

Subject: Studies in the News: (August 30, 2008)



Studies in the News for



California Department of Mental Health

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NEW CONFERENCES

NEW WEBCASTS

CHILDREN AND ADOLESCENT MENTAL HEALTH

“Care for Children and Evidence-Based Medicine.” By Robert D. Sege and Edward De Vos, Boston University School of Medicine. IN: Pediatric Annals, vol. 37, no. 3 (March 2008) pp. 168-172.

[“Primary care for children is at a crossroads. On the one hand, we had made considerable advances in the prevention and treatment of infectious diseases and chronic disease in the 20th century. Now, however, primary care focuses increasingly on the optimization of children’s health in a manner far broader than the disease model. This transformation, for better or worse, strains the conventional approaches to evidence-based healthcare.”]

Full text at: <http://www.pediatricannalsonline.com/showPdf.asp?rID=26862>

Related article: Mental health care for children and adolescents worldwide: A review.

Full text at:

<http://www.pubmedcentral.nih.gov/picrender.fcgi?tool=pmcentrez&artid=1414760&blobtype=pdf>

“The Effectiveness of Self Help Technologies for Emotional Problems in Adolescents: A Systematic Review.” By Muna Ahmead¹, Al-Quds University, and Peter Bower, University of Manchester. IN: *Child and Adolescent Psychiatry and Mental Health*, vol. 2, no. 20 (July 23, 2008) pp. 1-12.

[“Adolescence is a transition period that involves physiological, psychological, and social changes. Emotional problems such as symptoms of anxiety and depression may develop due to these changes. Although many of these problems may not meet diagnostic thresholds, they may develop into more severe disorders and may impact on functioning. However, there are barriers that may make it difficult for adolescents to receive help from health professionals for such problems, one of which is the limited availability of formal psychological therapy. One way of increasing access to help for such problems is through self help technology (i.e. delivery of psychological help through information technology or paper based formats). Although there is a significant evidence base concerning self help in adults, the evidence base is much weaker in adolescents. This study aims to examine the effectiveness of self help technology for the treatment of emotional problems in adolescents by conducting a systematic review of randomized and quasiexperimental evidence....

At present, the adoption of self help technology for adolescents with emotional problems in routine clinical practice cannot be recommended. There is a need to conduct high quality randomised trials in clearly defined populations to further develop the evidence base before implementation.”]

Full text at: <http://www.capmh.com/content/pdf/1753-2000-2-20.pdf>

Related article: “Relationship between entry into child welfare and mental health service use.”

Full text at:

<http://www.pubmedcentral.nih.gov/picrender.fcgi?tool=pmcentrez&artid=1519415&blobtype=pdf>

“Families, Clinicians, and Children and Youth with Special Healthcare Needs: A Bright Future.” By Polly Arango, Family Voices, and others. IN: *Pediatric Annals: A Journal of Continuing Pediatric Education*, vol. 37, no. 4 (April 2008) pp. 212-222.

[“Bright Futures Guidelines for the Health Supervision of Infants, Children, and Adolescents, third edition is many things beyond a rich source of clinical guidance. For families like ours, Bright Futures, third edition, is a validation of our concerns and experiences as parents of sons and daughters with special healthcare needs. Like you, we are caregivers and experts on our children. Additionally, like most of you, most of us also have other children who do not have special healthcare needs. Families and professionals alike, we seek materials that guide us to make informed decisions on behalf of our children. We — and thousands of other families — will find Bright Futures invaluable. We will use it in its many iterations now and well into the future.”]

