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Mental Health Support: Through the Early Development Networks Team's Perspective

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MENTAL HEALTH SUPPORT: THROUGH THE EARLY DEVELOPMENT
NETWORKS TEAM'S PERSPECTIVE

By

Heather Post

A DISSERTATION

Presented to the Faculty of

The Graduate College at the University of Nebraska

In Partial Fulfillment of Requirements

For the Degree of Doctor of Education

Major: Educational Administration

Under the Supervision of Dr. Jeanne L. Surface

Omaha, Nebraska

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ABSTRACT

MENTAL HEALTH SUPPORT: THROUGH THE EARLY DEVELOPMENT NETWORKS TEAM'S PERSPECTIVE

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University of Nebraska, 2021

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The purpose of this phenomenological case study was to explore the implementation of Nebraska Rule 52 Primary Service Provider model from the perspectives of the Primary Service Providers as well as the Services Coordinator. This study explored how the Primary Service Provider model is effectively meeting the needs of the child and family in the areas of mental health and social emotional support.

This research added to the knowledge and information of our key stakeholders to determine a more intensive training for our Early Development Network team and how to best support these professionals as they are working with the most vulnerable and impactful population. In this study eight early development network professionals participated in interviews which were transcribed and coded. Thematic analysis indicated that when discussing components of the primary service provider model and how the model supports family's mental health and the child's social emotional development. The interview data brought about themes representing observation and assessments of development and learning, family support and partnership, continuous improvement and professionalism, individualized supports and inclusion-based practice, barriers and challenges of implementing primary service provider model, child find process, and collaboration with school professionals, educational service units, or planning region

teams. Therefore, according to these eight early development network professionals it is important to have all of these characteristics when implementing the primary service provider model in order to meet the needs of the families. It is important that the barriers of implementing the primary service provider model addressed to be able to support all of the needs of the child and family. Since the barriers and challenges constituted for 23% of all of the coded thematic data.

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Chapter 1 Introduction

When I think about the early intervention services that are being provided to the birth to three populations in the state of Nebraska I think about the story of Jonah and his families. Jonah was a child who was being removed from his home due to drugs in the home. The referral came through the Department of Health and Human Services as a Child Abuse Prevention Act (CAPTA) case. Once the Early Development Team received the referral it was processed and an Early Childhood Special Education Teacher was assigned to the case as well as an occupational therapist. Once the intake, routine based interview, ecomap, and the assessments were completed. The team determined that Jonah qualified for early intervention services due to the removal from his home and the potential of developmental delays.

Jonah was currently placed in a foster placement so the services were determined by the biological parents. The biological parents determined that they would like services so the Primary Service Provider that was assigned to the child was an Early Childhood Special Education (ECSE) teacher. The ECSE teacher was in charge of the coaching for the family with the foster parents and biological parents. The Services Coordinator on the team was also assigned to the family to help provide access to the community resources.

Jonah had significant trauma from the multiple removals from his parents and home. He also had behaviors when he moved in with his foster parents and during the home visits with the Primary Service Provider. The team discussed the need to structure the visits when he was with his biological parents but sometimes the visits would consist so much about the resources or struggles of the parents that it was hard to coach the

adults in his life on how to support his needs in both environments. Since the team had an early childhood team consisting of an early childhood special education teacher, speech-language pathologist, and an occupational therapist in this district the early childhood special education teacher was the primary service provider for this family. The primary service provider had access to the team who had knowledge in the area of mental health and social-emotional but she was the one delivering the coaching to the family. The Primary Service Provider expressed frustration that she was unable to provide any services to the child because they were working so hard on getting the family's needs met and being able to make sure that the parents were mentally available to be coached with the natural environment. These are often the struggles that many Services Coordinators as well as the Early Development Network Team face as well.

By providing early intervention in the area of social-emotional learning, children have the ability to be successful later by meeting their basic skills. However, some research has been done to discuss the correlation between teacher preparation and training of professionals to provide research-based social-emotional learning to help support all birth to three children. The population of early childhood was chosen because it is important to be preventative and intervene as early as possible to have the greatest impact. Exploring how early childhood professionals are trained and providing evidence-based and developmentally appropriate practices for the birth to three population. This helps determine the best outcomes for the early childhood population to decrease the future needs of this population.

In the state of Nebraska, the birth to three early development network teams has a process in how they identify and serve children in their communities. Each team could

consist of an early childhood special education teacher, speech-language pathologist, occupational therapist, school psychologist, physical therapist, and other related service providers. All of the birth to three teams have a services coordinator that is an active member of the identified child's team.

In the area of birth to three identification processes, there are specific timelines to ensure that children have access to timely evaluation and the services are provided as quickly as they can because the early childhood population is the most vulnerable. When the team receives a referral, they then identify two service providers along with a services coordinator who will go out to the family's home or natural environment to complete a series of assessments and observations. The first thing that the team completes is an assessment called a Routine Based Interview (Appendix E) along with an ecomap (Appendix D) of the family's support systems. After the routines-based interview, the team performs an early childhood assessment that evaluates all domains of the child's development to determine if the child has a delay or disability according to the Nebraska special education laws of Rule 51 or Rule 52. The child's assessments are completed in all five developmental areas of cognitive, communication, physical, social-emotional, and adaptive.

If the child qualifies for services under Rule 52 or Rule 51 then there is a primary service provider that is assigned to the child as well as a services coordinator. Any child in the birth to three identification process can be identified as having a developmental delay through Rule 52 which is a law that only pertains to the birth to three populations (Nebraska Department of Education, 2013). When evaluating a birth to three children they can meet verification according to Rule 51 as well in one of the 13 categories if

developmental delay is not their primary disability (Nebraska Department of Education, 2017). Once the child is identified the team develops family goals that are part of the child's Individual Family Service Plan (IFSP) and then the team develops service minutes based on the needs of the family a sample IFSP is in Appendix F. The services coordinator typically only sees the family once a month and alternates months of face to face contact and phone meeting or touching base with them through a home visit. They can meet more frequently with the family if the family chooses so. In Appendix G is a sample of a home visit form for the services coordinators.

The services coordinators can often have 30 to 60 families on their caseloads and often do not get to spend as much time with the families as some of the families need these supports. Services coordinator role is to connect families to resources in the community as well as support any of the family goals that they can. It was also noted that some of the service coordinators may have earned bachelor's degrees in non-education related fields depending on the district.

Some of the families that are being provided these services need more individual mental health support and the team can connect them to resources but often the team may not have the skill sets to intervene with an intense support family. In the state of Nebraska families automatically meet the criteria for services when the child has had a traumatic experience, medical condition or that may lead to a developmental delay.

As one may notice through these early intervention services some children and their families may not have the appropriate Primary Service Provider to meet their needs because the team is not trained or the early development network team consists of only a couple of individuals.

Statement of Purpose

Therefore, the purpose of this phenomenological case study was to study the lived experience of Nebraska's primary service team members in providing social-emotional and mental health support for families of the young children population of birth to age 3. By completing a phenomenological case study the researcher heard the passion and experiences of many early development network team members. A phenomenological case study allows the researcher to experience interviewees journeys in their education and how they use their expertise to support their families. Through this phenomenological case study, the researcher hopes to gain an understanding and obtain knowledge about how the states can better support families, children, and educators on their journey of providing early intervention services. In this case study, the researcher will be using the reflexivity process to examine the researcher's own values, passion, and experiences that influence the research process. The researcher understands that they hold their own personal values, experiences and take a certain position on certain topics but by using the reflexivity process the researcher hopes to bring these biases and positions to the surface in the research study.

In the area of early childhood birth to three, it is important to be able to intervene and support children and families at a young age. The research and the history of early childhood development are centered around supporting children as early as birth to help the child be the most successful and supported. The focus of the study was in the areas of social-emotional and mental health of families and children in the birth to three early intervention programs. According to Zero to Three (2012) "infant-early childhood mental health (I-ECMH), sometimes referred to as social and emotional development, is

the developing capacity of the child from birth to 5 years of age to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, community, and culture.” There are many factors that attribute to the development of young children and their families such as support, trauma, brain development, legislation and services, roles of the professionals, and the training and expertise of the professionals. The process of a home visit and the services that are provided during these home visits are also key to the success of the child. The home visit consists of some of the following processes: effective team meetings, routine based interviews, coaching, services coordination, and the use of the primary service provider model to best support the families of our children in the birth to three programs with disabilities.

Central Research Question

The research was guided by one primary research question:

- How do four rural Nebraska School Districts implement Rule 52 birth to three Primary Service Provider Model, in particular social-emotional support for the child?

Key Terms to Know

Early Development Network. Any educational staff (school psychologist, occupational therapist, speech-language therapist, physical therapist, special education early childhood teacher, etc.) serving the birth to three population as well as the service coordinators.

Evaluation. Evaluation means the procedures used by qualified personnel to determine a child’s initial and continuing eligibility under this Chapter consistent with the definition of infants or toddlers with a disability.

Early Intervention Services (EIS). The term to describe the services and supports that are available to babies and young children.

Individual Family Service Plan. A family-based approach to services that is written in this plan to address the child's and family's needs.

Mental Health. A person's condition with regards to their psychological and emotional well-being.

Primary Service Provider Model. Is a family-centered, capacity building method to intervene with young children with developmental delays that use a primary coach (one team member) as the liaison to and agent of the early intervention program to coach parents and caregivers on how to foster growth in development or capacity of children.

Primary Service Provider. A member of the team who serves the family and is the liaison to the rest of the team.

Results Matter. Result Matters was implemented in 2006 to meet federal requirements. Results Matter examines three areas: student outcomes, parent involvement, and program quality.

Routine Based Interview. A semi-structured interview that helps the team examine and understand the day to day activities of the child in the family and community setting.

Rule 11. The Nebraska Department of Education guidelines for preschool programs within Nebraska to provide consistency among grant preschools and school district preschools.

Rule 52. The Nebraska Department of Education guidelines for the birth to three population within the state of Nebraska for special education services.

Rule 51. The Nebraska Department of Education guidelines for the three to twenty-one

population within the state of Nebraska for special education services.

Services Coordinators. They assist and enable an infant or toddler with a disability and the child's family to receive the services and rights, including procedural safeguards, required under part C.

Social-Emotional. A child's social-emotional ability is the integrated functioning of effectiveness in interaction and distinct skills that include the knowledge, identification, regulation, and expression of emotions.

Teaching Strategies GOLD. Seamless system for assessing children from birth through kindergarten with measurement in all developmental areas

Delimitations

The delimitations of this phenomenology case study included setting, participants, years of service, and location within Nebraska. This study involves a focus on rural school districts and their perspective on how they implement the primary service provider model and service delivery.

The participants in this study were selected based on their school district populations, district size, and planning region team for early childhood in the state of Nebraska. Not all of the districts were equal in size or had similar access to resources but they were chosen based upon demographic factors. These team members were also chosen by their administrators for the interview and were not selected based on certain criteria other than their job roles.

Limitations

The limitations of this study may include a lack of ability to generalize to other planning region teams or other states due to resources, participants that make up their

early development network team, and how the team functions as a whole. There may be a lack of shared characteristics specific to how the teams implement the primary service provider model and support that are given to families. Conducting another study with varying roles and more criteria on the selection process of participants is possible and would add to the research and support of services that are provided in the early childhood field. While there may have been more early intervention rural districts team that could have been selected, time constraints and the nature of the qualitative study limited it to eight participants. Data collection was subjective and may have been interpreted differently by another researcher.

Rationale and Significance

The paradigm of social constructionism, which was used in this research, focuses on interpretation of subjective meaning and shared knowledge that was developed through interactions (Savin-Baden & Major, 2013). The social constructionism theory explored the perspective of members on the early development network planning region teams in how they implement the primary service provider model and the support that they provide families in the areas of social-emotional and mental health. The researcher explored how participants and society construct meaning in an area of interest by using social constructionism theory. It is imperative to the field of research to explore how cultural influences play an important role in the way that individuals construct knowledge through interacting with each other (Savin-Baden & Major, 2013). An American historian and philosopher named Kuhn who discovered this paradigm many years ago was thought to be very controversial at the time but now this paradigm is used by many (Savin-Baden & Major, 2013). Kuhn documented how knowledge socially and culturally

constructed and ultimately changed and transformed (Savin-Baden & Major, 2013). Through the exploration of a new paradigm of research when the paradigm is challenged and anomalies arise these challenges and anomalies become an issue and are questioned by many. A crisis arrived from this creating more research which develops more paradigms. Using the paradigm of social constructionism for this research study helped to provide the field of early childhood with knowledge about how services and supports are been given to families and children in the area of social emotional and mental health. Social constructionism created deeper meaning for this researcher through having individuals construct social meaning and their own shared realities through the interaction that happened during the interview process.

The significance of this study lies in developing a support system, continuing education, additional resources, and funding to help support all families and young children when they are in the key developmental areas which are most critical for growth. The study looks in-depth at how the everyday practices, resources, and supports for the early development network teams and families are able to access the mental health and social-emotional supports that are needed to give their family and young child the best opportunity at growth and success. The information has great relevance to lawmakers, staff, and the community on how the lack of funding and support may be costing us more money when they enroll in schools or later in education. By breaking some of these barriers and obstacles now for the family we are providing them with the knowledge and developing the support system that is needed.

The paradigm in this study was social constructionism. Social constructionism believes that the researcher can not maintain a detached or objective position and they

believe that both the researcher and subject should actively collaborate in the meaning-making process (Savin-Baden & Major, 2013). Through this theory, the researcher emerged in the research and created a dialogue between the researcher and participants. As well the researcher captured the participant's perspectives but the researchers' interpretations of the participant's views need to be understood and verified by those in the research (Savin-Baden & Major, 2013). The researcher used phenomenography which is a type of phenomenology study. A phenomenography study is to understand the variation of experiences as well as understand different ways in which people experience and apprehend various phenomena of the world (Savin-Baden & Major, 2013). Through this type of phenomenology case study, the researcher uncovered differences of understanding, located socially significant ways of thinking and sharing across a particular group, and understood concepts of the world.

