CHILD THEMATIC PROGRAMME

School-, and Community Based Psychosocial Care for Children in Areas of Armed Conflict in
Burundi, Nepal, Sri Lanka, Sudan and Indonesia

In collaboration with:
Center for Trauma Psychology (CTP)

Summary Programme Outline

1. SUMMARY

HealthNet TPO, based in Amsterdam, the Netherlands, is currently implementing community-and school-based projects in five identified countries, namely Indonesia, Sri Lanka, Burundi and Sudan. These projects involve providing psychosocial support to children in areas of armed conflict, and more specifically for displaced child populations, for war orphans and child soldiers.

The *'lessons learned'*, based on the results of the impact research that is an integral part of the project, help us to develop *'best-practice'* methodologies and materials, which can then be implemented in other countries facing similar challenges. In the second year the efficacy research into the project's core component (Classroom Based Psychosocial Intervention – CBI (Macy et.al, 2004) is conducted and adopts a Randomized Controlled Trial modality. In the third year the program adapts its interventions, based on the outcome study, and experiences and subsequently expand in number of children reached and/or areas covered.

The programme is structured through an integrative, multi-sectoral and multi-leveled approach to psychosocial care provision, combining a school-based program with a larger set of community based interventions. The Child Thematic Programme will cover approximately 130,000 children over 3 years in the four implementing countries combined. A set of additional and complimentary psychosocial interventions (such as family support, counseling, public awareness, strengthening community resilience) parallels the CTP. The programme targets acute traumatization, chronic traumatization/ accumulated distress and general psychosocial effect of violence on children.

In terms of interventions for children in armed conflict there is little uniformity in thought on the exact modalities (Barenbaum et al, 2004). From a multitude of experiences some guidelines seem to currently be relatively agreed upon, such as the importance of normalization of the child's daily life structure, the importance of

social reconnection and social support mechanisms in the child's surrounding and the importance of existing family, coping and support systems within the child's setting (Macksoud, 2000; Betancourt, 2004).

On the other hand, it remains a challenge on how to reduce the experienced distress and psychosocial and mental health problems in settings where these problems are not recognized or prioritized or where the existing healing systems are not sufficient, while at the same time recognizing the essential support mechanisms, explanatory models and idioms of distress that exist within different cultures and to use these as the starting point on the need and modality of intervention.

2. PROJECT FRAMEWORK

2.1 Project objectives

- To provide psychosocial support to groups of children in areas of armed conflict (children affected by armed conflict, displacement and child soldiers), using a combined school-based and community-based approach.
- To conduct research and collect data on psychosocial/mental health problems and impact of interventions.
- To develop and promote 'good practice' methodologies and materials in this field for interventions and lobbying.
- To create awareness and lobby for and sensitize on the plight of these children and the support structures needed.
- To build (further) capacity in the field of psychosocial care provision for children.

2.2 Project aims

- Mobilization of internal strength and coping strategies
- Mobilization of external support to augment community resources
- Capacity building in the field of psychosocial care providers
- Attain a level of normalcy in the children's daily lives
- Increase of social support and social support systems for the children and youth activities
- Provision of curative and/or supportive psychosocial support for children, families and communities
- Increase community/public awareness and sensitization of psychosocial issues among children to assist prevention

2.3 Project approach

Public health approach; as described below programmatically the project follows the three-tier intervention strategy. This in turn is based on a public health perspective

on care provision, which entails that most efforts goes to the largest group of affected children and not to the relatively small group of severely affected children, while at the same time ensuring that interventions targeting the latter group, as well as the society in large, are included (see figure 1). This approach is both curative and preventive by focusing on direct service provision to children with functional disability due to psychosocial distress, as well as reducing the risk of mal-adaptation, increasing empowerment, mastery, resilience and normalcy of participating children. The different interventions combined have a problem containment function, supportive function and a protective and empowerment function, depending on the psychosocial and mental well-being of the participating children.

