



Prepared for Child and Youth Mental Health Services - British Columbia Ministry of Children and Family Development

Welcome

Spring 2008 — Preventing and Treating Childhood Depression

Welcome to our Spring 2008 issue, on preventing and treating childhood depression.

- Our *overview* answers basic questions about childhood depression
- Our *review* presents new research on promising programs for preventing depression in children
- Our *feature* looks at the latest findings from the Treatment for Adolescents with Depression Study (TADS), comparing cognitive-behavioural therapy with medication for treating depression
- Our *letters to the editors* column responds to readers' comments, questions and suggestions

We hope you enjoy this issue. We welcome your letters and suggestions for future topics. Please email them to erika_harrison@sfu.ca.

About the Quarterly

The *Quarterly* is a resource for policy-makers, practitioners, families and community members. Its goal is to communicate new research to inform policy and practice in children's mental health. The publication is funded by the British Columbia Ministry of Children and Family Development, and topics are chosen in consultation with policy-makers in the ministry's Child and Youth Mental Health Policy Branch.

The *Quarterly* is designed to be read on the Internet. We encourage you to share it with others and we welcome its use as a reference (for example, in preparing educational materials for parents or community groups). [Click here](#) to download a print-friendly PDF. Please cite this issue as follows:

Schwartz, C., Waddell, C., Harrison, E., Garland, O., Nightingale, L., Dixon, J., Barican, J., & Gray-Grant, D. (2008). Preventing and treating childhood depression [spring issue]. *Children's Mental Health Research Quarterly*, 2(2), 1-15. Vancouver, BC: Children's Health Policy Centre, Faculty of Health Sciences, Simon Fraser University.

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Next Issue

Our Summer 2008 issue covers *childhood bipolar disorder*, including new research on the importance of a careful assessment to ensure that this problem is not overdiagnosed in children.

About the Children's Health Policy Centre

We are an interdisciplinary research group in the [Faculty of Health Sciences](#) at [Simon Fraser University](#). We aim to connect research and policy to better children's social and emotional well-being, or *children's mental health*. We advocate the following public health strategy for children's mental health: addressing the determinants of health; preventing disorders in children at risk; promoting effective treatments for children with disorders; and monitoring outcomes for all children. Please see www.childhealthpolicy.sfu.ca to learn more about our work.

Current Articles

OVERVIEW:

Why Does Childhood Depression Matter?

Clinical depression is the third most common mental disorder in childhood, affecting an estimated 23,000 children in BC at any given time. We discuss the symptoms of childhood depression, how to assess it and why intervening early is so important.

REVIEW:

Could Prevention Be the Best Medicine?

To determine whether programs aimed at *preventing* depression (and not just treating it) actually succeed, we undertook a systematic review of the latest high-quality research. We examine seven promising programs described in this research.

FEATURE:

A Tale of Two Treatments

In treating adolescent depression, clinicians often recommend either cognitive-behavioural therapy (CBT) or fluoxetine (an SSRI). When used independently, both produce positive outcomes. But are two treatments better than one? We consider the evidence.

LETTERS TO THE EDITORS:

Readers offer a variety of responses to our recent review of parenting programs. We welcome your feedback on this or any other issue. You can contact us via [email](#) or by regular mail (see our [contact page](#)).

REFERENCES:

We provide all references cited in this edition of *The Quarterly* in one, easy-to-use link.

OVERVIEW:

Why Does Childhood Depression Matter?



Fleeting experiences of sadness are common for children. These experiences usually resolve on their own, particularly when children have good supports and the cause of the sadness is addressed. But sometimes sadness progresses to become clinical *depression*, causing distress and interfering with children's development and ability to function at home, at school and in the community.

How common is childhood depression?

At any given time, clinical depression affects an estimated 3.5% of children or approximately 23,000 in BC (or 185,000 in Canada).¹ This makes depression the third most common mental disorder in childhood, with girls being more affected than boys.^{1,2} Depression frequently persists or re-emerges in adulthood.³ The consequences are profound, with global surveys now showing that depression is a leading cause of disability worldwide, second only to cardiovascular disease.⁴

What causes childhood depression?

