

All Children Should Know Joy

Inclusive, Family-Centered Services for Young Children with Significant Disabilities

Barbara Thompson, Donna Wickham, Jane Wegner, and Marilyn Ault

Our experiences with the Circle of Inclusion Project (CIP) at the University of Kansas have contributed to our interpretations of the issues facing families with infants, toddlers, and preschoolers who are just beginning to learn about the formidable barriers of an enormous and complex system. We do not really believe we are writing about “children who challenge the system.” Instead we believe that we are writing about little children and their families who are challenged by the system—a system that is frequently unresponsive, often demeaning, sometimes rejecting, and occasionally cruel.

This chapter includes stories about children, results based on systematic data collection, and programmatic outcomes as well as reflections about our shared experiences over a 10-year period. All that we have to share is supported by rich empirical and theoretical literature about developmentally appropriate early childhood practices, effective early childhood special education practices, integration of children with and without disabilities, the roles of families in early childhood services, the value of the collaborative process, and issues of system change. This knowledge has now become “our knowledge” in the sense that it has evolved over time as a result of direct engagement with children, families, personnel, and programs in restructuring inclusive early childhood services for young children with significant disabilities and their families. Theories, principles, and practices acquired their meaning through genuine and prolonged engagement with the process we sought to understand.

In keeping with other discussions of CIP (Thompson, Wickham, Ault et al., 1991; Thompson, et. al, 1993), the first section of this chapter, *Children and their Families: Stories of Our Pathfinders*, describes some of the children and families we have known through out work. The next section, *Our Work and Our Values*, provides an overview of the values, history, and activities of CIP. *Our Knowledge About Knowledge: A Summary of Results and Outcomes*, summarizes our strategies for understanding the process with which we have been associated and blends program outcomes, results of studies, and our experiences into thematic topics. The last section, *Final Comments and Recommendations: Features of an Exemplary Program*, offers a brief overview of the elements that we believe emerged as important for early childhood services for young children who “challenge the system.”

CHILDREN AND THEIR FAMILIES: STORIES OF OUR PATHFINDERS

We are including stories of the children we have worked with and their families because it was these children and their families’ stories that taught us the most. With much difficulty we selected three children, Dana, Ashley, and Sheronda to illustrate important aspects of our experience.

Dana: The First Child

At the time of this writing, Dana is a sixth grader in an elementary school in Lawrence, Kansas. We met Dana, the first child in the program that was to evolve into CIP, when she was 3 years old. Dana is beauty with enormous brown eyes, thick dark hair, olive skin, and a warm smile that speaks directly to the heart. She has multiple disabilities, including mental retardation, spastic quadriplegia with very limited head control, and no ability to walk, sit unsupported, or speak. The quality of her vision is not known. These remarks reflect out earliest memories of Dana:

When I met Dana she was three years old. She was lying on a mat in an overcrowded day room of an institution surrounded by people of all ages (mostly adults) with profound disabilities. The room was crowded and filled with the sounds and smells that occur when persons with profound mental retardation, significant physical disabilities, and serious medical conditions are crowded together in a sterile, under-staffed, hospital-like environment in a state institution. The only speaking voices came from a large TV bolted to the wall about eight feet above the floor. (Thompson, Wickham, Ault, et. al., 1991, p. 12)

Shortly after my visit I found myself thinking about my three year old granddaughter, Chelsea, and about the marked differences in Dana's and Chelsea's daily life experiences. A quotation which has been attributed to Nicholas Hobbs came to my mind. "All children should know joy." From where was Dana's opportunity to know joy to come? (Thompson, 1994, p. 3)

Within several months, Dana was welcomed into a wonderful foster family in Lawrence, Kansas, community. Consequently, in the fall of 1986, we were looking for a community-based early childhood program whose staff would be willing to accept Dana. Initially there was no space in a special education preschool classroom, nor did the program accept children with severe multiple disabilities. Her foster parents believed (as did we) that it was important for Dana to have opportunities to be around other children and to be involved in preschool activities away from her foster home for a portion of the day.

We decided to contact one of the most respected programs in the community, Raintree Montessori School, a program that always has a long waiting list of children whose families are seeking early childhood education and child care. When we called Raintree, we began with a description of Dana. We also explained that a university student interested in the integration of preschoolers with disabilities would be available to assist Dana's Montessori teacher in meeting Dana's special needs and to enhance the adult-to-child ratio while Dana was in the classroom.

I was half expecting to be turned down and certainly assumed that I needed to do a real "sales" job on why Raintree staff might want to consider accepting a child like Dana. As long as I live, I will never forget Pam Shanks' answer, "Lleanna McReynolds, our Program Director, and I are so excited you thought of us! We would love to have Dana. When would you like for her to start?"

Just a few months later when I first saw Dana in Raintree Montessori School, her presence in this children's house was in such marked contrast with my memory of *Dana* in the institution that it evoked one of the most emotional experiences of my life. Dana looked valued, respected, and at home surrounded by other preschoolers who accepted her as one of them—which, of course, she was. (Thompson et. al., 1993, p. 13)

Ashley: the "Dignity of Risk"

Ashley is a 6-year-old kindergartner. She is large for her age and quite striking. She wears her black curly hair in a braid pulled to the side with a bright ribbon. Her face is round and pretty with dark eyes and long lashes that accentuates her soft brown skin. We first knew her as a 2-year-old who had just suffered a spinal cord injury in a car accident in which she was a passenger without a seat belt. After months in a pediatric intensive care unit in which she was termed a "miracle child" for surviving such a significant injury, she returned home with full paralysis beginning at the first cervical vertebrae, a permanent tracheotomy, a respirator for assisted breathing, and a button gastrostomy.

Initially Ashley received home services from an early intervention program in which therapists and an early childhood special education teacher worked directly with Ashley, her mother, and a nurse. During her third year, Ashley's mother expressed a strong interest in having her attend preschool with other children. During the next 2 school years, she was placed in an excellent preschool located in an elementary public school building funded through Elementary and Secondary Education Act (ESEA), Chapter 1. She also attended a private Montessori preschool during the intervening summer. Ashley began by spending less than a full session for a few days a week. Within the first year, her attendance was increased to the full daily for all 5 days per week.

Ashley brought with her the challenges of a medically complex condition and very significant physical disabilities. Fears about caring for Ashley were common across special education and general early childhood staff. Concerns were related to her breathing, suctioning procedures, and management of the range of physical problems associated with her condition. What was *not* a challenge was finding understanding peers who welcomed her into the classroom and, with some adult guidance, made the accommodations in their play needed to include her in activities.

We became used to pointing out that if Ashley was too fragile to be in an inclusive preschool classroom, she was too fragile to be in a special education classroom. Because there were risks for Ashley associated with her participation in a preschool program, some medical personnel has recommended she remain at home with 24-hour nursing care. Her mother's decision to involve her in an inclusive early childhood program was based on a commitment for Ashley to be an active participant in life. Ashley's participation taught the involved staff (teachers, therapists, paraprofessionals, and nurses) much about revising traditional beliefs about roles and responsibilities as well as about establishing consistent, reliable medical and emergency procedures within the context of a preschool classroom. Most important, it once again reminded those around Ashley of the importance of her right to be a child and to know joy.

