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ABSTRACT

This manual describes how the Kidlink early education program in Topeka, Kansas, evolved from a segregated program serving physically disabled children to an integrated one including day care services. Chapters include "PROJECT KIDLINK: Bringing Together Disabled and Nondisabled Preschoolers" (Julie Keller); "KIDLINK CLASSROOM: An Integrated Learning Experience" (Brant, Green and Heim); "COMPUTERLINK: Suggestions for Computer-Based Activities in an Integrated Classroom" (Keller, Molineux, and McCormick); "MOTORLINK: Occupational Therapy in an Integrated Preschool Program" (Clarke Beale); "MOTORLINK: Physical Therapy in an Integrated Preschool Program" (Brenna Richmond); "SPEECHLINK: Integrating Speech, Language, and Communication Services into the Preschool Classroom" (Barry Molineux) and "FAMILYLINK: Serving Families in an Integrated Preschool Program" (Agnes Kazminski). Appendices include sample forms used and contact information for groups practicing reverse mainstreaming. Each chapter also includes references. (PB)

PROJECT KIDLINK: Bringing Together Disabled and Nondisabled Preschoolers

Developed by
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Topeka, Kansas

EC 23 1874

PROJECT KIDLINK:

Bringing Together Disabled and Nondisabled Preschoolers

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The Board of Trustees of The Capper Foundation has been supportive of this innovative concept from the beginning. President Emeritus Frank McGrath, President Edward Gibbons, and Vice-President Monty Nelson have provided administrative leadership in making the many changes necessary within The Capper Foundation Early Education Program to adapt to an integrated setting. Benith MacPherson, Director of Programs for The Capper Foundation, and Dr. Nancy Peterson, of the University of Kansas, collaborated on writing the grant proposal and have both contributed to the development and refinement of this model program.

Several persons have contributed their expertise in consulting with our staff throughout the past three years. Among them are members of the Technical Assistance Development System, especially Dr. Joicey Hurth, Dr. Sonya Prestridge, and Tal Black. We also wish to acknowledge Linda Gil, Northwest Center Child Development Program, Seattle, Washington, for providing project members with her insight into the development of integrated programs; Dr. Linda McCormick, University of Hawaii, for her invaluable input into the integration of speech-language programs and computer activities; and Dr. Doug Guess, University of Kansas, for providing specific direction and developing operational models to integrate speech-language pathology and the preschool classrooms.

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We also appreciate the important contribution made by the parents of the children enrolled in Project Kidlink for their continuing support and enthusiasm.

Preface

In July, 1984, The Capper Foundation Early Education Program received a three-year demonstration grant funded by the United States Department of Education, Handicapped Children's Early Education Program (HCEEP). The purpose of this project was to convert our segregated preschool program for children with physical disabilities into a more conventional setting by including normally developing children in the educational and therapeutic programs.

This manual describes how the early education program evolved from a segregated program to an integrated one that included day care. It is intended to help professionals who are interested in providing reverse mainstreaming services in their program, whether it be a classroom, therapy session, or parent group. Other preschool personnel who serve normally developing children but include children with disabilities in their program also will find this information useful. The policies and procedures expressed herein are the sole responsibility of the staff members of the Project Kidlink Preschool Program.

Although this manual was written from our experiences with children who have physical disabilities, we believe the concept of integration and the development of an integrated program can be applied to all handicapping conditions.

PROJECT KIDLINK:

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"Oh, what a miracle. Oh, what a miracle every little part of me.
I'm something special, so very special. There's nobody quite like me."
— *Hap Palmer*

The Cooper Foundation early education staff decided to integrate normally developing children into a preschool program serving children with physical disabilities. Several studies have indicated that both disabled and nondisabled children benefit from integrated education. Usually this integration has been achieved by placing students with disabilities into a normal classroom, a process often referred to as *mainstreaming.*

What Is Mainstreaming?

Mainstreaming is a frequently used term that has different meanings to different people. Winton, Turnbull, and Blacher (1984) define mainstreaming as educating children who have disabilities in classrooms with normally developing children for at least a portion of the school day. According to Kaufman, Gottlieb, Agard, and Kukic (1975),

> mainstreaming refers to the temporal, instructional, and social integration of . . . exceptional children with normal peers based on an ongoing, individually determined, educational planning and programming process [that] requires clarification of responsibility among regular and special education, administrative, instructional, and supportive personnel.

Children with disabilities traditionally have been educated in a segregated setting. More recently, several events have led to the mainstreaming movement within education. The 1954 *Brown versus the Topeka Board of Education* decision set a precedent for numerous court rulings decreeing that "separate is not equal." In November 1975, Public Law 94-142, the *Education for All Handicapped Children Act,* mandated a free, appropriate public education for all children with disabilities without regard to the type or severity of disability. This law also states that children with disabilities, to the maximum extent possible, are to be educated with children who are developing normally. This is usually referred to as the *least restrictive environment* (LRE) for children with handicaps. Although the concept underlying this term may be clear, the application is not as clear-cut. The least restrictive environment differs for each individual, depending on the type and degree of the person's disability. Special education services are provided in a range of settings, from hospital or institutional placement (the most restrictive type of placement) to regular class placement (the least restrictive type of placement). The law mandates that each person is entitled to the least restrictive environment appropriate for the individual's circumstances. This environment is often difficult to determine.

Meeting the Needs of Preschoolers with Special Needs

Three options for creating the least restrictive environment include a special preschool (only children with disabilities enrolled), a mainstreamed preschool (a few children with disabilities enrolled in a traditional preschool), and a reverse-mainstreamed preschool (normally developing children enrolled with peers who are disabled). The segregated special preschool does not allow children with disabilities to learn from normally developing models, especially if the program is operated in a separate building from the one used by normally developing children. For children who are severely disabled, a special class, special school, hospital, or institution could be the least restrictive setting, but this type of program does not qualify as a least restrictive environment for many other children with special needs.

A mainstreamed or reverse-mainstreamed setting constitutes a least restrictive environment for many other children with disabilities. An integrated educational environment is more normalizing for children with disabilities. Although bringing these children together with normally developing peers will not take away the disability, integration does create a more normal and less stigmatized environment. The benefits from such integrated programs are many.

The Benefits of Integration

Both groups of children benefit from integration in numerous ways:

1. The children with disabilities have an opportunity to observe, interact with, and imitate peers who provide developmentally appropriate models of behavior.
2. Normally developing children and their parents develop more positive attitudes towards people with disabilities.
3. All children benefit from the more diverse and stimulating environment in an integrated setting.
4. By being in contact with normally developing and disabled children, teachers and parents may develop more realistic expectations for the children with special needs. In turn, this may lead to more effective stimulation and educational programs for the latter children.
5. Integration can also help to widen the normalcy range within a given group and avoid children being labeled.
6. Preschool children with disabilities who experience an enriched, stimulating environment have a greater probability of succeeding in school and living more independently as adults, with a corresponding decrease in cost to society.

An Overview of The Capper Foundation

The Capper Foundation is a private nonprofit charitable organization in Topeka, Kansas, founded in 1920 by Senator Arthur Capper. The Foundation began in a two-story house, expanded to a larger building, and later added residential facilities. Although the buildings, staff, students, and programs have changed through the years, The Capper Foundation's purpose has remained constant—to educate and habilitate students with physical disabilities. A variety of services are available to assist each individual to achieve the maximum potential. Currently, the agency serves more than 120 full-time students and adults in the clinical, educational, residential, and adult work center programs. The Capper Work Center provides extended sheltered employment for adults in the community who are unable to meet the standards of the competitive job market due to physical disabilities.

The education program consists of the early education program for infants and preschoolers and the special education program for school-age students. The staff works in interdisciplinary teams of therapeutic and educational specialists to assure that all areas of development are being addressed. The early education program is accredited by the Kansas State Department of Education and licensed by the Kansas State Department of Health and Environment. Children from birth to 2 ½ years of age attend weekly infant sessions. Children from 2 ½ to 5 years old attend one of three center-based integrated preschool classrooms. Day care is offered for these children before and after preschool sessions.

The special education program for school-age children is staffed by seven special education teachers certified by the Kansas State Department of Education, Division of Special Education, who are employed through Unified School District 501. Physical, occupational, and speech-language therapies are provided based on individual need. Social workers, a psychologist, a licensed practical nurse, and an adaptive physical education teacher complete the support services staff. Residential services are available to school-age children who live beyond commuting range. Approximately 30 children live in the three residential units on the grounds. The residences are staffed by child-care workers and live-in houseparents, who are supervised by a registered nurse.

The Capper Foundation is managed and controlled by a Board of Trustees. The Board employs a president, who is responsible for carrying out the overall operational procedures in accordance with accepted standards and policies. An advisory council composed of parents and professionals in the community meets bi-monthly to provide feedback to professional staff on programming issues.

The Development of Project Kidlink

Because The Capper Foundation was a segregated setting, we realized that many of our preschoolers had limited opportunities to come into contact with other normally developing youngsters at school or in the community. Yet, within our facility, preschoolers had the benefit of full-time therapists and teachers who were certified and experienced in early childhood special education. Also, many of our children's physical disabilities were such that a regular preschool could not meet their individual needs. Realizing the many benefits of mainstreaming and the obstacles we would have to overcome in our setting, we thought, "Why not bring the normally developing children to us?" We had the staff and the space; we just needed to know how to begin.

Investigation in the community and throughout the state confirmed the need for alternative mainstreamed settings. We realized that several segregated preschools served children with disabilities, and several regular preschool and day-care centers included only a few children with mild disabilities in their programs. Including more than a few children with special needs in regular preschools usually necessitates hiring more staff to meet licensing requirements. Many centers cannot afford the additional expense involved in training and hiring the staff to accommodate these additional children.

Overview of Project Kidlink

To understand the conversion of our segregated program to an integrated one, one must understand the philosophy and team approach of Project Kidlink. The philosophy of Project Kidlink is to facilitate each child's development by creating an environment in which children with varying abilities can learn and grow from the experiences they share. The individual strengths and weaknesses of each child, whether normally developing or disabled, are identified as a foundation for presenting developmentally appropriate experiences and therapeutic intervention, if needed.

The children participate in motor, language, social/emotional, and cognitive activities to promote their overall development. Each child's needs are met through individualized instruction in a classroom or therapy setting. Small and large group activities enhance interaction among the children. Because play is essential for the optimal learning and growth of any child, the preschoolers are encouraged to play alone and together in structured and unstructured situations.

Parents play an important role in promoting the education and development of their children. Parents of normally developing and disabled children share mutual concerns regarding the care and education of their children. Involving all parents in a mutual support system enhances the integrative experience.

Team Concept

Staff members can work together in a variety of ways. When designing an integrated program, one must analyze the existing staff and how services are provided. A solid team approach is important, especially when serving more children who have a greater variety of needs.

The Capper Foundation operates with an interdisciplinary team approach. This approach to service delivery involves specialists working together to serve a group of children by meeting, planning, coordinating services, and collaborating in the delivery of a common service plan (Peterson 1987). To be effective, it requires good communication and interaction among staff members. As normally developing children were included in the program, the Project Kidlink team chose to continue this approach.

In an interdisciplinary team approach, each team member independently evaluates children referred for services. Everyone then shares and discusses the results. Staff members from different disciplines usually divide up responsibility for implementing the child's program. For example, the speech-language pathologist carries out speech and language objectives, the physical therapist motor objectives, and the classroom teacher social and cognitive objectives. Staff members collaborate to assure that all the child's goals and objectives are being met during various activities. For example, the speech-language pathologist comes into the classroom to provide language enrichment activities for a child or group of children. The classroom teacher can then incorporate that treatment plan into other classroom activities for that child, thereby extending the child's treatment. With the enrollment of normally developing children, appropriate language models often occur spontaneously in the classroom. The classroom teacher can capitalize on these moments to facilitate the learning of new skills.

Where to Begin

The transition from a segregated to an integrated setting can be relatively bumpy or smooth, depending on how the program staff meets the new challenge. Beginning direct service is much easier if one's present program is clearly defined. Identifying important issues in the transition process is helpful in making the change. First, one must analyze the existing components of the program and then revise them or add to them as needed when integration begins. In Project Kidlink, we identified five major issues: (1) administrative concerns, (2) physical surroundings, (3) parent involvement, (4) service delivery, and (5) staff preparation.

Administrative Concerns

Administratively, one of the first steps in making the transition is to help staff members develop a clear understanding of integration. The staff may conceptually agree that integration is a good idea but may not be aware of the specific ways in which integration will benefit their program. We reviewed literature on mainstreaming and integration to help us determine our program's philosophy, approach, goals, and objectives. Talking with others who had firsthand experience of integration and could share their enthusiasm was also helpful. The Bibliography and References section of this chapter includes literature that our staff found particularly helpful. Other programs that have implemented reverse mainstreaming are listed in Form 1 in the Appendix.

Another administrative consideration is scheduling the staff meetings necessary for coordinating the program. As more children enter the program, and the program takes on a new dimension, administrative personnel need to review the decision-making and information-sharing processes. Our staff members became increasingly anxious as they realized that we would have to discuss additional topics during our regularly scheduled meeting times. We were unable to fit more meeting times into our already congested schedule so we had to find ways of accomplishing more within our existing time frame.

Examining the existing needs within the community is an important step in attracting the parents of normally developing children to a previously segregated preschool program and in determining the types of services to offer. Prior to developing Project Kidlink, we conducted an informal survey to determine how receptive the community would be to an integrated preschool program. We also considered other associated services we could provide to attract normally developing preschoolers. From this survey and discussion, we realized that our own staff had children who could benefit from a preschool and day-care program. We also found that no other major preschool facilities in the area could accommodate additional children. Although we were uncertain whether the community would support our program, we were encouraged to realize that providing day-care services would not only allow us to integrate our program, but also benefit the community and our staff.

Public awareness is another matter that needs immediate attention when making the transition to an integrated program. Contacting newspapers and television stations, designing and distributing flyers or pamphlets, and participating in local community display events are ways of informing the community about new services. Our preliminary surveys also helped to determine the most cost-effective manner of publicizing our program. We have found that one of the better ways to continue to attract normally developing children is to have individuals who know about our program (and like it) share their views with friends.

Physical Surroundings

Obviously, one has to modify the physical environment in the facility to accommodate normally developing children. The first step is to review the handbook of licensing regulations and your state's guidelines for preschools. Class ratios will be determined by the number of children a preschool is allowed to serve in a given classroom space. A simple inventory of furnishings will also immediately resolve the number of additional tables, chairs, and cots your program will need to purchase. You also need to review the types of toys in the classrooms and therapy rooms.

Consider which toys and furnishings promote and hinder peer interaction. The benefits of integration derive from children with disabilities interacting freely with normally developing peers. However, the materials in our segregated program tended to be teacher-directed and, because they were designed for children with special needs, more appropriate for individual use. The philosophy underlying integration dictated that we purchase more child-directed materials. We identified particular weaknesses in our classroom equipment for dramatic play and our playground equipment for gross motor development.

Parental Involvement

The feelings of the parents of children with disabilities are important to bear in mind throughout the transition process. The way in which the staff presents the integration process to parents can strengthen or weaken the program. Initially, we chose to inform the parents of children with disabilities about the new services in writing. This approach assured that all parents would receive the same information at the same time. In the letter, the parents were encouraged to discuss their concerns about their child's involvement in this new approach with our social worker. The staff also met with these parents to discuss the change from a segregated to a reverse mainstreamed setting. This gave parents an additional opportunity to express their feelings about the involvement of normally developing children.

Our staff also discussed how to facilitate interaction between the parents of both groups of children. The entire staff was concerned about how the parents of children with disabilities would accept the normally developing children and their families. We knew that the high level of parent involvement prior to integration was largely based upon the shared experiences of parents of children with disabilities. We feared that integration might disrupt the communication lines we had worked so hard to establish. To make the transition smoother, we blended information and discussion sessions with social events for the entire family. We also designed a parent questionnaire to give our staff the information they needed to plan appropriate parent and family activities and services (see Form 18 in the Appendix).

Service Delivery

As the service delivery model changes, the staff must plan how to adapt existing services to meet the needs of normally developing participants without compromising the highly specific learning needs of children with disabilities. An initial decision was whether to establish an evaluation procedure for the normally developing children entering the program. A second decision was how to place these children into the classrooms and therapy sessions. A third decision was how to structure the classroom and therapy curricula to accommodate them. We also needed to revise our recordkeeping forms for these children. To provide for a more unified program, we found it best to use the same enrollment forms for all children. We also had to develop additional forms as our program expanded to include day-care services. The Appendix contains examples of some forms currently being used in Project Kidlink.

We also needed to examine our fee structure to meet the costs of integration. We charge a daily fee for the normally developing children who are enrolled in the preschool and day-care program and for the children with disabilities who receive day-care services. This fee is competitive with other preschool and child-care facilities in the area.

Staff Preparation

Another issue to examine is staff preparation, in particular the expertise and needs of the staff. For example, some staff members may feel uncertain about how to maintain discipline in the classroom as more active children enter it. They may require some information or firsthand training in this area in order to serve normally developing children effectively in classroom or therapy settings. Identifying staff needs and providing appropriate in-service training will result in an easier adjustment period.

As the focus of the program changes, so do the roles and responsibilities of the staff. Bringing more children into the program or expanding services to the integrated group may alter the way in which direct services are provided. To make a smooth transition, the administration needs to review and revise job descriptions as needed and communicate these revisions to the entire staff.

Major Hurdles

When beginning any new program, one is likely to encounter certain obstacles. These may differ from program to program, depending upon the type, number, and relative abilities of the children involved, the staff's expertise, the physical environment, and the operating budget. In reviewing our progress to this point, we have identified four major hurdles.

The Selection Process for Normally Developing Children

One of the first tasks was to develop a selection process for normal models. Our staff felt uncomfortable about admitting students without first observing and evaluating them. This was largely due to their background in working exclusively with children who have disabilities, where observation and evaluation prior to enrollment are necessary to ensure proper placement for each child. Based on the parents' responses to questions on the application forms, we were also concerned about ensuring that the children were indeed developing normally. If a child who appeared to be developing normally were found to have problems after being admitted to the program, we would feel obligated to provide additional specialized services in our facility or refer the child to a more suitable preschool program. By retaining this child in our program, we would also compromise our definition of a normal model.

After deciding that we needed criteria for selecting the model children, we needed to select a screening tool. We chose the *Dial-R* (Mardell-Czudnowski and Goldenberg 1983) because it assesses the child's overall development of language, cognitive, and motor skills and because it has a broad range for normalcy. This screening procedure has been successful in identifying children who possess developmental weaknesses, such as social or emotional immaturity. By screening the children, the staff also has been able to better understand each child's behavior and how the child will blend into the integrated program.

Planning Considerations

Planning considerations included making the most efficient use of our facilities, revising the daily schedule, organizing field trips and home visits, and selecting appropriate toys and equipment.

Use of facilities. In planning the use of our facilities, we first looked at how we would need to use our rooms differently in order to accommodate a larger number of children. Also, with the addition of day-care services, we had to secure additional space in the agency. Coordinating these changes with the rest of the agency was not difficult, but it was time consuming. For instance, we wondered where we could hang more coats and store the cots for nap time, where the children would eat lunch, and who would be responsible for outdoor toys after 3:30 p.m.

Daily schedule. We found that scheduling became more of a problem than anticipated. For instance, with children arriving earlier in the morning for day care, staff members needed to give direct service at that time; therefore, less time was available for staff meetings and preparing the day's activities. We also found it difficult to hire additional personnel early and late in the day to provide child care.

Logistics. Other issues, such as the logistics of taking field trips or making home visits, were also affected by scheduling. For example, we now had 29 homes to visit during the four days allotted for home visits, as opposed to 19 in previous years. Our goal of making the program internally consistent for all children enrolled became an issue every time we considered the special events we had conducted in the past.

Types of toys. Identifying the types of toys and equipment our program needed without ever having had normally developing children in the classrooms for long periods of time was difficult. By visiting other preschools and day-care centers, we became aware that we needed a greater number of toys in the classroom. For instance, one tub of pegs or one small container of interlocking toys would not be sufficient for the increased activity and creativity levels we anticipated in the model children.

Classroom Program

Within the classroom program we found there to be two major stumbling blocks. The first was whether we should provide the normally developing children with structured awareness activities concerning disabilities. About a month into the program, we realized we had done nothing to educate these children about their peers in the classroom. After discussing this, we determined that, for young children, it is better to answer questions as they arise in terms they understand rather than to provide formal instruction.

The second stumbling block was how to monitor the performance of the normally developing children. We had developed a refined procedure for periodically assessing the developmental skills of our children with disabilities. Some of the staff felt that we were neglecting the remaining children by not providing the same detailed assessment. Others believed that such detailed assessment was not necessary for normally developing children. Our decision was to continue the same procedure with the children who had disabilities and to use a checklist for ongoing developmental assessment with the remaining children. This checklist provided useful feedback about their child's developing skills to parents of normally developing children.

Therapeutic Strategies

In a setting designed for children with disabilities, service delivery generally centers around the therapy needs of the children. The predominant approach, therefore, has been one-to-one treatment sessions with the therapist initiating, prompting, and directing the child's activities. In contrast, the usual approach in working with normally developing children is educational rather than therapeutic. Most activities are conducted in groups, which enables children with varying abilities to learn from one another. Using models with age-appropriate behaviors to enhance the development of children who have disabilities requires an approach to service delivery in which most therapists have not been trained. When we introduced normal models into the program, the therapists expressed apprehension regarding their ability to develop appropriate integrative therapy sessions. Some believed that the presence of normally developing children would detract from the therapy services the students with disabilities received. We realized that we were trying to integrate the educational approach with the therapeutic approach. With our staff's increased understanding of the philosophies involved and their growing acceptance of the presence of normally developing children, we were able to explore ways of including these children in therapy sessions.

As we involved normally developing children in therapy sessions, we had to decide whether to pair a disabled child with a nondisabled child on a one-to-one basis or to provide an integrated group experience. We also had to settle which children would participate in particular sessions and whether it would be beneficial for the child receiving therapy to have the same normally developing peer participate in all therapy sessions. Finally, we had to analyze the target skills within a session and the activities being used to address them. For instance, when teaching cutting skills, how could we involve the normally developing child in a way that enhanced the ability of the child with a disability and still challenged the normally developing child? The integration of therapy has been the most difficult obstacle we have encountered. The Motorlink and Speechlink chapters suggest solutions to some of the problems of integration.

In Retrospect

As we complete the third year of Project Kidlink, our staff can use their experience to reflect on the factors that are important in developing an integrated program. We have four major suggestions for other programs that might be considering an integrated program.

Time Management

Not until the end of the first year did the staff examine how individual time was managed during the working day. After we implemented a time-management system, we found ourselves becoming more productive and efficient. We noticed that a lot of time was being wasted in meetings. We realized that a memo could, at times, convey a message more efficiently than directly contacting each person involved. From an administrative point of view, a time-management system can allow staff members greater freedom to organize their day. If individual staff members have identified their most efficient times for report writing, telephone conversations, and other duties, the administration can take this into consideration when organizing the schedule, even before the program begins. If the staff's time must be documented, a time-management code system can gather that information in a nonthreatening manner.

Labeling Children

One major issue we did not anticipate was the concern parents of children who were disabled had about the terminology used in referring to their children. We found this to be a highly emotional area during an initial parent meeting at which we introduced the integration concept. The parents openly discussed such terms as *special needs, disabled, handicapped, models,* and *normal.* Although no consensus was reached, allowing these parents some input into the choice of terms helped them accept an integrative program.

