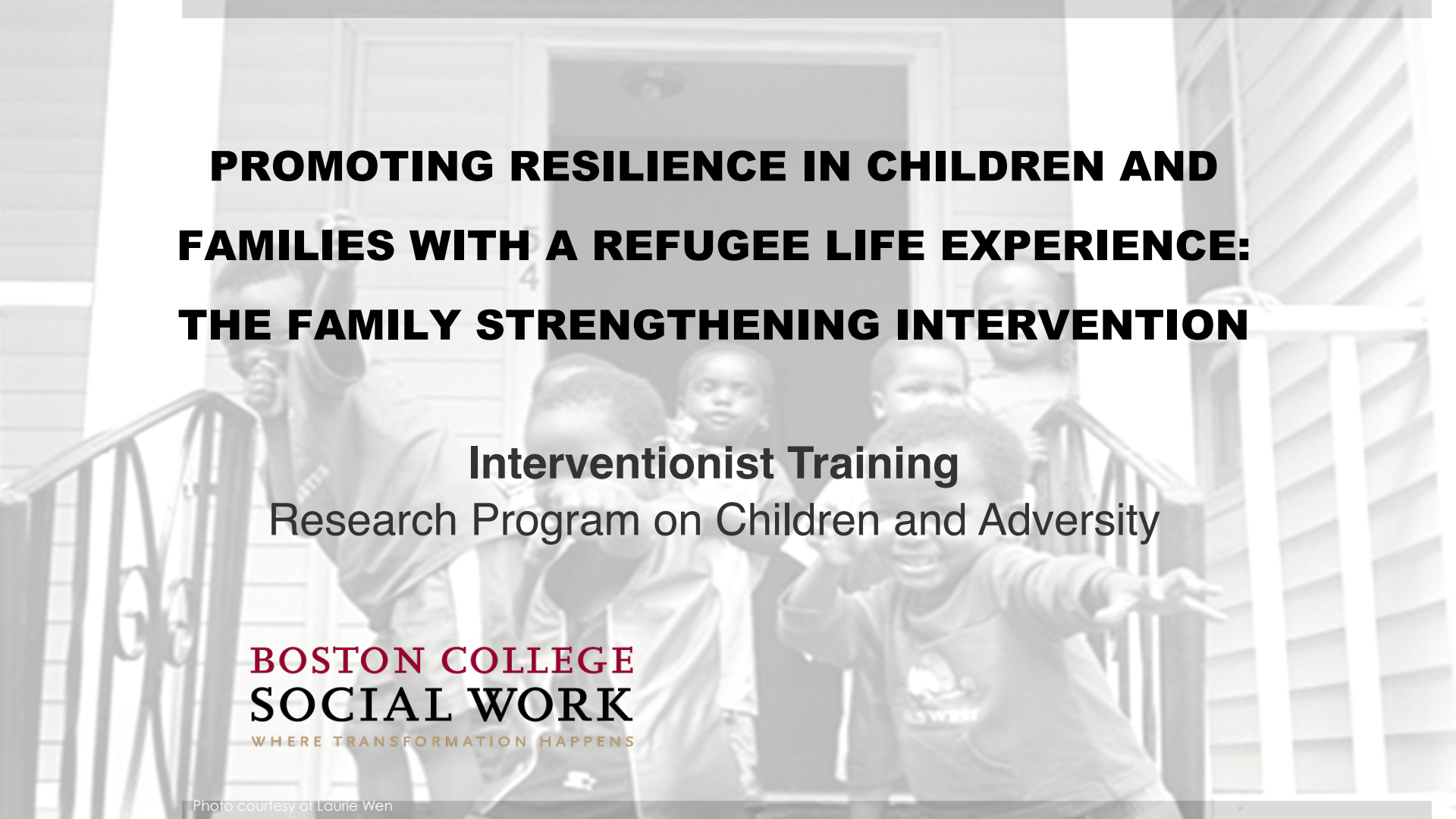

PROMOTING RESILIENCE IN CHILDREN AND FAMILIES WITH A REFUGEE LIFE EXPERIENCE: THE FAMILY STRENGTHENING INTERVENTION

Interventionist Training

Research Program on Children and Adversity

BOSTON COLLEGE
SOCIAL WORK
WHERE TRANSFORMATION HAPPENS

Photo courtesy of Laurie Wen

Training Agenda

- Check-in/introductions
- Background Information on RPCA
- FSI-R History
- FSI-R Program
- Afghan Adaptation
- Fidelity Monitoring
- Supervisor Discussion
- Questions

Check In and Introductions

Please introduce yourself to the group:

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Helen McGuirk, MPH
Refugee State Health Coordinator, Michigan

Research Program on Children and Adversity (RPCA)

- Though implementation science, RPCA identifies factors contributing to ***risk and resilience*** in children, families, and communities facing adversity globally.
- **Led by Dr. Theresa S. Betancourt, Salem Professor in Global Practice & Director of the RPCA**, Boston College of Social Work.
- Expands the evidence base on trauma-informed intervention strategies **to close the implementation gap**, and **supports the development of high quality, effective programs and policies** in low resource settings and for vulnerable groups in the US.

