently, this calls in to question why in many cases the extended application process is required, and whether there is a greater role to be played by practitioner professional judgement and parent/carers' voices?

An alternate suggestion was made by a few participants to adopt a profiling model, similar to the DEIS model used in primary schools. This would see the profile of the pre-school setting be considered in order to allocate funds and support. The pre-school setting would then have autonomy to allocate the funding to recruit staff. The advantage of this approach over the current AIM Level 7 model is that it would allow for greater long-term planning and recruitment of staff, rather than having to find new staff on an annual basis. It was also suggested that the profiling model moves away from tying the supports to individual children and takes a more holistic view of the context of the pre-school setting and provision of high-quality universal support as foundational for all children. However, the inevitable limitation of this approach is that it may fail to provide sufficient specialist support for children with complex needs or disability whose incidence is outside of the profiling of a particular geographical area. A suggested middle ground is to reduce the adult to child ratio within the pre-school room from 1:11 to 1:8. This would bring the ratios in the ECCE Scheme hours down to the standard ratio for children aged 3 to 6 years in full day care outside of the ECCE Scheme hours. The advantage of this

proposal is that it would take pressure off AIM Level 7 being used as a staffing model. In addition, it would raise the overall quality of the provision within the pre-school room which would be of benefit to children with a disability as well as the other children in the room.

Participants felt that AIM Level 7 had a significant positive impact on access to - and meaningful participation in - the ECCE programme for children with additional needs and/or disability. The uptake of AIM Level 7 has risen annually since AIM's introduction in 2016, to around 4.5% of the ECCE population exceeding initial predictions that it would be required by 1.5% of children. Participants held mixed views regarding this trend:

- Pre-school settings are believed to have a good understanding of the application process for AIM Level 7.
- Participants spoke highly of the fair and equitable nature of the assessment conducted between Better Start and Pobal.
- Questions remain regarding the fidelity of the implementation of AIM Level 7 and role undertaken by the additional adult. Participants indicate there is currently no monitoring or impact data collected.
- The largest area of misconception amongst parent/carers and ELC providers is perceived to be that the role of the additional adult is to provide 1:1 support for the child, rather than being an additional adult support for the ECCE room.
- There remain significant challenges in recruiting and retaining staff with the required QQI Level 5 Childcare qualification. This is reported to present a significant barrier to inclusion where a suitable applicant cannot be found. In response, some participants suggested that the criteria be widened to allow applicants with alternate qualifications to fill the role.

Some participants questioned whether greater account should be taken of the professional judgement of ELC providers in the application process:

- The majority of applications for AIM Level 7 are awarded, suggesting that settings are appropriately identifying the children who have the highest level of need.
- It was questioned whether the number of steps within the application process are necessary and could be streamlined.
- It was proposed that EYS could play a greater role in supporting the implementation of AIM Level 7 through their existing approaches to coaching, mentoring, and modelling.
- Conducting monitoring of AIM Level 7, through professional conversation and support, would reflect the wider principles of AIM of providing support to ELC providers to support children.

Some participants expressed concern that AIM Level 7 is used as a 'staffing model', although this is in contradiction to previous claims that the application process if fair and equitable. It was deemed important to understand the underpinning reasons that ELC providers may need to take this approach, which are thought to relate to the additional quality the additional adult brings to the room. Consequently, it was proposed that an alternative approach to providing AIM Level 7 support could be to reduce the adult to child ratios within the ECCE Scheme from 1:11 down to 1:8.

8.9: Summary

This subsection offers a summary of the rich data arising from interviews with the AIM project team and delivery agencies. A summary of the findings will be reported in relation to the four key questions posed by the end of year three evaluation of AIM. To reiterate, these are:

From the perspective of the AIM project team and service delivery partners who participated in interviews:

- Is AIM effective in achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities and additional needs?
- Has AIM influenced practice, or increased the capacity of the workforce?
- Is the current approach appropriate in the national context?
- Should AIM be extended to School Age Care, hours outside ECCE and to younger children?

Each of these questions is addressed in turn, with reference to the findings and the conclusions that may be drawn from them. Section 13 combines the findings from all inquiry and data collection methods, to conclude on each of these questions.

Is AIM effective and achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities and additional needs?

Generally, participants were very positive about the way that AIM had been developed and rolled out. They noted the following as key to the success of AIM's rapid development and implementation:

- A cross-departmental approach had been taken to design and implementation planning, and parental representatives were involved.
- Consultation and project management were highly effective
- Ministerial leadership and proactive drive from the Department had been highly effective.

Participants observed that AIM responds to the commonly held expectation amongst families and ELC settings that all children have a right to access the two year ECCE programme. Most participants spoke of the structure of AIM as providing support to pre-school settings which helped them to provide support to children and their families. It is not just the policy of AIM that has secured positive impacts for children and families, but the way that this has been implemented in pre-school settings. This has been instrumental in embedding the core principles of AIM: meaningful participation and full inclusion.

Participants felt that AIM is having a positive impact on pre-school settings by increasing their confidence and willingness to be inclusive. This has been secured through access to training within AIM Level 1 and 3, alongside ongoing support and mentoring from the EYS within AIM Level 4. This is felt to have a subsequent positive impact on families who are believed to have greater confidence in the ability of mainstream pre-school settings to meet the needs of their child. Participants also felt that the increased visibility of other children with a disability was supportive of families feeling included and welcome within the ELC sector. When discussing the impact of AIM on children, the majority of participants felt that the facility for children to attend a local pre-school setting alongside their peer group was a significant achievement of AIM.

Participants felt that non-participation in AIM affected both families and pre-school settings. Non-participation in AIM by families was thought to be associated with an absence of prior engagement with other services and professionals. For families who had no prior engagement, the communication of AIM and the use of the term 'disability' was felt to be a significant barrier. For families who were at an early stage of understanding the needs of their child, this terminology did not reflect how they themselves viewed their child, and in some cases where children have acute needs was not the appropriate term to be used. In contrast, for families who have prior engagement with services there may be some concern regarding the extent to which AIM can provide specialist support to meet their child's needs. There was a high degree of uncertainty reported regarding the ongoing provision of therapeutic supports for families who chose to attend mainstream pre-school settings. Both groups of families would benefit from clearer communications and carefully balanced information which would allow them to picture their child in the context of AIM. It is proposed that the focus should be on the provision of personalised, tailored supports to meet the needs of the individual child and therefore enable their meaningful participation and full inclusion within the ELC setting.

Has AIM influenced practice, or increased capacity in the workforce?

Workforce capacity development was viewed as an essential principle of AIM. Collectively, participants recognised that this responded to two interconnected issues. Firstly, for children to be included within pre-school settings, it is imperative that ELC practitioners have the skills and knowledge required to respond to their needs. Secondly, increasing ELC practitioner confidence contributes towards a cultural shift towards inclusive practice.
Participants identified the following factors which contributed to increased capacity in the ELC workforce:

- AIM also responds to the training and development needs of pre-school settings and ELC practitioners. It was noted that a range of training, development and mentoring opportunities are offered across AIM Levels 1, 3 and 4 to build confidence and upskill the ELC workforce (10)
- The financial incentives offered encourage and support engagement in training and CPD (4)
- The support provided by the EYS within AIM Level 4 (though mentoring coaching and modelling) was viewed as fundamental to workforce capacity development. This was because it built capacities for inclusive practice in ways that could reduce reliance on targeted supports. Participants' views were that AIM seeks to empower and build the capacity of ELC practitioners to provide inclusive practice (14)

However, areas remain where more could be done in order to support the retention of qualified and experienced staff.

- Poor pay and working conditions are identified as having a negative impact on recruitment and retention of ELC practitioners (6)
- Concerns were also expressed regarding the retention of LINC graduates as significant numbers leave the ELC sector once they have completed the Level 6 Special Purpose Award (6)

Is the current approach appropriate in the National Context?

Overall, participants were positive about AIM as appropriate within the National Context. Across AIM's universal and targeted levels of support, participants expressed clear examples where needs-based support was provided to secure children's *meaningful participation* and *full inclusion*. The prominent levels of engagement by ELC practitioners, coupled with positive public awareness were both

deemed to be supportive of the future sustainability of AIM. Where participants were less positive this tended to be due to perceived gaps in the coverage of AIM which result from challenges associated with interagency working, recruitment, and retention of ELC practitioners. In what follows, participants' perspectives on what is working well and what needs to improve are summarised for each Level of AIM (1-7).

Areas that are working well

Levels 1-7

AIM Level 1:

- Participants described AIM Level 1 as being foundational to inclusive practice in pre-school settings.
- The fully funded LINC programme was described by participants as being both high quality and well received within the ELC sector.
- Successful completion of the LINC programme allows ELC practitioners to undertake the INCO role within the setting. This role was viewed as providing leadership and expertise on disability within ELC settings.
- It was suggested that the INCO role had most impact when undertaken by a dedicated member of staff who was given awarded time to fulfill the range of roles associated with their responsibilities.

AIM Level 2:

- Participants identified that the AIM website had been revised at the time of writing in order to adopt a more user-friendly interface. This now includes greater information for parent/carers and ELC practitioners regarding universal and targeted support and the application process.
- Interagency collaborative working was seen as essential in ensuring that information about AIM was disseminated widely amongst families.
- The CCC were identified by most participants as key project partners in providing information at a local level.

AIM Level 3:

- Participants identified that AIM Level 3 responded to the 'hunger to learn' within the ELC sector.
- ELC practitioners are currently able to engage in CPD opportunities including Hanen, Lámh and SPEL. The different courses are reported to have good levels of uptake.
- Participants identified that the impact of engagement in AIM Level 3 CPD could be seen in increased levels of ELC practitioner confidence, knowledge, and skills. This was felt to enable pre-school settings to be more open to children with a disability whilst also strengthening the quality of universal provision for all children.

AIM Level 4:

- The EYS were felt to have a key role in building capacity within the ELC sector. Participants identified that the EYS provided coaching, mentoring and support to pre-school settings in order to facilitate the inclusion of children. This is achieved through the development of positive relationships with pre-school settings.
- During the past 18 months, EYS have had greater contact with families when they have been unable to visit pre-school settings in person to conduct observations. It was identified that this has been a positive experience where families are able to share a more detailed account of the strengths and needs of their child. It was suggested that going forward, the forms

completed by parent/carers could include open text boxes in addition to the existing tick box format.

AIM Level 5:

- ELC practitioners have a good understanding of AIM Level 5 and the application process, however, it was felt that it often took far too long for equipment and resources to be provided.
- Some participants felt that AIM Level 5 provided an example of the principles of AIM working well: where equipment and resources have been provided, they are in response to individual need and facilitate meaningful participation and full inclusion.
- Some ideas for the future development of AIM Level 5 were suggested by participants. This included the provision of a fixed annual grant to provide small resources similar to those previously supplied in the AIM inclusive play pack. A further suggestion was to revisit the Universal Design Guidelines and allow pre-school settings to pursue projects to enhance areas within the learning environment.

AIM Level 6:

- A number of changes were underway at the time of writing within the HSE which could improve the engagement of pre-schools with applications for Level 6 (targeted supports). These include the implementation of new national Children's Disability Network Teams and policies related to the management of waitlists. This may a) improve perceptions of the availability of HSE support, and relatedly b) incentivise engagement with Level 6 (targeted) by EYSs and pre-schools.

AIM Level 7:

- Participants felt that the provision of AIM Level 7 support has had a positive impact in supporting children with additional needs and/or disability to access mainstream pre-school settings.
- Pre-school settings are perceived to be familiar with the application process and confident in making requests for AIM Level 7 support.
- The application and assessment process for AIM Level 7 is felt to be fair and equitable.

Participants perceive that AIM is relevant in the National context, responding to the widespread perception that children have a right to *meaningful participation* and *full inclusion* in the ECCE programme. AIM Level 1 is viewed as foundational in achieving inclusive practice in settings, and this is well supported where settings have an INCO with dedicated time to undertake their role. AIM Level 7 was believed to have a significant positive impact on supporting children with additional needs and/or disability to access mainstream pre-school settings. The findings demonstrate that AIM is embedded in the ELC sector. Demand for training, CPD and the LINC programme demonstrates that AIM is strengthening workforce capacity development. Practitioners are believed to have a good knowledge and understanding of the application processes for targeted support with the exception of AIM Level 6.

Throughout their responses participants drew upon their encounters with AIM rather than objective data or the outcomes of oversight or data collection activity. This does not undermine the credibility of their close-to-practice perceptions but reinforces the need for routine systems of monitoring and regulation focused on implementation fidelity and outcomes. The next section explores AIM project team and service delivery partners' perspectives on the areas of AIM in need of development.

Areas that are in need of development

Overall

Overall, participants perceived AIM to be in place and active across the ELC sector, noting that there is an openness to children with additional needs/disability and a 'hunger to learn' and develop inclusive practice. However, participants argued that the uptake of universal support was variable across regions, raising concerns about its reach.

Whilst AIM is largely embedded across the ELC sector, there are reported to be large variations in the uptake of individual levels targeted support. AIM Level 7 is intended to support children with the highest level of need once the preceding Levels from 1-6 are established to provide insufficient levels of support. However, the high uptake of AIM Level 7 suggests that there are gaps in the levels that come before.

Prevalent in the data was the proposal that now AIM has been rolled out there is a need to change focus to look at regulation and monitoring of fidelity and impact. Participants were able to propose priorities and strategies for improving AIM's quality and impact. These tended to focus on communication, workforce capacity development and the implementation of targeted support, and are listed in what follows:

Levels 1-7

AIM Level 1:

- Some participants voiced concern regarding the ability to retain graduates beyond completion of the LINC programme. It was noted that the Level 6 qualification awarded to ELC practitioners allowed them to secure work outside of the ELC sector in other professions with better pay and working conditions. As a result, there will be an ongoing need to fund the LINC programme on a rolling basis until the underlying causes of attrition are addressed.
- Some participants raised questions regarding the fidelity of the INCO role across pre-school settings. Whilst the INCO role is often undertaken by the owner/manager of the pre-school setting, it was suggested that the INCO role had most impact when undertaken by a dedicated member of staff who was given time to fulfill the range of roles associated with their responsibilities.
- Participants held mixed views regarding the EDI training offered to ELC practitioners through the CCCs. Whilst it was felt that there was value in the content of the course, which sought to broaden knowledge and understanding of inclusion, it was noted that there were regional variations in the uptake of the course. Participants felt that this was due to the EDI training being viewed as less important than other funded training, such as the LINC programme. The difference in financial reward was identified as being a contributory factor.
- Some participants felt that EDI training should be mandatory in order to secure a commitment to inclusive practice across the ELC sector.
- From the perspective of participants, the challenges associated with the training and retention of ELC practitioners are situated within wider issues related to the professionalisation of the ELC sector. Whilst it was felt that the introduction of leadership roles, such as the INCO, have a positive impact on quality, greater clarity is required regarding the scope and expectations associated with these.

Participants proposed the following priorities and strategies for developing the quality and impact of AIM Level 2:

- There is a need to reconsider the language and terminology used in initial communications with families regarding AIM. It was noted that parent/carers were often at different stages of understanding regarding the needs of their child. For some families, the use of the term 'disability', was not well received.
- Ensure that sufficient information is provided to families to enable side-by-side comparisons between AIM support in mainstream pre-school settings and specialist pre-school settings.
- Most participants felt that parent/carers did not have knowledge or understanding of AIM prior to their child starting in a pre-school setting. It was recommended that all organisations, services, and professionals who have contact with families from birth are briefed regarding AIM's universal and targeted supports. This will ensure that those who engage with families are able to contribute to sharing information about AIM.

Participants proposed the following priorities and strategies for developing the quality and impact of AIM Level 3:

- Develop a series of optional, specialist modules that ELC practitioners can choose to engage with in response to emergent need within the ELC setting. A review is required to establish the topics of greatest interest to ELC practitioners; however, subject areas proposed to respond to current demand include autistic spectrum disorders and medical needs.
- Develop a rolling programme of CPD to maintain skills and knowledge within the ELC workforce. For example, where practitioners have previously completed a Level 3 course provide a facility for this to be revisited and updated over time.
- Consider the provision of an annual training bursary to ELC providers to allow practitioners to select from available training courses and choose those which are most relevant to their current training needs.

AIM Level 4:

- Participants noted that there is a tendency for Level 4 to be overlooked in favour of higher levels of targeted support, in particular AIM Level 7. This presents a challenge if AIM is not implemented with fidelity. It was proposed that the EYS could have a future role in monitoring and supporting the implementation of AIM targeted supports.

AIM Level 5:

- The uptake of AIM Level 5 had been far lower than participants initially predicted. Whilst this was believed to be explained in part by the reduced need over time for capital grants to conduct alterations to the physical environment, there remain areas within the application process which may contribute to the lack of uptake.
- The current need to coordinate external services, reports, and letters of support places undue pressure and responsibility on the ELC setting.
- The delays experienced by ELC settings were identified by participants as presenting unnecessary barriers to inclusion and have the potential to result in unsafe practices.

AIM Level 6:

- Participants were not sure whether AIM Level 6, in its current form, was meeting the needs of children and families.
- The perceived lack of availability of AIM Level 6 was felt to have a subsequent impact on increased demand for AIM Level 7 because of the complexity of the referral process for AIM Level 6 (targeted), and the perceived improbability of receiving therapeutic support through

this route.[67] Level 7 offered a more streamlined route to support for children with complex needs.

- A minority of participants felt that parent/carers were not able to access mainstream pre-schools and subsequently mainstream primary schools due to the lack of therapeutic supports available to them in the early years. Though this issue lies outside AIM and is related to broader knowledge/experience of waitlists, it impacts on AIM's capacity to give parent/carers more choice, including choices about mainstream placements.
- The need for valid and robust measurement of AIM Level 6 was needed to form a true picture of:
    - How many children were supported by AIM Level 6 (universal) and what type of liaison and impact had occurred.
    - How many children were supported by AIM Level 6 (targeted) and what type of support and impact had occurred following an accepted referral.
    - How many referrals to AIM Level 6 (targeted) were accepted
    - How many children were in receipt of HSE support within five weeks, and how many were not
    - How many children were waitlisted and what support and impact was put in place once the child had progressed from the waitlist.

- It was recommended that new KPIs be developed firstly to allow measurement of the impact of health on AIM Level 6 and secondly the contribution of health across AIM's universal and targeted Levels of support (Levels 1-7).
- Further collaboration with the HSE was identified as an area which could lead to greater awareness of disability and medical needs amongst ELC providers, and HSE engagement was seen as crucial to enriching the impact of AIM.

AIM Level 7

Participants proposed the following priorities and strategies for developing the quality and impact of AIM Level 7:

- There remains some misconception amongst ELC providers and parent/carers regarding the implementation of AIM Level 7 and the role of the additional adult.
- Greater monitoring of the implementation of AIM Level 7 support is required to ensure fidelity across the ELC sector. It was proposed that this could take the form of professional conversations and support from the EYS through coaching, mentoring, and modelling.
- Increasing pressure on Level 7 threatened the sustainability of Levels 1-3 and hence the sustainability of AIM overall.
- Recruitment and retention present a significant barrier to inclusion where qualified and experienced staff cannot be found to fill the additional adult role within AIM Level 7. Steps

[67] It is noted that Level 6 (targeted) was designed for the small cohort of children who were not known to the HSE and who needed bespoke and individualised therapeutic advice or support because it was crucial to their full inclusion and participation. It is also noted that the number of children referred for Level 6 (targeted) support totals 133 over five years, with 47 of these referrals being for children not known to HSE. This represents 0.21% of the total number of AIM supports between 2016 and 2021 and describes referrals rather than dispensations. Though this cohort is small, it has been observed to be smaller than expected by a participant representing the National Disability Association. Hence, it is not clear if AIM Level 6 (targeted) is reaching its intended cohort effectively enough.

should be taken to enhance the pay and conditions for ELC practitioners. The fractional, fixed term contracts given to the additional adult should be explored to consider whether longer term appointments can provide greater stability for ELC settings and their staff.

These findings provide evidence for the claim that developments to AIM must prioritise information sharing (AIM Level 2) and workforce capacity development (AIM Levels 1, 3 and 4) in combination with strategic and operational developments that will enable targeted support (AIM Levels 4-7) to work more effectively.

Communication to families was viewed as important in ensuring AIM reaches the intended cohort. Non-participation in AIM was felt to stem from families' lack of prior knowledge of AIM coupled with the language and terminology used in initial communications with families upon attending pre-school. Therefore, information-sharing by professionals and organisations who interact with families from birth was proposed as a potential solution.

Participants were aware that the success of AIM was dependent on the development of workforce capacity. This was viewed as essential in ensuring pre-school settings have an inclusive culture and the skills and knowledge deliver targeted support in response to children's needs. Consequently, the need to address the challenges associated with recruitment and retention of staff emerged as a key theme.

The availability and application processes associated with AIM targeted support at Levels 5 and 6 were identified as a further area for development as they place pressure on AIM Level 7 as the highest level of support. Participants suggested changes to the monitoring of AIM targeted support to enable identification of the uptake and impact of AIM Levels 5-7.

To what extent can/should AIM be scaled up and out?

Participants held mixed views regarding the future scalability of AIM. Examining the scalability of AIM presented the opportunity to reflect upon the implementation of AIM to date. The findings suggest that whilst the current model of AIM is good, there remained some gaps in the coverage and reach of AIM which have been made apparent over time.

Collectively, participants evaluated a range of different options for scaling AIM up to meet the needs of a greater range of children, this included:

- Increasing the availability of AIM for children within the current ECCE Scheme.
- Broadening the scope of AIM within the current ECCE Scheme to respond to a wider range of needs.
- Making AIM universal (Levels 1-3) and targeted (Levels 4-7) support available to younger children in pre-school settings, before they start the ECCE Scheme.
- Making AIM universal (Levels 1-3) and targeted (Levels 4-7) support available to older children in pre-school settings, including School Aged Childcare.
- Making AIM universal (Levels 1-3) and targeted (Levels 4-7) support available to older children in primary school settings.

There remain some contradictory stances amongst the AIM project team and service delivery agencies regarding who can avail of AIM support, which influenced their views regarding the

scalability of AIM. The findings revealed opposing perspectives regarding whether the purpose of AIM is solely to support children with a disability, or to provide needs-based support more broadly. This was further observed in the range of perspectives expressed regarding scaling up and out of AIM to support the needs of a wider range of children. Participant views regarding the scaling up and out of AIM are as follows:

- Most participants felt that AIM should be scaled up to provide support beyond the ECCE Scheme hours to provide support for children attending full day sessions and aid transitions throughout the day.
- There were mixed views regarding the provision of AIM targeted support to younger children. Some participants questioned how a needs-based assessment could be conducted equitably in the 0-3 years age range, whilst the existing lower ratios were felt to limit the impact of the provision of an additional adult within the context of AIM Level 7.
- Amongst some participants there was a strong feeling that where children had needs, these should be supported for the duration that they are in setting. Therefore, when older children return for School Aged Childcare they should receive needs-based support.
- Whilst it was acknowledged that there were a number of barriers to scaling AIM up to meet the needs of children within primary education, participants felt the philosophy of AIM had potential for successful application within School Age Childcare.
- Supporting effective transitions between and within settings was perceived as a positive outcome for scaling AIM up and out, across the different age groups.

It was questioned by some participants whether existing financial support outside of the ECCE Scheme, including the NCS could be used by ELC settings to cover staffing and resource costs and therefore render the scaling up of AIM unnecessary. Participants agreed that AIM should not become a staffing model and that this was a risk of scaling up or out.

Participants held **mixed views regarding AIM's ability to be enhanced through scaling up or out**. Where participants held mixed or negative views, these were related to beliefs that AIM was solely for children with a disability or that existing funding and ratios were sufficient to meet the needs of children outside of the ECCE programme.

Where positive views were held, the scaling up of AIM is thought likely to increase *full inclusion* and *meaningful participation* and support children's transitions between and within settings. AIM could be scaled up successfully by:

- Inclusion of younger children within the universal levels of AIM
- Enabling support to be provided outside the ECCE qualifying hours for children who attend full days
- Extension of the AIM model to after-school care

Participants agreed that AIM should not become a staffing model and that this was a risk of scaling up and out.

Overall summary of findings: Interviews with AIM project team and service delivery partners.

In summary, AIM emerged as relevant in the National context, responding to the widespread perception that children have a right to *meaningful participation* and *full inclusion* in the ECCE programme. Participants agreed that AIM is embedded across the ELC sector but that further work is required to increase families' knowledge and awareness of the range of supports available to them.

Collaboration and interagency working were upheld as vital to the inception and implementation of AIM. Participants spoke highly of the leadership of AIM in embedding a culture of openness and communication which has enabled innovation. Where experiences of interagency working have been less successful, gaps have emerged particularly in relation to AIM Level 6, where matters of operation and monitoring were raised as important focusses for future development.

In participants' view, continuing improvements need to be made, focused on the fidelity and alignment of the implementation of AIM to its core principles. One key proposal for improvement was the introduction of routine and systematic monitoring and oversight for AIM Level 1, and 4-7. Whilst participants shared their close-to-practice perceptions, the introduction of systems of monitoring focused on outcomes would assist in answering the questions that remain regarding non-participation and the impact of AIM on children and families.

The recruitment and retention of experienced and qualified ELC practitioners poses a significant challenge to the sustainability of AIM. Whilst high-quality training and support is provided to the ELC practitioners, in the context of AIM Levels 1, 3 and 4, this alone is insufficient in maintaining workforce capacity. Action is required to address the perceived poor pay and working conditions in the ELC sector.

9: Interviews with representatives from the Disability Sector: Findings

This section reports on the findings from interviews with 6 representatives from the disability sector. More details on the characteristics of this participant group are provided in Section 7. The reporting begins with a focus on the *overall* implementation and impact of AIM from the perspective of the disability sector. This is followed by the reporting of findings that are pertinent to *each level of AIM* (Levels 1-7). The section ends with a summary of key findings overall, and for each level of AIM in the context of the evaluation's four research questions. The characteristics of the sample for disability sector interviews was described in Section 7, along with a description of the methods used to recruit, collect, and analyse data. In summary, the participant group included a senior adviser from the National Disability Authority, an independent, statutory body that advises the government on issues relevant to the lives of people with disabilities; senior leaders and researchers from the Disability Federation Ireland (DFI), an influential advocacy group for the sector, a senior leader from Inclusion Ireland, which campaigns for disability rights and access, and a senior member of the Equality and Diversity in Early Childhood Network (EDeNn). These participants were connected to AIM in various ways, either as members of AIM's Implementation Development Group (IDG), or as advocates and advisers to parent/carers whose children have disabilities, and who would be AIM's targeted beneficiaries.

Introduction: Approach to presenting the findings

Findings are presented under each of the key lines of enquiry constructed for this evaluation (see subsection 1.2). Summarily, these comprise the views of representatives from the disability sector on AIM's implementation, AIM's impact, aspects of AIM that are working well, and aspects of AIM that need to be improved. Findings are described, and where relevant, direct quotations are used to illustrate a key theme arising from the analysis of the data. In this section, organisations are not identified under quoted raw data, to protect the identity of participants.

Overall, the following approach has been adopted to provide a guide as to the strength of responses:

- All – all participants
- Most – at least three quarters but not all participants
- Majority – between half and three quarters of participants
- Some – between a quarter and a half of participants
- A minority – less than a quarter of participants
- Very few – one or two participants only

The next subsection explores representatives from the disability sector's perspectives on AIM overall, beginning with their view of AIM's rationale, purposes, and principles.

9.1 AIM overall

This subsection explores the perspectives of this stakeholder group, as these relate to AIM in general.

Disability sector stakeholders' perspectives on AIM's rationale, purposes, and principles.

When asked to describe the principles and purposes of AIM, participants' accounts were in harmony with the stated objectives of the programme. Participants perceived the rationale for AIM as the

strategic attempt to achieve a unified and inclusive approach to Early Childhood Care and Education (ECCE) for children with disabilities and additional needs. Before AIM, pre-schools were working without a nationally endorsed inclusive policy, meaning that some families were not able to access ECCE because settings would not accept them, in part because of a lack of capacity and knowledge for inclusive practice.

One of the participants described this as a process of 'muddling through without an inclusive ethos', a situation which was unsatisfactory, and caused parent/carers frustration. Parent/carers were left with uncertainty about whether their children would be accepted within mainstream settings and were often forced into sending their children to special pre-school settings, due to a lack of other options. All participants referred to a post-code lottery, with provision and funding for support (whether this be in the mainstream or in special provision) dependent upon where parent/carers lived. For those parent/carers who did have access to therapeutic services these were often limited and inconsistent, and AIM was an attempt to create a national offer of support, universal for all who wanted to access it.

All participants emphasised the importance of bringing about equitable educational provision for all children, in a manner that meant that every family could access the state-funded ECCE programme:

> 'AIM was a way of making sure that all children could benefit from ECCE. It wasn't enough just to get the children through the door. AIM was also about ensuring that the child experienced full inclusion and meaningful participation.'

For participants, AIM is about making mainstream pre-schools accessible to children with disabilities and ensuring that they can participate meaningfully in all activities with their peers. Importantly, participants noted that one of the lesser-known principles of AIM is that its intention is to give families real choice, including the option of dual placements (e.g., some days in ECCE and other days in a special-pre-school), or home tuition. This participant (who worked to support parent/carers in navigating the system), had seen first-hand, that professionals in the system were unaware of these options, and were closing them down due to a lack of knowledge. AIM is about allowing children with disabilities to be placed in the most appropriate setting within their local community and not automatically a specialist setting that could be located at least an hour's journey from their home.

For the participants, the purpose of AIM was broader than opening mainstream pre-schools to children with disabilities. AIM is also about stimulating cultural change by challenging negative attitudes towards disability and creating a more inclusive society. Some participants placed emphasis upon AIM as a vehicle to change attitudes towards ECCE, by raising its profile, prominence, and value within political and public discourse.

In summary, representatives from the disability sector, focused on AIM as a rights-based model, designed to give parent/carers choices with an intention to support access and full participation in what ECCE had to offer. To do this, the quality of knowledge and inclusive practices needed to develop, and this was a core purpose for AIM.

Disability sector stakeholders' accounts of how AIM has evolved over time

When invited to reflect upon the challenges that are encountered when trying to implement AIM's principles, participants proposed a number of these. Important for AIM, was that it was designed to implement a distributed model of additional support, so that an adult would not be assigned to a child in a 1:1 model, but not all parent/carers had trust in this idea:

> 'The [Special Needs Assistant] (SNA) model is strongly engrained into parents' thinking. AIM still has a lot of work to do to convince parents that the most important thing in the ECCE years is participating as part of a group.'

Participants indicated that a significant shift occurred over the past four years in terms of parental understanding and expectations of AIM. They highlighted that after the first-year review large numbers of parent/carers sought a special educational needs assistant to be allocated to their child.

Over the past 12 months, participants had noticed that parental attitudes had begun to change. Increasing numbers of parent/carers are turning to online peer support networks as a starting point before their child begins pre-school. Through forums, there is a sharing of experiences between parent/carers who are new to AIM and those who have been involved since its implementation. Specifically, participants have noticed that parent/carers have greater awareness about the preparatory steps taken by pre-schools and what support they need to apply for before their child begins. Also, it was noted that a noticeable increase in understanding has occurred with parent/carers using associated terminology.

Disability sector stakeholders' views on the sustainability of AIM

Participants considered AIM to be sustainable in terms of uptake, especially as parental confidence was growing, and AIMs benefits were beginning to be seen.

Participants did highlight some specific areas that could undermine the sustainability of AIM:

- Some participants reported concerns, based on their own observations and interaction with practitioners in the sector, that AIM brought new challenges to a low-paid sector, which might result in burnout and further challenges to retention. They argued that consultation with pre-schools must figure as key to the next stage of policy development.

- Participants had observed that, among parent/carers and providers, Level 7 support (additional adult assistance) had developed to be the 'golden' level and demands and hence costs are rising. Some participants explained that there were dangers in this, since where funding was directed to more adults in the pre-school, the fundamental value and importance of Levels 1-3 is diminished, as is the resource available to invest in it. One participant described this as a complex issue, that policymakers would have to get right in the longer term, for determining the 'right' level of support is far from simple in a context where a child's needs are continually changing.

Disability sector stakeholders' views on the scalability of AIM

Overall, most participants assessed that significant progress had been made to increase and develop pre-school capacity to offer provision for children with disabilities. Some highlighted that they would now like to see the principles of AIM being applied to primary and secondary education, as well as to wrap around School Aged Childcare. These participants suggested that the work of making provision for children with disabilities and additional needs equitable across all educational settings had already begun. A participant gave the example of legislation that removed some soft barriers, such schools recommending that children with additional needs are sent elsewhere.

All participants emphasised that the transition of AIM to primary school is not a simple one, especially as schools and early years education sit in separate government departments. One participant called for a broad evidence base to be established before rolling AIM out to other age groups (such as

School Age Childcare). Participants argued that there were significant issues that need to be addressed to improve the current functioning of AIM in pre-schools that would impinge upon its effective roll-out across primary schools. They highlighted the following:

- Some participants suggested the *First 5 strategy* acts as a barrier as it promotes individualised interventions to support children with disabilities. They believed the policy contradicted the key principles of AIM whereby provision is moved from the level of the individual to the setting to create inclusive education in mainstream schools.

- In some areas, there is still a lack of available mainstream pre-schools accepting children with disabilities creating a postcode lottery and this unevenness in provision needs to be urgently addressed. One stakeholder reported that within their locality there was poor planning and co-ordination of agencies at a local level. They called for better connectedness and lines of communication between different agencies to ensure full awareness of how AIM is operating across Ireland.

- One participant raised concerns that in some primary schools, children with disabilities, especially those diagnosed with ASD, are being accommodated in specialist units attached to schools rather than in mainstream classrooms. They were extremely concerned about segregation in mainstream school based upon (dis)ability. In some mainstream schools, children with differing disabilities being separated and placed in units dedicated for ASD and GLD. The participant believed that this was due to funding being attached to individual children and not classrooms.

To ease the transition to primary school, it was suggested that clear communication between settings is vital to ensure that the supports in place in pre-school should be automatically carried across to primary school. Participants were mixed about whether this transition should occur with their peer group or whether the school transition is deferred, and the child stays at pre-school for longer. All agreed that no matter when the transition begins it should be done with appropriate support in place.

Disability sector stakeholders' experience and view of cross-departmental working in the context of AIM

Most participants had an experience of working with the DCEDIY through advisory roles, contributing to guidance and/or designing training resources. The majority viewed cross-departmental working as highly effective. Participants were impressed at how well the various departments had collaborated and this was key to the successful rollout of AIM.

They found AIM to be effectively led by the ministerial team and that there was a proactive drive from across the organisation to roll out and implement AIM rapidly. One participant stated that the prominent level of consultation and effective project management from the outset had led to AIM being well thought out. Some participants described the approach taken as inclusive and responsive. Examples given included a representative for parent/carers being nominated onto the steering committee and being able to communicate arising problems, which were addressed and resolved quickly. However, one participant found that the DCEDIY was not always open to accepting and responding to EDI issues.

Participants indicated that cross-departmental working was not always effective at a local level with relationships between national and local agencies still being refined. This was identified as a core issue to address, to make support for families more effective and cohesive.

Disability sector stakeholders' view of the impact of AIM on related services

Participants thought that it was likely that fewer children were being referred to early intervention and specialist settings. Some participants considered that the impact of AIs had been limited by a lack of understanding of AIM by professionals in related services, such as HSE and the National Educational Psychology Services (NEPS).

Disability sector stakeholders' views on the impact of AIM on children, parent/carers, and pre-school settings

Children
AIM has enabled children with disabilities, who have been able to access its support, to attend mainstream pre-schools. This has allowed them to maintain local connections and form friendships with a broad range of children that will hopefully continue when they make the transition into primary school. Participants reported that children are more prepared when they transition to infants/primary school and that over time they believed that these foundations would mean that children will become more independent in the classroom.

Parent/carers
AIM has given parent/carers greater choice by making mainstream pre-schools a realistic option. Before AIM participants outlined how parent/carers were often directed towards special early years settings. AIM has given effectively raised parental expectations that mainstream education is accessible to them. However, the way AIM is currently functioning means that opportunities for additional support are often communicated with little notice and parent/carers need to react quickly to opportunities that arise. One stakeholder described this as a 'flight or fight' situation placing tremendous pressure on families.

Pre-schools
Some participants reported that there are still a sizable number of pre-schools who are not AIM providers. One participant estimated that a third of pre-schools was not engaging in AIM. Therefore, there was some way to go before inclusion could be considered universal.

Participants also highlighted in mainstream pre-schools there has been a tendency to skip levels 1 to 3 with a focus on levels 4 to 7, due to extra funding at these levels for staff and resourcing. A participant suggested that this highlights disability rather than promoting full inclusion.

Disability sector stakeholders' views on the factors that have helped and hindered impact in the context of AIM

The impact of AIM and its rapid roll-out had been supported by the international policy context with a participant drawing attention to Article 24 of the UN or the UN Convention on the Rights of People with Disabilities, and the need to honour children's right to high-quality early education in their local communities. Participants argued that this had been a catalyst and given momentum to the government moving the Irish education system away from its current dual system of having specialist provision and mainstream provision to a single form. Participants have highlighted how the implementation of AIM has been supported and driven by leadership teams within several departments. Participants considered that the fast and far-reaching rollout of AIM has made access to CPD a reality for practitioners, whose skills have developed as a result.

There were concerns about whether AIM went far enough in terms of mainstreaming special education with calls for change to go beyond organisational structures to enabling ECCE practitioners to respond to the broader sociocultural development of children.

Broadly, participants identified the following barriers that may have hindered the impact of AIM, these are examined below:

Poor understanding of AIM

It was felt that there was a poor understanding of what AIM was and how it worked among ECCE practitioners, supporting staff *in HSE and other services,* and parent/carers. All participants were aware that AIM was perceived to be only for children with diagnosed disabilities, rather than being an inclusive intervention that can support all children within a pre-school, including those with additional needs who did not have a diagnosis. At times misunderstandings had left parent/carers being given poor advice about AIM. For example, being led to believe that if they had accessed the home tuition fund for children with autism (provided by the Department of Education), they could not also access AIM-supported ECCE. The consequence was that parent/carers and children were not accessing their entitlement, with limiting consequences for inclusion.

Inflexibility

Some participants raised the issue of inflexibility around a third ECCE year. Parent/carers who wanted their child to have an extra year in pre-school (as is permitted in the Irish system) were either *not* informed of their choice or discouraged from taking it, sometimes with a refusal from the pre-school to keep the child for an additional need. One participant argued that to be truly child-centric, this kind of flexibility needed to be built in and supported. Most participants were keen to report on how, from first-hand experience, they had seen how stressed and anxious parent/carers were about making choices for their child's education. Participants noted that parent/carers needed advocacy or support when asking the system to do something it did not like, and this was not in the spirit of AIM. There were concerns that flexibility was not universally offered to parent/carers in terms of when they could access sessions, with settings placing limits on these in ways that limited opportunities for parent/carers to work. There were calls for parent/carers to be offered more flexible provision through dual placements between specialist and mainstream pre-schools. In some pre-schools a lack of flexibility prevented effective adaptions to changing situations. One example given was when the additional adult is absent children with additional needs are unable to attend pre-school until they return. This in turn has reinforced the perception that children with additional needs can only access mainstream pre-schools if Level 7 support is present. For parent/carers this situation presents them with insecure childcare.

Cultural barriers

Participants had seen, first-hand, reluctance from mainstream pre-schools to accommodate children with complex additional needs, due to misunderstandings, prior assumptions, and concerns of staff. Some participants felt that this was driven by pre-school leadership having a lack of understanding and confidence about how to respond to disability. A participant suggested that within the sector a significant minority of ECCE practitioners had engrained attitudes that specialist pre-schools as the most suitable setting for children with disabilities, and this was exacerbated by the resource shortage in HSE services.

A resource crisis in HSE services

The majority of participants made note of the limiting impact that shortfalls in HSE services had on AIM and access to mainstream pre-school. Since it was difficult to access HSE

support during the pre-school years (with long delays to assessment and intervention), the minority of practitioners who believed that the child was 'better off elsewhere' were also being pragmatic, since attendance at a special pre-school would mean that therapeutic supports could be accessed more easily. One participant gave examples of how parent/carers had been 'bullied into specialist settings' because knowledge of other ways to get support (such as home tuition combined with ECCE) was not known about or promoted.[68]

A lack of multi-service working and support for parent/carers

A majority of participants argued that local services were poorly coordinated. For example, members of the Better Start Early Years Support Service (EYSS), were not working well with HSE (and vice-versa), and in turn those services were not working with Special Educational Needs Organisers (SENOs). With better integration, AIM's connection to HSE (through Level 6 and more generally) and transition into school would improve, and parent/carers would feel more secure about continuity. One participant was very clear that, an essential next step would be to improve communication and cross-working among professionals. The space between AIM, the SENOs services and the HSE Children's Disability Network Teams (CDNTs) at the regional level needed to be developed so that there were stronger connections between these services.

Parent/carers being lost in a fragmented and confusing system

Related to the point noted above, the majority of participants argued that parent/carers were still dependent on advocacy, and that at the moment, AIM was not providing a universal resource for that:

> 'We need specialists within the regional teams supporting children (like SENO's and the EYSS), and they should be advocating for parent/carers – it is where the advocacy should be happening – like at transition to primary school – every child needs advocating for – not just those whose parent/carers have the time or the contacts to access the choices and the rights they have.'

Disability sector stakeholders' views on non-participation in AIM

Participants gave several reasons to explain non-participation of parents these included:

- *A lack of early support* was a common issue raised participants was that some parent/carers were struggling to access AIM. A participant explained that unless parent/carers know to contact Inclusion Ireland or a disability advocacy group then they are unlikely to be supported in beginning AIM processes. Other professionals are not supporting families pre-AIM, such as social workers or family liaison, families are left in a situation where they do not know how to navigate the system. This poor early support and communication has created a fundamental gap in parental understanding that AIM can be accessed without a diagnosis. For families this had added an extra burden of searching for a diagnosis when one is not required and delayed their child's access to pre-school.

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[68] Home Tuition can be accessed in addition to AIM for children in the qualifying group, but not within it (https://www.gov.ie/en/service/d15f58-home-tuition/)

- *Slow release of funds* had created a situation whereby parent/carers were not able to participate in AIM-supported ECCE For some parent/carers they have been put in a position where they are forced into self-funding equipment and/or staff to allow their child to attend pre-school in a timely manner. This excludes those parent/carers who do not have the social or financial capital to do this, and those parent/carers that have been able to self-fund are the minority.

- *Exclusion of some families.* There were concerns that some families had been excluded from accessing AIM provisions in pre-schools. Some parent/carers who accessed home tuition have been told that they are unable to have AIM support in addition to home tuition. One participant highlighted that AIM did not provide provision for children with life-limiting conditions. To include these children would require additional therapeutic supports that are not currently available through AIM. Concerns were raised that families from Traveller communities were not accessing AIM, due to a lack of effective engagement with Travelers reinforcing mistrust towards the education system. If Travelers did access AIM, it was observed by a participant that some families were receiving reduced hours.

A majority of participants reported that AIM is often experienced by pre-schools as highly bureaucratic, time-consuming and arduous to administer. Pre-schools have found AIM difficult to navigate because of its administrative burden (complete applications and associated paperwork). Once AIM supports are received by a pre-school participants reported that they found a lack of flexibility. For example, Level 7 is funded for only 3 hours a day with no alternative combinations. Participants argued that this situation contributes to many pre-schools operating at a loss when they accept a child with a disability into their setting.

In summary, **participants' perspectives on AIM's purposes, evolution, sustainability, impacts, and scalability** were as follows:

- AIM was needed as an approach to bring about equitable educational provision for all children.
- AIM is a rights-based model
- One of its lesser-known principles is to bring families real choice (including the option of dual placements, and home tuition. This choice was limited by a lack of knowledge among professionals about the choices available.
- AIM is also about stimulating cultural change toward creating a more inclusive society – AIM is a vehicle for changing attitudes. It gives the pursuit of inclusion value and prominence in political and public spaces.

From the perspective of participants, risks for AIM's sustainability were:

- The pressure it placed on an already under-paid and under-valued professional sector
- Rising demand and valorisation of Level 7 could threaten funding for Levels 1-3.
- The *First 5 strategy* emphasised individualised intervention above inclusion as a universal offer

Expansion of AIM from the perspective of participant

- This was supported but there were some operational issues that needed to be addressed before such an expansion.
- The expansion of AIM's distributive model of support may stem the tide of specialist, segregated classes for ASD in mainstream schools.

Participants views on the development of AIM

- Participants observed that parent/carer attitudes knowledge and understanding of AIM is developing, and that over the past 12 months there had been more activity on online peer support networks, starting before children start pre-school. Knowledge of the preparatory steps prior to starting pre-school was growing, and the terminology of AIM was spreading.
- Effective ministerial and departmental leadership had helped AIM to develop deliberatively and quickly, with good cross-sectoral and parent/carer engagement. Cross-sectoral collaborative working at the local level was not as developed and was a key area to work on.
- Participants believed that as AIM was becoming more embedded, there would be fewer referrals to specialist pre-schools.

Participants views on the impacts of AIM

- It had enabled children with disabilities to enrol in their local, mainstream pre-schools
- It helped children to be more prepared for transition to primary school
- It had made enrolment in mainstream pre-schools a realistic option for parent/carers
- Poor understanding (negative attitudes to disability, cultural barriers, inflexibility around the ECCE third year, a resource crisis in HSE, a lack of multi-service working around the family, and a confusing and fragmented system were factors that limited AIM's impact.
- Non-participation in AIM was seen to be caused by a lack of early support (and hence prior knowledge of AIM), slow release of funding and the exclusion of some communities (e.g., the Traveller community)

9.2: AIM Level 1: Universal supports in the pre-school

Participants emphasised that levels 1 to 3 were vital to the functioning of AIM, as one stated using an illuminating metaphor:

> 'Parents don't see Levels 1 to 3; it is, however, *the tide that will raise all the boats* [our emphasis] … parents can't see the work that's gone in behind it: LINC, practitioner training and Hanen.'

Despite participants' view of the importance of levels 1 to 3, they raised concerns about the national programme of Diversity, Equality, and Inclusion (DEI) training provided by County/City Childcare Committees (CCCs). This training is based on the DCYA (now DCEDIY) Diversity, Equality, and Inclusion (DEI) Charter and Guidelines for ECCE[69] because a) it was not compulsory for providers in receipt of DCYA funding and b) specialists did not always provide it. Some participants suggested that there were knowledge and skills gaps related to DEI within the ECCE workforce and low participation rates in DEI training have not done enough to address this. This was compounded because the DEI training programme had been halted in March 2020 and had not yet restarted (May 21). One participant noted that it is common for pre-schools to assume that DEI training is not relevant because the children enrolled in the setting are not ethnically diverse. A participant concluded that there is a lack of confidence to address critical issues related to racism. Therefore, they recommend that a critical area for practitioner development is understanding and being able to address the broader sociocultural development of children, including issues related to identity and anti-biased approaches, such that all children (including those with disabilities and from minority groups) were valued.

9.3: AIM Level 2: Information for parents and carers

Participants reported that over the past 2 years there have been increasing numbers of parent/carers sharing information and connecting with other parent/carers on AIM forums. A participant highlighted the positive contributions of ECCE practitioners (who are contributing as parent/carers), particularly through their use of AIM terminology. Some participants felt hopeful from the messages posted to the forum that AIM is becoming embedded. All participants reported that they felt that the information provided to and communication with parent/carers could be improved. They highlighted parent/carers lacked clear and accurate information about the choices they have, how to access AIM, the transition to primary school, what each level involves and the resources that can be allocated. A participant commented, 'And it's parents who are giving them the information that they should be getting from the state services, you know, so how clear that information is going to be is based on parents, and other parents own experiences'. Therefore, although the participants welcome the success of the forums for allowing parents to share information, they also felt clear and accurate information should be shared first by the professionals involved in AIM.

9.4: AIM Level 3: A qualified and confident workforce

Participants affirmed that there had been a growth in the workforce becoming more qualified and confident in being able to meet the needs of individual children within a pre-school room. Participants had observed high levels of participation in LINC training. The reasons given were that it was being fully funded, accredited, and successful completion of the course is linked to a salary increase. A

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[69] Department of Children and Youth Affairs (2016) *Diversity, Equality and Inclusion Charter and Guidelines for Early Childhood and Care Education*. [Online]. Available at: https://assets.gov.ie/38186/c9e90d89d94b41d3bf00201c98b2ef6a.pdf. Accessed 05/12/2020

participant also reported that completion of LINC training led to pre-school room leadership roles for some practitioners. Another participant observed, through the experience of working with ECCE practitioners, that LINC graduates were learning about and becoming more skilled in responding to the diverse range of needs.

Some participants raised concerns about what happens after the training. They believed there was a lack of monitoring of the impact of CPD, and also of the current needs of the ELC community. This also applied to the monitoring of the quality of CPD provided through AIM. As AIM developed, it would be important to find ways to connect staff with other practitioners supporting children with disabilities, due to often only one staff member LINC trained within a pre-school. Participants suggested the following focuses for CPD as relevant to AIM and more inclusive practice in pre-schools:

- ECCE practitioners to be offered mentoring that supports their whole practice holistically, so that inclusion for all is part of the milieu of their work.
- A network for practitioners who support children with disabilities from across a range of settings supporting the creation of a community of practice.

Overall, most participants suggested there was still a long way to go before there was a qualified and confident workforce across all AIM levels. Concerns were raised that the salaries of ECCE practitioners are often at minimum wage or just above, which does not adequately value the knowledge and skills needed to effectively support children with a range of (dis)abilities. Also, the contrast in incentives between DEI and LINC training resulted in a gap in workforce skills with few ECCE practitioners completing both sets of training. A participant stated that this undermined the delivery of inclusive and effective provision at AIM levels 1 to 3. Overall, participants argued that it was important to reflect on how well things are going and to take stock. Though it was clear that AIM was being rolled out with good levels of participation across pre-schools, the focus must now be on what the impact of CPD has been on practice in pre-schools, and what now needs to be done.

9.5: AIM Level 4: Expert early years educational advice and support

Participants suggested the role of Better Start Early Years Specialist (EYS) was to provide guidance and develop knowledge on how to include children with disabilities/additional needs. Part of this involved coaching and mentoring around the implementation of AIM, such as helping with applications for Level 5 and Level 7. Many participants reported that they had seen first-hand that the support and advice provided by the EYS service were variable with gaps in understanding about AIM shown by some staff. A participant suggested that this may be due to more experienced staff not having the in-depth AIM training that newer staff have received. Another issue highlighted was that there is lack of appropriate shared language to refer to EYSs, with them often being referred to as the 'AIM lady,' reinforcing existing gendered stereotypes.

9.6: AIM Level 5: Equipment, appliances, and minor alterations grants

Though participants welcomed AIM Level 5 as an important element within the development of an inclusive system, some also reported that in some cases, it was taking up to six months for specialist equipment to reach pre-schools, causing frustrations for settings and parent/carers. There reported a clear need for a process to ensure that equipment (such as hearing systems or adapted chairs) prior to a child's start at pre-schools – they had seen first-hand, slow administrative processes that were

creating considerable delays to a child beginning pre-school. In this way, Level 5 has become a barrier to inclusion rather than a support for it.

Another issue raised by participants was related to the portability of equipment on the transition to primary school. Some participants had been supporting parent/carers who were trying to move the sound systems installed in the pre-school, into their child's primary school. However, it was unclear who 'owned' the equipment, and the lengthy delays in getting the resources installed in the pre-school were now being duplicated on transfer to primary school. This was an indication of the transition problem, one which limited longer-term AIM's effects and was an important issue to address.

9.7: AIM Level 6: Therapy Services

Participants reported that health service interventions only appeared to be visible and available in specialist pre-schools, and none who referred to it, were able to report examples of it being acquired through AIM Level 6.

Outside of AIM and in relation to the broader issue of HSE support for families with children with disabilities, participants reported strong concerns about long waiting lists for assessments and the provision of early intervention services which might follow. In most participants' view, this was preventing parent/carers from accessing specialists before children completed pre-school, having consequences for their stress levels and the children's development. Participants reported that some families had waited 2 years for an assessment. Participants asserted that children with autism, who do not display visible complex needs by their first birthday, were among those with the most challenging pathways to assessment, diagnosis, and intervention. However, there was a lengthy process ahead of them, with assessments involving the completion of a service statement and then a referral to an intervention list. Participants were concerned about the impact of these lengthy processes and waits for diagnosis and intervention upon families with a participant stating,

> 'Parents (with autistic children) are coming into a pre-school in panic mode already because they're at the level of anxiety is raised. They're already getting doors closed...and that's the start of a very, very long journey of battling that will continue right through for years, if not decades, unfortunately, for some if not many.'

Participants had firsthand experience of parent/carers choosing to self-fund assessments or seeking assistance from charities to help them to receive a diagnosis in a timelier manner. Participants explained that this was a wider systemic issue which made Level 6 a moot point, since where services were limited, AIM was also impacted.

9.8: AIM Level 7: Additional assistance in the Pre-school room

All participants noted the rising numbers of applications and dispensations for Level 7. Some noted that pre-schools and parent/carers perceived Level 7 *as* AIM. The consequence was that the relevance and value of other levels as a route to inclusion and participation were devalued and overlooked. Some participants were hopeful that as knowledge, skill, track record and impact grew for Levels 1-4, so would confidence in them, potentially reducing the demand for AIM's targeted support. Participants concluded that emphasis was often placed upon level 7 at the expense of the other levels, as one participant commented:

> 'Level 7 is seen as the top of the tree, and parents are talking with other parents about getting another person in the room even before they have met with a pre-school…before the pre-

> school has gone through the levels with them. But sometimes for the pre-school also L7 seems the golden goose.'

As with some of the other levels, participants commented that level 7 was taking too long to implement, often taking over 3 months. Also, for some children with complex needs level 7 provision does not sufficiently fulfil their needs and participants gave examples of how parent/carers had been left with no option but to self-fund additional staff/equipment.

In summary, **participants' perspectives on areas of improvement for each of AIM's levels were as follows:**

Level 1

> To make DEI training compulsory for all services and professionals who work with children 0-5, and who provide ELC, and to ensure that the quality and impact of the training is monitored
>
> To extend LINC into follow up training, including peer-support forums for practitioners who lead inclusion in their settings.

Level 2

> To ensure that all services and professionals understand the options that parent/carers of children with disabilities have (e.g., home tuition, dual placements, AIM supported ECCE) and to integrate into regional professional teams (e.g., CDNTs), capacity for advocacy and support for parents in making informed choices around these options.

Level 3:

> To develop a national strategy for a rolling programme of CPD, in a context where sector needs, and impact is monitored.

Level 4:

> Ensure all EYSs are well trained and have the capacity to support settings in the development of inclusive practice at the universal and targeted level.

Level 5:

> It is important to reduce waiting times for Level 5 and ensure that equipment moves with the child at transition to other pre-schools or primary school where this is possible.

Level 6:

> Through a situation outside of AIM Level 6, participants called for acknowledgement of the limiting impact of long waitlists for HSE assessment and intervention on AIM and on parents' choices of mainstream AIM supported pre-school.

Level 7:

> Reduce waiting time for Level 7 support through improving pay and conditions and encourage settings to use this flexibly in relation toned and context. Monitor where settings are using absenteeism of Level 7 staff as a reason for reducing a child's ECCE hours.

9.9: Summary

This subsection summarises the findings from interviews with representatives of the disability sector. It is structured around each of the four evaluation questions, beginning with exploration of how well AIM is achieving its intended outcomes.

Is AIM effective and achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities and additional needs?

Participants described some of the complexities involved in implementing AIM. According to the participants and their experience of the ELC sector, AIM has had the following positive impacts:

- In general, AIM has increased and developed mainstream pre-schools' capacity to offer provision for children with disabilities.
- Children with a broad range of disabilities and additional needs have been able to attend mainstream pre-schools.
- Children are more prepared for when they transition to primary school because of the inclusive experience of pre-school

However, participants also asserted that there was a long way to go before all children with disabilities and their families were fully included and able to participate meaningfully in mainstream pre-schools. Therefore, AIM is yet to deliver inclusion and equity for all, with wide variations in the experiences of families across the country. On these points, participants raised the following concerns:

- In some areas there remains a shortage of available mainstream pre-schools accepting children with disabilities.
- In mainstream pre-schools there has been a tendency to skip levels 1 to 3 with a focus upon levels 4 to 7 undermining the foundations of inclusive provision.
- Parent/carers believe (or are led to believe) that choosing AIM-supported ECCE for their children means that they cannot also access home tuition (if eligible) or opt for a dual placement (part-time in ECCE and part-time in specialist pre-school).
- Long waits for equipment, additional staffing and assessments of need had resulted some parent/carers self-funding provision and interventions.
- Some marginalised communities, such as the Traveller community, have not been accessing AIM or if they have provision, it has been limited.

Has AIM influenced practice, or increased capacity in the workforce?

Participants suggested that there had been a growth in the workforce becoming more qualified and confident in being able to meet the needs of individual children within a pre-school room, due to high levels of participation in LINC training. Although, there were doubts about the development of fully inclusive practice due to:

- EDI training not being mandatory, with low participation rates and variable quality, exacerbated by EDI postponement during COVID 19.
- An absence of Key Performance Indicators, particularly of impact, means that the effectiveness of the CPD provided through AIM cannot be monitored.

- For LINC, there are few opportunities beyond the initial training offer for CPD and a longer-term national, and strategic plan for the development and support of INCOs will be necessary. This is also true for the sector as a whole.
- Poor pay and working conditions impact on recruitment and retention in the ELC sector, which also has consequences for AIM (particularly at Level 7).

Is the current approach appropriate in the National Context?

Most participants suggested that AIM principles were appropriate and could create a more inclusive education system, but that there was much work to do in ensuring that it was being implemented effectively and inclusively in all pre-schools. Barriers to success were an inconsistent understanding of AIM and the options available to parent/carers among professionals within pre-schools and beyond (e.g., HSE staff).

Areas that are working well

Generally, all participants agreed that AIM was the right model for supporting inclusion in ECCE, and that it had enabled children with disabilities to attend mainstream pre-schools and experience inclusion and meaningful participation. They used a shared language when talking about AIM's rationale and purposes to focus on equity for all, inclusion, and participation. They noted the high levels of engagement with LINC training, and developments to capacity and confidence in the system. The majority of participants believed that, as parent/carers become more familiar with the language of AIM, and were supporting each other on peer forums, there was likely to be some growth in trust and understanding. Similarly, as pre-school staff developed more confidence and skill, practices would improve such that reliance on targeted support (particularly Level 7) could diminish.

Areas that are in need of development

Overall

Participants referred to the following areas of development as necessary for AIM's continuing improvement:

- To develop Key Performance Indicators (KPI)s for the CPD offer, to include monitoring of impact and repeated auditing of sector needs
- To improve pay and conditions in the workforce
- To acknowledge the limiting impact of pressure on HSE services and the manner in which this gave parent/carers little choice but to fund assessment/services themselves or choose a special pre-school over AIM-supported ECCE.
- To acknowledge the additional challenges and administrative burden that AIM places on pre-school staff who are already working in an underpaid sector.
- To reduce the turnaround time for applications
- To create more integration of services for young children and their families at the local level (EYSS, SENOs, CDNTs) to support inter-service working and more coordinated transition of young children into pre-school and primary school.
- To ensure that all services working with children from babyhood, were informing parent/carers about AIM and the choices it offered so that parent/carers were better informed prior to enrolling their child in pre-school.

Levels 1-7

Level 1

To make DEI training compulsory for all services and professionals who work with children 0-5, and who provide ELC, and to ensure that the quality and impact of the training is monitored
To extend LINC into follow-up training, including peer-support forums for practitioners who lead inclusion in their settings.

Level 2

To ensure that all services and professionals understand the options that parent/carers of children with disabilities have (e.g., home tuition, dual placements, AIM-supported ECCE) and to integrate into regional professional teams (e.g., CDNTs), capacity for advocacy and support for parent/carers in making informed choices around these options.

Level 3:

To develop a national strategy for a rolling programme of CPD, in a context where the sector needs, and impact is monitored.

Level 4:

Ensure all EYSs are well trained and have the capacity to support settings in the development of inclusive practice at the universal *and* targeted level.

Level 5:

It is important to reduce waiting times for Level 5 and ensure that equipment moves with the child at transition to other pre-schools or primary school where this is possible.

Level 6:

Though this lies outside AIM Level 6, to acknowledge the limiting impact of long waitlists for assessment and intervention from HSE services on AIM and on parent/carers' choices of mainstream AIM-supported ECCE.

Level 7:

Reduce waiting time for Level 7 support by improving pay and conditions for this role, and by encouraging settings to use additional support flexibly. Monitor the way that pre-schools deploy Level 7 support, for example, where settings are using absenteeism of Level 7 staff as a reason for reducing a child's ECCE hours.

To what extent can/should AIM be scaled up and out?

Overall, some participants highlighted how they would now like to see the principles of AIM being applied to primary and secondary education, as well as to wrap around care. They would like to see children with disabilities accommodated in mainstream classrooms and not segregated into specialist units. However, all participants acknowledged that this would not be an easy task and that the following would need to take place:

- Clear communication between settings is vital to ensure that the supports in place.
- Improved planning and co-ordination of agencies at a local level.
- Schools are properly supported to make adequate adjustments including funding, staff development and additional resourcing.

10. Interviews with ELC providers: Findings

This section reports on the findings from interviews with 23 practitioners who work in the Early Learning and Care (ELC) sector and whose settings have been engaging with the Access and Inclusion Model (AIM). The reporting begins with a focus on the *overall* implementation and impact of AIM from the perspective of practitioners. This is followed by the reporting of findings that are pertinent to *each level of AIM* (Levels 1-7) The section ends with a summary of key findings overall, and for each level of AIM in the context of the evaluation's four research questions. The characteristics of the sample for practitioner interviews was described in Section 7, along with a description of the methods used to recruit, collect and analyse data.

Introduction: Approach to presenting the findings

Findings are presented under each of the key lines of enquiry constructed for this evaluation and relevant to this participant group (see subsection 1.2). Summarily, these comprise practitioners' views on AIM's implementation, AIM's impact, aspects of AIM that are working well, and aspects of AIM that need to be improved. Findings are described, and where relevant, direct quotations are used to illustrate a key theme arising from analysis of the data.

The following approach is used to indicate the prevalence of a theme across the participant group.

- All – all participants
- Most – at least three quarters but not all participants
- A majority – between half and three quarters of participants
- Some – between a quarter and a half of participants
- A minority – less than a quarter of participants
- Very few – one or two participants only

For each subsection, findings are summarised in a coloured text box.

10.1: AIM overall

This subsection explores practitioner perspectives on AIM overall, beginning with their view of AIM's rationale, purposes and principles.

Practitioner perspectives on AIM's rationale, purposes, and principles

Findings of the interviews with Early Learning and Care (ELC) practitioners (referred to here as participants) suggest that there is a good deal of shared understanding about the rationale, purposes and principles underpinning AIM in their settings. What follows is an exploration of that shared understanding and the various emphases that practitioners place on the nature of AIM as they see it.

The fundamental rationale for AIM is to enable access to Early Childhood Care and Education (ECCE) among children with additional needs[70]. Some participants described this as the ability of the pre-school setting to provide for the full inclusion of children with additional needs, where full inclusion

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[70] Report of the Inter-Departmental Group (2015) Supporting Access to the Early Childhood Care and Education (ECCE) Programme for Children with a Disability, accessed at https://aim.gov.ie/app/uploads/2021/05/Inter-Departmental-Group-Report-launched-Nov-2015.pdf on December 3rd 2012.

means not just attendance at pre-school sessions but entails meaningful participation in activities taking place during those sessions. AIM is consequently seen as the mechanism through which settings are enabled to achieve both full inclusion and meaningful participation for children with additional needs.

Implicit in most of the participants' comments is the view that the achievement of full inclusion and meaningful participation relies upon pre-school services being child-led or child-centred. One participant described this as enabling the child to have a 'voice'. Some participants describe AIM's purpose is to ensure that the child gets what they need to participate in pre-school at a particular time in their lives. Emphasis was placed on pre-school settings focussing on the child as a whole, and not just on how to manage their additional or specific need. One participant explained that meaningful participation is always 'individualised' to the needs of the child and their family; she argued that meaningful participation can only be viewed in the specific context of the child. For example, she described two children thought to be on the autistic spectrum and explained that the additional need of one child was to become comfortable in a peer group setting before any attempt could be made to develop their social skills, and the other child's needs included the encouragement of sensory play. The participant further clarified this approach by commenting that settings need to take their lead on what comprises meaningful participation from each child. Another participant concurred, and explained that:

> '…it is not about the child has X, it is about seeing the child and saying at that time the child needs this support.'
>
> [Manager, urban area]

A key purpose of AIM is the involvement of parent/carers in identifying and planning how to address their child's needs. Participants described working closely with parents/carers but acknowledged that some parent/carers may not always share their understanding of what AIM is for. When asked what the impact of AIM on parent/carers had been, one participant described a parent/carer of a severely autistic child who expected the support provided through AIM Level 7 to be on the basis of 1:1 supervision throughout the session and was disappointed when this could not be provided. Other participants commented that some parent/carers are in denial about the needs of their child. For example, a parent/carer was reported to have removed their two children from the setting when attempts were made to assess one of the children for additional support. Comment was made that where the child is a firstborn or only child it is particularly difficult for parent/carers to accept that there may be an additional need as they have less opportunity to compare the child to the development of other children in the family. Further, references to the term 'disability' either verbally in settings or via the AIM website are reported to have a negative effect on some parent/carers, particularly those who are finding it difficult to accept their child has additional needs.

Participants reported that a key purpose of AIM is enabling the inclusion of all children irrespective of their additional needs; that is, no child should be 'left out' of activities and that all children are involved and included in all activities. Most participants agreed that AIM enables settings to support children who would not otherwise be able to participate in pre-school learning. One participant suggested that where full inclusion is working well, it would not necessarily be possible to identify the child with additional needs. Another emphasised AIM's purpose is to enable integration of the child with additional needs into the peer group in the setting:

> 'I think ideally it should be that every child, wheelchairs, physical disability, language ability, any kind of struggle, any child should be able to come in the door.'
>
> [Manager, INCO, urban area]

Supporting children’s integration in pre-school through AIM is distinguished from the provision of Special Needs Assistants (SNA) and participants welcomed the fact that support from AIM does not rely upon any formal diagnosis of specific or additional learning need. One participant suggested that this is particularly helpful because sometimes a developmental delay (for example) can be sufficiently supported during pre-school and that it no longer presents as an additional need on entry to primary school. AIM’s rationale and approach in this regard were thought to be supportive of parent/carers, who are resistant to the labelling of their child’s additional needs at too early an age. Conversely, having AIM support in place during pre-school was considered likely to be of value to parents/carers in applying for SNA. Specifically, AIM allows the setting to acknowledge the nature of children’s additional needs, devise ways to support children, and prepare children for primary school individually.

Another participant saw AIM’s purpose as providing the capacity to tailor learning support to the child and deliver specific plans around the child’s needs and interests:

> ‘They get to join in in all that you are doing, and you can adapt the curriculum around what the child’s interests are, and the child’s ability. It’s not just about age; it’s about stage as well. You might have a child that is not at the same stage [as the others] but you can plan your activities around that [more specifically] if you have the support. The specialist can give you tips and ideas and if you have the Level 7 assistance you can bring in those ideas and use them in the room for the children.’
>
> [Manager, INCO, urban area]

Full inclusion also means that children should be enabled to participate meaningfully[71] alongside their peers as part of a learning community and ultimately make a successful transition to primary school. A key purpose of AIM for some participants is to make the best use of the resources within the pre-school room. A participant illustrated this with a child whose additional needs related to language delay and for whom the reduced child: practitioner ratio released time for a member of staff to sit and talk with the child and was also used to increase the child’s experience of inclusiveness because other children joined in small group activities with the targeted child. This example suggests that the AIM purpose of providing targeted support can be achieved via moments of 1:1 work, alongside whole or part group activities:

> ‘So, this is where the Level 7 assistants in the room, if you have a child in the room that needs specific support, you can also work with other children in the room, you have a little bit more time to spend with all children.’
>
> [Manager, INCO, urban area]

Some participants reported that the significant purpose of AIM is to support the staff to support the children to engage in their education. Participants saw AIM as being for the support of staff and enabling settings to address additional needs specifically via the provision of staff training, learning resources, and the staff time necessary to develop inclusive practice and meaningful participation. However, a minority of participants did describe circumstances where AIM support did not achieve the

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[71] Department of Children and Youth Affairs (2016) DIversIty, EqualIty and InclusIon Charter and GuIdelInes for Early ChIldhood Care and EducatIon, Dublin, Government publications, accessed at https://assets.gov.ie/38186/c9e90d89d94b41d3bf00201c98b2ef6a.pdf on December 2nd, 2021.

inclusion of some children with additional needs. Those children for whom AIM is not fit for purpose are most frequently described as having complex behavioural, social and/or medical needs. Although participants in settings are proud of their capacity to admit all children, there remain a small number of children for whom overriding concerns about safeguarding prevent their full inclusion and meaningful participation.

Participants' comments conveyed a broad consensus of the principles underpinning AIM, which are consistent with their view of the rationale and purposes of AIM and which in summary are that:

- Every child has a right to an education as well as care
- There should be equality of opportunity for all
- Settings should continue to develop an inclusion culture
- Every child should be included
- Children should be given the opportunity to become independent learners
- Access to pre-school education should be universal
- Participation in pre-school education should be meaningful
- Barriers to participation in pre-school education should be removed
- Pre-school is a necessary part of the transition to primary school education
- Inclusive practice benefits the whole class or group
- Children with additional needs should be integrated into pre-school learning and share in the same experiences as children without additional needs
- Meeting the needs of children involves consultation and communication with their families/carers
- Early identification of additional learning need enables targeted support
- Pre-school learning should be child-centred
- Inclusive culture means celebrating and respecting diversity

Putting the principles into practice was described as challenging. What follows are some participants' observations about the difficulty of turning principles into practical action to support children with additional needs. Settings have to be ready to admit the child. This means that consultations with parent/carers, observational assessments and applications need to be made before the child starts pre-school. This requires settings to work to timescales determined by the AIM processing routines in other agencies. Effective ongoing communication with parent/carers is required to ensure that the child's interests can be accommodated and learning resources obtained or prepared in good time. Very few participants felt that financial resources for staffing are not available early enough in the process of assessing and planning for additional needs and that AIM takes little account of the need for the staff time necessary to undertake report writing or meetings with the child's family prior to the child's admission.

One participant explained that where a child in receipt of AIM support is absent for a prolonged period, for example for hospitalisation, then AIM funding stops and can be restarted. Managing the cessation and restart of funding can be disruptive for settings and compromises the employment of staff paid for with AIM funding. Another participant reported an inability to recruit to a nursing role approved under AIM because the funding did not provide for a competitive salary to be offered. The practice of using AIM funding to supplement a full-time salary was also reported, along with the view that the provision of AIM staffing on the basis of a specified number of hours per week inhibited applications from suitably qualified/experienced candidates.

Some participants noted that staff employed under AIM are not distinguishable from other team members, are not expected to work exclusively with the child with additional needs, and in practice are working with all children and all staff in the pre-school. This team approach is used as a strategy

to avoid the child being separated out from their peers or be excluded from participation in activities and leads to the child's additional needs being supported by the whole team working in the pre-school.

By contrast, whilst acknowledging that AIM's purpose is not to operate an SNA model, one participant expressed the view that 1:1 support is the only way to address some types of additional need; she provided an example of a child for whom 1:1 specialist medical support had been applied for through AIM and which had not been permitted.

> '… they are the forgotten AIM children as they don't come up in the funding applications. They may come under AIM Level 5 for equipment but do not exist at Level 7.'
>
> [Administrator, trainer, urban area]

In summary, all participants were able to describe and illustrate the **rationale and purpos**es of AIM in terms of their own practice. There was a high degree of consensus about the core principles underpinning AIM. Notions of full inclusion and meaningful participation were to the fore but were nuanced by practical experience of AIM in their particular setting. Practitioners occupy a privileged position from which to assess the shortcomings as well as the benefits of AIM.

Participants' comments conveyed a **broad consensus** of the principles underpinning AIM, which are consistent with their view of the rationale and purposes of AIM and which in summary are that:

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- Children with additional needs should be integrated into pre-school learning and share in the same experiences as children without additional needs
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- Early identification of additional learning need enables targeted support
- Pre-school learning should be child-centred
- Inclusive culture means celebrating and respecting diversity

Practitioner views on what is working well in AIM

Overall, practitioners' accounts of their own experiences with AIM are positive. In the interviews, participants were asked for their views about what is working well as a consequence of their

involvement in AIM. What follows is a review of their responses beginning with what is working well for children.

Children with additional needs

AIM was created to benefit children with additional needs by facilitating access to ECCE in the pre-school setting. Participants in the survey confirmed that AIM facilitates access to ECCE in ways that recognise and respond to the individual needs of the child. AIM is child-centred by design and participants interviewed frequently illustrated the ways in which AIM is working well by describing the experiences of children with additional needs and their parent/carers. A key question for participants was whether there was evidence of particular types of additional needs being met more effectively than others, and specifically whether the needs of children with autistic spectrum disorder (ASD) could be met through AIM. NB: it should be noted that in most cases children believed to be presenting with the characteristics of ASD would not have had a formal diagnosis by the time they entered pre-school; indeed, diagnosis may not take place for several years and/or after the transition into primary school. The majority of participants understood that children with diagnosed and undiagnosed ASD had been admitted to their setting because AIM helps settings to provide for a wide range of behavioural, as well as physical, emotional, social, linguistic, or developmental needs which includes those described as children with ASD. One participant felt that AIM can support children with ASD but cautioned that staff need to be appropriately trained and knowledgeable:

> 'You need to have the skills to support these children. You need to be able to identify where their challenges are. Sometimes they're obvious and sometimes it's not so obvious for autistic children.'
>
> [Manager, INCO, urban area]

She argued that childcare professionals understand what autism is, but it is difficult to diagnose clinically, and behavioural traits can be caused by developmental delay or trauma and:

> '...we probably have much more neurodiversity than that which is supported.'
>
> (Manager, INCO, urban area)

Another participant agreed that the capacity of settings to address children's ASD needs depends on having an appropriate form of experience and training amongst the staff team in the room. The participant argued it would not be acceptable to accept a child with ASD into pre-school if they could not be included meaningfully in activities. She described herself as having attended ASD courses and had learned by experience over many years of providing support to autistic children. Staff training and support provided through AIM is an ongoing process. One participant felt that AIM benefits children because it benefits staff in settings:

> '…we don't just do the training and then leave; we have constant support after the training.'
>
> [Manager, INCO, urban area].

Another example was provided of a child with a severe form of ASD, whose behaviour was so challenging that they could not be admitted into the regular ECCE morning sessions. The setting was able to make a successful case to the City and County Childcare Committee (CCC) for permission to accommodate the child in a special afternoon ECCE session, and then applied to AIM for additional staffing support to reduce the staff: child ratio in that session. The child began to make progress and has since progressed on to an Applied Behaviour Analysis (ABA) school. Whilst this case may be

exceptional, it illustrates that where a setting is willing to try to include a child with a disability, flexibilities can be introduced to make that happen. A participant described another child with ASD, for whom the creation of an outdoor space was instrumental to their inclusion. The outdoor resource coupled with the additional staffing (both provided through AIM) enabled the child to be taken out of the session for brief periods of 'time out' in moments of stress. This practice enabled the child to re-join the group and continue with regular activities rather than having to be sent home to 'cool off'. The example illustrates that brief periods of 'time out' can be used to support full inclusion.

Another child presenting with an inability to interact socially found the sessions were too noisy and became distressed. As a result of AIM additional staffing, the child could be supervised outside for brief periods before being re-introduced slowly to the session. This child was reported to have learned to interact with peers and recognise pretend play during the two years of pre-school and has now progressed to mainstream primary school. Another example was provided of a setting that negotiated a third year of pre-school for a child who presented with social, linguistic, and emotional delay. The participant felt that the child progressed because AIM support enabled more individual attention to be given over a longer period of time. She also noted that children whose first language is not English/Irish could also benefit from an extended period of time in pre-school.

A few participants expressed concern about their inability to fully include children with complex needs, (including medical needs) for whom appropriate support appears to be more care than learning related. Children described as being likely to need specialist care throughout their lives were thought unlikely to be able to benefit from mainstream pre-school attendance even with the support of AIM. One participant described this as 'AIM works best where the child has few additional needs, and the additional staff member can cope with these needs whilst also contributing to supporting other children in the room'. Another perceived that settings need to ensure a good experience for all the children in the room:

> 'Yes, it's fantastic that we are able to include [children with additional needs], but only if they are part of the experience for every child in our room. Sometimes when you have a child who's a moderate to severe disability, that can really impact negatively on the rest.'
>
> [Manager, urban area]

Conversely other participants felt that AIM made it possible to acquire physical resources (e.g., hoists, minor adaptions) to support children with complex needs or physical/medical conditions where previously it had been very difficult to do so.

AIM has contributed to a shift in emphasis towards support for learning rather than care. One participant welcomed that focus is now placed on children's education and preparation for primary school. Another felt that AIM could be used to benefit children with any type of additional need and that AIM did not distinguish whether additional needs were physical, emotional, genetic etc., as AIM seeks to include all children with additional needs.

> 'The EYS when she comes in will look at what does the child need, what does the room need and how can this be supported in the setting regardless of condition.'
>
> [Manager, urban area]

Parent/carers of children with additional needs

An important contribution of AIM is to seek to ensure parent/carers are fully informed of and involved in services that are available to support children's' additional needs. Participants described AIM as having improved or stimulated communications with parent/carers, from the initial contact stage and throughout the child's journey through pre-school. Through AIM support participants felt they had more time to talk to parent/carers, to not only provide feedback on their child's progress but to give reassurance that there is someone 'fighting their corner' with them. Some parent/carers were described by one participant as being exhausted by the time they contact the setting, having had to fight for everything and join long waiting lists for support services. Contacting the setting and finding out there is support available is reported to give parent/carers hope that their child can be integrated into mainstream education:

> 'And I just feel the parents find it great because they don't feel like they're on the road, that they are fighting their own battle, you know, and sometimes they may come in and ask questions. They don't want an answer to that question. They just want to know their child is being included. So yes, I do think it benefits the parents, you know, they need someone else to talk to. They need to know that there's someone there that the child is being looked after and the child is getting the best care that they can get.'
>
> [Owner, urban area]

Strengthening communication with parents/carers enables settings to take account of what is happening in the home and provides an opportunity to support the child's learning in the home. For example, one participant described explaining to a parent/carer how activities and strategies were being used in the setting and now the parent/carer is trying out these approaches in the home. Another commented that the Early Years Specialist (EYS) invites parent/carers to meet with her and any problems identified can be responded to without delay or referral for further assessment. A child's attendance at pre-school provides parent/carers with valuable respite; one parent/carer was reported to have said they felt that the huge weight of rearing their child was now shared with professionals who knew what they were doing. Participants spoke of working collaboratively with parent/carers, of involving them, building strong relationships, and giving them ownership of their child's progress. Importantly this approach values and respects the parent/carers' role as the child's first educator.

