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Preparedness of First-Contact Helping Professionals in Slovakia to Provide Crisis Intervention in War-Related and Migration Crises

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Готовність фахівців допоміжних професій першого контакту в Словаччині до надання кризової інтервенції під час воєнних та міграційних криз

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Introduction

War-related and migration crises are major social events that affect safety, social functioning, mental health and quality of life at both individual and community levels. People affected by armed conflict, forced displacement, loss of close persons, disruption of social ties, economic uncertainty and adaptation to a new environment are exposed to increased psychosocial burden. Crisis intervention and psychological first aid aim to provide humane, supportive and practical assistance to people exposed to serious stressors and to support safety, calming, orientation, connection with resources and access to further help [1].

In the context of mass displacement, psychosocial support cannot be limited to specialised psychiatric or psychotherapeutic services. The Inter-Agency Standing Committee guidelines conceptualise mental health and psychosocial support in emergencies as a layered system, ranging from basic services and community support to focused non-specialised and specialised care [2]. This approach is particularly relevant for first-contact helping professionals who work in health, social, community, educational, counselling and non-governmental services.

The importance of preparedness is supported by evidence on the mental health consequences of conflict and forced migration. A systematic review and meta-analysis of conflict-affected populations estimated substantially elevated levels of depression, anxiety, post-traumatic stress disorder and other mental disorders [3]. Refugees and asylum seekers also show considerable mental health needs, although prevalence estimates vary according to methodology, context, pre-migration trauma and post-migration living conditions [4; 5]. These findings highlight the need for early recognition, basic stabilisation and timely referral to appropriate services.

In Slovakia, the topic of crisis intervention has become particularly relevant in connection with the arrival of people fleeing the war in Ukraine and with the need to ensure accessible support for people in acute or persisting crisis. In many situations, the first professional contact is not provided by a specialist mental health service, but by nurses, physicians, social workers, psychologists, crisis line workers, counsellors, community workers or employees of non-governmental organisations. Their ability to recognise signs of crisis, communicate safely, reduce acute distress, assess risk and refer to further help may influence the subsequent course of coping with the crisis situation.

At the same time, the provision of crisis intervention in migration contexts is complicated by language barriers, cultural differences, uncertainty about competencies, insufficient referral pathways and psychological burden on workers. Communication barriers between refugees or migrants and service providers have been identified as a significant obstacle to access to mental health care and to the quality of support [6]. Despite the increasing practical need, the preparedness of first-contact helping professionals in Slovakia to provide crisis intervention in war-related and migration crises remains insufficiently explored.

The aim of the research was to analyse the preparedness of first-contact helping professionals in Slovakia to provide crisis intervention to people affected by war-related and migration crises. The study focused on practical experience, self-assessed competencies, previous training, organisational support, perceived barriers and needs for further education in crisis intervention. The results may contribute to the formulation of recommendations for strengthening crisis preparedness in public health, social services and community support.

Object, materials and methods of the research

The object of the research was the preparedness of first-contact helping professionals working in Slovakia to provide crisis intervention to people affected by war-related and migration crises. The study focused on their

experience with persons in crisis, previous education in crisis intervention, self-assessed professional competencies, availability of organisational support, perceived barriers and further training needs.

The research was designed as a quantitative cross-sectional questionnaire study. The research sample consisted of 142 respondents from the group of first-contact helping professionals working in Slovakia. The sample included physicians, nurses and other health professionals, psychologists, social workers, crisis line or counselling workers, and workers of non-governmental organisations and assistance centres. The sampling was purposive. The inclusion criterion was professional or service involvement in which the respondent could encounter people affected by war-related, migration or psychosocial crisis.

Of the total number of respondents, 85 were women (59.9 %) and 57 were men (40.1 %). The largest age group consisted of respondents aged 36–45 years (75; 52.8 %). According to professional orientation, the most represented groups were nurses or health professionals (44; 31.0 %) and social workers (43; 30.3 %). Second-cycle university education was reported by 58 respondents (40.8 %) and first-cycle university education by 34 respondents (23.9 %). The largest proportion of respondents had 6–10 years of professional practice (58; 40.8 %).

Data were collected using an anonymous author-designed questionnaire focused on preparedness for crisis intervention. The questionnaire included socio-demographic and professional characteristics, experience with people affected by war-related or migration crises, previous training in crisis intervention, self-assessment of competencies, organisational conditions, perceived barriers and training needs. The questionnaire contained closed single-choice questions, multiple-choice questions, five-point Likert scale items and open questions.