Sheronda: From Medical Center to Kindergarten

Sheronda is currently doing well in a multi-age inclusive classroom for 5-, 6-, and 7-year-old children in an elementary building. She has a number of friends, several best friends, and a very best friend, Matt. While she still challenges her teachers to provide positive behavior supports, Sheronda is starting to talk quite a lot and is learning to read and write. When we first met Sheronda, she was a cute 3-year-old who participated in a self-contained special education preschool for children with autism that was housed within a university medical center. There were four children in the classroom, which was staffed by a teacher and two assistants.

Sheronda was nonverbal and had a number of challenging behaviors. One of her most problematic behaviors was running away. She was easily provoked into major tantrums when asked to comply or when a change occurred in a routine or in the environment. Sheronda sometimes attacked the other children by biting and slapping without obvious provocation.

During her second year in preschool, when Sheronda was 4, her program was moved from the medical center. She and her three classmates were placed in different inclusive preschool programs, and their teacher supported the teachers in these programs. Special education and related services were offered on a collaborative/consultative basis, and an additional paraprofessional with specialized training was added to each of the classrooms the children attended. The program in which Sheronda was placed offers full-day child care, which met important needs for her working mother and father. Despite these facts, there was a considerable concern about her placement in this preschool classroom of 18 children. Her very challenging behavior and quick exits from home and classroom were viewed as major threats to a successful outcome.

The initial period of adjustment to this program was a stressful time for Courtney, Sheronda's early childhood special education teacher. It was a difficult transition from being the lead teacher with four beautiful children in her own classroom within a prestigious medical center to serving as an itinerant and collaborative teacher with four different early childhood teachers in community-based early childhood classrooms. Courtney likes to recall an early transformational experience when she entered Sheronda's classroom and was unable to find her. Courtney remembers her feeling of utter panic in her certainty that Sheronda had escaped the confines of the classroom and was wondering around the center or the urban neighborhood. She approached the classroom teacher, who calmly pointed to a small group of children building with blocks. Courtney looked intently at the children and suddenly realized that Sheronda was one of them:

It astounded me, because she blended into the group so well. It wasn't really that she was cooperatively involved with the children, but she was engaged and very near the children. She looked just like one of them. My eyes filled with tears until, once again, I couldn't see her. (C. Erickson, personal communication, October 12, 1992.

Sheronda needed a summer school placement for all 3 months, something that the program she had been attending did not offer. Consequently, in the summer before her fifth birthday, she moved to an all-day child care program in a private Montessori preschool. The same special education supports and services that were available in the previous school were made available to Sheronda in this program. Sheronda continued to progress and adjusted very well to the child-initiated work routine that was part of the program's method. It was during this time that she first spoke. Excited to hear about the details of this important event, we eagerly asked for the story:

[What did she say? Who did she talk to? What was going on when she talked?]

"Move, please [to a peer who was a little too close to her materials]." (J. Keating, personal communication, April 10, 1993)

Sheronda's mother was and remains closely involved with each of Sheronda's experiences and programs. Her mother faithfully attended biweekly and the monthly core team meetings on her day off from work in order to communicate with Sheronda's preschool staff and special education teacher. She visited the elementary school that Sheronda would attend and met with the principal and the multi-age classroom teacher in the spring before Sheronda's entry into primary education. Sheronda's mother is an involved parent in the school. She knows what she wants for her daughter and is comfortable planning and working with professionals as an equal member of a team.

Insights from the Stories

Many more stories could be related like these about Dana, Ashley, and Sheronda, stories that portray the powerful transformational moment that can occur upon first seeing a child with significant disabilities within an accepting inclusive setting. This is a moment when our assumptions about a child are unexpectedly suspended as we see them through a different frame of reference. The "Aha!" moment occurs when a shift in paradigms becomes possible (Covey, 1989, Kuhn, 1970) and one truly understands what it means to see a child with significant disabilities as a child with the same rights and needs for a joyful childhood as all children.

These stories offer evidence of what the participating adults have noted consistently: Young children do not view or respond to the presence of a person with disability as adults do. The stories offer powerful confirmation of the belief that early childhood is the most opportune time to begin breaking down the societal barriers and discrimination that confront those with disabilities and their families.

Our observations, however, do not suggest that the typically developing children are unaware of the differences presented by their friends with significant disabilities. Their countless questions related to disabling conditions of their classmates show that they are aware. Comments such as these offer evidence of their interest in and need to understand the differences they recognize in their peers: "I never knew a 5-year-old who couldn't walk on the bottom of the pool," "Why can't he say it with his mouth?" (i.e., talk), and "Why does he spit all the time?" (i.e., drool) (Thompson, Wickham, & Wegner, 1991).

Children's questions about their classmates with disabilities do not, however, reflect value judgments about individual worth, signal rejection, or suggest a questioning of a classmate's right to be part of the same setting (Shanks, 1990). It is common to hear a child repeat the content of an adult's response to explain something about the child with a disability to another classroom peer or to a new

adult in the setting. A child may repeat this information even he or she did not ask the question, but was present and listening when it was first answered. The role of informant, interpreter, and facilitator for a child with a disability is often naturally assumed by his or her typically developing friends who are 3-5 years of age. A child who has never asked a single question, but who has watched a classmate who experiences a disability with interest and openness, may offer an explanation like this:

Jacob can't talk because his muscles don't work very well, but he knows all about the sound cylinders. He can't shake them . . . he nods his head if they are the same. He knows all about them.

OUR WORK AND OUR VALUES

As noted in the introductory section of this chapter, CIP has been directed toward the inclusion of young children with the most severe disabilities into a variety of early childhood programs that predominantly serve typically developing children. CIP has focused on initiating and implementing inclusive early childhood program services and on investigating and documenting important features of those services. The implementation of inclusive early childhood services has involved 1) starting the process, 2) preparing and then providing ongoing support for families and personnel, 3) accommodating the often intensive and individualized needs of children and families, and 4) providing ongoing facilitation of the social and instructional inclusion of children. This section describes CIP in greater detail.

A Value-Based Approach for Program Strategies

The strategies employed by CIP are grounded on an understanding and application of a milieu and naturalistic approach to meeting the needs of young children by embedding instruction and therapeutic services into existing activities and routines of the natural setting (e.g., home, child care center/preschool) (Bailey & McWilliam, 1990; Bricker & Cripe, 1992; Guess et al., 1978; Kaiser, Hendrickson, & Albert, 1991; Noonan & McCormick, 1993). In addition, attention has been directed to procedures that result in the meaningful inclusion of the children and their families. For example, strategies and variables have been investigated that support sustained positive reciprocal social interactions (friendships) among children and productive relationships among the families and personnel who are brought together within the context of these programs. Early in our work together, a value base was articulated in the form of seven value statements that guided CIP procedures and activities (see Table 1).

Emergence of the Circle of Inclusion Project

By 1992, 20 children with disabilities, two special education preschools, and four community early childhood programs had participated in CIP. The first 20 children to participate in CIP activities and investigations are described in Table 2, which provides information about these children at the time of their transition into inclusive preschool programs. As can be noted, the children were between the ages of 3 and 5 years, and all had diagnoses, medical conditions, and/or assessed developmental levels indicative of significant disabilities.

