



TENTS

The European Network for Traumatic Stress

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THE TENTS GUIDELINES

**FOR PSYCHOSOCIAL CARE
FOLLOWING DISASTERS AND MAJOR INCIDENTS**



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TENTS Guidelines

These guidelines were developed through systematically reviewing the current research evidence regarding psychosocial care following disasters and major incidents, and a Delphi process involving 106 professionals and experts from 25 different countries. It is recognized that the content and organization of services differ between countries. The TENTS Guidelines are therefore recommended to be used as a model for the delivery of care in all European countries without being made mandatory. The guidelines are aimed at the provision of psychosocial care for areas with a population of 250,000 to 500,000 people although can be adapted for larger or smaller areas. They are divided into six sections that cover: planning, preparation and management; general components; and specific components to be included at particular phases of the response. Several of the components focus on individuals but all aspects of psychosocial care should only be provided with full consideration of individuals' wider social environment, especially their families and communities.

1. Planning, preparation and management

- 1.1 Every area should have a multi agency psychosocial care planning group which includes mental health professionals with expertise in traumatic stress who have a designated responsibility for psychosocial care following disasters and major incidents. Individuals affected by disasters or major incidents should also be represented.
- 1.2 Every area should have guidelines on the provision of psychosocial care in emergencies (a psychosocial care plan) that are incorporated into the overall disaster/major incident plan and regularly updated.
- 1.3 Inter-agency co-operative planning and coordination should occur to ensure that the psychosocial care plan is effective.
- 1.4 Existing psychosocial services should be fully mapped and incorporated into the psychosocial care plan.
- 1.5 The psychosocial care plan should be tested through exercises.
- 1.6 Politicians/government officials should be involved in management training and exercises.
- 1.7 A training programme should be in place in every area to ensure that individuals involved in the psychosocial care response are prepared for their roles and responsibilities.
- 1.8 All care providers should have undergone formal training and receive ongoing training, support and supervision.
- 1.9 The content and level of training should be carefully tailored to correspond with the roles and responsibilities of the providers of psychosocial care.
- 1.10 Care providers (professionals and volunteers) should be recruited, in advance if possible, and screened for suitability before being accepted.
- 1.11 The planning group should monitor for possible secondary traumatization and burn out symptoms among care providers including volunteers
- 1.12 Governments/authorities should provide adequate funding to maintain an appropriate psychosocial care plan that can be effectively delivered should a disaster occur.

2. General components of the response

- 2.1 The response should promote a sense of safety, self and community efficacy/empowerment, connectedness, calm and hope.
- 2.2 The human rights of individuals should be explicitly considered.
- 2.3 Conditions for appropriate communal, cultural, spiritual and religious healing practices should be facilitated.
- 2.4 Responses should provide general support, access to social support, physical support and psychological support.
- 2.5 Responses should involve and provide support to the family as well as the individual.
- 2.6 Responses should provide educational services regarding reactions to trauma and how to manage them.

- 2.7 Provision of specific formal interventions such as single session individual psychological debriefing for everyone affected should not occur.
- 2.8 Formal screening of everyone affected should not occur but helpers should be aware of the importance of identifying individuals with significant difficulties.
- 2.9 Where local resources are limited, priority should be based on need amongst those affected by the disaster/major incident and other groups.
- 2.10 Responses should provide access to specialist psychological and pharmacological assessment and management when it is required.
- 2.11 Self-help interventions are required to address the needs of large affected populations.
- 2.12 Local individuals who are aware of local cultures and particular communities should be involved if not already members of the psychosocial care planning group.
- 2.13 General Practitioners/local doctors should be made aware of possible psychopathological sequelae.
- 2.14 Efforts should be made to identify the correct supportive resources (eg family, community, school, friends, et cetera).
- 2.15 Other services should be made available, for example financial assistance and legal advice.
- 2.16 Memorial services/ceremonies should be planned in conjunction with those affected.

3. Specific components of the initial response (within the first week)

- 3.1 The initial response requires practical help and pragmatic support provided in an empathic manner.
- 3.2 Information regarding the situation and concerns of individuals affected should be obtained and provided to them in an honest and open manner.
- 3.3 Written leaflets containing education about responses to traumatic events, helpful coping and where to seek help if necessary should be provided.
- 3.4 Individuals should be actively provided with education about reactions to trauma if they are interested in receiving it.
- 3.5 Psychological reactions should be normalised during the initial response.
- 3.6 Individuals should be neither encouraged nor discouraged from giving detailed accounts.
- 3.7 A telephone helpline staffed by trained personnel that provides emotional support should be launched.
- 3.8 A website concerning psychosocial issues should be launched.
- 3.9 A humanitarian assistance centre/one stop shop should be established where a range of services potentially required can be based.
- 3.10 Those overseeing the initial psychosocial response should work closely with the media.
- 3.11 The creation of a database to record personal details should be considered.

4. Specific components of the early response (within the first month)

- 4.1 Individuals with psychosocial difficulties should be formally assessed for further input.
- 4.2 Treatment with trauma focused cognitive behavioural therapy should be available for individuals with acute stress disorder or severe acute post traumatic stress disorder.
- 4.3 Evidence based interventions for individuals with other mental health difficulties should be available.
- 4.4 Individuals with high levels of distress should be contacted proactively to maintain contact.
- 4.5 The option of further pro-active contact should be made to those affected and their families.

5. Specific components of the response one to three months after the disaster

- 5.1 Individuals with psychosocial difficulties should be formally assessed by a trained professional with consideration for their physical, psychological and social needs before receiving any specific intervention.
- 5.2 Treatment with trauma-focused cognitive behavioral therapy (TF-CBT) should be available for individuals with acute post traumatic stress disorder and is recommended as the treatment of choice.
- 5.3 Other treatments with an evidence base for chronic post traumatic stress disorder should be available for individuals with acute post traumatic stress disorder when TF-CBT is not available or is not tolerated.
- 5.4 Evidence based interventions for individuals with other mental health difficulties should be available.
- 5.5 Individuals with high levels of distress should be contacted proactively to maintain contact.
- 5.6 The option of further pro-active contact should be made to those affected and their families.

6. Specific components of the ongoing response (beyond three months)

- 6.1 Individuals with psychosocial difficulties should be formally assessed by a trained professional with consideration for their physical, psychological and social needs before receiving any specific intervention.
- 6.2 Evidence based interventions for individuals with mental health difficulties should be available.
- 6.3 Work/rehabilitation opportunities should be provided to enable those affected to re-adapt to everyday life routines and be independent.
- 6.4 Detailed planning should occur with local authorities/governments and existing services to fund and provide appropriate extra provision to support local services for several years following the disaster.

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