CHAPTER 4

Development of a comprehensive psychosocial support system for children in areas of political violence

Abstract

Very few comprehensive psychosocial and mental health intervention models have been reported for children affected by political violence. In addition, there is a paucity of research-supported recommendations. This paper describes an example comprehensive psychosocial care approach for children (focus age between 8-14 years), aiming to translate common principles and guidelines into a broad support system. This community-based approach includes different overlapping levels of interventions to address varying needs for support. These levels provide assessment, prevention and treatment of problems ranging from the social consequences of political violence, emotional distress and psychiatric problems. Specific intervention methodologies and their rationale are described within four low- and middle-income countries affected by political violence. This description aims to contribute to bridge the divide in the literature between guidelines, clinical practice, consensus and research recommendations in the field of psychosocial and mental health care in low- and middle-income countries.

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Introduction

There is ample literature available to demonstrate the impact of perpetual political violence on children (Barenbaum, Ruchkin, & Schwab-Stone, 2004). A broad spectrum of consequences have been reported, including disruption of normal developmental pathways (Punamäki, 2002), breakdown of social structures such as family and school systems (Machel, 2003; Yule, 2002), increased psychopathology such as depression, PTSD and anxiety (Stichick, 2001; Ward, Flisher, Zissis, Muller, & Lombard, 2001), as well as literature stressing the non-pathological nature of children's reactions, i.e. generic distress reactions such as increased aggression, withdrawal, pre-occupation with negative thoughts (Jones, Rrustemi, Shahini & Uka, 2003). Furthermore, there is a sizeable body of literature warning for pathologizing entire populations and advocating children's and community's resilience (Summerfield, 1996).

On the bases of this knowledge, treatment and interventions are much needed and advocated, yet children during and after wars rarely receive such care and actual psychosocial assistance is to a much lesser extent represented in the discourse than studies on the impact of war and violence (Barenbaum et al, 2004). Patel and colleagues (2008) report a vast gap between child and adolescent mental health needs and mental health resources in low- and middle-income countries, advocating for increased promotion and prevention activities. Compounding this problem is the lack of an evidence-base for much of the current consensus with regard to appropriate and effective child-focused interventions in complex emergencies (Morris, van Ommeren, Belfer, Saxena, & Saraceno, 2007). Concerned about the impact of violence and lack of attention for subsequent care, the international community has developed a framework of protection, incorporating psychosocial and mental health care for children in complex emergencies like war (Convention for the Rights of the Child, 1999; IASC, 2007; Eisenman et al., 2006). Based on a number of published guidelines and research-informed recommendations, the following consensus seems to emerge:

Complementary and ecological approach

Within complex emergencies, there appears consensus among experts on an integrated approach that includes both individual clinical needs (curative approach) and broader needs of addressing contextual protective and risk factors (preventative approach) (Weiss, Saraceno, Saxeno, & van Ommeren, 2003). Moreover, there is a trend away from single intervention approaches to recommendations for multi-sectoral, multi-level, ecological and systems- oriented intervention programs (de Jong, 2002; Stichick, 2001; Sieger, Rojas-Vilches, McKinney, & Renk, 2004; Saltzman, Layne, Steinberg, Arslanagic, & Pynoos, 2003; Wessells & Monteiro, 2006). However, besides guidelines and discourse, there are scarce examples of such comprehensive systems in practice, especially for children (Jordans, Tol, Komproe, & de Jong, 2009a).

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Exceptions are the models presented by de Jong (2002) and by Saltzman and colleagues (2003), who present mental health programs in middle to low-income countries following a public mental health approach.

Programmatic principles and therapeutic foci

Though there is little uniformity in modality for psychosocial and mental health interventions for children in armed conflict (Jordans et al, in press), available guidelines and key publications all advocate the importance of (a) normalization of the child's daily life and recreational activities; (b) social reconnection/reintegration and social support mechanisms; (c) utilization of individual and community coping and resilience mechanisms; (d) discouraging child-family separation stressing the important role of caregivers; (e) focus on education and health care systems; (f) emphasis on reduction of social discrimination and non-medicalization, expression of feelings, memories and thoughts, and youth participation (Save the Children Alliance, 1996; Arntson & Knudsen, 2004; Eyber, 2002; Stichick, 2001; de Jong, 2002; Barenbaum et al, 2004; Tolfree, 1996).

Balancing 'vulnerability' and 'resilience' perspectives

With growing criticism on approaches that follow a predominant medical model there has been an increased tendency towards interventions that foster community and individual resilience. The resilience paradigm includes a focus on mobilizing social support systems, community mobilization and strengthening existing coping strategies (Tolfree, 1996; Tol, Jordans, Reis, & de Jong, 2009). While acknowledging this shift, there are numerous authors that warn for an artificial dichotomy and recognize that there is a substantial group of children with severe and sustained problems that require more focused care (Apfel & Simon, 2004; Silove et al, 2000; van Ommeren, Saxena & Saraceno, 2005; IASC, 2007).

