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ABSTRACT

This document describes the proceedings of a conference of early childhood education planners on the provision of the least restrictive environment (LRE) for young children with disabilities. The goal of the conference was to positively impact on the development of state early childhood plans in the areas of integration and the provision of the LRE. Topics discussed included: (1) major issues facing states as they develop policies and practices for providing appropriate early childhood special education to young children; (2) administrative approaches to providing LRE; (3) the process of fostering friendships between children with disabilities and other children; (4) the process of integrating the concept of LRE into early intervention services for the child and support for the family; (5) intensive special education for handicapped preschoolers without segregation from nonhandicapped children; (6) the funding of integrated services for young children with disabilities; (7) benefits and barriers to the provision of integrated preschool. The appendix contains seven recommended state plans for the implementation of LRE for the birth through 5 population. For each state, definitions, and descriptions of barriers and action steps, are included. (SM)

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Dennis J. Sykes, Editor

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**PLANNERS ' CONFERENCE
ON INTEGRATION AND THE LEAST
RESTRICTIVE
ENVIRONMENT FOR YOUNG CHILDREN**

DECEMBER 7-8, 1988

O'HARE HILTON HOTEL

CHICAGO, ILLINOIS

PS 020857

*A REGIONAL CONFERENCE INVOLVING THE STATES OF ILLINOIS, INDIANA,
MICHIGAN, MINNESOTA, OHIO, PENNSYLVANIA, AND WISCONSIN SPONSORED BY THE
GREAT LAKES AREA REGIONAL RESOURCE CENTER*

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INTRODUCTION

The Planners' Conference on Integration and the Least Restrictive Environment for Young Children was held on December 7-8, 1989 in Chicago, Illinois. The conference provided a rare opportunity for early childhood planners from seven states (IL,IN,MI,MN,OH,PA,WI) to come together to consider important issues related to the provision of the least restrictive environment for young children with disabilities. The impetus for the conference occurred during the March, 1988 Great Lakes Area Regional Resource Center advisory committee meeting. At that meeting, the early childhood representatives to the advisory committee were asked to identify an issue which could serve as the focus of a regional activity. These representatives selected the issues of integration and the provision of the least restrictive environment, believing that they were issues which must be addressed by all states as they engage in planning comprehensive services for children with disabilities, birth to 5, and their families. A work group was formed to assist in planning this activity. Through several teleconferences and a planning meeting, the work group contributed their expertise and time to the development of this conference.

The Great Lakes Area Regional Resource Center wishes to thank the members of the regional work group for their assistance.

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The goal of the conference was deceptively simple. That is, to positively impact on the development of state early childhood plans in the areas of integration and the provision of the least restrictive environment. It is the hope of the conference planners that conference participants were provided with sufficient information and support to develop and implement recommendations which will have a positive impact on programs for young children with disabilities and families in your respective states. These proceedings are provided to further that goal.

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LRE for Preschool Children with Handicaps: What We Know, What We Should Be Doing

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Phillip S. Strain, Ph.D. received his doctorate in Special Education from George Peabody College in 1974. prior to this time, he held positions as a special education teacher and teacher supervisor. Since 1974, Dr. Strain has held faculty positions at American University, George Peabody College, and, since 1980, at the University of Pittsburgh. Administrative and research appointments include: Supervisor of Research, Tennessee Department of Mental Health, John F. Kennedy Research Scientist, and Director, Early Childhood Intervention Program, University of Pittsburgh.

Dr. Strain is the author of over 200 research papers and reports on the education of young children with handicaps. Additionally, he is the author of six books, including: Mainstreaming Children in Schools, Social Development of Exceptional Children, Children's Social Behavior, Utilization of Classroom Peers as Behavior Change Agents, and most recently, The Handbook of Developmental and Physical Disabilities.

Dr. Strain's specific experience related to LRE includes: a) directing a national model preschool for autistic and normally developing children since 1981; b) replicating the model program in sites throughout the U.S. and in Europe; c) directing the 5-yr. Early Childhood Research Institute on LRE; d) developing curriculum materials for use in integrated settings; and e) consulting nationwide on integrated programs for young children with handicaps.

WHAT WE KNOW

LRE for preschool-age children with handicaps has gained national attention with the passage of Public Law 99-457 in 1986. P.L. 99-457 addresses the least restrictive environment (LRE) question by extending the provisions of P.L. 94-142 to children three Years of age and older. While we might well expect to see challenges to the LRE language in P.L. 99-457, the importance of integrated services for young children with handicaps is not in doubt. Over the last 10 Years, the evidence regarding integrated service delivery for young children with handicaps has accumulated rapidly. What we know at this point, on the basis of scientific evidence, is that:

One of the things that parents of young children with handicaps most desire is for their youngsters to develop friendships with same-age peers.

No study that has assessed social outcomes for children in integrated versus segregated settings has found segregated settings to be superior.

If we ask the question, "What developmental outcomes are most likely to lead to successful post-school adjustment," social skills is always the answer.

The positive social outcomes attributable to integrated settings have been seen only when interaction is frequent, planned, and carefully promoted by teachers.

Normally developing children have shown only positive developmental and attitudinal outcomes from integrated experiences.

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The positive social outcomes attributable to integrated settings have been seen only when interaction is frequent, planned, and carefully promoted by teachers.

Normally developing children have shown only positive developmental and attitudinal outcomes from integrated experiences.

There is no evidence that children with certain handicapping conditions or levels of impairment are poor candidates for integrated programs.

On measures of how well children maintain skills after some initial teaching, developmentally segregated settings have been shown to have a toxic effect (i.e., children no longer use their newly-taught skills).

Programs that are characterized by integrated service delivery tend to be state-of-the-art on a variety of other dimensions, including extensive parental involvement, highly structured scope, sequence, and method of instruction, and attention to repeated outcome assessment.

WHAT WE SHOULD BE DOING

Given the empirical findings described above, it is reasonable to ask how we might translate this information into an ongoing service delivery model. In this regard, the empirical findings speak to the following programmatic issues: a) child referral to integrated settings; b) continuum of services; c) teacher training; d) class organization and structure; and, e) administrative practices.

Child Referral. There is great intuitive appeal to the notion that less handicapped children are better candidates for integrated service delivery than more involved youngsters. However, this is a case where intuition is not supported by science. By and large, we have a case of missing evidence; and what evidence there is does not support the intuition. From a policy and procedure standpoint, we must recognize that there are no available data upon which to exclude children from integrated placements. There are also demonstrations of successful integration with severely handicapped children. Based upon the evidence to date, we should only screen children away from maximally integrated options after those high quality options have been tried and after they have failed.

Continuum of Services. P.L. 94-142 has essentially promoted the evolution of a working definition of LRE that is best described as a continuum of service, with points on the continuum ranging, for example, from segregated class in segregated building, to segregated class in regular building, to regular class in regular building. Depending on the IEP, various points along the continuum can meet the legal requirements of the LRE provision. For preschool children with handicaps, our policy and procedures on LRE must begin with matching the "working" continuum with the scientific evidence. When we do that, the range of options that lead to positive outcomes is severely narrowed. Specifically, we only have evidence that integrated services produce the outcomes we desire when young children with handicaps are integrated at least several days per week into the social and instructional environment with normally developing peers. From a policy and procedure standpoint we may be faced with not so much a continuum but a dilemma. The dilemma being that LRE requirements may be bureaucratically satisfied with a service option that is benign or possibly harmful to our clients.

Teacher Training. One need only review the dates in the resource section at the end of this paper to see that the technology and tactics for operating high quality integrated programs is very new. If we further consider that the bulk of this technology is contained in research papers, then it is fair to assume that most direct service providers require intensive, competency-based preservice and inservice experiences related to LRE. The successful teachers in LRE arrangements will be those who, at a minimum, know how to:

- 1) Assess the current educational and social needs of all children and plan instruction accordingly;
- 2) Meet the individual goals of all children within a group teaching format;
- 3) Plan and arrange for daily interactions between children;
- 4) Utilize class peers as instructional agents;
- 5) Frequently monitor child outcomes and modify instructional procedures, if necessary;
- 6) Communicate effectively with parents and enlist their help, where needed; and
- 7) Plan for child and family transition to the next educational setting.

For integrated service delivery to fulfill its potential, it seems clear that a much greater emphasis on teacher preparation is needed. Attempting innovations like integrated service delivery with less than the best prepared staff will likely yield poor services, poor outcomes, and ultimately less integration for children with handicaps.

Classroom Organization and Structure. As noted earlier, programs that have been characterized by high quality integration and excellent child outcomes have also been state-of-the-art on a variety of other dimensions. In order to fully realize the potential of integrated service delivery, programs for young children with handicaps should include:

- 1) Provisions for early screening, referral, and programming to ensure a minimal time delay between problem development and intervention;
- 2) Provisions for the assessment of family strengths, weaknesses, and skill needs; and, intervention that is planned accordingly;
- 3) Provisions for repeated curriculum-based assessments and instruction that is related directly to said assessments; and
- 4) Provisions for overall program evaluations that include the opinions of consumers (e.g., parents, teachers, administrators).

From a policy and procedure standpoint, the institutionalization of quality service delivery will require that we certify educational practices, not merely personnel. We

can do this by developing new program standards and scrupulously monitoring, providing technical assistance and training for deficient programs and personnel, and de-certifying programs and personnel that are chronically deficient.

Administrative Practices. Any educational innovation, be it preschool integration or otherwise, will have little hope for long-term success without the support and vigilance of competent administrators. The administrative-level practices needed to ensure high quality integrated services include:

- 1) Eliminating, where needed, state and local policies that promote disincentives to integration;
- 2) Providing personnel, time, and fiscal resources needed for necessary teacher training;
- 3) Expanding options for service delivery and teacher arrangements to include, for example, team teaching and consulting models; and
- 4) Providing professional leadership by encouraging innovative options for integrating children with handicaps, and providing specific incentives for other administrators to promote integrated service delivery.

LRE RESOURCE MATERIALS

Background and Rationale for LRE

Bricker, D.D. (1978). A rationale for the integration of handicapped and nonhandicapped preschool children. In M. Guralnick (Ed.), Early intervention and the integration of handicapped and nonhandicapped children. Baltimore: University Park Press.

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Teacher Issues and Concerns

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McEvoy, M.A., Nordquist, V.M., & Cunningham, J.L. (1984). Regular and special education teachers' judgments about mentally retarded children in an integrated setting. American Journal of Mental Deficiency, 89, 167-173.

Parental Issues and Concerns

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Bricker, W.A. & Bricker, D.D. (1976). The infant, toddler, and preschool research and intervention project. In T.D. Tiossem (Ed.), Intervention strategies for high risk infants. Baltimore: University Park Press.

Turnbull, A.P. & Blacher-Dixon, J. (1980). Preschool mainstreaming: Impact on parents. New Directions for Exceptional Children, 1, 25-46.

Turnbull, A.P. & Winton, P. (1983). A comparison of specialized and mainstreamed preschools from perspectives of parents of handicapped children. Journal of Pediatric Psychology, 8, 57-71.

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OVERVIEW OF ISSUES

Patricia Place, National Association of State Directors of Special Education

*Patricia Place, Ph.D. of the National Association for State Directors of Special Education (NASDSE) has been involved in many activities regarding LRE for young children with special needs. Recently, she was invited by the faculty of Wheelock College, Boston, MA, to author a chapter on LRE issues for a book on current issues in early childhood special education. In addition, she developed an LRE packet for the National Information Center for Handicapped Children and Youth. Dr. Place is a staff member of the National Early Childhood Technical Assistance System's (NEC*TAS) expert team on LRE and as such she has participated in several activities related to this area.*

Introduction

I will present an overview of the major issues facing states as they develop policies and practices for providing appropriate early childhood special education to young children in the least restrictive environment. Shelley will identify some general approaches to resolving these issues. Additional sessions this afternoon will provide information about specific approaches used by states and service providers to implement LRE principles.

ISSUES

Issue # 1: Why Integrate?

This discussion must start with an essential first question. It's one I hope all of you have asked in your pre-conference preparatory activities and one which I hope will be made explicit in the state team sessions before any additional work is begun.

If you represent Part H you are interested in this topic because of the programmatic ramifications since there is no federal requirement to consider the least restrictive environment for infants and toddlers and their families. If you represent 619 and your response is that you are doing so because you are legally required to do so, you're right. In addition to the legal reasons, there are ethical and developmental supports for providing education in the least restrictive environment.

The ethical position is best summarized in the publication Purposeful Integration .. Inherently Equal (1987).. "After all, isn't this the purpose of education - to prepare students to live in society? ... Segregated settings prepare students to function in segregated settings" (p 15). Safford and Rosen (1981) stated, "The forced isolation of any group of human beings deprives them of rights inherently theirs, and it is clear that educational segregation on any basis is intolerable" (pg. 1). As Doug Biklen (1974) said, "We believe that children who have disabilities have a right to grow up in typical settings with their typical peers We believe that most decisions involving children who have disabilities are not scientific questions for professionals to answer. Rather, they are political and moral decisions that the entire community, and especially consumers themselves (parents and children) should make".

Phil's research, just presented, has demonstrated the empirical foundations of the benefits of integrated experiences on children's developments. Let's talk now about the legal support for LRE for young children. This is such an important and confusing topic that I have assigned it its own issue number.

Issue #2: Legal Requirements

The primary problem, as I see it, is the lack of clarity of guidance at the federal level. It seems to me that Congress, through legislation, and the Administration, through regulations, have left states on their own. Unfortunately, past history has shown that when there is ambiguity at the federal level, policies often end up being decided through the resolution of court cases and due process procedures. This places the burden on each state to develop policies which they determine to most appropriately address the letter and intent of the law. Of course, the problem with that is that so much of this seems to be open to individual interpretation. Well, let's look at what we've got.

THE LAW. Children who are ages 3-5 and are eligible for special education are covered by Part B of PL 94-142. Preschool children ARE Part B children. Everything that must be done for and to children of typical school age years who are handicapped must also be done to and for preschool aged students with handicaps. Unfortunately, this has caused a lot of confusion to states. A staff person at OSEP provides some advice whenever you have a question about the provision of services to a preschool age child.

When considering a question for a 4 year old, first ask yourself, "What would my answer be to this question if the child were a 14 year old?" Then, whatever the answer is for the 14 year old it is the same for the 4 year old.

OK, that is very helpful advice in most situations. As we all know, the law says, " To the maximum extent appropriate ... " The language in P.L. 94-142 is as follows.

Sec. 1412. Eligibility requirements

(5) The state has established (A) procedural safeguards as required by section 1415 of this title, (B) procedures to assure that, to the maximum extent appropriate, handicapped children, including children in public or private institutions or other care facilities, are educated with children who are not handicapped, and that special classes, separate schooling, or other removal of handicapped children from the regular educational environment occurs only when the nature or severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.

Sec. 1414. Application

(a)(1)(c)(iv) to the maximum extent practicable and consistent with the provisions of section 1412(5)(B) of this title, the provision of special services to enable such children to participate in regular educational programs;

However, the school probably does not provide education to 4 year olds and so the issues regarding LRE become muddled.

So, we turn to the Part B regulations proposed by the Department Education for clarification. Unfortunately, they lack the specificity to clarify.

The requirements of 300.552 as well as the other requirements of 300.550 through 300.556, apply to all preschool handicapped children who are entitled to receive a free appropriate public education. Public agencies that provide preschool programs for non-handicapped children must ensure that the requirements of 300.552 (c) are met. Public agencies that do not operate programs for non-handicapped preschool children are not required to initiate such programs solely to satisfy the requirements regarding placement in the least restrictive environment embodied in 300.550 through 300.556. For these public agencies, some alternative methods for meeting the requirements of 300.550 through 300.556 include:

- (1) Linking (even part-time) the program for preschool handicapped children to other preschool programs operated by public agencies (such as Head Start);
- (2) Placing handicapped children in private school programs for non-handicapped preschool children or private school preschool programs that integrate handicapped and non-handicapped children; and
- (3) Locating classes for handicapped preschool children in regular elementary schools.

In each case, the public agency must ensure that the placement is based upon each child's individualized education program and meets all of the other requirements of 300.552.

Federal Register, March 14, 1988.

As stated in NASDSE's comments on the NPRM, this language is problematic: What is "linking"? How should financial responsibility be determined, etc.?

In the Report of Congress on the implementation of P.L. 99-457 it is difficult to determine their intent with regard to this issue. The programmatic comments refer to Alternative Delivery Systems. " The Committee also wishes to observe that there are currently a variety of effective special education models for serving handicapped children aged 3-5 being utilized across the country. Based on the unique needs of the particular child, these models range from part-day home-based services to part or full-day center-based." (pg. 20).

MONITORING STANDARDS. Our next step involves the M word. As you know, current monitoring practices have caused a lot of concerns to many states and NASDSE has had a task force working with OSEP to make recommendations about the process. One of the major issues of contention is that the standards are not written. Some people question whether the same standards are applied equally to all states. So,

one might conclude that the only way to tell if you are in compliance is to develop policies, wait for your next monitoring visit and cross your fingers.

I have a copy of some draft program guidelines that were issued in 1986; unfortunately, it's not clear what the status of this is right now. We cannot use this as any kind of legal guidance but it might be useful to provide a condensed summary of components in the law. It just saves us the time to do that ourselves. Just as useful is the excellent summary on legal requirements and LRE developed by Dennis in August, 1988, I hope you all have copies of that.

CASE LAW Obviously, there are many possible contradictions in the components of the law. It's impossible to predict how individual states, hearing officers and courts will interpret these. I'm not an attorney and I don't want to lead us into a discussion of case law, but I thought it might be illustrative to look at the rationale behind two opinions offered by state hearing officers on only two issues: the continuum and individualized education. The U.S. Department of Education regulations related to these decisions are provided below.

c. Each public agency shall ensure that a continuum of alternative placements is available to meets the needs of handicapped children for special education and related services.

(300.551(a)) This continuum must include the alternative placements listed in Section 300.14(a) of Subpart A (instruction in regular classes, special instruction in hospitals and institutions).

(300.551(b(1))). In addition, provision for supplementary services (such as resource room or itinerant instruction) are to be provided in conjunction with regular class placement whenever appropriate. (300.551(b(2))).

g. Each public agency shall ensure that the various alternative placements include under Point c above are available to the extent necessary to implement the IEP for each handicapped child. (300.552(b)).

The comment included in 300.552 reiterates that a state is required to consider the extent to which a handicapped child can be educated with children who are not handicapped. THE OVERRIDING RULE IN THIS SECTION IS THAT PLACEMENT DECISIONS MUST BE MADE ON AN INDIVIDUAL BASIS.

A Vermont hearing officer, in Feb., 1986, ruled that a preschool child's LRE was a private preschool program, not the center-based segregated program offered by the school district, and caused the District to pay for this placement. The decision was based on the fact that the District made categorical placement decisions rather than individualized decisions. In addition, "By excluding from consideration any alternative placement options, the District did not meet the Act's requirement that a "continuum" be available.

Further, in a hearing in Massachusetts in May, 1985, the hearing officer rejected a District's offer of home-based intervention and ordered the District to locate or develop an integrated preschool program for a child. The decision stated, "Once a child's right

to special education services is established, the question is not whether the child needs a classroom experience as well, but rather what is the least restrictive setting in which those services can be appropriately provided.... There is no evidence to suggest that John cannot take advantage of services offered in a classroom setting. Yet [the District] proposes to offer special education services in the home, the most restrictive of settings."

These cases illustrate some of the ambiguities in the Preschool program prior to passage of P. L. 99-457 and there is no reason to assume things will be any less ambiguous as a result of the law. As I interpret the above information, the implication for states is that you need to write policies which, at a minimum, clearly require districts to CONSIDER alternatives, to have alternatives available, and to make placement decisions based on each child's INDIVIDUAL needs.

Of course, there remain the usual additional Part B LRE requirements such as the requirement for the state to review and approve LEA procedures to ensure that states are providing appropriate education in the LRE and for the States to provide TA and training to ensure that teachers and administrators are fully informed about their responsibilities for implementing LRE.

Review and Approval of LEA procedures to ensure that to the maximum extent practicable, and consistent with 300.550 - 300.553, the LEA provides special services to enable handicapped children to participate in regular education programs. (34 CFR 300.227)

a. Each LEA application submitted to the SEA must describe: i. The types of alternative placements that are available for handicapped children; (300.227(b)(1)) and ii. The number of handicapped children within each disability category who are serviced in each type of placement. (300.227(b)(2)).