What had begun so informally in the fall of 1986 with one child, Dana, was merged into the service delivery systems of two public school districts beginning in the fall of 1992. Two applications were submitted for state grants to support efforts to restructure part of the early childhood service delivery system. Both projects were funded through Title VI-B Special Project state funding from the Kansas State Board of Education to implement programs of inclusive early childhood special education as a service delivery option within the two Kansas districts. The Lawrence, Kansas, project, Project LIM (Lawrence Early Education Program Inclusion Model), and the Kansas City, Kansas,

Project WIN) Wyandotte Cooperative Inclusion Network), both focused on continuing to implement and expand components of the CIP and are describes in Table 3.

TABLE 1. The Circle of Inclusion Value Statements

Value One

We reject the notion that children with disabilities must be “fixed” (frequently couched in terms of meeting certain criteria) before they are ready to take their place in families, neighborhoods, and community environments and experience the normal flow of everyday life and friendships available to children without disabilities. Specifically we are concerned that preschool children with severe disabilities and their families have the opportunity for inclusion in high-quality child care and preschool programs within the mainstream of community programs available to typically developing children and their families.

Value Two

We recognize that typically developing children must have an opportunity to develop relationships with children who experience disabling conditions, including children with the most significant disabilities. We acknowledge the importance of children learning to live in a pluralistic society and to accept individual differences at an early age. We believe that typically developing preschool children are at a critical readiness period for the experience of knowing a child with a disability and that their lives will be enriched by reaching out to friends who experience disabilities.

Value Three

We believe that a viable program must reflect involvement, input, and ongoing collaborative efforts from all participants, including the families receiving services and the special education and mainstream early childhood program personnel.

Value Four

We hold deep respect for the uniqueness and dignity of each child as an individual human being who merits our careful observation and response to his or her needs. We reject the application of any aversive procedures and believe that the acknowledgment of child preference and the development of choice-making skills, a sense of self, and personal autonomy are critical.

Value Five

We believe that inclusive programming efforts must incorporate exemplary practice approaches using developmentally appropriate activities and materials available to all children in a high-quality program. Objectives and activities must be guided by family priorities and developed via a team process with the family as the principal decision makers. The principle of partial participation should be used to maximize involvement when the child is not able to perform all aspects of an activity.

Value Six

We accept the concept of natural proportions and believe that it is best to place young children with severe disabilities in “mainstream” programs in accordance with realistic population distributions.

Value Seven

Our time and energy should be vested in investigating the variables that make inclusive endeavors work in the best possible way.

From Thompson, B., Wegner, J., Wickham, D., Shanks, P., Reinertson, B., & Ault, M. (1991). An investigation of the transition and integration of preschoolers with severe and profound multiple disabilities into a Montessori community preschool program: Program history, features, and research activities in progress, Circle of Inclusion Project. *Kansas Early Childhood Research Institute on Transition, Project 2.2, working Paper No. 1.* Lawrence, KS: Schiefelbusch Life Span Institute, University of Kansas.

Recently, CIP components have been implemented, expanded, and disseminated via two US Department of Education Office Special Education Outreach Training Projects. One of the projects has been directed toward expanding aspects of the model for young elementary children with severe disabilities and autism, and the other project has been extended to community training teams to initiate and implement inclusive early childhood services that address the needs of children with the most significant disabilities.

TABLE 3. LIM and WIN Program Overviews

Table 2. Original participants in Circle of Inclusion Project at time of entry into inclusive community preschool.

Child/ number	Inclusion transition date	Age in months	Gender	Diagnosed condition	Assessed development in months at entry into mainstream program ^a			
					Cognitive	Social	Language	Motor
DD 1	10/6/86	39	F	Deaf-blind Cerebral palsey	0-6 ^b	6-18	0	g. 0-6 f. 0-6
CS 2	2/1/88	41	M	Cerebral palsey Microencephaly	1-6	8-15	e. 3-8 r. 3-9	g. 2-5 f. 1-4
MA 3	2/1/88	56	M	Deaf-blind	3-8	6-9	e. 4-6 r. 6-7	g. 5-6 f. 5-9
JF 4	2/8/89	39	M	Cerebral palsey	3-6	6-7	e. 6-7 r. 10	g. 3-6 f. 3
CA 5	2/8/89	35	M	Cerebral palsey	6-9	9-15	e. 4-6 r. 8-10	g. 6 f. 3-6
GM 6	4/3/89	46	M	Down syndrome	22-27	28-30	e. 28 r. 28	g. 24 f. 26
MA 7	4/3/89	51	F	Down syndrome	36-48	36-39	e. 34 r. 32-37	g. 26 f. 24
SD 8	9/28/89	52	F	Cerebral palsey Visual impairment	11-12	11-18	e. 8-9 r. 8-10	g. 6-15 f. 12-15
SB 9	9/10/90	60	F	Cerebral palsey Microcephaly	24-36	24-36	e. 19 r. 36	g. 18-21 f. 6-15
SW 10	9/10/90	56	F	Down syndrome	30-42	32-34	e. 19 r. 8-30	g. 18-21 f. 28
LB 11	4/18/91	65	F	Cerebral plasey	12-24	10-30	18-24	g. 12 f. 12-15
NA 12	9/3/91	52	M	Speech-language delay Hearing impairment	18-24	16-24	e. 4-12 r. 3-18	g. 12-24 f. 12-21
LW 13	9/16/92	45	F	Cerebral palsey Visual impairment	6-9	3-6	e. 3-24 r. 3-18	g. 12-24 f. 12-21
MG 14	9.17/91	60	M	Down syndrome	27-32	25-36	e. 18-21 r. 25	g. 18-41 f. 15-35
MB 15	11/27/91	62	M	Trisomy 6	9-18	6-18	e. 6-9 r. 3-6	g. 4-9 f. 4-7
BS 16	12/9/91	48	M	Cerebral palsey	0-9	0-9	e. 0-9 r. 0-9	g. 0-6 f. 0-9
DW 17	12/11/91	54	M	Meningitis Hydrocephaly	24	No score assigned	e. 28 r. 27	g. 19-24 f. 18-27
RH 18	1/1/92	38	M	Developmental delays	18-24	18-24	e. 16-18 r. 18-24	g. 12 f. 18-20
CB 19	2/4/92	64	F	DeMorsier's syndrome Cerebral palsey	6-9	6-9	7-8	g. 8-9 f. 8-9
TM 20	2/17/92	46	F	Cerebral palsey	1-15	0-6	e. 4-18 r. 4-13	g. 3-9 f. 3-9

Adapted from Thompson, Wickham, & Wegner (1991).

Note: e. = expressive language score; r. = receptive lannguage score; g. = gross motor score; f. = fine motor score^aScores obtained from developmental assessments conducted by interdisciplinary professional team in special education program.^bRepresents a range of subscores in months (e.g., 3-6 months).