Effectiveness of interventions

Increasingly, both from humanitarian and scientific sides, there is a call for evaluation of interventions. Few available studies demonstrate potential of psychosocial interventions for children in low- and middle-income countries to reduce mental health symptoms (Bolton et al, 2007; Dybdahl, 2001; Tol et al, 2008; Jordans et al., In press), while other studies show no beneficial effect of treatment (Thabet, Vostanis, & Karim, 2005; Bolton et al, 2007). A recent systematic literature review into the evidence base of psychosocial and mental health interventions for children in war-affected countries demonstrates that there is a serious lack of rigorous studies, with mixed results (ranging from no treatment effect to moderate effect sizes at most) and heavily skewed towards a PTSD focus (Jordans et al., 2009a).

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Cultural sensitivity

Cultural variables play a crucial role in the expression of problems, help seeking, feasibility and acceptability of interventions. As a result, assessment of and services to affected children need to be adapted to the socio-cultural context, building on local perceptions of needs, traditional notions of healing including reconciliation and cleansing rituals and integration within existing services (de Jong, 2002).

Targeted conditions

The prevalence of traumatic stress sequelae among child survivors of political violence has been established. However, like in adult public mental health, the field seems to move away from a primary trauma model to a focus on more generic, chronic and secondary distress that impair or hamper daily functioning of the child (Stichick, 2001). The use of (validated) screening tools has been advocated, when targeting a wide range of conditions and with a system of interventions to offer in place, as it permits identification of children or groups at risk and subsequent treatment planning (Balaban et al, 2005; Barenbaum et al., 2004; Jordans, Komproe, Ventevogel, Tol, & de Jong, 2008).

Based on these six principles of care delivery, we set out to provide an example of a comprehensive intervention model, translating above-mentioned intervention foci, principles, existing guidelines and scientific literature on the impact of war on children to an actual framework of care provision. The intervention model follows a public mental health framework and was implemented in four (post-) conflict settings, i.e. Burundi, Sudan, Sri Lanka and Indonesia.

Model presentation

A public mental health framework ensures that the majority of the resources are allocated to the majority of the population, taking into account primary, secondary and tertiary prevention interventions (de Jong, 2002). The first level comprises of interventions targeted to the general population or the whole target group to prevent healthy, albeit at-risk, populations to develop psychosocial problems (e.g. broad-scale school interventions to promote adaptive post-war adjustment and community resilience). The second level consists of interventions that target sub-groups of the population at-risk for developing mental health problems or show mild problems (e.g. focused, more specialized school-based interventions to reduce psychological distress). The third level comprises of interventions that target treatment of sub-groups with more severe mental health problems (specialized interventions to reduce

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several psychological distress, suicidal risk and other high-risk behaviors). This means that those children whose needs are not met by first level resilience-focused interventions or who continue to manifest symptoms after secondary level intervention will require and be entered into more specialized level of care.

As we frequently refer to a comprehensive and psychosocial approach, we will briefly define these terms. *Psychosocial* is defined as "the very close relationship between psychological and social factors". While mental health and psychosocial wellbeing are overlapping concepts, in this document we use the latter to refer to a broad concept that encompasses psychological wellbeing and mental illness, in addition to emphasizing the social ecology and the significance given by existing culture and values (Psychosocial Working Group, 2003). Our conceptualization of *comprehensive* care includes; (1) a focus on communities at large, rather than children affected by armed conflict as a sub-population; (2) multiple interventions, rather than a single intervention approach, structured within an interconnected and complementary multi-level care system; (3) interventions being planned to work on different interdependent ecological levels; (4) multi-sectoral approach, linking care provision with non-psychosocial services (e.g. education, poverty reduction).

The three-tiered public health model of interventions described in this chapter (see Figure 1 and table 1) aimed to primarily provide services; (a) increase community awareness on children's psychosocial and mental health problems; (b) mobilize coping strategies and community resources; (c) increase social support systems, and (d) reduce psychosocial distress and severe psychological difficulties amongst children. Second, long-term and skill-based capacity building of entirely local teams for clinical service provision to conflict-affected populations, emphasizing supervised and continued learning was identified as an objective. Third, service provision was accompanied with research into the efficacy of interventions, treatment mechanisms of interventions, validity of locally constructed instruments, in order to increase the evidence base for psychosocial and mental health interventions in war-affected settings. The outcome of this research is presented in different papers.