Questions about Disabilities

One of the main differences between mainstreaming and reverse mainstreaming is that when a child with a disability enters a regular classroom, the normally developing students may need some type of structured orientation because the incoming child is viewed as an exception to the norm. However, when a normally developing child enters a segregated classroom, this child is the exception. Formal instruction about disabilities under such circumstances could overwhelm the child and create fear or apprehension. Moreover, a formal discussion of disabilities when the children first enter the classroom accentuates the differences between the children rather than the similarities. We have come to believe that it is better to address the normally developing child's questions regarding disabilities when those questions arise as part of the child's normal curiosity and observation of others.

The normally developing children should be allowed to familiarize themselves with adaptive equipment as they adjust to the new environment. However, as they try out adaptive chairs, wheelchairs, or feeding utensils, it is important to remind them that these types of equipment are not toys but part of the disabled child's person.

The ABCs of Integration

Answering questions. We could not allow ourselves to be overwhelmed by all the questions we had regarding the integration process. To some questions we were able to provide immediate, clear-cut answers. To others, the first answer simply brought more questions, sometimes more difficult than the first. Some questions have been ongoing, and we have refined the answers as the program evolved.

Being prepared. The administration should prepare staff members for the changes that will take place with the introduction of normally developing children. These changes include increased activity levels, the need for more structure, and the need to meet an even broader scope of children's and parents' needs.

Communicating. All team members, including parents, must keep the lines of communication open. There are a variety of methods to use during the transition phase. These include scheduling times for individuals and groups to air concerns, developing newsletters to inform parents about the integrative program, allowing parents to meet informally without staff members present to discuss the program, and designating a person on the staff to whom the parents may turn to share their feelings. In all that we have done in the last three years, the success of our program thus far has largely been the result of developing and cultivating channels of communication between parents and staff.

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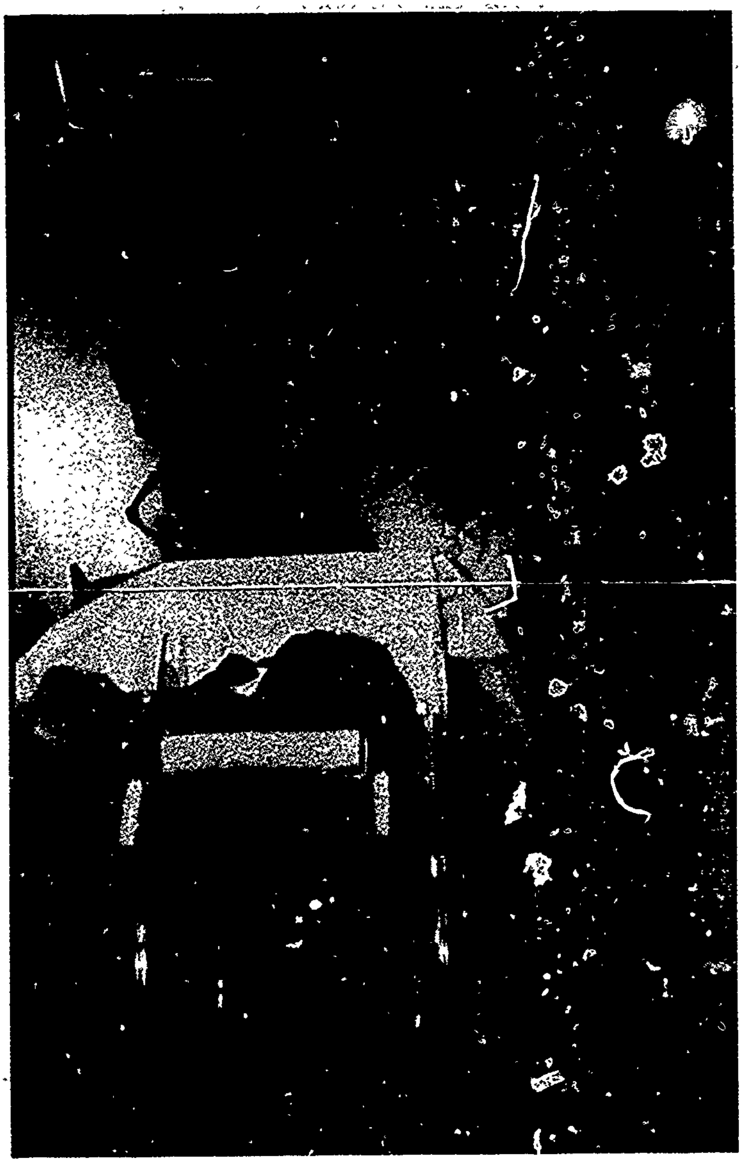
KIDLINK CLASSROOM:

An Integrated Learning Experience



KIDLINK CLASSROOM:
An Integrated Learning Experience

"Observing the joy of the children at our school as they create has made me want that joy for all children." — *Bev Bos*

Making the Transition

Making the transition from a self-contained classroom for children with physical disabilities and developmental delays to an integrated classroom requires some self-analysis on the part of the teacher. One needs to examine one's own attitudes concerning integration, as well as questions and concerns that will arise both before the new children arrive and as the program progresses. The teaching staff of Project Kidlink felt strongly that integration would be a valuable and positive experience for all the children involved. We hoped that the children would learn from each other and that all the children, their parents, and their families, would benefit. In spite of this conviction, we had many questions and concerns to address, including the following:

1. ***Will I still have enough time and energy to devote to the children with disabilities with more children in the classroom? Will I still be able to individualize the children's programs (both groups) as needed?***

   We found that the philosophy in special education of assisting every child to achieve the highest potential extends easily to normally developing children, and it becomes an exciting challenge to find ways to meet the needs of both groups of children in the classroom. There is less time for individual attention, but there are ways to work with children in groups or pairs so that the normally developing children can serve as models and motivate the children with special needs. The advantages of meeting individual needs through integration outweigh the disadvantages: The children teach and learn from one another. They tend to be more motivated by another child's enthusiasm for an activity than by adult prompting. Integration encourages teachers to think of creative ways to meet each child's needs by scheduling daily time to work with children individually and by individualizing instruction within small groups.

2. ***How can we prepare the children for an integrated classroom? How will the children react to each other? How will we deal with questions concerning other children's handicapping conditions? How will the children with disabilities respond to these questions?***

   We decided initially not to present a formal unit about physical disabilities. It seemed less threatening for the children and more comfortable for the staff to respond to questions as they arose. At times, answering a question about a handicapping condition in terms which a child can comprehend can be difficult. Children do not need or expect long, complicated answers to such questions; a short answer such as, "He uses his wheelchair to get around because he can't walk like you," usually satisfies children. One way to help a child understand an assistive device is to say, "You know how you (or someone close to the child) have to wear glasses to see better? Donna has a walker to help her walk."

We were also concerned about the feelings of the children with disabilities when other children asked these questions in their presence. Again, a simple, straightforward answer without signs of frustration, embarrassment, or discomfort on the part of the teacher usually satisfied the question without disconcerting either child. Another method for handling questions and curiosity about special equipment is to refer the question to the child who uses the equipment. The child can get a sense of pride and accomplishment by demonstrating the adaptive equipment. We also emphasize the similarities between normally developing children and children with disabilities to help them see each other as children first, more alike than they are different. For example, "Juan likes music and trucks like you do and can play ball in his chair." This strategy also focuses on something the child with a disability can do, rather than on the disability.

Adults (teachers, parents, therapists, and staff) need more preparation for integration than the children do. Young children tend to be more naturally accepting of individual differences. Although they will be curious and ask questions, once their curiosity is satisfied, they seem to accept the situation and the other child and go on with their agenda. They are more likely to reject a child who has behavior problems, such as aggressiveness, than a child who has a physical disability that does not infringe on them. Initial acceptance can become frustration if the child does not understand why another child destroys a well-built tower or comes over and grabs a toy without asking. Coping with this type of behavior is normal in a classroom. Help the children verbalize their frustration: "That made you mad when Dwayne grabbed the truck from you. Let's find another truck for him so he can give you yours." In this example, the teacher is mediating not only verbally but also by demonstrating appropriate methods for both children to cooperate in play.

3. *How will parents of both the normally developing children and the children with disabilities feel about the program? Will parents of the latter children be fearful of what this change will mean for their child and themselves?*

Parents did have concerns initially. Parents of children with disabilities were concerned about whether their children's needs would be met as well in an integrated setting as they had been previously. Parents of normally developing children were concerned about dealing with their children's questions and observations about handicapping conditions. They were also concerned that their children might pick up negative behaviors from the children with disabilities, for example, Katie trying out Robbie's way of eating. An initial "buzz session" allowed the parents to air their concerns and questions and receive input from other parents and staff. Having parents observe classroom activities through the observation window was also helpful.

Seeing the children together during the first week was exciting. Initially, all the children were shy, yet very observant of each other. By the end of the month, having children with a wide range of abilities and skills in the classroom seemed normal. In retrospect, seeing their children interact as the program swung into action tended to alleviate parental fears and concerns to a much greater extent than did the talking and preparation time, although this was also very important.

4. *Will the normally developing children play together and exclude the children with disabilities?*

   The normally developing children do tend to cluster together in free-play situations. They do not necessarily include the children with special needs in their games just because they are together in the same classroom. Your role in facilitating integration becomes crucial. The physical environment of the classroom, the availability and accessibility of toys and materials, the way children are seated and grouped together during structured activity times, the way activities are presented, and strategies to foster integration through play are important elements you can plan and implement during the daily routine. Sometimes just physically bringing a child with a severe disability near where a group of children are playing will cause them to incorporate the child into their play. Other times, cues or suggestions may be helpful in teaching the normally developing children how to include a child with a disability or in helping that child learn ways to be included in a group.

5. *How must the curriculum, materials, daily schedule, and so on be adapted for an integrated classroom?*

   The transition to an integrated classroom will require you to assess the classroom environment, structure, and curriculum to determine what changes will be necessary. Here are some things to consider:

   a. Are the materials and equipment appropriate for children with a wide range of abilities, and are there enough materials and toys to accommodate the increased number of children?

   b. Are the activity areas well defined, with easy access from one to another?

   c. Is the classroom environment either too "busy" and cluttered or too sterile for optimal learning to occur?

   d. Have you made adjustments in your daily lesson plans to accommodate the wider range of cognitive levels among children in the same group?

   e. Do the classroom activities you select promote integration and meet the needs of all the children?

   f. Is the daily schedule sufficiently well organized to accommodate larger numbers of children, yet flexible enough to allow for slower children, and does it provide a smooth transition from one activity to another?

   g. Do you have well-defined methods for assessing the skills of all children enrolled in the program?

   h. Do the program format and staff composition allow for implementation of individual educational and therapeutic goals and objectives, as specified in each child's Individualized Education Program?

   i. Does the class schedule allow for frequent movement of children in and out of the classroom to individual and group therapy sessions?

   j. Does your attitude foster a friendly, caring atmosphere in which all children are valued for their unique contributions to the classroom?

Classroom Goals within an Integrated Setting

The *Dictionary of Special Education and Rehabilitation* (Kelly and Vergason 1978; 65) defines *handicap* as "the result of any condition or deviation, physical or mental, that inhibits or prevents achievement or acceptance."

The overall goal of our program is to change at least one facet of this definition— that a handicapping condition necessarily means a lack of acceptance from others in our society. In making the transition from a segregated to an integrated classroom, you will need to establish classroom goals to facilitate acceptance. Our classroom goals for Project Kidlink include the following:

1. To provide preschool and day-care services for normally developing children and children with special needs in a classroom setting.
2. To meet the individual needs of all the children, with and without disabilities, and to provide a quality program for both groups of children.
3. To provide opportunities for children to interact with peers who have varying developmental levels, broadening their understanding, creativity, and acceptance of individual differences and similarities.
4. To provide opportunities for informal parental interaction and involvement, such as bringing parents together for classroom parties or a dinner after school.
5. To encourage constructive and accepting relationships between children with and without disabilities and to promote positive interactions between children during play.
6. To develop children's independence and to make any necessary adaptations in toys, materials, and activities to help children explore their environment and learn through play.
7. To foster the development of internal controls that help a child distinguish right from wrong and develop a moral sense.
8. To encourage the development of creativity in all children through providing varied materials, enriching experiences, and teacher assistance to help children develop and extend their ideas.
9. To foster children's abilities to choose activities and make and carry out plans.
10. To nurture a positive self-concept in all children through giving them a sense of being loved and accepted in the classroom environment.

Classroom Composition

There are three integrated preschool classrooms in Project Kidlink, serving a total of 30 children between 2½ and 5 years of age. Project Kidlink maintains a ratio of one normally developing child for every two children with special needs in the early education classes. The children's physical needs, chronological ages, and developmental ages determine the classroom composition for an academic year. Each classroom is staffed by paraprofessionals and a teacher certified in early childhood special education. Classroom A serves the youngest and most severely disabled children (chronological or developmental age approximately 2 1/2 to 3 years). This classroom includes 6 children with special needs and 3 normally developing children with one teacher and one paraprofessional. Classroom B serves children 3 to 4 years of age and includes 6 children with disabilities and 3 normally developing children with one teacher and one paraprofessional. Classroom C serves older children with mild to moderate disabilities. These children are generally ambulatory. This classroom may contain up to 12 children between 4 and 5 years of age—8 children with disabilities and 4 normally developing children—with one teacher and two paraprofessionals.

Day-care services are available to 15 of the 30 preschoolers. Early education classes are held from 9:00 a.m. to 12:00 noon. Day-care services are offered from 7:30 to 9:00 a.m. and from 12:00 noon to 5:30 p.m.

Individualization of Children's Programs

Individualization means meeting the needs of all children, yet it does not necessarily mean one-to-one instruction. The term individualization, in our integrated program, takes on a much more global meaning and occurs before placement in the classroom and during the classroom activities.

Before Placement

All children are evaluated before being accepted into the program. The evaluation procedure—including the staff involved, tools used, and the length of the evaluation—varies depending on the individual child's needs. The early education teachers are primarily responsible for assessing the cognitive and social skills of the preschooler. Other team members evaluate the child in their respective domains. The following assessment tools have been beneficial and easy to administer to our preschool population:

Learning Accomplishment Profile, Diagnostic Edition (Revised) (Griffin et al. 1977)
Early LAP (0-36 months) (Glover et al. 1978)
Las Lunas Curricular System (fourth edition) (Everington et al. 1982)
Portage Guide to Early Education (Bluma et al. 1976)
Wisconsin Behavior Rating Scale (Jones and Song 1979)
Brigance Diagnostic (Brigance 1978)
Capper Preschool Checklist (The Capper Foundation, no date)
Boehm Cognitive Skills Assessment Battery (second edition) (Boehm and Slater 1981)
DIAL-R (Mardell-Czudnowski and Goldenberg 1983)

The information obtained at the evaluation is used to develop an Individualized Education Program (IEP) for each student with a disability. The IEP form is the standard form used within our school district. Although normally developing preschoolers do not need targeted developmental goals and objectives, we have devised a form similar to an IEP, called the Individual Developmental Plan (IDP). This is the basic form used during conferences with parents of normally developing children. A copy of the IDP is contained in the Appendix, Form 10.

After the staff has written IEPs or IDPs for all the children, the teacher can coordinate this information in planning activities for individuals, small groups, or large groups of children. Even though the needs of the whole group may be very diverse, you can individualize instruction within the group by knowing each child's developmental abilities and needs.

Classroom Individualization

With an increased number of children and a wider array of developmental needs, ongoing assessment of the children's abilities and interactions can be challenging. We have developed three primary techniques for evaluating the individual needs of all children within the classroom setting.

Ongoing assessment of children's skill levels: You can frequently measure children's abilities during teacher- or child-directed group activities. For instance, you can assess color skills during an activity that involves color matching and color identification. When playing a game in which players or moves are determined by color, have the children identify the colors on the markers, spinners, or cards. This type of assessment is a good way to see which children have generalized a specific skill.

At times a child's skills must be evaluated individually. Because of the greater number of children in the classroom, we have had to schedule individual testing times in advance and to involve the other children in a group activity with another staff member, usually the paraprofessional. Having all the testing material set up in advance allowed for the best use of testing time.

Observation notes or videotapes: Observation notes are a valuable tool for documenting children's daily interactions and developing skills, especially in the area of social skills. Although making observation notes requires extra time (either during or immediately after an activity or during regularly scheduled planning time), these notes are invaluable in documenting children's actions and reactions in the classroom, monitoring how integration is developing within the classroom, and identifying activities that are particularly effective in achieving integration.

Videotaping is another useful method of documentation, although the drawback is that an instructor often has to leave the classroom to set up and run the equipment. Reviewing videotapes of classroom activities helped us to identify subtle as well as not-so-subtle interactions within the classroom. These interactions were not always obvious while the activity was being presented. We also used the videotapes during conferences with parents to document their children's development and interactions.

Communication notebooks: A communication notebook passed between the teacher and parents of each preschooler was another tool for individualizing programming. For our children with special needs, the notebooks informed the teacher and parents about events at home and in the classroom that the child might not have had the communication skills to relay. For normally developing children, the notebook provided an easy way to update everyone about the child's school and home activities, especially when the child was enrolled in day care, and the teacher didn't see the parents daily.

Classroom Organization

When integrating normally developing children into the classroom, you will need to consider three aspects of classroom organization: room arrangement, toys and materials, and program planning.

Room Arrangement

Room arrangements are affected by classroom size and the needs of the children in the classroom. Observing other preschool centers and, if possible, observing an integrated program can be extremely helpful in making the conversion. Observe traffic patterns, how equipment is stored, and the types of toys and equipment provided to identify adjustments you will need to make as you incorporate active, normally developing children into your facility.

When arranging the classroom, consider the needs of both ambulatory and nonmotile children. Wide open spaces are essential for accommodating children who crawl or use such adaptive equipment as wheelchairs, trays, braces, and walkers. Areas need to be partially divided, however, to provide boundaries for various activities. In many traditional preschools, the interest areas are divided by bookcases, shelves, lockers, and similar furnishings. In an integrated setting, however, it is important that all the children can be seen at any given time. To make the best use of an observation room, the room also should be organized so that children face the observation mirror during group activities.

At The Capper Foundation, each classroom is arranged in centers or areas, and materials are labeled and stored where they are easily accessible to the children. This fosters independence, helps children develop a sense of order, and promotes cognitive skills such as sorting and sequencing. The classrooms include an art center (paints, crayons, brushes, markers, paper, chalk, scissors, modeling clay, collage materials, glue, tape, staplers, sponges, pencils, and so on), a quiet center (books, puzzles, games, and other table activities), a block center (various kinds of blocks, trucks, cars, building toys, and so on), a dramatic play center (housekeeping and dramatic play materials), and a computer center. A large rug in each classroom is used for group activities such as morning circle, reading to a large group of children, or music activities. With wheelchairs in the room, the preferred rug is bound, does not scoot on the floor, and has a low pile or is fairly smooth. A large rug in the housekeeping center is recommended.

Do not overlook the bathroom when considering room arrangement. Is the bathroom large enough for toileting, diapering, and cleaning up additional children? You may be able to adjust the traffic pattern to accommodate more children, rather than remodeling the bathroom.

Toys and Materials

Generally, toys for preschool children, whether in a regular or special preschool, will still be appropriate in an integrated setting. Due to larger classroom enrollment, we found that we needed a greater quantity of certain items, such as blocks or beads, rather than a larger variety of toys. How you use toys and materials to meet the varied needs of individual children in the classroom and promote integration is more important than the specific toys you select.

Toys to use when teaching children with different ability levels in the same group. Activities that can be adjusted to different ability levels promote integration, whereas those that are geared to one level stifle it. Instead of having the children sit down to count beads, for instance, you might pull out several containers of small counting and sorting objects. Some children will immediately start sorting, others will count, and others may need help with one-to-one correspondence. A more involved child may need to practice following directions such as, "Put it in." For a group activity with numbers, provide pictures, objects, and numerals. One child might count the number of blocks in a sack containing blocks and other items. A second child might just count all the objects; another child might discriminate and find the cup; and another might just practice taking things out of the bag.

Toys for promoting social integration skills. Sometimes a child needs to adapt to a toy; other times the toy needs to be adapted to the child. Toys that two children can use together are great for integration. Take a regular pounding bench toy with one hammer, for example. Why not set out one bench and two hammers? Or try putting out two benches and two hammers. Depending on the children's level of play, integration can occur spontaneously. Two hammers with one bench can foster turn-taking. If children are still using parallel play, giving a bench and hammer to each child may promote a new awareness of the other child.

Special toys to purchase. Include toys in the dramatic play area that both groups of children can identify with and that can spontaneously foster their growth. Be sure to include dolls representing a variety of ethnic groups and disabilities. HAL'S PALS™ are excellent dolls to include in a dramatic play center. (They are available from Hal's Pals, P.O. Box 3490 Winter Park, CO 80482.) Stuffed animals that have disabling conditions (a monkey in a wheelchair, a snake on a scooter board, and an elephant with a hearing aid) can be purchased from Special Friends, P.O. Box 1262, Cowell, MD 01853.

Computer. How does a computer fit into an integrated preschool program? How can one game or program fit the needs of two or three children with different developmental levels? The solutions to these challenging questions are mostly attained through trial and error along with continual reassessment and readjustment. Just as technology is constantly changing, so too are children's needs and developmental levels. The programs you select should adapt to varying developmental levels and be reevaluated and readjusted as the children's skills change. Here is a list of key points to consider when using computer activities:

1. Resources: Use your resources! Search, explore, and experiment! Consult with experts about the variety of available software and input devices and the sources for obtaining them. Borrow the software so the teachers can review it and try it out with children. Children's skills with computers are often amazing.
2. Types of programs: Look for programs that a child with disabilities can use together with a normally developing peer. Both children do not necessarily need to understand the entire program, but it should be interesting enough to hold

their attention. You also can use one program to achieve different goals with each child. For example, one child may be learning cause and effect by hitting a switch to make a color appear, while the other child is matching a color-coded key to the color on the screen.

3. Turn-taking: Turn-taking is a learned skill that is an important prerequisite for many daily activities. Children often develop or refine this skill when working together on the computer. Additional hardware for the computer, such as switches, can enhance turn-taking, especially for physically limited children. The following chapter gives suggestions for promoting turn-taking on the computer.
4. Input devices: Game paddles can be used with a variety of programs and are excellent for turn-taking among two or more children. If the children use one paddle, they will have to pass it back and forth, which is better for children with less understanding of turn-taking. Paddles can also be adapted with jacks to incorporate switches. When using a paddle and switch, the child using the switch needs to understand when to take a turn. Encourage the child using the paddle to signal the other child's turn by placing the paddle in view of the second child. If you do not institute a structured protocol for turn-taking, two children may try to take a turn simultaneously.
5. Positioning the children: Several variables affect positioning. For example, do nonambulatory children work best in their wheelchairs? If so, how should the other children be positioned around them? What are the developmental ages of the group? Younger children (up to 3 years old) may work better sitting on rugs or in chairs to define their space. Older children may work just as well standing, sitting on the floor, or possibly lying down on their stomachs.