The Lawrence, Kansas, model (**Project LIM**, *Lawrence Early Education Program Inclusion Model*) has expanded inclusive services via interagency agreements with five community early childhood programs and involves services to children with a full range of delays and disabilities (i.e., mild to severe/profound). Approaches to services implemented in this model include: 1) employment of an early childhood special education teacher in two community preschools that hold openings for placement of children with disabilities, 2) intensive itinerant early childhood special education services in Head Start and two additional community preschools that hold openings for placement of children in the program in which they were enrolled at the point they are identified for these services.

The Kansas City, Kansas model (**Project WIN**, *Wyandotte Cooperative Inclusion Network*) includes children with severe and profound disabilities and children with autism. Children previously served in segregated classrooms in the University of Kansas Medical Center are placed in classrooms with typically developing children that are: 1) part of community service centers established as interagency community programs designed to meet the needs of families living in urban settings, 2) in private community preschool/child care centers, 3) in Head Start programs.

By the end of the school year in 1994, early childhood teachers and child care professionals in 23 preschool classrooms within 10 community early childhood programs (including two Head Start Programs), primary general education teachers in 10 kindergarten programs, first-grade, and second-grade classrooms, as well as personnel from early childhood special education programs in two communities (Lawrence and Kansas City) received training to implement inclusive programs for young children with severe disabilities (Thompson & Wegner, 1993). At that point, more than 600 typically developing children and 35 children with severe disabilities had participated as members of inclusive classrooms that employed components of the CIP model.

OUR KNOWLEDGE ABOUT KNOWLEDGE: A SUMMARY OF RESULTS AND OUTCOMES

Early in our work together in the implementation of inclusive early childhood services for pre-school-age children with significant disabilities, we began documenting the experiences and reflections of all the participants. We kept field notes in which we recorded events and experiences as they happened, along with notes reflecting our thoughts and feelings in the role of participant-observers. We also periodically made audio tapes of interviews with the involved parents and professional so we could have verbatim transcriptions of their thoughts and recollections. Extensive videotape records of the children directly participating in inclusive classes, which now span 10 years, were also maintained and have been a rich source of data as well as a resource for training. In addition, we conducted a number of observational studies using internal and time-sampling approaches for data collection and single-subject experimental studies that validated and provided insight into what we believed we understood through our participation.

We became convinced that a combination of qualitative and quantitative approaches offers a particularly rich environment for understanding the development and evaluation of new program models within a system change endeavor. As already noted, our multifaceted approach has been grounded in observation, data gathering, reflection, and direct participation over 10 years of creating and maintaining inclusive and family-centered services. Inherent in such an approach is the flexibility to adjust perspectives and units of analysis. A qualitative approach made possible a holistic view of a complex system and offered a means of addressing multiple components of the program and its impact. Linking a quantitative approach to this process offered opportunities to verify or reject impressions and to discover other factors of importance. Three studies primarily addressed qualitative components of our work (Perez, 1992; Stargardter, 1988; Thompson, Wickham, & Wegner, 1991). Six studies conducted as part of the project involved direct observation and coding of environmental, adult, and child variables; and several studies involved comparing a range of variables such as training procedures, equipment, adult style, and setting characteristics across programs, children, and personnel (Brooke, 1992; Kimura, 1991; Lit, 1993; Stegemann, 1993; Wegner, 1991; Wickham, 1993).

We focus on providing an overview of nine themes that emerged as meaningful for organizing results from specific studies, informative experiences, and outcomes of our program (Thompson &

Wegner, 1993). The themes discussed in this chapter include 1) factors affecting program success, 2) evidence of participation of children and partners, 3) influence of adult on development of friendships among children, 4) accommodations for welcoming environments, 5) experiences and perspectives of parents of children with disabilities, 6) experiences and perspectives of parents of typically developing children, 7) transitioning for adults to inclusive services for children, 8) paraprofessionals as facilitators, and 9) preparation of adults to serve as a child's partner. While offering specific findings and impressions, liberty has been taken to interpret some of the results and to emphasize important implications.

Factors Affecting Program Success

Acceptance of the inclusion program and its overall success (long-term participation and quality implementation) seemed to be highly related to the extent to which *both the* director of a community program and the program's early childhood teachers held a consistent, articulated philosophy and a sense of mission centered around meeting the needs of children and families. Examples of the kinds of programs with which we have worked most successfully and that operate with an explicit philosophy and sense of mission are Montessori programs, Head Start programs, and National Association for the Education of Young Children (NAEYC) accredited programs. Other features of programs that we generally considered as having had an impact on success included program longevity and reputation in the community, employing of qualified teachers, low staff turnover, and a stable financial base for the program.

The education of children and youth with significant disabilities has a history of implementing teacher-directed approaches (Guess & Thompson, 1990; Thompson & Guess, 1989). Despite this fact, we have consistently found that classrooms with a child-initiated, child-centered to early childhood education grounded in developmentally appropriate practice (Bredekamp, 1991) seem particularly able to sustain the successful placement of young children with significant disabilities.

We have had long-term, successful experiences with the Montessori approach to early childhood education (Thompson, Wickham, Ault, et. al., 1991). For example, the initial placement site for our program, a private Montessori program accredited by the American Montessori Society, has increased its involvement over the past 10 years. One of the teachers was appointed as the coordinator for special education services to ensure optimal ongoing placement and coordination with the public school early childhood special education certification with a specialization in children with severe disabilities. By 1992, part of her salary was paid through a contract between the public schools and the private community program. Another teacher in the same program has begun graduate work in special education, and two additional teachers have worked actively with the multidisciplinary teams who serve children in their classrooms. This program also added ramps, purchased adaptive equipment (such as a toilet), installed a visual fire alarm, and altered the playground to increase accessibility.

A number of considerations make Montessori programs an attractive model for the inclusion of young children with significant disabilities (Thompson, Wickham, Ault, et. al., 1991). Certified Montessori teachers must meet rigorous performance standards and are well-qualified early childhood educators. In addition, Montessori environments have features associated with developmentally appropriate practice as articulated by NAEYC guidelines (Bredekamp, 1991). These features include mixed age groups, child-initiated focus of the classroom with a predictable structure, prepared classroom environments that enhance choice and autonomy, and a rich array of functional and interesting materials that can meet a wide range of developmental needs. A practical consideration relates to the relative consistency in the curriculum and method of replicating effective procedures across multiple settings. (For other relevant features of the Montessori approach, see Chattin-McNichols, 1992; Krogh, 1982; Lillard, 19973; Loeffler, 1992; Safford, 1989; Thompson, Wickham, Ault, et. al., 1991; and Wegner, 1989.)

More recently, Head Start programs have become actively involved in the inclusion efforts of both districts we worked in, and eight Head Start classrooms in two communities have participated in our program quite successfully. The relationship with Head Start was facilitated by the Head Start regulations, which support collaborative arrangements with school districts and call for the inclusion of children with severe disabilities (Division for Early Childhood of the Council for Exceptional children, 1993). Although Head Start classrooms may implement a variety of curriculums, two approaches that are frequently implemented and are particularly viable for inclusion include the High Scope program (Hohmann & Wiekert, 1995) and Creative Curriculum (Didge & Colker, 1992). Several noteworthy features of Head Start include the high level of involvement with families, the broad range of health and nutritional programs available to children and families, and ongoing required staff development activities.