It is important to note that the paper aims to present a model of inclusive and systemic thinking and implementation of psychosocial services for children affected by conflict, within which the described interventions are working examples that can and should be adapted, further developed and used in an eclectic way. At the same time it aims to demonstrate that carrying out a comprehensive model is a feasible alternative to a single intervention approach. For example, the combined tier 1 activities are aimed at promoting community resilience (i.e. creating a renewed sense of connectedness and increased social cohesion), however we recognize that these are still insufficient to comprehensively enhance resilience and that locally unique contextual factors would necessitate other complementary activities. Similarly,

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as is demonstrated in figure 1, the presented model should have linkages with other sectors (poverty reduction, health, education, rural development, and women's organizations). Each intervention is introduced with the rationale for including it in the model and subsequently what it consists of and how it is implemented in the four-country project.

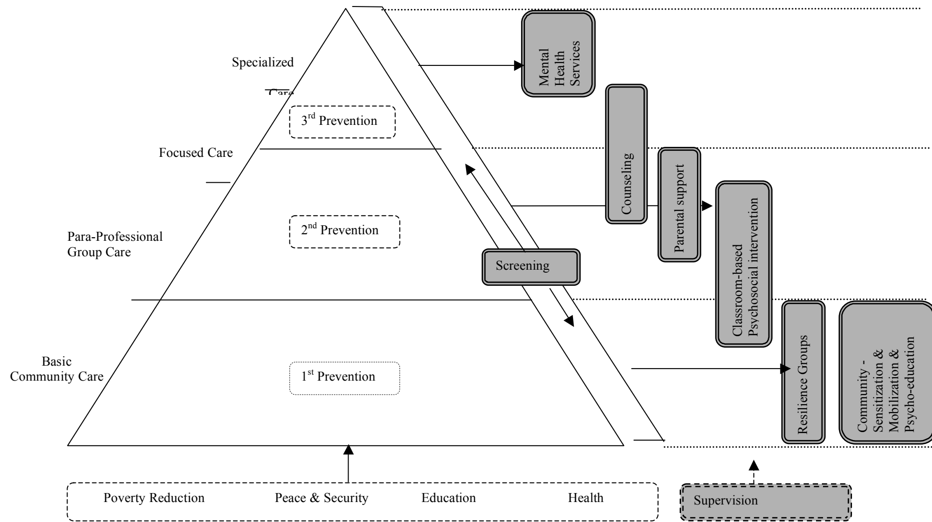

Figure 1: Comprehensive Child Psychosocial Care

Community psycho-education and sensitization (tier 1)

The overriding rationale behind community sensitization is that of primary prevention. Review of the literature (Tyano & Fleischman, 2007) on public awareness of child and adolescent mental health has raised the following issues: (1) Prevalence of mental disorders among children ranges between 10 and 20% globally, over 40% of the countries have no mental health policy and 90% of the countries have no mental health policy for children. Globally, mental health needs of children are seriously underserved; (2) besides scarce resources, the main barriers to relevant care are, (i) lack of awareness by parents and children of mental health disorder and services and, (ii) lack of understanding by primary health care workers and teachers of mental health problems; (iii) the stigma and discrimination related to mental health (WHO, 2005); (3) Increased public knowledge has a significant effect on help seeking (e.g. in Sudan and Burundi providing information about the nature and treatment of epilepsy was essential in order to provide appropriate services).

Within the four-country project, the combined sensitization activities aimed to achieve the following. First, it aimed to promote project acceptance. Political, cultural and ethical accept-

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Table 1. Overview of interventions

Public mental health model	*Primary objective*	*Module*	*Specific objective*	*Intervention modality*	*Personnel*	*Level of training*[1]
Tier 1: Primary prevention	Strengthening Ecological Resilience	Child Resilience Groups	Reduce stigmatization Secondary screening Increasing social support Strengthening of resilience Normalization	Group activities		
		Awareness Raising	Provide information on project Raise awareness on general psychosocial issues Raise awareness on community and/or target population- specific topics Mobilization of existing resources and roles	Group psycho-education sessions with: - Teachers - Parents - Community groups	Community Psychosocial Workers	2 weeks
		Existing resources	Utilization of existing community resources	Mapping, case-management and referral		
Tier 2: Secondary prevention	Care for children at risk for developing more severe problems	CBI	Reduce psychosocial distress to sub-threshold Reduce risk of maladaptation Facilitate resilience and normalcy	Classroom-based group sessions	CBI Facilitators	10-12 days (with subsequent regular 4-day booster courses)
		Parent/ Family-based Intervention	Support child-parent relationship Child rearing support	Home visits or family sessions		
Tier 3: Tertiary prevention	Advanced care for children with severe distress	Psychosocial counseling[2]	Care for children with more severe problems	Individual or group counseling	Counselors	4-6 months
		Referral to external services	Specialized care (formal and informal) for severe problems	Case-management		
Tiers 1, 2 and 3	Improving access to, and quality of, care system	Monitoring and Evaluation	Monitoring of outputs/ service users Evaluation of services Improve services	Questionnaires, observation/ discussions, program output monitoring	Service providers and beneficiaries	n.a.
		Screening	Detection of indication for treatment	Child Psychosocial Distress Screener	CBI facilitators/ Community psychosocial workers	2 days
		Clinical Supervision	Continued learning Clinical support through case discussions Support to service providers Project implementation issues	Group inter-vision meetings	Mental health professional (incl. experienced counselors)	Significant clinical experience