One participant felt that it can be a very lonely journey for a parent/carer, and another observed that parent/carers can be fearful that the informal assessment processes involved in AIM will result in their child being excluded from pre-school or mainstream education. Providing reassurance and dealing with sensitive or emotional conversations appears to be an on-going part of providing support through AIM, particularly where parent/carers may have a misconception about the nature of support available. For example, some parent/carers were reported to be unclear about the differences between AIM and SNA and expected continual 1:1 support for their child or found the use of the term 'disability' inappropriate in relation to a child with behavioural needs believing disabled children to be those with physical needs.

The notion that settings should provide support to parents/carers of children with additional needs appears to be agreed by all participants; this support is generally seen as beneficial to parent/carers. What is less clear is whether participants agree that there is acknowledgement within AIM of the amount of time it takes settings to provide for carer/parental support and involvement, or whether this time is adequately funded. One participant commented that the involvement of parent/carers in curriculum planning is invaluable because they know their child, but that for parent/carers who use another language or have literacy difficulties themselves, this can be challenging. Participants reported an example of a parent/carer whose child could only be offered one hour's participation at the setting due to safety concerns, and whose parent/carer had to sit in the car and wait for the hour;

another parent/carer was reportedly asked to sit with their child until they settled into the room which denied them the respite, or time for education/work that they had hoped for.

Staff working with children with additional needs

Participants in the survey were asked to identify what was working well for their staff as a result of the setting becoming involved in the support of children with additional needs through AIM. The majority of participants felt that there were clear benefits to staff, and one declared that AIM had:

> *'…absolutely changed their lives.'*
>
> [Manager, urban area]

The majority of respondents commented that the availability of funding for an additional member of staff had enabled staff: child ratios to be reduced within the room. This feature of AIM enabled far more than an additional resource to work with a child with additional needs; it had complemented pre-school practice in a broader range of ways. For example, the additional staffing enabled staff to work with all children in small groups or 1:1 for periods of time during the typically 3-hour sessions. The additional time available meant that staff could spend more time with parent/carers, involving them in session planning and providing feedback on the progress of their child. The additional staff time provided through AIM also helped to reduce staff feelings of being stressed or under pressure, which was described by one participant as feeling like running a marathon every morning. Another provided an example of working with a child identified as potentially dangerous to manage. The extra person in the room enabled the staff team to feel confident that they could cope with this child's unpredictable or unsafe behaviour. Reducing ratios not only provides for the support of the child with additional needs but also enables every child in the room to benefit. One participant commented that:

> '…. every child within my group now is getting a little bit of extra attention because there is an extra staff member in to help.'
>
> [Owner and room leader, rural area]

Typically, rooms provided learning opportunities for up to 22 children and a staff team of 2 reduces the staff: child ratio to 1:11. Eleven two-year-olds remains a large number to work with and so the addition of a third member of staff in the room to support a child with additional needs enables the staff team to better cope with everyday emergencies such as needing to change a child who is not toilet-trained.

The extra resource in the staff team also appears to have strengthened team-working within pre-school rooms and also within the wider professional team of external services with which the setting has contact. One participant felt that strengthening the staff team within the room was preferable to bringing in external expertise on a peripatetic basis as staff members who are employed directly are more likely to share the ethos of the setting. By contrast, other participants felt that AIM had enhanced their contact with external services such as the EYS and the completion of the Access and Inclusion profile supports staff to document and share conversations with EYS which in turn facilitates specialists to offer advice on strategies to manage particular children. AIM appears to have strengthened relationships between settings and other services. For example, the EYS was described by one participant as:

> '… someone looking through another lens [for] things we might miss.'

[Owner, urban area]

One participant described team working as being the ability of staff members to work together in the interest of the child, irrespective of their level of training or experience. She describes team members planning together and adapting activities together as a team so that the supported child can participate meaningfully, and other children do not notice that changes have been made. This team-working approach embodies the principles of inclusion in practice and in this way the child's additional needs become invisible to other children. An often-mentioned benefit of AIM accruing to pre-school staff is that of increasing their knowledge and expertise through training and continuing professional development. Some participants identified particular courses such as the Leadership for INClusion in the Early Years (LINC) programme, which have stimulated reflection on practice and introduced new strategies to try out in the pre-school room. For example, one participant described how she now reflects on what might be causing difficult or challenging behaviour in the child. This reflection-in-action also appears to be a function of the increased availability of time brought about by reduced ratios.

However, some participants felt that achieving change in the way staff members undertake their roles takes time. Mention was made that in some settings staff may still be trying to implement an SNA model which runs counter to AIM's goals of full inclusion. One participant expressed disappointment that staff do not receive the mentoring support that was anticipated through AIM. Another felt that the attitude of the manager of the setting could undermine AIM and argued for annual updating training to support staff in implementing AIM as designed.

In summary, practitioners identified the following aspects of AIM as working well:

- Children with a **diverse range of additional needs**, including those with autistic spectrum disorder, are being included fully in ECCE and enabled to participate in meaningful ways.
- **Flexibilities** in the operation of AIM have produced positive learning experiences for children.
- Parents/carers are relieved and **reassured** to know that their child is being supported by professionals and that there are opportunities for communication and interaction with those professionals.
- AIM has facilitated the **constructive involvement of parents/carers** in the education of their children.
- Staff in settings have benefitted from **increased time to support all children** including those with additional needs, training to increase their knowledge and expertise, and access to learning resources and equipment.
- Reducing staff: child ratios and **team working** in the room has reduced day-to-day pressures and increased staff capability to address children's additional needs.

Practitioner views on the impact of AIM on children, parent/carers, and pre-school settings

In this section, we review practitioner views on the impact of AIM on children, parent/carers, and pre-school settings.. To report upon practitioners' views of the impact we begin with some of their stories of children supported by AIM to illustrate the impacts described. NB: all child names are pseudonyms.

- Annie struggles with communication and has a short concentration span but loves to play in sand and water as messy things appear therapeutic and calming for her. She also enjoys doing puzzles and painting and likes to explore varied materials through her mouth. With support, she is learning not to put everything into her mouth.
- Lucy has type 1 diabetes. The room has been reorganised in order that her blood sugar levels alarm can be heard and her glucose levels can be monitored without taking blood samples. She is now participating safely in pre-school on a full-time basis.
- Joe is nearly 5 years old, has poor motor skills and has not developed verbal language. He has a poor diet comprising drinks and cereals taken by bottle and needs to wear a nappy. Joe communicates through cries and sobbing. He has not been accepted for progression to primary school and will spend another year in pre-school where he is brought into close proximity to other children and where he is exposed to a rich language and a range of activities.
- Mollie has cerebral palsy and epilepsy and uses a wheelchair. She wears a brace to support her head and neck which has to be removed at mealtimes. She loves colours, dolls, songs, and soft toys and with support can play with a tambourine. Mollie does not use language but communicates with her eyes by looking at things that engage her interest. The other children have learned to follow her gaze and will often play with her on her tray or at the back of her wheelchair. Laughter and the other children surround Mollie, and her peers appear to accept her as a friend; they are reported to be unaware of the wheelchair. Two children from the setting wrote to the Easter Bunny to ask that eggs be delivered to Molly's front garden, not the back garden, so that she could see the eggs from her window.
- Lee has Down's Syndrome and communication needs and had heart surgery during his pre-school years. He settled into the setting well and although reported to have mood swings sometimes, he learned to play well with his peers and showed little sign of frustration despite his communication needs. He has transitioned to primary school along with his peer group.
- Ben is in his second year of pre-school and is now 4 years old. He has been diagnosed with ASD and is considered to be a flight risk who requires constant supervision. He needs to be carried in and out of the setting each morning. Ben is unlikely to start school until he is 5 and a half years old, and decisions have yet to be made about whether he attends a mainstream or a special primary school. Ben has learned to play with sensory toys, enjoy music and some books, and likes to play with wheeled, and spinning toys.
- When Jenny started pre-school, she did not play with other children, preferring to 'do her own thing' on her own. Now she is described as the most welcoming little girl who is excited about being at pre-school. Jenny now enjoys being with lots of other children and will be moving on to mainstream school with them next year.
- When Dan started pre-school, he had significant language delay and was effectively non-verbal. Within three months of starting at the setting and having support he has begun to sound words. He is now asking for help, is helping his peers, and is reported to be making rapid progress with his verbal communication.

The participants' stories about children above exemplify not only the diversity of additional needs being supported in settings through AIM but also the impact that inclusion in pre-school activities is having on children with additional needs. It is clear from their comments that participants' views on the impact of AIM on children are framed in the lived experiences of the children with whom they are in contact on a day-to-day basis. **Participants confirmed that AIM has been instrumental in enabling children to progress in ways that were not possible before its introduction.**

Most participants noted the impact of AIM on parent/carers has been positive overall; their view of the benefits of AIM is reported earlier in this section. However, a minority of participants report that parent/carers could be more actively involved in planning and preparing for children's entry to pre-school. They describe parent/carers being put off by standard messaging, particularly that involving the use of the term 'disability' which parent/carers do not always recognise as applying to their child, and not responding to emails from settings. Participants' comments suggest that the impact of AIM on parent/carers could be improved by more and diverse ways of communicating with them. Some participants described parent/carers as being 'in denial' about their child's additional needs and that conversations initiated as a result of AIM could be distressing for them. One participant described parent/carers as being in shock and needing time to grieve when observations of children in settings identify atypical behaviours or learning needs. A positive impact of AIM on parent/carers has been respite from caring for a child who is enabled to attend ECCE. Most participants described parental involvement as very necessary and would welcome more communication with them. A perceived impact of AIM on parent/carers is their greater involvement in the education of their child, but this may not be happening for all parent/carers.

There is little evidence in participants' comments to indicate the impact of AIM on parent/carers of children without additional needs as this was not a focus of the interviews with them. Nonetheless one participant cited an important (for her) impact of the inclusion of a child with severe physical needs, was that parent/carers of unsupported children were pleased that their children had the opportunity to interact with this child. This may be an indication that attitudes to additional needs are changing and the focus on full inclusion and meaningful participation is working. Change is difficult to pinpoint whilst experiencing it. Some participants referred to the period before 2016 as a time when things were done slightly differently, but with the introduction of AIM full inclusion for children with additional needs is not simply the goal of leaders in settings, it is an educational strategy supported by governmental policy. Some participants were able to identify specific activities, resources and processes that had changed as a result of AIM. For example, accessibility to the EYS had improved, staff are less stressed and feeling more competent and confident about including children with additional needs, access to support for additional needs is now easier, advice received has enabled settings to provide a more 'professional' service. One participant felt that as a result of AIM the setting is using its teaching resources more effectively and creatively and commented that

> '…people are seeing that there is more to early years than just keeping people safe.'
>
> [Team leader, urban area]

Other participants noted that there seem to be more children with additional needs admitted to pre-school settings where previously they would not have been.

Very few participants felt that there has not been much change and that change had been for the worse, for example that AIM had increased the burden of workload which was not adequately covered by the resources provided.

One participant felt that settings would benefit from being able to keep the equipment provided for particular children and that to have to give back equipment or toys when a child leaves the setting, or prevent their use by other children, does not promote full inclusion. Yet another disagreed, having used AIM to create a sensory room to support a child with sensory needs, now has a facility for other children to use on an occasional basis.

Participants described the inclusion of children with additional needs as giving staff opportunities to gain experience and extend their professional expertise. Comments suggest that AIM may have impacted their job satisfaction:

> '...her needs were great and the smile she brought to the setting was profound…we learned so much about what she had to give.'
>
> [Owner, urban area]

> 'The first child I had was of very high need, very aggressive, and it taught me a lot, you know, of how every child has a trigger and there has to be a trigger, and there's ways of trying to get that under control and it made me want to train more, to do more CPD to get more information.'
>
> [Team leader, rural area]

> 'Without AIM we couldn't do any of those things. We couldn't bring him out of his room for a movement break. So now it's only November and already that boy is starting to sound words…. he's just like already a different child. So, it's amazing.'
>
> [Manager, urban area]

Some participants explained that the policy of the setting was to take everyone into pre-school irrespective of need:

> '…we never turn a child away; our ethos is around supporting those most in need in the community.'
>
> [Manager, urban area]

This 'open door 'approach, whilst consistent with full inclusion, was reported to be difficult to conduct and settings very quickly identified training and support needs for their own staff. One participant felt that the introduction of AIM requires the setting to give much more detailed consideration of a child's additional needs, than had previously taken place.

A minority of participants expressed concern that supporting children is the responsibility of the setting. Whilst external advice and support to settings are welcomed, *'…really, it's up to us*' (Owner, urban area) and

> '…the workload has tripled…the additional workload is unpaid.'
>
> [Manager, INCO, urban area] Practitioner views on the relationship between the type of additional need/disability and the extent to which AIM is impactful

Practitioners were asked about whether they felt that AIM is more effective for children with some types of additional needs than others, and also whether AIM is more effective, equally effective, or less effective for autistic children.

The majority of participants indicated that the approach taken is to seek to include all children, irrespective of additional need or disability, and to use AIM targeted supports to the best advantage of the setting in supporting the child. A strong principle appeared to underpin this view which is that every attempt would be made to include all children and that only in exceptional circumstances would a setting be forced to turn away a child. The section below on non-participation in AIM identifies the circumstances under which settings might not be able to provide for children with complex or severe additional needs.

Participants described a wide and diverse range of emotional, behavioural, developmental, and physical needs having been accommodated with the support of AIM. One participant felt AIM had been helpful in supporting children with multiple needs (e.g., a child was described who had both emotional and linguistic needs) whilst at the same time supporting all children because through AIM the setting had more time to respond to all the needs in the pre-school room.

Another participant described how AIM enabled the setting to support a younger child with linguistic difficulty within a group of older children so that the supported child could benefit from hearing more advanced language being used by other children.

Such flexibilities were argued to be less likely to achieve without AIM support. Another referred to her practice of noticing and observing children's needs, of standing back and offering encouragement, and of consciously helping children to get ready for school, for example, by helping them to learn how to share or make friendships. All of the comments made appear to reinforce the notion that AIM targeted children are supported within an inclusive, whole group setting and assisted to participate meaningfully as one participant commented:

> '...you might have two children on AIM, but you might have other children with other behavioural difficulty or a child from another country who doesn't speak English. I don't apply for AIM for them, but the AIM support will be working for them.'

[Manager, urban area]

Most participants felt that because AIM is child-centered it is as effective for autistic children as for those with other types of additional need, and many described examples of how their pre-school had successfully accommodated ASD. Participants reported that in a few settings staff had been working with autistic children over many years and had undertaken specialist training courses. The two examples here are illustrative:

> '…we brought in hens, children with ASD love the animals. They have been able to find their niche and relax, holding the hens and collecting eggs.'

[Owner, urban area]

> 'Yes, when she [an autistic child] started here she had no social interaction at all with anybody. After a few days even she had a connection with me. That meant that if she was upset, she found me comforting …she really improved over the two years. This was due to AIM support being available to her. Because she had individual time on her own, she developed the understanding of pretend play and could get on with others. The main thing would be when she would get upset with the noise, I was to bring her away, relax her and bring her back slowly...she is doing really well at the moment in mainstream and her parents are pleased.'

[Level 7-funded AIM worker, mixed urban and rural intake]

Practitioner views on the relationship between the location of the pre-school and the extent to which AIM is impactful

Practitioners were asked for their view on whether the geographical location of the pre-school impacts upon the effectiveness of AIM. There were relatively few comments by participants about the impact of the location of the pre-school setting. Of those who did comment, location is reported to have impacted AIM via the following: proximity to county borders, the physical accessibility of the location, and the recruitment and retention of staff. One participant reported the setting was based in one local authority area and many children lived in the neighbouring local authority area. This had led to communication difficulties for the setting, particularly in respect of AIM EYS support. The participant commented that sometimes the AIM EYS had visited the setting to undertake assessments irrespective of where the child lived, but on another occasion had been unable to resolve a problem because it was out of the specialist's area.

A few participants felt that the physical location had helped AIM to be impactful. Settings described as purpose-built, easily accessible from the local town, having an outdoor space, and a good-sized car park for parent/carers to use, were all features of location that were helpful. Conversely the physical layout of very few settings appears to be contributing to the non-participation in AIM amongst some children. A minority of participants commented that geographical location can affect the recruitment and retention of staff. One felt that in rural areas hiring Level 7-funded staff is more difficult than in urban areas, because of the relative availability of people with appropriate skills and qualifications. However, another participant from a rural area described an effective local road arrangement that had meant that attracting candidates had not been a problem, although she was aware that colleagues in other rural areas did have problems filling posts.

There did not appear to be any evidence to suggest any differences in the extent of impact of AIM on the basis of an urban/rural split per se.

In summary practitioners' view of the **impact of AIM on children, parents/carers, and settings is as follows:**

- AIM is achieving a **positive impact on the inclusion and meaningful participation** of all children, including those with additional needs and including those with ASD.
- There did not appear to be any convincing evidence to suggest a relationship between the **type of additional need and the extent AIM is impactful** except in relation to the non-participation of children with complex additional needs.
- AIM's impact on parents/carers has been **to provide reassurance** that their child's additional needs will be met, by involving them more in planning and preparing for pre-school.
- The impact of AIM on settings has been **to increase knowledge, experience, and professionalism** about how to support children with additional needs.
- There does not appear to be a relationship between the **location** of the pre-**school** and the extent to which AIM is impactful.

Practitioner accounts of how AIM support is being implemented in the setting

In the following subsection we will discuss practitioner accounts of how AIM was implemented to achieve these impacts. As described in 2.5, AIM comprises seven levels of support that pre-school settings can access to support the inclusion and meaningful participation of children with additional needs. Levels 1 – 3 are described as Universal Supports and Levels 4 – 7 are Targeted Supports, approved in response to requests for assistance to support individual children.

Subsections 10.2 to 10.8 below describe practitioners' views of the ways each Level has been used in practice, and their relative strengths and weaknesses. What follows in this subsection is an overview of how AIM Supports are being used in settings to support children with additional needs.

Participants were asked about which Levels have been accessed by their setting. Interestingly, the majority of participants did not comment on Universal Supports but instead talked about Targeted Supports and how these had been used. Most participants reported having accessed Level 7 (8); a majority reported having accessed Level 5 (15); around half had accessed Level 4 (11) and no participants reported having accessed Level 6 support. The emphasis placed on Targeted Supports may reflect participants' focus on meeting the needs of particular children, or it may be that AIM's Universal Supports are to an extent taken for granted.

Of the participants who did describe Universal Supports, a minority commented positively on the availability of play resources provided through AIM, and on the provision of initial and continuing professional development opportunities - particularly the Leadership for INClusion in Early Years Care (LINC) programme from which graduates can progress to the role of Inclusion Coordinator (INCO) and which is associated with a higher rate of capitation. One participant felt that play resources should be replaced and updated regularly and there should be acknowledgment of the cost to settings of producing their own learning resources.

There is clearly much greater emphasis on implementing AIM with Targeted Supports. Most participants had implemented support for children by drawing down Level 7 funds. There was a very strongly held view that the capacity of Level 7 funding to reduce ratios and usher in additional staffing was key to the support of children with additional needs. Some participants described using Level 7 funding to buy in sessional staff, and very few explained that Level 7 funding was being used to supplement the pay of full-time staff because attracting staff with appropriate qualifications and experience is not always possible with the offer of a part-time job, or at the hourly rate provided through AIM.

> 'I have to get the best people. These children deserve to have people that are able to support their needs and have a level of expertise and skill, and £13.50 is not going to pay for somebody to hang on. One year I got 9 hours at £12.50 – who even works for 9 hours?'
>
> [Manager, urban area]

Level 5 funds had been used extensively to implement AIM and these were generally welcomed. Participants described Level 5 funding that was used to create permanent structures, such as paths or outdoor spaces which contributed to the capacity of the setting to be an inclusive environment, and others described Level 5 funding attaching to items in support of an individual child.

Although around half of participants referred to availing Level 4 support, it is possible that these perceptions under-estimates the position. More settings may actually be working with EYS prior to children's admission (during an assessment for example) than is reported as most participants' comments about Level 4 support related to the ongoing advice that they received from EYS whilst children attended ECCE. Most comments were complimentary. The EYS were also cited as being

part of the process of information-giving to parent/carers as part of Level 2. However, one participant did voice concern about the mentoring capability of the EYS.

> *'…my experience is that I don't feel that the mentors are qualified enough, if I'm honest, the big issue is that it's seen as behaviour management, rather than supporting the child … maybe the caseloads are too high, and they haven't got the time. …The expertise wasn't there, the follow up wasn't there and the general interaction wasn't there…'*
>
> [Manager, urban area]

Participants' views about the use of Level 6 support are conspicuous by their absence. Comments suggest that all participants agree that Level 6 support is not happening in practice except in cases where therapeutic services, or specialist staff were already involved in the child's care. Applications for Level 6 support as part of the implementation of AIM are reported as not being made by all participants, with many reporting that this is because they know there are resource shortages in this sector.

The following examples show how AIM support has been implemented in settings to include children with additional needs:

- Reduction of staff: child ratio to support ASD
- Bluetooth microphone for a profoundly deaf child
- Staff training on how to manage PEG feeding
- Creation of an outdoor space for children with ASD
- Provision of a specialised chair and swing for a child with mobility needs
- Microphones and speakers for a child with cochlear implants
- Handrails, adapted toilet seat and changing facilities
- Drawing board adapted for child with cerebral palsy
- Picture Exchange Communication System (PECS)
- Raising of flower beds to enable access by wheelchair users
- Staff training in the management of epileptic seizures
- Advice from EYS on resources and strategies
- Training in Lámh for use with a child with intellectual disabilities
- Extension of time in pre-school to 3 years
- Advice from occupational therapists and psychologists for child diagnosed with ASD
- Provision of sensory toys
- Use of a communication board to support language delay
- Modelling interactions and turn-taking
- Introduction of a buddy system to support socialisation
- The setting of goals and plans with EYS

In summary, participants accounts provide **positive stories of how AIM support is being used and its impact:**

- Practitioners' accounts show that **AIM Targeted Supports** are being used extensively by settings to support inclusion and meaningful participation and to respond to additional needs. The use made of Level 5 and Level 7 support is particularly high.
- There may be some evidence that **AIM Universal Supports** are so well embedded as to have become taken for granted.
- The following examples show how AIM support has been implemented in settings to include children with additional needs:
    - Reduction of staff: child ratio to support ASD
    - Bluetooth microphone for a profoundly deaf child
    - Staff training on how to manage PEG feeding
    - Creation of an outdoor space for children with ASD
    - Provision of a specialised chair and swing for a child with mobility needs
    - Microphones and speakers for a child with cochlear implants
    - Handrails, adapted toilet seat and changing facilities
    - Drawing board adapted for child with cerebral palsy
    - Picture Exchange Communication System (PECS)
    - Raising of flower beds to enable access by wheelchair users
    - Staff training in the management of epileptic seizures
    - Advice from EYS on resources and strategies
    - Training in Lámh for use with a child with an intellectual disability
    - Extension of time in pre-school to 3 years
    - Advice from occupational therapists and psychologists for a child diagnosed with ASD
    - Provision of sensory toys
    - Use of a communication board to support language delay
    - Modelling interactions and turn-taking
    - Introduction of a buddy system to support socialisation
    - The setting of goals and plans with EYS

Practitioner perspectives on the factors that have helped and hindered AIM's impact

Participants were asked their views on what the strengths of AIM are and what might be improved. From the rich commentary provided by them we have distilled factors that they feel have helped AIM to be impactful, and those that have hindered. In this subsection, we report on both a broad consensus of views and also minority perspectives where these appear to be important. We begin with factors that have helped.

Factors that have helped

Fundamentally participants felt that AIM is right. It was acknowledged that AIM resulted from policy decisions at government level, and that the policy direction was appropriate and timely. Specifically, the purposes and principles underpinning AIM are appropriate for the pre-school sector, and participants welcomed the fact that AIM is here, and that children and their families gain benefit from the supports it provides. The inclusion model of seven levels of support was seen as helpful. AIM had increased the visibility of equality, diversity and inclusion issues in the sector and provided opportunities for conversations about achieving fairer access to education for children with additional needs. Universal supports were considered to be helpful, particularly in relation to Level 3 support for staff training, including the LINC programme, the Equality, Diversity, and Inclusion (EDI) training, and the availability of Continuing Professional Development (CPD) for INCOs.

Participants agreed that targeted support at Levels 5 and 7 had been particularly helpful in enabling settings to provide support to individual children, and to achieve their meaningful participation in activities with their peers. Level 7 support to reduce ratios and provide an additional member of staff in the room was universally viewed as helpful.

Level 4 support was agreed to be helpful and the ease of communication with EYS was seen as a particular strength. The advice and support provided by EYS was welcomed and one participant felt the mentoring support had been valuable. For the most part the role of EYS and external services in the observation/assessment of children was viewed as helpful, although the more experienced staff in settings indicated that goal setting could be undertaken by them.

The involvement of parent/carers in the process of identifying and planning for their child's additional needs was seen as helpful and essential. There was a view that parental involvement in the application process made them feel included, supported and listened to, and that this was helpful particularly where parent/carers had been struggling to cope with their child's additional needs. The early timing of these processes (i.e., by early summer before enrolment in September) also helps.

A number of helpful and impactful factors arise from the implementation of AIM in settings. These include the provision of a 3rd year of AIM in ECCE for some children, the practice of separating children with Level 7 support into different rooms/sessions each; using Level 7 support flexibility to support 1:1 moments, small group activities and team teaching; the preparation and use of the Access and Inclusion Profile; the availability of resources and equipment via Level 5 support; the recent ease of making online applications for support; and the information available to parent/carers and setting's staff on websites. A practice described as helpful by one participant involved staggering the start time of two Level 7-funded members of staff in order to provide support during lunchtime and early afternoon but regrettably this was not permitted as part of AIM.

The fact that AIM does not require children to have a prior diagnosis was viewed as helpful and enabled settings to view the child's needs holistically. Participants reported that the culture of inclusion stimulated by AIM has reinforced a 'can do' approach in settings in respect of addressing additional needs, and this is helpful. A culture of not saying 'no' to families and children helps them to get the support they need.

Factors that have hindered

A cluster of factors described as unhelpful relate to staffing. Participants reported that the part-time, 15 hours per week per child contracts offered to Level 7-funded members of staff hampered recruitment and retention of staff. The terms and conditions that could be offered to Level 7-funded staff functioned as a further disincentive for candidates to apply for or employees to stay in posts. These included: the rate of hourly pay; absence of sickness or holiday pay; the ambiguity of job role; payment for contact hours only; no contract to cover the summer holiday period; no allowance in the funding model for the payment of Level 7 staff to undertake administrative duties such as report-writing or meeting with parent/carers, or attend staff meetings; the cessation of contracts when the supported child progresses to school; and the inability to automatically roll over staff contracts from year one to year two without making a fresh application for Level 7 support. Participants commented that the recruitment and retention of staff is an ongoing problem.

One participant felt particularly strongly that the sector should be seeking to upgrade its expectations on qualifications for working in the sector, suggesting the target of moving to an all-graduate workforce. Another suggested that staff employed with Level 7 funding in pre-schools should be employed in parity with SNAs or teachers in school. Participants observed that recruitment to many job roles is reported to be difficult at the moment and currently the terms and conditions offered to Level 7-funded members of staff do not compete well with other job vacancies in the local labour market.

There was agreement that the role of INCO requires a lot of non-contact time (for report-writing, meetings with parent/carers and other professionals, setting plans in place, monitoring, and recording progress etcetera.) for which the higher capitation allowance does not compensate. One participant felt that the expectation that INCOs will be able to cascade training to other members of staff is unreasonable because of time pressures and a lack of skills in teaching for staff development. Another factor widely reported to be hindering AIM's impact is the limit to 3 x hours per day supported attendance for children. Many participants felt that extending the supported hours could be beneficial for children, families, and staff, and noted that full inclusion could be compromised for children who attend pre-school full-time and who experience a fully supported morning and a less or unsupported lunchtime and afternoon. The practice of stopping the funding when a child is absent for a lengthy period but intends to return (e.g., for hospitalisation) and financial penalties for short-term absence, and the inability to back-date applications for support are considered to be unhelpful and put settings under financial pressure.

Participants identified difficulties in the process of applying for support. Of note were participants concerns about the length of time it takes to acquire equipment under Level 5 which has sometimes resulted in children not having support in place at the start of ECCE or, in at least one case, not at all. Since some children's additional needs require support to be in place in order for them to participate, delays can result in children being unable to access ECCE. Some participants felt the transfer of equipment with the child, or withdrawal of equipment when the child leaves the setting is unhelpful. In participants view, a particularly disappointing and unhelpful factor is the inability of settings to acquire Level 6 support.

Most participants felt that the use of the words ‘disabled’ or ‘disability’ in information about AIM or application documents is unhelpful. Participants reported parent/carers associating these words with diagnosed physical or cognitive ‘impairments’ and not applying to behavioural or development needs. The use of these words is understood to be off-putting for parent/carers whose child is newly identified as needing additionally support.

Another factor which is viewed as unhelpful concerns the early identification of additional need. In settings where children attend as babies or toddlers, it is argued that identification of disability could reasonably be made before 2 years 8 months, and thus enable earlier assessments and/or fast-tracking of the application for support which would obviate some of the concerns settings have about being ready for full inclusion at the start of ECCE. Not being able to assure parent/carers that support will roll over from year one to year two is reported to be unhelpful. Participants suggested the requirement to re-apply for support annually is unhelpful. The geographical location of settings was mentioned infrequently but participants whose premises were near county boundaries felt that liaison with more than one local authority was unhelpful. Inaccessible locations were reported to exacerbate recruitment difficulties.

That COVID 19 has been an unhelpful factor is not surprising, but participants felt that its impact could be considerable. For example, participants reported concerns about observing more language delay in children and mental stress in parent/carers. COVID 19 may also be a factor in slowing the supply of equipment and resources. The pandemic has also interrupted the face-to-face observations undertaken by EYS and other professionals.

Practitioners offered a range of factors that affect the impact of AIM.

Significant amongst the **factors that help AIM** to have impact are:

- Governmental policy and raising the visibility of social inclusion,
- The system of Levels of support that can be targeted around individual needs,
- Staff development,
- Parental involvement,
- Enhanced practice in Early Years education,
- The development of a culture that aims to include all children in pre-school learning irrespective of need.

Factors that **hinder the impact of AIM** are:

- Recruitment and retention of staff,
- The complexity of the role of the INCO and increased burden of workload on settings,
- Financial pressures for settings,
- The time taken to acquire equipment and resources, and
- The use of the term ‘disability’ in information accessed by parents/carers.

Practitioner views on the sustainability of AIM.

Sustainability is sometimes described as the capacity to meet current needs without compromising the ability of future generations to meet their needs. The focus on both the present and the future is captured here in participants’ comments about what they would like to see improved in AIM. What follows is a broad range of suggestions for the sustainability of AIM, some of which attracted widespread agreement, whilst others reflect the insights of individuals.

As the previous section foregrounded perspectives on staffing, we begin with participants' views on ways to improve this; the first topic is staff training. It was suggested that all staff in pre-school settings be encouraged to take the LINC programme and enabled to join in the follow-up CPD. There was even greater support for all staff to undertake the EDI training because of its focus on inclusion and equality. Some participants requested further training in specific areas relevant to children's needs, particularly to support frequently occurring needs such as ASD and speech and language development. It was suggested that a Quality and Qualifications Ireland (QQI) level 5 qualification is not appropriate for staff providing specialist support.

Training in first aid and minor medical/health interventions was also suggested. The provision of incentives for staff and/or settings to engage in training and CPD was suggested. The importance of training to update and extend skills and expertise was stressed; it was noted that many INCOs had completed their training 5/6 years ago.

Suggestions for improvement to the terms and conditions of Level 7-funded staff included the drawing up of a standard job description that settings could adjust to meet local needs, and which clarified the scope of the role and the person specification. The provision of regulations and/or funding to enable settings to employ Level-7 funded staff over the school holiday periods, provide sickness pay and holiday pay, enabling automatic progression from year one to year two of ECCE, and reviewing the hourly rates of pay along with the introduction of greater flexibilities in the way that these staff are deployed. For example, employing additional support for short periods during a child's induction into the setting. Changes to staff development and terms and conditions are thought likely to improve recruitment and retention and help settings to model full inclusion in their own employment practice.

A number of participants felt that the expertise of staff working in pre-schooling was not valued in the same way as other parts of education and that it would be helpful to review the relationship between Level 7-funded assistance and that of the SNA in schools. One participant felt that there is need to recognise the complexity of pre-school education and strengthen public trust in the profession. One participant advocated for all pre-schools to be linked to local mainstream primary schools to aid communication and support children's transition. One participant suggested that a simple, annual evaluation to collect the views of staff, parent/carers, and children could be carried out on a national basis. It was suggested that it is particularly important to try to capture the 'child's voice.'

There was agreement for the reduction of the age for AIM support to 2 years, the increase of supported hours to support children attending full-time, and the inclusion of summer camp activities for AIM support. Participants felt this would aid full inclusion and support working families.

Enabling settings to apply for funding to buy specialist toys or equipment for use in the home was suggested. One participant reported that on the advice of an occupational therapist the setting had been asked to provide a peanut ball for a child to use at home, but this was not allowed under Level 5 support.

The suggestion to enhance parental/carer involvement in AIM was made. Comments suggest that participants felt that parent/carers can easily be 'left out' of communication with settings once the initial assessments/applications had been made, and attention should be given to strengthening meaningful home-school dialogue.

Suggestions included the setting up of support groups and the use of social media. One participant suggested the provision of access to psychological or counselling services to support parent/carers and staff working with children with life-limiting conditions. In particular the provision of bereavement

support was suggested. It was suggested there is scope for developing stronger collaborative working with related agencies and services.

Practitioners' accounts suggested **a wide range of ways to build upon the achievements of AIM** and ensure a sustainable future for inclusive practice in early years settings.

In particular their comments suggest there is scope to:

- Make improvements to the employment and training of staff
- Continue to develop a confident and competent workforce.

Practitioner views on the scalability of AIM

In this subsection we review practitioners' views on how AIM could be scaled up and whether benefits might be accrued. What follows are participants' responses to five questions - Which children can benefit from targeted AIM support? Should AIM support be provided for younger children? Should AIM support be provided outside the ECCE qualifying hours for children who attend for full days? Should the AIM model be extended to School Aged Childcare? and should the AIM model be duplicated in schools?

Most participants felt that AIM is for all children and most settings' policy is to seek to admit all children irrespective of need. This appears to be due to a general understanding that the earlier education begins, the better the outcomes for children are likely to be. AIM is thought to be beneficial to children who have a wide range of (often undiagnosed) behavioural and developmental additional needs, as well as those who have specific physical or medical needs. Participants commented that additional needs can also arise from children being from disadvantaged backgrounds, or from belonging to a minority group, or having psychological needs, or English as a second/additional language, or being in foster care, or belonging to the Traveller community or being a refugee. One participant commented:

> 'Do you know I'm actually going to answer that with all children within the pre-school if you want me to be honest with you. Our little one, that's special with their very complex needs… our other children are actually very protective and helpful with her. So, they want to help her do things as well. So, I think it benefits all the children that's within the pre-school, to be honest with you.'
>
> [Owner, urban area]

Most participants agreed that there would be benefit in extending the reach of AIM to younger children. A strong reasoning for that view is that many additional needs become known before 2 years 8 months of age, especially where the child is already attending the setting or is known to EYS and health services or has a diagnosis. Some younger children are reported to be receiving additional support now at the expense of the setting. A minority of participants felt that not providing AIM to younger children could be considered discriminatory on the basis of age, and not consistent with full inclusion. One participant reported that a nurse had recommended a two-year-old be included for support, due to speech and language delay, on the basis that 8 or 9 months of support could make a significant difference to the child's development. Another felt that providing support at an earlier age would help families struggling to manage their child. One participant suggested that unless a child already has a specific diagnosis, that identification of additional needs becomes possible at 1 – 2

years of age, and that training and/or resources would be beneficial for staff working with children under AIM's target age group.

Most participants agreed that there would be benefit in providing AIM support outside the ECCE qualifying hours for children who attend full days as children have additional needs 24/7. A minority of participants felt that it would provide families with much-needed support, could impact positively on parent/carers' mental health, and support working parent/carers. An example was given of families having more than one child with additional needs and the provision of more supported hours was thought likely to enable parent/carers to manage their childcare more effectively. Extending the supported day from 3 hours to 5 hours was suggested to be likely to increase full inclusion for children who have difficulty joining in and could be used to facilitate small group work. A few participants commented that possible changes would have to be considered in light of the National Childcare Scheme and attention given to the financial implications for settings, such as penalties for non-attendance. One participant suggested that AIM be extended to summer camps, between years 1 and 2 of ECCE, and between ECCE and starting school.

A majority of participants agreed that the AIM model should be extended to School Aged Childcare. One participant commented that some additional needs become increasingly difficult for families and children to manage as children become older. A minority of participants commented that the typical staff: child ratio of 1:12 in School Aged Childcare may not be appropriate for children with additional needs. Providing AIM for School Aged Childcare could be used to continue full inclusion and meaningful participation by keeping ratios low. An example was given of a child who had been supported through AIM and now attends school with SNA support. The child joined the School Aged Childcare at the setting, but the SNA did not attend with her. The child became anxious in School Aged Childcare and had to be withdrawn by her parent/carer. One participant felt that extending AIM to School Aged Childcare would be preferable to SNA support transferring into School Aged Childcare as AIM is focused on inclusion in meaningful activities rather than 1:1 support.

Fewer views were expressed about the AIM model being duplicated in schools and whilst the notion of AIM in schools was welcomed participants felt that the prevalence of the SNA model might make the implementation of AIM difficult to achieve. For example, school teaching staff would need to be trained. Participants expressed the view that if AIM could be duplicated in schools there would be a benefit for children transitioning from pre-school to school, and opportunities to share resources.

The view of practitioners is that AIM could be extended in the following ways:

- The **inclusion of younger** children through provision of AIM to the pre-qualifying age
- Enabling support to be provided **outside the ECCE qualifying hours** for children who attend for full days
- The extension of the AIM model to **School Aged Childcare**
- The duplication of the **AIM model in schools** would be welcomed but additional staff training, and development would have to be put in place to ensure a shared understanding of AIM
- The scaling up of AIM would be likely to **increase full inclusion and meaningful participation** in schools in children with additional needs and support their transition from pre-school to mainstream primary or special school more successfully.

Practitioner views on non-participation in AIM

All the participants interviewed had either participated in AIM previously or were doing so currently; most were making or had made applications for Targeted Supports for the current year. The predominant Targeted Supports applied for were at Levels 5 and 7. All participants had participated in Universal Supports Levels 1, 2 and 3 either in the past or currently. In this section we explore participants' views of the application process to find out whether there is evidence that it contributes to non-participation and participants' views of the reasons why there is non-participation in AIM. We begin with participants' views of the application processes.

Most participants reported the online applications processes to be easy to use for settings but less so for parent/carers. It was suggested that more support for parent/carers to complete application documents would be helpful.

Participants reported that delays in approvals could be lengthy, especially for Level 5 support, and the time from application to approval was generally longer for new applications than re-applications. Communication between key parties (e.g., EYS, occupational therapists, families) and settings about submitted applications could result in further delays. Participants felt that the earlier an application for support could be made the better. One participant felt that in children with a diagnosis the application for support could be made before registration at the setting.

A minority of participants felt that staff in settings should be trusted to make assessments and applications without the help of external agencies. One reported videoing a child so that the EYS could view it remotely. Another indicated that successful applications for a third year of AIM were difficult to achieve. There did not appear to be any evidence of the process of applying for support that discouraged participation in AIM amongst settings.

Although a minority of participants expressed concern about aspects of the AIM funding no-one gave this as a reason for non-participation amongst settings, although it should be noted that the practitioners interviewed here worked at settings that did participate in AIM.

Participants' views about the non-participation of children with additional needs are more nuanced. Some participants described situations where children could not be admitted to ECCE even with the support of AIM. Such children included those with complex medical needs or those whose behaviour was assessed as dangerous to themselves or others. An example was given of a child who had to be carried throughout the day. Very few participants expressed concern about the level of responsibility involved in the participation of children with severe needs. Some of them reported known cases of children being excluded from other settings.

One participant described a child's parent/carer withdrawing them from ECCE because the setting was trying to obtain support; the parent/carer disagreed that the child had additional needs that could be supported through AIM.

The reasons given for not being able to include children with severe additional needs were that the setting did not have access to suitably trained staff, or that medical issues meant that children needed more care than could be provided by Targeted Supports, or that the location was not suitable and/or could not be adapted to be so.

Practitioners described the **non-participation in AIM** of some children with severe additional needs, such as extremely hard to manage or dangerous behaviour, or medical and physical needs that could not be addressed with Targeted Supports.

Two other reasons suggested for non-participation were that:

- The setting did not have access to appropriately **trained and experienced** staff,
- That **the location** of the setting was unsuitable.

Non-participation appears unlikely to be the result of the application process for support, although it was noted that some parents/carers would benefit from more support in completing forms.

10.2: AIM Level 1: Universal supports in the pre-school

The Access and Inclusion Model (AIM) was designed to support access to the Early Childhood Care and Education Programme (ECCE) for children with a disability. Figure 2.2 offers a summary of AIM and demonstrates that it has a foundation of universal design for quality (Levels1, 2 and 3) combined with targeted support (Levels 4, 5, 6 and 7). We begin this subsection with participants' views of AIM Level 1: Universal supports in the pre-school, which is focused on the development of an inclusive culture.

AIM Level 1 support provides initial training of staff in pre-school settings on matters related to equality, diversity, and inclusion, and comprises two components: the Leadership for INClusion in Early Years Care (LINC) programme, and training focussed on the Diversity, Equality, and Inclusion (DEI) Charter. Courses are free to participants and enrolment is via the City and County Childcare Committee (CCC). The LINC course is a pre-requisite for taking up the role of Inclusion Coordinator (INCO) and having a graduate of the LINC course confers an uplift in capitation. The EDI training is used to promote an understanding of equality, diversity and inclusion and encourages settings to develop their own charter and to reflect on their own practices. Level 1 support also includes a pack of toys and learning materials designed for use with all children in inclusive play.

Most participants agreed that there were at least one, and sometimes two, members of staff at the setting who had done the LINC course. The INCO's role following training was to facilitate the operation of AIM in the setting; this included the dissemination of information, liaison with parent/carers, help to initiate applications for Targeted Support, supporting other staff, and communicating with external services. One participant reported that liaison with parent/carers was not always carried out by the INCO as the practice in that setting was for the member of staff with the best relationship with the parent/carer to initiate discussions about a child. Some participants were critical of the LINC training, considering it to be of too low a level academically, and rather basic, particularly for experienced practitioners. One participant suggested it was not sufficiently interesting and challenging and thought that courses aimed at training in specific disabilities, such as the TEACCH programmes for ASD, Teach Me as I Am, or the PECS programme would give staff more appropriate skills and knowledge.

Some participants felt the EDI training had been of greater value. One described it as having:

> 'Changed lives…a wonderful and powerful course to do.'
>
> [Manager, urban area]

Another regretted that it had been reduced in length from 11 days to 15 hours. The EDI training appeared to be valued because it had encouraged professional reflection and encouraged staff teams to talk about diversity and equality and what these might mean for practice. Another regretted that there had been no financial incentive to undertake the EDI training. A minority of participants commented about their use of the DEI Charter and felt that it had helped settings to explain AIM to parent/carers.

One participant reported that she used the Charter all the time in relation to thinking about the physical environment of the setting. Another felt that the messages in the charter opened up discussion of wider equality issues, such as the way that minority ethnic groups access the service. This participant was concerned about the way AIM supports children from the Traveller community. Another participant concurred that AIM may not be taking enough account of diversity issues in relation to English as a second language, or children's cultural backgrounds. She observed that in her own community there had been significant demographic changes over the past 20 years that need to be accommodated by AIM.

Participants were asked for their views on their use of the Inclusive Play materials; their responses were mixed. Some felt they were very useful and had added to them, but a minority felt disappointed that there was no training or advice given on how to use them. Some participants had used the play den and toys so extensively that they had become worn; the weighted toys and kinetic sand were also mentioned as being used. One participant had found the sensory toys to be of particular value in helping her to better understand children's need for and use of sensory toys. However, one participant had given the materials to parent/carers to use with children at home, and she reported that she was aware of a colleague (in another setting) who had not used the materials at all. It was suggested that the materials could be updated and worn ones replaced.

Practitioners expressed **generally positive views of the staff training support in AIM Level 1**, in particular the Equality, Diversity and Inclusion (EDI) training arising from the EDI Charter.

There was some concern that notions of social inclusion did not include matters relating to **cultural diversity or issues faced by those from minority ethnic groups.**

Some practitioners advocated **staff training at a higher academic level** than the current level 6 Leadership for INClusion in Early Years Care (LINC) course.

Inclusive Play materials appear to be used extensively; in particular:

- The den
- Kinetic sand
- Soft toys
- Weighted sensory toys
- All other sensory toys

Inclusive Learning materials and play resources are now in need of updating and there are suggested to be benefits in **training staff in how to use them**.

10.3: AIM Level 2: Information for parents and carers

As explained in 2.5, AIM Level 2 focuses on the information needs of parent/carers and seeks to ensure that they have access to sufficient information to make the best decisions for their pre-school child. Information underpins parental/carer decision-making upon entry to pre-school and during the child's attendance. Settings are closely involved in providing information about AIM because consulting with the intended pre-school is the parent/carer's first step in seeking admission to ECCE and making an application for AIM support.

Information about AIM is currently available through websites (e.g. www.betterstart.ie and www.aim.gov.ie), through information leaflets or notices produced by pre-school settings, via email and telephone communication with related services such as EYS, and through informal channels (e.g. friends and family) and ancillary services (e.g. health services).

In this section, we explore participants' views of the way information about AIM is communicated to parents/carers. We begin with information upon entry.

Most participants felt that parent/carers were unaware of AIM until it is mentioned by staff in settings. There appears to be a generally held view that most parent/carers' first knowledge of AIM is when they approach the setting for a place unless they are already involved with the Early Intervention Team (EIT) or other professional services. Settings convey information about AIM through meetings with parent/carers, notices, and information leaflets. Some participants felt that parents/carers of undiagnosed children lack time to read information and tend not to research websites; parent/carers of diagnosed children, however, are thought to be more likely to be aware that support is available before they approach the setting.

Most participants felt that wording in information that includes the term 'disability' is off-putting for parent/carers, particularly those who do not perceive their child to have a disability and/or who may be fearful that their child's additional needs might exclude them from participating in ECCE or mainstream education. An example was provided of a parent/carer who had to be advised not to take the wording of the information too literally.

Applications for AIM support are made by parent/carers in collaboration with settings, and on the basis of an informal assessment of the child's needs. Communication with parent/carers is reported to be via meetings to share information and agree action. Participants describe their role is to explain what is available through AIM, and what level of targeted support might work best for the child in that setting. Conversations with parent/carers can be difficult to conduct sensitively. One participant explains to parent/carers that AIM support is largely for the setting, to help the setting better meet the needs of all children. This kind of strategy suggests inclusiveness and not trying to identify problems that give parent/carers cause for concern. Another felt that it is possible to give more information than parent/carers need to hear and gave an example of a parent/carer who Googled AIM and could not sleep for worrying about what it might mean for their child. Getting the balance right between giving enough information to assist parent/carers in making decisions about AIM and raising alarm in parent/carers about the child's future progression, is reported to be challenging.

Participants suggested that getting information about AIM to parent/carers via the community, for example through GPs, social workers, etc., could be helpful. Translating information into a wider range of languages and making information simpler to understand was also suggested. One participant felt that the AIM diagram showing the levels of support was unhelpful and overly academic and that parent/carers only need to know what support there is for their child. Showing a parent/carer that their child is eligible for the highest level of support could risk full inclusion if that parent/carer expects their child to be given 1:1 support or isolated from their peers. Information presented on websites was agreed by most participants to be helpful for both settings and parents/carers, although parent/carers would be unlikely to search online for information unless directed to do so.

Parent/carers need information about AIM throughout their child's participation in pre-school. Participants described continuing to meet with parent/carers to update on progress and using a variety of techniques, such as, sharing resources, and diaries in children's bags, to convey information. Parent/carer's ongoing need for information about how AIM is impacting was seen as an important, if time-consuming, role for settings, especially at key decision points such as the end of year one, or transition to primary school. One participant suggested that parental support groups could be established.

In relation to **information for parent/carers**, practitioners felt that:

- Most **parent/carers are unaware of AIM** until they approach the setting to register their child.
- Appropriate information about how AIM supports children's additional needs should be made available **both upon entry** to pre-school and **throughout the child's progression** through pre-school.
- Information could be better communicated by **widening information sources** to include other professionals, such as GPs, and the wider community.
- Parent/carers may be better supported by having access to information that is **relevant to their own child**.

10.4: AIM Level 3: A qualified and confident workforce

In this subsection we explore participants' views of their continuing professional development (CPD) which is the focus of AIM Level 3.

Opportunities for CPD within AIM are promoted through the AIM website at www.aim.gov.ie and comprise Hanen Teacher Talk, a three-day training course for settings to help them enable young children to develop language and literacy skills; Lámh, a manual sign system used by children and adults with intellectual disability and communication needs; and Sensory Processing E-Learning (SPEL) which helps settings support children with sensory processing difficulties. These CPD courses are delivered by Better Start. A wide range of online CPD courses, covering specific and general topics, is promoted on the *First 5* website. Courses are free for participants and attendance is voluntary. Participants' views of their CPD were at times contradictory and we have inferred that perception of the appropriateness of CDP options depends upon existing levels of staff experience and training. Some participants felt that the (Level 1) LINC training and updates should be provided as CPD to all staff, and that settings would benefit from having a LINC-trained person in each room. They also felt that the EDI training (also Level 1) should be available as CPD to all staff working within

AIM; one participant thought it is so important attendance should be mandatory. A minority of participants identified a lack of CPD opportunities to address understanding of cultural issues and the way AIM could address the additional learning needs of minority ethnic groups. They also felt that there are no opportunities for training in special needs and health or medical care. One participant described how the setting took the initiative to ask its visiting nurses to provide staff with training in the management of PEG feeding.

Very few comments revealed a concern about the relationship between CPD/initial training and the recruitment of staff. One participant commented that it is difficult to attract staff with appropriate skills and length of experience and felt that INCOs should have at least five years' experience; a comparison was made to degree programmes in childcare where five years' experience is a pre-requisite. Another felt that higher level training should be more readily available as this helps settings to attract able candidates into the profession. The CPD provided through Level 3 received mixed reviews; a minority felt that courses such as the Lámh and Hanen training were too basic and others felt the CPD offer, particularly that available online (and during Covid interruptions) had been excellent. A few comments endorsed the idea that more training to support specific additional needs (e.g., ASD, or linguist delay) should be provided. The major barrier to the take up of CPD is the availability of staff time. The comment was made that training had to be undertaken during the working day, or in evenings and weekends, as there is no opportunity for services to release staff to attend elsewhere during the day. One participant expressed the view that courses were not free of charge to settings as staff time had to be paid for. Another suggested it is inappropriate to expect INCOs to cascade training as they may not be adequately trained or have sufficient time to do so.

Practitioners' views on AIM's achievement of a qualified and confident workforce varied:

- Views of the appropriateness of continuing professional development courses available through AIM Level 3 support appear to depend upon the **prior qualifications and experiences** of staff.
- The use of Equality, Diversity and Inclusion training and the Leadership for INClusion in Early Years Care course are **advocated for the development of all staff** in settings.
- Lack of time to complete courses is the main barrier to participation and some **settings incurred costs in paying for staff** to undertake courses in the evenings or weekends.

10.5: AIM Level 4: Expert early years educational advice and support

AIM Level 4 comprises the provision of expert early years educational advice and support to both settings and parents/carers by Better Start Early Years Specialists (EYS). The advice and support are aimed at ensuring that appropriate goals for children in ECCE are set and that those goals can be delivered through AIM supports. Part of the role of EYS through Level 4 support is the provision of mentoring and coaching of staff working in settings.

A key component of Level 4 is the completion for each child of the Access and Inclusion Profile which identifies children's abilities and lays the foundation for goal setting and monitoring of progress in My Inclusion Plan, together with the provision of advice to settings in the achievement of children's goals. The EYS service also advises and inputs applications for targeted support at Levels 5 and 7 and initiates referrals for Level 6 support. In this subsection we will explore the views of participants about the educational advice support they have accessed, and their views on the Access and Inclusion Profile.

All participants' views of the EYS were positive in one way or another. Comments such as 'the support has been excellent', 'the EYS are very responsive and helpful', 'She's brilliant [referring to the EYS]' are commonplace in participants' responses. The reasons frequently offered for the positive assessment of the EYS services included the ease of contact with the EYS, the rapid turnaround of requests for information, their ability to maintain contact with parents/carers, their resourcefulness in finding out information, providing another perspective on the needs of the child, and their advice on strategies to use with particular children. The EYS service appears to have been able to build up effective working relationships with staff in settings, with parents/carers, and with staff in related services, and appear to 'hold the ring' on communication between parties. Whilst EYS services have been adjusted to take account of the pandemic – there appear to be fewer face-to-face visits – specialists are reported to still be in contact with settings. One participant indicated that an EYS undertook a child observation via Zoom; another recalled a conversation with a parent on video call.

The view of participants that EYS are easily accessible, by phone and email, contributes to staff in settings feeling valued. The only critical view of EYS related to the mentoring and coaching element of their role. One participant felt that, whilst the idea of having a mentor has value, there is doubt about specialists' expertise and a concern that their advice is overly focussed on behavioural management rather than inclusive practice. One participant felt little need for EYS services as she felt the expertise already existed among the staff at setting. This indicates that pre-schools have different needs and may require a flexible approach from the EYS.

EYS services communication with parent/carers is most frequent at the initial stages of contact with AIM, after which the focus shifts to the pre-school. Ongoing contact between parents/carers and the EYS service appear to vary. One participant commented that there is no contact beyond the initial assessment stage; another that parents/carers can feel left out of conversations and decisions. Yet another participant had experienced the EYS organising meetings between herself, the parent/carers, and the setting. It appears that the level and type of on-going communication with parent/carers may be determined by the child and their family's needs, or by EYS caseloads and how much time they have available to engage in collaborative work with pre-schools and parent/carers.

The creation of the Access and Inclusion Profile was reported as an activity that involves parents/carers, EYS and settings working collaboratively.

Most participants reported being involved in creating profiles, and commonly setting objectives and goals for children. Parental/carer involvement varies from agreeing with the profile shared with them, to actively completing it on behalf of their child. One participant felt the forms used to set up profiles were considered intimidating for some parents/carers, and not inclusive, and there is a need for forms to be in accessible formats. Parents/carers (who themselves may have a learning need) may find recording information about their child difficult or not appreciate the need for it:

> '[the form] uses terms like expressive language- parents don't know what it is. There should be an example so the parent can picture this and relate to their child.'
>
> [Administrator, trainer, urban area]

Some participants commented that a new component of the profiling system is working well, particularly the *My Inclusion Plan's* capture of the child's voice.

AIM level 4 expert advice and support is reported to be working well.

- AIM Level 4 advice and support provided by Better Start through Early Years Specialists is **very highly regarded** by practitioners in settings, particularly in relation to their responsiveness and accessibility.
- Applications for support and the completion of the Access and Inclusion Profile provide opportunities for Specialists, settings, and parent/carers to **work collaboratively** in the interests of children.
- There may be need to **strengthen opportunities for some parent/carers** to access advisory support, especially those who have learning needs.

10.6: AIM Level 5: Equipment, appliances, and minor alterations grants

Some reporting of practitioners' use of equipment, appliances and minor alterations grants is included in the section above-entitled *Practitioner accounts of how AIM support is being implemented in the setting* which includes a list of examples of support for the inclusion of children with additional needs.

In this subsection we explore participants' views of the acquisition of grants for equipment, appliances, and minor alterations (EAMA) made available through AIM Level 5.

All participants were aware of the availability of AIM Level 5, and most had experience of making applications for it. Participants whose applications were successful report using EAMA to achieve full inclusion and meaningful participation. For example, a microphone was used to enable a child with a hearing difficulty to join other children on nature walks, a specially adapted chair was used to enable a child to sit with her peers to eat lunch and a visual board was used to facilitate communication with a child with cerebral palsy. These and other EAMA were welcomed.

However, interviewees expressed concern about the operation of Level 5, notably on the length of time taken to process applications. Most participants felt the time from application to delivery was too long and, in some cases, the EAMA could not be used to support ECCE from the outset or at all. For example, one participant described an incident of a PECS package being applied for in December that was delivered in June, and which was passed straight on to the school as the child was about to leave ECCE. The slowness in obtaining EAMA was attributed to a variety of factors, including the need for sign-off by multiple therapeutic services, the pandemic, the need to renew quotes, and supply chain delays. One pre-school had self-funded the purchase of a trike and chairs to enable a child with restricted growth to be included in the pre-school. The participant commented that some additional needs are known before entry to ECCE, though some only become known once they have enrolled. A solution advocated by one participant is the provision of a grant for settings to purchase items of choice as they need them, and this would avoid the need to wait through the process of application and/or HSE referral.

Some of the participants felt that it was not always appropriate that the equipment gained as a result of Level 6 funding should leave the setting when the child leaves because it could be used again with other children accessing ECCE. Typically, when equipment moves on with a child (to school for example) the setting can make a fresh application for Level 5 support if that equipment is needed by a subsequent child. An example was provided of a setting where a special changing table was provided for a child at a cost of circa 4500 Euros and when that child progressed to school the table was passed on to the school; two other children required the use of the same type of table and the same thing happened twice more. The participant reported that the setting has now had three changing tables at an approximate cost of 14000 Euros and feels that if the changing table had been of the type that attached to the wall the setting would have been able to keep it and that that would have been a more effective use of funds. She argued that settings could reasonably anticipate frequently needed items of that type and instead apply for general adaptions that could be in place for longer term use.

By contrast a minority of participants reported that Level 5 support is easy to obtain, and that it is consistent with inclusive practice that the equipment should move on with the child.

A minority of participants explained their need for more sensory equipment and comment was made that resources in the kit provided under Level 1 needed replacement (inclusive play materials). One participant had been involved in local fundraising to build a sensory room at the setting. One suggested that assisted communications tablets would be valuable for children with speech delay.

Grants for equipment, appliances and minor alterations are being made with AIM Level 5 support:

- A **wide range** of equipment, appliances, and minor alterations have been provided to support access to ECCE in children with additional needs.
- Concern was expressed that the **time taken to acquire AIM Level 5 support is too long** and that delays compromise full inclusion and meaningful participation for some children.
- There were mixed views about equipment following the child into primary school and the suggestion was made that settings could be enabled to **buy permanent forms of equipment** to meet frequently experienced needs.

10.7: AIM Level 6: Therapy Services

The AIM website describes Level 6 as providing a range of services with the Health Service Executive (HSE) under therapeutic supports.

These services can be either universal or targeted. Universal services are the provision of leaflets or other supporting information. Targeted services are individualised and could include; behaviour support plans, classes, equipment, professional advice or pre-school visits. Supports may be provided through a Children's Disability Network Team (CDNT), HSE Disability Service, HSE funded Voluntary Organisation or HSE Primary Care Services.
(https://aim.gov.ie/aim-supports/targeted-supports/, accessed on December 3rd, 2021)

Despite prompting and probing from interviewers, none of the participants interviewed could describe a situation where a Level 6 HSE engagement (universal) or Level 6 referral (targeted) had been made or provided. All participants knew of the support potentially available but most reported that they understood that applications would not be successful and therefore there was no justification for making them. Reasons suggested for this were that the specialist therapeutic services already have large numbers of referrals and are working to lengthy waiting lists, so the likelihood of securing services in time for a child's participation in ECCE was thought to be negligible (we note here that Level 6 is reported to be undersubscribed by HSE rather than unavailable).

The only exception to this appeared to be in situations where the child had already had contact with one or more HSE services. One participant mentioned a therapeutic service visiting the setting to show staff how to massage a child to stimulate muscle movement, but this was not understood by the pre-school to be part of AIM Level 6 support. Another mentioned having had advice from speech and language therapists, but no intervention had been provided for the child, and the participant did not recognise this as Level 6 support either.

One participant suggested that settings might be more successful in attracting health service interventions if they had direct access to the services (although there is no evidence in their comments to indicate that the application processes are at fault). It is also noted that in the current model, pre-school access to HSE is via the EYS within Level 4, but participants did not recognise this as actually happening in their experience.

AIM Level 6 support was absent from participants' accounts of their experience of AIM. No practitioner interviewed had experienced something that they would recognise as Level 6 support.

- Practitioners did not make application for this support out an **understanding that it would not be made available.** This was because they had observed long waitlists external to AIM and considered these to be impacting on the likelihood of gaining therapeutic supports through AIM.
- It emerges that practitioners tend to associate the concept with 'Level 6 support' with the delivery of a therapeutic intervention, rather than as a support that has universal and targeted forms, and where long term therapeutic programmes are not the only or most likely outcome of an AIM Level 6 support request or referral.

10.8: AIM Level 7: Additional assistance in the Pre-school room

The following section describes participants' accounts of the ways in which AIM Level 7 support is used in settings with particular reference to the management of children in the setting and how the additional staff resource is deployed. Most participants reported that Level 7 support was used to provide an extra person in the room, to lower the ratio, and contribute to the activities of all children. Participants agreed that lowering the ratio enabled all children to benefit from more adult attention and those with additional needs received the support they needed.

Participants' explanations suggest they understood that policy around Level 7 support was developed to deliver the twin goals of full inclusion and meaningful participation, and the notion of isolating children from their peers with 1:1 SNA-style support runs counter to those goals. A minority of participants expressed the view that there is still some confusion at some settings and amongst some parents/carers about whether Level 7 support should operate as SNA. Practice in pre-school rooms is more nuanced than an either/or arrangement. A minority of participants did describe Level 7 support being used to support children with additional needs on a 1:1 basis in some circumstances, and at some points during the ECCE session. For example, in response to children's behaviour where the facility of an extra member of staff enabled a child to be taken into an outdoor space or another room for some respite from whole group activities, or to change a child who is not yet toilet-trained. 1:1 support was described as part of ensuring meaningful participation with the whole group. For example, in the case of a child with language delay, a participant described sitting next to them to encourage them to use words with their peers and to model verbal behaviour. Another participant described how Level 7 support is used to create small group activities, where the supported child is invited to work with two or three of their peers. These participants' accounts suggest there are productively blurred boundaries in practice between Level 7 staffing as 1:1 support, as a facilitator of small group work and as contributor to team teaching of the whole group. Participants' comments suggest the balance of activities changes within each session and is dependent on the needs of all children on the day. To have three members of staff in the room allows for a variety of group sizes and activities within the overall number of 22 children.

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A minority of participants commented that the number of hours provided for by Level 7 support is inadequate and takes no account of holidays or administrative/planning/handover time, and this adversely affects recruitment of staff into the roles.

> ‘Level 7 is invaluable really and AIM couldn’t work without level 7. Cos even although all the level 7 children have support, this level of support would be worthless if you didn’t have a third member of staff because 2 staff to 22 children is difficult on a good day so the third member of staff really helps things.’
>
> [Team leader, urban area]

Practitioners’ comments suggest AIM Level 7 funding is being used to meet the needs of all children.

- The use of AIM Level 7 support in settings is extensive and thought to be **essential in supporting full inclusion and meaningful participation** in children with additional needs.
- Practitioners report that in practice additional assistance in the pre-school room is **used flexibly to support the learning of all children** in the room via the reduction of staff: child ratios.
- The effectiveness of Level 7 is hindered by poor pay and conditions for these staff members and funding should increase.

10.9: Summary

Is AIM effective and achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities and additional needs?

Practitioners’ view is that AIM is achieving a positive impact on the full inclusion and meaningful participation of children with disabilities and additional needs including those with autistic spectrum disorder (ASD). There did not appear to be any compelling evidence to suggest a relationship between the type of additional need and the extent AIM is impactful except in relation to the non-participation of children with complex additional needs. AIM’s impact on parents/carers has been to provide reassurance that their child’s additional needs will be met, by involving them more in planning and preparing for pre-school.

The impact of AIM on settings has been to increase knowledge, experience, and professionalism about how to support children with additional needs. There does not appear to be a relationship between the location of the pre-school and the extent to which AIM is impactful.

Practitioners offered a range of factors that affect the impact of AIM. Significant among the factors that help AIM to have impact are governmental policy and raising the visibility of social inclusion, the

system of Levels of support that can be targeted around individual needs, staff development, parental involvement, enhanced practice in Early Years education, and the development of a culture that aims to include all children in pre-school learning irrespective of need.

Practitioners described the non-participation in AIM of some children with severe additional needs, such as extremely hard-to-manage or dangerous behaviour, or medical and physical needs that could not be addressed with Targeted Supports. Two other reasons suggested for non-participation were that the setting did not have access to appropriately trained and experienced staff, or that the location or building of the setting was inaccessible. Non-participation appears unlikely to be the result of the application process for support, although it was noted that some parents/carers would benefit from more support in completing forms.

Practitioners confirmed that in general **AIM is effective** in achieving its intended outcomes of enabling meaningful participation and full inclusion of children with disabilities and additional needs.

In providers' view, AIM achieves a positive impact on children with additional needs, including those with autistic spectrum disorder, and there did not appear to be evidence to suggest a relationship between the type of additional need and the extent that AIM is impactful from the perspective of practitioners.

AIM's impact on parent/carers has been to provide reassurance that their child's needs will be met by involving them more in planning and preparing for pre-school.

Practitioners report increases in knowledge, experience, and professionalism about how to provide for full inclusion and meaningful participation.

A range of factors are reported to have helped AIM to achieve its intended outcomes:

- Government policy
- Raising the visibility of social inclusion
- Provision of staff development
- Greater involvement of parent/carers
- Enhanced practice in Early Years education
- Development of a culture that aims to include all children in pre-school irrespective of need

Practitioners reported that AIM is not achieving its intended outcomes for a small minority of children, that is, children with complex or severe additional needs. Non-participation in AIM is largely due to a lack of trained/experienced staff and/or the suitability of the physical location of the setting.

Whilst AIM is achieving its intended outcomes for the majority of children with additional needs, the non-participation of children with complex or severe needs should be addressed.

Has AIM influenced practice, or increased capacity in the workforce?

Practitioners expressed generally positive views of the staff training support in AIM Level 1, in particular the Equality, Diversity and Inclusion (EDI) training arising from the EDI Charter. There was

some concern that AIM did not sufficiently embrace matters of cultural diversity or issues faced by those from minority ethnic groups (e.g., those who spoke English as a second language). Some practitioners advocated staff training at a higher academic level than the current level 6 Leadership for INClusion in Early Years Care (LINC) course since the level did not meet their needs or add to their qualification profile. Practitioners also noted that earning materials and play resources are now in need of updating and there are suggested to be benefits in training staff in how to use them.

Views of the appropriateness of continuing professional development courses available through AIM Level 3 support appear to depend upon the prior qualifications and experiences of staff. The use of EDI training and the LINC course are advocated for the development of all staff in settings. Lack of time to complete courses is the main barrier to participation and some settings incurred costs in paying for staff to undertake courses in the evenings or weekends.

AIM Level 4 advice and support provided by Better Start through Early Years Specialists is very highly regarded by practitioners in settings, particularly their responsiveness and accessibility. Applications for support and the completion of the Access and Inclusion Profile provide opportunities for Specialists, settings, and parents/carers to work collaboratively in the interests of children. There may be a need to strengthen opportunities for some parents to access advisory support, especially those who have learning needs.

Practitioners confirmed that **AIM has influenced practice** and there is evidence of increased capacity for inclusive practice in the workforce.

- Staff development opportunities provided via the Equality, Diversity and Inclusion programme, the Leadership for INClusion in Early Years Care, and online Continuing Professional Development (CPD) have been taken up. It has been suggested these development opportunities are rolled out to all staff working with children with additional needs.
- Practitioners' views on the appropriateness of CPD depend upon the prior experience of individual members of staff. It was suggested that the level of academic achievement amongst staff be raised.
- Inclusive play materials have been used by most settings and there is a request for CPD training to make better use of them.
- The provision of advice and support through the Early Years Specialists is highly regarded by most practitioners and foreshadows gains in workforce capacity via collaborative inter-agency working.
- Whilst there is evidence of increased capacity in the workforce, further improvement could be made.

Is the current approach appropriate in the National Context?

All participants were able to describe and illustrate the rationale and purposes of AIM in terms of their own practice. There was a high degree of consensus about the core principles underpinning AIM. Notions of full inclusion and meaningful participation were to the fore but were nuanced by practical experience of AIM in their particular setting. Practitioners occupy a privileged position from which to assess the shortcomings as well as the benefits of AIM.

Areas that are working well

Practitioners identified the following aspects of AIM as working well.

Overall

- Children with a diverse range of additional needs, including those with ASD, are being included fully in ECCE and enabled to participate in meaningful ways.
- Flexibilities in the operation of AIM by practitioners have produced positive learning experiences for children.
- Parents/carers are relieved and reassured to know that their child is being supported by professionals and that there are opportunities for communication and interaction with those professionals.
- AIM has facilitated the constructive involvement of parents/carers in the education of their children.

AIM Levels 1-3

- Practitioners are generally satisfied with the quality and impact of CPD at Levels 1 and 3 and agree that it is having a positive impact on the development of inclusive practices and cultures in their settings.

AIM Targeted Supports: Levels 4-7

- Practitioners' accounts show that AIM Targeted Supports are being used extensively by settings to support full inclusion and meaningful participation and to respond to additional needs.
- The use made of Level 5 and Level 7 support is particularly high.
- There may be some evidence in practitioner accounts that AIM Universal Supports are so well embedded as to have become taken for granted.
- The use of AIM Level 7 support in settings is extensive and thought to be essential in supporting full inclusion and meaningful participation in children with additional needs. Practitioners report that in practice, additional assistance in the pre-school room is used flexibly to support the learning of all children in the room via the reduction of staff: child ratios
- Staff in settings have benefitted from increased time to support all children including those with additional needs, training to increase their knowledge and expertise, and access to learning resources and equipment. Reducing staff: child ratios and team working in the room has reduced day-to-day pressures and increased staff capability to address children's additional needs.

Areas that need development

Overall

Practitioners felt that most parents/carers are unaware of AIM until they approach the setting to register their child. Appropriate information about how AIM supports children's additional needs should be made available both upon entry to pre-school and throughout the child's progression through pre-school. Information could be better communicated by widening information sources to include other professionals, such as GPs, and the wider community. Parent/carers may be better supported by having access to information that is relevant to their own child.

Practitioners identified a range of factors that hinder the impact of AIM. These are recruitment and retention of staff at Level 7 and more generally, the complexity of the role of the INCO, increased

burden of workload on settings, financial pressures for settings, the time taken to acquire equipment and resources, and the use of the term ‘disability’ in information accessed by parent/carers.

Level 5

A wide range of equipment, appliances, and minor alterations have been provided to support access to ECCE in children with additional needs. Concern was expressed that the time taken to acquire AIM Level 5 support is too long and that delays compromise full inclusion and meaningful participation for some children. There were mixed views about equipment following the child into primary school and the suggestion was made that settings could be enabled to buy permanent forms of equipment to meet frequently experienced needs.

Level 6

Practitioners had not made an application for this support via AIM Level 6 because they have come to assume that it would not be made available. They did not recognise any of the engagements they had had with HSE staff as AIM Level 6, and it is unclear whether this is because they were outside of AIM, or whether they were not clear about the actual content of AIM Level 6 (and its targeted and universal elements).

Level 7

Practitioners observed that the pay and working conditions for Level 7 staff posts needs to improve to ensure that settings can deploy this resource effectively and employ and retain high quality staff.

Practitioners’ comments suggest **AIM is appropriate in the National Context**.

- There is a high degree of consensus about the core principles underpinning AIM, with notions of full inclusion and meaningful participation to the fore. It appears that AIM Universal Supports may have become so well embedded as to have become taken for granted.
- Practitioners report that children with a diverse range of additional needs are being supported to access ECCE through AIM and enabled to participate meaningfully.
- The use of AIM Targeted Supports at Levels 5 and 7 are being used extensively and flexibly to include children with additional needs and disabilities. Support to reduce ratios is regarded as essential.
- Practitioners were able to identify a range of areas for development; key among these are the recruitment and retention of staff, and acknowledgment of the increased burden of workload on settings.
- The lack of availability of HSE support outside AIM is cause for concern among practitioners and is thought put AIM’s goals of full inclusion and meaningful participation at risk and their perception that referrals for AIM Level 6 (targeted) would be unsuccessful, had led them not to prioritise applying for this type of support.

To what extent can/should AIM be scaled up and out?

The view of practitioners is that AIM could be scaled up successfully by the inclusion of younger children, enabling support to be provided outside the ECCE qualifying hours for children who attend for full days and the extension of the AIM model to School Aged Childcare.

- The duplication of the AIM model in School Aged Care (SAC) would be welcomed but additional staff training and development would have to be put in place to ensure a shared understanding of AIM.
- The scaling up of AIM would be likely to increase full inclusion and meaningful participation in schools among children who had been supported through AIM and support their transition from pre-school to mainstream or special school.
- Practitioners' accounts suggested a wide range of ways to build upon the achievements of AIM and ensure a sustainable future for inclusive practice in early years settings.

In particular, their comments suggest there is scope to make improvements to the employment and training of staff and continue to develop a confident and competent workforce.

Practitioners agreed that **AIM can and should be scaled up and out**:

The scaling up of AIM is thought likely to increase full inclusion and meaningful participation and support children's transition into mainstream and special education.
AIM could be scaled up successfully by:

- Inclusion of younger children
- Enabling support to be provided outside the ECCE qualifying hours for children who attend full days
- Extension of the AIM model to School Aged Childcare

Successful duplication of the AIM model in schools was considered to be dependent upon putting in place staff development opportunities for school staff to ensure a shared understanding of AIM.

Practitioners felt that it is necessary to make improvements to the employment and training of all staff and to continue to develop a confident and competent workforce.

Whilst broadening the scope of AIM attracted widespread support from practitioners (who envisaged advantages for children and families) it would need to be considered in in relation to aspects of AIM that currently need to be strengthened.

11. Interviews with parents/carers: Findings

This section reports on the findings from interviews with 18 parent/carers who have children that have been/are being supported by AIM in pre-school. The reporting begins with a focus on the *overall* implementation and impact of AIM from the perspective of parent/carers. This is followed by the reporting of findings that are pertinent to *each level of AIM* (Levels 1-7). The section ends with a summary of key findings overall, and for each level of AIM in the context of the evaluation's four research questions. The characteristics of the sample were described in Section 7, along with a description of the methods used to recruit, collect and analyse the data being reported in this section.

Introduction: Approach to presenting the findings

Findings are presented under each of the key lines of inquiry constructed for this evaluation and relevant to this participant group (see subsection 1.2). Summarily, these comprise parent/carers' views on AIM's implementation, AIM's impact, aspects of AIM that are working well, and aspects of AIM that need to be improved. Findings are described, and where relevant, direct quotations are used to illustrate a key theme arising from analysis of the data. The next subsection explores parent/carer perspectives on AIM overall, beginning with analysis of whether their view of AIM is positive, negative or mixed.

The following approach is used to indicate the prevalence of a theme across the participant group.

- All – all participants
- Most – at least three quarters but not all participants
- Majority – between half and three quarters of participants
- Some – between a quarter and a half of participants
- A minority – less than a quarter of participants
- Very few – one or two participants only

For each subsection, findings are summarised in a text box.

11.1 AIM overall

Very few (1) of the parent/carers reported an entirely negative experience of AIM. A majority of parent/carers described AIM positively (8) or as a mix of positive and negative (9). Where experiences were mixed, this was usually because the child had attended two pre-schools, with one being positive and one being negative (6). Parent/carers had chosen to move their children from one setting to another because they were not happy with the way the child was being supported. Parent/carers gave the following reasons for moving their child from one AIM-supported setting to another:

- The setting was not using AIM Level 7 support as 1:1 and the child wasn't coping well or was not developing (3)
- The setting was not challenging the child sufficiently or striving to get the child to participate in things they were hesitant about (5)
- The setting did not want or welcome the child and interpreted their behaviour negatively (2)
- The setting made no adaption to the child's sensory needs (2).

One parent/carer gave the following explanation for moving her child to a new pre-school:

> 'I felt that the first setting was not developing or progressing him. The second were more proactive in responding to his additional needs – this is what the pre-school was like in general, it included children around their needs… they knew he needed to be pushed and not just accept him choosing not to participate.'
>
> [Parent/carer of child with hearing loss and global developmental delay]

In a similar vein, a parent/carer described the reason for moving her child as a combination of the settings' unwillingness to adapt the environment for her child and a lack of challenge for him in the pre-school:

> 'We removed him from the first pre-school because he was overwhelmed by the noise and wasn't given an opportunity to find a quiet place to calm down. He was bored, and they said he would do better elsewhere.'
>
> [Parent/carer of child with ASD]

These findings imply that the success of AIM support depends on the capacity of settings to use it in ways that reassure parent/carers that their child is being challenged whilst having their needs supported and understood in a context where they are welcome. This was further evidenced by one case where a parent/carer reported a positive experience of AIM-supported ECCE in the first year, and a negative one in the second because of changes of staff within the same pre-school.

Two of the parent/carers who reported mixed experiences of AIM, had moved their children from an AIM-supported Early Childhood Care and Education (ECCE) setting to a specialist pre-school. In one case, the parent/carer had wanted to keep her child in ECCE for a third year with the hope that this would be a preparation for entry into the local mainstream school and its autistic syndrome disorder (ASD) class since her child's ECCE setting was linked to it. She was told that a third year of ECCE was not something that the pre-school would provide, and she also knew that long waiting lists for Heath Service Executive (HSE) support meant that the child would have quicker access to therapies in an early intervention pre-school (which is a special pre-school for children with disabilities). In the second case, the event of an ASD diagnosis brought an option of AIM support at Level 7, or a specialised setting. The parent/carer chose the latter because she thought that it might offer more bespoke support for her child's needs. Though she had positive things to say about AIM support in the first pre-school, in retrospect she felt that the specialised pre-school had challenged him more and helped him to develop more quickly. In both cases, the children had an ASD diagnosis. One child had moved into an ASD unit within a mainstream school (though this was not her first choice), and the other to a special school. Both cases illustrate that steps could have been taken to make to make AIM-supported ECCE an option. Parent/carers were making decisions that they believed to be realistic, and pragmatic given long waitlists for HSE supports among children who were not attending a special pre-school.