For Likert scale items, respondents expressed agreement with statements on a scale from 1 – strongly disagree to 5 – strongly agree. The items focused on the ability to recognise signs of acute psychological crisis, distinguish a normal stress reaction from a state requiring professional intervention, know the basic principles of crisis intervention, communicate with a person in crisis, assess risk, provide basic psychological first aid, refer to further professional help and evaluate organisational support, supervision and the need for further training.

Participation in the research was voluntary and anonymous. Respondents were informed about the purpose of the research and that the data would be processed only in aggregated form for scientific purposes. The research did not collect personal data that would allow identification of respondents.

Data processing. The obtained data were processed using descriptive and inferential statistics. For categorical variables, absolute frequencies (n) and relative frequencies (%) were calculated. For five-point Likert scale items, the mean score (M), standard deviation (SD), 95 % confidence interval of the mean, and the number and percentage of agreement responses were calculated. Agreement was defined as responses 4 – rather agree and 5 – fully agree; disagreement was defined as responses 1 – strongly disagree and 2 – rather disagree.

For an indicative inferential assessment of whether mean Likert scores differed from the neutral scale value, a one-sample t-test against the test value of 3 was used. The value 3 represented the neutral response. Statistical significance was assessed at alpha = 0.05. Effect size was expressed using Cohen's d. Given the ordinal character of Likert scales, the t-test results were interpreted as a supplementary analysis to descriptive statistics.

For multiple-choice questions, results were interpreted as the proportion of respondents who selected a given option; therefore, the total number of responses could exceed the number of respondents. Statistical processing was performed in Microsoft Excel. A total of 142 valid questionnaires were included in the analysis. Control of totals confirmed that the number of valid responses corresponded to the total number of respondents ($N = 142$) for single-choice questions and Likert items.

Group comparisons using one-way analysis of variance (ANOVA) were not performed because the available data matrix had an aggregated character and did not contain individual-level linkage of answers to profession, education, length of practice or completed training. Correct use of ANOVA, or its non-parametric alternative, the Kruskal – Wallis test, requires an individual respondent database in which total or domain preparedness scores can be calculated for each respondent.

Research results

Characteristics of the research sample

The research sample consisted of 142 first-contact helping professionals working in Slovakia. There were 85 women (59.9 %) and 57 men (40.1 %). The most frequent age group was 36–45 years (75; 52.8 %). The most common level of education was second-cycle university education (58; 40.8 %), followed by first-cycle university education (34; 23.9 %) and third-cycle university education (28; 19.7 %). The most represented professional groups were nurses or health professionals (44; 31.0 %) and social workers (43; 30.3 %).

Experience with people affected by crisis and previous training

Regular work with people affected by war-related or migration crises was reported by 34 respondents (23.9 %) and occasional work by 55 respondents (38.7 %). Another 50 respondents (35.2 %) stated that they worked with such persons only exceptionally, and 3 respondents (2.1 %) did not work with them. Thus, some form of contact with people affected by war-related or migration crises was declared by 139 respondents (97.9 %).

Education or training in crisis intervention in some form was reported by 85 respondents (59.9 %); however,

Table 1

Characteristics of the research sample (*N* = 142)

Characteristic	Category	*n*	%
Sex	Female	85	59.9
	Male	57	40.1
Age	Up to 25 years	5	3.5
	26–35 years	22	15.5
	36–45 years	75	52.8
	46–55 years	15	10.6
	56 years and over	25	17.6
Education	Secondary vocational	22	15.5
	University I. degree	34	23.9
	University II. degree	58	40.8
	University III. degree	28	19.7
Profession	Physician	12	8.5
	Nurse / health professional	44	31.0
	Psychologist	13	9.2
	Social worker	43	30.3
	Crisis line or counselling worker	12	8.5
	NGO / assistance centre worker	18	12.7
Length of professional practice	Less than 1 year	1	0.7
	1–5 years	34	23.9
	6–10 years	58	40.8
	11–20 years	27	19.0
	More than 20 years	22	15.5

certified crisis intervention training was completed by only 2 respondents (1.4 %). A short course or training was completed by 22 respondents (15.5 %), and 61 respondents (43.0 %) reported exposure to the topic only during their studies. No training in crisis intervention was reported by 57 respondents (40.1 %).