Program Planning

"What are we going to do now?" was a frequent question with the enrollment of normally developing children in our program. That the children had a wide range of abilities, interest levels, and attention spans was very apparent upon screening and even more evident after the first few weeks of Project Kidlink. To answer this question, we reviewed how we planned activities for the day, the week, and the month. We found that scheduling was a key ingredient in successfully meeting the needs of all children. In planning our schedules, we had to work within the following parameters:

1. Length of the school day
2. Regularly scheduled events (lunch, opening/closing of the day)
3. Individual teaching styles of teachers
4. Set blocks of time (half-hour time blocks)
5. Abilities of the children in the classroom

We plan activities in thematic units lasting from one to four weeks. The themes themselves are less important than the types of activities that evolve from them. All three classrooms follow the same theme plan, with each teacher being allowed the flexibility to choose activities that meet their classroom needs. Each classroom follows a similar daily lesson plan, although the activities within each time block vary from classroom to classroom. We follow a cognitive and developmental approach to teaching, adapted for each group of children and individual teaching styles. We had difficulty scheduling time blocks for all areas of development within one day (that is, fine and gross motor, cognitive, speech-language, and social/emotional), so we organized these activities around a consistent weekly schedule.

These activity time blocks highlight specific skill areas, although any activity can enhance all developmental areas:

Time Block	*Primary Skill Area*
circle time	cognitive
art time	fine motor, self-expression
music time	language
story time	language, cognitive
choice time	all areas
snack time	fine motor, social/emotional
outside time	gross motor
adaptive P.E.	gross motor

Activity Strategies for Developing Interactions

This section describes management techniques to use for promoting integration in the classroom.

Peer-to-Peer or Buddy System

In peer-to-peer activities, a normally developing child is paired with a child who has a disability. After initially pairing the children, allow them to play freely. Intervene as needed with indirect suggestions: Rather than saying, "Tell John to play with the blocks," say something like, "Maybe you can ask John to play with the blocks" or "I'll bet John can help you build a tall tower."

This system seems to promote associative play, which is appropriate for children who are developmentally 3 to 4 years of age. Such a pairing sometimes can promote interactive play (for example, sharing the same toy or activity or building together with blocks). You may be able to suggest ways for the normally developing child to adapt the game to the friend's disability. For example, "Joanna, you set up the blocks, and Elaine can knock them down."

Small-group situations were designed to include one normally developing child in each group. It wasn't always necessary to purposely divide the children this way. Occasionally, children would go to an activity spontaneously because they wanted to be near a friend. Small-group work on cognitive skills encouraged the children to learn from each other. Children with differing cognitive levels were able to work successfully in a group using one set of materials. In a group setting, emphasize that all children are playing in their own ways and encourage the children to be spontaneous and creative.

Learning Centers

One purpose of learning centers is to foster independence. They can be designed to enrich cognitive, fine motor, gross motor, dramatic play, or prereading skills. Learning centers should be simple and easy to put together and clean up, and the activities should be easy to explain to children.

Children will naturally cluster in areas that interest them. Younger children will require more direction to make purposeful use of the centers. Although the dramatic play area is a natural medium for integration, children who are developmentally too young to initiate pretend play may not interact without intervention.

Tips for Integrating the Classroom

Q: How can turn-taking promote integration?

A: Allow the normally developing child to take the first turn, thus modeling an appropriate response for the other child. This also encourages the child with a disability to respond appropriately. Turn-taking promotes awareness of others: "First it's my turn, and then it's Mary's turn." The children can take turns being leader, and the leader then picks the next child to take a turn.

Q: What materials promote integration?

A: Materials that require children to share or work together will give them increased opportunities to notice each other. Children may imitate what they observe other children doing with the materials. In this situation, children may begin to play together cooperatively and may talk back and forth while cooperating on a group project (such as a mural).

Q: Is it necessary to require that disabled and nondisabled children play together all the time?

A: A child should never be told to play with another child. Qualities that foster integration—loving, kindness, caring, curiosity, and a natural need to make friends—are all qualities that most children develop independently. Many children choose to play with children who have similar interests, although motor activities may need to be adapted. Perhaps a normally developing child could sit on the merry-go-round with a child who has a disability or help the child during selected activities. For example, during a recent recess, Susan, a normally developing child, was observed sitting on the seesaw with Mike, a 4-year-old who cannot sit independently. Susan has a younger brother who is 10 months old. As they were seesawing, Susan remarked, "This is how I sit with my baby brother. I know how to hold you, too, Mike!"

When two or more children play or work together, they observe, imitate, share, and talk to each other. When children who have different levels of development play together, you may want to praise them or give them positive suggestions: "You and Joe can work together to cook the dinner" or "I like the way you and Julie are building together." Most group activities can promote integration if you plan the activity to involve and interest children who have different skill levels.

Limited Selection

The teachers of the 2½- to 3½-year-olds needed to arrange more teacher-directed or structured activities in the various interest areas because the children required prompting to select toys. One teacher commented, "If I don't set out any toys at the quiet table, no one wanders over there. When I set out crayons and paper at the table, no one thinks to go to the art shelf for scissors or glue." Younger children need more direction and limited choices.

Field Trips

Although field trips are not necessary in preschool, they can enhance pre-academic and social development and provide an added dimension to the experiences children have in the program. Most field trips are a natural setting for integration. For instance, a trip to the zoo is enjoyable and stimulates language. Buddies interact verbally, ask questions, and respond to each other's comments.

Choose a field-trip site that will provide an array of visual and tactile stimulation and involve age-appropriate subjects. When preparing for a field trip, make sure the tour guide will be able to give simple explanations and information. You will also have to schedule appropriate transportation and recruit additional adults as chaperons. This is an excellent opportunity to involve parents in an enjoyable outing with their children, where the parents can meet their children's friends and become better acquainted with other parents. Taking field trips also heightens community awareness of your facility and children with special needs.

Children's Reactions to One Another

> *"A child is innocence meeting the world with a trusting, outstretched hand, curiosity discovering the world unhurriedly, unplanned. A child is laughter, conquering the world with an open, smiling face. A child is love, uplifting the world to a happier, higher place."*
>
> — *Kay Andrew*

Social skills are learned: Infants begin interacting with others as soon as they enter the world. A child cries out for comfort; a nearby adult cuddles or feeds the child. The child reaches out; the adult responds. Relationships develop through give and take. When social skills are reinforced, children learn and integrate these skills into their social development schemes.

Preschool children are just beginning to explore feelings, to reach out and test the waters of emotions. They are barely beginning to develop values and generalizations about the world. Blind acceptance is beginning to fade as the children begin to ask questions. This is the perfect time to influence children's opinions and feelings in a positive way. Young children are open to learning about and accepting differences. They learn that similarities and differences are a part of everyday life.

An integrated classroom can teach a healthy, positive understanding of individual likenesses and differences. Young children learn through play. Children learn by interacting with objects and people in their environment, asking questions, and receiving positive feedback. For optimal social development, it is important that children receive positive and honest answers to their questions.

From the very beginning of our integrated program, parents of normally developing children have asked, "How do we answer our children's questions about ______?" The response was usually, "Short and brief, positive and honest." This theory is supported by H. James Holroyd, M.D., clinical professor of pediatrics at the University of Southern California School of Medicine and advisor to Mattel, who stated in *Ladies Home Journal* (1987, 48), "It's just like questions about sex. Answer the immediate question; don't explain the universe."

Sometimes children ask questions and sometimes they don't. Very young children (2½ to 3 years) often watch and observe rather than asking questions. Older children (3 to 5 years) are more able to express themselves verbally and to formulate their observations into questions. Children at every stage are developing and refining their understanding of feelings. They need to know that questions are okay. It is important never to hush a question or ignore it. This could cause a child frustration, embarrassment, and confusion.

Questions seem to occur in one of four contexts:

Child asks child. Often children answer each other's questions in a more satisfying and understandable way than an adult would. One child with an ileostomy was asked by a peer, "How come ya' still wearing diapers?" The child's response was, "The doctor told me to." No adult interference was necessary. The question was answered briefly and to the point, and the questioner was satisfied.

Child asks child and adult intervenes. At other times, adults may feel the need to step in and reword questions or guide answers. For example:

Susie: "Johnny, clap your hands!"
Kathy: "He can't clap his hands."
Susie: "Why not?"
(Silence)
Teacher: "He can with help. Maybe we can help him."

Stepping in with a positive answer and a solution will help children see similarities between themselves and the child who has a handicap. (Johnny can clap like me even if he needs help.) The child with the disability will feel similar to, rather than different from, the other children. (I can clap like they do, even if I need a little help.)

Another strategy might be to give the child an alternative to clapping, such as banging on the table with the hands. The other children may learn that people can participate in an activity together and enjoy being in a group, even if they participate differently.

Child asks adult. Some questions will be directed at adults in the classroom:

Q: "How come Johnny can't walk?"
A: "His muscles aren't strong enough."

Q: "Why can't Susie stomp her feet?"
A: "She can if she sits down, or if we help her."

Q: "Why does Leroy use that switch?"
A: "So he can take turns with the computer, too."

These examples illustrate positive problem solving. Keep answers short and pertinent to the situation at hand. Taking turns with the computer is not the only reason why Leroy uses a switch. Perhaps another child would continue to question, "But why doesn't he use his hands to push the keys?" The teacher could continue by saying, "Because the switch works better for him."

Child asks child and then adult. One child may ask another child, not receive an answer, then look to an adult to answer. You may help the child who was originally asked to answer the question. For example, Bill, a child with a mild physical disability, had his pant leg rolled up, exposing his brace. Sarah asked, "What's that?" Bill looked at the teacher for help, and the teacher said, "Go ahead and tell her." He said, "It's my brace." Kara, another normally developing child, asked, "What does it do?" Bill replied, "It hurts." Then the teacher whispered to him to say, "It helps me walk." That statement satisfied everyone. Bill's answer was honest, but it was also important that the teacher help him continue his answer to include the positive function of the brace.

Questions at Home

Sometimes children will ask questions or talk about feelings at home that they do not even think about at school. Often they need to digest their thoughts and feelings before expressing them. Questions come in all shapes and sizes, just as children do. Encourage parents to answer specific questions briefly and positively, and the children will take it from there, building on their own knowledge. Children's questions and the answers they receive are like bricks in a building: Each one contributes to the final product.

Exploring Feelings

During the preschool years, children develop a sense of self-worth and self-confidence. They learn to feel pride and disappointment, joy and sorrow, excitement and anger. In an integrated setting, a child with a disability may feel afraid when trying to imitate a normally developing child in a task that the disability makes challenging. A normally developing child may feel scared of a child who "talks funny" or uses braces or a wheelchair. As the children become acquainted and discover common interests, these fears will disappear or be reduced. As friendships form and trust develops, differences in ability levels become secondary to the relationships.

Kids Are Kids

Integrated classrooms are catalysts in bringing together two groups of children in a setting where likenesses are reinforced and differences are accepted. Within these classrooms, we have evolved, developed, and changed new programming ideas. By fostering social interactions among preschoolers, we have broken down barriers of prejudice at an early age. As child-to-teacher ratios have increased, the teachers have refined their teaching skills to meet the needs of all children. Also, parents have bridged the gaps between one another by discovering that they have more similar experiences in parenting than differences.

The discovery of one's similarities and differences has been an enjoyable experience for the children involved in Project Kidlink. As teachers, we have found that children are children and people are people. We believe that children are more alike than not and that differences are all right and can be positive. How one handles the situation makes the difference.

We in Project Kidlink have always tried to present a positive attitude towards children and classroom situations. The children have internalized this positive attitude and shared it with one another. For example, a nonverbal child, Jeff, was included in circle/music time. A peer, Jerry, observed this child "singing." The teacher asked everyone to help during the song. Jerry commented, "Jeff's singing. He's just moving his mouth and singing quietly!" Jerry did not say, "Jeff can't sing." He did not ask, "Why isn't he singing?" He made a positive statement, "Jeff is singing." Teacher, staff, and parent attitudes do make all the difference. Children learn from those around them.

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COMPUTERLINK:

Suggestions for Computer-Based Activities in an Integrated Preschool Classroom

COMPUTERLINK:
Suggestions for Computer-Based Activities in an Integrated Preschool Classroom

The substance of this chapter was presented to the Council for Exceptional Children, Chicago, 1987.

One issue of concern in the early 1980s was the effect of the microcomputer on the social and language interactions of young children. Some researchers have cautioned that early use of a microcomputer could have a deleterious effect on development. They feared that teachers and parents would allow microcomputers to replace manipulation, imaginary play, and experiential learning, leading to social isolation and subsequent language deficiencies in young children.

Fortunately, early fears that the use of microcomputers would isolate children, reduce social interactions, and hamper social-emotional development have not been borne out. It has been noted that electronic programs can be either toys or tools. Indeed, the most appropriate perspective for preschoolers and their best introduction to computers may be as toys. Identifying computer activities as play has an added advantage: In addition to being a productive and satisfying enterprise in and of itself, play is the preschool activity most likely to stimulate high levels of social and communicative interaction.

The available research on computer use with young children strengthens the contention that microcomputers have benefits that go beyond their potential as a tool or as a tutor. Computer activities seem to be effective in promoting interactions among normally developing preschoolers and among preschoolers who have disabilities. To date, however, there has been little attention to the effects of a computer activity on interactions between preschoolers with and without disabilities. Among the questions to be answered are, What type of peer combinations and which software-hardware combinations promote the most communication and the most complex social interactions, and What are the characteristics of different computer activity arrangements that account for observed interactive behaviors?

Staff members at the HCEEP-sponsored preschool program at The Capper Foundation are conducting pilot investigations to answer some of the many questions related to young children and computers. What follows are some tentative findings (expressed in the form of recommendations) that derive from this pilot research.

Arrange a Computer Activity Center

The children should view the microcomputer as a permanent fixture in their classroom. It should be kept in a designated activity area where it is easily accessible to individual children or small groups. (The teacher may move it to a more central location for large-group activities.) The computer activity center should be well lighted and away from the general traffic flow in the classroom.

If placed on a low table or shelf (14 to 18 inches high), the monitor will be at eye level for children seated on the floor. This floor-sitting arrangement (with or without carpet squares) seems best for most small groups, as it minimizes the disruptions of shuffling chairs and of children being out of their chairs and blocking others' view of the monitor. If one or more of the children are seated in adapted chairs or wheelchairs, however, the other children should be at or near the same height so the monitor is at eye level for all participants. Placement of input devices (including the standard keyboard) will, of course, depend on the motor capabilities of participants.

Minimize Adult Input

Adults seem to have a suppressive effect on children's vocalizations in computer activity groups. Children in integrated small groups (one child with a disability to two models or two children with disabilities to one model) tend to vocalize substantially more when no adult is present or when the adult refrains from offering comments and suggestions.

Teachers should arrange to provide each child with initial individual instruction sessions so the child is competent with the input device(s). They should then make an effort to minimize their input in dyadic and small-group computer activities. Encourage the children to experiment with and attempt to understand their new plaything. Permit them to solve their own problems and resolve their own conflicts, to the extent possible.

The interest level of the software and the type of input device will have a pronounced and dramatic effect on the amount of cooperation and turn-taking. The best software programs have a variable or flexible difficulty level that is suitable for children at different cognitive levels. Teachers should be able to customize at least some parameters of the program (for example, speed and pace). Another very important characteristic of programs for preschoolers is appealing auditory and visual feedback.

Reinforce Cooperation

Children can be persistent, creative, and successful in prompting and achieving turn-taking and in coordinating their movements and energies with other children. Moreover, in a computer activity, normally developing preschoolers seem to be generally responsive to the needs of their peers with disabilities, often briefly assuming an instructional role. They should be reinforced (on some variable schedule) for these positive behaviors.

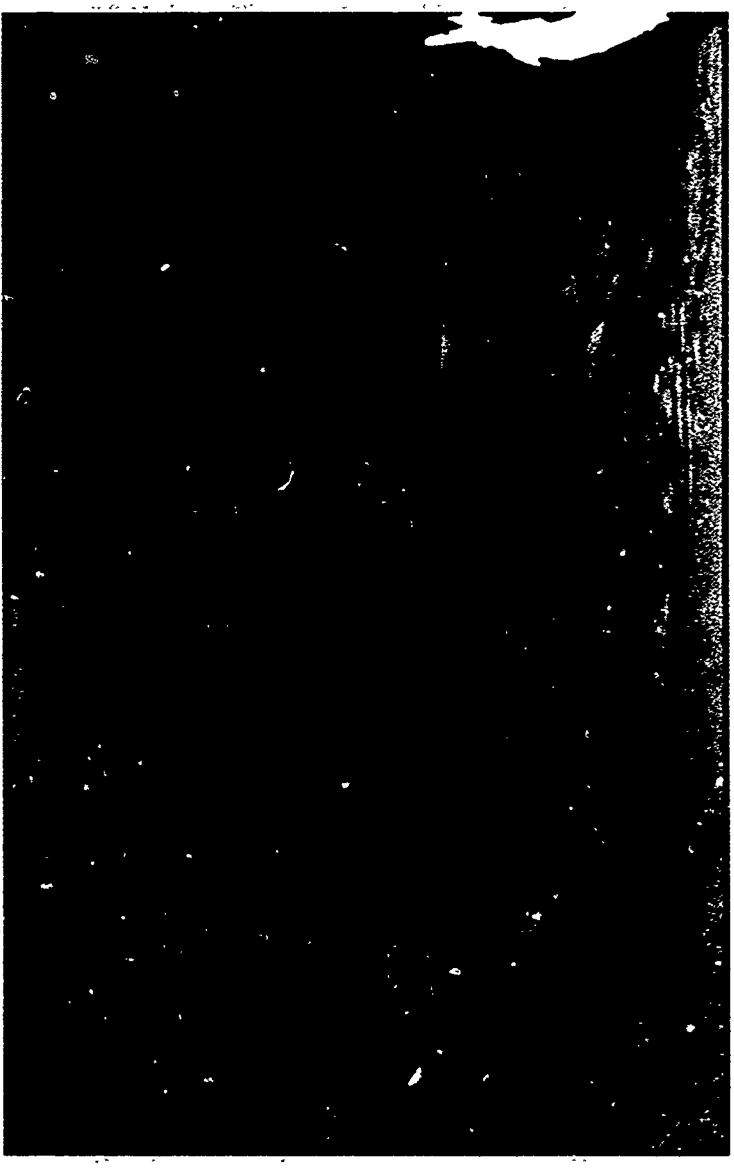
Presenting preschool computer activities as cooperative (as opposed to competitive) situations is very important. The only externally imposed rule is that the children take turns. In this context, it is not important whether the children receive any particular instructional benefits from the software. It is a good idea to follow computer activities with other activities that include opportunities for cooperation and turn-taking and to point out the commonalities. (For example, "We take turns and help one another with the wagon just like we do with the computer.") Also make cooperation and turn-taking the topic of discussion at morning circle and snack time for a week or two. Discuss the numerous ways that children can share and help one another at school, at home, and on the playground.

Try to Equalize Input Possibilities

Even the most minimally controlled physical response can be adequate to permit a child to participate in a computer activity with peers. There are a variety of factors to consider when deciding on the type of alternate input device or standard keyboard adaptation to use with a child who has a physical impairment. (An overview of input devices and decision factors is beyond the scope of this chapter.) Once the most appropriate input device (joystick, pressure-sensitive pad) has been selected for the child with a disability, having the other group participants use the same device is usually best. Exceptions to this recommendation include cases where the child needs a specialized input device for a specific body part, such as a chin switch.

MOTORLINK:

Occupational Therapy in an Integrated Preschool Program



MOTORLINK:
Occupational Therapy in an Integrated Preschool Program

"Therapy is most effective when the child directs his own actions while the therapist unobtrusively directs the environment." —*A. Jean Ayres*

Occupational Therapy Before Integration

Prior to the initiation of this demonstration grant, the children attended a three-hour preschool Tuesdays through Fridays. The child left the classroom to receive direct occupational therapy, physical therapy, and speech-language pathology services. We offered occupational therapy on an individual or small-group basis (two or three children) in the occupational therapy department, which is physically separate from, but in the same building as, the three preschool classrooms. Large groups of six to eight children participated in a weekly fine motor activity in the classroom, which emphasized activities requiring eye-hand coordination and the use of tools such as scissors, glue, and writing utensils. The occupational therapist and occupational therapy aides managed the class while the teachers and paraprofessionals were free to perform other duties elsewhere in the building. Biweekly swimming sessions were held for each classroom with instruction and supervision from the occupational and physical therapists and various classroom and therapy aides. We shared information with the teachers via in-services, unscheduled consultation, and weekly team meetings.

Children were enrolled in occupational therapy to manage such conditions as abnormal muscle tone, congenital malformation of the upper extremities, delayed self-care skills, including feeding and dressing, tactile system disorders, vestibular and bilateral disorders, and delays in fine and gross motor skills. The frequency of therapy was determined by the severity and extent of the child's physical involvement, tolerance for therapy, involvement in other therapies, and the number of days the child attended the program. Also taken into consideration was the level of individualization and specialization the child's program required. For example, a less physically involved child may have received more sessions per week, but a portion of these would be administered by an aide or in a group setting. Children with age-appropriate fine motor and self-care skills and apparently normal sensory and motor system integration did not receive occupational therapy prior to the inclusion of normally developing children in the program.

The Challenges of Providing Integrated Occupational Therapy Services

Project Kidlink challenged the occupational therapy department and gave us the opportunity to change our service delivery model. This challenge brought with it several concerns: The reasons for having an integrated classroom were clear, but why integrate therapy? Would it accelerate or detract from a child's progress to have a normally developing child included in therapy? Wouldn't the additional child be bored? Distracting? What if the new child made the child with the disability feel inferior, thus discouraging rather than encouraging the child?

Other challenges were those of improving communication and follow-through of occupational therapy treatment with the teachers and enhancing the skills of therapists in providing self-directed therapy. As Jean Ayres states, "Within every child there is a great inner drive to develop . . . a child searches his environment for opportunities to develop . . ." (1979; 15).

We were able to observe a wide range of age-appropriate motor, self-care, and social skills in the normally developing children during the initial screening and again later during more in-depth testing and observation conducted to pair each child with a buddy for therapy. The extended day-care hours also made our schedules more flexible, as certain children were available in the building during the afternoons for demonstrations, treatment, or fitting of adaptive equipment and splints.

A drawback to initiating an integrated therapy program was the time demand of starting any new program (researching the literature, brainstorming with consultants and team members, and observing integrated classrooms). Working out plans with the grant coordinator and consultants—mostly educators—to determine how to make integration work for occupational therapy was also time consuming.

As the program evolved, it became apparent that the success of integration is influenced by several variables. Some pairs of children mix well and others do not. Some treatment procedures work well and others do not. Each therapy session has to be evaluated on its own merit.

Selecting the Normally Developing Preschoolers

All models were arena screened for motor, conceptual, and language development using the *DIAL-R* (Mardell-Czudnowski and Goldenberg 1983). The occupational and physical therapists were responsible for administering the motor portion, an early childhood educator administered the concepts portion, and the speech-language pathologist administered the language portion. This format allowed the team to meet each child being considered for the program and insured a certain base line of skills and abilities in the children. In addition to specific assessment items, the child's willingness to perform, hand preference, dexterity, balance, and general coordination were observed.

The model children attended the classroom program daily for several months before being integrated into the therapy programs. This allowed the therapist to make further observations of the children's activity levels, interactions, and personalities. We individually tested most of the models further using the *Peabody Developmental Motor Scales* (Folio et al. 1983) whenever a child regularly scheduled for therapy was absent. This is the assessment we use most frequently to assess gross and fine motor skill development in children from birth to 8 years of age.

Integrating Occupational Therapy Services

We began to examine new methods of providing treatment that promoted integration. Teachers suggested taking equipment into the classroom and carrying out the prescribed treatment in that setting. This option, although reasonable, did not fully integrate occupational therapy intervention. We were also afraid that the distractions and noise level in the classroom would increase with the additional people and activity.

