CHAPTER 1
Introduction to the Preschool Inclusion Manual

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In this chapter you will find information on the following topics:

- A philosophy of inclusion which grounds the content set forth is this manual
- An introduction to some of the children who have participated in the inclusive early childhood programs described in this manual
- A brief description of the three innovative early childhood state funded projects that contributed to the content of this manual

Our Philosophy of Inclusion: Values and Vision of What Could and Should Be

As early childhood educators and special educators, we, the staff of the projects recognize the value of including young children with disabilities in programs with their typically developing peers. We believe the benefits for *all* children are considerable and that preschool age children with and without disabilities are at a formative period for getting to know each other. We are appreciative of the extensive legislative, moral-philosophical and research base that supports the development of least restrictive environment (LRE) models for preschoolers with disabilities. Because the purpose of this manual is to share strategies for initiating and implementing inclusive programs for young children with disabilities, this introductory discussion is offered only as *a brief overview* of the important work of many researchers and practitioners nationwide, concerning the foundations of inclusion.

In the November 1989, Philip Strain, keynote address at the National Conference of the Division for Early Childhood, later reprinted in the *Journal of Early*

Intervention (Strain, 1990), set forth the issues of the inclusion movement in the early childhood arena:

> There is no evidence that children with certain handicapping conditions or levels of disabilities make more or less good candidates for integration. Now obviously children with severe disabilities require more accommodations to maximize their growth and development. Here we have the root of the conventional wisdom that children with mild handicaps are better candidates for integration. What is true is that they (children with mild disabilities) may, only may, require less change in the structure and function of current service delivery (than children with severe disabilities) to meet their learning needs (pp. 293).

This statement fits well within the context of the growing and substantial body of literature attesting to: (a) the positive outcomes of education for children and youth with severe disabilities in settings with their typically developing peers (Halvorsen & Sailor, 1990; Hanline, 1993, Rainforth, York, & MacDonald, 1992; Salisbury, 1993; Thompson, et. al., 1991, Wegner, 1992); and, (b) two decades of research indicating that for preschool children with disabilities special education and related services can be more effective when provided in appropriate mainstream settings such as Head Start, preschool/child care centers, and kindergartens (Guralnick, 1991; Peck, Hayden, Wandschneider, Peterson, & Richarz, 1989; Salisbury, 1990; Smith & Rose, 1993; Strain, 1990).

The strategies we have employed in our projects are grounded on an understanding and application of a milieu approach to meeting the needs of young children by embedding instruction and therapeutic services within existing ac-

tivities and routines of the natural setting (i.e. homes, child care centers, and preschools) (Bailey & McWilliam, 1990; Bricker & Cripe, 1992; Guess, et al., 1978; Kaiser, Hendrickson, & Albert, 1991; Noonan & McCormick, 1992). Additionally, attention has been directed to procedures that result in the "meaningful" inclusion of the children and families. For example, our investigation have been directed to: (a) supporting sustained positive reciprocal social interactions (friendships) between children and, (b) creating productive relationships among the families and personnel who are brought together within the context of these programs. The value base embraced for our work is set forth in the following seven 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 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 soci-

ety 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 maker. 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 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.

Our Children

Ashley

Ashley is now a six year old kindergartner. She wears her curly black hair in a thick braid pulled to the side with a bright ribbon. Her face is round and pretty with dark eyes and long lashes that accentuate her soft brown skin. We first knew her as a two year old who had just suffered a C-1 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 site of her injury, a permanent tracheostomy, a respirator for assisted breathing and a button gastrostomy.

Ashley initially received services in her from the preschool related service therapists and an early childhood special education teacher worked directly with Ashley, her mother and nurse. During her third year, Ashley's mother expressed a strong interest in having her attend preschool with other children. She was placed in Chapter One preschool in an elementary building during the next two school years. She began by spending less than a full daily session and only attended a

couple of days a week. Within the first year her attendance was increased to the full daily session for five days per week.

Ashley brought challenges associated with medically complex conditions and very significant physical disabilities. Fears about caring for Ashley were common across special education and general early childhood staff and were particularly related to her breathing and the suctioning procedures required for her case. 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.

Several medical personnel believed that Ashley should remain at home in her bedroom with 24 hour nursing care - a recommendation of some medical personnel. 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 staff involved (teachers, therapists, paraprofessionals and nurses) much about role release and letting go, as well as establishing consistent, reliable medical and emergency procedures within the context of a preschool classroom. Her teachers 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. Most importantly, participation reminded us of her and the dignity with risk and participation of Ashley's right to be a child.

Sheronda

Sheronda is currently doing well in a multi-age classroom for 5, 6 and 7 year old children in an elementary school. She has a number of friends, and her very best friend is named Matt. She is starting to talk, read and write. When we first met Sheronda she was three years old and participating in a self- contained special education preschool for children with autism that was housed within a university medical center. There were four children with autism in the classroom and it 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. Additionally, she was easily provoked into major tantrums when asked to comply or when a shift in a routine or change in the environment occurred. She displayed some aggressive behaviors toward other children such hitting and biting, and particularly disliked physical contact.

