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Short report

Post-disaster psychosocial services across Europe: The TENTS project

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A B S T R A C T

At present post-disaster activities and plans seem to vary widely. An adequate estimation of the availability of post-disaster psychosocial services across Europe is needed in order to compare them with recently developed evidence-informed psychosocial care guidelines. Here we report on the results of a cross-sectional web-based survey completed in 2008 by two hundred and eighty-six representatives of organizations involved in psychosocial responses to trauma and disaster from thirty-three different countries across Europe. The survey addressed planning and delivery of psychosocial care after disaster, methods of screening and diagnosis, types of interventions used, and other aspects of psychosocial care after trauma. The findings showed that planning and delivery of psychosocial care was inconsistent across Europe. Countries in East Europe seemed to have less central coordination of the post-disaster psychosocial response and fewer post-disaster guidelines that were integrated into specific disaster or contingency plans. Several forms of psychological debriefing, for which there is no evidence of efficacy to date, were still used in several areas particularly in North Europe. East European countries delivered evidence-based interventions for PTSD less frequently, whilst in South- and South-Eastern European countries anxiety suppressing medication such as benzodiazepines were prescribed more frequently to disaster victims than in other areas. Countries across Europe are currently providing sub-optimal psychosocial care for disaster victims. This short report shows that there is an urgent need for some countries to abandon non-effective interventions and others to develop more evidence based and effective services to facilitate the care of those involved in future disasters.

Introduction

Over recent decades the knowledge base on psychosocial responses after trauma has increased greatly. For example, several evidence-based guidelines for post traumatic stress disorder (PTSD) have been developed (Foa, Keane, Friedman, & Cohen, 2009; NICE, 2005) and recommend first-line treatments with a considerable evidence base such as trauma-focused cognitive behavioural therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR) (Bisson & Andrew, 2007) or selective serotonin reuptake inhibitors (SSRIs) (Stein, Ipser, & Seedat, 2006). Recently, guidelines were developed for post-disaster psychosocial care based on the current research evidence and expert consensus (Bisson et al., 2010). These guidelines primarily recommended that every area

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should have a multi-agency psychosocial care planning group, that early application of formal interventions for all should not occur, that trauma-focused CBT should be used as the first-line intervention for acute stress disorder and acute PTSD, and trauma-focused CBT or EMDR for chronic PTSD.

In order to accurately disseminate and implement evidence-informed post-disaster guidelines such as those formulated by (Bisson et al., 2010), knowledge of existing service provision is essential. It has not been clear to what extent evidence based, or at least evidence informed, practices are currently available or implemented in post-disaster psychosocial management throughout Europe. Post-disaster psychosocial activities and plans (if present) seem to vary widely across nations. Evidence-based interventions may not be available and non evidence-based interventions may still be used. To address these issues, The European Network for Traumatic Stress (TENTS) was launched in May 2007. One of the aims of TENTS was to compare its evidence-informed guidelines with existing planning and provision of psychosocial services to disaster victims across Europe in order to appropriately plan dissemination and ultimately implementation of them. This paper reports the mapping of the existing planning and provision of psychosocial services.

Method

Mapping procedure

The international, multi-agency group of TENTS main partners (from fifteen countries and all with expertise in the trauma field) designed the mapping procedure which had three main aims: 1) to build a network of trauma experts across Europe in order to have access to the necessary information, 2) to develop and administer a web-based survey to assess currently available services for the psychosocial care and management for victims of natural and other disasters, and 3) to collect qualitative data through local visits to EU (candidate) member states. Qualitative and quantitative data was to be collected in a standardized and structured manner covering the following areas: planning and delivery systems (e.g. guidelines for psychosocial response following trauma/disasters, contingency plans); methods of screening for trauma/disaster related disorders; treatments for post traumatic disorders, and training and supervision of care providers.

Network building

The project's main partners were allocated different areas of the European region and liaised with local organizations in these countries to map current service provision (Table 1). At the same time, other collaborating partners provided information and contacts mainly from their own countries. These included clinicians and emergency planners who represented services and organizations in the field of psychosocial care and post traumatic stress management for victims of psychological trauma and of natural and other disasters, e.g. hospitals and clinics, governmental and non-governmental organizations, profit and non-profit organizations.

Mapping tool

A web-based survey, the Disaster Care Mapping Questionnaire (DCMQ), comprising 28 main questions was developed and piloted at the Academic Medical Centre in Amsterdam. Drafts of the survey were circulated to the project partners for consultation to achieve optimal face and content validity. It was subsequently piloted within the consortium of partners, adjusted and re-tested before being integrated in the website. The DCMQ included dichotomous, multiple choice and open-ended questions which were divided into 6 sections:

1) demographics of participant and organization (e.g., types of psychosocial care delivered)
2) planning and delivery systems (e.g., participation in multi-agency coordination of disaster response or use of specific post-disaster guidelines and contingency plans)
3) target populations of service provision (e.g., children or victims of war)
4) screening and diagnostic instruments in use (e.g., structured diagnostic interviews or questionnaires)
5) interventions (e.g., immediate interventions, psychological, pharmacological and community based interventions including subtypes of each)
6) education, training, supervision and needs of service providers

The survey was translated (and back translated) into six local languages (i.e., Turkish, Finnish, Hungarian, Polish, Spanish, Swedish and French) and administered between May and December 2008.

Table 1
Numbers of participants per country per area.

Area	Country	*N*
West (23%; $n = 64$)	Belgium	5
	The Netherlands	35
	Northern-Ireland	1
	United Kingdom	23
North (15%; $n = 43$)	Denmark	2
	Finland	13
	Norway	17
	Sweden	11
Central (25%; $n = 72$)	Austria	2
	Germany	51
	Switzerland	19
South (7%; $n = 19$)	France	4
	Italy	4
	Malta	1
	Portugal	5
	Spain	5
East (10%; $n = 30$)	Czech Republic	7
	Latvia	3
	Lithuania	3
	Poland	16
	Slovakia	1
South-East (20%; $n = 58$)	Bulgaria	1
	Bosnia-Herzegovina	4
	Croatia	6
	Cyprus	2
	FYROM	2
	Georgia	3
	Greece	2
	Romania	5
	Serbia	6
	Slovenia	1
	Turkey	26

FYROM = Former Yugoslavian Republic of Macedonia.

Interviews

The TENTS main partners visited key contacts in the countries they liaised with during the mapping process. The visiting partners organized an interview with the key local contact(s) or set up a focus group to meet with several key local contacts. The partner interviewed the contacts about local planning and delivery systems (e.g., coordination of care), methods of screening, assessment and interventions for trauma-related