With each of the components of policies you develop you might want to think to yourself, "If I am monitored on this item or if I am taken to court and the judge refers to the legal foundation for this item, will my policies be acceptable?" I don't have any answers for you but I know there are important questions that must be addressed at this point in time.

It may be likely that preschool LRE may not be a first priority for OSEP monitoring staff at this present time. Some reasons for assuming this are that it appears that OSERS first priority with respect to preschool children is to get them served. Everyone realizes that it is going to take some time to develop a full range of services for young children and their families. However, LRE is in the law and one might be correct to assume that once children are being served greater attention may be directed to the range of options being made available to these children.

In concluding discussion about the legal issues, I would recommend keeping this in mind when you formulate your policies. Our society is in a state of change and the policies you develop today should be appropriate for the trends which are currently apparent. A major trend who's time is at hand is the national child care movement; it is

likely that the public will very soon be in the business of providing care for preschool aged children at which time the entire LRE issue will be seen in a new light. What effect will this movement have on the policies you develop today? The policies you begin to develop over the next two days must be future oriented and forward thinking.

What are some of the other issues which you must consider as you propose policies and recommend practices?

Issue #3: What is "Special Education and Special Instruction?"

At first this seems as though it would have an easy answer but try specifying it and you quickly run into confusion. Difficult as this may be it seems that this should be among the first questions you address. For example, the decision has been that the least restrictive environment in which Manuel, a 4 year old child with handicaps, can receive an appropriate education is Sunshine Nursery School. An itinerant teacher comes to the program three times a week for an hour to work with Manuel and the teacher. A PT comes to the school once a week as does an OT.

Is the time that Manuel attends the school but the special education teacher and therapists are not there "special education"? Is the teacher required to meet the standards of a special educator? Is it illegal to use Part B money to pay for the time when the special education teacher or therapists are not there?

The answers to these and other questions associated with this topic may depend on your own state's policies.

If the decision is made that the least restrictive environment in which Manuel can receive an appropriate education is the nursery school, your policies might clearly specify that there are two components to the special education program. The first is intensive special education delivered by a special education certified teacher or qualified therapist. The second is a more general follow-up provided by "general education" teacher, i.e., one who meets the state standards for providing services to other children in the program.

Another solution is to use state SEA money or other agency funds instead of federal money for that portion of the day that the special education teacher or therapists are not working with Manuel.

Issue # 4: General Supervision

Federal statute and regulations require that each SEA establish and exercise general supervision over all educational programs for handicapped children administered within the State. There are at least 6 administrative responsibilities included in general supervision but I will just bring up 2.

According to EDGAR, 76.101 e)(3), the state must conduct monitoring of programs serving children and must have the authority to compel the correction of deficiencies identified in program operations. This must include a method to compel corrections of deficiencies in other State agency programs.

Also, the law requires that the SEA develop procedures to insure that all personnel which carry out special education and related services are "qualified" (300.380 (b)).

What does this mean with regard to preschool children placed in community placements? How much general supervision is enough? Who should do it? How do you document it? What are appropriate standards and how can these be monitored and enforced? What is "qualified?"

Some states think these and other requirements will be problematic for them. They may not have the authority to compel other agencies to make the changes required. There may be many areas where they feel they do not have control over what happens to children on a day to day basis and they are reluctant to assume responsibility where they do not have the control. Other states have developed comprehensive interagency agreements to insure that the SEA can fulfill its legal responsibilities.

A Comment in the law provides states with several suggestions on how to meet this requirement, including the interagency agreements, Governor's directive establishing the SEA responsibility, or State law, regulation, or policy could designate the SEA as responsible for establishing standards for all educational programs (300.600)

Issue # 5: Liability

I just want to say a few words about liability. One of the reasons why it is expeditious to have detailed policies and standards is to avoid, as much as possible, issues dealing with liability. This is certainly not my realm, but I would recommend consulting your state's attorney general to make sure these issues are addressed thoroughly and satisfactorily. Just a reminder that it is essential you are absolutely certain that any school in which you place a child meets all state standards. The site must meet health and safety standards as well as appropriate educational and child care standards. Finally, the child in a program off school grounds must never be provided with less than children in programs in the school building.

Other Issues

In addition to the above, the policies you are developing must address transportation, funding, personnel standards, program space and location and other matters. If you are contracting with a program that is affiliated with a church, for example, a nursery

school located in a church basement, you need to consider separation of church and state provisions. Many of these will be discussed in future sessions at this conference.

In conclusion, I have drug all of the skeletons out of the closet during this session and the idea of confronting these multiple and complex issues must seem pretty gruesome by now. But a parent was quoted as saying, "I really do wish I could sit back sometimes and not worry about my son's education. I know I can't do that right now. It can be very tiring but our children are worth it. Why want anything less than the best?"

I know that all of you, committed to excellence for all children, agree that we want nothing less than the best. I look forward to working with all of you over the next couple of days on this exciting and adventurous task.

ADMINISTRATIVE APPROACHES TO PROVIDING THE LEAST RESTRICTIVE ENVIRONMENT TO PRESCHOOL CHILDREN

Shelley Heekin, National Early Childhood Technical Assistance System

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The following information was obtained from a National Association of State Directors of Special Education (NASDSE) survey and examples of policy/guidelines which have been sent to the National Early Childhood Technical Assistance System (NEC*TAS)

The survey demonstrated that:

- 1) 14 states reported having LRE policies/guidelines while 10 are in the process of developing such policies;
- 2) States called many different things "policy;"
- 3) States were in very different stages of dealing with the issue.

The information was looked in two ways.

1. States with mandates

Mandated states had policies which could be assigned to the following categories:

- 1) Policy which was in supportive pre-school statutes and regulation/standards;
- 2) Policy which looks like 94-142 statements (AK) or language that outlines procedures, definitions, (NE) placement options;
- 3) Language within the Early Childhood Grant Package which includes strong a commitment to LRE;
- 4) The federal language in PL 94-142 is the only written policy.

2. States Without Mandates

Policy was seen in various ways including:

- 1) Guidance papers from State Education Agency addressing: Service delivery, certification, Models, Hours of contact, and Commitment to parent involvement;
- 2) A requirement that the LEA must address LRE in grant application;
- 3) No written policy just dollar incentives.

This information really did not show which states were really integrating children with handicapping conditions with their non-handicapped peers. Phone calls to states gave a lot of information and answers to questions. It was found that states that had a strong administrative commitment along with a local commitment and autonomy were getting the job done.

Two profiles follow that demonstrate a state commitment (both have mandated services for pre-schoolers)

State #1

The state policy is contained in P.L 94-142.

For FY'89 and FY'90, the major priorities of the Allocation Grant Program are to (These are not rhetoric but actually acted upon):

- 1) Educate the majority of young children in an integrated setting that is developmentally appropriate;
- 2) Provide increased parent support services (i.e. educate parents on least restrictive environment, initiate parent support groups).

In addition, the state is working on joint teacher certification. That is, a system which would offer one Early Childhood certification in which teachers would be certified to teach both "regular" children and children with special needs from age 3-8.

The state is also developing Early Childhood Program Standards in which all standards are joint, not separate. For example, the environment for young children should be accessible for all; teacher ratio would not be 1:18 as previously required in "regular" early childhood, but 1:15 as advised by special ed. early childhood.

"Regular" education has also included integrated programs as a priority. To reinforce this process the early childhood staff is integrated at the state level while issues of program quality and staff qualifications are decided by an Office of Children's Regulation

On the local level, parents are offered a catalogue of program options which are the product of developed networks and agreements in the local community.

State #2

This state has the following attributes related to LRE:

- 1) Development of a policy statement on LRE;
- 2) A mechanism for implementation of this policy is written in their state rules;
- 3) Decisions on specific implementation issues are left to the LEA. Each agreement was worked out individually with the SEA and each situation is different;
- 4) The SEA provides "hands on" T.A. to each LEA when they are writing local agreements;
- 5) The SEA provides substantial administrative support.
- 6) 4 of 40 programs are now segregated, while before mandate there was only one integrated program in the state (all in 9 months time).
- 7) An HCEEP statewide inservice training grant provided support and training to: Special Education Staff, Regular Education staff, and administrators.

SUMMARY

Other information gleaned from the survey and telephone contacts includes:

- 1) Some states which have had a mandate for years, whose children are currently in segregated programs, are having a difficult time moving to LRE. It is difficult to break down an existing system. Rural settings seem to be the most agreeable to change;
- 2) There was no consistency in models or funding/tuition;
- 3) One state uses P. L. 99-457 bonus money led to develop collaborative agreements between the LEAs and Head Start which had not existed previously;
- 4) Two states, with mandates, are documenting that using community programs is a great cost saver (\$2,500 vs. \$5,000);
- 5) Utah is funding a study of effectiveness on the consultative model. They can find no difference in effectiveness of direct special education versus a consultative model;

- 6) Some states claim that 50% of identified children who leave an integrated program go on to regular kindergarten while 90%-100% of children who leave a segregated program go on to special education.

In summary what became evident from interviews and reviewing policy examples is that LRE happens when there is a commitment from top and bottom. It happens because people want it to happen believing that it is right for kids. They work around what others see as barriers with considerable flexibility. They make it happen. Now is the time to make it happen in your state.

Fostering Friendships

Lisbeth Vincent, University of Wisconsin-Madison

Lisbeth Vincent, Ph.D. is currently a professor in the Department of Rehabilitative Psychology and Special Education at the University of Wisconsin-Madison. She is a Past-President of the Division for Early Childhood of the Council for Exceptional Children. She has worked with public schools, Head Start, private day-care, and others in order to improve services for young children with disabilities. She has worked with children and families for the last 20 years and has trained teachers for the last 18 years.

I thought what I'd do today is to look at friendship. What is it? What kind of practices have we developed in special education to foster friendship and what kind of practices are getting in the way of friendship. I want to talk a lot about parents and families and what they want out of us. And I want to talk about the future. Most of us deal with children who are birth to five years of age and we transition them. This is a new word. We have whole processes for transition now. We talk about it as if it really exists, but in reality the child is exactly the same tomorrow as he was today. We forget, by the way, that parents never transition. Parents stay with the kids all the way through. And so I want to talk about that future life, that future quality that exists beyond early childhood special education.

I think it's real appropriate for us as interventionists to look at friendship. I've been in the field of early childhood special education now for nineteen years. Since 1975 I've been looking at IEP's around the country, for little kids, and in all those years all over the country I've seen one IEP that said anything about friendship. Dr. Phil Callisan is the director of special ed for Los Angeles Unified School District. He said to me, "Since 1975, I've looked at 1500 IEP's in a year on all aged kids, and I've never seen a goal about friendship."

So I find myself talking about a topic that makes interventionists uncomfortable. They say, "How can we control friendship? Is that our responsibility? What can we do in the area of friendship? Is that not outside the domain of school?" Yet, all of our research on friendship shows that schools and programs the children are in on a daily basis are the major influences on friendship.

I thought another reason that would be real important to look at friends is that we have P.L. 99-457. We have new legislation; we have a new opportunity with young children. We have a chance to build programs, modify the programs we already have, to really examine what our state-of-the-art practice is. For many of us in this field, we've been given a second shot at building the future. When we first got started we didn't have mandates. We didn't have funding. We built our programs through private means or in ways through school districts that every year we'd worry about whether or not the money was going to be there. And so for all of us that have been doing this for a long time, we have a second shot. We have a chance at looking at building the best services possible. And of course for all the new people that are now coming in because we're moving into the public education environment, this is the chance for you all to really critically analyze what should be happening. What should programs look like.

Phil Strain talked very clearly this morning about what our research says about integration, what we've learned in the last 15-20 years. Yet it's very clear that what we've learned through research has not become common practice. In fact, a recent report from the U. S. Office of Education points out that children are likely to be more segregated during their preschool years than they will ever be again. Some reports right now say that anywhere between 75 and 90 percent of children receiving services are receiving them in segregated settings. So we have research, and we have practice. And now you know why I see a chance to take a new look to the future, because we can no longer continue to justify our programs by saying that was the best we could do under the circumstances. The circumstances have changed and we have a new opportunity. And I hope it's an opportunity that we will take very seriously. Its going to be very difficult.

Over the years I have been involved in building two different service systems for kids with disabilities, one through a university, which was a reverse mainstreaming model, another through a public school system. And in building those, many people invested enormous amounts of time, energy and resources. Now we're seeing that what we built is not good enough anymore. I think we need to be very careful not to imply that the people that built those services did a bad job, or that what they did was inappropriate. When they built those services, particularly in the mid-seventies and into early eighties, the best we could do was to get a hold of the kids. We didn't have the mandates and the LRE pleas that would allow us to look at serving them in exemplary, integrated ways.

It's interesting though that if you look back into the early seventies, when the first set of early childhood special education projects started around the country, there were two cornerstones for most of those models. One of them was active family involvement and the second was integration. From the beginning in early intervention we have known some of the pieces of quality service, and our early demonstration projects, our early research said integrate and actively involve families. Then we moved out of those model projects into reality and how many of you know in your own states that the reality was that you started with lots of family involvement, you started with home visits, you started with....and then more kids got referred and more classrooms were built, and less time was spent with families. So much so that in a survey in the state of Minnesota it was found that of children in birth to six programs that had a center-based component, less than one-third of the parents had even monthly contact with professionals.

The reality around the country now is that preschool special education means segregation and parents stay home. How many of you know that that is a piece of what has happened to us from where we started? I think it happened because we didn't have the administrators' support, we didn't have the mandates, we didn't have the opportunity, much as I hate to make lawyers rich, to go into court on the LRE for preschool age children. It wasn't required to be serving these kids, so there was a sense that we should just do something that was acceptable.

Here we are, we're almost two decades into education for our handicapped kids. we have almost twenty years of experience as a public educational system working with our communities serving kids with disabilities. When we look at those twenty years, it's

interesting that there are some pretty strong findings that come out of all different areas of research, whether it's research on kids with learning disabilities, severe handicaps, high school, early childhood special education. The number one finding is successful programs actively involve parents as decision-makers. And that is the major predictor of programs that will be considered successful in communities. The second is, and this cuts across all the levels, whether or not a child has had an integrated school experience is a stronger predictor of success in adulthood, vocationally and on the job, than any other variable. Integration is a stronger predictor than severity of handicap, type of handicap, number of years in the educational program, number of dollars that were spent. Integration is the strongest predictor. Integration was a stronger predictor than whether or not community-based instruction had been done. Community-based instruction was the second strongest in predicting success. So we have twenty years of research and practice that you have to involve families, and that success is correlated with integration.

What kind of success is it that I'm talking about? Am I talking about grades, am I talking about scores on developmental measures. No, what I'm talking about when I talk about success is what we generally call quality of life. That is, after school hours, on the weekends or on Christmas vacations, or the summer, and after school years, beyond age 21, 22, 25, depending on what state you're in, where do people with disabilities end up? Where do they spend their lives? What are they able to do? How much are they integrated into the community? We have some successes around the country, but I'd like to share with you three recent failures that I experienced, that have really had an impact on what I see is our purpose in special education. The first is a recent experience with a grandmom, who has a little boy by the name of Joseph that she's raising. Joseph has Down Syndrome. He's been in an early intervention program where his brothers and sisters come with him, the brothers and sisters of other children with disabilities are included with him. Moms, grandparents, dads, uncles, etc., are included too. So, although they have a center, everybody sort of comes in and then once a week somebody goes and does a home visit. They have a structured curriculum with a scope and sequence. Parents actually do the evaluation of the project and conduct the questionnaires and summarize the results and present them to the administrators, so that the parents know what they think about it before the administrators know what they think about it. And Joseph is "transitioning" out of there at age three, because this program ends at three (how many of you have had that problem in your state?) and grandmom really wanted him to be in an integrated preschool setting. She thought that he had done real well with the other children. She went to a Head Start program with him and his early childhood special education teacher and as they walked in the director of the center came over and said "We don't take that kind" to grandmother, to Joseph, and to the teacher--1988.

Number two example of what concerns me was a letter recently in Dear Abby. How many of you read Dear Abby? (Applause if you're Abby readers. I won't tell you what else I read for factual information.) There was a letter in Dear Abby about going out to a restaurant to eat and one of those people was there in a wheelchair drooling over their food, and why didn't those people recognize that other folks didn't want to be subjected to that at their meal time. After all, they could eat at home. Dear Abby did a do a wonderful job, by the way, she really does, by defending the rights of all people to eat out. But that was 1988 too.

The third example occurred in 1987, and I really won't identify the community where it occurred. A small community outside of Madison was about to have a group home located there. It was going to be a group home for women who were labeled chronically mentally ill, mentally retarded. They had been institutionalized for a long time, they were coming out. How many of you have had this in your community? And in this group home there was going to be four of them. Because they were four unrelated people, you had to get a zoning variance. How many of you live in residential areas where that's required? How many of you don't know? I was appalled to find out that that's true in the neighborhood where I live. I don't know that I ever would have bought there if someone would have said to me, "If you're going to live there, you have to get a zoning permit." The group home developer really didn't think there would be a problem. They had good staffing and the women had no history of violence. So they go before the zoning board, and I happened to be there that evening with a parent to talk about something else. I'm sitting there and the first person that gets up to talk about this group home is the Catholic priest from the parish right across the street from the group home. So I thought: well this is great, and then the priest proceeds to point out to the zoning board that he really understands that these women need somewhere to live and that it would probably be better for them to live in the community, but he really thinks that the zoning board could probably help find a better place than that house, because, after all, he has lots of parishioners that come into his church service on Sunday and those women might be wandering around the parking lot while his parishioners were there. And I thought to myself, although I didn't jump up and say it, "I don't understand this. From what I knew, God would invite them in! Never mind wandering around in the parking lot!" But he wasn't going to invite them in.

So where are we in 'quality of life'? Where we are is that we have a lot of individuals with disability that we're diverting an enormous amount of public educational money to, with very little chance of them being successful in adulthood. Because the adult community is very unready to take on these people. And so when we look at that and look around and we talk to families of individuals with disabilities who are adults, one of the things that seems to be missing is that in the educational process our IEPs tend to focus on very specific skills. Those skills do not necessarily lead to, when you put them all together, successful community functioning. Because very often the skills we teach are the ones that we can teach in isolation, that we can sit the child down and accomplish. And yet, in order to succeed in life in the way I'm talking about, the skills we teach have to somehow impact on a community's respect and the dignity that is given to individuals with disabilities. And it doesn't just rest on what they can learn in our programs. We can't teach communities to respect and value individuals with disabilities by keeping people with disabilities in our separate programs.

When I reached that great revelation a number of years ago, it was startling that I also found that its something that parents have been trying to tell us for years and that they figured out way before 94-142, and as a continuing part of 94-142, they keep saying to us, "What about the future?" "What about tomorrow?" "What about the neighborhood?" And, in fact, Chris Salisbury and I did a little bit of research a couple of years ago where we asked families of all different kinds of kids with disabilities to write down what are the five things you would like for your child in adulthood, when they reach 21 and 22? What are the five most important things for you? We also

asked companion professional staff to write down those five things. The first very interesting thing was that there was only 23% overlap between what the parents said and the professionals said. The other thing that was really fascinating was that within the parents there was enormous consensus in what they said and within the professionals there wasn't...How many of you have been to a multidisciplinary team meeting recently? You have the occupational therapist, the teacher, the speech clinician, etc., all with their own opinions. There was very little consensus among professionals about what the focus should be. We started wondering about what are the common themes that parents were telling us. What were they saying to us they really wanted for their kids? And could we take that to heart? Could we take those goals and look at building special education services, early childhood onward, that would reach those goals?

The first goal that was listed by over something like 85% of the families was "In adulthood I want my child to be happy and have friends." Just as Phil Strain was saying this morning with the early childhood kids, friendship--feeling good about yourself, having people who like you--was a recurring theme in all the families with whom we talked. They all talked about that piece. They wanted their child to know that other kids liked them. They wanted their child to know that somebody interacted with them who wasn't paid to and didn't have to. They wanted a sense that their child was a capable interactor, could be a friend to somebody else.

The second thing the parents said to us, and again they said in a lot of different ways, was that "I want my child to live in the community." Bob Perske says this by saying "I want him to be a neighbor." I want my child to grow up and be somebody's neighbor and have them know that he or she is their neighbor, and want them to be their neighbor and know their name; and know that they can go to the local store and people will know who they are; and that they can ride the busses and they can go to restaurants and they can go to bowling alleys and parks--that they are a part of our community. That they have that community respect that says they belong in this neighborhood as much as anybody else.

