Disabling Consent: Discourses of Disability and Inclusion in Ontario's Early Childhood Education and Care in 1994

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Abstract and Keywords

Today, disabled children have access to child care programs, but access is provisional, not rights based. This is a study of what happened to push children with disabilities into a subordinate concern when, in 1994, Ontario’s Group K hospital programs for children with disabilities were closed and children were pointed toward inclusive child care instead. This critical discourse analysis of four early childhood education and care (ECEC) documents uses Thomas Hobbes’s social contract theory to show how ECEC planning and system design that excluded disabled children created further disabling conditions for children already experiencing impairment. The study asks: (1) How was children’s disability responded to in ECEC at a time of transition in social policy and administration in children’s programs? (2) What might Hobbes’s social contract theory contribute to a study of ECEC inclusion to understand how disability was produced? (3) How did discourses produce situations of exclusion, separation, and disappearance for children with disabilities in inclusive ECEC? (4) How was ECEC set up to fail children with disabilities by the Ontario government through its poor planning and child care system design? This study finds that two ECEC discourses—*disability is a natural phenomenon of the body* and *children are children first*—prioritize the nondisabled child and make children with disabilities disappear, in and from ECEC. Therapy discourses, originally of medicine but strengthened in the ambiguous governing infrastructure of ECEC in which disability is represented as weakness and vulnerability, are found to subordinate children with disabilities while also leaving educators with a great deal of unanticipated, invisible work. In 1994, the conditions of policy, planning, and available information had the potential to move ECEC into a better system for children with disabilities; however, this study concludes that the path that was taken instead—to not develop good policies and plans for disability in ECEC—meant that the conditions whereby children with
disabilities are subordinate, less than, and not fully human were locked into ECEC. Now, the
development of a Canada Wide Early Learning and Child Care (CWELCC) system presents an
opportunity to change the discourses that created the disabled subject in ECEC in 1994. A clear
statement about disabled children as an assumed focus for all ECEC systems, including
CWELCC, could shift the rhetoric of inclusion that has been so limiting to ECEC in Ontario
since 1994.

Key words: Early childhood education and care (ECEC), inclusive child care, disability, special
needs, social policy, Thomas Hobbes, social contract theory
Summary for Lay Audience

Disabled children have access to early childhood education and care programs (ECEC), but access is not guaranteed. In this study, I discuss how children with disabilities are disadvantaged by the social, political, and physical environments of ECEC. In other words, I examine how “disability” is produced—or brought about by practices and norms of ECEC. This is a study of what happened to children with disabilities when, in 1994, Ontario’s Group K hospital programs for children with disabilities were closed and children were pointed toward inclusive ECEC instead. This study uses Thomas Hobbes’s social contract theory to show how disabled children were made to disappear in, and from, ECEC in 1994. When people with disabilities are treated differently than people without disabilities, it creates impressions of what it means to “belong” in society. The lack of planning for children with disabilities in ECEC sent a message that they do not belong in ECEC. I show how the lack of planning and ambiguous governing infrastructure of ECEC that existed in 1994 also reinforced the perception that disability means “weakness” and “vulnerability.” Because of the underdeveloped planning and organization of ECEC for effectively including children with disabilities in 1994, children with disabilities were invited to come to child care, but the invitation was conditional. Children with disabilities faced extra barriers to participate in ECEC compared to children without disabilities. In 1994, the conditions of policy, planning, and available information had the potential to make ECEC into a better system for children with disabilities. This study concludes that the path that was taken instead—to not develop good policies and plans for disability in ECEC—meant that the conditions whereby children with disabilities are subordinate, less than, and not fully human were locked into ECEC. Now, the development of a Canada Wide Early Learning and Child Care system
presents an opportunity to change the way children with disabilities are included in ECEC. What is needed is a clear statement about disabled children as an assumed focus for all ECEC systems.
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Chapter 1: Introduction

There is a problem in early childhood education and care: Children experiencing disability are denied regular rights and citizenship when they are promised to be included in child care programs, and child care programs are not created with them in mind. Group K hospital children’s programs were places for rehabilitation and care for children and adults with disabilities who were living in their homes with their families, and in 1994 they were closed. Families of children with disabilities were pointed toward inclusive child care instead. This thesis conducts a critical discourse analysis (Fairclough, 2003, 2010) using Thomas Hobbes’s social contract theory to show that, in 1994, the discourses of inclusive child care denied children regular rights and citizenship by producing disability.

Disability is viewed as socially constructed in this thesis. I use the term disability throughout as a social condition that is “brought about by social norms, practices and beliefs” (Hirschmann & Linker, 2015b, p. 4). In this thesis I discuss how the disadvantages experienced by children who have disabilities are made more complicated by the social, political, and physical environments of early childhood education and care (ECEC) in Ontario: The complications of attending child care—or being denied access to child care—for children with disabilities, create more disablement for them. In Ontario, the disabled child is promised that they can attend child care, if they meet certain criteria.

This is a study of the production of disability in ECEC that involves an examination of citizenship in ECEC (Hirschmann & Linker, 2015b). Citizenship entails declarations of who belongs, their entitlements, and their obligations within social groupings (Hirschmann & Linker, 2015b). The zones of citizenship can be big, such as a country, or small, such as a toddler room. The hallmarks of citizenship may be formal and informal and are by no means limited to political
activities such as voting or jury duty; rather, citizenship is a “symbolic representation” of what it means to belong (Hirschmann & Linker, 2015b, p. 3). For people with disabilities, because of denial, rejection, and exclusion, discourses of citizenship can also be imbued with messages of their status as persons and their “very right to exist” (Hirschmann & Linker, 2015b, p. 15). In 1994, inclusive child care in Ontario focused on the nondisabled child and therefore denied children with disabilities regular rights and citizenship in ECEC.

Citizenship—and the right to exist—for Thomas Hobbes, relates to “the state of nature” in which all people are free and equal (Hobbes, 1651/1996). The state of nature, however, is also a state of war. All individuals are considered of equal strength in the state of nature such that, in this individualized state of existence, no individual is able to rely on their ability to dominate others in order to survive (Green, 2012; Hobbes, 1651/1996). To survive and for peace, individuals agree (contract) to be part of social systems that are governed by a unifying force that also protects them (Green, 2012; Hobbes, 1651/1996). Coercion of any individual to agree to be part of the social contract would deny that individual their freedom; therefore, “consent” is a fundamental concept for Hobbes’s social contract. In ECEC, it is suggested that when children with disabilities are not included in programs it is because of their bodily incapacity to function, when the true reasons for exclusion are the social arrangements of ECEC. This is a study of the governance decisions that occurred in 1994 regarding inclusion of children with disabilities in ECEC and how a lack of clarity in process and planning had an impact on people’s ability to freely consent to the terms of ECEC, which should have treated all as equals but did not.

Ontario’s children have a right to attend elementary school and high school. Rights and entitlement rhetoric in education can, admittedly, be further complicated when considering childhood disability due to the problem of “different ideas of what constitutes ‘appropriate
supports’ and for whom these supports are appropriate” for a child’s participation in an educational activity (Carey, 2015, p. 171). What is important here is that ECEC in Ontario is not this kind of publicly funded and operated education because it lacks a universal framework. Children do not have a right to attend ECEC. Governance for ECEC in Ontario is distinct from that for the education system, but ECEC is sometimes construed as part of the Ontario education system. The Ontario Ministry of Education declares that education includes early years learning, elementary school, high school, and postsecondary (Government of Ontario, 2022a). Nevertheless, ECEC in Ontario has only some elements of public administration and only some public funding; it is mostly privately planned, organized, and delivered and, so far, is mostly funded by fees that families pay. No child in Ontario is entitled to a space in a child care program.

This dissertation makes a crucial distinction between education and ECEC due to their different governance and the universal nature of the primary and secondary education system (“Education”), which is not a characteristic of ECEC. Interpreting ECEC as “Education” plays a part in children with disabilities being denied the same rights that other children have to participate in ECEC. In ECEC, there are difficult-to-see additional barriers for children with disabilities in inclusive child care that are made so by rhetoric related to “right to education,” “appropriate supports,” and chosen participation levels.

Education is in the business of abilities such that Education aims to improve all people’s abilities. Child care programs are also in the “abilities business”—and some might say child care has “even greater potential” than the education system because the goals and aims of ECEC are more expansive (K. Underwood, personal communication, October 18, 2022). My argument begins with the idea that misinterpreting ECEC as a form of education that children have a right
to in Ontario wrongly extends assumptions related to rights to education into early childhood education and care.

This study is a critical discourse analysis of inclusive child care. Discourses serve specific purposes within institutions (Fairclough, 2013). Policy, practice guides, and advocacy documents are all texts of ECEC that contain the discourses of ECEC. Working from the perspective that knowledge produced in the upper reaches of Ontario ECEC in 1994 has become embedded in the lower reaches (Fairclough, 2013) of child care programs still today, I have examined how the organization of inclusion in ECEC that year made inclusion limited, underdeveloped, and lacking in possibilities. Even now, ECEC in Ontario can still make children with disabilities invisible because the inclusion expectations for child care remain almost insignificant in policy and, where they exist, vague, even at the most formal level, for instance, in the Child Care and Early Years Act, 2014, in the Early Childhood Educators Act, 2007, in the administration guidelines for funding, and in the practice guidelines for educators. As a result, ECEC has been hindered in its capacity to become better for children experiencing disability ever since 1994.

By examining the discourses of inclusion and disability in ECEC using Thomas Hobbes’s social contract theory, I show how inclusive child care involves an “invitation” into child care, not a right. For social contract philosopher Thomas Hobbes, inequalities among humans occur in social arrangements—they do not exist in a nonsocial or natural state. In child care, disabled children are encouraged, and sometimes welcome, to come to child care programs: They have some access to child care programs, but the invitations are provisional offers; they are not rights-based. Using Hobbes’s social contract theory, I interrogate the inequalities between disabled
children and nondisabled children in child care that are connected to such gestures as the invitation offered to disabled children—while nondisabled children need no invitation.

The obligation to not discriminate based on disability is entrenched in the Canadian Human Rights Act (R.S.C., 1985. c.H-6); in Ontario, the Human Rights Code states that service providers, including child care providers, have the “duty to accommodate the needs of people with disabilities to the point of undue hardship” with the goal of allowing people to “equally benefit and take part in services” (Ontario Human Rights Commission, n.d., “Duty to accommodate, para. 1). Yet, I argue that the distinction between having access to something and having a right to something demands highlighting, because “access to” involves a generosity granted by someone else opening a door and inviting you in, whereas “right to” is an open door—it is no wrong door (Pascal, 2009), and it is no wrong person for that door.

In 1994, there was a possibility for a better child care system in Ontario, for children with disabilities and children without disabilities. In this dissertation I demonstrate how the inequalities produced by the arrangements of inclusive child care were to the detriment of children; meanwhile, the planning conditions created by the government of Ontario at the time of the closure of Group K hospital children’s programs were also to the detriment of ECEC and to the working conditions of educators. I interrogate discourses of inclusion and disability in early childhood education and care in Ontario during a pivotal year of change in provincial child care policy and planning to provide evidence that, for children with disabilities, opportunities for a better child care system were wasted. Even now, in 2023, ECEC and children with disabilities are still paying the price.
My position in the study of inclusive child care

I am positioned in this study of ECEC and inclusion of children with disabilities as a nondisabled ECEC policy-directed researcher. I have worked for almost 30 years in Ontario’s ECEC system in child care program evaluation, system planning, and policy analysis. I once developed an inclusive child care model for the child care service delivery system of a municipality in Ontario that is still in place today. In 1994, I was hired for a three-month contract position to complete a full review of special needs child care in an Ontario region that included recommendations for children’s program delivery and services in the region. A significant part of the contract was to develop an implementation plan for an integrated children’s program at a Group K hospital children’s treatment centre that was slated to close. After that contract ended, I pursued a master of science degree in child studies at the University of Guelph, and in 1999 completed a thesis in which I studied the inclusion attitudes, beliefs, and experiences of early childhood resource teachers in Ontario, with Donna Lero and Kathleen Brophy as my academic advisors. Since then, in roles of project coordinator and policy analyst, I have critiqued, analyzed, and worked to improve models for inclusive child care for a large part of my career in early childhood education and child care. For years I worked from the standpoint that my involvement in developing better approaches for inclusive child care is a kind of “good guy” emancipatory work (Costa et al., 2012) that benefits ECEC, educators, and children with disabilities. While formalizing my plans for this dissertation, I realized that there is some significance to my first job in inclusive child care planning coinciding with the closures of Group K hospitals across Ontario that now confounds my perception of this work as “good guy” work. While tracking down historical documents for this study (during the global pandemic), I remembered that I have in my possession print copies of draft reports, finished reports, and other
documentation, such as letters and meeting notes, that could accurately and accountably (Reaume, 2018) fill some gaps in my analysis of what happened in 1994 that would exist were I to use only publicly available documents.

Currently, I am a full-time professor in the Bachelor of Early Learning Program Development at Conestoga College in Ontario.

**The purpose of this study**

This study is a critical discourse analysis (Fairclough, 2003, 2010, 2013) that interrogates the discourses of inclusive child care and disability in ECEC that were operational in Ontario in 1994 and have been detrimental for children and for ECEC. The discourses of inclusion in ECEC that were intensified in 1994 during a period of change in children’s programming for individuals with disabilities have ensured that disability still exists as a marginalizing characteristic of the child (not the program) that makes it easy to exclude “the child with disabilities” from child care now. Because of the work that occurred in 1994, with the closures of Group K hospitals where children with disabilities were attending specialized preschool programs, and with the unwitting involvement of ECEC used as a tool by the province of Ontario, the government was able to discharge themselves of further responsibilities for entitling children with disabilities to early education and care programs. Now, inclusion has reproduced the disabled child in ECEC because “inclusion” was made vague in 1994 and remains vague.

Disability cannot make someone less than human, but the construction of what is thought to be “normal” using the nondisabled human subject as its model makes it easy to justify policy that separates disabled individuals from the social contract (Russell, 1998, p. 17). The social conditions of inclusive child care, guided by ECEC planning and policy developed in 1994, made children with disabilities into human subjects who can be treated as though their existence
is dubious (Kafai, 2021). By doing so, children with disabilities in ECEC in 1994 did not have the same rights as nondisabled children, and now, because the same system exists, this distinction in rights is still occurring. By denying children with disabilities clear declarations of their right to belong “as citizens” with entitlements in ECEC, children with disabilities in ECEC have been made into subjects who are less than human (Russell, 1998). This is how ECEC produces disability in children. The conditions of ECEC construct disability in children in the ways that they “cast” (Preston, 2014, p. 1) children with disabilities as not entitled to the same programs, access, and participation levels in child care that children who do not have disabilities are entitled.

Disability is most often perceived as a burden in society (Kittay, 2011) and it is this way in ECEC too. When disabilities are made countable by rates and prevalence, and when disability is understood as a biological phenomenon—as health gone wrong, as needing intervention, rehabilitation, and treatment—this implies that, if fixed, those experiencing disability will then assume their natural nondisabled place in the developmental trajectory (Titchkosky & Aubrecht, 2015). Inclusion policy shapes ECEC practice for supporting children experiencing disability in child care settings, but such policy is difficult to identify (Allan, 2007). Inclusion has, for the most part, also “been uncritically introduced and implemented” (Liasidou, 2008, p. 483) in child care. Lack of clarity in inclusion policy in ECEC camouflages how complex it can be for children experiencing disability, and their families, to be part of a child care program (Frankel, Chan, & Underwood, 2019). As well, there is an implied narrative in ECEC that the social and financial burden of disabled participants is an extraordinary expense, not a regularly occurring expense of operating a program. Case in point, a Canada-wide snapshot of inclusive child care indicates that 31.7% of families of children with severe disabilities were refused child care
services (Halfon & Friendly, 2013). Given that there have not been substantial policy, funding, or practice changes in ECEC since the 2013 snapshot was taken, one can assume that almost one-third of such families are still being denied access to child care services in Canada. In fact, one-third of families denied access is a substantially low estimate according to recent evidence from the Inclusive Early Childhood Service System longitudinal research project which shows that, across Canada, almost 80% of that study’s participating families report exclusion related to gaining entry to child care, and 61% report that they cannot maintain enrolment in child care programs once they gained entrance (van Rijn et al., 2021).

In this dissertation I bring attention to the disabled subject in inclusion discourses of early childhood education and care. I have used feminist perspectives, namely feminist Hobbesian social contract theory, to cast doubt on the dominant knowledges that shape the conventions of inclusion in early childhood education and care. The conventions of inclusion contain unexposed and dominant social and political ideas about who belongs (Hirschmann & Linker, 2015b) and who is not human enough (Russell, 1998) to be part of ECEC.

**Research questions**

1. How was children’s disability responded to in ECEC in Ontario at a time of transition in social policy and administration in disabled children’s programs in 1994?

2. What might Thomas Hobbes’s social contract theory contribute to a study of ECEC inclusion to understand how disability was produced in ECEC in 1994?

3. How did early childhood education, disability, and inclusion discourses in 1994 produce situations of exclusion, separation, and disappearance for children with disabilities in inclusive ECEC?
4. How was ECEC set up to fail children with disabilities by the government of Ontario by its poor planning and child care system design?

**Situating this study within disability theory**

Situating this study within disability theory and social contract theory has allowed me to explore my research questions by provoking the ordinariness (Titchkosky, 2008) of ECEC planning and system design that excludes disabled children from being considered citizens with regular rights to participate in child care.

In this study I refer to a social model of disability. Social models of disability assume that disability is constructed through the complex relationships that happen among impairment, response to impairment, and the social environment (Barnes, 2012; Hirschmann, 2012a; Oliver, 1990). Social models of disability emphasize that disadvantages experienced by disabled people are situated in the social, political, and physical environment that fails to meet the needs of people who do not match the predominant expectations of the population setting the terms for the group (Hosking, 2008). Social models are largely preferred for understanding disability now and help in identifying the ways that society is organized and structured that produce further disabling conditions for some bodies that are already experiencing impairment (Hirschmann & Linker, 2015b, p. 6). Experience of disability also involves chronic pain, aging, changes in disability status, and the *deeply human work* of adjusting to these things (Siebers, 2015, p. 224), making any singular model of disability potentially limited in telling “a complete story of disability” (Hirschmann, 2016, p. 10). In this way, disability is examined as a “feature” (Norris, 2014, as cited in Titchkosky, Cagulada, & DeWelles, 2022, p. 3) of the social relations of early childhood education and care that give us opportunities to better understand ourselves (Titchkosky, Cagulada, & DeWelles, 2022). Social models of disability can be useful for
understanding freedom and barriers to freedom; they have been developed extensively in the past two decades in interesting and exciting ways, including a social relational model that is rooted in the capabilities approach to disability (Reindal, 2021), and disabled children’s childhood studies (Curran & Runswick-Cole, 2013), which critically interrogates the intersections of childhood and disability, making it a useful approach for challenging ableist and adult-dominated discourses in children’s rehabilitation (Mosleh & Gibson, 2022, p. 124). When disability is viewed as socially constructed and not inevitable, rather than as natural, this allows for a more focused consideration of early childhood education’s policy and administration as performative rules of engagement (Barad, 2012) that could be changed, and it illuminates a distinction between “the body and the social . . . [that] retains an epistemological and political importance” (Hirschmann, 2016, p. 112) that is important to this study. Social conditions that require conformity to function are faced with a challenge when presented with “disabled bodies,” hence their need to put disability in its proper place (Hirschmann & Linker, 2015b, p. 1). Mine is a study of the social conditions that put disability into its place in ECEC in 1994.

Situating this study within disability studies is also my attempt at advocating for a valued visible (Titchkosky, Cagulada, & DeWelles, 2022) presence of disability in early childhood education and care. In this study, I have debated the basic freedoms of people experiencing disability within the human social contract and have argued that the perspectives, interests, and experiences (Hirschmann, 2016) of early childhood education and care reflect the subset of the human population that excludes impairment. I demonstrate in my findings and conclusion that early childhood education and care in Ontario produces human subjects who are made disabled by inclusive child care, and this further excludes children with disabilities from the social contract.
Situating this study within Thomas Hobbes’s social contract theory

As Arneil and Hirschmann (2016, p. 1) assert, “political theory has for the most part ignored” disability. For this study, Thomas Hobbes’s social contract theory was used to systematically explore the production of disability in early childhood education and care. Contemporary Hobbesian scholars (e.g., Ivison, 1999; Pateman, 1989; Rustighi, 2020; Schochet, 2012; Shapin & Schaffer, 1985; D. Skinner, 2011; Q. Skinner, 2002) make use of Hobbes’s social contract theory, alongside the concepts of sovereignty and absolute power, to understand, explore, and explain aspects of human existence, most often with an emphasis on laws and governance in society. A handful of scholars rewriting the canon of Western philosophy (Arneil, 2016; Boucher, 2012; Hirschmann, 2013; Jaquette, 2012; Wright, 2002) have shone a light on Hobbes’s social contract theory in feminist theorizing, often citing Hobbes’s unsentimental portrayal of social and political life as a useful characteristic for feminist analysis. Thomas Hobbes, write Hirschmann and Wright (2012), is the lone “theorist of the original contract who begins with men and women as equals in the state of nature” (p. 20). For Hobbes, all humans are equally vulnerable to death despite all other bodily attributes that may weaken one human more than another. This is a valuable characteristic of Hobbes’s theory that allows feminists to find “common intellectual terrain” with his political philosophy (Boucher, 2012, p. 224). Hobbesian social contract theory shows that the assumption that the world as we experience it is “natural” is incorrect (Hirschmann, 2016). Rather, humans cannot exist in a world that is natural1 and

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1 Part 1, Of Man, Chapter XIII, “Of the natural condition of mankind as concerning their felicity, and misery”: “1. Nature hath made men so equal, in the faculties of the body and mind; as that though there be found one man sometimes manifestly stronger in body or of quicker mind than another; yet when all is reckoned together, the difference between man, and man, is not so considerable, as that one man can thereupon claim himself any benefit, to which another may not pretend, as well as he. For as to the strength of body, the weakest has strength enough to kill the strongest either by secret machination, or by confederacy with others, that are in the same danger with himself” (Hobbes, 1651/1996, p. 82) … “3.
without social arrangements that come with living with others (Hobbes, 1651/1996, pp. 82–83).

For Hobbes, the “commonwealth”2 is how the socially contracted arrangements of society make human existence possible (Hobbes, 1651/1996, p. 111). And yet, in the commonwealth—meaning, in society—subordination exists among humans. Subordinations in society, for Hobbes, “reveal something important about the nature of political relationships” (Wright, 2002, p. 124), not about individual persons. In this study, I examine how the social arrangements in ECEC that were unproblematic, negligible even, for children without disabilities were problematic for children with disabilities. The social arrangements, I argue, using a Hobbesian analysis, had the effect of producing the disabled subject of children with disabilities in 1994 who could then be viewed as not fit for ECEC.

Methodology and methods

As a critical discourse analysis (Fairclough, 2003, 2013), this is a study of language that constructs versions of the world. With an overarching purpose of bringing attention to discourses of disability, inclusion, and ECEC, I used feminist Hobbesian social contract theory to help to cast doubt on the conventions of ECEC that were put in place in Ontario in 1994. The conventions of ECEC, I argue, contain unexposed and dominant social and political ideas about

From this equality of ability, ariseth equality of hope in the attaining of our ends. And therefore if any two men desire the same thing, which nevertheless they cannot both enjoy, they become enemies; and in the way to their end, (which is principally their own conservation, and sometimes their delectation only,) endeavour to destroy, or subdue one another” (Hobbes, 1651/1996, p. 83).