It should be noted that the child care components of the inclusive community programs were consistently used by families and were often the reason they preferred one community program over another (Thompson & Wegner, 1993). As conveyed in the literature (Berk & Mense, 1990) and reflected in our experience, finding child care for children with significant disabilities is very difficult for families. By starting relationships with programs for inclusive early childhood education, doors were opened to many children for extended child care.

Finally, the issues of accessibility of a program for children with significant physical challenges has definitely been a factor in whether a program worked or not. While making shift, temporary adaptations are often possible, some programs are located in buildings in which it is virtually impossible to safely include a child with significant physical challenges. This fact has important implications because accessibility has an impact on the safety of all young children.

Evidence of Participation of Children and Partners

Although we have documented countless touching personal observations of growing relationships among children with significant disabilities and their typically developing peers, we have also documented quantitative evidence of the children's experience. During a period of split enrollment in both an inclusive preschool and a special education preschool, three studies documented and compared aspects of the same children's communication, engagement in activities, and interaction with partners in both settings (Brooke, 1992; Stegemann, 1993; Wegner, 1991). The Brooke and Stegemann students used the CEVIT (Coding Environmental Variables and Interaction on tape) (Kimura, 1991; Leon, 1992) to code interactions and environmental variables of the same three children in the two settings. Each student sampled different episodes during a similar time period. The Stegemann (1993) study used exactly the same video episodes as the Wegner (1991) study. The observational analysis conducted by Wegner involved the analysis of verbatim transcripts obtained from the video episodes. All three studies involved comparisons of data for statistical significance. The results indicated that an inclusive setting offers more desirable social and communicative environment for children with significant disabilities on both a quantitative and qualitative basis and that it matches a high-quality special education program on environmental adaptations. Some of the most interesting conclusions derived from these studies are summarized here:

- Children with severe disabilities had significantly more peer partners and more communicative interactions in the inclusive community preschool than in a special education preschool.
- The children initiated more frequently and took more participatory turns in the inclusive community preschool
- The children interacted with more children in the inclusive community preschool than in the special education preschool.
- The children interacted with more adults in the special education preschool than in the inclusive community preschool.

- The length of time a child with a severe disability engaged in a single activity was consistently longer in the community preschool than in the special education class, although the difference was not significant. Furthermore, children with disabilities tended to spend more time on activities within a mainstream program over time.
- Accommodations (e.g., adaptive equipment for supporting positions, augmentative communication devices, and provision's for accessibility of materials) in an inclusive program were comparable with those provided in high-quality special education classrooms. In addition, children with significant disabilities spent more time out of their wheelchairs and engaged in floor and table activities in the inclusive program.
- When compared with adult partners in a special education program, adult partners in the inclusive community program were more facilitative of communication in their interactions with children with severe disabilities. Adults invited response, offered choice, redirected others to interact with the child, and interpreted the child's nonverbal responses as communicative significantly more often than did the partners in a special education program.
- When compared with adult partners in an inclusive program, adult partners in a special education program were more directive in their interactions with children with severe disabilities. They gave commands and instructions significantly more than did the children's partners in a mainstream program.
- Peer partners in the inclusive community preschool initiated more frequently, took more turns, and used more redirections than did the peer partners in the special education preschool.

Influence of Adults on the Development of Friendships Among Children

The results of this project confirmed the importance of the role of the adult partner in the development and maintenance of peer interactions among children with significant disabilities and typically developing children (Brooke, 1992; Lit, 1993; Stegemann, 1993; Wegner, 1991; Wickham, 1993). Frequently, adults must mediate initial peer interactions by offering support for interaction. Successful strategies included: 1) inviting participation, 2) answering questions and offering content for interaction on behalf of the child with a disability, 3) assessing and providing for needed adaptations that allow participation of the child with a disability, and 4) teaching peers to interact directly with the child with a disability and fading from child-to-child interactions when appropriate (Thompson et al., 1993).

Children with significant disabilities do form special relationships (friendships) with some of their typical peers that appear to be mutually satisfying and are maintained when the children are in the classroom together. Evidence of such friendships includes reports of the typically developing children's comments to their parents (Perez, 1992), invitations to play or attend parties (Stargardter, 1988; Thompson, Wickham, & Wegner, 1991), and consistent interactions over time among the children as noted in observational records and videotaped episodes that show the presence of peers (Brooke, 1992; Jenson, 1994; Kimura, 1991; Leon, 1993; Shanks, 1990; Stegemann, 1993; Wegner, 1991). Some of our conclusions and observations related to the process include the following:

- Preparation for first meeting the child with a significant disability, although often part of inclusion programs for school-age children, need not be extensive with very young children because their attitudes are still being formed rather than changed; and information is ought quite naturally (Shanks, 1990; Thompson et al., 1991).
- Although children are apt initially to place a child with severe multiple disabilities on a parallel with infants and toddlers, this view diminishes over time as information about the child and his or her disabling condition is offered typical peers (Shanks, 1990; Stargardter, 1988; Thompson et al., 1991).
- Children with typical development or with mild disabilities follow the model of adults in

communicating with children with significant disabilities. If adults are facilitative partners, the children are more facilitative partners; if adults are directive partners, the children are more directive and more likely to refrain from involvement in cooperative activities with a child who has significant disabilities (Lit, 1993; Wegner, 1991).

- Same-age peers who are friends with children with significant disabilities learned to use supportive strategies that are related to physical assistance and facilitative support (e.g., supporting a friend's head and arm, supporting a friend's trunk, wiping saliva from a friend's chin, providing with assistance to eat, pushing a wheelchair, getting necessary positioning materials, presenting and handling materials, interpreting communications, selecting activities that their friend previously enjoyed) (Jenson, 1994; Lit, 1993; Stegemann, 1993; Wegner, 1991).
- Children responded fearfully to a child who was aggressive to them and noticed asocial and unusual behavior (e.g., stereotypy) (Thompson et. al., 1993). They also accepted explanations of the communicative and/or coping nature of such behavior and the need for their peer to acquire new strategies. Typically developing children persisted in interactions with children whom they initially feared or avoided and assisted their classmate in practicing new strategies, generally but not always with adult support and encouragement.

Accommodations for Welcoming Environments

Environmental accommodations should be planned through ongoing environmental assessment, and the initial lack of adaptation *should not be used as a reason to reject placement in an inclusive program*. Our review of videotapes and direct observation consistently indicated that there was more focus in the inclusive settings on how accommodations would enhance participation than in the special education settings (Brooke, 1992; Stegemann, 1993; Wegner, 1991).

When children required specialized equipment and devices, many early childhood teachers found it helpful to explain and demonstrate equipment and devices as part of a large group activity in which its purpose and use were presented in a manner that was respectful to the child who would be using it and, to the extent possible, involved this child's position and keeping the child with a disability on a face-to-face level with his or her peers was important (Thompson et. al., 1993).

The availability of ongoing support for assistive technology was used. Much time and considerable difficulty were involved in identifying appropriate assistive technology devices such as augmentative communication devices, as well as in programming the devices, identifying appropriate and functional child positions to facilitate effective use of the devices, and teaching children and staff to use the devices correctly (Thompson et. al., 1993). The factors that interfered significantly with the availability and use of augmentative devices in an inclusive setting seemed very similar to the problems associated with these devices in self-contained special education programs.