The third thing that parents said to us they said in a lot of different ways, because we were talking about parents with very very severely involved kids, as well as parents of learning disabled kids. They said to us, "I want you to figure out a way that my child can give back to society as well as my child can take from society. I want you to figure out a way that my child can make a contribution. I know right now that he can't work full time for minimum wage, he's going to need a job coach, he's going to need a supported employer and the co-workers are going to have to help, but there must be some way that my child could do that, and can have that sense of mastery, and that sense that comes with contributing and not just taking."

How many of you in this room have kids without disabilities? How many of you would set these three goals as the goals for your kids? I want them to have friends, I want them to have respect, I want them to contribute. And I want them to be on the go out there, I want them to make a difference.

Parents knew what kind of future they wanted. It wasn't the future that we looked at as professionals. And so we decided that maybe we should look at how close we were to

getting that future. And so I went out and I looked, particularly at the last one, making a contribution to society. And interestingly enough we found out that this really wasn't all that difficult to do (You sort of feel you take the most improbable first). Well there are folks all over this country who have individuals with very severe disabilities out doing community work. And, in fact, school districts and programs they have chosen have almost 100% graduation rate to community work rather than sheltered employment. It looks pretty clear if you look at Virginia Commonwealth, San Francisco, Madison and De Kalb, Illinois that people do not need to go in to sheltered workshops. And in fact we can build employment in the community that is as successful for even the most difficult worker. One of the more interesting findings to me has to do with "Do you want to?". For example, Madison, Wisconsin decided that all of the kids graduating from their program for moderately and severely handicapped students would go into community work. They made that decision, implemented the curriculum, got the job coaches. Last year 95% of the kids graduated and went into community work. At the same period of time in the state of Montana they did a study of where do students with learning disabilities go after high school graduation. The end result: 95% were unemployed. Now that is an example of what do you choose to do, what is your goal, what do you want to get out of this. Have you looked to the future, are you letting a future drive part of what you're doing now.

So I think the message I give you is that we can make a difference in terms of contributions to society, we can get folks out in jobs. The other thing that's very interesting about that is that whether a person stays in a job does not have to do with their skills related to the job, but has to do with social skills. And again, it's very clear that the ability to interact with the non-handicapped workers, bosses, whoever, on the job site is more important than the exact job task. If a person can't do a job fast, somebody will figure out how to adapt it or teach it to them. If they are having trouble interacting it is likely to get them moved to another job. So we come back to that social piece.

What about the other two goals? How about the goal of happiness and friendship, and how about the goal of community respect and dignity? Well, I think one of the things that's really clear, as I started saying a few minutes ago, is that we can't teach those directly in our special education programs. To the extent that we are focused on mainstreaming our segregated special education programs we can't work on two of the things that parents think are very important. The reason for that is that success in the friendship and community dignity areas depends on children without disabilities seeing children with disabilities as possible friends, as capable contributors, as people who make a difference. Now my earlier examples of Dear Abby and a priest and a preschool program would say that there are a lot of folks out there that don't see individuals with disabilities as capable, as deserving community respect, as having a place. And in fact it looks like there are a lot of folks out there that still believe that it's not o.k. to have a disability. And, in fact, if you have a disability, you need to be separate. How many of you know that your parents believe that? How many of you know people in your your own school districts that believe that? We have programs all over the country, where if you have a disability, you automatically are separated. As soon as we do that we can't be successful in reaching those life goals. And so what we have to do is figure out a way to teach typical kids that children with disabilities are potential friends.

The literature on friendship formation is really easy. It says one thing: "In order for friendship to occur, there must be proximity and frequent opportunity for interaction." In fact the literature on young kids friendship is pretty clear, as Phil Strain was saying, that needs to be almost daily, and it needs to encompass the whole time that children are in learning settings. And so there is some research that shows if there is a whole day program and some kids are only there a half day, and the rest of the kids get a whole day, the whole day kids make friends with each other and the half day kids make friends with each other. And maybe this makes sense, and maybe you've seen this with your own kids. I mean, that's why I like research, you know, it's really simple. It gives you these nice conclusions. And so it's real clear that friendship is based on proximity, opportunity and inclusion as an equal. Not somebody that gets put in for play time and then leaves for the whole rest of the day.

Now the second thing that seems to govern kids' friendships is that they have to believe they have something in common. This can be with three and four year-olds, you say "She's my friend" ... well why is she your friend?... "She sits next to me". That's a very standard reason for labeling someone. Isn't that wonderful when you talk about kids with disabilities? And in fact the literature is really clear that the first part of friendship is inclusion, and that that is absolutely essential, necessary, but not sufficient. The second thing is shared activity and a shared sense that you have something to contribute. Now the other thing that's really nice about little kids is that this is really easy to do because shared interest between children is totally governed by adults and parents. How many of you have been in day care centers recently and preschools and know that dinosaurs are in? How many of you believe that the children are into dinosaurs? How many of you know that the adults are into dinosaurs? I have a little two-year-old friend named Nathan whose first word was dinosaur. His whole room is dinosaurs, the shower curtain is dinosaurs, everything. He has suspenders and he'd walk up to you at 18 months and he'd point and say dinosaur! Everywhere this kid went that I went out in the community with him and we encountered other parents of preschool kids, they immediately could talk about dinosaurs. Nathan had a common interest with other children because his mom and dad love dinosaurs and their mom and dad love dinosaurs. Another example of that is a little guy I know out in Colorado whose 7 now, he lives in Denver, and he's a Denver Bronco's avid nut. His mother is a Denver Broncos' fan, and his whole room is decorated in Denver Broncos, and he has Denver Bronco shirts... And when he got integrated into a regular first grade--he's a severely handicapped child, wheel chair bound, hearing impaired, he's got a tracheotomy--the first day he wore his Denver Bronco's shirts, he had three new friends in the classroom, who liked the Denver Broncos. And they would start coming over and so the teacher wrote a note so his mom would send Denver Bronco stuff in. Pretty soon Winslow was getting invited to birthday parties. Friendship with little kids is such an easy piece. It is one that we have so much control over, that if we take some time with typical kids we can give them the skills to foster those friendships. We can also give kids with disabilities skills to foster friendships. We can build that into their IEPs. Mostly we talk about the benefit for kids with disabilities of friendship and we talk about all the things that they're going to get out of this and that it's so important for them to be in these settings and to have these friends. I've actually become convinced that it's probably more important to the typical kids in some ways, than it is for the kids with disabilities. And I've really have become more aware of that this last year, as I traveled around the country talking to

kids who are between about 7 and 12, who have brothers and sisters with disabilities that get sent to different schools than them, and get bussed out of the neighborhood. How many of you have areas like that? If you have a disability, you don't get to go to school where your brothers and sisters are. And I started asking these kids, "Now, why does that happen?" And it was really scary, because they started telling me why it happens, and they told me, "Well, it's because he doesn't belong with us." "She can't learn with us." "It would be too hard for us to learn if she was there." "The teachers wouldn't know what to do if Ryan was in our classroom." Aren't those all reasons that we don't integrate as professionals? Are those kids all making up something that we don't also know. So what's happening is all over this country we've got typical kids that are learning it's not o.k. to be different. It's not o.k. to have a handicap. It's not o.k. to need special help. It's not o.k. to be not exactly like everybody else. And when I think about that kind of message for today's kids with the stresses that we have on kids, and the issues of drugs later on, and the fact that kids have to really believe in themselves to resist that, we're missing an enormous opportunity to teach kids about individual difference. And we are creating settings that are artificially the same, and in doing that we're giving kids the message "You'd better be like everybody else, because it's only if you're like everybody else that you get to stay in this school." How many of you are in districts where if you need special help with reading, you may get sent out of your home elementary school? You may get sent to another elementary school on the other side of town. There are kids all over this country that are having problems just with reading, that are being sent somewhere else. And then of course there are kids with more moderate and severe handicaps who right away get sent somewhere else. And so I think that we're really creating a myth with typical kids, and we're teaching them some things that those of us who are in early childhood special education really regret in the long run. That is, we're teaching them as the future parents, cousins, in-laws and brothers and sisters of children with disabilities, because some of those typical kids out there are going to have someone with a disability come into their family, we're teaching them that that's not o.k. And the difficulties that we report in our literature on parental adjustment and adaptation, all the stress we may be actually perpetuating by our segregating programs. Because the kids are worrying that if your child has a disability, they're going to have to go somewhere else, it's not o.k., they can't compete, they can't be part of the group. And so I think we are really hurting our own causes as well as hurting the kids without disability, as well as hurting the kids with disability. It's really clear that if we're going to get there in adulthood, we're going to have these people who go out and live in communities and have community respect, we need to teach typical kids that it really is o.k. to have a handicap, that it really is o.k. to be different, that you can actually learn from people that have handicaps. And that just because you have a handicap you're not always the tutee and somebody else the tutor. Just because you're typical doesn't make you always the model.

There are, in fact, individuals with handicaps that can do some things better than you can. They may be able to run faster or read better or do their math better than you can. And I think that one of the biggest mistakes that we've made in our special education efforts so far is that we have done what we've call mainstream kids and you notice that almost everybody today isn't talking about "mainstreaming". We talk about integration, we talk about least restrictive. One of the reasons I think we made a mistake is that when we built the mainstreaming model, and I hope it's something we don't do in early

childhood special education, we built it on the concept that you got included with typical kids, if you could compete with those typical kids, and you could do exactly what those typical kids were doing. How many of you have kids with disabilities with whom this will never work? They're not going to be able to compete and be in that setting. And so what happened in mainstreaming is we kept trying to find ways that kids with disabilities didn't have disabilities. And kids with handicaps didn't have handicaps. And then what we would do in those settings, is that we would say to the regular educator who had 25 or 30 of them, "Oh, and by the way, Bill will be joining you for math, because he's o.k. in math."

When I talk about this I always see some special educators eyes light up because they were never sure they liked regular education anyway. And so some of the opposition to mainstreaming was from special education teachers. And in fact some of the attitude research that's been done says the worst attitude towards mainstreaming is held by special education teachers, and the best attitude is held by parents of typical kids. They think it's a great idea, parents of kids with disabilities think it's a great idea, teachers of regular kids think it's an o.k. idea, and teachers of special education think it's the worst thing they've ever heard of. And so integration has none of that--it says we have resources, we have kids, we know what's important to them to learn, we really know the importance of social skills, we know the importance of communication and communicative intent. We're not going to leave fine motor, gross motor, cognitive and all those things behind, we're going to work on those skills as well. But we're pitching for the future. We're looking at age 22. We want to make sure that the educational dollars that we invest for 22 years in a child's life pays off. In a community that is responsive and accepting, a community that really makes the difference.

I just recently got introduced to a group of principals and assistant principals for segregated preschool programs as one of those radical integrationists. And given I was a child of the 60's, I kind of like the idea that I was a radical. The problem is that integration is not radical. In fact, integration has been around for 20 years. And then I got kind of worried because I thought I was supporting an establishment cause. It was time to figure out something else to support here! As I get introduced and as I talk to groups like this I've learned to say something really clearly. That is, I do not believe that the solution is to put children in regular education with no help. I fully believe that every single dollar that we invest in special education programs must follow children into regular education, regular day care and regular preschool environments. We're not talking about an alternative to specialized help, we're talking about help that delivered in a different setting, and maybe delivered in some different kinds of ways--maybe kids with each other rather than adults all over the top of them--but we're talking about the same cost. The little bit of cost data that I've seen will say it's really the way we want to go because the integrated settings provide more resources. If you hold on to all your dollars, you know I saw a figure recently that the average early childhood special ed program in this country cost \$8100/year by the time you figure transportation. I remember back in the days when it was \$450. So we have a lot of money available to use for the integrated setting, and I'm not advocating to integrate to save money. I'm advocating we use all this money and volunteers to make integration work (Grandparents, parent volunteers and high school students can be trained to work with children). We're talking about lots of ways that we can use people, and it's not going to be easier out there in an integrated setting. I think we're going to have to

look at a lot of alternatives. There isn't going to be one model that fits every school district or every program. I think within school districts you probably will want to have a range and then that gets to the issue of a continuum. Continuum is really difficult for me, because I think by building that in to 94-142, as much as I really love that law, we created the notion that segregation was appropriate for some children. And by putting it on the continuum, segregated classroom, segregated schools, we've said to people some of the children that you look at belong in this category. And so then people started trying to find those kids. And once they found those kids in their view, every other child like that became one of those kids. And I would like to see us, at least in early childhood special education, start with the notion that least restrictive environment means that you are placed in the setting which you would go to if you did not have a disability and if that's center-based, then you will be placed in a setting that other children in your neighborhood would go to who needed a center based setting. And only after we've attempted to adapt that environment, train personnel, hire additional staff and change materials, will you be removed to a segregated setting. Now I'd like to say that kids don't move at all, I mean the teacher has to figure it out from that setting. I have enough confidence if we do it that way we'll figure it out, that I sort of allow that probability. Have you gone through that? And you've taken ninety days, and you've worked with the parents, and you've trained staff and you can't do it. then we probably should send an outside consultant to come out and help you... The other thing is I know not all teachers want kids with disabilities. You know that we don't need all teachers to work with us.

It's real clear now that the regular education staff that is buying into integrated models is having a much better time. They're having a lot of fun, and they will tell you how much more motivated they are. So we don't need to make every teacher do that. But we need enough range and models to fit the situation, and we have enough people out there that are willing to integrate, then it's really not an issue. And all over the country I have people saying "Lisbeth, the regular educators aren't going to allow me to do it." Day care center teachers, preschool teachers, family day homes are saying, give us some assistance, give us some support. Very often when they won't buy in it's because someone told them, they didn't know how, it would be too difficult, and no one would give them any extra help.

And so for me integration is, you put them all in, you take your resources, and you figure out how to make it work. And we know what some of those pieces of quality are now. We know how to make it work. That's not experimental at this point in time, that's not the experimental piece. We know what makes the difference in terms of structure, instruction and intensity. The model that I talk about is one where you adapt environments, you change environments rather than changing children's placements. It's one that is built on the notion that from the earliest time possible kids with disabilities and kids without disabilities should be together as frequently as we can possibly figure out how to do it as a community. Because young kids are forming their attitudes and that is when they learn about disabilities. And that's when we have the best opportunity to create similarities between kids and tap similarities that are already there to really pay off friendships that form. That's when it's easiest for us. The difficult behaviors are often less. The discrepancy is less. The proclivity to want to be together and interact with each other is more. The curiosity about kids with disabilities is higher

at 3, 4 and 5 some researchers say. That curiosity, if it's not dealt with, turns into fear and age 7, 8, and 9. We have real opportunities at the young ages.

I think what we have is the opportunity to learn something, that families have had to learn all along, and have tried to talk to us about as professionals. We've always shyed away, we've always been uncomfortable when parents have started talking to us about their feelings and their kids and the value that these kids had in their lives. And I always see early intervention professionals squirm when parents start talking about how important it is and what they've learned, and the brothers and sisters have learned, and it's brought their family closer together. They really had to examine their values. They've had to figure out what's important. They have had to make decisions about what priorities for this family will be. As families talked to us about that I think where our discomfort comes because we're trained to see the disability. We're trained to put the disability first. We're trained to make it the most important thing about this child. And we're going to do it in a negative way, in a way that says that this kid doesn't measure up.

Parents end up looking at their kids really different than that. They see the whole child. They see temperament rather than a wheel chair. They see humor rather than the problem behavior. They see interaction between two brothers rather than the lack of writing and math skill development. They see this kid as fitting in and being a contributing member of their family. I think that's why they're so convinced their children can be a contributing member of our society, because if they can do it as part of their family, then truly they can do it out there. And in a sense I think that what the families have learned is like probably 20 years ahead of where we were.

In the seventies we started integrating kids, and if you read the literature (and it really appalls me when I read it now) we talked about tolerance, we talked about the purpose of doing this was that people could be taught to tolerate individual differences. And then in the late 70's, and I wrote some of this stuff, you read the literature and we start talking about acceptance, and the idea we should accept people for who they are and what they bring. We were all more comfortable with that and we felt a lot better about ourselves. We still have a step to go as professionals. It's a step that families have already made. And that is that the issue is neither to tolerate not to accept. This issue is to cherish, and the issue is to respect. And the issue is to recognize that each child is a unique individual that we have the opportunity to learn from, with whom we have the opportunity to be friends. And while we may look and see severe handicaps and we may look at two kids interacting in a classroom and say "You know, Adam is doing all the giving here, and Aaron is doing all the getting here, is that really friendship?" A measure of friendship is not what you and I think when the two of them describe themselves as friends. And I think probably the most important thing to remember is that for many of us, if we look back or we take a minute to reflect, situations we thought we were giving so much, are the very situations where we ended up getting the most, and the situations in the long run we realize we were the learners. We were the person that benefitted, as much as that friend with whom we were interacting.

And so I hope that now with our new legislation we can join the parents in their dream. A dream that isn't just vocational success, but a dream that is community respect; a

dream of friendship; a dream that in a sense would have us 20 years down the line look out there and be able to say "Individuals with disabilities are in every part of my life. They're where I work, they're where I live, and they're where I play. Thanks very much.

Techniques to Encourage Social Interaction

Phillip Strain, Ph.D., University of Pittsburgh

There are 4 basic questions which should be addressed relative to the implementation of social intervention training. These are: 1) how do we know who should receive social intervention training; 2) what are the specific skills that should be taught; 3) who should provide the intervention; and 4) what is a reasonable way to evaluate the success of the intervention?

It is not appropriate to make the assumption that all children identified as requiring early intervention are in need of social skills training. A more fine-grained approach in this area is required. Staff at the University of Pittsburgh have developed a relatively simple rating scale which retrospectively evaluates a child's potential for social skill development. This scale has been developed primarily for use with young, autistic children, but is adaptable for other disabilities. Children identified as having 3 or more indicative social behaviors have been shown to be at risk in the area of social skill development. It has also been found that interactions with adults are not good predictors of future social skill development. Interactions with age-mates appears to be a much more accurate predictor of later development in this area.

There is a vast universe of possible social skills which might be taught. These skills are extremely complex and defy a standard, special education, task-analysis approach. It is important to reduce this universe of skills to a simpler set which can be effectively taught. Through observation of handicapped and non-handicapped young children, we have attempted to determine which behaviors distinguish children who typically have friends from those who do not. The following list of behaviors have been observed to elicit positive responses from peers and lead to friendships among young children (% of Positive Response):

- 1) rough and tumble play (92%);
- 2) sharing (79%),
- 3) organizing play (67%),
- 4) providing assistance (63%),
- 5) questioning (51%),
- 6) imitating (46%),
- 7) commanding (45%), and
- 8) making a statement (33%).

It has been our experience that the most effective agents for teaching the above skills at the pre-school level are the typically developing age-mates of disabled children. Such an approach seems to promote excellent retention and generalization of skills in

children with disabilities. This includes children with relatively severe disabilities. The approach to teaching these peer intervention agents is relatively quick and precise. Upon entering the program, typical children are provided with 20 minute modules of instruction each day over a 4 day period. This training is preceded by the presentation of a rationale for the training about to be provided to the children. The children are told that they will all be together in a class to learn and that they will be learning about some things that will help them to learn and play better together. The approach is highly structured, but seems to be easily elaborated by the typical children and to eventually lead to enhanced 2-way interactions among the children.

After the initial training is completed, teachers facilitate the implementation of the skills in a classroom of 6 typical and 6 disabled children. The classroom utilizes a modified High/Scope approach where self-planning is emphasized for the children. This approach allows the two teachers to give suitable attention to the behavior of the children with disabilities. The data supports the prediction that disabled children will generalize these social skills as taught by their peers to situations beyond the classroom. It also demonstrates that the typical children tend to generalize more supportive attitudes toward children with disabilities than do children who had not had such training.

INTEGRATING THE CONCEPT OF THE LEAST RESTRICTIVE ENVIRONMENT INTO EARLY INTERVENTION

Patricia Place, National Association of State Directors of Special Education

Part I: Introduction to the Issues

In the typical course of events, a young child becomes an integral part of the family unit, becomes attached to parents and siblings and comes to participate in the daily activities and the rituals of the family and community. Developmentally, the child acquires basic motor, communicative, cognitive and social skills in the context of informal daily interactions with family members and caregivers. The "normal" environment for children under the age of three is in their home, and frequently in some type of group setting (child care, nursery school, play group, etc.).

The concept of least restrictive environment (LRE) was developed in regards to placement decisions for school age children and adults. The concept should be applied to decisions about placements for all children, regardless of their age, once they begin receiving center-based services. For infants and toddlers with developmental delays and disabilities, the least restrictive environment resides in the context of a well functioning family unit. Therefore there are two focuses of early intervention services: services for the child and support for the family. Early intervention services should be individualized for families within the context of their communities. This view is congruent with the principle of normalization, which underlies the concept of LRE in special education.