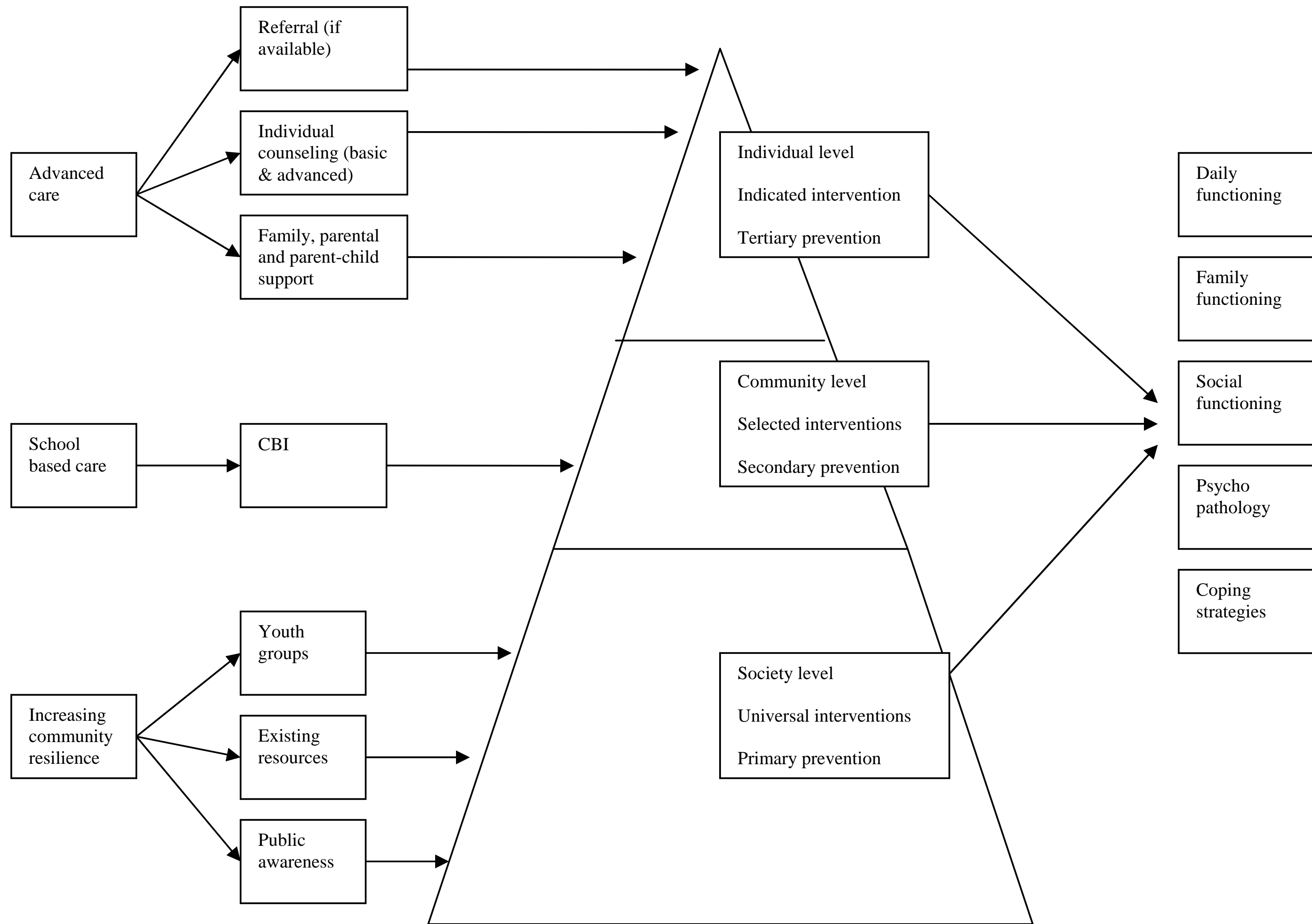
As figure 1 shows there are a set of *universal interventions,* aimed at the community-at-large and children not in need of any curative interventions, which mainly focus on psycho-education, existing coping strategies and social reconnection. The middle level represents the *selected intervention* for children with expressed psychosocial problems aimed at reducing distress and promoting adaptive adjustments through a school-based program. The third level represents *indicated interventions*, which entail a set of more advanced, individual and long-term interventions for children/families with severe problems and/or psycho-pathology aiming at reducing severe psychological distress.

Advisory committees; all country projects form 2 advisory committees; one consisting of influential people from the targeted community; and one with representation of youth of the specified target group. At development level and throughout the project these two committees are consulted and included in the decision making process and implementation process, as much as possible.