Contact with persons in acute psychological crisis was reported daily by 11 respondents (7.7 %), several times per week by 27 respondents (19.0 %) and several times per month by 60 respondents (42.3 %). Crisis intervention to a person affected by war-related or migration crises was provided repeatedly by 46 respondents (32.4 %) and once or several times by 52 respondents (36.6 %).

The most frequently encountered types of crisis were loss of a close person (28; 19.7 %), domestic violence (26; 18.3 %), forced migration or refugee experience (19; 13.4 %), suicidal thoughts (17; 12.0 %), loss of housing or work (15; 10.6 %), and crisis in children and adolescents (15; 10.6 %). War trauma was indicated by 14 respondents (9.9 %) and acute anxiety or panic reaction by 8 respondents (5.6 %).

Self-assessed preparedness and intervention competencies

Self-assessed preparedness was evaluated on a five-point Likert scale from 1 – strongly disagree to 5 – fully agree. The highest mean score was obtained for the item "I can provide basic psychological first aid" (M = 4.44; SD = 1.15), where agreement was reported by 116 respondents (81.7 %). A high proportion of agreement was also recorded for the item "I know where to refer a person in crisis for further professional help" (122; 85.9 %; M = 3.91; SD = 0.82).

Lower results were found for items related to specific work with persons after war-related or migration trauma and to managing intensive emotional reactions. Only 28 respondents (19.7 %) agreed that they could work with people who had experienced war trauma or forced migration, while 82 respondents (57.7 %) disagreed. Only 47 respondents (33.1 %) felt sufficiently prepared to provide basic crisis intervention.

In terms of summary domains, knowledge and recognition of crisis reached a mean score of 3.00, practical intervention skills reached 3.37 and overall preparedness reached 3.20. These results indicate a moderate level of overall self-assessed preparedness, with the weakest area being work with the specific consequences of war-related and migration trauma.

Inferential analysis of Likert items

One-sample t-tests against the neutral value of 3 showed that several items differed significantly from the neutral midpoint of the scale. Significantly higher ratings were found for providing basic psychological first aid (M = 4.44; t = 15.02; $p < 0.001$), referring a person in crisis to further professional help (M = 3.91; t = 13.13; $p < 0.001$), proceeding when suicidal risk is suspected (M = 3.87; t = 10.17; $p < 0.001$) and establishing safe and supportive contact (M = 3.68; t = 8.15; $p < 0.001$).

Significantly lower than neutral ratings were found for working with people who had experienced war trauma or forced migration (M = 2.37; $t = -5.88$; $p < 0.001$), working with a person experiencing strong anxiety, fear or panic (M = 2.51; $t = -4.16$; $p < 0.001$), and knowing the basic principles of crisis intervention (M = 2.62; $t = -3.65$; $p < 0.001$). The overall feeling of being sufficiently prepared to provide basic crisis intervention did not differ significantly from the neutral value (M = 3.04; t = 0.30; p = 0.763).

Table 2

Experience with crisis intervention and previous training (*N* = 142)

Variable	Category	*n*	%
Work with people affected by war-related or migration crises	Yes, regularly	34	23.9
	Yes, occasionally	55	38.7
	Only exceptionally	50	35.2
	No	3	2.1
Training in crisis intervention	Certified training	2	1.4
	Short course / training	22	15.5
	Only during studies	61	43.0
	No	57	40.1
Frequency of contact with people in acute psychological crisis	Daily	11	7.7
	Several times a week	27	19.0
	Several times a month	60	42.3
	Rarely	25	17.6
	Never	19	13.4
Provision of crisis intervention to a person affected by war-related or migration crises	Yes, repeatedly	46	32.4
	Yes, once or several times	52	36.6
	No, but I was in contact with such a person	44	31.0
	No	0	0.0

Table 3

Self-assessment of knowledge and intervention skills (*N* = 142)