Like most mental health problems, depression likely arises from gene-environment interactions.⁵ For example, if a child with a depressed parent (genetic susceptibility) also experiences maltreatment (environmental stressor), that child is then at risk of developing clinical depression.⁶

Other stressors that put children at risk include having a serious physical illness and experiencing a significant loss.⁷ At the same time, factors such as positive relationships with adults and good learning abilities can buffer children from stressors, making depression less likely.⁸ Many environmental stressors are modifiable, making them a good target for intervention.

Factors such as positive relationships with adults and good learning abilities can buffer children from stressors, making depression less likely

How do we assess childhood depression?

When a child is suspected of having depression, an assessment by a qualified child and youth mental health practitioner or team is important. (New investments in prevention programs and in service models that can reach more children more efficiently are urgently needed, given that the majority of children with depression currently do not access specialized mental health services.)¹ A comprehensive assessment ensures that children do not get inappropriately labelled or receive the wrong treatments. It can also ensure that underlying causal factors are addressed wherever possible. Along with assessing depression itself, the practitioner or team will also assess for problems that frequently occur along with depression, such as anxiety or substance abuse.^{2,9}

To meet the standard diagnostic criteria for depression, children must exhibit at least *five* of the following *symptoms* and *impairment* in their functioning on a day-to-day basis over *two weeks* or more:¹⁰

Symptoms of Childhood Depression


- | | |
|---|--|
| - Pervasively depressed or irritable mood | - Loss of interests and pleasures |
| - Significant changes in weight or appetite | - Significant decreases in energy or activity levels |
| - Sleep disturbances | - Reduced concentration |
| - Feelings of worthlessness or hopelessness | - Recurring thoughts of death or suicide |

Why is it so important to intervene early?

Once an episode of depression starts, it may last for several weeks or several months if undetected and untreated. Unfortunately, most depressed children are not identified and do not receive treatment.¹¹ These children may go on to experience more severe episodes, affecting their ability to thrive and meet their potential over the long term. Depression can also continue into adulthood, perpetuating distress and poor functioning across the lifespan.¹² Childhood is therefore the optimal time to intervene — to address underlying causes of depression where possible and to prevent unnecessary distress and impairment across the lifespan.

Is there something we can do about childhood depression?

Fortunately, we can do a great deal to prevent and treat childhood depression. The first step is to recognize that children can and do experience depression and that depression is a serious public health concern. This recognition can help reduce the stigma associated with mental health problems.¹³ The second step is to recognize underlying causal factors of childhood depression (such as child maltreatment or parental mental health problems) and intervene where these are modifiable.



Prevention programs are a particularly viable means of reaching many more children in need

The third step is to ensure, at a policy level, that all children in need are reached with effective prevention programs and treatment services. Prevention programs in particular are a viable means of reaching many more children in need, when offered on a continuum along with treatment services. The remainder of this issue reviews new research on these programs and services.

Government staff can access original articles from BC's [Health and Human Services Library](#).

References

REVIEW:

Could Prevention Be the Best Medicine?



Prevention programs intervene before disorders develop, promoting healthy child development and preventing distress and impairment from arising or worsening. Prevention programs are either *universal* or *targeted*. Universal programs include all children in a given population, whereas targeted programs focus on children at risk (e.g., those who already have some risk factors or early symptoms).¹⁴ Whether universal or targeted, *every* program needs careful evaluation to ensure that children have better outcomes as a result. To this end, we review new research, evaluating universal and targeted programs for preventing depression in children.