2 Part 2, Commonwealth, Chapter XVIII, “Of the causes, generation, and definition of a commonwealth”: “The final cause, end, or design of men, (who naturally love liberty, and dominion over others,) in the introduction of that restraint upon themselves, (in which we see them live in commonwealths,) is the foresight of their own preservation, and of a more contented life thereby; that is to say, of getting themselves out from that miserable condition of war, which is necessarily consequent (as hath been shown, chapter XIII) to the natural passions of men, when there is no visible power to keep them in awe, and tie them by fear of punishment to the performance of their covenants, and observation of those laws of nature set down in the fourteenth and fifteenth chapters” (Hobbes, 1651/1996, p. 111).
who is not human enough (Russell, 1998), by nature, to be part of society as it is created in ECEC.

Fairclough (2013) describes language in policy as discourses that are ordered in specific ways related to the institution they are connected to; he argues that the ordering of the discourses creates and reflects ways of acting and ways of being that represent that world. A challenge in analyzing discourses of inclusion and disability ECEC in Ontario is the historical and current institutional ambiguity of the child care system. There is murkiness to past and present child care policy influenced by an ongoing lack of clarity in what it is—such as: Does “child care” include family focused drop-in programs? Informal / unlicensed care at home? Summer camps and recreation programs that include very young children? —that makes studies of discursive governance texts related to disability in ECEC less straightforward than other studies of social and educational policy are. In part, due to the ambiguous nature of the institution of ECEC in Ontario, governing regulatory texts related specifically to inclusion and children’s disability are minimal. The few direct references to inclusion and children’s disability that exist in the broad policy landscape of ECEC can be found now in ECE practice documents from the College of Early Childhood Educators (2019), and sometimes in minimal ways as part of municipal child care service funding guides (Ontario Ministry of Education, 2021), curricular documents, and child care centre policies. Such documents are guidance documents, not governance documents, and they do not regulate activities and practice in ECEC as firmly as legislative and legal texts would.

Texts included in the critical discourse analysis

In this dissertation text excerpts that are used for the CDA are highlighted with **shading** and, for most, indented to make them visually obvious as the reader encounters them. The four
documents selected for analysis include three publicly accessible ECEC documents and one draft working document that is not publicly available. My systematic search for Ontario-focused publications from the year 1994, or in the time-range of 1994, that were specifically related to ECEC and child care, resulted in the discovery of one document—*Caring for Play*—that I have included in this study. In addition to searching databases and libraries for electronic documents that fit my criteria for inclusion in the study—publication in or around 1994, ECEC focused, and regarding Ontario—my search involved consulting with individuals who professionally maintain extensive collections of such documents and have expertise and knowledge of the types of child care policy documents that would have been desirable for my study. The final 4 documents included in the study were chosen because of the strength of their relationship to the “moment” of the social elements (Fairclough, 2013, p. 178) of ECEC and inclusion occurring in 1994. They are:

- *Caring for Play: The School and Child Care Connection, A Guide for Elementary School Professionals, Child Care Professionals and School Board Officials* written by Noel Young (1994) for the Ontario Coalition for Better Child Care. I obtained the document as a PDF from the web-based resource ERIC, Institute of Education Sciences, operated by the United States Department of Education.

- Chapter 11 of *As If Children Matter: Perspectives on Children, Rights, and Disability*, “Inclusive Child Care in Canada: Advances at Risk,” written by Sharon Hope Irwin (1995). A PDF of the document was obtained through HathiTrust Digital Library accessed through the Western University library system.
• *Integrating Children Experiencing Special Needs in Day Nurseries* (Ontario Ministry of Community and Social Services, 1988). A hard copy of this document was borrowed from the University of Guelph library system.

• A draft strategic planning document for a Group K hospital transition in a midsized Ontario community (referred to in this dissertation as “Children’s Treatment Centre”) dated January 1994 that is part of my personal collection of notes from a work contract in 1994.

These documents were chosen for this study because they are discursive texts of ECEC in Ontario in 1994. Each document was prepared by research and practice professionals with specific expertise in early childhood disability, or child care systems, or inclusion. In all four documents, the writers offer recommendations—and more specifically, identify specific ECEC approaches that should be taken, including proposed service delivery targets. As a child care policy analyst from 2004 to 2017, I have experienced that advocacy documents such as these are often included in the body of research evidence that service planners and policy makers use to develop programs and make policies. And—perhaps more relevantly—these documents are often used by planners and policy makers to strategically frame the policies to satisfy critics and defenders of their initiatives (Lewis, 2011, p. 83). In this capacity, I am working from the assumption that such documents work in similar ways to policy documents, by setting out the discursive contours (Liasidou, 2008, p. 485) of ECEC, inclusion, and disability. These attributes make the documents I have chosen highly suitable for identifying what happened in 1994 in inclusive child care in Ontario.
The critical discourse analysis in this study

The analysis in this study had three main components, it: (1) followed the main features of Norman Fairclough’s critical discourse analysis (2003, 2013), (2) was based on the theoretical frameworks of disability and of social contract theory and, (3) was informed by my own professional and experiential knowledge as a policy analyst and policy-focused researcher in the field of ECEC for almost 30 years.

To identify discourses of inclusion, disability, and ECE and how they are operationalized in these texts, I paid attention to, documented, developed coding for, and examined the relationships of (Creswell, 2009) the semiotic genres, discourses, and styles that comprise the activities of, representations of, identities of, and absences (Fairclough, 2013) of disability in inclusive early childhood education. By using Hobbes’s social contract theory as a means for interpreting the disability and ECEC discourses that I have considered, critical discourse analysis (CDA) was incorporated as a methodology for systematically examining these discourses.

Norman Fairclough (2010) prefers to use the term “*methodology*” to describe CDA given that it is a theory-driven process of gathering data; further, Fairclough (2013) describes CDA as not simply a way to describe existing situations but also a tool for evaluation. With that in mind, and while CDA tends historically to assess social realities in terms of material and semiotic relations (i.e., Marxist analysis), Fairclough also views CDA as a method for “semiotic emphasis and ‘point of entry’ into transdisciplinary critical social analysis” (Fairclough, 2009, as cited in Fairclough, 2013, p. 179), therefore making it (in my interpretation) possible to analyze CDA data using Hobbes’s social contract theory.

To develop my understanding of the social relations and identities that are discursively constituted for people with disabilities in ECEC in these texts—and how they are meaningful
from a Hobbesian social contract analysis perspective— I asked questions such as: What views of
disability are revealed in this text? What views of inclusion are revealed? How are the discourses
of disability and early childhood education related? What values emerge in the text with respect
to the terms disability, natural/nature, competent, potential, special, ordinary, exclusion,
 inclusion, equity, and entitlement? How are these discourses ordered? How does the ordering of
the discourses relate to disability—and serve the purpose of the institution of ECEC?

Ensuring my interpretations of the data were sound included continuous referencing to
the inclusion, disability, social contract theory, and ECEC literature referred to throughout this
study.

I began the discourse analysis with a close line-by-line reading (Creswell, 2009) of the
four documents. From each document, I extracted textual data for an initial reading of their
communicative or strategic action. The next step in the process of analysis involved paying
attention to, documenting, developing coding for, and examining the relationships within the data
(Creswell, 2009) at a level that Fairclough (2003) refers to as a “detailed linguistic analysis of
the text” (p. 213). For this analysis, I engaged in a process of generating “clauses” (Fairclough,
2003) from the lines of text I extracted from the original documents. Clauses are simple
sentences or phrases that have process, participants, and circumstances that are meaningful to the
examiner. To illustrate the process, a meaningful clause that I might have extracted for further
analysis would look like this:

Canada is usually seen as occupying the middle ground (S. H. Irwin, 1995, p. 77)

Then, using the clauses that I extracted from the documents, I asked the questions of
these texts that I listed above. Asking these questions of the texts is one of the essential processes
of CDA because it connects the discursive practice of the texts (and the way the texts are
produced) to social practice. The next step in my analysis involved examining the clauses of text for microstructures of the text; these include the social and political contexts that are part of the text (Fairclough, 2003) but not always stated. I also explored the text for the semiotic genres, discourses, and styles that comprise the representations of, identities of, and—especially, as I proceeded through the analysis—the absences (Fairclough, 2013) of disability. At this step in the analysis, I engaged in a focused effort to understand how the text was representing aspects of governance for early childhood education and disability, because governance is connected to the activities within an institution that tries to manage social practice (Fairclough, 2003), and, as I argue in this dissertation, there are failures in ECEC with respect to what its institution is and where its governance comes from.

As I worked to recognize the potential effects (intended or not) of the texts and their connections to the origins and stability of disability discourses in ECEC, I followed (Doucet, 2021) the data to ensure my interpretations were sound. The intended outcome was that I identify discourses that were truly stable, relatable, and at a scale (Fairclough, 2003) that would also be meaningful to others, so I engaged in continuous referencing of the disability, social contract theory, and ECEC literature upon which this study rests.

I based my analysis on the four documents I identified above, drawing on my years of experience as a policy and research analyst in child care, and I also went back to other historical and recent documents that have been published in Ontario about ECEC, special needs resourcing of child care programs, and disability in order to trace the relevance of the 1994 discourses in today’s ECEC disability landscape.
Organization of this dissertation

In Chapter 2 I review the literature and describe the ECEC context in Ontario, including the changes to children’s programming in Group K hospitals and the inclusion practices in child care in 1994.

In Chapter 3 I discuss the CDA finding that in 1994 disability was “something bodies have” in ECEC. Because ECEC was intended for children who are not disabled, by viewing disability as something inherent to the child, children could be more easily denied inclusion in child care. In this chapter I demonstrate how ECEC reproduced “the misfit” of disabled children through lack of planning and limited organization regarding how to include the children with disabilities coming into child care with the closures of Group K hospitals.

In Chapter 4 I expand on the CDA finding that in ECEC the discourse “children are children first” pushed children with disabilities to “fit in” with the rest of the children. A variation of the “community is best” narrative once deeply associated with deinstitutionalization and the disability rights movement was altered, so that, in 1994, it served a different and potentially destructive purpose in ECEC. In this chapter, I show how ECEC’s lack of readiness for disabled children who would be invited to their programs with the closures of Group K hospitals resulted in educators being relied on for their “virtue” in practicing ECE. The absence of provincial supports and the workings of existing policy related to equality, equity, innovation, and quality in ECEC in 1994 helped push children with disabilities into being a subordinate concern in child care. As a result, children with disabilities were required to “blend in” and function without adequate supports that might have ensured higher levels of participation in child care activities alongside their nondisabled peers.
Chapter 5 demonstrates the CDA finding that the shift of children with disabilities from Group K hospitals to community ECEC produced disability because of the lack of a common authority for ECEC. The lack of governance and policy infrastructure for ECEC combined with ECEC’s lack of preparedness for children with disabilities was a set-up for failure for all involved. A result was that children with disabilities in child care were no more than a “side hustle”—a supplementary job in addition to their regular work, for the educators. The shift in institution—from Group K hospital to community child care—reflects a historically significant move for persons with disability, from a place of medicine (medical model) to a place of community, and it created unanticipated chaos for child care. There is the possibility that some degree of chaos—or at the very least ineffective child care inclusion—was anticipated by the province of Ontario. The impact on children with disabilities and on ECEC since 1994 has been significant; however, as a problem that demands attention in ECEC, even now it remains relatively invisible. This is because children with disabilities in ECEC are mostly invisible.

Chapter 6 is the conclusion. In this final chapter, I return to the research questions that guided this study and summarize how the findings I presented in Chapters 3, 4, and 5 effectively support my arguments. In this final chapter, I discuss how this study and my analysis and findings contribute to ECEC service system design and policy, and to ECEC and social contract literature.
Chapter 2: Literature Review and Context

This chapter reviews the literature on inclusive ECEC and describes the context of ECEC in Ontario, including the changes to children’s programming in Group K hospitals and the inclusion practices in child care in 1994.

The literature on inclusive early childhood education and care

Child care programs, when they are inclusive, help mothers of children who are disabled to participate equally in the workforce (Brown & Clark, 2017; Chou et al., 2018). Canadian families of disabled children experience more stress than other families, and their stress is exacerbated by problematic, noncoordinated child care service delivery (Office of the Provincial Advocate for Children and Youth, Ontario, 2016; Underwood, Frankel, Spalding, & Brophy, 2018; Underwood, Smith, & Martin, 2019). Also, Canadian children experiencing disability have, and have always had, less access to child care and early childhood education than their nondisabled peers (S. H. Irwin et al., 2004; Killoran et al., 2007; Roeher Institute, 2003). When Canadian children with disabilities participate in early childhood programs with their same-age peers (inclusion), this is broadly understood to benefit all children (Frankel, Chan, & Underwood, 2019; S. H. Irwin et al., 2004; Killoran et al., 2007; Roeher Institute, 2003). This view prevails despite a relatively small supply of Canadian child care research on the specific child development outcomes. Most Canadian scholars who write about inclusive child care cite American sources for the evidence of outcome benefits to participation in inclusive early childhood programs (Buysse & Bailey, 1993; Clarke-Stewart & Allhusen, 2005; Guralnick, 2001).

Studying inclusion in Canadian child care has involved looking at inclusion as an indicator of quality (S. H. Irwin, 2005; Irwin & Mayer, 2007; Lero, Brophy, & Irwin, 2009) and
inclusion as an expected practice (Lero & Irwin, 2008). The level of activity in research on inclusion quality roughly coincided with higher levels of research interest in evaluations of structural and process quality in child care in general in Canada (Doherty et al., 2000; Pence, 1988). Including children with disabilities in child care settings—and the corresponding development of practice guidelines to support inclusion—also paralleled similar activities that were occurring in Canadian primary schools (S. H. Irwin et al., 2004). In child care, however, unlike in primary schools, the guidelines for inclusion were not substantiated by formal legislative powers (S. H. Irwin et al., 2000).

Despite that human rights legislation covers child care, the processes of monitoring and implementing human rights conventions is not a coordinated activity in Canada. Rather, Canada relies on civil society and advocacy organizations for ascertaining compliance with the United Nations Convention on the Rights of the Child and Convention on the Rights of Persons with Disabilities, which results in gaps in the realization of basic rights for children with disabilities (Shikako-Thomas et al., 2020).

For decades, across North America, including in Canada, Bronfenbrenner’s (1979) ecological model of human development has been used as a primary theoretical framework for understanding the nested layers of individual, family, child care environment, policy, and societal factors influencing inclusion quality (Kontos et al., 1998; Lero, Brophy, & Irwin, 2009; S. H. Irwin et al., 2000; Peck et al., 2000; Pence, 1988). Program characteristics and activities that demonstrate the degree of inclusivity of children with disabilities in child care have been used as ranking indicators in research that focuses on evaluating and comparing child and family policy across Canadian provinces and territories (Roeher Institute, 2003; Wiart et al., 2014).
Of the empirical studies on ECEC in Canada, many have specified a goal of examining aspects of child care quality and how those aspects correlate with children’s developmental outcomes when children participate in child care (e.g., Borge et al., 2004; Perlman, et al., 2016). Studies that bring together child care quality and child outcomes are firmly anchored in a body of research evidence that began with examinations of institutional, group, and nonparental care and their potential harm on children in the early and mid twentieth century (e.g., Ainsworth et al., 1978; Bowlby, 1982). This foundation might explain a strong and continued North American emphasis in child care research that focuses on children’s developmental outcomes when they participate in early childhood education programs (e.g., Belsky et al., 2007; Belsky & Rovine, 1988; Goelman & Pence, 1987; McCartney et al., 1982). This style of research tends to be very specific, by methodological necessity, to one or two domains of childhood development, and rarely, if ever, focuses on specific developmental effects of child care quality on children experiencing disability.

Canadian researchers have, however, dedicated some specific research interest in early childhood education to developmental screening and the early identification of developmental delay (Janus et al., 2018; Nipissing District Developmental Screen Intellectual Property Association, 2000). This body of research targets the intersections of childhood development and population health, which includes assessing social and economic conditions that influence children’s vulnerability to developmental delay (Willms, 2002). Most of this research argues that family and environmental risk factors may result in children’s lack of preparedness to learn in primary school, school failure, developmental delay, and/or eventual poor health and well-being (Doherty, 1997; Janus & Offord, 2007; E. M. Thomas, 2006)—and warns of social and economic costs later in life (Keating & Hertzman, 1999; Schroeder et al., 2009) if uneven access to early
childhood education is sustained in Canada (S. H. Irwin et al., 2007). These studies demonstrate the essential role of children’s care providers (including parents and early childhood educators) to help children, through nurturing caregiving, meet their developmental potential; they also recommend improvements to social and early childhood development policies (Britto et al., 2017). This body of research has had a tangible influence on early childhood education whereby ECEC professionals have been encouraged to adapt their practice to focus on supporting children’s specific developmental skills (Bouchard et al., 2010; Cohen, 1994) and attend to specific disorders among children in child care such as autism spectrum disorder (Frankel, Hutchinson, Burbidge, & Minnes, 2014; Mitchell & Locke, 2015; Moore et al., 2011; Penner et al., 2018; Shepherd & Waddell, 2015) in order to generate positive results for children, families, and the community (Child Development Institute, 2020).

The Canadian early childhood education and inclusion body of evidence includes studies of early childhood educator characteristics, knowledge levels, attitudes, roles, and experiences and how these relate to effective inclusion (Brophy, Hancock, & Otoo, 1993; Brophy, Webb, & Hancock, 1995; Coulman, 1999; Denholm, 1990; Frankel, 1994, 2006; Hundert et al., 1993; Hutchinson & Schmid, 1996; S. H. Irwin et al., 2004; Thornton & Underwood, 2013). Preservice training, in-service training, and professionalization of early childhood educators and other early childhood professionals to support better inclusion have also been studied (Frankel, Hutchinson, Burbidge, & Minnes, 2014; Hundert & Hopkins, 1992; Underwood & Killoran, 2009).

More recently, Canadian research has begun focusing on early childhood education and disability through examinations of families’ experiences using inclusive children’s programs, services, and systems (Frankel, Chan, & Underwood, 2019; Underwood, Frankel, Spalding, & Brophy, 2018; Underwood, Smith, & Martin, 2019). The body of research looking at the
involvement of families and children in inclusive systems, and the effectiveness of those systems (Hodgetts et al., 2013; Koller & San Juan, 2015; Villeneuve et al., 2013) is expanding, fuelled in part by an ongoing Canadian longitudinal study of inclusive early childhood service systems in four provinces and territories led by Kathryn Underwood at Toronto Metropolitan University (Underwood, 2013–2025).

Construction of disability as a factor in exclusion from school has been studied within a Canadian educational context (Underwood, 2012), just as early childhood disability and participation in children’s programs has been examined through rights-based frameworks, social modelling, and social identity approaches (Snoddon & Underwood, 2014; Thornton & Underwood, 2013; Underwood, Frankel, Spalding, & Brophy, 2018; Underwood, Valeo, & Wood, 2012).

The focus of this dissertation—the production of disability in early childhood education and care from a historical, feminist, social contract perspective—is unique but connected to what I have learned, experienced, and read about inclusion, disability, and early childhood education and care in a Canadian context over the past 30 years.

This study contributes to the body of ECEC literature by suggesting that considering how disability is produced in ECEC from a social contract perspective might be a means of reconceptualizing early childhood education. In most ECEC literature, children’s disability has been handled as a special need that bodies have, rather than a created social condition. ECEC literature predominantly discusses children’s programs as a form of early intervention that children require to fix or reduce the impact of their impairment on themselves, their future lives, and the community. Successful, effective inclusion in ECEC is presented in the literature as that which is achieved through the seamless integration of children into ECEC in ways that make
their presence unremarkable and invisible. All the while, the existing body of research takes for
granted that existing practical approaches to ECEC and disability need to be improved rather
than reinvented. The existing literature emphasizes inclusion in early childhood education
whereby children experiencing disability are brought into an existing system: a system that
accentuates and prioritizes normalized childhood experiences by focusing on the special effort
(Titchkosky, 2008) that disabled children require to be included.

By bringing together feminist social contract theory and disability, I question the status
quo of early childhood education and care by critiquing its production of disability. In this
dissertation, I argue that ECEC as we know it diminishes the rights and freedoms of children
experiencing disability in the way that it socially produces the disabled subject. My study
contributes to scholarly literature by challenging the taken-for-granted idea that ECEC is
unproblematic (Taguchi, 2006) in its social preference for normal bodies (Hirschmann, 2016)—
and by challenging the underlying assumptions in the existing early childhood special needs,
inclusion, and rights-based literature that disabled children experience their full rights and
freedoms (freedoms including, desire, ability, will, and action (Hirschmann, 2016, p. 101) in
child care by fitting in.

The context of the study: Inclusive ECEC in Ontario

Child care, the most significant arrangement of ECEC in Ontario, Canada, is private,
regulated, nonparental care services for children. While some might argue that ECEC is more
than custodial care while parents are elsewhere (i.e., it is education), provincial legislation

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3 Barbara Arneil (2016) and Tanya Titchkosky (2001, 2008, 2012), along with other writers, acknowledge
an ongoing debate over “people first” language and take the stance that the position of the person or
disability in a phrase, while potentially important for demarking whether the author follows a “civil rights
versus oppression model of disability” (Arneil, 2016, p. 20), has resulted in little real change with respect
to policy (Titchkosky, 2012). Thus, in this dissertation, I use the terms disabled children, children with
disability, children with disabilities, and children experiencing disability (or disabilities) interchangeably.
emphasizes that ECEC is substantively custodial care. Legal requirements for what kind of activities should occur within ECEC settings are, in 2023, regulated by the Child Care and Early Years Act, 2014 and guided by a pedagogical framework. The Ontario Minister of Education’s responsibility with regard to child care is “issuing policy statements regarding programming and pedagogy that constitute high quality child care and early years programming and pedagogy that support children’s learning and development” (Government of Ontario, 2021a). In a 2016 mandate letter to the Ontario minister of education (the most recent of its kind) dictating what is to happen within early childhood education programs, the directives are vague in focus and explain that the education minister’s responsibility is to develop a plan for a continuum of high-quality, accessible, and affordable early years and child care programs that support parent choice and flexibility and promote healthy development (Government of Ontario, 2016).

At the provincial level, in Ontario over the past decade or so, a process referred to as child care modernization has resulted in updates to the Day Nurseries Act into what is now known as the Child Care and Early Years Act, 2014; the child care and early years policy framework now includes the work of the College of Early Childhood Educators as regulator of early childhood educators’ practice in this province. Another result was the early learning pedagogy How Does Learning Happen? (Ontario Ministry of Education, 2014), which is intended to guide educators in their programming with children. Child care modernization has resulted in more child care spaces, more children in licensed child care centres, and more women in the workforce in Ontario (Cleveland, 2022). Currently, changes are in the works for Canada’s funding of provincial and territorial ECEC strategies (Government of Canada, 2022a). Recent federal bilateral agreements with each province and territory are part of the national early learning and child care strategy that promises a shift in how—and how much—funding is
delivered to child care programs across Canada. The primary intention of the Canada-wide early learning and child care strategy is reducing the prices that child care programs charge families for care (Government of Canada, 2022a).