Basic to the principle of normalization and the concept of least restrictive environment is the notion that individuals with disabilities should be fully integrated into the normal environment and activities of society. This notion may be manifested in several ways for children under three years of age. First and foremost, children should be fully integrated into their own families and their families' cultural systems. This means that adaptations must be made to maximize the child's and the family's abilities so that the child is included in and be an integral part of normal family activities and rituals. This also means that one of the roles of early intervention services is to assist families in thinking about and implementing adaptations that will facilitate this integration. In addition, to avoid the isolation which commonly occurs for families with children who have disabilities, early intervention services should assist families to remain integrated into their communities (child care, work, church, social groups, etc.) to the extent they desire. Families of young children with disabilities should be provided the same opportunities for participation in child and family activities that are afforded other families, such as, appropriate babysitting and child care programs, parenting and child care classes, library story hours, and play groups. Finally, when child care (in any of its many manifestations) is used, it should be with typically developing children.

Part II: Details of a Particular Area of Intervention Which Needs Exploration and Clarification

One of the benefits of the Part H program is the ability for states to develop creative and innovative ways of meeting the infant or toddler with handicaps and their families. I would suggest we spend some time discussing some innovative programs.

A population which is of paramount importance in terms of magnitude of needs and resources expended consists of children who are medically fragile and/or technology-assisted. When we consider LRE for an infant and toddler we usually think of the home, however, many of these children live in hospitals because the community lacks the services to support them at home. Just in terms of dollars, it's necessary to develop community programs; e.g., in the D.C. area, the cost of caring for a baby who is ventilator assisted is as much as \$40,000 a MONTH compared with less than \$15,000 a month for home care (according to the American Federation of Home Health Agencies).

if we state that the goal of LRE for infants & toddlers and their families is to integrate the child into the family then there are special challenges for the baby living in the hospital. Intervention must begin in the NICU in order to facilitate this integration. Programs that you develop must include the following components. Some programs demonstrating these guidelines are identified in the resource listing provided at the end of this article.

Components for programs in the Neonatal Intensive Care Unit (NICU)

An IFSP should be developed to describe the interventions which will occur for the child and family.

In addition to the child's obvious medical needs there is a need to facilitate the child's emotional development. All of the suggestions presuppose that they will not threaten the baby's viability but the standard should be to assume such activities will occur unless there is evidence to the contrary. Otherwise, it is often easy for staff to revert to previous routines. The LRE includes the following, if any are not provided there should be documentation that these were considered and rationale provided for why they were excluded from the present plan and plans to add them with criteria for when. This list of components is suggestive not exhaustive.

While in the Hospital

The intervention program must be operated in such a way to allow the infant to develop a special bond with the members of her family. This means structuring the therapeutic environment in such a way as to allow one-on-one and small familial group interactions to occur in less stressful surroundings.

There should be a toll-free number and one nurse each shift assigned as the baby's case manager to whom the parent can talk at any time of the day or night.

If parents or siblings can not visit the infant immediately there should be videotapes and pictures taken and shown to family members.

Family members must be empowered from the very beginning to begin to feel that the baby is a part of the family and they control the decision-making as far as possible. This should include any aspect of the baby's care and environment over which the family can exert control, even if, to some professionals, they might seem like trivial decisions. Parents should be allowed to make decisions at whatever level they can deal with them at any given period of time. For example, families could be encouraged to bring in sheets, blankets, infant clothes and other items which they would usually use with their infant at home. Mothers should be given the option of providing breast milk for feedings, if possible; this can be used even in NG or gastrostomy tubes.

Family members must be taught and encouraged to become pleasure objects for their infant. They should be helped to learn to hold and cuddle their infant and provide other such tactile and vestibular stimulation. Great effort should be expended, if needed, so that family members do not have to engage in intrusive or painful activities with their infants.

All family members, identified by the parents, should be welcome at the NICU.

There should be appropriate play spaces for siblings or other young children to go to when they are not with their infant. Young children will want to spend far less time with the infant than adults will.

All families members should be encouraged to participate in the counseling, support group and/or training sessions individualized for their developmental levels and needs. Families should have significant roles in determining the content and nature of these interactions.

Arrangements should be made for over-night stays of family members. One hospital allows families to stay in empty beds for a minimal linen fee. Others arrange for stays near the hospital and arrangements can be made to subsidize these sites. Arrangements for day and respite care for family members should be provided.

Attention must be paid to developmental as well as medical needs. Plans must always be long range.

Transition From the NICU

Families should be given more control over the infant's care as time goes on so that families feel competent and comfortable in having their child exit the NICU, exit the hospital and move to another, less restrictive, environment. The goal should always be to prepare the child and the family for the child's living in the family home.

A range of program options needs to be available to meet the unique needs of individual infants, such as:

Programs need to be developed which provide residential placement for children who still need this type of care but do not need to be in the hospital environment. The goal should always be to provide care in the child's home. This may not always be

possible. The next best environment may well be a foster home where the child can be a member of a family and experience typical activities. Obviously, changes need to be made in social services systems to facilitate the development of much needed placement sites and to support the biological and foster family's efforts to provide appropriate care for the infant and toddler.

While programs are beginning to develop and expand home-based options, residential placement in a group setting may be required. If such is the case, the IFSP should be explicit about what steps are being taken to develop these program options and the expected timetable for the child to be placed in a home setting. If residential care is absolutely necessary, the environment must be as home-like and typical as it is for children who do not have special needs. The environment consists of interactions with loving adults and peers as well as the physical environment.

Programs such as the Prescribed Pediatric Extended Care (PPEC) program described in detail in the handout, need to be developed to offer an intermediate, and less restrictive, environment for young children who require extensive daily medical care but who, if they receive these services, do not have to reside in the hospital or other group setting. Excellent case management must be provided to coordinate services for the optimal development of the infant or toddler with special needs and the family.

The concept of least restrictive environment as it applies to family based services should be balanced by a strategy of using the least intrusive yet, most effective approach. The term LRE has been used throughout this paper in a very deliberate manner. The purpose has been to stimulate the reader to think creatively about the concept as it applies to infants and toddlers and their families. It may be more appropriate to refer to Early Intervention in the most supportive, rather than least restrictive, environment. The amount and type of assistance and services a family receives should be supportive of individual child and family needs, strengths, and preferences. Support should not be prescribed or limited by present availability of services.

In summary, it is necessary to take a broad view of the concept of the least restrictive environment as it applies to children under three years old. Policies and programs must recognize that there is no "typical family." In early intervention, LRE means providing experience and expertise to the existing family structure to provide adequate opportunities for the young child who has disabilities. This intervention should utilize and support all family members and community resources and should enrich the family situation as much as possible, respecting the cultural and economic structure of the family. The challenge to policy developers and service providers is to create the most supportive environment which promotes optimal development of every member of every family in America.

RESOURCES FOR INFANT & TODDLERS WITH SPECIAL HEALTH CARE NEEDS

The following programs have been recommended to NEC*TAS as incorporating most if not all of the above components. NEC*TAS has not provided on-site observation and inclusion below does not constitute an endorsement.

Neonatal Intensive Care Units

GEORGETOWN UNIVERSITY NEONATAL INTENSIVE CARE UNIT
Child Development Center
Georgetown University
3800 Reservoir Rd. N.W.
Washington, DC 20007-2197
Contact: Judith Pokorni

EXTENDED CLINICAL SERVICES

Department of Pediatrics
Texas Tech Regional Academic Health Center
P.O. Box 30600
Amarillo, TX 79120-0600
Contact: Aileen Dunn Jackman

CHILDREN IN HOSPITALS, A MODEL PROGRAM

Department of Pediatrics
UCLA Medical Center
DMCC 12-311
Las Angeles, CA 90024
Contact: Nancy Brill

Medical Day Care

PRESCRIBED PEDIATRIC EXTENDED CARE (PPEC)
Contact: Patricia A. Pierce, 5700 S.W. 34th St., Suite 323, Gainseville, FL, 32608.

Affiliation: Dept. of Pediatrics, College of Medicine, University of South Florida.

Purpose and population: The PPEC is a non-residential, family centered, health care service prescribed for a child who is medically or technology assisted. It is offered as a less restrictive environment than the hospitalization that would be required if such placement was not available.

Location: Separate Center

Personnel: Referral is made by the child's pediatrician. Initial evaluation is conducted by the PPEC's developmental pediatrician and the program is developed based on that. PPEC staff consists of RN with extensive experience in pediatric care, supplemented by contracts with PTs, OTs, social workers, psychologists, and child life

specialists. A teacher is provided by the county school system to provide special education to the 3-5 year old students. Personnel ratio is 1:3.

Financing: Completely self-supporting using private insurance and some public health funds. Charges are based on hourly rates determined by the intensity of nursing interventions required (There are 5 levels of intensity) by the child's medical condition and therapeutic regime. For 5 days a week, up to 12 hours a day, the charges run from \$132/day to 350/day (for child with 1:1 care). The cost effectiveness of this approach has been evaluated by an external evaluator who determined that the costs were significantly less than the alternatives: 20% of the cost of hospitalization and 66% of the cost of in-home skilled nursing care. The evaluation also found that there was reduced stress on the families.

Intensive Special Education for Handicapped Preschoolers without Segregation from Normal Peer Models: Reverse Mainstreaming as an Alternative

Nancy Peterson, University of Kansas

Nancy Peterson, Ph.D. is a professor of education in the Department of Special Education at the University of Kansas. She coordinates the personnel training programs in the area of early childhood special education. She established a demonstration preschool for handicapped children in 1969 which has evolved into the current interagency collaborative program that serves her local county area. Under her direction, a reverse-mainstreaming approach was implemented in the program beginning in 1973. Her research under the Kansas Early Childhood Research Institute dealt with social interactions and play behavior of handicapped and non-handicapped preschoolers in integrated settings. Dr. Peterson is author of a comprehensive new textbook on early childhood special education entitled: Early Intervention for Handicapped and At-Risk Children: An Introduction to Early Childhood Special Education (Love Publishing Co.).

Introduction

The press to meet the 1991-92 mandate for full services to 3-5 year old children with disabilities is on. As school districts organize these new programs, administrators are making important decisions thereby setting policies and establishing traditions for the kinds of service delivery systems we will use to serve this population of young children. In the rush to get these new service systems in place, it is tempting to repeat history by following the same initial paths educators have taken in past years when special education programs for school-age students were being established initially and expanded for populations not served before. That is, it is tempting to simply create new special classroom units, segregated ones, where the new population of service eligible young children can be placed once they are identified as handicapped and needy of educational intervention. It is easy to fall back upon our earlier thinking that special education is equivalent with special classes and to revert back to this one service delivery approach as "the way" to help handicapped preschoolers. Tradition is an easy answer that can deter us from asking other important questions such as..."What are the most appropriate service delivery strategies for intervening effectively in the lives of children so young? What is an appropriate environment wherein special help and training can be provided to children whose development is not progressing as expected? What is the "least restrictive environment" for a preschooler when the purpose of early intervention is to provide special training and therapy that is not typically available in regular preschools?

Underlying the development of a nation-wide system of early intervention services for 3-5 year olds is a crucial basic question: What interpretation of LRE (least restrictive environment) should be applied to handicapped 3-5 year-old children? It is apparent that to separate children from their normally developing peers for the purpose of early intervention removes them from one of the most important resources for the kind of learning that so predominates the early childhood years, modeling and imitation with peers, especially peers who offer more skilled, advanced models of behavior. Yet there is the other plaguing question that if handicapped children are merely placed in regular preschool programs under the curriculum and teacher-child ratio that is typically found there, how can these children get the special training they need in a

timely and intensive way enabling it to provide an effective intervention in their development?

The issue of LRE boils down to this: **How can the benefits of the service intensive special education intervention classroom be combined with the benefits of keeping handicapped young children in an environment where they can associate and learn with normally developing peer models?** *Reverse Mainstreaming* offers an alternative that special education administrators and program planners will find well worth considering.

What is Reverse Mainstreaming?

Reverse mainstreamed programs, also referred to as "integrated programs", are special education preschool settings set up to serve young children with disabilities. Handicapped young children constitute the majority of the classroom population. Nonhandicapped children are enrolled as "peer models" comprising approximately one-third to one-fourth of the classroom group. The program is designed to provide special education and therapy to the handicapped children while providing appropriate educational experiences for the nonhandicapped participants. Thus, curriculum is highly individualized and focuses upon specific goal-directed activities that promote skill learning across all developmental domains (e.g., speech-language, motor, self-help, cognition, pre-academic learning, play and social skills, etc.).

Why Reverse Mainstreaming as an Alternative?

Integrated preschool intervention classes make it possible to offer the intensive training and therapy that handicapped children need if they are to receive a timely intervention in their lives that might alter their course of development. Simultaneously, they are maintained in a social environment that includes normally developing peers. What are the possible effects of this arrangement?

- 1) Integrated programs allow handicapped children to associate with age-mates who can model age-appropriate speech, social and play behavior, and provide developmental skills which the handicapped children would not necessarily see if they were placed in preschools containing only children with similar developmental deficits as their own.
- 2) Integrated programs offer a potentially more stimulating, responsive environment for a handicapped child. That is, peers are available who are more likely to engage in constructive play, engage in verbal interaction, and initiate a variety of social activities. In contrast, a classroom of only handicapped children who lack skills in these areas is likely to have less spontaneous, imaginative play and social interaction.
- 3) Integrated programs provide an opportunity for children to learn about individual differences, to become accepting of those differences, and to learn not to fear or to ridicule those who are handicapped or different in appearance or intellect.

- 4) Integration of handicapped and nonhandicapped preschoolers creates some natural "helpers" in the classroom who can provide a form of social structure that helps all children participate in activities more readily and make transitions from activity to activity quicker.
- 5) Inclusion of handicapped and nonhandicapped preschoolers helps teachers maintain a perspective of normal development and behavior and of the skills they need to help young handicapped children acquire in order to function optimally in their homes, community, and school environments. Teachers also benefit in that young children are natural teachers for each other. Good peer models encourage the spontaneous learning that can occur through modeling and imitation among young children.

Administrative Logistics for Creating Reverse Mainstreamed Programs

Setting up a new early intervention program using a reverse mainstreaming model or converting to such a program approach involves more than the mere enrollment of nonhandicapped children. Effective integration and the smooth operation of program serving both handicapped and nonhandicapped children goes much beyond the recruitment of "models." Additional administrative and programmatic tasks become important in establishing effective integrated intervention programs. These include:

- 1) Selling the notion of reverse mainstreaming to important constituency groups (e.g., district level administrators, teachers, and parents) is crucial. This involves educating these important individuals about what integrated programs are including their prospective benefits, and dealing with questions/concerns such individuals may have about the approach. This is an important first step to assure good support for integration when it is formally adopted and to alleviate initial fears or disagreements about the value of integration. If unaddressed and unresolved, these issues could undermine the effort and detract from a comfortable transition over to an integrated approach. It is best to openly discuss and address these concerns, drawing from the experiences of others who have made a transition. This can help everyone feel that the move to an integrated approach is worth trying and will ultimately produce the expected benefits for children.
- 2) Recruiting the "models" who will participate in the program and establishing administrative policy regarding their recruitment, enrollment, and tuition payment is important. It is not unusual for programs to charge tuition fees from the "models" since funding for handicapped children does not typically include free services to nonhandicapped individuals. Tuition fees, which need to be competitive with local preschool/day care tuitions, can then be used to hire additional paraprofessional staff, materials, etc. Initial recruitment may take more effort until the idea of "integrated preschool programs" becomes accepted in the community and until the program establishes its reputation for quality integrated services. Partial day care for children of staff members or for others working in the same vicinity is a good means for attracting applicants. Newspaper articles and ads, contacts with local preschools, posters, and direct

contacts with potential applicants are all effective strategies for obtaining nonhandicapped models.

- 3) Preparing the staff for operating an integrated program and providing staff time to plan what changes in child management, instruction methods, and curriculum will be important for the transition. Effective teaching of integrated groups of handicapped and nonhandicapped children in the same classroom does mean some change in how staff plan and implement curriculum. The move to an integrated program does not mean that teachers can accept a few nonhandicapped peer models in their classroom and continue teaching and managing children as they always have done. Achievement of the goals underlying the integrated preschool is dependent upon the occurrence of actual instructional/social integration of children in the classroom. Classroom procedures must facilitate physical proximity between the two groups if peer modeling is to occur. There must be opportunities for the handicapped and nonhandicapped children to interact in play and in structured learning activities. Since teachers have so often clustered children by ability level for instructional purposes, they are easily tempted to simply regroup children in ways that recreate segregation. But if this occurs, the very purposes for integrating the children will be thwarted. Effective integration requires teachers/therapeutic staff to work with children, plan and deliver curriculum, and to encourage social interactions that capitalize upon the modeling-imitation potentials between handicapped and nonhandicapped class members. These events do not occur automatically, however. Staff need to be prepared to anticipate these needs and help to carry them out successfully, especially in the initial stages of integration. It is a new experience for everyone that clearly requires the learning of new teaching and instructional skills.
- 4) Helping staff work through and manage the curricular and instructional adaptations needed to adequately serve an integrated group of children. The inclusion of nonhandicapped peer models in an EC-SPED intervention program does present several realities that affect staff. If the classroom already includes children with a wide variety of disabilities and special need, the enrollment of nonhandicapped children increases this diversity even more. It also increases the complexity of program operations for several reasons. First, the diversity of persons involved is increased including their reasons for participation and what they want each child to get out of their enrollment in the program. Second, the necessity for individualized curriculum and teaching methodologies is increased. Thus the need for formalized systems of planning, program implementation, and coordination become more important. Third, the necessity for staff to apply teaching strategies that are applicable to both groups of children is added including the need for more varied instructional materials, toys, and equipment in the classroom. Finally, it becomes even more important for staff to keep track of how children are learning by using some form of systematic record keeping/data system to help them make informed decisions about children's learning needs and progress. These tasks may be viewed as positive, exciting avenues for staff teamwork, change, and innovative planning that will benefit all children and staff. In the end, successful integration of

handicapped and nonhandicapped children into a single classroom depends, in part, upon how well staff plan for and address these tasks.

Potential Problems/Issues in the Implementation of Reverse Mainstreaming

Implementation of any new approach brings questions about how it will work. Issues arise that require additional planning or changes in the approach as implemented or adaptations in the way staff go about working with and teaching children. From the author's experience in working with integrated programs and in helping programs transition into an integrated approach, there are five issues or problems that oftentimes emerge when programs adopt an integrated program approach. The point is, these are issues that need to be addressed for their resolution is essential if an integrated program is to be operated effectively. These issues include:

- 1) Parental fears about "those other kids" whether it be parents of handicapped children worrying about what those normally developing children will be like and how they will affect the classroom, or parents of the nonhandicapped children wondering about what the handicapped children will be like and how they will affect their child's education;
- 2) Staff biases about "those other kids" (the nonhandicapped peer models) and how they will affect the delivery of special education services to the handicapped children;
- 3) Conflicts in staff or parent expectations regarding what the needs are of the handicapped children versus the needs of the nonhandicapped peer models;
- 4) Staff re-segregation of handicapped children from the nonhandicapped peers in the actual classroom through their teaching, grouping, and child management procedures;
- 5) Lack of enthusiasm and support for integration and perceived "inconveniences" of this unfamiliar approach by administrators.

While it is not possible to address all of the issues above in this paper, the first two items warrant special attention.

Parental Fears About "Those Other Kids"

Parents of handicapped children may be concerned about the effects of the nonhandicapped children upon their children. Likewise, parents of the nonhandicapped children may be uncertain about how the presence of handicapped children in their child's preschool classroom will affect their child and the special education he/she needs. Both groups of parents share similar concerns: whether the presence of "those other kids" will detract from the attention given their child and from the quality of education their child might receive. Both sets of parents are concerned that their child be around peers who have a positive influence upon their child's behavior and development. Both groups of parents are uncertain about how the presence of "those other kids" will alter the preschool classroom and how staff teach

and interact with the children. Dealing with these questions openly and forthrightly when an integrated program is being considered and when the transition is being made, or at the time concerns are voiced will alleviate later problems. If parents are left with feelings of concern or uncertainty and if actions are not taken to help parents feel comfortable with each other and to see children and staff interacting with one another in positive ways, this can greatly undermine the feelings of everyone about the approach before it is given a chance to operate successfully. If it is handled well, such concerns do not typically continue and once parents see the positive benefits that can come from integrated programs. It has been the author's experience that parents typically become enthusiastic advocates for integrated programs once they have participated.