Item	M	SD	Agree 4 + 5 *n* (%)	Neutral *n* (%)	Disagree 1+2 *n* (%)
I can recognise signs of acute psychological crisis	3.19	1.11	50 (35.2)	56 (39.4)	36 (25.4)
I can distinguish a normal stress reaction from a state requiring professional intervention	3.20	1.21	57 (40.1)	48 (33.8)	37 (26.1)
I know the basic principles of crisis intervention	2.62	1.24	32 (22.5)	54 (38.0)	56 (39.4)
I can establish safe and supportive contact with a person in crisis	3.68	1.00	90 (63.4)	28 (19.7)	24 (16.9)
I can work with a person experiencing strong anxiety, fear or panic	2.51	1.41	36 (25.4)	21 (14.8)	85 (59.9)
I can assess whether a person in crisis represents a risk to self or others	3.57	0.87	67 (47.2)	64 (45.1)	11 (7.7)
I know how to proceed when suicidal risk is suspected	3.87	1.02	78 (54.9)	54 (38.0)	10 (7.0)
I can provide basic psychological first aid	4.44	1.15	116 (81.7)	12 (8.5)	14 (9.9)
I can work with people who have experienced war trauma or forced migration	2.37	1.29	28 (19.7)	32 (22.5)	82 (57.7)
I know where to refer a person in crisis for further professional help	3.91	0.82	122 (85.9)	10 (7.0)	10 (7.0)
I feel sufficiently prepared to provide basic crisis intervention	3.04	1.39	47 (33.1)	45 (31.7)	50 (35.2)
During work with a person in crisis, I can remain calm and professional	2.95	1.10	42 (29.6)	61 (43.0)	39 (27.5)

Table 4

Inferential assessment of selected Likert items against neutral value 3 (*N* = 142)

Item	M	*SD*	*t*	*p*	Cohen *d*	Interpretation
I can provide basic psychological first aid	4.44	1.15	15.02	< 0.001	1.26	Significantly higher, large effect
I know where to refer a person in crisis for further professional help	3.91	0.82	13.13	< 0.001	1.10	Significantly higher, large effect
I know how to proceed when suicidal risk is suspected	3.87	1.02	10.17	< 0.001	0.85	Significantly higher, large effect
I can establish safe and supportive contact with a person in crisis	3.68	1.00	8.15	< 0.001	0.68	Significantly higher, medium effect
I can work with people who have experienced war trauma or forced migration	2.37	1.29	–5.88	< 0.001	–0.49	Significantly lower, small-to-medium effect
I can work with a person experiencing strong anxiety, fear or panic	2.51	1.41	–4.16	< 0.001	–0.35	Significantly lower, small effect
I know the basic principles of crisis intervention	2.62	1.24	–3.65	< 0.001	–0.31	Significantly lower, small effect
We have the possibility to consult difficult cases at the workplace	2.64	0.96	–4.45	< 0.001	–0.37	Significantly lower, small effect
I have access to supervision or professional support after difficult interventions	2.54	1.61	–3.40	0.001	–0.29	Significantly lower, small effect
I would be interested in further training in crisis intervention	4.45	0.58	29.89	< 0.001	2.51	Significantly higher, very large effect
Regular supervision should be available to all workers in contact with people in crisis	3.94	0.47	24.03	< 0.001	2.02	Significantly higher, very large effect

Organisational support and systemic conditions

Results in the area of organisational support showed lower evaluation of workplace conditions. Clear procedures for work with people in crisis were confirmed by 45 respondents (31.7 %), while 68 respondents (47.9 %) disagreed. Available contacts for professionals or organisations to which a person in crisis could be referred were confirmed by 53 respondents (37.3 %).

A more pronounced deficit was observed in the possibility of consulting difficult cases, where only 23 respondents (16.2 %) agreed and 87 respondents (61.3 %) disagreed. Access to supervision or professional support after difficult interventions was confirmed by 50 respondents (35.2 %), while 76 respondents (53.5 %) did not have such access. Sufficient attention to burnout prevention at the workplace was confirmed by 30 respondents (21.1 %).

The summary score of organisational support was 2.64, representing the lowest rated area among the observed domains. Conversely, the area of the need for further education reached a mean score of 3.78. Interest in further training in crisis intervention was expressed by 136 respondents (95.8 %), and the need for regular supervision for workers in contact with people in crisis was supported by 122 respondents (85.9 %).

Perceived barriers to providing crisis intervention

The most frequently reported barriers were language barriers and high psychological burden of workers, each selected by 89 respondents (62.7 %). Other important barriers were unclear competencies of individual professions (84; 59.2 %), lack of follow-up services (83; 58.5 %), missing methodological procedures (79; 55.6 %) and cultural differences (78; 54.9 %). Lack of supervision was reported by 68 respondents (47.9 %), lack of time by 64 respondents (45.1 %) and lack of professional education by 58 respondents (40.8 %).