Our systematic method for selecting research

To find the highest-quality research, we used systematic methods adapted from the journal *Evidence Based Mental Health*.¹⁵ To identify studies, we first applied the following search strategy:

Sources	- Computer searches of Medline, PsycINFO, Cochrane & Campbell databases - Hand searches of previously (systematically) identified systematic reviews	
Search Terms	- <i>Prevention and depression</i>	- <i>Randomized trial and controlled trial</i>
Limits	- English-language articles published in 2002 through 2007 - Study populations comprising children aged 0–18 years	

Next, we applied the following criteria to ensure we included only the highest-quality studies:

<ul style="list-style-type: none">- Clear descriptions of child characteristics, settings and interventions- Interventions occurred before diagnosable mental disorders emerged in majority of children- Random assignment of children to intervention and comparison groups at outset- Maximum dropout rates of 20% post-test- Post-test follow-up of three months or more- Measures of child symptoms and/or diagnoses related to depression- At least two symptom measures and/or one diagnostic measure reported at follow-up- Child outcomes assessed according to two or more sources (child, parent, teacher and/or clinician)- Levels of statistical significance reported at follow-up for all outcomes/groups

Two different team members checked the results at each stage to ensure accuracy. Findings were then summarized.

Seven well-evaluated programs

Of several hundred articles screened, nine met all our criteria. These nine articles described seven programs for preventing depression in children. Five programs were targeted, one was universal and one was both. All the targeted programs were aimed at children with depressive symptoms. In one program, children also had a parent with depression.¹⁶ Six programs used cognitive-behavioural techniques (CBT) and one used interpersonal techniques (IPT). Five programs were delivered exclusively in schools^{17–22} and one exclusively in a clinic.²³ One program was conducted in both schools and clinics.^{16, 24}

Programs for Preventing Depression in Children

Program	Approach	Child Age
	Type	Child Gender
	Country	Total # of Children
<i>Taking Action:</i> ²³ 16 weekly 60-minute <i>group</i> sessions + 2 booster <i>group</i> sessions, including psychoeducation, activity scheduling, cognitive restructuring & self-monitoring; parents invited to participate halfway through sessions	CBT	9–11 years
	Targeted	75% female
	Belgium	20
<i>Penn Prevention Program:</i> ^{17, 18} 12 weekly 120-minute <i>group</i> sessions, including psychoeducation, cognitive restructuring, managing family conflict, assertion, negotiation, coping & social skills, decision-making & problem-solving	CBT	11–13 years
	Targeted*	50% female
	Australia	189
<i>Teen Talk:</i> ¹⁹ 2 <i>individual</i> & 8 weekly 90-minute <i>group</i> sessions, including psychoeducation with communication & interpersonal strategies applicable to interpersonal problems	IPT	11–16 years
	Targeted	85% female
	United States†	41
<i>Problem Solving For Life:</i> ²⁰ 8 weekly 45-minute <i>group</i> sessions, including identifying thoughts, feeling & problem situations, challenging negative & irrational thoughts & problem-solving skills	CBT	12–14 years
	Universal	52% female
	Australia	1,500
<i>Queensland Trial:</i> ²¹ <i>Universal:</i> 8 weekly 45-minute <i>group</i> sessions, including cognitive restructuring, problem-solving skills, thought & feeling identification, & challenging irrational thoughts <i>Targeted:</i> 8 weekly 90-minute <i>group</i> sessions, including cognitive restructuring, problem-solving skills, interpersonal skills & self-reward	CBT	13–15 years
	Targeted + Universal	54% female
	Australia	2,479
<i>Coping with Stress:</i> ^{+16, 24} 15 45-minute ²⁴ or 60-minute ¹⁶ <i>group</i> sessions, including identifying & challenging negative & irrational thoughts, learning new coping skills; 1 trial ¹⁶ included 3 separate parent sessions	CBT	13–19 years
	Targeted	68% female
	United States	150 ²⁴ & 94 ¹⁶
<i>Frames:</i> ²² 3 weekly <i>individual</i> sessions & varying # of <i>group</i> sessions, including psychoeducation, challenging distorted negative thoughts, self-management strategies, emotion expression & social stigma reduction; optional art session	CBT	15–19 years
	Targeted	70% female
	Thailand	70

CBT = Cognitive-behavioural techniques

IPT = Interpersonal techniques

† 92.7% Hispanic

‡ Data combined from two separate trials.