Project principles

- Working within schools and the community at large
- A multi-sectoral approach to psychosocial care
- Culturally sensitive care
- Emphasis on not over-pathologizing the existing problems
- Skill-based training courses
- Emphasize on sustained learning
- Working with people from targeted communities
- Scientifically informed
- Emphasize on reduction of social discrimination
- Youth participation

Figure 2: CTP interventions overview within public health approach


Advanced care
Referral (if available)
Individual counseling (basic & advanced)
Family, parental and parent-child support
School based care
CBI
Increasing community resilience
Youth groups
Existing resources
Public awareness
Individual level
Indicated intervention
Tertiary prevention
Community level
Selected interventions
Secondary prevention
Society level
Universal interventions
Primary prevention
Daily functioning
Family functioning
Social functioning
Psycho pathology
Coping strategies

3. PROJECT INTERVENTIONS/ACTIVITIES

3.1 Interventions

Programmatically, the proposed project is implemented through a 3-tier structure, as indicated in figure 2 below. It is recognized that each of the participating countries have different needs, different situations, different experiences, different interests and different capacities. At the same time the situation in the different countries have similarities (i.e. conflict affected; minimally existing psychosocial care systems, especially for children) and the entry point to the project is similar. That is why we have a broad framework that encompasses all the different needs of the implementing sites, while at the same time constructing conceptual clarity on the larger picture. Moreover, the reasons for having such overall project framework is; to ensure that the project overall aims to target different age groups through age-specific interventions; to ensure that the project adheres to the overall principle of HealthNet TPO (e.g. that interventions are need-based, that they focus on existing community capacity and coping).

The School-Based Psychosocial Intervention (CBI) is the core component of the project and serves as the entry point for intake. In turn, CBI is embedded in a package of additional psychosocial interventions (*Minimal Psychosocial Care Package – MPCP*), as one intervention in itself cannot sufficiently cater for the needs of the large scope of problems and large variety of children. These two levels are again embedded in a third level of services, the existing resources within the different countries, interventions and programs that can benefit the plight of children and families in need of support.

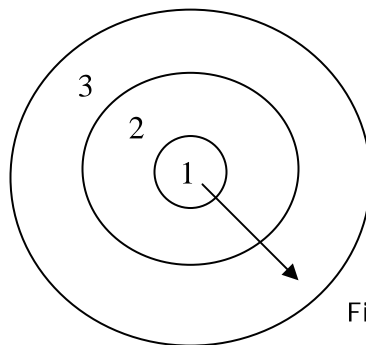


Figure 2: Three-tier care structure

Clinical supervision is integrated in all of the above components and is considered an important strategy for sustained learning and caring for the service providers. The country project coordinator is responsible for conducting or arranging for clinical supervision for al the service providers within this project. A set of guidelines has been developed for such (peer) supervision sessions.

Screening

A developed screening procedure determines whether a child is indicated to start the CBI sessions and/or whether a child is indicated for additional interventions (MPCP) or whether no curative interventions are indicated. This basic screening procedure assesses the level of functional impairment (school attendance & school functioning and worrisome behaviors) and level of trauma exposure; and subsequently assesses whether group functioning is possible, whether severe child psychopathology might be indicated and whether additional psychosocial care might be indicated. Based on this screening method children are placed in CBI groups and/or MPCP interventions or no curative intervention at all.

***Tier 1- CBI**:* The central component to this project is the CBI intervention. This is a highly structured community-based intervention, which aims at increasing children's capacity to deal with the psychosocial problems that having been/ being exposed to extreme stressors can cause, and aims to include components that enhance existing resources to deal with these consequences (individual coping methods, play, social support, existing rituals, etc.). It entails a five-week long, 15-session intervention implemented with groups of children in a class-room setting. It includes mainly group activities (including games, music, art, and drama). In the first two weeks activities are aimed at stabilizing traumatic stress reactions, securing a safe place and building internal resources. In the third week and fourth week activities are aimed at exposure to the possible difficult reactions and memories associated with the conflict exposure, through non-verbal means and in the final, fifth week activities are aimed at identifying and installing external and internal resources and coping strategies.

CBI's objectives are fivefold (Macy, Macy, Gross & Brighton, 2004):
(1) *Reduce the risk of maladaptation*. Reduce the susceptibility of youth for developing intermediate and long range maladaptive behaviors, acute traumatic stress disorders and long term mental illness and performance dysfunction;

(2) *Facilitate resiliency & return to normalcy*. Augment immediate and sustained recovery from their stress reactions to danger by supporting and increasing the resiliency of youth, thereby returning their lives to as close to normal as possible, so they can pay attention to teaching and learning in the classroom. Following a traumatic event, children may perceive the world as undependable. As they gain a positive sense of self through mastery and cooperative interaction with peers, their sense of resiliency and self-control increases. They also gain a more positive sense of the world around them and gain access to parts of themselves that may be drawn upon for strength during future difficult times. The development of resiliency and reconnection to physical and social environments is most easily accomplished through the use of rhythmic and creative activities that elicit positive and constructive responses. Please see the section on methodologies for an overview of the activities that are drawn from during this intervention program.