At the child care centre or program level, child care in Ontario is delivered by independent businesses that provide care services for infants and children. The operator of the child care program has the choice of size, location, and what kind of specific services they wish to deliver (Government of Canada, 2022b). Because ECEC is delivered predominantly in the form of child care and child care is a service that users pay for, this makes ECEC primarily a service used by Ontario families to care for their children while the adults are somewhere else. There are provincial rules for child care in Ontario, established in the Child Care and Early Years Act, 2014, and these rules focus on children’s health and safety while also defining the parameters of oversight of child care program operation (Government of Ontario, 2022b). The government of Ontario states that the Child Care and Early Years Act, 2014 provides parents with information to support them in choosing child care (Government of Ontario, 2021a, Purposes of Act); however, longitudinal data consistently show that Canadian parents choose child care based on location above all else (Statistics Canada, 2021).

Interest in what and how well children are doing in ECEC generally falls into questions of the quality of care and education of children’s programs (e.g., Dahlberg et al., 2013; Goelman & Pence, 1987; Perlman et al., 2016; Singer, 1993). The North American body of evidence regarding the quality of child care (e.g., Goelman & Pence, 1987; Lero, Brockman et al., 1993; Pence, 1992; McCartney et al., 1982) and how to go about measuring the quality of child care (e.g., Phillipsen et al., 1997) expanded in the 1980s and early 1990s, and eventually, two main categories of quality in child care were identified and distinguished in the scholarly literature:
structural quality and process quality (Doherty et al., 2000). In the last 20 years or so, questions have been raised regarding whether child care quality could be improved by its rendering as education rather than service (Moss & Bennett, 2006; Moss & Petrie, 2002).

To date in Ontario, ECEC is politically, socially, and legislatively entangled with intervention, prevention, care, and economic development services—not education. In North America, child care, as a provision of care service while parents are away, has been heavily influenced by the industrial revolution. Preschools and children’s nurseries, as well as public health care programs for mothers and babies in the United States and Canada, were developed to help families thrive in the new and progressive social and economic context driven by new and bigger industrial activity. Nursery school programs aimed to counteract parents’ “low bred idleness” (Ferguson, 2002, p. 125) and to reduce the chances that North Americans could not participate, for whatever reason (e.g., race, religion, ignorance), in the increasingly industrious society as workers.

In short, achieving industrious, successful societies like Canada aspired to be necessitated supporting families to raise children who could eventually be part of the new and progressive economic context. The Ontario provincial political machinery of regulation and delivery of child care was quite fittingly established during this time (Spicer, 2015). In Ontario, early into the 20th century, the provincial jurisdictional responsibilities for administering public services and education, including asylums, charities, nursery schools, prisons, and public institutions (Rossiter & Clarkson, 2013), were becoming well established, forming the foundation of provincial public policy. A desire for swift action combined with a high potential for underestimating the diversity of the province outside major centres such as Toronto (Spicer, 2015) was part of Ontario’s public policy foundation.
During the early 20th century and over the decades, children with disabilities were sometimes *included* in children’s programs that nondisabled children were participating in (Ellis, 2017), and this inclusion sometimes involved participation in child care centres and nursery schools throughout Ontario. Inconsistencies in what disabled children’s participation and inclusion entailed in any program in Ontario at this time make it difficult to make bold statements one way or the other about children’s programs and whether children with disabilities were included (Mooney & Lashewicz, 2015). As the decades rolled on into the middle of the 20th century, practice, operations, and terminologies regarding “handicapped children” were beginning to change within ECEC—and in other child and adult institutions in Ontario too.

In 1958, the Canadian Association of Community Living was founded by families of disabled children and adults in an effort to promote better living conditions for their loved ones (Ouellette-Kuntz et al., 2005). Their work prompted the development of disability supports and services in children’s home communities rather than in institutions. Ultimately, public policy defines which programs and environments individuals with disabilities will spend time and receive care in (Ouellette-Kuntz et al., 2005), and in the latter few decades of the 20th century, programming and health care policies for people with disabilities were shifting. In 1971, an amendment was made to the Day Nurseries Act—the provincial legislation governing child care—allowing provincial funding to be available for nursery programs to be operated for developmentally handicapped children (Ontario Ministry of Community and Social Services, 1988). Some of these provincially funded nursery programs were in Group K hospitals in Ontario. As they were places for rehabilitation and care programs for children and adults with disabilities who were living in their homes with their families, Group K hospital programs and services are not to be confused with the Ontario government institutions, such as the Huronia
Regional Centre in Orillia, the Rideau Regional Centre in Smith Falls, and the Southwestern Regional Centre in Chatham Kent, which were closed between 2008 and 2009 (Rubinoff, 2017). Group K hospitals were usually day programs for children and adults, and in 1993, they were mandated to “minimize institutionalization and maximize secure and stable home, family and community living for [their] clients” (Children’s Treatment Centre, 1994, p. 1).

In 1993, a policy directive was given to Group K hospitals in Ontario. The reasons for the changes being made to Group K hospitals, sometimes termed deinstitutionalizing policy, were primarily cost savings (Baranek et al., 2004; Children’s Treatment Centre, 1994).

Cost savings were deemed necessary in Ontario, due at least in part to the 1991 federal government limits on social funding transferred to more affluent provinces across Canada—and Ontario was an affluent province (Irwin & Lero, 2020). Local strategic planning groups involved in the reorganization activities of Group K hospitals were compelled to seek “innovative programs and funding approaches” (Children's Treatment Centre, 1994, p. 6) in lieu of sustained federal funding levels. Before this, the 1984 Canada Health Act had encouraged provinces to meet the terms and conditions of the federal government health strategy to receive the full range of health care transfer payments available for each province. If provinces did not follow the Canada Health Act terms and conditions for creating and delivering a universal, publicly administrated, comprehensive, and portable health care system, they would be subjected to funding penalties (Baranek et al., 2004). The Canada Health Act prompted provinces to create specific parameters distinguishing between the kinds of health services that would be delivered “universally on the basis of need” (Baranek et al., 2004, p. 7) and therefore also fully funded without additional user fees and the kinds of health services that would be delivered by the social service system and potentially be cofunded or fully funded by user fees (Baranek et al., 2004).
The organization of community-based services for individuals with lifelong conditions such as chronic illness and disability and their streaming into one of the two dichotomous sectors, the health sector or the social service sector, had “significance both historically and in terms of reform” (Baranek et al., 2004, p. 10).

The closures of Group K hospitals and children’s treatment centres were cast in a favourable light because it was called deinstitutionalization. Deinstitutionalization was consumer driven, a central part of disability activism and mobilization, and an important and necessary response to the abuse and devastating acts of cruelty that occurred in Ontario institutions (Reaume, 2010). Deinstitutionalization was also supported by a view that services located “closer to home,” combined with consumer choice and people’s independence, were connected to better quality and improved health and well-being for individuals who had been spending time (for some, living out their lives) in institutionalized care (Baranek et al., 2004, p. 4).

The image of deinstitutionalization that the government of Ontario performed sent a convincing message that honourable work was occurring (See: Ontario Ministry of Community and Social Services, 1988, p. 3). Deinstitutionalization is ethical (Carrington-Decker, 2018), and evidence shows it results in better living situations for most people (Rossiter & Clarkson, 2013). The government of Ontario used a highly persuasive approach to frame a critical shift in policy whereby children would be deinstitutionalized from Group K hospitals into the community-based services of child care, but the frame of deinstitutionalization camouflaged its main impetus, which was cost cutting (Children’s Treatment Centre, 1994; Ontario Ministry of Community and Social Services, 1992b, 1992c). Under health, children with disabilities were in a medicalized system that guaranteed funded programs; under social services, children with disabilities would be supported by “soft” (Baranek et al., 2004, p. 11) services through local
programs, while being means tested for government funding to cover costs of care (Baranek et al., 2004).

For children experiencing disability in Ontario, the closure of Group K hospitals meant that those who had been attending preschool programs at children’s treatment centres were to begin attending child care programs in their communities instead. But child care centres were technically and legislatively independent businesses that had final discretion regarding who they allow to participate in their programs. Early childhood education and care in Ontario has never been a public service or a program that children are entitled to attend. In 1994, Ontario child care was not inclusive of all families as it was a fee-for-service program that many families found unaffordable. It was not inclusive of all children, regardless of childhood disability, because not all families used child care for their nonparental care or for early education.

A few years earlier, in 1988, the Ontario Ministry of Community and Social Services released a background report that described the operational and policy issues of child care in Ontario for children “with handicaps” who were or might be integrated into day nursery programs. The report provided a broad examination of child care services in the late 1980s and showed that funded and not funded integrated child care programs, segregated nursery programs, and resource service delivery programs (e.g., resource teachers and consultants) were providing various supports and care for children “with handicaps” across Ontario. The report concluded that some child care programs were already regularly providing services to children and families with “special needs” (Ontario Ministry of Community and Social Services, 1988), despite the fact that integration in day nurseries was never formally launched as an official program. The report stated that when child and family intervention programs and children’s aid societies used child care programs in their communities to support vulnerable children, fewer children ended up
in day treatment programs and specialized intervention and family support programs (Ontario Ministry of Community and Social Services, 1988, p. 91). The report specifically highlighted the point that child care might be a valuable resource for children who would potentially require extensive emotional, behavioural, and other mental health services in the future. But, the report declared, “diagnosed handicapped children now require most of [the child care staff]’s time and energy” (p. 87).

Recognizing that there might be capacity challenges in the day nursery system, including the documented concern that the child care educators’ time and energy were focused on “handicapped children,” the authors of the report suggested that further study would aid understanding of the extent to which programs would be “less willing” to accept children who were handicapped (Ontario Ministry of Community and Social Services, 1988, p. 87) in their regular (i.e., nonsegregated) child care programs. The report itself called the existing state (up to 1988) of the integration process in Ontario’s child care programs haphazard, uncoordinated, and lacking oversight. The range in services provided by the different community agencies helping out child care programs and the various approaches of resource teachers, the report said, were likely the result of there not having been a formal introduction of integration in the day nursery system, and, because of this lack in strategic introduction of a program, agencies were required to problem-solve their way through for several years (Ontario Ministry of Community and Social Services, 1988). Yet, a major theme articulated in this report was the “minimal attention” paid to children “experiencing special needs other than handicapped children” and these children in particular needed support services to ensure effective programming in the day nurseries system (p. 10).
Complicating matters—and further setting the scene for what happened in 1994—was the instability of Ontario public policy and an impending shift in the administration of social services and child care planning and management (Spicer, 2015). The administrative volatility regarding child care service planning and management was already in play in the late 1980s and lasted throughout the 1990s in the province (Ontario Ministry of Community and Social Services, 1989, 1992a, 1992b). Provincial and municipal administration systems of social services were undergoing structural and functional changes that would, a few years later (in 1998) with a conservative government (Spicer, 2015), result in the downloading of Ontario’s social services—including housing, income and employment supports (later, called Ontario Works), and child care—to 47 local government entities referred to as Consolidated Municipal Service Managers (CMSMs) and District Social Services Administration Boards (DSSABs) (Ontario Municipal Social Services Association, 2014). In short, in 1998 child care service system administration was downloaded and decentralized to 47 municipalities and public education system administration was uploaded and centralized to the province (Spicer, 2015).

Processes of transferring policy or, in this case, of downloading of policy and system management to local government, are often “fraught with difficulty” (Spicer, 2015, p. 347) and typically inhibited by technical incompetence, communication failures, and problematic conflicts of interest (Spicer, 2015). As it was, the downloading of service planning and administration of child care services to 47 different municipalities in Ontario was being planned and was deemed necessary back in 1988, well before the fiscally motivated Progressive Conservative Party and Premier Mike Harris came into power in Ontario. According to government documents written in 1988, 1989, and 1992, local planning for child care would lead to greater stability and quality of

In 1992, a series of background papers titled *Child Care Reform in Ontario*, spurred by the 1988 report on inclusive child care (Ontario Ministry of Community and Social Services, 1988), discussed the problematic limitations of the Day Nurseries Act term *handicapped* and its definition and explained that the definition needed to be broadened to include children experiencing behavioural, emotional, social, and temporary difficulties (Ontario Ministry of Community and Social Services, 1992b). The term *special needs* had already been recommended in the 1988 report—and then, in 1992, was identified again as a better phrase than handicapped. Both reports indicated that referring to children’s special needs could improve access to and quality of child care services for a larger group of children. The term special needs as an alternative to handicapped would open up the possibility for children experiencing “temporary difficulties, such as coping with a death in the family, or recovering from an illness or surgery” (Ontario Ministry of Community and Social Services, 1992b, p. 1) to get individualized attention without “necessarily resorting to restrictive labels” (p. 2). Child care for children with special needs could involve more flexible programming for a wider range of children and would address additional financial and human resources needs associated with the care required to support the higher numbers of children who could be identified to fit in this broader category (Ontario Ministry of Community and Social Services, 1992b). Included in the 1992 background paper were the comments that “it is generally agreed that specialized training for staff is required” and that “some child care staff . . . could be required to have nursing training” (p. 3). The other suggestion was that “resource teacher[s] could . . . be available as a consultant” to child care centres and work with staff and the children directly, while the child care staff were able to
increase their skills and knowledge (p. 3) and learn to effectively include children with special needs in their programs (Ontario Ministry of Community and Social Services, 1992b).

Broadening of the scope of who was considered to have special needs in child care was intended to give more Ontario children more access to child care and early intervention resources than had been available to them previously. The more “inclusive” term special needs was also proposed to correct ongoing limitations and reduce the complexities of the “creative interpretations” (Ontario Ministry of Community and Social Services, 1992b, p. 2) of legislation and funding arrangements that were resulting in service and access to service inconsistencies for children across the province. With the focus no longer on children who were “diagnosed with a physical or developmental condition” (Ontario Ministry of Community and Social Services, 1992b, p. 1), children who faced barriers to normal development or were more vulnerable to social and environmental stresses (e.g., poverty or poor parenting) would also be considered as having special needs in child care programs. It is worth noting that at this same time another Ontario child, family, and community development research project was taking place—the multi-ministry (Community and Social Services; Health; Education), multi-university, collaborative and cofunded primary prevention initiative Better Beginnings, Better Futures—and this project was tasked by the Ontario government to “formulat[e] a model of primary prevention” (Gottlieb & Russell, 1989, p. 151) for children who were deemed at the highest risk of emotional and behavioural disorders due to living in environmentally disadvantaged communities (Gottlieb & Russell, 1989). During this time, Ontario was responding to a federal call to action to consider the rights of children, to address their long-term needs, and to prevent, promote, protect, and partner on their behalf. Promoting efforts regarding children’s rights and well-being as a virtuous
focus of government and social programs was gaining some social, economic, and policy interest.

In 1994, the changes to Group K hospital policy in Ontario were quietly moving the site of care for young children experiencing disability and shifting the greater “proportion of care” (Baranek et al., 2004, p. 4) from the medical system to the social system. Within the social system in 1994, child care was fragmented, less politically mobilized than the medical system (Ho, 2011), and fee based. This government-driven process of deinstitutionalization involved moving children experiencing disability out of one system (however problematic) into another system that failed to respond. The failure to respond is what perpetuates childhood disability as an “unwanted way of being” in ECEC (Titchkosky, 2015, p. 9).

In 1994, the planning for the closures of the Group K hospitals that would result in the transition of children experiencing disability to ECEC programs in the community was, for the Group K hospitals, a highly strategic, six-year-long event (Children’s Treatment Centre, 1994). The documentation that I have in my possession from my own involvement in this work shows that there were at least 15 different provincial activities, including appointed councils, committees, projects, reports, and strategic direction plans, that occurred between 1987 and 1993 to prepare for the closures (Children’s Treatment Centre, 1994). But, as I uncovered in this study of what happened in 1994, the formal documentation of strategic planning or public policy, or traceable efforts in funding guides or programming recommendations in the interest of proving that child care programs were or are supportive, accessible, inclusive programs for disabled children and their families, faded away once children were sent to the social service system and community child care programs.
The decline in planning, consultation, and strategic effort as children were relocated from one site of care to another—from health to social services; from Group K hospitals to child care—in 1994 was a “hostility” (Hirschmann, 2013, p. 141) that made their lives more difficult. Deinstitutionalization was not the hostility. The lack of preparedness that characterized ECEC in 1994—a characterization that remains to this day in terms of ECEC system funding, planning, and delivery—was the hostility that produced the disabled subject in child care in Ontario.

1994: Child care for children with disabilities in Ontario

In 1994, children with disabilities could participate in child care settings across Ontario—and some did. Child care programs were said to be taking it upon themselves to include children with disabilities in their programs—mostly without any specific guidance or direct resources from the province (Ontario Ministry of Community and Social Services, 1988, 1992b). At the time, including children with special needs in child care was not a directive from the provincial government, so it was also not supported by sustained resources or funding in a formal way. In addition, for children with disabilities and special needs, their participation (Frankel, Chan, & Underwood, 2019) and assumed engagement levels in all aspects of ECEC, were unclear at this time. The absence of specific guidance or policy, lack of clarity in practice expectations, and the fact that programs were taking it upon themselves to include children with disabilities were conditions that “brought about” disability (Hirschmann & Linker, 2015b, p. 4) for children in ECEC in 1994.

Chapter summary

In this chapter, I reviewed the literature related to ECEC and inclusive child care, child care quality, and child care service planning and program evaluation that provides the most important evidence for this study of what happened in 1994 to produce the disabled subject in
ECEC. I then provided the necessary details regarding the social, policy, and planning contexts of ECEC and Group K hospitals up to and including 1994 to set the scene for reading and understanding the findings of the critical discourse analysis that follows in the next three chapters.

Next, in Chapter 3, I begin sharing the findings of my study of what happened in 1994 to produce disability in ECEC. In the chapter, titled “Making Children with Disabilities ‘Misfit’ in ECEC,” I discuss the implications of the discourse that disability is something bodies have, particularly how it served ECEC by perpetuating the assumption that children with disabilities could be legitimately excluded from programs. As a result of this discourse, children with disabilities could be refused opportunities to attend child care altogether or were only able to access child care if they met certain conditions because ECEC is for children who are not disabled.
Chapter 3: Making Children with Disabilities “Misfit” in ECEC in 1994

In this chapter, I explore how the discourse that existed and was perpetuated in ECEC in 1994 that disability is something naturally occurring—that it is something “bodies have”—allowed children with disabilities to be legitimately (from the perspective of ECEC) excluded from child care programs. In 1994, ECEC was intended for and designed for children who were not disabled. Therefore, within a discourse that disability is something natural and something that bodies have, children with disabilities could be—at least from this perspective—understandably or “naturally” refused opportunities to attend child care altogether, or, as a compromise, might be offered varied access to participation in child care at the discretion of the program. The assumption that exists in ECEC discourses that disability is a natural or bodily condition is questioned in this chapter. By using Hobbes’s social contract theory, I explore how this discourse holds back better planning and programming for children with disabilities in ECEC because they are placed in the position of culpability rather than the social arrangements of ECEC being to blame for the inequalities that children experience in ECEC.

I provide evidence that, in 1994, the “misfit” of the disabled child in child care was produced by a lack of planning and preparation of ECEC for disabled children coming to ECEC from Group K hospitals. Ultimately, the misfit of the disabled child in ECEC was inevitable with the closures of Group K hospitals and the poor planning of the ECEC system, and this was because ECEC was not prepared to include disabled children in the first place. The discourse that there are “right kinds of bodies” for ECEC already existed, and in 1994, it was strengthened. To this day, effective, equitable inclusion of children with disabilities in ECEC anywhere in Canada is not a given (Frankel, Chan, & Underwood, 2019; Irwin & Lero, 2021). Children who do not have the “right kinds of bodies” might still be invited into ECEC; however, in 2023, the
invitation remains at the individual discretion of the child care program (Government of Ontario, 2021b), despite the efforts to encourage regulated, registered early childhood educators to support the full participation of children with disabilities in their practice (College of Early Childhood Educators, 2019).

In this chapter, I trace the discourse that, for ECEC, disability is something bodies have and show how this discourse leads to the belief that there are “right” kinds of bodies in ECEC. Ultimately, I provide evidence that this discourse makes it possible for ECEC to argue that it is “only natural” that some children can come to child care while others cannot.

The discourse that disability is a natural phenomenon of the body

Discourses of disability as a natural phenomenon of the body have been explored at length by disability scholars and activists (e.g., Barnes, 2012; Garland-Thomson, 2011; Goodley & Runswick-Cole, 2016; Hirschmann, 2016; Linton, 1998; Russell, 1998; Terzi, 2015;
Titchkosky, 2015). Medical epistemologies, too, have reinforced the positioning of disability as something “bodies have” (Aston et al., 2014; Ho, 2011), and some scholars find it clearer to distinguish between “impairment” and disability to illuminate that people with impairments are made disabled by the built environment around them (Gibson, King, Kingsnorth, & McKeever, 2014; Titchkosky, 2015; Whitburn, 2017). From this perspective, “impairment” is a condition “of the body” that is associated with biophysical functioning, while “disability” refers to the limitations that occur in society (Ho, 2011). Viewing disability as a simple binary such as either “biophysical” or “social” is considered by many scholars to be “as pedestrian” as seeing humans as either gay or straight (Hirschmann, 2013, p.141). As well, naming is, itself, a political, ontological, and epistemological issue; for disability, naming remains murky and unresolved, and the divisions in how disability is named can create as many problems as they address (Hirschmann, 2013, p. 140).

An explanation for why people tend to be more comfortable situating disability in the person, that is, attaching disability firmly to “the body” and placing it on the person, is fear (Hirschmann, 2013). Unlike other human characteristics—especially when considering identities such as race, gender, and sexuality (which, it is argued, do not fall upon someone overnight [Siebers, 2008, as cited in Hirschmann, 2013]), disability remains an “icon of all human vulnerability” (Hirschmann, 2013, p. 141; see also Vidali, 2010)—and “disabled” is something people most likely know that they can “become” at any time (Garland-Thomson, 1997, as cited in Hirschmann, 2013, p. 141).

Fear that one might encounter disability is reduced by exaggerating differences between being disabled and not disabled. In other words, by othering disability in this particular way—and making it bodily situated—there is an impression that one can protect oneself from
becoming disabled (Hirschmann, 2013): If the body has the disability, my body can avoid disability.

Goodley, Liddiard, and Runswick-Cole (2018) explore othering of people with disabilities by describing how disability becomes disavowed, or rejected from normative culture, due to the way that it symbolizes “lack” (p. 209); on the other hand, they write, it is rather ironic that disability is also “adored” because of the assumption that disability means “dependency” and dependency is a complicated but still very present desire of most humans (Goodley et al., 2018, p. 209).

Putting disability onto the body discursively reinforces that it is a “who” that holds the problem; it is not everyone’s problem, and it is not society’s problem. That individualizing—and embodying—of a problem (any problem) gives most of us the impression that the method for sorting out the right thing to do will be simpler. When disability is viewed, instead, as something that is moving, or indeterminate, or uncertain rather than something stable, that it naturally occurs to one person and is a bodily phenomenon, then not only is it too complicated for simple solutions, it further increases the fear that disability could befall anyone (Hirschmann, 2013).