In one case where the child was aged 3, had no diagnosis, had been in ECCE for 6 months and had been allocated AIM Level 7, the parent/carer reported a mixed experience because the pre-school was very supportive to her and her child, but she felt that AIM had let them down. When asked about her child's experience of pre-school, her comment was:

> 'I do feel like the pre-school are making every effort to include him, but the AIM programme is making every effort to exclude him even though its title is inclusion.'
>
> [Parent/carer of child, aged 3, no diagnosis]

This was because it had been impossible to recruit someone to the Level 7 post, meaning that the child could not access the full ECCE programme being restricted to one morning a week. The parent/carer reported high levels of frustration and distress around this situation. Problems with recruitment, retention and quality in AIM Level 7 came up often in interviews and are discussed in later sections in more detail.

In summary, few parent/carers (1) reported an entirely negative experience of AIM supported ECCE for their child. The majority of parent/carers (16) had positive things to say about AIM, with 8 being entirely positive and 9 reporting a mixed experience. In the case of a mixed experience, most (5) had moved their children to a new ECCE provider because they were not happy with the way settings were using AIM support, and with the pre-schools' practices more generally. In all 5 of these cases, parent/carers were happy with AIM in the second pre-school. In 2 of the cases of a mixed experience, parent/carers had moved their children from an ECCE placement they were largely happy with, to a special pre-school because they were aware of long waitlists for HSE therapeutic support and were being pragmatic.

This indicates that for these parent/carers, AIM had not offered a sufficient solution to the wider contextual constraints in the system. 1 parent/carer's mixed experience arose because her child was attending a supportive setting but had been unable to recruit a suitable Level 7 support worker. For 1 parent/carer, the experience of AIM had been entirely negative because the setting did not have an inclusive culture and did not have sufficient training in supporting children with additional needs.

The next subsection reports on parent/carer perspectives on their children's pre-schools and the support from staff in those pre-schools.

Parent/carer experiences of inclusion in the pre-school and staff support for inclusion in the context of AIM

It has been noted that 8 parent/carers reported an entirely positive experience of AIM, and 9 a mixed experience. Only 1 parent/carer was entirely negative about AIM-supported ECCE, and this was because the pre-school did not have an inclusive culture and was inexperienced around inclusion and additional needs. It is important to explore how these data illuminate the factors involved in the construction of positive and negative perspective.

Pre-school practices that parent/carers describe when talking positively about their child's pre-school experience in the context of AIM

When sharing their perspectives on pre-school practices that were experienced positively, parent/carers referred to the following:

- Being flexible around the needs of the child and personalising (10)
- Challenging the child and developing their independence in a supported way (5)
- Including the child in everything through supported participation (8)
- An engaging curriculum and resources (8)

- An inclusive culture – staff commitment and expertise around inclusion (10)

10 parent/carers described *personalised practices* where staff were responsive to their child's uniqueness. For example, 3 parent/carers explained that the setting had brought in visual schedules and communication systems for their child, which was helpful to their participation. For example, one parent/carer commented:

> 'Her Aim worker is focussing on the choice-board, working with using the choice-board for her to pick what she wants to do – and also working on Lámh signs and building up her Lámh vocabulary.'
>
> [Parent/carer of child with Learning Disability, aged 3]

The above example is an example of how parent/carers valued efforts to allow their child the lead in choice-making and learning. 2 parent/carers made mention of this practice, and an example is below:

> 'In my child's second setting, they are all about diversity and equality – everyone is included, and my son's interests were taken on board, and he could lead things.'
>
> [Parent/carer of child with ASD diagnosed during time at pre-school]

3 other parent/carers explained that the pre-school had built on their child's interests in a very responsive way. Two examples of this are as follows:

> 'When they discovered that she loved make-up, they set up a make-up station for her to play at inside.'
>
> [Parent/carer of child with medical needs]

> 'He enjoyed eating and the chef would sometimes come out and sit with my son at lunchtimes and they would let him go into the kitchen and watch what is happening.'
>
> [Parent/carer of child with complex medical needs]

Parent/carers valued the way that the pre-school had inducted their children gently, both into the start of pre-school and into new activities that they were less familiar with. When reporting a positive experience, parent/carers recounted the way that staff were very observant in picking up difficulties and barriers to learning, which in one case had led to a diagnosis of ASD, and in another had led to additional support for participation in outdoor learning where staff had noticed that the child was shyer about playing with other children. Practices that involved *challenging children and helping them to become independent* were valued by parent/carers, with 4 referring to this directly. For example, when asked whether there were barriers to inclusion and positive relationships in the pre-school, a parent/carer commented:

> 'He is unique and tends to react emotionally. He was encouraged by the setting to speak about his feelings and learn that it is OK to feel happy or sad. We just thought that was brilliant, that they told him it was okay to be happy or sad, or not to do that thing or this thing…It's brilliant for a child of that age with an angry diagnosis, that it is okay to express himself like that.'
>
> [Parent/carer of child diagnosed with ASD after leaving the pre-school]

This practice had helped the child cope with critical, anger-triggering incidents and had averted the need to send him home when he became distressed. Building children's independence and confidence through challenging was important to parent/carers, since this was seen to be essential to their development, and in some cases, preparation for school. When asked about how her child had developed in pre-school, a parent/carer commented:

> 'In the second setting, yes [the child has developed] absolutely. He is obsessed with drawing trains but he would be behind in the fine motor skills for drawing so he would say he wants to do it, but would get an adult to do it, but in the second setting, they would get him to start doing the lines on the page himself or they would start, and he would do a bit more – they pushed back on him a bit with a lot of encouragement.'
>
> [Parent/carer of child with genetic condition and hearing loss]

For parent/carers, this kind of supported challenge was a sign that things were going well for their child's inclusion since their development and participation was being scaffolded. 8 parent/carers gave examples of how their child was being *helped to join in, in a sensitive way*. For example, when asked to describe the pre-school activities that the child was being included in, a parent/carer commented:

> 'The water pan, the singing songs, and story time, circle time definitely. And any game that he was coaxed over to. He was good at being coaxed over but he would need help – he wouldn't start a game himself.'
>
> [Parent/carer of child diagnosed with ASD and supported by AIM in its first year]

An *engaging curriculum and high-quality resources* were referenced by 8 parent/carers when describing positive experiences of AIM-supported ECCE. These made pre-school enjoyable for children and in the case of two children, meant their sensory needs were met too. Some parent/carers mentioned outdoor facilities as key to their children's positive experience:

> 'They used to go out gardening. There was a vegetable plot and she loved playing in the mud.'
>
> [Parent/carer of child with no diagnosis, awaiting ASD assessment]

Staff expertise and willingness to include figured in 10 parent/carers' accounts of a positive experience. Where managers and other staff were willing to go the extra mile to include children, parent/carers felt supported. It mattered that their child was welcomed, valued, and accepted:

> 'Nobody ever didn't want her there because they needed to spend extra time with her. I always felt that she was wanted. She was the highlight of the staff's day.'
>
> [Parent/carer of child with learning disabilities]

Effective support from Level 7 staff had also been important for a positive experience, though as explored later, some parent/carers felt more positive about this provision when it was 1:1, and others when it was not 1:1. One parent/carer explained that support from the Inclusion Co-ordinator (INCO) and an external advisor (who may have been a therapist or an Early Years Specialist, the parent/carer was unclear) had helped the Level 7 worker to improve her practice.

It is interesting to note that many of the practices described by parent/carers when talking about a positive experience of AIM-supported ECCE, can be associated with the model of best practice described in the Diversity, Equality, and Inclusion (DEI) Charter (DCYA, 2016)[72]. For example, in terms of the imperative that, 'Children with a disability have the same rights as other children to a child-centred pedagogy that meets the individual interests and needs of the child' (DCYA, 2016, p18).

In this sense, positive practices are characteristic of the principles of the development of an Inclusive Culture (AIM Level 1), since they focus on universal matters of curriculum, anti-biased approaches, reflective practice, and resourcing. However, in the cases of a positive experience of AIM-supported ECCE, the data show that AIM support was regarded by parent/carers as an essential part of this picture, as is explored later.

In summary, **when giving examples of the pre-school practices that were part of a positive experience of AIM supported ECCE**, parent/carers referred to the following:

- Being flexible around the needs of the child and personalising (10)
- Using visual communication aids (3)
- Taking children's interests on board (5)
- Inducting children gradually into the pre-school and unfamiliar activities (3)
- Letting children take the lead in their learning (2)
- Picking up and acting on the detail of children's difficulties and barriers to
- participation (2)
- Challenging the child and developing their independence in a supported way (5)
- Coaxing and supporting children to get involved in unfamiliar and unpreferred activities (3)
- Teaching the child strategies for independence (2)
- Including the child in everything through supported participation (8)
- An engaging curriculum and resources (8)
- Equipment in the pre-school to support hearing (2)
- Outdoor curriculum and facilities (2)
- Enjoyable activities (2)
- Sensory experiences that supported the child (2)

An inclusive culture – staff commitment and expertise around inclusion (10)
Manager and other staff work hard to support the child (2)
Staff work together to improve practice (1)
Staff are welcoming, valuing and accepting of the child (6)
Effective Level 7 support (defined variably by parent/carers as 1-1 or not 1-1)

Pre-school practices that parent/carer describe when talking negatively about their child's pre-school experience in the context of AIM

Parent/carers referred to the following practices when describing negative experiences of AIM-supported ECCE:

[72] Department of Children and Youth Affairs (2016). Diversity, Equality and Inclusion Charter and Guidelines for Early Childhood Care and Education. [Online]. Available at: https://assets.gov.ie/38186/c9e90d89d94b41d3bf00201c98b2ef6a.pdf. Accessed 11/12/2020

- Negative attitudes to their children amongst staff and towards inclusion (6)
- Low expectations and disinterest in the child (3)
- Lack of knowledge and inexperience among the staff working with their child (6)
- Not implementing advice or promised adaptions (4)
- COVID impacts (6)

Six parent/carers voiced concerns about staff willingness to understand their child's needs and behaviours. One parent/carer reported that the Level 7 support worker reporting the child's behaviour negatively. For example, referring to the child as 'exposing himself' when he pulled down his shorts. For this child, the parent/carer felt there had been little attempt to understand what was triggering his behaviour, and use of the phrase 'exposing himself', was the final straw leading her to withdraw the child from the setting and start him somewhere else. Parent/carers perceived a lack of interest in managing children's behaviour positively, and this led one parent/carer to report the following:

> 'My child told her doctor she wasn't a good girl because she couldn't use the reward system in the setting.'
>
> [Parent/carer of child diagnosed with ASD during pre-school, whose older sibling had recently died]

Parent/carers were unhappy when staff had low expectations of their child and/or took a laissez-faire approach to including them. When asked about their child's pre-school experience of inclusion, one parent/carer offered the following reflection:

> I don't think he made any friends in the pre-school. We hardly ever got feedback that he was showing interest in the other children and was mainly ignoring them. He wandered around in his own world. Some staff would ignore this and not intervene, even when other children were taking toy off him. They would not make much effort to include the child or get him to join in with others. It depended on the staff.'
>
> [Parent/carer of child with complex medical needs]

This parent/carer also believed that when the setting applied for Level 7 for her child, it was to fill gaps in general staffing rather than to support her child. She also had to encourage them to apply. A specialist teacher from the Early Intervention Team was going into pre-school to support her child but the setting disliked this arrangement and ended it after 2-3 weeks. The parent/carer reports that the setting said no to other therapists coming in at all, but that they passed information from the therapist to the AIM co-ordinator with the hope that it was being used. This was the parent/carer who reported an entirely negative experience of AIM in the pre-school.

Four parent/carers also described instances where the pre-school was not implementing the adaptations they had promised or following up on advice received from the Early Years Specialists (EYS) or therapists. For example, a parent/carer reported that the school had not implemented the EYS advice on using social stories. Another parent/carer explained that a hopeful start to her child's pre-school had been tarnished by poor follow-up by the 'AIM Service' in a context where a Level 7 support worker could not be found:

> 'I thought it was great at the start, when we were doing the application, they were telling me about all these wonderful things that we were going to get and that they'd supply. I'd say he was interested in water and climbing, and they said oh yes, we can get those kind of things. We can help him use those tools to kind of bring on… but there's been nothing since then'

> 'Not only have we not got a person in, but they haven't engaged in anything with the service that I was maybe getting, and those things that would pull him … you know, there's been nothing.'
>
> [Parent/carer of child with hearing difficulty and speech delay, age 3]

When describing experiences of their child's inclusion that they were unhappy about, parent/carers also referred to the need for more training so that pre-school staff were able to implement AIM support effectively. One parent/carer commented:

> 'Montessori need more training on identifying additional needs and how to get the support, and how to help them in the classroom.'
>
> [Parent/carer of child receiving a diagnosis of ASD after pre-school]

When asked about what additional supports might be needed through AIM to support their own and their child's experiences, another parent/carer made the following observation:

> 'I am not sure that every pre-school knows how to use AIM support. I had AIM support in both settings and the approaches in using the AIMS model was very different in the second. I can't see how AIM support wouldn't support the child but can see how it might not be used in the correct way by the setting.'
>
> [Parent/carer of child with learning disability and hearing difficulties]

Parent/carers had found some settings defensive, particularly if the staff team were young and/or inexperienced around disability and inclusion. Staffing fluctuations had also not helped with continuity of support, since so much depended on the attitude and skill of the staff working with a child. The issue of poor communication also came up when parent/carers were describing difficulties with inclusion in the pre-school, and this is discussed when reviewing the data related to improvements for AIM.

COVID had impacted negatively on 4 parent/carers' experience of AIM-supported ECCE, with the issues identified as:

- Early intervention support was cut short.
- Early Learning Support Grants were applied for, but side-lined due to COVID
- Opportunities for communicating with the AIM support worker were closed down by COVID
- Exacerbation of child's isolation (in the context of not being able to recruit Level 7 support and consequent reduction of ECCE to half a day a week)

These findings provide evidence of the continued need for training across the sector (AIM Level 1 and 3), and more robust monitoring of how AIM support is being used in settings in the context of the 2016 DEI charter.

Parent/carer views on the impact of AIM on their children's full inclusion, meaningful participation, and development

Most parent/carers (16) were able to describe at least one positive, tangible impact for their child. 2 parent/carers reported that AIM had no positive impact on their children. In both of these cases, this was perceived to be a consequence of failures in Level 7 support. 1 parent/carer believed that Level 7

should have been 1:1 to have impact on her child's development. In the other case, Level 7 support had been granted, but the setting was not able to fill the post meaning that the child could only attend ECCE for one morning a week. However, this parent/carer was keen to point out that she still believed that AIM could work when this support was in place, since her child's pre-school was supportive and inclusive.

On this point, it is worth noting that when parent/carers referred to *AIM support* during the interviews, most (16) were using the term as a synonym for Level 7, with 1 recognising Level 4 as AIM support and another (whose child has a hearing difficulty) recognising Level 5 as AIM support. Parent/carers have relatively low awareness of AIM as a model of progressive support ranging through Levels 1-7, and this is further discussed in subsections 11.4 to 11.10.

Parent/carers described a range of positive impacts related to participation and inclusion. These centred on the opportunity that AIM support brought for being included with peers and making friends (8). When asked her views on the strengths of AIM, one parent/carer remarked:

> 'The child is getting the opportunity to be more included in the educational side of the ECCE. Two years exposure to the peer group is a strength. I would not have known about those relationships with other children without his AIM worker and his communication with me. It is lovely to think that these positive relationships with other children can happen in a pre-school setting for a child with ASD.'
>
> [Parent/carer of a child diagnosed with ASD during pre-school]

Another parent/carer was delighted that her child had made such solid friendships in his ECCE placement, since these had continued into the mainstream. One child had become more interested in playing with other children:

> 'In the time that he's in the classroom he is more open to other children approaching him. Before like he didn't really have any interest in them, someone may have played near him but now, not always, but like he does have more interest in a child playing beside him or he might start engaging them in play. He does start to initiate a game, gives a nudge or a push I know its small but …"
>
> [Parent/carer of child with undiagnosed additional needs who is awaiting recruitment of Level 7 support]

Most parent/carers saw a crucial connection between AIM support and the child's ability to participate in the ongoing activities of the pre-school. The way that this is achieved in the pre-school has been discussed in previous sections, but the following comment encapsulates the position that parent/carers took on this:

> 'The AIM's model suits him because he could understand so many instructions, things he was able to do when he was included, when he also needed directions. He always had support and I loved that about AIM model.'
>
> [Parent/carer of child with diagnosis of ASD before pre-school]

Most parent/carers offered descriptions of how their child had progressed as a consequence of their engagement in AIM-supported ECCE, including developments to social skills, speech and interaction, and practical skills. Social interaction and speech skills were important to parent/carers since these were seen as routes to being ready for school and life more generally. One parent/carer reported that her child had moved forward so much, that they sometimes doubted his ASD diagnosis:

> ' …we noticed that when he came home from pre-school he was so much more interactive …we noticed, even to the extent that it put a doubt in our heads that he even had autism … a lot of that was probably denial as well, you know, that we didn't want him to have autism, but he was getting on so well and had been brought along so well, you could see the resemblance with the themes that were being worked on in school in what he was saying to us.… His life skills came on in leaps and bounds.'
>
> [Parent/carer of child with diagnosis of ASD during pre-school]

Parent/carers were pleased when AIM-supported ECCE had enabled their child to develop more conventional social behaviours, since this was key to participation in their view. For example, when asked to consider whether AIM is more effective, equally effective, or less effective for children with a diagnosis of ASD, the parent/carer responded that it was more effective for children with ASD, offering the following observation in support of her view:

> 'Originally, my child would sit at the edge of table, then after a few months she would sit and have lunch with the other kids. Then started to join activities e.g., blocks, with other people.'
>
> [Parent/carer of child with diagnosis of ASD during pre-school]

The broadening of the child's interests and preferences was also noted as a development arising from AIM-supported ECCE. This could be in relation to new activities, new people, new contexts, and new foods. A profound example was cited by a parent/carer whose child looked very different as a consequence of a medical condition. The parent/carer commented:

> 'One of the biggest and most important experiences for him was learning how to cope with other people and how they behave – or they make decisions and how they might be inclusive of you…I suppose it was the simple thing of getting on with different characters of people and playing with children his own age.'
>
> [Parent/carer of child with genetic condition and hearing loss]

Children had also learned practical skills, such as managing their own sensory needs, washing hands after using the bathroom, waiting for your turn, learning how to do day-to-day things by watching peers, learning the order of how to take things out of a lunchbox and eat, and following routines. Parent/carers did not underestimate the importance of learning these every-day skills.

In summary, **when describing the positive impacts of AIM on their children's inclusion, participation, and development**, most (16) parent/carers were able to describe tangible benefits from AIM. Parent/carers focused on the opportunity the child had had to make friends and interact with other children. The also described positive developments to their children's:

- Confidence (7) and Independence (8)
- Practical skills and social skills (6)
- Ability to follow instructions, rules, and social conventions (2)
- Ability to manage other people's reactions to their disability (1)
- Speech and interaction (3)
- Reading (1)
- Willingness to try new activities and experiences (e.g., food) 3

1 parent/carer reported that AIM support had no significant impact on her child because it was not 1:1 and hence he had not developed. 1 parent/carer reported that their child had experienced some positive impact from ECCE but not from AIM since the setting had been unable to recruit a Level 7 worker and their child was limited to half a day of week in ECCE as a consequence. This demonstrates for this group of participants at least, that when AIM support is being used effectively, it has the positive impacts it was designed to deliver. AIM Level 1 emerges an essential precursor for the success of targeted support. Though parent/carers are not explicitly aware of the importance of AIM Levels 1-3, the experiences they report demonstrate implicit awareness of the importance of inclusive culture and staff expertise.

Parent/carer views on what is working well in AIM

Most parent/carers (16) identified at least 1 aspect of AIM that was working well. These aspects were as follows:

- AIM support (particularly Level 7) creates opportunities for inclusion, participation, and development in pre-school (16)
- AIM's flexibility makes it fit for purpose (3)
- Additional equipment makes ECCE accessible (2)
- Collaboration between settings and EYS/visiting teacher in the context of AIM is beneficial (2)
- Positive relationships between pre-school staff and parent/carers are a key factor in AIM's effectiveness (5)
- The AIM model helps to educate other children and their parent/carers about difference (2)
- Parent/carers are less anxious about their child being away from them because they know their child is supported (1)

Most prevalent (12) was parent/carers' view that AIM support *created opportunities for inclusion and participation*. Key to this was the support offered by Level 7, which enabled children to get the personalised support they needed to be included and develop. For example, when reflecting on how AIM had impacted positively on the development of life skills, one parent/carer noted the following:

> 'It's having the support to get his voice out, giving him time to explain himself. He was never rushed because he had the support. The [AIM support worker] was very good. She was very

good. She would come to the service and visually watch them in the morning, or she would watch [my child]. She is also VTEC qualified so she could see what [my child's] weaknesses would be and be able to give suggestions. Plans of action, what to do to help him, and then would ring me to ask if I agree.'

[Parent/carer of child diagnosed with ASD]

AIM support was seen as crucial to the *flexible inclusion of the child.* For example, in expanding the teaching team so that the child could work independently with other children or offer support whilst the child was working alongside other children and needed to use a skill that was more challenging for them. Parent/carers viewed Level 7 as the support strategy that made inclusion possible in the context of a pre-school with an inclusive culture

> 'The strengths of AIM are that it provides a way of supporting children with disabilities in a very kind of cohesive way and that is exactly why a child is here for. He was cared for on every level. We did focus on those independent skills like life skills, but he was supported in all ways… socially and emotionally. He was always happy because he was included. He knew he was included.'

[Parent/carer of child diagnosed with ASD before pre-school]

The parent/carer cited above noted that it was not possible to separate out the impact of Level 7 from the impact of inclusive practice in the setting more broadly since one depended on the other. Belief in the child's ability to develop emerged as important within this milieu, with AIM support being crucial to this. Parent/carers whose children had attended ECCE settings were also aware that the impact of AIM support on an individual child depended on the pre-school's ability to it effectively:

> 'Because of the support and what the AIM's programme does and what their intention is, skills can be homed in on and specifics can be worked on but only if AIMS is done in the right way. I am very grateful for the AIM support being available and that my child could get the AIM support during pre-school.'

[Parent/carer of child with a learning disability]

Without AIM support (particularly at Level 7), parent/carers explained that they would have been more anxious about their child attending pre-school. For example, one parent/carer explained the way that Level 7 support brought flexibility:

> 'If AIM wasn't there, I would have been more nervous and anxious about [child's name] being away from me. He had one-to-one with the teacher which he needed. They used to go for a tour – a walk down by the docks. [My child] would have been a flight risk. He would have run. He needed a one-to-one teacher who was specific for him to participate in an activity like that.'

[Parent/carer of child diagnosed with ASD]

Positive relationships were also cited as elements of AIM that were working well. Parent/carers felt particularly supported when external specialists (EYS and therapists) were working with the setting to build better practices. Children thrived through their positive relationships with the staff in the pre-school, and when parent/carers had open channels of communication with pre-school staff, they were positive about how well AIM was working. One parent/carer offered a useful evaluation, noting that 'AIM is the only model for inclusion that I have ever said is fit for purpose' because of its enablement of mainstream participation. When citing the strengths of AIM, the parent/carer of a child with a complex medical condition relates:

> I think that there's quite a lot of paperwork, but it is broad and meets the child where they are at that point in time - you don't have to have a diagnosis and this gives a lot of flexibility - a parent/carer can coordinate with the playschool setting and discuss how best to support the child in the setting and engage with the day, not making it too prescriptive is very good- there is a larger area of flexibility to assist. For example, the child did not need the 1:1 support to shadow him (L7), so we didn't apply for this as his needs were met through AIM in other ways.'
>
> [Parent/carer of child with a learning disability]

These data indicate how AIM support wins the trust of parent/carers in contexts where it is being used effectively within an inclusive milieu to achieve the meaningful participation of their children. However, parent/carers also suggested ways to improve the effectiveness of AIM which will be discussed in the next subsection.

Parent/Carer views on how AIM support could be improved

Parent/carers were able to suggest a range of ways in which the impact of AIM could be improved. In summary, these suggestions were:

- A more formal and agreed approach to feedback and communication between the pre-school, AIM supporters (EYS) and parent/carers, including support and advice for parent/carers (11)
- The structure and governance of Level 7 support (9)
- Training on AIM and inclusion for all professionals (5)
- Use of a 'team around the child' approach, including reduction in waiting lists for HSE assessment and support (7)
- Reduction in scarcity of pre-school spaces (3)
- Reduction in 'red tape' (1)

This is discussed in more detail in what follows.

Communication, feedback, and co-construction

Across the full range of perceptions on AIM (positive, mixed, and negative), there were calls for better communication between pre-schools, AIM agencies (such as the EYS), and parent/carers. When asked about her child's experience of pre-school and what might be improved, a parent/carer commented:

> 'There were no formal guidelines for communication. We had our own AIM worker during COVID so things changed in the creche so we couldn't go into the room – so I never actually met his AIM worker because she would finish before I collected [child's name] so someone else brought him out. Out of kindness, she would e-mail me, but otherwise I would not have had the details at all. I literally knew nothing because my child was non-verbal so he couldn't tell me how his day went.'
>
> [Parent/carer of child with additional needs – ASD diagnosed prior to pre-school, mixed experience of AIM]

This same parent/carer suggested that the INCO could take over this communication role and reported feeling in the dark and isolated, when what she needed was advice and support:

> 'I mean just to say, I felt as a parent/carer completely at sea and there was absolutely no support and guidance offered to me. A small quantity was offered to the teachers [by the EYS] but there was nothing for me, about how I could support my child at home. For example, transition to pre-school and then transition back home – no support on how I could help him moving forward.'

When asked whether staff in the pre-school worked in partnership with them, one parent/carer reported feeling very separate from the process of getting AIM support:

> 'I didn't get to meet anybody or talk to anybody about it. It was the manager in the pre-school who organised it, so I just signed the paperwork and the social worker signed paperwork, but I wasn't contacted at all by anybody that was coming into assess him – I didn't have any contact at all, which I thought was a bit strange.'
>
> [Parent/carer of child, no diagnosis, mixed experience of AIM]

Parent/carers also felt that more formal policies of communication (at regular intervals) would allow their voice to be heard, since their insights into their child's needs could help practitioners find effective ways to support their participation and inclusion:

> 'Staff are open to children…but not open to hearing the parent/carers' knowledge and experience – e.g., recommending the 'first and then' board that was used at home. I felt I might have stepped on the teachers toes – they don't respect us.'
>
> [Parent/carer of child with ASD, diagnosed during pre-school, mixed experience of AIM]

Another parent/carer offered an insight into how a more collaborative approach would have helped, identifying this as a priority for action in improving AIM:

> 'Would be nice to have maybe starting off a plan for the term, for the month to say, okay, this is what we are going to work on - ticking off goals and targets as we go along - this would be structured plan – maybe if it was that the parent/carers were included in the plan and had input into the plan themselves? The setting know that her communication is poor, I might not have added something to her plan, but it would be nice to have a formal structure and opportunity to contribute. In my setting there is no problem with me speaking to them and asking them, but it would be nice for all parent/carers to have this formal structure and have this formal plan.'
>
> [Parent/carer of child with learning disability, diagnosed during pre-school, Positive experience of AIM]

This was true the other way around, since parent/carers also felt a need for support and advice around how they could manage their child's difficulties at home, whilst supporting their development in a way that was in tune with what was being done in pre-school. Parent/carers believed that such communications would also allow them to access advice about AIM and additional needs, in ways that supported their child's inclusion and helped them to navigate the available offer:

> 'It would have been useful for me to use the strategies at home to ensure we were on the same page - I didn't have this information. The parent/carer is the first person in the child's

life. I know they might not be the same at home as in setting but if the three EYS, setting and parent/carer worked together it would be fantastic.'

[Parent/carer of child with ASD, diagnosed during pre-school, mixed experience of AIM]

Open channels of communication were often cited when parent/carers were describing a positive experience of AIM. Parent/carers who had reported a positive experience of AIM were also of the view that more regular, formal communication and support could be offered as a way to improve inclusion. This would be through day-to-day feedback, scheduled meetings, and a more formal needs/targets/progress report. 4 parent/carers were aware that there had been an Access and Inclusion report, but they did not describe this as something that was supportive to them or that they had been involved in producing.

Generally, the need for a more co-constructive approach to assessment and support emerged strongly in the data from these interviews. It is important to note that such approaches are central to the quality frameworks for Early Learning and Care (ELC) in Ireland. For example, *Síolta* (CECDE, 2006) identified effective partnership with parent/carers and inclusive decision-making as core to quality practice, along with an effective plan/do/review cycle to inform practice. The development of communication and co-constructive approaches is supported in the literature as factored in successful inclusion and parent/carer trust (see Section 3). It seems like this is an important development to prioritise as AIM develops in the future.

The structure and governance of Level 7 support

As has been noted previously, most parent/carers identify Level 7 support (when done effectively) as crucial to the successful inclusion of their children. However, they described a number of barriers in this area. They called for a more centralised approach to recruitment, accountability, and governance around level 7. For example, one parent/carer noted:

> 'This is my major issue with AIM. They couldn't fill the position because its part time hours and not well paid – this should be taken out of the hands of the setting Better Start or the government should employ these people.'
>
> [Parent/carer of child with ASD, diagnosed during pre-school, mixed experience of AIM]

The cause of recruitment difficulties to Level 7 were identified as low pay and poor working conditions for these practitioners and as part of the scene in the sector more broadly.

Some parent/carers explained that though their child's Level 7 worker had been appointed, the quality of their work and the fit of their experience/qualifications was not always sufficient. Parent/carers felt that they were prevented from knowing about the suitability of the appointed person (in one case, GDPR was cited as a reason why they were not to be informed).

Parent/carers suggested more monitoring of the quality and impact of the work that these practitioners were doing. When asked about what should be prioritised for action in improving AIM, a parent/carer offered the following:

> 'I suppose to make mainstream more accessible. I feel that the AIM worker should maybe qualified with some sort of special educational need qualification

> hired by Pobal or Better Start with more accountability for what they are doing with the child.'
>
> [Parent/carer of child with ASD, diagnosed during pre-school, mixed experience of AIM]

Given that parent/carers identified the presence and then the quality of Level 7 support as crucial to their child's inclusion, participation and development, the improvement of this AIM support emerged as a priority for many, with one parent/carer suggesting that she be involved in designing the person specification for the person who was coming to support her child.

Training for ELC and HSE staff on AIM and supporting children with additional needs

Training for Level 7 staff was raised as a way to improve AIM, as was training for the professional community more broadly. In parent/carers' view, this training would reach less experienced pre-school staff, doctors and HSE staff and staff in Montessori schools. Two parent/carers noted that more training on ASD was needed, particularly around Picture Exchange Communication System (PECS) and sensory issues. The purpose of this training, in parent/carers' view, is also to get everyone on the same page, so that advice for the parent/carer is comprehensive and accurate. This connects with another priority for development raised by parent/carers, which is to build better connections between AIM and other services. This is discussed in what follows.

Use of a 'Team around the Child' approach, with reductions in HSE waiting lists for assessment and support

Parent/carers called for a more joined-up approach between pre-schools and external sources of support (therapists and specialist teachers). They were active in finding ways to navigate the system to get support for their child from whatever source seemed most open to them, whether that be AIM or HSE. Reports of HSE and AIM working together to strengthen support for children were absent from the data. Parent/carers who had received support from AIM or from HSE felt fortunate that they had managed to do so:

> 'Luckily, I had started a separate process of assessment with HSE – I had gone to meetings with a therapist before [my child] started school – there was no support through AIM for me or [my child].'
>
> [Parent/carer of child diagnosed with ASD, negative experience of AIM]

Parent/carers had also become aware that the engagement of HSE staff was important for the identification of additional needs, or for advising parent/carers on how to make referrals since pre-school staff could benefit from this clinical input and were not always aware of the referral process. They also noted that therapeutic staff and specialist teachers could offer useful advice to settings and to parent/carers about how to support children as individuals. Building a better connection between AIM, HSE and specialist teachers was identified as a priority for development by 7 parent/carers.

Long waiting lists in HSE were recognised as part of this picture, with parent/carers asking for AIM to find ways to address this problem. One parent/carer explained that waiting lists were longer if your child had a behavioural difficulty or speech delay, rather than classic ASD, physical or intellectual difficulties. There were advantages to 'being in the system' in terms of waiting lists:

> ‘A priority is whether AIM can address these waiting lists – we paid [for an assessment] because we couldn’t afford to wait 4 years for speech assessment. With my older son – because you could see the physical and intellectual needs, everything was just done – he was in the system. Friends who got an early diagnosis of ASD are also in the system…there is a gap for those children who are high functioning, and [whose needs] are dismissed as speech and language problems or behaviour problems rather than ASD. You are fighting to get in the system.’
>
> [Parent/carer of child with additional needs, awaiting assessment for ASD]

As is explored later in the discussion of AIM Level 4, parent/carers were aware of the EYS service, with some rating this positively, but in the main, they had low awareness of Level 4 and/or felt that its purpose was to support the staff in the setting with the child rather than parent/carers. Overall, parent/carers offer valuable insights into where the problems are in AIM and how they might be resolved. The emphasis is on joining up parent/carers, pre-schools, and other services through better communication, and on more centralised management of Level 7 quality assurance. HSE waiting lists are also identified as an area for priority action.

In summary, **when describing what is working well in AIM**, parent/carers selected the following elements:

- AIM support (particularly Level 7) creates the opportunities for inclusion, participation, and development in pre-school (16)
    - Children get the personalised support they need (11)
    - AIM support makes it possible for the setting to include the child effectively (8)
- AIM's flexibility makes it fit for purpose (3)
    - AIM does not require a diagnosis (2)
    - The AIM model provides a menu of options and choices (1)
- Additional equipment makes ECCE accessible (2)
- Collaboration between settings and EYS/visiting teacher in the context of AIM is beneficial (2)
- Positive relationships between pre-school staff and parent/carers are key factors in AIM's effectiveness (5)
- The AIM model helps to educate other children and their parent/carers about difference (2)
- Parent/carers are less anxious about their child being aware from them because they know their child is supported (1)

However, parent/carers were aware that all of these positive elements depended on the interaction of the inclusive culture at the pre-school with the AIM supports since one depended on the other. This section has cast further light on the factors involved in constructing a positive experience for children and their parent/carers and a positive impact.

In summary, **what needs to be prioritised for improvement in AIM is identified by parent/carers** as:

- A more formal and agreed approach to feedback and communication between the pre-school, AIM supporters (EYS) and parent/carers (11)
    - More involvement of parent/carers in the development and review of the Access and Inclusion Profile (or other forms of formal plan/do/review assessment) (3)
    - More regular feedback on child's inclusion, participation, and progress (8)
    - Co-construction of support with parent/carers (4)
    - Support, advice, and information for parent/carers from pre-school staff and AIM (4)
- The structure and governance of Level 7 support (9)
    - Centralisation of responsibility for recruiting Level 7 staff (3)
    - Better regulation and accountability for the quality and impact of Level 7 staff (2)
    - Improve pay and conditions for Level 7 staff and the sector generally (6)
    - Involve parent/carers in recruitment of Level 7 staff (1)
    - Provide more training for Level 7 workers (1)
- Training on AIM and inclusion for all professionals (5)
    - Training on ASD (2)
    - Training for Montessori schools on identification and support of additional needs (1)
    - Training for HSE staff (doctors, therapists) on AIM so that advice is based on comprehensive knowledge
- Use of a 'team around the child' approach, including reduction in waiting lists for HSE assessment and support in the wider context (7)
- Reduction in scarcity of pre-school spaces (3)

However, parent/carers were aware that all of these positive elements depended on the interaction of the inclusive culture at the pre-school with the AIM supports since one depended on the other. This section has cast further light on the factors involved in constructing a positive experience for children and their parent/carers and a positive impact.

Parent/carer views on the relationship between the type of additional need/disability and the extent to which AIM is impactful

Parent/carers were asked whether AIM works more effectively for children with some types of additional need than others, and whether AIM works more effectively, less effectively or equally effectively for children with diagnosed with autism/ASD than for other types of need. Most parent/carers (13) did not feel able to comment on this, but some (5) parent/carers offered insights into how the type of disability might interact with AIM to determine impact. Each parent/carer's view on this is paraphrased below:

- Where a child is non-verbal and has ASD, it is harder to facilitate them in a mainstream environment, which is why I chose a specialist pre-school after starting him in ECCE.
- AIM is very effective for children with ASD
- AIM-supported ECCE will work better for children whose needs are not severe. My child was physically quite capable, so AIM worked well for him.
- Children with autism need AIM at that young age, though I think it can benefit children with all types of needs.
- High-functioning children can benefit from AIM since they are not prioritised by HSE for assessment.

For the parent/carers who shared insights, the important factor was the severity of difficulties. Where children's needs were complex or 'severe', it was harder to make AIM-supported ECCE work effectively, though previous sections have also identified practices that are mediating factors in the effectiveness of AIM.

Parent/carer views on the relationship between the location of the pre-school and the extent to which AIM is impactful

Parent/carers were asked whether the geographical location of the pre-school impacted on how effective AIM was. The majority of parent/carers did not feel able to comment on this, but a minority (3) did, to note that (paraphrased):

- HSE in Dublin is overloaded with 'extremely long' waiting lists. We were lucky that we didn't have to wait for assessment and provision.
- It is harder (and even impossible) to recruit to Level 7 support posts in rural areas
- It is very hard to find a pre-school school place in Dublin since there is a shortage of available places for all children

Pressure on services and pre-school places were noted as relevant to AIM's impact in Dublin (urban area). Difficulties with recruiting to Level 7 posts was cited a barrier in rural areas.

Parent/carer views on the impact of AIM on their child(ren)'s transition to school

The issue of transition to school after AIM-supported ECCE (or the special pre-school placement they chose after a period in ECCE), was important to parent/carers/carers, and transition was a prevalent theme across the data.

The themes related to transition were as follows:

- Parent/carers' view of AIM-supported ECCE as the right way to prepare children for transition to Mainstream primary school (8)
- Mainstream school being the desired destination after pre-school (7)
- Distressing or disappointing experiences of how the transition from pre-school to Mainstream was managed (5)
- The importance of a professional role focussed on supporting the transition to primary school (4)
- Parent/carers wish for their child's future to be one where they were happy, included, and independent (3)

Parent/carers regarded AIM-supported ECCE as a way to get their child ready for primary school. For one parent/carer who had wanted her child to attend a mainstream setting rather than a special class or unit, her hopes for ECCE were:

> 'We were hoping that his 'following instructions' goal was met, so when he does attend school, he can follow simple instructions.'
>
> [Parent/carer of child diagnosed with ASD who currently attends special pre-school]

This parent/carer had a strong wish for her child to be in mainstream:

> 'I would have loved this - the other children were mad about him - he had lots of friends. I only know that from the email from the AIM worker, the other kids used to give him hugs and play ball outside with him - that was a massive positive for the mainstream, but he is now in a setting with 6 boys all of which are non-verbal.'

For this parent/carer, the barriers to effective inclusion in the mainstream were to do with a mismatch between her child's level of need, and the expertise of the staff working with him. Another barrier was the long waitlists for provision outside of the special pre-school sector. Another parent/carer (whose child was diagnosed with ASD after pre-school and was now in mainstream school), the parent/carer saw AIM-supported ECCE as an opportunity to develop socially. This father, who described a positive experience of AIM, emphasised the development of social development and learning school routines. In his view, it had helped to have the pre-school on the same site as the primary school.

The majority of parent/carers whose children were now in school (11) described ways in which AIM-supported ECCE had helped prepare their child for a successful transition to school. One parent/carer commented:

> 'He developed very well in pre-school, definitely he matured, and I could see a change from when he started to when he finished. And if he hadn't done pre-school, I don't think he'd have been ready for mainstream school. "If I hadn't had AIMs then I don't know what I have been comfortable sending him to a mainstream school. I might be very reluctant. I wanted to see if he would have been able first. But I knew that from AIM, that with the right support at school he definitely would have been able to remain to mainstream. He loves being around his peers. Definitely benefits him, I think.'
>
> [Parent/carer of child diagnosed with ASD who is attending a special class in mainstream school]

Another commented that:

> 'If we had not enrolled him at pre-school and had the AIMS programme…I don't think he would have been able to go on to mainstream school if he had not got the support that he did.'
>
> [Parent/carer of child diagnosed with ASD who is attending a special class in mainstream school]

Across the data, inclusion in a mainstream school emerged as the outcome of AIM that parent/carers valued most. Though parent/carers were not unhappy with the quality of provision in their children's specialist placement (either pre-school or school), they express disappointment that mainstream was not possible:

> 'The change from AIM to an early intervention setting was difficult, but they were great. They really understood his needs, but they didn't have a primary school that could meet his needs - they didn't have a primary unit for him to attend, and that was a pity, but it was just how it was.'
>
> [Parent/carer of child diagnosed with ASD who currently attends special pre-school]

One parent/carer explained that she had wanted her child to attend a mainstream school but had met resistance, and her experience was distressing. When she requested an additional year in pre-school, they refused to keep her for fear that she might regress. Eventually, through friends and other contacts she found a small mainstream primary school that accepted her. Though the principal had been a little resistant about taking her and advised her 'to put her in a unit', the parent/carer felt that AIM-supported ECCE offered her a useful argument for a mainstream placement:

> 'With the AIM support in pre-school it gave her the chance to shine- they knew she had needs but under no circumstances would she need a special pre-school - she was learning she is now able to use her own independent sentences rather than copying and mimicking.'
>
> [Parent/carer of child awaiting assessment for ASD, now attending mainstream school]

When considering the transition to primary school, parent/carers gave further suggestions on how AIM could be improved, noting that support from an INCO, Level 7 worker or therapist could aid transition – not just in terms of securing the right placement (with most parent/carers preferring mainstream) but in supporting the preparation of both the child and the school. Two parent/carers also argued that the AIM model of support should continue through the infant years, since the curriculum and philosophy of ECCE and the infant age were in alignment. Sudden cessation of support, and delays in reinstating it at the point of school transition, had caused distress for some parent/carers who wished that there had been more continuity from one phase to the next:

> 'I wish she had that continued support in primary school - the early intervention has been a disaster. she went to salt and was referred on and a phone call and that's all we have had in 2 years - we have been taken off the lists - she has no SNA and no support in school- this is really unfair on the child who had support in the pre-school. It is like she has been abandoned again so if AIMS could continue through it would be good - I don't think the teacher in the classroom would mind an extra helper with the child.'
>
> [Parent/carer of child with ASD, now attending mainstream school]

When asked about their hopes and wishes for their child's future, parent/carers emphasised their wellbeing, happiness, and opportunity to live an independent life. One parent/carer expressed this as follows:

> 'To live independently which I think he will, with the skills he's learning from us and from school. I think society is getting a bit more, it's getting people with different needs in. It's not very judgemental as it used to be.'
>
> [Parent/carer of child diagnosed with ASD]

This theme permeates the data from interviews with parent/carers - when parent/carers are hopeful about their child's future and see the promise of an included life in their child's ECCE experience, they are positive about AIM. Where parent/carers perceive poor practice or indifference in their child's pre-school, or limits in the system that they cannot fight, they lose hope and perceive AIM negatively. In the cases where parent/carers have moved their children to a better, second pre-school, they are proactive in resetting this optimism because they have faith in AIM's potential to take their child forward

Parent/carer views on the expansion of AIM

Parent/carers were asked to share their views on the expansion of AIM to:

- School Age Care (SAC)
- Longer hours (beyond ECCE 3 hours per day for children attending Early Learning and Care (ELC) provision for full days.
- Younger children (who don't yet quality for ECCE)

In the case of SAC, 12 parent/carers agreed that AIM support in SAC would be beneficial, even in cases where it was not an option that they would personally choose. They had questions about how this would work (1:1 or whole group) but were in favour of it because it could enrich the child's opportunities for inclusion and development. For example, one parent/carer commented on how the more informal nature of SAC would give her child the opportunity to develop social skills if support was there:

> 'It would be fantastic if he could have this - my issue with after school is that you are just left there. It is great that aim can support in pre-school. In school there is an SNA, but afterschool it could help with what he needs, for example, social skills.'

SAC was seen as a place where social and emotional skills could get more attention, as one parent/carer remarked:

> 'Yes. I suppose after-school care is equally important for children's' social and emotional development, especially for children with disabilities.'

In the case of *AIM extension into ELC hours beyond ECCE*, 13 parent/carers viewed this as important to the child's full inclusion in the pre-school, and 1 disagreed with the proposal. There were a number of reasons for supporting this proposal among the parent/carers/carers interviewed:

- Consistency for the child (1)
- Supporting the child through lunch to develop their social skills in readiness for school (1)
- Their participation could be supported through the day, so they got the most out of pre-school

(2)
- It is logical – if a child needs the support to access ELC, they need the support throughout the day (3)
- It would improve recruitment and retention, bringing better pay and working conditions for Level 7 staff (3)
- It would mean parent/carers could work (4)
- Not having full day support in ECCE was a reason why the parent/carer chose a special-education pre-school (though she would have preferred AIM-supported ECCE)

They also raised the following concerns:

- If it is 1:1 support, it might lead to the child being isolated from non-disabled peers (1)
- Settings might use it to bring down ratios rather than including the child (1)
- It might put pressure on the child when they were tired (1)

In the case of *extension of AIM to children who are not at the ECCE qualifying age* but attend pre-school or may attend pre-school (self-funded and/or through the National Childcare Scheme) 5/15 parent/carers were unsure whether this would help for the following reasons:

- Their child wasn't ready to benefit from pre-school until he reached ECCE age (3)
- The setting may use the additional funds to reduce ratios rather than support the child (1)
- Younger children belong at home with their parent/carers, and government should design programmes that fund home-based support for families (1)
- Earlier diagnosis may be stigmatising with consequent limitations to AIM's capacity for inclusion.

10 parent/carers were in favour of extending AIM to younger age groups, for the following reasons:

- It would support earlier identification and support (3)
- Opportunities for earlier HSE therapy to start (2)
- It might accelerate a child's speech development (2)
- Parent/carers could go to work (2)
- It would be unlikely to be detrimental (though wouldn't have helped own child) (1)

One parent/carer argued that the system needed either AIM support at a younger age or a stronger, better-resourced system of HSE support.

In summary, **most parent/carers were in support of the extension of AIM support to other phases of ELC and SAC**

- 12/15 parent/carers agreed that support in SAC would be beneficial for the child's inclusion, participation, and development.
- 13/15 parent/carers viewed the extension of AIM support beyond ECCE hours as potentially beneficial.
- 10/15 parent/carers saw potential benefits in the extension of AIM support to younger children who were accessing ELC (or who might access it) prior to the ECCE qualifying age.

The main reasons given for supporting these proposals were that they would support fuller inclusion, participation, and development (particularly social and emotional); they would allow parent/carers to work; they could improve pay and conditions for Level 7 support staff. The main reasons for not supporting these proposals were that, if the support were 1:1 it might create barriers to inclusion; that earlier support might be stigmatising, that the children might not be ready for pre-school at a younger age; that staying at home with parent/carers is an option for younger children that government should support more.

The next subsection explores parent/carer awareness and perceptions of the implementation of each Level of AIM (1-7). Details on the content and purpose of each AIM level are provided in Section 2 of this report.

11.2: AIM Level 1: An Inclusive Culture

When introducing questions about AIM Level 1, interviewers provided a summary of what it included. Participants were also sent an information sheet which summarised AIM supports. However, all parent/carers who responded to questions about AIM Level 1 (18) indicated that they had not heard of it and did not know much about it before the interview. Most parent/carers (17) did not know whether there was an INCO in the setting, but one did, and noted that they were in contact with them. 2 parent/carers of the parent/carers who didn't know whether there was an INCO said that they were in touch with the pre-school manager. Though parent/carers did not know whether there was an INCO, some (3) did mention managers or Level 7 workers they were in touch with, who were supportive in communicating with them about their child and who they believed to be effective at inclusion. It is important to note that though parent/carers do not use the term AIM Level 1 when describing the practices that were associated with a positive experience of AIM, they were often describing the principles and practice of an inclusive pre-school culture in their reflections on their experiences of AIM. As reported earlier, these included:

- Being flexible around the needs of the child and personalising (10) and challenging the child and developing their independence in a supported way (5)
- Including the child in everything through supported participation (8 and providing an engaging curriculum and resources (8)
- Having an inclusive culture – positive staff commitment and expertise around inclusion, including being accepting of the child (10)

The 6 parent/carers who reported a mixed positive/negative perception of AIM because they had moved their child to a second setting that was more effective at using AIM supports, were doing so because they were looking for a pre-school with a more inclusive culture. Though parent/carers were not familiar with the term 'AIM Level 1', they were aware that it was an essential foundation for the effectiveness of AIM support, and that positive outcomes were an interaction between AIM support (usually Level 7) and the skills and attitudes of the pre-school.

In summary for **AIM Level 1 (An Inclusive Culture)** all (18) parent/carers were unaware of the term 'AIM Level 1' and had not heard of it before the interview.
The majority (17) did not know whether there was an INCO in the setting or not, but 1 was aware and was in touch with this practitioner. 3 participants reported that they were supported by the pre-school manager or a Level 7 support worker who had been very supportive. It is important to note, that though parent/carers do not use the term AIM Level 1, when describing the practices that were associated with a positive experience of AIM, they were often describing the principles and practice of an inclusive pre-school culture in their reflections on their experiences of AIM. As reported earlier, these included:

- Being flexible around the needs of the child and personalising (10)
- Challenging the child and developing their independence in a supported way (5)
- Including the child in everything through supported participation (8)
- An engaging curriculum and resources (8)
- An inclusive culture – staff commitment and expertise around inclusion, including being accepting of the child (10)

This implies that parent/carers were aware of the importance of AIM Level 1 as the foundation for the effective use of AIM targeted support.

11.3: AIM Level 2: Information for parents and carers

The majority (9) of parent/carers had heard about AIM through their pre-school (6) or the pre-school and HSE practitioner combined (2). 1 parent/carer had heard of AIM through HSE services because her child was already known to the service, and 1 had been briefed on it by her foster child's social worker. 2 parent/carers learned about AIM as a 'need to know' when they were applying for AIM support, and 1 reported that she had to research AIM for herself, with no support from professionals. 1 participant referred to the AIM website but had not used it, preferring to talk with pre-school and HSE professionals.

One of the 6 parent/carers who had learned about AIM from her child's pre-school described an information pack she was given to read by the pre-school and noted that it was given freely and easy to understand. However, she did not like the message that she perceived to be central to this information, since she believed that AIM was best delivered as 1:1 support:

> 'We were given the AIM pack to read. It didn't really describe our child or what he needed. It was all about integration and helping the children to do things the same as other children. My child does not want to do the same things as everyone else. It did not suit their child or their preferences e.g., being included alongside everyone else. The pack was given, and it was very straightforward though but not what we were looking for.'
>
> [Parent/carer of child diagnosed with ASD during pre-school]

Most (9) parent/carers were appreciative of the way that pre-schools, HSE practitioners and social workers had helped them to navigate information about AIM. This is another example of how communication and being kept informed supported parent/carers' positive perception of AIM. One parent/carer noted:

> 'I don't remember being given information about AIM – it was quite a while ago, but the pre-school manager did seem to know and understand and process, she was engaging with it all the time previously - she was an administrator and manager - she needed these skills to get her head around the process, organising the multidisciplinary team that were involved - this would have been hard for parent/carer to get her head around.'
>
> 'I appreciated the work of the pre-school owner in understanding and organising all of this.'
>
> [Parent/carer of child diagnosed with speech difficulties identified prior to pre-school]

For this group of participants, information about AIM had largely come through the support network of pre-school, HSE and social workers. Though participants had accessed information themselves, this was when they needed to because of an AIM support application. This demonstrates how much parent/carers depend on and trust the advice of professionals on AIM. The AIM website seemed largely untapped by participants, since they preferred to talk with others about how AIM was relevant to their child or had no knowledge of AIM before pre-school started. Parent/carers connected to HSE services were more likely to report being aware of AIM before pre-school

For AIM Level 2 (Information for parent/carers):

- The majority (9) of parent/carers had heard about AIM through their pre-school (6) or through the pre-school and HSE practitioner combined (2).
- 1 parent/carer had heard of AIM through HSE services because her child was already known to them and hence 'in the system, and 1 had been briefed on it by her foster child's social worker.
- 2 parent/carers learned about AIM as a 'need to know' when they were applying for AIM support with the support of the EYS or via their own web search
- 1 reported that she had to research AIM for herself, with no support from professionals. 1 participant referred to the AIM website, but had not used it, preferring to talk with pre-school and HSE professionals

This demonstrates how much parent/carers depend on and trust the advice of professionals on AIM. It also demonstrates that in the majority of cases, pre-schools, and other support agencies, were proactive in sharing information about AIM with parent/carers, though one parent/carer reported 'having to become an expert' to navigate the system on her own. Some did this on an ongoing basis, which parent/carers valued. HSE practitioners and social workers had helped them to navigate information about AIM. This is another example of how communication and being kept informed were factors in parent/carers' positive perception of AIM.

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11.4: AIM Level 3: A qualified and confident workforce

When asked to share their experiences of how well-trained and well-prepared the staff in the setting were for inclusive practice, parent/carers communicated relatively low awareness of AIM-supported professional development. None of the participants had heard of the LINC (Leadership for Inclusion in Early Years Care) programme, but one thought that the pre-school manager was doing something that sounded like it. 5 parent/carers described the pre-school staff as knowledgeable but did not feel able to identify any training gaps since they didn't know enough about this. 1 parent/carer was aware that one of the practitioners working with her child had completed the Lámh training.

4 parent/carers did identify training gaps in the following:

- Intensive training in additional needs such as sensory difficulties and autism (3)
- Where a child has very specific needs (e.g., epilepsy), training from the HSE therapist would support effective practice (1)

For AIM Level 3 (A qualified and confident workforce)

Parent/carers reported low levels of awareness about AIM supported training for inclusion at Level 3. The majority (14) did not feel able to identify training gaps.

Where these were suggested, they were: training in a range of additional needs (including ASD), and direct training by medical/therapeutic staff/specialist teachers for pre-school staff on the very specific needs of an individual child and how they could be supported. They were not aware of the way in which AIM Level 6 (universal) was a method for supporting this.

11.5: AIM Level 4: Expert early years educational advice and support

As was the case with AIM Levels 1-4, parent/carers awareness or engagement with Level 4 support was relatively limited. Some parent/carers (6) had no contact with an EYS, though all of these had been allocated Level 7 support. Two explained that they had not been in touch with an EYS because they were already known by HSE and seemed to have Level 7 support through this route. 2 parent/carers could not remember if they had been in contact with an EYS. 7 parent/carers described their contact and communication with an EYS as very brief and perfunctory. This would usually involve a phone call to the parent/carer at the start of the application process (6), with no follow-up whilst the application was in progress or after it. One parent/carer reported, 'I only saw the EYS for 10 minutes' and another explained, 'For Level 7, the EYS did not ring me in the second pre-school, and this may have been because my child was already known to her from the previous setting.' It surprised parent/carers that the EYS did not visit the child in the pre-school or engage them more fully in writing an assessment report (which researchers presume to be the Access and Inclusion Profile, a term parent/carers did not use). Parent/carers were not always sure if the EYS had given the setting advice, or if they had implemented it (4). This is another example of how loops in communication are experienced as incomplete for parent/carers.

One parent/carer reported a negative experience and her shock at having the Level 7 application refused initially:

> 'I did have a contact with a lady, and she did an interview with me in the pre-school then she observed my child in the setting to watch him with other children and how they were going to support - initially they refused my application - she said that he could communicate by using gestures and using hands to show what he wanted. I disputed this and said he had no language. If you were to put him in the setting without someone to look after his needs - he wouldn't manage he was a danger- he had no knowledge - a flight risk at the time.'
>
> [Parent/carer of child diagnosed with autism who transferred to a special pre-school]

Her experience of AIM Level 4 convinced her that AIM was still dependent on a diagnosis, and that this was likely to limit its reach:

> 'I think when the EYS from Better Start- if there was less emphasis on diagnosis or more attention to the actual needs of the child - I found it really distressing when the application was refused.
>
> He was non-verbal and risky in the setting- he had never been anywhere before, and change was really hard. You shouldn't have to have the diagnosis - if I wasn't in the position to pay for the diagnosis - I would have been very distressed - I don't think he would have got the support if I hadn't really pushed for it - we had the doctor writing letters of support to get through the L4 gateway.
>
> I think other children may be missing out not many children have that diagnosis of ASD before the age of 5. A lot comes down to the diagnosis and the piece of paper and not seeing the individual child.'
>
> [Parent/carer of child diagnosed with autism who did receive Level 7 and transferred to a special pre-school]

3 parent/carers reported fuller engagements with the EYS, with 2 describing helpful practices, such as explaining how the setting were supporting the child, and in another case, how the EYS provided advocacy for the family on transition to primary school:

> 'She was fabulous because after the issues I had with her finding a school place- I rang her and she gave great advice - because of the inclusion module my daughter should be included in the primary school. I found her very helpful, and she listened to me - she felt that repeating a year in pre-school wouldn't help if she was just going to copy behaviour.'
>
> [Parent/carer of child awaiting assessment for ASD]

1 parent/carer believed that a multidisciplinary assessment involving an EYS, and an Occupational Therapist would have helped to bring more personalised practice into the pre-school, and another mentioned the potential value of having her child's audiologist involved in the assessment process. 1 parent/carer reported that the setting was advised by an EYS that they did not implement the advice. These data indicate that the majority of parent/carers were either unaware of Level 4 support or had experienced it as perfunctory and distant from them. They were surprised that there was no follow-up after an allocation of support had been made e.g., monitoring), and would have liked more communication with the EYS in the context of linking up with the pre-school and knowing more about what had been advised. The Access and Inclusion Profile was something that only 1 parent/carer reported being involved in, aside from an assessment phone call, and this is surprising since parental consent and involvement is a required element of any application for AIM support. As reported earlier, parent/carers would welcome more regular updates and feedback on what is being implemented, what the impact is on their child, and how they can support.

AIM Level 4 (A qualified and confident workforce): Participants' experiences were:

- 8 parent/carers had no contact with an EYS, though all of these had been allocated Level 7 and 2 in this group explained that they had not been in touch with an EYS because they were already known by HSE had accessed Level 5 or Level 7 support through this route. A further 2 could not recall any contact with an EYS.
- 1 parent/carer was shocked that an EYS had refused her application for Level 7 and came to believe that AIM depended on a diagnosis. This led her to fund her own assessment prior to a repeat application.
- 2 parent/carers could not remember if they had been in contact with an EYS.
- 7 parent/carers described their contact and communication with an EYS as very brief, and 4 of these were surprised that there was no follow up or support for the child, the parent/carer, or the pre-school in the implementation/review of the Access and Inclusion Profile.
- 4 parent/carers noted that they were unsure whether the EYS had worked with the setting and whether advice was being implemented.
- 1 parent/carer reported being fully involved in the writing of the Access and Inclusion Profile. This is another example of how loops in communication are experienced as incomplete for parent/carers, and where a co-constructive approach may have offered a more positive experience, gaining their fuller trust in AIM and its implementation and impact.

11.6: AIM Level 5: Equipment, appliances, and minor alterations grants

12 parent/carers were aware of AIM Level 5, so awareness was higher than it was for AIM Levels 1 – 4. 1 parent/carer reported that the Occupational Therapy team and HSE had installed facilities in the pre-school so that the child could get changed (child had a complex medical condition). 3 parent/carers knew that the school had high-quality equipment that was used with their child, but they were unsure if it had been resourced through AIM, for example, a parent/carer referred to the positive impact of resources in her child's pre-school:

> 'They provided a big, huge box of stuff for [my child], including a cushion to sit on, a timer, a blackout tent to sit on his own if he needed space, brushes, cameras. Excellent, excellent, it has given him the skills that I think he has brought into the mainstream school with him.'
> [Parent/carer of child with diagnosis of ASD during pre-school]

3 participants were aware that AIM Level 5 was available, but their children didn't need it. One parent/carer noted that AIM had helped with purchasing the equipment which linked his hearing aid to the classroom sound system, and another was aware that once her child's hearing aids were provided, then an application for a sound link system could be made via AIM Level 5 retrospectively.

One parent/carer had been helped with equipment for her child through the fostering agency, and this was being used to support speech development. Generally, parent/carers were more aware of Level 5 AIM support and were positive when describing the impact of high-quality, bespoke equipment and resources, whether provided by AIM or via other sources

11.7: AIM Level 6: Therapy Services

None of the parent/carers that were interviewed had experienced AIM Level 6 (universal or targeted). 12 participants explained that their access to HSE support had occurred external to AIM in one of the following ways:

- Paying for an assessment or therapy themselves (2)
- Through HSE because the child was already known to HSE services (9)
- Therapeutic or specialist support was through a specialist teacher allocated to the child (1)

2 parent/carers reported no knowledge of Level 6, including one who had wondered why it had not been suggested as an option. 2 participants had not seen Level 6 provision in their child's setting, and 1 commented, 'I don't think anyone would come in to support because my child's provision happens elsewhere.'

Parent/carers were generally satisfied with their child's HSE support outside pre-school, and 6 commented that they felt lucky to receive it. 2 parent/carers explained that therapeutic support was hard to get, because of very long waiting lists, and this has been the reason why they had taken their children out of ECCE and placed them in a special pre-school. 2 parent/carers noted that their child had been accepted for Early Intervention support, but this had been stopped or postponed because of COVID.

These data provide further evidence of the way in which Level 6 support exists outside AIM rather than within it, though 2 parent/carers did give accounts of communication between health and social

care professionals, specialist teachers and the pre-school, they reported that these had demonstrated a lack of connection between these services rather than collaboration, and they were not sure if the collaboration had come about because of the EYS engagement of therapists at Level 6 or not. 1 parent/carer reported that her child's therapist had begun to work in the setting to support the child, but that the pre-school ended this arrangement and were resistant to working with HSE staff from that point onward. These data imply some sustained disconnection between AIM and HSE, with Level 6 support being outside these parent/carers experience or awareness.

AIM Level 5 (Equipment, appliances, and minor alterations grants)

- 12 parent/carers were aware of AIM Level 5, and awareness was higher than for Levels 1 – 4. 1 parent/carer reported that the Occupational Therapy team and HSE had installed facilities in the pre-school so that the child could get changed (child had a complex medical condition).
- 3 parent/carers knew that the school had a lot of high-quality equipment that was used with their child, but they were unsure if it had been resourced through AIM
- 3 participants were aware that AIM Level 5 was available, but their children didn't need it. One parent/carer noted that AIM had helped with purchasing the equipment which linked his hearing aid to the classroom sound system (a microphone the teacher wore), and another was aware that once her child's hearing aids were dispensed, then an application for a sound link system could be made via AIM Level 5 in retrospect.
- 1 parent/carer had been helped with equipment for her child through the fostering agency, and this was being used to support speech development.

Generally, parent/carers were more aware of Level 5 AIM support and were positive in describing the impact of high-quality equipment and resources on their child's inclusion. Parent/carers were not always clear on whether the equipment had been purchased through AIM or within the setting's own budget.

AIM Level 6 (Therapeutic Supports)

None of the parent/carers had received HSE assessment or intervention through AIM Level 6, but through referrals and interventions outside AIM.

12 participants explained that their access to HSE support had occurred external to AIM in one of the following ways:

- Paying for an assessment or therapy themselves (2)
- Through HSE because the child was already known to HSE services (9)
- Therapeutic or specialist support was through a specialist teacher allocated to the child (1)

2 parent/carers reported no knowledge of Level 6, including one who had wondered why it had not been suggested as an option. 2 participants had not seen L6 provision in their child's setting.
1 parent/carer could not imagine therapeutic support coming into pre-school for her child though 2 described communication between therapeutic staff/specialist teachers and staff in the pre-school. These communications were not identified by parent/carers as emerging from AIM Level 6 (universal) or as positive or productive.
1 participant explained that her child's therapist had come into pre-school to provide support during ECCE sessions, but this had been stopped by the setting who were then resistant to any engagement with staff from that service. In summary, the participants had not experienced Level 6 as an integrated AIM support.

11.8: AIM Level 7: Additional assistance in the pre-school room

For most of the parent/carers interviewed, AIM Level 7 was the most positively impactful and/or troubling element of support provided for their child. References to Level 7 have arisen in the findings to indicate that the majority of parent/carers interviewed (16), regard good quality Level 7 support as crucial to their children's successful inclusion in pre-school for a range of reasons. These include flexibility for the child, sensitive coaxing of the child into unfamiliar activities, scaffolding for social interactions and the development of skills for independence.

Parent/carers had differences of opinion on whether additional assistance should be 1:1 or not[73]. 6 parent/carers were aware that Level 7 was not delivered as a 1:1 model, and this was their expectation, and they recognise that the support can become 1:1 when needed. When asked to reflect on how Level 7 support was used, and whether this was what was expected, one parent/carer (like 5 others) related the following perception:

> '[The additional assistance] was in the room generally, rather than 1:1 and I supposed it matched my expectations because I wanted him included in the room. You'd have to wonder as well, as I know they were short-staffed, whether she was covering breaks and so forth – I hope she was offering the support 1:1 when needed, but I am not completely sure that happened.'
>
> [Parent/carer of child diagnosed with ASD during pre-school]

One parent/carer had taken her child out of a setting because they were not using the additional assistance as 1:1 support. The second setting did not use a 1:1 approach either, and the parent/carer was disappointed in this, but was happy to report that in his mainstream primary school, a Special Needs Assistant (SNA) was allocated and that he was 'a different child' as a result. However, another parent/carer reported that the pre-school integrated the child into activities wherever possible, but because of his complex needs worked mainly on a 1:1 basis. Another setting had chosen to deploy the pre-school room teacher to the AIM support because the person appointed did not have the experience needed to support the child's needs. The parent/carer who reported this was happy that this decision had been made.

This demonstrates that settings adopt different options according to the child. Parent/carers tend to be more positive about the way additional assistance is deployed when it is explained to them, but 1 parent/carer rejected the idea that a distributed model (not involving intensive 1:1) would ever be inclusive or appropriate for her child.

However, another parent/carer (whose child had a hearing difficulty caused by a genetic disorder), wanted a distributed model of support, and had moved her child to his second setting for that very reason:

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[73] The AIM Rules 2020-21 (Pobal, 2021, p26-27) outline permitted uses of Level 7 as follows:

- Where Pobal confirms approval, pre-schools can use the additional capitation granted through AIM Level 7 to reduce the child-to-adult ratio by enrolling fewer children.
- AIM Level 7 additional assistance staff is a shared resource for the pre-school, and 'does not fund Special Needs Assistants (SNAs)' and is 'a shared resource for all children in the pre-school room.' (DCEDIY, 2021, p26).
- One additional staff member may be deemed to be sufficient to meet the needs of two or more children who have been granted Level 7, within the same session. Staff members providing the Level 7 additional assistance cannot be included in the child-to-adult-ratio (e.g., the presence of this additional staff member cannot lead to the enrolment of a further eleven children

> 'In the first setting, they literally just took care of his physical needs. I didn't see any development. I got the impression they had an AIM support and did what he needed. I think in the second one, it was used as an extra person in the room so there was more interaction between my child and the pre-school teacher – sometime the AIM support worker did things with my child and at other times, the teacher did – he was exposed to both staff, and they set goals for him – little things like more interaction with his peers and making him a bit more independent.'
>
> [Parent/carer of child diagnosed with ASD and hearing difficulty]

Parent/carers were aware of the challenges with recruitment and retention to Level 7 support roles This has been reported previously, and it was an area for improvement that the majority of parent/carers mentioned with a proposal for greater centralisation of recruitment so that parent/carers and children could avoid the disruption and distress caused by not having Level 7 support in place. 1 parent/carer was deeply distressed by the delay in getting support in place. Parent/carers also suggested more monitoring and regulation of this support (2), so its quality could be assured, and were surprised that the EYS did not follow up on this (2). Parent/carers reported that they felt lucky when the Level 7 support worker was experienced and effective, since they were aware (from experience in their child's previous pre-school) that this was not always the case. Parent/carers recognised that the impact of Level 7 support depended upon the quality of the person appointed, combined with the inclusive culture of the setting. Level 7 was not a guarantee of inclusion and participation, but for many parent/carers, it was crucial to it.

One parent/carer understood that the pre-school room could only have 1 AIM support worker, and she felt that this has compromised the quality of support her child received. 3 parent/carers did not trust pre-schools' motivation for getting Level 7 support (particularly in a failed first pre-school placement), and called for this to be monitored, since it had not been used to support their child effectively. 4 parent/carers had applied for Level 7 support themselves and found it time-consuming, noting the delay in decisions, and no contact from AIM.

However, where parent/carers were supported by the pre-school, with advocacy from HSE and specialist teachers, the process went more smoothly. Another parent/carer reported that she learned that Level 7 support depended on a diagnosis, which in the end she had paid for to secure Level 7 support in her child's second year of ECCE. However, it is important to note that two children represented in this sample of participants, had received Level 7 support without a diagnosis.

These data demonstrate that, in parent/carers' view, Level 7 support is a priority for action in relation to:

- Improving pay and working conditions for Level 7 support workers
- Centralising recruitment and quality assurance of Level 7 support.
- Convincing parent/carers of the value of distributed, flexible models of support (though recognising that 1:1 may be essential for some children, at intervals and durations that are individual to each child.
- Ensuring that all parent/carers who are applying for Level 7 are supported by professionals. However, the broader data from interviews with parent/carers also shows that the success of AIM Level 7 is dependent on the extent to which a pre-school has an inclusive culture, and the conditions in which such a culture can flourish.

It can be proposed that this indicates a return to first principles, as emulated in the DEI charter (DCYA, 2016)[74], Siolta[75] (CECDE, 2006) and *Aistear* (NCAA, 2009)[76] . These principles are also embedded in AIM's model of progressive support which itself is founded on a principle of Universal Design where the readiness, willingness, and ability of pre-schools to be inclusive is understood to emerge from a foundation of quality practice for all.

These data also demonstrate that parent/carers are aware that the efficacy of Level 7 depends on two conditions. Firstly, the presence of an inclusive culture within the pre-school where the support is being implemented, and secondly strategies that address operational barriers, such as working conditions and systems of monitoring and regulation.

AIM Level 7 (Additional Assistance in the pre-school room)

- AIM Level 7 is the AIM support that parent/carers are most aware of.
- 16 parent/carers regard good quality Level 7 support as crucial to their child's inclusion and meaningful participation and see it as the most impactful element of AIM targeted supports.
- 6 parent/carers were aware that their child's pre-school setting was delivering this support in a distributed model rather than 1:1 and this is what they expected, though they also hoped that the setting would provide 1:1 when it was needed (in a flexible way)
- 1 parent/carer did not agree that a distributed model of Level 7 support could ever be sufficiently inclusive.
- Settings were reported to use different approaches to deploying Level 7, including 1:1 care for a child with complex medical needs (which the parent/carer did not like since it meant he was not included, participating, or developing), distributed model and in one case, the pre-school room leader taking the Level 7 support role because the member of staff appointed was not experienced enough.
- Parent/carers were aware that the quality and impact of Level 7 support was variable.
- Parent/carers were also aware that Level 7 support was most effective in pre-schools where there was an inclusive culture
- Parent/carers were aware of the problems with recruitment, retention and quality that surround Level 7, and identify this as a priority for action. 1 parent/carer proposed that centralised recruitment should be implemented. Another argued for tighter regulation and monitoring of the quality, use, and impact of Level 7 support.
- 4 parent/carers had applied for Level 7 support themselves, and this had been time consuming and stressful with long wait times and delays. Parent/carers were happier with the application when they were well supported by other professionals, with advocacy from HSE staff and specialist teachers being particularly important.
- 1 parent/carer argued that Level 7 depended on diagnosis (though she knew it shouldn't) and she paid for her child's ASD assessment so that Level 7 would be improved on the second application (which it was). However, the sample for interviews did contain 2 parent/carers whose children had been allocated Level 7 without a diagnosis.

These data demonstrate that parent/carers are aware that the efficacy of Level 7 depends on two conditions:

1. An inclusive culture within the pre-school where the support is being implemented
2. A strategy that addresses operational barriers, such as working conditions and systems of monitoring and regulation.

11.9: Summary

This subsection provides a summary of the findings in relation to the four key questions posed by the end of year three evaluation of AIM. To reiterate, these are:

From the perspective of the parent/carers who participated in interviews:

- Is Aim effective in achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities and additional needs?
- Has AIM influenced practice, or increased the capacity of the workforce?
- Is the current approach appropriate in the national context?
- Should AIM be extended to School Age Care, hours outside ECCE and to younger children?

Each of these questions is addressed in turn, with reference to the findings and the conclusions that may be drawn from them. Section 13 combines the findings from all inquiry and data collection methods, to conclude on each of these questions. The subsection begins with a summary of the characteristics of the sample.

Characteristics of the sample

The parent/carer sample included 8 parent/carers who had a positive experience of AIM, 9 had a mixed experience (usually because they had moved their child to a setting that was doing better with AIM), and 1 had an entirely negative experience. The sample included parent/carers of children with a diagnosis of autism/autistic spectrum disorder (ASD) (9), no diagnosis (3), complex medical needs (1), learning disability and hearing difficulty (1), learning disability (1) hearing difficulty and speech delay (1), complex medical needs and learning difficulties (1) and speech and language difficulties (1). The higher representation of ASD in the sample was deliberate because of the lines of inquiry arising from the survey where parent/carers of children with autism/ASD were found to be statistically significantly less likely to be positive about AIM. Among this group, 3 participants reported a positive experience of AIM, 5 a mixed experience and 1 a negative experience. 10 counties were represented in the sample including West Meath, Tipperary, Meath, Mayo, Limerick, Kildare, Dublin, Cork, Clare, and Carlow.

A mixture of private, community, creche and special-education settings were attended by children of the parent/carers/carers interviewed. 9 parent/carers described their child's pre-school as being in an urban area, 6 were rural and 3 were in towns. In 12 cases, children were currently attending school, with 10 being in mainstream school (most with a Special Needs Assistant – SNA), 1 was attending a special class within a mainstream school and was 1 attending a special school. This meant that the majority of participants had experienced AIM-supported ECCE prior to 2021-22. In summary, the samples were well formed to serve purposive inquiries, at the same time as being diverse enough to represent a range of perspectives. This was important given the evaluation's intention to review AIM in a pluralistic way.

Is AIM effective and achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities and additional needs?

When describing the positive impacts of AIM on their children's inclusion, participation, and development, most (16) parent/carers were able to describe tangible benefit. Parent/carers focused

on the opportunities that their child had had to make friends and interact with other children. They also described positive developments to their children's:

- Confidence (7) and Independence (8)
- Practical skills and social skills (6)
- Ability to follow instructions, rules, and social conventions (2)
- Ability to manage other people's reactions to their disability (1)
- Speech and interaction (3)
- Reading (1)
- Willingness to try new activities and experiences (e.g., food) (3)

1 parent/carer who had a mixed perception of AIM, reported that support had no significant impact on her child because it was not 1:1 and hence he had not developed. 1 parent/carer reported that their child had experienced some positive impact from ECCE but not from AIM since the setting had been unable to recruit a Level 7 worker and their child was limited to half a day a week as a consequence. 1 parent/carer who reported a negative experience of AIM, felt it had little impact because of practitioners' lack of knowledge of additional needs, and how best to use the additional assistance provided by AIM.

The finding was that for this group of participants at least, when AIM support is being used effectively, it has the positive impacts it was designed to deliver. AIM Level 1 emerges as an essential precursor for the success of targeted support in delivering this impact.

The issue of transition to school was important to parent/carers when reflecting on AIM's impact (or hoped for impact for those children still in pre-school. The themes related to transition were as follows:

- Parent/carers view of AIM-supported ECCE as the right way to prepare children for transition to Mainstream primary school (8)
- Mainstream school being the desired destination after pre-school (7)
- Distressing or disappointing experiences of how transition from pre-school to Mainstream was managed (5)
- The importance of a professional role focussed on supporting transition to primary school (4)
- Parent/carers wish for their child's future to be one where they were happy, included, and independent (3)

A positive transition to school was the benefit (and potential benefits) of AIM-supported ECCE that parent/carers valued the most. Hope for their children's future and continued inclusion in education and society underpinned their reflections on transition to school. Where they perceive poor practice or indifference in their child's pre-school, or limits in the system that they cannot fight, they lose hope and perceive AIM more negatively.

Even where parent/carers have had negative experiences in one pre-school, causing them to move to another, they express their faith in AIM's capacity to bring positive benefits to children's transition to school and beyond. The 1 parent/carer reporting an entirely negative experience saw the potential of AIM to support effective transitions, where pre-school practices were strong.

Has AIM influenced practice, or increased capacity in the workforce?

When giving examples of the pre-school practices that were part of a positive experience of AIM-supported ECCE, parent/carers referred to the following practices within their child's pre-school:

Being flexible around the needs of the child and personalizing (10)

- Using visual communication aids (3)
- Taking children's interests on board (5)
- Inducting children gradually into the pre-school and unfamiliar activities (3)
- Letting children take the lead in their learning (2)
- Picking up and acting on the detail of children's difficulties and barriers to participation (2)

Challenging the child and developing their independence in a supported way (5)

- Coaxing and supporting children to get involved in unfamiliar and unpreferred activities (3)
- Teaching the child strategies for independence (2)

Including the child in everything through supported participation (8)

An engaging curriculum and resources (8)

- Equipment in the pre-school to support hearing (2)
- Outdoor curriculum and facilities (2)
- Enjoyable activities (2)
- Sensory experiences that supported the child (2)

An inclusive culture – staff commitment and expertise around inclusion (10)

- Manager and other staff work hard to support the child (2)
- Staff work together to improve practice (1)
- Staff are welcoming, valuing and accepting of the child (6)
- Effective Level 7 support (defined variably by parent/carers as 1-1 or not 1-1)

17 of the 18 parent/carers interviewed had experienced at least one pre-school where these practices were in place, sometimes because they moved their child to a new setting where practice was better. Though parent/carers had no awareness of 'AIM Level 1 (An inclusive culture) and had not heard of it (see subsection 11.1), they were aware when such a culture was present or absent, though they did not see this as directly attributable to AIM. The data revealed variability in the readiness, willingness, and ability of pre-schools to implement AIM effectively such that it achieves its intended outcomes. It also demonstrated that when there is an inclusive culture (AIM Level 1), and knowledge about inclusive practice for children with disabilities/additional needs (AIM Level 3), AIM can deliver to its intentions.

The challenge lies in reducing the variability in the quality of inclusive practice across the sector. Given that this good practice exists in at least 17 of the pre-schools experienced by parent/carers, it will be important to find ways to move this knowledge and practice around the system

Is the current approach appropriate in the National Context?

Few parent/carers (1) reported an entirely negative experience of AIM-supported ECCE for their child. The majority of parent/carers (16) had positive things to say about AIM, with 8 being entirely positive and 9 reporting a mixed experience. In the case of a mixed experience, most (5) had moved their

children to a new pre-school because they were not happy with the way settings were using AIM support, and with the pre-schools' practices more generally.