This research study used a narrative approach with the use of interviews of eight early development network professionals about the implementation of the primary service provider model and services. Through the use of online transcribing and interviewing the interviews took place then the researcher started the thematic process with the data and determined how it aligns with the Early Childhood Essentials Framework.

Chapter 2 Literature Review

Introduction

A child's social-emotional ability is the integrated functioning of effectiveness in interaction and distinct skills that include the knowledge, identification, regulation, and expression of emotions (Yang, Datu, Lin, Lau, & Li, 2019). The increased needs of families and children in the United States in the area of social-emotional and mental

health have been increasing over the past years. Most services that are being provided are for the age range of 18-25 years old meaning that services for children younger are being provided a one size fits all or none at all approach (Islam,2011). With the limited number of professionals working with the younger population and the lack of services the children are not being provided the preventative services, they may need to decrease potential concerns in the future.

According to Zero to Three (2012) “infant-early childhood mental health (I-ECMH), sometimes referred to as social and emotional development, is the developing capacity of the child from birth to 5 years of age to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, community, and culture.” Social-emotional or mental health issues may be shown through physical symptoms such as (poor weight gain or slow growth), delayed development, inconsolable crying, sleep problems, aggressive or impulsive behavior, and paralyzing fears (Zero to Three, 2012). Infants and toddlers are experiencing these behaviors anywhere from schools, homes, and child care centers. Some of the barriers that are impacting services to infants and young children are the following: infant-early childhood mental health (I-ECMH) is not yet reflected in public policy, reimbursement issues that hinder the ability to pay for I-ECMH services, eligibility determinations, not enough providers with training in I-ECMH and broader systems that serves young children that do not incorporate I-ECMH services (Zero to Three, 2012).

It is important to provide social-emotional support to children early in life to help curve the behaviors and challenges before they become unmanageable. By intervening

and using preventative services within the first few years of life this will decrease the number of children needing intensive support later. In the State of Nebraska, there are regulations and laws put into place to support children as early as birth.

Importance of Social Emotional Learning in birth to five

Social-Emotional learning. Social-emotional learning is something that teachers are becoming more and more aware of as their classes become more dynamic and diverse with behaviors and needs of the child and family. Many programs are trying to support the teachers with learning and opportunities to collaborate on how to support the families and the children that are struggling with these issues. In a recent study, it was found that teachers have a strong perception that children need to learn through adult and peer modeling of appropriate behaviors as well as that significantly violent behaviors need adult intervention (Dellamattera, 2011). If teachers are seeing the needs in the classroom and at the homes of families then as educators and leaders we need to support these individuals with research, resources, and support to help their students and families grow. By providing the groundwork of social-emotional learning the teachers are helping to be preventative for future behaviors and deficits later in life. When children struggle with antisocial behaviors they are seen as a problem to their families, to other children, and to early educators according to Gilliam and Shahar (2006). Then once children have the perception of how others see them as well as how they see themselves then they may fall into the self-fulfilling prophecy and these behaviors may worsen (Housman, 2017).

Researchers generally agree upon five key competencies of SEL for school-aged children, i.e., self-awareness, self-management, social awareness, relationship skills, and responsible decision-making (Durlak et al. 2011). All of this research has focused on

more of the later ages rather than early childhood.

Early Development of the Brain

Ninety percent of the brain develops in the first 3 years during a period of plasticity (Perry, 2000). Knowing that the brain is able to be shaped at such an early age why are we not intervening and supporting these children in all aspects of their life.

Secure relationships are an important part of brain development and lay the foundation for emotional development and help protect them from many stressors that they may face as they age (The Ounce of Prevention Fund & Zero to Three, 2000). Children who receive sensitive, responsive care from their parents and other caregivers in the first years of life enjoy an important head start toward success in their lives (The Ounce of Prevention Fund & Zero to Three, 2000). Parents play a key role in providing nurturing and stimulation, in order to develop these skills they need the support and knowledge from others (The Ounce of Prevention Fund & Zero to Three, 2000). Grandparents and extended family tend to help provide this support and knowledge to form affecting parenting practices.

Mental health. Multirisk and multiproblem families require intensive team problem solving and it is even more important but also very difficult to carry out (Greenspan & Wieder, 2006). When working with families and young children it is key to remember that every child is different and every family is fighting their own battle. Some of the different types of children that early development network professionals work with are shy, quick to anger, inattentive or distractable, clinging, or negative child (Greenspan & Wieder, 2006). All of these personality types bring about different family dynamics, stressors, and parenting styles that some families struggle to deal with. To

help support these families it is important that the support and knowledge building happens quickly after the birth of the child because of the importance of intervening with these children before these at-risk factors start to impact the brain. Some of the key components to help with the prevention of at-risk and stressors on the young child's brain are to prevent abuse and neglect, provide access to quality mental health services for parents, and ensuring adequate nutrition prenatally and in the first years after birth (The Ounce of Prevention Fund & Zero to Three, 2000).

Legislation

The federal government through laws and regulations mandated services to children birth through 21 through the Individuals with Disabilities Act. In 1975, the federal government put a law into place covering age 3 to 21 services, and then in 1986 put into law birth to three services as well (Lipkin et al., 2015). In the state of Nebraska, preschool and home-based programs must meet the guidelines of the Nebraska Department of Education Rule 11. Through the guidelines in Rule 11 birth to five services, both parts B and C have requirements on how to serve students along with the requirements of the district. In 2006, the Nebraska Department of Education (NDE) initiated the Results Matter movement in order to be in compliance with federal regulations. Results Matter examined three areas: student outcomes, parent involvement, and program quality. Prior to the 2006-2007 school year, Nebraska school districts implemented their own curriculum and assessments to monitor student progress within school-based preschool settings. Creating more guidelines and policies help hold districts accountable and require them to report how educators are educating the birth to five population.

Over the years, children with and without special education needs have been served within homes, community settings, and school-based preschool programs (Marvin, LaCost, Grady, & Mooney, 2004). With the growing needs of students later in elementary school, professionals have tried to be more preventative and serve populations at a younger and younger age. In the state of Nebraska, professionals abide by Rule 52 to verify and serve children under the age of three. In accordance with Rule 52, children who have a mental or physical impairment that may lead to delays or children who meet the developmental delay criteria can have special education services. When evaluating children under the age of three the team has to evaluate in all developmental areas. Whereas for children who are three or older the child would be evaluated in accordance with Rule 51. It is important to have early identification and support for children to help reduce the risk of developmental delays later in life. By supporting children from birth to five the state is taking a preventative approach.

Accountability

Limited to no funding. As many school districts try to implement high-quality preschool and early childhood programs many of them struggle to implement these mandates when there is little to no funding through the state departments of education. As early childhood education has become a greater issue for many individuals the mandates and policies have increased as well. Even though the continued current research has proven the importance of early childhood education the reality of having limited to no funding for the implementation of these quality programs to be successful is impossible (Finn, 2010).

Explanation of early learning guidelines. The early learning guidelines are standards for the birth to five population in the state of Nebraska. According to the Nebraska Department of Education (May 2018) these early guidelines are intended to support any adult who is working with a child and provide experiences and environments that supports learning and development in the following domains:

- Social and Emotional Development
- Approaches to Learning
- Health and Physical Development
- Language and Literacy Development
- Mathematics
- Science
- Creative Arts

These domains cover all developmental areas that support the importance of a well-rounded child. Having early learning guidelines helps teachers to gear their curriculum towards developmentally appropriate practices and expectations that the children should have reached by the age of five. In the state of Nebraska, it is important that children are ready for kindergarten with a well balanced early childhood program.

Teaching Strategies GOLD

The GOLD assessment is used to help ensure that all students are evaluated fairly regardless of their culture, language, or disability. The GOLD assessment is a universal tool that is used by teachers to measure growth in a child's development and the learning of children from birth through kindergarten, including English Language Learners (ELL) and children with disabilities (Burts, Lambert, & Kim, 2014). According to Burts,

Lambert, and Kim (2014) that the Teaching Strategies GOLD assessment consists of 38 research-based objectives, and the objectives contain items in the following areas: social-emotional, physical, language, cognitive, literacy, and mathematics. The GOLD assessment would help measure the growth of our students in all of the five developmental domains and indicate if they are developing at an appropriate rate as well as observe if they are hitting their developmental milestones. These observations that are included in the GOLD assessment are recorded three times per year fall, winter and spring.

According to the 2016-2017 Early Childhood State Report, the Nebraska school district and educational service units (ESUs) serve 18,558 of this number. Of this number, 8,306 (45%) children are receiving special education services. The amount of infants and toddlers served by district and educational service units (ESUs) has increased from 12,726 infant and toddlers served in 2008-2009 to 18,558 served in 2016-2017. A measure called Teaching Strategies GOLD measures developmental progress in all areas of development (cognitive, social-emotional, physical, cognitive, and communication). From the 2016-2017 state report students who were in the three to five categories grew their skills from 59.5% to 91.6% of mastery on the Teaching Strategies GOLD assessment in the area of social-emotional from fall to spring. This indicates that with appropriate supports and services children can make the growth necessary to be successful but early intervention is imperative in order to make this growth.

When discussing how the state and federal government are intervening with a child's social-emotional needs, it is sometimes forgotten how these regulations and laws are implemented in the state. Through these laws and regulations, it is important to make

sure our early childhood educators are being trained and prepared to serve this population of children and their families. As a state, it is important to look at what training programs are preparing our future early childhood educators and if the education is efficient and effective for our teachers to be able to serve all children from birth to five.

Services Coordination

Roles and responsibilities. A services coordinator can serve many roles on the team and assist the family in different capacities based on the family's needs. According to the Department of Health and Human Services (2014) who partners with Nebraska schools to contract the services coordinators for the district indicated the services coordinators can serve the following roles:

1. Assisting parents of eligible children in obtaining access to needed early intervention services and other services identified in the IFSP, including making referrals to providers for needed services and scheduling appointments for eligible children and their families;
2. Coordinating the provision of early intervention services and other services (such as educational, social, and medical services that are not provided for diagnostic or evaluative purposes) that the eligible child needs or is being provided
3. Coordinating screenings (if applicable), evaluations and assessments;
4. Facilitating and participating in the development, review and evaluation of IFSPs;
5. Conducting referral and other activities to assist families in identifying available service providers;

6. Coordinating, facilitating and monitoring the delivery of services to ensure that the services are provided in a timely manner;
7. Conducting follow-up activities to determine that appropriate early intervention services are being provided;
8. Informing families of their rights and procedural safeguards and ensuring that the family rights are safeguarded
9. Coordinating the funding sources for early intervention services and
10. Facilitating the development of a transition plan to preschool or other services, if appropriate.

Some districts employ their own Services Coordinator while others do not which creates different pieces of training that these individuals may receive. Services coordination is a great tool to help fill the gaps that parents or caregivers may not be able to access or know are accessible without the help of other professionals. It is important to make sure our teams are supported and knowledgeable about the support and services that can be offered to our families and children.

Home Visits

Effective teams. Effective teams consist of individual who are agreeable, conscientious, have high general mental ability, area competent in their area of expertise, are high in openness to experience and mental stability, like teamwork, and have been with the organization long enough to be socialized (Rush & Shelden, 2013). On an early development network team, it is important to have members on the team from a variety of disciplines. Each discipline should be well represented and be specialized or licensed in a particular area of expertise or knowledge.

Primary service provider model. A primary service provider model (PSP) or primary coach approach is a family-centered, capacity building method to intervene with young children with developmental delays or disabilities that use a primary coach as the liaison to an agent of early intervention services to help promote child competence and development (Rush & Shelden, 2006). It is important that the family has a team that can help them navigate the services that are available to them as well as support their basic needs (Greenspan,& Wieder, 2006). When using the primary service provider model, the primary service provider or coach receives coaching from other team members to help support and strength their own competencies to provide coaching to the parents. The fundamental purpose of using the PSP approach to teaming is to help families establish and maintain an ongoing working relationship with a lead team member with needed expertise, who then becomes an expert on the “whole” child and family rather than promoting isolation focus on developmental domains and deficits by each practitioner (Rush & Shelden, 2013).

The Primary Service Provider (PSP) approach to teaming is the most beneficial to the early childhood learning environment. Being able to efficiently use the resources is another important benefit of the PSP approach to teaming with the primary provider model it allows for increased coordination of support and services instead of a more fragmented approach to addressing the child and family priorities (Rush & Shelden, 2013). Another benefit to using the primary service provider approach is the relationship that is fostered between the practitioner, family members, and other care providers as well as it focuses on the important caregivers and adults being able to focus on developing trust, respect and open communication with one key person instead of having

to experience this process with multiple people who have different interaction styles, levels of expertise and knowledge about the child and family (Rush & Shelden, 2013). One last benefit of the Primary Service Provider (PSP) approach is decreasing both gaps and overlaps in supports and services by having only one individual involved with the family (Rush & Shelden, 2013). When there is only one professional who is in charge of the whole child services will not be forgotten or assumed that the only team member is taking care of the steps needed for the service. In the Primary Service Provider approach selecting one team member to serve as the liaison to the family and child is an essential part of the early intervention practices (Rush & Shelden, 2013).

To best serve families through the Primary Service Provider (PSP) approach five implementation conditions must be present in this approach. The five implementation conditions are the following: all therapist and educators on the team must be available to serve as a PSP, all team members attend regular team meetings for the purpose of a colleague to colleague coaching, the team uses a process to select a PSP, joint visits, and the PSP should change as infrequently as possible (Rush & Shelden, 2013). It is important that even when goals of the family or child change or objective are met that the PSP doesn't change for the family to help with consistency and the relationship that the PSP has built with the family. During the team meetings, it is essential that all members make the meetings a priority and use this time to provide coaching and schedule joint coaching opportunities.

Selecting a PSP for a family is a part of the process that shouldn't be taken lightly or based on the availability of individuals on the team. In order to provide the family with the best support and resources based on their needs the PSP needs to be chosen by

the team based on the early development network professionals who have the knowledge, education, or past experiences that would best serve the family.