Full text at: <http://www.pediatricannalsonline.com/showPdf.asp?rID=27519>

DISPARITIES

“Approaching Health Disparities From a Population Perspective: The National Institutes of Health Centers for Population Health and Health Disparities.” By **Richard B. Warnecke, University of Illinois, Chicago, and others.** **IN: American Journal of Public Health, vol. 98, no. 9 (September 2008) pp. 1608-1615.**

[“Addressing health disparities has been a national challenge for decades. The National Institutes of Health–sponsored Centers for Population Health and Health Disparities- are the first federal initiative to support transdisciplinary multilevel research on the determinants of health disparities. Their novel research approach combines population, clinical, and basic science to elucidate the complex determinants of health disparities. The centers are partnering with community-based, public, and quasi-public organizations to disseminate scientific findings and guide clinical practice in communities. In turn, communities and public health agents are shaping the research. The relationships forged through these complex collaborations increase the likelihood that the centers’ scientific findings will be relevant to communities and contribute to reductions in health disparities.”]

Full text at: <http://www.ajph.org/cgi/reprint/98/9/1608>

Related article: “Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care.

Full text at:

<http://www.pubmedcentral.nih.gov/picrender.fcgi?tool=pmcentrez&artid=1497553&blobtype=pdf>

EVIDENCE-BASED PROGRAMS

“An Ethnographic Study of Implementation of Evidence-Based Treatments in Child Mental Health: First Steps.” By **Lawrence A. Palinkas, University of Southern**

California, Los Angeles, and others. IN: Psychiatric Services, vol. 59, no. 7 (July 2008) pp. 738-746.

[“The experiences of clinicians in regard to initial and long-term intention to use evidence-based treatments were examined in order to better understand factors involved in implementation of innovative treatments. **METHODS:** Ethnographic methods of participant observation and extended semi structured interviews with four trainers, six clinical supervisors, and 52 clinicians at five agencies in Honolulu and six in Boston were used to understand treatment implementation in the Clinic Treatment Project, a randomized effectiveness trial of evidence-based treatments for depression, anxiety, and conduct problems of children. Grounded-theory analytic methods were used to analyze field notes, interview transcripts, and meeting minutes. **RESULTS:** Three patterns in regard to long-term intention to implement the treatments were evident: application of the treatments with fidelity, abandonment of the treatments, and selective or partial application. These patterns were perceived to be associated with three preimplementation factors: lag time between initial training in the treatment protocol and treatment use in practice, clinician engagement with the project, and clinician-treatment fit. Four additional factors were proximal outcomes of the three determinants as well as first steps of implementation: clinicians' first impressions of the evidence-based treatments after initial use, competence in treatment use, clinician and researcher adaptability, and clinician-researcher interactions. **CONCLUSIONS:** Interactions between preimplementation factors and initial implementation experiences and between researchers and clinicians during the early implementation steps were related to intentions to sustain treatment.”]

Full text at: <http://www.psychiatryonline.com/>

Related article: “Innovations in mental health services implementation: A report on state level data from the U. S. Evidence-Based Practices Project.”

Full text at:

<http://www.pubmedcentral.nih.gov/picrender.fcgi?tool=pmcentrez&artid=1562440&blobtype=pdf>

The Role of the Patient/Consumer in Establishing a Dynamic Clinical Research Continuum: Models of Patient/Consumer Inclusion. By the National Working Group of Evidence-Based Health Care. (The Working Group, Alexandria, Virginia) August 2008. 12 p.

[“The person who has the most at stake when it comes to healthcare decisions — the patient — should be involved in research, advocacy and all segments of the health care system, according to a key finding of a report released today by The National Working Group on Evidence-Based Health Care. The Role of the Patient/Consumer in Establishing a Dynamic Clinical Research Continuum: Models of Patient/Consumer Inclusion

describes successful examples of groundbreaking patient/consumer engagement in evidence-based healthcare. Designed for patients/consumers, providers and decision-makers, this report identifies best practices for meaningfully involving patients/consumers, especially given discussions about increasing the U.S. capacity for comparative effectiveness research and the potential for a new centralized entity to conduct the research.”]