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ability of proposed services have to be addressed before starting actual service provision (de Jong, 2002). Second, extensive explanation of mental health and psychosocial care and problems, and its origins played a crucial part in reducing stigma attached to these concepts and care. Misconceptions about mental health problems among community members prevented for example the reintegration of ex-child-combatants (as was experienced in Burundi). Third, increasing understanding and identification of psychosocial issues and problems of children to increase normalization and acceptance of complaints and community referral. Fourth, it aimed to raise awareness on psychosocial issues specific for certain communities or target groups. Psycho-education on issues such as alcoholism, child rearing or conflict mediation, related to the psychosocial wellbeing of the community at large, in turn have an impact on the well being of children. Fifth, it aimed to mobilize existing community resources and roles. Through facilitating discussion with, and activating capacity of, relevant stakeholders, existing coping and healing strategies were strengthened to support children with problems and vulnerable families. Three levels of sensitization were followed, community-level awareness for acceptance, school-level awareness for identification and implementation, and subgroup-level awareness for mobilization, moving from initial short-term sensitization to increasingly specific psycho-education. For example, in Sudan a weekly radio program was organized focusing on psychosocial problems of children, and in Nepal a flip-chart tool was developed to facilitate parent discussion groups on children's well-being.

Child Resilience Groups (tier 1)

Resilience can be defined as "good outcomes in spite of serious threats to adaptation or development" (Masten, 2001). Increasingly within psychosocial care programs for children in non-Western settings, attention is shifting from focus on treatment of symptoms to promoting resources and resilience (Kalksma-van Lith, 2007). A resilience approach has been advocated to emphasize child protective factors, primary prevention and empowerment (Tolfree, 1996). Positive peer relations and group activities have been identified as a protective factor for children in adversity, contributing to restoring damaged social fabric by developing stronger trusting relationships (Wessells & Monteiro, 2006; Tol et al, 2009).

Within the four-country project Child Resilience Groups is the generic name for a set of semi-structured group activities for those children without indication for psychosocial intervention or mental health care. The first aim of these group activities was to strengthen existing resilience and thereby prevent development of symptoms or need for treatment by encouraging social support systems, engagement in recreational or traditional activities and normalization through peer-group discussion and activities (these resilience elements were also integrated in the intervention for indicated children, see below, which additionally had active therapeutic ingredients). The second aim was to reduce stigmatization due

to (non-) enrolment in psychosocial interventions for both the indicated and non-indicated groups of children. A potential risk for conducting screening is that the indicated group is stigmatized or that the non-indicated group is 'envious' for not receiving any care. Two strategies to overcome such challenges are through community awareness and ensuring that all children receive some intervention, matched for the level of need for psychosocial care, i.e. in our case child resilience groups. Thirdly, structured and recurring non-therapeutic group activities provide the opportunity for secondary screening. Initial screening is based on a brief assessment procedure (see below), which generally results in a group of 'false positives' and 'false negatives'. Within the context of non-therapeutic groups, facilitators can still assess these false negatives and subsequently refer to more active-therapeutic care. Practically, implementation happened through group formation based on screening outcomes and participatory determination of activities, which ranges from recreational and traditional activities to theme-based discussion groups (e.g. life-skills focused discussions combined with songs and dances in Sri Lanka; drumming-, dancing- or football-practices resulting in inter-community competition or presentations in Burundi).

Working with existing resources (tier 1)

It is obvious that communities should not be considered devoid of resources in dealing with psychosocial and mental health problems. The present resources can be termed 'ecological resilience', defined as those assets and processes existent on all social-ecological levels that have shown to have a relationship with good developmental outcomes after exposure to situations of armed conflict (Tol et al, 2009). We see ecological resilience as a reservoir of factors at different social-ecological levels that can enhance psychosocial wellbeing. Children under strain can seek out and utilize resources from this reservoir to enhance their chances of retaining or obtaining psychosocial wellbeing. The question is to what extent ecological resilience and existing resources are sufficient to restore the balance between present risk and protective factors and to what extent external programs can support this? From a primary prevention perspective there are several reasons to focus on strengthening ecological resilience. First, the impact of war on social structures has often disrupted the functioning of exactly these existing resources. Second, it encourages integrated, non-vertical care systems, which are likely more sustainable and cost-effective. Third, working with both formal and informal existing resources is preferred for reasons of availability, sustainability and cultural relevance. Moreover, working with contextual community activities, traditional healing and religious practices, availing norms and coping, will increase cultural sensitivity of a combined (i.e. traditional and novel interventions) care system (Tolfree, 2006). Fourth, active community involvement taps into the responsibility of the community to support, reducing dependability on external service/resources.