Staff Biases About "Those Other Kids"

No doubt, the integration of nonhandicapped peer models into a classroom typically designed only for handicapped children is a new idea and a different arrangement than most teachers or therapists have ever experienced. Expectedly, staff will be uncertain about their ability to operate and to teach successfully in a room that includes children with such a range of ability. Given the newness of the reverse mainstreaming concept, every teacher will not necessarily jump at the opportunity to try this new approach. Teachers who have always taught in special education classrooms, like parents, typically wonder how an integrated classroom will affect their teaching. They are typically uncertain how this new approach will affect the individualization of learning activities when such able children along with others who require so much more assistance. Given our traditional approaches in education to group children by ability level or to cluster those with similar types of disabilities, some teachers greet the idea of integration with a "no way" point of view. They may argue that it is just too difficult, too cumbersome, and will surely detract from the special education they are trying to provide for the special preschoolers. An attitude of "let's try this" is important if staff are to work through the changes and adaptations needed in the classroom when handicapped and nonhandicapped children are integrated. Administrators need to assume this same attitude. If staff can be helped to approach the task with an open attitude, they will be much more likely to greet the transition to an integrated program as a challenge and a new teaching adventure. Many a staff who have embarked on this adventure have answered their own concerns and questions and, when given the choice later to continue or not continue and integrated program, have unanimously advocated for its continuation. But staff who are coerced into an integrated approach, and who resent the presence of nonhandicapped models from the beginning, can only communicate this attitude through their dealings with children in the classroom. No program, whatever the approach used, will work when staff are not committed to its implementation. If staff biases are too strong, these may need to soften before reverse mainstreaming should be tried.

In summary, reverse mainstreaming does offer a viable alternative to the issue of least restrictive environment for preschoolers with handicaps who need intensive special education and therapy. Integrated programs offer benefits to both handicapped children and their nonhandicapped peers including both the social benefits of letting these children play and work together, learn acceptance, and enjoy the instructional benefits that can come from skilled teachers and highly individualized programs.

Consider this: if you were the parent and you felt the urgent need for your child to have the special training/intervention he/she needs, yet you faced the option of receiving this service in an integrated or segregated program setting what option would you select?

Creating a Vision and Making It Work

Linda Brown, Madison, Wisconsin

Linda Brown is the mother of two children: Adam, 11 and Aaron, 7. Aaron has been multiply disabled since birth. Aaron is currently being served in an integrated elementary setting and has benefitted from several integrated placements throughout his educational career. Ms. Brown has been active in advocating for her child and for other individuals with disabilities. She has spoken on behalf of integrated education and family support issues at numerous local and state-wide events.

Much has been written about visions. The visions some people have are a bit frightening and can make those listening roll their eyes and mutter about the visionary's grip on reality. But I want you all to put aside those thoughts and imagine, or envision, a totally integrated society. This society would have everyone, regardless of ability, naturally included in all areas. No, don't sit and stop yourself from imagining. Don't say, "How?" or "We can't afford this!" or "Our policy isn't conducive." Just think hard about a totally integrated society. Add detail after detail until this vision looks real in your imagination. When doubts arise, add a specific detail to make it more real. This, then, becomes a driving force which makes that vision a reality. This is what I used in the face of impossible odds regarding the integration of my son Aaron into kindergarten. It worked for me. I hope you can make your visions into reality, too.

My husband Ben and I live in Madison, Wisconsin with our children Adam, 11, and Aaron, 8. I'm opening a window into our family so you can understand why it is critical to look at the whole family. The experiences thrust upon me ever since my son Aaron was born have changed me drastically. So often I've been dragged through them mentally kicking and screaming, "No, No, Not again! Not me! I can't stand this!" But, like it or not, my life most certainly will remain anything but dull because of the birth of my second child, Aaron Stephen Brown. Often I find myself lulled into a false sense of normalcy and think our family is like everyone else's - until I tell someone who asks what's entailed in getting up and going or what's involved with getting ready for bed. Or how about an illness? No, the Browns are marching to the beat of a different drummer. Mostly I listen and smile when others talk about their families - or ask a couple pertinent questions. I used to envy what seemed so normal but now it seems that normal is in the eye of the beholder. It just isn't worth worrying about someone else's life. I know people don't envy me. And, so, occasionally I allow a wistful sigh to escape my lips with a whisper of, "I wonder what it would be like if..." and then I shake my head and say, "Nah. Don't even think about it."

I have dreams to be sure. It took me awhile to get them back but I have them. And they are tempered with a strong sense of reality. They are ambitious, too. And they are driven by my vision that we are all citizens of the world and every one has the right to participate in his or her neighborhood, community, city, state or nation, regardless of his level of ability, to his/her fullest potential. No one, unless they're a criminal, should have to earn his way into a less restrictive environment. It is our obligation as a society to figure out ways to make this happen and not give excuses as to why it can't.

I didn't use to feel this way. In fact, I rarely even considered the possibility of integration vs. segregation. Of course, in the civil rights movement I was vigorous in stating that all people, regardless of color, should participate in every aspect of our society, but it never struck me that the issue was broader than race alone. I just never thought of people with disabilities, let alone what rights they weren't receiving. I rarely saw a person with disabilities, especially a child, in my daily societal activities. And then, Aaron was born.

Aaron will be eight in January. Aaron attends our neighborhood elementary school. He's in a regular first grade class with supports from an OT, PT, speech, nursing, specialists for the hearing impaired, teacher of the physically handicapped, special transportation and consultation from an expert in the visually impaired. The school he attends is inaccessible and he is transported from floor to floor by a machine called a Stair Trac. This year is incredible in its swings from very positive to down in the dumps. It's been full of challenges, and I'm sure will continue to be so. I'd like to come back to this year later. First I'll give a little history of our involvement with programming for Aaron over the past seven years so you can get an idea where I'm coming from. So, if you'll go back in time with me, I'll show a little of our family's story so you can see how my vision for Aaron evolved over the years. I'm not ungrateful for what we had or have but feel it has to change to truly meet children's and their families' needs. Perhaps you know or will know families like ours as technology enables more children like Aaron to survive and grow up in our communities.

Aaron arrived in January of 1981, January 11th to be exact. He was due on April 16th. We certainly weren't prepared for an emergency Caesarian section so early in my pregnancy but due to a possible infection after premature rupture of my membranes, an emergency C-section was the order of the day—actually it was 3 a.m. On the medical summary I read it described Aaron's condition as limp and blue. Heart massage was done, 100% oxygen was given and my tiny frail son was intubated and whisked off to the Intensive Care Unit. Apgar scores were 1 and 2.

I had never dreamed that there was another nursery that existed alongside those regular ones with orderly rows of tiny beds sporting their pink or blue blankets and serene nurses moving slowly about, doing regular baby-type chores. This wasn't where Aaron went. Aaron's nursery was glaring with bright lights. Machines whistled and beeped. Monitors read out graphs and numbers. Nurses and doctors moved feverishly, lips pursed and frowns lingering all over their faces. And there was Aaron in the middle of a table-like bed with lamps over it, covered by wires and tubes, supported by a ventilator, looking brown, tiny-at 2 lbs.. 3 oz., and totally unlike any baby I'd ever seen. My first words when I saw him were, "He's dead. You're lying about his being alive. Get me out of here." It was a heck of a way to start a relationship. Thank goodness it improved.

The only way to understand and cope with the constant emotional upheaval was to get savvy about his medical procedures. These were Aaron's reality and how progress was measured. And so, we got savvy just to try to make sense of our new life. Looking back I'm so glad I had a chance to be crazy and young and carefree before Aaron's birth. I'm so fortunate that I tried to do some interesting and daring things before we became parents and I'm especially happy I relished every moment of my son Adam's

infancy and immersed myself in his childhood until he was 3 1/2 years old. Because once Aaron came into our lives and his needs were not only great but monumental, our lives would have very little resemblance to anything it had been before. We had to do a lot of changing and when I think how young some parents are in similar situations I wonder how they can cope.

In any event, after over 3 months in the hospital, Aaron come home. He was on no machines, he was breast feeding, he weighed 4 lbs. 7 oz.. and the hospital staff said he was acting like "a typical preemie." And we thought that meant he was A-Ok. Somehow a miracle had occurred. He was fine. We could be a regular family again.

We were so very wrong in our assumptions.

Aaron grew and thrived at home. He seemed happy about all that was going on around him. But, two things became clear right away—he threw up a lot and we noticed he was developing an unusual startle response at around six months of age. That startle can be described like this: once he began to react to something he kept on reacting and couldn't "rein himself back in" without physical help. At first I thought it might be a seizure but he didn't seem to lose focus or appear blank so I didn't know what was happening. Both these issues were brought up time and time again at the millions of hours spent in various clinics—at least it seemed like millions. The medical professionals said he'd outgrow the vomiting and they said little at first about the startle but finally said we should make an appointment in the neurology clinic. One physician also recommended we get Aaron's hearing checked because he was at risk for being hearing impaired due to severe jaundice and various drugs used to keep his lungs open.

And so, at eight months Aaron was tested and diagnosed as having a severe to profound bilateral sensori-neural hearing loss. It wasn't what I wanted to hear but I don't remember feeling overly anxious about it. Being the chatter box I was, and still am, I knew I'd keep on yakking regardless.

Less than a month later I was alone with Aaron in the neurology clinic. My husband was out of town and Adam was at a baby-sitter. Aaron and I had waited 1 1/2 hours to be seen and finally went into a room where a resident examined Aaron for ten minutes and, while I stood holding him in the middle of the room, said this, "Well, Mrs. Brown, this is what I see. He's spastic quadriplegia cerebral palsy. He'll never walk, never talk and probably is severely retarded." As the words sank in the world around me began closing inward and I felt as if I were numb and tingling. I couldn't talk. I couldn't think. I didn't know what to do, so I stood and cried. Whereupon he patted my shoulder and said, "Oh, I'm sorry Mrs. Brown. I thought you expected this. I'll get another doctor to confirm the diagnosis." And he left us standing in the middle of a room that seemed both large and small and suddenly extremely nauseating.

How I got home that day, I don't know. And even though I wasn't totally sure of what all those words meant, I knew it was horrible and I dreaded seeing how Aaron would be when he grew up. "Will he drool all the time?", I'd ask Ben. "Will he grimace and look so gross that people will always stare?" I was sure I'd never be able to handle the horrified looks on people's faces—or the buckets of pity.

What will become of us, I'd often cry. But, the most vehement cries from my lips were, "Why me? I can't do this." I hated Aaron for surviving. I hated him for letting us down by being disabled. And, I didn't have any idea of where to turn for comfort.

And this was my state when we called Madison Metropolitan School District to attempt getting Early Intervention Services. It wasn't my idea, it was Ben's because of his Special Ed background. He said the programs were designed to help kids like Aaron get a head start on skills and that Madison had good programs. I could have cared less. I was too numb and scared and bitter to do anything but I didn't want to hold Aaron back (guilt feelings were running rampant) so I reluctantly went along with opening the door to the parade of professionals. Even though most people were kind and tried to be supportive I could see that they'd often get antsy when I'd try to talk about some of my feelings. And so often it seemed that each individual professional would focus on a piece of Aaron that was wrong or needed fixing so that he was lots of pieces that just wouldn't really come together to work in any way that was useful. I was going to doctor's appointments constantly, visiting clinics to get OT or PT or hearing aids or ear molds or I was driving to a school during specific 45 minute time slots to have Aaron have time with special teachers for the Hearing Impaired. And when I wasn't doing that—dragging Adam along, too (Funny, I don't remember much of his growth during this time) professionals with expertise in feeding, hearing, PT and OT were also coming to my house. And I just kept wondering how I'd ever be a mother to Aaron when I couldn't possibly maximize his potential to its greatest—there just weren't enough hours in the day. So the resentment grew toward Aaron and I became more angry and bitter. Because, you see, the equipment and gas for trips and special foods began to mount up in cost and we just couldn't seem to stretch our budget any further. Funding sources we were sent to were a bust because, "we made too much money." The message I got from this was, "It's all your fault and you just aren't managing your finances well enough." This just strengthened my feelings of inadequacy.

At about 15 or 16 months of age, Aaron's health began to slide. He missed lots of school. Vomiting was still a severe problem and it seemed to accelerate. Weight loss or no gain began to occur and Aaron looked wasted and tired a great deal of the time. I remember his sleeping through the night very rarely during the first two years of his life. The words "failure to thrive" began occurring on reports. My fault, again, I concluded. I can't even feed my own child!

After a month-long battle with a flu-like illness in November of 1982 (Aaron was almost 2 years old) I looked at Aaron and saw a hollow-eyed child who was listless and losing ground. I became frightened because I was certain all my resentment toward him was going to culminate in his death. And I suddenly realized that I hadn't given him a chance to be himself, no matter what that would be. I woke up and pledged I'd change and be a real mom. I demanded from physicians that they find out what was wrong with him. They hospitalized him and did a barium swallow which showed he had an esophageal reflex. Surgery was done and a gastrostomy tube was placed.

What these events did for me was to make me realize that physicians definitely didn't know everything. Saying to me that he'd outgrow vomiting for two years was

ridiculous. I began, ever so slowly to gain confidence in asserting what I knew. That was good—but the "new" Mom I became was ridiculous.

I threw myself into parenting and supporting Aaron's every need. I tried to carry through on everything every professional at school would say Aaron needed to maximize his potential. You see, even though I thought doctors didn't know, Aaron I still thought teachers knew best and it was my job to agree with them and leave goals up to them. So I always did. I signed papers without ever asking what an I-team or IEP was. They wrote goals, I signed off. I rejected offers for respite because, after all, no one could take care of Aaron as well as me.

And all the while, stress from lack of supports, breaks, and financial burdens were eating away at our family. I didn't know what to do or where to turn. We continued being rejected for financial help because of our middle-class income.

And then Aaron's health changed again. He began missing school extremely often again because a simple cold became a nightmare. Aaron's g-tube made him grow, yes, but a cold would come on, he wouldn't cough at all and fill up with secretions and lapse into unconsciousness during the night. I'd find him, couldn't awaken him, would call the ambulance and we'd rush to the hospital. Over the course of a year we repeated this procedure six or seven times. Two times Aaron was so bad I didn't think we'd make it to the hospital on time. Once an IV had to be started in his jugular vein because veins in all his extremities were shut down. I got so good at predicting that a bout of distress was coming on that I'd take Aaron to the clinic before it did and say that he was getting sick and was going to be in the hospital very soon unless they could do something to prevent it. They never did, citing that clinically there was no reason to hospitalize him. You see, HMOs were coming into vogue and unnecessary hospitalizations were frowned upon. In any event, during this year of respiratory problems, I tried to go back to work because our family just couldn't make ends meet. But it was a disaster with Aaron getting sick at day care and school and having to go into the hospital. I quit my job after 1 1/2 months because I couldn't stand to leave him in the hospital crying and afraid and wondering how he'd gotten there. I didn't know how we'd do it, but we had to figure out another way. The doctors finally decided, after a year, to remove Aaron's adenoids and then a week later to do a tracheotomy. My pediatrician was against it but pulmonary docs and the head doctor of the ICU felt they had no choice or we'd continue the same routine we'd had over the last year. I felt so desperate I was ready to try ANYTHING but I had no idea how I'd react when I saw the tiny white tube protruding from Aaron's neck. In spite of the fact that Aaron took to his new open airway very well, I saw it as a frightening and disgusting addition to him. In fact, I felt certain he would have to go into an institution because I would never feel comfortable with suctioning, sterile procedures and the ton of equipment which accompanied the tracheotomy. But, try as I might, I just couldn't do it, and dug down into my reserves deeper saying I'd figure out something. Aaron was three years old and our family felt as if it had already lived a lifetime.

And, finally, help came. During the 1 1/2 months of my attempt at working, I had met the director of a new pilot program, The Family Support Program. I had continued on her advisory board even after resigning because she asked me and I thought the Program sounded WONDERFUL.

One day she called me right after Aaron got his trach and asked me how I was and how I was doing. "Oh, I'm fine, Anne," I replied. "I'm learning all about Aaron's trach changes and suctioning. It's still a little nerve-wracking but everything's fine. I'll have it under my belt in no time."

"Stop it, Linda!" Anne's voice almost shouted. "Your life's not normal. There's nothing very normal about it at all. Stop trying to pretend everything is fine. You need help!"

"Yes, I do!" I shouted back. "But where do I get it? What do I need? Heavens! No one will help so I have to do it all. We make too much money."

"I want you to come into the Family Support Program, Linda," Anne said. "I want you to start asking for help."

But I argued that other families needed it more than we did. Anne wouldn't take no for an answer, so I finally agreed to begin letting others help our family, and I agreed not to say, "That's okay, I'll do it," until I really thought it over.

This program was our family's life saver. We hadn't seen how consumed by daily living we had become. We had been pushed around by the service delivery system. Finally, someone was saying, "What do you need to help. Daily life for your family is full of stress. Let us help you deal with it. You know best what you need."

Our first big request was competent, caring child care so we could be at ease and go out once in a while. It felt so good to begin living our lives again and enjoy each other. We looked back and saw how stressed we had been before Family Support. It was frightening, but we were very grateful to be moving forward again.

After Aaron got his trach our school district was fearful to leave him in class without my being close so, even though he attended school only occasionally, I took him to school and stayed there, too. I still felt that educationally the special educators knew what Aaron needed better than I. Almost every other area of our lives I was saying, "I knew best," but not in education. And then I attended a TASH (the Association for the Severely Handicapped) conference in Boston in December of 1984 to talk about WISCONSIN'S FAMILY SUPPORT and I happened to walk in on a room packed with people listening to a woman named Marsha Forest.

The workshop being held was one on integrated education. I had never heard of such a thing and Marsha quickly dispelled the notion that it was the same as "mainstreaming," a word I had heard. I sat listening, not having any notion that Aaron wasn't getting the proper education. But, suddenly, I realized that it definitely was a segregated education, disguised, but certainly segregated in a self-contained early childhood room.

As I listened I became more intrigued and more upset that Aaron was being segregated and that I hadn't noticed! I watched slides that Marsha showed of a young woman in a special ed classroom who was hanging down off a chair and whose eyes were dull, mouth slack and who slumped around everywhere. "She wasn't the same

as Aaron," my mind tried to rationalize. "She can walk and talk for starters." Her parents were upset with her education. She had no friends. She spent the whole weekend at home alone. Her skills at socialization were nil. Her parents asked for some changes to help at school, but they were denied. So, they asked a private school if she could come there. The private school said yes. and she began at a new, Catholic school as a young woman who needed a little extra help, not as a disabled or handicapped young woman.

When I saw the slides of her at her new school, I almost fell off the chair. One had to stare hard to see which person in the picture was her! By now I found myself very upset with segregation but I feebly raised my hand to ask one more question, "What about kids with high medical needs? Certainly they can't be integrated, can they?"

Marsha's quick reply was, "What about them? Medical needs are a part of them. That shouldn't prevent integration."

That was it. I knew she was right. I knew Aaron had been denied being around typical children. I knew he just had to have a try at regular education with typical children. And, most of all, I knew that before this day I had been placing limits on how far he could go. My vision for integration was planted and it began to grow right then.

It's one thing to be suddenly struck with a vision that is burned indelibly into your brain—that you don't want your son to spend school in Special Education, but supported in Regular Education. It's another thing to realize what a monumental job it will be to accomplish that vision.

But, I was determined to try. The more I thought about it, the stronger my desire became. And suddenly I realized I had no idea what an IEP, an M-team or any of the other jargon from Early Childhood Programs meant. I felt I had been asleep for almost 4 years! At this time Aaron was with some good teachers with whom I had a good working relationship so I began dropping bits and pieces of information on them regarding my new thoughts. They would look askance at times but supported me pretty well. This gave me confidence that our district would welcome this idea with open arms—Aaron would be in a regular kindergarten because it was the right place for all 5-year olds

Did I ever have a rude awakening when I broached the subject with administrators! Still, not wanting to appear unreasonable, I decided to allow what they felt best figuring that Aaron would prove he belonged in kindergarten and we would get there anyway.

Without going into lot of details, it was a disaster when Aaron went to a new school at age five to be with all new teachers. He was held in Early Childhood again so "information could be gathered." We were so distressed by Aaron's depressed state by Thanksgiving that we withdrew him from school and really caused a big furor. Suddenly the reasonable Browns became totally unrealistic and unreasonable. Even though we argued that this placement wasn't in Aaron's best interest, our rash move of withdrawing him caused hard feelings and no one wanted to deal with us at all. It was a time I soul-searched. "What did I think I was doing?" or had I had been totally crazy,

but I kept coming up with, "No." I also studied the law, read articles and was determined I'd be an equal partner in the process to get Aaron an appropriate placement—a kindergarten class. I'd be forceful even if it made enemies. Why not? I had already made plenty by now.

