WHO has advised countries to make social and basic psychological interventions available to the whole population in the community through a variety of sectors in addition to the health sector. Such interventions may address widespread distress in people without any disorder. These interventions may also provide some support to those people with mental disorders who do not seek help within the health sector. Examples of social intervention outside the health sector that tend to be relevant after disaster include: (re)starting schooling, organising child friendly spaces, family reunification programmes, and economic development initiatives.⁴⁻⁶ Professionals outside the health sector (for example, in disaster coordination, education, communication, protection, and community development) tend to lead the implementation of social interventions. An example of a basic psychological intervention that may be made available outside the health sector is teaching listening and psychological support skills to a non-health community worker.⁴ Social and basic psychological interventions outside the health sectors may involve the school system or existing traditional and religious resources in the community. Many social and psychological interventions require a thorough understanding of the sociocultural context, which outsiders typically do not have. Mental health professionals from affected regions should have an important role in designing, training, and supervising basic psychological support interventions.

In addition, WHO has been advising countries affected by the tsunami to urgently make sustainable mental health care available in the community. Mental disorders become more prevalent after a disaster, and people with a mental disorder—whether or not induced by the disaster—should have access to basic mental health care in general health services and community mental health services. WHO is helping governments in assessing, planning, and coordinating mental health care within the health sector.

We are concerned that many clinical interventions (for example, psychotherapy focused on post traumatic stress disorder) that are not basic are being introduced outside the health sector in an uncoordinated and standalone manner. Also, we are concerned with international aid initiatives that focus on training only—without an understanding of the culture and without ensuring sustained supervision after the training. WHO advises outside international groups to study the

guidelines of the International Society for Traumatic Stress Studies and the document *Psychosocial care and protection of tsunami-affected children* carefully before initiating training initiatives focused on trauma.⁷⁻⁸ These documents steer readers away from initiatives that may cause more harm than good.

We applaud that unprecedented efforts have been made to address the mental and social suffering of surviving populations. What is needed now is a thoughtful, long term approach with a focus on developing sustainable services inside and outside the health sector to ensure optimal long term outcomes.

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Management of stroke in childhood

Guidelines are welcome, but have some gaps—such as perinatal stroke

Stroke care for adults has been revolutionised in recent years, possibly in association with the publication of national clinical guidelines for stroke.¹ In consequence, rehabilitative care after stroke for adults is now considered the norm. Stroke is less common in children, and clinical experience and anecdotal evidence indicate that children may receive a

variable quality of care. A welcome development therefore has been the publication last year of guidelines by the UK Royal College of Physicians paediatric stroke working group.²

The guidelines deal mainly with the diagnosis, investigation, and management of acute arterial ischaemic stroke in children beyond the neonatal

period, covering acute presentation, management, rehabilitation, and longer term care. They emphasise the need for early imaging and input from a paediatric neurology tertiary centre. They also appropriately emphasise that these children should be investigated for an underlying prothrombotic tendency and should undergo echocardiography.

With respect to acute care, the working group found no studies specifically examining the efficacy of acute treatments and made its recommendations based on consensus opinion. In the main, whether or not to anticoagulate a child with cardiac embolism is therefore a decision that should be based on the individual patient. Similarly no current evidence supports the use of thrombolytic agents. By contrast good evidence exists for the use of aspirin in a dose of 5 mg per kg body weight per day unless imaging suggests intracranial haemorrhage or the child has sickle cell disease.

Alongside the acute medical (and more rarely surgical) management, the guidelines recommend that at an early stage the child's disability be assessed and that acute clinicians liaise with community child health services.

It is disappointing but unsurprising that specific rehabilitative techniques and approaches that are recommended do not have an evidence base: the information that is available is largely derived from practice and experience in children with cerebral palsy.

The guidelines tackle longer term rehabilitation needs, emphasising the requirement for psychological, cognitive, and family assessments together with the likelihood that rehabilitation for many children will extend into their adult lives.

Against the background of a paucity of hard data, the working group has made various audit recommendations that relate to acute care and longer term care of children who have had a stroke.

A working group report such as this raises issues around paediatric disability that go beyond its remit. These are both general and specific. The general point

to be made is that models for assessment and rehabilitation in stroke have much in common with those for most neurologically disabling conditions in childhood. These include prompt and appropriate diagnostic formulation, comprehensive assessment to include an understanding of family functioning and dynamics, appropriate health interventions at an early stage, and realistic multidisciplinary rehabilitation based on evidence based practice wherever that is possible. Hence one would wish to see paediatric stroke services integrated into and as a component of wider paediatric neurodisability services.

Specifically, what is disappointing about the deliberations of the working group is that they have not addressed the issues that relate to perinatal stroke and its usual sequel of congenital hemiplegia. Lynch et al have summarised recent knowledge of this subject.³ The diagnostic issues in this group of children are at least as complex as when stroke has its origin later in childhood, and specifically the links with intrapartum adversity are a current subject of interest and potential litigation.⁴ Expertise in obstetric, fetal, and neonatal medicine will need to be added to any future working group if these wider aspects of stroke in childhood are to be addressed satisfactorily.

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Clever searching for evidence

New search filters can help to find the needle in the haystack

Do people who write about and propagate evidence based medicine use its principles properly? A paper in this week's *BMJ* and two other recent *BMJ* papers report on such authors' abilities to find the best evidence.¹⁻³ On the way, they have provided excellent search strategies, using filters they call "hedges" (as in hedging one's bets) that help to separate the wheat (scientifically strong studies of diagnosis, treatment, and systematic reviews) from the chaff (less rigorous ones) in one of the most frequently accessed medical literature databases, Medline.

Why is this important? We still often need to search large databases such as Medline to find original research data because reviews may not cover our questions, may be out of date, and may not be relevant

enough to real clinical problems. Databases of primary research are staggeringly large (there are more than 12 million citations in Medline, and 7 million in Embase). Most research papers are written as communications from scientist to scientist and relatively few have immediate clinical relevance. Most of the remainder are not rigorous enough to warrant applying clinically.⁴ Subsequently, the proportion of useful information is very small.^{w1}

This lack of high quality, clinically relevant research studies leads to insecurity about the results of literature searches (table). Finding evidence can often seem easy,

Additional references w1-w5 are on bmj.com

Papers p 1179