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Within the four-country project different strategies have been employed to strengthen ecological resilience and community self-help strategies; (1) assessment of existing healing practices and community services; (2) creation of resource maps; (3) negotiation and involvement of community stakeholders; (4) collaboration and referral to existing care and (traditional) healing services; and (5) development of a case management system. Specific examples are; facilitation of child-to-child support activities in Burundi; tapping into religious structures in Indonesia and linkage with mother groups and using extended family structures in Sudan.

Screening (tiers 1 and 2)

When establishing a comprehensive care system a screening mechanism is required to properly allocate services, especially when targeting large at-risk populations, as is the case in post conflict situations. Commonly described reasons for primary screening are; lack of mental health professionals to do clinical assessments within large populations (WHO, 2005); early detection of at-risk populations when lay-screening is largely absent due to un-awareness or stigmatization (Saltzman et al, 2003), and; planning for therapeutic interventions (Barenbaum et al, 2004). Within a public mental health approach a psychometrically sound screening procedure for large-scale interventions can facilitate early detection, treatment planning and better matching of resources with needs. The Child Psychosocial Distress Screener (CPDS) is a multi-indicator and multi-informant instrument that measures non-specific psychosocial distress (Jordans et al, 2008; Jordans, Komproe, Tol, & de Jong, 2009b). It is developed in and for non-Western complex emergency settings, and is contextualized through the inclusion of setting-specific probes. The CPDS is a brief community screener that includes the child's appraised traumatic and current distress, resilience components like coping and social support and school functioning, with demonstrated validity.

Within the four-country project screening followed several steps. First, pre-screening briefing is conducted for the children, teachers and the parents to explain the reasons and procedure of screening to minimize false expectations and socially desirable answering and increase acceptability. Second, primary screening is conducted by administering the CPDS and assessment of exclusion criteria. These include; (a) the inability to function in a group setting (e.g. violent behavior), and (b) a group of psychiatric problems (mutism, mental retardation, substance abuse, epilepsy without medication, panic/ phobic disorders, and child psychosis) which are expected to obstruct participation and benefit from a group intervention. The CPDS score (following a locally validated cut-off score) and exclusion criteria give an indication for; non-curative group activities; group-based psychosocial intervention; counseling or referral (see below). Third, during each of the consequent interventions, service providers will assess the child with the aim to determine whether a more (or less) specialized, or other, intervention is indicated.

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Classroom Based Intervention (CBI) (tier 2)

Secondary prevention interventions, in conflict-affected settings with little resources, are typically large-scale low-intensity interventions. As a result it concerns interventions that can be carried out by para-professionals and within a community setting. Schools are often recommended as the most effective setting to organize provision of psychosocial care for children in complex emergencies. Schools offer a familiar, non-stigmatizing setting and provide the broadest access to children and their families (Saltzman et al, 2003; Stein et al, 2003; Macy, Macy, Gross, & Brighton, 2003). Moreover, usually group work rather than individual work is preferred; because (a) group members can recognize that they are not alone with their problems, (b) group members can learn new strategies and coping skills from each other, (c) the group can function as a place to try out new problem-solving skills, and (d) economic constraints and limited available mental health professionals (Barenbaum et al, 2004).

CBI is a 15-session classroom or community-based intervention, involving a series of highly structured expressive behavioral activities, which aims at increasing children's capacity to deal with the psychosocial problems that having been/ being exposed to extreme stressors can cause (Macy et al, 2003). CBI's objectives are to; (1) reduce the risk of maladaptation; (2) facilitate resiliency & return to normalcy; (3) facilitate empowerment and mastery; (4) use a natural learning environment, and; (5) screen for high risk youth. It includes mainly group activities such as cooperative games, music, drawings and psychodrama that focus on stabilization and safety, individual coping strategies, traumatic exposure narratives, and future-oriented resources. CBI implementation included the following subsequent steps; (a) initial target area selection based on public health criteria (de Jong, 2002); (b) obtaining permission for care provision from local authorities; (c), review and adaptation of intervention within the give context; (d) skill-based capacity building of the facilitators; (e) coordination with school principals, teachers and parents for practical arrangements; (f) pre-intervention community awareness raising (see above); (g) 1-2 hours sessions, spread out over 5 weeks, within the school premises; (h) post-intervention follow-up and referral when indicated and finally structural monitoring and evaluation.