Table 5

Organisational support and need for further education (*N* = 142)

Item	M	SD	Agree 4 + 5 *n* (%)	Neutral *n* (%)	Disagree 1+2 *n* (%)
There are clear procedures at my workplace for working with people in crisis	2.58	1.50	45 (31.7)	29 (20.4)	68 (47.9)
I have available contacts for professionals or organisations to which I can refer a person in crisis	2.98	1.36	53 (37.3)	34 (23.9)	55 (38.7)
We have the possibility to consult difficult cases at the workplace	2.64	0.96	23 (16.2)	32 (22.5)	87 (61.3)
I have access to supervision or professional support after difficult interventions	2.54	1.61	50 (35.2)	16 (11.3)	76 (53.5)
My workplace pays sufficient attention to burnout prevention among workers	2.54	1.09	30 (21.1)	28 (19.7)	84 (59.2)
Crisis intervention is sufficiently organisationally ensured in our organisation	2.58	1.15	32 (22.5)	26 (18.3)	84 (59.2)
I would be interested in further training in crisis intervention	4.45	0.58	136 (95.8)	6 (4.2)	0 (0.0)
Crisis intervention should be part of compulsory education for health and helping professions	3.83	0.56	106 (74.6)	36 (25.4)	0 (0.0)
Regular supervision should be available to all workers who come into contact with people in crisis	3.94	0.46	122 (85.9)	20 (14.1)	0 (0.0)
System preparedness for psychosocial crises is as important as preparedness for medical or material consequences	2.89	1.15	41 (28.9)	44 (31.0)	57 (40.1)

Table 6

Barriers to providing crisis intervention (*N* = 142; multiple responses possible)

Barrier	*n*	% of respondents
Language barrier	89	62.7
High psychological burden of workers	89	62.7
Unclear competencies of individual professions	84	59.2
Lack of follow-up services	83	58.5
Missing methodological procedures	79	55.6
Cultural differences	78	54.9
Lack of supervision	68	47.9
Lack of time	64	45.1
Lack of professional education	58	40.8
Other	0	0.0

Training needs of respondents

The results showed a very high need for further education in crisis intervention. The most frequently selected area was managing aggression and strong emotions, reported by 136 respondents (95.8 %). This was followed by burnout prevention (134; 94.4 %) and basics of crisis intervention (133; 93.7 %). Psychological first aid was selected by 112 respondents (78.9 %). Communication with a traumatised person and work with refugees and migrants were both selected by 99 respondents (69.7 %).

Table 7

Preferred areas of further education (*N* = 142; multiple responses possible)

Training area	*n*	% of respondents
Managing aggression and strong emotions	136	95.8
Burnout prevention	134	94.4
Basics of crisis intervention	133	93.7
Psychological first aid	112	78.9
Communication with a traumatised person	99	69.7
Work with refugees and migrants	99	69.7
Work with children and adolescents in crisis	98	69.0
Suicidal risk	89	62.7

Overall, the results show that first-contact helping professionals in Slovakia have substantial practical experience with people in crisis situations, but their preparation is uneven. Respondents rated themselves stronger in basic psychological first aid and referral to further professional help, but weaker in working with war trauma, forced migration, intense emotional reactions and organisationally supported crisis intervention.

Discussion of research results

The study identified an uneven profile of preparedness among first-contact helping professionals in Slovakia. Respondents reported frequent practical contact with people affected by crisis, but only a small proportion had completed certified crisis intervention training. This finding is important because international guidance emphasises that psychosocial support in emergencies should combine specialised services with basic, safe and accessible support delivered by trained persons in first contact with affected populations [1; 2].

The high proportion of respondents who had at least some contact with people affected by war-related or migration crises confirms that crisis intervention in Slovak conditions is not limited to specialised psychological or psychiatric services. This corresponds to the layered model of mental health and psychosocial support, where first-contact workers can function as an entry point into the system of assistance [2]. However, the role of first-contact professionals should be clearly defined and supported by referral pathways, supervision and organisational procedures.

The mental health relevance of the topic is supported by international epidemiological evidence. Conflict-affected populations are at increased risk of depression, anxiety and post-traumatic stress disorder [3], and refugees and asylum seekers show substantial and context-dependent mental health needs [4; 5]. In addition, linguistic and cultural barriers may reduce access to mental health services and complicate communication between clients

and providers [6]. These findings are consistent with the barriers reported by respondents in the present study, especially language barriers, cultural differences and lack of follow-up services.

