

**Children’s Behavioral Health**

**Knowledge Center**

**Annual Report**

**2017-2018**

**February 2018**

Overview

Established in Chapter 321 of the Acts of 2008: An Act Relative to Children’s Mental Health, the mission of the Children’s Behavioral Health (CBH) Knowledge Center is to ensure that:

* The workforce of clinicians and direct care staff providing children’s behavioral health services are highly skilled and well-trained;
* The services provided to children in the Commonwealth are cost-effective and evidence-based; and
* The Commonwealth continues to develop and evaluate new models of service delivery.

The Children’s Behavioral Health Knowledge Center is located at the Department of Mental Health in the Child, Youth, and Family Services Division.  As part of the state’s mental health authority, the Knowledge Center's purview is the entire children’s behavioral health system, across Executive Office of Health and Human Services (EOHHS) agencies and public and private payers.

The Knowledge Center fills a gap in the children’s behavioral health system by serving as an information hub, through its Annual Symposium, website, workshops, and webinars. Center staff members work with colleagues who are developing, implementing, and advocating for practices, programs, and service delivery models that are based on the best available evidence about what works to improve outcomes for young people.  As an intermediary organization, the Center’s activities facilitate connection among the rich array of children’s behavioral health researchers, program developers, providers, practitioners, and consumer advocates in Massachusetts. The Center’s projects generally focus on the application of research knowledge, not the production of it.

## Major Activities and Accomplishments

### Parents with Mental Illness

**Let’s Talk Parenting**

In 2017, the CBH Knowledge Center continued its work with **Let’s Talk Parents**, a brief interview protocol and discussion guide for adult mental health service providers, focusing on the impact of parenting and family experiences on the adult/parent living with mental illness.  Let’s Talk Parents  is adapted from the original Let’s Talk about Children model, developed in Finland, which is a brief, evidence-based psychosocial interview protocol and discussion guide to assist providers and their adult clients who are parents to identify and meet the needs of their children, with demonstrated effectiveness in improving children’s outcomes. From January to December, investigators worked to identify and engage interested stakeholders from selected agencies delivering Community Based Flexible Support (CBFS) services to help design and pilot the intervention. The Let’s Talk Parents intervention manual was then further developed to incorporate feedback from CBFS providers and prepare training materials.  Select CBFS agency providers/peer specialists participated in two half days of training addressing the relevance of parenting as a life domain (for minor and adult children, custodial and non-custodial), how emphasis on parenting fits into the larger DMH vision, mission and values, and how to implement Let’s Talk Parents with their adult clients who were parents. These providers then received four months of scheduled, onsite-coaching sessions. In addition, data were collected from CBFS providers as well as adult clients using the intervention, to measure satisfaction with the intervention, ease of use and suggestions for modifications. Standardized measures were used with providers to document attitudes and beliefs regarding the importance of the parenting role, and needed agency supports and infrastructure to integrate parenting as a targeted life domain.  Participating parents who were enrolled in CBFS completed standardized measures documenting parenting self-efficacy, parenting stress, symptoms, well-being and functioning.  Experiences and findings from the training, coaching and data collection were then incorporated into further revisions of the Let’s Talk Parents protocol and discussion guides.

### Promoting Adoption Competency

**Training in Adoption Competency (TAC)**

In two surveys of its own cases (first conducted in 2008 and repeated in 2013) DMH found that children who are adopted under age 18 comprised over 30% of children who are in its residential programs. Locating mental health clinicians with expertise in the unique issues facing children who are adopted and their families can be extremely difficult.[[1]](#footnote-1) Increasing the number of available practitioners with specialized training in adoption is a priority for DMH’s Division of Child, Youth, and Family Services.

In response to the critical need for adoption-sensitive mental health services, the Center supported scholarships for 12 behavioral health clinicians to participate in the 72-hour [Training for Adoption Competency](http://adoptionsupport.org/adoption-competency-initiatives/training-for-adoption-competency-tac/) (TAC) course. The TAC is a post-Master’s curriculum designed by the Center for Adoption Support and Education with the assistance of a National Advisory Board of adoption experts. An evaluation of the course found that students who complete the TAC score an average 43 points higher on post-tests than control groups of comparably qualified professionals not enrolled in the training. The course began in the fall of 2017 and will continue through the spring of 2018.