During her second year in preschool, Sheronda program was moved from the medical center. She and her three classmates were placed into inclusive preschool 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 offered full-day child care which met an important need for her working mother and father. Despite this fact, there was considerable concern about her placement in this preschool classroom of 18 typically developing 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 to shift from serving as the lead teacher of her own classroom within a prestigious medical center to serving as an itinerant and collaborative teacher in four different community-based early childhood classrooms. Courtney likes to recall an early and transformational experience when she entered Sheronda's classroom and was unable to find her. Courtney remembers a feeling of utter panic in her certainty that Sheronda had escaped the confines of the classroom and was wandering around the center or urban neighborhood. She approached the classroom teacher who calmly pointed to small group of children building with blocks. Courtney recalls

looking intently at the children and suddenly realizing 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.*

Sheronda needed a summer school placement for all three 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 preschool 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 and to whom did she say it"?!!.* The answer: *"Move, please"* to a peer who was just a little too close to her materials.

Sheronda's mother was closely involved with each of her experiences in inclusive programs. She faithfully attended biweekly and then monthly core team meetings on her day off from work in order to communicate with the preschool staff and special education teacher. She visited the elementary school that Sheronda would attend and met with principal and the multi-age classroom teacher in the spring before Sheronda's entry into primary education. Currently, Sheronda's

mother is an involved parent in the elementary school. She knows what she wants for her daughter and feels comfortable planning and working with professionals as an equal member of a team.

David

When we first met David, a classmate of Sheronda's, he was also a three year old child with a diagnosis of autism. He was a small child with sandy blonde hair, an angelic face and intense blue eyes. At the time that the inclusive program was initiated, his foster mother was looking for a full-day child care program to provide respite and improve her ability to meet his needs in the home.

Unfortunately, David's initial placement in a child care center was unsuccessful. His foster mother felt that the early childhood staff did not want him and were rejecting in their behavior toward David. She withdrew him from the program after about four weeks. A full-day program was then located for David in a Montessori preschool and child care center. The staff in this program was eager to have him and to work with the special education team to learn strategies to involve David in the program. Despite a successful six month placement, his foster family decided that caring for David was no longer feasible. David was then placed in a residential facility, but continued in his early childhood program.

David initially demonstrated aggressive behavior to other children (biting and hair pulling), and behavior that was injurious to himself (head banging, face slapping and air swallowing). He also engaged in stereotypy including body rocking, humming and occasionally "shrieking or laughing" that appeared unrelated to environmental events.

David required a considerable amount of adult support. As part of his program, he received intensive one-on-one assistance for individual activities from his teachers and therapists and also received intensive adult support and facilitation during all periods of interaction with peers in routine and play activities. On his

first day in the inclusive Montessori program he pulled a handful of hair from a friendly little girl who got a little too close to him. Through her tears, she wailed, *"He doesn't like me!"*

The children definitely noticed David's behavior and were leery of approaching him, although their tenacity and persistence at establishing a relationship with him was long term and heart warming. The children came to understand that David needed a way to approach them and say hello. With the support of a para-facilitator, they practiced faithfully with David, until he established a more suitable way of approaching his peers. His friends also became willing partners in establishing joint attention and interaction in play and other classroom routines.

During the time David attended the inclusive program his needs were many and complex. Attention to issues of transition and advocacy were particularly critical for this little boy as he moved from home to home and program to program. Ongoing communication between special education, early childhood education, and child care program staff, his foster family and social welfare staff was essential. This picture became even more complicated when he lived in a "hospital residence" maintained by personnel across three shifts. A new foster home was located about a year after his residential placement and David moved to a new community. He was greatly missed by all.

Jessica

We first met Jessica when she was two years old and was referred to the infant and toddler early intervention program. We knew right away that if an inclusive program would be available for Jessica when she turned three (in just ten months), we would need to begin the transition process immediately. A transition outcome was written into her Individualized Family Service Plan (IFSP) to help the team prepare to meet Jessica's special needs and to overcome barriers to an inclusive

education for her.

Jessica lived in a small trailer on the edge of a very small rural community with her grandmother. Transportation was always a problem. Her grandmother didn't drive due to her poor health and transportation resources were not available in the local community. A church member helped when possible. Jessica's family physician was reported to comment at each checkup that Jessica was living proof that he could be wrong. He had never believed she would survive more than a few weeks, and yet here she was gaining new skills slowly but steadily. While the physician was supportive, he consistently urged the grandmother not to plan ahead or get her hopes up.