Coaching. Coaching is an adult learning strategy in which the coach promotes the learner's ability to reflect on his or her actions as a means to determine the effectiveness of an action or practice and develop a plan for refinement for the future (Rush & Shelden, 2006, Rush & Shelden, 2011). The capacity-building approach of coaching with infants and toddlers with disabilities helps to support parents competence and confidence for promoting child learning within the natural learning opportunities (Trivette & Dunst, 2007). Capacity building is a process that assists parents in recognizing and taking advantage of everyday activities and situations that have development-enhancing qualities to enhance children's learning (Dunst & Trivette, 2009). The five key components of coaching are initiation, observation, action, reflection and evaluation (Hanft, Rush, & Shelden, 2004). Many of the short-term outcomes that are developed during the coaching session become part of the Individualized Family Service Plan (IFSP). Coaching is an important part of the development of the IFSP as well as the assessment process because of the valuable information that the team can gather from the interaction with parents. Reflection is an imperative of the coaching process and it is what differentiates it from other processes of problem-solving (Hanft, Rush, & Shelden, 2004). The coach and learner have the opportunity to learn new skills as well as to adapt their thought process during the coaching process. Through the coaching process, it provides the family with alternate options that they may not have thought of as well as reflecting on the current situation.

Not only is coaching used between parent and the early childhood coaches but

also between expert coaches and other professionals within the early childhood team. Two approaches to peer coaching identified in the literature are expert and reciprocal (Hanft, Rush, & Shelden, 2004). In expert approach, peer coaching is provided by a practitioner with acknowledged content expertise in a specific area and in this process, the expert with expertise knowledge in a designated area will observe, reflect and provide feedback to the individual who would like to be coached (Hanft, Rush, & Shelden, 2004). The reciprocal approach to peer coaching, is where a pair or small group of early childhood practitioners observe one another, reflect afterward and share the feedback regarding specific topics (Hanft, Rush, & Shelden, 2004). In the reciprocal approach in peer coaching, all individuals don't have to have the same level of expertise in the area of discussion. Reciprocal peer coaching uses scheduled sessions where early childhood practitioners are able to exchange coach and learner roles; these types of coaching can be part of a team member that happens weekly (Hanft, Rush, & Shelden, 2004). It is an important part of the coaching process to have planned and spontaneous planned coaching sessions. Planned and spontaneous coaching sessions help professionals expand their knowledge and skills sets through the coaching process of reflection (Hanft, Rush, & Shelden, 2004).

Routine based interviews. A Routine Based Interview (RBI) is a semi-structured interview that helps the team examine the day to day activities of the children within the context of their family and community settings. Some of the goals of the RBI are to begin to 1) develop a relationship with the family and/or caregivers, 2) obtain a rich description of how the child functions within his daily activities, and 3) create a list of functional child and family outcomes/goals. These outcomes/goals are based on the

family's priorities and concerns (Boyle, 2017).

Getting ready framework. Through the team's routines based interviews, ecomaps, coordinating of services on the IFSP, determining the primary service provider and anything else the family needs support with at that time. In many of these opportunities the team is collaborating and determining how to best coach the family, adults in the child's life or the professional to best meet the needs of the child and family. By meeting the needs of the child and family the team is providing a comprehensive approach to their needs. When determining how to meet the needs of the family there are frameworks, strategies, and interventions the team should consider or utilize when planning their home visits. The conceptual framework that this study is using to categorize and base the research on is Getting Ready Strategies.

The Getting Ready strategies include the following (Sheridan, Knoche, Boise, et al., 2019):

- Establish parent-child interaction
- Communicate openly
- Focus attention
- Share information and resources
- Use observations and data to guide decisions
- Make Mutual/joint decisions
- Model/Suggest

The Getting Ready intervention also includes the collaborative planning process and these strategies that are included are the following:

- Share observations about the child's strength and needs

- Establish goal and immediate targets
- Share ideas and develop a plan for home and school
- Monitor progress toward goal/modify, continue, or establish new plan

The strategies helped to create a home visit environment in unstructured and structured settings that is productive and beneficial to the child and parent. This framework provides educators guidance on how to successfully implement a plan, monitor it, and develop new ones based on the family's needs. Embedding key interaction strategies within a collaborative solving process is not always easy but it can advance parent-professional relationships as well as give parents more ownership over their children's education, development, and overall success (Knoche, Marvin, & Sheridan, 2015).

The Getting Ready Intervention provides an approach to be used within existing community agencies and early childhood intervention programs with a focus on the dual relational contexts (Knoche, Edwards, Sheridan et. al, 2012). The Getting Ready Intervention (Sheridan, Knoche, Edwards, Bovaird, & Kupzyk, 2010) was designed to provide an integrated, ecological, strengths-based approach to school readiness for families with children in the birth to 5 years of age participating in the early intervention program. The Getting Ready Intervention is grounded in the triadic strategies, which is a early childhood consultation approach with young children with disability and it is grounded in the collaborative consultation models.

By using the Getting Ready Intervention strategies teams will be promoting parent engagement and relationships that are grounded in the ecological theory (Bronfenbrenner, 1977, 1992), which views children's learning as a result of the

child/family system interacting in reciprocal fashion with the school/schooling systems. These relationships and interactions are important to help promote and give the child the necessary skills that they need to be able to regulate their emotions. Young children with delayed development manifest heightened social-behavioral problems as young as age 3 (Sheridan, Knoche, Boise, et. al, 2019).

Conceptual Framework

The Early Childhood Essentials Framework (Appendix C) is to synthesize and communicate the essential skills and competencies children should be acquiring before they enter kindergarten and competencies that early childhood educators must cultivate in order to provide high quality early learning experiences that will set all children on the path to success in school and life (Meloy & Schachner, 2019, p.V). The essential child skills that are needed were identified in these five developmental areas of social-emotional development, cognitive development, language and literacy development, mathematical and scientific reasoning, and physical development. The five essential educator competencies are as follows: developmentally appropriate practice and environments, observation and assessment of development and learning, individualized supports-based practices, family support and partnership, and continuous improvement and professionalism (Meloy & Schachner, 2019).

In order to make sure that all early development network professionals are able to support families the best that they can is ensuring that they receive high quality job training, college preparation classes, professional development, and a supportive environment in which they work. The goal of the framework is to convey the link between early educator competencies, early education practice, and the school readiness

and success of all children and to acknowledge the foundational conditions necessary for children and educators to achieve these essential skills and competencies (Meloy & Schachner, 2019). The leaders of early childhood educators need to be able to convey and support their teams in these areas across diverse early learning environments which may be a center, home, facility, or other caregivers place. The five core foundational conditions for educators to succeed are facilitative leadership, competitive compensation and benefits, job-embedded professional development, pair planning, and collaboration time, and emotionally supportive environment (Meloy & Schachner, 2019). Part of this framework discusses that there are five basic needs that must be met in order for children to learn and be accessible, those five areas are as follows: adequate nutrition, continuity of care, access to health services (including dental and mental health supports), stable and safe housing and access to specialized educational supports (Meloy & Schachner, 2019).

Chapter 3 Methods

Introduction

The purpose of this study is to describe how Primary Services Providers and Services Coordinators carry out the implementation of the primary service provider model of Nebraska Rule 52 (Nebraska Department of Education, 2014), in particular social-emotional support for the child and mental health for the family. Rule 52 requires that each district implement the primary service provider model to deliver comprehensive services to the child and family. In delivering social-emotional support for the child, the Services Coordinator often connects the entire family to appropriate support resources which may include mental health support.

With a social constructionism theory, the researcher can not maintain a detached or objective position and they believe that both the researcher and subject should actively

collaborate in the meaning-making process (Savin-Baden & Major, 2013). Through this theory the researcher emerged themselves in the research and created a dialogue between the researcher and participants. Through this theory, the researcher captured the participant's perspectives but the researcher's interpretations of the participant's views need to be understood and verified by those in the research (Savin-Baden & Major, 2013). Using a narrative approach through the use of interviews the Early Development Network professionals had the opportunity to express their reality of how services and the implementation of the Primary Service Provider Model is carried out in the field of education.

The social constructionism paradigm was chosen because of its ability to capture the researchers and participants' understanding of the early childhood services and how their experiences and access to resources are impacting their ability to carry out the families services. The research question was answered by seeking to understand perspectives of the participants through questions and conversations. An American historian and philosopher Kuhn who discovered a controversial paradigm is currently one that is used by many to document how knowledge socially and culturally constructed changed and transformed (Savin-Baden & Major, 2013). By individuals constructing social meaning and their own shared realities through interaction through the interview process will help the researcher gain a broader knowledge and great understanding of the supports and services for mental health and social emotional for the birth to three population and their families (Savin-Baden & Major, 2013).

The phenomenon investigated in this social constructionism research paradigm is the structures of mental health, social-emotional, and primary service provider model.

The research approach in this case study is the narrative approach. Through the narrative approach, the researcher is able to hear the professionals discuss their experiences through stories and dialogue. The researcher was an investigator in the research to collect and analyze the data to make meaning of the interviews, socials and lived experiences.

Role of the Researcher

In a qualitative case study, the researcher's role was an active participant and include themselves in the research. The researcher was considered an instrument of the data collection process (Denzin & Lincoln, 2003). The researcher believes that their values are evident in the ways in which a researcher asks questions and interprets the results of the study and interviews (Savin-Baden & Major, 2013). Researchers must show respect for the participants, acting ethically toward them and engage participants as co-researchers (Savin-Baden & Major, 2013).

To abandon preconceived notions of how the researcher believed that Rule 52 was being implemented and families were being supported in the state of Nebraska in the area of social-emotional and mental health bracketing was used. Bracketing can assist the researcher in abandoning preconceived notions and to support a reflective research process (Tufford & Newman, 2010). The researcher used bracketing to help accurately analyze the data. Bracketing was used to avoid telling the researcher story rather than the researched story (Savin-Baden & Major, 2013). "Bracketing is the researcher must bracket out the world and personal bias in order to understand the essences of the phenomena being studied (Savin-Baden & Major, 2013, pg.217)." Bracketing can be a difficult process and time consuming but it gives the researcher valuable and clarity of

the interviews. The researcher will complete bracketing on the interviews to protect themselves from the effects of examining what may be an emotionally challenging situation or topic area (Tufford & Newman, 2010).

Researcher's context and experiences. The researcher has a passion for supporting children and their families in the younger years because of the impact they can make. It is important that interventions and supports are provided early in life to help mitigate the supports early in the child's development. I am a school psychologist who works with the birth twenty-one population and provides support in all developmental areas including behavior and mental health. The passion I have to help others be as successful as they can be as well as helping them gain access to resources is extremely valuable and important. My personal belief about how services and coordination of these services should look from a best practice standpoint as well as past early childhood experiences the researcher has an interest in maximizing resources as well as making sure all teams have access to these supports for families.

In my professional experiences I have been on multiple early development network teams where I served in varying capacity. I have been on some very strong teams who had strong leadership and implementation of the law and others where the team was able to form their own processing and procedures to carry out the implementation of the law. Some of the teams that I have been a part of have been composed of only three to as many as twenty individuals. With the varying sizes of these teams the process of the implementation of the primary service provider model as well as the role of the Services Coordinator also varies. Depending on how the Services Coordinators are employed depended on their caseloads and their capacity to serve the

families. Some of the families had consistent access while others did not.

While I was serving on my Early Development Network teams I was always striving to meet the needs of the family and tie them to the appropriate resources. Even though in the early intervention services it was hard to overcome the diversity of the families that we were working with and the adversity that they had been facing but the team always tried their best to provide the most appropriate services as well as assign the individual that was trained the most in the area that the parents needed the most support. The most difficult component of this model was that there were many families that struggled with their own mental health as well as their child's trauma and social-emotional needs that it was very difficult to be able to access the best primary service provider when the teams may not have access to a school psychologist, behavior coach, therapist, or another individual that is highly trained in mental health and behavior.

When Nebraska Rule 52 changed to addressing the automatic qualifiers being added to the guidance and qualifications many individuals on the teams that I served felt very overwhelmed by the idea of qualifying children whom have been removed or were a Child Abuse Prevention Act (CAPTA) referral. These children who will automatically qualify for services typically had significant trauma or behaviors that needed to be addressed. When working with these teams, the teams often felt that the family had significant mental health needs and they didn't know what services to provide or if they were being effective with their coaching. As an early childhood professional who provides coaching the coach may feel the need to fix the situation and not support the parents to give them the tools which is more difficult but in the long run will have the most impact and long term success by coaching the individuals who have the most

contact and connection with the child.

As a mother of two children of the ages one and three, I understand the importance of fostering a child's mental health and social-emotional needs in all environments of their life. I also understand as a parent and school psychologist the difficulty in carrying out plans to foster these skill areas as well as if a child struggles significantly in these areas. The struggles of parents carrying out intervention plans and support for their own children can be difficult and time-consuming which is difficult at times. Being a coach to other families I understand how overwhelming all of the information can be and how to support your children the best that you can.

Reflexivity

Before researchers can explore the perspectives and experiences of other Early Development Network professionals it was important for the researcher to examine her own experiences and opinions about the Primary Services Model and the services that are being provided to children and families. Reflexivity helps the researcher to consider that it was not possible to remain outside the subject or process of the research and look in; rather the researcher is both integral and integrated into the research (Savin-Baden & Major, 2013, pg. 76). The reflexivity process helps researchers consider their position and influence during the study and helps to know how they have constructed and imposed meaning on the research process (Savin-Baden & Major, 2013). When capturing the voice of the participants it was important to share the analysis of the data to make sure that the researcher was capturing the voice of the participants accurately (White, 2015).

It was important for the researcher to be cognizant of her own bias and experiences that may influence the interpretation of the data. The researcher has spent

many years advocating for services, funds, and resources in the smaller districts with a specific focus on how you utilize the entire team to support these families and children.

Design

Qualitative research focuses on a person's experiences and their perceptions of the social world around them as well as discussion of a person's lived experiences. Qualitative researchers seek to learn about, describe, and explain individuals based on their perceptions and experiences (Savin-Baden & Major, 2013). Qualitative research was a less rigid approach that used open-ended questions. The researcher must show respect for the participants act ethically toward them and where appropriate engage participants as co-researchers (Savin-Baden & Major, 2013).