Developed, researched, and licensed 2 evidence-based interventions:

Family Strengthening Intervention (FSI) and FSI for refugees in the US.

Youth Readiness Intervention (YRI)

Refugee children and mental health: Changing times in the US

- **Refugee children and families, due to extensive trauma exposure and loss face increase risk of poor mental health outcomes**
- **For example, among refugee children: Depression (13.81%), PTSD (22.71%) and anxiety disorders (15.77%)** - compared to 4.4% Depression, 5% PTSD, and 9.4% Anxiety in general US children population, (Blackmore et al. 2020; Bitsko et al. 2022, Merikangas et al, 2010)

- **Children in US have poor access to mental health service**s; situation **exacerbated in refugees** (Betancourt et al., 2012; de Anstiss et al., 2009)

Impact of War and Forced Migration on Children and Families

- Refugee children are at **high risk for common mental disorders** due to pre- and post-migration trauma and adversity
- War and forced migration can **negatively impact the family system**- changing family roles, parenting problems, family conflict and poor mental health and functioning in caregivers.
- **Family is also a critical context for support and coping** with ongoing adversity in resettlement.
- **Positive social support from the family** associated with better mental health and psychosocial functioning in refugee children and caregivers.

Mental Health Burden among Resettled Families

- Family strengthening services for refugees are needed to **reduce common mental health problems** and **strengthen family relationships** that are essential for physical/mental health, well-being, and long-term adaptation into their new environment.
- The prevalence of **common mental disorders** such as depression, anxiety, and post-traumatic stress disorder (PTSD) **tends to be highe**r among migrants and refugees.
- About **1 out of 3** asylum seekers and refugees experience high rates of depression, anxiety, and post-traumatic stress disorders.
- Refugee families are found to be more **reluctant to seek out services**
  - Stigma around mental health
  - Lack of resources
- Families can be **overwhelmed** by their own migration experiences
  - Services access is very poor; especially for children—families may not be able to recognize needs
  - Unaware of what services are available
- **Limited referral** networks from schools, pediatric clinics, health centers, etc.

APA Refugee Report (2021), UNICEF World Health Report (2022), Fazel et al., 2012; Edberg et al., 2010)

FAMILY STRENGTHENING INTERVENTION FOR REFUGEES

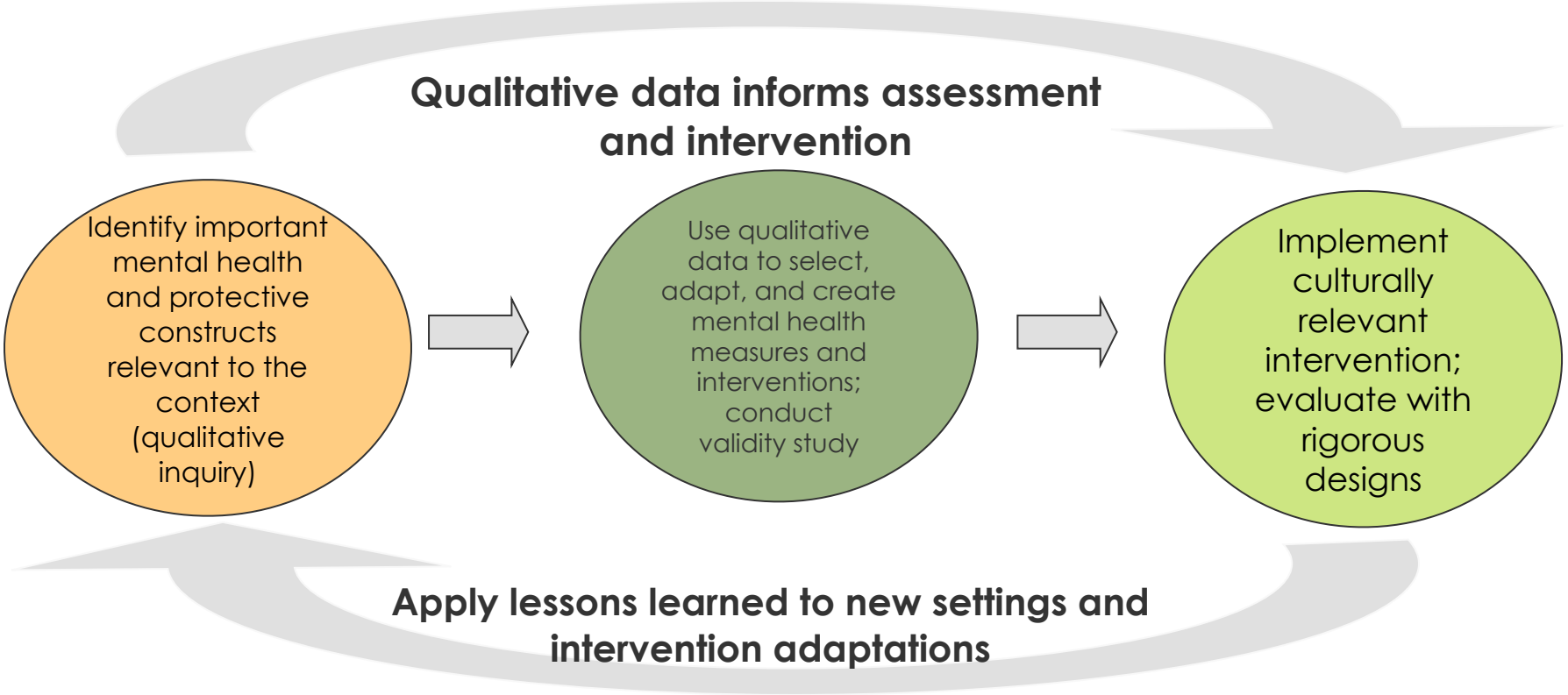
A family-based preventive mental health intervention for use with children and families with a refugee life experience

