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QUESTION

Question: What is the efficacy of a school based intervention on the psychosocial wellbeing of children in violence affected communities?

Patients: 495 children (mean age 9.9 years (range 7–15), 51% boys), selected from 14 randomly selected schools within Poso, Indonesia, an area affected by communal violence since 1998. For inclusion, children had to have been exposed to at least one violent event and show symptoms of post-traumatic stress disorder (PTSD) and anxiety. Exclusions: children displaying violent behaviour, unable to follow instructions, mutism, substance abuse, psychosis, panic or phobic disorders, mental retardation, dissociative disorders or epilepsy without medication.

Setting: 14 secondary schools in the Poso district, Central Sulawesi, Indonesia; March to December 2006.

Intervention: School based group psychosocial intervention (237 children from seven schools) or wait-list control (258 children from seven schools). The psychosocial intervention consisted of 15 group sessions over 5 weeks (about 15 children per group) of a manual classroom based intervention. The intervention integrated cooperative play and exercises based on drama, dance and music with cognitive behavioural therapy techniques. Sessions were delivered by individuals selected from target communities who underwent a 2 week training programme. These individuals had no formal mental health training.

Outcomes: Exposure to violent events (contextually constructed child rated checklist); PTSD (Child Post-traumatic Stress Scale, CPSS); depressive complaints (Depression Self-rating Scale, DSS); anxiety symptoms (Self-Report for Anxiety Related Disorders 5 item version, SCARED-5); physical signs of traumatic stress (4 point scale assessing six signs); hope (child rated Children's Hope Scale, CHS); and functional impairment (contextually constructed checklist).

Patient follow-up: 403 children were assessed at 6 months (81%).

METHODS

Design: Cluster randomised controlled trial (schools were the unit of randomisation).

Allocation: Unconcealed.

Blinding: Unblinded.

Follow-up period: 6 months (not including 5 week treatment period).

MAIN RESULTS

Children had been exposed to a mean of 3.7 violent events in the intervention group and 4.0 in the control group. After 6 months of follow-up, the intervention had improved PTSD symptoms (mean change difference on CPSS: 2.78, 95% CI 1.02 to 4.53) and increased hope more than the control at 6 months (mean change difference on CHS: -2.21, 95% CI -3.52 to -0.91; negative values indicates greater improvement with intervention). There were no significant differences between the groups in anxiety symptoms, depressive complaints, physical signs of stress or functional impairment (mean change differences: SCARED-5 +0.12, 95% CI -0.31 to +0.56; DSS +0.70, 95% CI -0.08 to +1.49; physical signs of stress +0.50, 95% CI -0.12 to +1.11; functional impairment checklist +0.52, 95% CI -0.43 to +1.46).

CONCLUSIONS

A school based psychosocial intervention provided by para-professionals helps maintain hope and reduce symptoms of PTSD in children affected by political violence.

ABSTRACTED FROM

Tol WA, Komproe IH, Susanty D, et al. School-based mental health intervention for children affected by political violence in Indonesia. A cluster randomized trial. *JAMA* 2008;**300**:655–62.

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Tol and colleagues found that a school based intervention developed in Boston was feasible in this low resource environment. They also found that it was useful but not effective for all problems, being helpful for PTSD symptoms but not for other trauma and non-trauma problems, such as depression and anxiety. The study has therefore begun the process of developing an evidence base by beginning to demonstrate the populations and issues for which the intervention is appropriate. They point out that their study is practically unique as there is little attention given to, or data on, the impact of mental health interventions among war affected children in low resource environments despite a strong consensus that such studies are a priority. The authors could also have stated that there is little evidence for the effectiveness of any child mental health interventions outside highly resourced countries. Therefore, rather than adding to

what should already be an impressive body of knowledge, this study instead stands with a handful of others as the current sum of evidence for child based interventions for the world's 150 or so developing nations. So the findings, while a good start, are far from providing adequate evidence on which to base future mental health practices in low resource countries.

In addition to the study's clinical implications, the authors have also demonstrated that solid scientific study of child mental health programmes is possible in low resource environments. Clearly the lack of such studies is not a function of feasibility but rather of the will and resources to do them. If child mental health interventions in this type of environment are to be evidence based, many more such studies are needed. If this is left solely to research institutions it will be decades before sufficient studies are done.

Most low resource countries have organisations providing "psychosocial programmes". Few of these are well evaluated for effectiveness. The present study should propel programme implementers and policy makers of clinical programmes in low resource countries to consider the current state of evidence and to try to improve this by seeking ways to evaluate their programmes. Only if many organisations take on this role and publish their results will the global youth mental health field develop sufficient knowledge to guide services.

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Competing interests: None.