Finally, the use of specific equipment does not appear to negatively affect interactions among children. In fact, using a device such as an augmentative communication device in an inclusive program offers many more opportunities for practice in using the device with speaking partners who are also peers in natural situations. Further, devices and special equipment often served as attractors for partners who were curious about them and interested in using them. In fact, one might venture to say that these devices sometimes took on a "status" quality. Pushing a child in a wheelchair was a highly valued activity. One 5-year-old who was negotiating with her classmates for how they might merit invitations to her birthday party was overheard approaching Shannon, who had just received a communication device. The child told Shannon that she could be one of the lucky invitees if she would "bring her box" to the party (D. Leon, personal communication, April 16, 1991).

Experiences and Perspectives of Parents of Children with Disabilities

Our experiences over 10 years offered us some important insights into the experiences of parents.

The concerns and fears expressed by parents of children with disabilities and personnel before transition into inclusive environments are consistent with a body of emergent literature (Hanline, 1993). Over the course of this project, we experienced a shift in parents' awareness of inclusion. Initially we had to invite parents to consider participating, whereas parents are now requesting, and sometimes, insisting on, inclusive placements. Following are conclusions about the experiences and perspectives of parents and about strategies that were successfully implemented to facilitate the process of inclusion for the family (Thompson et. al., 1993):

- Parents who had experience with special education preschool programs with high staff-to-child ratios sometimes expressed concern over their lack of contact with the regular education teacher.
- Some parents were less likely to attend general early education conferences and programs offered by the inclusive community program than those offered by the explicitly special education components of the program. Formal ways of linking these families with families of typically developing children who are in the program were needed to enhance the feeling of belonging for parents of children with severe disabilities.
- The parents and personnel tended to become more positive about the effects of inclusion on the children after direct participation in a program.
- Participation in an inclusive early childhood program appeared to affect the parent's placement preferences for inclusive school-age services. This result had an impact on the transition to school-age services (kindergarten and primary grades in elementary schools) and will ultimately have an impact on the nature of special education services through the life span.
- Whether or not parents requested the placement, activities, and strategies for involving and informing parents were critical (e.g., tours of program, involvement in environmental assessment, small group meetings with veteran parents, a handbook). The MAPS, Making Action Plans or the McGill Action Planning System (Vandercook, York, & Forest, 1989), which is based on a futures planning approach that has been adapted for educational planning, was also useful for initiating the child's entry into a program and developing an individualized education program (IEP).
- A way of ensuring ongoing and frequent communication was very important. Daily notebooks were particularly useful for some families. The parent, early childhood teacher, and special education support team members all communicated in writing through the use of notebooks.
- Parents who participated as members of a core team that met bi-weekly or monthly to problem-solve and plan participatory strategies for the child in the classroom seemed most involved and empowered.
- Parents of children in an urban setting tended to demonstrate less confidence in advocating for their child with public school personnel. However, their interest in inclusive experiences and their need for child care were similar to that of the parents in more affluent, suburban communities.

Experiences and Perspectives of Parents of Typically Developing Children

Parents of typically developing children can be valuable resources. Although we did not sufficiently explore strategies for involving these parents, results suggested that parents of typically developing children should be educated and involved along with parents of children with disabilities and participating personnel. The following points all emerged from Perez's (1992) qualitative study of eight parents whose typically developing children had formed special relationships with their classmates who experienced significant disabilities:

- Parents of typically developing children supported the concept of integration at the preschool

level and recognized that integration can be beneficial for their typically developing children, as well as for the children with disabilities. More specifically, parents stated that exposure to people with disabilities fostered acceptance and contributed to important changes in society.

- Without prompting by the interviewer and without responding to a specific question, all parents we formally interviewed brought up the role of the additional paraprofessional as an integration facilitator in the classroom. All these parents indicated that the addition of a knowledgeable person who could assist the teacher and the child with a disability was the most important factor in making the program work.
- Most parents indicated that while their children expressed acceptance and positive regard for their peers with disabilities, their children did not talk much about their peers with disabilities at home or describe any special type of relationship with them. Parents said that their children talked about the children in the school, although parents were also quite sure that their children were aware of the peers' disabilities. One parent noted that her little girl sometimes played "handicapped preschool" with her dolls.
- Conversely, the parents of a 5-year-old boy talked about the lengthy and detailed comments of their son about his friends with disabilities. This was consistent across 3 years of preschool. His parents attributed his close attachment to his friends with disabilities (three different children over a 3-year period) as instrumental to his adjustment and happiness in the program. Interestingly, these were also parents who expressed initial concern that the presence of children with disabilities would take too much teacher time away from their son.
- All of the parents indicated that they lacked specific knowledge about integration programs, but although they would like to know more about the program in which their child participated, this lack of information did not affect their positive attitude toward the concept of inclusion.
- In general, parents of typically developing children were open to and supportive of the inclusion of children with severe disabilities under the circumstances of CIP, in which the number of children with disabilities in a single classroom generally reflected the natural proportions in the population at large. Although parents did not use the term "natural proportions," they were clearly aware of this issue and spoke about ratios of children with typical development and children with disabilities.

Transitioning for Adults to Inclusive Services for Children

The immense power of the involved personnel to affect program success or failure must be recognized, and the need to educate and support these adults cannot be overemphasized. Although special education personnel working with children in inclusive settings initially expressed concern about their roles, most believed it was their responsibility to give their best effort for the sake of the children and were willing to sustain a period of discomfort to that end (Stargardter, 1988; Thompson, Wegner, et. al., 1991). Conversely, the general early childhood staff indicated pleasure at the opportunity to participate in an inclusive program, but expressed concern about their ability to meet the needs of the child and about the degree of support and assistance they would receive. Fear of actually handling a child occurred consistently as a new program began including a child with significant disabilities.

As relationships with other professionals and families developed around addressing the needs of a child, most special education personnel became more positive and supportive of inclusive practices; and most general early childhood personnel became more comfortable and more interactive with the children. However, the search for strategies that fit this new paradigm from both special and general early childhood personnel seemed ongoing. Over 10 years we have encountered a number of issues related to the involved personnel and their work that discuss the following topics including: 1) competition among program (special education preschools and inclusive community programs); 2) the confusion that confronted personnel undergoing changes in their role; 3) the lack of understanding

that caused discomfort or conflict between the early childhood education personnel (program director, early childhood teacher, classroom assistant) and special education early childhood personnel (administrator, teachers, related service staff, paraprofessionals); and 4) the controversial role of the paraprofessional as a facilitator for a child with significant disabilities (Thompson et. al., 1993; Thompson & Wegner, 1993), which are presented as a major theme in the next section.

When two or more service delivery models exist within a community, competition may occur between the two program staffs. For example, when the split program arrangement was used (children attended a special education classroom for half a day and a community preschool for the remaining half day), issues arose over which program was benefiting the child the most, although some professionals described this split as the best of both worlds (Stargardter, 1988). This underlying sense of competition also arose when one component of a school district early childhood special education program moved to an inclusive model and another component of the same program did not.