**Disability is considered a natural phenomenon of the body in ECEC in 1994**

To ECEC in 1994, children’s disability was, maybe, too “uncertain” to consider in a comprehensive and planful way, because ECEC itself was uncertain. If children’s disability is understood as a state of “undecidability” (Hirschmann, 2013, p.143), this might have been too complex for an underplanned, underprepared ECEC to accept. Undecidability and ambiguity would make it, for ECEC, too difficult to “do inclusion” the way it should be done. Questions about who was best qualified for working in child care in general already existed in 1994, but regarding children with disabilities in child care, who is best has been discussed since the 1960s,
when the Ontario Day Nurseries Branch first prompted nursery programs to provide opportunities for children with handicaps to participate in programs that could enhance their development (Panitch, 1992). For ECEC, before the closures of Group K hospitals, children’s disability was already presenting some challenges with respect to child care inclusion (Ontario Ministry of Community and Social Services, 1988). Educators often were thought to be (or saw themselves as) novices at including children with disabilities in child care (Allan, 2007; Brophy, Hancock, & Otoo, 1993). They needed outside help for children who had uncertainties that were a part of them. In the following text, it is recommended that for full participation in child care to be possible, the person most suitable to support the child with special needs ought not be the educator; rather, it should be the principal or supervisor—someone other than the educator:

> When programs serve children with special needs, it is helpful if either the principal or the child care supervisor is qualified either through training or experience to facilitate their full participation. (Young, 1994, p. 57)

When disability is situated as something that bodies have rather than something that the environment produces, then terms and conditions (Titchkosky, 2015) can be more directly put on the child. Systematically privileging some kinds of children (i.e., children without special needs), was also a process of systematically privileging some kinds of bodies (Hirschmann, 2015). By situating disability in the body—on the person—this also allowed child care to prevent children from coming to a program at times or for activities where it was deemed unsuitable for the program. This was how disabled children’s participation levels could be limited to part time, or to when it was better for the program, or to when someone with qualifications was present, or to not participating at all.

People who are considered to be “legitimate participants” rarely confront access as a question (Titchkosky, 2008). For children with disabilities, in 1994, participation in child care
was perhaps possible, but it was considered more legitimate when extra program staff were present. This is one way that the discourse of “disability is something bodies have” creates the perspective that children’s special needs are an additional form of neediness that is not regular for an ECEC program.

The activities of inclusion, therefore, are those that should be overseen or dealt with by the supervisors or administrators of a program, or by someone else, but not by the educators. This reinforces the idea that special “card carrying designators” of disability (Slee, as cited in Allan, 2007) exist whose presence is necessary for such children with their special “bodily condition” to be served. The children with disabilities are not legitimate participants in the program without that person with additional experience or training.

The trouble is, for ECEC, the person with “additional training” happens to be someone not expected to be with children regularly—as it is in the text above. The supervisor of the child care program or the principal of the school adds to the already present ambiguity regarding whose responsibility it is to fully include children experiencing disability. Framing disability in this way—that it is “okay” as a responsibility for some other partly disassociated person who is not regularly with children, and that while their presence could then influence the social processes of the regular environment while also displacing the disabled child from the space of mutual recognition (Titchkosky, 2012, p. 102)—alleviates ECEC while burdening the disabled child. Such displacement of the disabled child also helps to rationalize why children should not attend programs due to their excludable conditions (Linker & Abel, 2015), which vary depending on the situation, which is controlled by the program.

The discourse that disability is of the person was also, in 1994, a way of putting the onus on the child to overcome their own body to be eligible for participation in a program. Now, in
2023, in children’s programs, schools, camps, and child care it is not uncommon to hear children described by their “behaviour,” their “diagnosis,” or their (perceived) intentions—like the description of a child who seems to want to leave the group: “she’s a runner.” When the child possesses “the problem” that puts pressures on a program, the quickest way toward correction is via the child, not the program.

**Creating the “inferior” child in ECEC**

Disappearing (Titchkosky, Cagulada, DeWelles, & Gold, 2022) children experiencing disability is more easily achieved when disability is a natural phenomenon of the body. While bodily impairment does indeed exist and might be of the child, impairments are not inferiorities. Instead, social arrangements, social rules, and social conventions (Hobbes, 1651/1996) make people experiencing disability inferior, and in 1994, the conventions of ECEC were what created the disabling inferiorities that children have experienced in child care ever since.

Inferiority, for children with disabilities in ECEC in 1994, was produced by seeing disability as of the child and then claiming that their disability was an “extra” that programs were not usually prepared for. Children who were disabled in ECEC were “the others” who were different from the children who usually participate in the program.

This discursive othering of children in the following text

> Programs serving children with special needs frequently require extra staffing. (Young, 1994, p. 57)

has the effect of making children who have disabilities disappear too, by making it seem legitimate that the child is not a part of ECEC.

Sometimes children with disabilities are presented as the “persistent menace” (Garland-Thomson, 1997, as cited in Hirschmann, 2013) so that it makes “better sense” not to include
them in the program. The idea that a child is a “misfit” for an ECEC program is not about social attitudes per se but because technically, materially, and “legitimately” the shape and function of their bodies conflict with the shape and stuff (Garland-Thomson, 2011, p. 593) of the ECEC program. Their exclusion is often put in a “for their own good” narrative.

Highlighting that society’s attempts at making disabled people disappear are ubiquitous (Titchkosky, Cagulada, DeWelles, & Gold, 2022) is not meant to suggest that every function of “disappearance” is negative. Hirschmann (2013) suggests that voluntary invisibility can offer people a political strategy of ambiguity and uncertainty that can be used to unsettle the ability of the nondisabled to police the boundaries of “their community” (p. 146). This implies that person who is disabled possesses a certain degree of control and consent (not to mention community). In ECEC in 1994, children and their families were not able to choose their invisibility in ECEC because of the limits in choice (voluntary consent), and they did not have an assumed presence in ECEC in the first place.

Instead, in 1994, ECEC was implementing an “invisible rubric of ‘normality’” (Hirschmann, 2015, p. 218) that would disable children and remove choice from families by making statements of why a child might be too challenging (i.e., a misfit) for the ECEC setting:

Children with special needs benefit from a high degree of continuity and coordination between home, school and childcare. In fact, lack of continuity may contribute to inappropriate behaviour on the part of some children. (Young, 1994, p. 57)

When disability is something that bodies have, inaccessibility or outright exclusion of children with disabilities could be perceived as “sensible” under certain situations (Titchkosky, 2008, p. 42). In precautionary messages such as this—about inappropriate behaviour, something expected among children but resented among children with disabilities (Baynton, 2015)—the
“what if” implies that children with disabilities are so “not a regular part” of the program that including them would have such consequences that it is more reasonable not to include them (Titchkosky, 2008).

The role of ECEC programs and staff were not made clear in 1994, and in this text, the suggestion that children might need “more” staffing or would benefit from “a high degree of” continuity and coordination blurs the kinds of real supports people with disabilities might need to participate in a child care program. By being vague, this statement helps neutralize disability while emphasizing that humans exist on a continuum (Linton, 1998). The word “more” and the phrase “a high degree of” help promote the impression that, for ECEC, “there should be no distinction between disabled and non-disabled people” (Linton, 1998, p. 536). A “no distinction” story like this “doesn’t wash” (Linton, 1998, p. 536) when it is serving an invisible rubric of normality. In 1994, the invisible rubric of normality that was hidden in vague descriptions of how to include children in ECEC was a way of positioning children with disabilities in a “separate class” (Ho et al., 2014, p. 350).

There is a history to “it should be evident to all” messages that imply that people with disabilities might be more difficult (Baynton, 2015). Such messages tend to lurk in places where consent and coercion are difficult to distinguish (Wright, 2012). In 1994 the families of disabled children already had the least amount of choice in child care compared to all other families in Ontario (Irwin & Lero, 1997; Panitch, 1992; Roher Institute, 1996). For these families, full choice and what they were agreeing to in terms of the services for their children was not clear in 1994 given that the service providers and policy makers who were responsible for the ECEC system admitted to being unclear in their own knowledge of inclusive child care (Ontario Ministry of Community and Social Services, 1988, 1992b). Early childhood resource teachers
were a part of Ontario’s ECEC in 1994, and they were employed by community organizations to support child care programs—or, in some situations, by child care programs themselves to support the integration of children with special needs in the program. Resource teachers’ roles and responsibilities in Ontario had limited regulatory guidance and their activities varied depending on several different factors related to the children, the ECEs, the child care program supervisors, and, in general, to peoples’ attitudes related to inclusion and to child care (Brophy, Hancock, & Otoo, 1993; Brophy, Webb, & Hancock, 1995; Coulman, 1999). In Ontario in 1994, some of the planning for how children with special needs were supported in child care took place at child care planning tables that were regionally established across the province (Ontario Ministry of Community and Social Services, 1988, 1992b). A “challenge to child care reform” identified in 1992 was the “loose collection” of child care services across Ontario, which, in addition to licensed child care centres and home child care agencies, included “family/child resource programs” that employed resource teachers and consultants, many of which had “been in operation less than 5 years” (Ontario Ministry of Community and Social Services, 1992c, p. 4). Key issues discussed at regional planning tables were expansion or change in the delivery of resource teacher services and planning for ways for the various child, family, health, early childhood development, intervention, and community living agencies and services to work together to improve services for children with special needs in a more coordinated way for children and families (Ontario Ministry of Community and Social Services, 1992a).

By making it seem that, for ECEC, it was sensible, rational, and justified for child care programs to not take on the “extra” of special needs children, families’ options regarding their children’s ECEC were made even more elusive. Locating the problem of disability on the child allowed ECEC to be depoliticized. ECEC could present itself as neutral, hence avoiding a
potentially fraught situation of being directly responsible for coercion (Wright, 2012). “Evident to everyone” justifications for excluding children with disabilities make the exclusions conditions of circumstance. In 1994, children with disabilities could be granted or refused inclusion to an ECEC program and the decision was justifiable because it was preserving ECEC. In this discourse that children’s bodies have disability, ECEC was made neutral—ECEC could preserve status as an inclusive, equitable, and doing no harm service (Ho, 2011) that could be justified in excluding some children, because ECEC was designed for children’s bodies without disability.

**Was ECEC ever supposed to be in the business of including children with disability?**

In 1994, Group K hospital staff were not optimistic about child care’s capacity to support children with disabilities (Children’s Treatment Centre, 1994). Strengths of ECEC in 1994 were its currency, its responsivity, and its role as a “neighbourhood institution” (Young, 1994, p. 12). Some children, especially those who interrupted the good, innovative, progressive work of ECEC were better “edged out” (Kittay, 2011, p. 316) of this community. In 1994 ECEC and Group K hospitals were in uncomfortable agreement: some bodies have no place in ECEC.

If disability is of the body it can be argued that those who are closest to our bodies (i.e., mothers [Landsman, 2009] and families [Carey, 2015]) are the relationships that matter most. Citizenship, for people with disabilities, is pushed to smaller arenas when disability is something bodies have. In 1994, “the policy framework currently in place in Ontario was never designed to accommodate the range of needs being placed on it” (Young, 1994, p. 12). Regarding Group K hospitals, their closures were not unexpected—planning had been underway for years (Children's Treatment Centre, 1994). The condition of not being ready was in the ECEC system. Some children were simply not intended to make it into ECEC.
It is unreasonable to include certain children in ECEC

Ninety years prior to 1994, at the 1904 Chicago World’s Fair, education and science were displayed to North Americans as the modern way to improve the capacity of American cities to compete on an international scale (Trent, 1998). Famously, Helen Keller delivered a keynote address at this fair. Also, there were popular exhibits of children from schools for the deaf and schools for the blind singing, reading, and reciting poetry for the purpose of demonstrating their natural intelligence and how it could be made into something wondrous, how they were able to overcome their flaws and impairments with proper guidance and education (Trent, 1998). Other children were on display at the World’s Fair: children who could not improve regardless of the education offered to them. They were referred to at the time as feebleminded (Trent, 1998, p. 204), and another purpose for displaying such children was to promote segregation, sterilization, and euthanasia. Such displays of children were not just to serve the “public interest,” they were also to promote and advertise private schools and private institutions at this huge venue (Trent, 1998).

There is a tacit re-establishment of “who is in” and “who is out” (Titchkosky, 2008, p. 39) in the way the word some is used to refer to groups of children in a community. At the World’s Fair, which was unequivocally a social and economic device of the 20th century, who’s in and who’s out was part of the new competitive human capital discourse that was just beginning to establish itself in the early 1900s in North America. The World’s Fair reflected and reinforced a new constitution for North America: Some children can learn, and some children cannot learn. Some children can be reasonably accommodated, and others cannot. The discourse that disability is something bodies have is more visible now in the following text:

Children with special needs benefit from a high degree of continuity and co-ordination between home, school and childcare. In fact, lack of continuity may
contribute to inappropriate behaviour on the part of some children. (Young, 1994, p. 57)

Reasonable accommodation situates disability as an individual problem, not a social problem (Liasidou, 2014). In 1994, the problem making them excludable from ECEC was the child’s—it was their body that had disability, and it just made good, justifiable sense that in certain situations they did not attend ECEC. ECEC was never intended for them in the first place.

**Conclusion and chapter summary**

In this chapter I discussed how the discourse that disability is something bodies have produced the disabled subject in ECEC. This discourse justified why, for ECEC, some children could be “legitimately” excluded from programs—for their own sake or for the sake of others. I provided evidence that ECEC was only ever intended for nondisabled children, which created problems for child care when, in 1994, there was an Ontario-wide plan for children to be removed from Group K hospital preschool programs and moved toward the unprepared child care system. Because of a lack of preparedness for children with disabilities, ECEC then produced the “misfit” disabled child. For ECEC, the discourse that disability is something bodies have reinforced an idea that there are “right kinds of bodies” for ECEC, and that, still now, in 2023, depending on the discretion of the child care program, children might or might not be invited to attend child care.

Next, in Chapter 4, I discuss the impact of the discourse *children are children first* on inclusion in ECEC in 1994 and how this, in combination with a significant change in terminology in ECEC, helped to make children with disabilities disappear within and from child care.
Chapter 4: Identity Theft by “Children Are Children First”

In the previous chapter I described how the discourse *disability is something bodies have* neutralized the responsibilities of ECEC toward including children with disabilities in 1994. Children were faced with exclusions from child care because of their conditions, and ECEC was off the hook for having to include some children due to the workings of this discourse. The discourse *disability is something bodies have* allowed certain children with disabilities to be understood as legitimately excluded from child care because, ultimately, ECEC in 1994 was for bodies without disability, not bodies with disability.

In this chapter, I demonstrate how the ECEC discourse *children are children first* worked to produce the subordinate disabled subject in child care in 1994 by minimizing the real work of inclusion and by endorsing the idea that children will just fit in with their nondisabled peers as long as they are seen as children first. The province of Ontario promoted the new, more inclusive term *children with special needs*, and in 1994 this move pushed children with disabilities to fit in with all children. In this chapter I discuss how the discourses and activities of *children are children first* had the consequence of disappearing children with disabilities in child care and from child care yet again.

Working to respond to the research questions (1) *How was disability responded to in early childhood education and care in Ontario at time of transition in social policy and administration in 1994? and (3) How did early childhood education, disability, and inclusion discourses in 1994 produce situations of exclusion, separation, and disappearance for children with disabilities in inclusive ECEC?* I explain that the province of Ontario and ECEC are both involved in producing the disabled subject by using variations of a *community is best* message
that is deeply associated with disability activism, but, when altered, this message served a
different purpose in ECEC that pushed children with disabilities out of reach.

Further, I argue that because ECEC was not made ready for the children who would be
coming to ECEC programs with the closures of Group K hospitals, the educators in ECEC were
forced to perform “heroic,” “virtuous” acts in the absence of good planning, policy, and system
supports. Because of the workings of both present and absent provincial policy related to
equality, equity, innovation, and quality, in ECEC in 1994, children with disabilities were
required to blend in, which was a form of coercive subordination in child care. Responding to
research question 2, *What might Thomas Hobbes’s social contract theory contribute to a study of*
*early childhood education and care inclusion for understanding how disability was produced in*
*ECEC in 1994?*, in this chapter I go deeper into feminist social contract theory to support my
discussion.

**In this chapter, the discourse discussed most is for ECEC, children are children first:**

Because children are children first, there could be “other deserving” children who should
also be considered to have “special needs” so that they too can benefit from ECEC.

Because ECEC is for all children, it is inclusive. It would be more equitable for all
children to participate; therefore, it might not be able to prioritize children with disabilities.
**Children are children first**

In 1994, children’s programs in Group K hospitals were closing, and the legislated changes that would eventually move disabled children’s rehabilitation and care services from the medical care system of Group K hospitals to early childhood education and care were implemented. If there were second thoughts regarding the implications of the move of children from Group K hospitals to child care, they were not discussed in the province of Ontario’s ECEC-directed materials. Ontario was looking forward to the day nursery system accepting “the principle of integration” (Ontario Ministry of Community and Social Services, 1988, p. 3), and was looking forward to child care programs being able to “support children with exceptionalities” (p. 3).

For ECEC, inclusion is a persuasive idea because inclusion involves everyone—and it benefits all: Human rights, tolerance, equality, progress, and democracy are virtues that ECEC associates with. Childhood disability can disrupt these virtues (Terzi, 2015), but the ECEC discourse that *children are children first* could help smooth such disruption. Children with disabilities, as *children first*, will more simply “fit in” with other children if given a chance. By 1994, the province of Ontario had produced a number of documents (e.g., Ontario Ministry of Community and Social Services, 1988, 1989, 1992b) that included messages on “the value of inclusion for all children” (S. H. Irwin, 1995, p. 79). Ontario was keen to illuminate that there would be benefits for both “typical” peers and children with special needs who were all together in child care programs.

This kind of advocacy, which was also apparent in national child care inclusion documents (S. H. Irwin, 1995), is connected to a perceived need to assuage a “time and resource stealing” (Allan, 2007) view that the presence of children with disabilities in ECEC compromises
the care and education of children without disabilities who are also in the program. The message or perception that children with disabilities “take from” other children could put an end to inclusion initiatives. The province of Ontario had to squash impressions that disability is, on its own, a “self contained crisis” (Titchkosky, 2012, p. 94) that child care would be better off avoiding; however, there can be a cost to such messages too. By refocusing the benefits of inclusion to “all children,” children with disabilities were displaced by “all children” and by “inclusion” in 1994. In 1994, all children and inclusion became a higher priority for ECEC than children with disabilities.

Many advocates in these programs promote inclusive child care because of a strong theoretical grounding in normalization theory. Many hold strong ethical or religious beliefs that is wrong to discriminate. Underpinning both these rationales is the belief, and emerging research to substantiate the belief, that children with disabilities benefit from inclusion in programs with their typical peers. Other advocates emphasize the value of inclusion for all children—the benefits to typical peers as well as children with special needs. (S. H. Irwin, 1995, pp. 78–79).

A few years prior, in 1988, the Ontario Ministry of Community and Social Services had “accepted the principle of integration” and promoted a day nursery system that could support children with exceptionalities (p. 3). Family focus, staff attitude, staff involvement, the need to see children on a continuum, variation of services according to the specific needs of the child—these were all proposed as the principles of integration with which this new system would be built (Ontario Ministry of Community and Social Services, 1988). Rationale for this new approach to integration was that, “in the day nursery system, minimal attention [had] been paid to integrating children with special needs other than handicapped children, or to what support services [were] required to ensure that they receive effective programming” (Ontario Ministry of
Community and Social Services, 1988, p. 10). In the text *Minimal attention has been paid to integrating children with special needs other than handicapped children*, disability (i.e., being “handicapped”) is posed as a problem, and this problem is reducing others’ right to attention. Attention, in this case, is the scant resource that is unfairly distributed when handicapped children are present.

Efficiency as a rationale was rarely mentioned specifically in provincial materials regarding decisions for “placement” of people with disabilities, but was almost always present. Inclusion is a complicated efficiency strategy set out by the Ontario government, and because it was not overtly addressed as such, it had the result of becoming a tool for exclusion. Justification narratives for institutional strategies are more often associated with exclusion of people with disabilities than with inclusion. The way that Sharon Hope Irwin positioned the term inclusion in the excerpted text above—as a benefit for all children—in this case also functioned as forewarning of what was going to become neoliberalism dressed in inclusion drag (Simpson, 2014).

Justification for exclusion of people with disabilities shows up in appeals that we need to *just be sensible* and see that in some situations exclusion is warranted, such as not including people with disabilities because of the “obvious” lack of space, unsuitable bathrooms, or not enough qualified staff for them to be safe or adequately cared for—but these are, in fact, glossed-over cost and efficiencies rationales (Titchkosky, 2012). More recent events show these rationales to still be in play: In a 2014 article, Barbara Gibson and colleagues wrote about the holes in provincial justification regarding why young people with profound impairments are transitioned from childhood homes to adult homes arbitrarily in Ontario, leading the authors to
conclude that this was a cost-related decision and not at all about dignity of the person (Gibson, King, Kingsnorth, & McKeever, 2014).

Cost of care is a consideration in the Canadian tradition of mixed social economies for care for the sick and the poor. Despite a vision of independence and self-sufficiency, organizations for the poor, the criminal, the insane, and the disabled were funded by government but operated by “hardy pioneers” and “charitable philanthropists” (Valverde, 1995, p. 43). The vision of such organizations as independent and self-sufficient was more myth than reality (Valverde, 1995). Government grants have long funded such organizations, which is why policy is needed in the first place—to steer the direction of the funding for only government-approved activities. (Case in point: Ontario’s first “convalescent lunatic asylum” was established in a hotel in Orillia in 1857 with funding from the Department of the Provincial Secretary [Rossiter & Clarkson, 2013]). But, regardless of who is paying for the cost of care, people’s long-term impairments of almost any type create challenges for public funding, administration, and delivery of services. This challenge was rearing its head (again) in the 1990s when hospitals and home- and community-based services for people with disabilities (and people with chronic illness, or the elderly) were no longer going to be supported through the existing models of dedicated funding (i.e., the Canada Assistance Program, CAP). All kinds of solutions needed to be worked out—and, for many, this meant a return to home and community (Baranek et al., 2004). Deinstitutionalization is one of the functions of the state’s role in defining and categorizing disability that determines how individuals go from the space of a building to the space of a community (Park et al., 1998).

From a historical perspective that includes more than 150 years of institutional shifts for people with disabilities in Ontario, institutionalization and return to community have both been
associated with marginalization, isolation, and stigmatization of disabled people. Community placement systems were intended to reduce the costs of care of people who were (intellectually) impaired, and these systems required the development and organization of community agencies—and, for efficiency’s sake, the taxonomization of disability to sort out who and what were funded (Park et al., 1998). Program complacency that once made people more vulnerable in institutions could now make them vulnerable outside of institutions too (Rossiter & Clarkson, 2013).

The principle of return to home and community is not in itself being presented as either negative or positive, but here, I am arguing that when it is used as the end game (the central point in the argument)—without due consideration given to how people who are transitioned from one place to another will be supported in living a good life (Terzi, 2015), the outcome is likely to be negative.

The strong theoretical grounding in normalization theory that Irwin mentions in the text that I have been discussing is shown here:

> Many advocates in these programs promote inclusive child care because of a strong theoretical grounding in normalization theory. (S. H. Irwin, 1995, p. 78)

This language is notable because this concept of normalization theory is strongly anchored to social justice. In 1972, the National Institute for the Mentally Retarded (NIMR, which would eventually be known as the Roeher Institute) published a book by authors Wolfensberger, Nirje, Olshansky, Perske, and Roos called Normalization, the Principle of Normalization in Human Services. The premise of this book is that institutionalization is incompatible with living a normal life—and all humans have a right to a normal life. The following year, in 1973, Wolf Wolfensberger wrote a book on “deathmaking” about how society
was essentially making disabled people invisible or dead before their demise. Wolfensberger identified numerous ways that society was successfully deathmaking, or abbreviating through killing, such as abortion, infanticide, and euthanasia; he also referred to decadences such as individualism, sensualism, and utilitarianism as socially acceptable ways of shortening the lives of societally devalued people (S. Thomas, 2017). Wolfensberger’s argument for much-needed normalization—the physical and social integration of people with disabilities in all aspects of social life—like Jean Vanier’s work that showed how well people with disabilities flourish in supportive environments, were part of the consumer movement swelling in the 1970s that was based on the premise that people with disabilities have the right to select and monitor the services they use and where they live (DeBeer, 2011). While both Wolfensberger and Vanier have many critics, the “theology of disability” (Watson, 2014, p. 25) they touted was deeply rooted in disabled individuals having the right to determine their own involvement in society, for their own “good.” Not part of this idea is the principle of for the good of all; rather, Wolfensberger and Vanier worked from the idea that people with disabilities could determine their involvement in society because they have lives that are valuable.

