NATIONAL INDIVIDUALIZING PRESCHOOL INCLUSION PROJECT

IMPLEMENTATION MANUAL

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IDEAs that Work
U.S. Office of Special Education Programs

Contributions

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Integrated Therapy and Special Education

Integrated therapy and special education means different things to different people, therefore it is important to provide a definition of integrated therapy as applied in this model. Basically, integrated therapy and special education is the coordination of therapy or specialized services and education. It is not the same thing as inclusion, which is providing educational services or care to children with and without disabilities in the same setting. It is possible to provide integrated therapy and special education in segregated settings (e.g., a classroom of children with special needs only) as well as in inclusive settings.

Dimensions

Many people conceive of integrated therapy and special education as a service that is provided in the child's classroom rather than in a separate therapy room. However, there are at least five additional dimensions to integrated therapy and special education that are identified in the literature: presence of peers, adult versus child initiations, context of intervention, goals of therapy, and the role of the specialist (McWilliam, 1995). Each of these dimensions is affected by the other dimensions to make service delivery more integrated or segregated.

	Segregated	Integrated
Location	Therapy room, or setting away from the rest of the class	Classroom, or setting in which the rest of the class occupies
Peers	Absent	Present
Initiator	Therapist initiates activity	Child initiates activity
Context	Activity unrelated to what the class is doing	Activity in which the rest of the is involved
Goals	Developmental or prerequisite	Functional, i.e., immediately useful
Therapist's Role	Working directly with the child	Consulting with the regular caregiver

Location

Clearly, therapy or special education that is provided in a therapy room is the most segregated option when considering location, but therapy or special education that is provided in the classroom can still be segregated. For example, a specialist can set up a work space in the corner of the child's classroom and work one on one with the child on a structured activity while the rest of the class participates in a cooking

activity. Even though therapy or special education is provided in the classroom, it is not fully integrated. In order for therapy or special education to be provided in the most integrated manner, regular classroom routines and activities should be the context for services with consideration being given to the other dimensions described here as well.

Presence of Peers

Therapy or special education can be done in the presence or absence of other children. Often, when therapy or special education is provided in the classroom, peers are present. Peer presence can result in active (e.g., four children playing dress-up together in the dramatic play area) or passive peer involvement in therapy or special education (e.g., children building with blocks side by side on the carpet). When therapy or special education is provided away from the classroom or in a therapy room, peers are less likely to be present, unless a specialist pulls out a group of children.

Adult versus Child Initiations

This dimension focuses on the specialist's intervention approach: Is the specialist directive or responsive when working with a child? A directive approach is less likely to fit within the context of classroom routines or respond to a child's interests. One of the reasons for integrating therapies or special education into the classroom is so that teachers can carry out interventions when the specialists are not present. Therefore, if a specialist is able to provide intervention while responding to a child's cues or following the child's lead, teachers are more apt to see how they can implement the intervention in the classroom- without interrupting the flow of routines or making major adaptations.

Context of Intervention

The context of intervention refers to whether the activity in which intervention is being provided is related to or separate from what the rest of the class is doing. When a child is pulled out of the classroom for therapy or special instruction, the context of the intervention is always separate from the rest of the class. The focus of intervention may be related to the activity or routine in which the rest of the class is involved (e.g., teaching a child to draw circles and lines while the rest of the class is involved in an art activity), but is nonetheless occurring in a separate context. If a specialist goes into the classroom and joins a child in a classroom activity or conducts a group activity, the context of intervention is the classroom routine. Therapy or special instruction provided in the classroom, however, does not preclude other contexts for intervention. For example, a specialist may bring a game into the classroom and play it with the focal child in the corner of the classroom. Although therapy or special instruction is being provided in the classroom, it is not being fully integrated into the classroom routine.

Goals of Therapy

Goals that focus on skills or behaviors that are immediately useful for a child are considered to be functional goals. Goals that focus on skills or behaviors that are developmental or precursors to other skills may or may not have any function for a child. Functional goals are easier to address in the context of regular classroom routines.

See It In Action: Thinking about Integrated Therapy!

Shelby's parents would like him to learn to walk. Currently Shelby, a two year old with Down syndrome, moves around the house by scooting on his bottom. Before Shelby walks, some members of his intervention team believe he needs to learn how to crawl first (developmentally, crawling comes before walking).