Full text at: <http://www.docuticker.com/?p=22081>

PREVENTION AND EARLY INTERVENTION

“The Bright Futures Training Intervention Project: Implementing Systems to Support Preventive and Developmental Services in Practice.” By Carole M. Lannon, Cincinnati Children’s Hospital Medical Center, and others. IN: *Pediatrics*, vol. 122, no. 1 (July 2008) pp. 163-171.

[“The objectives of this study were to assess the feasibility of implementing a bundle of strategies to facilitate the use of Bright Futures recommendations and to evaluate the effectiveness of a modified learning collaborative in improving preventive and developmental care.

Fifteen pediatric primary care practices from 9 states participated in a 9-month learning collaborative. Support to practices included a toolkit, 2 workshops, training in quality-improvement methods, monthly conference calls and data feedback, and a listserv moderated by faculty. Aggregated medical chart reviews and practice self-assessments on 6 key office system components were compared before and after the intervention.

Office system changes most frequently adopted were use of recall/reminder systems (87%), a checklist to link to community resources (80%), and systematic identification of children with special health care needs (80%). From baseline to follow-up, increases were observed in the use of recall/reminder systems, the proportion of children’s charts that had a preventive services prompting system, and the families who were asked about special health care needs. Of 21 possible office system components, the median number used increased from 10 to 15. Comparing scores between baseline and follow-up for each practice site, the change was significant. Teams reported that the implementation of office systems was facilitated by the perception that a component could be applied quickly and/or easily. Barriers to implementation included costs, the time required, and lack of agreement with the recommendations.

This project demonstrated the feasibility of implementing specific strategies for improving preventive and developmental care for young children in a wide variety of practices. It also confirmed the usefulness of a modified learning collaborative in

achieving these results. This model may be useful for disseminating office system improvements to other settings that provide care for young children.”]

Full text at: <http://pediatrics.aappublications.org/cgi/reprint/122/1/e163>

Related article: “Preventive health care for children with and without special health care needs.”

Full text at:

<http://www.pubmedcentral.nih.gov/picrender.fcgi?tool=pmcentrez&artid=2367154&blobtype=pdf>

“Multilevel Analysis of a Measure of Community Prevention Collaboration.” By Eric C. Brown, University of Washington, and others. IN: American Journal of Community Psychology, vol. 41, no. 1-2 (March 2008) pp. 115-126.

[“This study assesses a measure of communitywide collaboration on prevention-specific activities (i.e., prevention collaboration) in context of the theory of community change used in the Communities That Care prevention system. Using data from a sample of 599 community leaders across 41 communities, we examined the measure with regard to its factor structure, associations with other concurrent community-level measures, and prediction by individual- and community-level characteristics. Results of multilevel confirmatory factor analysis provide evidence for the construct validity of the measure and indicate significant ($p < .05$) associations with concurrent validity criteria. Female community leaders reported significantly higher levels of prevention collaboration and community leaders sampled from religious organizations reported lower levels of prevention collaboration than did their respective counterparts. Although no a community-level characteristics were associated significantly with prevention collaboration, community clustering accounted for 20–28% of the total variation in the measure. Findings support the use of this measure in assessing the importance of collaboration in community-based prevention initiatives.”]

Full text at:

<http://www.springerlink.com/content/263n111343q77061/?p=ff75bdd442d54bb7bd82f171f213e65a&pi=9>

RISK FACTORS AND PREVENTION

“Health Risk Behaviors and Mental Health Problems as Mediators of the Relationship between Childhood Abuse and Adult Health.” By Mariette Chartier and others, University of Manitoba, Winnipeg. IN: American Journal of Public Health, vol. 98, no. 10 (October 2008) pp. 1-8.

["Objectives. We examined the relationship between childhood abuse and adult health risk behaviors, and we explored whether adult health risk behaviors or mental health problems mediated the relationship between childhood abuse and adult health problems and health care utilization.

Methods. We used logistic regression to analyze data from the Mental Health Supplement of the Ontario Health Survey, a representative population sample (N=8116) of respondents aged 15 to 64 years.