Whatever the intentions of the Ontario Ministry of Community and Social Services were in 1988, by 1994, there was still limited ECEC legislation for inclusion—and there were increasing practical barriers to providing ECEC for children experiencing disability. Yet, some programs were still highly committed to actively working to be inclusive. Advocacy was an important part of their work (Irwin, Lero, & Brophy, 2000). This activity—from the educators and activists’ point of view—was primarily based on a commitment to not discriminate. That, and there was growing evidence in both research and practice suggesting that children
experiencing disability benefit from being in programs with their nondisabled peers, and vice versa (Buysse & Bailey, 1993; Peck et al., 1993).

A commitment to not discriminate, in many ways, problematizes disability. This might just be the critical entrance point where the language of tolerance and celebration of diversity was invited in to inclusion, enriching the *children are children, so children with disabilities will just fit in* discourse. Building an approach based on a wish not to discriminate is connected to the “fallacy of equivocation” that produces a normalized image of what the right to education, to housing, to a job looks like for everyone (Goodley & Runswick-Cole, 2016, p. 7). Rehearsing the mantras of inclusion without going deeper into the resources, practices, possibilities, and struggle of disability is an evasion tactic (Allan, 2007) that, in this case, in 1994, was ensuring ECEC would stay focused on what ECEC was preconditioned to deem most meaningful: a celebration of diversity in the range of the normal.

**The new kidz on the block: Children with special needs**

In 1994, the two texts below could be considered in dialogue with one another. There is a common language in the term “special needs” that would suggest that these two textual artifacts share the same intentions in ECEC at the time. How the term special needs is used—and why it is used—in these two texts can be seen to represent very specific contextual information about what was happening at this time that is distinct for each situation. The term special needs in these two texts can also be used to demonstrate the complexity of the discourse *children are children first so children with disabilities can just fit in* and how this discourse has had the impact of disappearing disability from ECEC.

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4 Dr. Jeff Preston, in a lecture at Western University, on this date said: “Why “special”? Stairs aren’t special, lightbulbs aren’t special: Why are his needs special?” (September 23, 2021).
Despite having no legislation and all these practical barriers, many Canadian programs promote and support inclusive child care. Many advocates in these programs promote inclusive child care because of a strong theoretical grounding in normalization theory. Many hold strong ethical or religious beliefs that it is wrong to discriminate. Underpinning both these rationales is the belief, and emerging research to substantiate the belief, that children with disabilities benefit from inclusion in programs with their typical peers. Other advocates emphasize the value of inclusion for all children—the benefits to typical peers as well as children with special needs. (S. H. Irwin, 1995, p. 78)

When programs serve children with special needs, it is helpful if either the principal or the child care supervisor is qualified either through training or experience to facilitate their full participation. (Young, 1994, p. 57)

Both authors use the term special needs—and each author has positioned the word children before “with special needs” intentionally—following the child-first language that situates special needs as a condition attached to only some people. When special needs is positioned after children, the condition of interest (unlike gender, race, or ethnicity) is only significant as a remedial or managerial issue (Titchkosky, 2001, p. 126).

In 1988, the Ontario Ministry of Community and Social Services published a background report on integrating children with special needs in day nurseries. In this document, the term special needs was the recommended terminology for children who might need support for being included in ECEC. The intention of this terminology change was to allow for more children who needed supports and services to be identified in the child care system because, in the day nursery system, minimal attention has been paid to integrating children with special needs other than handicapped children, or to what support services are required to ensure that they receive effective programming (Ontario Ministry of Community and Social Services, 1988, p. 10). A few years prior, in 1980, a consultation paper on new standards for licensing of child care centres and
home child care in Ontario reported that the public did not view the term special needs as suitable because it refers to a broader range of children than only children with physical and developmental handicapped diagnoses, and only these diagnosed handicapped children would likely require specialized programming or segregated settings that fit with the funding program being proposed. Following the consultation paper in 1980 a new funding standard was created specifically for “handicapped children in designated funded programs” (p. 10). An issue that the 1988 background report on integrating children with special needs in day nurseries sought to address was defining children and families with special needs, and this, it did. Using a definition of special needs that was developed in 1983 in Metro Toronto, the operational definition of a child or family experiencing special needs became:

A child or family which, at any point in time:

a) Faces barriers to normal development and functioning in one or more of the following areas of development: physical, social, emotional, communicational, intellectual, behavioural, and/or

b) Has increased vulnerability to environmental and non-environmental stresses, including those related to family, social, economic and cultural circumstances.

The needs which are being experienced at any one time will influence the resources required by the day nursery system to service children and families effectively. (Ontario Ministry of Community and Social Services, 1988, p. 19)

This definition of special needs indicates an important social and political attitude that was circulating about disability and ECEC at the time—that some people’s needs have been focused on for too long, and the focus had taken from others. The phrase children with special needs had the two-pronged effect of being both ambiguous and more inclusive, serving the
current policy agenda of ECEC to not be defined (and therefore not be fundable) in ways that would stand up to a close accounting of public funds allocations, and to be spread out to include more children, ideally at the same funding levels. Further, this ambiguity in definition helped make disability fade even further: Including more children in the definition and spreading resources among more units creates pressure to identify those in the group who need less and those who need more, almost always pushing those who could use more to the margins (Ouellette-Kuntz, et al., 2005), and, more subtly but apparent is the implication that “all children” are special sometime. In this definition, short-term special is being raised to compete with long-term special. By highlighting short-term special, this definition alerts us to a significant, long-term, slow change in funding approaches (i.e., “the needs which are being experienced at any one time will influence the resources required”) to funding that befits a dynamic, nimble, community-based, and community-driven model of ECEC. This was (and still is) a way that ECEC could distinguish itself from the dusty institutions of “long term” and “handicapped”—and while the anti-institution sentiment from disability activism focused on distinguishing community from institution to also show the harms of medicalization of disability (Rossiter & Clarkson, 2013), ECEC was being served by its association to community as an alternative to long-term, chronic, handicapping conditions of any kind that might interfere with the assumed progressive growth and development of children, families, or the community.

The message from the government of Ontario was that closures of Group K hospitals would result in more strategic emphasis on community-based services so that individuals could receive services in the environments of their choice—and that closures included more focus on cost effectiveness (Children’s Treatment Centre, 1994). For Group K hospitals, the focus was disability not inclusion; for ECEC, the focus was inclusion not disability. This distinction is
made clear in the following statement: Every effort should be made by day nursery centres to respond to each child in as normal a fashion as possible. Children should be served according to their common developmental needs, rather than according to their differences” (Ontario Ministry of Community and Social Services, 1988, p. 21). In ECEC, the message was that children should be responded to according to what they have in common, making inclusion the focus. This messaging fits with the discourse that children are children, so children with disabilities can just fit in, because, as this text clearly states, children should be served according to their common needs rather than their differences. This also fits with child development as a constructed discourse that normalizes and maintains the existing relations of power.

Inclusion was already an unclear concept in ECEC with vague practice (and funding) expectations—and it was about to get even less defined. In 1988, the challenges related to integration that child care programs were experiencing were identified in terms of who should receive services, who was responsible for integration, roles of educators and resource teachers in supporting programs and the children, and issues of space and costs. The report on integrating children with special needs in day nurseries did not make recommendations per se, but in its conclusions offered directions for addressing some of the identified challenges, including that, if day nurseries staff have assumed a variety of responsibilities in relation to serving children and families experiencing special needs, they are also engaging in preventive activities such as early identification and intervention, including screening, assessment, participation in case conferences, and assuming responsibility for case coordination, and therefore should be able to access specialized services and supports for doing all of this (Ontario Ministry of Community and Social Services, 1988). The 1988 report also identified two kinds of issues related to children with special needs. The first issue was case responsibility, which applied to “handicapped
children” whereby the staff (ambiguous here) who was responsible for cases would make referrals, be involved in case conferences, and develop individual program plans (IPPs) for the child. The second issue was service coordination, which involved collaboration between programs in the community to fill service gaps and ensure system responsiveness for “hard to serve” children (p. 99). In the most challenging situations, service coordination was to “see to it” that the child’s needs were met somewhere else (p. 100). In southwestern Ontario, one team of Group K hospital closure strategists were conscious of this new emphasis on community-based services that was being pushed forward by both the federal and provincial governments. While supporting the premise that people should be able to choose and receive services in the environments of their choice, they also warned of the possibilities for harm to people with disabilities that might come with a too-heavy choice and community rationale for change by the different levels of government. In this case, a rationale that promises more equitable distribution of services and improved accessibility for vulnerable populations while also expanding child care services for special needs children, while also engaging in long-term care redirection—that, incidentally, they point out, did not have a specific target planning group for reviewing the redirection plan for long-term care regarding children with physical disabilities, including children who were medically fragile or had serious brain injuries who were, at the time, living in long-term care (Children’s Treatment Centre, 1994).

“Vulnerable kids” and a new path for ECEC

Disability became even more inclusive by being changed to special needs, and this meant that more children could be part of the ECEC community if not necessarily recognized as part of a disability community. Special needs was the term for children “other than handicapped children” who may need shorter-term supports in day nurseries (Ontario Ministry of Community
and Social Services, 1988, p. 10). Distribution equity in resources for children meant that there was a new focus on children with special needs: children who were vulnerable to disability. This form of childhood vulnerability was temporary and less fragile than disability, and while still potentially misfitting children, it denotes a condition of flux that fit better with ECEC. Garland-Thomson (2011) wrote that vulnerability is “a way to describe the potential for misfitting to which all humans are subject. The flux inherent in the fitting relation underscores that vulnerability lies not simply in our neediness and fragility but in how and whether that vulnerable flesh is sustained” (p. 598). Special needs and vulnerability are changeable—not sustained; this is important for community-based ECEC that is served by a discourse of children are children and children with disability can just fit in.

In the early 1990s, ECEC was being studied for its protective capacity. American researchers Duncan, Brooks-Gunn, and Klebanov (1993) and Love, Aber and, again, Brooks-Gunn (1994) published research findings that were showing how child care could be a notable service for changing vulnerable children’s developmental trajectories. In Canada, Nancy Cohen published a paper, “The Protective Role of Child Daycare for Mainstreamed High Risk Infants and Preschoolers” (1994) in the Canadian Journal of Community Mental Health. The journal publishing the article is notable because it indicates a shift toward community and also toward the concept of mental health in the broader health care system in Canada. Shortly after, in 1998, Dan Offord, child psychiatric epidemiologist at McMaster University, with colleagues would publish the article “Lowering the Burden of Suffering from Child Psychiatric Disorder: Trade-Offs Among, Clinical, Targeted, and Universal Interventions.” These were notable publications that effectively articulate the value of early childhood programs for mitigating risk for impairment. In other words, in certain circumstances long-term impairment was only inevitable if
it were not interrupted by a well-timed intervention. Vulnerable children’s developmental trajectories could be changed, and early childhood education and care, or rather, *early childhood development*, was presented as the intervention that could change these trajectories.

But what was “vulnerable children” referring to? In the early 90s, these were children who were experiencing economic and social deprivations that might have an impact on their developmental outcomes (Duncan et al., 1993). At the time, scholars, public health departments, and a few cities across Canada were developing a social and epidemiological interest in identifying equity disparities among individuals, communities, and regions, using geo-political mapping systems demonstrating socioeconomic gradients in health (Hertzman, 1994). A benefit of social spatial modelling of health and social conditions was that communities, including neighbourhoods—right down to the census tract (the postal code)—could be described as vulnerable using this new method of presenting child- and family-related data (Brooks-Gunn et al., 1999). These data could be used to target specific areas as prioritized for extra programming, improved program coordination, and social welfare funding, which had a great deal of appeal for health and social service planning (Hertzman & Bertrand, 2007).

In 1994, ECEC was an ambiguous entity among the health and education sectors and the community. Sometimes ECEC was a mechanism for health—population and developmental health, in particular—and sometimes ECEC was associated with education. Before and after school programs were especially useful for equity discussions, and even better for geo-political mapping given their proximity to or location right in schools because *cooperation* among education and social services was considered important for reducing inequities (Hertzman & Bertrand, 2007). This meant that these programs for “school age children” (aged 6 to 12 years) were included in the equity movement in, arguably, a more embedded way than ECEC for
The school/child care connection is simple common sense. When almost 20 percent of children in some communities come to school without breakfast one or more times a week and more than 40 percent of six to 12 year olds go home to an empty house at the end of the day, educators must inevitably be concerned about the care and well-being of children during out of school hours. (Young, 1994, p. 1)

The value that emerges from this text is how essential participation in early childhood programs is for children who are vulnerable to disability because of their home life. Yet, these same children who are considered to be so vulnerable are in a doubly bad situation because they are not able to attend the programs that the new evidence is showing can help them most of all.

The stakes for ECEC were heightened by the new evidence that not only emphasized vulnerable children but strengthened the body of literature that could be used to validate and promote ECEC in Canada. There was sequence to this: (a) access to ECEC was preventive of future disability, but (b) there were ambiguities in how the context for change was described in the research—sometimes the context was referred to as child care, and other times it was referred to as early childhood development—that said (c) when the context was called child care, it was also made clear that the child care must be good child care to have an impact; this created another challenge, namely, (d) that children who were the most vulnerable to future disability were not going to child care; this challenge was potentially addressed by the development of (e) other programs in the spectrum of ECEC that were not exactly child care but that might change children’s trajectories too; however, missing from this discussion altogether were (f) children
with existing disabilities, who were not included in “vulnerable children”—only those with the potential for disability were part of this group.

High-quality child care was important—it could help children who were not experiencing disability. Disability was not overtly present in vulnerability, but there was a strong suggestion that when child care quality was low, it could impair children:

Good Care/Bad Care Does It Make a Difference? Research into the effect of infant, toddler and preschool child care on children’s growth and development has demonstrated that when children participate in good quality child care there is no negative effect on their well-being or development. In fact, there is sometimes positive benefit. Poor quality child care, however, has been shown to have negative consequences for young children’s development. (Young, 1994, p. 10)

This text stood on a body of research literature that, at the time, concerned itself with the hypothesis that full-time placement of very young children in child care was problematic (Belsky & Rovine, 1988), and at the same time offered a weak suggestion that, “in fact, there [was] sometimes positive benefit” that participation in child care had on some children. Overall, the reading here is that good ECEC is mostly neutral.

Discussion of the quality of early childhood education and its relationship to children’s vulnerabilities caused by social and economic deprivation was not new in 1994. Project Head Start and Project Home Start were part of extensive reforms in ECEC and research across North America in the decades prior, and they, like this new focus on vulnerability, worked in similar ways to help produce and reinforce the idea that ECEC could revert the impact that households and families might have on children (Clark et al., 2012). The connections among the individual, groups of people, and the population; the connections with national development; and the idea that counting statistics related to vulnerabilities and depicting them in a spatial way are all ways
of “thingifying” (Titchkosky & Aubrecht, 2015) disability (even when disability is not even mentioned) and making the person the problem that the system (or the country) cannot get ahead of. When the home environment is the producer of risk, then paradoxically ECEC becomes an early intervention that then widens from the child to the whole family as its focus, and families are viewed in a new kind of way that positions them as either cooperators with ECEC or, when they are not cooperators, the cause of the problem for their children. That families are a producer of risk for children’s development is an extension of a familiar discourse that parenting produces disability (Ferguson, 2002). Continuity between families and programs means developing systems of communication and an ability for everyone to be talking the same language to avoid misunderstandings. Building the rhetoric (the common language) necessary for continuity between environments was, realistically, likely to require more administration, more documentation, more time, and even more space (for meetings and for privacy)—or, as was suggested in 1988, a liaison between these separate environments (Ontario Ministry of Community and Social Services). The subtle warning was that if families were not able to accomplish the relatively simple task of communicating with ECEC, then that was what would create system failure.

A system that demands coordination, cooperation, and collaboration for it to function is, arguably, not a system. In this situation in 1994, if families—or the educators—could be identified as the lock pin that held it all together, then the community remained a benevolent entity and the programs that served children in the community could remain “sensible” (Young, 1994, p. 12). What was making the communities fail was those who added additional unanticipated pressures to the community:

Inevitably an ecological understanding of children’s development leads us towards more collaborative approaches to delivering community services such as
nutrition and child care services, together with out-of-school arts and recreational programs. However sensible such approaches may be, they run counter to the way in which educators, child care professionals and recreationists have come to see their role. The policy framework currently in place in Ontario was never designed to accommodate the range of needs now being placed on it. Communities committed to providing quality care for children will need a vision of what quality looks like. They also need to understand the current funding and regulatory frameworks that shape neighbourhood institutions. (Young, 1994, p. 12)

The community was widely understood as a solution to the institutions, like the Group K hospitals, that had separated and segregated people from their homes. Here, in this text, the appeal was for “frameworks that shape neighbourhood institutions”—suggesting that a departure from institutions (e.g., Group K hospitals that were negative and inconsistent with normal life) was the ideal. The timing of activities in the above quote is worth paying attention to here: As Noel Young writes, “communities . . . will need” is a sign that a reactive shaping of the neighbourhood institutions for the new responsibilities is good enough. What this does is it requires disability to be the active pusher or motivator for change, so that people with disabilities can participate in the neighbourhood institutions. Children with disabilities in ECEC requires charitable acts (because the work is optional) at the closest level to the person who is disabled (the most local), because no one else is going to take care otherwise.

Responsivity and innovation represented new virtues in Canada in 1994. National, provincial, and local trends in services for children and for people with disability were reflective of a general theme of economic and social rights and entitlements to a better future that was operating on an even bigger scale than Canada or its subordinate administrations. The influential variable was equity—equity for children, as stated in the UNICEF State of the World’s Children 1990 and in the 1992 Canadian government’s call to action, Brighter Futures that set out plans
for reducing the conditions that created risk for child development across Canada, and equity for all, as stated in Health and Welfare Canada’s Achieving Health for All: A Framework for Health Promotion, 1986. For ECEC, a system that was not a system, the new kids on the block, children with special needs, vulnerable children, allowed ECEC to be fresh, nimble, and responsive. Disability, on the other hand, with its permanency, would be an anchor holding back ECEC’s potential for progress into the new community era. Disability itself, in ECEC’s gaze, represented institutionality—and for ECEC to be viewed as a community-based tool for equity, this image of institutionality was too unmoving. The school/child care connection [was] simple common sense (Young, 1994, p. 1)—provided that the child care program could shift, change, flex, and respond where it was needed most. This busy action and resourcefulness of ECEC alleviates responsibility for disabled children while still maintaining a degree of “benevolent paternalism” (Kudlick, 2015) with respect to disability by focusing on families’ and society’s broader needs for work and health. The trouble is, by meeting children’s needs by addressing their vulnerabilities through innovation and problem solving, ECEC was producing disability lite.

It is clear that ECEC in 1994 had limited legislation and that this served ECEC and the government administrations at all levels: national, provincial, and municipal. If lucky enough, Canadian child care programs that wanted to include children with disabilities would support children with disabilities (S. H. Irwin, 1995, p. 78)—nothing was mandatory, and this made early ECEC a useful martyr in this situation. The practical barriers regarding inclusion are just another menace in ECEC, but the educators are resourceful in their position as the underdogs. Educators are the workhorses—low salaries, high staff turnover, minimal training, inadequate space, and high child-to-staff ratios are challenges indeed, but these challenges can be overcome by attitude, commitment, and personal investment. The work of educators offers a way out for ECEC and for
policy: educators will do the important work of inclusion regardless—and when they are unable to cope, their personal resilience is what needs to be improved (Beltman, et al., 2019). The image of ECEC itself can be changed to reflect the interest of government policy as government sees fit because of the work that educators are willing to do when they “want to include children with disabilities” (S. H. Irwin, 1995, p. 78). From the administration position, whether federal, provincial, or municipal, early childhood programs can *promote and support inclusion* in child care at a comparatively low cost, funders can demonstrate their good work of reducing vulnerability, and no one has to invest in children with disabilities directly.

*Children are children first* was a harmful discourse for inclusion of disabled children in 1994, yet it remains ubiquitous even now. Inclusion, too, suffered under the weight of this discourse of children are children first and its association with equity back in 1994. Moving away from the term “disability” and shifting to the supposedly more inclusive term special needs allowed for the coiled rhetorical energy of social justice and equity to be pasted onto ECEC. It is not that social justice and equity are unworthy goals; it is the ambiguity of these concepts in ECEC. Equity—especially in a framework of social justice for all—is useful for neoliberal and meritocratic perspectives that, when used superficially, can also end up excluding people who are understood as not contributing to the greater good of the marketplace (Liasidou, 2008).

Inclusion, in 1994, was not serving disability, children, families, or ECEC in an important way as intended: Inclusive child care was, for some, intended to help address the gender and disability gap that was particular to mothers of disabled children in Canada. Mothers of young children with disabilities faced significant barriers to workforce participation in 1994, and that there were fewer child care programs that would or could adequately support their children with disabilities was (and still is) a major part of the still true fact that family economic security is
destabilized by disability (Bach, 2000; Include Me Social Movement, 2021). Underemployment rates for parents ranges from 40% for those whose children have “mild” disabilities to 70% for those whose children have “severe” disabilities (Include Me Social Movement, 2021).

Conclusion and chapter summary

In this chapter, I explored how the community is best discourse served ECEC and also served the agenda of the Ontario provincial government in 1994, because this discourse was deeply associated with disability rights advocacy. The community is best discourse had a different impact on children with disabilities than one might anticipate, however, because in ECEC this discourse made children with disabilities invisible.

Because ECEC was not ready for the disabled children who would be coming to ECEC programs with the closures of Group K hospitals, educators in ECEC were required to perform heroic acts—that relied on educator virtue—to include children with disabilities in child care. Using feminist social contract theory to support my argument, I discussed how the policies that existed—and the policies that did not exist—in ECEC in 1994 reinforced greater interest in equality, equity, innovation, and quality, while disability was made a subordinate interest for programs. As a result, children with disabilities were required to blend in and perform like nondisabled children as best they could. I also discussed how the significant terminology change from handicapped children to special needs children created a more ambiguous pool of individuals who might be served by the emerging special needs resources in child care, thus removing children with disabilities, again, from being a central focus in child care. This shift led to a new movement toward supporting “vulnerable children” in child care, which also created new hurdles for children with disabilities in ECEC.
For Thomas Hobbes, challenge, controversy, or crisis can proceed acts of virtue or acts of viciousness, but how the virtuous or vicious response to challenge, controversy, or crisis is measured is in the laws. For ECEC in 1994, the laws regarding inclusion did not exist. What happened in ECEC with the closures of the Group K hospitals could not even be measured to clearly understand how effective ECEC’s response was. There were no defined or exact responsibilities or roles with respect to disability (or special needs) in ECEC. As Julie Allan (2007) wrote, it is difficult to identify inclusion policy, and when it does not exist at all, it is virtually impossible to measure the success or failure of that policy or the practices it directs. Not only did this push educators in ECEC toward technical solutions rather than seeking to understand what were or might be meaningful experiences of disability within child care (Allan, 2007), in 1994, this resulted in the blending in of disability, and, ultimately was a form of disability identity theft that is still part of the ECEC system now in 2023.