BOSTON COLLEGE
School of Social Work
RESEARCH PROGRAM ON CHILDREN AND ADVERSITY

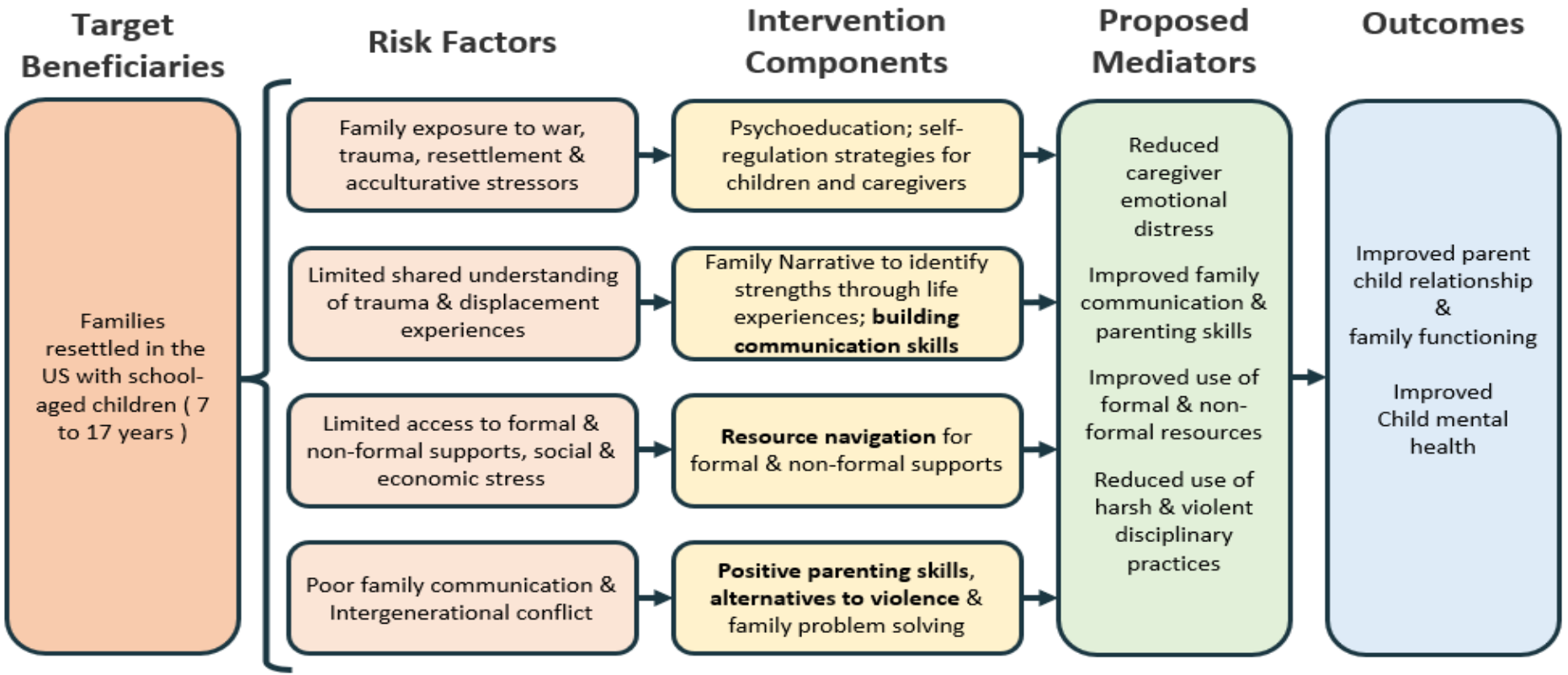
The FSI-R: An adaptation of the Family-Based Preventive Intervention (Family TALK)

- **Evidence-based intervention** (reviewed by the National Registry of Effective Programs & Practices) originally developed for offspring of depressed caregivers by Dr. William Beardslee
- Designed to be administered by a **wide range of providers**
- As a **family-based** preventive model, it focuses on identifying and enhancing resilience and communication in families who are managing stressors due to parental illness
- Had shown effects in reducing depression among children in HIV-affected families in Rwanda
- Good "fit" to be adapted to respond to the setting and context of resettled refugee families

A Model for Designing and Evaluating Mental Health Services in Diverse Cultural Settings