Adding models to individual sessions seemed relatively easy for skill practice, such as dressing, fine motor activities, and for sensory integration therapy. These therapeutic approaches require relatively little hands-on treatment and are activities that all children enjoy practicing. On the other hand, it seemed impractical to add models in hands-on treatment to decrease tone, increase range of motion, and normalize movement patterns.

As therapists schooled in the traditional mode of service delivery, we went through a process of moving from an approach with which we felt comfortable to one that included normal models. We reviewed the available literature on mainstreaming in education, as little has been written to date regarding occupational or physical therapy. We observed preschool and day-care centers for normally developing children, including the lunchroom, playground, and structured and informal classroom activities. We observed the normal models once they were enrolled in our integrated program. Finally, we moved into therapy by planning a simple, enjoyable session and bringing in a model to "play." The children interacted naturally with each other, and we used their behavior as a guideline for planning future treatment sessions. We also found it important to talk with other professionals, because they shared our concerns and helped stimulate ideas.

Selecting the Models for Occupational Therapy Sessions

As we became acquainted with the normally developing children, we developed the following criteria for selecting models for paired individual sessions:

1. *Developmental level.* The partners should have roughly similar fine and gross motor skills, although not necessarily equivalent chronological ages. Partners should also be matched for physical size and socialization skills. The models' motor skills averaged about twelve months higher than those of their buddies, with a maximum of eighteen months' difference. We did not establish a formal scale for ranking therapy participants by these criteria. Rather, we conducted informal matching by intuition.

2. *Activity levels.* We decided that the children should have similar activity levels — active children paired together and sedentary children paired together. We expected that the pacing of activities would be easier with this arrangement. Otherwise, the model might complete an activity and require further direction before the other child had finished the task, thus requiring us to repeat instructions.
3. *Compatibility.* Classroom teachers gave us input on which children would be well acquainted and compatible. Pairs of children were selected only from within the same classroom to avoid their spending time in therapy sizing each other up. The children ideally should be accustomed to working together, but you may need to incorporate time in the initial paired sessions for developing rapport.
4. *Compliance.* Our ideal models were cooperative and followed directions readily. Otherwise, we lost precious therapy time attempting to elicit cooperation.
5. *Personality.* Other personality traits we considered but did not necessarily use as selection criteria included competitiveness, creativity of movement, mothering, nagging, and willingness.
6. *Social age.* Some three-year-old models appeared to need as much attention as their peers. They weren't ready for a teaching role and expected as much therapist reward and reinforcement as the child receiving therapy. These children were not emotionally mature enough to help another child and, for this reason, would not be effective models in certain paired therapy sessions.

After establishing our guidelines for model selection, we felt it was important to inform the parents of the normally developing children what occupational therapy was all about. Before these children began attending occupational therapy sessions, a memo was sent to their parents describing typical activities, their purpose, and how the child would participate. A sample copy of the memo is found in the Appendix, Form 11.

Strategies of Integrated Occupational Therapy

We developed three strategies for providing integrated occupational therapy—individual paired sessions, large groups, and individual sessions staged within the large group.

Individual Paired Sessions

An *individual paired session* involves treating the child with a disability in the occupational therapy department with a model child present. Therapy works best if the model attends regularly but not every session. For example, a model may accompany a peer for one out of two or three weekly sessions. This allows individual time for more intense hands-on sessions, reevaluation, maintaining therapist/child rapport, and checking equipment and splinting. Having the same two children attend consistently is best, because it takes several sessions to teach therapy behaviors such as safety rules, when toys can be taken off the shelf, work area boundaries within the large clinic, and the restriction that only the therapist may physically manipulate the child receiving therapy. Well-planned sessions are important, but you need the flexibility to take advantage of therapeutic situations that evolve spontaneously from the dynamics of children's behaviors and interactions.

During the individual paired sessions, the model becomes a leader or an assistant to the therapist. The model serves as a *leader* with the following roles when paired with a child whose physical disabilities are mild to moderate:

Leader's Role	*Sample Activity*
1. Taking turns	Taking turns tossing bean bags
2. Cooperative activities	Throwing a ball back and forth
3. Parallel activities	Scooterboard games
4. Competitive activities	Tug of war

The leader serves as someone for the child with a disability to imitate, thereby heightening the latter child's interest in the activity. This is very natural and requires minimal prompting from the therapist. The children naturally bring out each other's drive to achieve and succeed.

With a child who is more severely physically disabled, the normally developing child becomes more of an *assistant* to the therapist, filling the following roles:

1. Encouraging the child who is disabled
2. Getting toys and equipment from the shelves
3. Stabilizing and positioning toys
4. Taking turns
5. Playing with the child as the therapist positions or moves the child through the normal movements of a particular activity

Here, the model child's involvement helps sustain the other child's interest during an activity and the transition to the next activity, and most importantly makes the sessions more lighthearted and active than they would be otherwise.

Large Groups

Large-group integrated sessions are composed of six to eight children with disabilities and two to four models performing parallel or cooperative activities in the classroom, in the pool, or in the occupational therapy department. In addition to swimming, these groups either focus on fine motor activities or tactile stimulation. Ideas for fine motor activities are readily available in several sources. Because tactile activities are more difficult to locate, we have included a list of ideas at the end of this chapter. The relationship between the model child and peer in large groups can take the following forms:

1. ***Parallel.*** The child with the disability and the model perform the same activity (such as tactile stimulation) or produce the same end product (such as a paper chain). You may have to break down activities that produce an end product into components that the disabled child can complete in the same time frame as the model, so the whole group is moving through the same step-by-step procedure at the same pace. For example, the model may use a ruler to draw lines on the paper and then cut strips, whereas the child with a disability cuts strips from paper with pre-drawn lines. Both children then can begin gluing strips into a chain at approximately the same time.

2. *Pairing.* The pair of children work together within a large group to administer tactile stimulation to each other or to teach such skills as folding paper for a fan.
3. *Assembly line for producing an end product.* Each child performs specific tasks that contribute to one end product. For example, the child with the disability colors a puppet face, and then the model glues on a beard or craft stick.
4. *Reverse modeling.* Sometimes the situation is reversed, and the child with the disability becomes a model for the normally developing child. This is especially evident in the swimming program, where several children who have disabilities are more advanced and less inhibited in the pool than some of the models. This is an excellent opportunity for these children to become peer activity models to the normally developing children.

Individual Sessions within Large Groups

When individual sessions are staged within large groups, the therapist performs the same therapeutic procedures in the classroom as would be performed in the occupational therapy department. This requires moving necessary equipment to the classroom for each session. The models interact with the disabled child on a spontaneous, open-ended basis. The remaining children in the classroom are involved in structured small-group activities, free play, or a combination of the two, supervised by teachers or paraprofessionals. The model children may react in several ways during the in-class individual therapy:

1. Questioning the therapist or child about what they are doing
2. Seeking attention from the therapist ("Would you read this book to me?")
3. Giving unsolicited assistance to the child receiving therapy (for example, helping to knock blocks over when we want the child to do it independently)
4. Passively observing the activity
5. Ignoring the therapist and child

Of the three basic integration strategies we tried, the most successful, beneficial, and comfortable method for us was individual pairing with a model during regular sessions in the occupational therapy department. The children who are disabled have attempted tasks more readily with encouragement and motivation from the model, as opposed to the therapist. We have also successfully integrated the tactile stimulation and fine motor groups. Although the quality of skills has not noticeably changed due to integration, the group performs more rapidly and is more creative and motivated to complete the activities.

We keep traditional individual daily notes and treatment plans on each child who receives occupational therapy. In order to obtain information about child interactions for documenting the effects of integration, we make notes and periodic videotapes of selected integrated therapy sessions.

Equipment to Use in an Integrated Setting

We found that having a variety of equipment is important for developing interactions between the normally developing children and children with disabilities. We found the following equipment useful when implementing integrated activities:

Vestibular System and Balance

- scooterboards, including ramp
- large cardboard blocks to build bridges
- ropes or dowels for pulling
- balance beam
- wooden blocks and wedges to make an obstacle course
- net swing
- barrel covered and lined with carpet
- tire swing
- moonwalk
- tricycle
- dual swing (available from Southpaw Enterprises)
- outside play equipment—slide, swings, merry-go-round

Fine Motor Skills

- foam and wooden beads to string
- various sized pegboards
- LITE BRITE® game
- BED BUGS® game
- blocks
- pens, markers, pencils, and crayons
- marbles and marble chute
- shape sorter
- sewing cards
- telephones to push and dial

Tactile System

- parachute
- shaving cream (to draw on mirrors, tables, paper, and other places)
- tubs full of dried beans, rice, lentils, and similar items
- baskets full of various textured objects and fabrics
- sand
- modeling clay, therapy putty

Strength and Gross Motor Coordination

- various balls—tennis, rubber, weighted
- tricycle
- suspended tennis ball and suspended large net ball stuffed with plastic bags
- racquetball racket
- bilateral paddle
- jump rope
- bean bags and target
- large tic-tac-toe game
- therapy balls
- sewing cards
- Foot Stompers® toys
- carpet squares
- lines and shapes taped on the floor

Positioning

- wedges
- therapy balls
- bolsters
- small tables of various heights to accommodate standing, sitting, and kneeling

Children's Reactions

Normally Developing Children

Accompanying a child to therapy answers some questions for the normally developing child. At the beginning of the school year, most of the models did not know what occupational therapy was, and they asked many questions: "What is OT?" "Why does she go to OT?" "What do you do there?" "Where is it?" "Who are you taking next?" "When are you going to take me?" Pairing gives these children a chance to see for themselves what the others do while they are away from the classroom in therapy.

Some of the models are more manipulative than one might expect. They are not in the habit of being included in therapist-directed activities, and they let us know when they are bored or when they are ready to change activities. We handle this by setting the room up prior to the session so that goal-oriented materials are available and within sight and other, distracting toys are concealed and out of sight.

Children with Disabilities

The children with disabilities appear to enjoy therapy more when a model is included. They show more interest, enthusiasm, and motivation and are less inhibited. The normally developing children add fun, encouragement, and creativity to therapy sessions. Children who are reluctant to leave the security of the classroom are more willing to attend therapy when accompanied by a model peer from their classroom. The children participate more readily in activities that they previously avoided and are challenged to imitate new motor responses that the normally developing models initiate.

When the children realized that they were going to be paired for therapy on a regular basis, the children with disabilities began to request that specific children accompany them, not always picking a normally developing child. By consistently pairing the same two children, we avoided having to explain why a certain friend could not accompany the child.

Jean Ayres and others have theorized that children will seek out the stimulation their bodies need. Therefore, a therapist ideally should be able to provide a therapeutic environment and allow children to fulfill their own instinctive drives. However, Ayres writes about children with neurological dysfunction that they cannot use this inner drive constructively due to poor brain organization. By adding a model to the therapeutic environment, we are also adding the organizational component of a nervous system similar to that of the child with the disability. The models are creative in their approach to stimulation and movement, and they introduce challenges never envisioned by an adult therapist.

Conclusion

One of the goals envisioned at the inception of this project was that of improving communication among therapists, teachers, and paraprofessionals in order to improve the handling and positioning of disabled children in the classroom. We shared information more frequently as the program director continually prompted us to show and tell each other what we were discovering as the integrated program evolved. Our communication improved, not because of program changes, but because we had made ourselves more conscious of this goal. An unanticipated improvement in communication came about because the teachers became more active as consultants. They observed individual and group therapy sessions, offering helpful advice on behavior management, group control, and task analysis. They also had suggestions for making ordinary therapeutic activities more creative and enticing.

One of the benefits of having normal children easily accessible was the opportunity to practice using assessment tools. For example, after integration, the occupational therapy department received a new evaluation for preschoolers. We were able to practice administering it to normal children, which provided us with norm-referenced criteria and improved our test-administration skills.

All children in the early education program are screened for vision by the occupational therapist (including distance acuity, pupillary reactions to light, depth perception, and tracking). The vision screening provided an additional opportunity to compare test-taking behaviors of both groups of children. The children with disabilities generally were much more distractible, had difficulty maintaining attention to the task and following directions, and took longer to screen.

We had few major problems with integration. However, one warning is in order: The initial questionnaire to parents of potential models must be thorough enough to detect subtle developmental problems. A child with potential problems should be referred to the appropriate agency before being screened as a model. Once the child has been screened, there is an obligation to grossly identify problems and become involved in a referral and follow-up process that can be very time consuming. Although it is important to establish a base line for acceptance to the program, a child doesn't necessarily have to have advanced motor skills to be included in the program. A child near the bottom of the normal range can be a good model to the younger or more severely involved children and may show improvement through being involved in the preschool experience.

Tactile Group Activities

Tactile stimulation is most effective with minimal clothing. Children should remove shoes, socks, shirt, and pants when appropriate. Pairing children enables them to both give and receive tactile input. Some activities can be performed outside.

1. Place stickers on body parts—on own parts, then on partner's.
2. Play rub-a-dub-dub hands-and-feet-in-a-tub with tubs of beans, rice, marbles, sand, polystyrene foam, or soapy water.
3. Wrap each other in green tissue paper; stick on shamrocks, ribbons, and similar items. This activity is seasonal; the children can make each other into presents, pumpkins, and so on.
4. Swing in an inner tube or hammock without cushions and rub hands on the carpet going forwards and backwards. Take turns pushing each other. Put textured fabric on the carpet to rub.
5. Rub each other down with lotion, then apply powder to self and partners; give back rubs in a circle.
6. Play with water and colored shaving cream (paint); rub cream on a partner, then wipe it off with a sponge. Squeeze a sponge in water. Put shaving cream on sidewalk, walls, arms, legs, feet.
7. People bag (an extra-large pillow case made of furry or textured fabric)—Put foam peanuts in the bag with the child. Others grab at the bag, trying to identify which body part they are touching.
8. Barrel rolling, foam roll-ups, parachute flips.
9. Jump on a moonwalk.

10. Feely bag—with vision occluded, children try to identify various shapes in the bag, such as a block, pencil, comb, ball, crayon, and button.
11. Riding scooterboards on tummy with objects (such as a bean bag) on the back.
12. Sand play outside—no spoons or trucks; children fill buckets with their hands, build mounds, draw names and shapes, add water.
13. Washing cars, tricycles, or each other using brushes of different temperatures and textures (wet, dry, hot, cold, and so on); outside, the children should wear shorts or swimsuits and go barefoot. Make pretend showers by pouring water through a colander.
14. Roll in boxes on the grass.
15. With swimsuits on, sit on parachutes on the grass—crawl under and on top of them; lie on them, roll, and so on. Add music. While the music plays, the children dance on the parachute; when the music stops, they must lie down. Play ring-around-the-rosy.
16. Go for a walk barefooted, experiencing various textures—grass, sidewalk (shaded and in the sun), carpet, bare floor, and so on.

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MOTORLINK:

Physical Therapy in an Integrated Preschool Program

MOTORLINK:
Physical Therapy in an Integrated Preschool Program

"Every person is such a big bundle of abilities." — *Susan Anderson*

Making the Transition

Physical therapy services in the early education program had traditionally been delivered in individualized half-hour sessions within the physical therapy department. Group treatment was rare except for summer swimming classes when the entire class was supervised by therapists with additional assistance from staff and volunteers. Treatment sessions in the classroom were very infrequent. Communication regarding a child's program was shared in team meetings, staffings, or during informal encounters with directly involved staff.

This mode of service delivery was based on several factors: a caseload small enough to support individualized sessions (20 children), the type of disability I served (mostly children with cerebral palsy), the children's ages, my orientation to a medical model of service delivery, and my theoretical approach to intervention (neurodevelopmental treatment). I was concerned that I would not be able to provide an appropriate sensory-motor environment without hands-on intervention. My approach to intervention with atypical motor performance was not compatible with the proposed model of observing and imitating the motor movements of normally developing peers. I had little experience managing groups without assistance from additional support staff, and I had previously integrated young siblings into infant sessions with questionable results. These factors influenced my initial reluctance to relinquish the traditional mode of service delivery in favor of integrated therapy. Despite my reservations, I attempted to incorporate an integrated model into my program. The purpose of including normally developing children was to determine whether physical therapy sessions could be adapted to include models with beneficial results.

Goals of Integrated Therapy

My global goal was to facilitate movement in the child who was disabled through peer motivation, that is, the desire to interact with normally developing children. Objectives for the small groups centered on improving strength and endurance and promoting acceptable compensatory movement patterns.

The children with disabilities I chose to group with normally developing children were all ambulatory and, with one exception, presented with minimal neurological dysfunction or musculoskeletal problems. All of these children required only minimal hands-on intervention to participate in a group. Their diagnoses ranged from mild hypotonia and failure to thrive to developmental delay and arthrogryposis (the most physically limiting disability of this group). Sessions were a half-hour long, in keeping with the structure of the early education classroom schedules. Children with motor deficits were grouped with normally developing preschoolers of the same chronological age and, whenever possible, similar verbal and motor abilities.

Most of the group sessions occurred within the physical therapy department. I experimented with using the gymnasium as a treatment room; however, the space was too open for the model children. These children freely and avidly used the entire space, which limited the ability of the children with disabilities to participate. The sessions were more successful when the group was restricted to a defined space within the therapy treatment room. I provided only equipment that was essential for the session. Props such as hats, canes, and necklaces distracted the children because they were more interested in appearances, ownership, and fantasy play than in therapy tasks.

Therapy Groups

Two groups, aquatics and aerobics, were conducted on a regular basis. Other groups were attempted but were less successful.

Aquatics

The aquatics program provided the most successful integration experience. All children in one classroom participated in aquatics every other week. There were a maximum of five children in this group, which insured safety in the pool, as well as reducing the potential for auditory and visual overstimulation. The children received one-to-one instruction with an adult staff member who was directly involved in the children's preschool program (occupational, physical, and recreation therapists, classroom teacher or paraprofessional, student affiliates, and social worker). The goals of aquatics were to develop confidence in the water, improve breath control, lip closure, and postural alignment, strengthen weak muscles, reinforce appropriate movement patterns, introduce elementary swimming skills, experience free movement, and, through a unique medium, reinforce social interactions.

The children interacted spontaneously in the pool and had numerous opportunities to observe their peers in water activities. A few children were confident and willing to take on challenges, which inspired increased risk-taking by the more cautious children. Because many of the children with disabilities had been involved in an organized aquatics program from infancy, they often had the advantage in water activities. In addition, the buoyancy of the water reduced the effects of gravity and helped to equalize the motor abilities of both groups of children.

There were four major activities during the 50-minute sessions:

1. Changing: A time to improve the undressing skills of the children with disabilities.
2. Group games: Playing games such as Tag, action songs, and Follow the Leader.

3. Individualized instruction: The children received individualized instruction in swimming skills and therapy treatment on individual goals adapted for the water.
4. Dressing: Although this would have been an appropriate time to promote dressing skills, the staff typically assisted the children with disabilities. This was done primarily because the cool air in the changing room negatively affected the children's physical abilities.

Aerobics

The second most successful integrated group was the aerobics session. Initially, I did not have selection criteria for including normally developing children. However, in retrospect, I identified several essential components. The normally developing children in the successful groups (1) were older and followed directions well, (2) were motivated by current trends in family fitness, (3) were creative in play with peers, and (4) were assertive, a trait that proved essential for effective use of modeling.

The aerobics class evolved to meet the needs of one child who was ambulatory, overweight, mildly hypotonic, and reluctant to participate in physical activity. This child's strength was his desire to interact with normally developing peers. For this group, a paraprofessional helped the children to dress in special clothing—exercise tights, sweat pants and bands, and tennis shoes. This clothing reinforced the purpose of the group and helped prepare the children psychologically for the upcoming activity. Although I conducted the group, in retrospect, a recreational therapist or adaptive physical education teacher might be the best person to lead the group, with a physical therapist consulting on the needs of children with disabilities.

Initially, I used three to four songs from a commercial children's exercise tape to have the children perform specific actions to rhythm. However, the rhythm sense of these 5-year-olds did not coincide with the pace of the songs. Therefore, we changed movements whenever I observed the children becoming bored or fatigued. Change was a key factor in maintaining the group's interest level. We used contemporary music in succeeding sessions and introduced a variety of aerobic movements. We introduced simple ball gymnastics in one session, having the children imitate arm or leg movements to nursery rhymes while sitting on the balls. We did not repeat this activity due to safety concerns. The normally developing children experimented with bouncing on the balls, and spotting them was difficult. Having the children pass and lift the balls with their arms and legs in supine position proved to be a safer activity.

Two other motor groups were attempted with less satisfying results. Again, the children with disabilities were all ambulatory; however, the normally developing children tended to be passive in leadership, scored lower in motor abilities on the *DIAL-R* (Mardell-Czudnowski and Goldenberg 1983), and required as much encouragement to attempt motor tasks as did the children who were disabled. The success of these particular attempts to achieve motor-related goals in integrated groups appeared to relate directly to the mix of children involved, rather than to the activity selected for the group session.

Classroom Integration

Physical therapy services were initially integrated into the classroom to establish rapport with newly enrolled children who had disabilities. These children were coping with separation issues, and the additional stress of removing them from the classroom appeared to heighten their anxiety. The classroom teacher suggested that I join the class during the opening circle. I was able to appropriately position the child and gently guide the child's movements while participating in the group activity. Although these sessions were not typical of an organized therapy session within the department, I was able to reinforce components of the therapy plan, such as trunk rotation, alignment in sitting, or mobility within a physically confining space, in an environment that was functional for the child. I also observed the degree of effectiveness of adaptive equipment during classroom activities. Because the classroom teacher, paraprofessionals, and I were working together, I was easily able to demonstrate specific handling and positioning techniques for specific children. This opportunity to exchange information became a major benefit of my presence within the classroom.

Observations

A significant number of our preschoolers with disabilities graduate from the early education program to attend public school with able-bodied peers. It is part of my role to project situations in which these children may require assistance, adaptation, or remediation to integrate into a more permissive, but physically demanding, setting. After integration, our classrooms more closely simulated the normal school setting these students would be entering. I was able to observe the children with disabilities moving about the building with normally developing peers and to evaluate the efficiency, speed, safety, motor planning and on-task behavior with which the children walked or propelled their wheelchairs. This information helped me plan the children's transitional therapy programs. The social effects of a child with a disability usually being the last to arrive at a destination or to be chosen for a physical activity made me aware of the importance of planning the safest and most efficient mobility possible as the child entered a mainstreamed school program.

Several therapists have observed the benefits of group intervention and providing therapy services in the classroom. In a group activity, children are relieved of some of the performance pressure that exists in individual treatment sessions. The children with disabilities may respond more easily in an environment of cooperation and competition with disabled and nondisabled peers, and working in groups supports their emotional and social growth (Levitt 1982). Integrated classroom therapy services also offer an opportunity for the therapist to demonstrate appropriate handling and positioning to classroom personnel.

My experiences working within the classroom were positive; however, these experiences may not be related directly to the presence of normally developing preschoolers, but may reflect the effectiveness of expanding my services into the functional environment of the child who is disabled. Children with mildly disabling conditions appear more appropriate for an integrated approach because the need for hands-on treatment is less than for a child with more severe involvement. Children with mild disabilities may be served best in groups by recreation therapists or physical education teachers with consultation from the physical therapist.

My enthusiasm for an integrated program has grown with each succeeding year of the project. I have followed the growth of both groups of children and have strengthened my knowledge of growth and development in the process. I have been continually reminded that children are unique in their rates of learning, physical structures, and motor abilities and that a textbook description of a child at any age is merely a composite of identifiable skills that cannot project a sense of the totality of being that is truly a child.