Next, in Chapter 5, I discuss how the shift of children from Group K hospitals to community ECEC was a disabling factor because ECEC had no common authority. In the chapter I demonstrate how the historical event of the closures of the Group K hospitals in 1994 occurred in a context of a bigger movement to change hospitals in Canada, and while the messages of inclusion were persuasive—and aligned with interests in shifting the medicalization

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5 This common measure, some say is right reason: with whom I should consent, if there were any such thing to be found or known in rerum natura. But commonly they that call for right reason to decide any controversy, do mean their own. But this is certain, seeing right reason is not existent, the reason of some man, or men, must supply the place thereof; and that man, or men, is he or they, that have sovereign power, as hath been already proved; and consequent the civil laws are all subjects the measures of their actions, whereby to determine, whether they be right or wrong, profitable or unprofitable, virtuous or vicious; and by them the use and definition of all names not agreed upon, and tending to controversy, shall be established. As for example, upon the occasion of some strange and deformed birth, it shall not be decided by Aristotle, or the philosophers, whether the same be a man or no, but by the laws (Hobbes, ELEMENTS OF LAW, 2.10.8 in endnote 15). Divine morality does not exist, morality and virtue are conventional (social).
of disability—the intentions of the Ontario government had little to do with children with disabilities at all. As a result, for very young children with disabilities in Ontario, this meant that they were moved out of a universally funded and publicly organized (hospital) system that focused on disability into a privatized, unplanned, chaotic ECEC system that was intentionally underprepared for their arrival.
Chapter 5: No Common Authority for ECEC and the ECE Side Hustle

In the previous chapter, I explored the ECEC discourse *children are children first* and the terms *children with special needs* and *vulnerable children* to show how children with disabilities were expected to fit into child care in 1994, and therefore were made to disappear into the rhetoric of inclusion.

In this chapter I discuss how the shift of children from Group K hospitals to community ECEC was a disabling factor because ECEC had no *common authority*. For Thomas Hobbes, in his philosophical social contract theory, consenting to the sovereign—“the common authority”—meant that all people in civil society had subjected themselves, for the sake of survival, preservation, and protection, to a single sovereign (Hobbes, 1651/1996). In this chapter, I respond to research questions 2 and 4—*What might Thomas Hobbes’s social contract theory contribute to a study of ECEC inclusion to understand how disability was produced in ECEC 1994?* and *How was ECEC set up to fail children with disabilities by the government of Ontario by its poor planning and child care system design?*—by discussing how inclusion of children with special needs in child care was presented as a progressive option for children with disabilities, to convince everyone—the children’s treatment centres, the ECEC programs, and families of children with disabilities—to support this change of systems for children with disabilities. What was not clear was the common authority—the planning and preparation of ECEC for these children—because, for all intents and purposes, the reason for shifting these children from Group K hospitals was so that the government of Ontario could close the Group K hospitals.

In this chapter, I propose that the historical event of the closures of the Group K hospitals occurred in the context of other, larger changes to hospitals in Canada. To do so, I provide
evidence that the intentions of the Ontario government had little to do with children with disabilities at all. And, while the changes to hospitals were an important factor in a much larger overall change regarding a global shift in attitudes toward medicalizing disability (Aston et al., 2014; Baranek et al., 2004; Rossiter & Clarkson, 2013; Schulz & Johnson, 1990), for very young children in Ontario, this meant that they were moved away from a universally funded and publicly organized (hospital) system. This move to ECEC did not resolve the issues of medicalization of disability for these children. In fact, the discourses of disability and medicalization that were historically established in the medical framing of disability (such as disability as weakness and vulnerability) as needing therapy were sustained and possibly intensified despite the shift from Group K hospitals to ECEC, because of the lack of preparation in the ECEC system to ensure participation, and welcome children. The impact was immense and lasting: The lack of preparation of the ECEC system for disability in 1994 pushed children with disabilities into a “side hustle”—a supplementary job in addition to their regular work for early childhood educators.
Group K hospitals to ECEC inclusion

In 1994, Group K hospitals where preschools for children with disabilities operated were closing. The closures were made in the interest of efficiency and cost reduction for the Ontario government in 1994 (Ontario Ministry of Community and Social Services, 1988, 1992b). These predominantly economic interests were dressed up in inclusion drag (Simpson, 2014) so that it looked like there was a good plan in place for children with disabilities to participate in ECEC. In reality, however, there was a lack of good planning, and this gap had the impact of further disabling children despite the government’s claims that good programming alternatives for families of children with disabilities existed. For all intents and purposes, without the Group K hospital programs, the options for preschool children with disabilities were to attend an inclusive ECEC program in the community—with no real information on how this would work—or to not have preschool programming at all. Families of disabled children used child care to work (Panitch, 1992), and this was a compelling reason for inclusion of children with disabilities in ECEC to be viewed as a good and progressive idea.

Because of the lack of a common authority for early childhood education and care, ECEC was not much more than a flexible tool that could be used to address any policy or programming gaps the Group K hospital closures might bring. The ambiguous governance and policy of ECEC could be used to generate an imagined promise that ECEC would be an ideal alternative for these children without the promise being truthful. The government of Ontario was making good use of

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6 RuPaul Charles’s statement “We’re born naked; the rest is drag” seems Hobbesian to me. I chose “drag” for the irony given the connection between homophobia, trans-phobia, gender discrimination, ableism, and, in my mind, social contract theory. Bradley R. Simpson (2014) uses “drag” to name the mimicking in narrative and analytical form of something that “we purport to understand” in the development of policies that are, in truth, “almost wholly from the perspective of state officials.” “Drag” in this case, is the dressing up of underdeveloped policy with the “better stories,” the drama, and “the seeds of a narrative arc” that are more likely to be supported by all of us (2014, p. 293).
existing principles of inclusion and community living to make ECEC look like a desirable context where children with disabilities would be fully included and supported.

The conditions of ECEC in 1994, and in the years following, had educators abandon their work of inclusion (Irwin & Lero, 2021), in part because these educators did not have sufficient preparation for children with disabilities. A result was a new layer of educator exhaustion that emerged out of ECEC disability work that, prior to 1994, might have been performed with more ease in child care centres that were open to welcoming children with disabilities into their programs. Instead, the activities of 1994 in the ECEC context made impairment become a lot more work because of the way the ECEC infrastructure was being built using images of the able child, not a disabled child, as its model child. The impact has lasted; in this context, the disabled child was (and is) expected to imitate the able, because for ECEC, able represents who is most human (Titchkosky & De Welles, 2020).

In 1994, what this meant in ECEC was that children with disabilities were new subjects in the making. The workings within ECEC at the time made it possible for children with disabilities to be reconceptualized as children with special needs who could be worked on to fit into the general population of children. Fitting disabled children into ECEC in this emerging scheme was going to establish the success of inclusion, and for inclusion to be successful, children needed to have special needs and not disabilities. So, while disability was unfit for ECEC in this new approach, special needs was a better fit for ECEC.

The very real shift that was taking place—moving children from what was a disability-focused institution (which the Group K hospital programs were) into ECEC programs—was eventually going to make disability (and children with disabilities) disappear. As I discussed in Chapter 4, in 1994, ECEC was becoming a service of prevention and reduction of risk for
disability; however, in this chapter I explore the premise that the lack of a common authority for ECEC—the missing sovereignty—made ECEC ambiguous, which also made it likely to fail at this new task of inclusion that was put upon it. The cost of this failure has lasted. The existing ECEC system, since 1994, still lacks coordination and effectiveness, but even more importantly, the cost has been that children with disabilities are still denied their identity, made invisible (Hirschmann, 2015), and rendered less than human in ECEC.

There is a from ... to transition that is of consequence in the move of children with disabilities from Group K hospitals to community child care programs. Of considerable importance is that children were being moved from a publicly funded medical system to a privatized social service system.

Earlier, in 1988, the Ontario Ministry of Community and Social Services was concentrating on the expressed problem of the “minimal attention” that children with special needs were receiving in child care programs. Children with special needs were not children who were handicapped in 1988. And, while the Ministry of Community and Social Services was also aware that concrete information about the “handicapped children” who were already included in regular day nursery programs was scanty, they claimed that regular day nursery programs were involved in a variety of activities related to serving these children (p. 11). They were also aware that child care staff had very little specialized training or available resources to support them in their activities related to serving these children (Ontario Ministry of Community and Social Services, 1988). As well, the Ministry of Community and Social Services knew about the weakness of the infrastructure of ECEC in Ontario. In fact, Noel Young, author of Caring for Play and a self-professed ally of ECEC, wrote openly about ECEC’s weak infrastructure in the document:
The barriers to developing a comprehensive child care system are many. Given current fiscal restraints, the child care system needed to meet Ontario’s requirements in the coming decades will have to be built, at least in part, on foundations already in place in local communities. The continued development of overlapping services for young children is not only undesirable but unaffordable. (p. 13)

This kind of acknowledgement of the weak ECEC system was common. Earlier, in 1984, Royal Commissioner on Equality in Employment Rosalie Abella called child care inadequate because of Canada’s “greatly behind the times” social policy. The Royal Commission’s work eventually led to the appointment of Katie Cooke as the lead for the Status of Women Task Force on Child Care, and despite an announcement by Ottawa in 1987 that there would be a national strategy on child care (Turgeon, 2014), child care was then and has remained ever since one of the stickiest problems in underdeveloped social policy and underorganized program delivery in Canada.

The Group K hospitals had a view of ECEC’s weaknesses too. Sharon Hope Irwin (1995) wrote that across Canada, children’s treatment centre program staff were worried about disabled children going to day care. Their worries related to educators lacking knowledge: They were concerned that they (treatment centre staff) knew disability and child care programs did not (Children’s Treatment Centre, 1994). Documentation shows that children’s treatment centre staff also saw themselves as already being community agencies (and not hospitals per se); however, they understood that the shift of disabled children to ECEC was being planned anyway, despite their beliefs about their programs. The children’s treatment centre staff and administration seemed keenly aware that this major programming shift for children with disabilities was one of many changes to Group K hospitals triggered at that time because of a problematic condition that they were operated under the auspice of the Public Hospitals Act (Children's Treatment Centre,
1994). The changes were being made to hospital policies and public health systems on a much bigger scale than the children’s programs; the issues of the children’s programs and their closures, and the disorganization of ECEC, seemed to be of low priority in the whole scheme of things (Children's Treatment Centre, 1994).

From the broader social and health policy perspective across North America, in the early 1990s, hospitals themselves were coming to the tail end of a slow shift away from a “prestigious” period of social positioning. Since the 1960s, hospital administrators, medical personnel, and physicians were, by their association with hospitals, highly valued professionals who were believed to have the most important kind of knowledge and to use the most special technologies in Canada. From the 1960s well into the 1980s, Canadian and American hospitals were promoted, merged, expanded, and aggressively marketed from single buildings to complex institutional systems (Schulz & Johnson, 1990). Hospital financial systems were dominated by models of corporate economics (even in Canada) producing powerful and expensive treatment and care systems that were (and in many ways still are) highly revered, influential corporations (Schulz & Johnson, 1990).

By the end of the 1980s, however, the centralized focus on hospitals as prestigious institutions was beginning to change, and a “managed care” system of care and medicine started emerging in primary health care. For the first time in decades, there were political and social pressures on hospitals demanding that they control and regulate their exponentially growing costs (Schulz & Johnson, 1990). Adding to the demand that hospitals control costs was a growing interest in hospitals repairing their highly rigid institutional characteristics that made them seem unduly inflexible to an increasingly skeptical public (e.g., hospitals associated with religious institutions that were unwilling to expand their scope of practice were falling out of
favour at this time) (Schulz & Johnson, 1990). Health care performance and patient outcome statistics were part of this movement toward institutional accountability for controlling costs and efforts to soften the rigidity of hospitals. The public was increasingly aware of patient outcome statistics (e.g., comparison data were used to assess hospitals’ death rates, successful surgery rates, etc.), and whether accurately or not, hospitals were being judged in terms of hospital health outcome data in new ways (Schulz & Johnson, 1990). As a result, patients’ long-term hospital stays were much less favoured by hospitals given how these patients could skew statistics that were now available for viewing by the public. It was during this time that debates about patient characteristics—for example, “smokers” or “alcoholics”—and how these behaviours and conditions might be used to sort out eligibility for health care were intensifying. As a result, certain types of medical specialties and technologies that could be delivered outside of hospital settings were increasingly popular in this hospital cost and health outcome data era. Disabled patients who might live long but not recover from their condition took on a new kind of negative status for hospital administrators who were looking for ways to improve their public image with respect to cost, institutional flexibility, and outcome statistics (Schulz & Johnson, 1990).

That hospitals were changing—even that they were being pressured to change—was not negative. Disability activist and scholar Wolfensberger described the prestige of hospitals and medical personnel as an essential factor in medicine’s unshakable image as the legitimate profession for deciding whose life is worthy or not. In fact, Wolfensberger saw the elevated stature of hospitals and medicine in society as a fundamental sign that social values regarding the sanctity of all human life had deteriorated. He called the outcome of this overvaluing of medical opinion for deciding whose lives mattered more than others the deathmaking of people with disabilities in North America (S. Thomas, 2017). That said, the deathmaking of people with
disabilities did not end at the overvaluing of medical judgment for important decisions about their existence; Wolfensberger also thought that dumping people from institutions into “independence” was yet another form of “indirect deathmaking” for people with disabilities; he viewed it as an activity that would ensure they remain on the bottom rung of society and ultimately live shorter than expected lives anyway (S. Thomas, 2017).

Even before hospitals were the prestigious institutions they became in the 1960s, in North America, medical professionals played a dominant role in deciding whose lives mattered more than others. During the early days of the North American industrial revolution, medical professionals were called upon to determine people’s capability to work or not, and this has been a distinct factor in influencing who is considered fit for society and who is not.

The industrial revolution was organized on the foundation of growing and developing suitable workforces for doing the semiskilled labour involved in producing goods in mostly large-scale factories across Canada and North America (Canadian Museum of History, n.d.). Those who were not contributing to the industrial revolution because they did not work were shamed as the reason for pauperism in the late 1800s and early 1900s. Pauperism was the type of extreme poverty that, depending on specific circumstances, was either deemed worthy of charitable help or not. Medical professionals were given the task of sorting out who might be the “feebleminded” draining society and mixing with good Canadian stock (Rubinoff, 2017); they were tasked with determining which folks were strong enough to work but, by not working, were draining the strength of social and economic progress, and which folks were indeed feebleminded. All levels of government—federal, provincial, municipal, as well as school boards—each had their own initiatives and committees whose purposes were to determine who
in society was “deficient”, “dull”, or “backwards” (p. 113) and therefore holding Canada back (Carrington-Decker, 2018).

Medical professionals, across North America, were hired and celebrated for the perceived fairness of their medical approach for sorting out the people who, at a minimum, were capable of working. Medical assessment was viewed as an objective way to identify those who were deserving of supports and services and those who were fit enough but chose not to work and were therefore undeserving. This perceived fair way of assessing potential workers was considered a triumph of the medical model of clinical health assessment (Abel, 1997).

Clinical health assessments for sorting students were documented by Toronto public schools in the early 1900s and established which children might eventually be suitably trained to be part of the Ontario workforce. Because there was always need for people who would do the rough work that the intelligent workers would reject, sorting which children would be streamed toward institutions or “custodial farm colonies just for mental defectives” was done in the interest of capitalism (Ellis, 2017, p. 490). From a social welfare perspective, based on the British model of charity, the deserving poor could legitimately receive charitable resources and aid, even if they were only temporarily impaired and not able to work for a short while, because to be the recipient of charity or social welfare, the judgment “deserving” was based on a single criterion: a willingness to work, and more specifically, a willingness to do as much work as one’s condition would allow (Abel, 1997).

The medical model was triumphant as a way to establish workers’ fitness because of its fairness. Medical assessment of disease and infection was believed to be useful for verifying legitimate impairment (Linker & Abel, 2015). When a person was verified to be legitimately medically impaired, this verification had the added benefit of circumventing biased patient self-
reports and avoiding cumbersome patient stories detailing their feelings about their own health. Medical assessment of fitness for work had the added bonus of being extremely valuable for identifying individuals who were feigning disability to get out of working (Abel, 1997). At this time, disability and discourses of fitness for work or “legitimate” dependency were intertwined with the image of a productive citizen that thrives in a progressive economy. In Canada, because social progress depended on a suitable workforce that was capable and willing to work, the “ideal citizen” was one who could be independent, employed, and therefore contributing to these social and financial economies (Linker & Abel, 2015). In this situation, except for a few nasty jobs in the workplace that no one else would want, disability—while a legitimate excuse for not working—was a sign of the not ideal citizen. And yet, the decisiveness of the medical model for determining whether someone was fit for work was, despite its sinister attributes of being cutting and deterministic, an unusually transparent, predictable, and consistent way of determining legitimate deservingness of social welfare.

**Some children deserve supports in ECEC**

It was recommended in 1988 that those who deserved inclusion in licensed child care were any “child or family” who “at any given point in time” experienced barriers to normal development and functioning and who had increased vulnerability to environmental and nonenvironmental stresses (Ontario Ministry of Community and Social Services, p. 85). This recommendation gives the impression that licensed child care was becoming more flexible regarding who most deserved inclusion supports in ECEC in Ontario, but it undercut the potential for better ECEC programming and policy for people with disabilities. It reinforced the belief that they were not the intended participants in such programs anyway.
To demonstrate this point, consider that long-term care (i.e., the planning for living and care environments) in 1994 for children who were extremely medically fragile was left out (p. 11) of the discussion and planning that were occurring with the hospital restructuring initiatives (Children's Treatment Centre, 1994). The overall shift of institutional responsibility for children from a medical infrastructure to a social infrastructure was, indeed, addressing a major problem of medicalization of disability, but it was moving children away from an organized system into one with limited transparency, no predictable services, and very little consistency.

Children with complex disabilities were not being planned for with the Group K hospital closures, and this, by comparison, makes the argument that ECEC was not ready for children with disabilities seem like a minor problem. Extreme medical conditions that make children particularly fragile and likely to need high levels of care and treatment, however, are connected in health and ECEC. Unlike care for people with acute health conditions, long-term care considerations for people with complex and lifelong impairments are understood as being both social and medical (Linker & Abel, 2015); therefore, delivery of supports and services for individuals in long-term care environments require complex policies and program delivery arrangements across institutions and involving various human service and care systems. In 1994, the closure of Group K hospitals and the accompanying changes to the place of programming for disabled children included children who were extremely vulnerable. These children were not likely to ever attend child care and might not have lived with their families 100% of the time, but also deserved thoughtful planning for their future care. Overall, for all children who would be impacted by the changes, regardless of the complexity of the social and medical care needs they might have had, a message being presented by the government of Ontario that this change to the
Group K hospitals and the subsequent fallout with other institutions and programs was not all that complicated.

What the change was, however, was an intentional drop of disabled children from systematized, universal care. By changing the institutional setting for disabled children from the medical system to the ECEC social system, the consequences were many. But the move of disability from a medical institution to a social institution seemed to make any negligence in planning and preparedness more palatable. The medical system was the “wrong” place for children with disabilities, but it was in many ways a better alternative to the ECEC programs that had limited capacity to receive them in the first place.

For ECEC, short-term special needs are preferable to chronic dependency

Eligibility for inclusion was changed to a “child or family” who “at any given point in time” experienced barriers to normal development and functioning. This shifted ECEC away from children with disabilities who might be “chronically” dependent. Chronic dependency has no place in the progressive model of ECEC that was, in the view of the Ontario government in 1994, a tool for social and economic livelihood in Ontario. In this way, ECEC reflected a discourse of disability that grew out of the “work therapy” approach to disability at the turn of the 20th century (Linker & Abel, 2015), which positions interventions and rehabilitation as methods for moving individuals (and families) from dependency to independence.

Because ECEC is primarily a tool for social and economic development, special needs that can be experienced “at any point in time” by children and families is a preferred way to consider children: as advancing phenomena within this dynamic context. This view leaves open possibilities that permanent disability would otherwise close, because in this context of social and economic development, special needs that are not permanent is a hopeful movement away
from the kind of condition—disability—that is “devastatingly negative” (Titchkosky, 2015, p. 9).

Permanent impairment represents lack of hope in a dynamic and progressive context like ECEC. So, while children in medical institutions were not likely to have been pressed into proving their deservedness for care—or for an environment that was designed for them in mind—children in ECEC would need to be assessed for their special needs resourcing supports—do they still need it?—often. Instead of being seen as a negative oversurveillance, more frequent assessment of children in child care programs could also result in a perpetually renewing formula regarding the virtues that matter in this dynamic environment, leading to the child’s optimistic “potential” to prove some degree of biological competence along the way and thus presenting, in the very least, a hope for future competence (Whitburn, 2017).

Distinguishing who is eligible for supports produces a web of surveillance that requires documents and documentation of individuals and their pathologies (Allan, 2007). Even in ECEC, it is still very much “medicine” that determines the “legitimate” distribution of public resources in child care programs for people with disabilities (Ho, 2011). The naming of conditions and diagnoses is deeply trusted when the assessment is made by a medical specialist (Ho, 2011). This is not necessarily negative because, by keeping assessment a medical domain, it is also possible that destructive evaluative commentary regarding children’s physical characteristics and behaviours can be minimized. However, by keeping the assessments for inclusion supports medical in ECEC, while the context that the children are included into is a social institution, creates an out for ECEC to develop its own systems regarding disability. In other words, this dissonance between medical and social, while maintaining both the medical and the social elements, makes it possible for the children who will not thrive or “get better” to be depicted in ECEC as a misfit for the context. For example, if such children have isolable phenomena
(Linton, 1998) of a medical nature that ECEC is unable to manage or change, then it proves that children’s disability—especially chronic disability—makes them just not suitable for inclusion in ECEC.

**Therapy discourses and ECEC in 1994**

In the Group K hospitals, therapy was a key element of the activities and physical design features of the children’s settings. Children attending these programs had a wide range of mobility challenges and conditions that could also have made them medically fragile. Disability in these children’s treatment centres was an obvious and identifiable element of the physical composition of the place itself and of the children’s programming. The staff working with children in these centres also had defined responsibilities for their work involving the children. Direct therapy with individual children in these settings was a key part of the programming in Group K hospitals (Children's Treatment Centre, 1994).

The following text provided evidence, in Chapter 3, for *disability is something bodies have*; now, in this chapter, it is used to show that the Group K hospital staff had their doubts about child care, because therapy was, for them, such a necessary part of the disabled child’s life:

> If the children went into regular child care programs, what would happen to the therapies? What if the settings were basements, church halls and other “found spaces” characteristic of day care? Was that really the best use of therapeutic time? And, if not, who was going to take the child to therapy? And if that were worked out, who would “integrate” the therapy in the regular day? (S. H. Irwin, 1995, p. 81)

Children’s treatment centre staff were concerned about the therapies children might miss in child care but also the more frequent transitions and overall programming chaos that children would experience by participating in a regular child care program. In their view, ECEC was not
at all prepared for the complications and intense needs of disabled children, most certainly not in
the same way they were prepared to support disabled children. They pointed out that there would
be a great deal of moving around of the child throughout the day; their concern about “a sliced-
up day” in which children might be moved from the child care centre to therapy and back all in
one day was prominent (S. H. Irwin, 1995, p. 81).