Theory of Change



Initial Collaborating Communities

- **FSI-R was developed to adapt to ever-changing refugee resettlement dynamics**
- Initial U.S. refugee populations: **Somali Bantu, Bhutanese** in New England; long history in refugee camps prior to resettlement
- **Somalis** are largest single group of resettled African refugees in U.S. history; In 2004, an estimated 12,000 **Somali Bantu** were resettled in 50 communities across 38 states; high involvement of youth in juvenile justice system, early marriage, low college attendance; Shanbaro Association of Chelsea formed to address some of these challenges in 1998
- **Bhutanese: Mental health concerns including** high rates of suicide among Bhutanese in the US (21.5 per 100,000), higher than national average (13 per 100,000); Bhutanese Society of Western MA formed to support growing new resettled community in Springfield

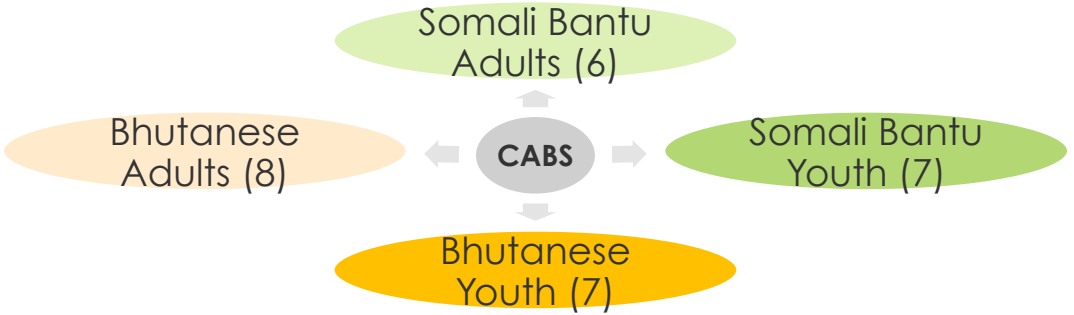
Community-Based Participatory Research (CBPR)

*"**Collaborative** approach to research that equitably involves all partners in the research process and **recognizes the unique strengths that each brings**. CBPR begins with a research topic of importance to the community, has the aim of **combining knowledge with action and achieving social change** to **improve health outcomes and eliminate health disparities**."*

WK Kellogg Foundation Community Health Scholars Program

Our CBPR Approach: "*For Us By Us*"

- Hire CHWs and research assistants from the communities—train **non-specialists**
- Host community outreach events to engage community members
- Build and utilize **Community Advisory Boards (CABs)** at every step:
  - Quarterly meetings
  - Liaison between researchers and the community
  - Advise on needs, culture, etc.



Addressing Health Disparities in the Mental Health of Refugee Children and Adolescents Through Community-Based Participatory Research: A Study in 2 Communities

American Journal of Public Health (AJPH), 2015

Theresa S. Betancourt, ScD, MA, Rochelle Frounfelker, MPH, MSSW, Tej Mishra, MPH, Aweis Hussein, and Rita Falzarano, BA

Objectives. We sought to understand the problems, strengths, and help-seeking behaviors of Somali Bantu and Bhutanese refugees and determine local expressions of mental health problems among youths in both communities.

Methods. We used qualitative research methods to develop community needs assessments and identify local terms for child mental health problems among Somali Bantu and Bhutanese refugees in Greater Boston and Springfield, Massachusetts, between 2011 and 2014. A total of 56 Somali Bantu and 93 Bhutanese refugees participated in free list and key informant interviews.

Results. Financial and language barriers impeded the abilities of families to assist youths who were struggling academically and socially. Participants identified resources both within and outside the refugee community to help with these problems. Both communities identified areas of distress corresponding to Western concepts of conduct disorders, depression, and anxiety.

Conclusions. There are numerous challenges faced by Somali Bantu and Bhutanese youths, as well as strengths and resources that promote resilience. Future steps include using culturally informed methods for identifying those in

There are disparities in the mental health of refugee children and adolescents resettled in the United States compared with youths in the general US population. For instance, the prevalence of posttraumatic stress disorder and depression among resettled refugee children is estimated to be as high as 54% and 30%,[1] respectively, compared with an estimated 5% (posttraumatic stress disorder) and 11% (depression) of youths with these disorders in the general population.[2] In addition to specific psychiatric disorders, refugee youths experience overall greater psychological distress than those in the general population.[3]

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Original article

Family-Based Mental Health Promotion for Somali Bantu and Bhutanese Refugees: Feasibility and Acceptability Trial

Theresa S. Betancourt, Sc.D., M.A. [a,*], Jenna M. Berent, M.P.H. [a], Jordan Freeman, M.P.H. [a], Rochelle L. Frounfelker, Sc.D., M.P.H., M.S.S.W. [b], Robert T. Brennan, Ed.D., M.A. [a], Saida Abdi, Ph.D., L.C.S.W., M.S.W., M.A. [c], Ali Maalim [a], Abdirahman Abdi [a], Tej Mishra, M.P.H. [a], Bhuwan Gautam, M.P.A. [a], John W. Creswell, Ph.D. [d,e], and William Beardslee, M.D. [c,f]

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Article history: Received May 10, 2019; Accepted August 20, 2019
Keywords: Refugees; Family functioning; Youth mental health; Prevention; Intervention

A B S T R A C T

Purpose: There are disparities in mental health of refugee youth compared with the general U.S. population. We conducted a pilot feasibility and acceptability trial of the home-visiting Family Strengthening Intervention for refugees (FSI-R) using a community-based participatory research approach. The FSI-R aims to promote youth mental health and family relationships. We hypothesized that FSI-R families would have better psychosocial outcomes and family functioning post-intervention compared with care-as-usual (CAU) families. We hypothesized that FSI-R would be

IMPLICATIONS AND CONTRIBUTION

This study used a community-based participatory research approach to engage communities in the delivery and testing of

Program History

2004-2008

Partnered with Lynn public schools to address the emotional & behavioral needs of school-aged refugee youth.