Researchers will often use qualitative research to explore the behavior, perspectives, and experiences of the people they study and qualitative research lies in the interpretive approach to social reality (Holloway, 1997). In qualitative research, the researcher was a human instrument with many potential biases that should be considered (Savin-Baden & Major, 2013). When analyzing the data qualitative research includes various strategies for systematic collection, organization, and interpretation of textual material obtained while talking with people or through observations (Malterud, 2001a). When conducting questions for a qualitative study the questions can fall into five categories of questions chronological/story-oriented, in-depth/descriptive, process, essence, and community action questions (Creswell, Hanson, Plano Clark, & Morales, 2007). The type of qualitative research question for this research is in the area of essence questions. Essence questions are questions about what is at the essence that all person's experience about a phenomenon (Creswell, Hanson, Plano Clark, & Morales, 2007).

The outcome of qualitative research is to seek to learn about, describe, and explain individuals based on their perceptions and experiences (Savin-Baden & Major, 2013). In particular, a phenomenological case study approach is a research approach that attempts to uncover what several participants experience a phenomenon have in common (Creswell, 2007). This phenomenological case study explored the lived experience of Nebraska Early Development Network team members in providing social and mental health support for families. Therefore, the type phenomenological case study is phenomenography which is appropriate for this research because the intent is to understand who and what services in the area of mental health are being provided to the family and child.

Phenomenography case study. A phenomenography case study is a study that seeks to gather information through a process of considering researchers' and participants' perceptions and presented in a case study (Savin-Baden & Major, 2013, pg. 159). The research phenomenography case study will explore how districts in the state of Nebraska are implementing Rule 52 primary service provider model and how is the support and interventions helping families in the areas of social-emotional and mental health. A phenomenography case study is appropriate for the research because of the structure of early childhood programs and the differences among them. The researcher wants to gain a perspective of the Early Development Network team members on how the needs of the child and family are being met. The best way to gain this information is through interviews and a phenomenological approach to be able to explore the experiences of different districts. Phenomenology is a research approach that attempts to uncover what several participants who experience a phenomenon have in common

(Creswell, 2007). Not only does phenomenological case studies seek to uncover what individuals experience but also how they experience the phenomenon and phenomenon is typically a concept (Savin-Baden & Major, 2013).

Through this case study the researcher used a phenomenography approach. A phenomenography study is to understand the variation of experiences as well as understand different ways in which people experience and apprehend various phenomena of the world (Savin-Baden & Major, 2013). The phenomenography study examined the concepts or experiences of the phenomenon and measured the variation of these experiences.

Research Setting and Context

In a phenomenography case study, the researcher gathers data from research participants about lived experiences to describe the commonalities as they experience the phenomenon (Creswell, Hanson, Plano Clark, & Morales, 2007). In this study the phenomenon was the lived experience of Early Development Network team members in providing social emotional development and mental health support for families of young children birth to age 3. Nebraska initiated updates to Rule 52 on July 15, 2014 and so the shared timing of creating and adopting new practices in response to the Rule 52 updates is similar and thus considered a case. The strategy of gathering information about the lived experience of primary service team members in providing social-emotional and mental health support for families of young children birth to age 3 in Nebraska were semi-structured interviews of team members.

The Early Development Network professionals varied in years of experience ranging from 1 to 25 years. The professionals represented multiple geographic areas in

the state of Nebraska and team composition differences as well as working with families and children from a variety of socioeconomic, cultural, linguistic, racial and ethnic backgrounds. The professionals completed and passed their routines based interviews requirements for home visits.

Central Research Question

The research was guided by one primary research question:

- How do four Nebraska School Districts implement Rule 52 birth to three Primary Service Provider Model, in particular social-emotional support for the child?

Study Participants

Four rural planning region teams were selected as the target group. Two early development network team members including a Primary Service Provider and a Services Coordinator were invited to participate in this study from the four planning region teams with 1 to 25 years of experience. Four rural planning region teams were included in the study to gain varying experiences, but not so large that the study was unmanageable. The districts within these planning region teams range in size and have varying sizes of early development network teams ranging from three to ten members. These districts were chosen because they vary in size and the services coordinators vary in roles and involvement with the families. The caseload sizes also vary for the services coordinators which may be a factor to the services and face to face involvement they have with the family and team. After district research approval, the invitation to participate in the study will be initially sent to each of the four district's primary services providers and services coordinator. Participation included semi-structured interviews recorded using Zoom and possible follow-up conversations through email, phone and zoom.

Data Collection

Creswell (2014) suggests that a phenomenological case study typically has a sample size ranging from three to ten participants (p. 189). In a qualitative study you are able to get rich stories and submerge yourself in the research and setting of the study. Through interviews, the researcher was able to get in-depth knowledge from the participants and be able to capture their whole story or dialogue whereas in a survey it is quick and to the point. A phenomenological case study was rooted in experience and allows intentionally gaining an understanding of the lived experience of others (Savin-Baden & Major, 2013). Phenomenological studies are demanding and require an in-depth understanding of the philosophical underpinnings and the nature of multiple interviews and it makes unique contributions to educational research (Savin-Baden & Major, 2013).

The participants were selected based on the demographics of the districts and their role in the early childhood programs within their districts. The initial emails that were sent to the participants included information about confidentiality, the purpose of the study, and time commitment for the interviews. The researcher explained the use of recording of the conversations and the data to all of the participants.

The interviews were semi-structured in nature. In semi-structured interviews, the researcher not only follows some preset questions but also includes additional questions in response to the participant comments and reactions (Savin-Baden & Major, 2013, p. 359). In these types of interviews, the questions are open-ended to allow the participant's view to be heard.

A letter was sent to the superintendent or qualified individual for district approval for the study. After district approval, the invitation to participate in the study was

initially sent to each of the one of the districts in the four planning region teams that were chosen by the researcher. A Primary Services Provider and a Services Coordinator were chosen to complete the interviews by their supervisors and then had the option to determine if they would like to accept the invitation. The invitation that was sent to a Primary Services Provider and Services Coordinator in specific planning regions is attached as Appendix A.

A Primary Services Provider and Services Coordinator were emailed to be invited to participate in the study. Then an individual email invitation was sent to the professionals who agreed to participate. The email invitation included the consent to participate in the study. The researcher accepted electronic signatures for consent forms. Once the researcher received the consent, the researcher set up a Zoom meeting within three weeks of receiving the consent for a time and date that was convenient for the participant.

Once the interview was scheduled, the interviewee received a Zoom link. The interview took place using Zoom. Transcribed audios were recorded during the interview with Vid Grid. The audio and transcript were stored in a secure, password-protected digital storage file. The interviews began with a strong emphasis on rapport building with the interviewee. The researcher then discussed confidentiality, informed consent, time requirements, and the use of the data from the recorded interviews.

Some of the information that was discussed at the beginning of the interviews was that the interviews were projected to last no more than 45 minutes and the participants were reminded that it was voluntary and they could revoke consent at any time that they

wanted to. It was also stated to the interviewees that this research was being supervised by Dr. Jeanne Surface from University of Nebraska at Omaha.

Interview Protocol. The interview protocol is attached as Appendix B.

After the proposal, the researcher practiced the protocol with non-study participants and refined it based on feedback. This allowed the practice of interview processes, ease of conversation, confidence with the technology, and refinement of questions to effectively get to the content of the lived experience of Nebraska early development network teams in providing social emotional development and mental health support for families of young children birth to three.

Data Analysis

Qualitative data analysis was an ongoing process that involves breaking data into meaningful parts to the purpose of examining them (Savin-Baden & Major, 2013). The following information was how the researcher determined to analyze the data from the interviews. The interviews were recorded via Zoom and transcribed using Vid Grid. The transcripts were coded and analyzed with the assistance of Dedoose qualitative analytic software. The interviews were recorded and then transcribed after the interview was completed. Both of these programs had closed captions which allowed for the transcription. After all of these steps were completed then the member checking process was completed. Member checking is defined as a strategy that involves checking with participants for feedback or verification of the interpretation (Savin-Baden & Major, 2013). The approach of member checking allows a voice to the findings and allows them to correct any misinterpretations of the researcher. Sharing the transcribed interviews

was the first step in the data analysis process. Once confirmation of accuracy was received from the participant's data analysis continued to the next step.

The researcher transcribed the interviews using Vid Grid so there was no error in the transcription. The researcher chose to use thematic analysis to identify, analyze and report patterns in the data. The analysis allowed the data to be organized into themes related to the research question, allowing patterns and trends to emerge (SavinBaden & Howell Major, 2013). The process the researcher completed when walking through the thematic analysis was by completing the following steps:

- Familiarizing with the data
- Generate initial codes
- Search for themes
- Review themes
- Define and name themes
- Produce the report

Credibility and Dependability

In qualitative research, it is more important to focus on the quality of the interviews and not the quantity of them. The research will analyze interview responses for similarities of answers in each of the three single locations. This is one form of triangulation (Schostak, 2006) that can be used in qualitative research refers to the correlation of perspectives. Internal validity as it pertains to this study refers to the regularity and consistency of patterns arising within an interview and a series of interviews with the same person or group (Schostak, 2006).

“The researcher was a witness to the ways in which different individuals and

groups give witness to their experiences and views. Approaching their different interests through interviewing is itself an ethical as well as a political act” (Schostak, 2006 pg.135). As a researcher, you are a witness to how lived experiences are interpreted through the interviews.

Confidentiality and Ethical Considerations

In order to ensure confidentiality, the researcher received approval from the research department from all four Nebraska school district locations. After it was approved at the district level for research, each member of the Early Development Network team can individually choose to participate or not. Through the reliability of qualitative data, validation of the interview situation, communication validity, and procedural validation the researcher conducted the following components (Flick, 2008). Voluntary consent means that each participant chose to be a part of the study and could revoke this consent at any time that they chose. By member checking the interviews this helped provide accuracy in the data but also was an ethical consideration as well (Creswell, 2014). The researcher’s study had proper Institutional Review Board approval before the interviews and study were conducted.

The research analyzed the interview responses for similarities of each of the four single locations. The research used a form called triangulation (Schostak, 2006) to correlate what is being said versus what is seen. “Triangulation means that the researcher has multiple data points that can broaden their understanding of the subject of their research” (Savin-Baden & Major, 2013, pg. 477). Through triangulation, it involves the process of taking multiple perspectives on the same topic and determining if it is the same under a variety of circumstances (Schostak, 2006). The emphasis of the qualitative

research through the semi-structured interviews is upon the internal validity of the interviews and the triangulation of the perspectives that they offer (Schostak, 2006).

Audio and transcript were recorded during the interview. The audio and transcript were stored in a secure, password-protected digital storage file. To ensure confidentiality the transcripts were destroyed after the transcripts have been coded and the dissertation was complete.

Chapter 4 Interview Data

Each Services Coordinator and Primary Services Provider participant was interviewed by the researcher. Interviews were used to explain some of the experiences, opinions, feelings and attitudes of early intervention professionals and their perception around the mental health support and social emotional development that is being provided to the birth to the families that are served through Nebraska Rule 52. Interviews were transcribed verbatim using a transcription software called Vid Grid. The research then conducted the thematic analysis with the organizational tools that were components of the Dedoose software.

First the researcher provided the participants an opportunity to read and review the transcriptions in order to determine if the transcriptions captured the interviews appropriately and were accurate. This first step was a part of the member checking process. Second the researcher organized and coded the transcriptions of the interviews into categories based on common questions and responses that occurred in the eight interviews. For example, if the participant talked about connecting the family to mental health services in the community this was coded under “Mental Health supports.” Or, if the participant discussed the home visitor training which is called “Getting Ready

Framework” or additional training the participants seek out this was coded under “professional development.”

After organizing the content by the categories into 20 initial codes, the researcher then looked a little deeper and was able to find additional commonalities in these codes. After the researcher became more familiar with the data, the researcher began to see new themes among the sorted codes and categories. The researcher took notes on the new emerging themes and recorded them in all eight interviews. After becoming more familiar with the data as well as using intuition and analysis, the researcher began to see new themes within and among the sorted categories (Savin-Baden & Howell Major, 2013). In total there were twelve new themes noted and recoded in all of the transcripts. The researcher used further reflection to look for new themes that were emerging. After looking at all components of the research and categories, the researcher further broke down the data into seven final categories. By immersion in the research and the data the research felt that these final seven codes captured the participants' voices and experiences of the primary service provider model the best. The final codes were as follows:

- Observation and assessments of development and learning
- Family support and partnership
- Continuous improvement and professionalism
- Individualized supports and inclusion-based practice
- Barriers and challenges of implementing primary service provider model
- Child find process

- Collaboration with school professionals, educational service unit or planning region teams

Table 1 shows the occurrence of each code within each participant interview and the total number of times the code occurred across all participants interviews.

Table 1

Themes/Code Frequency

<i>Themes</i>	<i>#1</i>	<i>#2</i>	<i>#3</i>	<i>#4</i>	<i>#5</i>	<i>#6</i>	<i>#7</i>	<i>#8</i>	<i>Total</i>
<i>Observation and assessment of development and learning</i>	2	7	1	3	5	1	2	3	24
<i>Family support and partnership</i>	1	2	4	2	1	3	2	3	17
<i>Continuous improvement and professionalism</i>	3	3	2	3	4	2	5	2	24
<i>Individualized support and inclusion-based practices</i>	14	19	4	1	3	11	29	12	93
<i>Barriers and challenges of implementing the primary service provider model</i>	17	10	3	3	1	3	16	10	63
<i>Child find process</i>	2	1	4	2	4	3	9	2	27
<i>Collaboration with school professionals, educational service unit or planning region teams</i>	2	2	2	2	5	5	2	5	25
<i>Total</i>	41	44	19	16	23	28	65	37	273

Observation and Assessments of Development and Learning

The concept of observation and assessment of development and learning was coded in eight interviews for a total of 24 code applications. More specifically this code focused on the ability to assess using the Developmental Assessment of Young Children (DAYC), Routines Based Interviews and additional assessments used to collect baseline data on the child and family to determine the family's needs. The early intervention team members reported the following supporting evidence.