The discourses apparent in this text can also be understood as deeply related to the
medical modelling of disability. The children’s treatment centre staff ask the question What
would happen to the therapies? and this contains an assumption that, for the disabled child, their
primary need in life is access to therapeutic services above all else. In other words, to the
children’s treatment centre staff, access to therapeutic services was already a reasonable reason
for separating disabled children from other children (or from participation in “regular” child
care) for several hours multiple times a week. This idea that therapy is a number one,
nonnegotiable activity for children with disabilities (i.e., they always require support) represents
a discourse that has long associated bodily impairment with neediness—the need for therapy for
disability is a discourse that is firmly nested in a medical model of disability (Barnes, 2012).
That may help to explain why the children’s treatment staff were so concerned about children
attending regular child care centres. However, there was something else in their concern: Their
worries about therapy extended into concerns about where the therapies would take place in child
care. They associated therapy with a kind of place that was designed for therapeutic activity, and
they worried that this was not understood by the ECEC programs. Their worries were about the 
found spaces in the centres (such as the hallway) and about who was going to take the children to
therapy that was delivered outside the program. Therapy required a special place.
If the children were at regular child care programs, presumably, they were not in the place where the therapies were. In this view, treatments and therapies for disabled people are not part of normal spaces and regular activities. This notion that therapies are special is a form of othering of disabled people that, according to Gibson et al. (2017), still takes place. Barbara Gibson et al. (2017) describe the firmly established discourse is that segregation is reasonable for people with disabilities because the activities during segregation are specialized. Such specialized segregation “undertheorizes the relationship between people, technologies and the socio-material places where they are immersed” (Gibson et al., 2017, p. 497). An outcome of such a view of therapy—the view that therapy is special because it involves special people, special technologies, and special places—is that disabled children spend much more time, more of their lives, in passive recreational activities (e.g., while waiting for therapy) and engage in far fewer social activities than their nondisabled counterparts. Indeed, over the course of a lifespan, for disabled children, youth, and adults, passive recreational activities can end up being the most dominant part of their lives (Gibson et al., 2017).

Therapy, dependency, and denial of choice for people with disabilities hold historical significance: They were built into the matrices of medical institutions by design, creating a tangible division between the patient and the expert (Ho, 2011). As Western medical systems evolved over the past century, so grew an impression that humans could control bodies, sickness, and death. Disability was increasingly viewed as an indication of something having gone wrong (Ferguson, 2002). In this framework of human control over bodies, disability could therefore be seen as the result of loss of control, or of poor judgement, or of poverty, or of parental depravity. This perspective reinforced the legitimacy of the professional, scientific, medical response to the disability a person experiences. This framing of disability as “something gone wrong” remains a
discourse in contemporary messages such as families need time to adjust to the bad news, families are not receptive to information about the possibility that their child is disabled, families need to grieve and adjust to disability, and, overall, having a child with disabilities is a “tragic” occurrence (Ferguson, 2002, p. 124).

Therapy discourses suggest healing, control over chaos, and hope (Linker & Abel, 2015; Titchkosky & Aubrecht, 2015). Viewing therapy as an essential response to disability is linked to the view that the worthy human is the person who is able and capable. Individuals who are not able or capable need to be adjusted, healed, controlled, and given hope. The sooner the problem is identified, the better. Early screening for disability is part of a therapy discourse because it is part of the promise that manipulation of the body (in whatever capacity) is associated with the production of bodies that are able. The ubiquity of infant screening, standard practice during pregnancy and for newborns in Ontario, is built on the premise that humans, even neonatally, are the “image of health” (Timmermans & Buchbinder, 2013). Early detection of circumstances that are something other than the image of health, gives the intervention the power of shaping bodies back into the image of health (Timmermans & Buchbinder, 2013).

In therapy discourses, mainly it is the medical profession that has the greatest capacity for shaping the healthy human, even pre-birth, and this discourse provides an image of the potential for transformation through biological malleability and plasticity. These potentialities contain semiotics of hope and better futures (Timmermans & Buchbinder, 2013). This is a discourse of disability that sees disability as an interference to health, and therefore to life. This discourse is blatantly obvious in stories of so-called merciful selection and termination of fetuses with genetic abnormalities “out of love”; it can be detected in discussions surrounding the 2021 amendments to Canada’s Medical Assistance In Dying law (Government of Canada, 2022c).
Historically this discourse was part of the North American and Canadian eugenics movements involving sterilization, abortion, infanticide, and assisted suicide of disabled people as a form of nationalism (Baynton, 2015). To view a focus on therapy and rehabilitation for young children in children’s treatment centres and in ECEC as an extension of the eugenics movement might seem like hyperbole, but, in 1994, the discourses of therapy and rehabilitation were built on the same premise as the eugenics movement: Disability is not health. Canada needs healthy citizens, and therefore citizenship in this society precludes disability.

Therapy—and rehabilitation—are the helping activities that are intended to change aspects of the person that need to be changed so that they can be citizens. Therapy discourses also build on the possibility that impairment and disability are not permanent. When disability is presented as a disease or ailment, a temporary condition to be treated or cured, then it can be altered. Therapy discourses present disability as an impossible characteristic of citizenship that can be changed by a heroic helper. This discourse maintains and reinforces the belief that restoration to an able body and mind can restore the person as a “quality human being” (Siebers, 2015, p. 224). It also serves the institutions that don’t want to change themselves because it removes any real motive for social change, or for fixing the discriminating, oppressing environments that produce disability in the first place (Siebers, 2015).

**Physical space and “who is in and who is out”**

In the children’s treatment centres, the environments were designed only for children with disabilities and their families. Despite marketing inclusion of children with special needs in child care as a way to enhance their dignity and independence (Ontario Ministry of Community and Social Services, 1988), it was a concern of children’s treatment staff that the child care settings where children’s therapy might take place were going to be basements, church halls, and
other “found spaces.” In Group K hospitals, to support children with physical, neurological, and orthopedic conditions, there were multidisciplinary teams on hand, and they had equipment for therapies and communication, seating, and recreation, plus they had physically accessible rooms, doors, floors, and pools (Children’s Treatment Centre, 1994). In 1994, data were limited on how physically accessible child care programs were. This lack of data has not changed; ratings or other systematically collected information on the physical accessibility of licensed child care programs is unobtainable information, now, in 2023. Data of this nature are not part of a systematized data collection strategy by the Ministry of Education or by CMSMs/DSSABs (the municipal early years system managers for the province of Ontario). In the 1990s, the word accessible was used in child care service planning and for advocacy purposes to refer to the cost of child care for families and the proportion of available child care programs for families to use; by 1994, accessibility was not used nearly as much for describing the physical accessibility of the spaces that child care programs were operating in with respect to disability. Hence, the children’s treatment centre staff were making a valid point: therapy was likely going to take place in found spaces in child care.

Access struggles for people with disabilities are often associated with physical space, and physical space contains the most glaring and obvious barriers. Physical space also has a way of establishing “who is in and who is out” (Titchkosky, 2008, p. 39). And yet, for ECEC in 1994 (and now), basements, church halls, and other found spaces are an important part of the funding formula for resourcing ECEC. About 14% of licensed child care programs in Toronto region were church affiliated in 2022. This does not prove that these programs are located in church basements, necessarily; however, this operational reality of using already funded buildings (i.e., intended for other activities, not children’s programs) for delivering children’s programs (as a
secondary focus) is an ongoing reality of the ECEC system in Ontario. Physical space costs for ECEC programs are considered part of capital expenditures, making them fixed. Beyond negotiations for rent or purchasing, physical space costs usually have little wiggle room for reductions. Retrofitting physical space for disability is most often considered an alteration or expense that penalizes the innocent, because the world as we know it has been viewed, designed, and built from a perspective that does not include disability (Hirschmann, 2016). And for ECEC in 1994, the physical spaces of child care programs were not ready for children with disabilities—nor were there plans in place to make these spaces more physically accessible.

As early as 1992, the Roeher Institute published the document Quality Child Care for All: A Guide to Integration in which the author, disability scholar Melanie Panitch, stated that the “real ingenuity” of practice in child care would be having therapists see children in child care centres (Panitch, 1992). This characteristic of therapeutic supports delivered in the child care setting in a way that is seamless and does not remove children from the space and the people who are meaningful to them is associated with good practice for disability and for ECEC. A principle of not removing a child from their people or space has been recommended and advocated for in one form or another, usually in terms of high-quality inclusive system design of programs, for decades in Canada (see Irwin & Lero, 2021; Irwin, Lero, & Brophy, 2000, 2004; Lero & Irwin, 2008; Pascal, 2009); however, now, at the local level, special needs resourcing agencies continue to be municipally funded to deliver these therapeutic supports to child care programs in each area and the models for special needs resourcing funding and service delivery vary across Ontario (Frankel, Chan, & Underwood, 2019).

Therapy remains an issue that can be seen to represent disability as pathology, which then drives the view of disabled people as always in need of care, the narrow and inflexible ideation
of disability and of therapy can create distortions regarding pedagogy and the role of hands-on specialists in learning environments that, with careful consideration given to the distortions, can lead to more universal design in education (Liasidou, 2014). Despite the opportunity that came with changes to the systems of Group K hospitals and ECEC, rather than consider therapy and its delivery in ECEC critically, and with ingenuity and care—as the Roeher Institute recommended—in 1994, Ontario started to move in another direction with a different set of intentions. In 1994, the new approach to both therapy and special needs supports was “toward a policy of family-centred” practices of early childhood education (Irwin, S. H., 1995, p. 82). This move, in Sharon Hope Irwin’s (1995) words “slowed, if not halted” inclusive child care and clearly signalled that ECEC in 1994 was decidedly not moving in a direction of “universal design” for place or learning (p. 82).

**ECEC is family centred, and how this moved disabled children out of the way**

“Family-centred practice” is an unclear, imprecise concept for ECEC and for inclusive child care, but for the most part, this rhetorical term has had lasting appeal. In 1994, the Association of Treatment Centres of Ontario had a vision of a client-focused model for service delivery, driven by client and family needs (Children’s Treatment Centre, 1994); however, as discussed in Chapter 4, the new definition of special needs for ECEC was also widened to include the whole family as the focus for special needs service delivery (Ontario Ministry of Community and Social Services, 1988). Sharon Hope Irwin’s concerns regarding this change were specific and were about the future of funding decisions focusing on children: Her first concern was there would be a watering down of funds for inclusion of children with disabilities in child care, and second, that any child care reform specifically for children with disabilities (i.e., that did not contextualize them in “the family”) that might come along would also have less
primacy in the event of significant policy development or any new dollars spent in child care in Ontario. Irwin’s fears were warranted, as these situations did occur, eventually, with expansion of child care spaces in the province, and, despite changes in provincial governments and child care funding ideology since 1994, the impact of the damaging undercurrent of a “family-centred” diffusion of focus away from disability (and disabled children) has had a deleterious impact on disability and ECEC for decades. The trouble is, “family centred” has an appealing banality to it that makes it sound virtuous, inclusive, and, to a certain extent, more considerate than “just” focusing on the child, but in 1994, it was also working to the advantage of the systems that would benefit from a need for the realities of disability for an individual to be disguised.

There is more harm in this than mere banality. “Family centred” also removes the right of disability from the person to a shifter entity: the family. In 2013, Dan Goodley and Katherine Runwick-Cole wrote about how the blurring of the networks and communities of resilience and disability has become so murky that disabled kids have little opportunity to celebrate and affirm their own status as a disabled person. These authors write that this is one of the more profoundly important costs of such a family-centred discourse. The personal rights of people with disabilities to choose, to have autonomy, to have the chance to work, to have the chance of love, and to consume (Goodley & Runwick-Cole, 2016), and also to work hard, to feel precious, to not be taken for granted (Gibson et al., 2017)—at any age—are not always achieved in families. Sentimental depictions of families of children with disabilities are often sustained without question. Indeed, a romantic notion of the burdensome infant and the caring mother⁷ is a ubiquitous discourse on its own, and here, in the context of family-centred services for disability,

⁷ Which did not pertain to motherhood in Hobbes’s day—the idea of children as burdens to be cared for by mothers in particular, “coheres with romantic visions of childhood and motherhood that developed in the eighteenth and nineteenth centuries” (Hirschmann, 2012b, p. 137).
it sustains *the burdensome disabled child* in the context of the caring family, which (even if it is true and the family *is* a caring family) sets up a condition of power and control related to disability and the child on the false pretense that “family” is a natural (i.e., thinking in Hobbesian terms, an entity in the state of nature) representative and an always accurate source of direct knowledge about the individual in question.

Thinking of families this way—as a natural representative (i.e., a spokesperson) for the disabled person—overworks the assumption that the family works exclusively on behalf of the individual. In other words, family centred gives the rights and freedoms of the individual to the family. The concern goes farther than who might give consent: *Family centred* manipulates our understanding of who gets to be considered to have equal standing with respect to disability (Terzi, 2015). For a system that is underprepared for the magnitude of the disabled *individual*, centring the family privileges the forces of that system that would prefer any possibility that new, bigger, future investments in child care not be consumed by disability.

By targeting the family as the entity with special needs, the children who are most costly, such as children with complex impairments that make it harder to include them in the program without new ramps, or additional staff, or smaller groups of children no longer merit consideration for inclusion in ECEC. When families are the entities that get equal standing regarding the right to be included in ECEC, then the disabled child can become secondary.

The American disability rights movement, which is deeply connected to the civil rights movement of the 1970s in which rights were considered an important strategy for addressing issues of social marginalization of groups of people, has placed parents and family members *within* the community of disability. However, as Allison Carey (2015) explains, this placement of families within the community of disability works to make it a legitimate “obligation to address
parents’ needs and interests” but it does not necessarily make it an obligation to “satisfy” parent needs and interests when focusing on an individual’s disability rights (p. 185). Thus, the relationships between families, the disabled individual, and whose rights ought to be considered first, at best, is “uneasy” (Carey, 2015, p. 185). Of utmost consideration here is the issue of paternalism and disability—and how, in many situations, people with disabilities are denied rights and freedoms (e.g., to live independently, to have their own children) by, and within, their own families (Carey, 2015).

There is a duality in a widened focus on family rather than on the individual that, on one hand, positions the family as more vulnerable because the disabled child’s presence creates new challenges for the family, putting them also in position of risk, and also provides families more paternalistic power over children and over decisions related to disability supports. Another outcome is that a focus on family obscures outside-of-family responsibility for disability and for children. Romanticizing the family and the family’s capacity for the care and education that disability might require is a form of invalidation, denying realities of care for disabled family members, but also shifting the feeling of disability and of inclusion—or exclusion—inauthentically, to the family.

Making families into the special needs unit simplifies disability, and when disability is simplified, then the work of disability is also simplified, making it somewhat inevitable that people will become exhausted (Allan, 2007). Goodley, Liddiard, and Runswick-Cole (2018) examined acts of discrimination toward disabled people, from hate crimes to invalidation to unintended stares, deeds, or words (e.g., you’re so brave; I never think of you as disabled), and related these acts of discrimination to how disabled people are also denied the highly appropriate right to respond to these discriminatory acts with anger and disgust, as yet another form of
“ontological invalidation” that people with disabilities experience (p. 207). Their research shows that there is a propensity to “sideline the emotional” in favour of focusing on structures and measurable external factors related to disability and the public sphere. In other words, the feelings of disability are not important—or useful for improving anything.

Denying individuals the right to have their own feelings about their disability while feeding the romantic idea that a family “hurts” as much as an individual not only creates an intensified focus on only the grim aspects of disability, it reinforces the notion that disability and any feelings a person might have of anger, pain, or sorrow are unworthy topics for discussion in public.

There is an important paradox here in a family-centred focus of ECEC. Simplifying the scope of practice (to families and not individuals, who are in theory and reality more varied than families) and oversimplifying the work of inclusion, the failures of the institution (the community) to provide adequate supports for children pushes the responsibilities back onto families (Carey, 2015). Thoughtful writers (e.g., Eva Kittay, Stacy Simplican, Allison Carey) have discussed this challenge—the complexity and ethics of deciphering family interest and families’ involvement in care for children with very complex disabilities. A real situation that has been used for this discussion is that of Ashley X, who, when she a six-year-old child in the early 2000s, was at the centre of a debate whereby her parents, arguing that it was a necessary procedure, were granted permission for her to have what would become “the Ashley Treatment”—surgeries and hormones that would ultimately stop her from growing (Kittay, 2011). The intention of keeping Ashley small was so that the family could continue to care for her in their home for the longest possible time. Kittay (2011) ultimately argued that this procedure, for a person who was referred to as a “pillow angel,” was a way of edging Ashley out
of the human community (p. 613). She pointed out that the complexity of this kind of ethical dilemma with respect to care and disability—and the choices that the family made to opt for life-changing procedures that interacted with Ashley’s humanity—came from a resigned acknowledgement that there will only ever be inadequate care and supports for children with disabilities such as Ashley’s outside of their family. In fact, Kittay recognized that the nature of the deeply discriminatory complexities of the decisions that were made by Ashley’s family—and the realities of the well-being of everyone around Ashley—made the argument against the Ashley Treatment unseemly too. Kittay has been accused of romanticizing care for individuals with complex disabilities because of the manner in which she depicted only loving experiences of care, thus obscuring the everyday struggles of carers and dependents (Simplican, 2015). Stacy Simplican (2015) reminds us that “people with disabilities and their families in abusive relationships will find little in care literature or disabilities studies that acknowledges their experience” (p. 219), which she attributes to an overfactoring of dependency as permanent vulnerability of the child within the care structure, a condition that she exposes as a false premise that creates dangerous, even deadly, situations for caregivers.

Simplican suggests that Joan Tronto’s model of care for people with disabilities needs to also account for and respond to conflict and complexity, and she advocates for continued questioning of the discourses that silence the multiple ways of thinking about disability and that perpetuate tropes of “the angelic child, the loving mother” (p. 230), which fail to make marginalized lives more intelligible (p. 231).

Focus of care, place of care, expertise, and therapy are intertwined concepts that can all be found situated in the medicalization of disability. The children’s treatment centre staff made a valid point that the place where they worked and the elements of the environment they were part
of (i.e., the “hospital”) was a better one for disability because the space was designed especially for children with disability. (Preschool programs in children’s treatment centres, for the record, were not bed-lined hospitals; they had toys, carpets, little tables and chairs and essentially looked like other children’s program spaces in 1994.) The staff and their professional expertise were also connected to the space where they worked, and because their work was therapy, therapy in an appropriate space was viewed by them as important for children with disabilities.

**Disability is just a side hustle, so it is called inclusion from 1994 on**

In 1994, the ECEC focus on inclusion implied that the work of the early childhood educator was going to be something quite different than the work of the staff of Group K hospitals. By 1994, the Roeher Institute had published several academic and practice documents about child care and how practices for inclusion could support children with disability, and these could have been useful for planning for ECEC as the Group K hospitals closed. Also, SpeciaLink, the national centre for early childhood inclusion, had been founded by Sharon Hope Irwin back in 1990, and by 1994 it had expanded to include an email listserv and a 1-800 number for access to its resources and supports for child care programs and families across Canada (SpeciaLink, 2022).

The one child care document in Ontario produced in 1994, *Caring for Play* by Noel Young, did not refer to the work of either the Roeher Institute or SpeciaLink but included the commentary that the existing policy frameworks for child care were inadequate for meeting the needs of children with special needs.

Also, despite the fact that *Caring for Play* was a Coalition for Better Child Care guide for schools and school principals, there was no mention of the current affairs of special needs resourcing at all, no mention of closures of Group K hospitals, nor references to any of the
available disability (or special needs) and inclusion planning documents or community living
planning strategies that existed at that time. These are the two texts from the entire document that
comment on children’s special needs:

The policy framework currently in place in Ontario was never designed to accommodate the range of needs now being placed on it. (Young, 1994, p. 12)

Programs serving children with special needs frequently require extra staffing. Different communities provide such staffing in different ways. The local office of the Ministry of Community and Social Services can provide information and advice. Wherever possible, efforts should be made to hire one individual to work with the child in both school and child care. (Young, 1994, p. 57)

It is a pervasive narrative that ECEC is an industry that attracts hard-working and resourceful educators who will do hard work for low compensation (Halfon & Langford, 2015), so it makes some sense that the educators’ view of work involving children with disabilities was viewed positively.

At this time—throughout the 1990s—the research that was focusing in on “integrated child care” in North America, Canada, and Ontario tended to look at the attitudes and beliefs of early childhood educators toward the inclusion of children with disabilities and special needs. In 1999, I completed a MSc thesis: Knowledge, Attitudes, and Experiences of Resource Teachers and Resource Consultants in Inclusive Child Care Centres in Ontario. My graduate work was supported by my thesis advisors, Donna Lero and Kathleen Brophy at the University of Guelph, and was helped by the input of Sharon Hope Irwin. They were, at the time, investigating inclusive child care across Canada for the publication A Matter of Urgency: Including Children with Special Needs in Child Care in Canada (2000), and I had the privilege of working as a research assistant for this project. It was a consistent finding among such studies that practical
experience with children with special needs reinforced educators’ positive attitudes toward inclusive child care and strengthened educators’ belief in their competence working with children with special needs (Brophy, Hancock, & Otoo, 1993; Denholm, 1990; Peck et al., 1993). While this was by no means the intention of researchers, this approach of studying educator attitudes, beliefs, and competencies—and using “positive” as the indication of success—can flatten the experiences of disability and ECEC into bland banalities that deny some of the undeniable struggles and hardships of disability (Burch & Joyner, 2015). Early childhood educators are do-gooders and the systems of ECEC maintain an image of “the good ECE” (Langford, 2008, p. 96), therefore educators would likely do the work that the province never intended to.

As a result of the good ECE image, in 1994, ECEC was further implicated in a situation which, for disability, was not a new phenomenon. The message was that, as long as ECEC tried its best, ECEC would be good enough. For the educators, the message was that as long as they (the ECEs) tried their best, their work would be better than nothing. This disability discourse states that for disability something is better than nothing (Titchkosky, 2008). The lack of common authority for ECEC made inclusion of children with disability a failed project from the outset. ECEC was both promised and trusted to be able to serve and welcome children with disabilities effectively enough into child care programs in 1994. Because on the surface there was no clear objective for this activity of inclusion—nor was there even a functional definition of a child with disabilities—there was, hypothetically speaking (I say “hypothetically” because evidence and good sense suggest that children’s treatment centres had a very good idea of who and how many children with disabilities were in their programs), no way, from the province of Ontario’s perspective, to formally establish what funding or operational resources might be needed to support disabled children included in child care centres.
The closures of the Group K hospitals, the lack of planning on the one hand, and the exploitation of the lack of planning on the other meant that children’s treatment centres and ECEC were all off the hook. Disability was made into a side hustle in 1994. ECEC has continued to work on the fumes of “something is better than nothing” for almost 30 years now.

Educators have never been required to know about childhood disability in their preservice training (their learning is inclusion focused, but very integrated in a special needs framework), nor are educators asked to consider disability in a specific, intentional way, because the promise to ECEC was that there would be no need for this kind of intentional effort. The province of Ontario was even aware that the skills and capacities of educators might not be suitable for children with disabilities (Ontario Ministry of Community and Social Services, 1988, 1992b).

Still, educators in ECEC were the intended instrument for inclusion to work. As Sharon Hope Irwin pointed out in 1994, there were already child care programs that “wanted” to invite children with disabilities into the program, but they were also already failing at this because their basic resources were inadequate:

> Canadian child care programs that want to include children with disabilities are often plagued with practical barriers such as low salaries, high staff turn over, minimal training, inadequate space and high child-to-staff ratios. (S. H. Irwin, 1995, p. 78).