* Children without elevated depression symptoms were included when there were ≤13 students in a participating class.

Several promising programs

Of the seven programs we reviewed, four were found effective. *Coping with Stress* and *Teen Talk* reduced new cases of depression while *Frames* and *Taking Action* reduced depressive symptoms. *Coping with Stress*, *Frames* and *Taking Action* used CBT techniques while *Teen Talk* used IPT techniques. All successful programs were targeted. Three other programs — *Penn Prevention Program*, *Problem Solving for Life* and the *Queensland Trial* — were not effective. These unsuccessful programs all used CBT, with a mix of universal and targeted components. The table below depicts these outcomes.

Program Outcomes at Follow-Up

Program	Follow-Up Period	# of Significant Depression Measures	Diagnosis Rates (intervention vs. control) [or Effect Size*]	# of Significant Other Measures	Effect Size
Programs effective at reducing depression symptoms or diagnoses					
<i>Coping with Stress</i> ^{16, 24}	12-month	1 of 3**	15% vs. 26%	0 of 2	–
	24-month†	4 of 5**	8% vs. 25%	1 (general functioning) of 4	NR
<i>Frames</i> ²²	3-month	2 of 2	NR	–	–
<i>Taking Action</i> ²³	4-month	2 of 2	[0.93 & 1.48]	1 (internalizing symptoms) of 3	0.97
<i>Teen Talk</i> ¹⁹	6-month	2 of 2**	4% vs. 29%	1 (general functioning) of 1	1.21
Programs ineffective at reducing depression symptoms or diagnoses					
<i>Penn Prevention Program</i> ‡ ¹⁸	30-month	0 of 1	–	1 (anxiety measure) of 7	0.23
<i>Problem Solving for Life</i> ²⁰	12-month	0 of 2	–	0 of 5	–
<i>Queensland Trial</i> ²¹	12-month	0 of 3	–	0 of 7	–

* Effect size measures the magnitude of treatment impact. Effect sizes are classified as small (0.2 – 0.4), medium (0.5 – 0.7) or large (≥ 0.8).

** Significant measures include actual depression diagnoses.

NR = Not Reported

– = Not Applicable

† Based on overall analysis rather than specific time, with exception of cases of depression, which was measured at 12-month follow-up.

‡ Previous trials of the *Penn Prevention Program* have shown significant positive results for follow-up periods up to 2 years.


Three of the six CBT programs produced positive results. All unsuccessful programs were delivered in Australian classrooms and included at least some children without depressive symptoms. (The “targeted” *Penn Prevention Program* trial included children without depressive symptoms when there were not enough students with elevated depression symptoms in a given classroom.)¹⁸ By including children free from significant symptoms, the programs were likely delivered to children without need and without room for symptom improvement.

The authors of the *Penn Prevention Program* study suggested their inability to replicate past positive findings for this program may have been due to challenges delivering the program in schools (such as coping with timetable changes) and using less qualified facilitators.¹⁸ The authors of the *Queensland Trial* noted that their program’s failure might have been due to its brevity (8 weekly 45-minute group sessions) and to students not acquiring skills associated with protective factors (reductions in negative thinking).²¹ The authors also speculated that outcomes might have been better with a broader focus, including risk and protective factors in the home and school environments in addition to individual child factors.²¹

Implications for policy and practice

Four of the six targeted programs — *Coping with Stress*, *Teen Talk*, *Taking Action* and *Frames* — had beneficial outcomes, including substantial reductions in new cases of depression. In contrast, the programs with universal components — the *Queensland Trial* and *Problem Solving for Life* — did not produce positive outcomes. Overall, the evaluations of universal depression prevention programs are equivocal. Two other recent reviews found some positive results for universal school-based programs; however, the effect sizes were small.²¹

Our review found three CBT-based targeted programs were effective in preventing depression, consistent with findings from previous systematic reviews.²⁵ The poorer outcomes for some CBT-based programs highlight the need for further research to identify how these programs can be delivered to produce the best results. For example, how do factors such as program content, program length, qualifications of instructors and ages of children affect outcomes for targeted CBT programs?