(3) *Facilitate empowerment and mastery*. Engage the students in various hands-on creative activities in order to actively involve students in self-expression, self-exploration, learning about their traumatic experiences, and practicing new ways of coping. The use of movement, music, and creative activities within a consistent, predictable framework that includes tasks, which the child is able to master (within the allotted time frame), facilitates a sense of empowerment. Mastering these tasks in the company of peers reduces his sense of isolation, encouraging a newfound sense of group empowerment.

(4) *Use a natural learning environment*. Allow the interventions to take place during camp or school hours and supervised by school staff so that children will "normalize" their reactions to the traumatic experience. Camp or Classroom based learning allows the youth to look upon their fearful experiences as learning experiences that can be safely studied, given expression and understood by trusted, caring adults.

(5) *Periodic screening for high risk youth*. Identify youth who are at the highest risk for developing prolonged acute stress disorder or chronic posttraumatic stress reactions and link them to appropriate psychosocial supports for additional follow-up care.

Tier 2- MPCP: It is acknowledged that psychosocial care for children in areas of armed conflict can not be addressed through any single intervention, but rather needs a multi-leveled approach, that ensures that as many children as possible get as qualitative care as possible with different psychosocial interventions for different types of problems. Therefore the CBI intervention is embedded in a system of additional psychosocial care interventions.

The Minimal Psychosocial Care Package provides services to those children that: (a) have been excluded from the CBI intervention during group selection and that are in need of psychosocial care, (b) those children that have been pulled-out from the CBI intervention because of severity of problems, (c) need follow-up care after the CBI intervention, (d) children with problems identified or screened (e.g. by family, teachers) outside the CBI selection and intervention, (e) children in need of psychosocial care in addition to ongoing CBI. These children are being screened by the project's staff, through other projects in the area or they might be self-identified by the community or families. Furthermore, it is reasoned that conducting the CBI in a given community will likely produce a spin-off effect of people that want services for their children that have problems but could not take part of the CBI or where screened not to take part of it.

The Minimal Psychosocial Care Package[1] interventions include the following components[2]:

Family support intervention assists the family/caretakers, depending on their expressed need (e.g. through parental support, child-parent relationship, family counseling), to increase their parental capacity to deal with the distresses and psychosocial problems of their children. The project has capable counselors/psychosocial workers available that assist in dealing with the family; if the child's problem seems to be related to or aggravated by the family situation, if the family expresses a need for support; if follow-up on child's well-being within the family after termination of CBI is needed.

Family support focuses on the following three levels: (1) *parental support* to increase the sensitivity of parents to the psychosocial issues of their children (psycho-education) and to increase the capacity of parents to manage psychosocial problems (parental guidance; linkages to resources); (2) *parent-child relationship support* to improve the parent-child communication patterns (i.e. emotional responsiveness); (3) *family conflict reduction,* to support the family system and assisting general family functioning, following the families needs for such.

[1] The reason for calling it a *minimal* care package, are primarily that TPO believes it is not feasible to have complete and professional services in place, in places where no so little services yet exist (e.g. the goal should be to reach as many children as possible, rather then focusing specialized services on a minority group with sever problems); secondly, as these are the minimal components that a comprehensive package should have in order to ensure that the project can cater for varying age groups and problems.

[2] Additional services will be described under level 3.

Individual care for those children that are screened by the different project components as needing more specialized or individualized care, following two levels; (1) *counseling,* which we define by three principal components; (i) the beneficial effects of a therapeutic relationship, (ii) providing emotional support, and (iii) assisting with problem solving; and which includes *expressive and child specific therapeutic practices;* (2) *Advanced individual intervention* for children with severe mental health problems (including screening for such).

Adolescent/Youth groups*;* in case the groups of children are not indicated for CBI or MPCP services youth groups will be initiated for three reasons; to minimize stigmatization for either of the two groups; to not exclude non-indicated group from the fun activities that CBI is clearly representing; to have a back-up referral mechanism for children that might have entered the program later or for children that were mistakenly screened as non-indicated.

Adolescents are an often overseen group that needs special attention. They are a group that is at increased risk for psychosocial problems and at the same time is a group with a lot of potential (e.g. future oriented, peace building). Such adolescent group takes the form of guided theme-, and/or activity-centered groups (discussion, recreational activities, sports, building projects).