Role confusion and frustration are major factors that can negatively affect the satisfaction of all personnel. The need to invent some strategies to match the needs of a new program model was particularly disconcerting to some personnel. As the number of community programs increased, the need to tailor one's role to best fit the specific staff and children within the programs, each of which functioned quite differently, placed great demands on personnel to be flexible and inventive. For example, the way that many of the related service professionals scheduled their time did not really fit the needs of some programs and children. In some cases, scheduling related service professionals with children in an inclusive program for a less frequent and shorter periods, was found to be more productive for effective consultation, transdisciplinary training, and integrated therapy (e.g., an occupational therapist spending all morning with a child in a preschool program every 2 weeks instead of two or three 20- to 30-minute sessions per week).

In-service training related to teaming, collaboration, and problem solving was valued and constantly sought by participating personnel. In retrospect, we believe we should have included more content related to understanding personality types and differing work styles as useful information for anticipating the reactions of some personnel to functioning in a program that requires inventiveness. A more thorough grounding in the process of system change would also have been desirable to assist individuals in anticipating their experiences and reactions.

One of the most common sources of confusion seemed to stem from a lack of understanding and respect for other program and personnel practices. Special education and related service staff needed to be informed about early childhood program models and procedures. Frequently these individuals did not have a background in early childhood education and in some cases lacked knowledge of child development. Personnel who were accustomed to working only with children with very significant disabilities within a segregated program setting sometimes had difficulty entering an inclusive environment in a productive and respectful way.

As investigators with long histories of working in segregated special education settings, we were aware of the tendency for adults to talk to adults in a classroom in which none of the children are able to speak. One scenario with which we are all familiar is a special education teacher or therapist showing another adult how to work with a child and offering a clinical explanation of a procedure in the presence of everyone (children and adults) in the classroom. This was often viewed by the early childhood program staff as demeaning to the child, a way of negatively setting the child apart from his peers, and as rude and disruptive. (Need we mention professionals walking into a classroom with a coffee cup and engaging in personal conversations?) Another scenario with which we are also familiar is the self-contained preschool program for children with significant disabilities in which there are as many (or more) adults as children present. We found it necessary to give considerable attention to minimizing the intrusion of specialized staff serving a child in an inclusive program.

Of course, early childhood educators and child care workers need to learn about the roles and contributions that related service personnel and special educators can make. They too must learn to adjust to becoming part of a team, opening their classroom to the expertise of other professionals and

their suggestions about working with a child with significant disabilities. This collaborative attitude was hampered or enhanced to the degree that the early childhood program staff felt empowered as principal players on the team, valued rather than judged, and supported rather than intruded upon.

Paraprofessionals as Facilitators

The adult-child ratios for children in most early childhood programs (1 adult to 10-12 children) must be enhanced if a child with significant disabilities is to be included. Attention to the training of all classroom personnel and the investigation of a range of approaches for increasing adult support are still needed. One of the approaches used in CIP was to assign an additional assistant to the inclusive community classroom and to have the school district pay this person as a paraprofessional. This individual functioned in a variety of ways and was generally co-supervised by the district early childhood special education teacher assigned to work with the children and personnel in the community program and by the early childhood teacher in charge of the classroom. In some cases, this person functioned primarily as a classroom assistant across children and tasks. In many cases, however, this person functioned as a "facilitator" for the child with significant disabilities. This was most true when a child had significant and multiple physical and sensory challenges that limited the ability to move or participate in an activity.

The explicit assigning of a paraprofessional to a specific child in an inclusive preschool had both advantages and disadvantages, and these issues have been raised by a number of individuals involved in inclusive programs (Giangreco & Putnam, 1991; York, Vandercook, Caughey, & Helse-Neff, 1988). The results of several studies indicated that an individual serving as an "integration facilitator" of an adult partner was beneficial to a child's communicative competence, as well as supportive of the child's meaningful participation in the settings (Stegemann, 1993; Wegner, 1991; Wickham, 1993). The strength of this approach included the presence of someone who was able to become extremely sensitive and "tuned in" to a child's nonverbal communication, thereby empowering the child to be heard and to be a more active communicator and social participant in the classroom. The facilitator's role could be compared with the role of an interpreter. In addition, the individual taking the role of the facilitator became very skillful in supporting a child's ongoing physical participation, which is critical for a child with extremely limited movement capabilities.

Adults with good skills in relating to young children attracted more partners for a child with significant disabilities (Lit, 1993), while still providing the intensity of support and instruction required by children with significant disabilities. As noted earlier, adults are initially the primary interpreter and are usually essential in facilitating new relationships between children. There remains, however, a significant need for more research about how adults can recognize when child-to-child interactions can be maintained without their support and how to fade from these interactions.

We also found problems associated with the assigning of a paraprofessional to a particular child. Our data indicated that paraprofessionals supporting the inclusion of children with disabilities sometimes appeared to negatively affect the frequency with which the regular early childhood teacher interacted with the child (Lit, 1993). It was fairly common for a facilitator to become overly attached to a child and to prevent the rest of the classroom staff from becoming meaningfully involved with the child. Another problem that sometimes arose was the tendency for some early childhood classroom teachers to turn over complete responsibility for the child to the paraprofessional facilitator. This result brought the loss of an appropriate teacher-child relationship and inhibited the child's true membership in the class group.

Preparation of Adults to Serve as Child's Partner

Individuals supporting the inclusion of a child are likely to miss opportunities to support interactions, instruction, and participation unless directly trained to do so (Wickham, 1993). Instruction on

facilitative strategies that support child-to-child interactions for *all adults* who were involved with the program was necessary to ensure application of these strategies in the classroom. Direct training using videotaped episodes of children and paraprofessionals in inclusive classrooms that were part of CIP was conducted by Wickham (1993). The results of this study indicated that this training was an effective way to enhance the use of strategies that facilitate child-to-child interactions and specialized instructional procedures. Paraprofessionals in training viewed video taped episodes of their interactions within a classroom, focused on observing specific strategies, and reflected on possible improvements with a specific trainer. Their results were moderately encouraging in regard to generalization to other children and maintenance over time, but suggested that ongoing and direct training is important for a considerable length of time.

FINAL COMMENTS AND RECOMMENDATIONS: FEATURES OF AN EXEMPLARY PROGRAM

Our prolonged involvement with CIP has contributed much to perspective on the short- and long-term issues regarding inclusive services for young children with significant disabilities and the sustainability of emerging programs. Mindful that approaches to the development of service models should meet standards of exemplary practice, as well as reflect the unique characteristics of the community in which they are implemented, we have developed recommendations for features of an exemplary program (Thompson et. al., 1993). These recommendations are designed to enable programs and personnel to move from the “believing” to the “doing” stage and to establish a lasting structure.

Embracing a Shared Value Base and Vision

The establishment of a set of values (see Table 1 on p. 31) to which a very diverse group of individuals ascribed made it possible to transcend a number of the differences in agency functions and procedures as well as in participating program approaches to early childhood education. These shared values and the vision of inclusive early childhood education and child care for all young children and their families provided the impetus to continue the program over a number of years.