In all 5 of these cases, parent/carers were happy with AIM in the second pre-school. In 2 of the cases of a mixed experience, parent/carers had moved their children from an ECCE placement they were largely happy with, to a special pre-school because they were aware of long waitlists for HSE therapeutic support and were being pragmatic. This indicates that for these parent/carers, AIM had not offered a sufficient solution to the wider contextual constraints in the system. 1 parent/carer's mixed experience arose because her child was attending a supportive setting but had been unable to recruit a suitable Level 7 support worker. For 1 parent/carer, the experience of AIM had been entirely negative because the setting did not have an inclusive culture and did not have sufficient training in supporting children with additional needs.

This gives further support to the claim that the targeted support provided through AIM is experienced positively by parent/carers in settings where there is an inclusive culture. It also indicates variability in the quality of AIM supported practice, indicating that there is still work to do in building consistency across the system in the National Context. However, it is clear that the AIM model does have the potential to work effectively in this context, in a context of continuous improvement. The priorities for action emerging from interviews with parent/carers are reported later in this summary section.

Following lines of inquiry arising from the survey, parent/carers were asked whether AIM works more effectively for children with some types of additional need than others, and whether AIM works more effectively, less effectively or equally effectively for children with diagnosed with autism/ASD than for other types of need. Most parent/carers (13) didn't feel able to comment on this, but some (5) parent/carers offered insights into how the type of disability might interact with AIM to determine impact. Each parent/carer's view on this is paraphrased below:

- Where a child is non-verbal, and has ASD, it is harder to facilitate them in a mainstream environment, which is why I chose a specialist pre-school after starting him in ECCE.
- AIM is very effective for children with ASD
- AIM-supported ECCE will work better for children whose needs are not severe. My child was physically quite capable, so AIM worked well for him.
- Children with autism need AIM at that young age, though I think it can benefit children with all types of needs.
- High functioning children can benefit from AIM since they are not prioritised by HSE for assessment.

For the parent/carers who shared insights, the important factor was the severity of difficulties. Where children's needs were complex or 'severe', it was harder to make AIM-supported ECCE work effectively.

Parent/carers were asked whether the geographical location of the pre-school impacted on how effective AIM was. The majority of parent/carers didn't feel able to comment on this, but a minority (3) did, to note that (paraphrased):

- HSE in Dublin is overloaded with 'extremely long' waiting lists. We were lucky that we didn't have to wait for assessment and provision.
- It is harder (and even impossible) to recruit to Level 7 support posts in rural areas
- It is very hard to find a pre-school school place in Dublin since there is a shortage of available places for all children

Pressure on services and pre-school places were noted as relevant to AIM's impact in Dublin (urban area). Difficulties with recruiting to Level 7 posts was cited a barrier in rural areas.

Areas that are working well

Overall

When describing what is working well in AIM, parent/carers selected the following elements:

- AIM support (particularly Level 7) creates opportunities for inclusion, participation, and development in pre-school (16) Children get the personalised support they need (11) AIM support makes it possible for the setting to include the child effectively (8)
  AIM's flexibility makes it fit for purpose (3) AIM does not require a diagnosis (2) The AIM model provides a menu of options and choices (1)
- Additional equipment makes ECCE accessible (2)
- Collaboration between settings and EYS/visiting teacher in the context of AIM is beneficial (2)
- Positive relationships between pre-school staff and parent/carers are key factors in AIM's effectiveness (5)
- The AIM model helps to educate other children and their parent/carers about difference (2)
- Parent/carers are less anxious about their child being away from them because they know their child is supported (1)

However, parent/carers were aware that all of these positive elements depended on the interaction of the inclusive culture at the pre-school *with* AIM targeted supports since one depended on the other. In what follows, parent/carers perceptions of each level are summarised.

AIM Levels 1-7

<u>AIM Level 1 (An Inclusive Culture)</u>

All (18) parent/carers were unaware of the term 'AIM Level 1' and had not heard of it before the interview. The majority (17) did not know whether there was an INCO in the setting or not, but 1 was aware and was in touch with this practitioner. 3 participants reported that they were supported by the pre-school manager or a Level 7 support worker who had been very supportive. It is important to note, that though parent/carers do not use the term AIM Level 1, when describing the practices that were associated with a positive experience of AIM, they were often describing the principles and practice of an inclusive pre-school culture in their reflections on their experiences of AIM. As reported earlier, these included:

- Being flexible around the needs of the child and personalising (10)
- Challenging the child and developing their independence in a supported way (5)
- Including the child in everything through supported participation (8)
- An engaging curriculum and resources (8)
- An inclusive culture – staff commitment and expertise around inclusion, including being accepting of the child (10)

This implies that parent/carers were aware of the importance of AIM Level 1 as the foundation for the effective use of AIM targeted support but did not use the terms associated with this in the model itself.

AIM Level 2 (Information for parent/carers and carers)

- The majority (9) of parent/carers had heard about AIM through their pre-school (6) or through the pre-school and HSE practitioner combined (2).
- 1 parent/carer had heard of AIM through HSE services because her child was already known to them and hence 'in the system', and 1 had been briefed on it by her foster child's social worker.
- 2 parent/carers learned about AIM as a 'need to know' when they were applying for AIM support with the support of the EYS or via their own web search
- 1 reported that she had to research AIM for herself, with no support from professionals. 1 participant referred to the AIM website, but had not used it, preferring to talk with pre-school and HSE professionals.

This demonstrates how much parent/carers depend on and trust the advice of professionals on AIM. It also demonstrates that in the majority of cases, pre-schools, and other support agencies, were proactive in sharing information about AIM with parent/carers, though one parent/carer reported 'having to become an expert' to navigate the system on her own. Some practitioners did this kind of communication on an ongoing basis, which parent/carers valued. HSE practitioners and social workers had helped them to navigate information about AIM.

This is another example of how communication and being kept informed were factors in parent/carers' positive perception of AIM.

AIM Level 3 (A qualified and confident workforce)

Parent/carers reported low levels of awareness about AIM-supported training for inclusion at Level 3. The majority (14) did not feel able to identify training gaps.

Where these were suggested, they focussed on additional training around specific needs, rather than in relation to general best practice:

- training in a range of additional needs (including ASD),
- direct training by medical/therapeutic staff/specialist teachers for pre-school staff on the very specific needs of an individual child and how they could be supported.

AIM Level 4 (Expert early years educational advice and support)

Parent/carers had varied experiences and awareness of AIM Level 4. In summary, these were as follows:

- 8 parent/carers had no contact with an EYS, though all of these had been allocated Level 7 and 2 in this group explained that they had not been in touch with an EYS because they were already known by HSE and had accessed Level 5 or Level 7 support through this route, working with the pre-school. A further 2 could not recall any contact with an EYS.
- 1 parent/carer was shocked that an EYS had refused her application for L7 and came to believe that AIM depended on a diagnosis. This led her to fund her own assessment prior to a repeat application.
- 2 parent/carers could not remember if they had been in contact with an EYS.

- 7 parent/carers described their contact and communication with an EYS as very brief, and 4 of these were surprised that there was no follow up or support for the child, the parent/carer, or the pre-school in the implementation/review of the Access and Inclusion Profile.
- 4 parent/carers noted that they were unsure whether the EYS had worked with the setting and whether advice was being implemented.
- 1 parent/carer reported being fully involved in the writing of the Access and Inclusion Profile.

More generally, when parent/carers were reporting a negative experience of AIM or suggesting improvements, they talked about incomplete loops in communication which left them feeling in the dark about what pre-schools were doing to support their child, and what impact this was having.

AIM Level 5 (Equipment, appliances, and minor alterations grants)

- 12 parent/carers were aware of AIM Level 5, and awareness was higher than for Levels 1 – 4.
- 1 parent/carer reported that the Occupational Therapy team and HSE had installed facilities in the pre-school so that the child could get changed (child had a complex medical condition).
- 3 parent/carers knew that the school had high-quality equipment that was used with their child, but they were unsure if it had been resourced through AIM
- 3 participants were aware that AIM Level 5 was available, but their children didn’t need it. One parent/carer noted that AIM had helped with purchasing the equipment which linked his hearing aid to the classroom sound system (a microphone the teacher wore), and another was aware that once her child's hearing aids were dispensed, then an application for a sound link system could be made via AIM Level 5 in retrospect.
- 1 parent/carer had been helped with equipment for her child through the fostering agency, and this was being used to support speech development.

Generally, parent/carers were more aware of Level 5 AIM support than Levels 1-4 and were positive in describing the impact of high-quality equipment and resources on their child’s inclusion. Parent/carers were not always clear on whether the equipment had been purchased through AIM or within the pre-school’s own budget.

AIM Level 6 (Therapeutic Supports)

None of the parent/carers had received HSE level 6 support through AIM. 12 participants explained that their access to HSE support had occurred external to AIM in one of the following ways:

- Paying for an assessment or therapy themselves (2)
- Through HSE because the child was already known to HSE services (9)
- Therapeutic or specialist support was through a specialist teacher allocated to the child (1)

2 parent/carers reported no knowledge of Level 6, including one who had wondered why it had not been suggested as an option. 2 participants had not seen Level 6 provision in their child’s setting. 1 parent/carer could not imagine therapeutic support coming into pre-school for her child though 2 described communication between therapeutic staff/specialist teachers and staff in the pre-school. 1 participant explained that her child’s therapist had come into pre-school to provide support during ECCE sessions, but this had been stopped by the setting who were then resistant to any engagement with staff from that service.

In summary, the participants had not experienced Level 6 as an integrated AIM support, seeing it as something that was accessed outside pre-school via HSE services, though in three cases

parent/carers described interaction between HSE, specialist teachers and staff in their child's pre-school. These interactions were not described as productive or harmonious and demonstrate that this group of participants experienced some disconnect between their child's pre-schooling and HSE. Parent/carers were not aware that AIM Level 6 (universal) was a space for building collaboration, the sharing of expertise or training.

AIM Level 7 (Additional Assistance in the pre-school room)

AIM Level 7 was the AIM support that parent/carers were most aware of, and most (16) talked about it as the most beneficial aspect of provision. To summarise:

- 16 parent/carers regarded good quality Level 7 support as crucial to their child's inclusion and meaningful participation and see it as the most impactful element of AIM targeted support.
- 6 parent/carers were aware that their child's pre-school setting was delivering this support in a distributed model rather than 1:1 and this is what they expected, though they also hoped that the setting would provide 1:1 when it was needed (in a flexible way)
- 1 parent/carer did not agree that a distributed model of Level 7 support could ever be sufficiently inclusive.
- Settings were reported to use different approaches to deploying Level 7, including
    - 1:1 care for a child with complex medical needs (which the parent/carer did not like since it meant he was not included, participating, or developing)
    - A distributed model
    - The ECCE teacher taking the Level 7 support role because the member of staff appointed was not experienced enough.
- Parent/carers were aware that the quality and impact of Level 7 support was variable.
- Parent/carers were also aware that Level 7 support was most effective in pre-schools where there was an inclusive culture
- Parent/carers were aware of the problems with recruitment, retention and quality that surround Level 7, and identify this as a priority for action. 1 parent/carer proposed that centralised recruitment should be implemented. Another argued for tighter regulation and monitoring of the quality, use, and impact of Level 7 support.
- 4 parent/carers had applied for Level 7 support themselves, and this had been time-consuming and stressful with long wait times and delays. Parent/carers were happier with the application when they were well supported by other professionals, with advocacy from HSE staff and specialist teachers being particularly important.
- 1 parent/carer argued that Level 7 depended on diagnosis (though she knew it should not) and she paid for her child's ASD assessment so that Level 7 would be approved on the second application (which it was). However, the sample for interviews did contain 2 parent/carers whose children had been allocated Level 7 without a diagnosis.

These data demonstrate that parent/carers are aware that the efficacy of Level 7 depends on two conditions:

1. An inclusive culture within the pre-school where the support is being implemented
2. A strategy that addresses operational barriers, such as working conditions and systems of monitoring and regulation.

This indicates that improvement must continue to focus on support for change at the level of inclusive culture, at the same time as strategic and operational issues surrounding the implementation of AIM Levels 4-6.

Areas that need development

Parent/carers were able to identify priorities for development from their perspective as follows:

AIM Levels 1-3, and 4

- A more formal and agreed approach to feedback and communication between the pre-school, AIM supporters (EYS) and parent/carers (11)
  - More involvement of parent/carers in the development and review of the Access and Inclusion Profile (or other forms of formal plan/do/review assessment) (3)
  - More regular feedback on child's inclusion, participation, and progress (8)
  - Co-construction of support and inclusion programmes with parent/carers (4)
- Support, advice, and information for parent/carers from pre-school staff and AIM, supported by better feedback and communication (as above) (4)
- Reduction in scarcity of pre-school spaces (3)

AIM Level 3

- Training on AIM and inclusion for all professionals (5)
  - Training on ASD (2)
  - Training for Montessori schools on identification and support of additional needs (1)
  - Training for HSE staff (doctors, therapists) on AIM so that advice is based on comprehensive knowledge

AIM Level 6

- Use of a 'team around the child' approach, including reduction in waiting lists for HSE assessment and support (7)

AIM Level 7

- The structure and governance of Level 7 support (9)
  - Centralisation of responsibility for recruiting Level 7 staff (3)
  - Better regulation and accountability for the quality and impact of Level 7 staff (2)
  - Improve pay and conditions for Level 7 staff and the sector generally (6)
  - Involve parent/carers in recruitment of Level 7 staff (1)
  - Provide more training for Level 7 workers (1)

These findings provide further evidence for the claim that developments to AIM must focus on the development of an inclusive culture (AIM Levels 1-3) combined with strategic and operational developments that will enable targeted support to work more effectively. Parent/carers were aware that the success of AIM Level 7 was dependent on the extent to which a pre-school has an inclusive culture, as well as the conditions in which such a culture can flourish (such as good pay and conditions for ELC workers). They also suggested changes of strategy and operation for Level 7 to make it more effective. A clear theme emerging from the findings was also related to co-constructive approaches where parent/carers are informed and involved in the plan/do/review cycle in a more formal, and regular way. Parent/carers raised this regularly as a practice that would improve their experience of AIM. Though parent/carers were less aware of AIM Levels 1-3, their awareness of the importance of a pre-school's willingness, readiness, and ability to be inclusive does permit a return to first principles for quality ELC, as emulated in current quality frameworks - *Síolta* (CECDE,2006), Aistear (NCCA, 2009). The Diversity, Equality, and Inclusion Charter (DCYA, 2016) and Schedule 5 of the Early Years Regulations, 2016.

Given that AIM is modelled on a foundation of universal quality and inclusive provision (AIM Levels 1-3), and that parent/carers identify aspects of good practice embedded in existing quality frameworks

for ELC (e.g., responsiveness to each child's uniqueness, partnership with parent/carers, quality curriculum, positive behaviour policies, anti-biased approaches, and reflective practice), the question becomes how can pre-schools be supported in extending this quality provision to all children, including those with disabilities and additional needs? In the data from interviews with parent/carers, there were cases where Level 7 support was awarded but was ineffective because an inclusive culture was not in place. For parent/carers, part of the answer lies in tighter monitoring and regulation of how AIM support is used. The need for pre-school inspections focussed on the extension of quality practice to children with disabilities, emerges from these findings.

Should AIM be expanded?

Most parent/carers were in support of the extension of AIM support to other phases of ELC and School Aged Childcare (SAC)

- 12 out of 15 parent/carers agreed that support in SAC would be beneficial for the child's inclusion, participation, and development.
- 13 out of 15 parent/carers viewed the extension of AIM support beyond ECCE hours as potentially beneficial.
- 10 out of 15 parent/carers saw potential benefits in the extension of AIM support to younger children who were accessing ELC (or who might access it) prior to the ECCE qualifying age.

The main reasons given for supporting these proposals were that they would support fuller inclusion, participation, and development (particularly social and emotional); they would allow parent/carers to work; they could improve pay and conditions for Level 7 support staff.

The main reasons for not supporting these proposals were that, if the support were 1:1 it might create barriers to inclusion; that earlier support might be stigmatising, that the children might not be ready for pre-school at a younger age; that staying at home with parent/carers is an option for younger children that government should support more.

Overall Summary of Findings: Interviews with parent/carers

In summary, AIM emerged as potentially relevant in the National context, and impactful on the meaningful participation, full inclusion, and development of children with additional needs and disabilities. Parent/carers reported positive experiences and impact in 17 pre-schools, and even where their experience was negative, they spoke up for AIM's potential.

AIM was also seen as potentially supportive to transition to primary school, and for many parent/carers AIM supported ECCE was regarded as a strategy for accessing mainstream schooling. In parent/carers view, continuing improvements need to be made, focussed on the development of inclusive cultures (Levels 1-3), and on improvements to the strategies and systems supporting AIM Levels 4-7, including more general pay and conditions in the sector. One key proposal for improvement was the tightening of monitoring and regulation for AIM Level 1, and 4-7 in the context of Ireland's existing quality frameworks for ELC.

It is also important to note that AIM Level 6 was not identified as an integrated element of AIM itself, since where children were receiving assessment and support for specialist teachers or therapeutic staff, it was through avenues external to the pre-school.

12. Case studies: Methods and Findings

This section reports upon Phase 3 of the evaluation. Live and distance fieldwork was conducted to gather data to illustrate how AIM is perceived, experienced, and applied on the ground. Though the case studies do include some examples of excellent practice, they are not offered as exemplars – rather they are illustrations of how AIM is being implemented on the ground, and through the eyes of providers, parent/carers, and the children themselves.
When introducing individual children, we have indicated their strengths and preferences in order to take a strengths-based approach. However, we have also described their needs fully and clearly since AIM supports are responses to those needs. We also note that observations of support from adults, are not always supports provided by staff appointed to provide Level 7 support, but by a range of staff.

12.1: Introduction: Method and Sample

Data was collected by specially trained Practitioner Researchers (PRs) who had practice expertise. Their fieldwork activity resulted in two types of case study. The first was a case study of a child to report their experience of full inclusion and meaningful participation in their pre-school. This was informed by the creation of a multimodal map text alongside playful, participatory encounters with children in their pre-school setting. The second was a case study of the setting that the child attended, and exploration of how the Access and Inclusion Model (AIM) was perceived and applied within the setting. The setting case study was informed by analysis of documentary artefacts within the setting alongside spontaneous and scheduled interview/conversations with stakeholders including practitioners, parent/carers, Better Start Early Years Specialists (EYS). Figure 1 presents an overview of the case study approach to show how children's perspectives, elicited through mapping and participatory encounters, are brought together with stakeholders' views and documentary evidence to present a close-to-practice account of AIM in context.

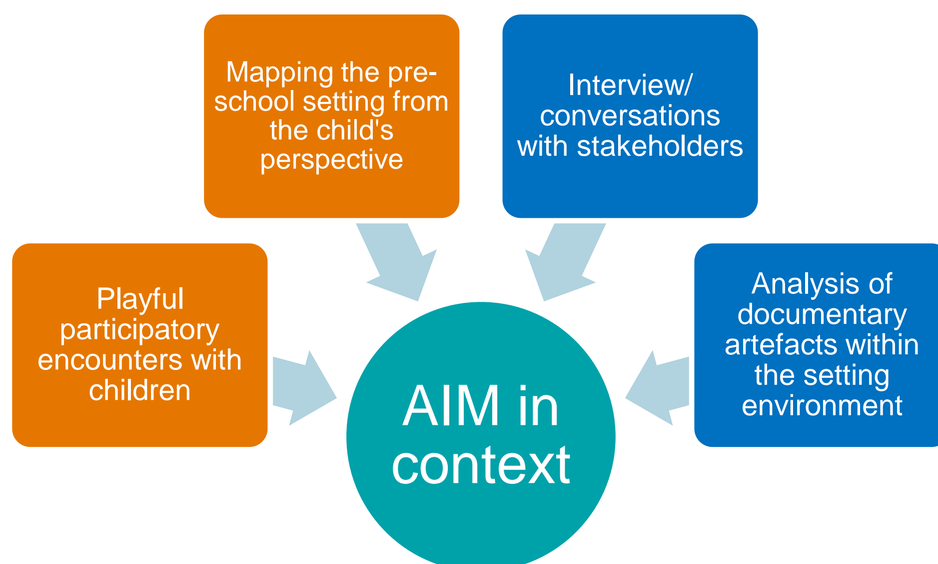

Figure 12.1: Overview of the case studies

In collaboration with researchers at the University of Derby, Dr Lisha O'Sullivan from Mary Immaculate College (MIC) and Dr Sophia Gowers (UoD) were responsible for designing and delivering training and support for the team of Practitioner Researchers who were deployed to case study development. This included quality assurance of data collection, analysis, and reporting.

Objectives

The purpose of the case study phase of the evaluation was to:

a) Access children's own accounts of inclusion and participation within their pre-school settings.
b) Ensure children's voices are included in the evaluation.
c) Illustrate the implementation and impact of AIM within those Early Childhood Care and Education (ECCE) settings from the perspective of people associated with those settings (e.g., practitioners, parent/carers, Early Years Specialists (EYSs), members of therapeutic services, other stakeholders).
d) Provide illustrations of how AIM is working on the ground.

Practitioner Researchers

With support from Early Childhood Ireland (ECI), the consortium recruited and trained 17 PRs from the Early Learning and Childcare (ELC) sector. This approach was taken for three key reasons:

- To draw on the skills and insight of expert practitioners whose interpretations would be enriched by their close-to-practice status.
- To build sustainability into the project, since the skills and tools used by our PR group could be disseminated to support self and peer review of AIM in the ELC sector.
- To validate the expert status of practitioners in the sector.

A set of criteria was devised for individuals wishing to undertake the PR role by the research consortium in consultation with ECI and agreed by the DCEDIY AIM Evaluation Oversight Committee. Table 12.1 outlines the essential and desirable criteria for PRs.

Interested applicants were directed to submit the following information, in support of their application:

- A short Curriculum Vitae which must include details of their Level 8 Degree and their LINC Award
- A copy of a certificate of completion of the TUSLA Children First e-learning programme
- A letter of support from their ELC/SAC setting.

The selection process was in two criterion-led phases to ensure it was objective, fair and robust. ECI facilitated the initial short-listing of applicants who met the essential criteria and notified applicants of the outcome of Round 1 shortlisting. The shortlist was shared with the University of Derby Research Consortium which completed a further round of short-listing. Decisions relating to final selection were based on applicants' demonstration of desirable criteria and their geographical location. Round 2 applicants who were not selected were invited to engage in the PR training programme. The University of Derby notified shortlisted applicants of the outcome of Round 2 shortlisting.

PRs were chosen to conduct case study research in pre-school settings due to their significant practice expertise. Their prior professional experience of working with children and families equipped them well to communicate sensitively when conducting research within the pre-school context. In addition, their first-hand knowledge of the implementation of AIM, equips them well to understand and analyse the implementation of AIM within the ELC sector.

Once recruited, the PRs engaged in training led by Dr Lisha O'Sullivan from Mary Immaculate College (MIC) and Dr Sophia Gowers (UoD). This consisted of three, 2-hour sessions delivered online. This

was followed up by a series of drop-in sessions as the PRs began to undertake and finalise their case study data collection. This was part of the quality assurance process in ensuring the quality and validity of the research activity and case study products. Table 12.2 outlines the key dates and stages of training.

Table 12.1: PR recruitment and selection criteria

Essential criteria	• Hold a minimum Level 8 qualification in Early Childhood Education which is approved by the Department of Children, Equality, Disability, Integration and Youth (DCEDIY). • Hold the Leadership for Inclusion in the Early Years (LINC) Level 6 Special Purpose Award. • Has a valid TUSLA Children First e-learning programme-Certificate of completion (completed since January 2019).
Desirable criteria	• Currently occupying the role of Inclusion Coordinator (INCO). • Knowledge and experience of Access and Inclusion Model (AIM) supports. • Has completed Lámh or basic ISL training.
Recruited PRs were also required to meet the following conditions:	• Provide a letter of recommendation from their Early Learning and Care (ELC) Setting. • Complete Garda vetting. • Have access to a computer, internet connectivity, access to digital meeting platforms such as Zoom/MS Teams, and a mobile audio recording device such as a mobile phone. • Have a full clean driving licence and access to transport.

Table 12.2: Overview of PR development programme and dates

Date	Training focus
24th May 2021	Deadline for PR applications to be received by ECI
23rd June 2021	*Session 1*: Introduction to the AIM evaluation, the PR role, ethical protocols, and instrumentation for case studies of settings.
30th June 2021	*Session 2*: Using the mapping method and its alternatives, conducting the pilot study, contacting your settings, planning your time.
A pilot study conducted in PR's pre-school setting	
15th September 2021	*Session 3*: Reflection on the piloting of the instruments, preparing for fieldwork, reflection on initial contact and planning with settings and families.
13th October 2021 28th October 2021 18th November 2021	*Drop-in sessions:* PRs were given an opportunity to discuss their initial contact and planning with settings and families, initial fieldwork, recording of the case study and approach to completing the case study forms.
30th November submission of child and setting case studies	

As part of the initial training, a pilot study was conducted in the pre-school setting of each PR. This provided an opportunity for the PRs to trial the methods and approaches informally and allow them to apply information gained in the training sessions in the context of their own setting. This was another process used to support quality assurance.

Following the pilot study, PRs shared accounts of their experiences of the case study instrumentation and the mapping approach. This allowed the researchers opportunity to clarify misconceptions and highlight examples where the case study instrumentation had been carried out with fidelity. In response to feedback from the PRs, the flexible nature of the case study approach to be used with children was reinforced. It was deemed imperative that the case study component of the evaluation was led by close-to-practice researchers to build a clear picture of how AIM is experienced "on the ground". However, as a result of this closeness to practice the training for PRs was designed to support the development of the key skills needed for managing potential bias including reflection and active listening.

Method

Once recruited and trained, PRs were assigned to a pre-school setting that was close to their home location. The purpose was to reduce the burden on our participating PRs. Pre-school settings were recruited and selected to cover a range of types, counties, and geographical criteria in order to build a picture of how AIM is working on the ground. Settings were selected from those who completed the practitioner survey and those who responded to a call for participants via the Departmental social media account. It was an essential criterion that the ELC setting must be currently engaged in AIM, through either universal (AIM Level 1-3) or targeted support (AIM Level 4-7). A full overview of the characteristics of the 14 case study settings, and the 14 case study children who attended, is presented in the subsection "characteristics of the sample".

PRs collaborated with the ELC setting prior to the field visit(s) to:

- prepare for COVID-19 protocols and other safeguarding protocols operated by the setting,
- choose which combination of face-to-face and telephone/video call is most fitting,
- schedule data collection events that included
    - a) case study of a child who the setting identifies as being supported by AIM universal or targeted support
    - b) case study of setting drawn from scheduled ('in person' or telephone/video call focus group) or spontaneous interactions with people and/or documents and artefacts in the setting
- establish contact with the family chosen for the case study of the child, using the setting as gatekeeper.

Following this initial contact with the setting and family, the 14 PRs conducted visits to the pre-school setting where they spent the equivalent of 1 full day collecting data, through a combination of face-to-face visits and phone calls depending on circumstances. In recognition of the burden placed on participating settings, a payment of €75 was made as a compensation for staff time.

There were two focusses for data collection. Firstly, to conduct case studies with children to elicit their perspectives regarding meaningful participation and full inclusion and secondly, to conduct case studies on how AIM support was used in the pre-school and how various stakeholders associated with the pre-school perceived AIM and its impacts.

Case studies of settings

The second focus of the case studies was on how AIM support was used in the pre-school and how various stakeholders associated with the pre-school perceived AIM and its impacts The pre-school studied was attended by the child who engaged with the mapping activity. The field work comprised of the following stages:

- PRs were assigned to a case study setting according to their geographical location.
- Once allocated, the PR initiated contact with the setting manager or owner who acted as a gatekeeper.
- Consent forms and information sheets were provided to the setting, and shared with other key stakeholders (ELC providers, practitioners, parent/carers, Better Start Early Years Specialists).
- Dates were agreed to conduct the face-to-face visit to the pre-school to engage with the case study child and meet with key stakeholders.
- During the face-to-face visit to the setting, interactions between the PR and stakeholders took the form of spontaneous conversation within the setting environment as well as group or individual interview.
- Each PR spent the equivalent of one full day collecting data in the pre-school setting to inform the case study of the setting and the case study of the child.
- In total, 13 of the case studies of settings were completed through face-to-face visits, with 5 being supplemented by follow up telephone calls to stakeholders. One of the case studies had to be completed solely by telephone call due to COVID 19 social distancing requirements.

During the face-to-face visits and telephone calls, the PRs interacted with stakeholders (lead practitioners, practitioners, parents, Better Start Early Years Specialists) to collect data on their perceptions and engagement with AIM. Interactions were guided by a topic provided by the evaluation team to PRs. This contained a series of prompts and questions to be used flexibly in response to the individual stakeholder and their role. Scheduled conversations were audio recorded by the PR and later transcribed by the evaluation team. Spontaneous conversations were recorded through the PR's field-notes.

Whilst conducting face-to-face visits, PRs invited ELC practitioners in the setting to share documentary artefacts or other objects relevant to AIM and its implementation. PRs were directed to consider the term 'documents' in its widest sense, including:

- The built environment, including alterations made.
- Artefacts and objects, including children's toys and play materials, certificates, and awards.
- Material on display in the setting, including photographs of children and their families, children's artwork.
- Notice boards for families, including information on daily/weekly routine and tip sheets for parent/carers.
- Children's learning journals.
- Assessment information, including *Aistear* learning record.
- Documents such as home-setting diaries.

Where relevant, field-notes and photographs were taken to record examples of documentary artefacts.

PRs reflected upon their scheduled and spontaneous conversations with stakeholders and the documentary artefacts they had viewed and used this to inform the completion of a setting case study form (see Appendix X). They were asked to consider the following aspects when completing their setting case study:

- Perspectives on the philosophy and purposes of AIM in the setting.
- How the setting is using AIM support.
- What the benefits of AIM have been to the setting, practitioners, children, parent/carers, and families.
- What AIM supports and processes have worked well and why.

- What AIM supports and processes have worked less well and why.
- Participant views on participation in AIM.
- Participant views on extensions to AIM.

The setting case study template provided clear prompts to assist the PRs to collate and analyse the raw data they had collected during their fieldwork.

Figure 12.2 presents an excerpt from a completed setting case study form on the topic of *What AIM supports and processes have worked less well and why*.

5. What AIM supports and processes have worked less well and why.

Example themes to write about in this section - L1, L2, L3 - L4, L5, L6, L7 -Communication -Application processes -Whether there are types of disability/additional need that AIM has worked less effectively for (e.g. physical, emotional disturbance, ASD, learning disability, multiple, speech and language delay). - Views on why particular AIM supports/processes worked less well. - Participant suggestions on how the problems could be solved.

Method used to collect data referred to in this section (*select all that apply*)	X Live conversation X Live observation ☐ Live observation of document ☐ Live focus group discussion ☐ Online conversation ☐ Online observation ☐ Online observation of document ☐ Online focus group discussion
PR commentary *Please provide details of your findings (including direct quotes where needed), being clear about the role of the participants being referred to. Do not include actual names- please use pseudonyms.*	Evidenced in written notes 30th September to 4th November the owner/ manager relayed her frustration that when a child moves from another setting where they have previously availed of AIM Level 7 support that this is not immediately transferred to the new service. The waiting time for a new application has meant that children have been excluded for periods as the setting and families involved have agreed that the support was not there to enable them to attend. (8.10.21). Accessing training such as LINC and LAMH is limited to individuals in the service (19.10.21). The

Figure 12.2: Setting case study form excerpt

Case studies of children

The first focus for data collection was eliciting the child's perspective on their experience of *meaningful participation* and *full inclusion* within their pre-school setting. In this end of year three Evaluation of AIM, it was important to find innovative ways to capture the voice and perspective of the key beneficiaries – children themselves. This was a key principle within the research design. A multimodal mapping approach was used to be accessible and enjoyable for the child.

The creation of map texts is viewed as a way of linking young children's experiences to the contexts in which they occur (Gowers, 2020[77]; 2021[78]). Although map texts are commonly conceptualised as a visual means for recording physical locations, additional layers of meaning can be communicated. Powell (2010)[79] describes the act of mapping as a 'multisensory research method' due to its ability to evoke relationships between place, lived experience and community. As a result, the creation of multimodal map texts is proposed to provide a link between children's engagements, experiences, and the environments in which they occur.

The mapping approach taken within the child case studies is informed by social semiotic theory (Halliday, 1978[80]; Kress, 2010[81]). This recognises the multimodal nature of contemporary communicative practices that allow people to draw upon the range of available modes to create meaning. Multimodal texts may combine image, sound, gesture, movement, animation, and written language. As a result, reference is made to the map 'text' as a cohesive unit of meaning in communication, rather than as a synonym for the printed word.

Throughout the case study approach, children are respected as competent message creators who are able to use a range of modes of communication to convey meaning. In previous participatory research with young children, this methodological approach has been demonstrated to slow down observation and thereby reveal knowledge, perspectives and contextual information which may otherwise be overlooked (Gowers, 2021)[82].

The approach to data collection adopted for the case studies consisted of four stages, as outlined within Table 12.3.

Table 12.3: Overview of approach to developing the child case studies

Stage 1- Introduce
The purpose of this stage is to introduce children to the concept of maps. This will include introducing maps as a resource or artefact for recording experiences, both positive and negative. Children will read the text 'My Map Book'[83] at home with their family or with a practitioner in their pre-school setting. *Key output:* Children will become familiar with maps as a means for recording places and experiences.
Stage 2- Mapping
The purpose of this stage is for children to create an individual map to record the places they visit within the pre-school setting, including objects and people of interest and things that happen there. *Key output:* Children will produce an individual map to represent their pre-school setting.

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[77] Gowers, SJ (2020) 'Mapping young children's conceptualisations of the images they encounter in their familiar environments', *Journal of early Childhood Literacy.* https://doi.org/10.1177%2F1468798420919479
[78] Gowers, SJ (2021) 'Making everyday meanings visible: Investigating the use of multimodal map texts to articulate young children's perspectives', *Journal of Early Childhood Research.* https://doi.org/10.1177/1476718X211062750
[79] Powell, K (2010) 'Making sense of place: Mapping as a multisensory research method', *Qualitative Inquiry*, 16(7): 539–555.
[80] Halliday, MAK (1978) *Language as Social Semiotic*. London: Edward Arnold
[81] Kress, G (2010) *Multimodality: A Social Semiotic Approach to Contemporary Communication*. Oxford: Routledge.
[82] Gowers, SJ (2021) 'Making everyday meanings visible: Investigating the use of multimodal map texts to articulate young children's perspectives', *Journal of Early Childhood Research.* https://doi.org/10.1177/1476718X211062750
[83] Fanelli, S (2006) *My Map Book*. London: Walker Books.

Stage 3- Context
The purpose of this stage is to explore the setting, using the child's map as a starting point. The map text may be used as a stimulus for conversation, or a walking tour may be given. *Key output:* The child's individual map will be captured through photography, along with any key objects and activities within the pre-school setting that the child refers to. The walking tour will be recorded as line drawing by the PR.
Stage 4- Investigate
The purpose of this stage is to record the narratives children use to give meaning to their map and facilitate exploration of experiences, engagements and feelings of the child in relation to meaningful participation and full inclusion. The creation of the paper-based map-text is accompanied by conversation to form an overarching multimodal text which combines gesture, spoken, visual and written modes. Conversation between the PR and the child takes the form of storytelling with questions posed through focused conversation. Picture exchange and visual resources may be used in place of verbal communication methods, in response to the needs of the individual child. *Key output:* The child's personal narratives will be audio recorded. Interpretation of the multimodal map text will be given from the child's point of view.

For most children, the stages of data collection led to the following approach being taken by the PR in the setting:

- A picture book was used as a stimulus to introduce maps and mapping.
- Children were invited to create a map text as a means for recording their experiences, perspectives, and feelings alongside the context for these.
- The map text was shared between the child and PR. The child showed the PR different activities, resources, and spaces within their pre-school setting.
- Focused conversation took place between the PR and child to further explore their perspectives on meaningful participation and full inclusion.

Throughout the data collection, a flexible approach was used to foreground the child's strengths and preferences. Attention was paid to the range of communicative forms used by the child. Consequently, non-verbal forms of communication were noted including gesture, eye gaze, facial expression, and movement in addition to their verbal utterances and mark making. Alternative methods for data collection were also provided to the PRs including walking tours, picture exchange activities and observation. It was anticipated that the PR would select from the range of methods in consultation with the ELC provider, family, and child in order to adopt an approach which was sensitive to their interests, strengths, and needs.

PRs reflected upon the range of multimodal data collected through the map text the child had created their observations of the child and their engagement with the child during the visit to the pre-school setting. They used this information to write a case study of the child's experience of inclusion, reported through the lens of the Diversity, Equality, and Inclusion (DEI) Charter (DCYA, 2016[84]). This facilitated the recording of a child case study in a way that privileged their individual experiences, their voice, and their perspective. Practitioners were directed to report their case study through the lens of the DEI

[84] Department of Children and Youth Affairs (2016) *Diversity, Equality and Inclusion Charter and Guidelines for Early Childhood and Care Education.* [Online]. Available at: https://assets.gov.ie/38186/c9e90d89d94b41d3bf00201c98b2ef6a.pdf. Accessed 05/12/2020

Charter, aided through the inclusion of additional prompt questions, to enable investigation of meaningful participation and full inclusion as it was supported by or manifested in:

- Provision
    - What adaptations have been made within the setting in response to the needs of children?
    - How are staff deployed in response to the needs of children?
    - Which sessions are attended by the child as part of their ECCE provision?
- Practitioners
    - To what extent do practitioners support all children as active learners?
    - What steps are taken to ensure that all children's views are heard and considered?
    - How do practitioners respond to children's play comments while they are interacting with materials in the setting?
- Peer relationships
    - What opportunities are there for shared activities and peer contributions?
    - To what extent are children with a disability given tasks with responsibility?
    - How are achievements of all children celebrated?
- Emotive responses
    - How does meaningful participation feel?
    - How does full inclusion (and being included) feel?
    - What emotive response does the child give to the provision and activities within the pre-school setting?
- Physical response
    - To what extent are learning activities/experiences accessible for all children?
    - How are the children within the setting represented in materials within the environment?
    - How does the physical environment support development and learning?
- Resources
    - How are visual and non-verbal means used to communicate effectively?
    - Which resources are used to support the access of children to learning activities/ experiences?

A child case study template was provided to assist the PRs to collate and analyse the raw data they had collected during their fieldwork (see Appendix 2). Figure 12.3 presents an excerpt from a completed child case study form on the topic of *Peer Relationships*.

3. Peer relationships

Method used to collect data referred to in this section (select all that apply)	☐ Map text ☐ Photograph provided by setting ☐ Focused conversation response ☐ Child's narrative ☐ Touring exploration of setting ☒ **Other (describe in commentary)**
PR commentary *Please provide details of your findings (including direct quotes where needed), being clear about the role of the participants being referred to. Do not include actual names- please use pseudonyms.*	During the observation, CS3C1 was observed to interact with some of the other children. He was at the table awaiting his snack when he began interacting with the other children at his table. They were playing a game with their hands. He was rubbing a particular girls hand and during conversations with the staff, this is his best friend. He has been speaking about her at home and she and another girl really look out for him during the day. While the staff are encouraging him to be more expressive, these girls have been known to speak up for him and aid him to the best of their abilities. He is also starting to hug some of the children in his room. However as he has low muscle tone this generally tends to look like he is throwing himself on top of them. The children are familiar with this now and know that he is trying to give them a hug.

Figure 12.3: Child case study form excerpt for 'Peer Relationships'[85]

Submission and analysis of case studies

The PRs were directed to use an online template to complete two case study forms: one to record their child case study, and one to record the setting case study (see Appendix X). A template was used to define the parameters of the two case studies and ensure consistency of reporting across the PR group. All pre-school case study settings and case study children were assigned a participant identifier code. No names of participants or settings were recorded in the case study forms.

PRs were also provided with a secure online area hosted within a central UoD platform to upload and store documentary artefacts, images, audio recordings and field notes that had been collected during the face-to-face case study visits. Once the two case study forms were complete, they were subject to a two-stage quality check first by staff at MIC, before being independently checked by the evaluation team at UoD.

How data from the setting case study was analysed

Data arising from the face-to-face and distance fieldwork was used by PRs to write a setting case study. This was informed by analysis of documentary artefacts within the setting alongside spontaneous and

[85] The child identifier code (CS3C1) has been used by the PR in place of the child's name to maintain anonymity.

scheduled interview/conversations with stakeholders including practitioners, parent/carers, and EYS (see Figure 12.4).

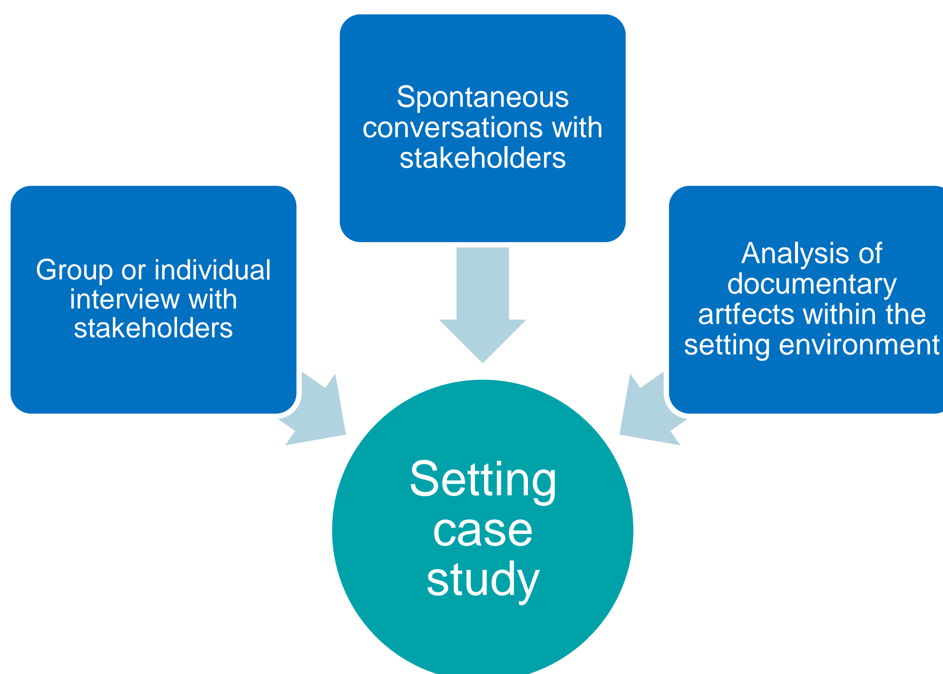


Figure 12.4: Components which informed analysis of the setting case study

This led to an individual case study of each pre-school setting which was analysed thematically to identify how individual pre-schools, and the case study group as a whole, were implementing inclusive practice in the context of AIM. First, this required the researchers to look across the individual case study forms to look for patterns and themes within the responses made by stakeholders to each section of the case study form at the individual setting level. Next, the patterns and themes identified for each of the case study form sections were compiled for the 14 case study settings in order to identify the existence of commonalities and patterns across the stakeholder responses. The case study findings are subsequently presented using the same subheadings used within the PR case study form itself to allow a direct link to be made from the observations made 'on the ground' to those reported in the final report. Key quotes from individual stakeholders were noted and reproduced where they exemplified a common observation, challenge, or benefit of AIM.

How data from the child case study was analysed

Data arising from face-to-face fieldwork was used by PRs to create a child case study to report their experience of full inclusion and meaningful participation in their pre-school. This was informed by the creation of a multimodal map text alongside playful, participatory encounters with children in their pre-school setting (see Figure 12.5). Each case study is a rich illustration of the child's perceptions and the pre-school context, however, the analysis presented in this section is to explore how these come together to create a story of AIM as it is applied in the 13 pre-school settings

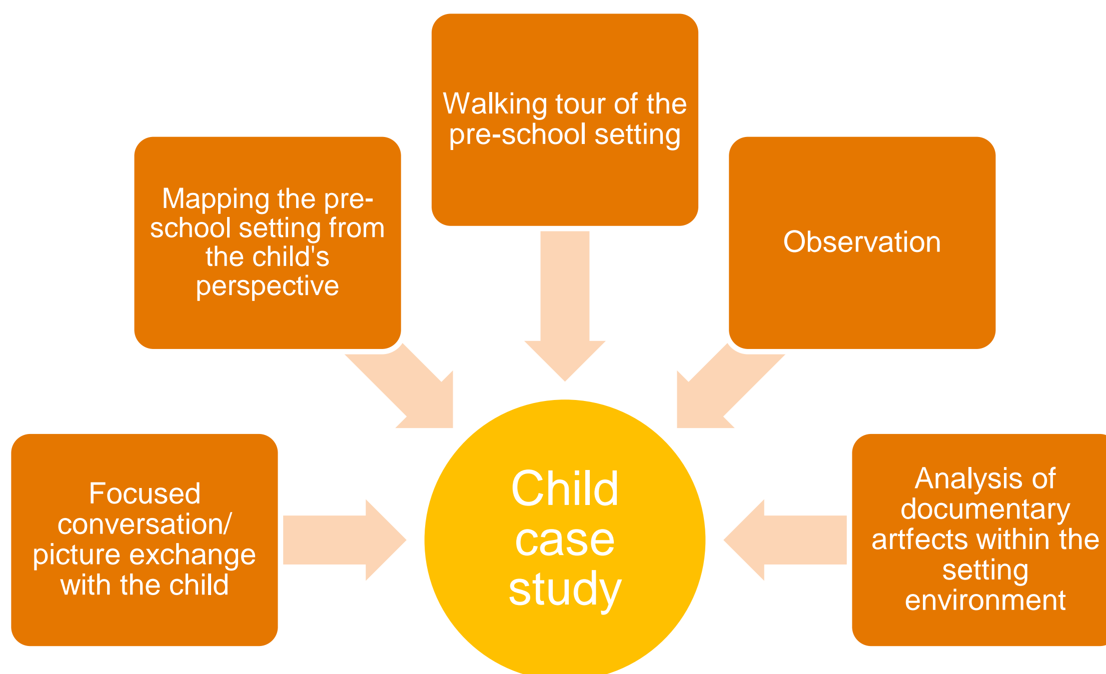


Figure 12.5: Components which informed analysis of the child case study

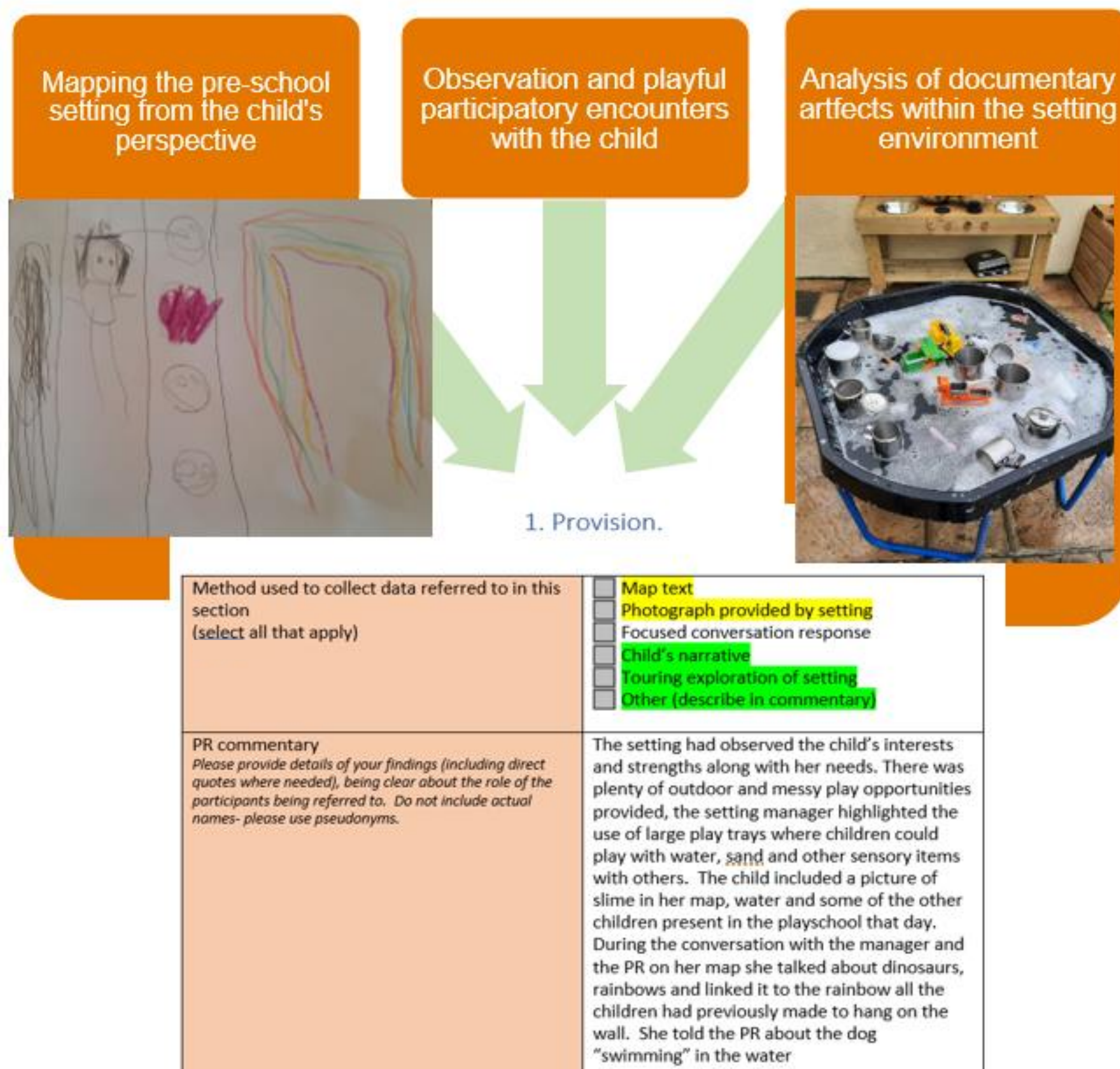
Data arising from the mapping method was used by PRs to write a case study of the child's experience of inclusion, reported through the lens of the Diversity, Equality, and Inclusion (DEI) Charter (DCYA, 2016)[86]. The different data sources (map texts, observations, audio recordings and photographs) were viewed as complementary components, which together give insights into children's perspectives on their full inclusion and meaningful participation as it was supported by or manifested in the following five elements:

- Provision
- Practitioners
- Peer relationships
- Emotive responses
- Physical response
- Resources

This helped the evaluation team to evaluate how included children were in a way that privileged their individual experiences, their voice, and their perspective. In this way, the method was in the spirit of AIM and its concern for the social inclusion of all children. Researchers at the UoD then analysed all of the child case studies to report on the findings at the level of the individual child and the meta level. First, the data set for each individual child was examined. Analysis was conducted through the lens of the DEI Charter thereby collating the child's perspectives on each of the subheadings within the case study form as key themes. Care was taken to give due weight to the different modes of communication used by the child. For example, when analysing the child's perspectives on 'resources', where the child depicted a preferred activity within their map text, attention was also paid to photographs taken within the setting, field-notes, and excerpts of the conversation between the PR and the child. This helped to

[86] Department of Children and Youth Affairs (2016) *Diversity, Equality and Inclusion Charter and Guidelines for Early Childhood and Care Education*. [Online]. Available at: https://assets.gov.ie/38186/c9e90d89d94b41d3bf00201c98b2ef6a.pdf. Accessed 05/12/2020

build a picture of the child's experiences of resources in the pre-school setting and their perspectives on the extent to which they supported their meaningful participation and full inclusion. Once individual analysis was complete for each child, comparisons were drawn across the group of case study children in order to identify patterns in response or meaning. By compiling and reducing the data, identification of the main themes was made for each of the five elements. Figure 12.6 illustrates the complementary components of raw data collected on the topic of *provision* which informed the reporting of one aspect of an individual child case study.



Method used to collect data referred to in this section (select all that apply)	☐ Map text ☐ Photograph provided by setting ☐ Focused conversation response ☐ Child's narrative ☐ Touring exploration of setting ☐ Other (describe in commentary)
PR commentary *Please provide details of your findings (including direct quotes where needed), being clear about the role of the participants being referred to. Do not include actual names- please use pseudonyms.*	The setting had observed the child's interests and strengths along with her needs. There was plenty of outdoor and messy play opportunities provided, the setting manager highlighted the use of large play trays where children could play with water, sand and other sensory items with others. The child included a picture of slime in her map, water and some of the other children present in the playschool that day. During the conversation with the manager and the PR on her map she talked about dinosaurs, rainbows and linked it to the rainbow all the children had previously made to hang on the wall. She told the PR about the dog "swimming" in the water

Figure 12.6: Components on the topic of 'provision' which informed analysis of the child case study

In order to strike a balance between reporting the child's voice in relation to their individual experiences and representing the themes identified across the case studies, the findings are reported as follows:

- Each child is introduced individually, along with key contextual information relating to provision within the pre-school setting.
- Following this, each subsequent element (practitioners, peer relationships, emotive responses, physical response, resources) is presented individually.
- For each element, an initial overview is presented of the main themes and patterns observed across the child case study data captured for the 14 children who participated.

- Illustrative vignettes are selected for each element which present an individual child's perspectives and experiences. These include images of the child's map, photographs taken within the child's setting, field-notes, and quotes from the child. This approach is taken to preserve the child's voice within the evaluation.

Together, the child and setting case studies offer a close-to-practice account of how well AIM is working on the ground and what its strengths and weaknesses are from the perspective of its intended beneficiaries.

Characteristics of the sample

Settings

Live and distance fieldwork was conducted in 14 ELC settings to gather data to illustrate how AIM is perceived, experienced, and applied on the ground. The case study settings comprised 2 community and 12 private ELC settings. The settings were situated in 6 rural, 6 town and 2 city areas across the following 9 counties of Ireland: Co Clare, Co Cork, Co Dublin, Co Kildare, Co Offaly, Co Tipperary, Co Westmeath, Co Wexford, Co Wicklow.

For each case study setting, interviews were conducted through a face-to-face visit to the pre-school, telephone, or video call. PRs interacted with a range of stakeholders (lead practitioners, practitioners, parent/carers, Better Start Early Years Specialists) to collect data on their perceptions and engagement with AIM. In total, 29 stakeholders were interviewed across the 14 ELC settings.

Children

Across the 14 case study settings, 14 children participated. The children were aged between 2 and 5 years. Each child was assigned a pseudonym for anonymity. Face-to-face fieldwork was conducted in 13 ELC settings to gather data to access children's own accounts of full inclusion and meaningful participation within their pre-school settings in the context of AIM. As one child had yet to start pre-school, distance fieldwork was conducted through the production of a digital map and the use of video-call to allow the PR to interact with the child and their family.

The strengths and needs of the case study children were individual and diverse. Whilst some children were supported through the universal provision within the setting (AIM Levels 1-3), others were in receipt of AIM targeted support (Levels 4-7). Across the 14 case studies, 1 child who participated had yet to start pre-school but had begun transition activities, 2 children were being supported by AIM Levels 1-3 and 12 children were in receipt of AIM Level 4, AIM Level 4 and 7 or AIM Level 4, 5 and 7.

Further detailed information regarding the provision for each child is detailed in the subsection 'provision.' Table 12.4 presents the 14 case study settings. It identifies the ELC setting the child attended, the stakeholders who engaged in interview and the Level of AIM the ELC setting have availed of to provide support to the child.

Table 12.4: Sample characteristics of settings visited for child and setting case studies

Case Study	Setting type	Participant role (total number interviewed)	Level of AIM
CS1	Community, urban town	Room leader (1)	Universal 1, 2, 3 Targeted 4 and 7
Child	Joe 3 years old, first year of ECCE		

CS2	Private, rural	Owner/INCO, mother of case study child (2)	Universal 1, 2, 3 Targeted 4 and 7
Child	Ben 3 years 6 months old, first year of ECCE		
CS3	Private, urban town	INCO, Room leader and Owner (3)	Universal 1, 2, 3 Targeted 4, 5 and 7
Child	Sean 4 years old, second year of ECCE		
CS4	Private, rural	Owner/INCO and mother of the case study child (2)	Universal 1, 2, 3 (Planned targeted support: 4, 6 and 7)
Child	a) Richard 2 years old, has not yet started pre-school b) Jenny 4 years old, second year of ECCE		
CS5	Community, urban city	Manager/INCO and practitioner (2)	Universal 1, 2, 3 Targeted 4 and 7
Child	Liam 3 years 2 months old, first year of ECCE		
CS6	Private, rural	Owner/INCO (1)	Universal 1, 2, 3
Child	Mary 4 years old, second year of ECCE		
CS7	Private, rural	Owner and room leaders (3)	Universal 1, 2, 3 Targeted 4 and 7
Child	Finn 4 years 6 months old, second year of ECCE		
CS8	Private, urban town	Owner/manager, and two practitioners (3)	Universal 1, 2, 3 Targeted 4 and 7
Child	Kiernan 3 years 5 months old, first year of ECCE		
CS9	Private, rural	Manager/pre-school room leader and mother of the case study child (2)	Universal 1, 2, 3 Targeted 4, 5 and 7
Child	Ruby 5 years 6 months, ECCE overage exemption		
CS10	Private, urban city	Manager/INCO, practitioner, and mother of the case study child (3)	Universal 1, 2, 3 Targeted 4 and 7
Child	Ciara 4 years old, second year of ECCE		
CS11	Private, rural	Manager/INCO (1)	Universal 1, 2, 3 Targeted 4 and 7
Child	Connor 3 years 6 months, first year of ECCE		
CS12	Private, urban town	Manager/INCO (1)	Universal 1, 2, 3 Targeted 4
Child	Max 3 years old, first year of ECCE		
CS13	Private, urban town	Owner/manager, INCO, practitioner, Better Start EYS (4)	Universal 1, 2, 3 Targeted 4 and 7
Child	Tom 3 years old, first year of ECCE		
CS14	Private, urban town	Owner/INCO (1)	Universal 1, 2, 3 Targeted 4 and 7
Child	Child withdrew from the case study		

12.2: Findings

The findings from the 14 case studies are presented in two sections to reflect the two aspects of field work conducted by the PRs. Firstly, the findings from the child case studies are reported in subsection 12.3 in response to the following objectives:

a) To access children's own accounts of inclusion and participation within their pre-school settings
b) To ensure children's voices are included in the evaluation

Findings are reported through the lens of the Diversity, Equality, and Inclusion (DEI) Charter (DCYA, 2016)[87] and its key areas of inclusive practice, to present a thematic account of children's full inclusion and meaningful participation as it was supported by or manifested in:

- Provision
- Practitioners
- Peer relationships
- Emotive responses
- Physical response
- Resources

This subsection begins with an overview of the individual provision made for each of the 14 children. This is intended to provide valuable contextual information about the child and aid a holistic view of their strengths and needs. Following this, overall findings for each of the remaining five elements are reported ahead of illustrative vignettes which present individual children's perspectives and experiences. Images of the children's map texts are included to present the child's voice and representation of their experiences within the pre-school setting, from their own point of view. This is aided by the inclusion of photographs from within the ELC settings to further illustrate the provision and resources the children referred to.

Following this, the findings from the setting case studies are reported in subsection 12.4 in response to the following objectives:

c) illustrate the implementation and impact of AIM within those ECCE settings from the perspective of people associated with those settings (e.g., practitioners, parent/carers, Early Years Specialists (EYSs), members of therapeutic services, other stakeholders).
d) provide illustrations of how AIM is working on the ground.

Findings are presented in response to the key lines of enquiry constructed for this evaluation (see subsection 1.2). Summarily, these comprise setting stakeholders' (lead practitioners, practitioners, parent/carers, Better Start Early Years Specialists) views on AIM's implementation, AIM's impact, aspects of AIM that are working well, and aspects of AIM that need to be improved. Findings from the setting case studies are described, and where relevant, direct quotations from stakeholders are used to illustrate a key theme arising from analysis of the setting case study data.

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[87] Department of Children and Youth Affairs (2016) *Diversity, Equality and Inclusion Charter and Guidelines for Early Childhood and Care Education*. [Online]. Available at: https://assets.gov.ie/38186/c9e90d89d94b41d3bf00201c98b2ef6a.pdf. Accessed 05/12/2020

The following approach is used to indicate the prevalence of a theme across the participant group:

- All – all participants;
- Most – at least three quarters but not all participants;
- Majority – between half and three quarters of participants;
- Some – between a quarter and a half of participants;
- A minority – less than a quarter of participants;
- Very few – one or two participants only.

12.3: Case studies of children

This subsection reports on the findings from the case studies, taking each of the key areas of the DEI charter.

Provision

This subsection details the *provision* currently made to support each child within the context of AIM and its impact on their full inclusion and meaningful participation. The findings reported in this subsection are drawn from playful interactions between the PR and case study child, alongside conversations which took place between ELC providers and families. When using the term 'provision' we are referring to the adaptations made in response to the needs of the child, the deployment of staff and the ECCE sessions attended by the child.

Across the 14 settings, children were observed to receive various levels of support matched to their individual strengths and areas of need. In support of the questions set by this evaluation, the findings related to *provision* have been grouped by Level of AIM (1-7) and are reported in the context of each child studied. Fittingly, the findings related to provision begin with a description of a two-year-old child who has yet to start the ECCE programme, to illustrate the approach taken by the pre-school to assist his induction. Following this, the provision for two children whose needs are currently met through AIM universal support is presented. Finally, the provision that has been implemented as part of AIM universal and targeted support for 14 children aged from 2 to 5 years of age is outlined. Together, the illustrations serve to demonstrate the diversity of children who are supported through AIM's universal and targeted support and the provision that has been afforded to them.

Children receiving support prior to starting pre-school

Richard is 2 years old and lives with his family on a farm. He was born with a cleft palate. He has yet to start pre-school however, contact has already been made between the ELC provider and his family to support his transition. He is due to start attending the pre-school setting from April 2022, with a view to starting the ECCE programme from September. In communication with Richard's family, the setting plan to apply for targeted support across AIM levels 4, 6 and 7 to support Richard's speech and language development. The pre-school setting is well-known to Richard and his family as his older sister, Jenny, already attends the setting. Jenny has been sharing her experiences of pre-school with her younger brother.

Children receiving AIM universal support

Jenny is 4 years old and is the older sister of Richard. She has been attending her small, rural pre-school for three years and will be leaving to start primary school in September 2022. She enjoys role-

play activities and reading stories. This year, the pre-school will be supporting Jenny to transition from pre-school to primary school.

Mary is 4 years old and is the youngest of three children. Mary is currently in her second year of pre-school and is currently supported through the universal provision within the setting. Mary is independent and has effective communication skills, through AIM universal support she is able to fully participate within the pre-school.

Children receiving AIM targeted support

AIM Level 4

Max is 3 years old, and his first language is Russian. He started pre-school in September 2021, and this is the first time he has attended an English-speaking setting. He enjoys playing outdoors and taking part in sensory activities, particularly with malleable materials. At times he can find transitions, socialising with others and regulating his emotions difficult. Max participates in activities alongside his peer group, but also enjoys choosing quiet time to do individual activities. The pre-school setting has applied for AIM Level 7 but at the time of writing have not yet received a decision from Better Start.

AIM Level 5

Sean is 4 years old, and in his second year of the ECCE scheme. In this time, he has made lots of positive relationships with ELC practitioners and other children in the pre-school setting. Sean has limited mobility due to a medical condition which causes low muscle tone. He is unable to walk and generally crawls or shuffles around the pre-school. Sean is supported to communicate by practitioners in the setting through the use of visuals, including picture exchange and choice boards. Sean currently avails of AIM Level 5 and 7.

AIM Level 7

Tom is 3 years old and has an older brother aged 4. Tom is an active child who likes the freedom to move and explore. He likes sensory opportunities, diggers, cars, and superheroes. Tom uses single words to communicate and can find it difficult to regulate his emotions. When frustrated he can direct his anger towards others. Tom previously attended another ELC setting in which he received AIM Level 7 to support his needs. However, the family have recently moved home leading to Tom enrolling in his current pre-school in October 2021. The pre-school setting applied for AIM Level 7 support for Tom, however, due to another child in the pre-school setting already availing of AIM Level 7 shared support has been awarded. This initially led to Tom being unable to access the pre-school setting. The EYS, ELC provider and Tom's family have been working together to support Tom to access provision within the pre-school setting. Currently Tom has been able to access the session for one hour at a time.

Kiernan is 3 years old. At home he has a baby sister and an older sister aged 8 years. He likes to watch Peppa Pig. He started pre-school in September 2021. After his initial settling in period in the setting, the ELC practitioners shared initial concerns about his rigid behaviour and limited speech with his family. Due to the long waiting lists for assessment, his family chose to pay for a private Educational Psychology assessment resulting in a diagnosis of autistic spectrum disorder (ASD). He remains on the waiting list for speech and language therapy and AIM Level 6 therapeutic support.

Finn is 4 years old and is in his second year of the ECCE programme at his rural pre-school setting. He comes from a farming family and is interested in anything farming related. He is a very sociable

boy with many friends in the pre-school setting. Within the setting the practitioners support Finn to focus and attend to activities during the session. Finn currently attends speech and language therapy at a local HSE clinic on a weekly basis. This takes place outside of the AIM programme and the pre-school setting have not received AIM Level 6 support.

Ciara is 4 years old and is in her second year of the ECCE programme. She has received AIM Level 7 support during both years of pre-school. She is imaginative, creative, and independent. She likes to play with others in her peer group, especially outdoors. Her verbal communication and expressive language are limited. At times this can lead to her becoming frustrated and she can direct negative behaviours towards others who are not responding to her. She attends speech and language therapy (SLT) outside of the pre-school setting, the pre-school setting does not currently receive AIM Level 6 support. Since attending SLT the clarity of her speech has improved over time.

Ben is 3 years old and is in his first year of attending pre-school. Ben has a chromosomal condition that affects his brain, eyes, and lymphatic system. His mother explained that it is likely that he will be delayed in comparison to his peers in reaching his motor milestones. Ben is very interested in farming and outdoor play but also enjoys spending time reading books.

Connor is 3 years old and started pre-school in September 2021. He loves puzzles and construction activities. He is particularly skilled at building towers during block play activity. He is currently non-verbal and can become quickly overwhelmed by change. He currently receives AIM Level 7 support.

Joe is 3 years old. He loves sensory play and is very sociable. This is his first ECCE year, and he is very settled at pre-school. He has diabetes and requires support throughout the day to manage his condition. Joe receives level 7 AIM supports.

Liam is a sociable 3-year-old, who readily joins in with activities at pre-school. He particularly likes outdoor play and is interested in cars and trains. He can find it difficult to regulate his emotions when others do not respond in the way that he wants them to. He started in the pre-school setting in April 2021 and an assessment for AIM was conducted before the summer in order to allow AIM Level 7 support to be in place for him to start the ECCE programme in September 2021.

Ruby is 5 and a half years old. She enjoys painting, playing in the tent and kitchen when at pre-school. Ruby has been diagnosed with epilepsy. At the time of writing, she had been attending the pre-school for 6 weeks have recently moved into the area. She has previously attended 2 other pre-school settings. An application for AIM Level 7 support has just been approved.

In total, 14 children aged from 2 to 5 years of age participated in the child case studies across 14 different pre-school settings. There is a diversity of need across the 14 children, with flexible responses made in the context of AIM's universal and targeted support. The proceeding subsections that follow present the overall findings for each of the remaining five elements (role of practitioner, peer relationships, emotive response, physical response, and resources) ahead of illustrative vignettes which present individual children's perspectives and experiences. Images of the children's map texts are included to present the child's voice and representation of their experiences within the pre-school setting, from their own point of view.

Role of practitioner

In relation to the *role of the practitioner*, data from the child case studies showed that all of the children who participated in the evaluation were well-supported in their inclusion and participation by practitioners in the setting. In providing support to the children, the practitioners undertook a range of

distinct roles in facilitating meaningful participation and full inclusion. This ranged from providing 1:1 support, to facilitating relationships with other children, to making changes to the physical environment. A few of the children, including Joe, Ben and Ruby required practitioner support to manage their medical needs. Drawing on the data collected for the child case studies, PRs reported that support was provided sensitively. Practitioners sought to normalise medical routines, making them an everyday visible occurrence within the setting, whilst including other children within them where appropriate. ELC practitioners knew the children in their setting well and used this knowledge to anticipate situations that they may find challenging, providing strategies to foster participation and ensure inclusion within the setting.

PRs reported that ELC practitioners played a key role in supporting the transitions of children. This was observed where Tom and Ruby joined the pre-school setting mid-way through the ECCE programme and where Richard was getting ready to begin pre-school for the first time. These findings demonstrate that staff are applying the principles of the DCYA DEI charter, in the context of AIM Level 1 because they took a holistic view of the child, seeking to understand their interests and strengths and represent these within the setting provision. For children already attending the pre-school setting, practitioners drew upon their knowledge and positive relationships with the child to support transition through the different activities within the ECCE session: entering the pre-school at the start of the session, moving from one activity to another during the session, accessing mealtimes, and from pre-school to home at the end of the session.

Across the child case studies, there was evidence that the children had formed positive relationships with the ELC practitioners in their setting which contributed to their meaningful participation and full inclusion. The findings from the case studies demonstrated that all children's achievements were celebrated, and their contributions were valued within the pre-school setting. The vignettes presented here give examples of children's perspectives on their meaningful participation and full inclusion with reference to the practitioner role.

Joe, 3 years old, town community setting, AIM targeted support (Level 4 and 7)

Joe's map of his community pre-school setting communicated the role of his practitioner in normalising the management of his diabetes. The bottom of his map features the dining area where Joe eats his lunch with his friends in a small 'restaurant' area. Rather than sitting in isolation with a practitioner to use his insulin pump, Joe is encouraged to invite his peers to join him at the table. When looking at his map with the PR, he told her 'This is where I sit with my teacher and my friend for lunch.' During a walking tour of the pre-school setting, he showed the PR the restaurant area, which is bright and inviting.

Within the setting, practitioners have included Joe's peer group in the management of his medical needs, including sharing information during Diabetes awareness week. The pre-school setting shared a photograph of Joe demonstrating his insulin pump to his peers (see Figure 12(ii). Joe has a puppet bear called 'George' who, like him, has diabetes and an insulin pump and this was shown to the PR. During the visit to the pre-school setting Joe was comfortable and confident in talking about his medical condition. He verbally identified that his 'mammy' and his 'teacher' both help him with his diabetes.

Figure 12(i): Joe's map of his urban community pre-school[88]

Joe's case study demonstrates the application of various levels of AIM by practitioners to meet his needs. It is evident that staff are applying the principles of the DEI charter, in the context of AIM Level 1, as they give Joe responsibility in explaining his medical condition to other children, and value his personal views and insight. Meanwhile the presence of an additional adult in setting, through AIM Level 7, provides flexibility and opportunity for interactions to take place between Joe and his peers in the restaurant area away from the main provision in the room.

Finn, 4 years 6 months old, private rural setting, AIM targeted support (Level 4 and 7)

During the visit to the pre-school setting, Finn engaged the PR in a game of hide and seek. He approached the PR confidently and told her, 'T-Rex is coming to get us!' Finn hid in places inside and outside of the pre-school setting. During the game he expressed many different emotions including excited, happy, and pretended to be scared of the dinosaur coming to get them. Although Finn created a map text which is included in Figure 12(ii), he did not wish to discuss this with the PR. Later in the session Finn came in to the setting from the outside area and was pleased to find the PR, telling her 'dere 'ou are!' Finn was observed to readily approach different adults within the pre-school setting to initate conversation and seek physical proximity.

Before the PR left the setting, Finn sat close to her during story time and rubbed her arm as the story was read aloud. The practitioners explained afterwards that this is something Finn often does to help him relax before home time as he appears to enjoy the sensory feeling and closeness to the practitioner.

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[88] Child names have been edited to maintain anonymity

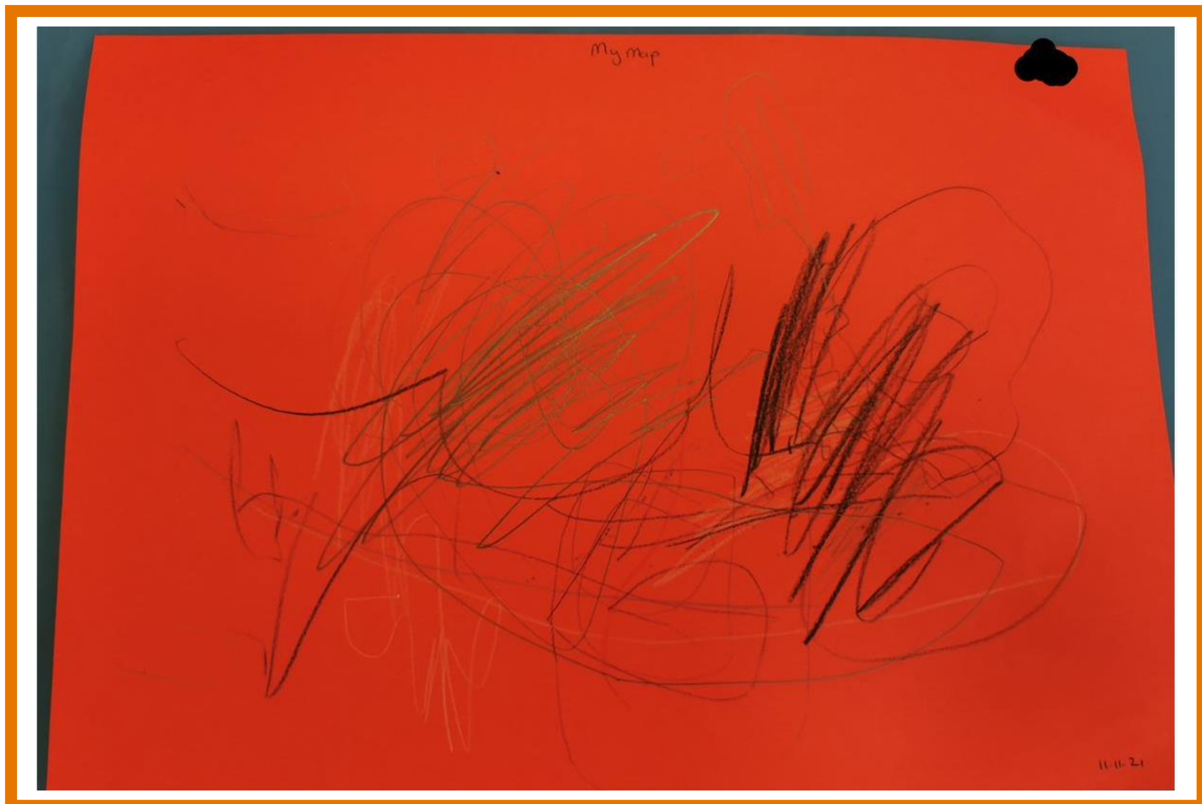


Figure 12(ii): Finn's map of his pre-school

The practitioners in the pre-school service expressed in conversation to the PR that they felt that their role in supporting Finn focused on his speech and language development. They explained that they conducted this through focused small group activities. Finn currently receives speech and language therapy in a local HSE clinc on Tuesdays. However, this is not accessed through AIM Level 6 and the therapist has no direct contact with the pre-school setting. The practitioners explained that Finn can find it difficult to transition back in to the setting after his speech and language therapy on Tuesdays. In response, they provide 1:1 adult support to facilitate his transition back in to the pre-school setting.

Finn's case study demonstrates the impact that having access to an additional adult through AIM Level 7 can have within pre-school settings. The additional member of staff can be deployed flexibly during the day to provide support for the room during the ECCE session whilst also having the capacity to provide targeted support for individual children and small groups. On the other hand, the lack of contact between the therapist and pre-school (as evidenced by the PR in the child case study) indicates a potential limitation in both AIM Level 4 and 6. Whilst the EYS provided support to the pre-school setting prior to the application for AIM Level 7, they have not provided support in relation to his speech and language therapy. The setting is not currently availing of AIM Level 6 as the child receives therapy in a community clinic. As a result, the setting do not receive contact or support from the therapist. The role of the practitioner in this instance is to support Finn outside of his therapy; this is achieved through the warm and positive interactions he has both in the wider pre-school room context and targeted small group time. The impact of this is visible in his confidence to seek verbal interaction and physical proximity with adults and peers. This implies that, in the case of Finn, more interaction and collaboration between the pre-school practitioner and HSE staff, could enhance the impact of provision on Finn's pre-school inclusion.

Richard, 2 years old, not yet attending pre-school

Richard has been preparing for the transition to pre-school ahead of his start date in April 2022. He knows the pre-school setting as his older sister, Jenny, currently attends. However, due to the COVID 19 pandemic, Richard waits in the car during pick up and drop off times and has not yet been able to enter the building or meet the children and staff face-to-face. As he has not been able to attend the pre-school setting in person, he has been communicating with the pre-school setting owner through the sharing of pictures and videos.

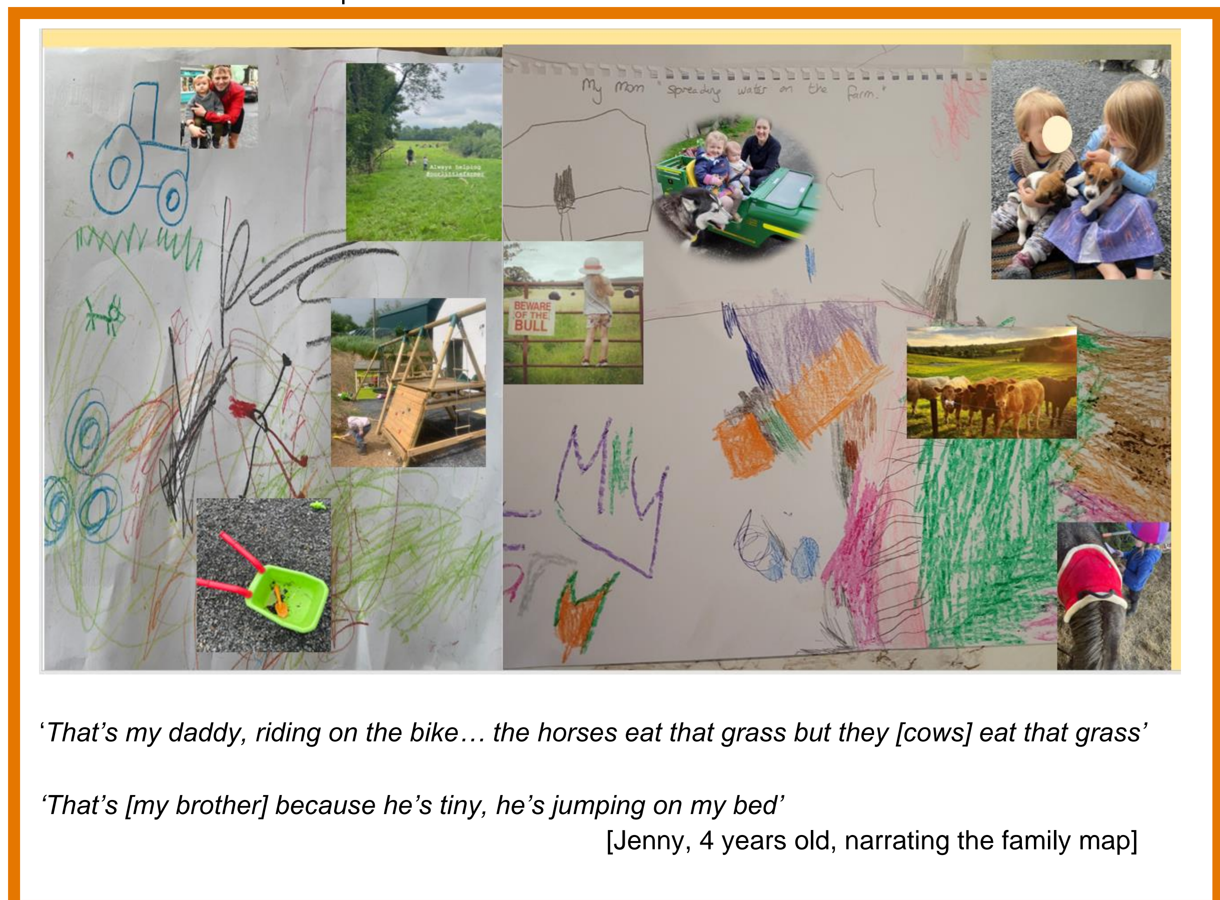
As part of the case study approach Richard created a map at home with his mother and sister to communicate his interests. Richard showed that he loves books and story time, his favourite toys include building blocks and farms. He also indicated that he likes to play outdoors and on a wooden playground; he particularly enjoys experiential play with mud, using tools and equipment like wheelbarrows and spades to dig and explore his natural surroundings. To share his existing interests and engagements with the setting owner, Richard created a digital map "My world of play" (see Figure 12(iii)).