2008-2013

Conducted a mixed methods needs assessment of Somali Bantu children in Greater Boston area, partnering with the Chelsea Collaborative
Funding: NIMH

2013-2018

CBPR Collaboration to develop and pilot test the FSI-R, adapted from work with Dr. William Beardslee at Boston Children's Hospital, Jewish Family Services, The Chelsea Collaborative, and The Refugee and Immigrant Assistance Center
Funding: NIMH

2017-2022

CBPR Collaboration and NIMHD-funded Hybrid Implementation Effectiveness Trial of FSI-R in New England with Jewish Family Services and Maine Immigrant and Refugee Services
Funding: NIMHD

2019- Present

Leveraging technology to adapt the FSI-R paper manual into a digital application.
Needs assessment of Afghan families to culturally adapt of FSI-R and pilot of FSI-R with resettled Afghan refugees. Development of training materials for ORR-funded service organizations through IRC Switchboard, Partnerships with service agencies around U.S. to administer FSI-R, development of culturally relevant screening tools with Afghan youth and families
Funding: BC, W.K Kellogg, ORR, IRC

FSI-R Module Characteristics

- Brief, **strengths-based** approach
- Recognize and build on existing family strengths to enhance **resilience**
  - Protective resources = "**active ingredients**" for preventing mental health problems
- **Manualized** protocol
  - Includes detailed set of materials Manual and Workbook
- **Weekly** meetings between family and interventionist
- Separate sessions for **children and adults**
- Two major concepts: **Family Narrative/Family Strengths and Goals and Family Meeting**

1 – 2	Introduction; Family Narrative/Family Strengths and Goals
3	**Children and Family Relationships**
4	**Responsive parenting and caregiving**
5	**Engagement with the US education system**
6	**Promoting Health, Wellbeing, and Safety**
7 – 8	**Communicating with Children and Caregivers**
9	**Uniting the Family**
10	**Bringing It All Together**

FSI GOALS

1. To help families talk about the challenges of their refugee life experience.

2. To inform refugee parents and children about adapting to life in the United States, mental health risk factors, and resilience.

3. To help families recognize and understand the current needs of each child, encourage healthy development of children, and know how to get help when needed

4. To help parents understand resilience and build it in their family

5. To improve communication in the family by developing strategies for talking about challenges and problems within the family.

6. To help families connect to the community and find/use community resources.

7. To help families plan for the future.

CREATING THE FAMILY - STRENGTHENING INTERVENTION FOR REFUGEES (FSI-R)

Who is it for?

- At least one refugee caregiver, and at least one school-aged child that is old enough to be able to participate (> 7 years old).
- The family is currently not in crisis (e.g., depressed parent is suicidal or hospitalized).
- Families need to be able to commit to approximately 10 weekly sessions and all of the core family needs to be willing to participate (including fathers!!)

Who will deliver the intervention?

- Community health workers from the Afghan refugee communities

The Impact of the FSI-R

A pilot study among resettled Bhutanese and Somali Bantu families showed:

- Improved Child Outcomes
  - FSI-R Children reported **less traumatic stress** reactions (β=-0.42; *p*=0.03)
  - FSI-R caregivers reported **fewer child depression symptoms** (β=-0.34; *p*=0.001)
  - Bhutanese FSI-R caregivers reported **fewer conduct problems** in children (β=-0.92; *p*=0.01)
- Family Outcomes
  - Bhutanese FSI-R children reported **reduced family arguing** (β= -1.32; p=0.04).
- Feasible and Acceptable
  - **Feasibility**: Retention rate = 82.5%
  - **Acceptability**: High reports of satisfaction = 81.5% with FSI-R overall

"Just to talk with my family was the best. I never talk with my parent like that."