### Implementation Science

**Practice profile development**

### Guided by the extensive experience of the National Implementation Research Network (NIRN) the Knowledge Center is leading efforts in Massachusetts to improve children’s behavioral health care delivery and practice using an implementation science framework. Implementation science is a body of research that suggests that that *how* a program or practice is implemented is just as important as *what* is being implemented. It is often the lack of attention to implementation supports such as high quality training, coaching, supervision, policy development, performance assessment and leadership that contribute to the disappointing results of many programs or practices.

Over the last year, the Center used the implementation science framework to support the development of practice profiles for three home and community-based behavioral health services for youth and families: In-Home Therapy (IHT), the Caring Together Continuum, and Young Adult Peer Mentoring. These services are all designed to support youth with very serious behavioral and emotional problems and their families. IHT is a MassHealth service that provides care to more than 7,000 youth in any given month. The Continuum is a service jointly procured by the Departments of Children and Families and Mental Health which can support approximately 420 youth a month with 12 providers operating 16 Continuum programs across the state. Young Adult Peer Mentors work in a number of behavioral health settings across the state including within DMH’s Intensive Residential Treatment Programs, Caring Together Continuum programs, and MassHealth’s Therapeutic Mentoring services. Peer Mentors are young adults with lived experience of mental health challenges and/or system involvement, who provide purposeful and culturally appropriate one-to-one support to assist transition age youth and young adults in achieving their goals.

Implementation science tells us that reliable implementation of a program or practice requires that it be specified with enough detail for a trainer to teach someone how to deliver the service, that it is clear enough that a new practitioner can learn how to provide the service and then reliably implement the service with youth and families. It breaks down large concepts such as “engagement” into discreet skills and activities that can be taught, learned, and observed.

Practice profile activities this year included:

* Development and testing of a set of tools for IHT supervisors to help them create a skill development plan for staff members. This toolkit is located at: <http://www.cbhknowledge.center/iht-supervisor-tool-kit>
* The Young Adult Peer Mentor practice profile was developed in a series of six workgroup meetings with young adults. The practice profile was officially released in November 2017 and can be viewed at: <http://www.cbhknowledge.center/young-adult-peer-mentoring-overview/> The practice profile also serves as the foundational document for associated trainings for young adult peer mentors and their supervisors.
* The extensive stakeholder process to develop the Continuum practice profile officially kicked-off in October 2016 with a series of 12 workgroup meetings to develop the profile between January and June 2017. Throughout the fall meetings were held with providers and state agency staff focusing on implementation of the profile. The profile is currently being finalized with plans for distribution in early 2018.

### Strengthening Supervision

A key aspect of the Center’s workforce development strategy is to focus on the competency development and support of supervisors. Supervisors have considerable influence over their staff and play a critical role in teaching, coaching, and supporting behavioral health staff members that are working directly with youth and families. Many supervisors are promoted based on their performance serving as a direct care worker but often receive very little support or training in how to be a supervisor. This year the Knowledge Center supported two projects designed to enhance the skills of behavioral health supervisors.

**Reflective supervision training and coaching**

The Knowledge Center worked with Dr. Elizabeth McEnany to train and coach supervisors in Reflective Supervision (RS). The practice of RS has its roots in infant and early childhood mental health but is applicable for those working with older youth and families, particularly those who have experienced trauma. RS is a relationship-based practice that is “characterized by three key elements: reflection, collaboration, and regularity (Fenichel, 1992, p.9).” Shamoon-Shanook and Gilkerson note that benefits of reflective supervision span both organizational and individual professional capacities while also increasing the quality of services to families and young children. RS strengthens the practice of trauma-informed care through its model of collaboration with and support of clinicians and other providers.

Learning community activities included:

* Twelve (12) hour training in RS practice for direct care supervisors and middle managers.[[2]](#footnote-2) The training was offered at no cost to the participants or the program. Continuing education credits were also offered to those who completed the full 12 hour supervisor training series.
* Four in-person learning community meetings focused on *the implementation of RS,* for change teams comprised of senior leaders, supervisors, and other staff from the organization.
* Mentoring/coaching through a combination of phone conferences and onsite meetings for six months after initial training.