If the team were to make crawling a goal for Shelby, it would be considered a developmental or prerequisite goal, not a functional goal. Learning to crawl would be of no use to Shelby- scooting has replaced the function for crawling. If crawling were a goal for Shelby, the team might actually be holding Shelby back from progressing towards walking. Some professionals could argue that Shelby needs to use crawling in order to build muscle tone and enhance the use of his arms. Strengthening the muscles can be addressed in other, more functional ways.

Continuing with this example, it would be much harder for a therapist or teacher to work on crawling with Shelby in the context of classroom activities. It would require the adult to consistently be on Shelby, repositioning him to his hands and knees every time he attempted to scoot. Not only is this quite demanding for the adults involved, Shelby is likely to object.

Role of the therapist

The role of the specialist can be to provide direct, hands-on intervention to the child, or it can be consultative, or some combination of the two. Over the years, the specialist's role has been largely to work with the child directly. Communication between the specialist and other caregivers might be very limited or focus on what activities or exercises the caregiver should work on with the child between therapy or

special education sessions, kind of like homework. We know from our work, however, that this approach is less effective for at least two reasons:

1. Specialists are not magicians. Therapy or special instruction for 30-minutes twice a week is not going to cure or magically enable a child to do new things. Children learn through dispersed trials across settings- what they do on a daily basis in their natural environments, not in isolated sessions or through massed trials (McWilliam, 2000). Therefore, therapy or special instruction should be tailored to support the child in daily activities- maximizing opportunities for practice and generalization. In order for this to happen, specialists need to know what a child does and does not need to do on a daily basis. Specialists get this information through observation of a child in his/her daily routines and consultation with child's regular caregivers.

2. Parents and teachers are not specialists. Giving a child's caregivers "homework" to do between sessions is an unnecessary burden. Families with typical children can be challenged to accomplish all they must do (getting everyone ready, transporting, working, preparing meals, doing laundry, cleaning) leaving little time to play and enjoy one another. Why make families of children with disabilities add therapy or special instruction time to their "to do" list? By talking with the family about their concerns and daily routines, specialists can come up with feasible suggestions for families to incorporate into their existing routines without making major accommodations or adjustments to their schedule. The same issues apply to teachers. In a classroom with several other children present, it is not reasonable to expect teachers to do therapy activities that are unrelated to what is happening in the classroom.

When therapy is integrated into classroom routines, research shows that four times as much communication takes place between the child's teacher and therapist than when pull-out is used. While therapists work with a child in the classroom, teachers have an opportunity to see what the therapist does with a child and implement those same strategies into the rest of the week when the therapist is not present. Intervention opportunities are increased dramatically- and the child practices target skills in context.

Just do the math!

Let's say Anne receives 60 minutes of speech therapy a week. The SL/P talks to the teacher while she is in the classroom working with Anne, so that Anne's teacher knows what strategies the therapist uses to increase Anne's communication skills. If the teacher is able to implement those same strategies with Anne on communicating her wants for 10 minutes out of every hour, and Anne is at daycare for 8 hours a day, five days a week (10 x 8 x 5), then Anne is actually getting an additional 400 minutes each week of intervention.

Integrated Services: Review of Research

There are many practices taking place in the field of special education that lack the empirical evidence needed to substantiate their use (McWilliam, 1999). Such controversial practices not only give families a false sense of hope, but also waste their time, effort, and money. It is important for professionals to investigate the efficacy of certain practices before implementing them. This section lists some of the major findings of the research conducted by McWilliam and others on integrated therapy[1].

Child Outcomes

- A reversal single-subject design was used to compare isolated therapy and integrated therapy for teaching a 13-year-old girl with multiple disabilities to use of a microswitch. Results indicated that more trials were correct using integrated therapy. In addition, performance lowered in return to baseline condition in isolated therapy (Giangreco, 1986).

- In a study comparing in-class and out-of-class physical and occupational therapy, no significant differences were found for 61 preschoolers using a standardized scale of motor development. Both small-group and individual models were used in both groups; services differed only in location (Cole, Harris, Eland, & Mills, 1989).

- In a random assignment study, occupational therapy services were provided one-on-one outside of the classroom in one group and through a collaborative consultation model in the other. IEP goal attainment for the 14 preschoolers participating in the study was similar across groups (Dunn, 1990).