Jessica had multiple disabilities including deaf-blindness, mental retardation, cerebral palsy, and serious health impairments. She was tube fed, needed regular suctioning, and frequently aspirated. There were few choices for programs for any child in the community. The nearby town did not have a preschool or even a child care program. The local school district participated in a special education cooperative program who at that time housed all ECSE programs 35 miles away in a larger city, Jessica's grandmother did not feel comfortable with any program that would not be close by in case of an emergency. Head Start offered home-based programs in the area was hoping to establish a site for a center in the community. The Head Start personnel were unsure of their ability to meet Jessica's needs even if a site was opened.

The early intervention team continued to serve Jessica and began a carefully planned transition to a home-based Head Start program with special education and related services provided within the home as Jessica turned three. All team members (both infant toddler and preschool) were frequently found at Saturday night Bingo in the local community hall to raise money for equipment Jessica needed and to help her grandmother cover expenses. It was during these kinds of events that

Jessica's team were beginning to know each other as people and not just teachers, physical therapists, and nurses.

At three and a half years, Jessica began to attend a Head Start center one afternoon a week. Her time at the center was slowly increased, but she missed frequently due to illness. She was alert to the children around her and they always looked forward to her arrival. The staff grew more comfortable with her special health care needs and were able to use her equipment in ways that helped her to be a part of the group and not just sitting on the outside. Her school district continued to use an IFSP, because it provided more support for her grandmother's involvement. Therapist's visited both at home and at Head Start to assure everyone was participating in Jessica's program.

Jessica's challenges were many—the severity of her disabilities, the family's limited resources, her poor prognosis, the limited access to community resources and the remoteness of where she lived. Yet, Jessica proved more than her physician wrong by living, she showed many of the educators in the area that inclusion could (and should) be available anywhere for anyone if it is the best program for the child. It wasn't easy and it didn't occur immediately, but it did happen. Everyone on her team overcame both personal and agency barriers by working with Jessica, and Jessica went to school like everyone else.

Projects Contributing to This Manual

By the fall of 1992, the ground work for inclusive program models within several communities had been laid. Community early childhood program personnel, early childhood special education school district staff, families, and university personnel within these communities worked collaboratively to develop and submit state grants to support efforts to formally restructure part of the early childhood service delivery systems. Three collaborative University of Kansas and local school dis-

trict projects were funded in Fall, 1992, as three year innovative projects through Title VI-B Special Project state funding from the Kansas State Board of Education. All three projects implemented programs of inclusive early childhood special education services. All three projects were also supported philosophically by the state department of early childhood representatives.

Each project involved the restructuring of the roles of school district or special education cooperative ECSE teachers and, to a considerable extent, related service staff. The three projects also involved a restructuring of the service delivery system for children three through five within each project area. Each project was grounded on the belief that their approach must meet standards of best practice as well as reflect the unique characteristics of the community.

Each project shared a commitment to the following recommended practices for early childhood inclusive services:

A shared value base.

Community early childhood program participation.

Links with child care services.

Program options or approaches to placement.

Supported placement via a paraprofessional as appropriate.

The concept of natural proportions guiding placements.

Teaming based on functional tasks.

Joint Early Childhood and Early Childhood Special Education program staff inservice education.

A family guided approach.

Collaborative transition planning and implementation.

Systematic program expansion.

Stated program outcomes.

To assist the reader in understanding the specific focus of each project, a brief overview is provided.

The ***Project LIM*** *(Lawrence Inclusion Model*), implemented in Lawrence, Kansas, offered inclusive services in community preschools and involved children with the full range of delays and disabilities (i.e. mild to severe / profound). Five preschools held openings specifically for children with disabilities. Two of these programs employed an early childhood special education teacher and related services personnel (such as occupational therapy, physical therapy, speech and language, social work, psychology) and were delivered on site by iterent related service providers. In addition to the five programs that held placement options early childhood special education services were also provided to those children already enrolled in a community program at the point they were identified as eligible for services.

Project WIN *(Wyandotte Cooperative Inclusion Network*) implemented in Kansas City, Kansas, was designed to support the inclusion of children with severe and profound multiple disabilities and children with autism as members of inclusive community preschools and child care programs. Participating programs include: (a) community service centers, established via interagency cooperative to meet the needs of families living in urban settings, as well as , (b) Head Start programs, (c) district supported four-year-old programs based in elementary schools, and (d) private community programs.

The Southeast Kansas model (***PITT**, Project Integration, Training, and Transition*) was designed to meet the need of a rural area for the provision of early childhood special education services within the least restrictive environment (LRE) for all children through the development of family-guided, community-based, early childhood service options. Three special education cooperatives serving school districts participated. Service delivery settings included child care centers, Head Start, community preschools, and family child care homes typical of rural areas. A special emphasis was on the implementation of family-guided transition from infant-toddler to preschool services and personnel training information sharing, and resource development.

Each project, which addressing specialized goals and geographical needs; adhered to the squared value based described and the listed recommended practices. The reader of experiences have been coordinated within this manual to provide the reader with field tested procedures and practice forms from the projects.