A positive result is that respondents rated themselves highest in providing basic psychological first aid and referring a person in crisis to further professional help. Psychological first aid is not psychotherapy, but a basic supportive approach focused on safety, calming, practical assistance, connection with social support and linkage to services [1]. Previous evidence suggests that psychological first aid training can improve knowledge, skills, self-efficacy and preparedness of providers, although the quality of implementation and practical training components remain important [7].

At the same time, respondents felt significantly less prepared to work with people who had experienced war trauma or forced migration, and to work with individuals experiencing strong anxiety, fear or panic. This difference suggests that respondents distinguish basic supportive contact from more demanding crisis situations requiring specific knowledge, skills and supervision. Such findings support the need for trauma-informed and culturally sensitive training focused on communication, stabilisation, risk assessment, work with interpreters and referral to specialised services.

The low rating of organisational support is one of the most important findings. Respondents reported insufficient possibilities for consultation of difficult cases, limited access to supervision, insufficient burnout prevention and unclear organisational procedures. The quality of crisis intervention depends not only on individual competence, but also on the conditions in which professionals work. Studies on supervision in humanitarian mental health and psychosocial support emphasise that supervision supports intervention quality, worker wellbeing and safe implementation of services [8; 9].

The high psychological burden of workers, reported by 62.7 % of respondents as a barrier, requires systematic organisational response. Workers in contact with people exposed to war, loss, displacement and acute distress may experience emotional exhaustion, secondary traumatic stress and burnout. Therefore, burnout prevention should not be understood only as an individual responsibility, but as a managerial and organisational task. Regular supervision, case consultations, team debriefings and realistic workload management are necessary components of safe crisis work [8; 9].

The study also confirms the importance of scalable and accessible psychosocial interventions for displaced populations. Reviews of scalable interventions for refugees emphasise the need to train non-specialised or partially specialised providers and to connect low-intensity interventions with specialised care when needed [10]. Recent studies focusing on Ukrainian refugees in Poland, Romania and Slovakia identified implementation barriers in mental health and psychosocial support, including language barriers, insufficient workforce capacity, trust-related problems and systemic limitations [11; 12]. These findings closely correspond to the barriers identified in the present study.

The respondents' very high interest in further education is a strong practical signal. Training needs were highest in managing aggression and strong emotions, burnout prevention, basics of crisis intervention, psychological first aid, communication with a traumatised person and work with refugees and migrants. Evidence on psychosocial interventions for refugees and asylum seekers shows that such interventions can be effective, but their implementation must consider cultural adaptation, provider training and service accessibility [13; 14]. Low-intensity approaches such as Self-Help Plus and guided self-help also illustrate the potential of structured, scalable interventions when they are delivered with appropriate training, support and linkage to accessible refugee mental health care pathways [15–18].

The study has several limitations. The cross-sectional design does not allow causal interpretation. The sample was purposive and therefore the results cannot be generalised to all helping professionals in Slovakia. The questionnaire was based on self-assessment, which may differ from objectively observed competence. Another limitation is the aggregated character of the available dataset, which did not allow group comparisons according to profession, length of practice, education or training. Future research should use individual-level datasets and should test whether training, professional background and supervision are associated with higher preparedness.

Recommendations for practice

1. Introduce systematic training in crisis intervention for first-contact helping professions. Training should cover psychological first aid, recognition of acute psychological crisis, communication with a person in crisis, basic stabilisation, assessment of suicidal risk, management of strong emotions and basic work with war-related and migration trauma.

2. Connect training with practical skills. Short theoretical lectures are not sufficient; training should include case studies, model situations, role play, de-escalation, work with interpreters and referral decision-making.

3. Develop clear methodological procedures for first contact with a person in crisis. Such procedures should include: establishing contact, ensuring safety, assessing acute risk, basic stabilisation, identifying needs, activating resources and referring to follow-up support.

4. Ensure accessible supervision and case consultation. Workers who come into contact with people in crisis should have access to individual or group supervision, case seminars and professional consultation after difficult interventions.

5. Strengthen burnout prevention and care for workers. Organisations should monitor workload,

support teamwork, provide psychological hygiene measures and implement early recognition of burnout symptoms.

6. Improve linguistic and cultural accessibility of crisis support. Qualified interpreting, translated information materials and culturally sensitive communication are needed, especially in work with refugees and migrants.