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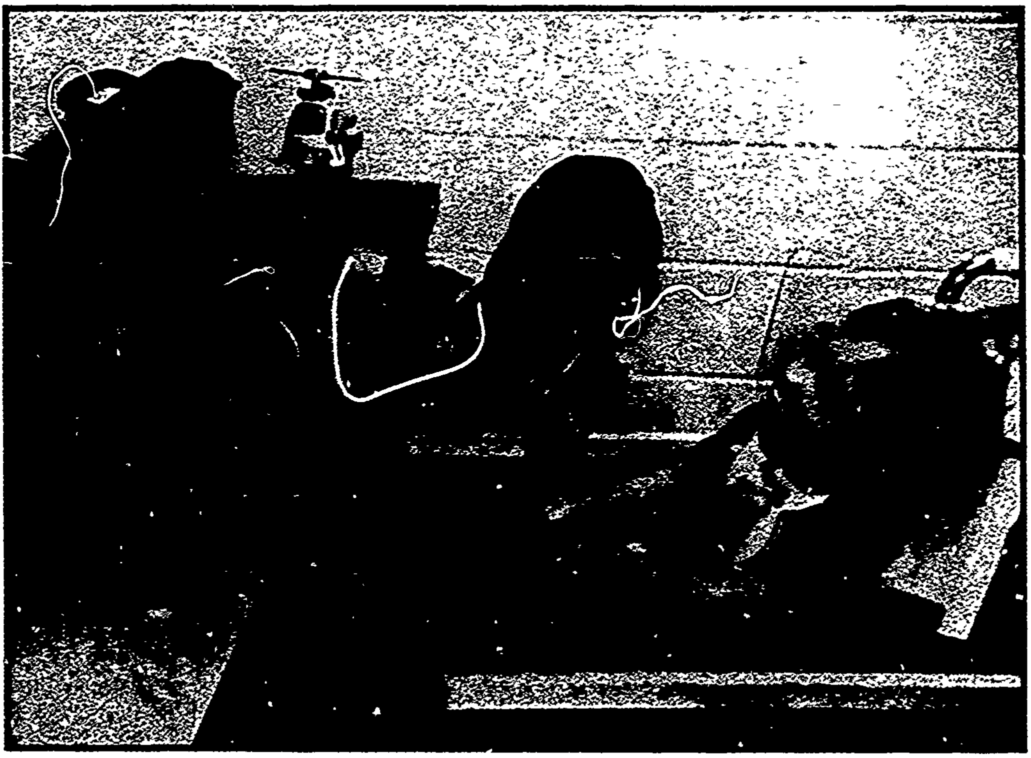
SPEECHLINK:

Integrating Speech, Language, and Communication Services into the Preschool Classroom



SPEECHLINK: Integrating Speech, Language, and Communication Services into the Preschool Classroom

"She couldn't think about it, so I whispered it in her ear."
— *Kenzie (a Kidlink preschooler)*

It was 9:00 a.m., opening circle time in one of the early education classes. The 3- and 4-year-old students were seated around the teacher. I was observing, occasionally modeling or commenting on the purpose of different functional objects to develop associations between objects and actions in expanded utterances. The teacher asked a student with an expressive language deficit, "What do you do with a telephone?" That student looked at the teacher but did not respond. The normally developing peer sitting next to this child very spontaneously put her hand up to the classmate's ear and whispered the answer to her. The child immediately repeated the answer, "I talk to people." Then the normally developing peer said to the teacher matter-of-factly, "She couldn't think about it so I whispered it in her ear."

This peer modeling happened spontaneously, quickly, and correctly—an example of one peer with regularly developing language skills helping another child with delayed language skills to produce an utterance successfully. Such modeling—both spontaneous and elicited—happens many times a day in the integrated program with significant benefits for the children with language impairments. It is very important for the speech-language pathologist to recognize these opportunities and to use the various people and events in the preschool to stimulate language and communication skills.

Positive and Negative Aspects of Integration

At the start of Project Kidlink, I had fifteen years' experience in providing speech-language-communication services to the population at The Capper Foundation. During this time, I had tried a variety of approaches with children of all ages to coordinate language and communication goals with classroom and therapy goals and residential services: (a) conducting language groups in the classrooms, (b) planning sessions with classroom teachers, (c) being a language partner with children in the classroom, (d) using peer-mediated approaches in the classroom via the *language dump and play* philosophy developed by John Muma (1975), (e) developing a communication buddy system as advocated by MacDonald and Blott (1974), (f) in-servicing staff and parents, and (h) conducting parent training programs. These approaches appeared to be successful, although I had collected no formal data to support this impression.

The funding of Project Kidlink provided an exciting opportunity to develop a formal integrated language and communication program. Although I was eager to develop such a program, I had several concerns:

1. How to develop innovative approaches, as I was aware of few integrated language programs
2. How to translate specific language objectives into effective language intervention during the variety of daily experiences the child may have in the classroom
3. That the children would not receive the type of concentrated speech and language training in the classroom that they would receive in individual therapy
4. That parents would feel that their children would not be receiving frequent and specific language instruction with an integrated approach
5. That the early education staff would have difficulty functionally integrating specific language strategies with the cognitive-social stimulation and training that is their primary intervention focus

These concerns were balanced by various comments I had heard frequently over the past several years during staffings or casual conversations with staff, parents, or other professionals. These comments indicated a strong need to take advantage of the opportunities of Kidlink:

1. *"He can say it in speech, but he can't say it in the classroom."* The speech-language profession has continually strived to address the problem of generalization. Learning theory has provided a variety of strategies for generalization that endorse using more natural settings to train responses. The classroom in a special school is a natural target for generalization.
2. *"She really liked talking about the goat that Jim brought to class yesterday."* The isolated speech environment allows for controlled evaluation, assessments, and probes, shaping responses, and implementing specific management procedures. However, the classroom provides natural, functional, ongoing experiences that one can apply to the children's language objectives. Observing the preschool classrooms at The Capper Foundation immediately reveals that there are multiple and daily opportunities for rich and unique language-learning activities. Reviewing the classroom lesson plans for one week in the fall, I noticed a variety of language-based activities: carving pumpkins, listening to stories about pumpkins, making paper-sack pumpkins and pumpkin-seed art, baking a pumpkin pie, making *witches' brew* for snack, making a letter "P" box, and singing special songs for holidays and everyday events.
3. *"She really has a lot of fun playing and talking with Katie in the building block area."* In the classroom, children are allowed to choose play and learning-center activities as a strategy for promoting cognitive and social growth. I hoped to use peers and activities the children chose themselves to promote their language skills.
4. *"He goes out for speech."* The statement is easily understood on one level but it is based on an assumption that learning language and communication skills is something unique that occurs outside the classroom. Although the professional services of an SLP are required to assess, manage, and monitor language needs,

children can learn language from a variety of individuals in a natural environment. The classroom, the teaching staff, and peers become the primary language interveners. The statement renegotiated becomes: "He stays in with us for speech."

5. *"The more serious the language problem, the more help they need."* Children with severe speech and language disorders require more direct intervention from an SLP. By managing children with mild to moderate language deficits in the classroom and having teachers assume a primary intervention role, the SLP has more hours available for children who require intensive therapy.

The Rationale for Classroom-Based Intervention

Having made the decision to work with peers and the teaching staff in the preschool classrooms, I reviewed the literature in this area. Recent articles support the effectiveness of using more naturally occurring events in a pragmatic environment to develop language and communication skills. Several studies describe the transition from a structured therapy setting to an interactive environment in the classroom and suggest ways to use the teaching staff for training specific language and communication skills.

McCormick (1986a) reported that current language intervention trends should be based upon incidental teaching models as opposed to operant models. *Operant models* teach children a limited repertoire of responses, which are very different from the language input the child receives from caregivers during typical daily interactions. Directed teaching methods in the classroom give the children multiple opportunities to learn, use, and practice newly acquired communication skills. In this article, McCormick suggested strategies for measuring base line communication levels in the classroom and developed an activity matrix which one can apply to routine classroom activities involving peer interaction.

Cole and Dale (1986) compared the effectiveness of direct versus interactive language instruction in improving the language skills of preschool children with delayed language. Their findings revealed no differences between groups of children receiving direct instruction and interactive language instruction. This article cited previous studies that compared the features of direct language instruction and interactive language programs, information which was valuable in planning the move from an isolated training environment to an integrated classroom environment. They noticed the following differences in classroom instruction as opposed to direct language instruction:

1. Reinforcement procedures are less structured.
2. Modeling is the primary language training strategy.
3. Natural events and contexts are used for teaching language.
4. The child produces targeted language responses less frequently.
5. The child needs to be encouraged to initiate language.
6. The structure and sequence of language instruction is more variable.

The authors concluded that merging the two models probably would be more effective than using either one exclusively.

Guess and Noonan (1982) and Holvoet, Guess, Mulligan, and Brown (1980) described specific procedures for integrating into the classroom not only language and communication skills, but also other developmental skills. Odom and Strain (1984) reviewed additional specific strategies for using normally developing peers to promote social skills, including these peer-mediated interventions: (a) placing socially competent children near target children and encouraging or teaching these children to play with them, (b) training peers to prompt and reinforce the social behavior of target children, and (c) using peer initiation to promote positive social behavior. These strategies can potentially be applied to language intervention as well.

Campbell, Stremel-Campbell, and Rogers-Warren (1985) discussed a variety of issues in teaching functional language. Specifically, they addressed communication programming in the classroom and described specific activities that the teacher, as the primary trainer, and the speech-language pathologist as consultant would use to develop communication skills: The SLP was responsible for assessment and writing IEP goals and objectives. The teachers were responsible for implementing protocols written in the IEPs and facilitating generalization. The SLP assisted the teacher in selecting functional content to be taught and suggested training activities. The SLP was responsible for modifying the training protocols based on training and generalization data collected on the students.

Goldstein (no date) identified procedures that the SLP could use in establishing communication programming for children with language needs. In this model, the SLP acted as a consultant to the classroom teacher in the following ways: by observing in the classroom regularly, giving verbal and written feedback to the teaching staff, and modeling for the teaching staff specific language behaviors they could promote in naturalistic situations, such as descriptive talking, requesting, responding to questions, using basic language concepts, choral responding, and peer interactions.

Mand-model, discussed by Halle (1984) and Hart and Risley (1980), is a language-training procedure that is appropriate for the preschool teaching staff to use. A teacher provides a mand by asking the child to describe an object ("Tell me what this is.") then reinforcing the child. The teacher models a correct response when the child fails to respond appropriately. ("Say, 'I need more paint.'") Other applicable training procedures these authors discussed include the *time-delay* procedure to stimulate verbal initiations and *incidental teaching* procedures to prompt more sophisticated language and to improve conversational skills about specific topics.

McCormick (1985) discussed curriculum goals and facilitator behaviors which directly apply to developing an integrated approach in the classroom. The SLP would identify language-facilitating behaviors for the preschool teacher, including (a) acknowledging and responding to the intent of the child's communicative efforts, (b) encouraging nonverbal and verbal turn-taking, (c) encouraging all types of interactive play, (d) modeling and encouraging social rituals such as greetings, polite requests, and responses, (e) teaching to heterogeneous groups and planning activities that promote group interaction, (f) rephrasing the child's comments in ways that preserve the child's semantic intent, and (g) allowing the child to select conversational topics. These are skills an SLP can present to the teaching staff.

The Kidlink classroom is organized around a schedule that includes circle times, center times, snack times, story times, individual training times, art and music times, and large motor times. These daily events were seen as targets for integrating speech-language objectives in the classroom.

Developing rationale for the transition from an isolated approach to one of integration was not difficult; the need was evident. The task was to develop a workable model for integrated speech and language services.

Developing an Integrated Program

Prior to integration, all preschool clients requiring speech-language intervention received direct services during their daily classroom schedule from 9:00 a.m. until 12:00 noon, Tuesday through Friday. These children had a variety of diagnoses, including developmental dysarthria, delayed speech and/or language development, voice quality disorders, fluency disorders, and hearing impairment. All children also had physical disabilities, primarily cerebral palsy or developmental delay.

I evaluated all children on entry into the facility (usually in the infant or toddler program). The results of this evaluation determined their need for services. Regardless of the severity of their disorders, all children received individual sessions, usually in an attractive small training room containing an assortment of toys and picture displays. The children received from one to three sessions weekly, with the majority receiving one or two sessions. Caseload size was approximately 15.

I informed the classroom teachers of each child's speech-language objectives and progress and suggested strategies for facilitating speech-language development during two specific annual meetings—the annual IEP conference and the six-month staffing. Other communication occurred during informal discussions or occasional team meetings. The management program for selected children also included activities to generalize language skills learned in the speech setting to the classroom setting.

Developing a Model for Integrated Services

Following integration, each child's objectives were scheduled on a time line that indicated when intervention would occur by the SLP, the teaching staff, and parents. Specific strategies were developed for using the classroom as the center for management of children receiving treatment. I followed several steps to gather information before designing this model.

Classroom observation of children with language delays: I observed specific children in the classroom at various times to document their language and communication skills, what types of activities teachers used to stimulate cognitive and language behaviors, and how their peers used language when interacting with them.

Outcome: The children usually exhibited more spontaneous vocal behaviors in the classroom than in the therapy room because they had opportunities to communicate and learn during circle times, individual teaching times, computer times, sharing times, opening and closing times, and creative arts times. The children with disabilities showed various characteristics that are often associated with brain damage: (a) reduced attention to teaching tasks, (b) long response latencies to requests for vocal responses, (c) long response latencies to significant identifying features of objects or pictures, (d) low frequency of language output during competitive talking times, and (e) delayed acquisition of many speech acts, such as acknowledging, responding, initiating, repeating, or protesting.

The teaching staff used several language elicitation techniques, including asking children for labels—most frequently noun labels and modeling, primarily for first-person present tense forms. However, the teachers missed opportunities to stimulate more advanced language forms and to use specific communicative functions during cognitive training times or activity transition times.

Classroom observation of normally developing peers: I observed these children as they interacted with other children and staff during cognitive training times, group times, and free social interaction times (center, snack, and free choice times).

Outcome: The normally developing children differed from their peers in several significant language, cognitive, and social characteristics. They were able to (a) immediately attend to teaching events, (b) produce immediate vocal responses to information or questions during cognitive tasks, (c) produce age-appropriate linguistic forms and functions, (d) develop immediate associations with other normally developing peers, and (e) interact easily with peers who were disabled upon minimal prompting by the teaching staff.

Consultation: We consulted with special education professionals who had specific expertise in human development and early language intervention. In addition, I reviewed relevant readings to determine what strategies I could use in peer-mediated instruction and for speech-language management.

Outcome: The consensus was that, to achieve program integration, I would have to share responsibility with the teachers for implementing specific language stimulation strategies, rather than turning over the responsibility for language management to the teachers. We agreed that

1. communicative behaviors should be functional;
2. language instruction could be developed around routine activities in the classroom;
3. language instruction could be clustered with cognitive and social instruction in the classroom rather than designing specific classroom activities to address only language skills;
4. classroom instruction should be based on incidental teaching approaches;
5. language objectives should be ongoing throughout the entire day;
6. the role of the speech-language pathologist was to identify procedures the teaching staff could use throughout the day to develop language skills;

7. children with intensive program needs (for example, children with severe dysarthrias and apraxias) should be seen in individual treatment, as well as in an integrated program.

Model synthesis: I met with the early education teaching staff to determine how they would become more involved with language programming and how I would interact more directly and consistently with the students in the classroom.

Outcome: The teachers did not feel that they knew what speech, language, and communication skills their students were learning in therapy. The information they received in the annual IEP meeting and the mid-year staffing was inadequate for them to implement classroom programming. Both the teachers and I agreed that team meetings and informal discussions did not give them adequate information and support. I needed to increase my interaction with the early education teachers and to provide specific techniques they could use to develop communicative functions and increase language learning.

Observation of staff: I observed the teaching staff in classroom instruction for frequency of prompting, modeling, expansion, and other language elicitation strategies.

Outcome: I observed multiple opportunities to stimulate and reinforce targeted language and communication skills that the teaching staff did not make use of. In addition, the teaching staff used modeling as the primary means for stimulating language.

Model review: I met with the early education teaching staff to brainstorm a model for integrating services.

Outcome: Our consensus was that the most effective procedure was for the teaching staff (a) to know each child's objectives early in the year, (b) to assist in planning for stimulating those language skills in the classroom, and (c) to learn different techniques to use in the classrooms. I would develop a role-sharing attitude with the teaching staff, continually monitoring performance in the classroom and giving teachers appropriate feedback.

Parent participation: I met personally with the parents to discuss the plan for reducing each child's number of individual sessions in favor of increasing the opportunities for language use in the classroom.

Outcome: The parents supported this change in programming that would create an enriched teaching environment.

Development and demonstration of the model: I combined all the preceding information to develop a model for integrated services that we called Speechlink. The goals of this model were to increase children's use of targeted language and communication skills during classroom events and to increase their general language performance by teaching the classroom staff appropriate language stimulation strategies. Speechlink provided a link between me and the classroom teacher, between the language objectives I developed and the management strategies the early education staff carried out, between the target objectives for each child and daily events in the classroom, between evaluation strategies and therapy, and between the child with the language disorder and the normally developing peer.

Evaluation and Assessment

All children receiving my services are evaluated or reassessed yearly with a representative test battery for speech, language, and communication skills. The results of testing determine how each case will be managed. Children with disorders of language and communication are candidates for Speechlink; children with motor speech disorders, such as developmental dysarthria or apraxia, receive individual intervention. The children who were part of Speechlink had mild to severe delays in receptive and expressive language. The normally developing peers who became part of Speechlink had a range of age-appropriate speech and language skills. Some exhibited developmental articulation and language errors appropriate for their chronological ages.

Integrated Sessions

Integrated sessions were initially held in the classroom (but could be held in any setting) for at least one hour per classroom per week. I had a regular schedule for visiting each classroom, which I found it very important to follow. I requested one lesson plan per week from each classroom teacher so I could suggest ways to address children's language objectives during the planned lessons. During these weekly classroom sessions, I conducted the following activities:

Modeling: I demonstrated different language elicitation techniques for the early education teacher or paraprofessional—asking questions, prompting, modeling, reinforcing, stimulating, initiating, expanding, and correcting. For example, I demonstrated to a paraprofessional the visual scanning technique for object selection that one child used in the classroom. I demonstrated how to increase children's use of manding by having the children tell a puppet what to do with objects used in a group time to stimulate awareness of the letter "P."

Probing: I took a child to a separate part of the classroom to probe certain target language skills by recording the child's responses to classroom events, objects, or specific language training materials. This probe lasted about five minutes, after which the child returned to regular classroom activities.

Moderating: Then I joined various children with language delays to stimulate language as they interacted with peers. On one occasion, I joined a child with a language delay and a normally developing peer during play at the housekeeping center and assisted both children as they pretended to be a doctor and nurse. In another instance, I moderated at the art center where two children were involved in individual textured art projects, modeling and expanding utterances and encouraging the children to use certain speech acts as they completed their projects.

Observing: I frequently observed the teacher or paraprofessional interacting with various groups of children to provide the staff with feedback on a particular child's performance and on their success in stimulating language during the activity. While observing, I also took advantage of opportunities to stimulate language. I wrote out comments and gave them to the teacher at the end of the session for quick review.

Consulting: I met with the teachers once a month for a *magnet time* to discuss the progress of the children, to answer teachers' questions and to review the written feedback I had provided during the weekly Speechlink sessions. I also used this consulting time to monitor the progress of children with mild language delays who were not candidates for intensive service. These children were developing language skills at an appropriate rate for their developmental ages (as opposed to their chronological ages) or they had language delays related primarily to environmental deprivation.

Microsessions: I took aside a child to conduct a short session either individually or paired with a normally developing peer. For example, I took a child with delayed vocabulary development and a peer model to the coat lockers to stimulate noun and verb labels, clothing vocabulary, proper name identification, and using personal pronouns in two-word combinations.

Individual Sessions

I continued to see children with severe language disorders, severe motor speech disorders, and augmentative communication devices in individual therapy sessions for intensive management. They received two or three, occasionally more, sessions per week. The Speechlink program allowed me to adjust the intensity of programming to the needs of each child. I was able to accomplish specific language goals in the classroom for children with milder language disorders, provide individualized programs for those with severe disorders, and increase the generalization of language skills with both groups of children by maintaining a link with the classroom.

Selecting and Grouping Children

What makes a good model? I used models in different ways. Some children were exceptionally good for particular roles, and others were not as helpful. The effectiveness of the model depended on the role the child was to play, the integrative language activities I had planned, and the specific positive characteristics of the child with the disability. I used the following criteria to match children with language disorders to language-normal peers:

1. They were similar in chronological age. Certain children enjoved interacting with younger children, but generally comparable age appeared to be a consideration.
2. They were the same gender. Preschool children are generally oriented to interacting with children of the same sex. However, occasionally a boy and girl were paired with each other on request.
3. The model was available at the same time as the child with the disability. Children in the Kidlink preschool are heavily scheduled with physical therapy, occupational therapy, recreation therapy, and swimming. Occasionally, a child with a disability and a language-normal model were grouped because they were available at the same time.
4. The preschool teacher was an important resource in providing suggestions as to which children would work well together.

5. Some models had an especially caring and reinforcing manner in the classroom. While it was desirable to select these children, I took care not to over-schedule them as models and potentially affect their natural responsiveness to their peers with disabilities.
6. The model exhibited satisfactory language skills. There is a normal range in the acquisition of language milestones. When practicing specific forms, such as singular copula *is* or irregular past tense verbs, it can be important to formally or informally probe the model to see whether the targeted language form is occurring frequently enough in spontaneous utterances to serve as a model for the child receiving language intervention.
7. The models were compliant and socially mature. Some socially immature models may not have developed appropriate turn-taking skills. If the model is noncompliant, more time is spent dealing with these behaviors than in direct treatment.
8. The child with the language disability was ready for a model. Some children with disabilities have deficits in attention, social interaction, or other developmental behaviors necessary for learning from, and even playing with, another child. They may not tolerate other children receiving attention or may be distracted by the presence of another child in the room.
9. Some models had exceptional abilities to play, talk, and interact with children with mild to severe differences. Models who have worked easily with disabled peers in segregated therapy sessions have such qualities as high verbal output, ability to follow instructions, easy peer interactions, being easily stimulable for new tasks, and being easily stimulable for tasks below their cognitive/language level.

I observed several characteristics in which the models differed from the children with disabilities. These characteristics enriched the language environment in the classroom in a way that had not been possible when all the children were disabled:

1. The language-normal children gave immediate verbal responses to adults' questions, requests, humorous sayings, or funny actions. The child with a disability may or may not have been able to give such an immediate response.
2. The language-normal children paid direct attention to both routine and unique situations. That is, they focused quickly and easily on the target event. Peers with disabilities may be significantly more distractible.
3. The language-normal children used language much more creatively: One child said that the raisins flew off his banana during snack one morning as he tried to eat it. The remark was novel and immediate and was uttered in satisfactorily semantic, grammatic, and linguistic style. Many children with disabilities do not produce such creative utterances spontaneously.
4. Certain normally developing children interacted in a friendly, caring, helping manner with their peers who had disabilities. These children frequently helped their friends push switches, play with toys, look at books, or use the computer. They seemed to have the other child's interest in mind. Children with disabilities may or may not have this type of relationship with another peer. The staff believed that children with disabilities responded favorably to this attention.