Results. We found relationships between childhood sexual abuse and smoking (odds ratio [OR]=1.52; 95% confidence interval [CI]=1.16, 1.99), alcohol problems (OR=2.44; 95% CI=1.74, 3.44), obesity (OR=1.61; 95% CI=1.14, 2.27), having more than 1 sexual partner in the previous year (OR=2.34; 95% CI=1.44, 3.80), and mental health problems (OR=2.26; 95% CI=1.78, 2.87). We also found relationships between these factors (with the exception of obesity) and childhood physical abuse. Mediation analysis suggested that health risk behaviors and particularly mental health problems are partial mediators of the relationship between childhood abuse and adult health.

Conclusions. Public health approaches that aim to decrease child abuse by supporting positive parent-child relationships, reducing the development of health risk behaviors, and addressing children's mental health are likely to improve long-term population health."]

Full text at: <http://www.ajph.org/cgi/reprint/AJPH.2007.122408v1>

Related article: "Vulnerability and Unmet Health Care Needs: The Influence of Multiple Risk Factors."

Full text at:

<http://www.pubmedcentral.nih.gov/picrender.fcgi?tool=pmcentrez&artid=1490048&blobtype=pdf>

Surveillance of Certain Health Behaviors and Conditions among States and Selected Local Areas --- Behavioral Risk Factor Surveillance System (BRFSS), United States, 2006. By Greta Kilmer and others, Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion. MMWR Surveillance Studies. (Center for Disease Control and Prevention, Atlanta, Georgia) August 15, 2008. p 1-188.

["The leading causes of death in the United States include chronic diseases (e.g., heart disease and cancer), injuries (e.g., suicides and accidents), and preventable infectious diseases (e.g., influenza and pneumonia) (1). The risk factors associated with the leading causes of death include personal health behaviors (e.g., cigarette smoking) and nonuse of health services (e.g. cancer screenings) (2). The estimated prevalence of these risk factors varies across the United States, and constant surveillance is necessary to identify groups at highest risk.

The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing, state-based surveillance system that is used to monitor progress in achieving national health goals

and to direct the public health making decision process. BRFSS has been a source of data since 1984 and is the largest continuously conducted telephone survey in the world. Because of the large sample size, estimates are available for 53 states and territories and for 145 metropolitan and micropolitan statistical areas (MMSAs) and 234 counties across the United States.

Healthy People 2010 objectives have been established to monitor health behaviors and the use of preventive health services. Communities that achieve these goals are expected to attain decreased morbidity and premature mortality by preventing associated risk factors (3). This report contains comparisons between 2006 BRFSS data and *Healthy People 2010* objectives.”]

Full text at:

http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5707a1.htm?s_cid=ss5707a1_e

Related article: “A prospective study of cumulative job stress in relation to mental health.”

Full text at:

<http://www.pubmedcentral.nih.gov/picrender.fcgi?tool=pmcentrez&artid=1177967&blobtype=pdf>

STIGMA

“Part-time Hospitalization and Stigma Experiences: A Study in Contemporary Psychiatric Hospitals.” By Mieke Verhaeghe, University of Ghent, and others. IN: **BMC Health Services Research, vol. 8, no. 125 (June 10, 2008) pp. 1-9.**

[**“Background:** Because numerous studies have revealed the negative consequences of stigmatisation, this study explores the determinants of stigma experiences. In particular, it examines whether or not part-time hospitalisation in contemporary psychiatric hospitals is associated with less stigma experiences than full-time hospitalisation.

Methods: Survey data on 378 clients of 42 wards from 8 psychiatric hospitals are used to compare full-time clients, part-time clients and clients receiving part-time care as aftercare on three dimensions of stigma experiences, while controlling for symptoms, diagnosis and clients' background characteristics.

Results: The results reveal that part-time clients without previous full-time hospitalisation report less social rejection than clients who receive full-time hospitalisation. In contrast, clients receiving part-time treatment as aftercare do not differ significantly from full-time clients concerning social rejection. No significant results for the other stigma dimensions were found.