Targeted CBT programs have the strongest evidence of effectiveness in preventing childhood depression

The research on prevention programs using other theoretical techniques is just beginning. The reviewed IPT trial produced significant reductions in depression diagnoses among at-risk, predominately Hispanic American, children. These initial findings warrant follow-up research on IPT programs using larger and more diverse samples of children.

Targeted CBT programs have the strongest evidence of effectiveness in preventing childhood depression. These programs produced impressive results. For instance, *Coping with Stress* reduced new cases of depression by up to 17%.¹⁶ We therefore recommend that policy-makers and practitioners start with targeted CBT programs and conduct effectiveness evaluations in Canadian settings.

Government staff can access original articles from BC's [Health and Human Services Library](#).

References

FEATURE:

A Tale of Two Treatments



For children who *are* depressed, effective treatment is imperative. Researchers have identified treatments that are ineffective, such as tricyclic antidepressants,²⁶ and those that are effective, such as certain selective serotonin reuptake inhibitors (SSRIs).²⁵ Among effective treatments, cognitive-behavioural therapy (CBT) and fluoxetine (an SSRI) are recognized as first-line treatments.⁹ When used independently, both CBT and fluoxetine produce positive outcomes for approximately 60% of adolescents.⁹ However, up to 50% of adolescents suffer another depressive episode within the first year of treatment ending.⁹ These findings prompted researchers to identify how outcomes could be improved for adolescents with depression.

Does combination therapy work in “real life”?

Researchers with the Treatment for Adolescents with Depression Study (TADS) set out to determine whether combining CBT *and* fluoxetine would improve outcomes compared to using either treatment alone.⁹ The researchers recruited 439 adolescents from different cultural backgrounds and socioeconomic circumstances, including those with concurrent mental health conditions, to ensure that the study results would be widely applicable.²⁷

Participant Characteristics ²⁸			
Median age: 14.6 years	Ethnicity:* 74% Caucasian 13% African-American	Other current diagnoses: 27% Anxiety disorders 23% Disruptive behaviour disorders 3% OCD/Tic disorders 2% Substance use disorders	Primary resident: 53% Two-parent home 41% Single-parent home 6% Not living with either parent
Gender: 54.4% female	9% Hispanic 5% Other		

* Total percentage exceeds 100% due to rounding.

Across the 13 American study sites, adolescents were randomly assigned to one of four treatment conditions. Flexibility was emphasized in the treatments to minimize adverse events and maximize compliance.⁹ Special sessions were available for managing clinical emergencies.⁹

Treatment	# in Condition	Description ⁹
Fluoxetine	109	- Flexible dosing schedule based on clinician rating of functioning & adverse events - Starting dose of 10 mg/day up to a maximum of 40 mg/day in first 12 weeks - Up to 60 mg/day after first 12 weeks of treatment
CBT	111	- 14 60-minute sessions of either individual or family CBT in first 12 weeks, including following core topics: psychoeducation, goal-setting, mood monitoring, increasing pleasant activities, social problem-solving & cognitive restructuring - Flexible topics chosen jointly by therapist & adolescent, including communication, negotiation, compromise, assertion & social engagement
Combined	107	- Both fluoxetine & CBT
Placebo	112	- Pill without any active ingredients

The benefits of combining medication with CBT

After both 12 and 36 weeks, the combined treatment showed response rates between 5% and 28% greater than either CBT or fluoxetine alone. However, socioeconomic status affected outcomes. At 12 weeks, CBT was as effective as the combined treatment and fluoxetine alone among adolescents with family incomes greater than \$75,000 US per year.²⁹ Socioeconomic status and the potential effects on outcomes were not tracked at the 36-week follow-up.