- A random assignment language study compared target word acquisition using indirect therapy (classroom) versus individual pull-out therapy. Twenty children, 20-47 months of age, were randomly assigned to the two conditions. An interactive modeling intervention was used in both groups. Results indicated no difference in the use of target words in the classroom. However, the children in the classroom group better generalized words to the home setting (Wilcox, Kouri, & Caswell, 1991).

- An alternating treatments design determined the extent to which location affected acquisition and generalization of skills taught by a specialist. Intervention occurred either in the classroom or a small therapy room. Four children participated. No difference in acquisition was found between tasks taught in class and those taught in isolation. Results showed that the nature of the task had more of an effect than location. Supporting qualitative information suggested that to make instruction successful, tasks should be varied, responsive teaching should be used, and close attention should be paid to reinforcers. Moreover, to make in-class instruction successful, specialists should provide instruction during ongoing routines, form partnerships with teachers, and monitor peer involvement (McWilliam & Grabowski, 1993).

[1] A similar summary appears in the manual series for Project INTEGRATE.

- Three children participated in an adapted alternating treatments design to compare the generalization effects of integrated versus pull-out therapy. Integrated speech and language therapy occurred in each child's classroom. Pull-out speech and language therapy occurred in a therapy room furnished like a classroom. Target behaviors were selected from each child's IEP. Results showed that more target behaviors were displayed for the integrated goals than for the pull-out goals. However, no diverging or converging trends that might suggest one treatment was more effective than the other were seen. Additional results indicated that teachers and clinicians perceived advantages to the integrated therapy model (McWilliam & Spencer, 1993).

- No differences in fine and gross motor skill attainment were seen in a group comparison of individual and group treatment methods. Gains were seen in both groups in the home and the clinic setting (Davies & Gaven, 1994).

- Interactions between preschool children with disabilities and their speech and language pathologists during in-class and out-of-class therapy were compared. Fifteen children were matched in pairs by developmental profile and age and randomly assigned to in-class or out-of-class. After the children received 3 months of therapy, sessions were videotaped and reviewed for turn taking, functions of communication, and the effect of communication. Results indicated that speech and language pathologists took more turns in the out-of-class model but differences were not seen in the therapists' percentages of responses, information sharing, behavior requests, or acknowledgements. Children in the out-of-class model complied more with requests than children in the in-class model, but differences were not seen in the number of turns, percentage of responses, and behavior regulation (Roberts, Prizant, & McWilliam, 1995).

- One study, designed to collect information about developmental progress in 37 toddlers receiving early intervention services in two types of service delivery models, provided important information about integrated versus pull-out specialized services. One component of the study collected data related to the types and frequencies of specialized services provided weekly. Programs offering a segregated model were rehabilitation centers serving only children with disabilities. The state agency provided an inclusive model with services offered either in the home or in group programs in which children without disabilities participated. Child progress was measured at 3 points (24, 30, and 36 months), using the Battelle Developmental Inventory, the Peabody Developmental Motor Scale, and the Preschool Language Scale-3. Several analyses were completed to determine differences between the settings, and repeated measures analysis of variance was used to determine differences in groups over time. In addition, proportional change index scores and developmental assessments age equivalence scores were calculated to ensure that maturation and individual differences were carefully considered, and hierarchical multiple regression was completed to determine a potential relationship between change in development and setting. An analysis of the types of services children received showed that children in the segregated setting received occupational and speech therapy at a significantly higher rate than children in the inclusion setting. In addition, the intensity of therapies was greater for children in segregated settings. Analyses also revealed that children in both settings progressed developmentally but there was not a difference between the two groups. These results suggest that early intervention services provided in childcare settings were as effective as providing services in a segregated

setting that included higher rates and intensity of specialized services (Bruder & Staff, 1998).

Specialists

- Professionals from OT, PT, SLP, and special educators report that they would ideally use more integrated practices than they currently do (McWilliam & Bailey, 1994).

- Although professionals often would like to choose therapy models on the basis of the individual child's characteristics, these actually account for only 10% of the variance in their choice, after taking into account discipline, specific interventions, caseload, family preferences, and classroom characteristics (McWilliam & Bailey, 1994).

- The discipline of the provider is the most powerful predictor of his or her choosing an in-class approach (McWilliam & Bailey, 1994). Special educators report using and favoring the most integrated approaches, followed by occupational therapists, and then speech-language pathologists and physical therapists (no difference between the last two).