Participation of Community-Based Early Childhood Programs

A broad number of “community-based programs” including private for-profit, private not-for-profit, and head Start programs that predominantly serve typically developing children offer potentially excellent programs for the inclusion of young children with significant disabilities. One of the most compelling rationales for involving community programs is the opportunity for families to have the same options for selecting programs as do families of young children with typical development. Parents may have preferences based on a particular community program or may have attended a program with which the parents are comfortable.

Using Varied Approaches to Provide Inclusive Classrooms

A number of approaches offer communities ways to move toward establishing inclusive services for young children. These approaches include: 1) contractual arrangements that support certified staff who are employees of the community programs; 2) blended classrooms, such as the emergent practice of blending Head Start and early childhood special education programs or arranging for team teaching between an early childhood special education teacher takes on an itinerant role and works with staff and children in several programs. In some communities, two or more of these models are used in combination as they were in the programs employing components of CIP.

Creative and Flexible funding via Interagency Relationships

Sources of cost that are likely to be specifically associated with an early childhood inclusion program for young children with significant disabilities include child tuition and fees, additional personnel, facility accessibility adaptations, licensing adaptations, special equipment and materials, staff education programs, and numerous family programs. Administrative personnel involved in an early childhood inclusion program must have a good understanding of the potential resources available to the various agencies and individuals who might participate in the program. When several agencies work together (e.g., school district, head Start, community preschool, and child care centers), a creative and resourceful funding base can be built to support the program model that meets the unique needs of the community and is also responsive to the individual needs of families.

Linkage with Programs Offering Child Care Services

One solution to the problem of limited or nonexistent child care options for young children with significant disabilities is to assist service providers in existing child care programs to accept youngsters with severe disabilities and to assist families in gaining access to these services. A particularly viable application of this solution is to offer inclusive early childhood services in programs that offer full-day child care.

Providing High-Quality, Child-Centered Programs with Developmentally Appropriate Practices

As Safford (1989) points out, there is inherent value in good early childhood practices for all children; and considerable benefit can derive from using child-specific adaptations and interventions with teaching approaches appropriate to all children. Characteristics of child-oriented programs that support active learning include: 1) opportunities to practice developmental tasks, 2) teachers who understand developmental needs and characteristics of the children, 3) a curriculum that furthers cognitive development via concrete experiences, and 4) physical settings designed to encourage independence and motivate involvement (Day & Drake, 1986). Accreditation by NAEYC, AMS (American Montessori Society, or AMI (Association of Montessori International) generally are positive signs of a quality program.

Facilitating Membership Through Supported Placement

The use of a paraprofessional or another adult assigned as a classroom facilitator for a child with significant disabilities can offer the intensive support needed by children with severe disabilities within inclusive programs. In our experience, the inclusion facilitator plays a pivotal role in how well a child is accepted into a classroom because the facilitator often determines whether interactions occur or do not occur with other children and program staff. Interactions with young children with severe disabilities are fostered by teaching children to act as responsive and sensitive partners, by providing opportunities for meaningful interactions with peers, and by supporting a child in an interaction if he or she needs support. The person working directly with a child with a disability in an inclusive early childhood classroom must be a careful observer of children's behavior and must be sensitive to communicative attempts in order to promote interactions between children that are sustained, but not continuously supported by an adult. Using strategies that facilitate interactions among typically developing young children and their classmates with disabilities allows children to determine the content and direction of their interactions, encourages true communication, and fosters an environment in which friendships can unfold.

Establishing Collaborative Teams Based on Functional Tasks

Effective team functioning requires that all team members, including parents, share a common philosophy and commitment to the development of the whole child and be able to communicate openly and effectively with one another (Rainforth, York, & Macdonald, 1992; Swan & Morgan, 1993). An inclusive program model compounds the already complicated process of teaming because members often represent multiple community agencies, each with different administrative patterns, missions, and philosophies. Furthermore, the complex and intensive needs of children with significant disabilities and their families require an intensive effort on the part of the child and family team.

Joint Service Provider and Family Preparation

Change is stressful under the very best of circumstances. Staff and family preparation activities are absolutely critical to ensuring that each individual optimally approaches the shift to inclusive services (Klein & Sheehan, 1987). Participants must become acquainted with the nature of systematic change and the need to be proactive and inventive. The role confusion and negativity often experienced in a new program can be reduced by providing opportunities for participants to communicate with other members of the team about issues affecting their roles and by empowering participants with opportunities to affect their own role.

It is also essential that involved service providers show respect for individuals from programs and agencies that operate under different regulations and use different methods. Participants must learn how to enter a new system by suspending their assumptions about how things should be and follow the advice offered by Stephen Covey in his discussion of the habits of highly effective people: "Seek first to understand and then to be understood," and "Diagnose before you prescribe" (Covey, 1989). Service providers must learn this approach to work independently, with each other, and with families from diverse backgrounds and cultures. Ultimately, if we want individuals to work together in a collaborative and open manner, it is essential that we offer *joint* not *separate*, education and development activities.

Family-Guided Decision Making and Family-Centered Services

A consistent frustration faced by families as they seek to establish exemplary services for their child and to maintain these services throughout the life span are the lack of a truly seamless service system, and professional resistance to empowering families and to the assertive stance taken by many families. Although family involvement is a principle espoused with the best of intentions by all early childhood interventionists (Bricker, 1989; Peterson, 1987; Raver, 1991), the processes and procedures that include the family in meaningful self-determined activities are still sorely lacking (Bailey & Wolery, 1989; Bricker, 1989; Whitehead, Deiner, & Toccafondi, 1990). Our experiences with the CIP project confirmed this reality. Changing the way professionals interact with parents continues to be one of our greatest challenges. Program procedures must be implemented that offer promise for empowering families and help service providers value the interdependent nature of their work with families.

SUMMARY

It seems fitting to conclude this chapter with one of our favorite anecdotes, not only because it is humorous, but also because an important concept is voiced so clearly by the words of a child:

Five-year-old Shannon, a charmer with big brown eyes and a ready smile, experiences multiple disabilities. Shannon has a condition of microcephaly and cerebral palsy that is predominant on her left side. She is ambulatory, but non-oral. She also experiences intensive grand mal seizures which required that the community pre-

school have an emergency medical plan in place and included the immediate notification of an EMT unit. Finally, Shannon's condition is related to prenatal exposure to the cytomegalovirus (CMV). Although medical testing revealed that she was not currently shedding the virus, the community preschool personnel needed to take precautions related to infection control and limiting contact with pregnant staff and parents.

During the production phase of a video tape about the program of inclusion for young children with severe disabilities, four-year-old Sophie, also a charmer with blonde hair and blue eyes, was asked to comment about her classmate Shannon. One of the production crew members who was curious about what the children with typical development thought about the inclusion program was overheard asking, "Well, Sophie, do you think Shannon should be at Raintree or maybe do you think she should go to a preschool for other children just like her?" Sophie, after a short and what seemed as a reflective pause, responded. "No, she should go to Raintree, because—because, how would all the children know who the teacher was talking to—with everybody named Shannon in that school?" (Thompson et. al., 1993, p. 25).

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