Conclusion: Concerning social rejection, immediate part-time hospitalisation could be recommended as a means of destigmatisation for clients of contemporary psychiatric hospitals.”]

Full text at: <http://www.biomedcentral.com/content/pdf/1472-6963-8-125.pdf>

Related article: “Do beliefs about causation influence attitudes to mental illness?”

Full text at:

<http://www.pubmedcentral.nih.gov/picrender.fcgi?tool=pmcentrez&artid=1525129&blobtype=pdf>

“Predictors of Depression Stigma.” By Kathleen M. Griffiths, Australian National University, and others. IN: BMC Psychiatry, vol. 8, no. 25 (April 18, 2008) pp. 1-12.

[**“Background:** To investigate and compare the predictors of personal and perceived stigma associated with depression.

Method: Three samples were surveyed to investigate the predictors: a national sample of 1,001 Australian adults; a local community sample of 5,572 residents of the Australian Capital Territory and Queanbeyan aged 18 to 50 years; and a psychologically distressed subset (n = 487) of the latter sample. Personal and Perceived Stigma were measured using the two subscales of the Depression Stigma Scale. Potential predictors included demographic variables (age, gender, education, country of birth, remoteness of residence), psychological distress, and awareness of Australia's national depression initiative *beyondblue*, depression literacy and level of exposure to depression. Not all predictors were used for all samples.

Results: Personal stigma was consistently higher among men, those with less education and those born overseas. It was also associated with greater current psychological distress, lower prior contact with depression, not having heard of a national awareness raising initiative, and lower depression literacy. These findings differed from those for perceived stigma except for psychological distress which was associated with both higher personal and higher perceived stigma. Remoteness of residence was not associated with either type of stigma.

Conclusion: The findings highlight the importance of treating the concepts of personal and perceived stigma separately in designing measures of stigma, in interpreting the pattern of findings in studies of the predictors of stigma, and in designing, interpreting the impact of and disseminating interventions for stigma.”]

Full text at: <http://www.biomedcentral.com/content/pdf/1471-244X-8-25.pdf>

Related article: Stigma in regard to mental disorders: A comparison of Australia and Japan.

Full text at:

<http://www.pubmedcentral.nih.gov/picrender.fcgi?tool=pmcentrez&artid=1525161&blobtype=pdf>

SUICIDE PREVENTION

“Advancing Prevention Research on the Role of Culture in Suicide Prevention.” By Sean Joe, University of Michigan, and others. IN: *Suicide & Life-Threatening Behavior*, vol. 38, no. 3 (June 2008) pp. 354-362.

[“Despite evidence of considerable racial/ethnic variation in adolescent suicidal behavior in the United States, research on youth of European American descent accounts for much of what is known about preventing adolescent suicide. In response to the need to advance research on the phenomenology and prevention of suicidal behavior among ethnic minority populations, NIMH co-sponsored the “Pragmatic Considerations of Culture in Preventing Suicide” workshop to elicit through interdisciplinary dialogue how culture can be considered in the design, development, and implementation of suicidal behavior prevention programs. In this discussion paper we consider the three ethnic minority suicide prevention efforts described in the articles appearing in this issue, along with workshop participants’ comments, and propose six major areas where issues of culture need to be better integrated into suicidal behavior research.”]

Full text at: <http://www.atypon-link.com/GPI/doi/pdfplus/10.1521/suli.2008.38.3.354>

Related article: “Predictors of high rates of suicidal ideation among drug users.”

Full text at:

<http://www.pubmedcentral.nih.gov/picrender.fcgi?tool=pmcentrez&artid=1350972&blobtype=pdf>

“Psychological Tensions Found in Suicide Notes: A Test for the Strain Theory of Suicide.” By Jie Zhang, School of Social Development, Beijing, China, and David Lester, College of New Jersey. IN: *Archives of Suicide Research*, vol. 12, no. 1 (2008) pp. 67-73.