Outcomes by Treatment Condition

Condition	By end of 12 weeks of treatment: ²⁷		By end of 36 weeks of treatment: ³⁰	
	Response rates	Suicidal events	Response rates	Suicidal events
Fluoxetine & CBT	71% – significantly more effective than all other treatments	8.4%	86% – significantly more effective than CBT only	8.4%
Fluoxetine alone	61% – significantly more effective than CBT & placebo	11.9%*	81% – not significantly more effective than CBT	14.7%**
CBT alone	43% – not significantly more effective than placebo	4.5%	81%	6.3%
Pill placebo	35%	5.4%	Discontinued for ethical reasons	

*Significantly greater than placebo

** Significantly greater than CBT

Adverse events also varied by treatment condition. By the end of the study, adolescents taking fluoxetine alone were twice as likely as those in the combined treatment or CBT alone groups to experience a suicidal event (defined as worsening suicidal ideation and/or making a suicide attempt).^{30, 31} Nonetheless, the researchers found that fluoxetine decreased the risk for completed suicide.²⁷ Using CBT with fluoxetine produced significantly fewer adverse events compared to fluoxetine alone.²⁷

Policy and practice applications

The authors suggested that fluoxetine should be widely available.³⁰ However, they recognized that many practitioners, adolescents and families may want to start with CBT alone to avoid any side effects, then turn to medication only if needed.²⁷ Given the positive longer-term benefits of CBT, including outcomes “catching up” to combined therapy toward the end of treatment,³⁰ CBT alone remains a solid option for many.

Adolescents and their families need timely access to effective treatments delivered by skilled practitioners

For those choosing to include fluoxetine in their treatment, careful monitoring is essential. Health Canada³² has issued an advisory warning that fluoxetine “may be associated with behavioural and emotional changes, including an increased risk of suicidal ideation and behaviour” for children and adolescents. Additional side effects can include sedation, nausea and insomnia.

Adolescents suffering from depression need information about effective treatment options including CBT and fluoxetine. Practitioners need to describe both the risks and benefits associated with these treatments to ensure that decisions are well-informed. Adolescents and their families need timely access to skilled practitioners who can deliver these effective treatments.

Government staff can access original articles from BC’s [Health and Human Services Library](#).

References



In each issue of the *Quarterly*, we are pleased to respond to feedback from our readers. Whether you are a policy-maker, practitioner or community member, we invite you to contact us with your questions and comments. Here, we feature comments inspired by our [Winter 2008](#) issue on the topic of building children's resilience.

To the Editors:

A recently published evaluation of a universal parenting program found it did not reduce child behaviour problems among Australian toddlers [Editors' note: see Hiscock et al., 2008,³³ in the references]. Based on these findings, the authors concluded there was insufficient evidence to support using very early universal programs to prevent behavioural problems. Could you comment how on this fits with your own recent review of parenting programs [\[Winter 2008 issue\]](#)?

Cyril Lopez
Burnaby, BC

Unlike the children in Hiscock's study who came from diverse backgrounds, we focused on parenting programs exclusively aimed at families experiencing adversities. The four programs we reviewed were *targeted* to families experiencing socioeconomic disadvantages. All significantly improved children's behavioural outcomes. We therefore continue to recommend these targeted programs that are supported by high-quality research.

To the Editors:

I read with interest your review of evidence-informed parenting programs [\[Winter 2008 issue\]](#) associated with building resilience in children. One well-researched program, *The Incredible Years*, was not included. Could you explain why it did not meet your inclusion criteria and comment on the research that has been conducted on this program?