Twenty-five supervisors at six behavioral health provider agencies received training and coaching between September 2016 and June 2017. Four behavioral health agencies were selected via a competitive application process to participate in a new cohort of the project that began in November 2017. An additional 75supervisors and middle managers will be trained in RS practice over the course of the project.

**Strengthening Supervision**

The Knowledge Center and MassHealth jointly supported the opportunity for child and family serving agencies to participate in the Strengthening Supervision Initiative, a training and consultation program delivered by the Yale Program on Supervision (<http://supervision.yale.edu>). Four provider agencies, two from the eastern section of Massachusetts and two from the central part of the state participated in the initiative. Scott Migdole, LCSW, ACSW, Assistant Clinical Professor in the Department of Psychiatry at the Yale School of Medicine served as the lead consultant and trainer for this initiative. He is the Chief Operating Officer of Yale Behavioral Health and the Yale Program on Supervision.

Yale used a two-pronged approach to assist agencies. This involved: (1) the provision of consultation on strengthening agency standards, policies, and procedures related to supervision, and (2) training of frontline supervisors and mid-level managers on best practices in supervision. Providers sent nearly 120 staff members from across their programs for intensive three day training in the Yale approach to supervision. The project period ran for six months, from January through June of 2017.

The supervision initiative was predicated on helping to ensure that core supervision standards were implemented across each of the participating agencies. Within this context, each of the agencies implemented the following: (1) change management team, (2) informed consent process for supervision, (3) supervision session agenda, (4) policy regarding the frequency and duration of supervision, (5) process to document the frequency and duration of supervision, and (6) group supervision. During the on-site consultative process, agencies also actively addressed issues related to chain of command, clarity around required supervisor qualifications *prior* to agency promotion, the development of training curriculum for new supervisors, and a triage system for direct care staff and how/when they access their supervisors.

At an individual level, supervisors were helped to balance their own supervisory authority with staff support and accountability. Practical strategies were provided to help supervisors better manage staff conflicts and complete more accurate performance evaluations. The implementation of group supervision was also an area of focus as supervisors were assisted in refining their facilitation skills and in assisting their staff in applying theory and case conceptualization into clinical practice. This use of groups is very important as it will likely help agencies to develop greater staff continuity, support and critical thought over time. Finally, supervisors benefitted from a discussion regarding professional development and linking quality of care to staff development plans.

### Co-occurring Mental Illness and Substance Use Disorders

While estimates suggest that between 50 to 75 percent of young people with a substance use disorder also experience a co-occurring mental illness, our treatment systems are not organized to seamlessly meet the needs of these youth. A 2015 report[[3]](#footnote-3) co-authored by the Parent Professional Advocacy League (PPAL) and the Massachusetts Organization for Addiction Recovery (MOAR) offered further evidence of this problem. Through focus groups conducted around the Commonwealth they found that:

* Lack of services to address addiction AND mental health created stress on families and increased their burden of care.
* Families struggle to get youth and young adults into just one treatment center for mental health or addiction services much less being able to get them to two different services.

To support practitioners and providers in building their capacity to provide services to youth and young adults with co-occurring disorders the Knowledge Center supported two projects this year which are described below.

**Virtual community of practice**

This six session online training series offers licensed and license-eligible clinicians who work in a variety of settings with an opportunity to participate in discussions about providing care to young people with co-occurring **mental health and substance use disorders**. Each online meeting consists of a short presentation on a topic pertaining to co-occurring disorders, a brief presentation illustrating the topic, and facilitated discussion and resource sharing.

The CoP is **not** a series of single trainings but rather an opportunity for people to be a part of a larger community of practice. Twenty-five individuals working in the public behavioral health system participate in the CoP. The six online meetings which began in October 2017 and will continue through May 2018 are designed to offer support to a cohort of clinicians who are interested in developing their knowledge and skills related to clinical practice with young people with co-occurring disorders and their families.

**Co-occurring disorders learning community**

The Knowledge Center partnered with the Department of Public Health’s Bureau of Substance Abuse Services (BSAS), to implement a learning community focused on improving the capacity of organizations to serve youth with co-occurring mental health and substance use disorders. A learning community is a short-term (6- to 12-month) professional development approach that brings together teams of providers who are interested in seeking improvement in a focused topic area.