[“As a comprehensive and parsimonious theory explaining the socio-psychological mechanism prior to suicidal behavior, strain theory of suicide postulates that conflicting and competing pressures in an individual’s life usually precede a suicide. The theory proposes four sources of strain leading to suicide: (1) value strain from conflicting values, (2) aspiration strain from the discrepancy between aspiration and reality, (3) deprivation strain from relative deprivation such as poverty, and (4) coping strain from deficient coping skills in the face of a crisis. This research has content-analyzed 40 suicide notes (20 by suicide completers and 20 by suicide attempters) and found strong support for the strain theory of suicide. Although little difference is found in the number and pattern of strains between the completers and attempters, both groups have many aspirations and coping strains and few value and deprivation strains. Also, the older a suicidal victim is, the more he/she feels deprived and lacks coping skills and feels less bothered with value conflicts. Although the study has offered some support for the new theory, future research with more rigorous quantitative data needs to be conducted to further test the theory on a more comprehensive level.” **NOTE: This journal is available to be borrowed from the California State Library.]**

“The Zuni Life Skills Development Program: A School/Community-Based Suicide Prevention Intervention.” By Teresa D. La Fromboise, Stanford University, and Hayes A. Lewis, Institute of American Indian Arts. *IN: Suicide & Life-Threatening Behavior*, vol. 38, no. 3 (June 2008) pp. 343-353.

[“The Zuni Life Skills Development Program, an effective community-initiated and high-school-based suicide prevention intervention, is featured. Development and evaluation of this intervention are followed by note of the specific challenges associated with stabilizing the program. A more tribally diverse, culturally-informed model entitled the *American Indian Life Skills Development Curriculum* is then presented to illustrate a hybrid approach to the cultural tailoring of interventions. This curriculum is broad enough to address concerns across diverse American Indian tribal groups yet respectful of distinctive and heterogeneous cultural beliefs and practices. Finally, we reflect upon issues in community-based research that emerged during this collaboration.”]

Full text at: <http://www.atypon-link.com/GPI/doi/pdfplus/10.1521/suli.2008.38.3.343>

Related article: Outcome of an evaluation of a public health approach to suicide prevention in an American Indian tribal nation.

Full text at:

<http://www.pubmedcentral.nih.gov/picrender.fcgi?tool=pmcentrez&artid=1380310&blobtype=pdf>

NEW CONFERENCES

Register now for the 13th Annual Conference on Advancing School Mental Health,
<http://cf.umaryland.edu/csmha/confreg2/>

This year’s conference will be held in Phoenix, Arizona at the Hyatt Regency Phoenix (<http://phoenix.hyatt.com/hyatt/hotels/index.jsp>), September 25-27, 2008. The conference is sponsored by the Center for School Mental Health (CSMH) in collaboration with the IDEA Partnership, sponsored by the National Association of State Directors of Special Education (NASDSE). The Conference offers numerous opportunities to network and learn more about best practice in school mental health. The theme for the conference is "School Mental Health for All Students: Building a Shared Agenda for Youth, Families, Schools, and Communities."

To review the Annual Conference Brochure:

http://csmh.umaryland.edu/conf_meet/AnnualConference/download_files/FinalAnnualConferenceBrochure.pdf

To review session descriptions:

http://csmh.umaryland.edu/conf_meet/AnnualConference/Program%20Booklet%20as%20of%208.8.08.pdf

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NEWWEBCAST PAGE

Topics addressed on Webcast Page from California Institute of Mental Health:

Prevention & Early Intervention webcasts; Underserved Cultural Populations webcasts; Serious Onset of Psychiatric Illness webcast; Trauma Exposed Individuals webcast; and Suicide Prevention webcast.

<http://www.cimh.org/Learning/Online-Learning/Webcasts/Prevention-and-Early-Intervention.aspx>