Lee Cohene
Port Moody, BC

The program was not included in our recent review because the one randomized-controlled trial (RCT) published within the specified search dates failed to include sufficient child outcome measures at follow-up. However, our [Spring 2007 issue](#) of the *Quarterly* featured an excellent evaluation of *The Incredible Years*. The program was found cost-effective in reducing important risk factors for conduct disorder among Welsh children. Further evidence of effectiveness comes from older RCTs with American families, featured in our [Winter 2007 issue](#). Given this evidence, we strongly support this program being implemented and evaluated in Canadian settings.

To the Editors:

Thank you for your thorough and easily accessible review of parenting programs. As team leader for Mission's Child and Youth Mental Health Program, I am hoping you will devote a future issue to parent education, support and involvement given parents' importance to children's healthy development. I hope that such a focus would draw the attention of 'decision-makers' to invest more in parenting education and encourage practitioners to include parents more frequently in their interventions.

Gurmeet Singh
Mission, BC

We agree that parents are crucial partners in children's mental health. Programs involving parenting are often included in the literature we review and present. For example, in our [Winter 2007 issue](#), most of the successful programs we reviewed focused on parents. *Nurse Visitation*, *Perry Preschool* and *Fast Track* all aimed to improve parents' skills, thereby preventing behaviour problems in the early years (along with preventing child maltreatment in the case of *Nurse Visitation*). Parents were also included in many of the interventions reviewed in other past issues (including [Spring 2007](#), [Summer 2007](#), [Fall 2007](#)). While parenting has already figured into much of our previous work, we will also consider making parenting the main topic of a future issue, as you suggest.

We welcome your comments and questions. Please email erika_harrison@sfu.ca. Letters may be edited for brevity and clarity.

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[References](#)

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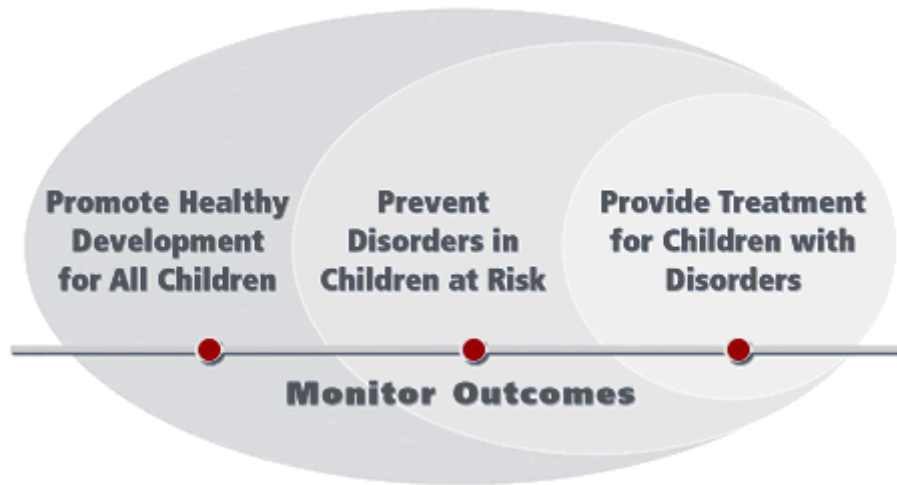
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About the Children's Health Policy Centre

We are an interdisciplinary research group in the Faculty of Health Sciences at Simon Fraser University. We focus on integrating research and policy to improve children's social and emotional well-being, or *children's mental health*. In doing so, we support a public health strategy for children's health: promoting healthy development for all children; preventing disorders in children at risk; providing treatment for those with disorders; and monitoring outcomes to ensure the effective and efficient use of public resources. Our work complements the mission of the Faculty of Health Sciences to integrate research and policy for population and public health locally, nationally and globally.

Public Health Strategy for Children's Mental Health



About *The Quarterly*

The Quarterly is an electronic publication prepared for Child and Youth Mental Health Services with British Columbia's Ministry of Children and Family Development. It provides updates on the best currently available research in children's mental health for policy-makers, practitioners, families and the public. Our research methods are detailed in our [first issue](#).

Please visit www.childhealthpolicy.sfu.ca to learn more about our ongoing work.