Providing Treatment in an Isolated Setting

The isolated treatment setting was necessary for specific children who were developing certain communication behaviors, who required highly specific training procedures, or who had delayed social skills. The following are examples of children who benefited from the traditional service delivery model:

1. A child with a hearing impairment and hemiplegia who was developing an initial vocabulary of approximated manual signs in a total communication program.
2. A child with a hearing impairment who was learning oral expression skills using a suprasegmental approach with an auditory trainer. This approach required a high degree of visual and auditory attention from both the clinician and the child, and the presence of a normal model would have been distracting.
3. A nonspeaking child who was being introduced to a picture/word communication board.
4. A child with a cleft palate who was improving vocal inflection and production of specific isolated speech sounds.
5. An easily distractible child with a severe physical disability who was learning to use a chin switch to operate a scanning light display.
6. A child with severe physical disabilities and considerably delayed social and emotional development. This child was highly distractible in a busy environment.
7. A withdrawn child who worked more easily with an adult in the isolated setting.

Providing Treatment in an Integrated Setting

In this context, the integrated setting refers primarily to the preschool classroom. This setting included children with and without disabilities, the early education teacher, the paraprofessional, and other adults such as volunteers or visiting parents. The room generally contained the type of classroom materials and staff found in any preschool setting, with the addition of specific materials and equipment for children with physical disabilities.

The classroom became the site for conducting a greater portion of language intervention for children with language delays. I had always conducted language groups in the classrooms, using both commercially packaged and custom-developed programs. Typically, I entered the classroom for a thirty-minute session once or twice per week, and the classroom teacher and paraprofessionals were present. These sessions provided general speech and language stimulation but were not directed to the needs of individual students.

Children who had achieved prerequisite language and communication skills or who required an environment that offered functional and natural communication opportunities benefited from the integrated setting. These characteristics were observed in the following children:

1. A child with a severe physical disability who used directed eye gaze to select a desired object from two choices and would generalize the skill to snack time and toy or object selection.
2. A child with a severe physical disability who used an eye-gaze board to choose one toy from a display of four and would generalize this skill to free-play choices.
3. A child with severe developmental dysarthria who had begun using a picture/word board to select snacks during the morning snack time.
4. A child with a mild language delay who did not require specific language management but had a good prognosis for improving language skills with structured opportunities to use language during classroom events.
5. A child with environmentally related delays in vocabulary and language who had a good prognosis for achieving age-appropriate skills.
6. Any children who performed at criterion level on targeted language or communication skills and were ready to generalize the skills or achieve the next level of language performance in the class setting.

Children's Reactions

This integrated approach used peer modeling in two ways: (1) the formal use of peers in an isolated setting and (2) the spontaneous and prompted interaction of peers in an integrated setting. The following are observations regarding the success of these two methods:

Peer Interactions in an Isolated Speech Setting

1. Peers, whether disabled or normally developing, did not tolerate repetitive tasks in the speech setting. I used a language-normal peer to model the targeted language skills for the other child to imitate. Initially, the model tolerated the activity but soon became tired and noncompliant.
2. Language-normal peers tired of contrived language elicitation techniques, such as asking the child to label, respond to questions, or imitate responses during highly structured sessions. My impression was that these techniques used models only as "little speech-language pathologists," which resulted in a lack of pragmatic interactions, an increase in noncompliant behavior, and poor attention to the task.
3. Some language-normal peers did not appreciate having to leave their classroom activities to go to a speech session, whereas others did. Individual children had different tolerance levels for participating in sessions.
4. My impression was that the language-normal peer was not motivated to interact in the isolated setting using language skills that were within the model's repertoire but not challenging enough to be interesting. Language tasks were not motivating to the model, and the isolated sessions did not contain any meaningful consequences for this child.
5. The more interactive and function-based the sessions were, the more closely and easily the children worked together. For example, in one successful isolated

session, a model acted as a partner for a child who needed to increase speaking intensity. The children played a game of exchanging information to locate hidden objects. In other words, the models were more successful at stimulating communication functions rather than forms.

6. Generally, what was boring to the language-normal child was also boring to the child with a language disability. Drilling a limited repertoire of responses in an isolated setting was not productive for either child. Successful training activities simulated normal language-learning contexts, which occurred naturally in the classroom.

Peer Interactions in Classroom Sessions

1. The children with language delays required a few weeks to adjust to my regular presence in the classroom. Initially, these children would attend to my interactions in the classroom rather than attending to the activity. Being in the classroom was awkward initially but became more comfortable as my presence became part of the classroom routine.
2. All children used language forms and functions more spontaneously in the classroom than in the therapy room. The rich assortment of interesting materials used for storytelling, cognitive games, art activities, snack times, and special centers or themes (holidays, circus, and field trips) provided a wealth of opportunities for natural language interactions which the isolated speech setting could not provide.
3. The language-normal peers easily imitated adults' modeled language utterances and followed requests to elicit language from other children: "Ask Jennifer where the puppet is."
4. The children with language disabilities responded well to language modeled by their normally developing peers. The interaction between two children was a useful context to teach attention, responding, looking, listening, and talking.
5. The children with language disabilities did not use appropriate language forms during social play. Their normally developing peers used more directive language to structure play interactions and obtain their wants whereas the children with language disabilities tended to respond nonverbally—by hitting, yelling, or crying when they were unable to play with desired objects or when objects were taken away. Frequently, an adult had to intervene and model an appropriate language utterance to correct the situation: "You need to tell (child), 'My toy. Give it to me.'" Usually the disabled child quickly imitated the model.

Clinician Observations and Outcomes

Speechlink was generally successful because we carefully planned a strategy for moving from an isolated setting to the classroom. Certain feedback I received from classroom teachers supported the success of certain procedures.

1. The teachers stated that they now knew each child's specific language and communication goals through my meeting with them in additional conferences and planning ways they could carry out the objectives in the classroom.

2. By seeing me in the classroom each week, they could ask questions about a child's language abilities and learn how to improve their language elicitation techniques and use the normally developing children to model language behaviors.
3. They learned by watching me model language stimulation strategies in certain lessons I taught during cognitive group times. By observing, they identified ways to integrate language targets into cognitive tasks.
4. The written feedback I gave after observing children in the weekly sessions was helpful and informative. This was another way to update and instruct the teachers in adding specific incidental learning techniques into their cognitive activities.
5. The *magnet* meetings once a month were helpful in monitoring the progress of individual children.

I felt the following outcomes demonstrated the success of the integrated program:

1. Children with more severe disorders were seen more frequently during the week than had been possible before integration. These children received a level of direct service that was more appropriate to their needs.
2. I was able to develop more functional training strategies by being in the classroom, observing and talking to teachers, and documenting the communicative functions needed and used by the children with language and communicative disorders.
3. By being in the classroom weekly and observing the progressive steps for generalizing performance from the entry skills established in the speech setting to higher-level skills, I was better able to plan for generalization of language and communication skills.
4. The teachers and I became increasingly successful in using language-normal peers to stimulate language learning.
   a. Modeling: We used manding and modeling more frequently. The staff increased their modeling and also requested that normally developing children model utterances. "Kenzie, tell Jeremy, 'I want the blue paint.'"
   b. We improved our skill at targeting important spontaneous utterances for the child with the language disability to imitate (for example, "Jeremy, tell me what Kenzie said: 'I don't like ghosts'" to practice contractions).
   c. Expansions: We expanded more of the children's utterances in the classroom and were more alert to the language used by both groups of children.
   d. We used such incidental techniques as modeling and expansions more frequently during natural language opportunities throughout the day, rather than targeting specific skills for specific situations.
   e. The language-normal children exhibited more spontaneous vocal and social interaction, using certain techniques carried into the classroom setting. For example, they would spontaneously encourage identification and use of a picture/word board during snack times. This spontaneous performance allowed the staff to use individual children to model specific utterances on the

communication board (for example, requesting of a peer, "I want more juice") rather than the adult modeling the utterance.

f. The staff used models as targets for communicative functions. A child with a language disability was asked to direct a request for an object or action to the normally developing peer; for example, "Tell her you need some more dishes."

g. The staff learned to promote turn-taking between children with and without disabilities. When we identified possibilities for turn-taking, we reinforced or elicited increased interaction between the pair of children.

h. The entry or initial language evaluation and assessment prior to the annual IEP conference became more important in establishing the most meaningful objectives to target in the classroom. It was important to acquire the most representative possible spontaneous language sample for analysis so I would not discover later that the child already used targeted language forms spontaneously in the classroom. Therefore, I placed increased emphasis on formal testing during the second year of this model project to assure that all measures were representative of the child's true functioning.

I made similar observations to those reported by Cole and Dale (1986).

1. Language response rates were noticeably reduced in the classrooms. I was accustomed to obtaining a high frequency of responses during the thirty-minute individual sessions; however, during the same length of time in the classroom, the number of targeted language responses might range from none to three or four. Also, there were certain events in the preschool curriculum during which language could not be stimulated, which concerned me. However, other benefits offset this concern.
2. More opportunities for eliciting targeted language responses occurred throughout the school day than could have occurred in a thirty-minute session. The rich environment of the preschool setting and the variety of classroom experiences provided more opportunities for generalization of specific language targets than could have been incorporated in an individual training approach.

In conclusion, the move from an individual therapy room in the speech-language pathology department to the three preschool classrooms was successful. The successful transition was highly related to the amount of planning and to the high degree of cooperation from the early education teaching staff. Still more program planning needs to be done in order to truly achieve integration; however, I will continue to work towards and advocate program integration at The Capper Foundation. Perhaps the following comment from a specialist in language and educational technologies best underscores the need for integration. I was concerned about all of the activity in the classroom and my inability to achieve the control and high response rate that had been possible in a segregated therapy session. The consultant responded, "You're right. This is the real busy, noisy world of young children." (McCormick 1986b).

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FAMILYLINK:

Serving Families in an Integrated Preschool Program

FAMILYLINK: Serving Families in an Integrated Preschool Program

"You don't raise heroes; you raise sons. And if you treat them like sons, they will turn out to be heroes, even if it is just in your own eyes."
— *Walter Schirra, Sr.*

Why Change Something That Works?

The Capper Foundation and its early education program were established to provide services to children with motor problems and developmental delays. Children aged 2 ½ to 5 years have received intervention according to their needs in individualized therapy sessions and have attended small preschool classes with family contact maintained by the treatment team. Children enrolled in the early education program have had the benefits of a high teacher-to-child ratio in the classroom and intensive physical, occupational, and speech-language therapies. Parents have benefited from close contact with staff in an atmosphere where they could share their concerns and receive guidance. Through school-sponsored activities and social events, parents have developed lasting friendships with parents of other children with disabilities. The preschool program has provided a sheltered environment in which children and families have felt nurtured, supported, and guided from one developmental stage to another.

Entry into kindergarten or another public school setting has often been accompanied by feelings of anxiety and misgivings among families of Capper preschoolers. No longer were their children surrounded by children with similar disabilities; no longer did they have a sense that others understood the special needs of their child and their particular concerns as parents. The early education staff recognized that a mainstreaming experience at an earlier age would help ease the transition for preschoolers entering public school. A number of our students who were physically, socially, and cognitively able were subsequently enrolled part-time in a regular preschool while still attending our program. This experience usually helped to prepare the child for enrollment in kindergarten; however, this change created additional adjustment and stress for the child and the family and additional work for the Capper preschool team. Other difficulties included finding a preschool without physical barriers and one in which the teacher was willing to deal with the additional work and adjustments necessary to accommodate a child with a disability. Maintaining good communication between the two schools was time consuming, although essential to the success of the endeavor.

The team learned that mainstreaming was not necessarily the answer to preparing preschoolers with disabilities for a kindergarten experience. In some cases, the child was not accepted by the other children, and some parents complained that their child was being stigmatized. Dorothy P. Cansler and Pam Winton (1983) state that staff support is another important variable to consider. For example, professionals in regular education may not understand or empathize with the additional stress a child with a disability causes in a family. They may not be familiar with community resources for the family. Parents may feel that they are not being supported and may feel insecure about their child being in a mainstreamed setting.

The difficulties we experienced in mainstreaming our children led the early education team to begin searching for a better way to prepare the children and their families for the public school system, while at the same time educating the community and helping the school population accept and adjust to differences. Our early education staff believed that this transition could be made much smoother by developing a program to bring normally developing children into our previously segregated preschool setting to learn alongside peers with disabilities. This reverse mainstreaming approach appeared to have many advantages:

1. The children with disabilities would still be enrolled in a specialized preschool with all the support services they needed, and they wouldn't have to adjust to a new setting.
2. Communication between teachers and other professionals would continue.
3. The child with special needs would have an opportunity to observe normally developing children modeling age-appropriate behaviors.
4. Friendships could be established between normally developing children and children with disabilities, and all children could develop an appreciation of individual differences.
5. Families of children with disabilities and families of normally developing children, through contact with each other, could recognize the many similar concerns and feelings they share. The social network for all families involved in the program would be expanded.
6. The stigma of being *different* by being enrolled in a special preschool would be diminished.

Although the concept of reverse mainstreaming was appealing, the staff realized that the inclusion of normally developing children in our center would necessitate major changes in day-to-day programming. We needed to make decisions concerning a myriad of details. One of the issues on which the treatment team focused concerned the receptiveness of parents to a change in program format. When we informally introduced the reverse mainstreaming plan to the parents, the response was generally positive; however, parents also expressed many concerns:

1. Will my child still get appropriate individual attention with an increase in the number of children served?
2. Will my child be pushed too hard when competing with normally developing children?
3. Will my child be teased by the normally developing children?
4. Will my child play *second fiddle* to the normally developing peers?

Once we had made the commitment to a reverse mainstreaming program, we invited the parents to a formal meeting. To make it possible for all the parents to attend, we scheduled the same meeting twice, once during preschool hours for the parents who bring their children into our center and once in the evening for parents who are employed during the day. We openly discussed questions and concerns, and we carefully noted the parents' suggestions so they could be incorporated into the new program as much as possible.

Who Are the Children?

The children in Project Kidlink come from traditional families with a working father and a homemaker mother, from families where both parents work, and from single-parent families. Occasionally children are being raised by a foster family or by members of the extended family.

Children with Special Needs

We have children from a wide variety of socioeconomic backgrounds in our preschool, although generally the families are middle-class or lower middle-class. Most do not have a family history of handicapping conditions. Usually these families have values of self-sufficiency, independence, and hard work. Their lifestyles are typically healthy, and the mothers have received appropriate prenatal care. The news that something is wrong with their child is almost always totally unexpected. Our experiences are similar to those Helen Featherstone, educator and mother of a child with a severe disability, describes in her book, *A Difference in the Family* (1981). She relates her own feelings and those of numerous other parents when they are confronted with their child's disability. This is one of the most devastating experiences a family can encounter. It takes time for family members to sort things out and reorganize their lives, to adjust to the new task at hand and the idea of caring for a child with special needs. It is our experience that sometimes parents avoid getting involved with formal groups of families who have children with special needs, because they desperately want to keep their own individual identity and not belong to *that* group.

Normally Developing Children

Most of the normally developing children in our program come from families where both parents are employed, and they usually stay after preschool for day care. About one-third of these parents are members of The Capper Foundation staff. Occasionally we have enrolled a sibling of a child with special needs. The majority of these parents are middle-class, well-educated professionals who choose the integrated program for their child because they recognize the value of their child learning to accept differences and social diversity at an early age.

Parent Involvement—A Family Affair

People with disabilities are more visible today than in the past, and barriers are diminishing for them, although ever so slowly. However, the general public is still uneasy about children with special needs. Children are supposed to run, hop, skip, shout, laugh, and sing. A child in a wheelchair or on crutches or who walks with an unusual pattern attracts the curiosity, but not necessarily the interest, of the average person. Some people feel pity or a sense of helplessness or embarrassment. A child who cannot use the voice successfully to communicate can be seen as *weird* or *dumb*. Our busy lifestyle is not conducive to waiting patiently or exploring creative ways to communicate with these children. Many times we hear from people, "I don't know how these parents cope. I could never do it." That impression, however, may be a hindrance to starting friendships because the two sets of parents feel they have nothing in common.

We had the parents of children in our program complete an attitude survey at the beginning of the project to determine their attitudes to integration. (A copy of the Survey of Parent Attitudes can be found in the Appendix, Form 12.) The results of this survey showed us that the parents believed an integrated classroom and day care would be an excellent opportunity for all children to learn and grow. Most parents agreed that both groups had something to offer and that both groups could learn from each other and become friends. However, they expressed the same concerns as had been expressed at the initial informal meeting. These concerns were similar to those of the team members and confirmed that these issues are indeed very valid and important:

1. Will there be adequate space for a larger group of children?
2. Will the teacher be able to give enough time and attention to each child's special needs?
3. Can the program adequately stimulate all the children according to their individual needs?

To help all the parents become better acquainted, we planned opportunities for them to meet. Our aim was to bring parents of both groups of children closer together, so they could experience the reality that they all have similar goals for their children and, therefore, can support each other. We decided to arrange a combination of formal and informal opportunities for interaction, such as parent/child classroom activities throughout the year, casual encounters in the hallway where parents drop off and pick up their children, incidental meetings when parents observe in the observation room, a wake-up café, and family get-togethers.

Classroom Opportunities for Parent Involvement

The parents are encouraged to observe their children during classroom time or therapy. All three classrooms are equipped with observation rooms with one-way mirrors to facilitate easy observation without disturbing the classroom routine. These observations also bring parents together casually and promote discussions among them.

The progression of the school year also brings other opportunities for the parents to participate in the classroom. Special events such as holidays and birthdays provide opportunities for involving parents. On occasion, the teacher in a particular classroom may organize a very special parent/child activity. Parents can formally sign up to be a room parent or can attend functions as their child's guest. Some of our parents also become involved by volunteering for special projects, field trips, or occasionally as a teacher's assistant in the classroom.

Kidlink Café—A Great Way to Start the Day

Working parents of children enrolled in our program have little opportunity to meet other parents. Only on rare occasions are they able to spend time in the observation room or to participate in parties; therefore, we felt the need to create a special informal opportunity where parents and staff could casually meet to exchange everyday news or feelings, such as their frustrations with the weather, a planned Halloween costume, or the crowded stores during the holidays. Such casual exchanges among the parents and between parents and staff would help make us aware that we all share similar everyday experiences and feelings. We would not handle expressed concerns about the child or the child's program in depth at this get-together. Rather, the social worker or another team member would follow up on them at a later date. For a parent-to-parent function, we gave special consideration to the following factors:

Time: The function should take little time away from the already full daily schedule of the parents.

Place: The location should be easily accessible, so the parents would not have to go out of their way to participate.

Format: The function should be something the parents would be attracted to and enjoy.

We organized a monthly casual drop-in wake-up coffee, called Kidlink Café, because it seemed to incorporate the preceding objectives. The occupational therapy kitchen is located near the day-care room where the children start their day, and it is not in use before 9:00 a.m. By borrowing the bar stools from the observation rooms, it was easily converted into a large breakfast nook. The Kidlink Café is open every third Tuesday morning of the month from 7:30 a.m. to 9:30 a.m. It takes very little time for the parents to drop in, have a cup of freshly brewed coffee or tea or a glass of juice, and eat a doughnut or a piece of coffee cake. The Kidlink Café is the responsibility of the social worker; however, other team members usually help by bringing baked goods or assisting with preparation. See Form 13 in the Appendix for a copy of a Kidlink memo to the parents.

An Evening Out with Kidlink

We have had by far the most success with parent participation at our family nights, which are held twice yearly, in the fall and spring. Children and family members are invited to share a simple meal with our team members. Over the years, we have tried different formats and menus. The function takes place in the early evening hours, around 5:30 or 6:00 p.m., in our multipurpose room. The first part of the evening is reserved for dinner and the second part for a special program. After experimenting with a variety of menus, the combination of catered food service with donated side dishes seemed to provide the proper mix. The last two family dinners have consisted of a catered main dish (chicken and mashed potatoes) with side dishes of salad, dessert, or rolls provided by staff and families. Drinks and table service are furnished by the agency.

This arrangement provides the families with a good, balanced meal for low cost and little work. Family contributions to the meal help give the evening the homey atmosphere of a potluck dinner. The children create seasonal table decorations in the classrooms, which gives children the satisfaction of having contributed to the evening.

The project director and the social worker share the overall responsibility for this event. However, since the other staff members participate, a duty sign-up sheet is a great help in organizing and carrying out this function. Form 14 in the Appendix lists the duties for staff members for Kidlink Family Night.

During the meal, families have an opportunity to get acquainted with each other. Often the first step is taken by the preschool child who wants to sit with a friend. Child-focused interaction brings the other family members together casually. Staff are also alert and helpful in introducing parents who don't know each other. Through a game-like activity, families are encouraged to report something about themselves which also helps to make everyone more comfortable.

After the meal, there is a transition to some type of formal program. During the planning stage, the staff decides whether to keep parents and children together or separate them at this time. We have done both, depending on the goals the team members wished to accomplish. During the early stages of the project, we wanted to give parents an overview of the integrated program. This was best accomplished through a formal presentation for the parents while the children participated in games led by classroom paraprofessionals.

During the second year, we were more interested in increasing interactions among parents of children in the program. We encouraged parents and children alike to join in staff-sponsored games that the children had learned during preschool. These games served several purposes. They gave children an opportunity to teach an activity they enjoyed, refreshed parents' memories about child-focused activities they could carry out at home, and provided a forum for enjoyable interaction among all age groups.

Although family night involves the whole team and demands a great deal of preparation, we feel the effort is very worthwhile for the following reasons:

1. Parents have an opportunity to get to know other families whose children attend our preschool.
2. Parents can become better acquainted with staff in an informal setting.
3. Staff members have an opportunity to observe family dynamics.
4. Siblings of children with disabilities get to know other children in a similar situation.
5. The students have an opportunity to introduce their friends to their families.
6. It provides a forum for staff to give and receive information in a group session.
7. Last but not least, family get-togethers are an enjoyable time for everyone involved.

Expanding Acquaintances

With the goal of increasing parents' acquaintances with other parents in mind, we analyzed the environment outside the classroom area and identified changes that would facilitate casual encounters among parents. The three preschool classrooms are all equipped with one-way mirrors so activities can be seen from an observation room. To make observing their children during classroom activities more inviting for the parents, we furnished the observation rooms with new bar stools for more comfort, framed educational posters, and a magazine rack to hold magazines of interest to parents, such as *The Exceptional Parent* and *Working Mother.*

The staff uses a large bulletin board in the hallway between two of the preschool classrooms to give up-to-date information about school and community programs available to the parents. We also encourage parents to use the bulletin board for their own information exchanges, such as special items they would like to buy or sell, child-care information, and so on. The social worker is responsible for keeping the bulletin board updated according to season.

Kidlink Newslink

Kidlink Newslink is a monthly newsletter designed to share program information with the parents. It covers such topics as classroom and therapy news, integration strategies, educational information, and parent/child activities. This newsletter is one way to bridge the gap between home and school and is especially helpful to those parents who have limited contact with team members. Form 15 in the Appendix is a copy of *Kidlink Newslink.*

Parent/Staff Teamwork

The parents work as a team with the staff at all stages of the referral and service-delivery process to ensure the best possible service to their children.

Screenings, Evaluations, and Staffings

Children can be referred to our program by parents or by personnel in other agencies. Agency referrals are most often made when a child has special needs. The social worker conducts the initial interview. At this time, we inform the parents about our program's philosophy and organization and encourage them to share their expectations for their child and the agency. Normally developing children are screened by teachers and therapists, using the *DIAL-R* (Mardell-Czudnowski and Goldenberg 1983), to rule out the possibility that they have a special need that has been overlooked.