Parental support (tier 2)

Targeting families, and specifically parents, to improve the psychosocial wellbeing of children is indicated for several reasons. Primarily because parents, as the natural child raisers, are influential mediators of children's reactions to (non-familial) violence (Wallen & Rubin, 1997). The family's stability, safety, parental wellbeing and emotional sensitivity are better predictors of social-emotional adjustment than exposure to violence *per se*. Moreover, the family system has often been put under enormous stress as a result of war and may need

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support in undertaking this role. At the same time, adults may underestimate, deny or be unaware of the difficulties their children are experiencing or vicariously contribute to the children's problems. Dybdahl (2001) further notes that parental capacities, including healthy parent-child interaction, are affected when parents are suffering. Wallen & Rubin (1997) have summarized the role of the family in mediating negative effects of violence as follows: (1) physical availability of the parents; (2) protection and physical safety by parental awareness about potential dangers and subsequently install rules, education and supervision; (3) support in working through traumatic events through communication and emotional sensitivity; (4) child rearing that fosters moral development to counter-balance the moral erosion as a result of conflict; (5) models of positive coping regarding safety, emotion regulation and sense of control.

In our practice the provision of family-oriented supportive counseling, mostly through home-visits, has focused on parental capacities. Children for whom family support was indicated were referred from individual counseling or the group activities described above. At the very least this has meant psycho-education sessions with parents to increase problem identification and awareness, and subsequently extending to child rearing support (i.e. simple behavior modification techniques), linking the family with services and social support systems, parent-child interaction support to work on parent's emotional responsiveness and interaction skills and finally provision of family problem solving support (based on existing parental coping strategies). Additionally, individual counseling for parents is offered, aiming to increase their wellbeing, in turn increasing their capacity to engage in their caretaking roles.

Psychosocial counseling (tier 2 and 3)

Moving up the public mental health pyramid, interventions get increasingly focused to treat increasingly severe problems, from low-intensity community-, and group interventions on one end and specialized psychiatric and psychotherapeutic care on the other end of the spectrum. Counseling can be positioned at the top of the secondary prevention level or the bottom of the tertiary prevention level depending on severity of problems. It is an easy-access level of care that targets more severe forms of distress, both non-specific and common mental disorders, that links with existing formal and informal care structures. In the humanitarian field the term counseling is often so widely used, that it becomes depleted of meaning. In the literature it is often associated with 'trauma-counseling' (Olij, 2005; de Berry, 2004). We define psychosocial counseling to refer to focused non-specialized individual or group supportive and problem-management care. Problem solving (i.e. problem/function-focused coping styles), symptom management (Egan, 1998), psycho-education, emotional support in a relationship offering trust and hope, and a focus on micro-skills (Ivey & Ivey, 1999) are the main components. It includes non-specific therapeutic elements, such as

empathy, intercultural sensitivity and basic communication skills, applying structured steps that aim to reduce both stressor-induced symptoms of distress as well as, whenever possible, problem situations. For application within a non-Western setting, basic concepts from medical anthropology (e.g., Kleinman, Eisenberg, & Good, 1978), such as working with clients' illness experiences, explanatory models and idioms of distress, have been included.

Within the four-country project, three steps were instrumental in integrating counseling services within the larger care system; (1) training; (2) identification; (3) care provision. We followed a longer-termed (4- to 6-months) skill-based capacity building approach to counseling, which has been described elsewhere (Jordans, Tol, Sharma, & van Ommeren, 2003; Jordans, Keen, Joshi, & Tol, 2007). Identification targets children who appeared severely distressed at the time of screening or for whom group interventions are contra-indicated, who displayed severe problems during other interventions, or who demonstrated no improvement as a result of the group-based psychosocial care (i.e follow-up). Practically, children were referred as a result of community psycho-education or the structured groups activities (CBI, child resilience groups etc). Subsequently, counselors, through a series of sessions, will develop treatment and case-management plans with specific intervention strategies based on the type and severity of the problems.

Supervision

Supervision is an overarching component within the psychosocial care system, to ensure continued development of knowledge and competence, and professional clinical support for the service providers, mainly through case discussions. It provides a forum for the supervisee to raise their concerns. Specifically, supervision is conducted to; (1) enhance and ensure the quality of work, in line with (ethical standards), by review of counseling and support skills and processes; (2) enhance the professional and personal capacities and increasing the self-awareness of the service provider; (3) help to better understand and deal with the problems of their clients; (4) monitor and evaluate service provision; (5) provide emotional support, through encouragement and empathetic understanding, to the service providers themselves (Van der Veer, de Jong, & Lansen, 2004). Additionally, especially in non-Western settings, implementation of community-based services raises many organizational and operational issues, which can be addressed through supervision meetings. Within the four-country project, supervision consisted in (bi-) weekly meetings with the service providers and regular visits to the field by the supervisor(s).