Figure 12 (iii) Richard's map of "My world of play"

Richard and his mother co-created a map and a story book through which Richard communicated the importance of his family and emotional responses to beginning pre-school. Figure 12 (iv) shows the 'family map' created in collaboration with Jenny and his mother. Richard's bonds with his family became stronger during the pandemic, especially with his sister, Jenny. She was referred to frequently by Richard; he had strong emotional responses of excitement when shown photos of her and she was prominent in his map and storybook through drawings.

To continue to support this strong bond, the ELC practitioners identified opportunities to work with both children through shared activities that they both did at home and enjoyed, such as reading

together and gardening. This demonstrates the application of the DEI charter[89] within AIM Level 1, as the setting sought to make themselves aware of Richard's capabilities, interests, and background. The PR studying Richard noted his anxieties about starting pre-school, particularly in relation to negotiating new relationships with a group of unknown children and not being with his mum. His mother expressed that he may demonstrate through his behaviour his frustrations at not being understood by others when he communicates. The ELC setting owner, who is also the INCO, has applied this information to create visual resources for Richard to use. These are anticipated to aid with communication about the items that he would like when at pre-school. The activity undertaken by the setting owner/INCO demonstrates the application of their engagement in the LINC programme, and engagement in continual professional development (CPD) through AIM Level 3. The pre-school has considered what Richard's needs may be when he enters the setting and reflected upon the changes that they can make to respond to these. This is a good example of the productive use of transition activities to inform inclusive practice in the context of AIM.



'That's my daddy, riding on the bike… the horses eat that grass but they [cows] eat that grass'

'That's [my brother] because he's tiny, he's jumping on my bed'

[Jenny, 4 years old, narrating the family map]

Figure 12(iv): "Family map" created by Richard and Jenny with their mum

The videos, pictures, map, and storybook were an important part of the engagement between Richard's family and practitioners for his phased transition to pre-school. They have shaped the responses of practitioners in their creation of scaffolds for his inclusion, as well as building positive relationships with the whole family and creating holistic support. The case study demonstrates an approach to transition which may be undertaken in other pre-school settings to develop greater

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[89] Department of Children and Youth Affairs (2016) *Diversity, Equality and Inclusion Charter and Guidelines for Early Childhood and Care Education.* [Online]. Available at: https://assets.gov.ie/38186/c9e90d89d94b41d3bf00201c98b2ef6a.pdf. Accessed 05/12/2020

understanding and awareness of the child's capabilities, interests, culture, language, and background as advocated within the DEI charter (DCYA, 2016[90]). It is from this knowledge that practitioners can develop their provision and promote inclusion in the context of their service.

Findings related to the role of practitioners in mediating full inclusion and meaningful participation are summarised in the text box below.

Practitioner support, inclusion, and participation in the context of AIM: findings from the child case studies

The children who participated within the case studies expressed that from their perspective, they were experiencing support from practitioners that contributed to their full inclusion and meaningful participation within their pre-school. Practitioners played a number of roles in supporting children's individual needs and organising provision across the pre-school setting. This included:

- Providing 1:1 support to children within the context of AIM Level 7.
- Facilitating positive relationships within the peer group
- Making changes to the physical environment.
- Providing support for children's medical needs and physical wellbeing.
- Supporting children's transitions within and to the pre-school setting.

Through their maps, conversations and playful interactions with the PR, children communicated that:

- The practitioner is a caregiver who can help you
- For some children, the practitioner was seen as someone who can support you with your medical needs, in place of your parent/carer
- Contact and physical proximity can be sought from the practitioner to provide comfort and a sense of security
- The practitioner is someone I can share my interests with
- The practitioner is someone my family engages with

Overall, the findings suggest that practitioners know the children in their setting well and use this knowledge to anticipate situations that they may find challenging, providing strategies and adaptations to foster meaningful participation and secure their inclusion within the setting. These are indicative of AIM Level 1, an inclusive culture, being applied in conjunction with personalised support in the context of AIM Level 7.

Peer relationships

In relation to *peer relationships*, data from the child case studies demonstrated the impact of engagement with peers on children's experience of meaningful participation and full inclusion. Across

[90] Department of Children and Youth Affairs (2016) *Diversity, Equality and Inclusion Charter and Guidelines for Early Childhood and Care Education.* [Online]. Available at: https://assets.gov.ie/38186/c9e90d89d94b41d3bf00201c98b2ef6a.pdf. Accessed 05/12/2020

the 14 case studies, children communicated the importance of belonging and being a valued member of their peer group. This was evident where they depicted friends in their multimodal maps or named their friends in conversation with the PR. During their time in the pre-school setting the PR observed the interactions the case study child had with their peers.

The DEI charter (DCYA, 2016[91]) asserts that inclusion involves being part of the peer group not apart. This was evident during the face-to-face visits to the pre-school setting where case study children were observed in play with or alongside their peers. The types of play children undertook with their peers varied. Some children, like Finn preferred parallel play alongside his peers, whilst others, like Sean, Mary, and Ruby, undertook more co-operative forms of play. Some children, like Sean, had formed close bonds with other children at pre-school, he referred to another girl as his 'best friend.' Their relationship was a tactile one, through touch they would communicate, providing reassurance and generating a sense of belonging.

The practitioners in the pre-school setting set the tone for interactions between children, in which empathy and care was modelled reflecting the inclusive culture of AIM Level 1. In some of the pre-school settings, children were observed to show care and concern for the case study child. In the relationships observed across the case studies, there were often strong protective elements with the close friend 'looking out' of them and being an advocate at times speaking up on their behalf. In Joe's case study, his friends took on roles and responsibilities to help support the management of his diabetes. Whilst in Connor's case study, other children were observed to know his likes, dislikes and interests and verbally recommended to the PR that Connor liked playing with blocks. Respect and trust were displayed by the way children shared things they had created at pre-school with their peers, sometimes showing things that were personal their peers. For example, Joe took considerable pride in showing his map to his peers and then they began to create their own maps sharing their favourite spaces and objects in pre-school.

For a few children, peer relationships were mediated and facilitated by adults where they found it difficult to interact spontaneously with others. Ruby found it challenging to initiate play with her peers, but once an adult facilitated social contact the peer group would become involved with Ruby, including her in their conversations and play. There were also instances where practitioners felt that they had to intervene to manage children's negative behaviour towards others. Both Max and Tom required support from the practitioner during the case study visit to prevent them from physically striking another child. Although practitioners worked hard to redirect the child to another activity and praised positive interaction the situation was challenging at times and became the focus of additional adult support within AIM Level 7.

The following vignettes provide insight into children's views regarding the impact of peer relationships on their meaningful participation and full inclusion.

Max, 3 years old, private town setting, AIM targeted support (Level 4)

The PR observed that Max appeared to find it difficult to form relationships with other children. The pre-school is Max's first experience of an English-speaking setting, at home he speaks Russian with his family. This can make it challenging for Max to communicate verbally with his peers as he has not

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[91] Department of Children and Youth Affairs (2016) *Diversity, Equality and Inclusion Charter and Guidelines for Early Childhood and Care Education.* [Online]. Available at: https://assets.gov.ie/38186/c9e90d89d94b41d3bf00201c98b2ef6a.pdf. Accessed 05/12/2020

yet developed the range of vocabulary, he needs to express his thoughts and feelings. To support Max to engage with others, the practitioners provided stimulating tactile and sensory materials to encourage Max to play alongside his peers.

During observation, a sequence of events unfolded between Max and his peer group as depicted in Figure 12(v). First, Max sat at the table with the practitioner to explore emotion cards, she used English and Russian words to name and label the emotions. Max showed that he found the cards interesting by picking them up and smiling at them. Next the practitioner set up a sensory tray on the table in front of him. Max began to dig and explore the contents. Other children were interested and came to play alongside him. Max allowed the other children to play in the tray too, but his body language expressed that this was not something he found easy to manage. He sat with a clenched fist and did not make eye contact with the other children.

Figure 12(v) Max engaged in a sensory tray activity alongside peers.

Although the practitioner sought to engage Max in an activity that he found interesting alongside his peers, they reflected afterwards that this was an activity he would have preferred to do on his own. Max's case study therefore illustrates a challenge ELC practitioners experience in realising AIM Level 1. Whilst the practitioner knew it was important to include Max alongside his peer group in line with the DEI charter (DCYA, 2016[92]), the underpinning support to manage this interaction appeared to be missing. The challenge Max experienced in interacting with his peer group was exacerbated by their lack of shared language to communicate. Max's behaviour and emotive response to the shared activity demonstrates that this peer activity was not experienced as meaningful participation.

There is no single solution to ensuring Max's engagement with his peers is more meaningful and facilitates full inclusion. The ELC provider has applied for AIM Level 7 to support Max and feel that once this is granted it will allow greater access to personalised support via the presence of an additional adult in the room. Consequently, Max's language and communication needs could be

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[92] Department of Children and Youth Affairs (2016) *Diversity, Equality and Inclusion Charter and Guidelines for Early Childhood and Care Education.* [Online]. Available at: https://assets.gov.ie/38186/c9e90d89d94b41d3bf00201c98b2ef6a.pdf. Accessed 05/12/2020

targeted more precisely which would support his subsequent interactions with his peer group and reduce the use of behaviour to communicate and express his frustrations.

Additional support and CPD on meeting the needs of children who speak English or Irish as an Additional Language could also be of benefit, however, this is not currently offered within AIM Level 3.

Mary, 4 years old, private rural setting, AIM universal support (1-3)

The child case study written by the PR about Mary records that she excitedly entered the pre-school setting and reached for "Lora Rue," a red squirrel soft toy. 'This is his bushy tail!' she exclaimed to the visiting PR. Lora Rue is depicted in the center of Mary's map with the squirrel shown resting in a nest within a tree. The toy is an important part of Mary's routine as she begins the ECCE session, providing comfort and familiarity. Once Lora Rue had been greeted, Mary was quick to introduce her friends, Lily, and Allie, to the PR joining them in the making of a large jigsaw on the floor. Mary chatted to the PR and her peers whilst doing the jigsaw, telling her 'Lily's my friend, she came to my house yesterday.'

Mary and her friends led the PR on a tour of the pre-school room. During this activity, the mutual and respectful relationship between the children was highly evident. Mary was animated whilst talking to her peers about the different spaces in the setting and gave them time to respond. Mary paused on the walking tour when the children arrived at the books. She chose 'The Hungry Caterpillar,' and narrated her own version of the story, 'On Monday he ate through an apple. On Tuesday he ate through 2 peas' When Mary came to the picture of the leaf in the book she declared, 'he wasn't a caterpillar anymore was a beautiful butterfly.' Lily and Allie also joined in and together with Mary they debated and discussed the colours of the butterfly. Eventually, they agreed that butterflies are lovely colours, 'blue, yellow, purple and white.'

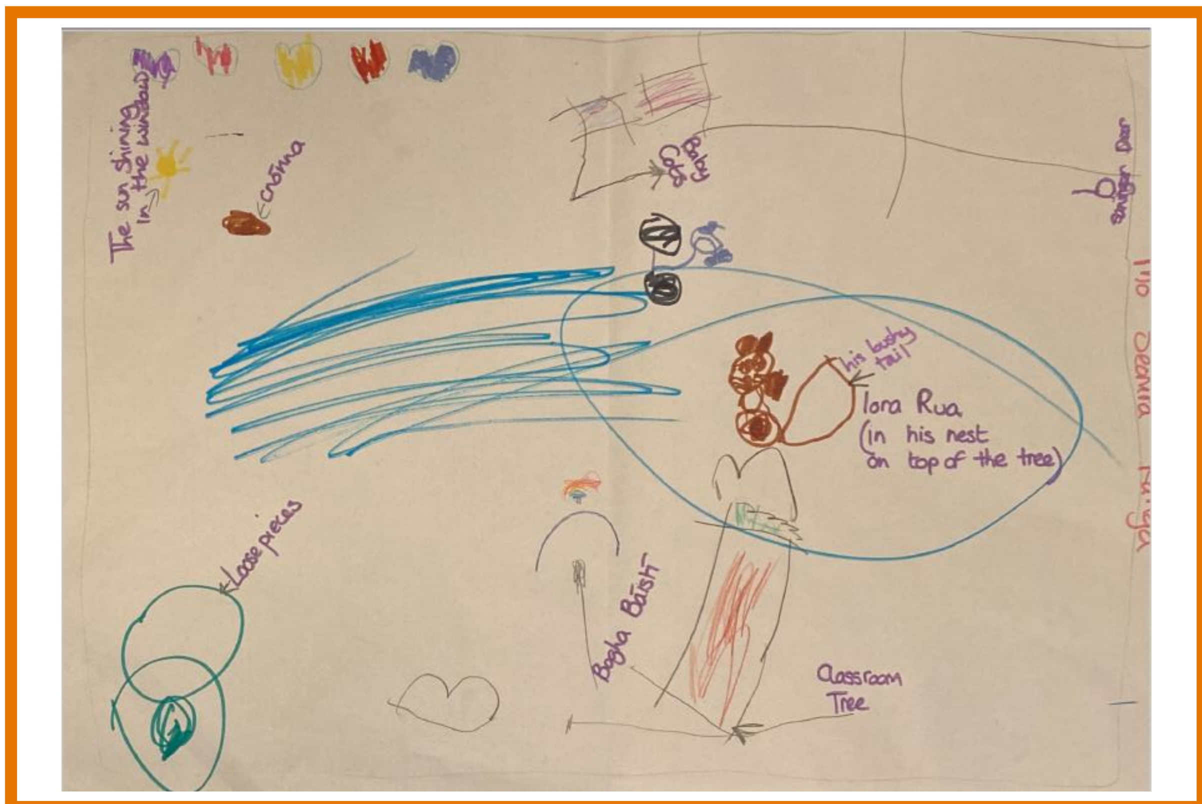

Figure 12(vi): Mary's map of her pre-school setting

Mary's case study communicates the importance of friendship to children during their time in pre-school. For Mary, having friends was a stable and predictable feature of her daily routine which supported her meaningful participation and full inclusion. It was from this secure base that she felt confident to communicate her interests and share her opinions. This reflects the assertion made within the *Aistear* early childhood curriculum framework (National Council for Curriculum and Assessment,2009, p. 25[93]), that when children feel a sense of belonging and pride in their peers 'they can be emotionally strong, self-assured, and able to deal with challenges and difficulties', with this creating a secure foundation for future learning and development.

Data arising in Mary's case study demonstrates the way that interactions with her peers took place on equal terms. When observing the three children together, it is not apparent what the individual needs of each child are. Importantly, within the group interaction the children took account of each other's views and opinions. This suggests that the pre-school setting have sought to uphold the principles of the DEI charter, in the context of AIM Level 1, because the climate and culture within the pre-school setting was one which fostered secure, respectful, and reciprocal relationships.

Ruby, 5 years 6 months, private rural setting, AIM targeted support (Level 4 and 7)

Ruby has been attending her new pre-school for a few weeks. She is beginning to get to know the other children and to form friendships. During the visit to the pre-school setting, the PR observed the efforts Ruby made to initiate play with her peers.

Ruby was playing outside with the buggy; she decided to stop and join some children playing with blocks under the shelter, sitting briefly with them. She then moved to the construction area where other children were digging. Ruby attempted to join the other children by standing in the middle of their construction area (see Figure 12 (vii)). She stood for a while watching them, but they communicated their annoyance at her standing in their game. Ruby redirected herself to the empty sand tray and asked the practitioner for sand, which they fetched and filled the box. This allowed Ruby space to play and led to children from the construction area coming to join her.

During the events, the practitioner was watchful but did not intervene immediately. This gave Ruby and her peers the opportunity to negotiate during play. Rather than stepping in, the practitioner gave the children in the construction area opportunity to communicate their displeasure at Ruby standing in their game, allowing Ruby to understand and take account of other children's point of view. Allowing these exchanges to take place will support future interactions and engagement as children grow to understand each other's preferences and the ways they are communicated. Importantly, the PR noted that practitioner understood that Ruby was communicating her desire to play with the children and facilitated this through responding to Ruby's request to set up the sand tray to start a new game.

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[93] National Council for Curriculum and Assessment (NCCA) (2009) *Aistear: The Early Childhood Curriculum Framework.* Dublin: NCCA.

Figure 12(vii): Ruby initiating play with her peers

Whilst Ruby is still developing her ability to initiate social interactions with her peers, it is important to remember that she has only been in the pre-school setting for a few weeks. Later in the session, the PR observed children approaching Ruby and speaking to her. Moments of co-operative social play also emerged where Ruby was drawn into a game with other girls enacting 'doing each other's make up.' Ruby was seen to be confident to communicate her own needs which other children were respectful of. Towards the end of the session, she entered the play tent on her own and withdrew from the other children which they understood signaled that she wished to break from the play for a while. Whilst it is still early days in Ruby's time in the pre-school, there are lots of signs that the children are learning about each other's interests and preferences, taking account of these in their playful engagements. The pre-school setting appears to be adopting an anti-bias approach to disability, as expressed within the DEI charter (DCYA, 2016) as they are facilitating Ruby to develop autonomy, independence, and confidence to express herself.

Ruby's map of her pre-school setting is presented in Figure 12 (viii). This records some of the places in the pre-school setting that are important to her. An overlap was observed between the places depicted on the map and the locations the PR observed her playing and interacting with others. The outdoor space where Ruby sought to initiate play with her peers is denoted by the inclusion of 'birds' and 'bikes' whilst the 'tent' included in her map is the space inside where Ruby chose to access when taking a break from the play. Ruby's map represents the purpose and special contribution of the map text to building a picture of children's perspectives and firsthand experiences of full inclusion and meaningful participation in the context of AIM.

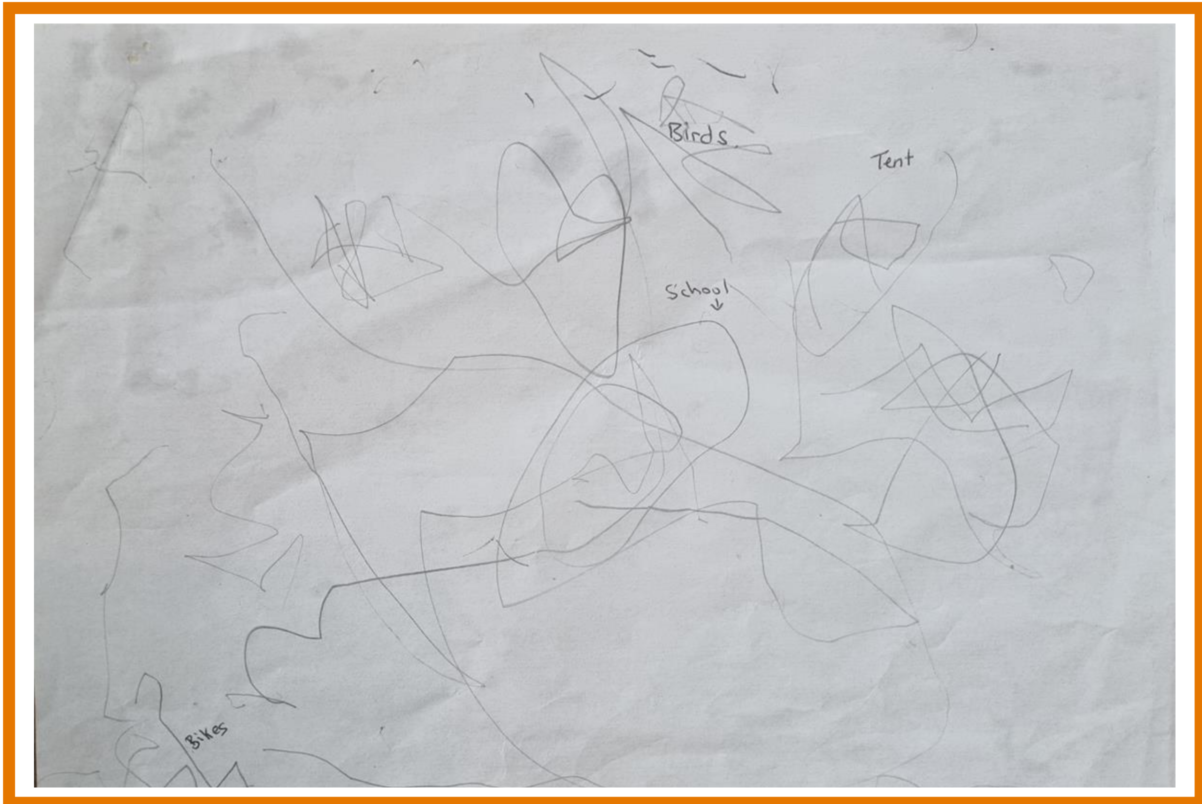

Figure 12 (viii): Ruby's map of her pre-school featuring tent, bikes, and birds.

In conversation, the ELC service manager commented that initially the other children were 'apprehensive' of Ruby as she is both older and bigger than the other children, and at times will walk through the space and toys where they are playing, but 'they are so used to her now.' In response to the DEI charter, the setting is fostering empathy and supporting children to be comfortable with difference. However, the manager also suggested to the PR that AIM Level 7 had been vital to building Ruby's peer relationships through facilitating play. They did not feel that universal provision alone would have been as effective. They identified that without the presence of an additional adult it would have taken much longer for the other children to get to know and become comfortable with Ruby, which would subsequently have had a negative impact upon her meaningful participation within the group.

Findings related to the role of positive peer relationships in mediating meaningful participation and full inclusion are summarised in the text box below.

Peer relationships, inclusion, and participation in the context of AIM: findings from the child case studies

One of the evaluation's four research questions asks whether AIM is effective in achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities and additional needs. Analysis of the 14 case studies revealed that children's meaningful participation and full inclusion was related to their feelings of belonging and being a valued member of their peer group.

This importance of peer relationships was communicated by children through:

- The depiction of other children within their maps of the setting.
- Verbal reference to a 'friend' or 'best friend' by either the case study child, or another child in reference to them.
- Observations of the child initiating or engaged in play with their peers.
- Some peers were observed to show care and concern for the case study child.
- Some peers took a role in 'speaking up' for the case study children.
- Children showed awareness, and took account of other children's likes, dislikes, and preferences.

Practitioners in the pre-school setting played a key role in supporting peer relationships and set the tone for positive interactions. This took place in the context of AIM's universal support as well as targeted support at AIM Level 7. The practitioners' response included:

- Modelling empathy, care, and concern.
- Facilitating contact and interaction between children
- Providing resources and provision which enabled shared and parallel play.

Within the context of AIM Level 7, there were also instances where practitioners felt that had to intervene to manage children's behaviour towards others. Although practitioners worked hard to redirect the child to another activity and praised positive interaction, the situation was challenging at times and became the focus of additional adult support.

Emotive response

Analysis of the case studies written by PRs identified a range of *emotive responses* displayed by children during their time in the pre-school setting. These were displayed in response to play and activities, interactions with peers, the setting routine, and to communicate their preferences and needs to practitioners. Children's emotive responses are relevant to inclusion as they reflect a form of non-verbal communication used by children to express themselves.

Children's emotive responses were recorded by PRs through playful participatory interactions and observations of the child's engagements and interactions within the setting. In addition, children's map texts were analysed for the presence of events and activities which depicted the feelings of the child or their peers. Across the child case studies, children's emotive responses were indicative of their feelings of meaningful participation and full inclusion. For some children, including Joe and Mary, this was observed through the ease and confidence they exhibited in interactions with others. Whilst for others such as Sean, this was observed through their physical actions through shared gaze and the initiation of physical contact to peers and familiar adults. Children also expressed an emotive

response when sharing their map text with the PR, for example Richard's emotive response indicated his familiarity and happiness at seeing pictures of his sister on his map text.

Not all emotive responses displayed by children were positive. At times, children communicated their discomfort, frustration, or anger. For example, Max signaled through his facial expression and body language when he did not like music being played in the setting. Whilst Connor and Ruby expressed when they needed to take a break and withdraw from the other children in the room for a period of time. In such instances, children's meaningful engagement and full inclusion was contingent on the practitioners' sensitive response to the emotions displayed. The vignettes presented here give examples of children's perspectives on their meaningful participation and full inclusion as expressed through their emotive responses within the ECCE session.

Tom, 3 years old, urban town private setting, AIM targeted support (Level 4 and 7)

During the visit to Tom's pre-school setting, the PR observed him during the session and followed his lead as he engaged with different activities and toys. Tom came into the pre-school setting laughing and calling the names of his peers. He was very excited to go and play outside but was not able to access the space at this time. The ELC practitioner redirected Tom to the small world cars inside and she modelled the cars going down the garage ramp. His emotive responsive to this activity demonstrated his excitement and enjoyment, he screamed with delight and readily joined the ELC practitioner on the carpet. To extend his play the practitioner modelled the play and gave short verbal suggestions to Tom regarding the movement of the cars down the ramp and around the garage. Tom responded with eye contact and single words 'yeah' and 'nice' to indicate his enjoyment of the activity and positive response to the practitioner engaging him. This was met with praise, shared eye-contact, and smiles from the practitioner.

Figure 12(ix) presents the line drawing the PR created whilst observing Tom's engagement and emotive response during his hour in the pre-school setting. Tom currently attends the pre-school setting for around one hour at a time. During this time, he receives shared support from an ELC practitioner. In conversation with the setting prior to the PR visit it was discussed that Tom may not wish to create a map. In response, the PR selected from the range of flexible approaches and recorded a map which recorded Tom's engagement and interactions in the setting.

The PR observed Tom's play during his time in the pre-school setting and observed his physical response to the toys and activities within the environment. On entry to the pre-school setting, he was extremely excited. In his excitement he knocked over books. The ELC practitioner redirected him to play with the small world cars where he played willingly, this is marked as activity 1 on the PR's line map. After a period of time, Tom accessed the role play area with tools and equipment at the work bench (activity 2). The practitioner engaged again with Tom by singing 'Bob the Builder' with him. He responded to this with smiles and eye contact, before laughing and dancing to the song. He then moved nearer to the speakers where there was music playing. Other children were in this area and Tom freely joined them to take turns with a toy phone. The practitioner observed but did not intervene. Towards the end of his time in the setting, the practitioner used the timer to signal that he had 5-minutes left before he had to go home (activity 4). Tom became upset. In response to this, the practitioner took Tom outside to play with bubbles (activity 5). After the observation, the practitioner explained that they wanted Tom to leave the setting on a positive note to make his experiences in the pre-school more enjoyable. He continued playing with the bubbles until his parent came to collect him.

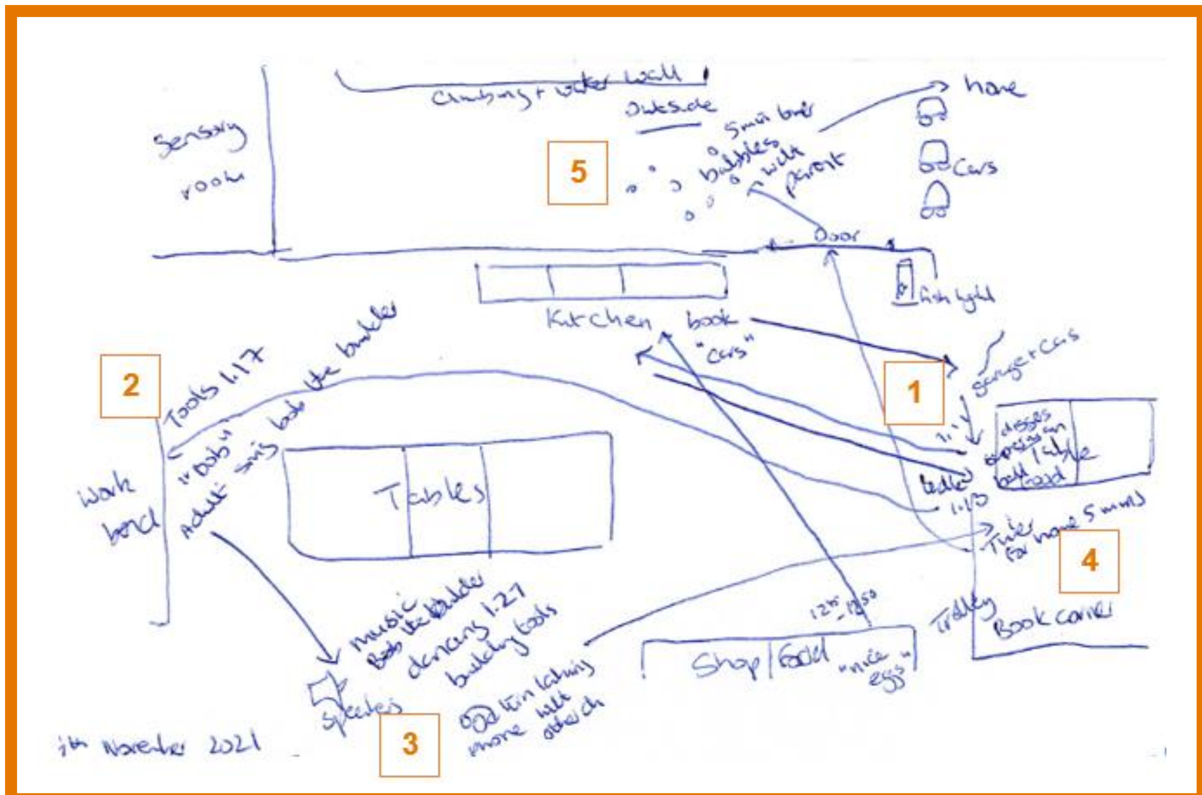

Figure 12(ix): PR line drawing of Tom’s movements and emotive response

The PR observed that Tom’s engagement within the pre-school setting was facilitated by the practitioner’s awareness and responses to his emotive response as a form of non-verbal communication. For example, where Tom was excited and over-stimulated, they diverted his attention and energy into the car game, modelling and scaffolding his play. Transition between activities were scaffolded through the use of timers and visual prompts to reduce Tom’s frustration. Equally, the practitioner was attuned to the signs of Tom becoming tired and overwhelmed toward the end his time in the session, leading to provision of a calming activity to blow bubbles away from the busy setting environment. These were all acts which sought to enable meaningful participation and increase Tom’s inclusion in the ECCE session. However, responding to Tom’s required significant adult time and attention. This is something that the ELC provider communicated was challenging as Tom is currently in receipt of AIM Level 7 shared support. Therefore, a barrier to meaningful participation is felt by the ELC provider to be present through AIM Level 7 as a limited resource.

Connor, 3 years 6 months old, private rural setting, AIM targeted support (Level 4 and 7)

During the visit to the pre-school setting Connor did not initially wish to interact directly with the PR, so she observed him from a distance. The PR was made aware that Connor enjoyed construction play, so she sat alongside him as he began to investigate the block construction toys. Connor became very engaged with his construction, becoming completely engrossed in this activity as he concentrated upon feeling the blocks before choosing one block to be part of his construction. The PR participated in this selection process, passing him blocks that he would then incorporate into his building. He took time balancing the blocks upon each other as he built structures that resembled a city skyline, see Figure 12(x). During this activity he was not aware of others around him, he was entirely focused upon building.

Figure 12(x): Connor's completed block construction

Within the pre-school, the ELC practitioner made attempts to engage Connor in story time alongside his peers. Connor expressed his immediate discomfort and dislike of the activity and ran away from the group. He vocalised his emotions through making loud noises during the story time. In response to this, the practitioner intervened and used calming techniques to settle Connor in a 1:1 context.

Connor's case study demonstrates the need to react and respond sensitively to the full range of emotions children display. During the block construction activity, Connor was calm and highly engaged but did not express an overtly positive demeanor. It would therefore be possible to overlook this example of Connor engaging positively in the pre-school environment and focus solely on instances where his feelings of discomfort were expressed more explicitly. Connor's case study also serves as an example of where, at times, AIM Level 7 may be required on a 1:1 basis. By removing Connor from the group story activity that he disliked, he was calmed through individual support. However, it is acknowledged that this is not a sustainable or desirable long-term approach, nor does it promote meaningful participation and full inclusion. As a result, the challenge remains in balancing the immediate preferences of the child with identifying approaches to gradually engage the child in a greater range of activities in the pre-school setting.

Liam, 3 years 2 months old, city community setting, AIM targeted support (Level 4 and 7)

Liam was discussing the various places and activities within his pre-school. As part of the discussion, he told the PR about the spaces within his community setting that helped him to manage his emotions. First, he referred to a preferred quiet area inside the pre-school setting. He explained to the PR that he went there when he felt angry. During the focused conversation with the PR, he expanded further upon this and indicated that the having the quiet space available to him gave him choice and opportunity to manage his emotions, but he needed some adult support to do this. He explained that he would go with the ELC practitioner and in the quiet area you can 'read a story or just lie down.'

A further area Liam enjoys in the community setting is the outdoor area. He explained that sometimes he would go outside with the ELC practitioner, and this gave him opportunity to calm:

> ‘She [the practitioner] is nice, when I get angry or shout, she helps me. We go to the quiet place or outside.’
>
> [Liam, 3 years 2 months]

Liam’s case study demonstrates the role the practitioner and the wider setting environment play together in supporting children to manage their emotional needs in the context of AIM. It was also noteworthy that Liam was able to describe and name his emotions, suggesting how these could be responded to. This suggests that the relationship he has built with the practitioner, within the context of AIM Level 7, are trusting and secure. He knows that there is an adult available to help him when he needs it.

Findings related to children’s emotive responses within the pre-school setting as indicative of their feelings of full inclusion and meaningful participation are summarised in the text box below.

Emotive responses to inclusion and participation in the context of AIM: findings from the child case studies

In summary, children displayed a range of emotive responses during their time in the pre-school setting. These were displayed in response to play and activities, interactions with peers, the setting routine, and to communicate their preferences and needs to practitioners.

Children’s emotive responses were highly indicative of their feelings of meaningful participation and full inclusion:

- For some children this was observed through the ease and confidence they exhibited in interactions with others.
- Most children expressed excitement, happiness, and engagement during playful interactions with others.
- Some children expressed their feelings through shared gaze and the initiation of physical contact to peers and familiar adults.

Not all emotive responses displayed by children were positive. At times, children communicated their discomfort, frustration, or anger. In such instances, children’s meaningful engagement and full inclusion was contingent on the practitioners’ sensitive response to the emotions displayed.

Physical response

The findings reported by the PRs regarding the *physical response* of settings revealed the role of the physical environment in supporting development, participation, and inclusion. Close examination of the 14 case studies revealed the places and spaces within pre-school settings that were valued by children. Across the case studies, some children expressed similar preferences for small, quiet, and enclosed areas such as those as observed in Ruby, Liam, and Mary’s pre-school setting. These provided calming, relaxing spaces for children away from the main setting provision when they required it. The outdoor environment was also referred to by most children, and a key feature across the case studies was access to natural materials and outdoor spaces. It is in these outdoor environments that children, including Ben and Jenny, showed great enjoyment in engaging in construction or experiential play alongside their peers. Analysis of the case studies showed that all of

the children who participated in the evaluation were able to access provision across the indoor and outdoor spaces of their pre-school. Activities and resources provided to children were accessible. In both Sean and Finn's setting ramps were provided to facilitate access to the outdoor areas, which were made further accessible through the provision of level access spaces and pathways. Such adaptations are important as they enable equal access and therefore increasing opportunities for meaningful participation across the setting's universal provision, in the context of AIM Level 1. Whilst children's maps did not depict the adaptations made to the setting environment, they did indicate the range of spaces across the pre-school setting children were able to access freely. There was some evidence within the case study settings of materials within the physical environment positively representing children's background, disability, and interests, thereby reflecting the guidance on 'proofing' the physical environment outlined within the DEI charter (DCYA, 2016). This was most common where toys and activities had been set up which reflected the type of play children engaged with at home. Joe's pre-school, on the other hand, provided positive materials to inform and promote awareness of diabetes. However, there was less visible evidence of materials in the pre-school settings reflecting the home language or culture of children in the pre-school. For example, in Max's pre-school setting visual aids and some verbal phrases from his home language were spoken, but there was not yet evidence of his home language being presented elsewhere in the setting, or his culture being shared with other children in the setting. The proceeding illustrative vignettes provide examples of children's views regarding the materials, resources and activities present within the physical environment of the pre-school setting and their perceived role in supporting participation and inclusion.

Jenny, 4 years old, private rural setting

The PR reported that Jenny spends at least 2 hours outdoors in the setting each day. The outdoor space at her pre-school includes a natural wooded environment with lots of access to natural play materials and loose parts. Jenny represented her love of the outdoors in the map she created at home with her mum and younger brother, Richard. Whilst drawing her map (see Figure 12(xi)) she explained 'that's my brother, he's tiny, and that's my mum she's wearing a dress but she's trying not to get it muddy'. The opportunities to be outside when she is at pre-school reflect her interests and engagements at home.

Figure 12(xi): Jenny creating "My Farm" map

The owner of Jenny's rural pre-school described the physical environment as 'completely designed with the child'; she explained that:

> 'All children are completely included in the daily-, short-, medium- and long-term planning through mapping, documentation and discussion.'
>
> [Owner/INCO, private rural setting]

The outdoor area of the pre-school is over one acre in size and is zoned into 4 distinct areas. Jenny created a digital map of the 'things I can do at my pre-school' (see Figure 12(xii)). This depicts the different outdoor spaces she likes to play in including the mud kitchen and playhouse area. This is located next to a huge conifer that Jenny refers to as 'the umbrella tree' because the children can shelter under it from the rain. Jenny's map also includes a photograph of the 'digging area'. The setting owner explained that the outdoor area is continually changing and evolving in response to the children. Last year the children were interested in fairies and together they co-created a fairy garden area which remains in the outdoor space. This year there is a lot more interest in farming and animals. Jenny and her peers have created a 'baby chicken area' underneath a bamboo tree beside a 'crocodile log'. This activity has engaged all the children in imaginative play; the chickens themselves are little sticks and the children including Jenny swaddle the sticks and gather food for them.

Figure 12(xii) Jenny's map of "Things I can do at my pre-school"

The physical environment also provides opportunity for children to make links between the pre-school and their home lives. Jenny has had opportunity to grow flowers and garden vegetables, harvest and eat these in her pre-school setting.

The setting owner explained that 'to continue the learning children take home harvested food and seeds.'

Ben, 3 years, and 6 months old, private rural setting, AIM targeted support (Levels 4 and 7)

Ben was aided to access and navigate around his pre-school through the organisation of his physical environment. He has a chromosomal condition which affects his mobility. The presence of adaptions to the physical environment, including ramps and handrails through previous engagement with AIM Level 5, were accompanied by visual prompts and environmental signage. These adaptations ensured that the physical environment of the pre-school was inclusive and supported meaningful participation in the context of AIM Level 1, for Ben and his peers. The indoor and outdoor environment contained numerous learning opportunities for all children. The ELC provider explained that the physical environment evolved, constantly changing, and adding new areas of interests in response to the children. One example of this within the indoor environment, where children had become co-creators of the space, was observed in the provision of a new quiet space. The ELC provider explained that the children chose the colours, soft furnishings, and the materials that they wished to be included, including a light box.

> 'I didn't want Ben wrapped up in cotton wool.. [that's why I] liked this service so much as it had a wonderful indoor and all year round outdoor area that was really easy for Ben to access mostly on his own but with careful observation.'
>
> [Ben's mother]

The PR observed Ben in an outdoor space that was accessible all year round where he appeared to be flourishing. There was a farm themed area, complete with ride on tractors. Ben took turns to sit on the tractors and be pushed along by another child. In this moment, his face lit up, smiling, and waving as they moved along. The space provided opportunities for hide and seek, which was a favourite game of the children. These games stimulated children's conversations as the PR observation reveals:

Ben: I'm a really good hider, aren't I?

Rhys: You are, Ben!

Ben then runs, smiling, as he finds a new hiding space. As the game goes on the practitioners and children point out new places for each other to hide.

Figure 12 (xiii): Ben's play-based interaction, taken from the PR's fieldnotes

In the game of hide and seek all children were able to participate on their own terms. Ben was observed to experience meaningful participation and full inclusion within the game as he was more than an observer or passive participant. Ben's comments to his peers and actions were responded to and reciprocated suggesting that Ben was a valued member of the group with the agency to direct his own and other's actions.

The outdoor space provided Ben with opportunities to explore independently and play with other children in an environment that was stimulating and challenging. A key feature of Ben's case study were the opportunities he had to play independently and on equal terms with his peers, without an adult intervening. This reflected Ben's mother's strong assertion that she did not want her child to be 'wrapped up in cotton wool.' Whilst the practitioner was on hand to provide support should this be required in the context of AIM Level 7, the majority of her interactions were directed to the group as a whole, rather than singling Ben out. Equally, rather than cautioning and reminding the children of what

Ben was and was not able to do, the practitioner engaged in the play and made suggestions alongside Ben regarding the direction the play could take.

The findings of Ben's case study reflect the DEI charter (DCYA, 2009) as positive attitudes toward disability were fostered, and high expectations were upheld of all children. Findings related to children's physical responses within the pre-school setting as indicative of their experience of full inclusion and meaningful participation are summarised in the text box below.

Physical responses to inclusion and participation in the context of AIM: findings from the child case studies

Children's meaningful participation took place in a range of physical locations across the pre-school setting. Across the case studies, some children expressed similar preferences. For some children, small, quiet, and enclosed areas provided calming, relaxing spaces for children away from the main setting provision when they required it. The outdoor environment was referred to by most children, and a key feature across the case studies was access to natural materials and outdoor spaces.

It is in these outdoor environments that children showed great enjoyment in engaging in construction or experiential play alongside their peers. Analysis of the case studies showed that all of the children who participated in the evaluation were able to access provision across the indoor and outdoor spaces of their pre-school. The findings demonstrate that the physical adaptations made to settings in the context of AIM are effective and achieving intended outcomes of enabling the meaningful participation and full inclusion of children with additional needs and/or disabilities. Activities and resources provided to children were accessible through

Resources

In relation to the *resources* present across the pre-school setting, data from the child case studies showed that all of the children who participated in the evaluation had access to a range of resources which supported their participation and inclusion. Analysis of the 14 child case studies, demonstrated that from their perspective, the resources provided within the pre-school setting environment contributed to their full inclusion and participation within their pre-school. The findings demonstrated that the positive use of resources to promote full inclusion and meaningful participation were not limited to specialist materials or equipment provided within AIM Level 5 but were part of the universal provision across pre-school settings within the context of AIM Level 1.

The resources used by ELC providers may be categorised as providing children with support, choice, and challenge. For some children, resources were used as an additional tool to support their meaningful engagement and full inclusion. Examples of this were found where visual prompts were used to support a child to transition from one activity to another during the session or to break down a task into smaller, structured steps. During the setting case studies, ELC practitioners referred to receiving information and guidance on the use of visual resources from their EYS as part of AIM Level 4. This was observed to have a positive impact on the inclusive practice.

Choice was evident where children had access to different activities across the setting which reflected their interests and preferences. For some children this involved the provision of quite spaces, a sensory den or a tent as a resource that allowed them to spend brief periods of time alone or opportunity to regulate their emotions. Examples were found in Ruby, Liam, and Connor's case studies.

For other children, choice was evident where they were able to revisit and re-engage in a preferred activity as observed in Ben and Jenny's case studies. Finally, challenge was a vital component afforded by the resources deployed within ELC settings. This ensured that children were given opportunity to progress towards their individual targets and make incremental progress. Where children accessed a preferred activity, which motivated and engaged them, there were also opportunities for them to develop skills or target an area of need. The proceeding vignettes which follow provide examples of the role of resources in proving choice, challenge, and support. The children's engagement and response to these resources is identified, along with the contribution they made to children's meaningful participation and full inclusion.

Ciara, 4 years old, private city setting, AIM targeted support (Level 4 and 7)

Ciara's map depicts the different resources she engages with in her pre-school setting. She has drawn a picture of purple slime, water and some of the other children who are present in the pre-school that day, see Figure (xiv). The rainbow on the right-hand side reflects Ciara's recollection of creating a rainbow in the pre-school setting with her friends.

Figure 12(xiv): Ciara's map of her city pre-school setting, featuring slime, water, and friends.

The provision of sensory activities which appealed to Ciara's interests supported her to be included and participate alongside her peer group. During the visit to the setting, the PR observed Ciara playing with soapy water alongside two other children. She took an active role in play and all three children showed elevated levels of enjoyment in the activity. Ciara requires support at times to communicate and engage with her peer group, but the activity provided opportunity for her to practice her developing communication skills. Ciara's mother felt that her speech had 'come on from her integration in the playschool.' This example from the pre-school setting demonstrates the role

resources can play in facilitating meaningful participation. The slime and water reflect Ciara's interests and areas of strength, therefore motivating her to engage, whilst the nature of the activity within the universal provision challenges her to use her speech to communicate with others in play. It was observed that the sensory resources available within the universal provision are accessible and enjoyable for all children, whilst responding sensitively to the strengths, interests and needs of specific children. This creates positive situations in which all children are able to meaningfully participate alongside their peer group.

Kiernan, 3 years 5 months old, town private setting, AIM targeted support (Levels 4 and 7)

The pre-school setting uses visual prompts to support Kiernan's participation within the session routines. During her visit to the setting, the PR observed a visual schedule being referred to a number of times within the indoor environment to guide him toward activities available. During lunch time, the pre-school setting has established a colour coded system with clear stages to organise where children sit: first the child wash their hands, next they choose a choose a coloured flower token and finally they sit at the table that has the corresponding-coloured flower mat. The two different visual prompts are shown in Figure 12(xv). During a spontaneous conversation with the ELC practitioner in the room it was noted that AIM had given them a 'new outlook on how to change things to suit everyone and little changes can make a significant difference to the child that needs it.' All children in the pre-school setting use the same visual prompts to follow the lunch time routine as part of the universal provision however this minor change was noted to be of particular benefit to Kiernan. Kiernan communicated his engagement and understanding of the lunch time routine through his facial expression and body language. He was visibly smiling and content as he chose his flower, found his table, and sat down. The ordered, step by step approach appeared to provide security and ensured that he had the space he needed around him. The manager of the pre-school explained that although they had introduced the system for all children, it had a significant impact on Kiernan since its introduction as it prevents him from being overwhelmed by other children being too close to him. This helped to ensure that he is fully included in mealtimes and able to participate alongside his peers.

Figure 12(xv)- Visual resources to support the lunch time routine in Kiernan's pre-school setting

Sean, 4 years old, private town setting

A range of alterations and resources have been provided within Sean's pre-school setting to ensure that all children are able to access provision across the setting environment. A ramp has been installed to aid access to the outdoor space freely for all children. Sean has a low muscle tone associated with his medical condition. He is able to crawl or shuffle on his bottom to get around the setting and access the toys and equipment he wants to play with. Sean uses lots of physical contact to interact with his peers; he likes to hug his friends and during the PR visit he stroked the hand of one of the other children when playing alongside her. Sean was also observed to wave his arms and wiggle in legs when he is happy and enjoying an activity, something peers and practitioners in the pre-school setting are attuned to as communicating his feelings.

To ensure his physical wellbeing, the practitioners working within the room stay close to Sean as he can fall over sometimes when he tries to stand. During the PR's visit to the pre-school setting, all practitioners who work in the room were observed to interact with Sean. They explained to the PR that they had undertook their own research to find out more about his medical condition, ensuring that they were all able to provide appropriate support to him when required. The private pre-school setting Sean attends applied for AIM Level 5 support in order to purchase a specialist chair to be used within the setting (see Figure (xvi)). Unfortunately, due to delays in the application process and sourcing the chair, he has nearly outgrown it and will require a replacement shortly.

Figure 12 (xvi): Specialist equipment and adaptations to support inclusion (L: specialist chair, R: ramp and level access outdoor area

Findings related to the provision and use of resources in supporting full inclusion and meaningful participation in the context of AIM are summarised in the text box below.

Resources, meaningful participation, and full inclusion in the context of AIM: findings from the child case studies

Analysis of the 14 child case studies, demonstrated that from their perspective, the resources provided within the pre-school setting environment contributed to their full inclusion and participation within their pre-school. The findings demonstrated that use of resources to meet children's needs incorporated specialist equipment provided through AIM Level 5 as well as materials and resources available within the universal provision within the context of AIM Level 1.

The resources used by ELC providers may be categorised as providing children with support, choice, and challenge. Through their maps, conversations, and playful interactions with the PR, it was observed that:

- Visual resources gave activities a clear structure and routine.
- Children enjoyed resources which reflected their interests and capabilities.
- Children's speech and communication needs were scaffolded through the provision of activities which encouraged peer interaction.
- Specialist equipment provided in the context of AIM Level 5 was present in the setting.

Overall, resources were used as an additional tool to support children's meaningful engagement and full inclusion. However, their use was contingent on practitioners 'knowledge of the child and understanding of which resources were best suited to respond to their needs. The influence of the DEI chart is evident in practitioners' approach to using resources to promote inclusion and increase accessibility. Practitioners also referred to the support and information they had received from the EYS in the context of AIM Level 4 as guiding their use of visual resources.

Children's experience of full inclusion and meaningful participation in their pre-school

The findings from the child case studies were reported in response to the following objectives:

a) access children's own accounts of inclusion and participation within their pre-school settings
b) ensure children's voices are included in the evaluation

Analysis of the case studies written by PRs revealed a core set of factors which were important to children in their pre-school setting. Children's emotive responses were highly indicative of their feelings of meaningful participation and full inclusion:

- For some children this was observed through the ease and confidence they exhibited in interactions with others.
- Most children expressed excitement, happiness, and engagement during playful interactions with others.
- Not all emotive responses required facial expression or verbal communication. Some children expressed their feelings through shared gaze and the initiation of physical contact to peers and familiar adults.

The positive relationships children formed with the practitioners in their setting played a significant role. The knowledge and understanding the practitioner had of the child allowed them to be

responsive and sensitive to their needs. Through their maps, conversations and playful interactions with the PR, children communicated that the following aspects contributed to their meaningful participation and full inclusion:

- Children viewed the practitioner as a caregiver who could provide help and support, including for emotional and physical needs.
- Practitioners facilitated contact and interaction between children.
- Being able to make physical contact with peers and practitioners was important to children. For some it provided a means to communicate and express feelings, whilst for others it provided calming reassurance.
- Physical proximity to the practitioner provided a sense of security for some children.
- It is important to children that their interests and preferences are acknowledged and responded to by practitioners and peers.

Having a friend, belonging, and feeling like a valued member of the peer group was observed across the case studies where children were observed to be participating meaningfully:

- Most children referred to a friend.
- Children initiated or engaged in play with their peers.
- Children became highly engaged with resources and provision which enabled shared and parallel play.
- Some peers were observed to show care and concern for the case study child.
- Some peers took a role in ‘speaking up’ for the case study children.
- Showing awareness, and taking account of other children’s likes, dislikes, and preferences.

At times, children’s meaningful participation and full inclusion was constrained. This occurred where:

- Children expressed behaviour that required practitioner intervention. Although practitioners worked hard to redirect children to another activity and praised positive interaction, the situation was challenging at times and became the focus of additional adult support.
- Children lacked a shared language or alternate means to communicate with their peer group or the practitioner.
- Where children communicated their discomfort, frustration or anger their meaningful engagement and full inclusion was contingent on the practitioners’ sensitive response to the emotions displayed.

In summary, data arising from the children’s maps and the child case studies demonstrated that, in the participating settings at least, AIM has influenced practice and is achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with additional needs and/or disabilities.

12.4: Case studies of settings

This subsection presents the findings from the case studies of 14 pre-school settings who are engaged with AIM

Approach to presenting the findings

Findings are presented in response to the key lines of enquiry constructed for this evaluation (see subsection 1.2). Summarily, these comprise stakeholders’ views on:

- AIM's implementation
- AIM's impact
- Aspects of AIM that are working well
- Aspects of AIM that need to be improved

Findings from the setting case studies are described, and where relevant, direct quotations from stakeholders are used to illustrate a key theme arising from analysis of the setting case study data. In total, 29 stakeholders were interviewed across the 14 ELC settings. The following approach is used to indicate the prevalence of a theme across the participant group.

- All – all participants (29)
- Most – at least three quarters but not all participants (between 22 and 28)
- Majority – between half and three quarters of participants (between 15 and 21)
- Some – between a quarter and a half of participants (between 8 and 14)
- A minority – less than a quarter of participants (between 3 and 7)
- Very few – one or two participants only (1 or 2)

AIM Overall

Analysis of all 14 setting case studies indicate that in all cases, AIM was felt to provide welcome support to ELC settings for their provision of inclusive practice. This is evident through their commitment to upskilling and developing their practice to meet the needs of children and their families. Across the case studies, there was a clear commitment to child-centred practice, communication with families and collaboration with external services. ELC providers demonstrated good knowledge and awareness of AIM and its underpinning principles. However, in the case studies of settings, PRs recorded evidence of practitioners' and parents' perceptions of gaps and areas for development in the AIM programme. More detail on this is provided in the subsection 'views on the aspects of AIM that are working less well within the setting.'

Perspectives on the principles and purposes of AIM

Data from the 14 setting case studies demonstrated that practitioners were clear that the purpose of AIM was to create an inclusive environment for all children. This was described as providing opportunities for all children to access the pre-school setting, irrespective of their individual strengths and needs, with the support of trained and qualified practitioners. Early years education was felt to lay the foundation for future learning and ELC practitioners were committed to providing the best start for all children during the two year ECCE programme.

ELC providers feel that all children benefit from an inclusive environment. Within ELC settings, practitioners felt that this had the following qualities:

- Access to a team of trained and skilled ELC practitioners who work together to meet the needs of the child.
- Adaptations should be made to the setting environment and resources to enable participation.
- The creation of 'community' that is like a 'home from home.'
- The provision of everyday experiences that are meaningful to all children.
- Children have opportunities to build confidence and develop independence.
- Children are supported to develop social and communication skills, to engage engagement with their peers.
- A few ELC practitioners felt that children should be able to choose to spend time alone or away from the main group during the day if they wished

Taken together, ELC practitioner responses demonstrate that they feel AIM is underpinned by the key principles of meaningful participation and full inclusion. This requires flexibility and practice which responds to the needs and interests of the child, rather than a "one-size fits all" approach. It was felt that AIM was supportive of high-quality provision within the ECCE scheme.

> 'Full inclusion is being able to offer a service to every child with all or any additional needs.'
>
> [Manager, rural private setting]

Both parent/carers and ELC practitioners understood that AIM did not require a diagnosis. Most stakeholders referred to and spoke positively of the fact that AIM was open to all children and responded to individual need without singling children out from their peers. Most parent/carers who participated understood AIM as providing 'support' to their child when they needed it.

> 'It is better than the primary school model as the children are not singled out for help.'
>
> [Owner and INCO, town private setting]

Whilst ELC practitioners felt that there were benefits within AIM for all children, it was recognised that there are currently limitations to AIM achieving its purposes as it is not equally supportive of the needs of all children. It was recognised that there was a need to adapt and adjust in response to the needs of the child, however, some ELC practitioners felt that the supports within AIM are overly generic and not currently sufficiently tailored enough to meet the specific needs of all children, including those with complex and/or medical needs.

> 'A child with a complex medical need versus a child who has less complex needs is very different.'
>
> [Owner/INCO, rural private setting]

Stakeholders' perspectives on the underpinning purposes and principles of AIM are summarised in the text box below.

Stakeholders' perspectives on the purposes and principles of AIM

Overall, stakeholders felt that the central purpose of AIM was to create an inclusive environment for all children. Practitioners frequently referred to notions of full inclusion and meaningful participation which demonstrates the influence of the DEI charter, in the context of AIM Level 1.

Practitioners related inclusion directly to the benefits and outcomes for children, and this presented nuanced understandings drawn from their practical experience of AIM in their own pre-school setting. There was consensus across stakeholders, including parent/carers, practitioners, and the EYS that AIM does not require a diagnosis. This was broadly viewed by practitioners as necessitating a flexible and reflective approach to practice.

Whilst practitioners felt that AIM could be of benefit to most children, some questioned whether AIM was overly generic and felt that AIM is not currently tailored enough to meet complex and/or medical needs.

How AIM support is being used in the settings

The purpose of the case studies was to provide insight into how AIM is being implemented in pre-school settings 'on the ground'. The proceeding subsection seeks to explore how the seven levels of AIM are being implemented, highlighting stakeholders' perspectives on the opportunities and challenges they create for inclusive practice.

The majority of ELC providers felt that they had a good understanding of AIM and how to implement AIM support within their setting. They understand the value of inclusive practice, although did not always relate this explicitly to AIM's Universal provision. ELC providers had a much clearer knowledge of Targeted support and different types support available across Levels 4 to 7, with the exception of AIM Level 6. The information practitioners have received regarding AIM has come from a mixture of sources including:

- The Better Start Early Years Specialist (EYS).
- Other members of staff who are employed in the setting, including the INCO.
- A few ELC providers referred to the County Childcare Committee (CCC) as a source of information and felt that they could provide further information in future.

Universal support

ELC providers identified that they take account of the observations and views of practitioners and families when planning supports for the child. The child's strengths and interests are considered as well as their individual needs in order to build an individual picture of the child.

> 'Full inclusion means that you are able to offer a service to every child with all or any additional needs.'
>
> [Manager, rural private setting]

Through AIM, 11 out of 14 case study settings had accessed the Leadership for INClusion in the Early Years (LINC) Programme. Most ELC providers felt that the LINC programme they attended had been good. However, some felt that the level of the programme was below their previous training, with some ELC practitioners already having completed a Level 8 Childcare degree qualification. As a result, they did not feel that the training provided a significant addition to their existing knowledge. A few ELC practitioners felt that rather than the qualification level of the LINC programme should be raised to higher than Level 6. It was also noted that one setting had been unable to secure a place on the LINC training course, despite the manager making three applications.

> 'LINC has given me a new outlook on how to change things to suit everyone and little changes make a big difference for the child that needs it.'
>
> [ELC practitioner, urban private setting]

Completing LINC programme enables one member of staff to undertake the role of inclusion co-ordinator (INCO), who was present in 11 of the settings. One large, private setting with 105 children on roll had two trained INCOs. ELC providers agreed that this was supportive of inclusive practice in the following ways:

- Having an INCO working within the ELC setting helps as they can 'support and guide the team'.
- The INCO role carries significant responsibility for coordinating applications for support, observing children, and conducting meetings with the EYS and families.

- The INCO role was described as most effective where the member of staff received time to carry out their role. This can be achieved through not including them within the room ratios however there is currently no funding available to facilitate this non-contact time.

As ELC practitioner knowledge of inclusion has increased they have been able to incorporate a greater range of strategies into their practice. Some practitioners referred to using the resources from the AIM Inclusive play guide, explaining that these are used with all children in the setting. As the resources are now a few years old and have been used extensively, ELC providers would welcome further resources to replace the original pack. Across the case studies, resources used within the universal provision included:

- Timers to support turn taking.
- Visual timetables to support transitions within the session.
- Use of 'now and then' charts to support engagement with a wider range of activities.
- Massage brushes to calm and support self-regulation.

Some of the ELC practitioners identified that they had completed EDI training within AIM Level 1. The feedback regarding this was rather negative. A few felt that it was too theoretical and did not provide practical strategies or approaches that they could embed in their practice. Others felt that the focus of the EDI was not balanced and did not reflect sufficient breadth of groups.

It was noted that families have relatively little knowledge of AIM prior to their child starting pre-school. Within ELC settings the INCO or manager seeks to share information with families to inform them of the support available to them through AIM. Whilst conducting face-to-face visits, PRs invited ELC practitioners in the setting to share documentary artefacts or other objects relevant to AIM and its implementation. Several examples of information sharing were identified. One setting displayed information about AIM, named the setting INCO and identified further contacts to families. In another setting, a poster about AIM was displayed clearly. This indicates the positive contribution that ELC settings can make to AIM Level 2.

AIM Targeted Support

AIM Level 4

ELC providers are able to support, advice and mentoring from the EYS through AIM Level 4 support.

- Some ELC providers described having a good relationship with their EYS who they felt provided high quality support.
- Some ELC providers feel that the EYS provides support to the pre-school setting and families.
- It was noted that the time available to individual ELC settings from the EYS was at times limited. Providers were aware that EYS have high caseloads, and this can delay access to support.

> 'They have supported us and the parents but there seems to be quite a lot for them to do and they do seem under pressure to meet the demands of services.'
>
> [Room leader, Urban community setting]

Some ELC settings felt that the support received from the EYS diminished after AIM Level 7 was awarded. This resulted in the child not receiving up to date learning goals, with some ELC providers describing setting their own or adapting old targets themselves. Greater support and guidance are required in order to ensure that where additional adult support is provided within AIM Level 7, that the maximum impact is achieved from this.

AIM Level 5

ELC providers have applied for AIM Level 5 in order to receive specialist equipment and resources as well as to fund adaptations to the physical environment. This is intended to support children to access the ELC setting.

- One setting described benefiting from financial support to allow them to make adaptations to existing equipment.
- Settings have also been able to invest in sensory equipment.

Delays in receiving equipment have presented a challenge to children's participation within the ELC setting:

- In one setting, delays in receiving a specialist chair resulted in it being too small for the child when it arrived. Staff also felt that they had not received enough training to adjust and use the chair.
- Another setting has been waiting 6 weeks for the delivery of a specialist chair. The child previously had a chair in their first pre-school setting but this has not been transferred over leading to a new application being required.

AIM Level 6

Currently the ELC providers studied, are not availing of AIM Level 6. Some ELC providers felt that they had no knowledge of AIM Level 6, including who was eligible and how you could apply for support. During conversation with the PR, a few ELC practitioners expressed that they would need to 'look up what AIM Level 6 is'.

There is felt to be a lack of communication to pre-school settings regarding therapeutic support. Where children have access to therapy externally to AIM, the pre-school setting does not receive information and relies upon parent/carers to share this with them. A few ELC practitioners felt that their previous experience of gaining information about therapies from parent/carers had not been straightforward and they did not feel they received clear information and strategies. It was also identified that whilst parent/carers are on the waiting list for therapeutic services outside of AIM, the ELC setting receive no support or information to support the child's needs during this waiting period. This was described by some ELC practitioners as reflecting a lack of collaborative practice which leads to a fragmented system of support.

In their case studies, PRs provided evidence that practitioners would like to engage with therapeutic services in the future to support the needs of children in the following ways:

- To try to get the processes in place to engage with a multidisciplinary team to support inclusion for each child through engagement with OT, Physiotherapists and Public Health.
- To provide additional support regarding the medical needs of children in the ELC setting where the EYS is not able to advise.

One ELC provider had previous experience of receiving therapeutic support for a child in 2019. They described this as being highly beneficial to support the needs of a child with a hearing difficulty. The child was already known to the HSE so this may have facilitated access to support. The pre-school setting was visited by an occupational therapist (OT) and a speech and language therapist who conducted observations. Advice was provided to support the child to engage with his peer group during play. However, it was noted that the ELC setting was not able to access support directly; therapeutic support was provided to the child with the family having to act as a conduit to share

information. From conversations with participants in the setting, the PR notes that there was no collaboration between the ELC setting and the therapist.

AIM Level 7

The accumulated evidence from the case studies indicates that AIM Level 7 was viewed by most practitioners as being the most valuable support to the setting. For some practitioners, having AIM Level 7 support in the setting has allowed children who may not otherwise have been able to, to access a mainstream pre-school setting. Amongst the ELC providers there were differences in the ways AIM Level 7 support was used.

In some ELC settings, an additional adult is employed to provide support for the room:

- Some practitioners spoke of using the additional adult to reduce the ratios in the room.
- The additional adult was described as allowing shared support to be provided across the team.
- Small group work and interventions that are beneficial for several children can be led by an additional adult during session time.

In some ELC settings, AIM Level 7 support was used to provide 1:1 support for the case study child. This was described within the case studies as follows:

- When providing support for a child with diabetes it was felt that 1:1 support was required in order to manage his medical needs. However, this was not seen as a barrier to inclusion with his peer group. The ELC practitioners in the setting encouraged children to learn about his medical condition. Mealtimes were also used as an opportunity for the child to build relationships with his peer group. It was also noted that all staff in the setting worked as a team to provide support across the room.
- One child displayed some challenging behaviours, including presenting a flight risk. It was identified that they required 1:1 support to maintain their safety. Practitioners felt that this was inclusive as it supported the child to remain in the setting and participate in activities.
- For most children, 1:1 support was provided at certain points during the day in response to their individual need. For example, to provide a 20-minute daily speech and language intervention.
- Where children require significant periods of 1:1 support during the session, settings describe sharing this support across the staff team.

Taken together, it appears that ELC providers understand the purposes of AIM Level 7. However, they are each using the support of the additional adult in a way that they feel responds to the child's individual needs. One ELC provider explained that they found the support provided within AIM quite generic and that they were required to adapt and adjust the supports that they provided. This was described as taking a 'trial and error' approach at times.

Evidence within the case studies indicates that some ELC providers experience barriers to implementing AIM Level 7. Some settings have staff vacancies that remain unfilled. It was also identified that there were delays in the application process which resulted in children having to wait to receive AIM Level 7 support.

Stakeholders' views on the use of AIM support in settings. Practitioners' accounts show that AIM targeted Supports are being used extensively by settings to support inclusion and meaningful participation and to respond to additional needs and/or disability. AIM Level 7 was viewed by ELC providers as being the most valuable support to the setting, and it was felt to unlock access to mainstream provision. Examples were found across the child and setting case studies of AIM Level 7 being implemented in the following ways:

- Some practitioners spoke of using the additional adult to reduce the ratios in the room.
- The additional adult was described as allowing shared support to be provided across the team.
- Small group work and interventions that are beneficial for several children are led by an additional adult during session time.
- Support for medical needs was provided on a 1:1 basis.
- Some behaviours were felt to require 1:1 support to maintain children's safety. Practitioners felt that this was inclusive as it supported the child to remain in the setting and participate in activities.
- For most children availing of AIM Level 7, 1:1 support was provided at certain points during the day in response to their individual need. For example, to provide a 20-minute daily speech and language intervention.

AIM Level 5 has been used historically to allow adaptations to the physical environment to ensure accessibility. Pre-school settings appear to have little demand for AIM Level 5 equipment but when this is required significant delays are reported. AIM Level 6 on the other hand was not used in any of the pre-school settings. This presented a significant gap from practitioners' perspectives. Some ELC providers had no knowledge or understanding of the purpose of AIM Level 6, nor the application process. Where children had availed of therapeutic support, this was entirely external to the pre-school setting. ELC providers would welcome engagement and collaboration with the HSE to increase their knowledge and understanding, and therefore enhance inclusive practice.

There is evidence that AIM universal supports are well embedded within the case study settings. Engagement with training and CPD was reported to be high, whilst 11 of the 13 settings had an INCO. The following examples show how AIM support has been implemented in settings to promote meaningful participation and full inclusion of all children:

- Use of resources within the universal provision including timers to support turn taking, visual timetables to support transitions within the session and massage brushes to calm and support self-regulation.
- Information was shared by pre-school settings in the context of AIM Level 2 both verbally and through documentary artefacts. Parent/carers and practitioners identified the significant role the setting, and INCO, played in disseminating information.

Overall, when considering how the levels of AIM are implemented and perceived, the evidence from the case studies indicates that the combination of universal support with personalised AIM Level 7 support is particularly effective in securing the meaningful participation and full inclusion of children with additional needs and/or disability.

Views on the benefits of AIM for children, parents, families, staff, and the setting

Overall, most ELC providers spoke of the role of AIM in changing relationships within settings. Some ELC practitioners spoke of AIM as helping to foster a sense of community which centres around the ELC setting.

Benefits to children

All participating settings believed that AIM had a positive impact on all children within the setting. It was described that the inclusive environment allowed children to:

- Developing greater understanding and empathy for the needs of others.
- Develop relationships with a range of peers from their local community.
- Children grow in confidence and build trusting relationships with others.
- Access scaffolded support to enable progress toward individual goals and targets.
- Be supported to access all areas of the pre-school through the provision of specialist equipment or adaptations to the environment.
- Small steps progress is made, and individual children's achievement is celebrated.

ELC providers felt that the AIM programme works well to support the needs of most children. The provision of an additional adult within the room through AIM Level 7 was deemed to allow greater access to adult support. This was felt to provide greater opportunities to participate, whilst ensuring that this engagement was meaningful. Some practitioners felt that the provision of AIM Level 7 support allowed all children to attend a mainstream pre-school setting if their family chose this.

> 'Meaningful participation means that the child will not just come in and do their own thing and sit in a corner, that you are actually there with them and that you're helping them participate and socialising with other children and helping their development and that they get their time within the pre-school setting.'
>
> [Manager, rural private setting]

During the child case study visits children's maps, engagements with practitioners and peers and playful interactions with the PR revealed that the benefits of AIM they experienced:

- Children's emotive responses were highly indicative of their feelings of meaningful participation and full inclusion. This included excitement, happiness, and engagement during playful interactions with others.
- Not all emotive responses required facial expression or verbal communication. Some children expressed their feelings through shared gaze and the initiation of physical contact to peers and familiar adults.
- Children viewed the practitioners as a caregiver who could provide help and support, including for emotional and physical needs.
- Children's range of communication methods were recognised and responded to sensitively. For some children physical contact provided a means to communicate and express feelings, whilst for others it provided calming reassurance.
- Physical proximity to the practitioner provided a sense of security for some children.
- Children's interests and preferences were acknowledged and responded to by practitioners and peers.
- Most children referred to a friend.
- Children with additional needs/and or disability initiated or engaged in play with their peers.

- Children became highly engaged with resources and provision which enabled shared and parallel play.

At times during the case study visits children's meaningful participation and full inclusion was constrained. This occurred where:

- Children needed behavioural support that required practitioner intervention on a 1:1 basis in segregation from peers and the main session activity. Although practitioners worked hard to redirect children to another activity and praised positive interaction, the situation was challenging at times and became the focus of additional adult support within the context of AIM Level 7.
- Children were still developing their use of a shared language or alternate means to communicate their needs or feelings with their peer group or the practitioner.
- Where children communicated their discomfort, frustration or anger their meaningful engagement and full inclusion was contingent on the practitioners' sensitive response to the emotions displayed.

During the child case study visits, in all settings a range of strategies and approaches were observed which promoted meaningful participation and full inclusion for children. However, concerns remained amongst practitioners regarding the extent to which the current model of AIM was sufficient to support complex and/or medical needs. Children's behaviour towards their peers was at times felt to necessitate 1:1 support, including separating the child from their peer group. This suggests that the model of AIM in its current form is not as successful at meeting the emotional or behavioural needs of children who do not have a visible disability. Most ELC settings described AIM as being effective to in supporting mild or moderate needs but was less effective as a support for children with more complex needs.

Benefits to families

The building of positive relationships was identified as a key benefit for families. Some ELC providers identified that this had been more difficult during 2020 and 2021 due to the Covid-19 pandemic. This reduced the opportunity for informal conversations and allowing families in to the ELC setting has been more difficult to facilitate.

ELC providers described AIM as having the following positive impacts upon families:

- AIM fosters an ethos of respect and care for families and their children
- The commitment to inclusion within AIM is supportive of positive everyday interactions and relationships between ELC practitioners and families
- Families can see that their child is receiving support and is included in a mainstream pre-school setting. This has helped to build confidence.
- The fact that AIM is not diagnosis-led was felt to encourage families to engage.
- The lack of requirement of a diagnosis allowed families to access supports quickly.
- It was felt by a few practitioners that receiving AIM Level 7 made it more likely that a child would receive SNA support when they started primary school. This was viewed as supporting transition between the two settings.

In some ELC settings, practitioners share information about the child's engagement in the setting through the use of 'Learning Stories'. This is identified as being beneficial as it allows families to see the progress the child is making and feel confident that the child is well-supported and included within the setting. This approach could to information sharing could be adopted in other ELC settings to foster positive communication between practitioners and families.

In some of the ELC settings, parent/carers were present and spoke to the practitioner researcher. They felt that AIM had a positive impact on them and their child as:

- Knowing the support their child needed was available to them brought peace of mind.
- They felt relief that someone else was aware of their child's needs and could offer advice and support.
- Being able to access high-quality pre-school care for their child, allowed them time to attend to their other family caring commitments.
- One parent/carer spoke of the change she had seen in her child, 'her better speech has helped with her frustrations'. This had a positive impact on her family life at home.
- One parent/carer felt that engagement in pre-school had a positive impact on their child outside of the pre-school setting and allowed them to engage with others in the wider community.

Benefits to ELC practitioners

Through engaging with AIM, ELC providers expressed that they were more able to open their setting up to children with a range of needs. One practitioner expressed that because they know they can apply for AIM if required 'they never have to turn a child away'.

ELC providers felt that AIM had a positive impact on all staff working within the setting. They felt supported through greater access to training and ongoing contact with their EYS. ELC practitioners identified that the EYS worked hard to provide information regarding the steps the setting can take to make the setting more inclusive and ensure the participation of all children. Some practitioners felt that this contribution shaped the way they operate on a daily basis.

It was identified that engagement in AIM provided benefits to practitioners in the following areas:

- Staff have become more reflective practitioners.
- AIM encourages the sharing of ideas and working as a team.
- The ELC setting as a whole benefits from having an additional adult employed through AIM Level 7.
- The ELC setting have greater access to resources, including funding where specialist equipment is required.
- ELC practitioners have access to advice and support, through the EYS.
- ELC practitioners have greater confidence to identify emergent needs.
- ELC practitioners feel more able to signpost support to families.

Overall, the majority of settings see AIM as a key catalyst for the development of inclusive practice. In contrast, some settings see AIM as providing enrichment and support for the inclusive practice that was already taking place prior to 2016; the key difference that AIM has made is that there is a greater structure to the support that they can now access to meet the needs of children. **Together the findings provide evidence that AIM has enhanced inclusion in the pre-school settings studied.**

Stakeholders' perspectives on the benefits of AIM for children, parents, families, staff, and the pre-school setting are summarised in the proceeding text box.

Stakeholder's views on the benefits of AIM

In summary stakeholders' view of the impact of AIM on children, parent/carers, and settings is as follows:

- AIM is supportive of practitioners' desire to build a sense of community between the pre-school setting and families.
- AIM is achieving a positive impact on the inclusion and meaningful participation of all children.
- The impact from children's perspectives centered on the formation of positive, reciprocal relationships with practitioners and peers. Where this occurred, children's feelings of meaningful participation and inclusion were expressed through their physical and emotive responses.
- AIM Level 7 support was viewed as incredibly important, for some practitioners this marked the difference between the child being physically in the setting and being able to participate meaningfully.
- AIM's impact on parent/carers has been to provide reassurance that their child's additional and/or medical needs will be met.
- The impact of AIM on settings has been to increase knowledge, experience, and professionalism about how to support children with additional needs and/or disability.
- There were mixed views amongst stakeholders regarding the relationship between the type of additional need and the extent to which AIM is impactful. Whilst some practitioners felt complex and/or medical needs were not as well supported through AIM, parent/carers felt that their child's physical wellbeing and medical needs were met well.
- Some practitioners expressed the children's emotional and behavioural needs were not well supported in the context of AIM Level 7. This was supported by findings from the child case studies, where some children were observed to require significant amounts of 1:1 support which segregated them from their peer group.

Views on the aspects of AIM that are working well within the setting

In identifying the aspects of AIM that work well, settings drew upon their range of prior experiences of providing support to children. A key theme which emerged across the child and setting case studies was the provision of universal and targeted support by all members of staff within the setting.

Where a 'whole team approach' has been taken in the context of AIM, most practitioners in the pre-school settings studied believed that this provided good levels of support. This enabled all staff within the pre-school setting to build relationships with the child and develop a shared understanding of their strengths and needs thereby contributing positively to meaningful participation and full inclusion of children.

As a result, practitioners perceived that the aspects of AIM that work particularly well are those which contribute the ability of the team to respond to need, namely through training and development opportunities.

Support from the EYS

The support of the EYS was viewed positively by most ELC providers. They gave the following examples of positive engagement and support from the EYS:

- ELC providers spoke positively of receiving advice and strategies to support the needs of children within the pre-school setting.
- Meetings have been organised in some settings with the EYS, parent/carer and ELC practitioners present. This works well as strategies can be co-created and used at home and within the ELC setting.
- In some settings, the EYS has conducted phone calls with families to explain AIM and the type of support that can be provided. This has been particularly beneficial where families have no prior knowledge of AIM.

However, PRs reported evidence of practitioner calls for a rolling programme of CPD, since this would maintain consistency in the quality of support provided. Some ELC providers noted that where they had experience of working with two different EYS, that the quality of support and advice was inconsistent.

Training and CPD

In most settings, practitioners were reporting that staff need to feel that they have the skills and knowledge to support inclusive practice. At times it can be a challenge to get the correct training due to limited time and availability. The following training opportunities were identified as having a positive impact on developing ELC practitioner skills and knowledge:

- Hanen training was described as being very good, however, some ELC providers would prefer a more hands-on workshop approach.
- ELC providers praised Lámh training.
- SPEL training was identified as beneficial as it reflected targeted training to meet specific needs. ELC practitioners would like to receive further specialist training.

ELC providers identified that they would like to see further refresher courses being rolled out in the future to provide ongoing support for practitioner development. It was noted that in order to avail of some AIM Level 3 training, such as Hanen, it was required that the setting be already engaging in AIM targeted support. Some ELC providers would like wider access to the training for all staff.