In 1994, legislation at the federal and provincial levels did not exist to support this work that added to the educators’ existing work. Instead, if they “wanted to,” educators could include children with disabilities while also struggling with inadequate salaries, with high staff turnover, minimal training, inadequate space, and high ratios. The educators could do something that was better than nothing by including children with disabilities in their programs—but, as there was nothing mandatory saying they must, the choice was theirs.
The low salaries, high staff turnover, minimal training, and inadequate space that were already part of educator experiences in ECEC, combined with the arbitrary nature of the planning for children with disabilities who would be coming into ECEC, are evidence that the ECEC system had no common authority. ECEC is a long-suffering martyr and a collaborator in this situation. The virtuous nature of ECEC and the educators is an out for policy, because educators will do the work of inclusion regardless. It will just remain inadequate.

**Conclusion and chapter summary**

In this chapter, I discussed how, without a common authority—which means without a suitable and strong governing infrastructure for ECEC—inclusive practice in child care was so ambiguous it could serve neither children nor educators well. The province of Ontario and the workings of present and absent policy, combined with the closures of the Group K hospitals for children with disabilities, all reinforced that children with disabilities never were the intended participants in ECEC, and, as a result, educators were left to do the side hustle work of inclusion on their own. For the educators, this meant that they were left with a great deal of unanticipated and sometimes even invisible work, leading them to wonder “Who are the handlers for these children?” To understand inclusion in the years following 1994, researchers (myself included) asked educators and other support workers in ECEC about their attitudes and responses to inclusion and children with disabilities, but this too “perpetuated a conception” of disability as removed as far as possible from social life (Titchkosky, 2001, p. 237). Ultimately, through inclusion in child care, children with disabilities were pushed into submission.

In this chapter I also went deeper into feminist social contract theory to support my discussion. Hobbes’s positioning as an “ambiguous feminist idol” (Hirschmann, 2012b, p. 126) provided me with an analytical tool in my interpretation of what happened in ECEC in 1994 that
allowed me to expose how children were left out of the social contract because of discourses involving fitness, family-centred approaches, found space, expertise, and therapy. The closures of the Group K hospitals, the lack of planning on the one hand and the exploitation of the lack of planning on the other meant that children’s treatment centres and ECEC were off the hook. The province of Ontario might very well have determined that there would be no need for any intentional effort, because our social worlds are constructed by human choice, and in 1994 children with disabilities were not intended to be part of ECEC.
Chapter 6: Conclusion

In this chapter I return to the research questions that guided this dissertation, by returning to the arguments I presented in Chapter 1. I will show how the findings I presented in Chapters 3, 4, and 5 are the evidence to support my arguments and therefore effectively respond to the research questions. Finally, I will discuss how the study and my analysis and findings contribute to ECEC, to disability literature, and to feminist social contract literature now.

I began this study with a problem in early childhood education and care: children experiencing disability are denied regular rights and citizenship as they are promised to be included in child care programs, but child care programs were not created with them in mind. Through this historical critical analysis, I provided the evidence that inclusive child care denies children regular rights and citizenship by producing disability. The distinction between ECEC and education in Ontario (and Canada) is an important one, because all people are welcome participants in education because of its universal framework. In this study I provided the evidence that for ECEC, this is not the case: “All people” are not welcome in ECEC. Misinterpreting ECEC as education effectively extends assumptions related to the business of education into ECEC, which then diminishes the rights and freedoms of children experiencing disability. In this study, I demonstrated how the discourses of disability and inclusion in ECEC proved that ECEC invites children with disabilities to participate in child care, but on ECEC’s terms. For ECEC, disabled children are encouraged, welcomed, to come to child care programs. They have access to child care programs, but these invitations are provisional offers; they are not rights based. Instead of full access to or a right to child care, access to involves a generosity granted by ECEC. Instead of the potential of “no wrong door” that Charles Pascal proposed to the premier of Ontario in 2009, for children with disabilities, there are wrong doors. In this study
I examined how inclusive child care, as it was proposed in the late 1980s in Ontario, produced the disabled subject in 1994—a time when the possibilities were there for a better child care system in Ontario. As Flyvberg and Gardner (2023) have stated, “People often say projects ‘go wrong.’ They don’t go wrong so much as they start wrong” (para. 9). In 1994, the start was wrong for inclusion in child care, and now we have an ECEC system in Ontario that continues to produce the disabled child who is not part of the child care system.

**Responding to the research questions**

This study asked the following research questions:

1. How was children’s disability responded to in early childhood education and care in Ontario at a time of transition in social policy and administration in disabled children’s programs in 1994?

2. What might Thomas Hobbes’s social contract theory contribute to a study of ECEC inclusion to understand how disability was produced in ECEC 1994?

3. How did early childhood education, disability, and inclusion discourses in 1994 produce situations of exclusion, separation, and disappearance for children with disabilities in inclusive ECEC?

4. How was ECEC set up to fail children with disabilities by the government of Ontario by its poor planning and child care system design?

In this dissertation, in response to the first research question, *How was disability treated in ECEC in Ontario at a time of transition in social policy and administration in 1994?*, I interrogated several discourses of inclusive child care (inclusion), disability, and special needs in Ontario in 1994. In Chapter 3, I explored the impact of the discourse of disability as a naturally occurring phenomenon and how this, in the context of ECEC in 1994, created situations in which
children with disabilities were more easily denied access to ECEC programs because of a perception that exclusion of children with disabilities in certain kinds of circumstances in child care (e.g., the presence of stairs, or lack of adequate staff, or inadequate space) was not only justified but made “good sense” because the child’s body created too many challenges. I demonstrated how, within the discourse that bodies have disability, ECEC programs could “other,” or create a misfit of, or choose to include on some occasions, or choose to exclude children sometimes, or always, based on “the kinds of bodies” that were preferred or not for ECEC. I argued that in ECEC, the “invisible rubric of normality” (Hirschmann, 2015, p. 218) meant that supports for children with disabilities were viewed as extra and, therefore, children with disabilities were perceived as troublesome bodies and not the “right kinds” of bodies for ECEC. I argued that the discourse of disability as something bodies have served both ECEC and the government of Ontario’s closures of the Group K hospitals, because the disabled child could be considered “the problem” and not the poor planning of the closures or the underprepared ECEC programs who were not including all children with disabilities.

In Chapter 4, I studied the discourses of ECEC and disability, including children are children first, children with special needs, and vulnerable children to demonstrate how, in 1994, ECEC was so underprepared for children with disabilities, and was beginning to focus on a new kind of child—the child with special needs and the vulnerable child—that it resorted to a familiar discourse of ECEC that all children can fit in, which helped to disappear disability from ECEC. In this chapter, I showed how the idea of equality used by ECEC worked to blur children with disabilities into the background, and with the introduction of a new, broader category of children who would be supported in inclusive child care programs—special needs, proposed by the policy makers at the time—the more inclusive and intentionally ambiguous term was able to serve both
the underprepared and underfunded ECEC programs and the government of Ontario, but pushed children with disabilities farther into the margins in child care programs. In 1994, another situation was emerging in ECEC, whereby researchers had identified the long-term impact of social and economic deprivation in early childhood to problems in adulthood, and ECEC was being presented as an early intervention strategy to reduce the impacts of such deprivation before harm is done. Children at risk of social and economic deprivation were called vulnerable, and the resulting advocacy associating early childhood development and ECEC as an intervention created a new and more powerful intersection of health, ECEC, and social welfare that served ECEC as municipal tool for economic and social development. This, like the other discourse of ECEC that suggests that children are children first, created a more inclusive ECEC, but because there was limited interest in or development of resources that would make the full participation of children with disabilities possible, this strategy was an evasion tactic (Allan, 2007) that ultimately required children with disabilities to just fit in—or be misfits, not to be seen or recognized as having a rightful place in ECEC.

In Chapter 5, while responding to the first research question, I also responded more specifically to the second research question, What might feminist interpretations of Thomas Hobbes contribute to early childhood education disability? In this chapter, I developed my argument that in 1994, without a common authority—without a suitable and strong governing infrastructure—ECEC could not serve children with disabilities well. I discussed how the province of Ontario and the workings of present and absent policy, combined with the closures of the Group K hospitals for children with disabilities, all pushed children with disabilities into the side hustle of doing the work of inclusion on their own. In this chapter, I demonstrated how the province of Ontario was closing Group K hospitals based on another agenda, but made good
use of the ambiguous nature of ECEC, due to its lack of a common authority, and made good use of the compelling and persuasive images of ending medicalization of disability through inclusion to convince the people who would be most influenced by the changes (children with disability, families, early childhood educators) that the hospital closures and shift of children to ECEC was a virtuous activity. The impression was that there was clear consent for these changes when, in reality, effective inclusion of children with disabilities in ECEC was set to fail. There was not a plan for ECEC, and despite the false narrative that with closures to Group K hospitals, disability would no longer be medicalized, in ECEC medical discourses of disability were distorted and perpetuated. Additionally, the closures of Group K hospitals represented a shift of institutional responsibility for children from a medical infrastructure to a social infrastructure, which meant that children with disabilities were dropped from an organized system into one with limited transparency, no predictable services, and very little consistency.

Throughout this study of what happened in 1994 and in discussing the findings of this discourse analysis of disability in ECEC, there has been an essential understanding: that in the state of nature, humans are equal, and subordination occurs in civil society. This premise of feminist Hobbesian social contract theory shares common ground with the social model of disability, which holds that disability is not a physical or naturally occurring condition of the body; rather, “disability is constituted in the interaction between environmental factors and the particularities of specific bodies” (Hirschmann & Linker, 2015b, p. 4). In this study of disability in ECEC in 1994, I have used Hirschmann’s argument that the conventions of ECEC were influenced by disability discourses about who is not worthy—or, more explicitly, not human enough (Russell, 1998)—to be an equal part of ECEC. I also made use of Joanne Wright’s (2002, 2012) argument that, in some circumstances, inequality, in Hobbes’s theory of the social
contract, is gained by duress while having the appearance of being gained through full consent. I demonstrated that, for ECEC in 1994, the Ontario child care system was in no position to fully consent to what was to come with the province’s planned closures of the Group K hospitals, nor were the educators. For Thomas Hobbes, the social contract is both binding and self-enforcing, and while the bounds of the social order in Hobbes’s social contract should be understood as essentially unstable (Ivison, 1999), the welfare of the people is why social contracts are agreed to in the first place. In 1994, the conditions of policy, planning, and available information had the potential to move ECEC into a better system for children with disabilities; however, the path that was taken instead—to not develop good policies and good plans for disability in ECEC—meant that, in 1994, the conditions whereby children with disabilities were subordinate, less than, and not fully human were locked into ECEC.

Implications of this study for ECEC now

Now, in 2023, ambitious planning activities are taking place across Canada for the implementation of the Canada Wide Early Learning and Child Care (CWELCC) system (Government of Canada, 2022a). Currently, the majority of the questions discussed are about “who is in” and “who is out” (Titchkosky, 2008, p. 39) for which kinds of programs that could receive funding to deliver child care across Canada and not about children with disabilities (Parliament of Canada, House of Commons, 2023). The word “inclusion” is used, but not specifically regarding children with disabilities. The CWELCC is the biggest policy event in Canada’s ECEC history. Thomas Hobbes in 1651 wrote that for individuals to survive, to live in peace, and for their ongoing self-preservation (Hobbes, 1651/1996), they engage in a contract to be part of something together with other people. In the situation of nation-wide child care, the contract that will eventually be the system of ECEC for children and families is being established
(in its various iterations over the next few years) by the sovereign in this situation: the
government of Canada. As I have discussed throughout this dissertation by showing what
happened in 1994 in Ontario for children with disabilities and for ECEC, the decisions made by
the sovereign—at any point in policy—have implications for children with disabilities and,
obviously, for the ECEC system. Policy has implications when it is specific, but as I have shown
here, it also has implications when it is vague. I have provided evidence that in 1994 the unequal
disabled child was produced by discourses of ECEC, disability, and inclusion that reinforced that
ECEC is for nondisabled bodies, that children with disabilities could be made to disappear in and
from ECEC—and in some situations what disappeared the child was promoted as the best thing
for the disabled child, the other children, and ECEC; I also provided evidence that children with
disabilities, as a side hustle for educators, demonstrated the virtue of the educator. In 1994, the
actions (and inactions) of government forces to plan and prepare for an impactful shift in the care
and education of children, combined with a lack of a common authority for ECEC, strengthened
existing discourses that resulted in detrimental conditions for children and families experiencing
disability in ECEC.

Now, as the policy and funding foundation for ECEC in Ontario is being reworked by the
more powerful policy forces of a Canada Wide Early Learning and Child Care system, the
window of opportunity to change the discourses that created the disabled subject in ECEC in
1994 is closing. A clear statement about disabled children as an assumed focus for CWELCC,
including their full participation in all aspects of this nation-wide ECEC system, could shift the
rhetoric of inclusion that has been so limiting to ECEC in Ontario since 1994.

This study has attempted to show how much policy matters, and how the practice guides
and advocacy documents of ECEC matter too. Policy, practice guides, and advocacy documents
are all texts of ECEC that contain the discourses of ECEC. In this study I showed how, in 1994, the knowledge produced in the “upper reaches” of ECEC became embedded in the “lower reaches” (Fairclough, 2013, p. 11) of Ontario child care programs. The discourses that existed and were perpetuated in ECEC in 1994 were able to limit the system of child care until now, and even with the enormous potential of a nation-wide system, because the discourses I have discussed in this dissertation have not changed, they will potentially inform a larger and more impactful ECEC system that could be just as underdeveloped and lacking in possibilities as the ECEC system has been for children with disabilities in Ontario since 1994.
References


https://doi.org/10.1016/s0140-6736(16)31390-3


https://www.historymuseum.ca/cmc/exhibitions/hist/labour/labh15e.html


https://childdevelop.ca/programs/early-intervention-services

Children’s Treatment Centre. (1994). *Strategic plan* [Confidential draft for discussion]. District Children’s Treatment Centre.


Cleveland, G. (2022). *Early learning and child care in Canada: Where have we come from, where are we going?* Institute for Research on Public Policy.


Sched.1. https://www.ontario.ca/laws/statute/14c11


https://www.ontario.ca/page/questions-ask-child-care-provider


https://www.ontario.ca/page/provide-child-care-and-early-years-programs


doi:10.1017/S004727410000280


http://89.28.209.149/fileLibrary/pdf/briefingpaper_Moss_Bennett.pdf


Office of the Provincial Advocate for Children and Youth. (2016). *We have something to say: Young people and their families speak out about special needs and change*. Author.


https://www.ourcommons.ca/Committees/en/HUMA/StudyActivity?studyActivityId=12022948


https://www.oise.utoronto.ca/atkinson/UserFiles/File/Resources_Topics/With_Our_Best_Future_In_Mind_-_Charles_Pascal.pdf


https://doi.org/10.1186/s13229-018-0201-0

https://doi.org/10.1371/journal.pone.0167660


https://ir.lib.uwo.ca/etd/2386/


https://yorkspace.library.yorku.ca/xmlui/handle/10315/33583


doi:http://dx.doi.org/10.15353/cjds.v1i1.21


# Laura Elizabeth Coulman

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<th>Personal Information</th>
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<tr>
<td>Laura Elizabeth Coulman</td>
</tr>
<tr>
<td>Full time Faculty, Bachelor of Early Learning Program Development</td>
</tr>
<tr>
<td>School of Community Services, Conestoga College</td>
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<tr>
<td>PhD</td>
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<tr>
<td><strong>Western University, Faculty of Education, Curriculum, 2023</strong></td>
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<tr>
<td>Dissertation—<em>Disabling Consent, Discourses of Disability and Inclusion in Ontario’s Early Childhood Education and Care in 1994</em> (with the supervision of Dr. Veronica Pacini-Ketchabaw)</td>
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<tr>
<td>PhD Candidacy achieved</td>
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<tr>
<td>Master of Science, Child Studies</td>
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<td><strong>University of Guelph, Family Relations and Applied Nutrition, 1999:</strong></td>
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<tr>
<td>Bachelor of Arts</td>
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<tr>
<td>Ryerson University, Early Childhood Education, 1992</td>
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<td>Bachelor of Arts Philosophy, 1988</td>
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<td>Human Growth and Development: The Early Years</td>
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<td>Health and Wellness in Early Learning Community Programs</td>
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<td>History and Philosophy in Learning and Education</td>
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<td>Population and Developmental Health</td>
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<td>Field Placement IV (BA Early Learning Program Development)</td>
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<tr>
<td>Human Growth and Development: The Later Years</td>
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<tr>
<td>Development, School of Community Services</td>
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<td>Child, Family and Society</td>
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<td>Mentoring and Leading Community Programs</td>
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<td>Administration of Programs for Children and Youth</td>
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<td>Curriculum Issues for Child Care Administrators</td>
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**Professional Designation**
- Registered Early Childhood Educator: Ontario College of Early Childhood Educators, 2009 to present

**Professional Experience (Industry)**

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<th>Job Title</th>
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<th>From Date</th>
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<tr>
<td>Sessional Professor</td>
<td>Conestoga College, Early Learning Program Development and Early Childhood Education</td>
<td>September 2019</td>
<td>April 2020</td>
</tr>
<tr>
<td>Policy and Research Analyst</td>
<td>County of Wellington Child Care Services</td>
<td>September 2005</td>
<td>May 2018</td>
</tr>
<tr>
<td>Sessional Professor</td>
<td>University of Guelph, Child Studies</td>
<td>January 2005</td>
<td>April 2005</td>
</tr>
<tr>
<td>Sessional Professor</td>
<td>University of Guelph, Open Learning</td>
<td>September 1997</td>
<td>April 1998</td>
</tr>
<tr>
<td>Graduate Teaching Assistant</td>
<td>University of Guelph, Child Studies</td>
<td>September 1995</td>
<td>December 1995</td>
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<tr>
<td>Committee Title</td>
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<td>From Date</td>
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<tr>
<td>AECEO eceLINK Peer Reviewed</td>
<td>Assistant Editor</td>
<td>Publishes peer reviewed scholarly papers related to early learning and child care in Canada</td>
<td>Fall 2021</td>
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<td>AECEO eceLINK Peer Reviewed</td>
<td>Publication Co-Chair</td>
<td>Publishes peer reviewed scholarly papers related to early learning and child care in Canada</td>
<td>January 2017</td>
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**Section 3: Scholarly Activities**

**Scholarship of Service**

*Committee Activities (in community)*

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<td>Date of Renewal</td>
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<tr>
<td>Association of Early Childhood Educators, Ontario – member</td>
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<tr>
<td>College of Early Childhood Educators, Registered ECE</td>
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<tr>
<td>Member of the Interdisciplinary Centre for Research in Curriculum as Social Practice, Western University</td>
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<tr>
<td>Association of Early Childhood Educators, Ontario</td>
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Ontario, (AECEO) Provincial Board of Directors

Association of Early Childhood Educators, Ontario, Provincial Board of Directors

Interim President

Political Advocacy Group for ECEs in Ontario

October 2018 January 2019

Association of Early Childhood Educators, Ontario, Provincial Board of Directors

Treasurer

Political Advocacy Group for ECEs in Ontario

2016 2017

Association of Early Childhood Educators, Ontario, Provincial Board of Directors

Secretary

Political Advocacy Group for ECEs in Ontario

2018 2021

Academic, Industry or Community Presentations and Engagement

Title & Scope

Conference/Organization & Location

Presentation Date

Ontario Provincial Child Care Training and Support Program Advisory Committee Geneva Centre for Autism

Informed the development of an Ontario-wide program for training and supporting children experiencing Autism

2007 2008

Chair, Guelph and Wellington Quality Child Care Initiative Steering Committee

Provided leadership for the development and implementation of the Quality Child Care Initiative – a 100% municipally funded program for supporting child care quality in Guelph and Wellington County

2006 2007

Wellington-Dufferin-Guelph Coalition for Report Cards on the Well-Being of Children

Development of a comprehensive database and strategy for “raising the profile” of children’s health and well-being in Guelph, Wellington and Dufferin.

2006 2017

Wellington-Dufferin-Guelph Coalition for Report Cards on the Well-Being of

Strategies for selecting, analysing, sharing, and communicating the relevance of data describing the health and well-being of

2007 2017
<table>
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<tr>
<th>Children, Data Analysis Working Group</th>
<th>children and families in Guelph, Wellington, and Dufferin</th>
<th>2019</th>
<th>2020</th>
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<tr>
<td>Provincial Centre of Excellence for the Early Years &amp; Secretariat for the Centres of Excellence, Western University</td>
<td>Developed comprehensive profile of the 47 early years (municipal) service managers for the strategic development of an outreach model for the Ontario (English language) Centre of Excellence, and for the governing secretariat of the Francophone, Provincial, and Indigenous Centres of Excellence for the Early Years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inclusive Early Childhood Service System (IECSS), Ryerson University</td>
<td>Research Partner involved in the initial project design and early implementation of a study of the inclusive services used by families in, initially 4 areas in Ontario. The project has expanded to a pan-Canadian study</td>
<td>2013</td>
<td>2017</td>
</tr>
<tr>
<td>Principal Investigator: Kathryn Underwood</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Academic Course Development: Pedagogy in the Early Years ECE71015, BELPD, Conestoga College</td>
<td>Developed new course including course outcomes, unit outcomes, evaluations, and selection of resources for first year introduction course to the foundations of curriculum, pedagogy, and learning in the early years for delivery bachelor students in BELPD starting fall 2023</td>
<td>January 2023</td>
<td>April 2023</td>
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**Policy Creation & Analysis, Round Table Discussion**

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<th>Title and Scope</th>
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<td>“Our Recommendations for Bill C-35, An Act Respecting Early Learning and Child Care in Canada (Canada Early Learning and Child Care Act)”</td>
<td>Brief to the Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities (2023), Co-author with Dr. Petr Varmuza.</td>
<td>March 17, 2023</td>
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<tr>
<td>“Our Recommendations for the Renewed Framework for Early Years and Child Care in Ontario”</td>
<td>Submission to Province of Ontario (2017), Co-author with Petr Varmuza.</td>
<td>2017</td>
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<td>“Our Recommendations to Ontario for Funding and Quality in Child Care Modernization”</td>
<td>Submission to Province of Ontario (2016), Co-author with Petr Varmuza.</td>
<td>2016</td>
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<tr>
<td>Title</td>
<td>Institution</td>
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<tr>
<td>The impact of full day kindergarten on rural child care</td>
<td>University of Toronto, Atkinson Centre for Society and Child Development Policy Monitor #5</td>
<td>2011</td>
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<tr>
<td>QC Wellington: A Community-Wide Approach for Improving and Sustaining High Quality Child Care in Wellington County.</td>
<td>Research Project Manager, Centre for Families, Work &amp; Well-Being, University of Guelph</td>
<td>2003-2005</td>
</tr>
<tr>
<td>Program developer of Play-FULL participation, the early childhood education and care inclusion model for children experiencing disability in Guelph and Wellington County</td>
<td>Contracted by the County of Wellington Child Care Services, for the purpose of evaluating the existing program and designing the new model of inclusive resource support and child care service delivery for children experiencing disability in Guelph and Wellington County</td>
<td>2002-2003</td>
</tr>
<tr>
<td>Early Years Project Action Plan for Wellington-Dufferin-Guelph</td>
<td>Researched, developed, and proposed new directions of early years service delivery which resulted in the Ontario Early Years Centres in Wellington, Dufferin, and Guelph.</td>
<td>2001-2002</td>
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