reasons for immediate implementation. However, urgency is not an excuse for bad science. Animal experiments should be conducted to understand further the host destination and integration of transplanted cells, and the risks of neoplasia arising in cells implanted into new environments.[1] The ethics of transferring human stem cells into animal hosts in order to develop new therapies for debilitating disorders must be considered as part of the wider stem cell ethical debate.[11]

Commercial companies are springing up around the world with all the fervour of a new "biological dot-com" era, but with selective memory loss for the fact that unrealistically high expectations burst that bubble. We can only hope that any corporate failure to make immediate financial success out of stem cell research does not drag down a promising technology. Stem cell therapy needs to be nurtured safely and methodically to provide real benefit to patients in the future.

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Competing interests: PB and SLM are recipients of Medical Research Council grants for human stem cell derivation, and SLM has participated in visits sponsored by the Department of Trade and Industry to stem cell labs in the United States and the far east. PB will be speaking at this week's public debate in London, "Stem Cell Research: Hope or Hype?" but will not receive a fee.

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Aid after disasters

Needs a long term public mental health perspective

Clinical review
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The crisis caused by the earthquake and tsunami in South East Asia six months ago elicited an unprecedented aid response by humanitarian agencies financed by numerous governments and private citizens. With communicable disease more or less under control, aid agencies now focus increasingly on the mental suffering of surviving populations. We estimate here the likely mental health and psychosocial support needs of those affected and provide a public health framework for long term assistance.

Although no reliable data exist on numbers of people with problems related to mental health in countries affected by the tsunami, the estimated rates described in the table give a rough picture at the population level of what may be expected. Observed prevalence rates will vary with case definition, method of assessment, time since the disaster, and community. Across and within countries, communities differ in current and previous disaster exposure and in sociocultural factors that may influence social support, coping, and readiness to endorse symptoms in surveys. Disaster affected populations comprise people with non-pathological mild psychological distress that resolves in a few days or weeks; people with non-pathological moderate or severe psychological distress that may resolve over time or with mild distress that becomes chronic; and people with mental disorders such as psychosis, severe depression, and severely disabling presentations of an anxiety disorder (see table on bmj.com).

That post-traumatic stress disorder is the main or most important mental disorder resulting from disaster is a misconception. It is only one of a range of often comorbid common mental disorders (such as mood and anxiety disorders) that tend to make up the mild and moderate mental disorders and which become more prevalent after disaster.[1] The low level of help seeking behaviour for post-traumatic stress disorder in many non-Western cultures implies that it is not the focus of many survivors of trauma.[2 3] WHO is concerned that some groups are directing disproportional resources to clinical care focused on post-traumatic stress disorder. WHO argues for a public health perspective that considers all mental problems, ranging from pre-existing severe mental disorder to widespread non-pathological psychological distress induced by trauma and loss.[4]

P+ *See table on bmj.com*

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

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