- “Both the service coordinator and the primary service provider help to develop the IFSP. And then, it's the PSP who needs to make sure that they start services with the family within 30 days. They're kind of always doing ongoing assessments of the child to see the kiddo's strengths and needs. And then both PSP and SC share responsibility for developing a transition plan with the family, of course.”
- “They provide the families with strategies to help them towards the goals that they've identified through the RBI. So that's one of the main purposes of their visits is to give them some strategies. Services coordinator, main responsibilities are to make sure that the families are getting the services that they're entitled to, act as a liaison between providers and the family or other agencies, to relay information, make sure that everything's done in like a timely manner. Make sure services are initiated, IFSPs are completed, all those deadlines are met.”
- “We have an ASQ social-emotional that we use sometimes and as a services coordinator, I do use those things just because I do feel like families are very unaware that that's part of a child's development sometimes. So just helping them see that connection and see how it affects all parts of development too, is super important.”
- “So the best way that we can get a picture is honestly, by knowing a little bit of the background that we get when they come as a referral, what we're looking at and how they should maybe qualify in this area. Even if they say everything else is fine. So it's a tricky thing. And sometimes what does come down on paper, and you see it doesn't paint the picture of the kid.”
- “We work together at scheduling, obviously, the routines-based interview with families. So generally, the way we do it in our areas that the primary service providers, the primary interviewer and the services coordinator is usually the secondary or the note taker.”

- “They're kind of always doing ongoing assessments of the child to see the kiddo's strengths and needs. And then both PSP and SC share responsibility for developing a transition plan with the family, of course. I was just trying to think of what else. They provide the families with strategies to help them towards the goals that they've identified through the RBI.”
- “I have to get like the consent to tests signed, um, a release of information. And, uh, just for us, like the early development network just wants a procedural safeguards just to make sure that parents have that parent parental rights booklet with them.”

The importance of observation and assessments in early intervention services is supported in the literature as well. By completing the routines based interview (RBI) the team is providing the family the opportunity to discuss the highlights as well as times of day that are the most difficult. As part of the RBI, the team completes the ecomap to discuss the families external and internal support for themselves and the child. The outcomes/goals that are generated through the Routines Based Interview are based on the family's priorities and concerns (Boyle, 2017). When families are physically and psychologically healthy they are able to promote and facilitate child well-being and growth (Davis & Gavidia-Payne, 2009). It was noted in the interviews that social emotional development may not always be a concern that is based on the referral but the teams go out to start the assessments and evaluation these concerns may arise from the Routines Based Interview. By providing strategies that parents can use for behavior support and family routines was important (Lambarth & Green, 2019).

Family Support and Partnership

The concept of observation and assessment of development and learning was coded in eight interviews for a total of 17 code applications. Family support and partnership includes an educator's ability to initiate and engage in regular and responsive communication with families, collaborate with families to ensure consistency and support

culturally and linguistically diverse families (Meloy & Schachner, 2019). The early intervention team reported the following evidence of family support and partnership through the Primary Services Provider model.

- “We have different agencies and we all get together and discuss because we share kids from across agencies.”
- “I feel like we are able to, but it's mostly because of some of the resources that we're accessing outside of the area, if that makes sense? We have a really great resource through the planning region team that has been huge for us.”
- “It's hard, especially in like rural Nebraska and outside of like the metro area. Connecting them with resources, that's a big role, just different resources that they can access just based on what's going on or what they need.”
- “It's nothing that the state has adopted as far as, you know, what are we using to support social emotional. There's no hard and fast. This is what the state is using, you know, and maybe, because I don't think the state's there yet either I could be wrong.”
- “I think this is really tricky and hard. I mean, looking for resources and finding resources that the family is able to use or want to use is really tricky at times.”
- “I'd say in the past couple of years is our planning region has access to Carrie Gottschalk. Who's a licensed mental health therapist, specially specializing in infants and toddlers. We can periodically sign up to access her, which has been very helpful. So that's kind of how the, unfortunately we just kind of are in that mode of grabbing at what we can.”
- “We say would you like to start with twice a month and then kind of explain how it can be more than that, but it can't be less than what we put on the document.”
- “I have had a couple of families that have really found benefit in it and we have formed relationships. And so that's been positive as well. But I think that in order to get there, you have to like, for me as a provider, in those couple of instances, when we have talked about something that they need help with I was able to give them a suggestion that actually worked.”
- “But I think the parents are the integral part of that team too.”

Family support and partnership support the findings in these themes. There are five basic needs that must be met in order for children to learn and be accessible, those

five areas are as follows: adequate nutrition, continuity of care, access to health services (including dental and mental health supports), stable and safe housing and access to specialized educational supports (Meloy & Schachner, 2019). Partnering and building relationships with the families through the supports and services that the teams offered, teams are able to address the physical and mental health needs of the family. “Family-centered practices emphasize the importance of parents playing an active role in their child’s care to build capacities based on parents strengths and helps parents make decisions that they consider important for their families and take control of their lives (Davis & Gavidia-Payne, 2009).” Through family partnership and implementing the coaching model with the early childhood population the teams are able to work together on the common goals that are on the families IFSP through the primary service provider and services coordinator that is assigned to the family.

Continuous Improvement and Professionalism

The concept of observation and assessment of development and learning was coded in eight interviews for a total of 24 code applications. This theme indicates that educators are professionals and should have the ability and opportunity to engage in reflection, develop and use professional development plans, participate in professional learning and maintain professional and ethical standards to excel (Meloy & Schachner, 2019). The following quotes were in support of evidence for continuous improvement and professionalism.

- “ I mean, over the years you could say there's been a conference here at training here and there, but as I, as I feel like planning region gets more access to serving all of the tiny districts around the Metro and how all of us kind of struggle with having those supports. I feel like you know it's coming through our coach training, I feel like that has a level of not necessarily being prepared to handle the social emotional, but it just puts you in a different frame of mind where you, you

know, through that coaching and through that model, you kind of have a different lens. So all of that training, I think, supports, you know, what we're trying to do with families. As we evolve, keep evolving, I think really having the district behind a set goal for supporting social, emotional across our whole program is where we're headed, hopefully.”

- “And I think, well, I've been doing this for 20 years and so we've had Babies from the Bench and we've had a ton of training from the state on social-emotional and CAPTA and trauma and that sort of thing. So I do feel like we do have a lot of, we have had a lot of information in the past on this and we know the importance of our services for families in poverty and especially CAPTAs. But I can remember providers saying hey, I am not a social worker. I am a speech pathologist. It's been a movement and I think we've made good progress.”
- “Well, I did complete the mental health first aid for child and for adult. But that was just kind of, I mean, it was on my own, my work supported me.”
- “I think that the only trainings that I have are ones that I have sought out and paid for myself. Our ESU does some good trainings as well in those areas”
- “I do feel like we really train our service coordinators and primary service providers, especially the ones that the ESU owns, but districts are good to train them, as well. Give them information about trauma, CAPTA. We talk about it at our planning teams. We have after our planning teams, I think it's just quarterly, we do provider trainings and we share that information as an ESU and so districts are pretty good to get their providers involved in those trainings. And I feel like that's where they keep on top of the CAPTAs.”
- “I've had some training with that, through the mental health first aid.

Through the interviews the early intervention team indicated that there are training available to them through the educational service units, early development network and the state. All eight participants stated that they have to seek these opportunities out that none of them are required for them. The only required training are the home visitor training and routine based interview training which involves components of coaching and primary service provider training. Some of the service coordinators indicated that they have sought out additional mental health training such as babies from the bench, mental health first aid, and circle of security. By seeking out and attending

early childhood professional learning it has the capacity to improve outcomes for children (Schachter Gerde, & Hatton-Bowers, 2019). Beyond the required training that is offered to education professionals very few of them focus on the early childhood components that increase the capacity aligning with the current practices of the early intervention professionals (Schachter Gerde, & Hatton-Bowers, 2019).

Individualized Supports and Inclusion-based Practice

The concept of observation and assessment of development and learning was coded in eight interviews for a total of 93 code applications. Individualized supports and inclusion-based practice is defined by an educator's ability to provide safe and inclusive learning environments and opportunities; individualize learning experiences to support all learners and to work collaboratively with a multidisciplinary team and the family to provide individualized supports (Meloy & Schachner, 2019). The following is documentation of individualized supports and inclusion-based practices.

- “We're going to try and do that with the pyramid model and, and using that system to support MTSS for early childhood. It's just not there yet. But that's at least looking to the future on, you know, how can we be supporting, you know, on that baseline level, but then also with the tiers, how can we learn to support families? Going back to kind of the, the pyramid model, which is it's been around for a long time but I guess getting it rebooted and then with the lens of how do you support the family as opposed to just when the kid is here in preschool.”
- “So if a family wants those visits to be front-loaded at the beginning, and then we could taper off towards the end of six months. So that gives us a little flexibility in how we, you know, work with each family, but its pretty family driven as far as, you know, how much time we always ask, you know, in the meeting, how can we support you? And then if they, a lot of times you get parents that just kind of look to you.”
- “I guess the urgency of, or just the family schedule we start with twice a month knowing that that's the minimum amount of time and what we do in our area is we put twice a month over the time period of six months.”

- “So I think it kind of becomes a little bit difficult if the family hasn't directly identified something, but you, as a team member are seeing different things on the side that potentially could be addressed, but yet the family hasn't identified them.”
- “And so actually we have, not everyone has gone through the coaching training yet. And so it was awesome, a learning experience during COVID when we were doing remote. And you know, this might sound like a bias, but typically, the physical therapists are the ones that have struggled with this the most. And I feel like it's because they are actually putting their hands on their student, their patient, or whatever. But they got creative and I loved watching them grow because the one brought her up her own her own child in, and would, during a Zoom, use her child to demonstrate to the parent.”
- And so, and then following up with those kinds of concerns to the appropriate people. I do have a lot of DHHS referral cases and families struggling with abuse, and as far as substance abuse, so, you know, reporting to the correct people what I see. And so, yes, I feel like I'm addressing it”

Individualized supports and inclusion-based practices is an important concept when addressing the needs of supports and services that are provided to families. Individualized supports are directly related to the need of the family and the access to resources to help reduce the gap for their family and child (Balcells-Balcells, Giné, Guàrdia-Olmos, Summers, & Mas, 2019). Through an IFSP the team will develop goals and service minutes that are individualized and unique to the family's needs and priorities. The Individualized Family Service Plan (IFSP) is reviewed every six months to determine progress, additional goals for the family, and to adjust the service time or additional professionals needed to help with some coaching sessions. Acknowledging the child's and family's needs to be a regulation of components that are to make up a plan with the inclusion of a family-driven assessment (Epley, Summers, & Turnbull, 2011).

Barriers and Challenges of Implementing Primary Service Provider Model

The concept of observation and assessment of development and learning was coded in eight interviews for a total of 63 code applications. Barriers and challenges were defined as constraining access to a service or supports as well as challenges or obstacles that arise (Champine, Shaker, Tsitaridis, Whitson, & Kaufman, 2019) .

Evidence of barriers and challenges of implementing the primary service provider model were stated in the interviews.

- “And maybe the service coordinators have more training, I guess sometimes we don't know, you know, which is somewhat of a barrier too, because we don't know all the training that they have to do or sometimes it's hard for them to share, you know?”
- “I don't feel like I have immediate access to any behavior outside behavior supports or social emotional that's again, where we go back to and start pulling in, you know, different things that maybe planning region has provided or that we've found on our own. We don't have, you know, district level access necessarily to vision because that's contracted as well as anything related to hearing those are all contracted services.”
- “We go digging for those supports because we know we don't generally have a lot of those supports in our area.”
- “Our team doesn't have access to a lot of those supports. So then I feel like we're in this constant motion of digging for resources and trying to come up with, with people and with programs in it's a lot of time spent making phone calls and, you know, just reaching, grabbing for straws because we don't have, I don't know. And maybe that's just where the location of where we are.”
- “And if there are, then we don't know about them, which is, which kind of goes back to my initial thought is no, because I look at our entire community and unfortunately it's not there's not a lot of time spent on early childhood like initiatives or now they do fun things for kids in our community, but there's not now some communities just have a, you know, like a, a strong kind of foundation.”
- “And so they don't want to hear anything that you have to say. They, I mean, they won't even make eye contact with you. They're just doing it because they have to. I have had a couple of families that have really found benefit in it and we have formed relationships. And so that's been positive as well. But I think that in order to get there, you have to like, for

me as a provider, in those couple of instances, when we have talked about something that they need help with I was able to give them a suggestion that actually worked.”

- “But I can remember providers saying hey, I am not a social worker. I am a speech pathologist. It's been a movement and I think we've made good progress.”

Some of the barriers that the teams stated about meeting the needs of their families that they served surrounded some of the mental health supports that are available and within their own communities to serve their families. Another barrier that the teams discussed was not having all members on the team to be able to appropriately pair the family with the appropriate services provider. Typically, most of the early intervention referrals stem from a lack of or delay in a child’s speech and language ability (Epley, Summers, & Turnbull, 2011). Team expressed that within their rural communities the access for families to receive the mental health supports that are needed are not always available so they try to help families access support in another town or city that is close in proximity. This challenge seems to become greater when the distance to a mental health service is a long distance. The literature supports that there are barriers to families being able to access the services that are needed (Champine, Shaker, Tsitaridis, Whitson, & Kaufman, 2019). It is noted within the research that access to health services is even greater in lower-resource and lower socioeconomic status communities (Champine, Shaker, Tsitaridis, Whitson, & Kaufman, 2019). The early intervention teams also stated that sometimes it is the perceived stigma of accessing services or even early intervention services in their own communities. Through the interviews it was noted that the CAPTA referrals that are placed in the early intervention services are typically court mandated which sometimes frustrates parents who don’t want to participate in the program. The

literature indicates that families anticipated and perceived stigma is a barrier related to seeking psychological or emotional health needs for themselves or their family (Champine, Shaker, Tsitaridis, Whitson, & Kaufman, 2019).

Child Find Process

The concept of child find process was coded in eight interviews for a total of 27 code applications. Child find is defined as providing information to parents, school personnel and service providers on child development and special education for children from birth to age of 21 and it helps parents access information on rights and resources to help them advocate for an appropriate education for their child according to Nebraska Rule 52 (Nebraska Department of Education, 2014).