- Therapists say they would like to use and do use a combination of approaches (McWilliam & Bailey, 1994; McWilliam, 1996) but the data show they actually tend to be very consistent in using one approach across all children and, with any one child, across sessions (McWilliam, Scarborough, & Chaudhary, 1995).

- The therapist's style, especially encouragement, is even more important than the type of therapy or location (McWilliam & Scarborough, 1994).

- Among OT, PT, and SLP, only the location of PT appears to have an impact on generalization, with in-class therapy being more successful than out-of-class therapy (McWilliam & Scarborough, 1994). Regardless of location, however, OT produced more generalization.

Teachers and Parents

- Classroom staff prefer in-class, small-group PT and OT sessions to out-of-class, individual sessions (Cole, Harris, Eland, & Mills, 1989; McWilliam, 1996).

- Teachers seldom attend to therapists' target goals during nontherapy time (i.e., generalization setting), and children do not display the target skills in nontherapy times (McWilliam & Scarborough, 1994; McWilliam, 1996).

- Teachers and therapist prefer integrated to pull-out services when they have experience with both (McWilliam, 1996).

- When teachers are taught to embed instruction in everyday routines, children demonstrate concomitant increases in IEP-targeted behaviors (Peck, Killen, & Baumgart, 1989).

- Parents believe that more therapy is better (Hinojosa, 1990; McWilliam, Young, & Harville, 1996).

- The rate of interaction between child and specialist is higher in a one-on-one situation than in an in-class situation (Roberts et al., 1995).

The research generally supports the idea of integrating specialized services, however, there is not solid (i.e., replicated) findings that one model is substantially more effective with child outcomes. In light of this, we still promote integrated services because

- ✓ What little difference can be found in child outcomes is in favor of integrated rather than segregated approaches;

- ✓ It strengthens all team members, stretching them to be more knowledgeable and skillful in more areas; and

- ✓ It is more developmentally appropriate, allowing the child to learn through natural routines rather than separate sessions

Helpful Tools – Integrated Therapy and Special Education

Below are several tools to assist professionals implement integrated therapy and special education.

Scale of Integrated Therapy (pg. 85)

This discrepancy tool is designed to help professionals examine their typical and ideal practices in providing services to young children with disabilities.

Consultation Checklist (pg. 90)

What information should teachers and specialists be prepared to provide to support each other in providing integrated therapy? This checklist helps professionals make the most of consultation time.

Specialist Documentation Form **– SDF** (pg. 91)

The Specialist Documentation Form is a tool for use by consultants, such as therapists or itinerant teachers, in indicating the model of service delivery they used to address the outcomes or goals for children with disabilities. There are six models of service delivery to choose from: individual pull-out, small group pull-out, one-on-one in the classroom, group activity, individualized within routines, and consultation. The six models are listed from most (individual pull-out) to least segregated (consultation). The professional is asked to check the model used for most of the time during the session and to specify how long the session lasted. The form was designed to be used by consultants each time they work with a particular child. The Specialist Documentation Form is useful for professionals to begin thinking about the manner in which therapy and specialized instruction are provided to children. It is recommended to be used when programs are trying to provide more integrated services. The form serves as a way to monitor how therapy and specialized instruction are currently provided and to gradually move down the continuum towards more integrated models.

*Name:*_____

Date: __/__/__

Scale of Integrated Therapy

Classroom Version

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Frank Porter Graham Child Development Center
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Project INTEGRATE
1998

IDEAs that Work
U.S. Office of Special Education Programs

Remember, for each item, circle one number for Typical Practice and one number for Ideal Practice.

Typical & Ideal Practices

Instructions

This scale focuses on your typical and ideal practices in providing specialized services* to children under the age of 6 years. For each item, please make **two** ratings. Above the item, circle the number that best reflects *how services are **typically** provided*. Below the item, circle the number that best describes *how you think services **ideally** ought to be provided*. If you are a specialist, you should rate your own typical and ideal practices. If you are a classroom teacher, parent, administrator, or other person, you should rate how specialists typically and ideally provide services.