Public Awareness on the psychosocial consequences of violence of children and the communities' role in the care for these children. Such awareness activities are conducted for (a) the children themselves, (b) community members, to; (i) improve identification of children in need of care, (ii) promote the existing and available care and coping systems in the community (e.g. traditional healing practices), (iii) increase the community in preventing psychosocial problems among children (such as limiting additional negative psychosocial effects on affected children, avoiding re-victimization), and (iv) de-stigmatize (e.g. children who have been involved as perpetrators such as child soldiers). The topics of awareness raising may be different as per need, though typically include issues such as; effects of violence and abuse on children, stress, coping, Convention on the Rights of the Child, guidelines for adults on dealing with children in distress etc. Public awareness activities include *working with existing community coping strategies;* strengthening existing social, recreational, cultural and curative community systems to promote normalcy and social connections in the lives of the affected children and as an element of the overall care provision is encouraged. Existing social networks will be utilized to implement such activities.

Tier 3 – Existing resources: The third level entails the *mobilization and linkage of, and subsequent utilization of and collaboration with, existing curative and care services* with the previous described levels of the project. This entails that the CBI and the MPCP interventions are supported by a set of interventions, services, care programs or care systems that are existing in the different organizations and/or settings. As opposed to tires 1 and 2, these interventions are *not* provided by the CTP project, but only in terms of collaboration and referral. These interventions are used as additional care to best cater for the experienced needs and problems in the targeted communities and youth and ensure that the current project is linked to other ongoing care efforts for children affected by violence. Example of such existing programs differ per country, and may include; peace-building activities, psychiatric services, medical services, legal assistance.

3.2 Research

An empirical study on the efficacy of the CBI is conducted following a Randomized Controlled Trial (RCT) methodology, being the main scientific method to assess outcomes of (mental) health interventions. The research results are the prime indicator for the development of a 'best practices' module.

The research is conducted in two phases. The first phase consists of an ethnographic exploration of the cultural context relevant to the research questions at hand and systematic translation of materials following a 7-step procedure developed by HealthNet TPO (Van Ommeren, 1999). The second phase consists of the quantitative RCT.

It has been widely acknowledged that mental health research in low-income countries should combine qualitative (e.g. ethnographic) as well as quantitative methodology (e.g. Hohmann & Shear, 2002; de Jong & Van Ommeren, 2002). Moreover, due to a lack of research establishing efficacy for traumatized children, with no evidence for efficacy in the non-West, several authors call for urgently needed research into efficacy of trauma treatment interventions (Taylor & Chemtob, 2004; Bolton, 2004)

4. PLAN OF IMPLEMENTATION

The project covers a three-year period, and follows the following broad time line:

Year one focuses on capacity building, preparation and first cycle implementation. Capacity building includes both a CBI training of trainers program combined with follow-up training course, and needed capacity building for the Minimal Psychosocial Care Package development. Preparation includes mobilizing and adapting the existing interventions and setting the stage for carrying out the planned interventions, leading to several CBI groups (cycle 1 – pilot phase). Each trained CBI facilitator leads and co-leads a group during the first cycle, which is followed by an in-country refresher course. Hereafter, the master-trainers start a training program for a group of 20-30 CBI facilitators that subsequently initiate cycle 2 implementation. Furthermore year one is used to develop guidelines and protocols for the interventions (e.g. detailed CBI plan of action, screening protocol, referral mechanism, public awareness package, project monitoring tool) and translation of the existing CBI manual in the local languages. As the present project has a major research component, to assess the efficacy of the CBI intervention (as explained in more detail above), year one is used for preparation of research design and tools and a thorough and systematic in-country training of national research coordinators.

Year two emphasizes research implementation. The project research coordinator works with the national research teams to execute an empirical study following a Randomized Control Trial methodology. Each country receives a thorough (approximately 4-5 weeks per country) in-country training on the research project, research methodologies, data-collection, data-entry, SPSS/statistics etc. This initial training course is followed up through regular supervision and booster visits by the research coordinator, during research preparation and data-collection periods. The research adopts a methodical procedure to translate the research tools, to augment cultural sensitivity. Moreover, a qualitative pre-study (through semi-structured interviews of key informants) is conducted to collect contextual data. All interventions (both CBI and MCPC) are continued during this period, however

without expanding them. Furthermore, year two is used for material development, specifically the preparation of a final adapted and translated CBI manual for each of the participating countries. This manual is adapted for cultural appropriateness and based on the experience of cycles one and two interventions. Secondly, the MPCP module is elaborated and further developed, based on year one experiences, on quality assessment and continued monitoring.

Year three entails expansion of the interventions, to increase the number of children reached through the project. More facilitators are trained, who conduct the planned activities following the prepared documents. During year three final adaptations – informed by the initial results of the impact study - are made to come to the intervention package for psychosocial assistance for children in areas of armed conflict. Year three also entails analyzing and writing up the research data, collected during year two, followed by dissemination of results.

ANNEX 1. PROJECT STRUCTURE