Four outpatient providers[[4]](#footnote-4) from the Southeast region of Massachusetts applied to participate in the project which began in December 2017 and concluded in May 2017. The initiative included the following activities:

* A national expert on co-occurring disorders among youth from the [Center for Innovative Practices](http://begun.case.edu/cip/about/) (CIP) at Case Western Reserve University conducted a day-long onsite review using the Dual Diagnosis Capability in Youth Treatment (DDCYT). The DDCYT is a measure of a program’s capacity to address the co-occurring substance abuse and mental health disorders in children and adolescents. Following the review, each provider received a customized report with recommendations for how the organization could become more co-occurring capable.
* Providers also participated in a three learning community meetings held between December 2016 and May 2017. The learning community was organized around the [NIATx model](http://www.niatx.net/Home/Home.aspx?CategorySelected=HOME) of process improvement to support them in making organizational changes to improve outcomes for youth with co-occurring disorders. With the support of the project faculty, [change teams](http://www.niatx.net/Content/ContentPage.aspx?NID=48) from each organization selected an aim to work on and then defined a [change project](http://www.niatx.net/content/contentpage.aspx?NID=46) to help them achieve their aim. The change project results are described in more detail below.
* As is typical in a NIATx change project, each provider also conducted a [“walk-through”](http://www.niatx.net/Content/ContentPage.aspx?NID=146) of the identified outpatient clinic site to identify opportunities for improving the client experience. For example, one of the providers noticed while doing their walk-through that there was not adequate signage to direct young people and their families to the clinic and so they created more visible signs to help people find their location.
* Providers also received coaching in the form of regular calls and onsite meetings from a BSAS NIATx coach to support them in the implementation of their project, as well as consultation in clinical practice issues from the team from Case Western Reserve.

### Results

In just under five months these four providers made many important improvements to their capacity to serve youth with co-occurring disorders. Changes included:

* The change team from BAMSI focused on improving identification of youth with substance use disorders at their outpatient clinic in Whitman. They began by conducting a pilot of the CRAFFT which a small number of clinicians (six) that grew over time to more than 15 staff. Based on the positive feedback from staff members about the tool, BAMSI opted to make the CRAFFT tool available in their electronic health record (EHR). BAMSI also took advantage of various training opportunities made available through this initiative including CRAFFT training, Motivational Interviewing Training, and sending three staff to [ARISE certification training](http://www.arise-network.com/arise-training/). Their participation in this project contributed to the organization’s decision to create a co-occurring disorders clinical team which begins operation in July 2017. This team will include staff members with specialized training and expertise in the treatment of substance use disorders and mental illness.
* High Point Treatment Center wanted to do more to improve access to care for youth with co-occurring disorders at their outpatient clinic site in Middleborough. They were aware that once a young person has agreed to accept help it is critical that they are able to get an appointment as soon as possible in order to capitalize on their motivation. As part of this project they created a Youth and Young Adult Co-occurring Disorders Urgent Care Program. To make this a reality the High Point change team: developed an internal and external marketing strategy to help “get the word out”, made changes to their EHR to capture necessary data about the program, provided training to staff on co-occurring disorders, and created a shared drive with internal resources and information for staff about co-occurring disorders. The program officially went “live” on March 13. High Point now has urgent capacity 5 days per week with 17 hours of walk-in availability in the schedule. The organization hopes to implement the urgent care model at other High Point Outpatient Clinic sites in the future.
* South Shore Mental Health’s outpatient clinic in Wareham also conducted a pilot test of the CRAFFT with a small number of clinicians who volunteered to test out the use of the tool. Feedback from these “early adopters” found that the tool was easy to use and helped them to identify a number of youth with risky substance use and/or a probable substance use disorder. From this small pilot, the organization chose to implement the CRAFFT throughout *their entire system.* It is now mandatory for all staff to use the CRAFFT for intakes/assessments for youth aged 12 and older. They also recognized that their workforce needed more tools to help support them in working with young people with co-occurring disorders, so they implemented a monthly training program focused on improving the co-occurring capability of their staff members.
* Leaders from the Old Colony YMCA’s (OCY) outpatient clinic in Brockton wanted to engage more youth from the community with co-occurring disorders in treatment. As relative newcomers to the Brockton area, they recognized that many people in the community were unfamiliar with the fact that the YMCA provided behavioral health care services. They engaged in a marketing and outreach campaign to raise awareness about their services including hosting a large open house in February 2017. During the walk-through of their clinic they observed that signage was poor, that the waiting area was not welcoming nor did it include any information or materials for young people about substance use. As part of this project, the OCY made many environmental changes to improve the experience of young people and families including making the waiting room more warm and welcoming, improving signage, and adding young adult friendly materials about substance use. In addition, they conducted in-house training for staff on co-occurring disorders and began a pilot of the CRAFFT screening tool.