Children with special needs receive a comprehensive evaluation to determine whether our program is appropriate for them, since the target population for intervention is children with physical impairments. The child's level of functioning, strengths, and special needs are also important to determine in order to develop an appropriate Individualized Education Program (IEP), as mandated by Public Law 94-142. The evaluation is usually spread over several sessions, involves professionals in early education and special education, physical therapy, occupational therapy, speech-language pathology, and psychology, and concludes with a meeting involving the parents and the staff members who participated in the evaluation process. At this time, the team members share the evaluation findings and make recommendations for programming.

At the beginning of the school year, all parents of children with disabilities are invited to participate in an IEP conference in order to set goals and objectives appropriate to the child's strengths and special needs. Another formal staff/parent meeting is held in March or April to update the child's goals and objectives and to address concerns the parents may have about their child or the program. When we set the appointments for these meetings, the social worker asks the parents to complete an *Assessment of Your Child* form to assist them in preparing for the meetings and so we can incorporate their goals and objectives for their child into our program. Form 16 in the Appendix is a copy of this assessment form.

Parent/teacher conferences with the parents of normally developing children are scheduled at least once a year. These meetings help to assure coordination of efforts between the school and home. Together with other family involvement activities, these conferences build mutual support between parents and staff for the benefit of the child.

Home Visits

Knowing from what kind of environment and family a child comes makes it easier to understand the child's needs; therefore, the early education team considers it important to have good contact with the family and, whenever possible, to make a home visit at the beginning of the school year. Because our center is closed during the month of August, home visits provide a nice transition for the child, whether the child had been in the program the year before or had been evaluated during the month of July for fall enrollment.

Generally, the child is excited to have the teacher and one or two other team members visit at home and to show off toys, the backyard, and the child's room. The parents also appreciate the opportunity to demonstrate what they meant when they explained a home activity or equipment to staff in the clinic. Home visits are also a good opportunity to give the parents information about upcoming enrollment and the start of classes, to discuss such things as transportation, clothing changes, and snacks, and to answer questions and give instructions.

Few parents have expressed difficulty with receiving team members in their homes. Even parents who are employed regard this visit as important enough to make arrangements to be at home.

One week is set aside at the beginning of the fall term to visit all the children enrolled in the early education program. The social worker's task is to organize a schedule with the help and input of other team members, so each child is visited by one to three staff members. This master schedule takes into consideration the geographical location of the family, the parents' time schedule, and the availability of staff. Although creating this schedule is quite work-intensive and time consuming, it assures that as many families as possible are visited with a minimum amount of staff time.

Counseling

The child's disability affects most of what parents do together—sleep, work, mealtime, outings, and so forth. It also affects the lives of siblings and may affect extended family members and friends. Often families see themselves confronted with changed social relationships due to time constraints or misunderstandings by others. Also, in our dynamic, fast-paced society, extended family support systems are not always available. The family's involvement in the life of the community may decrease and feelings of isolation increase as a result of the demands and stresses that accompany the birth of a child with special needs. A major role of the social worker is being available to support parents as they search for ways to cope with these changed circumstances.

A disabled child is not the only reason a family may encounter a crisis. Life events, such as the birth of a child, a death, loss of a job, or marital problems, may have an impact on everyone. Even a child who is not old enough to understand what is happening is affected by the stress and will react to it in some way; therefore, social work services are not limited to families who have a child with special needs, but rather are available to all families who have a child enrolled in the early education program.

Parents' Reactions

The Capper Foundation early education program has traditionally offered a variety of parent involvement activities. With Project Kidlink, however, we felt a need to focus more specifically on the kind of activities that would be most helpful to the parents in an integrated setting. After the initial year of integration, we felt the need to solicit parent input in order to evaluate the usefulness of the parent program component; therefore, we adapted a *Parents' Strengths and Needs Assessment* form that had been developed by NAPA Infant Program in California and asked our parents to complete it at the end of the first project year. This form was accompanied by a list of activities that had been offered throughout the year. This assessment is Form 17 in the Appendix.

We learned that all parents generally value good cooperation between the home and the school, desire knowledge of child development, health care, and handicapping conditions, and good family interaction. Surprisingly, knowledge about different support systems in the community and legal issues seemed of lesser importance to the parents of children with special needs than to the parents of normally developing children.

Parents of children with special needs saw themselves as less knowledgeable about the preceding subjects than did the parents of normally developing children. This discrepancy is likely related to the fact that the majority of the latter parents are professionals, whereas the parents of children with special needs come from all walks of life. On the other hand, the parents of children with special needs regarded themselves as more skilled in child care and general life tasks than the parents of normally developing children. Parents preferred to receive information in written form or individual sessions rather than in group sessions.

We regard ongoing parent assessment of the various components of the program as an important ingredient in evaluating program effectiveness. The *Parents' Strengths and Needs Assessment* data provided valuable input for gauging parent interests following the initial year of program operation. Because the turnover of children from one year to the next is fairly low, reusing the same survey the second year would not be appropriate. Instead, the team developed the *Questionnaire for Parents* and the *Family Involvement Activities Sheet* to solicit feedback about the parent component of the early education program and whether it was meeting their needs. Copies of these questionnaires are found in the Appendix, Forms 18 and 19. Parents were asked to rate the effectiveness of the activities in which they had participated. They were also asked to indicate whether they would attend a similar function again. Survey results gave us an understanding of what areas the parents would like to see changed and what they saw as important. Overall, the parents felt they received sufficient input into their child's program. Staffings and IEP evaluations were seen as very important meetings, and family night received the highest vote for group activity.

Resources for Families

We have provided several formal sources for parents to receive information. These include a library of resource books for family members and children's books which parents may borrow, and regular seminars given by staff members or professionals from the community.

Parent Library

Our *Parents' Strengths and Needs Assessment* survey showed that parents prefer to receive information on child development, health care, parent education, and handicapping conditions in written form. This data confirmed the importance of having a parent library. Thanks to a memorial fund, our agency already had a library for use by parents and staff. It is located in a conference room near one of our preschool classrooms, easily accessible for parents. The library contains books about child development, different handicapping conditions, research, and treatment strategies, as well as books written by parents who share their stories about coping with the challenges of raising a child with special needs. A collection of pertinent articles that could be of interest to parents and pamphlets from such resources as the Epilepsy Foundation, the United Cerebral Palsy Foundation, and the Spina Bifida Association are available as well. We also keep a selection of children's books in the library, which families can check out. We typically select books for the library that will help parents deal with the various feelings their children may be experiencing.

In order to make the large variety of books, magazines, articles, and pamphlets more accessible to the parents, we developed a take-home bibliography that contains short descriptions of the books, and we periodically update the list of available articles. Parents can thus make an informed choice about the kind of reading material they would like. The social worker also prepares book reviews for inclusion in the monthly issue of *Kidlink Newslink*, the preschool newsletter.

Parent Seminars

Formal presentations on topics related to the needs and interests of parents of young children and staff who work with them enrich any early education program. Such presentations complement both formal and informal interactions between parents and staff and bring to life written information in the field of early education and family life.

We have drawn upon the expertise of our own staff and resource persons in the community for formal presentations throughout the year. Possible topics for presentations include the following:

- Seizure disorders—types, treatment, management
- Cerebral palsy—types, treatment, management
- Parent education—parenting skills, coping strategies
- Health education concerning childhood diseases
- Educational rights—parents' rights, children's rights, resources
- Doctor/patient relationships
- Assertiveness training
- Improving communication skills

From time to time, parents have indicated an interest in discussion groups. In response to their concerns, we have offered a series of topic-oriented group sessions on subjects such as "The Emotional Development of the Child" or "Concerns for Siblings of Children with Disabilities." In order to make these groups more accessible to all parents, we offer the seminars during the day and in the evening hours. If a speaker can come at only one time, we videotape the presentation so parents who were not able to participate can view it at another time.

Advisory Council

Parents have a formal voice in the overall planning and development of the early education program through their participation in the Capper Advisory Council. Four of the twelve members are parent representatives. Other members include professionals in the community who represent the fields of medicine, health, social services, and education. The function of the advisory council is to provide feedback to The Capper Foundation program staff and administration on policy and programming issues and to represent the agency as informed council members in their contacts with other parents, professionals, and the public at large. The advisory council meets bi-monthly during the lunch hour at The Capper Foundation.

And That's the Way It Is!

We had several reasons for incorporating the reverse mainstreaming concept into our preschool program. One was to promote better understanding between families of disabled and nondisabled children. We also wanted to strengthen the role of parents in facilitating their child's emotional, physical, social, and cognitive development.

We live in a fast-paced, ever-changing society. The answers to rearing our children do not necessarily lie in memories of our own childhood experiences. Today's parents and children are often confronted with new challenges that accompany divorce, single parenting, blended families, full-time employment of caregivers, and technological advances that affect every aspect of our lives.

It is imperative that those of us who provide services to young children and their families be sensitive to their varied lifestyles and to the unique blend of stressors, resources, and coping strategies that each family brings to the early education setting. Commitment to the child implies commitment to the family as well. The Project Kidlink staff allows for flexibility within a structured program format, thereby acknowledging the complexity and diversity of family systems and supporting the parents as primary caregivers. Good communication between families and the program staff is of vital importance in successfully meshing the efforts of the two systems. Such collaboration involves mutual trust, understanding, respect, and support of the roles assumed by each system in facilitating the growth and development of the child. The goal of parents and staff is the same—to provide a secure, happy, stimulating environment for children in order to prepare a new generation for an exciting life, which may be even more diverse and different from our life than ours is from past generations.

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APPENDIX

Appendix

Form 1

Programs Implementing Reverse Mainstreaming

Albuquerque's Special Preschool
Albuquerque Integration Model
3501 Campus Boulevard, N.E.
Albuquerque, NM 87106
(505) 266-8811

Early Childhood Intervention Preschool
Department of Special Education
University of Kansas
3150 Haworth Hall
Lawrence, KS 66045

Early Education Center
Box 399
Hutchinson, KS 67504

Northwest Center Child Development Program
2919 First Avenue West
Seattle, WA 98119
(206) 281-9222

Form 2

Early Education Application Form

Date ________________

Child's Information

Name ____
(First) (Nickname) (Middle) (Last)

Address ______________________________ Home Phone ______________

____
(City) (County) (State) (Zip)

Date of Birth ______________________________ Sex ______________

Family Information

Name of Father ______________________________ Birthdate ______________

Address (if different) ______________________________ Home Phone ______________

Occupation ______________________________ Education ______________

Place of Employment ______________________________ Work Phone ______________

Name of Mother ______________________________ Birthdate ______________

Address (if different) ______________________________ Home Phone ______________

Occupation ______________________________ Education ______________

Place of Employment ______________________________ Work Phone ______________

Legal Guardian: *(Please check one)* ☐ Mother ☐ Father ☐ Both ☐ Other

Brothers and Sisters

Names	Ages	Education and Special Services

Other persons living in the home ______________________________

Language(s) spoken in the home ______________________________

Does any member of your family have a disability?

____

Any recent births, deaths, divorce, separation, or other major changes in the family?

____

■ **In Case of Emergency Contact:** (Other than parent of child)

Name ______________ Address ______________________ Phone ______________

Name ______________ Address ______________________ Phone ______________

Prenatal, Birth, and Health History

Birthplace ________________________________

Were there any unusual events during your pregnancy or delivery with this child (for example, toxemia, x-ray treatments, rubella, other maternal illness or injury, drugs, bleeding, or other problems)?

Was your child premature? ________________ How many weeks? ________________

Did your child have any birth defects or require special care after birth? (needed oxygen, had cleft palate, webbed feet or fingers, heart or lung condition, malformation of spine)

List any diagnosis your child has been given ________________________________

Describe any serious accidents, illnesses, hospitalizations, or surgeries:

Type	Date	Child's Age	Doctor/Surgeon

Has your child had seizures or convulsions? ____________ When? ________________

If your child has allergies, please list: ________________________________

If your child is on medication, please list type and dosage: ________________________________

If your child is on a special diet, please describe: ________________________________

List your child's pediatrician and other specialists who have seen your child:

Name	Address	Date Seen

List other agencies that have been involved with your child (clinics, hospitals, physical or occupational therapists, speech therapists, preschools, public health nurses, and so on):

Name	Address	Date Seen

Growth History

Indicate age accomplished.

Held head erect ____
Sat unsupported ____
Crawled ____
Walked ____

Rode trike ____
Climbed stairs ____
Ate solid foods ____
Finger-fed self ____

Fed self with spoon ____
Gave up bottle ____
Drank from cup ____
Toilet trained ____
Dressed self ____

Motor Development

If you have concerns about your child's motor development, please explain: ____

My child: *(Please check those that apply to your child)*

☐ seems clumsy.
☐ feels tight.
☐ feels floppy.
☐ falls frequently.
☐ moves slowly or jerkily.
☐ uses one side of the body differently than the other side.

How does your child get from room to room (for example, crawls, is carried, scoots, walks)? ____

Which hand does your child use most often? ____ Does your child switch for eating? ____
Pencil use? ____ Ball throwing? ____ Batting? ____

Communication

■ Hearing

If you have concerns about your child's hearing, please explain: ____

Has your child had frequent ear infections? ☐ Yes ☐ No If yes, explain: ____

Has your child had a recent hearing exam? ☐ Yes ☐ No If yes, explain: ____

My child responds to: *(Please check those that apply to your child)*

☐ doorbell or phone.
☐ children playing outside.
☐ truck or motorcycle outside.
☐ speech when facing speaker.
☐ speech on TV.
☐ speech with back to speaker.
☐ speech from another room.
☐ whispered speech.

■ Speech and Language

If you have concerns about your child's speech and language, please explain: ____________________

____

My child: *(Please check those that apply to your child)*

☐ drools.
☐ babbled or cooed during the first 6 months.
☐ spoke the first words with meaning by about 1 year.
☐ spoke in short sentences by about 2 ½ years.
☐ spoke in complete sentences by 4 years.
☐ began to babble or talk and then stopped.

My child uses speech: ☐ frequently. ☐ occasionally. ☐ never.

Comment ____

Give an example of your child's typical speech. ____________________

____

If your child uses other forms of communication, such as communication board or sign language, please explain: ____________________

____

Which of the following is most typical of your child's ability to understand speech? *(Check one.)*

☐ Does not understand what is said.
☐ Understands very little of what is said.
☐ Understands what is said when speaker gestures.
☐ Understands familiar statements or questions.
☐ Clearly understands everything said.

Which of the following is most typical of your child's ability to communicate? *(Check one.)*

☐ Does not use speech or gestures to communicate.
☐ Uses gestures or motions but no speech.
☐ Uses babbling sounds but doesn't try to talk.
☐ Uses sounds when trying to talk.
☐ Uses speech, primarily single words.
☐ Uses sentences that are understood by the family but not others.
☐ Sentences can be understood by others.
☐ Speech is clearly understandable.

Social and Cognitive Development

■ Social Behavior

If you have concerns about your child's social interaction with others, please explain: ____________________

____

____

My child: *(Please check those that apply to your child)*

☐ smiles.
☐ laughs spontaneously.
☐ cries.
☐ likes to be held and cuddled.
☐ recognizes familiar people.
☐ makes eye contact.
☐ reaches to be picked up.
☐ separates easily from me.
☐ has unusual mannerisms.

Describe your child's favorite toys and activities. ____________________

____

Describe how your child plays with toys (for example, length of play, supervised or unattended, pretends with objects). ______________________________

____

Describe how your child interacts with other children. ______________________________

____

Describe how you discipline your child. ______________________________

____

■ Cognitive Behavior

If you have concerns for your child's learning ability, please explain: ______________________________

____

____

My child: *(Please check those that apply to your child)*

- ☐ plays peek-a-boo.
- ☐ plays pat-a-cake.
- ☐ waves bye-bye.
- ☐ responds to "no."
- ☐ looks at books.
- ☐ stacks blocks.
- ☐ puts together puzzles.
- ☐ uses a pencil or crayon.
- ☐ uses scissors.
- ☐ identifies letters.
- ☐ identifies colors.
- ☐ identifies numbers.

Normally developing children will participate in a screening by the early education team prior to enrollment. Children with disabilities will complete a screening or evaluation by the early education team prior to enrollment.

I give my permission for ______________________________ to complete the appropriate preenrollment testing procedures.

______________ (Date)

______________________________ (Parent or Guardian Signature)

Form 3

Preschool Applicants

Name	Age	Date Screened	Application Completed	Accepted to Program	Starting Date	Screening Results Started	Health and Immunization Form	Press/Photo Release	Attendance Transportation	Lunch-Income Eligibility	Fee Schedule Payment		

Form 4

Attendance Form

Child's Last Name: **First Name (1)** ______________ Birth Date (1) ________

______________________ **First Name (2)** ______________ Birth Date (2) ________

Mother's Full Name ______________________________________

Home Address ______________________________ Home Phone __________

City ______________________ State __________ Zip __________

Father's Full Name ______________________________________

Home Address ______________________________ Home Phone __________

City ______________________ State __________ Zip __________

Mother	Father
Employer	
Phone	
Hours of Work	

Authorized Escort ______________________________ Phone __________

Address ____

Authorized Escort ______________________________ Phone __________

Address ____

In Case of Emergency Call (Other than Parent):

Name ______________________

Address ______________________

Phone ______________________

Doctor's Name ______________________

Address ______________________

Phone ______________________

	Child 1	**Child 2**
Admission Date:		
Days of Week:		
Hours of Daily Care:		
Fee:		
Discharge:		

If your child receives child care outside of the preschool/day-care program please list

Child Care Provider's Name ______________________________

Address ____

Phone ____

Form 5

Fee Schedule Contract

Name of Child: ______________________________ Birth Date: ____________________

Parent's Name: ______________________________ Enrollment Date: ______________

Address: ___________________________________ Termination Date: _____________

Phone: _____________________________________

I, ____, am enrolling

__________________________________ in _______________________ for the

following weekly schedule:

Monday _____________________________________

Tuesday _____________________________________

Wednesday __________________________________

Thursday ___________________________________

Friday ______________________________________

at the daily rate of _________, including lunch and snacks.

Schedule of payment:

Weekly ______________________________ Monthly ____________________

Two weeks' notice is required to terminate this contract.

____
(Parent's Signature)

____
(Date)

Form 6

Dear ______________________________:

We are pleased that you are interested in enrolling your child in ______________________. Enclosed is an application form for you to fill out. It is necessary to return the form in the stamped envelope before your child's screening date.

As I mentioned on the phone, an intake screening is part of our selection process for model children. The intake screening is a series of brief activities that give us an indication of how your child performs selected tasks. Model children will be selected based upon information given on the application form, the child's performance on the intake screening activities, and the number of openings in each preschool classroom.

The intake screening date is scheduled for _____________ on ___________ at __________.

When arriving, please come with your child to the receptionist's desk. Since our schedule is very tight, your promptness is appreciated. The screening will take about 1½ hours.

If you have any further questions or concerns, please call __________ and ask for ____________. We look forward to seeing you on your scheduled intake screening date.

Sincerely,

Form 7

Referral Sheet

Child's Name: ______________________ Birth Date: ______________

Parent's Name: ____

Address: ______________________ Phone: ______________

____

Other Information:

____

____

____

____

____

____

____

____

How Referred:

____

____

____

____

____

____

____

____

____

Scheduled Date of Screening:

____

Form 8

Intake Procedure for Normally Developing Children

	Person Responsible
I. Referral Call	
A. Explain program/possible forms needed	*Director of Social Work*
B. Fill out application for service (pg. 1)	
C. Set up time/date for intake procedure (if parents are interested in program). Follow-up with appointment reminder (form).	
II. Intake Procedure (Thursday afternoon at 1:15)	*Director*
A. Set up materials/arrange room	
B. Parent and child arrive in waiting room 1. Greet parent and child—explain procedure. 2. Take instant photo 3. Take parent to social worker and child to activities	*Director*
C. Intake for parent 1. Parent signs consent forms 2. Parent completes application form/checklists 3. Discuss procedure 4. Upon completion, parents observe child	*Social Worker*
D. Intake for child (using *DIAL-R*) 1. Motor (15 minutes) a. Physical developmental profile b. Gross and fine motor 2. Concepts (10 minutes) 3. Communication (10 minutes)	*Physical Therapist* *Occupational Therapist* *Teacher* *Speech-Language Pathologist*
E. After completion, Director exits with parent and child explaining when they will be notified, etc.	*Director*
F. Classroom candidates 1. Team decisions meeting for children in day care after complete intake procedure (3:30-4:00) 2. Observation notes packaged and given to Director	
G. Notification to parents (the next day or as soon as possible) 1. Call parents to inform of decision 2. Send results of intake to parents	*Director*

Form 9

Screening for Normally Developing Children

Name ______________________________ Birth Date ________________

Date of screening ________________________

How did you hear about our program?

____

____

What attracted you to our program?

____

____

What do you expect from the program for your child?

____

____

____

What additional information can we give you?

____

____

____

Additional Information:
- My role as social worker
- Library
- Toy lending library
- Others

Form 10

Individual Developmental Plan

Name ______________________________ (Last) (First) (Middle)

Entry Conference Date ______________________

D. O. B. ____________________ Age ________________

Projected Exit IDP Date ____________________

Summary of Present Educational Performance

Skill Areas Assessed	Individual Developmental Goals	Date Implemented	Exit Date	Parent's Comments

Activities Provided

____________________ ____________________

____________________ __________ __________

Any Special Concerns (Entrance) ____________________

____

Any Special Concerns (Exit) ____________________

____

Members Present (Signature and Position)

Parent ______________________________

Teacher ______________________________

____

____

____

____

Form 11

Memo

Date:

To: Parents

From: ______________________________ , Occupational Therapist

Subject: Occupational therapy goals of improving motor and self-care skills

I will be pairing children for half-hour sessions. Some of the activities your child may be performing in occupational therapy include:

1. Vestibular stimulation to improve balance: moon walking, swinging, merry-go-round, riding a scooterboard down a ramp, pulling a rope to tow another child on a scooter, and rolling in a barrel
2. Resistive activities to improve strength: wearing weights, pushing and pulling objects, tug-of-war, crawling
3. Gross motor activities to improve skills: jumping, stair-climbing, hopping, ball-throwing, and catching
4. Fine motor activities: building with blocks, stringing beads, playing with clay, buttoning
5. Tactile stimulation to enhance body awareness: playing with shaving cream and sand, rolling in a barrel, moon walking, hiding beneath assorted blankets

The paired children will be asked to do the same activities and will be taking turns or performing at the same time. My goal is to show the less physically able child that it *is* fun to move!

Form 12

Survey of Parent Attitudes

Developed by Dr. Nancy Peterson
University of Kansas

Part I: Individual Information

Directions: Part I of this survey asks for some general information about you and your family. Please read each question carefully. Indicate your answer by placing an "X" by the statement that applies to you.

Individual Information

1. Who is answering this survey?

____ mother (natural mother, foster parent, or guardian)
____ father (natural father, foster parent, or guardian)
____ both parents

2. What is the father's current level of education?

____ did not complete high school
____ high school graduate
____ have some college hours, but do not have college degree
____ bachelor's degree
____ graduate degree (master's or doctoral degree or equivalent)
____ don't know—father is not present in the home

3. What is the mother's current level of education?

____ did not complete high school
____ high school graduate
____ have some college hours, but do not have college degree
____ bachelor's degree
____ graduate degree (master's or doctoral degree or equivalent)
____ don't know—mother is not present in the home

4. What is the father's current age?

____ 15-19
____ 20-30
____ 31-40
____ 41-50
____ 51-60
____ 60 or older
____ don't know—father is not present in the home

5. What is the mother's current age?

____ 15-19
____ 20-30
____ 31-40
____ 41-50
____ 51-60
____ 60 or older
____ don't know—mother is not present in the home

6. What previous contact(s) have you had with people who have disabilities? Check all that apply to you.

____ I am a parent of a child with a disability.
____ I have a job that brings me into regular contact with individuals who have disabilities.
____ I have a close relative or close friend(s) who is disabled.
____ I have done volunteer work with people who have disabilities.
____ I have actually had very little exposure.