A. Location of Therapy/ Instruction

Typical Practice

1	2	3	4	5	6	7	8	9
All therapy/ instruction is provided in a separate room **away** from child's classroom		Most therapy/ instruction is provided in a separate room away from child's classroom		Therapy/instruction is **equally divided** between **in-class & out-of-class settings**		Most therapy/ instruction is provided in the child's classroom		**All** therapy/ instruction is provided in the child's **classroom**

Ideal Practice

B. Presence of Peers

Typical Practice

1	2	3	4	5	6	7	8	9
Peers are **never allowed** during therapy/instruction		Peers are **rarely present** during therapy/instruction		About half **the time**, peers are included in therapy/ instruction		Peers are **sometimes encouraged** to participate in therapy/ instruction		Peers are **always encouraged** to participate in therapy/ instruction

Ideal Practice

"Specialized services" refers to OT, PT, SLP, consulting/ itinerant special education, and home based services.

Remember, for each item, circle one number for Typical Practice and one number for Ideal Practice.

C. Context of Child-Level Interventions

Typical Practice

1	2	3	4	5	6	7	8	9
All therapy/instruction is provided **apart** from ongoing classroom routines & activities		Some therapy/instruction is provided **apart** from ongoing classroom routines & activities		About **half** the therapy/ instruction is provided **as part** of ongoing classroom routines & activities		Most therapy/instruction is provided as part of ongoing classroom routines & activities		All therapy/instruction is provided as part of ongoing classroom routines & activities

1	2	3	4	5	6	7	8	9

Ideal Practice

D. Goals

Typical Practice

1	2	3	4	5	6	7	8	9
Instructional goals are based on developmental **checklists** but not necessary for current routines		**Instructional goals** address **skills that help development** but irrelevant for current routines		**Instructional goals** address **skills that might be necessary in the future** but not for current routines		**Instructional goals** address **skills that are useful** but not necessary for current routines		**Instructional goals** address **skills necessary** for current routines

1	2	3	4	5	6	7	8	9

Ideal Practice

E. Assessment

Typical Practice

1	2	3	4	5	6	7	8	9
All information used to determine a child's needs is based on standardized measures or developmental checklists		Most information used to determine a child's needs is based on standardized measures or developmental checklists		About half the information used to determine a child's needs is based on standardized measures or developmental checklists		Most information used to determine a child's needs is based on observations during natural routines		All information used to determine a child's needs is based on observations during natural routines

1	2	3	4	5	6	7	8	9

Ideal Practice

Remember, for each item, circle one number for Typical Practice and one number for Ideal Practice.

F. Specialist's Role

Typical Practice

1	2	3	4	5	6	7	8	9
The specialist's **only** role is to provide **direct therapy/ instruction** for the child		The specialist's role is **mostly** to provide **direct therapy/ instruction** for the child with some **consultation** to the teacher		The specialist's role is **equally divided** between **direct therapy/ instruction** to the child and **consultation** to the teacher		The specialist's role is m**ostly** to **consult** with the teacher, with some direct therapy/ instruction for the child		The specialist's **only** role is to **consult** with the child's regular teacher

Ideal Practice

G. Classroom Teacher's Role

Typical Practice

1	2	3	4	5	6	7	8	9
The classroom **teacher does not provide** the specialist with the **classroom curriculum***		The **teacher** does provide the curriculum but **does not seek** the specialist's **input** for individualizing the curriculum		The **teacher** asks the specialist for **general ideas** for individualizing the curriculum		The **teacher** asks the specialist for **specific suggestions** for individualizing the curriculum		The **teacher and specialist** work **collaboratively** to individualize the curriculum

Ideal Practice

H. Working on Goals

Typical Practice

1	2	3	4	5	6	7	8	9
Specialists work on goals in their own area- the **c**lassroom teacher does not work on IEP/IFSP goals		**Mostly, specialists** work on goals in their own area- the **classroom teacher** works on only a **few**		**The** classroom teacher **works** on **about half** of IEP/ IFSP goals		The classroom teacher works on most IEP/ IFSP goals		The classroom teacher works on all of IEP/ IFSP goals

Ideal Practice

Remember, for each item, circle one number for Typical Practice and one number for Ideal Practice.

I. Consultation Style

Typical Practice

1	2	3	4	5	6	7	8	9
Specialist assesses needs and makes recommendations		Specialist assesses needs, **seeks teacher input** and makes recommendations		Specialist and teacher assess needs and specialist makes recommendations		Specialist and teacher **assess needs and make** recommendations **to each other**		Specialist and teacher assess needs and arrive at solutions together

Ideal Practice

J. Communication

Typical Practice

1	2	3	4	5	6	7	8	9
Essentially **no communication** between specialist and classroom teacher		Occasional written notes between specialist and classroom teacher		Occasional meetings between specialist and classroom teacher		Brief conversations most days the specialist is present		Conversation every day **the specialist is** present

Ideal Practice

Now look back over your responses. If there is generally a difference between your typical practices and what you consider to be best practice, what factors contribute to the discrepancy?