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Specialized care (tier 3)

Though current trends in the field of psychosocial and mental health care are warning for an over-medicalized approach, many authors still emphasize the needs of those with severe mental health problems and significant difficulties in daily functioning (Yule, 2002; Saltzman et al, 2003). Current consensus guidelines state that assistance should include specialized clinical psychological or psychiatric assistance, when the needs exceed the capacity of existing primary and secondary level services. The top of the pyramid is needed only for a small percentage of the affected population, but it may still concern thousands of individuals in most large emergencies (IASC, 2007).

Within the four-country project, children with severe mental health problems and/ or suffering were identified during the screening procedure or during the course of the offered interventions. Due to a scarcity of mental health resources and the inability to raise such capacity on the short term, tertiary service provision proved to be challenging. Two strategies were used for this target group; (1) utilization of a professional network of mental health specialists (i.e. within a hospital setting), and (2) utilization and training of the most senior/experienced counselors. In settings with available services referrals to, and collaboration with, mental health professionals were part of the project implementation. Collaboration with hospital-based multidisciplinary teams of professionals in Sri Lanka was a good example of that. In Burundi children were referred to clinic-based care, especially for epilepsy treatment.

Implementation

Planning and implementing a comprehensive psychosocial care system depends to a large extent on the context, needs and resources. At the same time, in practice, the availability of a common framework for developing and implementing such system is an advantageous starting point. This section gives an overview of the successive steps followed during implementation (see figure 2). In our case we used schools as the entry point to a community-based care system as it concerns children's natural environment and thus promotes normalcy. School-based interventions were subsequently embedded in complementary services. Initial preparatory work included need assessments and social mapping, recruitment and structured two-leveled capacity building of service providers. Subsequently, proposed services were presented to local authorities (i.e. education and health) for permission and collaboration. In each of the countries, both the school-based and other interventions needed support and involvement of local government structures. With mental health services still carrying risk of stigmatization, screening and clinical services in any new community was preceded by community awareness raising about psychosocial issues, screening and interventions. This

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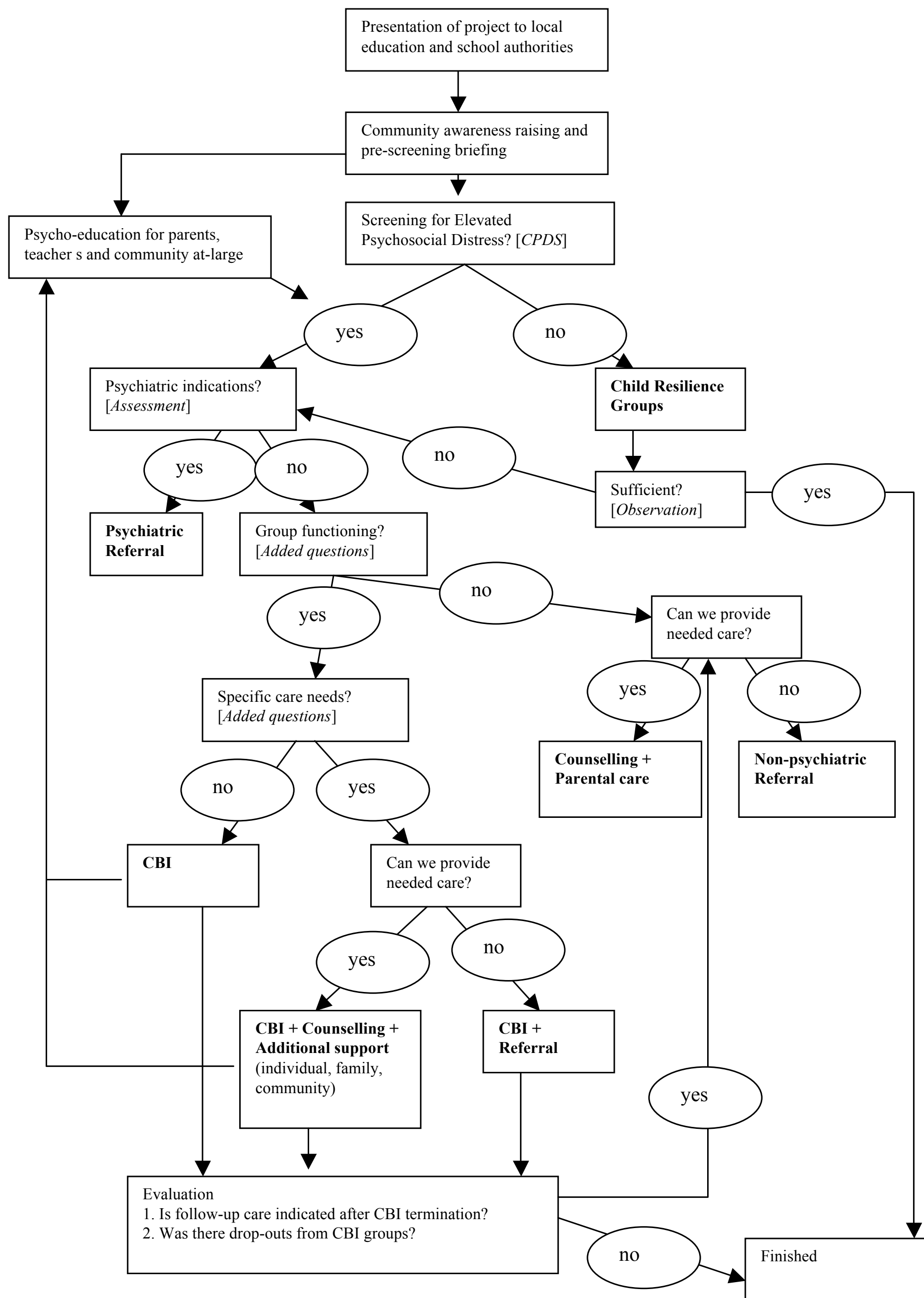