So, we started the process again. In a nutshell the result of a new M-team and IEP was not full-time in a regular kindergarten. Placement was to be part-time EMR (without an MR label and part-time kindergarten. No one would budge. It was August of 1987 and we knew Aaron was going to have to be in a private kindergarten or receive home instruction. We just couldn't accept the placement offered. There was only one tiny ray of hope and I decided to go for it.

During the year we had removed Aaron from school, a friend of mine had told me about sharing my desire for kindergarten for Aaron with a kindergarten teacher in our neighborhood school. The teacher's response had been, "Well, I think both Aaron and his parents should at least have a chance before people say no." When I heard this, something told me to tuck it away in a spot in my mind that I could get to easily. So, I called my friend now to find out if the teacher had really meant it. The teacher just happened to be visiting, so I asked her directly. She said she would be willing to try having Aaron in class, but I'd have to talk to the principal.

My neighbors had told me how open and caring the new principal was. Some of my neighbors also suggested I talk to him about Aaron's going to school in our neighborhood school. A few were ready to sign a petition stating their children should have an opportunity to attend school with Aaron because he lived in our neighborhood. So, since there was no other option except a private placement, I went down to our school, about four blocks away, and walked in to see Dr. Kailin on a warm August day, one-and-a-half weeks before school was to start. With me I had the proposed schedule for Aaron's day from the placement offered as a result of our recent IEP.

I decided that directness was best, so I introduced myself to Dr. Kailin and told him I would like to discuss my son's coming to our neighborhood school. I told him I knew that a kindergarten teacher would be willing to take Aaron in her class and that some of my neighbors really supported his coming there. But, besides all that, I told him that Aaron was a little boy first and that I felt that the offer from Special Education divided him up into too many pieces.

"I'm not saying that he doesn't need help to get places or do things," I told him, "but he's a little boy first and, therefore, a kindergartener first."

Dr. Kailin looked at Aaron's proposed schedule and said, "But this school isn't accessible for Aaron's wheelchair."

"I know," I said. "I've thought about that and, if there's no law against it, I'll carry him in, put him in his wheelchair, and carry him to all his specials. In fact, I'd be his aide for free, Dr. Kailin. I would do whatever anyone needed to help him participate."

Dr. Kailin looked at me long and hard. I didn't blink. "Why should you do that?" he finally asked.

"Because I know an aide would cost money," I said, "and I don't want that to be the reason he can't be in regular kindergarten. It's that important to me, and him, too."

Dr. Kailin said he'd call and talk with appropriate administrators downtown and get back to me. I told him to feel free to stop by and meet Aaron any time. And he did come two days later to see who was at the center of all this hub-bub. In fact, he asked to hold Aaron and had a heart-to-heart chat with him about how great he was.

The result: somehow, Dr. Kailin and another supportive administrator got other people at our central office to agree to allow Aaron to attend our neighborhood school. And, they agreed to provide an aide for him. Dr. Kailin and I interviewed the applicants!

Aaron started in a regular kindergarten on the first day with everyone else. Even though I was told that this was to be a one-year placement only, I was already thinking about how to get Aaron into first grade.

The stipulations were that we had to 1) give up all supports, and 2) provide transportation. Later, when the kindergarten teacher wanted additional help, we started the M-team process all over again to get the necessary supports.

And, now, Aaron is in first grade.

It seems so right having Aaron at school down the street within walking distance. It seems so right seeing kids he goes to school with in the neighborhood and having them wave. It seems so natural seeing the kids at Emerson crowding around him at recess or lunch, saying "Hi" or pushing Aaron's wheelchair. They're great helpers. It seems so right being a volunteer tutor at Aaron's school, being an active participant in his schooling, finally having a voice and pushing for what I think is best and winning people over, little by little. Because, it's an issue of quality education for all children, really.

Why do I want Aaron to be in regular education? Because he'll know how to be in the world with people, not apart from it. Aaron will not walk or talk because he's around typical kids but he's learning to take risks and try some physical tasks he's never done before. Perhaps he'd have gotten there anyway, but I don't think it would have been at the rate he's done so. So often I find in special ed you have to prove you know A before going to B. To me the most important thing Aaron can learn is to be a participating and valued member of society. If ABC's and adding can be achieved too, it's icing on the cake. To see the delight he gets out of various activities he has never done before is truly inspiring. The difficult task is measuring what he's getting and it may be years before that can be done. We have to take some leaps of faith in many areas.

Another challenge is how to provide supports so as not to overwhelm the regular ed teacher. Everyone always wants to have a meeting and she just can't. This is a

learning process but I can see supports needing to be streamlined so that the teacher and Aaron won't feel bombarded.

I'm not suggesting that special education is bad for kids—on the contrary, with creative approaches and appropriate intervention children with challenging needs can often go beyond predictions about what is expected. Supports are essential but where these supports are provided is also paramount. Natural settings provide situations that cannot be contrived and skills acquired there make more sense in the context of life. How to create a model is a puzzlement for in truly recognizing each child as individual a model to be duplicated is made more difficult. Still, all I can say is go watch an integrated situation. See what's happening. Then commit to it.

This year has been more up and down than kindergarten. Trying to provide supports in a supportive, non-intrusive way is a challenge. Many, many times it has been disruptive to the regular classroom and the "experts" had driven a wedge between Aaron and the regular ed teacher because they, supposedly, knew more about special kids.

One day the teacher's son was in the classroom for the afternoon and got to observe what was happening with Aaron regarding "the regular curriculum." There were no "experts" there that afternoon. Aaron's aide was on a break and Aaron was allowed to be in a regular math group. After school, the teacher's son exclaimed "Oh, Mom, Aaron really liked math today."

"He did?" she questioned.

"Oh yes," he promptly replied. "Whenever you wrote on the board he got really excited. I know he's getting a lot in your class." As she related this story to me, she said that no one had ever told her anything like that. Since then, they have had a much richer and reciprocal relationship. The process involved in integration is full of such examples.

If I had to go back to starting Aaron's early programming now, knowing what I know, I would definitely do many things differently. But, I'm so grateful to have seen that vision which led me to where I am and led me to fight for what Aaron has today. There are new challenges every day to try to achieve an integrated quality education. But I believe the rewards will be worth the risks and bruises we get to help Aaron and other challenged children become participating citizens of our world.

DISCUSSION SESSION: DEFINING THE LEAST RESTRICTIVE ENVIRONMENT FOR THE 0-5 POPULATION

Discussion Leader: Barbara Smith, Private Consultant, Pittsburgh, Pennsylvania

Barbara Smith, Ph.D. has concentrated in the study of special education public policy for a number of years. She worked for 6 years in the Council for Exceptional Children Office of Governmental Relations where she dealt with the development of state and federal special education policies. Dr. Smith was very involved in the development of P.L. 99-457. She is now a private consultant working with states on the implementation of P.L. 99-457. Dr. Smith is the recent recipient of the Merle B. Karnes Outstanding Service Award from the Division for Early Childhood of the International Council for Exceptional Children.

In order to develop a definition of LRE for services for preschool handicapped, it is important to understand the background of the term--"Least Restrictive Environment"--and to study existing definitions.

Background and Existing Definitions:

- 1) Legal basis for term: the concept of "least restrictive alternative" is a legal concept related to when the government takes a citizen's rights away, or restricts his/her freedom, it must be done by the least restrictive alternative method. This concept began to be used in education in court cases requiring that handicapped children be educated in the least restrictive environment if they had to receive special education services out of the regular education mainstream. This concept in turn was embodied in P.L. 94-142;
- 2) P.L. 94-142 contains the requirement that handicapped children, "to the maximum extent appropriate," are educated with children who are not handicapped. Any placement other than with non-handicapped children must be made on an individual basis and is based on the IEP. Each public agency must have in place a continuum of alternative placements and children must be served in the least restrictive environment.
- 3) P.L. 99-457, Sec. 619: proposed regulations state that the LRE provision of P.L. 94-142 pertains to preschool aged children (3-5); however, that schools do not have to initiate programs for non-handicapped children to meet this requirement.
- 4) Each state probably has a definition of LRE, at least as it applies to the 6-18 year old population.

All definitions need to be studied, as well as opinion papers from the field such as the Division for Early Childhood's Policy recommendations. This study will reveal: a) whether there is a need to create a new definition as opposed to adopting an existing one; and, b) will identify the components of existing definitions that may not be appropriate to the 3-5 year old population.

LRE Issues Related to a Definition for Preschoolers

- 1) Whether the definition will be for 3-5 year -olds, 3-21, or b-2, b-5, etc.
- 2) Whether the definition will attempt to define LRE for all children or rather will define a decision-making process that will account for individual needs (e.g., who, what, when, how, etc.).
- 3) Will the definition list alternative placements? How will they be funded? Administered? Monitored?
- 4) Will the definition require an accounting of why and how each individual placement decision was made?
- 5) Will LRE decisions for preschoolers address all areas of development including social? Also the needs of the family?
- 6) How will existing definitions and terms be dealt with, e.g., P.L. 94-142: "regular educational environment," "removal from...", "classrooms," "placement in," vs. "environmental," "home/community," "preschools, day care, home," "supporting in natural environments," etc.

Each states' definition should be derived by people from that state and should meet that state's needs and have considerable input from the public.

Discussion Session: Funding Integrated Options

Discussion Leader: Dennis Sykes, Great Lakes Area Regional Resource Center

Dennis Sykes, M.Ed. is currently a program assistance specialist for the Great Lakes Area Regional Resource Center located in the Center for Special Needs Populations at the Ohio State University. He serves as the early childhood specialist for the RRC as well as the liaison for the state of Indiana. Prior to taking this position in the spring of 1988, he served as coordinator of the Great Lakes Resource Access Project at the University of Illinois where he worked with the Head Start programs and state education agencies of the 6 states of federal region V. He also served as President of the Illinois Division for Early Childhood during 1987-88.

There are a number of issues facing state planners regarding the provision of the least restrictive environment (LRE) in programs for children with disabilities ages birth through five. The key issue resides in the fact that, with the exception of the federal Head Start program, there are few public programs for non-disabled children of this age which might serve as integrated environments. While this is changing in some states, it is still largely true that non-disabled children, birth through five, spend their days in a variety of private settings which may include center-based child care, home-based child care, nursery schools, a variety of recreational and enrichment programs and, of course, their own homes and neighborhoods.

If states are serious about including the possibility for integration and normalization in the programs which they provide to young children with disabilities, then the various private placements mentioned above will have to be utilized as that is where the non-disabled children of this age may be found. Many issues arise when this option is considered. Not the least among these issues is how such placements might be realistically funded.

Services provided to 3-5 year olds under P.L. 94-142 are defined as a "free, appropriate public education." It would not be permissible to assess a fee to parents in order to provide a private placement for the sake of LRE. Nor would it be permissible to utilize federal funds under P.L. 94-142 to underwrite the private placement fee as these funds would not be purchasing a "special education or related service" as defined by the law. Are states then caught in an irreconcilable "catch 22?"

Participants in the December 8th discussion identified several possible strategies that might be utilized to address this situation. These are offered in no particular order of priority.

- 1) Utilize a "reverse mainstreaming" strategy. That is, open special education early childhood programs to non-disabled peers on a tuition basis. In this manner, a "free, appropriate public education" is provided to eligible handicapped children while parents of typically developing children support the costs for inclusion of their children in the program
- 2) Utilize other sources for funding of private placement tuition costs. State funds may be utilized for this purpose if the appropriate language is found in statute and regulation. Funding from other state agencies other than education (Health, Mental Retardation, Mental Health, Human Services, etc.) might also

be utilized. Finally, local philanthropic and other private sector organizations might also be utilized as a source of funding for these placements.

- 3) Fund only that portion of the private tuition which underwrites the time necessary to implement the IEP/IFSP. This would be determined through the IEP/IFSP process. Either the parents or other funding sources would then be responsible for underwriting the cost of additional time in the program should that be a need for the parents unrelated to special education.
- 4) Allow special education staff to be used in a number of different ways. State rules and regulations are often restrictive in their definition of "special education and related services." In order for integrated settings to work for the birth through five population, state rules and regulations must allow for the possibility of reimbursing local education agencies (LEA) for the provision of out-of-classroom, itinerant services. Reimbursement formulas should be constructed in such a way that they do not provide a disincentive for the use of integrated placements.

Participants agreed that there were considerable obstacles to funding integrated service options for young children with disabilities. However, the consensus seemed to be that these obstacles could be overcome if the will to do so was present at all levels. Developing this "will" is the most difficult challenge.

Planning Integrated Programming on a State-Wide Basis

JoAnn Woodley, Arizona Department of Education
Heidi Gray, New Horizons, Lake Havasu City, Arizona

JoAnn Woodley, Ed.D. is currently the preschool coordinator for the Arizona Department of Education, Division of Special Education. Prior to this, she was an assistant professor of early childhood education at Idaho State University. Her professional training has been in the fields of speech pathology, audiology, human development, and early childhood education.

Heidi Gray, M.S. has worked for the Lake Havasu (Arizona) Association for the Handicapped since 1982. Her current responsibilities include the development of mainstreamed programs for preschool children with disabilities. She is also a parent trainer for the outreach program of the Arizona School for the Deaf and Blind. She has been instrumental in the development of a hearing screening program for children 0-5 years of age. Her professional training has been in the areas of speech pathology and audiology.

The purpose of the presentation was to share information regarding Arizona's efforts to provide educational intervention and habilitation for preschool children with special needs.

Discussion focused on the benefits and potential barriers to the provision of integrated preschool from the perspective of the State Department of Education, local school districts, community and state agencies, early intervention specialists, and families and children with special needs.

Successful integration depends on the philosophy and attitudes promulgated by not only the SEA but the LEA, the community in which each program resides and the specific professionals involved. It is somewhat related to values in that it depends on more than legislation.

Educational strategies are, simply stated, the myriad of options and alternatives used to implement a Least Restrictive Environment. Those strategies may include such models as segregated preschools within the local school district, Head Start Programs, high school or Junior College child development preschools, community-based preschools, or other settings where three- and four-year-old children typically spend their days.

Strengths and potential barriers of each option must be considered for each child and family. While one setting may be considered a strength for the family by professionals, the family could view that setting as holding potential barriers to service delivery for their child. When considering a setting for any family or child, one must ask for whom that setting is a strength and for whom it is a barrier.

ISSUES:

Rural versus Urban - Community-based preschool programs may be the most appropriate program in rural areas where there is a small number of children requiring special services.

Community Consideration - Some communities have religious beliefs that dictate the type of preschool or special education services that will be successful. One community may be cohesive and nurturing within itself while another may be independent and self-reliant.

Integrated Therapies - Within atypical and seemingly strange settings the delivery of speech/language, occupational, and physical therapy may need to begin to look different than the traditional "pull out" program. Appropriate therapy might be a version of integration in itself. Therapists working within the classroom on a variety of goals at more than one level is an approach that is being utilized with great success. Therapists may need additional training in order to feel comfortable working in such a climate.

Tuition - Who pays for children with special needs in community based preschools?

Preschool Licensure - Health Department Day Care Facilities licensure must be assured. Private School Status is also required for any facility that contracts with LEAs.

Noncategorical/Eligibility - Are all children regardless of the handicapping condition placed in segregated settings? Do we place even sensory impaired children and severely handicapped children in community-based preschools?

State/Federal Regulation - Are there some conflicting issues in implementing least restrictive programs and maintaining the integrity of state and federal rules, regulations, and statues?

Church Programs - Many community-based programs are held in church buildings. If the regulating board for the preschool differs from the church board, does that allow LEAs to place children without fear of an audit exception?

Multiple Funding - Who can pay for what and when and who counts the child on December 1? This relates to Head Starts and Native American programs more specifically than to others but could still be an issue between state agencies.

Logistics - Least restrictive environment often means the school closest to the child's home and that may very well not be the community-based preschool. Who buses and who pays for the busing.

Credentials - Head Start Programs and community-based programs do not have the same certification requirements for teachers, therapists, or evaluators as do the LEA

programs. How can this be solved and still use the professionals who are not credentialed but who are extremely wise about educating young children.

Developmentally Appropriate Programs/Curriculum - Because many states, Arizona included, have required Special Education Certification for professionals working in the preschool programs, the preschools look amazingly similar to primary grade special education programs which may not be appropriate for three and four year old children, especially those with special needs. It may be a matter of habilitation and not rehabilitation.

Confidentiality - What assurances can be made by the LEAs that confidentiality is maintained when files and records are the shared responsibility of a larger group over which the LEA has no real authority?

Monitoring/Evaluation - Monitoring and file review may present a problem or at least require a different approach than the usual ones. How is the integrity of the IEP maintained and implemented? Can we assure quality programs or do we lose control when the program is outside of the LEA? How are the programs evaluated? Can the NAEYC Self-Study/accreditation or something similar be used to assure that the programs in which we place very young children chosen to assure that the programs in which we place very young children are the best possible places for them to be?

Even when the above issues have been addressed and resolved along with the myriad of other not yet uncovered, successes in early intervention, regardless of the strategies chosen, depend upon early childhood professionals who are committed to and value the notion of Least Restrictive Environment for preschool children.

Integrated Models for the 0-2 Population: The Delaware Experience

Deborah A. Ziegler, Ed.D., Director, Delaware Early Childhood Diagnostic Center

Deborah A. Ziegler, Ed.D. is currently the Director of the Delaware Early Childhood Diagnostic and Intervention Center. She has served as the supervisor of the Part H and 619 programs for the Delaware Department of Education for the last 1 and 1/2 years. She is currently the Governmental Relations Chairperson for the Division for Early Childhood of the International Council for Exceptional Children.

The state of Delaware is just beginning the process of systematically utilizing integrated placements to serve the early intervention needs of children with disabilities aged 0-2. Many issues have been identified and not all of the answers have been discovered. The past two and one half years have been an exciting time within the state.

There are two Delaware projects currently in place which support the use of typical child care settings for infants and toddlers with special needs. The projects are entitled "Delaware First," a family day care model; and Del Care, a center-based model. The projects will be described below and a series of issues relating to these projects will be then be addressed.

The "Delaware First" Project is in its third year of operation as a federally funded, Handicapped Children's Early Education Project (HCEEP). The project trains family day care (FDC) providers to integrate infants and toddlers with special needs into their homes. The state of Delaware licenses FDC providers and stipulates that the provider/child ration shall not exceed 6 to 1. All providers in the state were surveyed regarding their interest during the first year of the project. Interested providers were then screened using the Early Childhood Environmental Rating Scale (Thelma Harms & Richard Clifford, 1980). Homes meeting a criteria of 4.0 on a 7 point scale were selected as target sites. Homes scoring below the criteria were allowed to participate in training and were re-evaluated at a later date. The training consists of 20 hours of general training and 6 hours of specific training individualized according to the needs of the child and family to be placed. 55 FDC providers were trained in the first 2 years of the project and 24 infants and toddlers with special needs are currently placed in homes. There has been an overwhelming positive response from parents and providers, but numbers are currently being kept low for the purposes of the model demonstration. It is hoped that this model will demonstrate best practice for the state and the nation in providing an array of options for serving infants and toddlers with disabilities.

The "Del Care" project is 1 year old and is funded through the Delaware Department of Education with the support of the state Interagency Coordinating Council (ICC). It provides support and training to staff of center-based child care programs to enable the integration of infants and toddlers with disabilities. Through a survey, screening and training process similar to that provided in the "Delaware First" project, 60 providers were trained in 11 centers in the first year of the project. There are currently 18 children in supported placements as a result of the project.

The training package for both projects consists of 20 hours of general training consisting of 4 components: 1) infant and toddler development (typical and atypical), 2) teaching infants and toddlers with disabilities, 3) communicating with and supporting families, and 4) community resources. In addition to this general training, 6 hours of training specific to the child's and family's needs is provided. This specific training often involves the families as both participant and trainer. The format of training delivery is individualized according to the needs of participants. Training specific to administrators is also provided.