Overall the project was well-received by participants and proved successful in helping organizations take the first few steps towards better integration of mental health and substance use services. Comments from project participants included:

* *“We appreciated the expertness of the faculty and the opportunity to explore an important gap in our service model that would likely not have been addressed in a meaningful way without this opportunity.”*
* *“I LOVE THIS PROJECT.”*
* *“Well organized and many tasks accomplished. We left with a specific goal and associated task.”*
* *“I enjoyed setting a goal and using the PDSA format. I think it kept us on track to hit our different goals in our aim process.”*
* *“I really enjoyed it. The time commitment wasn't too overwhelming. The check-in phone consultations were helpful and the in person presentations were great to see what other agencies are working on in regards to things that have gone well or not so well, collaborating with others in the field, being exposed to new resources. It was a great experience. I hope we can continue to make progress in this area.”*

### Attachment Self-Regulation and Competency Training

More than two thirds of children in the United States report experiencing a traumatic event by the age of 16.[[5]](#footnote-5) To assist providers in delivering state of the art care to youth and their families who are suffering from exposure to a traumatic event, the Knowledge Center partnered with MassHealth, the Justice Resource Institute (JRI), and the Technical Assistance Collaborative to train 10 IHT providers[[6]](#footnote-6) in the Attachment, Self-Regulation, and Competency (ARC) home-visiting model known as GROW. The goals of this initiative are to 1) enhance the trauma-informed knowledge of service providers working with parents and 2) teach trauma-informed skills and strategies rooted in evidence-informed techniques to parents of youth who are experiencing distress as a result of exposure to a traumatic event(s).

The ARC/GROW home visiting model is a 13 week in-home intervention designed for caregivers of youth who have experienced adversity in early childhood. ARC is a skills-based intervention that provides caregivers with opportunities for experiential learning, practice and in-home application of strategies designed to strengthen attachments, support child/youth regulation and enhance perceived competency in both the caregiver and the child/youth.

### Facilitating Access to Evidence-Based Trauma Treatment

A 2012 report of the United States Attorney General’s National Task Force on Children Exposed to Violence, estimated that more than half of the children currently residing in the United States can expect to have their lives touched by violence, crime, abuse, and psychological trauma.[[7]](#footnote-7) While not all children exposed to a traumatic event develop negative symptoms that require treatment, many do. It is critically important to assist children and their families in accessing treatment as quickly as possible to reduce the impact of trauma on their functioning. Historically, across our state, despite multiple wide-scale dissemination efforts to train up the workforce in evidence-based trauma-focused treatment, children who have experienced trauma have had to sit on waiting lists until services were available, with average waiting times as long as 4 to 6 months for treatment.

The Knowledge Center contracts with the University of Massachusetts Child Trauma Training Center’s (CTTC) LINK-KID referral service to: 1) Rapidly refer children in need of trauma treatment to those providers/practitioners who can provide state-of-the-art care and 2) reduce the burden inherent in navigating the complex treatment systems on families and other referral sources (e.g. social workers, etc.) by maintaining a statewide database of providers trained to deliver evidence-based trauma treatments and facilitating a timely referral to a provider(s) based on age, gender, geography, and insurance type.

LINK-KID is a FREE resource for families, providers, and professionals looking to refer children to trauma-focused evidence-based treatment throughout Massachusetts. When a caregiver, parent, or professional calls LINK-KID **(1-855-LINK-KID)** to make a referral for services, the individual will be speaking with a clinically trained Resource and Referral Coordinator (RRC) who will collect the basic demographic information of the child and will also complete a full trauma screen with the referral source and/or the caregiver, including collecting a description of the child’s trauma history including various trauma types and related symptoms, reactions, and responses connected with the trauma experience(s).