A summary of stakeholders' responses regarding the aspects of AIM that are working well are presented in the following text box.

Stakeholders' views on the aspects of AIM that are working well in the setting

In summary, ELC providers felt AIM worked well when the staff team were able to work together to support children. This enabled all staff to developed knowledge and understanding of the strengths and needs of children who have additional needs and/or disability.

The team approach was facilitated through training and CPD within the context of AIM Level 1 and 3, in conjunction with mentoring and support from the EYS in the context of AIM Level 4:

- Practitioners valued opportunities for joint engagement with families and the EYS. They would like this approach to continue.
- Co-creation and sharing of strategies were identified as a crucial factor in providing personalised support.
- There is a desire to learn and maintain knowledge amongst the ELC workforce. The provision of further refresher courses increased availability of CPD opportunities would further strengthen practitioner confidence and expertise.

Views on the aspects of AIM that are working less well within the setting

The case studies include valuable data on how practitioners within settings were reflecting on their experiences of AIM since it began in 2016. They report a number of areas where further improvements could be made which include:

- Communication with families
- AIM application processes
- Recruitment and retention of staff
- Collaboration with healthcare
- Further training and CPD opportunities

Communication with families

Communication was identified as a challenge and ELC providers felt that this needs to improve if AIM is to succeed. During interview, practitioners identified the following barriers to effective communication with families about AIM:

- The lack of knowledge and understanding that parent/carers have regarding AIM prevents them from raising initial concerns about their child.
- For some families 'disability' and 'additional needs' are still seen as a taboo subject.
- Some practitioners felt that the word 'disability' was not in keeping with AIM being non-diagnosis led.
- ELC providers felt that the language used to provide information to ELC practitioners and families' needs to be simplified as they do not always understand the different types of support available within AIM.
- Further support is needed for families who speak English or Irish as an additional language. ELC providers identified that it can be very challenging to communicate to families about AIM. Having information and leaflets available in a range of languages was suggested as a potential solution.

PRs reported that pre-school settings can find their role challenging when managing parent/carers' expectations regarding the provision of AIM support. Where they identify emergent needs, ELC providers can encounter resistance as families are not ready to have conversations about their child requiring additional support. Some ELC providers described families as fearful, and this was felt to be due to a lack of knowledge and understanding of AIM. ELC providers felt that the focus should be on supporting individual needs as AIM is not diagnosis-led, rather than communicating to parent/carers that their child has a disability. Equally, some pre-school settings were reported to encounter challenges where they are not able to provide the type of support that the family feel their child needs. Pre-school settings related that some parent/carers thought AIM Level 7 support would provide 1:1 support for their child.

At times, where pre-school settings are not able to support a child, they believe that they are not able to share their concerns. Whilst the ELC practitioners expressed their commitment to inclusion, there felt that they were not able to say that the ELC setting did not have the right level of support to meet the needs of the child. This suggests that the current model of AIM is not felt to be specialised enough to meet the needs of all children.

> 'The staff feel that they don't have the knowledge or skillset to provide the care sometimes.'
> [Room leader, urban community setting]

Illuminating data within the case studies illustrated that most families are unaware of AIM until their child starts attending pre-school. It was suggested that families would benefit from receiving information about AIM much earlier. Some ELC providers felt that families should be informed about AIM as soon their child has their developmental check. This could form part of the assessment for all children. AIM should be explained in simple terms so that parent/carers are aware that should their child require supports when attending ELC services, that they are available within AIM. It was hoped that communicating about AIM earlier would increase awareness.

AIM application processes

ELC providers felt that the application process needs to be simplified and streamlined. Currently, ELC providers experienced the following challenges in relation to the AIM application process:

- There can be delays in the EYS coming to visit the setting, with some ELC practitioners stating it takes around 6-8 weeks before someone can visit the setting to observe the child as part of the application process.
- Some ELC providers felt that there are currently not enough EYS in their County area.
- The application process was described by some ELC providers as being overly generic.
- Where a child joins the setting from another setting, a new application for AIM support is required. Participants feel that the AIM funding and paperwork should follow the child as opposed to the new service having to apply all over again.

The majority of ELC providers described completing the AIM application form with the family of the child. Whilst some practitioners found this to be a relatively straightforward process, others found the wording of the form quite 'harsh'. It was identified that some families did not recognise their child in the wording of the form when asked to identify the extent of the child's needs.

It was also identified that within the application process there can be times where the ELC provider does not feel believed. They described feeling that they are having to 'fight' to receive the correct support for the child. This suggests that there is a lack of respect for the professional judgement of ELC providers. The following observations were made with regards to the AIM Level 7 application process:

- One ELC setting described having to lie about the ratios in their pre-school room in order to receive the AIM Level 7 support that they felt was required.
- Some participants felt that shared supports, where one additional adult is required to provide support to more than one child, were not suitable to meet the needs of the child and have a negative impact on meaningful participation.
- One ELC provider identified that they had to appeal in order to receive funding for a second additional adult for the room. This enabled them to staff the room with 3 adults to 8 children ratio which is highly unusual.
- A few ELC providers felt that certain areas or types of need were prioritised over others. Children with a physical disability or more than one area of need were felt to be more likely to receive support, than a child with only one area of need.
- Children with challenging behaviour were felt to be overlooked by the current system.

The application process associated with AIM Level 5 was felt to take too long and be overly complex. In one ELC setting, a specialist chair took so long to arrive that it was too small for the child. In another example, a child has transferred to the service from a different ELC setting. The specialist equipment they had used has not been transferred and the ELC provider has had to make a new application. The setting and child are currently waiting for the new equipment to be delivered. Collectively the response of ELC providers suggests that they do not feel that the application and assessment process is fair and equitable. It was felt that fighting for support, appealing against decisions, or making false claims, could improve your chance of receiving AIM Targeted support. However, this could be seen to unfairly privilege some settings over others, further increasing the lack of parity amongst settings.

Recruitment and retention of staff

Poor pay and working conditions are reported to make it hard to recruit staff across the ELC sector. This disproportionately affects children with disabilities or additional needs. ELC providers report that they have very few applications for additional adult roles associated with AIM Level 7. Some ELC providers suggested that widening the qualification profile for those who are able to fill the additional adult role would increase the number of applicants and potentially the skill set within the workforce. Currently, a QQI Level 5 Childcare qualification is required. However, it was suggested that an SNA qualification or degree in a related area could also be acceptable to providers if this were permitted within the AIM programme.

Limitations were identified in relation to the funding available to settings. ELC providers felt that the sector as a whole was undervalued and underfunded and that AIM alone was insufficient to redress this. This was reported to be a particular challenge when covering staff costs associated with AIM Level 7:

- Some ELC providers described having to access the Employment Wage Subsidy Scheme (EWSS) in order to cover staff wages.
- ELC providers felt that the current funding for AIM Level 7 is insufficient to cover the costs of employing a trained and experienced member of staff. Pre-school settings are having to cover the shortfall in funding themselves in order to recruit staff.
- Whilst the settings are waiting for AIM Level 7 to be awarded, they must cover the costs of an additional adult and this money is not reimbursed. This places the setting at a financial disadvantage if they offer an inclusive service.

Collaboration with healthcare

Evidence in the 14 case studies indicates that the majority of practitioners perceive that they do not currently have the training they need to provide an inclusive service to children with complex medical needs. Although support is offered by the EYS, they do not have specialist medical expertise. As AIM is not diagnosis-led, it can be difficult for a service to ensure that the correct care is provided for that child.

ELC providers identified that they would welcome the support and advice of HSE staff in creating a more holistic experience of support for the child, including a cross over curriculum. In a few case studies, practitioners were reporting that they had several children in receipt of speech and language therapy attending their setting, however, they had not received a visit by the therapist to the setting itself. It was felt that if the therapist could visit the setting, they could offer specific advice regarding the children's needs as well as model interventions and strategies.

The settings studied had children on roll with diagnosed medical conditions including epilepsy and diabetes. PRs reported that providers needed to rely on previous knowledge or source their own training to meet the child's needs safely. For example, the setting attended by a child with epilepsy were very concerned for the child's safety should she have a seizure in the setting and took it upon themselves to ensure that all staff were knowledgeable and informed on the correct procedure to follow when administering the required anticonvulsant medication. ELC providers questioned in this setting, and the setting attended by a child with diabetes, suggested that AIM Level 6 might be better monitored for the extent to which it was present and effective as a support for settings who had children with medical needs.

Further training and CPD opportunities

ELC providers felt that AIM should be available to support all children in the pre-school setting. However, they feel that they need further training in order to support the range of needs children in the ECCE programme have. When referring to the existing training they have received:

- Some ELC practitioners expressed that the level of training currently offered was too low and did not sufficiently extend upon their existing knowledge.
- ELC practitioners prefer training that is hands-on and practical rather than theoretical.

ELC providers working in small settings, typically run by an Owner-INCO, identified that the practitioners working within the setting were often at a disadvantage as they had less access to training and CPD. Training, such as the LINC programme, was usually undertaken by the Owner of the setting as only one person may attend. This has a negative impact as the Owner-INCO must occupy several roles whilst other staff do not have opportunity engage in professional development. It was identified that training should be opened up to allow more staff to engage, through removing limits on the numbers of staff who can attend per setting.

Participants identified that they would benefit from further training and support in the following areas:

- Support for children with complex medical needs
- Further training on supporting children with autistic spectrum disorders (ASD).
- Music and movement. Practitioners felt that this would be beneficial to support the expression of children who are non-verbal.

- Support for working with families and children who speak English or Irish as an additional language. ELC providers identified that it can be very challenging to communicate to families about AIM and they would welcome support in this area.
- Further training specific to the additional adult employed within AIM Level 7, in addition to their QQI Level 5 qualification. Hanen training or a module to allow progression toward a full Fetac Level 5 qualification would be beneficial.
- Some ELC providers suggested that one way to increase the level of expertise within the setting could be to employ staff with alternate qualifications outside of Childcare.
- Many ELC settings offer after-school care for children over the age of 6 years. However, the current training and CPD they have access to does not include information regarding support and strategies for older children.

Overall, ELC providers spoke of a need to be able to liaise with an external team who can provide and advice on how best to support the individual needs of a child, irrespective of their age. It was identified that this would further support inclusive practice.

A summary of stakeholders' priorities for the development of the AIM programme are presented in the proceeding text box.

Stakeholders' views on the aspects of AIM that are working less well

Practitioners in most of the settings studied were observed to identify a range of areas for development in the AIM programme; key among these are the recruitment and retention of staff, and acknowledgment of the increased burden of workload on settings.

Communication to parent/carers regarding AIM was viewed as challenging and felt to result from the lack of external information provided to families prior to their child starting pre-school. Practitioners felt that AIM should be framed as a model of support, rather than a response to 'disability.'

The lack of availability of AIM Level 6 support is cause for concern among practitioners and is thought put AIM's goals of full inclusion and meaningful participation at risk. ELC providers would welcome opportunity to collaborate with therapists in order to embed strategies into their existing practice.

ELC providers felt that training and CPD currently privileges owners and managers and should be widened to meet the needs of the wider ELC workforce. Practitioners identified a series of areas where they would benefit from further training and support:

- Support for children with complex medical needs
- Further training on supporting children with Autistic Spectrum Disorders (ASD).
- Communication methods for children who are non-verbal, including music and movement.
- Working with families and children who speak English or Irish as an additional language.
- Further training specific to the additional adult employed within AIM Level 7, in addition to their QQI Level 5 qualification.
- Meeting the needs of children over the age of 6 years who may access the setting in after-school care.

Views on participation and non-participation of AIM

ELC providers identified that families who have knowledge of AIM and a positive relationship with the setting are more likely to engage in AIM. Having clear information provided allows parent/carers to conduct research and make an informed decision regarding AIM. One parent explained that that prior to their child starting pre-school they had been worried and 'stressed to bits over her starting'. They had not been aware that AIM existed, but once the ELC provider informed them they felt this could provide the extra support their child needed. The parent felt that since this point, she had 'peace of mind' whilst her child had 'come on leaps and bounds'.

Where parent/carers were knowledgeable about AIM, this came from their previous engagement in either another pre-school setting or with healthcare. In such instances, parent/carers became strong advocates for their child's right to access mainstream education. Examples of this were found where the parent/carer:

- Privately funded an assessment to ensure that their child's needs were identified (CS8)
- Engaged in transition activity and meetings with the ELC provider to ensure that the setting was well informed regarding their child's needs (CS4)
- Took legal action through a solicitor to secure their child's right to an overage exemption. In this instance, the mother described being 'made to feel like you're lying' (CS9)

ELC providers felt that participation in AIM is supported by the presence of an INCO within the setting. Parent/carers were described as happy to discuss their child's progress with the INCO as a central point of contact. This made it easier for the ELC practitioners working within the setting to share information with families. It was also identified that having a single point of contact enabled consistency, reduced the need for parent/carers to repeat messages to several different people and made it easier for ELC practitioners to share any concerns or observations they had made of the child.

ELC providers identified that families engage in AIM as they want their child to receive support and have the opportunity to engage in a mainstream pre-school setting. For parents/carers who have concerns about their child's development, or have identified that their child has individual needs, AIM can come as a welcome support. It was also identified that families experience long wait times for therapeutic supports and assessments outside of AIM. During this time, the provision of AIM can provide targeted support for the child's emergent needs without the need for a diagnosis.

Perspectives on non-participation

ELC providers expressed that some families do not wish to engage in AIM as they feel upset and overwhelmed. It can be a sudden and shocking message for families to hear that there is a concern about their child's development. Some practitioners identified that families can be put off by the use of the term 'disability' and this contributes to non-engagement. In one setting, the ELC provider had to write a letter to accompany the application for AIM Level 7 support that expressed explicitly that the child was not viewed as having a disability in order to gain the consent from the family to make the application for support. Some practitioners felt that they would benefit from further support when communicating to families about their child's emergent needs.

ELC providers proposed that engagement in AIM could be increased by framing AIM as equivalent to engaging in Speech and Language Therapy or OT. These are both accepted by parent/carers as a support for children whereas AIM is not currently felt to be viewed in the same way. Increasing parent/carer knowledge and awareness over time would help to increase awareness of inclusion.

ELC provider views were mixed regarding the reasons why settings may not engage in AIM. Most practitioners stated that they did not know of any setting who did not engage in AIM. On the other hand, some practitioners felt there were occasions when the setting did not feel they had the capacity to support the needs of the child. In a few of the case study settings, children with complex needs are only able to attend the setting for reduced days or a reduced number of hours. In one case study setting, AIM Level 7 support has been awarded but they have been unable to recruit a member of staff to provide support. As a result, the child's family has been informed that if no adult assistance is found in the next four weeks, the child will no longer be able to attend. The ELC provider has already suggested that the family might like to approach other local settings to enquire if they have more capacity.

Stakeholders' views regarding the participation and non-participation of families in the context of AIM are summarised in the proceeding text box.

Stakeholders' views on participation and non-participation in the context of AIM

In conversation with the PRs, stakeholders identified that participation in AIM was most likely to occur where families are informed and have a positive relationship with the pre-school setting. Where parent/carers are able to research and equip themselves with knowledge about AIM they become powerful advocates for their child's right to attend a mainstream pre-school setting.

Practitioners suggested that the reasons for non-participation were that:

- Families who had limited knowledge or understanding of AIM were put off by the language of disability they encountered in the application process.
- The setting did not feel they had the capacity to support the child, as they had either not been awarded individual support through AIM Level 7 or where unable to appoint an appropriately trained and experienced member of staff.

The majority of pre-school settings agreed that the solutions to non-participation lay in the provision of information regarding AIM to families prior to starting pre-school by the services and organisations they encounter from birth.

Views on whether AIM should be expanded

Overall, there was agreement that AIM should be extended to meet the needs of all children, for the whole time they are in the ELC setting. Whilst AIM seeks to increase inclusion by supporting the meaningful participation of children, it was felt that excluding certain age groups and placing limits on the number of hours that support is available presented a significant barrier.

For children within the ECCE scheme, it was felt that the number of hours AIM support can be provided for should be increased to cover all of the hours the child attends. It was noted that some children attend for longer than the three hour ECCE session and continue to require support. For some families, being able to avail of additional hours of pre-school care can provide respite and allow them to care for other family members. In addition, AIM support is not available during the summer holiday. This means that children with an additional need or disability may be unable to access

holiday clubs alongside their peer group. Most ELC practitioners felt strongly that children who qualify for AIM Targeted support should be supported throughout their time in the setting in order to secure their full inclusion and meaningful participation.

A few ELC providers felt that AIM should be scaled up or extended to meet the needs of children who speak English or Irish as an additional language. At present, it was not felt that AIM Targeted support could be used to meet their needs. One private setting in an urban city environment felt that they had many families who spoke a range of languages at home, but they did not receive enough support to cater for language needs within the setting. This observation poses an interesting challenge to AIM. Whilst the threshold for individual need may not be sufficient to require Targeted support, collectively the needs of the group of children may require greater capacity within the ELC setting.

Some ELC providers felt that AIM could have greater impact if the current model were extended to include younger children. Practitioners felt that this could increase participation in the ECCE Scheme as children would have access to early identification and early intervention. However, a minority of practitioners felt it could be challenging to identify the needs of young children or infants without prior diagnosis which was not in keeping with the AIM model. Some practitioners noted that many young children attend settings through the National Childcare Scheme (NCS) slightly before the age of 2 years and 8 months and miss out on being eligible for AIM supports. It was also identified that funding prior to AIM for a fixed term period could support transitions to pre-school for young children who are already in receipt of therapeutic supports or primary health care.

A mother of one of the children, Ruby, identified that AIM does not currently provide support for children with overage exemptions, who have delayed entry to primary school. The child had letters of support from a neurologist and physiotherapist which advocated the need for the child to receive one extra year of the ECCE programme however this application was initially refused. The ELC provider felt that overage exemptions were most common amongst children who avail of AIM, but there is no direct access to support for children entering a third ECCE year. It was proposed that AIM should be flexible and continue to offer support for children who require an overage exemption.

The transition from pre-school to primary school was referred to be some of the ELC providers and this is an area where AIM could be scaled up further. A few of the practitioners felt that ensuring that children received AIM Level 7 in the pre-school setting would make it more likely that their needs would be recognised on entry to primary school, leading to the provision of an SNA to support them in class. However, this presents as being linked to a lack of communication and continuity between the two different phases of education. One of the ELC providers identified that it would be beneficial for AIM to be carried over into primary school so that the work that has already been put in place to support the child continues. Whilst some settings have their own approaches to share information, for example through the creation of a 'learner passport' which lists the child's strengths and areas of need, there is no official approach adopted across pre-school settings for children who avail of AIM. As a result, it is proposed that further guidance is issued pre-school and primary school settings regarding information sharing, with the provision of a template or format to adopt to ensure that key information is captured and shared to support transition.

Some ELC providers also operate after-school care for children over the age of 5 years. It was felt that when the children return to the setting, they would continue to benefit from some support to meet their needs. This could take the form of additional training and CPD for practitioners. Some ELC providers feel that they are not able to meet the needs of older children and in some cases, this has resulted in the child no longer being able to attend after-school care. It was questioned why children could be deemed to require access to a 1:1 SNA during the primary school day, but not be deemed to require support during after-school care. However, it was acknowledged that it would be difficult to

recruit an additional member of staff to provide support during after-school care if this were for just one hour per afternoon.

The proposals stakeholders' expressed to the PR for the expansion of AIM are summarised in the text box that follows.

Stakeholders' views on the expansion of AIM

Practitioners and parent/carers agreed that the scope and remit of AIM should be expanded. Whilst AIM seeks to increase inclusion by supporting the meaningful participation of children, it was felt that excluding certain age groups and placing limits on the number of hours that support is available presented a significant barrier.

The scaling up of AIM is thought likely to increase full inclusion and meaningful participation and support children's transition into mainstream and special education. AIM could be scaled up successfully through:

- Inclusion of younger children, through AIM support and transition activity
- Enabling support to be provided outside the ECCE qualifying hours for children who attend full days
- Extension of the AIM model to after-school care, including the provision of targeted support and training to meet the needs of older children.
- Support for transition to school for children currently availing of AIM.

Whilst stakeholders perceived benefits for children and families in expanding AIM, they expressed that it is necessary to provide further training specific to the age range eligible for AIM to continue to develop a confident and competent workforce.

12.5: Summary

This subsection provides a summary of the findings in relation to the four key questions posed by the end of year three evaluation of AIM. To reprise, these are: From the perspective of the children and stakeholders (ELC providers, practitioners, parent/carers, EYS) who participated in the case studies:

- Is AIM effective in achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities and additional needs?
- Has AIM influenced practice, or increased the capacity of the workforce?
- Is the current approach appropriate in the national context?
- Should AIM be extended to School Age Care, hours outside ECCE and to younger children?

Each of these questions is addressed in turn, with reference to the findings from the child and setting case studies and the conclusions that may be drawn from them jointly. Section 13 combines the findings from all inquiry and data collection methods, to conclude on each of these questions.

Is AIM effective and achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities and additional needs?

The case studies demonstrated that in the majority of settings studied stakeholders communicated clear definitions of full inclusion and meaningful participation which held fidelity with AIM's principles as a programme. Full inclusion was associated with every child having the opportunity to participate in the life and activity of the setting, with the required adaptations being made to practice and provision to facilitate this. Meaningful participation was described as occurring where children are engaged in activities that engaged and interested them, alongside their peers.

When observing the positive impacts of AIM on children's inclusion, participation, and development, a tangible benefit was observed for most of the case study children. This was seen where:

- The child was able to access all areas of the setting due to adaptations to the physical environment (CS3).
- Activities were provided to encourage engagement between the case study child and their peers (CS1, CS10, CS6).
- Children were able to direct their play, confident in their ability to speak up and share their ideas and opinions (CS6)
- Personalised support, focused on the child's speech and language needs was provided in small group situations (CS7) as well as in the universal provision (CS10).
- The pre-school setting sought to develop greater understanding and awareness of the child's capabilities, interests, culture, language, and background (CS4).

This was mirrored in the spontaneous and scheduled conversations which took place with practitioners. They described positive developments to the children's:

- Progress towards individual goals and targets.
- Speech and communication.
- Relationships with a range of peers from their local community.
- Confidence and ability to build trusting relationships with others.
- Access all areas of the pre-school through the provision of specialist equipment or adaptations to the environment.

Parent/carers who participated in the case study additionally felt that:

- The pre-school setting responded sensitively to their child (3)
- Practitioners understood and nurtured their child's abilities and interests (1)
- They were confident that their child's medical needs and physical welfare were being met (2)

However, for a minority of children the impact of AIM was more limited. This was reported to be due to the lack of availability of targeted supports, necessitated by challenging behaviours:

- Shared support at AIM Level 7 was deemed ineffective to support children who displayed behaviour which required 'constant support'.
- A minority of ELC providers identified that although they were aware that AIM Level 7 was not intended to be used as 1:1 support, it was necessitated to ensure the safety of the child in the pre-school setting.
- One ELC provider described the challenge of striking a balance between meeting the needs of the individual child, whilst also responding to the other children in the room. It was suggested that at times other children in the room are worried by the behaviour they observe.

The findings suggest that for some children, AIM Level 7 is seen as the solution to managing behaviour. However, even where AIM Level 7 support is provided on a 1:1 basis to children during session time this can be described as largely reactive to behaviour that is exhibited rather than supportive of the underlying reason or needs behind the behaviour.

Stakeholders' perceptions of the effectiveness of AIM in achieving its intended outcomes of enabling meaningful participation and full inclusion of children with disabilities and additional needs are summarised in the proceeding text box.

Stakeholders' views on the outcomes of AIM

Stakeholders confirmed that in general AIM is effective in achieving its intended outcomes of enabling meaningful participation and full inclusion of children with disabilities and additional needs.

Significant, tangible benefits were observed through AIM for most of the case study children. This was seen where:

- Children were able to access and engaged in all areas of the pre-school environment.
- Activities were provided which encouraged positive engagement between peers.
- Children were confident and able to direct their play, speaking up and sharing their ideas and opinions.
- Opportunities allowed children to develop their speech and language skills in small group situations and across the universal provision.
- Activities within the universal provision responded to children's capabilities, interests, culture, language, and background.

AIM has a subsequent benefit to parent/carers as it provided confidence and reassurance that their child's needs needs were being met, and that children were being responded to sensitively by practitioners.

However, though all children benefited to an extent, for a minority of children the impact of AIM was more limited:

- Shared support at AIM Level 7 was deemed ineffective to support children who displayed behaviour which required 'constant support'.
- Although practitioners were aware that AIM Level 7 was not intended to be used as 1:1 support, they felt it was necessitated to ensure the safety of some children in the pre-school setting.

Whilst AIM is achieving its intended outcomes for the majority of children with additional needs, the support provided within the context of AIM Level 7 to a minority of children who have medical and behavioural needs requires further examination.

Has AIM influenced practice, or increased capacity in the workforce?

Overall, examples were identified across all of the child and setting case studies to demonstrate that AIM had influenced practice within ECCE provision. In the case studies of children, this was evident

through children's interactions with practitioners and peers, and their engagement with universal and specialist provision within the pre-school setting.

In the setting case studies, the influence of AIM on practice, and the perceived increased capacity instilled within the workforce was remarked upon by ELC practitioners and parent/carers.

When looking across the 14 child case studies conducted, the following practices were observed during face-to-face visits or reported in conversation to be present, and active within the pre-school setting:

Access to resources within the universal provision which provided choice, challenge, and support:

- Materials and resources provided to children reflected their interests and strengths, giving them choice in the activities they engaged in.
- Resources were present across the universal provision to support all children, and not reserved for children with additional needs/ disabilities.
- Children were given challenge to pursue their individual targets through provision which allowed them to develop skills in the context of a preferred activity.
- Use of visual resources and visual communication methods across the setting.
- Support to transition within the setting routine was provided through the use of timers and visual prompts.

Children were provided opportunities and supported to engage alongside their peer group:

- The ELC practitioner modelled and scaffolded play.
- Sensory activities were provided in most pre-school settings which were large enough for several children to join in at once.
- Group events, such as mealtimes, were assigned a structure and routine with visual prompts in one pre-school setting to make the experience accessible and enjoyable for all children.
- The positive attitudes modelled by staff were observed in children's responses to each other. Children cared about their peers and responded sensitively in their interactions.

An inclusive culture – staff commitment and expertise around inclusion:

- Practitioners took steps to engage and inform the wider peer group regarding medical and/or additional needs. This helped to normalise routines and increase awareness of diversity.
- Children were recognised as equal members of their peer group.
- Some ELC practitioner demonstrated awareness and understanding of children's different approaches to communication. Non-verbal communication and eye gaze was responded to warmly and praised.
- Practitioners sought to develop greater understanding and awareness of the child's capabilities, interests, and background.
- High expectations were held regarding all children.

The proceeding text box summarises stakeholders' perceptions of the influence of AIM on practice and the impact of AIM on developing workforce capacity.

Stakeholders' views on the influence of AIM

Practitioners confirmed that AIM has influenced practice. This was evident across the 14 child case studies through children's interactions with practitioners and peers, and engagement with universal and targeted provision in the context of AIM. There was evidence across the setting and child case studies of increased capacity in the workforce through increased knowledge and skills in supporting the diverse needs of children who engage in the ECCE programme. This was demonstrated through the interactions and provision within the pre-school setting:

- Inclusive play materials have been used by most settings and featured throughout the child case studies.
- Materials and resources within the universal provision afforded choice, challenge, and support.
- Children were provided opportunities to engage with their peer group, with appropriate modelling and scaffolding when required.
- Visual resources provided alternate means for communication.
- Routines and structure were clearly communicated through the use of timers and visual prompts.
- Practitioners consistently modelled high expectations and recognised children as equal members of their peer group.
- Practitioners demonstrated their interest in the child's capabilities, interests, and background through interactions with families and the provision of materials in the setting environment.

Is the current approach appropriate in the National Context?

Stakeholders' comments reported by the PRs suggest that AIM is appropriate in the National Context. Overall, AIM was viewed by most settings as a welcome addition to the ELC sector. PRs reported that most practitioners believed that it responded to children's right to attend a mainstream pre-school setting and access the ECCE programme.

Of the 14 setting case studies conducted, 8 presented broadly positive views regarding AIM and 6 had mixed views regarding AIM. Whilst the purposed and principles of AIM were well received and commented upon favourably by all participants there were mixed views amongst stakeholders regarding AIM's ability to achieve its expressed goals. The critical views expressed were as follows:

- AIM presents a 'one size fits all approach' to children, but in practice this does not work equally well for all children as there is a limit to the support provided within the context of AIM Level 7, and it may not be suitable for children with very complex needs (2)
- As ELC settings become more inclusive they will need to support increasing numbers of children with medical needs. There was felt to be limited support for settings regarding medical needs such as epilepsy and diabetes. Some settings expressed concern about the safety issues this created in the context of the Schedule 5 regulations (2)
- There is a lack of communication between the services who support the child in HSE, this hinders practice in the context of AIM (1)
- There is insufficient support for the training needs of practitioners in relation to complex medical needs and children who speak English or Irish as an additional language. (1)

- AIM does not adequately support children's behavioural needs (1)
- Delays in the assessment and application process for targeted support present a challenge to inclusive practice as practitioners do not have the funding and resources, they feel they need to support children (2)

Following lines of inquiry arising from the survey, stakeholders were asked whether AIM works more effectively for children with some types of additional need than others. The responses were as follows:

- Some ELC providers felt that AIM was flexible and therefore could be adapted to meet the needs of all children equally (CS4, CS6, CS8, CS10)
- AIM support was felt to be too generic and did not fully account for the diverse range of needs of children who may join the pre-school setting (CS2)
- ELC practitioners believed AIM was well equipped to support children with 'milder needs' (CS3)
- AIM was not felt to provide sufficient support for children with complex needs (CS3)
- Support for settings to manage medical needs was not felt to be provided in the context of AIM, pre-school settings have had to independently source training and/or information (CS1, CS3, CS9)
- The efficacy of AIM Level 7 support was felt to rely upon there being an additional adult available. Shared support was not felt to be sufficient to meet the needs of children (CS7, CS13).
- AIM was felt to respond well to visible, physical needs but did not respond so readily to behavioural needs that may fluctuate over time (CS12).

Areas that are working well

Overall

Across the 14 case studies, children were communicating that:

- They had opportunity to engage and interact with their peer group when they were playing or doing routine tasks like eating.
- They have a mutual, respectful relationship with at least one practitioner working within the pre-school setting.
- They have access to personalised support; sometimes this is experienced through support from an adult whilst at other times this is experienced through resources within the setting.
- There are ELC practitioners in the pre-school setting who provide a source of comfort and emotional support.
- They enjoyed being in the pre-school setting and held a positive disposition to learning activities. They communicate this through their physical and emotive responses.

Overall, children's perspectives on their meaningful participation and full inclusion demonstrate the value of developing an inclusive culture within pre-school settings. This was foundational and set the tone for all other targeted support that was offered additionally through personalised provision. For example, in the case of Ruby this was observed where an anti-bias approach was adopted in facilitating Ruby to develop autonomy, independence and confidence to express herself when initiating play with peers. Mary's case study on the other hand illustrated that the climate and culture within her pre-school setting was one which fostered secure, respectful, and reciprocal relationships.

When describing what is working well in AIM, stakeholders across the 14 setting case studies were observed to report the following, for each Level of AIM.

AIM Level 1 (An Inclusive Culture)

Through AIM, 12 out of 14 case study settings had accessed the LINC Programme. Most ELC providers felt that the LINC programme they attended had been good

The INCO role was identified as being a central point of contact regarding inclusive practice for families and practitioners. Having an INCO working within the ELC setting was described as beneficial as they can 'support and guide the team'. However, the INCO role carries significant responsibility for coordinating applications for support, observing children, and conducting meetings with the EYS and families. The INCO role was described as most effective where the member of staff received time to carry out their role. This can be achieved through not including them within the room ratios however there is currently no funding available to facilitate this non-contact time.

As ELC practitioner knowledge of inclusion has increased they have been able to incorporate a greater range of strategies into their practice. Some practitioners referred to using the resources from the AIM Inclusive play guide, explaining that these are used with all children in the setting.

AIM Level 2 (Information for parent/carers)

The ELC practitioners who engaged in the setting case study felt that the majority of parent/carers were unaware of AIM prior to their child starting in the pre-school setting. Exceptions to this observation were found where:

- Three children had transferred to the case study setting from another ELC provider. As the child had previously availed of AIM, the parent/carers understood what support their child needed and how to apply with support from the new setting.
- One child is due to start pre-school later in 2022. His parent/carers have a good knowledge of AIM as their older child already attends the pre-school setting and transition activity is underway to provide support for the child in place.

Despite the lack of prior knowledge of AIM, both parent/carers and practitioners felt that the pre-school setting provided clear information regarding AIM. They commented that the INCO was a key source of information for parent/carers and practitioners alike.

AIM Level 3 (A qualified and confident workforce)

The existing training that ELC practitioners have access to has been well received. ELC providers identified that staff need to feel that they have the skills and knowledge to support inclusive practice. The following training opportunities were identified as having a positive impact on developing ELC practitioner skills and knowledge:

- Hanen training was described as being very good by most practitioners, however, some ELC providers would prefer a more hands-on workshop approach.
- All settings who had taken up the Lámh training praised it.
- SPEL training was identified as beneficial as it reflected targeted training to meet specific needs. ELC practitioners would like to receive further specialist training.

Across all 14 settings, ELC providers talked about the importance of refresher courses being rolled out in the future to provide ongoing support for practitioner development. It was noted that in order to avail of some AIM Level 3 training, such as Hanen, it was required that the setting is already engaging in AIM targeted support. Some ELC providers would like wider access to the training for all staff.

AIM Level 4 (Expert early years educational advice and support)

Stakeholders had varied positive experiences of AIM Level 4. Of the 14 case study settings, 9 held positive views, 4 held mixed views and only 1 held a negative view. Where views were mixed, this was reported by the PR to be due to the lack of consistency provided following a change of EYS and the lack of contact and support provided following the award of AIM Level 7. Where a negative view was expressed, this was due to a complete absence of contact and support from the EYS.

The positive experiences of engagement with the EYS were reported as follows:

- Most ELC providers perceived that their EYS was supportive and approachable
- Some settings felt they had benefited from receiving mentoring from their EYS.
- Most ELC providers spoke positively of receiving advice and strategies to support the needs of children within the pre-school setting.
- A few practitioners described the positive impact of meetings between the EYS, parent/carer, and practitioner. This works well as strategies can be co-created and used at home and within the ELC setting.
- In some settings, the EYS has conducted phone calls with families to explain AIM and the type of support that can be provided. This has been particularly beneficial where families have no prior knowledge of AIM.

Overall, the findings demonstrate the valuable role of the EYS in supporting inclusive practice. EYS support is a complementary component to training and CPD offered within AIM Level 1 and 3 as it can respond to the individual needs of children and families in the context of the setting. An important theme emerging from the case studies as a whole, was how much practitioners valued opportunities to collaborate with others (EYS and HSE).

AIM Level 5 (Equipment, appliances, and minor alterations grants)

Across the case study settings there was evidence of previous engagement in AIM Level 5 through minor alterations to the physical environment. The influence of AIM Level 5 in creating an environment which is accessible to all children was also evident where funding had not been sought. This included:

- The provision of ramps to facilitate access to and from the outdoor area.
- Accessible outdoor areas with level access and pathways.
- A few settings identified that they have been able to invest in sensory equipment.

Within the case studies, only one child was currently availing of AIM Level 5 support. This had provided funding for a specialist chair.

AIM Level 6 (Therapeutic Supports)

None of the ELC providers or case study children had received HSE assessment or intervention through AIM. During conversations with the PRs, 4 settings explained that they did not know what

AIM Level 6 was and who it was for. One ELC provider is planning to make an application for AIM Level 6 to support a child who is due to start pre-school next year and did not mention the EYS role in this.

Parent/carers of 6 case study children explained that their access to HSE support had occurred external to AIM in one of the following ways:

- Paying for an assessment themselves (1).
- Through HSE because the child was already known to HSE services (5).

The stakeholders in all of the settings studied had not experienced Level 6 as an integrated AIM support, seeing it as something that was accessed outside pre-school via HSE services.

AIM Level 7 (Additional Assistance in the pre-school room)

AIM Level 7 was referred to frequently across the case studies and was availed of by 11 of the 14 case study children. The majority of stakeholders talked about it as the most beneficial aspect of provision which creates positive opportunities for inclusion, participation, and development in pre-school. To summarise:

- Some ELC practitioners spoke of using the additional adult to reduce the ratios in the room.
- The additional adult was described as allowing support to be provided across the team. This allowed members of staff opportunity to work closely with all children.
- Small group work and interventions that are beneficial for several children can be led by an additional adult during session time.
- Some parent/carers of the case study children expressed relief at knowing that there was support available to meet the needs of their child.
- The presence of an additional adult gave one parent confidence that their child would be safe when they were in the pre-school.

During the child case studies (CS), examples of the positive impact of AIM Level 7 on children were observed where:

- A child with medical needs was supported at mealtimes, in the context of a small peer group. The additional adult played a positive role in normalising a medical routine (CS1)
- Support from the additional adult was provided flexibly in response to need. At times this necessitated small group intervention to target an area of need, such as speech and language development (CS7)
- Where children had medical needs, the additional adult played a role in ensuring they were safe but not obstructed from playing with their peers (CS2, CS3, CS9)
- Relationships with other children were scaffolded and supported. This was effective where the practitioner was watchful and allowed children opportunity to negotiate in their play before intervening (CS9)
- The child had opportunity to withdraw from the main group activity and receive “in the moment” support in response to their emotional needs (CS5)
- The practitioner pre-empted events and activities the child may find challenging and sought to utilise visual and transitional resources to support the child pro-actively (CS8, CS13)

Areas that are in need of development

The case studies provide illuminating insights into how AIM could develop from the perspective of stakeholders within settings. These are reported for each of the AIM Levels:

AIM Level 1 (An Inclusive Culture)

ELC providers felt that the INCO role was hugely beneficial to the pre-school setting but was constrained by the amount of time available to the member of staff to undertake their role. The INCO role was felt to have most impact where release time was provided to allow the member of staff to undertake observations, meetings and completed required paperwork.

Some ELC providers felt that access to the LINC programme was limited and opportunity to engage should be scaled up:

- One ELC provider reported that they had applied 3 times, but not managed to secure a place.
- A few ELC providers felt that pre-school settings should be able to have more than one INCO in order to support inclusive practice across the pre-school setting.
- One ELC provider has chosen to employ two INCOs due to the high number of children on roll, but only receives funding for one post.

AIM Level 2 (Information for parent/carers)

ELC providers and parent/carers collectively expressed that the communication and information regarding AIM could be simplified and provided to families much earlier. A few ELC providers suggested that information about AIM could be provided to all families during their child's development checks, so that they had some awareness of it prior to the child starting pre-school.

It was proposed that the purpose and principles of AIM would be easier for families to access and understand if there was less emphasis on disability. Some ELC providers suggested that presenting AIM in the context of other, familiar therapeutic supports such as Speech and Language Therapy and Occupational Therapy would increase parent/carer confidence and acceptance of AIM as a positive source of support for their child.

AIM Level 3 (A qualified and confident workforce)

During the setting case studies, great interest was expressed in having access to more specialist training as part of a rolling programme of CPD. ELC providers who participated in the case studies prioritised several areas for further training and development opportunities:

- Meeting and managing the medical needs of children.
- Supporting speech, language, and communication needs.
- Providing personalised support for children with ASD.
- Support for children and families who speak English or Irish as an Additional Language.
- Further training specific to the additional adult employed within AIM Level 7, in addition to their QQI Level 5 qualification. Hanen training or a module to allow progression toward a full Fetac Level 5 qualification would be beneficial.
- Many ELC settings offer School Aged Childcare (SAC) for children over the age of 6 years. However, the current training and CPD they have access to does not include information regarding support and strategies for older children.

ELC practitioners felt strongly that training opportunities should be available to all practitioners, including the adult undertaking the additional adult role within AIM Level 7. It was perceived that currently, training and CPD prioritises setting owners and managers. However, this risks there being

gaps in skill and knowledge within the pre-school room for those staff who work most closely with children who have the highest level of need.

It was also observed within the child case studies that at times, the behaviour displayed by children was challenging and became the focus of AIM Level 7 support, rather than their learning and development. As a result, it is proposed that greater support is provided to ELC practitioners in managing behaviour either through AIM Level 3 CPD or through mentoring and modelling from the EYS within AIM Level 4.

AIM Level 4 (Expert early years educational advice and support)

Although most ELC providers felt that they had received positive support from their EYS, they had the following suggestions to improve the impact of AIM Level 4:

- EYS were perceived by practitioners to have very little time for each setting due to high caseloads. Increasing the number of hours contact provided to each pre-school setting would be beneficial as there would be greater opportunity to access support.
- COVID 19 was believed to have had a negative impact on EYS availability whilst the provision of telephone support was not viewed as equally beneficial as face-to-face contact. ELC providers hope that in-person visits will resume when possible.
- Some ELC providers felt that they received diminished support from the EYS following the awarding of AIM Level 7. The provision of ongoing support would be valued by pre-school settings.
- Some ELC providers identified that they had not received updated targets or goals from the EYS, so were having to devise their own.
- Due to COVID 19, EYS have had greater contact with families when conducting remote assessments. Most ELC practitioners and families felt that this was a positive experience and wanted this to continue in the future.

AIM Level 5 (Equipment, appliances, and minor alterations grants)

ELC providers expressed that there are currently limitations in the AIM Level 5 application process:

- Delays are experienced in the assessment and procurement of specialist equipment to meet the needs of children with a physical disability.
- Equipment to meet the needs of the child does not automatically get transferred over when a child moves from a pre-school in one county to a pre-school in another county.
- In one ELC setting, practitioners did not feel confident in using a specialist chair and did not feel they had been given sufficient training to adjust it.

The current limitations of the AIM Level 5 application process were observed ‘on the ground’ in Case Study 3 where a child had outgrown the specialist chair provided to the pre-school setting by the time it had arrived.

AIM Level 6 (Therapeutic Supports)

ELC providers and families felt that there could be much greater collaboration between therapists and pre-school settings. In two of the case studies, parent/carers were identified as being the sole source of information from therapists and were required to report to the pre-school what strategies and approaches were taking place in therapy delivered externally to AIM. This indicates that AIM Level 6

(universal) was not operating as a liaison between an EYS and the HSE as is structured in policy, but this may be because the pre-schools were not working with an EYS. A few ELC practitioners felt that their previous experience of gaining information about therapies from parent/carers had not been straightforward and they did not feel they received clear information and strategies. This implies that providers are not using AIM Level 6 (targeted) with the EYS to structure this liaison.

Attendance at an external therapist appointment during the pre-school session was observed to have a negative impact on the transition back into the setting for one case study child. From the child's perspective, therapeutic supports could have greater impact if there were greater links between the therapist and the pre-school setting.

It was also identified by both parent/carers and ELC practitioners that there should be greater availability HSE intervention (though Level 6 was not mentioned). Whilst one parent/carer was able to fund a private assessment for ASD, they remain on an external HSE waiting list for the therapeutic support their child requires. The majority of ELC providers expressed that they did not feel that AIM Level 6 was an option that was available for them to apply for.[94]

AIM Level 7 (Additional Assistance in the pre-school room)

ELC providers felt that there were currently limitations on their ability to use AIM Level 7 support. To summarise:

- The true costs of AIM Level 7 to the ELC provider are not felt to be met by the funding provided.
- ELC providers would like greater flexibility in the recruitment of staff to provide AIM Level 7 support. For example, in employing a member of staff with alternate qualifications to QQI Level 5.
- ELC providers would like greater flexibility in the hours staff are able to provide AIM Level 7 support.
- The current application system is felt to take too long. Some ELC providers experienced delays in the initial assessment taking place whilst a few felt it took too long to receive the outcome of their application.
- ELC providers report low numbers of applications for pre-school setting roles and state that they struggle to recruit a member of staff to fill AIM Level 7 posts.
- Where children move from one pre-school setting to another, the funding does not automatically move with the child. A few ELC providers expressed frustration as this meant they experienced delay in being able to provide the support that they and the parent/carer both knew the child needed.

Both ELC providers and families expressed concern regarding the use of shared support to meet the needs of children. It was described that where children have high levels of need it is not possible to meet these fully when an adult is also providing support to another child in the room. Within Case Study 13, this was observed to have a negative impact on the full inclusion of one child whose attendance was limited to one hour per session.

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[94] HSE have indicated that AIM Level 6 (targeted) is undersubscribed and hence the issue is not one of resource. This is another example of how participants' knowledge of long waitlists in the wider sector, impact on their engagement with AIM Level 6.

AIM in the National Context

Stakeholders' comments suggest that the goals of AIM are appropriate in the National Context. There is a high degree of consensus regarding the core principles underpinning AIM, with notions of full inclusion and meaningful participation felt to respond positively to children's right to attend a mainstream pre-school setting and access the ECCE programme. Practitioners and parent/carers report that children with a diverse range of needs are being supported to access ECCE through AIM and enabled to participate meaningfully. The use of AIM Targeted Supports at Level 7 are being used extensively and flexibly to include children with additional needs and/or disabilities. Support to reduce ratios is regarded as essential.

Children's perspectives on their meaningful participation and full inclusion demonstrate the value of developing an inclusive culture within pre-school settings. This was foundational and set the tone for all other targeted support that was offered additionally through personalised provision.

In spite of this, there were mixed views regarding AIM's current ability to achieve its expressed goals in practice:

- AIM presents a 'one size fits all approach' to children, but in practice this does not work equally well for all children
- There was felt to be limited support for settings regarding children's medical needs.
- There is a lack of communication between the services who support the child, this hinders inclusive practice in the context of AIM.
- AIM does not adequately respond to the behaviour displayed by children, beyond providing 1:1 support.
- Delays in the assessment and application process for targeted support present a challenge.

Practitioners were able to identify a range of areas for development; key among these are the recruitment and retention of staff, further training opportunities for the setting-wide workforce and acknowledgment of the increased burden of workload on settings. The lack of availability of AIM Level 6 support is cause for concern among practitioners and is thought put AIM's goals of full inclusion and meaningful participation at risk.

To what extent can/should AIM be scaled up and out?

ELC providers felt strongly that the model of AIM is good and could have greater impact if rolled out to include a wider range of ages and hours outside of the ECCE Scheme. Parent/carers on the other hand questioned why there were limits placed on the support their child was able to receive in the pre-school setting their child attended. Collectively, they prioritised the following areas for scaling AIM up and out:

- Provide greater opportunity for transition activity to take place for children joining the pre-school setting (before and within the ECCE scheme) and for those leaving the pre-school setting to enter primary education.
- For children within the ECCE Scheme, make AIM support available for all of the hours that the child attends the ELC setting.
- For younger children, support early intervention through allowing access to AIM support.

- For older children, stakeholders felt AIM could provide valuable support during after-school care. This could take the form of additional training to meet the needs of older children, or the provision of an additional adult to reduce the ratios in the room.

Stakeholders' perceptions of the scalability of AIM

Practitioners and parent/carers agreed that AIM can and should be scaled up and out.
The scaling up of AIM is thought likely to increase full inclusion and meaningful participation and support children's transition into mainstream and special education.
AIM could be scaled up successfully through:

- Inclusion of younger children, through AIM support and transition activity
- Enabling support to be provided outside the ECCE qualifying hours for children who attend full days
- Extension of the AIM model to after-school care, including the provision of targeted support and training to meet the needs of older children.

Practitioners felt that it is necessary to make improvements to the training offered to all staff and to continue to develop a confident and competent workforce.

13. Summary of findings and conclusions

This evaluation has explored the implementation and impact of the Access and Inclusion Model. The purpose was to build a picture of how well AIM was working from the perspective of multiple stakeholders, and in doing so, form conclusions to following research questions:

1. Is AIM effective and achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities and additional needs?
2. Has AIM influenced practice, or increased the capacity of the workforce to include children with disabilities and additional needs?
3. Is the current approach appropriate in the National context: What is working well and what needs to be improved overall and across all levels of AIM from the perspective of varied stakeholders?
4. To what extent should AIM be scaled up and out to include younger children, ELC outside ECCE hours, and School Aged Childcare (SAC)?

This section summarises the evidence related to each of these questions. For each question, conclusions are drawn from the findings. These conclusions are best read in the context of the full report. Inevitably, conclusory statements represent where the weight of the evidence lies, and where there is most consensus. However, in each section of the full report, we have tried to preserve the nuances and detail of varied participants' voices and experiences, whilst providing summaries throughout (in text boxes) and at the close of each section. This has been to support readers in navigating the key findings of the evaluation whilst being close to the original data.
When summarising findings, the following terms are used to describe magnitudes:

- **All** refers to every participant, and in the case of the quantitative data, 99% or 100% (to cover rounding errors)
- **Most** refers to more than three quarters of participants but not all, and in the case of quantitative data 75% to 99%
- **Majority** refers to more than half of participants, and in the case of quantitative data 51% to 74%.
- **Some** refers to between one quarter and one half of participants or 25% to 50%
- **Minority** refers to less than one quarter or 24%
- **Very few** refers to 1 or 2 participants or less than 6%

13.1: Is AIM effective and achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities and additional needs?

The evaluation has found that AIM is effective and achieves its intended outcomes of enabling meaningful participation and full inclusion for the majority of the children that it supports. It is also perceived to be benefiting most of these children. The evidence for this is clear. However, it is also clear that the extent of inclusion and participation experienced by children and their families is variable, and for a minority of children, it is not being achieved. These conclusions are supported by the evidence and key findings that follow.

Survey of parent/carers

In the survey of parent/carers, the majority of parent/carers (69%) agreed that their child was able to meaningfully participate and interact socially more frequently with other children as a result of AIM. Some (49%) agreed strongly with this. Survey data also indicated that:

- Most parent/carers (82%) reported that AIM had benefited their child, with the majority (52%) reporting this as being to 'a great extent', a minority (10%) reporting this to be 'a small extent', and 4% reporting no or negative impact.
- The majority (73%) reported that AIM had benefited them or their partner, and some (46%) that it had benefited their other children.
- Most (94%) of parent/carers agreed that the staff in their child's pre-school supported their full inclusion, and most (89%) reported that they were able to send their child to their first choice of pre-school.
- Preparation for school is reported as a positive outcome of AIM support by the majority of parents/carers (62%).
- A minority (15%) disagreed with the statement 'My child was able to meaningfully participate in pre-school activities.'

There were some statistically significant differences in perceptions about AIM's impact as follows.

In the survey, when asked to agree/disagree with positive statements about the inclusive culture at their child's pre-school, 83% agreed. Parents/carers were less likely to agree with the statement 'There is an inclusive culture at my child's pre-school (this means my child is included in learning)' if their child attended a setting in an urban area (56%) compared to a town (60%) or a rural area (64%). This difference is statistically significant. Additional qualitative and quantitative analysis was implemented to better understand the reasons for these differences, and these are reported later.

Those with children who have physical and sensory difficulties are significantly more likely to agree (93%) than those with emotional and behavioural disorders (81%), learning disabilities (85%), autistic spectrum disorders (82%), specific speech and language disorder (83%) and multiple main disabilities (85%).

Parent/carers of children with autism/autistic spectrum disorders are significantly more likely to disagree with the statement (10%) than those with physical and sensory difficulties. This is further indication of the difference in perception among parent/carers who have children with more visible disabilities/additional needs compared to those that are less visible and indicates how those with autism/ASD are more likely to have a variable experience. Further qualitative and quantitative analysis of the survey data was implemented to investigate these differences and the findings are reported later.

Parent/carers' positive perceptions of AIM

Content analysis of the survey's qualitative data showed that where parent/carers were positive about AIM's benefits to their children and family, they were often effusive in their praise, and gave the following reasons for perceiving AIM as beneficial:

Their child has developed and thrived

- Development in general (50) [95]
- Developments in practical skills that are important to independence (70)
- Developments in the emotional and behavioural domain (86)
- Developments in communication, social skills, and social confidence (461)
- Developments to general confidence (60)

Their child's wellbeing has improved:
- Seeing that their child is happier and more content (55)
- There were improvements to home life (12)
- The child's social skills and emotional wellbeing has improved bringing benefits to home life (179)

Their child's needs were understood and met (199)

They were feeling supported and less stressed, including at home:
- Parent/carers were feeling supported (24), and experiencing support that reduces parent/carer stress levels (36) helping them feel less isolated and anxious (285) and reassured that the right support is in place (286)
- Feeling informed (22) and able to access pre-school staff and other professionals (21)

Their child had the support they needed in place:
- Resources supporting the child's inclusion were in place (29)
- Learning about their child's needs and how to support them from pre-school staff and other professionals (36)
- There were reductions to the adult: child ratio that were key to bringing benefits (25)

Their child was included:
- Improved inclusion and participation (281)
- Their child could go to the local pre-school with their siblings (31)

Transition to school:
- Their child was more ready for primary school (63)

Parent/carers negative perception of AIM.

Where parent/carers were experiencing AIM negatively, analysis of the qualitative data identified the following reasons for these perceptions.

Inclusive Culture and Staff Knowledge:
- Parent/carers and/or the child did not get sufficient support in pre-school (34)
- Staff in the pre-school had negative attitudes to disability and/or the child (19)
- They experience settings to be unsuitable for the child and their needs, either following an enquiry or after a period in the pre-school (24)
- Staff in pre-school were perceived to be poorly trained (74)

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[95] Value is a prevalence count showing how many respondents gave this reason for their satisfaction with AIM

- Pre-schools will not accept their child because of the requirement for them to be toilet trained or verbal (8)
- The pre-school ended the placement because they could not cope with the level of need (16)
- They needed to seek alternative placements because a pre-school does not have an inclusive culture (12)

Problems with communication:

- Poor communication and feedback from AIM/pre-school (29)

Problems with support:

- Level 7 support not used effectively (59)
- Level 7 support not used effectively because it was not 1:1 (22)[96]
- It took too long to get AIM support in place (27)
- Their child did not get AIM support applied for following an assessment (121)
- They were unaware that there was any support available or in place (15)

Problems with pre-school capacity:

- The pre-school they wanted to send their child to is full, closed or with limited space (185). Though this is not an AIM issue, for parent/carers it had interacted with their experience of AIM and their perception of its benefit

Content analysis of free text comments in the survey indicates that positive views on AIM arise when their child is accepted, valued, thriving, and receiving the support they perceive is needed. The free text comments also show that the experience of being supported and well-informed (i.e., in the loop of communication) reduces stress with positive consequences for home life.

Where parent/carers report a negative stance on AIM (i.e., where they have been asked to share their views on why it had no impact or a negative impact), analysis of free text comments shows that this is often because they have not experienced positive relationships with pre-school staff and/or AIM representatives (EYS, Pobal). Where they perceive disinterest and poor knowledge from pre-school staff, and where they feel out of the loop of communication, they report a negative stance on AIM and its impact. These data demonstrate that parent/carers perceptions of AIM are connected with their experience of relationships and communication in the pre-school., as well as to the presence/absence of an inclusive culture.

The issue of partnership also arose as a theme in the qualitative analysis of text responses for the survey question 'What additional supports do you think would need to be put in place for staff to support your child's meaningful participation in pre-school activities?' 15 respondents noted the need to develop more partnership with parent/carers (working with them, listening to them, and having open lines of communication).Further evidence supporting the claim that relationships with parent/carers are implicated in perceptions of AIM comes from quantitative analysis of the survey data (parent/carers). This is reported in what follows.

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[96] The AIM Rules 2020-21 (Pobal, 2021, p26-27) outline permitted uses of Level 7 as follows:

- Where Pobal confirms approval, pre-schools can use the additional capitation granted through AIM Level 7 to reduce the child-to-adult ratio by enrolling fewer children.
- AIM Level 7 additional assistance staff is a shared resource for the pre-school, and 'does not fund Special Needs Assistants (SNAs)' and is 'a shared resource for all children in the pre-school room.' (DCEDIY, 2021, p26). One additional staff member may be deemed to be sufficient to meet the needs of two or more children who have been granted Level 7, within the same session. Staff members providing the Level 7 additional assistance cannot be included in the child-to-adult-ratio (e.g., the presence of this additional staff member cannot lead to the enrolment of a further eleven children

Relationship between perceptions of partnership and communication and positive views of AIM impact among parent/carer*s*

Findings were as follows:

- There is very strong evidence of an association between the perception that working in partnership has been beneficial and an overall positive view of the impact of AIM on the child. $p < .001$. The major departure[97] from independence is due to parent/carers who did not perceive partnership working as being a beneficial aspect of AIM were less likely to have a positive view of the impact of AIM on their child.
- There is very strong evidence of an association between the perception that AIM information or advice has been beneficial and an overall positive view of the impact of AIM on the child. $p = 0.167$. The major departure from independence is due to parent/carers who have perceived information or advice provided to pre-school staff as beneficial, having a positive perception of the impact of AIM on their child compared to those parent/carers who did not identify information to settings as a beneficial aspect of AIM. This suggests that those who do not feel that a benefit of AIM was information to staff (or did not select this as a beneficial aspect in the survey) were more likely to report that AIM had no positive impact on their child overall.

These findings demonstrate that the quality of partnership and communication that parent/carers experiences at their child's pre-school are implicated in perceptions of AIM. The importance of positive relationships and communication with parent/carers is confirmed by these data and offers insight into the future focus of CPD (Level 3) and coaching and mentoring (Level 4).

Significant differences between survey groups - reported main type of disability

The findings were as follows:

Though the picture of impact and benefit is very positive overall, there were statistically significant differences between groups within the survey as follows:

- Parent/carers of children with physical and sensory disabilities were more likely to perceive AIM's impacts positively and have satisfying experiences of inclusion and impact.
- Parent/carers of children with less visible disabilities (particularly autism/ASD) were less likely to perceive AIM's impacts positively and have satisfying experiences of inclusion and impact.

Further quantitative analysis was used to explore these statistically significant differences and findings are reported below.

The relationship between the reported main type of disability and parent/carer perceptions of the impact of AIM on inclusion and participation

- There is very strong evidence of an association between parent/carers agreeing that their child was able to participate more meaningfully in pre-school activities and the reported main areas of disability $p = 0.003$. The major departure from independence is due to parent/carers of children with physical disabilities and those with learning disabilities being more likely to

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[97] When using the term 'major departure' we are referring to a statistically significant difference.

feel that their child was able to participate meaningfully, whilst parent/carers of children with ASD were less likely to feel that their child was able to participate meaningfully than other main types of disability.

- There was strong evidence of an association between parent/carers agreeing that their child is more confident in educational settings and the reported main areas of disability. p =0.014. The major departure from independence is due to parent/carers of children with physical disabilities being more likely to feel that their child is more confident in educational settings, whilst parent/carers of children with ASD and those with speech and language disorders were less likely to feel that their child was more confident in educational settings than other main disability groups.
- There was no observable, significant association between parent/carer agreement with the statement "As a result of AIM, my child is more confident in interacting with peers" and the type of disability (p= 0.073).
- There was no observable, significant association between parent/carer agreement with the statement "As a result of AIM, my child was able to attend a mainstream pre-school" and the type of disability (p= 0.076)

In summary, these data confirm that parent/carers of children with physical and sensory disabilities are experiencing AIM and its impact more positively than parent/carers with other types of disability. Parent/carers of children with physical and sensory difficulties are also more likely to perceive AIM as having a positive impact on inclusion and participation.

The relationship between the reported main type of disability and parent/carers' experience of relationships with staff in the pre-school

- There is strong evidence of an association between parent/carers agreeing that they know who to talk to and the reported main areas for disability. p= 0.02. The major departure from independence is due to parent/carers of children with physical disabilities being more likely to know who to talk to whilst parent/carers of children with emotional disturbance were less likely to know who to talk to than other main types of disability. *No significant differences were observed from those expected for children with ASD.
- There is strong evidence of an association between parent/carers agreeing that staff worked in partnership with them and the reported main areas for disability. p= 0.007. The major departure from independence is due to parent/carers of children with physical disabilities being more likely to feel staff work in partnership with them whilst parent/carers of children with emotional disturbances were less likely to feel parent/carers work in partnership with them than other main types of disability. *No significant differences were observed from those expected for children with ASD.
- There is very strong evidence of an association between parent/carers agreeing that conversations with staff about their child's disability are handled sensitively and the reported main areas for disability. p < 0.001. The major departure from independence is due to parent/carers of children with physical disabilities being more likely to feel that conversations are handled sensitively, whilst parent/carers of children with emotional disturbances were less likely to feel that conversations were handled sensitively than other main types of disability. *No significant differences were observed from those expected for children with ASD.
- There is a strong association between the reported main type of disability and parent/carers agreeing that there is an inclusive culture in their child's pre-school. p= 0.033. The major departure from independence is due to parent/carers of children with physical disabilities being more likely to feel that there is an inclusive culture whilst parent/carers of children with emotional disturbances and those with ASD were less likely to feel that there is an inclusive culture than other main types of disability. It is important to note that all parent/carers of children with a physical disability felt that there was an inclusive culture in the setting.

These data indicate that parent/carers of children with physical and sensory difficulties are most likely to experience an inclusive, supportive relationship with pre-school staff. Where children have

emotional disturbance as their reported main type of disability, parent/carers are less likely to experience a supportive relationship of this type, and where children had emotional disturbance or ASD, they were less likely to perceive the pre-school culture as inclusive. This indicates that the quality of relationships with parent/carers is implicated in parent/carer perceptions of AIM. It also shows that it would be beneficial to focus CPD (Level 3) and coaching and mentoring (Level 4) on partnership working with parent/carers of children with psychosocial needs

The relationship between reported main type of disability and views of the benefits that specific levels of AIM support brought

- There is very strong evidence of an association between type of disability and additional equipment (Level 5) being viewed as beneficial. $p < .001$. The major departure from independence is due ot parents/carers of children with physical disabilities and those with speech and language disorders being more likely to describe these as beneficial.
- There is very strong evidence of an association between type of disability and building alterations (Level 5) being viewed as beneficial. $p < .001$. The major departure from independence is due ot parents/carers of children with physical disabilities being more likely to describe these as beneficial.

These data indicate that Level 5 supports are implicated in parent/carers perceptions of the benefits of AIM in the case of physical disabilities and speech and language disorders

- There was no evidence that the perceived benefits of working in partnership was associated with a particular type of disability. $p = 0.192$
- There was no evidence that the perceived benefits of information or advice provided to pre-school or staff on inclusion was associated with a particular type of disability. $p = 0.07$
- There was no evidence that the perceived benefits of therapeutic/health support were associated with a particular type of disability. $p = 0.091$
- There is no evidence that the perceived benefits of additional assistance (staff member) were associated with a particular type of disability. $p = 0.014$.

These data indicate that parent/carer perception of the benefits of AIM Level 1 (parent/carer partnership within an inclusive culture), Level 2, Level 6 and Level 7 are not associated with the reported main type of disability and have universal reach. This was also borne out in the analysis of the qualitative data from the survey, where universal elements of an inclusive culture (e.g., accepting the child, valuing the child, providing personalised support) were shown to be important to parent/carers when evaluating their child's experience of pre-school.

In summary, it is noted that there are some aspects where there are no significant differences (AIM's impact on confidence for peer interaction or child's ability to attend a mainstream pre-school), parent/carers of children with ASD (and to a lesser extent children with emotional disturbance (ED), specific speech and language difficulties (SSLD), and multiple main dDisabilities (MMD) report a more variable experience and are less likely to perceive staff as able to practice inclusively (ASD, ED), or work in partnership with them (ED). This serves to demonstrate that some providers will need continued CPD and coaching/mentoring in how to support children with psychosocial disabilities and complex needs (including challenging behaviour). They will also need training on how to work effectively with parent/carers of children with these types of disabilities. The findings also strengthen the claim that matters of inclusive culture (e.g., the attitude of practitioners to the inclusion of their child) are universally important, no matter what the type of need. In addition, the targeted supports provided by AIM emerge as relevant to a broad spectrum of disabilities, though Level 5 is implicated more strongly in the perceptions of children with physical and sensory disabilities. This is not surprising given that the equipment and alterations provided through AIM Level 5 are most relevant to the needs of this group. Overall, parent/carers of children with physical and sensory disabilities were significantly more likely to report a positive experience of AIM and its positive impacts.

Significant differences between survey groups - location of pre-school (city and large urban vs rural and town)

There was clear evidence that parent/carers of children who were enrolled in pre-schools in city or large urban areas were significantly less likely to perceive AIM's impacts positively compared to those in rural or town locations. Analysis of the free-text responses by parent/carers resulted in the following findings:

Few differences between the prevalence of themes in the *city and large urban* versus the *rural and town* groups were found in the qualitative analysis. Frequencies were broadly similar for responses about why the child was not enrolled in parent/carers' first choice of pre-school, additional supports needed for meaningful participation, benefits that AIM brought to the child and family, and reasons for AIM having no benefit or a negative impact. However, there was slightly higher tendency for respondents in the group 'rural and town' to identify the need for more training in additional needs among pre-school staff. Parent/carers of children who attend pre-schools in cities and large urban areas report reductions in stress less often (-0.55), their child being happier and more confident less often (-0.54), and their child being ready for school less often (-0.54). This may indicate that the outcomes of AIM are impacted by a range of factors. Families living in cities and large urban areas may be subject to more complex stresses than those in rural/town areas. Though the data cannot confirm this suggestion, it is important to note this intersectionality since AIM's success will depend on the extent to which parent/carers experience AIM-supported ECCE in a tangible way, and in a way that is responsive to their circumstances and the additional challenges they face. We conclude that the survey's qualitative data cannot explain the statistically significant differences between these groups but may indicate factors of relevance.

Further quantitative analysis led to the following key findings about associations between the location of pre-schools and parent/carer perceptions of AIM

- There is strong to very strong evidence of an association between the geographical location of the pre-school and parental perception that pre-school staff support their child's meaningful participation in pre-school activities. (P= 0.007 urban or rural, p=0.037 city, town or rural). The major departure from independence is due to families living in rural locations being less likely to report that staff do not support meaningful participation.
- There is strong evidence of an association between geographical location and main type of disability. p = 0.031. The major departure from independence is due to families living in rural locations being more likely to report a physical or sensory disability or a multiple main disability as their child's main type of disability. On the other hand, families living in urban locations being more likely to report ASD as their child's main type of disability.
- No significant association between geographical location and parent/carer perceptions on how well staff in the child's setting are trained (p=0.53 urban or rural, P=0.098 city, town or rural)
- No significant association between geographical location and parent/carer perceptions of how well staff support the child's full inclusion. (p=0.57 urban or rural, p=0.288 city, town or rural)
- No significant associations between perceptions of the benefits of AIM and geographical location (city or urban, p=0.170).
- There is no significant association between parent/carer reporting on the aspects of AIM which have made the greatest difference to their child and geographical location (e.g., Level 7 additional assistance, p=0.476 urban vs rural, Level 5 building alterations, p=0.444 urban vs rural)
- There is no significant association between geographical location and perceptions of participation (p=0.050 urban vs rural), social confidence and interaction (p=0.188) and being able to attend mainstream school (p=0.347)

- There is no significant association between the size of the setting and perceptions of participation (p=0.170 urban vs rural), social confidence and interaction (p=0.292) and being able to attend mainstream school (p=0.355).

These findings provide two potential explanations for the location-based differences in satisfaction. Firstly, parent/carers in rural areas are more likely to report that staff support their child's full inclusion. From this, we can infer that their experience of an inclusive culture at pre-schools is less variable. Secondly, in the sampled population, rural schools contained more children with physical and sensory disabilities (whose parent/carers have more positive perceptions of AIM overall) whilst urban pre-schools contained more children with ASD (whose parent/carers had less positive perceptions of AIM overall). Since an association between parent/carers' perceptions of AIM and the main reported type of disability has been demonstrated, these data show that location differences can be explained, at least in part, by the distribution of the survey population, and the overrepresentation of ASD. We are not positing that the problem lies within the children themselves (and their type of disability) but that pre-schools find it more difficult to enact an inclusive culture for this group of children, and that they will need continuing support.

Survey of ELC providers

Evidence to support the claim that AIM is achieving its intentions for most of the children it supports and delivering benefits to the majority of those children is present in data from the survey of ELC providers.

Most (94%) of providers report that AIM benefited children's full inclusion, meaningful participation, and their pre-school, with the majority (77%) describing the magnitude of the benefit to be to 'a great extent.' 88% also perceived benefits to other children in the setting, and 89% benefits to parent/carers, with 67% reporting that AIM had also brought benefits to the parent/carers of children who did not have disabilities or additional needs.

Location-based differences in estimations of AIM's impacts and benefits were not found in the ELC provider survey as evidenced below:

- No significant association between the geographical location of the setting and the perceived impact of AIM on inclusion, p=0.6 (Note: Only 4 practitioners in total felt AIM had a negative impact on inclusion).
- No significant association was observed between the geographical location of the pre-school setting and practitioner perceptions of the benefits of AIM on children, families or staff in the pre-school setting.

This indicates that there are differences in perceptions between providers and parent/carers. It has been noted that providers may bring some positive bias towards AIM since they are in receipt of AIM support and responsible for making these supports work effectively.

Significant differences between survey group - main reported type of disability

Though analysis of the provider data did not find statistically significant differences in provider perceptions of AIM's impact and benefits in relation to the main reported type of disability (in contrast to the parent/carer survey), qualitative analysis of free-text entries did uncover the following phenomena of interest:

- A higher frequency of respondents who have children on roll with autism/ASD reported that <u>no</u> AIM support had been received (0.62) but we note the count is relatively low for this category (n=9). However, this experience is also communicated in the category *insufficient AIM support* (n=12), with a higher frequency for the group 'ASD' (0.44). This implies that

providers experience less impact from AIM Level 4 for this group when impact is measured by the success or failure of applications for additional support. We can infer from this that providers are finding it more difficult to get AIM support for children with ASD, though the reasons for this are unclear, and are likely to relate to the visibility of the disability.

- Weighted differences between groups were usually very small, though settings who had children in the group 'ASD' reported both positive impacts more frequently (0.34 to 0.37), and negative ones too (0.30), implying that for this group, impacts are a little more variable than for other groups.

Interviews with stakeholders

Representatives from the AIM Team and service delivery partners (e.g., DCEDIY officers, Better Start, Pobal) reported that they had seen evidence of AIM's increasing embeddedness in pre-school practice, with positive consequences for the full inclusion and meaningful participation of children with disabilities and additional needs. The rapid and positive uptake of AIM by pre-schools was seen as instrumental to realising these intentions. Participants referred to uptake data published by Pobal to report this, and some referred to their close-to-practice experience and observations of this happening in practice. There was a clear acknowledgement amongst stakeholders of the variability in the quality of practices and outcomes. Therefore, stakeholders argued for a shift in focus from data focussed on the roll out of AIM (given that this had been an urgent priority) to monitoring and oversight with a focus on impacts. This would entail the collection of data that was more focussed on the quality of practice (e.g., the quality of inclusive practice and cultures; the effective use of AIM supports) and outcomes (e.g., parent/carer satisfaction, full inclusion, meaningful participation).

Participants representing the disability sector (such as the National Disability Authority), noted that AIM had meant that children with disabilities and additional needs could attend mainstream pre-schools in their local communities. Two other benefits were that parent/carers had more choices (including mainstream pre-schools) and that children were not only present in pre-schools but also actively included. Participants from the disability sector (3) commented on some continuing limits to participation, including a lack of available pre-schools that were willing to accept children with disabilities.

Very few (1 out of 18) of the parent/carers that were interviewed reported an experience of AIM that was entirely negative. A majority of parent/carers described AIM positively (8) or as a mix of positive and negative (9). Where experiences were mixed, this was usually because the child had attended two pre-schools, with one being a positive experience and the other being negative (6). Parent/carers had chosen to move their children from one setting to another because they were not happy with the way the child was being supported. Parent/carers gave the following reasons for moving their child from one AIM-supported pre-school to another:

- The view that the setting was not using AIM Level 7 support as 1:1 and the child wasn't coping well or was not developing (3)[98]
- The setting was not challenging the child sufficiently or striving to get the child to participate in things they were hesitant about (5)
- The setting did not want or welcome the child and interpreted their behaviour negatively (2)

[98] It is important to note that AIM rules note that 'additional assistance staff is a shared resource for the pre-school, and 'does not fund Special Needs Assistants (SNAs)' and is 'a shared resource for all children in the pre-school room.' (DCEDIY, 2021, p26).

- The setting made no adaptation to the child's sensory needs (2).

The majority (17 out of 18) of the parent/carers we interviewed had experienced at least one pre-school where their child's full inclusion and meaningful participation was in place, sometimes because they moved their child to a setting where practice was better. There were several reasons why parent/carers perceived a setting as unsuitable or exclusive, and many of these centred on the absence of an inclusive culture. Though the parent/carers were not aware of AIM Level 1, and had not heard of it, they knew when such a culture was present or absent though they did not attribute this to AIM. The experiences that parent/carers shared revealed variability in the readiness, willingness, and ability of pre-schools to implement AIM effectively such that it achieves its intended outcomes. Where parent/carers were talking about positive experiences of inclusion, they were also describing the practices associated with an inclusive culture:

- Being flexible around the needs of the child and personalising (10)
- Challenging the child and developing their independence in a supported way (5)
- Including the child in everything through supported participation (8)
- An engaging curriculum and resources (8)
- An inclusive culture – staff commitment and expertise around inclusion (10)

Among the parent/carers who were interviewed for the evaluation 17 out of 18 had experienced an inclusive culture in at least one of the pre-schools that their child had attended. The literature review (see Section 3) highlighted that AIM Level 7 embeds an input funding model (all be it with a throughput element due to the shared nature of the resource), which is open to valorisation (higher prizing) by parents/carers and settings, with the consequence that the importance of AIM's universal elements (Levels 1-3) is overlooked in favour of targeted support. Pressure on targeted (input) funding, may result in the diversion of resources for universal (throughput) resources. Moreover, the families of children whose needs are not met by Level 7 funding may be concerned that moves towards further inclusion will initiate the dissolution of funds they have fought to secure (UNESCO, 2020).

When giving examples of the pre-school practices that were part of a positive experience of AIM-supported ECCE, parent/carers referred to the following:

Personalised approaches

- Being flexible around the needs of the child and personalizing (10)
- Taking children's interests on board (5)
- Teaching the child strategies for independence (2)
- Including the child in everything through supported participation (8)
- Equipment in the pre-school to support hearing (2)
- Inducting children gradually into the pre-school and unfamiliar activities (3)
- Using visual communication aids that support participation (3)
- Sensory experiences that supported the child (2)

Understanding the child's needs

- Picking up and acting on the detail of children's difficulties and barriers to participation (2)

Children leading their learning with flexible adult support to encourage engagement in new things.

- Letting children take the lead in their learning (2)
- Challenging the child and developing their independence in a supported way (5)

- Coaxing and supporting children to get involved in unfamiliar and unpreferred activities (3)

Firsthand and stimulating activities
- An engaging curriculum and resources (8)
- Outdoor curriculum and facilities (2)
- Enjoyable activities (2)

The commitment of pre-school staff to including the child
- An inclusive culture – staff commitment and expertise around inclusion (10)
- Manager and other staff work hard to support the child (2)
- Staff work together to improve practice (1)
- Staff are welcoming, valuing and accepting of the child (6)
- Effective Level 7 support (defined variably by parent/carers as 1-1 or not 1-1) (2)

When combined, these elements are indicative of the presence of inclusive practices and pedagogies, and we can infer that AIM was working to improve pre-schools' capacity for inclusive practice given that parent/carers were experiencing inclusive cultures first-hand. It is important to note that many of the pre-school practices described by parent/carers as indicative of inclusive practice are also integrated into *Aistear*'s principles (NCCA, 2009).[99] For example, 'the nurturing of equality and diversity' (NCCA, 2009, p8), the role of the adult in altering 'the type and amount of support as the child grows in confidence and competence and achieves new things' (NCCA, 2009, p9), and 'ongoing assessment of what children do, say and make' to ensure relevant and meaningful experiences for children. (NCCA, p11). This suggests that in the context of AIM, where the practice is high quality under the terms of national quality frameworks, it is also inclusive.

The challenge lies in reducing the variability of inclusive practice in the sector. Given that this good practice exists in at least 17 of the pre-schools experienced by parent/carers, it will be important to find ways to move this knowledge and practice around the system, and to remind settings how important Levels 1-3 are to parent/carers. It may also be important to develop systems of self-evaluation and peer-evaluation, so that settings can engage in continuous monitoring and improvement in the context of a community of practice.

Transition to primary school emerged as an important theme in the interviews, and parent/carers agreed that AIM supported Early Childhood Care and Education (ECCE) was the right way to prepare children for school. Even where parent/carers have had negative experiences in one pre-school, causing them to move to another, they still expressed their faith in AIM's capacity to bring positive benefits to children's transition to school and beyond. The 1 parent/carer reporting an entirely negative experience saw the potential of AIM to support effective transitions, where pre-school practices were strong. The parent/carers who were interviewed were often thinking about the next stage in their child's life and how pre-school would prepare them for it. Hence, the transition was an important consideration for them. Their perceptions around transition were:

- Mainstream school being the desired destination after pre-school (7)
- Distressing or disappointing experiences of how the transition from pre-school to mainstream school was managed (5)

[99] National Council for Curriculum and Assessment (NCCA) (2009) *Aistear: The Early Childhood Curriculum Framework.* Dublin: NCCA.

- The importance of a professional role focussed on supporting transition to primary school – parent/carers had experienced the impact of both the presence and absence of this role (4)
- Parent/carers wish for their child's future to be one where they were happy, included, and independent (3)

Moving into mainstream primary school is an outcome from AIM that parent/carers placed particular importance on. It emerges as an important focus for AIM's development – meaning consideration of how key roles within AIM (e.g., the INCO and the EYS) might be developed to support transition from pre-school to primary school. In terms of the impact of the location of the pre-school, parent/carers did not feel able to comment, except to note that HSE services and pre-school spaces in Dublin are particularly overloaded and that recruitment to Level 7 (additional assistance) posts might be more difficult in rural areas. We note that overall, parent/carers in rural areas and towns are generally more positive about AIM than those in cities/large urban areas.

The practitioners we interviewed were positive about AIM's impact on full inclusion and participation noting that AIM's impact was helped by an enabling government policy (i.e., the AIM policy) and wider policy commitments to social inclusion. How AIM offered a targeted model to include staff development and the promotion of inclusive cultures was seen to contribute to the relationship between the model and the participation of children. Fundamentally, practitioners agreed that AIM is right and needed and that overall, it is correctly formed to support inclusion, though they noted several areas for development which are further explored in subsection 13.3. It was also noted that AIM also offered a framework for the constructive engagement of parent/carers. When asked to consider whether the location impacted on AIM's capacity to support inclusion, practitioners noted that for some pre-schools, physical attributes of buildings (such as parking spaces, lack of outdoor space and poor transport links) may limit access for some children/families. They also perceived that it may be harder to recruit staff in rural areas.