Remember, for each item, circle one number for Typical Practice and one number for Ideal Practice.

Consultation Checklist

Name:

Did the classroom teacher

Date:				
1. Discuss ahead of time how consultation would be provided (e.g., at the beginning and end of each session, by telephone, weekly meetings, by email)?				
2. Provide the specialist with lesson plans for the upcoming week?				
3. Review the IFSP/ IEP to determine the priorities for the child?				
4. Communicate, at the beginning of the meeting/session, what his or her concerns and priorities are ("I am not sure how to use this equipment", or "Johnny is not able to participate fully in centers because of…")?				
5. Discuss which goals will be addressed (e.g., "Since there are several art activities planned, why don't we work on reaching for/grasping items, such as brushes or sponges")?				
6. Discuss which service delivery models to use to address goals (e.g., group activity or individual within routines)?				
7. Report on any progress or difficulty the child has displayed in the classroom ("I've noticed that Sue is not sitting upright in her seat, but sliding down. This makes it difficult for her to stay engaged in an activity. What do you suggest?")?				
8. Ask the specialist if any adaptations or changes in activities should be made ("Do you think George could try using his walker when we do…)?				
9. Ask the specialist for feedback ("Is there anything I should do differently")?				
10. Ask the specialist for clarification on interventions to implement ("I have not felt comfortable using the stander for outside art activities")?				
11. Ask the specialist to clarify any terms or techniques that you do not understand ("Why do the child's gums and tongue need to be rubbed with this rubber brush before lunch")?				
12. Thank the specialist for their time ("I appreciate the information you provided me with")?				
13. Speak in a respectful, yet assertive manner (i.e., neither burdened nor subordinated)?				

Specialist Documentation Form

Date: _____ Child's Name: _____ Session Length (in minutes): _____

Special Service (circle one): SE SLP PT OT Other Service: _____ Specialist's Initials: _____

Model	Description	Model Used for Most of the Session (CHECK ONE)
Individual Pull-Out	Location: Outside of the child's classroom Focus: Child's functioning and his or her areas of greatest need. Peers are not involved. Therapy activities are determined by the specialist. Teacher's Role: Provide information before therapy and receive information afterward	
Small Group Pull-Out	Location: Outside of the child's classroom Focus: The functioning of the child with special needs. At least one other child is involved and he or she might or might not have special needs. Therapy activities are determined by the specialist. Teacher's Role: Provide information before therapy and receive information afterward. Schedule group sessions and decide (with the specialist) which peers will participate.	
1:1 in Classroom	Location: In the classroom, usually away from the other children Focus: Child's functioning and his or her areas of greatest need. Therapy activities are specialist- or child-initiated and typically unrelated to the ongoing classroom activity. Peers are present in the classroom, but they are not involved in therapy or specialized instruction. Teacher's Role: Conduct activities and play with other children, keep children from disrupting therapy, and watch the session. Provide information before the session and receive information after the session.	
Group Activity	Location: In the classroom in a small or large group Focus: All children in the group. Emphasis is placed on peer interactions and meeting the special needs of one or more of the children. Therapy activities are specialist- or child-initiated and may be planned with the teacher. Teacher's Role: Conduct activities and play with other children (when the format is small group), watch and participate in group activities, help to plan the large group and possibly the small group activities.	
Individualized Within Routines	Location: In the classroom, in the activity that the focal child is involved in Focus: The child with special needs (but not exclusively). Therapy is provided during ongoing classroom routines and is typically child-initiated. Peers are usually involved. Teacher's Role: Plan and conduct an activity that includes the focal child, observe the specialist's interactions with the child, provide information before the session, and exchange information with the specialist after the routine.	
Consultation	Location: In or outside of the classroom Focus: The classroom teacher (related to the needs of the focal child). The topic is specialist- or teacher-initiated and includes discussion of concerns, priorities, and recommendations. Teacher's Role: Exchange information and expertise with the specialist, help plan future sessions, and give and receive feedback.	

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