With the information that has been obtained during the trauma screening process, the RRC, in collaboration with the referral source/ caregiver, makes a clinical decision about which evidence-based treatment will be most appropriate for the child. In addition to telephone support, the RRC also offers to provide trauma related psychoeducational material to the caregiver, via electronic or postal mail. Once the screening has been completed, the RRC identifies a trained practitioner(s)/ agency(ies) that matches the geography, insurance needs, language needs, and treatment needs of the child and family (e.g., trauma specialty, gender preference, setting of treatment), and a referral to that practitioner/agency will then be made. Family preference will also inform the decision-making process (e.g., preferred agency/preferred clinician, etc.). The RRC will collaborate with the caregiver during this process regarding preferences and will inform the parent/caregiver and referral source about the location of the referral(s) submission. The entire process of making a referral through LINK-KID takes no more than two business days and the amount of time from initial call to the referral is tracked closely by LINK-KID staff. During the time period between January 1 and December 31, 2017, LINK-KID received more than 755 calls and made 672 referrals for evidence-based trauma treatment.

### Dissemination Activities

By serving as an “information hub” the Knowledge Center has the opportunity to broadly disseminate the exciting work occurring in the field that often is only learned about through “word of mouth” or other informal channels. The goal is to facilitate connections among local providers, researchers, and youth/family members, while raising awareness among policy makers and program funders about those projects, policies, or practices that could be scaled-up. The Knowledge Center has several dissemination vehicles for this work including its Annual Symposium, website, webinars, and its Children’s Behavioral Health Highlights best practices brief series.

**CBH Knowledge Center Symposium**

The Children's Behavioral Health Knowledge Center hosted its fourth annual Symposium and Gailanne Reeh Lecture on May 5th at the Worcester Recovery Center and Hospital. Over 150 people attended the day-long event hosted in celebration of Children's Mental Health Awareness Week. The focus of this year’s Symposium was on parenting from a variety of vantage points.

Dr. Joanne Nicholson, Professor of Psychiatry at the Geisel School of Medicine at the Dartmouth School of Medicine, served as this year’s Gailanne Reeh lecturer. She has an active program of research on parents with psychiatric disabilities, in partnership with people in recovery. She and her collaborators have developed rehabilitation education and training programs and materials for parents, integrating the current knowledge on parents with psychiatric disabilities and evaluating interventions for families, including the pilot Family Options intervention.

Additional presenters included:

* Dawna Aiello, a peer mentor at Riverside Community Care’s Community Based Flexible Support program and parent with lived experience;
* Julie Maida, Editor in Chief of Sober Mommies, an online support group for parents in recovery from substance use;
* Beth Barto, Executive Director of LUK Inc, and Dianne Lanni, a foster parent, who spoke about the National Child Traumatic Stress Network’s Resource Parent Curriculum;
* Margot Cheevers, a grandparent and Commissioner for the Commission on the Status of Grandparents Raising Grandchildren; and
* Malika Arty, Pamela Ferguson, Kristin Glenn, and Barbara Worsley, Coordinators of Family-Driven Practice for Caring Together, who led the audience in an experiential exercise designed to help participants better understand what it is like to walk in the shoes of a parent with a child with a behavioral health condition.

**Care coordination in outpatient therapy online resource**

The Knowledge Center partnered with MassHealth and the Donahue Institute at the University of Massachusetts to create an online, on demand, training resource for outpatient providers (individual practitioners, groups and facilities) providing diagnostic evaluations, individual counseling, group counseling, or couples/family counseling to youth under 21 who are enrolled in a MassHealth Managed Care Entity (NHP, BMCHP, HNE, Fallon, MBHP, & Tufts).

The resource details the critically important role of care coordination within the context of outpatient treatment for youth and families. It further describes how outpatient clinicians can take advantage of recent changes to billable activities that better support care coordination work in outpatient care. This resource was released in August 2017 and can be viewed at: [*http://www.cbhknowledge.center/op-online-training-resource/*](http://www.cbhknowledge.center/op-online-training-resource/).