When asked to consider whether AIM might work more effectively for children with certain types of disability compared to others, practitioners could not see a reason why AIM would not support children with autism/autistic spectrum disorder any less effectively than other type of need, though the case studies give some potential insights into why parent/carers of children with autism/ASD may be having a more variable experience of AIM's impact.

Practitioners described full inclusion as every child having an equal opportunity to participate in the life and activity of the setting, with universal and targeted supports and adaptions to facilitate this. Meaningful participation was about access to activities that mattered to the children themselves, alongside their peer group, and in a context where they were valued and were able to value others. It is important to note that similar conceptualisations were communicated by participants from the AIM team, AIM agencies, the Disability Sector. Parent/carers described these ideas in a different way and did not know how such concepts are integrated into AIM or embedded in its design. This demonstrates that there is a broad understanding and coherence of AIM's core principles across the sector, which researchers recognise as a strength to build on, and one that it is not easy to achieve.

Case studies of pre-school settings and children

Practitioners in case study settings attributed the following outcomes to AIM - positive developments in children's progress (e.g., speech and communication), the expansion of the child/family's relationship with others in the local community, access to participation in opportunities/activities in the pre-school and trusting relationships with children and parent/carers. However, they also described some aspects of AIM that needed to improve to ensure that such outcomes are equally positive for all children including better staff training in additional needs, more positive attitudes, and improvements to pay and conditions for pre-school staff. Participants argued that reducing staff attrition in the sector

would ensure investments in AIM Level 1-3 were not wasted due to attrition, and recruitment of high-quality staff to deliver Levels 1-3 and Level 7 was easier.

Parent/carers described positive experiences of inclusion for their child, including the nurturing of their child's interests by pre-school staff, sensitive responses to their children's needs and a feeling of reassurance that their child's physical and medical needs were being met. Researchers note that when practitioners in the case studies were talking about AIM's impact, they reported limitations in the ability of AIM to secure the inclusion of children with behavioural difficulties. They also reported the need for more training in this area. In one case study, Level 7 support was being used to manage and contain challenging behaviour, and this was being done effectively. However, deploying Level 7 support to enable the investigation of the causes and triggers for challenging behaviour, and for working with the family, may have brought other positive outcomes. The particular difficulties that the setting was having with behaviour, may explain why children with ASD experience more variable outcomes, and this is supported by wider evidence that demonstrates professional development needs around psychosocial needs.

For the 14 children who participated in this evaluation and who expressed their experience of inclusion and participation on their own terms, it was clear that they that they were all experiencing opportunities to access activities they enjoyed, join in with their peers and experience mutually respectful relationships with practitioners in the setting. Staff were providing comfort and support and were accessing additional support. All 14 children were enjoying pre-school and from their perspective, were experiencing full inclusion and meaningful participation.

Overall, children's experiences, as described by them, confirm their experience of being included, and imply that an inclusive culture is present in their settings. This was foundational and set the tone for all other targeted support that was offered additionally through personalised provision. For example, in the case of Ruby (pseudonym) this was observed where an anti-bias approach was adopted in facilitating Ruby to develop autonomy, independence and confidence to express herself when initiating play with peers. Mary's case study illustrated that the climate and culture within her pre-school setting was one which fostered secure, respectful, and reciprocal relationships. This is further evidence of the essential role that AIM Level 1 plays in securing full inclusion and meaningful participation for children.

Non-participation in AIM

The following reasons for non-participation in AIM were proposed across all groups who participated in this study:

- Awareness of AIM is higher where families have prior engagement with specialist services (such as HSE) or their child's pre-school. Where families do not have pre-existing relationships with these services, they may not come to know about AIM and how it can support their children's inclusion in mainstream pre-school
- Some families may wish to stay with special pre-school provision because they are anxious about losing therapeutic supports
- Since AIM is relatively new, some families may have more trust in specialist rather than mainstream provision
- The child's needs may be too complex (e.g., dangerous behaviour or very complex medical needs) and AIM insufficient as a model of support to meet their needs
- Too much use of the word 'disability' in general and in early communications with parent/carers
- Application processes are perceived to be complex and burdensome (though most providers note that this is not the case)

- When a setting is situated in an inaccessible building or location that AIM support is not sufficient to ameliorate.
- Some pre-schools may not engage with the CPD offer at Level 1 and 3 because it is not in an Irish Language medium (interviews with stakeholders, specifically an EY inspector who had observed this)

Literature Review

Analysis of the literature review drew the following implications for AIM:

- Families' human right to actively engage in their child's education needs to build trust through two-way communications, which enables every unique child's equitable participation in an inclusive environment.
- Families need to have confidence that the parameters of the AIM funding model will: meet their child's needs and prepare them for the next phase of their education (i.e., transition into primary school).

These implications are relevant to the findings reported in this section thus far, particularly in relation to the importance of supportive, trusting relationships and deeper partnership with parent/carers.

In summary, there is clear evidence that AIM is having a positive impact on the full inclusion and meaningful participation of most of the children it supports. It is benefitting the majority of children it supports and brings benefits to families too. From the perspective of stakeholders, AIM Level 1 is essential to this outcome. However, there are some children supported by AIM who are not experiencing positive outcomes, mainly because of the absence of an inclusive culture in the pre-school (and this is most likely to be experienced by children with ASD and to a lesser extent children with emotional disturbance, specific speech and language disability and multiple main disabilities), and shortfalls in the targeted supports that practitioners and parent/carers believe to be essential.

Conclusions: Is AIM achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities?

- There is clear evidence that from the perspective of multiple stakeholders, AIM is achieving its intended outcomes of enabling the full inclusion and meaningful participation of most of the children it supports. It is also perceived to be beneficial to the majority of the children who are in receipt of these supports.
- There are variations in the extent and reach of this impact, and continuous improvement is required. Variations were found to be as follows:
    - From the perspective of parent/carers AIM is reaching children with physical and sensory disabilities most effectively and children with ASD least effectively. Parent/carers are also less likely to experience an inclusive, supportive culture if their children have less visible disabilities (emotional disturbance, specific speech, and language difficulties) or more complex needs (multiple main disabilities).
    - From the perspective of parents/carers AIM is working more effectively in rural and town locations than it is in cities and urban areas. Providers in cities are also less likely to see the inclusive practice they have built through AIM as sustainable. The reasons for these differences are unclear but highlight the potential location-specific approaches (e.g., communication with parent/carers, acknowledgement of the more

complex context in cities – higher mobility, higher numbers of children with psychosocial needs (ASD), and intersecting disadvantage)[100].

- Implicated in parent/carers' perceptions of impact and benefit are the experience of a supportive inclusive culture for them and their child. The quality of relationship between parent/carers and settings is implicated in their positive or negative perceptions of AIM.
- Most parent/carers (94%) agree that their pre-school supports their child's full inclusion and meaningful participation, and the majority 69% report that these have been realised as impacts of AIM, there are variations in the extent of these outcomes and for a minority of children (from the perspective of parent/carers) they are not being achieved. This suggests that many pre-schools are implementing effective pre-school practice, whilst some others are not, and signals the benefits that could be gained by moving this good practice around the sector.
- Successful transition to mainstream primary school is one of the outcomes of AIM supported pre-school that parent/carers prize.

13.2: Has AIM influenced practice, or increased capacity in the workforce?

The evaluation has found that AIM has influenced practice and has increased the capacity of the workforce to include most of the children with disabilities and additional needs supported by AIM. There is some variability in relation to the location of pre-schools (urban, town, rural) and the reported main type of disability (ASD). The evidence for this conclusion is summarised in what follows.

Survey of parent/carers

94% of parent/carers agreed that pre-school staff supported their child's full inclusion, and 94% agreed that pre-school staff supported their child's meaningful participation. Most (78%) of parent/carers believed that staff in their child's pre-school were well trained. We also know that parent/carers of children with autism/autistic spectrum disorder were least likely to describe pre-school staff as well-trained when compared to all other types of disability/learning difficulty (73%).

- Parent/carers of children with physical and sensory difficulties were the most likely to describe pre-school staff as well trained (87%) when compared to autism/autistic spectrum disorder (73%) and emotional disturbance (72%, n=26), but these more positive ratings for physical and sensory difficulties are not statistically significant.
- Analysis of the qualitative data revealed that, when asked to describe the additional supports needed to enhance their child's inclusion, n=88 respondents suggested more training for staff on how to identify and support children with disabilities/additional needs, and 36 suggested this for autism/ASD specifically.

Further quantitative analysis of the parent/carer survey data resulted in the following findings:

- There is very strong evidence of an association between the perception of staff being well trained and an overall positive view of the impact of AIM on the child. $p < .001$
- There is strong evidence of an association between the perception that staff are well trained and the reported main areas for disability. $p = 0.037$. The major departure from independence is due to parent/carers of children with ASD being more likely to report that the practitioners in the setting

[100] Disadvantage in the Irish context is defined as 'the impediments to education arising from social or economic disadvantage which prevent students from deriving appropriate benefit from education in schools' (Education Act, 1998, 32, (9)0)

are poorly trained than parent/carers of children with other main types of disability. (Observed number = 64, expected 50.8)

- There is very strong evidence of an association between the perception that staff are well trained, and the following being perceived as being beneficial:
    - Information or advice provided to pre-school staff on inclusion
        - $p < 0.001$
        - 98% of parent/carers who perceived information to staff as being a beneficial aspect of AIM felt that staff were well trained.
    - Additional equipment so my child could participate fully in pre-school
        - $p= 0.009$
        - 95% of parent/carers who perceived equipment as being a beneficial aspect of AIM felt that staff were well trained. (It is important to note that 75% of the total surveyed did not identify equipment, but still felt staff were well trained)
    - Additional assistance (adult in the room)
        - $p < 0.001$
        - 62% of all who completed survey felt that additional assistance was beneficial, and that staff were well trained, whilst 96% of those who felt that additional assistance was a beneficial aspect felt that staff were well trained.
    - Working in partnership with pre-school staff to support my child's inclusion
        - $p < 0.001$
        - 36% of all who completed the survey felt that additional assistance was beneficial, and that staff were well trained, whilst 98% of those who felt that additional assistance was a beneficial aspect also felt that staff were well trained.
    - Other, $p=0.6$ not significant
    - Negative outcome
        - $p < 0.001$
        - Only 1.6% of all who completed the survey felt that AIM support had a negative outcome, and that staff were poorly trained, whilst 48% of those who felt that AIM support had a negative outcome also felt that staff were poorly trained (the exact count is much higher than statistically expected) (nb 52% felt they were well trained)
    - Made no difference to my child
        - $p < 0.001$
        - Only 4% of all who completed the survey felt that AIM support made no difference to their child and that staff were poorly trained, whilst 52% of those who felt that AIM support made no difference to their child also felt that staff were poorly trained, this is a higher count than would be expected (It is important to note that 48% felt they were well trained).

These data demonstrate that parent/carer perceptions of staff being well trained are implicated in parent/carer overall perceptions of AIM's impacts and benefits. They also demonstrate that parent/carers of children ASD are less likely to report that pre-school staff are well trained. This offers further support for the claim that pre-school staff need more support and training in inclusive practice for children with ASD and other types of psychosocial disability (emotional disturbance) and complex needs (multiple main disabilities).

Quantitative analysis has also revealed the following about the main reported type of disability and parent/carer perceptions:

- There is strong evidence of an association between the perception that staff support children's full inclusion in pre-school activities and the reported main areas for disability. $p= 0.037$. The major departure from independence is due to parent/carers of children with emotional disturbances and multiple main disabilities being more likely to report that the practitioners are not able to support their child's full inclusion than other main types of disability. (Observed number = 64, expected 50.8)

- There is a very strong association between the child's main type of disability and parental agreement that staff at their child's pre-school recognise when their child requires additional support and seek it. p= 0.007. The major departure from independence is due to parent/carers of children with physical disabilities being more likely to feel the pre-school recognises when the child needs additional support whilst parent/carers of children with emotional disturbances and those with ASD were less likely to feel staff recognise when their child requires additional support than other main types of disability.
- There is a strong association between the child's main type of disability and parental agreement that staff at their child's pre-school take the lead in making sure their child gets the most out of ECCE provision. p= 0.016. The major departure from independence is due to parent/carers of children with physical disabilities being more likely to feel that staff at the pre-school take the lead in making sure children get the most out of ECCE provision whilst parent/carers of children with emotional disturbances and those with ASD were less likely to feel staff take the lead than other main types of disability.

These data give further support to the claim that parent/carers of children with physical and sensory disabilities are most likely to experience positive capacities for inclusion among pre-school staff. Parent/carers of children with ASD and emotional disturbances are generally less likely to experience proactive commitment to inclusive practice.

Survey of ELC providers

In general, providers are very positive when reporting their experience of the benefits of AIM to staff in their setting, and to their capacity for inclusive practice. It is important to note that the data in the provider survey carries a positive bias since respondents are in receipt of AIM, ECCE and other supports from the DCEDIY, and responsible for implementing AIM effectively.

- Most (96%) reported that AIM had a positive impact on inclusive practice, with a statistically significant difference among those settings who began AIM in 2017-18 (100%) compared to all other years, and it was also true that 88% settings who began AIM in 2017 found this impact to be 'large' compared to 77% in 2019, and 60% in 2020-21. This is more evidence of the importance of longevity of engagement with AIM, and of the potential impact of COVID-19.

Sustainability

- Two thirds (67%) of respondents felt that the changes made in their setting as a result of AIM were sustainable, with 19% feeling they were not sustainable and 6% saying AIM had not resulted in any changes in their setting (a quarter overall). Pre-schools in city/large urban areas less likely to believe that practice improvement were sustainable (28%) when compared to those in towns (18%) and rural areas (14%). These differences were statistically significant

Findings from the analysis of the survey's qualitative data did not explain this difference, though researchers note that perceptions may be influenced by intersecting factors such as higher staff turnover, higher average numbers of children with disabilities/additional needs in urban settings (in the survey, the mean number of children with disabilities/additional needs in rural (2.7) and town (3.4) areas is lower than in city/large urban areas (4.4). Urban areas are also likely to have more complex populations with higher levels transience and socio-economically disadvantage. These explanations seem reasonable though it is important to note that the data cannot support them, and further investigation of such intersections may be required (beyond the scope of this evaluation).

As noted in subsection 13.1, we have also found that there are more parent/carers of children with ASD who attend pre-schools in urban settings than rural/town ones. This represents the group who were least likely to be satisfied with AIM. There were also more children with physical and sensory disabilities represented in the sample of parent/carers whose children attended pre-schools in rural

areas. This represents the group who were more likely to be satisfied with AIM. This results in some skewing of negative and positive perceptions. Such location-based distributions of the survey population may interact with providers' perceptions since where parent/carers are unhappy, and where practices are not having the impact that was hoped for (by both providers and parent/carers) it is reasonable to assume that belief in the sustainability of AIM is more likely to be challenged.

Further qualitative and quantitative analysis was implemented to investigate location-based differences in perceptions of sustainability, and these are summarised in what follows:

Significant differences between survey groups' perception of AIM - Location and Sustainability

Differences in perceptions of sustainability were as follows:

- There is very strong evidence of an association between the geographical location of the pre-school setting and practitioners' belief in the sustainability of AIM. P= 0.002. The major departure from independence is due to practitioners working in city pre-school settings being less likely to believe AIM is sustainable than those working in either town or rural settings. This further confirms that this difference exists for the sampled population.
- There is very strong evidence of an association between the number of children in the pre-school and the geographical location. p <0.001. The major departure from independence is due to rural settings being more likely to have 29 or fewer children than either town or city settings.
- No significant relationship between the size of the setting (under 29/0ver 30 vs belief in sustainability Y/N) has been found.

These data demonstrate that the size of the setting does not have a clear relationship with perceptions of AIM impact and sustainability, and hence cannot explain location differences in perceptions of sustainability, though other factors related to perceptions of LINC training offer insights into what may be going on.

Groups 'city and large urban' compared to 'rural and town'

Differences between these groups were very small though respondents working in settings located in towns and rural areas wrote text coded to the category *LINC course was effective and well managed'* more frequently, implying that the programme is a better fit with their needs.

Groups 'more than 30 on roll' compared to '29 or less on roll''

- Settings with higher numbers of children on role reported that the LINC course was challenging and that it was impacted by workload more frequently than those in smaller settings (0.45 and 0.40 respectively). This implies that workload pressures for LINC enrolees are greater in larger settings, and within the survey population, larger settings are more prevalent in urban locations.

These data offer a potential explanation for different perceptions of sustainability. This is because it can be inferred from these data that the workability of LINC, and indeed the LINC programme itself is important in building a sense of self-efficacy for implementing AIM (and hence of its sustainability).

Considering how the LINC programme can be made equally impactful in both urban and rural/town locations is an important task within the development of AIM.

Significant differences in pre-school providers' perceptions of AIM's benefits and impacts and the year started in AIM.

The following offers a collation of statistically significant differences among providers and the year their pre-school started with AIM.

Year started in AIM: 2020-21

- More likely to report that the impact of AIM was 'small' or brought 'little or no benefit'
- Less likely to report that AIM had benefitted parent/carers of children whose children did not have disabilities
- Less likely to report that AIM had benefited children, staff, parents, and carers
- Less likely to report that the benefit of AIM to children with disabilities/additional needs was 'a great extent'
- Less likely to believe in sustainability
- Less likely to rate the impact of Early Years Specialist Advice highly.
- More likely to be satisfied with the application process

Year started in AIM: 2016

- More likely to report that the INCO role had made a positive difference to their setting.
- Less likely to select 'none of the above' when reporting whether children with disabilities/additional needs were getting the most out of their ECCE programme because of Level 4 (EYS advice and mentoring)
- Less likely to report that advice and mentoring from the EYS (Level 4) had impacted positively on the development of inclusive pedagogy.

Year AIM started between 2017-18 and 2018-19

- More likely to report that AIM had benefited parent/carers of children with additional needs, and parent/carers of children who did not have disabilities.
- More likely to report that AIM had benefited children with disabilities/additional needs
- More likely to see the changes made to their setting as sustainable
- More likely to rate the impact of the Early Years Specialist Service highly.

These data demonstrate that providers are most likely to report both positive impacts and belief in sustainability if they started the AIM programme between in 2017-18 or 2018-19. Analysis of the qualitative data in the survey also revealed that pre-schools that AIM in 2017-2019 tend to report the benefits of AIM Levels 4-7 more frequently than settings that joined the programme later. From this we can infer that as providers come to view the impacts of AIM over time, their perceptions of AIM develop to be more positive. It is reasonable to assume that as experience of AIM's implementation grows and evidence of impact grows, so do positive perceptions. This is because inclusive culture and practices take time to build. The more negative perceptions among providers who joined in 2020-21 are likely to be associated with COVID 19 and related disruptions, in addition to the time needed for AIM to embed. This is more evidence of the importance of longevity in a provider's engagement with AIM.

Interviews with stakeholders

Members of the AIM team and AIM delivery agencies identified workforce capacity development as an essential principle of AIM since this was needed to transform the skills base and culture within the

pre-schools in readiness for the inclusion of children with disabilities. Participants had seen evidence that AIM was having a positive impact on the confidence and willingness of pre-schools, and it was noted that AIM Levels 1, 2, 3 and 4 were essential to this. The increasing presence of children in mainstream pre-schools was also seen as a catalyst for increasing confidence among parent/carers and practitioners. Where there was an inclusive culture, families would also experience a feeling of reassurance and acceptance.

Participants noted that financial incentives had been a reason for the take up and success of CPD. There were concerns about attrition rates following graduation from LINC, and this was perceived to be a consequence of poor pay and conditions in the sector, meaning that the retention of this skilled and knowledgeable workforce was at risk. In turn, this was putting AIM's impact at risk. This concern was also prevalent in the research literature, where there was wide support for quality and impact monitoring as embedded aspects in national strategies for inclusion. This is more evidence of the need for tighter monitoring and oversight and of the need for improved pay and working conditions in the sector as a whole.

This was evidenced in interviews with pre-school practitioners who agreed that CPD at AIM Level 1 had influenced practice and increased the capacity for inclusion in the workforce. Their focus tended to be on the use of these supports rather than general practices, which may indicate that universal provisions are so embedded as to be taken for granted. It will be important to continue to emphasise how essential these universal practices and attitudes are to the success of AIM. Interestingly, when practitioners were reflecting on the LINC programme, they were positive, but some felt that it needed to be at a higher academic level since it did not challenge them or add to their portfolio. This indicates some need to develop the CPD portfolio so that it is more personalise-able to practitioners' varied needs and existing qualifications profile.

Case studies of children and pre-school settings

In all 14 case studies of children, there was evidence of positive capacities for inclusive practice. Settings were seen to provide access to engaging resources which were used to facilitate choice, challenge, and support. There was evidence that the children were supported to engage in activities alongside their peer group (e.g., scaffolded play, group events like mealtimes, and staff encouragement of positive relationships between children). In all case studies of children, staff were observed to construct an inclusive culture with commitment and expertise deployed in ways that brought benefits to children (e.g., high expectations of children, normalising routines around medical needs such as diabetes, responsiveness to children's communication when they were non-verbal).

Overall, capacities for inclusion were more limited where children exhibited challenging behaviour or where the setting perceived a need for more support and advice from HSE specialists in meeting children's medical needs. Participants communicated that they would welcome more engagement and collaboration with external specialists as part of their journey towards including all children. This is more evidence of the need for CPD (Level 3), mentoring and coaching (Level 4) related to psychosocial disabilities with a behavioural dimension. It is also evidence of a perceived need for more access to specialist advice so that children with medical needs and/or complex needs could be supported in mainstream settings.

Literature Review

The literature review observations drew the following implications for AIM from the international literature

- CPD needs to be utilised effectively to develop the professionalism, agency and pedagogic knowledge of Early Years staff including those who provide additional assistance in the pre-school room (Level 7)
- AIM funding (targeted and universal) needs to avoid a CPD expenditure trend which is unnecessarily high due to staff attrition.
- The quality and impact of CPD provided through AIM Levels 1 and 3 need to be measured as an element of effective oversight and governance in relation to a) universal support and b) decentralised funding for staff development.

Conclusions: Has AIM influenced practice or increased capacity in the workforce?

- From the perspective of all stakeholders, AIM has influenced practice and increased capacities for inclusive practice in the workforce. Most (96%) of providers report that AIM has had a positive impact on the development of inclusive practice. Participants perceive that this impact is helped by an enabling government policy, incentivisation (funding) and the quality of the CPD offer. Participants have argued that this impact is put at risk by high workforce attrition rates caused by low pay across the sector. This has also been identified as a risk for inclusive practice in the evaluation's review of the literature (see Section 3).
- For parent/carers, an overall positive view of the impact of AIM is associated with the perception that staff are well trained. Parent/carers of children with ASD are more likely to report that staff are poorly trained than parent/carers for other types of disability.
- Though perceptions of the CPD offer (at Level 1 and Level 3) are generally positive and praised (sometimes lavishly) by participants (e.g., n=489 providers praised the LINC programme in the survey)[101], there are some differences of opinion. Across the data, two key reasons are given for positive or negative evaluations of AIM Levels 1 and 3. The first is that the programmes are not at the right level (either too basic or too challenging), and the second (related to LINC training) is that staff in larger settings (which in the sample are more prevalent in urban areas and cities) have workloads that impede their engagement with LINC training. These findings demonstrate that pre-schools would benefit from a more flexible CPD offer, with options suited to their qualification level. They also demonstrate that current providers can make their programmes more impactful by tuning them into providers' current circumstances (e.g., to consider how LINC training may be designed to be more workable in larger, urban settings), and how the challenge level of shorter courses (e.g., Hanen Teacher Talk) might be varied.
- There is a need for more training and support for providers in inclusive practice for less visible disabilities (e.g., ASD, emotional disturbance), behavioural needs and more complex needs.
- The majority (67%) of pre-school providers believe in the sustainability of the changes made to their pre-schools as a result of AIM. A quarter of the survey population was less positive: 19% believed that these changes were not sustainable and 6% that AIM had made no impact. Pre-schools in city/large urban areas were significantly more likely to doubt sustainability (28%) than those in towns (18%) and rural areas (14%). There is evidence that providers' perceptions of the workability of LINC training within their setting (due to workload) interact with perceptions of sustainability leading us to conclude that LINC has an important role in building self-efficacy for inclusion among its participants and graduates.

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[101] Please see further evidence related to AIM Level 1 and 3 in subsection 2.3.

- The quality and impact of CPD provided through AIM Levels 1 and 3 need to be measured as an element of effective oversight and governance in relation to a) universal support and b) decentralised funding for staff development.

13.3: Is the current approach appropriate in the National Context?

There is clear evidence that AIM's current approach is working in the National context, and participants continue to believe in its potential to perpetuate a more inclusive pre-school system. There is broad support for AIM and its intentions, as well as its structure as a combination of universal and targeted supports. Participants were able to describe the strengths of the approach and areas to be improved. These observations include reference to AIM overall, and reference to each level.

The summary begins with a focus on how well AIM is working overall. The focus then shifts to each of the AIM Levels

Areas that are working well in AIM overall

In what follows, findings on the appropriateness of AIM *overall* are reported drawing on the findings from each method of data collection. As reported in subsections 13.1, and 13.2, participants hold broadly positive views on AIM's impact on full inclusion, meaningful participation and workforce capacity for inclusive practice, and there is unambiguous evidence that most children are experiencing positive benefits from AIM, with some variations.

Documentary Analysis
In relation to its fit with the National context, analysis of the documentary evidence revealed that AIM was well-formed and coherent within the DCEDIY and its agencies. Since the end of year one review, continual improvement has been applied, including the movement of all applications and referrals for AIM to the Early Years Hive. It is relevant to note here that this has had a clear positive impact since we know that providers who joined AIM in 2020-21 are more likely to be satisfied with the application process, and this difference is statistically significant. The following findings are evidence of an improvement in AIM's take up.

- AIM has been developed and implemented both deliberatively and at speed to achieve its initial objectives. Since 2015, AIM has also been enhanced beyond its initial objectives through the continuation of LINC training beyond four years and the addition of the LINC+. Applications for AIM have moved to the Early Years Hive which is a system for managing all funding schemes for Early Learning and Care. Providers joining AIM in 2020-21 were statistically more likely to describe AIM application processes as easy to use than in previous years suggesting that this has had a positive impact.
- Investment in AIM has also grown, with a budget increase of 7% for the Level 7 payment to pre-schools announced in 2021.
- The spend on ELC is forecasted to increase to €1bn by 2028, in support of an improving wage profile for the sector, and hence, increased delivery costs. In light of the potential negative impact of staff attrition on AIM, this is positive.
- A general positive trend in participation in AIM is evidenced in data provided by Pobal. There has been an overall positive trend in the number of services benefiting between the first full programme year (2016/17) and 2020/21 (1,283 to 2,048), the number of children benefitting (2,486 to 4,262) and the total number of AIM supports provided (4,087 to4 0,603). The

number of visits by Better Start EYSs has also increased substantially during this period (7,900 to 16,541) with one drop to 3,247 in 2018/19.

- A study by researchers at the Economic and Social Research Institute (Whelan et al., 2021) was commissioned by Pobal to investigate the incidence of childhood disability among 3–5-year-olds in Ireland. The findings showed that the number of AIM-supported children in proportion to the number of children with disabilities increased considerably between 2016 (where it was equated to be between 10 and 20 percent in each county) and 2019 where this figure was between 20 and 40%. Whelan et al. (2019, p65) conclude that 'this indicates a rapid expansion of both take-up over the period from the launch of the programmes in 2016 up to 2019.'

AIM, along with the NCS and the PDS, is further evidence of the Irish Government's commitment to creating a high-quality ELC system through strategic policy-making and budgetary allocations. AIM emerges as one important programme within an ecology of strategies designed to make ECCE accessible for all families, including those with disabilities and/or additional needs. AIM is positioned within a cohesive portfolio of programmes designed to improve equity and quality in the sector. In summary, AIM's roll out at the National level has been successful in terms of the objectives set at its launch.

Literature Review

AIM sits securely and congruently within international policies for equity in ELC and is positioned with a Human Rights paradigm. It combines throughput (universal) with input (targeted) funding so as to develop inclusive pre-school cultures as the foundation for effective targeted support.

Survey of parent/carers

In general, the aspects of AIM that parent/carers felt had made the greatest difference to their child's inclusion were additional assistance (staff member) (62%); working in partnership with pre-school staff (34%); and the information or advice provided to pre-school staff on inclusion (26%). Numbers of parent/carers selecting L6 (therapeutic support) as having been most impactful are relatively low but similar to the numbers who had identified it as an AIM support that their children were receiving, which implies that when L6 is provided either within or outside AIM, it is deemed impactful by parent/carers. It is important to note that there is evidence that when selecting 'AIM Level 6 (therapeutic support), they are not always referring to HSE advice and intervention received through AIM but outside it (i.e., via a diagnosis prior to the pre-school start, or through a referral made by a HSE professional rather than an EYS). The number of parent/carers reporting that additional equipment had made the most difference was significantly higher in 2016 (21%, n=33) and 2017 (20%, n=35) than in later years. The number of parent/carers reporting that additional assistance had made the most difference was significantly lower in 2016 (54%) in comparison to the average for all years (62%). These data illuminate important phenomena. The first is that longevity of engagement in AIM by pre-schools is important for its effectiveness, and the second is that parent/carers tend to equate AIM with its targeted supports, specifically those that are most tangible and observable (Levels 5 and 7). The third is that HSE support, when referred to as Level 6, is relatively absent from participants' experience of AIM. These phenomena will be revisited throughout this subsection.

When parent/carers are reporting positive perceptions of AIM, these tend to be because pre-schools *did* manifest an inclusive culture, or because the targeted support they believed to be necessary to their child's inclusion was in place.

Quantitative analysis has shown that AIM support is seen by parent/carers as crucial to positive impact as follows:

- There is very strong evidence of an association between the perception of a negative outcome of AIM support and an overall negative view of the impact of AIM on the child ($p < .001$). The major departure from independence is due to parent/carers who perceived a negative outcome from AIM support were less likely to have a positive view of the impact of AIM on their child.
- There is very strong evidence of an association between the perception of AIM support making no difference to the child and an overall negative view of the impact of AIM on the child. ($p < .001$). The major departure from independence is due to parent/carers who perceived no difference to their child from AIM support being less likely to have a positive view of the impact of AIM on their child.

Survey of ELC providers and parent/carers

When asked to describe the elements of AIM Levels 1-3 that had the most impact on how the setting delivered inclusive practice, responses were varied but included to approximately equal degrees; training (e.g., Diversity, Equality, and Inclusion Training; Hanen, Lámh), resources (inclusive play materials), the INCO role, the AIM website, and the LINC programme. This implies that, for *universal provisions*, Levels 1 and 3 are experienced as having most impact, but settings vary in the aspect they select as most impactful. When asked to comment on the most impactful aspect of *targeted support*, qualitative analysis showed that Level 7 is perceived to be the most impactful AIM targeted support (403), followed by Level 4 (98), and Level 5 (22). Some participants grouped Levels 5, 6 and 7 to describe support with the most impact (10). This indicates that all elements of AIM are considered to be of value, with targeted support considered to have the most impact, and the most prized (Levels 4, 5 and 7).

This was also true of parent/carers perceptions. Qualitative analysis was conducted on free-text responses to the question, 'How much impact, if any, has AIM made to inclusion at your early learning and care (ELC) setting?' The following reasons were the most frequent in responses:

- AIM support has a positive impact on children with additional needs (412)
- AIM support in funding for extra staff (referring to Level 7) (162)
- Improvements in communication between pre-school, services, and families (153)
- AIM Level 4 support and advice (24)

Interviews with stakeholders and case studies

Members of the AIM project team and delivery services held a consensus view of AIM's purposes and principles. They were aware that AIM had been taken up by large numbers of providers and families (also evidenced in the documentary analysis) and reported that evaluations of the AIM application process confirmed that it was fair and equitable. High levels of engagement by providers and good public awareness were seen as key achievements for AIM, and beneficial to its future sustainability. Evidence from the evaluation did bear this out, but for parent/carers, AIM is generally conceived to be synonymous with Level 7 support.

Representatives of the AIM project team and delivery agencies believed that the successes were in large part attributable to effective cross-departmental working, in a context of effective leadership. A committed, proactive drive from leaders in the DCYA (later DCEDIY) was identified as crucial to this positive story. Effective engagement, consultation, and representation across departments, inclusive of representation from parent/carers and other advocates, was mentioned by participants, as an effective strategy in AIM's roll out and take up, though it was noted that this kind of cross-sectoral working was not working as well at the local level. Participants from the Disability Sector focused mainly on areas for development but agreed that AIM was the right model, at the right time, and that it filled a clear need. Hence, all of these stakeholders considered AIM to be appropriate in the National

context. Among this group of stakeholders, 25 recognised that the term disability was recognised negatively by many parent/carers or was not a term that they associated with their child. There were mixed views on whether this term should be revised though it is also important to note that 16 providers reported the term ‘disability’ in the information about AIM to be unhelpful, particularly where parent/carers were in the early stages of learning that their child might need additional support (a total of 91 instances of this issue being mentioned across the data.

When reflecting on AIM’s strengths, 11 of the 18 parent/carers who were interviewed believed that AIM was instrumental in ensuring that children with disabilities/additional needs got the personalised support they needed. Others emphasised the value of having a menu of choices and options, and 2 parent/carers celebrated the fact that AIM support was not dependent on a diagnosis. AIM support (particularly at Level 7) was regarded positively as a resource for creating opportunities for inclusion, participation and learning in the pre-school. Across all stakeholders engaged in this evaluation, there was a coherent and consistent understanding of AIM’s rationale and intentions. This is not easy to achieve and is an important strength to build on.

ELC practitioners considered AIM’s overall strength to be its effectiveness in ensuring that children with more diverse needs were able to access ECCE. In the pre-schools visited for case studies, all participants welcomed the principles of AIM and considered it a welcome addition to the sector.

Based on these findings, we conclude that overall, AIM is perceived by stakeholders to be the right model for supporting the inclusion of children with disabilities in the National context. It is welcomed by stakeholders and even where they have had a negative experience with AIM-supported ECCE, they still see its potential as a model that could work.

Aspects of AIM overall that are in need of development

The evaluation found evidence of the following areas that would benefit from continuous monitoring and improvement:

- Some participants experienced delays in assessment and allocation, particularly at Level 5 and 7. In the case of Level 7, this was often due to difficulties in recruiting staff to additional assistance posts. For parent/carers this had been a particularly painful experience. In the qualitative survey data for parent/carers, there were 44 mentions of delay as an impediment to children’s inclusion. In interviews and case study visits, 12 providers, and 2 representatives from the disability sector also described this phenomenon. Their view was that this was a challenge to inclusion because settings do not have the resources that they need to support children. Stakeholders argued that there is a need for allocation processes to be speeded up or supports substituted during the waiting period (case studies of settings and children, interviews with stakeholders).
- Providers argued that as expectations for inclusion rose in the system and among parent/carers, they would be called on to support children with an increasing range of medical needs and/or complex needs. They argued that advice and support from HSE specialists would help them to do this more effectively, and hence, increase their confidence to include all children (interviews with providers and case studies). This observation was also made in the OECD’s review on sector quality in Ireland *Strengthening Early Childhood Education and*

Care in Ireland (OECD, 2021)[102] which recommended further efforts to support inclusion through providing additional specialised expertise for pre-schools in relation to diverse children (i.e., disability and other types of disadvantage, in particularly the inclusion of children from Traveller and Roma communities). The OECD report also observed some evidence that stakeholders across the sector were calling for the involvement of specialists (documentary analysis)

- Parent/carers and providers argued that AIM's targeted support would not always be sufficient to support children with very complex needs[103], and the distributed model of support at Level 7 was not always appropriate in contexts where children's medical needs or challenging behaviour called for more intensive adult support. There was a call for more flexibility on this (case studies of settings and children, interviews with stakeholders).
- All stakeholders perceived that AIM's impact was being limited and would continue to be limited by poor pay and conditions in the sector. It would be important to acknowledge how this interacted with the additional challenges and administrative burden that AIM places on pre-school staff who are already working in an underpaid sector. This phenomenon also put the impact of Level 7 support at risk and caused wasteful attrition of staff who have become more expert and qualified in inclusion as a result of AIM (case studies of settings and children, surveys of parent/carers and ELC providers, interviews with stakeholders).
- Successful transition to school, and particularly mainstream school, was an outcome of AIM that parent/carers celebrated and/or hoped for. However, there were several accounts of difficult and distressing experiences in the data, with parent/carers feeling that they needed more advice on how to access a mainstream school or manage resistance from their first choice of school. Participants from the disability sector and the AIM team argued that more effective cross-sectoral working practices would offer a solution for parent/carers (for example between Special Educational Needs officers – Department of Education [DE], Children's Disability Network Teams - CDNTs, the Early Years Support Service – EYSS, and pre-schools). There also needed to be sufficient capacity within local services (e.g., CDNTs, CCCs) to provide information/advice/advocacy services for parent/carers who were trying to make choices and secure options (such as mainstream primary school placements) in a complex and confusing landscape (interviews with stakeholders).
- Participation in AIM by all families who might wish to avail of it, was limited because parent/carers depended on learning about AIM from professionals with whom they had prior contact. For families of children with additional needs (that might not yet be diagnosed or identified), knowledge and advice about AIM needed to be held and shared by those working with children and families since birth (e.g., General Practitioners, Public Health Nurses). There was a need for more training across this sector of professionals (interviews with stakeholders) so that parent/carers were aware of AIM earlier, and so that they were accurately advised of the full range of options (interviews with stakeholders).
- The documentary analysis found that although information about AIM was coherent and effectively communicated by the DCEDIY and its agencies/partners (CCCs, Pobal, Better Start), it was largely absent from intersecting organisations (DE, National Council for Special Education – NCSE, HSE and HSE linked agencies, demonstrating a need for cross-sectoral work on expanding presence and messaging for AIM (documentary analysis).

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[102] OECD (2021), *Strengthening Early Childhood Education and Care in Ireland: Review on Sector Quality*, OECD Publishing, Paris, https://doi.org/10.1787/72fab7d1-en.

[103] It was reported to us that a nursing supports pilot is currently underway to explore how such provision could be integrated into mainstream pre-schools.

- Where parent/carers are unhappy with AIM, it is often because of the lack of an inclusive culture, which they know *implicitly* to be the bedrock for effective use of AIM targeted support. AIM's sustainability will be at risk if calls for targeted support erode the resource for universal support and inclusive practice (interviews with practitioners), and if the resource invested in, and value of Level 1 is not explained more clearly. This is a phenomenon widely reported in the literature, where diligent governance of the quality and impact of universal supports is identified as a way to manage this risk (interviews with parent/carers, literature review).
- Parent/carers also report more positive perceptions of AIM's impacts and benefits when communication with pre-school staff is good, and where supportive relationships are in place. Parent/carers generally call for more of a partnership approach within AIM (survey of parent/carer, stakeholder interviews, case studies of settings and children). This finding has been reinforced by further quantitative analysis which shows the following:
    - There is very strong evidence of an association between the perception that working in partnership has been beneficial and an overall positive view of the impact of AIM on the child. $p < .001$. The major departure from independence is due to parent/carers who did not perceive partnership working as being a beneficial aspect of AIM being less likely to have a positive view of the impact of AIM on their child.
- Generally, among parent/carers, AIM is perceived as less impactful and beneficial when children's reported main type of disability is ASD. To a degree, this is also true for children with other types of less visible, psychosocial difficulties (emotional disturbance, specific speech, and language disorder) and complex disabilities (multiple main disabilities)[104] . Parent/carers of children with these needs have reported positive impacts and experiences (e.g., 69% of parent/carers with ASD reporting that AIM had benefited their child to a great or some extent), but they are significantly less likely to report impacts and benefits overall.
- Among parent/carer and providers, AIM is perceived to be less effective when the pre-school is in an urban or city area. [105] (Surveys of ELC providers and parent/carers). Further reporting on these differences is provided in subsections 13.1 and 13.2).
- Across stakeholders, there was a call for tighter monitoring and regulation of the way that AIM support is being used (in terms of implementation fidelity and quality), particularly in relation to AIM Level 7. Members of the AIM project team and delivery agencies recognise the importance of this in the next phase of AIM. The literature review contains alerts about the importance of tight governance systems for continuous monitoring and evaluation of universal supports. The need for more integrated and routine systems of monitoring focussed on fidelity, quality and impact is evidenced by this evaluation.
- Hope and faith emerge as less tangible but essential resources for AIM's sustainability. There are general indications that where pre-schools have been engaged with AIM for longer (i.e., year started 2017-18 or 2018-19), they are more positive about AIM and their ability to sustain inclusive practice (survey of ELC providers). This may indicate that AIM takes time to embed, and that providers become more convinced of its efficacy as they observe this over time. Where parent/carers' experience of support and impact are positive, they are also more hopeful about their child's future (interviews with parent/carers). It may be important to assert AIM as a parent/carer partnership model. This phenomenon was also highlighted in the review of international literature where two implications for AIM arose from international data and debate to emphasise:

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[104] See section 13.2 of the full Technical and Research report for a fuller analysis of these differences and explanations for them

[105] See section 13.1 and 13.2 of the full Technical and Research Report a fuller review of these differences

- Families’ human right to actively engage in their child’s education needs to build trust through two-way communications, which enables every unique child’s equitable participation in an inclusive environment.
- Families’ need to have confidence that the parameters of the AIM funding model will:
    - meet their child’s needs;
    - prepare them for the next phase of their education (i.e., transition into primary school).

A summary of conclusions follows.

Conclusions: Is AIM (overall) working in the National context?

Conclusions on what is working well in the National context (AIM overall)

- Stakeholders welcome AIM, regard it as the right model for supporting the inclusion of children with disabilities in mainstream pre-school and believe in its potential to deliver positive outcomes. A shared understanding of AIM’s rationale and intentions is in evidence across stakeholder groups, including parent/carers.
- There is clear evidence that AIM’s approach is appropriate in the current, National context. The evidence from the evaluation shows that to varying degrees, the benefits of Levels 1, 2, 3, 4, 5, 6[106] and 7 are being experienced by parent/carers, providers, and children. Again, to varying degrees, these supports are considered essential to the full inclusion and meaningful participation of children with disabilities and additional needs.
- Take up and engagement with all of these levels has been positive, and in most cases growing (exceptions are Level 5 and Level 6). The proportion of children with disabilities who are supported by AIM has grown rapidly between 2016 (10-20%) and 2019 (20-40%).
- Cross-sectoral collaboration in the development of AIM is seen by members of the AIM team and its delivery partners, as key to its success both now and in the future.
- There is clear evidence that AIM supports are being implemented effectively to support children, with positive impacts on their experience of full inclusion and meaningful participation.
- Parent/carers awareness of AIM supports is highest for Level 5 and 7, which are also the most tangible and visible elements of AIM support.
- There is evidence that parent/carers and providers prize targeted support (Levels 4-7) most highly, and Level 7 is regarded as the most impactful element of AIM overall. Receipt of Levels 4-7 is associated with positive perceptions of AIM and its impact.
- The INCO will play an increasingly important role in ensuring AIM’s effective implementation, continuous improvement, and sustainability.

Within a context of continuous improvement based on the findings of this evaluation, we conclude that overall, AIM is working well in the National context.

Conclusions on what needs to be developed in the National context (overall)

- Within a generally positive picture, there are areas for development in AIM overall. These are:

[106] It is important to reiterate that where participants are referring to AIM Level 6, there is evidence that they are conflating this with HSE interventions accessed outside of AIM.

- Developing AIM's impact on successful transition to primary school, and mainstream primary school.
- Improving all parent/carers' experiences of communication, collaboration, and partnership in the plan/do/review cycle of AIM in the context of the Access and Inclusion plan, and as part of an inclusive culture more generally.
- Ensuring that parent/carers have explicit awareness of the way that AIM's universal supports are fundamental to the inclusion of their child. Increasing their awareness of the contribution that AIM Levels 1, 2 and 3 make to meeting their child's needs.
- Developing AIM as a more effective strategy for connecting HSE services with pre-schools so that a) higher numbers of providers and parent/carers can benefit from specialist advice through AIM Level 6 (universal) and b) higher numbers of children can receive therapeutic interventions when needed through AIM Level 6 (targeted). This is in a context where other pilots and projects are exploring ways to deepen the connection between pre-schools/schools and therapy services (e.g., the PDS programme, the In-School and Early Years Therapy Support Programme[107]).
- Ensuring through continual monitoring that current strategies focussed on improvements to pay, and conditions impact positively on AIM and its outcomes (e.g., on recruitment and retention of highly qualified staff, in the recruitment and retention of high-quality additional assistance – Level 7)
- Making available, an independent information/support/advocacy service to parent/carers so that they are aware of the options available to them through AIM, and how to navigate these options, including at the point where they are preparing for transition to primary school.
- Developing communication strategies that inform parent/carers about AIM prior to pre-school enrolment so that awareness of AIM (and its capacity to make mainstream pre-school an option) is more equitable for children who do not enter pre-school with a diagnosis or with a prior relationship with specialist services or staff within the pre-school.
- Developing knowledge about AIM among HSE professionals who support children and families from birth (e.g., GPs, Public Health Nurses) such that they are an avenue to awareness about AIM for parent/carers of children who do not have a diagnosis prior to pre-school.
- Improving the capacity of AIM to impact all children equally (including those with less visible, behavioural disabilities such as ASD, emotional disturbance and specific speech and language difficulties), and more complex needs (multiple main disabilities)
- Developing robust methods of oversight so that the implementation of AIM supports is high quality and in keeping with AIM's intentions.
- Finding ways to reduce the negative impact of wait periods for AIM support on children's experience of inclusion.
- Reviewing AIM rules as regards employers' responsibility for ringfencing time for the INCO to perform their role effectively.

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[107] Lynch, H., Ring, E., Boyle, B., Moore, A., O'Toole, C., O'Sullivan, L., Brophy, T., Frizelle, P., Horgan, D., and O'Sullivan, D. (2020) *Evaluation of early learning and care and in-school therapy support demonstration project*, National Council for Special Education. [Online}. Available at: https://ncse.ie/wp-content/uploads/2020/11/Demo-project-evaluation-fInal-for-web-upload.pdf

Areas that are working well, and areas for development in each Level of AIM (Levels 1-7)

This subsection summarises the evidence for what is working well and what needs to be developed in each Level of AIM (Levels 1-7). Sources of evidence are identified in brackets.

AIM Level 1: An Inclusive Culture (aspects that are working well)

- 91% of providers agree that having a named INCO impacts positively on inclusive culture, pedagogy, and practice, and 78% agree that the LINC programme has impacted positively on their settings' ability to include children with disabilities (survey of ELC providers)
- Take up of the LINC programme has been high (by the end of 2020, there were 3,504 graduates which exceed AIM's launch objectives), and this is also true of the Diversity, Equality, and Inclusion (DEI) training provided by City/County Childcare Committees (CCCs) where 6,500 practitioners have participated (documentary analysis).
- Participants are generally satisfied with the quality and impact of Level 1 training (survey, interviews, and case studies with ELC providers), and the INCO role is regarded by 91% of providers to impact positively as a resource for leadership in inclusion in ELC settings (survey of ELC providers). Practitioners reported that they had experienced the DEI training as a useful space for reflection (interviews with practitioners). There is much praise for the quality and relevance of the LINC programme in qualitative data in the ELC provider survey.
- In visits to the settings involved, inclusive play materials were observed to be in use and were featured in all of the child case studies (case studies of settings and children).
- Case studies of children and settings demonstrated that pre-school practitioners understood and could apply effective inclusive practices, and that their developing knowledge was being deployed to the impactful design of universal and targeted support for children. Practitioners also held high expectations of children and promoted the mutual valuing of diversity. The visual environment was also observed to be supportive of children's inclusion at the universal and targeted level (case studies of settings and children).
- Evidence from the evaluation (as reported earlier) demonstrates the relationship between the presence of inclusive cultures in the pre-school and parent/carers' positive perceptions of AIM.

AIM Level 1: An inclusive culture (areas for development)

- All (18) of the parent/carers interviewed were unaware of the term 'AIM Level 1' and had not heard of it before talking with researchers. The majority (17) did not know whether there was an INCO in the setting or not, but 1 was aware and was in touch with this practitioner. 3 parent/carers reported that they were in touch with the pre-school manager or a Level 7 support worker who had been very supportive. It is important to note, that though parent/carers do not use the term AIM Level 1, when describing the practices that were associated with a positive experience of AIM, they were often describing the principles and practices of an inclusive pre-school culture in their reflections on their experiences of AIM (interviews with parent/carers). These positive experiences were positively related to knowledgeableness (e.g., staff expertise and commitment to inclusion, use of specialist practices) and high-quality practices reflected in *Aistear* principles (e.g., ongoing assessment and a rich curriculum). This suggests that in the context of AIM, where practice is high quality under the terms of national quality frameworks, it is also inclusive. This speaks further to the foundational nature of Level 1 for inclusion.
- Parent/carers' awareness of the types/levels of AIM support available at their pre-school was relatively low. For most levels, 40-50% of respondents answered that they didn't know if Level

1-4, and Level 6 support was available for their own child, Awareness of AIM support for children other than their own child was around 5-6% for these levels. This creates potential risks to Level 1, since where parent/carers are unaware of its presence and impact, they may devalue it in pursuit of targeted supports (survey of parent/carers, interviews with stakeholders) with pursuant pressure on funding for it. This phenomenon was also reported in the literature review (survey of parent/carers, literature review).

- Where parent/carers were unhappy about the level of inclusion for their child, it was often because the culture was not inclusive (as reported in subsection 13.1). In response to the survey question, 'What additional supports do you think would need to be put in place to support your child?' 15 parent/carers wrote that more partnership with parent/carers (communication and working with them) would improve things. This point was also raised by parent/carers who were interviewed implying that a more partnership-oriented approach (that engages parent/carers more), is likely to make AIM more impactful. Parent/carers raised the following suggestions about areas for development in AIM (interviews with parent/carers). Within policy, these activities sit within the INCO role, and have emerged in descriptions of an inclusive culture:
    - A more formal and agreed approach to feedback and communication between the pre-school, AIM supporters (EYS) and parent/carers (11)
    - More involvement of parent/carers in the development and review of the Access and Inclusion Profile (or other forms of formal plan/do/review assessment) (3)
    - More regular feedback on child's inclusion, participation, and progress (8)
    - Co-construction of support and inclusion programmes with parent/carers (4)
    - Support, advice, and information for parent/carers from pre-school staff and AIM, supported by better feedback and communication (as above) (4)
- Though there was much praise for the LINC programme, a minority of participants considered it insufficiently challenging, and some participants wanted it to be offered at a higher qualification level so it would add to their portfolio and be more relevant to their needs. Practitioners who were working in larger settings (with these being more prevalent in urban areas) were also struggling to engage with the LINC programme because their workload was so high. INCOs and LINC graduates reported a need for follow-up training and support (in the form of peer-to-peer networks) (interviews with stakeholders, case studies of setting and children).[108]
- Analysis of qualitative data in the survey of ELC providers shows that a few respondents were negative about LINC training, and this was for the following reasons:
    - The course was ineffective because it didn't cover practical elements of AIM such as the Access and Inclusion Profile (49)
    - The course was repetitive since it covered things already known by respondents (16)
    - A heavy workload impacted on engagement with the programme (13)

  As was discussed in subsection 13.2, participants working in urban settings are less likely to believe that the inclusive changes made to their setting are sustainable, and some personalisation of LINC training around varied contexts (e.g., large pre-schools, urban pre-schools) may positively impact on self-efficacy among these practitioners.
- In relation to AIM Level 1, when answering the free text survey question, 'What, if any, suggestions do you have for how AIM could be improved', n=33 respondents wrote that more than one member of staff in each pre-school should be able to enrol on the LINC

[108] LINC+ was in place at the time of writing and offer participants an opportunity to extend their learning within a community of practice. The programme is funded by the DCEDIY.

programme[109]. This was also suggested in interviews with ELC practitioners (Survey of ELC practitioners and stakeholder interviews) and indicates that providers are not aware of the option to enrol a second practitioner in LINC training.

- The INCO role, though recognised as essential, was often experienced as time-consuming, and it was suggested that capitation should be increased to fund regular non-teaching time so that the important work associated with making applications, liaising with parent/carers/EYSs and external agencies could be completed properly (interviews with ELC practitioners, case studies of children and settings). Though decisions about the use of the capitation payment are made by employers, some reviews of funding formulas for larger pre-schools and pre-schools in cities may impact positively on views about sustainability, and the building of an inclusive culture.
- Some participants raised questions regarding the fidelity of the INCO role across pre-school settings. Whilst the INCO role is often undertaken by the owner/manager of the pre-school setting, it was suggested that the INCO role had the most impact when undertaken by a dedicated member of staff who was given awarded time to fulfil the range of roles associated with their responsibilities (interviews with AIM project team, delivery agencies and Disability Sector representatives).
- Some participants voiced concern regarding the ability to retain graduates beyond the completion of the LINC programme. It was noted that the Level 6 qualification awarded to ELC practitioners allowed them to secure work outside of the ELC sector in other professions with better pay and working conditions. As a result, there will be an ongoing need to fund the LINC programme on a rolling basis until the underlying causes of attrition are addressed (surveys of ELC practitioners, and interviews with stakeholders).
- Participants held mixed views regarding the Diversity, Equality, and Inclusion (DEI) training offered to ELC practitioners through the CCCs. Whilst it was felt that there was value in the content of the course, which sought to broaden knowledge and understanding of inclusion, it was noted that there were regional variations in its uptake. Participants felt that this was due to the DEI training being viewed as less important than other funded training, such as the LINC programme. The difference in financial reward was identified as being a contributory factor. Some participants felt that DEI training should be mandatory in order to secure a commitment to inclusive practice across the ELC sector (interviews with stakeholders, case studies of settings and children).
- Reviews of the research literature evidenced the importance of *quality and impact* monitoring following programmes of universal CPD, and of regulation and accountability more generally.

AIM Level 2: Information for parents and carers (aspects that are working well)

- In 2021, a revised AIM website was launched to be more user-friendly and accessible. View numbers had increased steadily between 2016 (55,258 page views) and 2021 (192,312 page views), demonstrating clear growth in engagement with a spike in growth at the point where the website's redesign was launched (documentary analysis).
- It is clear that providers are playing an important role in sharing information about AIM with parents/carers, and that this is also being done by some HSE professionals. We know this because when parent/carers first heard of AIM when their child started pre-school, this was generally from pre-school staff/manager (76%) or a medical or care professional (14%).

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[109] LINC rules state that 'Settings that already have a LINC student or graduate working in their setting can nominate another staff member to participate in LINC (only one applicant allowed per setting)' (https://lincprogramme.ie/apply-now)

- There is a rising trend in the identification of the pre-school staff/manager as the source of information about AIM (73% 2016 to 81% in 2019). The information or advice provided to pre-school staff on inclusion (26%) was one of the aspects of AIM support believed to be most impactful by parent/carers, though we note that parent/carers gain most of their knowledge about AIM from providers and other professionals once they have started pre-school (survey of parent/carers).
- Though it was uncommon for parent/carers to know about AIM before their child started pre-school, this was most commonly from a source named as 'other'. Analysis of the 'other' sources of support shows that these were often visiting teachers, members of the early intervention team, therapists (e.g., speech and language, Occupational Therapy) and psychologists. Parent/carers were also accessing information about AIM from medical or care professionals (24%), support organisations (19%), family/friends (18%), and social media/support forums (12%). A smaller number were accessing information via Government publications/adverts/websites (9%) or knew about AIM because another child had been supported by it (7%).
- 83% of providers noted that they had signposted parent/carers to information on the AIM website, and 86% of respondents reported that when they had sought information, they did find information that met their needs (surveys and interviews with parent/carers and ELC providers).
- It was noted by participants from the disability sector, that parent/carer peer forums had been developing, with positive signs that knowledge about AIM was spreading through the system, with parent/carers who had experienced AIM, sharing their advice with other parent/carers. In this way, longevity in the AIM programme is likely to lead to increasing knowledge in the public sphere, and more awareness of it prior to pre-school enrolment. It may be useful to consider how the DCEDIY might support peer networks among parent/carers (interviews with stakeholders).

AIM Level 2: Information for parents and carers (areas for development)

- In addition to the wider issues reported in the analysis of areas in need of development overall, many participants felt that wording in the information that includes the term 'disability' is off-putting for parents/carers, particularly those who do not perceive their child to have a disability and/or who may be fearful that their child's additional needs might exclude them from participating in ECCE or mainstream education. This issue arose on 91 occasions (43 instances in the qualitative data from the survey, and 48 instances in interviews). An example was provided of a parent/carer who had to be advised not to take the wording of the information too literally. It was proposed that the purpose and principles of AIM would be easier for families to access and understand if there was less emphasis on disability.
- The AIM website has high traffic as noted but does not yet host alternative formats (large text/videos) for accessibility. It does not have a 'Did you find what you are looking for?' feedback link or 'Rate your experience of this website/feedback' type link.

AIM Level 3: A qualified and confident workforce (aspects that are working well)

- Providers have been enrolling in Lámh and/or Hanen Training with 364 enrolments in 2019-2020 (documentary analysis).
- Respondents in the provider survey also reported that staff had been engaging in CPD provided via AIM Level 3 as follows:
    - Lámh training (54%)
    - Learning Language and Loving It and Teacher Talk- The Hanen Programmes for Early Childhood (50%)

- Sensory processing training (49%)
- None of the above (18%)

- Some providers identified Hanen (96) and Lámh (213) training as the most impactful aspects of AIM Levels 1-3 (survey of ELC providers).
- The existing training that ELC practitioners have access to has been well received. ELC providers identified that staff need to feel that they have the skills and knowledge to support inclusive practice. The following training opportunities were identified as having a positive impact on developing ELC practitioner skills and knowledge:
  - Hanen training was described as being very good by most practitioners, however, some ELC providers would prefer a more hands-on workshop approach.
  - All settings who had taken up the Lámh training praised it.
  - SPEL training was identified as beneficial as it reflected targeted training to meet specific needs. ELC practitioners would like to receive further specialist training.
- As reported in subsection 13.2, with some variations across groups (type of disability and location of pre-school), most (78%) of parent/carers believe that staff at their children's pre-school are well trained (survey of parent/carers).

AIM Level 3: A qualified and confident workforce (areas for development)

- We know that parent/carers of children with autism/ASD and emotional disturbance were less likely to agree that pre-school staff were well trained than parent/carers of children with other types of disability (72-73% compared to an average of 78%). It was noted by many participants, that a rolling programme of training was required, and that this would be enriched if it was responsive to the sector's needs and flexible enough to be personalised to specific additional needs currently within a setting.
- Some participants identified that a training bursary could be awarded to pre-school settings to allow them to select from a range of courses, choosing which opportunities they would like to apply their bursary funding towards. The benefit of this approach is that it would allow CPD engagement to be responsive to the needs of the children within the pre-school setting. Collectively, participants identified that the following areas could be addressed through a broader catalogue of CPD (interviews with participants, case studies of children and pre-school settings):

  - Autism-specific training: Most participants identified that there was a great demand for specialist training to support the needs of children awaiting assessment or in receipt of a diagnosis of autistic spectrum disorders. The four EYS who participated in interviews indicated that this reflected the single biggest group of children on their caseload.
  - Medical needs training: Participants felt that there was a need to balance out training with responsibility. It was recognised that as part of the commitment to inclusive practice there were more likely to be children within mainstream pre-school settings with medical needs which would require practitioners to have additional skills and expertise. Due to the diverse range of different medical needs, this block of training could contain different training components including epilepsy, allergies, diabetes, and peg feeding.
- Overall, participants argued that it was important to reflect on how well things are going and to take stock. Though it was clear that AIM was being rolled out with good levels of participation across pre-schools, the focus must now be on what the impact of CPD has been on practice in pre-schools, and what now needs to be done (interviews with the AIM project team and representatives of the Disability Sector). The majority (14) of parent/carers who were interviewed did not feel able to identify training gaps. Where these

were suggested, they focussed on additional training around specific needs, rather than in relation to general best practice, and their suggestions were in harmony with those made by participants from the professional community:
    - training in a range of additional needs (including ASD),
    - direct training by medical/therapeutic staff/specialist teachers for pre-school staff on the very specific needs of an individual child and how they could be supported.
- Across all 14 settings visited for the case studies, ELC providers talked about the importance of refresher courses being rolled out in the future to provide ongoing support for practitioner development. It was noted that in order to avail of some AIM Level 3 training, such as Hanen, it was required that the setting be already engaging in AIM targeted support. Some ELC providers would like wider access to the training for all staff (case studies of settings and children).

AIM Level 4: Expert early years educational advice and support (aspects that are working well)

- Among parent/carers who had experienced support from a Better Start Early Years Specialist (EYS), most had experienced this as positive, and agreed that their child was treated like an individual (83%), and that they were well supported by pre-school staff in the process of engaging with an EYS (87%). 80% agreed that the advice given by the EYS was relevant to their child's needs, and 75% said the process was straightforward. A majority (57%) of parent/carers participated in completing an Access and Inclusion Profile (survey of parent/carers).
- In general, providers were satisfied with the specific types of support provided by Early Years Specialists and its impact on inclusion (survey of ELC providers):
    - 78% reported a positive impact on the inclusion of a child/children in a setting. In 2020/21 this was significantly lower at 66%
    - 95% of settings had sought advice and mentoring from Early Years Specialists (the proportion being higher for community pre-schools at 98%), and 87% had signposted parent/carers to advice and mentoring from Early Years Specialists.
    - 95% of settings had supported parent/carers to complete an access and inclusion profile (98% for community settings) [note: in practice this often seems to be done by ELC staff rather than a parent/carer], and it is noted that this is different from the parent/carer perspective where only 57% report being involved in this process.
    - Providers views on the quality of EYS support was as follows:
        - Satisfied with the quality of mentoring and coaching strategies (81%)
        - Satisfied with support provided in enhancing parent/carer partnerships (71%)
        - Satisfied with the support provided for implementing practices and strategies to support inclusion (80%)
        - Satisfied with the liaison with HSE and other professionals in providing advice on goals for programmes for the child (56%)
        - Access to health service supports to enable the child to access the ELC setting (49%)
- Providers recognised that the coaching, mentoring and support from the EYS was fundamental to inclusion and worked in tandem with the CPD at Levels 1 and 3 to develop their capacity for inclusive practice (interviews with practitioners).
- Of the 14 case study settings, the majority (9) held positive views. The positive experiences of engagement with the EYS were reported as follows (case studies of children and settings):
        - Most ELC providers perceived that their EYS was supportive and approachable

    - Some settings felt they had benefited from receiving mentoring from their EYS
    - Most ELC providers spoke positively of receiving advice and strategies to support the needs of children within the pre-school setting.
    - A few practitioners described the positive impact of meetings between the EYS, parent/carer, and practitioner.[110] It was argued that this works well as strategies can be co-created and used at home and within the ELC setting.
    - In some settings, the EYS has conducted phone calls with families to explain AIM and the type of support that can be provided. This has been particularly beneficial where families have no prior knowledge of AIM.
- Overall, the findings demonstrate the valuable role of the EYS in supporting inclusive practice. EYS support is a complementary component to training and CPD offered within AIM Levels 1 and 3 as it can respond to the individual needs of children and families in the context of the setting.
- An important theme emerging from the case studies, and the data as a whole, was how much practitioners valued opportunities to collaborate with others (EYS and HSE) in the development of inclusive practice around the child.

AIM Level 4: Expert early years educational advice and support (areas for development)

- Among parent/carers, there was relatively low awareness of Level 4 support, and the Access and Inclusion Profile. 48% of parent/carers had heard of an Access and Inclusion Profile and of those 57% were involved in completing one for their child and 43% were not, with 9% answering ‘don’t know’. This is surprising since parent/carer signatures and consent are required on the Access and Inclusion Profile before applications for targeted supports can be submitted[111]. This may be because parent/carers are familiar with the term ‘application’ rather than ‘Access and Inclusion Profile’, or because of limited communication with the pre-school and/or EYS. Other data has demonstrated that parent/carers have expressed a need for more communication, partnership, and collaboration with their child’s pre-schools. 34% selected ‘working in partnership with pre-school staff’ as an aspect of AIM making the greatest difference to their child. We have also found associations between parent/carers perception that working in partnership with pre-school staff has been beneficial and an overall positive view of the impact of AIM.
- On this theme, parent/carers were able to identify priorities for development to AIM from their perspective. Key among these is being more involved in the processes of planning for their child (and review) and experiencing more communication for pre-schools about support and progress for their child.
- When analysing the qualitative data from the survey of ELC providers, though 24 respondents commented that AIM’s positive impact was a consequence of AIM Level 4 support and advice, 24 noted that more visits and intensive support from EYSs would improve AIM (surveys of parent/carers and ELC providers). It became clear that in parent/carers’ view,

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[110] It is important to note that there is an expectation of parent/carer engagement in the production of Access and Inclusion profiles, so a higher number of reports on positive impacts would have been expected.

[111] It is important to note that though submission of an application may be done by the pre-school provider or the EYS (in the case of Level 6), signed parental consent and personal contact details are a requirement before any applications can be processed.

EYS support was oriented towards support for settings, though parent/carers held the expectation (and the wish) that it also included them. This is further support for the claim that INCO's should prioritise the integration of parent/carers in planning for their child.

- Providers in the pre-schools visited as part of the evaluation noted that there is a tendency for Level 4 to be overlooked in favour of higher levels of targeted support, in particular AIM Level 7. This presents a challenge if AIM is not implemented with fidelity. It was proposed that the EYS could have a future role in monitoring and supporting the implementation of AIM targeted supports, particularly Level 7, to ensure it is being implemented in the most effective way and with fidelity to the overall programme (case studies of children and settings)
- Although most ELC providers felt that they had received positive support from their EYS, they had the following suggestions to improve the impact of AIM Level 4 (case studies of settings and children):
    - EYS were perceived by practitioners to have very little time for each setting due to high caseloads. Increasing the number of hours contact provided to each pre-school setting would be beneficial as there would be greater opportunities to access support.
    - COVID 19 was believed to have had a negative impact on EYS availability whilst the provision of telephone support was not viewed as equally beneficial as face-to-face contact. ELC providers hope that in-person visits will resume when possible.
    - Some ELC providers felt that they received diminished support from the EYS following the awarding of AIM Level 7. The provision of ongoing support would be valued by pre-school settings.
    - Some ELC providers identified that they had not received updated targets or goals from the EYS, so were having to devise their own.
    - Due to COVID 19, EYS have had greater contact with families when conducting remote assessments. Most ELC practitioners and families felt that this was a positive experience and wanted this to continue in the future since it brought more flexibility for parent/carers who may be caring for other children at home, or at work. This could be a positive way to create forums for partnership working with parent/carers.

AIM Level 5: Equipment, appliances, and minor alterations grants (aspects that are working well)

- 19% of parent/carers participating in the survey for the evaluation, reported that they had applied for Level 5 grants. 38% of providers reported that they had applied, and 34% that grants had been awarded. The majority (69%) were satisfied with the ease of applying for the equipment, and with the ongoing support they received (50%). The majority were satisfied with the appropriateness of the equipment (surveys of parent/carers and ELC providers).
- Participants representing the AIM project team and delivery agencies, reported that the uptake of Level 5 had been lower than anticipated, perhaps because once resources and alterations were in place, there was not a need to apply again. Participants believed that Level 5 provided an example of AIM working well. Where equipment and resources had been provided, they were tailored to individual needs and to facilitate full inclusion and meaningful participation. Representatives from the Disability Sector agreed that Level 5 was bringing positive impacts, in a context where the need for substantial improvements to the process were voiced. Providers also noted that successful applications for Level 5 helped to achieve full inclusion and meaningful participation. For example, in using a microphone linked to a hearing aid when going on nature walks. Among parent/carers, awareness of Level 5 was higher than it was for other levels, and though they were not always sure if equipment had

been provided through AIM or not, they were positive when describing the impact of high-quality, bespoke equipment and resources (interviews with stakeholders)

- Across the case study settings there was evidence of previous engagement in AIM Level 5 through minor alterations to the physical environment. The influence of AIM Level 5 in creating an environment which is accessible to all children was also evident where funding had not been sought. This included:
    - The provision of ramps to facilitate access to and from the outdoor area.
    - Accessible outdoor areas with level access and pathways.
    - A few settings identified that they have been able to invest in sensory equipment.
    - Findings of quantitative analysis of parent/carer survey data showed a positive association between receiving an outcome following an application for AIM Level 5 support and parental perception that:
        - It is easy to access the support their child needed from AIM
        - As a result of AIM their child was able to participate meaningfully in pre-school activities

Quantitative analysis demonstrated that receipt of Level 5 support is associated with positive perceptions of impact on meaningful participation, and the view that support was easy to access. Receipt of Level 5 support is also associated with a positive view of AIM overall, among parent/carers who are reporting that an application was successful.

AIM Level 5: Equipment, appliances, and minor alteration grants (areas for development)

- Though the majority of respondents in the survey of ELC providers were satisfied with the timeframe from application to payment (57% satisfied, 27% dissatisfied), there were some reports of long delays to the provision of equipment and resources because they were so bespoke to the child, constructing barriers to inclusion.
- Participants also provided reports of the challenges that parent/carers had faced when transitioning to primary school. For example, after waiting for a prolonged period to get hearing equipment in place at their pre-school, lengthy delays began again once children were enrolled in their primary school (interviews with parent/carers). However, there were mixed views about equipment following the child into primary school and the suggestion was made that settings could be enabled to buy permanent forms of equipment to meet frequently experienced needs through an annual subsidy (interviews with stakeholders). ELC providers highlighted the following experiences (case studies of children and settings):
    - Delays are experienced in the assessment and procurement of specialist equipment to meet the needs of children with a physical disability.
    - Equipment to meet the needs of the child does not automatically get transferred over when a child moves from a pre-school in one county to a pre-school in another county, and this can disrupt inclusion
    - In one ELC setting, practitioners did not feel confident in using a specialist chair and did not feel they had been given sufficient training to adjust it.

Though it is not possible to make claims about how prevalent these experiences are, these illustrate why some focus on the management of resource transition/handover may be an important consideration moving forward.

AIM Level 6: Health Service Interventions[112] (context and aspects that are working well)

What is working well and what needs to develop in AIM Level 6 has been challenging to evaluate for the following reasons:

- It is the most complex of AIM Levels in terms of structure. This is because it has both universal and targeted elements. The universal level focusses on specialist advice about how to support children with the type of disability experienced by the child whose Access and Inclusion profile is being developed. Level 6 (universal) may be delivered in a range of ways (e.g., detailed phone calls between the EYS and the HSE specialist, e-mails, leaflets, drop-in consultation/training, and other supporting training). The targeted level is more bespoke to the individual and may include episodic (e.g., a visit to the pre-school to support the formation of a positive behaviour plan) or continuous (e.g., a longer-term individual programme) support (documentary analysis).

Level 6 is also complex in terms of its operation. This is to ensure compliance with data-sharing regulations and established HSE processes. There are two tracks, one for children known to HSE, and one for children not known to HSE, and referrals are made by EYSs in collaboration with parent/carers. Once a referral is made, some form of intervention must be provided within five weeks (unless the EYS confirms that it is appropriate to lengthen this period), and referred children are usually waitlisted for other HSE supports (documentary analysis)

- The number of children in receipt of Level 6 (universal) and Level 6 (targeted) support are relatively small (8% and 0.33% respectively of the total AIM supports provided between 2016 and October 2021, and 0.6% of the total number of children supported by AIM since it began). It has not been possible to gauge whether the number of referrals since AIM's first full programme year up to October 2021 (n=133) is smaller than may reasonably be expected since an estimate of the likely number of children who would be benefiting from AIM Level 6 (targeted) support has not been made. This is partly because such estimates are problematic. We know that from Whelan et al., (2021)[113] estimates of disability can be 8.8% at age 5. Broad definitions produce a rate of 18% at age 3 and 21% at age 5. The broadest definitions result in an estimate of over 33% of all children. Using the broad definitions, we might expect that the number of children being newly diagnosed (and hence new to HSE) is 3%, and referrals through Level 6 (targeted) currently represent around 20% of that group. This picture makes it difficult to assess whether or not Level 6 (targeted) is reaching a sufficient proportion of its intended cohort or not. However, take up of Level 6 has not grown and is reported by HSE to be undersubscribed, signaling some expectation/capacity for higher numbers of referrals. In addition, where the number of referrals for Level 6 (targeted) is rising, this may have a positive impact on achieving its intended purposes of early identification and prevention.
- Pobal[114] has provided counts of the number of HSE collaborations recorded by EYSs at Level 4 (also representing Level 6 universal), and for the number of referrals. It has not been possible to access data on the range/type/duration of HSE support provided at the Level 6

[113] Whelan, A., Bergin, A., Devlin, A., Garcia Rodriguez, A., McGuinness, S., Privalko, I., Russell, H. (2021) *Measuring childhood disability and AIM programme provision in Ireland*. [Online]. Available at: https://www.esri.ie/system/files/publications/RS127_0.pdf. Accessed 16/03/21
[114] Pobal Month Report (October 2021)

(universal) and Level 6 (targeted) levels. We also do not know how many children are waitlisted for further HSE support (documentary analysis).

- Despite purposive sampling (i.e., selection of respondents for interview who had indicated receipt of AIM Level 6), we were not able to find participants to talk with who had received it. This is because, when interviewing those we had purposively sampled (parent/carers and ELC providers), we found that they had accessed HSE support outside of AIM rather than within it (interviews with parent/carers, providers and case studies of children and pre-schools).
- We know that where parent/carers and providers are sharing perceptions on Level 6, they may also be referring to HSE advice and intervention outside of AIM (e.g., because their child received a diagnosis prior to pre-school, or because HSE support was accessed via a referral route that was not the EYS). This is likely given that the Likert scale for survey items related to Level 6 refers to applications made by 'you or staff at the pre-school' and we know from Pobal that there were a total of 133 AIM Level 6 (targeted support) referrals between 2016 and 2021[115]. The total number of applications for Level 6 (targeted support) among the survey population (n=124) is higher than would be expected in a survey sample of 1,157 (representing just under 10% of the target population) where a value between n=9 and n=14 would be more likely.
- We also know that parent/carers and providers tend to translate 'AIM Level 6 Therapy Services' as the continuous therapies they recognise in forms like Occupational Therapy, Physiotherapy and Speech and Language Therapy. Level 6 (targeted) referrals may result in services like this for a small number of children in the longer term, but it is more likely that the support provided (within five weeks of the referral or where appropriate within a longer timeframe) will be in the form of behaviour support plans, classes, equipment, professional advice, or pre-school visits.

This context is important to bear in mind when interpreting the reported findings from the evaluation which follow.

Survey of parent/carer and ELC providers

- Noting that parent/carers and providers are conflating Level 6 with HSE support outside AIM, satisfaction with therapeutic/health interventions was high and was generally between 70-85% as follows (survey of parent/carers):
  - Speech and language therapy: satisfied 76%, dissatisfied, 23%
  - Occupational Therapy: satisfied 77%, dissatisfied, 21%
  - Psychology intervention: satisfied 75%, dissatisfied, 20%
  - Psychotherapy; satisfied, 83%, dissatisfied; 13%
  - Paediatrician; 88% satisfied, dissatisfied; 0%.
  - Nursing: 50% satisfied, dissatisfied, 50%.
- As for the impact of the health services interventions, the majority of ELC providers who agreed that health services assisted them to: include a child/children with disabilities/additional needs (55% agree, 17% disagree); help a child/children with disabilities/additional needs get the most out of their ECCE provision (62% agree, 15% disagree); change their practice in how they include children (50% agree, 24% disagree); improve the way that staff communicate with parent/carers about inclusion and disability/additional needs (55% agree, 23% disagree); contributed to a culture of change, so

[115] Pobal Monthly Report (October 2021)

they are more inclusive (53% agree, 25% disagree); implement an inclusive pedagogy (57% agree, 21% disagree) (survey of parent/carers).

This demonstrates that overall, where HSE are engaged with pre-schools (whether through AIM or outside it), the majority of providers agree that it has a positive impact on inclusion.

Survey of parent/carers

- Quantitative analysis of the parent/carer survey data resulted in compelling evidence of an association between receiving AIM Level 6 support/HSE support outside AIM and parent/carer perceptions that:
  - it is easy to access the support their child needed from AIM
  - their child was able to participate more meaningfully in pre-school activities as a result of AIM
  - their child was able to interact socially more frequently with other children.
  - their child was more confident in educational settings
  - as a result of AIM, their child was more confident in interacting with peers
    as a result of AIM, their child was able to attend a mainstream pre-school (survey of parent/carers)
- There was strong evidence of an association between the presence of HSE engagement during their child's pre-school years and positive perceptions of AIM's impact (e.g., meaningful participation, social interaction, attendance of mainstream pre-school). This indicates that for the parent/carers surveyed, HSE engagement seemed to have enhanced AIM's effectiveness. It is also important to note that <u>not</u> getting Level 6 targeted support /HSE support following a referral was <u>not</u> associated with parent/carers feeling that AIM had made no difference. Rather, from the perspective of parent/carers, HSE engagement deepened AIM's impact in relation to its key goals (full inclusion and meaningful participation). This indicates how important it is to build AIM's effectiveness in catalysing collaboration between HSE specialists with pre-schools in terms of advice and intervention.

AIM Level 6: Therapy Services (areas in need of development)

- Participants were aware of or experiencing long waitlists for HSE interventions outside of AIM. There were several examples of parent/carers self-funding assessments and interventions for children. Awareness of long waitlists for HSE interventions (outside AIM) were impacting on parent/carer and provider perceptions of AIM Level 6 and their behaviour around it.
- Providers reported that they would not consider applications for AIM Level 6 from an assumption that it could not be availed in the context of long waiting lists. They were not aware of the option to have the 'within five weeks' type of intervention available through AIM Level 6 (targeted). This means that there is some opting out of AIM Level 6 (targeted) even before a referral is made. Providers did not provide examples of engagement with HSE via AIM Level 6 (universal), and it is possible that this is invisible to them because these interactions are between HSE and EYSs. However, it seems reasonable to assume that bringing pre-school practitioners and parent/carers into this interaction may serve to make Level 6 (universal) more visible to stakeholders and inspire more engagement with AIM Level 6 (targeted). This is a return to the issue of partnership and collaboration across professionals and parent/carers (as discussed under AIM Level 1).
- Members of the EYSS were reporting that the process of referring children for Level 6 (targeted) support was burdensome for settings and families (even in the context of EYS leadership of this process) and that where a referral was made, interventions were often brief and of limited value. Evidence to counter this perspective was hard to find in the data for the

reasons described in the preceding section. In essence it has been difficult to find, describe and report on activity within AIM Level 6.

