The Early Childhood Center Inclusion Research Series:

Children with Significant Disabilities Served in Inclusive Community Settings

Therapy Practices that Support Development and Membership

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Overview

Young children with significant disabilities CAN make developmental and social gains when they are served in inclusive community settings. This paper describes what we learned from our study of the practices implemented to successfully include young children with significant disabilities. "Successfully included," for this study, means that the child made progress on IFSP outcomes or IEP goals; made gains in general development and learning; and was accepted as a full member of the group. In addition, parents and professionals were satisfied with the child's gains and experience in the group setting. We interviewed and observed early intervention (EI), early childhood special education (ECSE), and early childhood education (ECE) providers and parents.

The inclusion of infants and young children with significant disabilities may require specialized services and the combined expertise of numerous professionals. The coordination of both people and services is essential to providing effective, inclusive services. Inclusive therapy services emphasize teaching and learning within the context of functional daily routines. These services are provided within the child's typical routines during meaningful activities that are supportive of the targeted goals and outcomes for the child. In this study, we found that the ways in which therapy services were provided, along with a positive attitude regarding inclusion, willingness to communicate, and flexibility of the person providing therapy were important factors in the successful inclusion of children with significant disabilities. These factors were identified through interviews and observed across all sites.

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Therapy: From the Literature

Therapy services may be described in a continuum of integrated (services provided within classroom routines) to segregated (services provided individually, outside the child's typical routines). In addition, there are several critical dimensions to consider: location, involvement of other children, adult-child initiations, routines, goal functionality, and the consultant's role. Each of these dimensions may also be considered along the continuum of integrated to segregated (McWilliam, 1995). When therapy is provided in the classroom it has been found that teachers and specialists consult with each other four times as much as when therapy is provided out of class (McWilliam and Scott, 2001). Therefore, we typically think of integrated services in relation to inclusive settings where specialists and teachers are in the classroom together and have more opportunities to consult with one another. The principles of inclusion, developmentally-appropriate practice, individualization, and collaboration all suggest that integrated services are preferable to segregated services. "Until conclusive evidence is found to support pull-out therapy that involves minimal contact with classroom teachers, integrated therapy is more compatible with current philosophical trends in early intervention" (McWilliam, 1996, p. 100).

Therapy provided within the inclusive environment is further enhanced by effective communication, and an understanding and flexibility about the role of each person on the child's team (Scott, McWilliam, & Mayhew, 1999). "Working collaboratively with the teacher in therapy or instruction and weaving the therapy or instruction into everyday routines might be the most critical aspects of service delivery (McWilliam, 1995, p. 33).

Therapy: Results of the Study – Key Practices Identified

MODE OF THERAPY

The mode of therapy observed in these settings followed a continuum of integrated to segregated, with the vast majority of services being provided within the context of the child's typical routine at school. Therapists commented that it made more sense to them to work on a skill at a time during the routine when everyone else was participating in that same type of activity (e.g. working on feeding at snack time). When services were provided in a segregated manner, therapists gave classroom teachers strategies to carry over in the curriculum. Within settings where children were successfully included, individualized therapy was provided. The following approaches were observed or discussed by therapists during interviews.

◼ Embedded/Individualized Within Routines

Therapists worked with children during ongoing classroom routines because they believe the child works harder and benefits more from therapy during those times.

> *"With (child), if we're in the group setting I get a lot more accomplished. He likes it. It's easier for him because if you take him out one-on-one, he hates it. He's going to fight you the whole time. But if you get in that group setting, he's participating with the other kids. And you do activities that the other kids are doing, he doesn't realize that it's work. It's what everybody else is doing."*

This mode of therapy enabled therapists to assess the child's skills within the context of how that skill is typically utilized. It also allowed skills to be taught in context and it provided an opportunity for therapists to demonstrate the recommended strategies and get feedback from teachers. Finally, this mode of therapy encouraged and supported the involvement of peers. There were times when a small group activity was initiated within the routine of the day for the benefit of one particular child. Therapists realized the value of having other children present for motivation or modeling during the therapy routine.

> *"We have a switch for the CD player, and I'll put in a CD, and if he just hits the mat-switch the music comes on. When the kids see us get it out they love it. And they like to take turns and then they like to take [child's] hand and help him take a turn."*

◼ Consultative

Together with the teacher and parents, the therapists identified the child's needs and they developed strategies to address those needs. Therapists provided an effective model of how to work with children. This was helpful for classroom staff and it was conducive to everyone's feeling of competence and success. The therapist only worked directly with the child for demonstration and assessment purposes, as needed. Because teachers knew what the specialists were working on with the child, it was possible for them to address those things outside of direct therapy and within the daily routine.