Somali Bantu 17-year-old girl

*"I also **learned that we should not avoid children… now we understand that we should talk to each other..** and **ask about how the other person is doing.. who he's with, where's he going**… we still share things between mother and son. We now know things happening in each other's lives."*

-Bhutanese mother

Pivoting to Afghan Resettlement

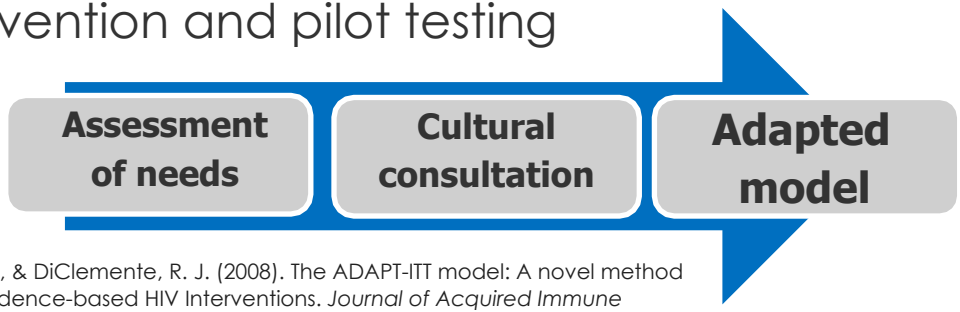
- Following US withdrawal, Afghan **government fell to the Taliban in August 2021,** Special Interest Visa (SIV) holders and humanitarian parolees were evacuated to military sites across the US and globally
- **US has resettled over 165,000 Afghans since the crisis**
- **40% are minor-aged children and adolescents.**
- Population **exposed to acute trauma** and dislocation, all of which **raise the risks of** mental health problems in children & families
- **Additional risk and vulnerability due to resettlement stressors** (e.g., **economic pressures, legal status, housing, education** and **health care access**)

(Parker, 2021, September; Maizland, 2021, September; Montoya-Galvez, 2021, August; Montoya-Galvez, 2021, September)

ADAPT-ITT Framework

Multi-step process:

- Assessment with new population to specify needs and guide intervention selection
- Convening a stakeholder group to guide modifications and adaptations to evidence-based models
- Recruiting and training providers in the adapted intervention and pilot testing



Wingood, G. M., & DiClemente, R. J. (2008). The ADAPT-ITT model: A novel method of adapting evidence-based HIV Interventions. *Journal of Acquired Immune Deficiency Syndromes*, *47*, S40-S46.

Adaptation Project Phases

Phase	Project Activities
Phase 1: Assessing Child and Family Needs	Family based assessments at Safe Havens to assess child needs & strengths. Cultural adaptation of the FSI-R to reflect Afghan culture and needs
Phase 2: Pilot Testing	Work with partners in Maine and Massachusetts to assess feasibility and acceptability of the culturally adapted FSI-R model.
Phase 3: Multi-State Community Implementation	Recruit and train Afghan interventionists & deliver FSI-R to Afghan families. Provide ongoing support and quality improvement to support scale out.
Phase 4: Expanding Access to Diverse Refugee Communities	Problem solve to increase access to FSI-R and evidence-based family mental health promotion services for culturally diverse refugee communities

Cultural Adaptation of the Manual

We followed **the ADAPT-ITT** framework

Common **mental health problems** and **cultural adjustment** challenges among children

- Lack of routines and educational opportunities in the base
- Family communications and spending time together

Due to Recent Acute Trauma:

- Removed family narrative in module 2, 3
- Emphasized identifying strengths and future goals within the family system

Overall Emphasis on **Strengths and Resiliency as a Whole Family**

Pilot of Afghan FSI-R (2022-2023)

- **Pilot Program** of the model for feasibility, acceptability funded by WK Kellogg Foundation
- Somali Bantu partners at **Maine Immigrant and Refugee Services (MEIRS)** led the pilot project in collaboration with RPCA.
- **Pilot with 13 resettled Afghan families delivered by non-specialist providers**

AFSI-R Pilot and Results

Funded by the W.K. Kellogg Foundation in partnership with Maine Immigrant Refugee Services (MEIRS) in Lewiston and Portland, ME

- **Preliminary AFSI-R pilot data** from a pre-post single group design showed improvements in anxiety and depression scores as well as reduction in trauma symptomatology and improved positive parenting practices among caregivers **(n =20).** We also observed positive trends of improvements in parental involvement, positive parenting and monitoring as reported by children **(n=13**).
- **Pilot data demonstrates strong feasibility and acceptability**

Afghan Pilot Preliminary Results

FSI-R Evaluations

PILOT 1: Feasibility and Acceptability Pilot

- CBPR, trained CHWs
- Pre-post t-test, exit interviews
- 13 Afghan families: (n= 20 caregivers, 40% male, 60% female; n=13 children, 53.8% male, 46.2% female)

Key Findings: Caregiver Outcomes

- Reduced anxiety symptoms $\left(Dif_{pre-post} = -0.32,\ p = 0.022\right)$
- Decreased depression symptoms $\left(Dif_{pre-post} = -0.32,\ p = 0.005\right)$
- Decreased depression symptoms $\left(Dif_{pre-post} = -0.32,\ p = 0.005\right)$
- Decreased PTSD symptoms $\left(Dif_{pre-post} = 1.27,\ p = 0.091\right)$
- Positive trends on Hope scale, Everyday discrimination, and Social Support outcomes (although not statistically significant)

Family and Child outcomes

- Decreased poor parental monitoring $\left(Dif_{pre-post} = -0.42,\ p = 0.017\right)$
- Improved positive parenting practices $\left(Dif_{pre-post} = 0.32,\ p = 0.088\right)$
- Reduced Daily Hardships $\left(Dif_{pre-post} = -6.59,\ p = 0.002\right)$
- Positive trends on family conflict and child depression symptomatology (although not statistically significant)