Some issues common to both projects include:

- 1) Many centers and homes failed to meet the basic quality criteria set by the project. Project staff decided to offer training to certain of those centers and homes in order to raise the quality of programs. These are the typical (and sometimes only) settings available in communities and it is felt that they must be utilized where possible. There were, however, some centers and homes which were not judged suitable for inclusion in the program.
- 2) The response to the projects by providers has been overwhelmingly positive. There seems to be a general willingness to involve infants and toddlers with special needs if adequate support and training is readily available. Fiscal incentives do not seem to be as important, especially to FDC providers.
- 3) Support services provided in addition to training through the project and other cooperating agencies are perceived as very important by child care staff and administrators. Services such as weekly visitation by staff, itinerant related services, toy and professional lending libraries, and a toll-free number have proven to be very useful. The toll-free number is especially popular with FDC providers.
- 4) The documentation of the implementation of the Individualized Family Service Plan has proven to be difficult. Providers, in general, need further training in the collection and evaluation of child progress data.
- 5) Insurance and liability are a current problem. The projects are working closely with the state insurance commissioner to develop guidelines. Parents and providers are apprised of the risks and release forms are processed where necessary.
- 6) Personnel qualifications are also areas of concern. There is currently a state regulation in place which requires providers to have 15 hours of in-service training per year. This regulation is currently not monitored and training is not systematically provided. A determination will have to be made as to which state agency is to be responsible. Proposed legislation will include a training package funded through state dollars to address this need.
- 7) The current approach to funding is to pay for that time in settings which is required to implement the IFSP. Title XX funds are used to supplement the special education funds for eligible children. The desire of providers to have as

many full-time slots as possible is a barrier which will need to be overcome through coordination of case-loads.

- 8) Transportation is basically seen as a state responsibility. Families currently utilize a mix of available options including mileage reimbursement . Such an approach will need to be supported in upcoming policy development.
- 9) The determination of the case manager is the result of the IFSP process and parental preference in this matter is of paramount importance . The recognition of this case manager by other service systems involved with the family is a continuing issue.

Other unresolved issues include the maintenance of confidentiality, monitoring of programs, and provision of procedural safeguards. It is important to realize that the two projects described above represent possible service options which will be components of a comprehensive service system. Other options such as home-based services and center-based early intervention services are currently, and will continue to be, available. It is an array of high-quality options which must be put into place to serve individual family needs.

Recommendations of State Teams

State Team Facilitators: Deborah Ditchen (Indiana), Shelley Heekin & Patricia Place (Illinois), George Jesien (Michigan), Heidi Gray (Minnesota), William Sullivan (Ohio), JoAnn Woodley (Pennsylvania), Barbara Smith (Wisconsin)

Participants in the conference were divided into seven state teams and given approximately three hours over the course of the two day conference to develop recommendations for their state related to the implementation of LRE for the birth through five population. Facilitators were provided by the conference planners. The summary of each of the seven state team meetings follows.

ILLINOIS

Definitions

- a. Children and youth found eligible for special education programs and services are not to be excluded from natural school and community environments in order to receive special programs and services.
 - b. Each public agency in Illinois shall be responsible for providing age appropriate opportunities and necessary support for the participation of persons from birth identified as handicapped with people not identified as handicapped in instructional, vocational, and extracurricular programs and activities. This participation will be to the maximum extent appropriate to the needs and interests of the students identified as handicapped.
- The assumption is that all children can benefit from integrated experiences.
- c. Definition: maximum extent appropriate - means the integration of students identified as handicapped with students not identified as handicapped in instructional and non-instructional environments consistent with the potential of the receiving students identified as handicapped to benefit from the integration experience. Burden of proof is on the school district.
 - d. Monitoring - Local school districts shall not routinely place students identified as having a particular disability or similar handicapping condition in the same program, nor shall placement in a separate facility be the only educational option considered for all students identified as having a particular disability or similar handicapping condition.

Goal Statement

We would like policy people to consider that there be:

- 1) Programs for family support;

- 2) Active family participation in all program decision making in planning, development, implementation and evaluation;
- 3) A definitive policy about universal LRE (where would child be if not handicapped) that all agencies would adopt and that would apply from birth to death;
- 4) A T.A. system that emphasizes and supports LRE for administrators, service providers, and families;
- 5) Support for interagency coordination and collaboration among and within agencies;
- 6) Community education.

Solutions

The team wishes to make five recommendations to the State Board of Education. These are that:

- 1) These statements be added to state plan;
- 2) There be equality between the ECE 02 or 04 certification, one should not supervise the other and Inservice should address the difference in training;
- 3) integration should begin at the screening level; Child Find wording needs to be less "handicapped" focused; the integration of all children must begin at the Child Find level;
- 4) all agencies within the state whose programs serve children between the ages of 0-5 should participate in the development of rules and guidelines for services to both handicapped and typical children;
- 5) the interagency council should recommend to the Federal ICC that they adopt a policy supporting LRE through the life-span.

Action Steps

- 1) Take back recommendations to State Board of Education.
- 2) Some recommendations regarding non-categorical eligibility should be made in writing to ICC.
- 3) AI can take information to individual who is responsible for revision of State plan.

- 4) GLARRC - have Linda Brown or Phil Strain attend Summer Institutes. Also possible to have Wayne Sailor or Paul Wehman.
- 5) Share recommendations with members of this team.
- 6) Share information with already established agencies in state: Head Start (Brenda H.); IAEYC (Eileen and Sandra); Day Care Council Members (Betsy and Linda); Parent Coalition (Margaret B.).
- 7) AI will take state plan revisions to Rene and to monitoring person.
- 8) Susan K. will make written comments to Interagency Staff team.
- 9) Department of Children and family services missing. There is a need to inform them of results.
- 10) TAPP Feb. 20-Mar 2 Conference, Patricia will make recommendation to their policy statement.
11. DEC representative will investigate mechanisms to disseminate to other groups and report back to members present.
12. Reconvene group.
13. The majority of young children should be served in integrated settings that are developmentally and age appropriate.

INDIANA

Definition of LRE

Early intervention and early childhood special education for young children (birth - 5 years) with special needs should be provided in age-appropriate environments with typically developing peers with any and all necessary adaptations for the child to benefit from the services.

Goal Statement

Young children with special needs should be fully integrated into the natural environment and activities of society. This would begin at birth by supporting the integration of the child into the family and the family into the community, including developmental educational and recreational settings.

A process to implement this goal and definition would include but not be restricted to :

- 1) individualized placement decisions;
- 2) specific decision making process (case conferences) and rationale for placements;
- 3) alternative placements options;
- 4) monitoring of progress of IFSP/IEP and setting with time lines.

What current or planned policies and practices documents exist?

LRE is addressed in Indiana Rule S-1, Indiana's Special Education regulatory rule.

The Joint Standard also addresses promotion of integration of services for 0-3.

Indiana supports LRE intensive demonstration projects for older students: primarily secondary education.

Barriers, Solutions and Action Steps

1) Barrier: Part H and Part 619 are in domain of 2 agencies. DMH and DOE.

Solution: Develop parallel policies and regulations to support LRE.

Action:

- Short-term:
- Launch public awareness activities
 - Support interim funding request
 - Put LRE on workplan of ICC and DOE task forces
- Long-term:
- Adopt 3-5 mandate for public schools
 - Revise Rule S-1 and Joint Standards

•Develop expanded LRE goal statement, definition and related procedural standards

2) Barrier: Lack of knowledge and understanding of LRE practices and benefits exists among professionals and consumers.

Solution: Increase level of knowledge and understanding of LRE practices and benefits.

Action:

- Short-term:
- Disseminate conference proceedings throughout Indiana, make articles and materials available through TAP*IN (Technical Assistance Project for Indiana)
 - Publish LRE articles in ICC and TAP*IN newsletters and build awareness of practices and information and training resources through community.

3) Barrier: Transportation costs to diverse community settings.

Solution: Identify creative, flexible transportation policy and practices.

Action:

- Short-term:
- Research transportation modes used by model LRE programs: e.g., vans, interagency funding, parent reimbursement etc.
- Long-term:
- Incorporate recommendations into proposed changes in policies and regulations.
 - Publicize options throughout provider network.

4) Barrier: Lack of intensive training opportunities/resources for providers.

Solution: Support training initiatives for current and potential providers serving birth to five year old population in the range of early childhood settings.

Action:

- Short-term:
- Maintain support to state funded TA and training efforts.
 - Increase awareness of existing resources (people and materials).
 - Involve early childhood leadership in all training activities.
- Long-term:
- Increase funding and expand training and technical assistance activities.
 - Maintain training and TA efforts overtime.

5) Barrier: Indiana lacks legislation mandating services for 3-5 or 0-2 year olds.

Solution: Support legislative and advocacy strategies.

Action:

- Short-term:
- In progress
- Long-term:
- To Be Determined

6) Barrier: Low standards and quality of care exist within many early childhood settings.

Solution: Work in concert with multiple agencies to support the development of upgraded standards and practices, resulting in improved quality for both typical children and children with special needs.

Action:

Short-term: •Involve ECE leadership in all planning activities.
•Enhance awareness of shared goals and objectives.

Long-term: •Pool resources and training opportunities across settings

Broad Recommendations

- 1) Develop parallel policies/guidelines regarding LRE for 0-2 and 3-5s. Incorporate LRE into the work plan of existing ICC and DOE task forces.
- 2) Increase public awareness of LRE through information dissemination via seminars, newsletters and information packets.
- 3) Identify and/or develop and disseminate information resources to support implementation of LRE practices in local communities (e.g., administrative manuals, program guide, community needs assessment instruments, local ICC formation).
- 4) Support training initiatives for current and potential personnel serving birth to five years in a range of early childhood placements.
- 5) Increase participation of ECE leadership in ICC and DOE planning activities.

MICHIGAN

Goal Statement

Basic to the principle of and the concept of LRE is the notion that individuals should be fully integrated into the environment and activities of society.

Given that each child has the right:

- to belong;
- to opportunities for friendships and relationships with age-mates;
- to a supportive environment which values diversity;
- to a "vision" for his/her future;
- to benefit from services derived from the collaboration of family, providers, and community.

It is the position of the Michigan Planning Committee that young children with disabilities or handicapping conditions should receive intervention programs and services in a chronologically age appropriate environment.

The challenge to policy developers, service providers, administrators, and families is to create environments which promote optimal development of all children and their families in the most supportive manner.

Action Steps

- 1) To formulate an ongoing work group and to meet with Administrators and staff in Special Education and Program Services Providers, parents and advocates, etc. to identify the issues and proposed strategies.
- 2) Increase public awareness concerning the concepts of integration, LRE and most supportive environment with all appropriate groups.
- 3) Training and technical assistance for Administrators, providers and policy makers (i.e. identify opportunities such as upcoming conferences meetings etc.).
- 4) Analyze existing data to determine range and scope of existing services in Michigan.
- 5) Review the existing State rules to determine potential needs for change/barriers to service/disincentives for provision of most supportive environments and make appropriate recommendations.
- 6) Request that this group be allowed to meet with Dr. Birch and Dr. Hansen to present what has been discussed/developed at this conference and our recommendations for future activities.

MINNESOTA

Specific Information Required

- 1) Child care models, especially family day care incorporating LRE.
- 2) What is function of Head Start with LRE?
- 3) How do you get the funding to follow the child in various programs?
- 4) How do you get information to local providers on how to have kids with disabilities in community based settings?
- 5) Staff development models related to how tos, general information and what is appropriate for: administrators, regular education teachers, school board members Head Start personnel, day care/nursery school providers
6. LRE interventions - what issues to look at in desegregation? Do you look at 4 year olds the same as 14 year olds? This needs clarification.
7. How does open enrollment affect LRE?
8. How will consolidation of school districts affect LRE?

Definition

Minnesota uses the federal definition for LRE.

Goal 1

Early intervention services should be provided for young children birth through 5 years of age and their families where the child would be if he or she did not have a disability.

Goal 2

To provide more quality integration options.

Policy Implications

- 1) Make spaces more accessible physically and fiscally.
- 2) Be able to use churches as spaces for services.
- 3) Teacher licensing requirements should be more flexible.
- 4) State policy should be changed that says that Special Education teachers can't provide instruction to non-Special Education students.
- 5) Encourage districts which are reluctant to purchase nursery school services.

- 6) Wage differences between public school and private centers should be minimized.
- 7) Nursery schools are licensed by Social Services. Perhaps they should meet educational requirements to allow better pay for nursery staff.
- 8) Hennepin County pays for nursery school for children. Perhaps that is an option for special needs day care.
- 9) Lower group size is rule for handicapped children.
- 10) Day cares may want training and on-site consultation for providers of special education students.
- 11) Vision in Minnesota is similar throughout state, i.e., all children should be integrated, poor, drug-related, handicapped and richer families. Options should be provided for parents. A parental leave of 6 months should be standard.

Barriers

- 1) Funding follows specific groups and cooperation is blocked by funding at state level.
- 2) There is a state decision that does not allow the commingling of funds.
- 3) There are limitations on the possible funding sources in Minnesota.
- 4) No need is felt at County level to dedicate money toward young children.

Action Steps

- 1) State legislators need to hear about the funding issues we've developed here.
- 2) There is a need to look toward a goal at the local level for specific children which will lead toward solutions.
- 3) Work together toward these goals at the Interagency Early Intervention Committees. (IEIC)
- 4) Support IEIC at local level.
- 5) Expand options that are developmentally appropriate for all children and their families to encourage integration steps.
- 6) Clarify certification standards/requirements and examine them in terms of LRE options.

- 7) Meet again and include Deb Peterson and Ken Nelson in the meeting.
- 8) Expand public awareness and acceptance of the benefits of an integrated service system for all kids.

Additional Barriers

- Barrier 1: Funding - shortage of level and funding restrictions
- Barrier 2: Certification
- Barrier 3: Coordination of efforts between agencies
- Barrier 4: Availability/accessibility of service options
- Barrier 5: Attitudes

Action Steps:

- 1) Impact children's policy academy where heads of agencies met last summer.
- 2) Impact Governor's Council on Children, Youth and Families.
- 3) Impact ICC.
- 4) Team should continue communicating among ourselves.
- 5) Work for an RFP that establish model programs and increases model/demo programs.

OHIO

Questions

- 1) ODE - Will there be a general framework to be sure all aspects of the issue are covered and participants have same frame of reference?
- 2) Can we identify issue papers from NECTAS and other sources as to Model Programs?
- 3) What are the future plans for Ohio/LRE workgroup?
- 4) Will there be a condensed conference summary for distribution to ICC, DEC, ODE, etc.?

Definitions

"Most supportive environments" (MSE) "Least restrictive environment" (LRE)

These statements impact in the following ways:

- 1) Child into family;
- 2) Family into community;
- 3) Child into integrated child care and school settings.

Guide should be based on preference of the family: where would this child be if he/she were not handicapped/at-risk

Definition of LRE: (approximate definition)

The program for children and the IFSP/IEP would offer the child the maximum opportunities for frequent, planned, structured interaction with typically developing peers.

The program would be based on the natural environment of the child - as if the child were not handicapped.

The family would define the natural environment. MSE/LRE 0-5

Beware of value judgments; "well functioning family"; home is the one best LRE" (what does this judgment mean if both parents work?)

How can we influence state-level policies to allow for existing creative options?

- 1) Explore "blended funding".
- 2) Explore policies addressing all children.

- 3) Continue the discussion of LRE in Ohio; make this an agenda item for this group or other groups.
- 4) What is the Ohio "menu" of MSE/LRE?

Barriers

- 1) Some LRE's cannot serve all the children identified due to the limited definition of eligibility at age 3 (under ODE).
- 2) "Total integration" is not currently an active goal of state agencies.
- 3) "Total integration" not valued by many/some professionals and parents.
- 4) LRE is sometimes determined by funding streams, limited "creative vision", policies, federal regulations; it is not CHILD CENTERED.
- 5) Special education dollars should follow the child into integrated settings, not necessarily be poured into regular education's purse (for example SST).
- 6) LEA's might be a barrier (administrators unaware of issues, not valuing LRE, etc.).
- 7) Levy passage strategies may have a negative effect on our LRE efforts.
- 8) Preschool teachers are not paid at same level as regular education and special education teachers.

Solutions

- 1) Define a child/family focused vision for all children, then operationalize this definition:
 - a) child is part of a family;
 - b) has a right to have friends;
 - c) has a right to be a contributing member of the community (what do we want for families; what do families want for themselves).

One way of looking at this is: What is the result of 22 years of investment? We need to have a vision of the future and then create the present which will lead there. Every ISP/placement must include the steps to transition to next ISP/placement.

- 2) Implement futures planning in IFSP, IHP, IEP by:
 - a) writing the process into guidelines;

- b) Making a recommendation from Ohio's Department of Education Transition Task Force;
 - c) developing an administrative planning process for the future that is child focused, not setting focused; plan from child's point of view.
- 3) Earlier planning, identification and parent involvement (empowerment) must be the underlying premise.
 - 4) Clarify the difference between "program" and "service"; look carefully at the definitions in legislation; service is not equal to program; program is one kind or an array of services.
 - 5) Decide which alternatives will be policy "menus" for LRE's and which are "best practice" guidelines. "Menus" can be viewed as an administrative "jump start", a way of beginning the discussion of options for children. Policies need to foster creativity to keep options open, to stimulate thinking. There is a danger in listing LRE's and including the phrase "but not limited to" since that tends to limit the thinking to the list; danger of defining LRE too specifically in policy since this too could limit options. At individual child level LRE is apparent when focus is on the child and not on the definition in the regulation/policy. Such menus should be determined locally (by county, by region?).
 - 6) Total integration means into a family, into a defined community.
 - 7) Department of MR/DD (and other departments) can take action via funding, rules, TA, etc. to promote "LRE/MiSE" precepts.
 - 8) Department of Education must write a single set of rules which are LRE responsive (use recommendations from their Issues Groups).
 - 9) An option for policy direction: Turn off flow into segregated settings, but don't close programs until children are out of the programs.
 - 10) MR/DD has already ceased funding new segregated facilities; may be willing to end use of segregated facilities as segregated settings but schools are not ready; future use of MR/DD facilities is an issue which must be addressed or else they will become an obstacle. Perhaps they could be early childhood centers and an expression of the "vision".
 - 11) Need to clarify ODE-MR/DD relationship in minds of LEA's and other agencies.
 - 12) Disseminate information and research on LRE to parents, advocates, professionals, administrators, legislators in order to build a commitment to integrate.
 - 13) Opportunity: Spring Conference: need a structured vision for presentation at that time (handout and session)

14) To articulate the vision and have it come from a neutral source, have GLARRC issue "a press release" and send it to:

- a) ODEC - ON-DEC/OEAYC;
- b) State Departments: MR/DD, Ed., MH, Health BCMH providers list; Head Start, Day Care, Healthcheck;
- c) LCG's,
- d) CO-SERRC mailing list ,
- e) EI list (Advocacy - ARC-OH, OCEYC-forum, SERRC's, OACBMR/DD,
- f) Futures forum,
- g) EI Council

Release to include reference to 7 states, research , elements of vision.

15) Share videotapes, resources related to integration, EI, early ID, etc. such as: Regular Lives, Every Child is a Promise, Family Centered Care, NCCI films.

PENNSYLVANIA

Proposed program standards with LRE provisions are currently out in the field for public comment.

Proposed eligibility criteria are out for comment. Possible revisions in current draft criteria are possible.

Questions

Some questions are related to:

- 1) Funding Options - blended funding options;
- 2) Child Care Initiatives - local, state, federal levels;
- 3) Third Party Reimbursement;
- 4) Salaries - parity between agencies;
- 5) Best LRE practices in other states

Implications of Current Policies

- 1) Results of public comments will identify implications.
- 2) Change of current regulations will result from public comment.
- 3) There will be a need for a transition period.
- 4) There will be an Increased number of Licensed Private Schools.

Funding

Some areas to consider include:

- 1) ICC initiatives to legislature,
- 2) Separate transportation appropriation, and
- 3) Private foundation resources.

Staff Development/technical Assistance for LRE

Some areas to consider include:

- 1) Needs identified at the local level IU/OMH/MR/Day Care/School District/Head Start;
- 2) Joint program offerings;
- 3) Local Children's Teams.

In addition, the State ICC needs to develop a Technical Assistance Plan (Personnel Prep Committee) which will determine what is currently in existence and develop guidelines for minimal participation.

February - Determine status of Interagency Agreements

June - Develop new guidelines

GLARRC may be able to assist in supplying or identifying TA consultants.