- “I mean, I would say half to at least, half to three fourths of our caseload across the board is probably a CAPTA referral mental health, and social emotional.”
- “When referral to CAPTA referrals the participant responded, “ I would say on average, we have close to 15 to 20 a year.”
- “I think that's been a common theme with a lot of services coordinators and PSPs, they're finally starting to get CAPTA referrals because of COVID. So it's been kind of a standstill.”
- “And especially if families are in middle class, what I noted, again, I'm not trying to sound like I have a bias, but a middle-class to upper-middle-class. In fact, I had two middle-to-upper-class medical referrals in the area and they signed out. Because they just, well, they both work in the medical field strangely enough, but I just think they, we don't have time for this, you know, we're very active socially and we're, you know, so I can see definitely where, you know, and I'm not to say as a parent, that that wouldn't be a choice I might make. If you want to go take your child and, I think it's uncomfortable.”
- “ I feel like there's always been a gap with DHHS and us, and we've tried, and we've tried, and we've tried, but with their turnover, I don't know if, what button they're not pressing on the system.”

- “We look at that data at our planning region team, and I believe the biggest referral that we have in the ESU region as a whole is still parent referral. But we have decided too, sometimes those are, maybe the doctor had a concern, but the parent made the referral.”
- “If we have a CAPTA referral, we may have multiple children on the program.”
- “We are not completing child find to the best of our ability.”

The literature supports the components of having a child find process that helps teams identify students as well as have a system for referrals. Some of the participants reported that their child find process is not comprehensive or they are only receiving the referrals from pediatricians or CAPTA but are not getting the referrals from daycare providers or additional community members. The majority of referrals to all eight rural early intervention interviewees reported that the majority of their referrals are coming from doctors or CAPTA referrals. According to the Early Development Network Guide Book (2014) a comprehensive child find process should include public awareness including access to early intervention materials, a central directory of services that is accessible to the general public and comprehensive identification and referral procedures. These supports are critical to being able to support families through the primary service provider model in rural Nebraska school districts.

Collaboration with School Professionals, Educational Service Unit or Planning Region Team

The concept of observation and assessment of development and learning was coded in eight interviews for a total of 25 code applications. Collaboration was defined by members unearthing assumptions, gaining from each other’s natural strengths, share strategies and ideas, and discovering what is possible in their environment and role (Kise

& Russell, 2010). The collaboration with school professionals, education service unit or planning region team was evident by the following statements.

- “I don't know that I would say they're like a continuous member of the team, but I know they do have access to them, especially now that they are sharing an office with the school psychologist. I think that has helped a lot, whether in really like constant and open communication.”
- “They have access to vision, hearing, psych, nurse, of course, but they really, those people aren't involved on a team consistently.”
- “The access and accessibility I have to a resource like this may not come that quickly to some rural communities.”
- “So we don't meet with those disciplines on a regular basis. Like we do as far as our core team, which is service coordination, speech pathologist, OT and PT. And this year we also don't have a teacher and in the role of early childhood birth to three. So that's something that we're also having to just meet the challenge of.”

All of the participants indicated that school psychologists, social workers and counselors were not an active member of the team but the district employed some of these professionals for the district. The birth to three teams stated that they typically collaborated with the early childhood planning region team members as well as accessing resources from multiple members of their teams or through their service coordinators if they were employed outside of the district. All of the rural communities employed their service coordinators through the educational service units or early development network.

Bracketing

The use bracketing was used during the before and during the interview process to capture some of the views of the researcher. The researcher stated that when the early intervention teams were discussing their roles that they currently serve and how the participants have been to implement some of the components of the coaching and co-coaching visit it was noted that the researcher perceived that this should of been a stated

that most of the early intervention team should of been strong in to support families. The researcher also noted some of the participants frustration of the caseload sizes that they have to serve and how this impacts being able to completely implement the primary service provider but they all indicated that their teams function very well and everyone is able to receive coaching among professionals that help them address all of the family's needs in any developmental area.

Chapter 5 Conclusion

Data in this research study from four interviews with the primary service provider and four interviews with Services Coordinator that serves families in the rural areas of Nebraska for the early intervention program. The researcher intensely reflected on the interview data and themes that developed from these interviews. This data suggests that Primary Services Provider and Services Coordinators perceive that they are meeting the needs of their families by providing these services through the primary service provider model but also have encountered numerous barriers when it comes to mental health and social emotional development. Some of the participants indicated that beside the CAPTA referrals or a doctor referral for behavior most of the parent referrals don't initially start as a social emotional or family mental health concern these may evolve through the assessment process. The data also suggest that rural early intervention teams are able to implement all components of the primary service provider model to the best of their ability to serve the needs of their families and in the area of social emotional development. The data may suggest that early intervention teams are needing additional professionals to carry out the pairing process of the primary service provider model and to help with the coaching opportunities of families and professionals.

All of the Services Coordinators reported that unless they seek out training pertaining to mental health of the family or social emotional development of the child these trainings are not provided to them. The team discussed how all of their districts or education service units support their want to grow as a professional and uphold their professional standards to address family's needs. The Services Coordinators did express the need to be more well versed in the mental health services that are offered within their own communities as well as knowing where to refer these families. The Services Coordinators stated that they often will try their early intervention teams about resources or additional knowledge or information about trauma, crisis, mental health or social emotional development. Another barrier that was consistent across the interviews was understanding their role and responsibility of being either the Services Coordinator or Primary Service Provider.

The purpose of this phenomenological case study was to explore the implementation of Nebraska Rule 52 Primary Service Provider model from the perspectives of the Primary Service Providers as well as the Services Coordinator. The data was collected through semi-structured interviews that allowed the professional to discuss their perception of how mental health supports for the family and social emotional development was addressed with the family. The research answered the following research question with semi-structured interviews: How do four rural Nebraska School Districts implement Rule 52 birth to three Primary Service Provider Model, in particular social-emotional support for the child? This chapter includes discussion of findings related to themes that emerged from the analysis of the interviews, implications of the results, and recommendations for further research.

Discussion of Results

The results of this research showed that addressing the needs of the whole family and how to support these needs through the primary service provider model. These results are supported through the current literature of addressing the need to support educators and families to help children be most successful. It is important that educators are able to have developmentally appropriate practice and environments, observation and assessment of development and learning, individualized supports-based practices, family support and partnership, and continuous improvement and professionalism in order to best support the family (Meloy & Schachner, 2019).

The researcher first coded and analyzed the data for common themes across eight interviews. The interview data brought about themes representing observation and assessments of development and learning, family support and partnership, continuous improvement and professionalism, individualized supports and inclusion-based practice, barriers and challenges of implementing primary service provider model, child find process, and collaboration with school professionals, educational service units, or planning region teams. These themes are essential components in order to meet family needs as well as the child.

The researcher reflected on the interviews and the themes that emerged from these interviews. Based on the interview data the researcher established that in this case study, primary service providers and services coordinators play a role in the implementation of mental health support and social emotional development when serving the birth to three population.

Looking holistically at what themes emerged from the primary services provider and services coordinators, allowed the research to analyze the perception of the supports and services that are provided to families through the primary service provider model in rural communities. After repeatedly examining the data that was collected the researcher was able to see seven overarching common themes across all categories of the interview data.

COVID-19 impact. At the beginning of the interviews the researcher gathered some demographic information to help understand the roles, years of service, caseloads and how they are employed on the early intervention. The Table 2 below shows this demographic information about the participants. A factor that wasn't considered at the beginning of the research was the COVID-19 pandemic and the effect it would have on some of the information the participants provided. All of the participants stated that most of them had very few CAPTA referral when typically those referral made up the majority of their caseload. Some of the districts even indicated that they had no CAPTA referrals this year. As displayed in this graph the caseload numbers before and during COVID-19 were almost 50 percent of their typical caseload.

Table 2
Demographic Information

Participant	Population Served	Participants Employment	Years of Service	Role Currently	Pre-covid caseloads	Average Caseload of participants
1	5 schools	School district	8 years	OT	11	7
2	All birth to 5	School District	21 years	SLP	21	12
3	All birth to 5, preschool, Sixpence home visitor	School District	18 years	SLP	13-17	6
4	All birth to 5 with preschool	School District	32 years	ECSE	19	10
5	3 school districts	EDN	1 year	SC	10	10
6	3 school districts	ESU	3 years	SC	40	35
7	9 school districts	ESU	6 years	SC	30	35
8	5 school districts	ESU	22years	SC	30	23

Observation and assessments of development and learning. Early intervention staff coded that in order to carry out the primary service provider model the process focuses heavily on the assessments performed and the observations that are completed through the coaching model. There were 24 codes that appeared in this category and this accounted for 8% of the interview data.

The current literature also confirms that it is important that parents are the driving force of the assessment process to determine what the parents prioritize as their highest priorities or the family need (Rush & Shelden, 2011). According to Nebraska Rule 52 it is required that families that qualify for early intervention services that they are provided with an Individual Family Service Plan (IFSP) (Nebraska Department of Education, 2014). Through delivery of the routine based interview and developmental assessment of young children (DAYC) to the families the participants discussed that these are the current assessments that are given to help provide if the family qualifies and if so what needs do the families have.

Today it is even more important that early intervention teams are able to adapt their practices and understand how to intervene with families where they are currently functioning. Therefore in order for early intervention teams to implement Nebraska Rule 52 primary service provider model it is important that they are able to assess the family's needs, develop the plan that meets the developmentally appropriate skill deficits and observe through the coaching model to determine if their services and collaboration has made an impact on their development or family mental health status.

Family support and partnership. The early intervention participants determined the most appropriate family supports based on the needs that were generated through the intake and routine based interview process. These supports are determined and then as a team with the parents input the goals are established. Through goal setting and assessment of the child to determine if there is a delay and if it is significantly discrepant from their norm population. Family supports and partnerships are established when a primary service provider is assigned to the families to help determine services and

build the relationship with the families. There were a total of 17 codes that appeared in this category and this accounted for 6% of the interview data.

The Primary Service Provider (PSP) approach is decreasing both gaps and overlaps in support and services by having only one individual involved with the family (Rush & Shelden, 2013). Families partnership can become overwhelming when multiple people are involved, that is support of having one person be the main contact through the primary service provider model. Through the early childhood essential framework (Meloy & Schachner, 2019), it is noted the importance of providing families with a liaison between services and to help navigate these services.

Continuous improvement and professionalism. Early intervention participants indicated that they have required training in the coaching model, routine based interviews and the primary service provider model but the rest of the training that they would like to attend are sought out on their own. The districts are typically not providing training that is geared towards the birth to three population or the coaching model that is used in this population. All of the participants indicated a desire to improve their skills to better serve their families and understood the need to continuously improve their skill sets. There were a total of 24 codes that appeared in this category and this accounted for 8% of the interview data indicating in order to be implementing the primary service provider model to support all areas of the family's needs especially in the areas of mental health and social emotional development it is important to continuously be able to attend trainings and adhere to professional standards.

Current literature supports the need to continuously educate oneself and adhere to their professional standards when working with families (Meloy & Schachner, 2019).

When early intervention staff have the ability to attend training sessions that provided coaching opportunities to practice the skill that they learned to support their family they were able to retain this skill to apply to a later situation (Rush & Shelden, 2011).

Individualized supports and inclusion-based practice. The code of individualized supports and inclusion-based practice was the most coded theme within the interviews. The early intervention teams indicated that in order to meet family's needs through the primary service provider model they had to individualize the support that they were giving the families. All participants expressed that in the early childhood field there are a lot of structures and models to follow on how to support families but there isn't a one size fits all since all families' needs and supports look different. The teams expressed that during the routine based interviews and coaching sessions the teams determine how they will individualize everything from the joint coaching, service minutes, service delivery model, and communication with the family. There was a total of 93 codes that appeared in this category and this accounted for 34% of the interview data.

The primary service provider indicates that priorities of the family should be individualized and include all members of the team and family that are needed to address this goal on the individual family service plan (Rush & Shelden, 2013). By having the early intervention professional going into the homes or in the community to support the families and their goals they are able to address the families individual needs (Champine, Shaker, Tsitaridis, Whitson, & Kaufman, 2019).

Barriers and challenges of implementing primary Service provider model.

The early intervention teams participants stated that they will do their best to implement

the primary service provider model and pair the family with the most appropriate provider on the team. Barriers and challenges accounted for 23% of all of the interview code data and there were 63 codes present in this area. Three of the four rural school districts contracted services for their early intervention teams in the areas of occupational therapy, physical therapy and services coordinators. The one district that employed their own occupational therapist indicated that they serve multiple districts but is employed through one district. The teams were stating often in the interviews that since their team only has a certain amount and role assigned to their teams consistently then the early intervention team would pair the families with the provider who had the most availability and smaller caseloads. The teams who contract their services indicated that sometimes it is difficult for these individuals to understand that coaching is the model that is used during home visits not the medical model. The fundamental purpose of using the PSP approach to teaming is to help families establish and maintain an ongoing working relationship with a lead team member with needed expertise, who then becomes an expert on the “whole” child and family rather than promoting isolation focus on developmental domains and deficits by each practitioner (Rush & Shelden, 2013).

Child find process. Through the child find process, districts develop ways to find infants and toddlers in their community who may automatically qualify for services or complete activities that would give the community an opportunity to refer these infants and toddlers to the school district. Through the child find process there is also a component of how districts or agencies set up the referral process as well. There was a total of 27 codes that appeared in this category and this accounted for 10% of the interview data indicating that if districts and agencies have a process of child find and the

referral process then families are able to qualify or receive the service of the primary service provider. The process of selecting a primary service provider for the family already starts at the intake of the referral. In the interviews it was noted that all four of the rural communities indicated that the participants are meeting the needs of most of the families but they felt as though there were still infants and toddlers that were not being referred that needed the support. The researcher often wondered how some of the larger rural districts that were interviewed why there wasn't a great caseload in these areas through their child find process. The larger district indicated that their teams are small and they don't complete many child find activities and opportunities in the community.

The research supports that it is important for early intervention teams to have a robust child find and referral process to meet the needs of infants and toddlers within their communities (Edwards, 2018). Through the child find process, teams are able to meet the needs of the families whom may be experiencing barriers in supporting their families and/or child's development. The child find process was noted in all eight interviews as a way to begin the services for families.