◼ Cotreatment

Therapists most often supported the idea of co-treatment when the child had intense needs, or when the child would benefit from working on two types of therapy at the same time.

INDIVIDUAL FLEXIBILITY

The therapists we interviewed approached their jobs with very flexible ideas about their role as well as the roles of other team members. This flexibility is critical to the effectiveness of the team.

- **Therapists did not see themselves as having the ultimate knowledge** or as always having the answers regarding the needs of a particular child. They relied on and respected the ideas, opinions, and knowledge of parents, teachers, and other team members.

- **Therapists saw themselves as a part of the classroom team** and helped out when they were needed.

- **Therapists attempted to be flexible about their schedule** so they could be in the classroom at times that were best for the child.

RESPONSIBILITY FOR IEP/IFSP

All of the specialists and most of the ECE staff expressed individual and team responsibility for ensuring that children met their Individual Education Program (IEP) or Individualized Family Service Plan (IFSP) goals and outcomes. Teachers and therapists also mentioned that the functionality of the goals and outcomes (independent feeding, toileting, indicating choices, etc.) increased the likelihood that they could find opportunities to help the child work towards achieving them. Classroom teachers, caregivers, and parents relied on the therapists to guide them in the implementation of the therapy-related goals and outcomes. Therapists supported team members in their implementation of goals by providing them with written directions and/or a hands-on demonstration of the intervention. The importance of all team members in working towards these goals was acknowledged by therapists. One therapist commented,

> *"Because I am only here twice a week for 30 or 45 minutes, if he only got the therapy those two times, he wouldn't progress nearly as much as he is."*

COMMUNICATION

Regardless of the service delivery model, the amount and quality of communication between and among team members is important. The following methods of communication occurred across sites:

- **Team meetings** were a time for team members to meet on a consistent basis to share information and solve problems.

  > *"This is definitely seen as a time for problem-solving. [We may ask ourselves], is (child) having a problem? What are we doing? What does he seem to need? What else could we be doing?"*

- **A Communication "Hub"** was the specialist who spent the most time in the inclusive setting and became the main contact for both teachers and parents. This arrangement seemed to enhance the level of communication, trust, and cooperation.

- **Communication between therapists and/or teachers** took place in person, via phone calls or communication notebooks. ECE teachers relied on the therapists to provide information on how to best implement the child's goals in their setting. Therapists took the time to explain to teachers why and how certain things were being done.

  > *"For it to work, teachers have to learn, teachers have to not be territorial or not feel like they are being monitored… When you make suggestions, it's not being critical; it's looking at what this kid is doing and what they need."*

- **Communication between therapists and parents** usually happened in person or via the child's communication notebook. Special Education personnel sincerely encouraged parents to communicate their ideas, disagreements, and concerns. They saw parents as being informed about their child, and were willing to listen to what parents believe is important for their child to do, and find ways of working on those goals.

Summary

Early childhood care and education settings that successfully include young children most often provide therapy services that encourage children to work on goals during the typical routines and activities of the day. Successful inclusion was reflected in settings where the team of people surrounding a child saw themselves as equally responsible and valuable in helping children to meet the goals and outcomes on the IEP/IFSP. With effective communication, a flexible attitude, and an appropriate therapy approach, this team of people can work together to provide effective and efficient therapeutic interventions for children in inclusive settings.

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For Additional Information . . .

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About the Study

In 2002-2003, staff at the Indiana Institute on Disability and Community's Early Childhood Center conducted in-depth qualitative research in six inclusive community settings across Indiana. Our team of researchers wanted to find out what contributed to the successful inclusion of young children with significant disabilities. The study design called for identifying children who were served in community settings. We expected to see children who were full participants in their settings and receiving all services within the classroom environment.

Seven children were identified in settings that included community preschools and child care programs. Data was gathered over a six-month period from the cluster of people associated with each child. More than thirty early intervention (EI) and early childhood special education (ECSE) therapists and teachers, early childhood education (ECE) staff, and parents participated. The data was collected through interviews, observations, and review of children's individual family service plans or individualized education programs. Qualitative study methods were used to analyze the data to discover essential elements that were present across the settings.

Key elements were identified which support children in inclusive settings. While all of the settings had features of each element, some were stronger in one aspect than another. The key elements were a) attitudes, b) parent-provider relationships, c) therapeutic interventions utilized within typical community settings, and d) adaptations to support children in the everyday routines and learning activities provided for all children.

The topics in this Inclusion Research Series address our findings around these key elements.

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