"This experience, in addition to improving our skills, has made us feel more progress and motivation in the new life path in America." *–Afghan mother*

Afghan Pilot Qualitative Data

Improved communication:

"When coming back from school I ask about their day, I ask about homework, and listen to stories about teachers/friends. Any problems I'm more willing to listen and speak to them about." – Afghan mother, age 36

School outcomes and improved child behavior:

"He is doing his homework and studying without me telling him to do it." – Afghan mother, age 31

Positive parenting:

"I am better able to cater to my son and have better mind with how to raise him. I also now realize the importance of having a strong family connection among everyone in the household." – Afghan mother, age 39

More involvement from fathers :

"…for example, before my father wasn't asking about our studies, now everyday he is asking about studies." - Afghan child

Feasibility:

"The program was very feasible, she (the interventionist) was on time, and there was no issue." – Afghan father, age 33

"She (the interventionist) made sure to work around my schedule- Afghan father, age 31

Acceptability of interventionist:

"My interventionist spoke Pashto, my language which I really liked. She had experience with being an Afghan Pashtun raised in the US like my kids will." - Afghan mother, age 36

Lessons Learned from Afghan FSI

Family Level:

- Parents have a lot on their plate **attending to jobs and housing; well-being of children isn't front and center**
- Resettled Afghan children are now **in U.S. public schools; education remains a huge priority but navigating US schools is a priority issue; most families in the dark**
- **Gender differences in school engagement**
- **Housing** remains a stressor, families are large
- **Stigma** around pursuing mental health services

Interventionist Level:

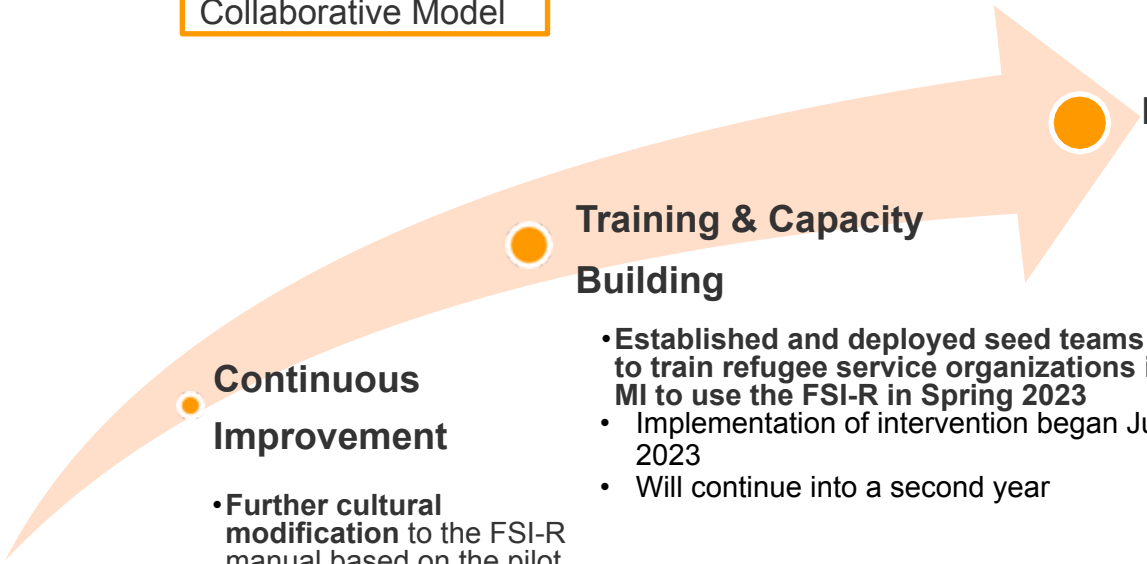
- **Both Afghan-American and Resettled Afghans** (male and female) have been trained as home visitor interventionists
- Issues differ by **type of home-visitor** (**language** ability, degree of experience with US systems)
- Given **acute recent trauma** some components like **the family narrative** needed **adaptation**
- **Weekly Super-supervision** for the whole group as well as **on-site clinical supervision** are ongoing

Technical Assistance: IRC Switchboard

Drawing by Nazi Sadiqi/Jesuit Refugee Service

Pathways to Scale

Multi State Learning Collaborative Model



Continuous Improvement

- **Further cultural modification** to the FSI-R manual based on the pilot experience
- **Integrating non-stigmatizing mental health terminology** from qualitative interview activities with resettled Afghans

Training & Capacity Building

- **Established and deployed seed teams to train refugee service organizations in MI to use the FSI-R in Spring 2023**
- Implementation of intervention began June 2023
- Will continue into a second year

Dissemination

- The BCSSW RPCA-UIC team has been **engaging interested stakeholders** since fall 2021 (ORR, refugee health coordinators, local resettlement agencies)
- Pursuing collaboration for quality improvement and **further technical assistance through a Multi-State Learning Collaborative** Model for states interested in implementing the FSI-R (WI, NH, MA, NM, MN, CA)

Dissemination of the Afghan FSI-R in the State of Michigan

- Working with the **State Refugee Health Coordinator** and Office of Global Michigan to bring the FSI-R to the state of Michigan.
- **Boston College RPCA and FSI-R interventionists experts initiated an in person** 2 week (10 day) role-play based training
- Each interventionist has a **clinical supervisor** at their agency who supports with navigating risk of harm issues, provides feedback on delivery, and connects the interventionist with a referral network. **Weekly virtual group "super-supervision" with the RPCA and seed team** to enhance fidelity and provide feedback.
- **Monthly calls with clinical supervisors and Global Michigan office** to monitor progress and problem solve implementation issues at the agency and state levels

Community Advisory Boards (CAB)

A Community Advisory Boards (CAB) is a core group of people who represent their community.