7. My preschooler who is to be enrolled here can best be described as

____ normally developing.
____ disabled—a child who has been diagnosed as blind or partially sighted, deaf or hearing impaired, physically disabled, mentally retarded, or speech impaired.
____ a child with special problems (such as developmental delay, behavior problems, or other *minor* physical or developmental problems).

8. How old is your preschooler?

____ 2-3 years old ____ 3-4 years old ____ 4-5 years old ____ 5-6 years old

Part II: Questions about Parent Attitudes

Directions: This part of the survey concerns your attitudes about people who are disabled and about preschool programs for children with disabilities. There are no correct, incorrect, or expected answers to the statements in this survey. Your answers will be confidential and will be reported only as a part of the overall group data.

Read the items on the next few pages and indicate your level of agreement or disagreement with each statement by making a check in the appropriate column:

I agree strongly
I agree slightly
I am neutral
I disagree slightly
I disagree strongly

Note: In this survey, we refer many times to "children with disabilities." By this we mean a child who has been diagnosed as blind or partially sighted, deaf or hearing impaired, physically handicapped, mentally retarded, speech impaired, physically handicapped, or orthopedically handicapped.

	I agree strongly	I agree slightly	I am neutral	I disagree slightly	I disagree strongly
1. When I see someone who is disabled, I feel very sorry for that person.					
2. I think a child who is disabled would be likely to learn better in a class that includes normally developing children.					
3. I think the preschool teachers are sufficiently skilled to teach *both* disabled and normally developing children in their classrooms.					
4. It is difficult for a child with a disability to truly be an equal member of a family just like other family members.					
5. Normally developing children can benefit, both socially and academically, if they participate in a classroom that includes both children with disabilities and normally developing children (as opposed to only normally developing children).					
6. I think a regular preschool setting would be better suited for having an integrated preschool class than a setting designed for children with disabilities.					
7. I believe that a disability doesn't necessarily have to limit a person's ability to live a satisfying and useful life.					
8. I think normally developing children will have to learn extra patience and tolerance if they are to be in a classroom that includes children with disabilities.					
9. I feel it is probably unfair to the children with disabilities to have normal models in their preschool classroom because it will take away from their care.					
10. I think that having a child with a disability is probably an embarrassment to most families.					
11. I suspect that only very "special" or kind children will enjoy being in a preschool that includes peers with disabilities.					
12. If children with disabilities are enrolled in this preschool, I doubt that the teachers will have enough time to do a good job with either group of children.					

	I agree strongly	I agree slightly	I am neutral	I disagree slightly	I disagree strongly
13. People with disabilities often have strange or unpleasant mannerisms that make people around them feel uncomfortable.					
14. Normal children are likely to take advantage of and tease children with disabilities if they are together in the same classroom.					
15. I believe the early education team will be able to give my child a *quality preschool program* in an *integrated* classroom that would be as good as my child would have in a classroom enrolling only children of similar ability levels.					
16. Children who are disabled probably have as many endearing qualities as do normally developing children.					
17. The presence of both normally developing children and children with disabilities in the same classroom would likely create a more stimulating, interesting environment for the kids than if each group were placed in separate classes.					
18. From my point of view, the integration of normal models into this preschool will not interfere with the staff's ability to provide quality therapy and individualized programs for the children with disabilities.					
19. A normal child could have as much fun playing with a playmate who is disabled as with another normally developing child.					
20. I think it may not be wise to combine normally developing preschoolers and preschoolers with disabilities in the same classroom because they are likely to learn bad behavior from each other.					
21. I suspect my preschooler is probably going to feel *less* comfortable in the classroom when we begin to integrate normal models into the program.					
22. People who are disabled probably care as much about being successful in life as people who are not disabled.					
23. I suspect that normal children would often reject kids with disabilities as playmates given the choice between a peer who is developing normally and one who is not.					

	I agree strongly	I agree slightly	I am neutral	I disagree slightly	I disagree strongly
24. I think it is unfair to put *normal* children in the special preschool because their needs are different, and the staff will probably not be able to meet all their needs.					
25. I think that a person with a disability probably will have difficulty conforming to the rules of society in the same way we would expect a person who is not disabled to do.					
26. If normally developing children and children with disabilities are together in the same class, their experiences would probably help them develop positive attitudes towards each other.					
27. I think that the preschool classrooms have enough space and the right kinds of toys and instructional materials and equipment to accommodate both groups of children.					
28. In my opinion, children with disabilities should not be treated any differently from children who are not disabled.					
29. By working and playing together, normally developing preschoolers and preschoolers with disabilities probably would learn to get along with a wider variety of people than if they were placed in separate classes.					
30. When the preschool integrates to include both children who have and don't have disabilities, I think the staff will be able to keep *both* groups constructively occupied at the same time in the classroom.					
31. In my opinion, people with disabilities (as a group) are not as well groomed and are not as concerned about their appearance as are people who are not disabled.					
32. Including normal models in a class for children with disabilities helps reduce the stigma attached to a special education classroom.					
33. When preschoolers who have and don't have disabilities are integrated in the preschool, I think that staff will probably tend to show favoritism to one group or another.					

Part III. General Questions

34. Rate your own enthusiasm, *at this time,* for the idea of integrating normally developing children into the preschool program (circle one).

    a. I am *very enthusiastic.*
    b. I am *mildly enthusiastic.*
    c. I am *neutral.*
    d. I am *mildly skeptical.*
    e. I am *very skeptical.*

35. Do you have any concerns about the integration of normally developing children into the preschool? If so, please list or explain.

36. What do you see as the potential benefits for you and your child that could come from the presence of normal models in your child's preschool class here? Please list. (If you see no possible benefits, write NONE.)

37. What do you see as the potential benefits for a *normal child* who might be enrolled along with children who have disabilities? Please list. (If you see no possible benefits, write NONE.)

38. What do you see as possible disadvantages for you and your child if children with disabilities are included in preschool classes? Please list. (If you see no disadvantages, write NONE.)

39. What do you see as possible disadvantages for the normally developing children who might be enrolled in preschool classes? Please list. (If you see no disadvantages, write NONE.)

40. Are there possible problem areas that you think the staff will need to address when the preschool classes become integrated? Please describe. (If you see no possible problem areas, write NONE.)

Form 13

Preschool Parents

This is a reminder that the Occupational Therapy kitchen becomes a coffee shop for two hours every month for all the parents of our preschoolers. The next date is:

Tuesday, October 22, from 7:30 to 9:30 a.m.

Come and join us for the wake-up coffee (or tea) after you have dropped off your child at preschool or day care.

Form 14

Duties for Kidlink Family Night

Duties	Description	Person(s) in Charge
Room setup	Set up tables and chairs; prepare plates, cups, flatware, napkins, iced tea, coffee, bread, butter	
Host	Greet people, help them put salad or dessert on buffet table, help them find a place for their family, introduce neighbors, if necessary	
Introduction/Welcome		
Cashier	Obtain cash box; collect $1 per adult in family	
Table decorations	Purchase pumpkins that children can decorate (4 real pumpkins for buffet table)	
Food	Order chicken, mashed potatoes, gravy; pick up and pay for food	
Games	Everyone participates after dinner	
Evaluation by parents	Get forms ready; hand out to parents	
Cleanup/Closing	Collect trash; rearrange tables and chairs	

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Form 15

Kidlink Newslink

March Calendar

- **Thursday, March 13, 1986—**
  Chicken Dinner Family Night, 5:30-7:30 p.m.
- **Tuesday, March 18, 1986—**
  Kidlink Café, 7:30-9:30 a.m.
- **Monday, March 24, 1986 and**
  Monday, March 31, 1986—
  Spring Break.
  No school *or* child-care services

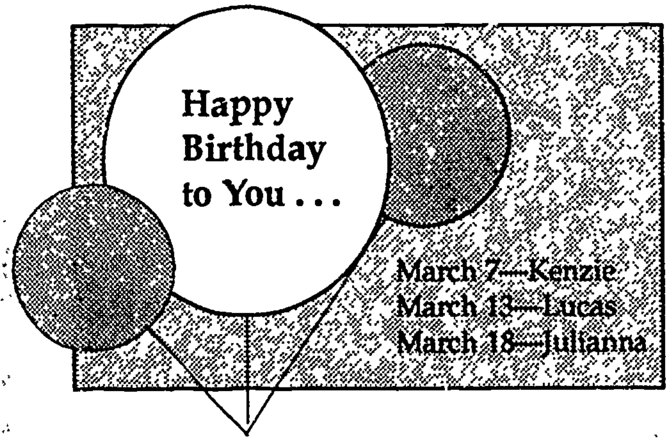
Shake-Rattle-Roll-A-Thon

By now, all of you should have received your Shake-Rattle-Roll-A-Thon packet. If you have not returned the white consent form, please return it quickly so your child will be able to participate in the Shake-Rattle-Roll-A-Thon on April 11, 1986. Parents are encouraged to attend. If you have any questions about the sponsor sheets, seeking the pledges, or collecting money, please contact Julie.

Attention: Spring Break

Please make appropriate child-care arrangements for your child on these dates. The preschool and day-care center will not be open from March 24 to March 31, 1986.

Preschool and day care will resume on Tuesday, April 1, 1986.



Happy Birthday to You . . .

March 7—Kenzie
March 13—Lucas
March 18—Julianna

March Is a Good Month to:

1. Wear a bit of green on St. Patrick's Day (March 17).
2. Say a color. Have your child look for that color on his/her clothes.
3. Make a kite for the first day of spring (March 21).
4. Read the book *Green Eggs and Ham* by Dr. Seuss (his birthday was March 4).
5. Take a springtime walk. Periodically STOP. Make a telescope by cupping your hands. Do you see a flower trying to open? A bug on the sidewalk?

Family "Chicken Dinner" Night

When: Thursday, March 13, 1986 from 5:30 to 7:30
Where: Blake Hall (Capper Foundation)
Who: Whole Family
Why: To get to know each other
To share experiences about the preschool program
What: A chicken dinner with salad and dessert; after dinner, a slide presentation by the team

Positive Attitude

Concentrate on being positive with your child. For example,

- Talk about what your child can do, rather than saying, "No, you can't do . . . "
- Give choices so your child learns to have some control over life: "Do you want an apple, a banana, or a pear for your snack?"
- When your child has a good idea, say "Yes, you can do that!"
- Let your child take the lead on your afternoon walk.

Form 16

Assessment of Your Child

Dear Parent(s):

The Individualized Education Plan (IEP) is an important tool in your child's educational program. In planning for the IEP meeting, please take a few minutes to give some thought to the following questions. By better understanding your concerns regarding your child, the early education team members will be able to work more closely with you at your child's IEP meeting.

1. What do you consider your child's strengths to be? *(Please list and discuss in detail.)*

2. What do you consider your child's weakness to be? *(Please list and discuss in detail.)*

3. Please list the goals you have for your child in this coming school year. *(Please list in order of priority.)*

   (1) ____________________

   (2) ____________________

   (3) ____________________

____

Parent/Guardian

Form 17

Parents' Strengths and Needs Assessment

Your Name: ______________________________ You are ☐ Mother ☐ Father ☐ Other

Please rate each of the following areas for
1. its importance to you as a parent,
2. your current level of knowledge in each area,
3. your current level of skill in each area (if appropriate), and
4. your preferred means of receiving information or training in each area.

	1. IMPORTANCE					2. KNOWLEDGE					3. SKILL					4. METHOD			
Education	No Importance	Very Little	Some	Very Important	Critical	No Knowledge	Very Little	Some	Considerable	Expert Level	No Skill	Very Little	Some	Considerable	Highly Skilled	Written Material	Parent Group Meeting	Individually with Teaching Team	Individually with Other Consulting Professional
1. Having productive conferences with teachers and team																			
2. Special education terminology											N/A								
3. Your child's educational program																			
4. Recording your child's progress at home																			
5. Assessment procedures and tools											N/A								
6. Integration of normally developing children with children who are disabled																			
7. Participating in your child's program																			
8. Future schooling											N/A								
9. Vocational or future job training																			

Adapted from NAPA Infant Program, Joan Ruskus, M.A. California Institute on Human Services, 1981; Northwest Center for Child Development Program, Seattle, Washington, 1985.

Child Development

	1. IMPORTANCE					2. KNOWLEDGE					3. SKILL					4. METHOD			
	No Importance	Very Little	Some	Very Important	Critical	No Knowledge	Very Little	Some	Considerable	Expert Level	No Skill	Very Little	Some	Considerable	Highly Skilled	Written Material	Parent Group Meeting	Individually with Teaching Team	Individually with Other Consulting Professional
10. Working with your child in motor development—small and large muscle coordination																			
11. Language development—what your child understands and what your child says																			
12. Cognitive development—problem solving and thinking skills																			
13. Social development—your child's ability to get along with others																			
14. Self-help—toileting, eating, and dressing																			
15. Behavior management																			
16. Selecting books and toys for the family																			
17. Improving your child's self-esteem—feeling good about self																			
18. Development of play skills											N/A								

Support Systems

19. Community resources/agencies that can help you and your child											N/A								
20. Respite/child care																			
21. Finding and using financial assistance																			
22. Interacting with professionals (physicians, therapists, counselors, educators, public health nurses, others)																			

	1. IMPORTANCE					2. KNOWLEDGE					3. SKILL					4. METHOD			
Family Interaction	No Importance	Very Little	Some	Very Important	Critical	No Knowledge	Very Little	Some	Considerable	Expert Level	No Skill	Very Little	Some	Considerable	Highly Skilled	Written Material	Parent Group Meeting	Individually with Teaching Team	Individually with Other Consulting Professional
23. Talking with grandparents and extended family members about your child's development																			
24. Talking to normally developing children (siblings, friends) about your child's handicapping condition																			
25. Clarifying your values in order to set priorities as a family																			
26. Communication skills among family members																			
Health																			
27. Nutrition											N/A								
28. First aid procedures																			
29. Dental needs/screening											N/A								
30. Medical problems of young children																			
31. Genetic counseling																			
32. Information on your child's handicapping condition																			
33. Vision screening																			
34. Hearing screening																			
Legal																			
35. Laws relating to Public Law 94-142											N/A								
36. Finding and using legal aid																			
37. Advocating for your child—getting what your child needs																			
38. Influencing school/county/state/federal policy and law																			

Please check any of the following activities that you would be willing to share with parents, children, or staff of ________________:

39. ____ Planning or participating in a field trip
40. ____ Participating in your child's classroom
41. ____ Attending therapy sessions
42. ____ Typing
43. ____ Forming a car pool
44. ____ Babysitting
45. ____ Making materials for use in the center (sewing, painting, carpentry, or other)
46. ____ Attending work parties
47. ____ Forming a support group
48. ____ Attending parent group meetings
49. ____ Being a room parent
50. ____ Participating on the advisory committee

If you have checked "parent group meeting" as a means of receiving information or training in any of the preceding areas, please indicate below which are the best times for you (and your spouse) to attend meetings. Circle your choice.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
morning	morning	morning	morning	morning	morning	morning
afternoon	afternoon	afternoon	afternoon	afternoon	afternoon	afternoon
evening	evening	evening	evening	evening	evening	evening

Signature ______________________________

Date ______________________________

Form 18

Questionnaire for Parents

Background and Reaction to the Program

1. **Please indicate your level of understanding about the following aspects of ________________ by circling a number from 1 (low) to 4 (high):**

philosophy of program	1	2	3	4
goals/purpose	1	2	3	4
screening/placement procedure	1	2	3	4

2. **Our child participated in ________________________'s classroom. (teacher's name)**
☐ P.T. ☐ O.T. ☐ Speech. ☐ Day Care.

3. **Our child's attitude towards coming to preschool was**
☐ always enthusiastic ☐ never enthusiastic ☐ sometimes enthusiastic

4. **In our opinion, the integration of the preschool has worked out well.** ☐ yes ☐ no
Comments:

5. **Transportation**

a. Our child is transported by
☐ a school van.
☐ our family.
☐ car pool.
☐ other.

b. Our child's transportation
☐ has worked out well.
☐ is a continuous problem.
☐ is satisfactory.

Program Content

1. **For each skill area, please circle the level of progress you feel your child has made during the year from 1 (low) to 6 (high):**

interaction with other children	1	2	3	4	5	6
independence	1	2	3	4	5	6
cognitive skills	1	2	3	4	5	6
gross motor skills	1	2	3	4	5	6
fine motor skills	1	2	3	4	5	6
speech-language skills	1	2	3	4	5	6
self-help skills	1	2	3	4	5	6

2. a. In our opinion, the amount of therapy our child receives in the following areas is

P.T.	not enough				very good		___ not applicable
	1	2	3	4	5	6	
O.T.	not enough				very good		___ not applicable
	1	2	3	4	5	6	
Speech	not enough				very good		___ not applicable
	1	2	3	4	5	6	

b. We are generally satisfied with the quality of our child's therapy. ☐ yes ☐ no

Comments:

3. The adaptive equipment my child uses is

☐ appropriate.
☐ inappropriate.
☐ well maintained.
☐ not well maintained.
☐ adequately updated.
☐ inadequately updated.
☐ not applicable.

Comments:

4. a. The IEP meetings and staffings or parent/teacher conferences are

☐ informative.
☐ helpful.
☐ well planned.
☐ confusing.
☐ stressful.

Comments:

b. The team listens to our opinions and wants our input. ☐ yes ☐ no

5. Communication with the following staff members is

	Highly Satisfactory	Satisfactory	Unsatisfactory	Has Broken Down * Completely	Not Applicable
Project Director	___	___	___	___	___
Social Worker	___	___	___	___	___
Teacher	___	___	___	___	___
Physical Therapist	___	___	___	___	___
Occupational Therapist	___	___	___	___	___
Speech-Language Pathologist	___	___	___	___	___
Day-Care Staff	___	___	___	___	___

* *Please explain*

6. Preschool field trips are ☐ well planned. ☐ appropriate for the functioning level of my child. ☐ too frequent. ☐ not frequent enough. ☐ well supervised.

Comments:

7. The swimming program is ☐ too frequent. ☐ not frequent enough. ☐ appropriate for the functioning level of my child.

8. The recreation program is ☐ too frequent. ☐ not frequent enough. ☐ not aware of program.

9. The parent involvement activities ☐ meet our needs. ☐ do not meet our needs.

10. If your child participates in day care, please answer.

a. We are generally satisfied with the quality of child care. ☐ yes ☐ no

Comments:

b. The fee for child care is ☐ too high. ☐ too low. ☐ adequate.

Comments:

11. Our overall satisfaction with the educational program is ☐ poor. ☐ fair. ☐ good. ☐ very good.

Additional Comments:

Name (optional): ______________________ Date: ______________

Form 19

Family Involvement Activities Sheet

Please rate activities according to their importance and enjoyment for you, whether you participated, and whether you would like to participate in such activities in the future. Please use the back of this paper for comments.

Participated this year	Interested in participating next year		ACTIVITIES			
			Poor	Fair	Good	Very Good
		Home visits				
		Enrollment/orientation day				
		Field trips				
		Field day				
		Volunteering in classroom				
		Halloween party				
		Christmas party				
		Circus				
		Shake-Rattle-Roll-A-Thon				
		Preschool graduation				
		Kidlink cafe				
		Kidlink family night				
		Parent sessions:				
		"The Secret Life of the Sib" (2/3/86)				
		"Parental Perspective" videotape (2/18/86)				
		"Childhood Diseases"—Jan Pitler (4/6/89)				
		"The Grieving Process"				
		"Active Listening Skills"				
		"Educational Rights"				
		"Doctor-Patient Relationship"				
		"Assertiveness Training"				
		"Community Resources"				
		Mothers Club				
		Swim nights (usually on Wednesday evening)				
		Other:				

Use these practical materials in your program . . .

K-TALK™

Kindergarten-Teacher Administered Language Kit (1989)

by Carolyn Ausberger, M.A., CCC-SLP, Judith Matlock Creighton, Ph.D., and Teresa Sue Lyons, M.S., CCC-SLP

Now you can call the solution to the At-Risk problem by Name—K-TALK™

K-TALK™ is a breakthrough language curriculum for at-risk kindergartners that gets results. It is the first developmental, language-based kindergarten kit that meets each child's current level of developmental need—not forcing them to fit into pre-set categories of development. **Catalog No. 7510-Y** **$699**

LET'S BE SOCIAL

Language-Based Social Skills for Preschool At-Risk Children (1988)

by Social Integration Project, adapted by Linda Levine

Here's a 10-week field-tested curriculum to use in your classroom with younger children. Initiate social interaction skills through teacher-led direct practice, skill discrimination exercises, modeling, and instructional activities. Follow the easy-to-use lesson plans to focus on a new skill each week. **Catalog No. 7571-Y** **$35**

STEPPING OUT WITH LANGUAGE

Classroom Simulations and Community Experiences (1988)

by Louise A. Belcher, M.A., CCC-SLP, Nancy S. Brothers, M.S., CCC-SLP, and Maureen F. Mitchell, B.S.

This unique classroom simulation curriculum helps students make the transition from classroom to community outings. Ten theme-based units using classroom simulations, vocabulary lists, photographs, and a variety of language activities help teach and reinforce socialization skills. Each unit offers objectives, preparations, testing, training procedures, and two community simulations for a specific community outing. Clinicians can use this resource effectively in therapy or with classroom teachers in team teaching situations. **Catalog No. 7530-Y** **$79.95**

WHAT ARE WE DOING TODAY? (1988)

with Language Activity Booklet by Marjorie Rees

This picture book with charming full-color illustrations follows a family through a typical day. You'll see the characters in action as they participate in a variety of familiar events such as waking up, getting dressed, going shopping, playing games, and more. Each picture page shows empty conversational balloons for each character. Your students fill them in with their own dialogues and monologues. The Language Activity Booklet offers suggestions for using the materials in your classroom or therapy sessions. **Catalog No. 7477-Y** **$19.95**

ORDER FORM

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____

____

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Please note previous zip code__________

Telephone (____) __________ ☐ work ☐ home

Payment options:

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☐ My school / clinic / hospital purchase order is enclosed.

P. O. # __________

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Expiration Date: Month ________ Year ______

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		TOTAL	

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Tucson, Arizona 85733

PROJECT KIDLINK:

Bringing Together Disabled and Nondisabled Preschoolers

All children have the right to be educated in the least restrictive environment possible. For some children with severe disabilities, mainstreaming in a regular classroom is not a realistic and beneficial alternative. A recent approach to giving these children a more normal environment has been reverse mainstreaming: Instead of taking the children with disabilities to a regular school, reverse mainstreaming brings normally developing children into a setting designed for children with disabilities.

Project Kidlink: Bringing together Disabled and Nondisabled Preschoolers is a firsthand account of how one school for children with physical disabilities integrated the preschool classroom and therapy programs. The chapters in this book, all written by staff members at the school, are filled with practical advice for creating an environment that promotes optimal development for both normally developing children and children with disabilities, an environment where all children are valued for their unique abilities and contributions. This is an indispensable guide to planning and carrying out the transition to an integrated setting. These professionals—the administrator, classroom teachers, occupational therapists, physical therapist, speech-language pathologist, and social worker—discuss honestly the concerns, challenges, rewards, and benefits they experienced as they learned how to teach normally developing children and children with disabilities together.

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