Figure 2: Flowchart of implementation

proved essential in avoiding misconceptions about the interventions. Upon pre-screening briefing of parents, teachers and children, groups of children were selected to undergo the brief screening procedure to allocate services (i.e. CBI; child resilience groups, counseling or referral to existing resources). While services were ongoing, community psycho-education was provided to parents and other community members to promote the role of parents and existing community resources in supporting children. Parallel and ongoing attention was given to issues of quality control, including; (i) monitoring; (ii) research; (iii) continued capacity building of service providers, and (iv) clinical supervision.

Discussion

In this paper we have argued that a psychosocial care program for war-affected children should follow a comprehensive, multi modal approach. Specifically, we have adopted a public health model, aiming to maximize the number of children reached with the limited resources available. This has resulted in a three-tier system of interventions with different intervention or therapeutic foci; (a) general supports to strengthen community resilience; (b) group based psychosocial supports to reduce moderate level psychosocial distress, and; (c) focused psychosocial and mental health supports to address severe distress and high-risk populations. Some of the strengths of the approach are that it aims to combine often diverging or unconnected approaches, i.e. combining vulnerability and resilience perspectives, interplay between research and clinical practice, the targeting of current life stresses as well as exposure to traumatic events, and a focus on new interventions alongside existing resources in the community. Moreover, it provides an actual (and replicable) working model for multi-level care in low- and middle-income settings, something that has been advocated (Stichick, 2001). In doing so this systematic approach to interventions, rather than stand-alone interventions, operationalizes a psychosocial care approach.

This paper aimed to provide an overview of a comprehensive psychosocial support model. Outcomes, evidence for effectiveness of interventions as well as adaptations of this approach are currently being assessed and will be presented elsewhere. Nonetheless, several challenges to this approach can already be noted. First, using schools as the entry point for service provision risks overseeing non-school going children. For example in Indonesia, qualitative research showed that a specific vulnerable group concerned children who dropped out of school (Tol, Reis, Susanty, & de Jong, in press). Second, a comprehensive approach, though through non-specialized paraprofessionals, may be difficult to sustain with limited financial resources. Cost analyses will need to inform about notions of feasibility in resource poor settings. Third, a common model risks being incongruent with the principle of cultural sensitivity. Careful attention should therefore be given to utilizing such model as a frame-

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work within which interventions and implementation is contextualized, based on existing needs and resources. Fourth, the here-described model lacks to specify further linkages with other sectors, i.e. livelihood or peace-building programs (see also Figure 1), considered particularly important in settings of extreme poverty. For example, in line with de Jong (2002), Wessells (2008) argues for integrated and inter-sectoral collaboration, in which livelihood or infrastructural programs complement psychosocial support (as well as vice versa) in that they often address pertinent distress within poverty-stricken populations. Fifth, and related, sustainability of a system of care will depend on their incorporation with existing systems of care. Although much effort was undertaken to integrate the project in existing community-based systems of care, more efforts could be undertaken to integrate the above described care system in governmental systems of care and policy. The above points demonstrate that the presented model is by no means a finalized product; rather it is a framework that in future years needs to be developed and adapted further, at each of the prevention levels.

In summary, psychosocial interventions for children in areas of armed conflict is a field that is increasingly getting attention and taking shape. This paper has described an effort to develop a replicable intervention model for comprehensive psychosocial care for children in complex emergencies.

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