The Purpose:

- CABs are a means for **community members to have their voices heard** concerning the research project.
- Make sure that members in the community are not harmed in any way and treated with respect.
- **Relay information between the institution and the community at large**.
- **CABs also provide advice** about how the project is going and help ensure that everyone is communicating with each other.

The Composition:

- **Size**: 9-12 members
- **Representation**: Everyone whom are passionate about wanting to serve for the greater good of the community;
  - Members are from **different families and different areas of the community**
  - Members are **from different age groups** (both teenagers and adults)
  -highly preferred if **an equal number of men and women** are represented.
- **Time**: plan on committing a minimum of 1 meeting a month, 1.5 hrs per meeting.

Preferred Qualifications of Interventionists

- Afghan men and women previously resettled and preferably with experience as a parent or caregiver (**women preferred**)
- Language skills in Dari, Pashto AND English **(Dari, Pashto speakers preferred)**
- **Strong interpersonal skills** (communication, time management, working under tight timeline, cultural competency)
- Preferably having previous experience in social services
- **Flexible timing** for accommodating family home-visits (even during the weekends and after school hours)
  - Dedicated for at least 3 months for covering entire module delivery
  - Willingness to travel to participating families
- ** May need to recruit and hire from incoming Afghan populations with limited existing Afghan population

Fidelity Monitoring

What is fidelity monitoring?

- **Fidelity** is defined by "how well the program is implemented without compromising the program's core components."
- It is the degree to which a program or intervention is carried out, or given, *as intended* by the person who created it.
- **Fidelity Monitoring** is the process of checking (or monitoring) how close we are to giving the intervention as it was designed.

Why do we monitor fidelity?

- In interventions such as the FSI, there will always be **differences and variety** in how it is given, based on the interventionist, the family and the circumstances etc.
- Moreover, the intervention is designed to be **tailored** to each family.
- The implementation, however, should be as **standard and consistent** across families as possible.
- Fidelity monitoring is a way to see both **variation and consistency.**
- The goal is to give **constructive feedback** to the interventionist, rather than to evaluate performance.

Why is fidelity monitoring important?

- It ensures the participants are receiving the same intervention
- It allows us to connect outcomes to intervention components
- It allows us to understand the circumstances in which an intervention is effective

Steps for Fidelity Monitoring

- Fidelity checklist at the end of each module in the workbook
  - Review before and after the module
  - Session-specific vs. cross cutting skills
- Supervisor can review this checklist that will guide them in supervision
  - He/she will assess **how well the CHW is delivering** the intervention and where they need the most **support**
  - He/she will **provide feedback and support** each week

Weekly supervision

- Each week you and your staff will talk for 30 minutes-1 hour
- Continuous learning and improvement
- Opportunity to ask questions and discuss challenges
- Super-supervision with Boston College team weekly

QUESTIONS for SUPERVISORS

1. What past experience, skills, and knowledge can you share as a supervisor to the interventionists?
2. Why do you want to become a supervisor for this program?
3. What are your goals as a supervisor
4. What challenges do you foresee that interventionists will experience in working with their families?

PSYCH CATION (TEACHING ABOUT PSYCHOLOGICAL CONCEPTS)

- Resettlement and how it impacts families
- Mental health (i.e. trauma)
- US education system

INTERV ST AS A PAR NER

- Exhibit respect for parents' natural leadership role
- Inquire about parents'knowledge
- Provide needed support and guidance

SKIL DING (ENHANCING)

- Problem-solving
- Social support
- Communication

POTENTIAL CHALLENGES

- Family becomes reliant on interventionist
  - We want to build skills and encourage self-sufficiency in the family
  - Important to balance providing support, with encouraging independence

- Self-disclosure
  - How much does the interventionist share of their personal experiences with family?
  - Cultural differences?

How can we, as supervisors, help our interventionists avoid and overcome these potential challenges?

SETTING BOUNDARIES WITH FAMILIES:

- Need to be friendly, but maintain role of interventionist
  - *How will this look in your community?*
- Need to stay within the bounds of their expertise/ability
    - *What are some examples of issues you can help with? What are some examples of issues that you cannot help with?*
- Always discuss in supervision if they have concerns or are unsure

FSI-R INTERVENTIONIST MATERIALS

- Intervention Manual
- Interventionist Workbook (Use one per family)
  - Family Information Worksheet
  - Module Logs
- Supplementary Handouts and Referral Spreadsheet
- Tablets if collecting data
- Toys for kids

Questions?

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