**Website**

The Knowledge Center’s website: [www.cbhknowledge.center](http://www.cbhknowledge.center) provides a forum for policy makers, providers, advocates, and youth and families to: locate information about local and national training events, learn about evidence-based and promising practices in Massachusetts, and share relevant information and resources. In 2017, the site had over 9,200 unique visitors.



### Webinars

The Knowledge Center partners with the Donahue Institute at the University of Massachusetts to host webinars on a variety of topics related to children’s behavioral health. Webinars were hosted on the following topics this year:

**Facts and fantasies about bullying and cyberbullying**

Professionals working with children tend to hear about "bullying" and "cyberbullying" problems continuously, but how often do children and parents use these terms accurately?  What behaviors are used to bully, and how often do online behaviors intersect with what happens in school?  Are bullying and cyberbullying always the result of emotional disorders, or can they be attributed to lack of knowledge and cognitive misperceptions? Elizabeth Englander, Ph.D., Director of the Massachusetts Aggression Reduction Center at Bridgewater State University presented recent research investigating the most effective ways of discussing and addressing these issues with children and adolescents. More than 100 people attended this webinar.

**Problem gambling: A youth and family perspective**

Problem gambling is an emerging public health issue in our society. A majority of the epidemiological focus has been on the measurement of prevalence and incidence within the adult population. With the rise of social gaming (fantasy sports, internet based games, candy crush) and expansion of gambling (casinos, slot parlors, lotteries) opportunities, there are growing concerns regarding the impact on youth, and families. Problem gambling among youth typically has a snowball effect which impacts their family and social circles. The earlier the onset of gambling experienced by youth the higher for the potential of experiencing other health related issues later in life.

This webinar presented by Victor Ortiz, Director of Problem Gambling Services, at the Massachusetts Department of Public Health, aimed at exploring the complexities of problem gambling and the various challenges and opportunities in the era of expansion gambling in Massachusetts. He discussed effective strategies for integrating problem gambling services into the service array along with current efforts in Massachusetts to mitigate the hams associated with gambling.

**Ways to Keep Babies and Young Children in Mind: Principles and practices for behavioral health providers working in home and community settings**

Often times, children served by through home and community based behavioral health programs have younger siblings. Practitioners have an opportunity to promote optimal social emotional health in these young children, too.

This webinar introduced participants to some principles of infant and young child mental health practices and suggest what practitioners should be listening for when it comes to attending to these young children and their needs. Participants also learned about resources and programs available to serve infants and young children in the Commonwealth. More than 60 people from across the Commonwealth participated in this webinar.

**Young Adult Peer Mentoring: Core elements training overview**

This webinar presented an overview of a new training that was developed to help young adult peer mentors understand their role and develop the skills necessary to perform their role effectively. This three-day core elements training serves as a companion to the Young Adult Peer Mentoring Practice Profile described earlier in this report. The webinar was designed to give peer mentor supervisors a basic understanding of what their supervisees will be learning in the three-day training and also allows peer mentors who are interested in the training a better idea of what to anticipate in the training.

1. <http://adoptionsupport.org/adoption-competency-initiatives/training-for-adoption-competency-tac/about/> [↑](#footnote-ref-1)
2. [↑](#footnote-ref-2)
3. Parent Professional Advocacy League and Massachusetts Organization for Addiction Recovery (2015). Bridging the Divide: The struggle for youth and young adults with co-occurring disorders in Massachusetts. Retrieved on January 13, 2017 from: <http://ppal.net/wp-content/uploads/2011/01/RR-Grant-Paper-FINAL-1.pdf> [↑](#footnote-ref-3)
4. Participating providers were: BAMSI (Whitman Counseling), High Point Treatment Center (Middleborough), Old Colony YMCA (Brockton), and South Shore Mental Health (Bayview Associates clinic in Wareham). [↑](#footnote-ref-4)
5. Copeland, W.E., Keeler G., Angold, A., & Costello, E.J. (2007). Traumatic Events and Posttraumatic Stress in Childhood. *Archives of General Psychiatry.* 64(5), 577-584. [↑](#footnote-ref-5)
6. Each provider agency could nominate up to seven staff to be trained in the model. [↑](#footnote-ref-6)
7. <https://www.justice.gov/defendingchildhood/cev-rpt-full.pdf> [↑](#footnote-ref-7)