WISCONSIN

Recommendations

- 1) Develop pilot models as options for LRE using preschool discretionary money in LEAs.
- 2) Investigate co-operative efforts between Department of Public Instruction (DPI) and community Developmental Disability programs.
- 3) Disseminate information regarding LRE options. This would access money from GLARRC and include a paper/monographs describing programs and inservice training availability.
- 4) Investigate program standards separate from school age for 3-5 or b-5 children with Exceptional Educational Needs. This will be accomplished via a study committee comprised of representatives from DPI and Department of Health and Social Services.
- 5) Investigate policy changes necessary for day care placements including funding sources, tuition reimbursement standards for program, and the monitoring of placements.
- 6) Investigate teacher training program requirements for parent involvement and education by DPI Early Childhood Consultant.

Guiding Principles for a definition of LRE

LRE needs to be addressed in the IEP/IFSP reflecting the individualized situation of each child.

Children are children first. Exceptional education needs are secondary to this.

Early intervention needs are different from day care needs but both need to be supported by effective case management.

The most supportive environment needs to be included in what is defined as LRE.

The quality of a program is directly related to effective integration efforts

Options for an Array of Integration Strategies and Settings

Day Care
Private Preschool
Reverse Mainstreaming
In-Home Services
Community Programs
Parent Centers

YMCA Programs
Library Story Hours

Programs may consider shared or blended programs and/or common facilities

Roles for providers

Itinerant teachers
Direct Instruction of Parent
Case Manager
Resource/Referring Agent
Facilitator for Resources and Funds

Summary Panel Discussion

Panel Members: Linda Brown, Patricia Place, Barbara Smith, and Lisbeth Vincent

Barbara Smith: I'm not going to start the summary actually, I want the Panel members to start and they have self-selected the topics they want to cover in the order they want to go in. As the moderator and one of the people who of course marched for the last few days, I'm going to exercise my prerogative and have the last word. So, I think we're going to start with Patti Place, who is going to summarize the recommendations from the state groups, then we will have Linda Brown, who will summarize, from a parent's perspective, what's been going on the last couple of days, and then Lisbeth will summarize for the overall conference, all the sessions, all the presentations; she's been sort of floating around, and I'll have the last word. If there's any time left, because we're running pretty close here, we would like to open to discussion and questions.

Patricia Place: I'd like to share with you a story. When P. L. 99-457 was passed, a friend of mine turned to me when we finally found that it had been signed over the skies of North Carolina on the tenth day, and said that this law is going to have a more profound impact on the lives of children in America than any preceding legislation that we've been involved with. I said, "Sure, sure, right, okay". I'm pretty fond of P. L. 94-142 and the changes that had occurred as a result. Well, I was sharing with people over lunch, I am so astounded at the activities and the commitment that have come from the work that you all have done in the last two days and I am beginning to realize the impact that this legislation is going to have on every child and every family in each community. For example, let me share with you some of the ideas that the states have developed to take back with them to implement LRE in their communities.

Wisconsin plans to develop standards and policies that will allow them to use day care placement; well, the implication of this is not just for the children with special needs who will be using this day care placement, but as we heard earlier, for those of you who were in the Arizona talk this morning, the implications for the other children in those day care placements also. Indiana is going to focus on the public awareness and share with every citizen in the state the need for integration and the need for people to be involved in their community. Pennsylvania wants to figure out ways to provide technical assistance and training to what they hope will be a regional network of Interagency Coordinating Councils to focus on planning and implementation of LRE. Well, if this movement gets generated, the impact on local ICCs, especially local ICCs who have good connections with training and technical assistance, will be profound. Ohio is developing a vision, and defining steps to implement this vision to involve parents and legislators in looking at the next step for LRE, and they want to develop a consensus for the implementation of LRE. Minnesota was explicit in that they wanted to improve day care for all children in Minnesota, and Michigan developed a goal statement which made this commitment to impact on the general public explicit; they want to promote the optimal development of each child in each family.

Finally, I think Illinois' goal statement sums up the profound impact that this movement of LRE for young children can have on all children in all agencies. They developed a universal LRE policy which says "each public agency in Illinois shall be responsible for

providing age appropriate opportunities for the participation of persons from birth on, identified as handicapped, with people not identified as handicapped and intervention. instruction, vocation and extracurricular activities to the maximum extent appropriate to the needs and interests of all people identified". I think that universal LRE statement sums up the philosophies and the activities that have occurred in the last two days. Thank you.

Linda Brown: I'm a lot more nervous today than I was last night, it kind of makes me really feel sad that I have had several people say; "I couldn't get to sleep last night after listening to you talk"; but I do feel flattered, and in a lot of ways I couldn't get to sleep either! I really would have liked to have slept because I have a feeling when I get home my son, Aaron, will really decide to test me because I've gone away, then I'm not going to get any sleep either. One of the things that concerned Barbara and kept her awake was the whole issue of integration that I feel I need to clarify. And that is, that integration is a process and it's going to take some time and we're going to make some mistakes. There are things that are just not going to work and we're going to shift to try something else. It doesn't mean it's not working, it means that particular approach may not work. So, it's an ongoing process.

Barbara was saying it's not exactly fair for a parent to be sitting in a position where they have to say, I either will have integration with no support from special ed or I'll have to have a segregated program with support. Even though that's what I had to do to get the support that I needed, I had to give them all up and start all over again. I would much rather go that route and find out what we needed and then do it that way, than to add a whole lot of stuff we may not need in the beginning and overwhelm the whole process and really bog it down.

I thought of a story I heard from a man named George Flynn in Canada. He was in Madison, Wisconsin last year and it was a great story about how they decided on integration. He's in charge of 10,000 students in his school district in Canada. He is totally committed to integration and he sat down with all his administrators and staff and said we're going to have this. They had a principal there from one of their elementary schools whose name was Brian, and he said what we did is we went in and said; "okay, parents, we're going to do integration, we're going to bring any children who want to come back to this school, as their home school, they can come back as their home school." But any parents who opted, because their children might be in the middle, like a third grader and they've already come to this school and maybe this isn't their home school, that they want to continue because they only have three more years and they just want to have continuity, you're welcome to have it. Otherwise you can have the option of going to your home school, wherever that might be. "But we're going to integrate all our children together". And the way they set it up was the principal said to the teacher; "this is what we're going to do, you've got all the support you need, but the first two weeks of school you're going to be by yourself." Now I want to make a caution about this, if it was a medically fragile child and there needed to be a nurse around; I'm not talking about that, I'm talking about that teacher being totally responsible for all the children together in one classroom for two weeks. "Because at the end of that two weeks you're going to know a lot of what that kid needs, and then you're going to come to me with your list and you're going to tell me what you need and then we'll get it for you." He said that he had a lot of nervous

teachers say "what am I gonna do?", but he said boy they were right on with what those kids needed by the end of two weeks. That's how they did it; I'm not saying this is the way it's always going to be done, but that is an idea.

I think there is one thing circulating; I'm really excited hearing about things like visions. A lot of people are having visions and good ones, and I like to hear that. I like to hear people getting that little seed because once you get that little seed growing, then it's really going to be a driving force. The one thing, even though I know you're not doing it on purpose, I've heard parents say a few times "Don't forget us; we want to be equal partners in this and there's a lot that we can contribute", and all the way along the line. And the other thing is when you talk about training parents, I know what you mean by that, but when you say to a parent that's new and kind of struggling, "we're going to train you", it's sounding like you're making an assumption there's something wrong with them in the first place. They need to be untrained about training, the word training, think about how you're using that so you don't freak out parents thinking "oh, I can't do it" or "something's wrong with me."

I think there are really tons of exciting things going on in all the states and I'm really glad to hear people saying "if something's in our way in public policy or policy law we're going to change it." Boy that is really exciting to hear, I think that is one of the most exciting things; "it's in the way of the best interest of our children and we're going to change it for that reason," I think that the vision and the "we're going to change it if it's in the way" and the willingness to do that saying "well how can we work around this. You're saying "we're going to change this because it's in the way." That's really exciting and I'm really happy that I have gotten to meet as many of you as I can and I just wish I would have had more opportunities to talk. Thank you.

Lisbeth Vincent: You notice the limited time and that we are all talking really fast; it hasn't occurred to any of us to reduce the information. I think one of the really exciting pieces from these last two days has been the notion of vision. And what is really exciting about that is for years people told me I had either hallucinations or delusions, and they have now become visions and positive and acceptable and that really is very exciting. I think the other really exciting thing is that the vision we're talking about is a vision for all of America's children and families. It is a vision that grows out of concern for our communities and grows out of the concern of the well being and health of families in general. I think that's how we're going to win, by joining all of the other coalitions and advocacy groups that are worried about young kids and their families, and not separating ourselves out and not being different but being a piece of the whole. And each of the states really talked about that when they talked about how do we work with regular day care? How do we work with family day care? How do we work with professional associations such as AEYC? How do we get the Department of Social Services and Department of Education to come up with a joint statement of what they are trying to do?

I think another really exciting piece that grew out of one of the sessions yesterday, that everybody has really adopted, is that when we talk about what is best for families and young children we actually get out of LRE and start talking about MSE or most supportive environment and that may be a better concept for young children than the notion of least restrictive. Least restrictive is an educational concept, it has some very

particular meanings for school age kids, most supportive environment is something that you would apply to all children in the family. And so, I think that it is the notion that people are really comfortable with the last two days and it's a piece of communality for all of us.

I think the other thing that was really good about the sessions the last couple of days and team meetings is how people got to know each other. All over the country people are doing it, people are working as community agencies, or building cooperation between regular and special education. They are involving families, designing services, contracting with day care when nobody thought you could, or figuring out how to get around the church/state kind of difficulties or figuring out how to operate joint programs without doing that terrible thing called commingling funds. You know the age of computers is really going to help us on that because the people that worry about commingling love budget statements and you just make sure your computer keeps it all separate for you and prints it out separate to give to them. And so I think that sense that we have a lot of models already, there's resource people in every state somewhere that have built individualized family focus supportive services for kids and families. It may only be 10 kids and families, it may not be a whole school district, it may only be one group in the corner of the state, but we really have done it and we have some instate expertise.

I think the other thing that is very exciting is to see that there are states that are tackling a statewide perspective. It is interesting that they are the smaller, Delaware, or the less populated, Arizona, kind of states. I haven't seen New York's statewide system and I haven't seen Pennsylvania's yet, I haven't seen California's yet, and I haven't seen Illinois', you know with the state and the kingdom, Chicago, and yet the solutions that the smaller states and the less populated states are using are going to be useful for the rest of us that have larger populations and more service systems.

This is the first meeting that I have been to in a long time where when people have talked about barriers the conversation has not ended. People have then talked about solutions. I think it is very easy to get together and talk about barriers to change and identify all the reasons, and whatever group I'm in that does that, they identify the next level of administration above them. And so the teachers identified principals, the principals identify area directors, and then when you get to the final state level people who do they identify? Where was George? You know, we have a tendency to kick the buck up and yet what we saw over these two days is that where people have chosen not to do that, they've have had a lot of success with kids and families. There are kids and families with disabilities at the "Mommy and Me Program," there are kids at toddlers' swim, there's kids in special reading programs, there's kids in public school classrooms that are reverse mainstreamed. There are kids in small family day facilities in rural areas; there are a lot of places that children and families are being successful. It's easy to look at that, it's particularly easy to look at what we know about how successful integration is and decide that it should happen tomorrow.

I think the other reality that was very clear in the work groups, as I floated around, and as they reported back, was something that I was taught in graduate school that I still haven't fully learned, some of us are slow learners, and that is that "change is a process that occurs over time and not overnight" and that "patience and persistence

and political skills and commitment, working with other groups is really necessary if we are going to effect the change that we want." That in designing our vision we have to design and look at some of the steps in between, we have to stop and evaluate whether taking a particular step is going to get us there later on. For many of our states and many of the locations that we are in, if we could ten years from now, have most supportive services for all of the kids and families we're concerned with we would be doing very well. There are some of us that will be able to get that in 3 - 5 years, but there are other places where realistically we are talking a decade down the road.

There are a lot of different ways to accomplish change. You can go in, for example, and say that all new children and families coming in will be in this system and we are not going to worry about changing for the families that are already there. You can look at statewide planning. You can start model projects and hope that by doing that their next door neighbors will see how successful it is and adopt the change. But in reality, my own experience is the change requires legislation and legislative support, because change requires funding, and so each of the groups really acknowledged the need for increased public awareness about least restrictive environment, increased legislative awareness about least restrictive environment. I think that this room is full of a lot of people that understand what we really are tackling and that is we're tackling changes in state law, we're tackling changes in definitions across agencies, we're talking changes in rules and regulations, but all of that is possible to do and has been done in other situations and has been done for other causes. Fortunately right now, family and children are a priority of the governors and the state legislatures, and it is probably a good time to be making the change. So I do have to remember that change is a process that occurs over time and that we're in this not just for the 100 yard dash but for more of a marathon.

In that I always come back again to parents and how is it we involve them and what to ask them to do. We have been in all the work groups today and parents haven't necessarily been there. You're going to go back to your states and meet again and the question is; where are the parents? And as we constitute our task forces and our change strategies, I really do hope that we will bring parents into every single planning effort, and everything we do, every document development, every policy statement has parents as one of the people that really looks at that.

I think that with that it's very clear that training for regular educators, training for special educators, training for family day home providers, training for administrators, is really necessary. As Linda said we're all comfortable with the concept of training as not negative. I think that there are people out there, teachers included, that when you start saying that become very defensive. And so I think we need to think about technical assistance, we need to think about allowing the parents, the service providers, and the administrators a piece of determining their needs, doing the kind of self needs assessment that you all did, so that we always bring the consumers into the process of determining what areas do we focus on and where we spend our time and effort.

There are some really neat ideas, one this morning was a toll free number that family day home providers could call for assistance. A lot of the groups identified the need to develop documents and materials that would go out. Clearly, and one of the things I didn't hear a lot of, but I know myself needs to happen, there's clearly a need for

change on the university level in how we train people for kids under 5 and we need to finally bite the bullet and quit doing separate special ed training and separate regular ed training and go ahead with all kinds of issues related to the health and allied health professions and what kind of training their getting. We have a massive look that higher education needs to take at this field. Coupled with that are the latest predictions that the lack of personnel, the personnel shortage in education, in special education is going to increase and the shortage for programs birth to 5 is going to be astronomical. The shortage in allied health people is already evident all over the country. So one of the things that all of us has to do as we talk about this vision is recognize that we have to have people to carry this vision out. And we must figure out ways to recruit new people to come into the field of little kids. There are many difficulties with that related to salary, related to states, related to all kinds of things, but I think a focus on public awareness is going to have multiple impact, multiple positive outcomes for us. And one will be that we will increase early childhood as a viable career choice, at the technical level, at the university level, and beyond.

I think the last thing that I sort of want to share is that when I went into the work groups it was fascinating to watch people go between broad philosophy to nitty gritty problems and solutions. And many of you got frustrated with that. You'd be heading down this track and then all of a sudden you're heading over there and in reality I think that happens because we're trying to solve multiple problems at one time, we're trying to be visionaries and we're also trying to figure out how to contract with Sunshine Nursery School. And how we do that in the same day is amazing to me and that need to remain visionary, but also practical, is a piece that must drive us. It was really good to see the work groups be able to shake loose of the nitty gritty problems and say we can't solve that here let's go back to our goal and our vision. It was also good to see work groups who were on the goal and vision say "Ok what are the barriers to that and what are some things that we can do." And I think the opportunity to work together like that may be one of the greater benefits of this kind of meeting. So overall I think it's been a really useful couple of days, I think we have created a cadre of people in this region and you certainly know other regions that can be looked at as resources on the issue of LRE; they have become experts; they have materials; they have experience; they have other people they can contact, and that I think is the beginning of the movement to create individual change agents. As I said last night when I introduced Linda, one person can make a difference; I hope that each of you will leave with that as your responsibility. You need to bring about change. Thank you.

Barbara Smith: Well I think indicative of the last couple of days, at least for me, is this piece of paper in front of me which is written all over it. upside down, sideways, and on the back and the front, of just some of the really key issues, trends and concepts I have heard of in the last couple days. This has been very stimulating for me. I think that what I wanted to summarize are those key concepts and terms that I have heard over the last couple days from the state groups, from the experts that were brought in, and from discussions in the hall, and over cigarettes. Those key concepts in terms that I think will define the success of our efforts. I think that we can have all kinds of LRE policies, we can have all kinds of integration policies, but there are certain terms and concepts we've heard of the last two days that will define whether or not we are successful for children and families. So that is what I wanted to share, the things that I heard that I thought were real key success criteria. One is that these

decisions must be individually based decisions and that our policies have got to build that in, we cannot have a policy that says this is what LRE is for a certain child. Every single decision has got to be individually based and some of the discussions that I heard, or were a part of, brought home to me the fact that I come from a state where the first thing out of somebody's mouth when you say integration or LRE for the birth through two year old, is home. Well, that's right, for some families. For some families that will be the most restrictive option because the mother or the parent either has to work or they want to work and if the child wasn't handicapped they would work. So I think that that is an example to me that every decision has got to be individualized. We have to build it into the IFSP process, we have to build it into the IEP process. A piece of that which I really liked yesterday, was Lisbeth's comment about how many IEP's have a goal of friendship building. That was really a new concept for me to hear yesterday, to really have that as a goal in an IEP.

Secondly, there is the whole idea of providing an array of service options, and that they need to be available so that every child and family LRE needs will be met. Some of the concepts or terms that fall under that are options arranged all the way from referral systems for children who are at risk, where we just want to keep up with but we want to maintain them in the community, to home, center base, all kinds of center based options. And that, again, all of it is based on individual needs of the child in the family. From that is the option that we talked about the most over the last few days which is, integration. I've listened to a lot of interesting discussions that periodically people would come around to thinking, wait a minute am I using LRE and integration interchangeably here, you know, and really thinking about the difference between those two terms and understanding the meaning and the purpose of integration. And personally, I have come away with a commitment to try to never use the term integration without the word effective in front of it.

Yesterday, I think we heard consistently from everyone, at least all the people I heard, that we have 20 years of knowledge now, particularly in the last 5 or 6 years, of how to integrate effectively and that it's not easy. And by effectively I mean to meet the needs of the child in an integrated setting. Yesterday we heard that that requires quite a lot, it requires daily, possibly, assessment of whether or not we are meeting that child's needs in the environment, reassessing the program that child is getting based upon that assessment, observation techniques, constant data collections, structural program, programming for social interaction, parent involvement, teachers trained in these techniques to promote social interactions, and teachers trained in how to individualize within a group. Nancy Peterson pointed out some really good, very concrete tasks that teachers need to know how to do, for instance how to individualize on a task within a group. Most of us are not trained to do that, most of us are either trained, if we are from special ed, to do real effective one to one work and individualize on a one to one level and a lot of people coming out of regular early childhood to do great group instruction, but if we are going to integrate we're talking about doing group instruction with a range of abilities in that group that is fantastic. And we know how to do that and we need to make sure all of our teachers know how to do that. And this gets me to what I think is critical for change and I'm the old political process person but I'm becoming convinced that probably the most effective and long lasting change comes from imparting knowledge and training. And I think until we do train our teachers, until we do train our administrators, on all these options and these effective

practices that go with these options we're not going to be very successful. And I think that we should be doing some real creative cross training between special ed types and related services types and regular early childhood types and I have been thinking a lot over the last couple of days and listening to things that my special ed colleagues were saying about kids and listening to things that early childhood people were saying about kids and I really felt like training would be useless without practical types and I believe that our special ed trained people should spend at least two weeks in a setting with normally developing young kids.

For people like me who have only contact with severe to profound handicapped preschoolers; when I am around a normally developing preschooler, first of all, it is mind boggling to me, and their ability to serendipitously learn is miraculous to me. On the other hand, people who have only had that experience and have not shared an environment on a consistent day to day basis with a severely or profoundly delayed child cannot understand that those children very often do not learn serendipitously. They do not interact spontaneously. And that's why we have to build those things into the program or it's not going to be effective. So I would like to see cross training with accents in those areas. I would like to see administrators have to meet the competencies before they get out too. I would like for them to be in these various sites, I would like for them to know what it takes not just on an administrative level but on the teaching level, what it takes to have an effective integrated program. And finally, I think the thing I've come away with is that all the people that I heard talk, no matter what the setting, really were interested in improving the quality of early childhood experiences for all our kids. And that we are really recognizing that we're not offering that. We are not offering that nationwide, to a large extent, to all the kids who need quality day care programs, kids who need quality intervention programs, it's just not there. I think that there is a trend building and I think there is interest building, but I was most impressed with the level of commitment in this group to that overall goal for all kids. Now that's my last word and Mickey says that we still have about a half hour so I'd be interested in seeing if there is any discussion, questions, comments, recommendations to GLARRC, or whether or not people just want to go home.