Collaboration with school professionals, educational service unit or planning region teams. There was a total of 25 codes that appeared in this category and this accounted for 9% of the interview data. Collaboration with all disciplines is an extremely important part of the primary service provider model. When implementing the primary service provider model it is important that the weekly team meetings that are happening are important for all members to attend. All eight participants reported that they have these team weekly team meetings but since all teams do not have all members, they only are able to receive coaching opportunities from the team members present. Since teams

are not complete with all members necessary to support all developmental domains it is imperative that teams gather knowledge and training in other developmental domains. The teams also participate in monthly planning region team meetings where they have access to other districts and team specialties.

Literature supports the need to have a structure, opportunities to coach other professionals on their questions on serving families, group norms, common vision, and collaboration time (Kise & Russell, 2010). Collaboration between professionals to support all needs of the family is crucial in order to be able to effectively coach the family in their areas of need. The skill of team meetings requires the team to engage in instruction and practice in order to build their knowledge capacity (Kise & Russell, 2010). During team meetings, the early intervention team professionals provided other professionals with coaching opportunities to be able to intervene with their families. Coaching is a partnership and reciprocal process in which both the coach and coachee bring knowledge and abilities to the relationship and current situation (Rush & Shelden, 2011).

Coaching is an important component in being able to implement the primary service provider model to the fullest. By utilizing the coaching model, it is important that early intervention teams are collaborating with their internal teams as well as references that are provided through the school. All eight of the participants indicated that they have access to a school psychologist, counselor, and social worker but they often do not access them because they are not a permanent member on their team. The majority of the teams typically had anywhere from 1.5 FTE to 3.0 FTE on their early intervention teams.

Implications

There are numerous practical implications of this research study. One of the implications of this study would be to further develop additional training and professional development that is offered to the entire state to support the early intervention teams that are supporting families. By building the capacities of the individuals that are working with the state's most vulnerable population this is the best opportunity to provide support to these individuals. By building more capacity of our services coordinators and primary services providers the early intervention team to provide more intensive mental health support or social emotional development to these families may result in a decrease in support and services later in their educational career. By providing the teams with the most effective and efficient ways to support these families it may have an impact on the amount and intensity of programming that may be needed for these children and families. All of the participants indicated that they are implementing the primary service provider model to the best of their ability and their current training. Some of them felt that mental health support and services was not in their current scope because of training and expertise but are willing to take on the role that the family needs.

The study indicates that teams need to be more knowledgeable about services that are available, professional development in the areas of mental health and social emotional development, and continued training in the primary service provider model. The following are recommendations to district, educational service units, health departments, and state leaders who support the early intervention:

- Increased awareness, knowledge and capacity building on to support family's needs in the area of mental health and social emotional development.

- Funding to increase the number of providers for families
- Increase child find opportunities and referral promoting
- Access to school based mental health supports
- Training and educating early intervention staff about all of the mental health support that they may already be providing through the primary service provider model.

Recommendations for Further Research

More research is recommended in this area to evaluate further training and the impact that this has on the strength of the skills that are developed through the primary service provider model. Additionally, this research study was completed in four Nebraska rural school districts and could be replicated in another rural birth to three mandated state or more rural school districts in the state of Nebraska to collect data about the perception and skill sets of early intervention professionals and how they implement the primary service provider model in their area in regards to the mental health and social emotional development support. Another research could examine the themes that were discovered as part of this research project independently and determine how they impact the primary service provider model in larger districts.

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APPENDIX A:Consent Letter



IRB PROTOCOL # 762-20-EX

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NARRATIVE CONSENT

Title of this Research Study

Mental Health Support: Through the Early Development Networks Teams Perspective

You are being asked to participate in a research study Mental Health Support: Through the Early Development Networks Perspective.

An invitation was extended to four local school districts to conduct interviews with early development network services coordinators as well as early childhood directors. You are being asked to add to the information and data about how early development network employees serve families in the natural environment in the area of social emotional and mental health.

The purpose of this study is to conduct semi-structured interviews with early development network professionals about their roles and how they implement the components of Rule 52 primary service provider model.

There are no known risk to you from being in this research study. You are not expected to get any direct benefits from being in this research study. This research study may help to strengthen and identify areas of social and mental health needs in our services being provided to the birth to three populations in the state of Nebraska.

Once consent is received and you agree to participate the researcher will send you an email to schedule a time to complete a zoom meeting in the following three weeks. The zoom meeting will last no longer than 45 minutes.

The research will be supervised by Dr. Jeanne Surface who is a University of Nebraska at Omaha faculty member in the doctoral program. You are able to stop the study at any time. Your consent is voluntary.

Reasonable steps will be taken to protect your privacy and the confidentiality of your data. The only persons who will have access to your research records are the study personnel, the Institutional Review Board (IRB), and any other person or agency required by law. The information from this study may be published in scientific journals or presented at specific meetings but your identifying information will be kept strictly confidential.

IRBVersion 1

IRB Approved


IRB PROTOCOL # 762-20-EX
Page 2 of 2

You have rights as a research subject. These rights have been explained in this consent form. If you have any questions concerning your rights or complaints about the research, talk to the investigator or contact the Institutional Review Board (IRB) at IRBORA@unmc.edu

Audio and video recorded will be used during this study to record the interviews that are completed. This recording will be used for the completion of the research and then destroyed after completion of the dissertation. You will not be able to participate in this study if the interview is not recorded due to coding purposes.

You are freely making a decision whether to be in this research study. Signing this form means that (1) you have read and understood this consent form, (2) you have the consent form explained to you, (3) you have had your questions answered and (4) you have decided to be in the research study.

Signature of Subject:

Date: _____

My signature certifies that all of the elements of informed consent described on this consent form have been explained fully to the subject. In my judgment, the participant possesses the legal capacity to give informed consent to participate in this research and is voluntarily and knowingly giving informed consent to participate.

Signature of Person Obtaining Consent:

Date: _____

Principal Investigator: Heather Post
hsmutny1@gmail.com; (402)841-0141
 Faculty Supervisor: Dr. Jeanne L. Surface

APPENDIX B: Interview Protocol

Name:	Time of Interview:
Interviewee:	Place: Zoom or In person

1. Introduction	Thank you for agreeing to take part in this research study I very much appreciate your time and expertise.
2. Purpose of study	The purpose of this phenomenological case study is to explore the implementation of Nebraska Rule 52 Primary Service Provider model from the perspectives of the Primary Service Providers as well as the Services Coordinator. This study will explore how the Primary Service Provider model is effectively meeting the needs of the child and family in the areas of mental health and social emotional support.
3. Semi-structured Interview	Today I want to ask you several open-ended questions so I can try to uncover the perception of how rural school districts implement the primary service provider model according to Nebraska Rule 52. Your results are confidential and you and your school will not be identified specifically in my report. Our conversation today will last no longer than 45 minutes.
4. Questions	Do you have any additional questions about what our plan is for today?
5. Review Informed Consent	
7. Build relationship	
8. Interview Questions	<p>1) When implementing the primary service provider model what are the roles and responsibilities of the Primary Services Provider, who is assigned and/or paired to the child and family according to the referral need, as well as the Services Coordinator, who is assigned to the family that is being referred? What specific roles does the Primary Services Provider and Services Coordinator have in addressing the mental health needs of the family as well as the social emotional development of the child?</p> <ul style="list-style-type: none"> ● Follow up Questions: How often are they typically able to meet with families? How many families are they serving at one time? ● On average how many automatic qualifiers, who

	<p>have a medical condition or mental condition that may result in a delay, are the early intervention teams receiving from Child Abuse and Treatment Act (CAPTA) referral or mental health related condition?</p> <p>2)How effectively are the Service Coordinators and Primary Service Provider meeting the needs of the family’s mental health and social-emotional needs?</p> <ul style="list-style-type: none"> ● Follow up Questions: Are you able to connect families and/or caregivers to resources and supports in their community ? <p>3)How does your district implement the guidelines for Nebraska Rule 52 primary service provider model? How are families paired with the primary service provider?</p> <ul style="list-style-type: none"> ● Follow up Questions: What type of access do you have to all professional disciplines in your district to be able to appropriately match families with the most appropriate Service Provider ? Are all disciplines a part of the early intervention team? <p>4)What training or professional development resources are provided to Service Coordinators and Primary Services Providers to provide resources in the areas of mental health to families?</p> <ul style="list-style-type: none"> ● Follow up Questions: How often is training provided in the areas of mental health, resource connections for families or social emotional developmental of a child? ● When receiving training in the areas of mental health what training opportunities focus around the crisis, trauma, behavior and family therapy?
9. Closing	<p>I appreciate you taking time today to participate in this interview. I know that time is short but I appreciate you being able to find some time to meet via zoom and talk with me. Again just so you know all of your responses will remain confidential. If you have any questions or concerns please don’t hesitate to reach out.</p>
10. Interview Summary	<p>Record all observations, feelings, thoughts and any reactions about the interviews.</p>

APPENDIX C: Early Childhood Essential Framework

Essential Educator Competencies

Within the Learning Setting

- Developmentally appropriate practice and environments
- Observation and assessment of development and learning
- Individualized supports and inclusion-based practices



Supporting the Learning Setting

- Family support and partnership
- Continuous improvement and professionalism



Essential Child Skills

- Social-emotional development
- Cognitive development
- Language and literacy development
- Mathematical and scientific reasoning
- Physical development



Foundational Conditions

For Educators to Succeed

- Facilitative leadership
- Competitive compensation and benefits
- Job-embedded professional development
- Paid planning and collaboration time
- Emotionally supportive environment

For Children to Learn

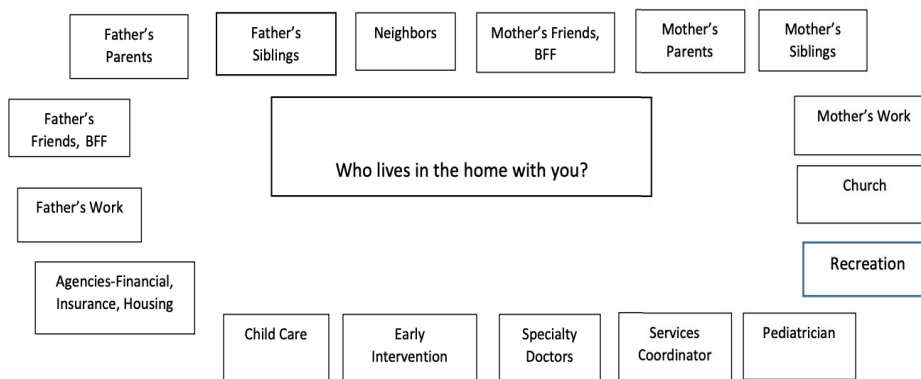
- Adequate nutrition
- Continuity of care
- Access to physical, dental, and mental health services
- Stable and safe housing
- Access to specialized educational supports

APPENDIX D:Ecomap

Introduction to the RBI and the Eco-Map

- 1) *The main purpose of today's meeting is to go through the day-to-day activities of your family to find out how early intervention can best support you and your family. This is the best way of organizing our thoughts. If there's anything you don't want to say, please don't say it! You can end this at any time. OK? At the end of the meeting, we'll have a list of priorities that you would like the EI team to help you with. If we don't finish today, we'll find another time, but we should try to finish today so we can get started on interventions as quickly as possible.*
- 2) *One of the tools we find helpful in getting to know families is the ecomap. The ecomap identifies all of the people who are currently involved in your and your child's life. This might include family members, friends, neighbors, doctors, agencies, and so on. This will help us make better recommendations when we are working with you and may help identify supports your family might need*
- 3) *Let's start with your immediate family; tell me, who lives in your home with you.*
- 4) Using the prompt – *Tell me about.....* ask about the potential family supports below:

Informal Supports



Formal Supports

Good Questions to ask about informal supports: **How often do you see or talk with this person? How are things going with them? If something cool happened with one of your children, who would you call? If you had an emergency (or had to call someone in the middle of the night), who would you call?**

Only for formal supports ask: **Do you like them or are you satisfied with this relationship?**

- 5) Draw informal supports above the nuclear-family box Draw lines of three thicknesses to indicate your perception of support: strong, moderate, simply present. Draw dashed line to indicate source of stress.
- 6) Wrapping up the ecomap: ***Does this picture look like what we talked about? Should I change anything? Are there any people you currently don't have that you would like to have on this***

picture? Give the family an opportunity to add to or subtract anything they wish. ***What do think about this picture?***

If the family says, "That's a lot of people," you can say things like, **"You're right. You have a lot of support"** (informal supports with thick lines) and, if they have lots of formal supports, **"We'll try not to complicate your life even further,"** which sets you up for streamlined service decision making.

If the family says, "I don't have a lot of people, do I?" which they rarely do, you can say, **"True. If you want to build this up, we can help you with that."** If you think it looks pretty thin, you can say, **"If you're happy with this, great. If you want to get connected to more people, we can help with that."**

- 7) Tell the family again that this information will be used to help meet the goals the family will decide on at the end of the RBI and tell them what will happen next with the ecomap, such as: ***This really helped me get to know you and your family. I'd like to keep it so that as we develop the IFSP, we can use this information to address your priorities. Just like all other information you share with me (and the team), it will be kept confidential and only shown to people you want to see it. Would you like me to make you a copy?***

APPENDIX E: Routine Based Interview

RBI Notes

Routine	Concerns	Notes	Rating
Main Concern		Kristy has spina bifida.	
Ecomap	*	Family has recently moved in with Grandma Jo who takes care of all of the kids (Kristy and 2 brothers) while Mary and Frank work the night shift. Getting to be a lot for Grandma and the boys don't get enough attention from Mary and Frank.	
Morning Play	*	Worried about Kristy learning to get around by herself. She tries to pull herself over to where her brothers are but can't get there fast enough. Really wish Kristy would be able to get to where she wants to go quicker so she can play with them.	2 out of 5
N/A	*	Family worried about keeping Kristy healthy. She has a lot of bladder infections due to the spina bifida. Want to reduce # of infections caused by frequent catheterizations.	
N/A	*	Really need Grandma Jo to be approved as a medical childcare provider for Kristy.	
N/A	*	Mary and Frank know they need to develop an emergency health plan for Kristy that has emergency contacts for family, respite and childcare providers. Would like help with this.	
N/A	*	Worry that if Grandma Jo gets sick or can't take care of the children, they do not have a back up plan and won't be able to keep their jobs.	
N/A	*	When Kristy is 3, family would like help finding a preschool program for Kristy so can play with other kids.	