- The documentary analysis also identified a need for more record-keeping around Level 6. This is because the type and intensity of supports provided at Level 6 (universal) are varied (because they are needs led). In order to get a fuller picture of activity in Level 6, it would be useful to develop record-keeping systems which allow both HSE and EYS professionals to report into Pobal (or another organisation) the numbers of children served by these activities, and the type of support provided. This would make AIM Level 6 more available for evaluation and improve conditions for governance through monitoring (documentary analysis).
- Providers, parent/carers, and disability sector representatives were calling for more connection between HSE and pre-schools. This was considered to be a key strategy for developing the sector's confidence in inclusive practice. Participants were keen to learn from the specialist knowledge of the HSE sector, and more distant forms of interaction (e.g., leaflets and collaborations between EYSs and HSE) did not emerge as the type of collaboration they desired. At settings that were visited for case studies, ELC providers and families felt that there could be much greater collaboration between therapists and pre-school settings. This was more evidence of stakeholders' desire to learn from working directly with specialists. It may also signal the potential value of consulting more fully with providers on what they might need from Level 6, and how it can be described to them so that a) its content and the benefit of that content is clearer and b) they are keen to engage with EYSs in referral processes (Level 6 targeted).
- At the point of writing, national forums have been established comprising of the HSE, the National Council for Special Education (NCSE), and the National Educational Psychological Service (NEPS). Forging links between HSE, CDNTs and education is identified as a priority for continuing implementation planning, and it will be important for AIM and the ELC sector to be participants in PDS implementation planning. This is because the PDS is an opportunity to build more collaboration and integration between HSE and pre-schooling. It is also because programmes that have piloted the delivery of therapeutic support within pre-schools, have identified positive impacts of relevance to inclusion (documentary analysis). At the time of writing, researchers could not find evidence that the ELC sector was represented in the national forums which were focused on schools rather than pre-schools. Given that AIM Level 6 is such a promising space for interprofessional collaboration, as well as being one of the earliest strategies for supporting this kind of collaboration, the presence of AIM in PDS implementation seems key to catalysing the connections between HSE and pre-schools (documentary analysis).
- The literature review also included evidence of the importance of cross-sectoral collaboration in the attainment of inclusion but noted that it was among the most challenging and complex tasks for policymakers and agencies, and one requiring sufficient resources, monitoring, and regulation (literature review).

AIM Level 7: Additional assistance in the pre-school room (aspects that are working well)

Documentary analysis

- In the case of AIM Level 7, there had been 25,278 applications and 19,354 (77%) awards (up to October 2021). This shows that there are high levels of participation in this AIM support. AIM Level 7 was anticipated to be critical to the inclusion of about 1.5% of children engaged in the ECCE programme. However, this figure is not reflected in current views of how often Level 7 support has been provided. Level 7 has been allocated to around 4.5% of this population (documentary analysis).

Survey of parent/carers

- When parent/carers were asked, 'Does your child's pre-school employ an additional member of staff to support your child?' most responded with 'yes' (73%). It was the AIM support that most survey respondents were receiving for their child. For the majority of parent/carers (62%), additional support in the pre-school room was considered the most beneficial aspect of AIM. Of those that had applied for additional capitation, 79% (n= 519) were satisfied with the application process. Additional capitation was most commonly used by settings to recruit additional staff (80%). 7% (n=47) used the funding to enrol fewer children without financial loss and 17% used the funding to achieve both recruitment of additional staff and to enrol fewer children without financial loss. This indicates that in principle, AIM Level 7 support was being used with fidelity by settings (survey of parent/carers and ELC providers).
- Quantitative analysis showed that receipt of Level 7 support is associated with positive perceptions of AIM and its impact on children's development, inclusion, and participation.
- These data have illustrated that parent/carers have strong belief in Level 7 as a route to inclusion for their children, since only 34/958 who had been involved in an application for Level 7 support described it as having a negative outcome, even where it had not been awarded. There was very strong evidence of an association between the perception that additional assistance has been beneficial and an overall positive view of the impact of AIM on the child ($p < .00$).

Survey of ELC providers

- Providers were positive about the impact of additional capitation funding. 90% agreed that additional assistance had helped children with disabilities to get the most out of their ECCE provision. 89% agreed that additional assistance had helped the setting to include a child/children with disabilities/additional needs. 84% reported that it had increased ELC staff capacity to implement inclusive pedagogy. In relation to the impact on inclusive practice and culture. The majority (74-75%) of providers reported benefits from Level 7. When considering the way that staff communicate with parent/carers about the inclusion and disability/additional needs, 75% reported that Level 7 had led to improvements (survey of ELC providers).

Interviews with stakeholders

- Participants from the AIM project team and delivery agencies felt that the provision of AIM Level 7 support had a positive impact in supporting children with additional needs and/or disabilities to access mainstream pre-school settings. Pre-school settings were reported to be familiar with the application process, and confident in making requests for AIM Level 7 support.
- ELC providers who were interviewed described positive and extensive use of Level 7 to secure full inclusion and meaningful participation for children with disabilities/additional needs. Practitioners report that in practice, additional assistance in the pre-school room is used flexibly to support the learning of all children in the room via the reduction of staff: child ratios. Staff in settings have benefitted from increased time to support all children including those with additional needs, training to increase their knowledge and expertise, and access to learning resources and equipment. Reducing staff: child ratios and team working in the room has reduced day-to-day pressures and increased staff capability to address children's additional needs.
- Among the parent/carers who were interviewed, AIM support was the element they were most aware of, and they prized. 16 parent/carers regarded good quality Level 7 support as crucial to their child's inclusion and meaningful participation and see it as the most impactful element of AIM targeted support. 6 parent/carers were aware that their child's pre-school setting was delivering this support in a distributed model rather than 1:1 and this is what they expected,

though they also hoped that the setting would provide 1:1 when it was needed (in a flexible way) (interviews with stakeholders).

Case studies of children and settings

AIM Level 7 was referred to frequently across the case studies and was being received by 11 of the 14 case study children. The majority of stakeholders in the case study settings talked about it as the most beneficial aspect of provision, creating positive opportunities for inclusion, participation, and development in pre-school. To summarise:

- Some ELC practitioners spoke of using the additional adult to reduce the ratios in the room.
- The additional adult was described as allowing support to be provided across the team. This allowed members of staff the opportunity to work closely with all children.
- Small group work and interventions that are beneficial for several children can be led by an additional adult during session time.
- Some parent/carers of the case study children expressed relief at knowing that there was support available to meet the needs of their child.
- The presence of an additional adult gave one parent/carer confidence that their child would be safe when they were in the pre-school.

During the child case studies, examples of the positive impact of AIM Level 7 on children were observed where:

- A child with medical needs was supported at mealtimes, in the context of a small peer group. The additional adult played a positive role in normalising a medical routine
- Support from the additional adult was provided flexibly in response to need. At times this necessitated small group intervention to target an area of need, such as speech and language development
- Where children had medical needs, the additional adult played a role in ensuring they were safe but not obstructed from playing with their peers
- Relationships with other children were scaffolded and supported. This was effective when the practitioner was watchful and allowed children the opportunity to negotiate in their play before intervening
- The child had the opportunity to withdraw from the main group activity and receive “in the moment” support in response to their emotional needs
- The practitioner pre-empted events and activities the child may find challenging and sought to utilise visual and transitional resources to support the child pro-actively.

AIM Level 7: Additional assistance in the pre-school in the pre-school room (areas for development)

- AIM Level 7 was the most talked about of the AIM supports among the stakeholders’ group, and it was one of the key reasons for high levels of satisfaction and dissatisfaction (surveys, interviews, and case studies).
- Some participants (from the AIM project team and disability sector) argue that this is, at least in part, a consequence of shortcomings in other levels, or shortcuts that providers are taking (skipping Levels 1-3). The idea of shortcomings in other levels has been borne out in some of the data because there is evidence that providers and EYSs are avoiding it for several reasons (because the process is too burdensome, the support received within the five-week timeframe was too light-touch or because they assume it cannot be availed). There is also evidence that parent/carers see Level 7 support as synonymous with AIM as a whole, and

valorise this level of support, without explicit awareness of the contribution that AIM Levels 1, 3 and 4 are making to their child's inclusion.

- ELC providers felt that there were currently limitations on their ability to use AIM Level 7 support. To summarise (survey of ELC providers):
  - The true costs of AIM Level 7 to the ELC provider are not felt to be met by the funding provided (10)
  - ELC providers would like greater flexibility in the recruitment of staff to provide AIM Level 7 support. For example, in employing a member of staff with alternate qualifications to QQI Level 5 (5). It is important to note that this is not currently feasible in the context of pre-school regulations.
  - ELC providers would like greater flexibility in the hours staff can provide AIM Level 7 support so that it extends beyond the three hours per day allocated (6)[116]
  - The current application system is felt to take too long. Some (7) ELC providers experienced delays in the initial assessment taking place whilst a few felt it took too long to receive the outcome of their application.
  - ELC providers report low numbers of applications for pre-school setting roles and state that they struggle to recruit a member of staff to fill AIM Level 7 posts (5)
  - Where children move from one pre-school setting to another, providers reported the funding does not automatically move with the child. A few ELC providers expressed frustration as this meant they experienced a delay in being able to provide the support that they and the parent/carer both knew the child needed (10)[117]
- Both ELC providers and families expressed concern regarding the use of shared support to meet the needs of children. It was described that where children have high levels of need it is not possible to meet these fully when an adult is also providing support to another child in the room (interviews with ELC practitioners, survey of ELC providers).
- Parent/carers reported the distress they had experienced when Level 7 support had been awarded but not provided because of difficulty in recruiting to the post, and they called for developments to structure and governance of Level 7 support, specifically:
  - Centralisation of responsibility for recruiting Level 7 staff so that settings were supported (3). (It is noted that this is not feasible in a context where pre-schools are privately owned and run and where the provider is the employer)
  - Better regulation and accountability for the quality and impact of Level 7 staff (2)
  - Improving the pay and conditions for Level 7 staff and the sector generally (6)
  - Involvement of parent/carers in the recruitment of Level 7 staff (1)
  - Provide more training for Level 7 workers (1)
- In the survey of parent/carers, analysis of free-text comments in response to the survey question, 'what additional supports do you think would need to be put in place for staff to

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[116] It is noted that DCEDIY is not the employer and therefore has no role in determining whether posts are temporary or permanent, or whether they are full-time/part-time (see p.599). While in principle additional funding could be awarded on a predictive model rather than in response to specific needs, and such a change might make it easier for service providers to offer permanent / longer-term contracts, this would be challenging in a context where most ECCE services are very small (e.g. up to 11 or 22 children) and may not have a child with a disability attending every year.

[117] Within AIM policy, it is stated that funding decisions should reflect the needs of the child *in the context of the specific pre-school setting.* This means they are not entitlements tied to a child.

support your child's meaningful participation in pre-school activities?' revealed that 49 respondents proposed providing additional support for their child. Parent/carers also called for more monitoring of how settings were using Level 7 support (16/137) in the survey, 9/18 in interviews with parent/carers). In the survey of ELC providers, 141/508 suggested that improvements to Level 7 pay and conditions would improve the impact of AIM (in free-text comments). Representatives from the disability sector described the poor pay and conditions (temporary, part-time, term time only, low-paid contracts) as a key risk for AIM's impact and sustainability.

- Documentary analysis revealed that advertisements for these posts indicated some difficulties around the name of the role (often described as an AIM support worker), indicating the need for professionalisation in terms of nomenclature and pay. Advertisements also used phrases that represented an SNA rather than an AIM distributed model. From this, we infer that AIM Level 7 continues to be conceptualised by some as an SNA model (documentary analysis)
- Parent/carers had mixed views on whether Level 7 is best delivered as a 1:1 or distributed model, with some believing that it would only work as 1;1, and some being dissatisfied that their child's pre-schooling was not using a distributed model. In interviews and case studies, participants gave examples of where intensive 1:1 support was necessary and more effective than distributed support for some children. Quantitative analysis has demonstrated that where Level 7 applications are declined, this is associated with negative perceptions of AIM and its impact.

Conclusions: Are AIM Levels 1-7 appropriate in the National context?

Conclusions on what is working well and needs to be developed in the National Context? (Each AIM Level)

AIM Level 1

Conclusions on what is working well

- Take up of LINC and DEI has been high and has exceeded AIM's launch objectives. Participants are generally satisfied with the quality of training and have particularly praised the quality and relevance of the LINC programme and are often effusive in their praise. Most providers agree that having a named INCO is working positively for inclusion and the majority agree that the LINC programme impacts their setting's capacity to practice inclusively. There is evidence that the presence of inclusive cultures in the pre-school is associated with positive perceptions of AIM among parent/carers. We conclude that AIM Level 1 is the foundation for inclusion, as was conceived in AIM's original design.

Conclusions on what needs to be developed

- Developing providers' awareness of how much parent/carers value an inclusive culture at their child's pre-school, and how important parent/carer partnership is within this culture.
- Improving the rigour of monitoring and evaluation of Level 1 (quality and impact).

AIM Level 2

Conclusions on what is working well

- There is increasing engagement with the AIM website, with a spike in engagement following the launch of its redesign. Providers are playing an increasingly important role in sharing information about AIM with parent/carers, and there are signs of growing knowledge of AIM among a parent/carer alumni who are sharing advice and experiences with other parent/carers in online forums.

Conclusions on what needs to be developed

- Managing the off-putting effect of the term 'disability' on parent/carers in their early engagements with AIM and AIM supports.
- Developing user feedback tools on the AIM website, and the range of accessible formats (large text, video)

AIM Level 3

Conclusions on what is working well

- Take up of funded CPD through AIM Level 3 has been positive, and providers regard it as an impactful aspect of AIM. Most parent/carers (68%) believe that pre-school staff are well trained.

Conclusions on what needs to be developed

- Developing the CPD offer focussed on less visible disabilities (ASD, emotional disturbance, speech, and language disabilities) and more complex needs.
- Developing the range of options for CPD so that providers could select according to their need and level of qualification.
- Improving the rigour of monitoring and evaluation for Level 1 (quality and impact)

AIM Level 4

Conclusions on what is working well

- Most parent/carers and providers had positive experiences of AIM Level 4 and found engagement with EYS's to be beneficial to inclusion. The majority of providers were satisfied with mentoring, coaching and the support they received in liaising with HSE services via the EYS. Overall, EYS were playing an important, valuable role in supporting the inclusion of children with disabilities in pre-schools. Providers valued opportunities to collaborate with others in the design of inclusive practice.

Conclusions on what needs to be developed

- Creating a more central space for parent/carers in collaborations between pre-schools and EYSs, and more capacity for EYSs to work with INCOs to work in partnership with parent/carers.
- Enabling opportunities for EYSs to monitor the implementation of AIM supports (especially Level 7) and support settings in making the best use of it.

AIM Level 5

Conclusions on what is working well

- Most providers are satisfied with the ease of applying for equipment, appliances, and minor alteration grants, and most are satisfied with its appropriateness. Participants were generally positive about the impact of Level 5 on inclusion, and awareness of it was high among parent/carers. Receipt of Level 5 support was associated with positive perceptions of AIM's impact among parent/carers, and most providers (57%) were satisfied with the timeframe for allocation.

Conclusions on what needs to be developed

- There were some examples of long delays to the provision of specialist equipment and resources, sometimes because they were very bespoke to the child.
- Where children needed the same specialist equipment in a pre-school or primary school they were moving to, it did not automatically move with them, and this caused some challenges. At the same time, there were occasions where the movement of equipment with the child made the pre-school less accessible in the longer term. There is a need to consider how equipment is to be managed in cases where the child moves pre-schools or moves onto primary education.
- A relatively large minority of providers (27%) were dissatisfied with the timeframe for allocation.

AIM Level 6

Conclusions on what is working well

- Where HSE specialists are engaged with pre-schools (whether through AIM Level 6 or outside it), parent/carers and providers agree that it has a positive impact on inclusion. Where HSE is supporting children during their pre-school years, parent/carers perceive AIM to have a deeper, positive impact. The majority of parent/carers are satisfied with HSE support their children receive within or outside AIM. The majority of providers agree that Level 6/HSE support is having a positive impact on inclusion in various ways (50-62%). Providers gain much from collaborating with specialists and would welcome more connections with HSE specialists since they believe that this will develop their self-efficacy for including children with more complex needs.

Conclusions on what needs to be developed

- Level 6 has been difficult to evaluate for a range of reasons and it is not very visible in the AIM landscape. Providers and parent/carers had relatively low awareness of Level 6 and were not giving examples of it being used in the context of AIM.
- Increasing the number of children who are supported by AIM Level 6 (universal) and AIM Level 6 (targeted) would develop capacities for early intervention, needs-based practice and prevention.
- Records on the type of support provided through AIM Level 6 (universal) and AIM Level 6 (targeted) are not kept, making it difficult to gauge the reach and impact of HSE engagement on the inclusion of children with disabilities in pre-schools.
- Providers and parent/carers do not have full awareness of the content and potential benefits of Level 6, and stakeholders are tending to sidestep engagement with it for a range of reasons including that the referral process is considered burdensome, and that the support provided following a successful application was too light touch to have impact).
- Among providers and parent/carers there is a widespread assumption that applications for Level 6 (targeted) will not be approved, though the counter-evidence is that Level 6 is under subscribed, and the resource is not being fully used. This suggest that clearer communication about the content and purpose of Level 6 is needed at all levels.

AIM Level 7

Conclusions on what is working well

- There are high levels of engagement with AIM Level 7 with a total of 19,354 allocations since October 2021.The majority of parent/carers are aware of AIM Level 7 (73%) and consider it to be the most beneficial aspect of AIM (62%). Receipt of Level 7 is associated with positive perceptions of AIM's impact and most providers (89%) report that it helps their setting to include children with disabilities. There are examples of the effective use of AIM Level 7

across the evaluation data, and for parent/carers it is the most prized aspect of AIM. We conclude that AIM Level 7 is working well in the National context.

Conclusions on what needs to be developed

- Though the majority of providers that were interviewed recognised the importance of distributed support and described using it as such, some argued that use of a 1:1 model was sometimes the most appropriate approach, particularly where children had complex medical or behavioural needs, and that they mixed this in with a group focused approach to ensure that children were supported in the way that was most propitious.
- Recruitment to Level 7 posts had been challenging for some settings, and this was considered to be a risk for AIM's sustainability. The main cause was perceived to be poor pay and working conditions for postholders.
- Level 7 continues to be conceptualised by some parents/carers and providers as an SNA rather than a distributed model.
- There is a call from parent/carers for more monitoring of how Level 7 support is used by settings to include their child.

Whilst holding an assumption of continuous improvement in the areas for development identified in this evaluation, we conclude that AIM Levels 1,2,3,4,5 and 7 are working well in the National context. Conclusions on how well AIM Level 6 is working in the National context have been difficult to draw, though we do observe that it is undersubscribed. We also know that providers and parent/carers value and have benefited from the support provided by HSE specialists (whether this is within or outside AIM). The involvement of HSE in support for their child is associated with more positive perceptions of AIM's benefits among parent/carers, and this is further evidence of what is to be gained from more collaboration between health and education services, and of the need to revisit and re-energise AIM Level 6 in a context of continuous improvement.

13.4: To what extent can/should AIM be scaled up and out?

The findings reported in subsections 13.1, 13.2 and 13.4 are relevant to the evaluation question, 'to what extent can/should AIM be scaled up and scaled out' since they identify the strengths and focusses for action/continuous improvement that must be factored into any expansion of AIM.

Generally, participants supported proposals that AIM be scaled up and out, and were keen to see the following happen:

- Extending AIM support to hours outside the ECCE entitlement, including full days where needed.
- Extending AIM support to children who were younger than the qualifying age.
- Extending AIM support into School Aged Childcare (SAC)

The reasons given for supporting these extensions were as follows:

- These changes would support fuller participation and inclusion (45)
- There could be better transition support for children coming into ECCE (if they had AIM support earlier), and when they were moving onto primary school (and School Aged Childcare (SAC) (5)
- The changes would enable parent/carers to go to work or study (7)
- The changes could bring better working conditions for Level 7 staff (8)
- The changes could enable earlier identification and intervention (12)
- Children should be supported for the entirety of their time in ELC and SAC (15).

Concerns raised about these changes were:

- Too much support too early could be stigmatising (3)
- Children may not be ready for pre-school, and governments should support parent/carers who want their children to stay at home more (e.g., by supporting parent/carer groups) (1)
- The changes would only work if training were provided for the workforce who may be new to AIM. (2)
- If the AIM support was entirely 1:1 outside ECCE hours as well as inside them, it might create barriers to inclusion, and relationships with peers (1)

There were mixed views about whether AIM should be extended beyond disability to other educationally disadvantaged groups of children (such as those from Traveller and Roma communities, those who speak English as an additional language). Some argued that this was a good idea, some that it was not because AIM was for children with disabilities, and some that AIM already had that option built in because it was for children with 'additional needs'. This did reveal some mixed interpretations among the participant group (including the AIM project team) about who AIM was designed to support. The AIM policy (DCYA, 2021)[118] makes it clear that AIM is for children with disabilities, where disability is defined as 'a long-term physical, mental, intellectual or sensory impairment which in interaction with various barriers may hinder a full child's full and effective participation in society on an equal basis with others.' (DCYA, 2016, p5). However, to ensure that children who do not have a diagnosis can also avail of AIM support, this is expanded to include a group who experience impairments not yet diagnosed, and children who have difficulties 'where the particular impairment may not be traditionally recognised as a disability' (DCYA, 2016, p5). Policy gives no examples of what an *impairment not traditionally recognised as an impairment* might include. Hence this term is open to interpretation. In this context it is difficult to draw conclusions about the group of children AIM might serve beyond those who experience:

- disabilities,
- difficulties not yet diagnosed as disabilities and
- difficulties not traditionally recognised as a disability

A strong call for the expansion of AIM beyond this group did not emerge from the evaluation.

Conclusions: To what extent should AIM be expanded?

- With some variations, AIM is working effectively to achieve full inclusion and meaningful participation for the children it supports.
- The evaluation has documented the aspects that are working well and the aspects that are working less well.
- Stakeholders are broadly in favour of AIM's expansion for a range of reasons. These include the potential for earlier identification (when expanded to young age groups), improvements to parent/carers opportunities to go to work/study (when expanded to younger and older age

[118] Department of Children and Youth Affairs (2016a) *Policy on the operation of the Access and Inclusion Model, June 2016*. [Online] Available at: https://aim.gov.ie/app/uploads/2016/06/AIM-Policy.pdf. Accessed 19/18/2020

groups) and as support for effective transition to primary school (where additional support could continue into School Aged Care (SAC).

14: Summary of findings and conclusions from the end of year three Evaluation of the Access and Inclusion Model

In this subsection, the broad conclusions of the evaluation are discussed, starting with headline conclusions to the four evaluation questions posed in this end of year three evaluation of AIM.

14.1: Headline conclusions

AIM has enabled many young children with disabilities to attend, be fully included and meaningfully participate in the ECCE programme in mainstream pre-schools.

AIM has catalysed the development of more inclusive cultures and practices in pre-schools and developed the confidence of the workforce in their capacity to include children with disabilities. Though the picture is positive overall, participants perceive some variability in impact according to types of disability and location. The evaluation has also identified areas where the model can improve. However, there is every reason to believe that AIM will continue to be effective as a model for enabling inclusion in mainstream pre-schools in a context where there is continuous, cross-sectoral improvement.

Conclusions to the four evaluation questions

1. ***Is AIM effective and achieving its intended outcomes of enabling the meaningful participation and full inclusion of children with disabilities and additional needs?***
   Yes, AIM has been effective in achieving its intended outcomes of full inclusion and meaningful participation for the majority of the children it supports. It also brings benefits to most of the children it supports, the majority of parents/carers, and many siblings. However, the impacts are not reported by parent/cares to be equal for all children, and those with less visible disabilities (ASD, and to a lesser extent, emotional disturbance and speech and language difficulty) and complex disabilities are not perceived to be gaining as much from AIM, as those with other types of disability. Almost all parent/carers of children with physical and sensory disabilities perceive AIM positively. This signals a need for continual vigilance in the development of AIM to ensure that all children are supported by it. There is a need to sustain and build all parent/carers' trust in AIM's ability to meet their child's needs, and to work with them in ways that strengthen the impact of AIM on children's inclusion. A smoother and more supported transition to primary school following AIM, can help to improve families' experience of the inclusive benefits of AIM.

2. ***Has AIM influenced practice, or increased the capacity of the workforce to include children with disabilities?***
   Yes, AIM has influenced practice and increased the capacity of the workforce to include children with disabilities. The impact is perceived to be positive and substantial by a range of stakeholders. There is a need to continually revisit the CPD offer, and to ensure that there is additional focus on disabilities related to cognitive, social, emotional, and mental health needs, and on working in partnership with parent/carers. The EYS and INCO roles will be crucial to the sustainability of this development, as will improvements to the pay and conditions of the workforce in the sector. There is a need to develop the CPD portfolio, so it is more responsive and personalised to the varied contexts and needs of providers and children. Cross-sectoral working and multidisciplinary specialisms within AIM are among its most innovative aspects and a reason that stakeholders give for its successful design and implementation. However, there is room for cross-sectoral working and the sharing of multidisciplinary expertise to be strengthened so that the workforce can intensify inclusive outcomes for children. Though the majority of providers believe that the changes made to inclusive practice in their settings are sustainable, those in rural and town

locations are more likely to believe in sustainability than those in cities and large urban areas. Data indicate that these perceptions may be related to the higher number of children with ASD in pre-schools in cities. We do not assume the problem to be within this group of children, and do not identify this group of children to have deficits. Instead, we apply a social model and draw from the wider evidence (parent/carer surveys, interviews with stakeholders, case studies) indications of a continuing need for training and development (including mentoring and coaching) focussed on inclusive practice for children with less visible, psychosocial disabilities. Children with physical and sensory disabilities were more prevalent in the sampled population of parent/carers whose children attended pre-schools in rural areas (the group who were more likely to report positive experiences of AIM). This adds more weight to the argument that pre-schools need more support in developing inclusive practice for children with ASD, and other less visible disabilities.

3. ***Is the current approach appropriate in the National context: What is working well and what needs to be improved overall and across all levels of AIM from the perspective of varied stakeholders?***
   Yes, there is broad support for AIM across varied stakeholders. Stakeholders understand the principles and rationale of AIM and believe it to be the right model for Ireland. Though all levels of AIM are contributing to the realisation of the model's intentions and are key to its success, continuous improvement of each is needed, and this includes improved systems of oversight and governance focussed on fidelity, quality, and impact. Raising parent/carers' awareness of the contribution that AIM Level 1-3 makes to their children's inclusion will be an important way to manage the valorisation of targeted supports (particularly Level 7).

4. ***To what extent should AIM be scaled up and out to include younger children, ELC outside ECCE hours, and School Aged Childcare (SAC)?***
   In a phased and deliberative way, and with reference to the findings of this evaluation and other projects commissioned by the DCEDIY (e.g., The in-school and ELC therapy demonstration project)[119] , AIM should be scaled up and out to include these age groups. There is widespread support for its expansion among stakeholders, though there are concerns about the practicality and impact of reducing the adult-to-child ratio even further in younger age groups.

14.2: Thematic summary of findings

To further contextualise the conclusions of the end of year three evaluation of AIM, this section summarises the key findings that have informed them. Findings are presented under the ten themes that emerged from the analysis of the corpus data as follows:

1. The impact of AIM on the full inclusion and meaningful participation of children with disabilities in pre-school
2. The appropriateness of AIM in the National context.
3. AIM and the location of pre-schools
4. The importance of cross-sectoral working and multidisciplinary specialism
5. Governance and oversight
6. Workforce development for inclusion, working conditions and the role of the Inclusion Co-ordinator (INCO)

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[119] Lynch, H., Ring, E., Boyle, B., Moore, A., O'Toole, C., O'Sullivan, L., Brophy, T., Frizelle, P., Horgan, D., and O'Sullivan, D., (2020) *Evaluation of Early Years Therapy Support Demonstration Project* National Council for Special Education. [Online]. Available at: https://ncse.ie/wp-content/uploads/2020/11/Demo-project-evaluation-fInal-for-web-upload.pdf

7. Partnership with and support for parent/carers
8. The valorisation of targeted supports within AIM.
9. AIM and transition to primary school
10. The phased expansion of AIM

When summarising findings, the following terms are used to describe magnitudes:

- **All** refers to every participant, and in the case of the quantitative data, 99% or 100% (to cover rounding errors)
- **Most** refers to more than three quarters of participants but not all, and in the case of quantitative data 75% to 99%
- **Majority** refers to more than half of participants, and in the case of quantitative data 51% to 74%.
- **Some** refers to between one quarter and one half of participants or 25% to 50%.
- **Minority** refers to less than one quarter or 24%
- **Very few** refers to 1 or 2 participants or less than 6%

1. The impact of AIM on the full inclusion and meaningful participation of children with disabilities in pre-school

The evidence from the evaluation shows that the impact of AIM on children's experience of full inclusion and meaningful participation in their pre-schools is positive and substantial. There are some variations in parent/carers' experience and perception of AIM according to their child's main type of disability.

From the perspective of all stakeholders, AIM is perceived to be impacting positively on the full inclusion and meaningful participation of the majority of children it supports and delivering benefits to most. In surveys of parent/carers, 69% of respondents perceived AIM to be supporting their child's meaningful participation and full inclusion at pre-school. Most parent/carers (82%) and providers (94%) reported that AIM had benefited the children supported by it. [120]

The majority of parent/carers (73%) report positive impacts on them or their partner, and some describe positive impacts on siblings. When parent/carers were describing benefits, these related to their child's development and progress (777)[121], their wellbeing (246) and reductions in their own stress levels (607). Benefits also included their child's positive preparation for school, with 62% of parent/carers describing this as a positive outcome in the survey. In interviews, providers confirmed that AIM is effective in achieving its intended outcomes for most children, and most parent/carers focussed on the opportunities that their child had to make friends and interact with other children. They also described gains in confidence, independence, and preparedness for school. This was also demonstrated in case study visits to pre-schools, where all of the children participating in the evaluation described their own positive experiences of being included and participating. All of these children were enjoying pre-school. Most were observed to be accessing a full range of opportunities and interacting with their peers.

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[120] A visual summary of findings from the surveys of parent/carers and providers is provided in appendix 2.

[121] Where a value is given, it refers to the number of times a category arose in the qualitative data, including free-text data in the survey.

Not all parent/carers perceive AIM as delivering these impacts and benefits equally and a minority (11% of survey respondents) describe AIM as having no positive impact. Some statistically significant differences in parent/carers' perception and experience of AIM were also found according to their child's main type of disability.

In relation to statistically significant differences, a higher number of parent/carers of children with physical and sensory disabilities are experiencing and perceiving AIM positively than parent/carers with other types of difficulties. This is in terms of the inclusiveness of the pre-school culture (e.g., the willingness of staff to be inclusive), their perceptions of staff capacities for delivering inclusive practice, and the extent to which they experience positive relationships with pre-school providers (e.g., communication and working in partnership). Parent/carers of children with physical and sensory difficulties are also more likely to perceive AIM as having a positive impact across a range of dimensions (e.g., development, preparation for school). The majority of parent/carers of children with less visible disabilities (Autistic Spectrum Disorder – ASD, and to a lesser extent emotional disturbance, speech, and language difficulties and multiple main disabilities) also report positive impacts and experiences, but these emerge as more variable.

There are some aspects where there are no statistically significant differences (AIM's impact on confidence for peer interaction, or child's ability to attend a mainstream pre-school) but parent/carers are less likely to perceive staff as well trained, able to practice inclusively or able to work in partnership with them if their child has ASD or emotional disturbance as their main reported type of disability. Parent/carers of children with emotional disturbance and ASD were less likely to report an inclusive culture, and those of children with ASD and a specific speech and language disorder were less likely to feel that their child was more confident in educational settings as a result of AIM than other groups.

Statistically significant differences in perception of AIM's impact and benefits according to children's reported main type of disability were not seen in the survey of providers. In part, this was because parent/carers were reporting on one child and their type of disability, whereas providers were reporting on multiple children with varied types of disability. Hence, associations between types of disability and perception of AIM were less likely to emerge. The account of parent/carer perception provided by the survey provides a useful insight into the parent/carer's lived experience of their child's inclusion and meaningful participation. As one proxy for AIM's intended outcomes, the parent/carer experience offers a lens through which to design improvements.

Though the evaluation has demonstrated that parent/carers of children with less visible disabilities (ASD, emotional disturbance, speech and language difficulties) and complex needs are more likely to have a variable experience of inclusive cultures and AIM's impact, it has also found that reasons for the difference are not specific to the type of disability but relate to universal aspects of best practice (AIM levels 1-3) combined with the provision of additional targeted support (AIM levels 4-7). When describing the practices associated with their positive perception of AIM in surveys, interviews and case studies, parent/carers refer to their child being accepted and valued, their child's needs being understood, having additional support (e.g., an additional adult in the pre-school room) and seeing their child develop. A reported experience of partnership-working with the pre-school, and good communication is also statistically associated with positive perceptions of AIM, and this is more likely to be reported by parent/carers of children with more visible disabilities, than less visible ones. All of this indicates the importance of AIM Levels 1-3 in a context of targeted support, and the need for

more training focussed on psychosocial disabilities[122], including how to work with the parent/carers of children with these needs to build their trust in AIM's capacity to meet need.

2. The appropriateness of AIM in the National context

The evidence from this evaluation demonstrates that AIM is the right model for supporting the full inclusion and meaningful participation of children with disabilities in mainstream pre-schools. This is the case for AIM overall, and each of its levels. The evaluation has found strengths that can be built upon and areas to improve of relevance to AIM's sustainability and continual improvement.

Findings - AIM overall
As a model for supporting inclusion in mainstream pre-schools, AIM is effective and appropriate. It is leading to positive change and development to a substantive degree, and most stakeholders are supportive of it. In surveys, 96% of providers perceived AIM as having a positive impact on inclusion in their pre-schools. Interviews with parent/carers have demonstrated that even where participants are critical of AIM or report negative experiences, they still see it as the right approach, and call for its continuation.

Take up and engagement with AIM has grown rapidly since its full programme year (2016-17), and there is clear evidence that the proportion of children with disabilities supported by AIM has also grown rapidly. A study by researchers at the Economic and Social Research Institute (Whelan et al., 2021)[123] was commissioned by Pobal to investigate the incidence of childhood disability among 3–5-year-olds in Ireland. The findings showed that the number of AIM-supported children in proportion to the number of children with disabilities increased between 2016 (where it was equated to be between 10 and 20 percent in each county) and 2019 where this figure was between 20 and 40%. A general positive trend in participation in AIM is evidenced in data provided by Pobal. There has been an overall positive trend in the number of services benefiting between the first full programme year (2016/17) and 2020/21 (1,283 to 2,048), the number of children benefitting (2,486 to 4,262) and the total number of AIM supports provided (4,087 to40,603). The number of visits by Better Start EYSs has also increased substantially during this period (7,900 to 16,541).

Cross-sectoral collaboration in the development of AIM is seen by members of the AIM team and its delivery partners, as key to its success both now and in the future. Stakeholders regard AIM as influential in bringing about culture change in the sector and perceive this to be a consequence of an enabling policy context and structured incentivisation for pre-school providers. There is a strong sense of collective consensus around AIM as the right model, and almost all of the participants engaged in the evaluation welcomed AIM and understood its rationale.

Key findings on the strengths and areas of improvement for each level of AIM follow.

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[122] When using the term 'psychosocial' we are referring to less visible disabilities related to cognition, social interaction, emotional and mental health.

[123] Whelan, A., Bergin, A., Devlin, A., Garcia Rodriguez, A., McGuinness, S., Privalko, I., Russell, H., (2021) *Measuring childhood disability and AIM programme provision in Ireland.* [Online]. Available at: https://www.esri.ie/system/files/publications/RS127_0.pdf. Accessed 16/03/21

Findings - AIM's Levels of Support 1-7

There is clear evidence that AIM's impact is supported by all of its levels, but there are strengths and areas to develop in each. To varying degrees and in different ways, the benefits of Levels 1, 2, 3, 4, 5, 6[124] and 7 are being experienced by parent/carers, providers, and children. AIM support is considered essential to the full inclusion and meaningful participation of children with disabilities and additional needs.

AIM Level 1 – An inclusive culture: *Aspects that are working well*

In a survey of providers, 91% agreed that having a named INCO impacts positively on inclusive culture and practice in their pre-schools. Take up of the LINC programme has been high (3,054 graduates exceeding AIM's launch objectives). This is also true of Diversity, Equality, and Inclusion (DEI) training. There is much praise for the quality and impact of the LINC programme.

In surveys of parent/carers, there was generally low awareness of Level 1, and Levels 2, 3 and 4 (40-50% of parent/carers were aware that this support was being provided for their child). However, interviews with parent/carers demonstrated that though none had heard of 'AIM Level 1' and few were using the term 'INCO', they were implicitly aware of Level 1's importance.

Where there were positive perceptions of inclusion at their child's setting, there was clear evidence that this was because of the presence of an inclusive culture (staff commitment to inclusion, communication, and the child being valued/accepted). This speaks to the foundational nature of AIM Level 1, as a substrate for high-quality, inclusive practice and offers support for the appropriateness of AIM's design as a universal offer, combined with targeted support.

AIM Level 1 – An inclusive culture: *Aspects that could improve*

Surveys of providers and interviews with stakeholders revealed concerns about the retention of LINC graduates in the ELC sector since the qualification created routes to higher-paid roles. Hence, the issue of attrition emerged as important to the sustainability of Level 1 and highlighted a need for the continuance of LINC training in the future. Reviews of the research literature identified evidence of the importance of *quality and impact* monitoring following programmes of universal CPD, and of regulation and accountability more generally (see 'Governance and Oversight' theme)

AIM Level 2 – Information for parent/carers and providers - *Aspects that are working well*

A rising profile of user engagement with AIM website resources was observed. In 2021, an updated AIM website was launched to be more user-friendly and accessible to users. View numbers had increased steadily between 2016 (55,258 page views) and 2021 (192,312 page views), demonstrating clear growth in engagement with a spike in growth at the point where the website's redesign was launched.

In surveys, 76% of parent/carers reported first hearing about AIM from the pre-school staff/manager or from a HSE professional (14%). A rising trend was found in parent/carers identifying the pre-school

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[124] It is important to reiterate that where participants are referring to AIM Level 6, there is evidence that they are conflating this with HSE interventions accessed outside of AIM.

staff/manager as the main source of information, indicating the increasing capacity of the workforce to support communication with parent/carers about AIM.

Most often, parent/carers responding to the survey had not heard of AIM before their child started pre-school, but where this was happening, this was most often through a HSE professional working with their child. Stakeholders reported growth in online peer-to-peer support forums for parent/carers, where experiences were being shared, and advice offered.

AIM Level 2 – Information for parent/carers and providers *- Aspects that could improve*

Many participants noted that the term ‘disability’ was off-putting for parent/carers, particularly those who are new to their child’s need for additional support. It was proposed that AIM might be more accessible and understandable to families in this group if there was less emphasis on disability in the communications available to them. The AIM website was observed to have high traffic, but not to host alternative formats (large text, videos, ISL-supported videos), or a user feedback mechanism (e.g., ‘Did you find what you are looking for?) which would be supportive of continuous monitoring.

AIM level 3 – A qualified and confident workforce – *Aspects that are working well*

The training that ELC providers have been able to access has been well received.

Providers have been enrolling in Lámh and/or Hanen Training with 364 enrolments in 2019-2020. Hanen training was described as being very good by most practitioners, however, some ELC providers would prefer a more hands-on workshop approach. All settings who had taken up the Lámh training praised it. SPEL training was identified as beneficial as it reflected targeted training to meet specific needs. Generally, ELC providers called for further specialist training around medical, complex, and psychosocial disabilities (e.g., ASD).

Most (78%) of parent/carers believe that staff at their children’s pre-school are well trained (survey of parent/carers). As noted under the theme **‘**The impact of AIM on the full inclusion and meaningful participation of children with disabilities in pre-school’, we know that parent/carers of children with autism/ASD and emotional disturbance were less likely to agree that pre-school staff were well trained than parent/carers of children with other types of disability (72-73% compared to an average of 78%) Providers called for more training in this area (interviews with providers, case study visits). It was noted by many participants, that a rolling programme of training was required, and that this would be enriched if it were responsive to the sector’s needs, and flexible enough to be personalised to specific additional needs currently within a setting (this is further reported under theme 6, workforce development).

Some participants identified that a training bursary could be awarded to pre-school settings to allow them to select from a range of courses, choosing which opportunities they would like to apply their bursary funding towards. The benefit of this approach is that it would allow CPD engagement to be responsive to the needs of the children within the pre-school setting. Collectively, participants identified that the following areas could be addressed through a broader catalogue of CPD (interviews with participants, case studies of children and pre-school settings):

- Autism-specific training: Most participants identified that there was a great demand for specialist training to support the needs of children awaiting assessment or in receipt of diagnosis of autistic spectrum disorder. The four EYS who participated in interviews indicated that this reflected the single biggest group of children on their caseload.

- Medical needs training: It was recognised that as part of the commitment to inclusive practice there were more likely to be children within mainstream pre-school settings with medical needs which would require practitioners to have additional skills and expertise. Due to the diverse range of different medical needs, this block of training could address epilepsy, allergies, diabetes, and peg feeding.

AIM level 3 – A qualified and confident workforce – *Aspects that could be improved*

The majority of parent/carers who were interviewed (14) did not feel able to identify training gaps. Where these were suggested, they focussed on additional training around specific needs, rather than in relation to general best practices, and their suggestions were in harmony with those made by participants from the professional community:

- training in a range of additional needs (including ASD),
- direct training by medical/therapeutic staff/specialist teachers for pre-school staff on the very specific needs of an individual child and how they could be supported.

Across all 14 settings visited for the case studies, ELC providers talked about the importance of refresher courses being rolled out in the future to provide ongoing support for practitioner development. It was noted that in order to avail of some AIM Level 3 training, such as Hanen, it was required that the setting be already engaging in AIM targeted support. Some ELC providers would like wider access to the training for all staff (case studies of settings and children).

Overall, participants argued that it was important to reflect on how well things are going, and to take stock. Though it was clear that AIM was being rolled out with good levels of participation across pre-schools, the focus must now be on what the impact of CPD has been on practice in pre-schools, and what now needs to be done. This was a central message emerging from the literature review for the evaluation.

AIM Level 4 – Expert early years advice and support – *aspects that are working well*

In general, providers were satisfied with the specific types of support provided by Early Years Specialists (EYSs) and its quality and impact on inclusive practice. In surveys, 78% of providers reported a positive impact on the inclusion of a child/children in a setting. In 2020/21 this was significantly lower at 66% implying a rising, cumulative impact. Providers recognised that the coaching, mentoring and support from the EYS was fundamental to inclusion and worked in tandem with the CPD at Levels 1 and 3 to develop their capacity for inclusive practice (interviews with practitioners). Of the 14 case study settings, the majority (9) held positive views and reported collaboration with their EYS to be supportive and productive.

In the context of reporting on Level 4, most (56%) providers reported that they were satisfied with the liaison with HSE professionals via the EYS.

For those parent/carers who were reporting on receiving AIM Level 4, most (83%) experienced it as positive, personalised, supportive, and valuing to their child. However, parent/carers had generally low awareness of AIM Level 4 as support provided for their child (evidence from surveys and interviews), and there was evidence that among those parents who were least satisfied with AIM, there was a wish for greater involvement in the processes of planning for their child, and of review.

Overall, the findings demonstrate the valuable role of the EYS in supporting inclusive practice. EYS support is a complementary component to training and CPD offered within AIM Level 1 and 3 as it can

respond to the individual needs of children and families in the context of the setting. An important theme emerging from the case studies, and the data as a whole, was how much practitioners valued opportunities to collaborate with others (EYS and HSE) in the development of inclusive practice around the child.

AIM Level 4 – Expert early years advice and support – *Aspects in need of development*

Providers and parent/carers would like more time with EYSs, and follow-up support once AIM supports are in place. Members of the EYSs reported high caseloads, and the wish to spend more time in settings. As reported under the theme 'Partnership with and support for parent/carers', there is a wider need to develop stronger partnerships with parent/carers.

AIM Level 5 – Equipment, appliances, and minor alternations - *Aspects that are working well*

19% of parent/carers participating in the survey for the evaluation, reported that they had applied for Level 5 grants. 38% of providers reported that they had applied, and 34% that grants had been awarded. The majority (69%) were satisfied with the ease of applying for the equipment, and with the ongoing support they received (50%). The majority were satisfied with the appropriateness of the equipment (surveys of parent/carers and ELC providers).

Participants representing the AIM project team and delivery agencies, reported that the uptake of Level 5 had been lower than anticipated, perhaps because once resources and alterations were in place, there was not a need to apply again. Participants believed that Level 5 provided an example of AIM working well. Where equipment and resources had been provided, they were tailored to individual needs and to facilitate full inclusion and meaningful participation. Representatives from the Disability Sector agreed that Level 5 was bringing positive impacts, in a context where the need for substantial improvements to processes were voiced. Providers also noted that successful applications for Level 5 helped to achieve full inclusion and meaningful participation.

Among parent/carers, awareness of Level 5 was relatively high, and though they were not always sure if the equipment had been provided through AIM or not, they were positive when describing the impact of high-quality, bespoke equipment and resources (interviews with stakeholders) Across the case study settings there was evidence of previous engagement in AIM Level 5 through minor alterations to the physical environment.

In surveys, receipt of Level 5 support was found to be associated with positive perceptions of an impact on meaningful participation, and the view that support was easy to access. Receipt of Level 5 support was also associated with a positive view of AIM overall among parent/carers who were reporting that an application was successful.

AIM Level 5 - Equipment, appliances, and minor alternations - *Aspects* *in need of development*

Though the majority of respondents in the survey of ELC providers were satisfied with the timeframe from application to payment (57% satisfied, 27% dissatisfied), there were some reports of prolonged delays to the provision of equipment and resources because they were so bespoke to the child, constructing barriers to inclusion. This implies some need to anticipate a child's needs prior to their start at pre-school. Participants also provided reports of the challenges that parent/carers had faced when transitioning to primary school. For example, after waiting for a lengthy period to get hearing equipment in place at their pre-school, lengthy delays began again once children were enrolled in their primary school (interviews with parent/carers). However, there were mixed views about equipment following the child into primary school and the suggestion was made that settings could be

enabled to buy permanent forms of equipment to meet frequently experienced needs through an annual subsidy (interviews with stakeholders). On this theme, ELC providers highlighted the following experiences (case studies of children and settings):

- Delays are experienced in the assessment and procurement of specialist equipment to meet the needs of children with a physical disability.
- Equipment to meet the needs of the child does not automatically get transferred over when a child moves from a pre-school in one county to a pre-school in another county, and this can disrupt inclusion
- In one ELC setting, practitioners did not feel confident in using a specialist chair and did not feel they had been given sufficient training to adjust it.

Though it is not possible to make claims about how prevalent these experiences are, these illustrate why some focus on the management of resource transition/handover may be an important consideration moving forward. These are further considered under the theme 'AIM and transition to primary school'

AIM Level 6 – Therapy Services

What is working well and what needs to develop in AIM Level 6 has been challenging to evaluate for several reasons, and it is important to explain this more fully.

Level 6 is the most complex of AIM Levels in terms of structure. This is because it has both universal and targeted elements. The universal level focusses on specialist advice about how to support children with the *type of disability* experienced by the child whose Access and Inclusion plan is being developed. Level 6 (universal) may be delivered in a range of ways (e.g., detailed phone calls between the EYS and the HSE specialist, e-mails, leaflets, drop-in consultation/training, other supporting training). Level 6 (targeted) is more bespoke to the individual and may include episodic (e.g., a visit to the pre-school to support the formation of a positive behaviour plan) or continuous (e.g., a longer-term individual programme) support.

The number of children in receipt of Level 6 (universal) and Level 6 (targeted) is relatively small. This cohort comprises 8% (Level 6 universal) and 0.33% (Level 6 targeted) of the total AIM supports provided between 2016 and October 2021, and 0.6% of the total number of children supported by AIM since it began. It has not been possible to gauge whether the total number of referrals to Level 6 (targeted) since AIM's first full programme year (133) is smaller than may be expected since an estimate of the likely number of children who would be benefiting from this support has not been made. This is partly because such estimates are problematic. We know from Whelan et al., (2021)[125] estimates of disability can be 8.8% at age 5. Broad definitions produce a rate of 18% at age 3 and 21% at age 5. The broadest definitions result in an estimate of over 33% of all children. Using the broad definitions, we might expect that the number of children being newly diagnosed (and hence new to HSE) is 3%, and referrals through Level 6 (targeted) currently represent one-fifth of that group. This picture makes it difficult to assess whether Level 6 (targeted) is reaching a sufficient proportion of its intended cohort or not. However, take up of Level 6 has not grown and is reported by HSE to be undersubscribed, signaling some expectation/capacity for higher numbers of referrals. In addition,

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[125] Whelan, A., Bergin, A., Devlin, A., Garcia Rodriguez, A., McGuinness, S., Privalko, I., Russell, H. (2021) *Measuring childhood disability and AIM programme provision in Ireland.* [Online]. Available at: https://www.esri.ie/system/files/publications/RS127_0.pdf. Accessed 16/03/21

where the number of referrals for Level 6 (targeted) is rising, this may have a positive impact on achieving Level 6's intended purposes of early identification and prevention.

Pobal[126] has provided counts of the number of HSE collaborations recorded by EYSs at Level 4 (also representing Level 6 universal), and for the number of referrals. It has not been possible to access data on the range/type/duration of HSE support provided at the Level 6 (universal) and Level 6 (targeted) levels. We also do not know how many children are waitlisted for further HSE support after being referred for Level 6 (targeted support) through AIM.

Despite purposive sampling (i.e., selection of parent/carers and providers for interview who had indicated receipt of AIM Level 6), we were not able to find participants to talk with who had received it. This is because, when interviewing those we had purposively sampled we found that they had accessed HSE support outside of AIM rather than within it (interviews with parent/carers, providers and case studies of children and pre-schools).

We know that where parent/carers and providers are sharing perceptions on Level 6, they may also be referring to HSE advice and intervention outside of AIM (e.g., because their child received a diagnosis prior to pre-school, or because HSE support was accessed via a referral route that was not the EYS). This is likely given that the Likert scale for survey items related to Level 6 refers to applications made by 'you or staff at the pre-school' and we know from Pobal that there were a total of 133 AIM Level 6 (targeted support) referrals between 2016 and 2021[127]. The total number of applications for Level 6 (targeted support) among the survey population (n=124) is higher than would be expected in a survey sample of 1,157 (representing just under 10% of the target population) where a value between n=9 and n=14 would be more likely.

We also know that parent/carers and providers tend to translate 'AIM Level 6 Therapeutic support'' as the continuous therapies they recognise in Occupational Therapy, Physiotherapy and Speech and Language Therapy. Level 6 (targeted) referrals may result in services like this for a small number of children in the longer term, but it is more likely that the support provided (within five weeks of the referral or where appropriate within a longer timeframe) will be in the form of behaviour support plans, classes, equipment, professional advice, or pre-school visits. Hence, where children have received such supports as AIM Level 6, parent/carers may not recognise it as the kind of support they have assumed Level 6 to offer. This context is important to bear in mind when interpreting the reported findings from the evaluation which follow.

AIM Level 6 – Therapy Services - *Aspects that are working well*

The majority of providers (62%) agree that HSE support (provided through AIM or outside of AIM) is helping children to get the best out of their ECCE provision, and 55% agree that it has assisted them in including a child with disabilities. Noting that in the survey parent/carers are conflating Level 6 with HSE interventions outside of AIM, satisfaction with HSE interventions was high (between 70% and 88%). This demonstrates that overall, where HSE is engaged with pre-schools (whether through AIM or outside it), the majority of providers agree that it has a positive impact on inclusion.

Quantitative analysis of the parent/carer survey data resulted in robust evidence of an association between receiving AIM Level 6 support/HSE support outside AIM and positive perceptions of AIM. From the perspective of parents, HSE engagement deepened AIM's impact on their children's full

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[126] Pobal Month Report (October 2021)
[127] Pobal Monthly Report (October 2021)

inclusion and meaningful participation. This indicates the value of collaboration between HSE and pre-schools in the context of advice and support.

AIM Level 6 – Therapy Services - *Aspects in need of development*

Providers reported that they would not consider applications for AIM Level 6 from an assumption that it could not be availed in the context of long waiting lists. They were not aware of the option to have the ‘within five weeks’ type of intervention available through AIM Level 6 (targeted). This means that there is some opting out of AIM Level 6 (targeted) even before a referral is made.

Members of the EYSS were reporting that the process of referring children for Level 6 (targeted) support was burdensome for settings and families (even in the context of EYS leadership of this process), and that where a referral was made, interventions were often brief and of limited value. Evidence to counter this perspective was hard to find in the data for the reasons described in the preceding section. It has been difficult to find, describe and report on activity within AIM Level 6. The documentary analysis also identified a need for more record-keeping around Level 6. This is because the type and intensity of supports provided at Level 6 are varied. The evaluation found that an integrated system for record keeping was not in place to account for the numbers of children served by these activities, and the type of support provided. This meant that AIM Level 6 was less accessible to evaluation.

AIM Level 7 – additional assistance in the pre-school room - *Aspects that are working well*

There are high levels of participation with 19,354 awards since the AIM programme began. Surveys demonstrated that parent/carer awareness of AIM Level 7 is the highest of all levels, and it was identified as the most beneficial and impactful aspect of AIM. Receipt of Level 7 support was associated with more positive perceptions of AIM’s impact. Parent/carers who were interviewed were more aware of Level 7 than other levels and prized it. They regarded good quality Level 7 support as crucial to their child’s full inclusion and meaningful participation.

In the survey, 90% of providers agreed that additional assistance had helped children with disabilities to get the most out of their ECCE provision, and the majority (75%) reported benefits from it.

The majority of pre-schools visited for case studies talked about it as the most beneficial aspect of AIM and were using it in a way that brought a positive impact.

AIM Level 7 – additional assistance in the pre-school room - *Areas for development*

Though the majority of providers that were interviewed recognised the importance of distributed support and described using it as such, some argued that use of a 1:1 model was sometimes the most appropriate approach during some parts of a session, particularly where children had complex medical or behavioural needs.

Recruitment to Level 7 posts had been challenging for some settings, and this was considered to be a risk for AIM’s sustainability. The main cause was perceived to be poor pay and working conditions for postholders. Difficulties with recruitment had caused distress to parent/carers (interviews with parent/carers) and had created barriers to inclusion. Level 7 continues to be conceptualised by some parents/carers and providers as an SNA rather than distributed model. There is a call from parent/carers for more monitoring of how Level 7 support is used by settings to include their child.

In the survey of ELC providers, 141/508 suggested that improvements to Level 7 pay and conditions would improve the impact of AIM (in free-text comments). Representatives from the disability sector described the poor pay and conditions (temporary, part time, term time only, low-paid contracts) as a key risk for AIM's impact and sustainability.

3. AIM and the location of pre-schools

There are differences in how AIM is perceived in rural areas/towns compared to cities/large urban areas.

Within a broadly positive picture, parent/carers whose children attended pre-schools in cities/large urban areas perceive AIM's impacts and benefits less positively than those whose children are at pre-schools in rural or town areas. Careful analysis of the data has found that one explanation lies in a higher proportion of children with ASD attending pre-schools in cities and towns (the group who were less likely to report positive experience of AIM).

We do not assume the problem to be within this group of children, and do not identify this group of children to have deficits. Instead, we apply a social model and draw from the wider evidence (parent/carer surveys, interviews with stakeholders, case studies) indications of a continuing need for training and development (including mentoring and coaching) focussed on inclusive practice for children with less visible disabilities. Children with physical and sensory disabilities, were more prevalent in the sampled population of parent/carers whose children attended pre-schools in rural areas (the group who were more likely to report positive experiences of AIM).

Within a broadly positive picture, providers in cities/large urban areas are less likely to believe in the sustainability of the inclusive practices they have developed through AIM. It is not clear why this difference exists, but there was some (weak) evidence that work pressures on INCO's in larger settings (which are more prevalent in cities/large towns) are implicated since providers in these settings and locations, give workload as the reasons for a less positive experiences of the LINC programme. In summary, AIM is working effectively to support inclusive pre-schooling for children with disabilities and is appropriate in the National context, though large pre-schools and pre-schools in cities/large urban areas may need enhanced targeted support at the level of CPD and/or funding.

4. The importance of cross-sectoral working and multidisciplinary specialisms

AIM was founded on the principle of cross-sectoral working and this approach has been sustained in its design, implementation and governance. It is regarded as a key reason for its success by varied stakeholders. The findings of the evaluation show that there is something to be gained in re-energising this cross-sectoral working so as to maximise AIM's impact and its status as a sector-leading programme.

As an innovating model for cross-sectoral collaboration around inclusion for young children, in particular across education and HSE, it is important that it continues to lead or exemplify such practices in a policy context where these form the lynchpin of strategies for childhood equity (e.g. Progressing Disability Services – PDS - programme, First 5).

In terms of communication to key stakeholders, AIM was observed to be well-represented, disseminated, and promoted by the DCEDIY and its partners (CCCs, Better Start, Pobal, LINC

consortium) and by Early Childhood Ireland (ECI). Information was coherent and consistent across these domains. AIM is largely absent from the communication platforms of its cross-sectoral partners (HSE, Department of Education - DE, and National Council for Special Education - NCSE). As noted earlier, effective leadership of cross-sectoral working was identified as a key factor in the success of AIM by members of the DCEDIY, its services providers (e.g., Pobal), quality assurance agencies (e.g., the Early Years Inspectorate), DE and disability advocates.

The main findings reported under theme 2 (the appropriateness of AIM in the national context) demonstrated that Level 6 is an essential and innovative element in AIM, and that the presence of HSE specialism and support is associated with more positive perceptions of AIM among parent/carers. However, its purpose and content are often misunderstood in the sector, and HSE have reported it to be undersubscribed. Members of the EYSS have reported that when targeted support is provided, it is often of short duration and not of the intensity that parent/carers or providers had expected, and that application processes are often cumbersome. Level 6 has been difficult to evaluate because it is complex, not very visible, of low prevalence compared to other AIM supports, and not well represented in the experiences of AIM that participants shared.

Providers, parent/carers, and disability sector representatives were calling for more connection between HSE and pre-schools. This was a key strategy for developing the sector's confidence in inclusive practice. Participants were keen to learn from the specialist knowledge of the HSE sector, and more distant forms of interaction (e.g., leaflets and collaborations between EYSs and HSE) did not emerge as the type of collaboration they desired. In settings that were visited for case studies, ELC providers and families felt that there could be much greater collaboration between therapists and pre-school settings. This was more evidence of stakeholders' desire to learn from working directly with specialists. This observation was also made in the OECD's review on sector quality in Ireland *Strengthening Early Childhood Education and Care in Ireland* (OECD, 2021)[128] which recommended further efforts to support inclusion through additional specialised expertise for pre-schools in relation to diverse children (i.e., disability and other types of disadvantages, in particular, the inclusion of children from Traveller and Roma communities).

The OECD report also observed some evidence that stakeholders across the sector were calling for the involvement of specialists. The evaluation identified the potential value of consulting more fully with providers on what they might need from Level 6, and how it can be described to them so that a) its content and the benefit of that content is clearer and b) they are keen to engage with EYSs in referral processes (Level 6 targeted).

At the point of writing, and as part of the PDS programme, a national forum had been established comprising the HSE, the National Council for Special Education (NCSE), and the National Educational Psychological Service (NEPS)[129] and local forums between education and health were also being established. Forging links between HSE, CDNTs and education is identified as a priority for continuing implementation planning, and it will be important for AIM and the ELC sector to be participants in PDS implementation planning. This is because the PDS is an opportunity to build more collaboration and integration between HSE and pre-schooling. It is also because programmes that have piloted the delivery of therapeutic support within pre-schools have identified positive impacts of relevance to inclusion. The literature review also included evidence of the importance of cross-sectoral collaboration in the attainment of inclusion but noted that it was among the most challenging

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[128] OECD (2021), *Strengthening Early Childhood Education and Care in Ireland: Review on Sector Quality*, OECD Publishing, Paris, https://doi.org/10.1787/72fab7d1-en.

and complex tasks for policymakers and agencies, and one requiring sufficient resources, monitoring, and regulation.

Overall, the evaluation identified a need to re-energise cross-sectoral activity in relation to shared communications/signposting about AIM by cross-sectoral partners, and a need to re-energise HSE/education collaboration through Level 6. This is in a context where the literature review for this evaluation has identified the importance of de-fragmenting systems of support (e.g., health and education) in pursuit of positive impact for children, whilst acknowledging the importance of leadership, oversight, and mutual accountability. In its development, AIM was observed to expound forms of cooperative engagement that embed the cultures proposed in the literature, and so has a firm basis from which to intensify the impact of collaborative working:

- being prepared to re-visit and challenge existing practice, setting assumptions and preconceived ideas to one side
- being open to innovative ideas and being ready to think differently
- being able to learn from one another, listening to other's perspectives and valuing other's attributes
- being able to evaluate current thinking and practice and plan to create functional new groups
- being able to recognise relationships and see connections between potentially disparate ideas and approaches. This will involve keeping the 'big picture' in mind as well as attending to the specific details.
- through ongoing dialogue and partnership, establishing a shared purpose, goal/aim

(Stoll, Fink, and Earl, 2003, adapted by Wharton et al., 2019)[130]

5. Governance and oversight

The evaluation contributes an account of the perceived appropriateness, efficacy, and impact of AIM on children, families, and providers, but the evaluation has identified a need for more routine, regular and integrated methods for evaluating AIM, as well as building continuous improvement in a context of cross-sectoral implementation.

Reliable and comprehensive counts of engagement in AIM are available via Pobal. These play an important role in measuring the growth of AIM's reach at the county and national level. The evaluation has identified a need to develop systems of oversight focussed on quality and impact/outcomes. These systems need to be routine, regular, and integrated so as to inform continuous improvement in AIM's capacity to develop the ELC sector as inclusive for all.

The review of the literature for this evaluation has also warned of the danger of loose governance of distributed funds for inclusion (in the case of AIM, universal supports at Levels 1-3 and the associated CPD) and recommends tighter monitoring of quality and impact.

6. Workforce development for inclusion, working conditions and the role of the INCO

Across stakeholders, AIM is perceived to have a substantial, positive, and culture-changing impact on pre-school practitioners' knowledge, confidence, and efficacy for inclusive practice.

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[130] Wharton, J., Codina, G., Esposito, R. and Middleton, T. (2019) *The SENCo Induction Pack*. Tamworth: nasen/DfE. Available at: https://www.sendgateway.org.uk/resources/senco-induction-pack-revised-edition Accessed: 10/12/21

This perception is held by most (and almost all) of the providers engaged in this study. The majority of parent/carers also perceive staff to be well-trained, and where they perceive this, they are also more positive about AIM's impact. This is less likely to be the case where parent/carers have children whose main reported type of disability is ASD.

Stakeholders regard AIM as influential in bringing about culture change in the sector. Most, and almost all (94%) parent/carers responding in the survey, agreed that pre-school supports their child's full inclusion and meaningful participation. Similarly, most, and almost all (96%) of providers are positive about the way that AIM has built their capacity for including children with disabilities. There is clear evidence that AIM supports are being implemented effectively by providers to support children, with positive impacts on their experience of full inclusion and meaningful participation (in a context of variation as noted earlier). The 14 children who engaged in this evaluation, reported their experiences of full inclusion and meaningful participation positively, and effective practice was observed in the pre-schools visited. Providers praise the CPD offer at Level 1 and Level 3, and the LINC programme is highly valued by the majority of participants.

Providers' ability to engage in LINC is impacted by their workload and location. Where their settings are larger (30 or more enrolled) and in cities, they are less likely to perceive it positively.

Evidence from the evaluation also demonstrates that there is a sector-wide need for more training on less visible disabilities (ASD, emotional disturbance, speech, and language difficulties) and more complex needs. This is also the case for CPD focussed on working effectively with parent/carers overall, and particularly where their children have these types of needs. Providers also call for more training on medical needs.

91% of providers agree that having a named INCO impacts positively on culture, pedagogy, and practice, though parent/carer awareness of the role is generally low. There is a need to consider what influence the state could have in ensuring that providers ringfence time for INCOs to enact their role effectively.

Stakeholders perceive the impact that poor pay, and conditions have on AIM, particularly on the recruitment and retention of high-quality staff for Level 7 posts.

Within a largely positive picture, there is evidence that some parent/carers experience AIM negatively and are not able to describe positive impacts. Given that the evaluation also delivers evidence of widespread, effective practice, it is important to find ways to spread this good practice around the system in ways that support continuous improvement.

7. Partnership with and support for parent/carers

AIM Level 2 provides supportive Information for parent/carers and providers, and as mentioned earlier/later, there is evidence that this is working increasingly well. However, parent/carers called for more communication and involvement with pre-school staff and specialists in the plan/do/review process around inclusion for their child.

There is strong evidence in the evaluation that where parent/carers have positive relationships and good communication with pre-school staff they also rate the impact of AIM more positively. This emerged as a strong theme throughout the evaluation and is also reported in international data and debate. The data for the evaluation contains several illuminating accounts of parent/carers feeling bewildered and somewhat powerless in the system. Representatives from the disability sector also

report that parent/carers are not always aware of the options available for their child, or how to secure those options. For these reasons, putting an increased focus on partnership with parent/carers emerged as an important route to improved outcomes and experiences for children.

8. The valorisation of targeted supports within AIM

Parent/carers have an implicit awareness of the contribution that an inclusive culture at their child's pre-school makes to their child's experience and their own experience. However, their awareness of AIM's universal levels is relatively low and they do not identify them as impactful elements of AIM. Parent/carers tend to prize AIM's targeted supports, particularly Level 7, and attribute to them, most of AIM's impact.

International data and debate highlight how the valorisation of targeted supports can lead to pressures on funding, and hence the erosion of universal supports as spending comes to be focussed on targeted provisions. When we use the term valorisation, we are describing a process by which targeted supports are elevated in value and status in a way that leads to universal supports being unrecognised or undervalued. There will be a need to monitor this tension and to communicate to parent/carers how AIM Levels 1-3, and also Level 4 contribute to the successful inclusion of their child. International data and debate include accounts of the need for diligent governance of distributed funding for inclusion (AIM's universal supports). Close monitoring of the quality and impact of AIM Levels 1-3 is proposed as a way to ensure the defence of funding and impact for these elements.

The evaluation has found that parent/carers are relatively unfamiliar with Levels 1-3, and the role these play in the inclusion of their children.

9. AIM and transition to primary school

An outcome/hoped for outcome of AIM that parent/carers value highly is successful preparation for and transition to primary school, particularly mainstream primary school. The evaluation found some evidence of turbulence for parent/carers of children with disabilities at this transition point (particularly when mainstream school was the goal). There is a need to consider how cross-sectoral collaboration through AIM could support the transition of AIM-supported children at this important point in life.

In surveys, the majority of parent/carers whose children had started school believed that AIM had supported their child's preparation for school (62%, 318) [131] though 26% (n=133) believed it had made no difference and 4% (n=20) believed AIM support had led to them being less prepared. Parent/carers of children attending a mainstream school are significantly more likely to report that AIM had a positive impact on the transition to school (66%, n=239) when compared to those attending special classes in mainstream schools (58%, n=58). Agreement with the statement, 'As a result of AIM, my child was able to attend a mainstream school' was significantly more likely if children had physical and sensory disabilities (66%) than in the case of all other types of disability.

When interviewed, most participating parents/carers viewed AIM-supported ECCE as being the way to prepare children for primary school. Transition to mainstream school also emerged as the outcome

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[131] The first figure refers to the percentage of respondents, and the second figure the number of respondents.

they hoped that AIM-supported ECCE would deliver. There were stories of distress and confusion at the point of transfer, and parent/carers felt that they did not have the tools to negotiate with headteachers who were resistant. Parent/carers, disability advocates and members of the EYSS recommended that transfer could be supported by cross-sectoral support from INCOs, EYSs, Special Educational Needs Officers and HSE staff, to ensure that needs were understood/supported, and adaptions could be made in advance of the child's start at school. Stakeholders also reported the challenges and barriers to inclusion created by the non-transfer of specialist equipment to the child's school.

10. The phased expansion of AIM

Stakeholders are broadly in favour of AIM's expansion to a) hours outside the ECCE programme entitlement including full days where needed, b) extending AIM support to children who were younger than the qualifying ECCE age, and c) extending AIM support into School Aged Childcare (SAC). A range of reasons for supporting these expansions were given. These included the potential for earlier identification, improvements to parent/carers opportunities for work/study, and as a support for effective transition to primary school (where additional support could continue into SAC). There were mixed views on whether AIM should be expanded beyond disability to other educationally disadvantaged groups (e.g., children speaking English as an additional language, children from Traveller and Roma communities), in part because AIM was a response to disability. Evidence from the evaluation supports the expansion of AIM to other age groups of children who may have a disability as defined in the AIM policy (assuming continuous development based on the findings and a phased approach) but does not offer sufficient evidence to recommend expansion to other educationally disadvantaged groups, mainly because its focus was on how AIM was working for children with disabilities.

Appendix 1 provides a summary of focuses for the evaluation and related research methods
Appendix 2 provides a visual summary of the survey findings
Appendix 3 provides a glossary

Appendices

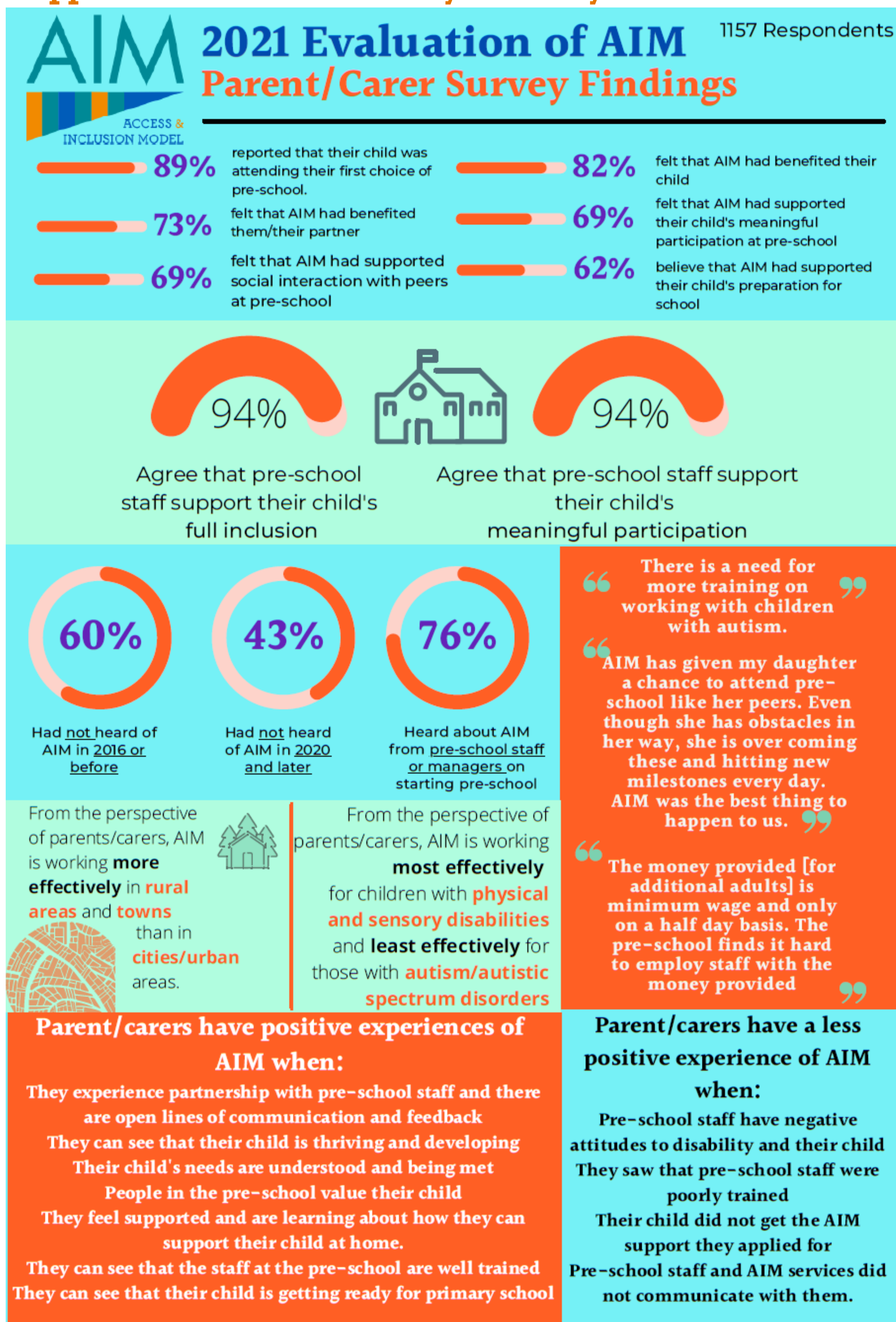
Appendix 1: Summary of focusses for the evaluation and match to methods

Objective	Focusses	Method							
		Documentary Analysis	Literature Review	Survey (Parent/Carers	Survey (Providers)	Interviews (AIM team and disability sector)	Interviews (Parent/carers)	Interviews (Providers)	Case Studies
Quality & Process: Relevance and effectiveness of approach, process, and implementation	The evidence-base, rationale, aims and objectives								
	Development and evolution of the overall approach								
	Implementation fidelity of the approach								
	The extent to which AIM reaches the intended cohort								
	Effectiveness of the overall approach, in respect of all levels of AIM, and from the perspective of all stakeholders								
	Engagement with AIM over time by services, practitioners, children, and families								
	Appropriateness and efficiency of application, assessment, and approval processes								
	Role and value of the Early Years Specialists								
	Reasons for non-participation of children, families, practitioners, and services in different levels of AIM, including barriers to participation								
	Efficacy of training provided, including LINC, Hanen, Lámh and Sensory Processing training.								
Outcomes and Impacts: Expected and achieved outcomes, contextual factors, causality	Impact on access to – and meaningful participation in – the ECCE Programme for children with disabilities					*			
	Outcomes across all levels of AIM, as perceived by all stakeholders					*			
	Impact on the quality and inclusiveness of early learning and care provided; sustained learning and knowledge transfer among practitioners; strengthening of workforce capacity					*			
	Embeddedness and sustainability of approach in settings					*			
	Role of AIM in supporting positive transitions to Primary School					*			
Governance: Leadership, coordination,	Collaboration, communication, and knowledge-exchange among stakeholders								

Objective	Focusses	Method							
		Documentary Analysis	Literature Review	Survey (Parent/Carers	Survey (Providers)	Interviews (AIM team and disability sector)	Interviews (Parent/carers)	Interviews (Providers)	Case Studies
communication, and accountability	Efficiency of the governance and leadership approach to AIM								
	Engagement with other key agencies and partners								
	Adequacy of available data and indicators for monitoring the effectiveness and efficiency of AIM								
	Position of AIM in the delivery of related supports								
	Adaptability, scalability, and sustainability of AIM								
	Potential enhancements to, and/or extensions of AIM								

* where appropriate to role

Appendix 2: Visual summary of survey data



2021 Evaluaton of AIM
Provider Survey Findings

732 Respondents

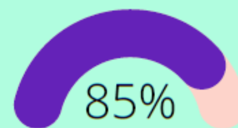
96% reported that AIM was having a positive impact in their setting

94% believed that AIM was having a positive impact on children with disabilities/additional needs

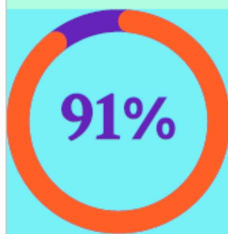
96% believed that AIM was having a positive impact on inclusion in their setting.

have adopted the Diversity, Equality and inclusion Guidelines

have attended the Diversity, Equality and Inclusion Training provided by County Childcare commitees

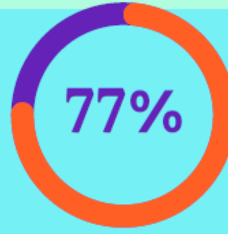


have a named inclusion co-ordinator

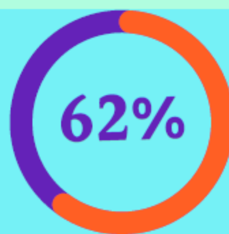


Level 1: Having a named **inclusion Co-ordinator** impacts positively on **inclusive culture, pedagogy and practice.**

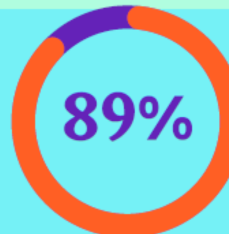
Level 4: Support from **Better Start Early Years Specialists** helps children with disabilities/additional needs to **get the best from their ECCE provision.**



Level 5: Specialist **equipment/appliances and minor building alterations** are having a **positive impact** on **children and staff** in the ELC setting.



Level 6/HSE support (in or out of AIM is helping a **children with disabilities** to get the **best out of their ECCE provision**



Level 7: Additional assistance is helping the setting to **include children with disabilities.**

> "AIM has been such a positive fundamental resource for our service. It has enabled us to include all children within our pre-school."

> "I would like to see AIM re-evaluate their application form. It has put some parents off applying for support when they see disability written all over the form."

> "We have been able to do so much more for the children in our pre-school than we would have been able to if we did not have access to the training, early years specialist support or the higher capitation that AIM provides."

> "[We need] better funding for level 7 support to pay someone to come in to support in the setting. The funding is way too low making it impossible to recruit without providers topping up the pay."

From the perspective of providers, AIM worked **most well** if their setting had joined the programme in **2017-18 or 2018-19**. It worked **least well** if they had joined in **2020-2021**

Providers from settings in **cities and urban areas** are **less likely** to believe that the improvements in their setting's inclusive practices supported through AIM are **sustainable** than those in **rural areas or towns**

Appendix 3: Glossary

AIM
Access and Inclusion Model
Aistear
Curriculum framework
Better Start QDS
Better Start Quality Development Service
CCC
City and County Childcare Committee
CCSP
Community Childcare Subvention Plus programme
COVID-19
Coronavirus disease
DCYA
Department of Children and Youth Affairs
DCEDIY
Department of Children, Equality, Disability, Integration and Youth
DE
Department of Education
DE Inspectorate
Department of Education Inspectorate
ECCE
Early Childhood Care and Education (A universal state-funded programme providing two years of free pre-school for children, not to be confused with ECEC, Early Childhood Education and Care), the term used internationally to describe childcare and education more generally.
ELC
Early Learning and Care (national term used to refer to early childhood education and care in Ireland)
First 5
Ireland's Whole-of-government ten-year strategy for babies, young children and their families
INCO
Inclusion Co-ordinator
LINC
Leadership for INClusion in the Early Years
NCCA
National Council for Curriculum and Assessment
NCS
National Childcare Scheme
Pobal
An organisation working on behalf of the Irish government to support communities and local agencies toward achieving social inclusion and development
SAC
School Aged Childcare
Síolta
National Quality Framework for Early Childhood Education
Tusla
Child and Family Agency (provides services to support child and family protection and welfare)
Tusla EYI
Tusla Early Years Inspectorate