RBI Notes

Routine	Stars	Notes/Concerns	Rating
Main Concern	*	Dahlia's pediatrician has been concerned about her development since her 2 year old check up. The pediatrician screened her for autism and said to contact EI. Would like more information about what an autism diagnosis might mean for Dahlia.	
Ecomap	*	Patty's sister has a son diagnosed with autism too. He is 4 and doesn't talk very much either, same as Dahlia. They have lots of friends and family but sharing another diagnosis of autism with others is tough.	
Morning Play	*	Family wants Dahlia to play with her sister. Dahlia isn't very interested in other kids and prefers to play alone. Her sister gets frustrated because Dahlia won't take turns so Patty just plays with Sarah (the sister).	2 of 5
After School Play	*	Neighbors frequently come over after school to play. They have young children who want to play with Dahlia but she refuses and wants to stay in the house. Wish she would at least play next to them in the yard.	2
Evening Play	*	Neal loves to play tickle with both girls after supper. Wish Dahlia would use words to let Neal know she wants to be tickled. She just pulls on his arm.	4
	*	Would like to talk with other parents of children with autism to find out more about the preschool program at the school.	
Breakfast & Lunch	*	At breakfast and lunch Dahlia points to what she wants to eat. If we don't understand, she screams. Really wish she could use words to tell us what she wants.	2
Grocery Shopping	*	Want to go grocery shopping as a family and have it be a pleasant experience. Right now, it usually falls apart and they end up going home; mad.	1

Family Priorities Form
Actual List of Things to Work On

Primary Interviewer:

Family: _____

Date:

*Order	Routine	Family Priorities
6		Don't get to spend enough time with just the boys. Want respite care for Kristy.
1	Morning Play	Want Kristy to get to where she wants to go quickly so she can play with her brothers
2		Reduce number of bladder infections due to frequent catheterizations
3		Get Grandma Jo approved as a medical childcare provider
5		Develop an emergency health plan for Kristy that includes emergency contacts
4		Have a backup childcare plan for the kids
7		Find a preschool for Kristy when she turns 3

Main Concerns

- a) *Before we start talking about your day-to-day life, what are your main concerns for your child and family?*

Main concerns:

- b) [Show interest and write these down but do not seek much elaboration.]
 c) [At any time in the interview, if the parent mentions something that is a problem, a desire, or otherwise a likely candidate for an outcome, mark it for easy retrieval. I draw a star next to it.]

Now we're going to talk about your family's daily activities.

The Day

Getting into the Routines

- 1) **"How does your day begin?"**
 - a) [Make sure the discussion is about how the parent's day begins, not the child's]
 - b) **START TAKING NOTES ON ROUTINES PAGES.**
- 2) **"Let's back up and deal just with your child's getting up."**
 - a) [Commonly, parents have to be slowed down, because they don't yet know the level of detail desired. These early-morning routines are the time to show the parent how much information to give in each routine.]
- 3) **"What's everyone else doing?"**
- 4) **"What is your child doing?"**
 - a) [Allow a response to the open-ended question and then, if necessary, follow up with these next questions.]
 - b) **"How is your child participating in this activity?" (Engagement)**
 - i) [Try to find out whether the child is highly engaged, just following the routine, or not participating.]
 - c) **"How much does your child do for him- or herself?" (Independence)**
 - i) [Ask developmentally appropriate questions about the child's independence. You have to know your child development!]
 - d) **"How is your child interacting [use simpler terms if necessary] with others at this time?" (Social Relationships)**
 - i) [Ask developmentally appropriate follow-up questions about communication, self-regulation, cooperation, and social skills. Generally, getting along with others during the routine.]
- 5) At any time, ask for the interviewee's perspective on behaviors (why he or she thinks the child does what he or she does).

- 6) Ask what the interview would like to see happen 6 months hence, if and only if there were no problems in the routine: ***"Six month from now, what would you like to see your child doing at this time of day that he's not doing now?"***
- 7) ***"On a scale of 1-5, with 1 being terrible and 5 being great, how would you rate this time of day?"***
- 8) ***"What happens next?"***
- 9) [Repeat Questions 2)-5) for each routine.]
- 10) [If necessary,] ***"Let's skip to dinner preparation time"*** [or another possible later routine. With some interviews, it is necessary to move the conversation along. You can also skip ahead by asking ***"What's the worst time of day for you?"***]

Routines

Concern ★	Routine Rating
	<div data-bbox="919 1514 1308 1703"> <ul style="list-style-type: none"> • What does this look like? Where is everyone? • How does the child participate? • How independent is the child? • What's the child's communication like? • How does the child get along with others? • Anything else? • Optional: What else could the child be doing? • 1-5 (terrible-great) scale </div>

Page 2 IFSP Family Concerns and Priorities Page

Date	Family Priority and Concerns
9-28-2014	<p>An RBI was completed on September 28, 2014 with Kristy's mom (Mary), dad (Frank) and Grandma Jo. Here is a list of their concerns and priorities on that date:</p> <ol style="list-style-type: none"> 1. Kristy to get to where she wants to go quickly so she can play with her brothers during morning play. 2. Family would like to see a decrease in bladder infections due to frequent catheterizations. 3. Family would like Grandma Jo to be approved as a medical childcare provider. 4. Mary and Frank want a back-up plan for childcare in the event Grandma cannot provide the care for the kids. 5. Mary and Frank would like help developing an emergency health plan including emergency contacts etc. for use by family, respite and childcare providers. 6. Mary and Frank would like some respite care for Kristy so they can spend more time with the boys and things won't be so much for Grandma. 7. As Kristy turns 3, Mary and Frank would like help finding a preschool program for Kristy so she can play with other children.

APPENDIX F: Individual Family Service Plan-IFSP

Name of Child:		CONFIDENTIAL
DATE:	FAMILY'S CONCERNS AND DESIRED PRIORITIES	

(----- Denotes Periodic Update)	Name of Child:	CONFIDENTIAL
CHILD'S PRESENT LEVELS OF DEVELOPMENT		
Area/Date of Evaluation	Current Abilities	
Vision <input type="text"/> <input type="text"/> yrs <input type="text"/> mos <input type="text"/> <input type="text"/> yrs <input type="text"/> mos	<input style="width: 100%; height: 40px;" type="text"/> <input style="width: 100%; height: 40px;" type="text"/>	
Hearing <input type="text"/> <input type="text"/> yrs <input type="text"/> mos <input type="text"/> <input type="text"/> yrs <input type="text"/> mos	<input style="width: 100%; height: 40px;" type="text"/> <input style="width: 100%; height: 40px;" type="text"/>	
Health Status <input type="text"/> <input type="text"/> yrs <input type="text"/> mos <input type="text"/> <input type="text"/> yrs <input type="text"/> mos	<input style="width: 100%; height: 40px;" type="text"/> <input style="width: 100%; height: 40px;" type="text"/>	

(----- Denotes Periodic Update)

Name of Child:

CONFIDENTIAL

CHILD'S PRESENT LEVELS OF DEVELOPMENT

Area/Date of Evaluation	Current Abilities
Self-Help /Adaptive Skills <div> <div></div> <div> yrs </div> <div> mos </div> </div> <div> <div></div> <div> yrs </div> <div> mos </div> </div>	<div></div> <div></div>
Fine Motor Skills <div> <div></div> <div> yrs </div> <div> mos </div> </div> <div> <div></div> <div> yrs </div> <div> mos </div> </div>	<div></div> <div></div>
Gross Motor Skills <div> <div></div> <div> yrs </div> <div> mos </div> </div> <div> <div></div> <div> yrs </div> <div> mos </div> </div>	<div></div> <div></div>

Name of Child:

CONFIDENTIAL

OUTCOME

Outcome:

Child/Family strengths and resources related to this outcome:

What will be done/by whom:

Progress will be reviewed by through
(How Often) (By Whom) (How Measured)

Plan Review for this Outcome

Date: Next Steps/Comments:

How much progress:

(----- Denotes Periodic Update)

Name of Child:

CONFIDENTIAL

CHILD'S PRESENT LEVELS OF DEVELOPMENT

Area/Date of Evaluation	Current Abilities
Cognitive/ Thinking Skills	
Communication Skills	
Social/Behavior Skills	

FAMILY CHOICE: Consent to the continuation of early intervention services or initiation of special education services

I/We have received a copy of the Annual Transition Notice.

I/We have been informed about the differences between, and the right to choose, early intervention services provided through an IFSP under the Individuals with Disabilities Education Act (IDEA) and the preschool special education services provided through an Individualized Education Program (IEP) under IDEA once my/our child reaches age 3.

I/We understand that if I/we choose for my/our child to receive special education services through an IEP, my child and family will no longer receive early intervention services nor will receive early intervention services coordination.

I/We understand that if I/we choose for my/our child to continue to receive early intervention services through an IFSP, at any time I/we may elect to receive special education preschool services instead of early intervention services.

I/We understand that my/our consent to the continuation of early intervention services is voluntary and that I/we may revoke consent at any time.

☐ I/We consent to the continuation of early intervention services for my/our child and family through an IFSP after my/our child's third birthday.

☐ I/We request initiation of preschool special education services for my/our child and family at or after age 3.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Goals/Outcomes for Waiver Example:**Goal #1**

During morning play, Kristy will get herself over to where her brothers are playing so she can play with them. We will know she can do this when she gets to where her brothers are playing and is able to share at least 1 toy they are playing with on three days in one week.

Goal #2

By October 15, Mary and Frank will talk with Kristy's medical team about strategies to reduce the number of bladder infections and catheterizations Kristy experiences.

Goal #3

By November 1, Mary and Frank will have completed the paperwork for Grandma Jo to be approved as a medical childcare provider.

Goal #4

By November 1, Mary and Frank will establish a back-up plan for childcare in the event Grandma cannot provide the care for the kids.

Goal #5

By November 1, Mary and Frank will have an emergency health plan in place for Kristy with emergency contact numbers.

Goal #6

By December 1, Mary and Frank will have respite care set up for Kristy so they will have more time with the boys and things won't be so much for Grandma.

Goal #7

By March 1, 2015, Mary and Frank will identify preschool programs in the community so Kristy can play with other children when she turns 3.

APPENDIX G: Homevisit plan



This GUIDE is for use on the first home visit following the IFSP.

GUIDE - Initial

A Guide for Interactions between Families and Providers in Structured Contacts

Child's Name _____

Child Age _____

Parent's Name _____

Date of Contact _____

Professional's Name _____

I. Opening

Establish/Re-establish the Partnership

- Engage in mutual social talk with parent/family.

Discuss Child/Family Strengths & Concerns

(Actively listen for possible priorities for the visit.)

- Ask about the child's strengths, new interests.
- Discuss new family developments since last communication.
- Ask about any concerns and what has been tried.

Co-Establish Purpose/Design for Visit

- Explore your ideas and parent ideas for today's visit.
- Co-determine parent-child-provider roles.

II. Main Agenda

Strategy, Routine, Skill selection

- Co-determine the IFSP outcomes to be addressed.
 - Consider outcomes established at IFSP meeting.
 - Consider current concerns, priorities and/or the child's development and interests.
- Review what we know he/she can do based on parents' recent observations, RBI and assessment data.
- Discuss what has worked and what hasn't to support the child (including routines and strategies).
- Record selected outcomes.

Getting Ready Strategies:

- Communicate Openly and Clearly
- Encourage Parent-Child Interaction
- Affirm Parent Competencies
- Make Mutual/Joint Decisions
- Focus Parent's Attention on Child's Strengths
- Share Developmental Information and Resources
- Use Observations and Data from Parents and Professionals
- Model and/or Suggest

Notes :

(over)



This GUIDE is for use on the first home visit following the IFSP.

Let's Try It! -

- Determine practice opportunity for visit.
 - Brainstorm how parent-child can practice a skill or strategy to support the selected outcome.
 - Decide on a routine.
 - What materials will we need?
 - Where will we try this?
 - What role will parent, professional play?
- Practice.
- Parent and provider discuss practice opportunity. *How did it go? What did child do? What were challenges? What went well? What would you do differently?*

Observe the Parent-Child Interaction

Watch for and comment on parent skills

- Engage in Sensitive and Responsive Interactions
- Sustain Interest and Engagement Through Positive Affect
- Encourage Joint Attention and Turn-Taking
- Follow Child's Lead
- Promote Elaboration through Challenges and Support

Develop Home Visit Plan

- Discuss what will happen between now and next visit.
 - Co-determine what skill/behavior you will see child demonstrate by next visit.
 - Consider the routines that provide the best opportunity to practice the selected outcome.
 - Consider the strategies that will support the child's progress towards the selected outcome.
- Discuss parent and provider* roles in implementing the Home Visit Plan.
- Discuss how we will communicate between visits.
- Check in on progress on other outcomes to inform future visits.*

**as appropriate*

Notes :

III. Closing

Reflect and Review

- What are each of us feeling good about right now?
- What, if any, are parent concerns?
- Any final questions?

Discuss/Review Possible Ideas for Next Visit

Review and Finalize Home Visit Plan

- Provide a copy of the Home Visit Plan for the parent.

Home Visit Plan

Child Name: _____	Date: _____	Provider: _____
Who participated in the visit? _____		
Date and time of next visit: _____		
<i>IFSP selected outcome:</i>		
<i>By our next home visit, child will.....</i>		
<i>What did we do on today's visit?</i>		
<i>What will happen in between visits (strategies, routines, skills)?</i>		
Family:		
Provider:		
Other Supports:		
<i>How will we communicate between visits?</i>		
<i>What are each of us feeling good about right now (parent and provider)?</i>		
<i>What is our plan for the next visit?</i>		
<i>Additional Notes?</i>		

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