7. Create and regularly update a map of follow-up services. First-contact workers should have current contacts for psychological, psychiatric, social, legal, community and crisis services available for people with migration or refugee experience.

8. Strengthen intersectoral cooperation between health, social, psychological, educational, community and non-governmental services. Effective crisis intervention requires clear competencies and functional referral pathways.

9. Include crisis intervention in broader public health preparedness. Psychosocial consequences of crises should be considered as important as medical, material and logistical consequences of emergencies.

Prospects for further research

Further research should compare the preparedness of individual professional groups, especially health professionals, social workers, psychologists, NGO workers and crisis service workers. It should also examine whether specialised training, length of practice and availability of supervision are associated with higher preparedness for crisis intervention. Future intervention studies should evaluate the effectiveness of structured training programmes in crisis intervention before training, immediately after training and with follow-up measurement.

Conclusions

The research showed that first-contact helping professionals in Slovakia encounter people affected by war-related, migration and psychosocial crises in their practice. Despite this practical experience, their preparation for crisis intervention is not systematic and has an uneven profile. Respondents felt most confident in providing basic psychological first aid and referring a person in crisis to further professional help.

Lower ratings were found in areas related to work with people after war trauma or forced migration, management of intensive emotional reactions and knowledge of the basic principles of crisis intervention. Significant deficits were also found in organisational support, especially access to supervision, consultation of difficult cases, burnout prevention and clear methodological procedures at the workplace.

The most frequent barriers were language barriers, high psychological burden of workers, unclear competencies of individual professions, lack of follow-up services, missing methodological procedures and cultural differences. Almost all respondents expressed interest in further training in crisis intervention, which indicates strong motivation in professional practice to develop competencies in this area.

The results support the need for systematic education, methodological support, supervision, burnout prevention, linguistically and culturally accessible services and stronger cooperation between health, social, psychological, community and non-governmental sectors. Crisis intervention in war-related and migration crises should be understood as a component of public health and as an important element of system preparedness for psychosocial consequences of emergencies.

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Purpose. The aim of the study was to analyse the preparedness of first-contact helping professionals in Slovakia to provide crisis intervention to people affected by war-related and migration crises.

Materials and methods. A quantitative cross-sectional questionnaire study was conducted among 142 first-contact helping professionals working in Slovakia. Data were collected using an anonymous author-designed questionnaire focused on socio-demographic and professional characteristics, experience with people in crisis, previous training, self-assessed competencies, organisational support, barriers and training needs. Data were analysed using descriptive statistics and one-sample *t*-tests against the neutral Likert value of 3.

Results. Regular work with people affected by war-related or migration crises was reported by 34 respondents (23.9 %) and occasional work by 55 respondents (38.7 %). Repeated crisis intervention with such persons was reported by 46 respondents (32.4 %). Only 2 respondents (1.4 %) had completed certified training and 22 (15.5 %) a short course. Respondents rated themselves highest in basic psychological first aid (M = 4.44) and referral to further professional help (M = 3.91). Lower scores were found for work with war trauma or forced migration (M = 2.37) and organisational support (area mean = 2.64). The most frequent barriers were language barriers and high psychological burden of workers (both 62.7 %). Interest in further training was reported by 136 respondents (95.8 %).

Conclusions. Preparedness was moderate and uneven. Systematic training, supervision, methodological guidance and organisational support should be strengthened in services that provide first contact with people affected by war-related and migration crises.

Key words: psychological first aid, psychosocial support, refugees, provider preparedness, organisational support, supervision, burnout prevention, public health.

Мета дослідження – проаналізувати готовність фахівців допоміжних професій першого контакту в Словаччині до надання кризової інтервенції особам, які постраждали від воєнних та міграційних криз. Дослідження було спрямоване на виявлення практичного досвіду, суб'єктивно оцінюваних компетентностей, організаційних умов, бар'єрів та потреб у подальшому навчанні у сфері кризової інтервенції.

Матеріали та методи. Дослідження було реалізоване як кількісне поперечне анкетне опитування. Вибірку становили 142 фахівці допоміжних професій першого контакту, які працюють у Словаччині у сфері охорони здоров'я, соціальних послуг, психологічної допомоги, кризового консультування, неурядових організацій або центрів допомоги. Для збору даних було використано анонімну авторську анкету. Вона містила соціально-демографічні та професійні питання, питання щодо контакту з особами в кризі, попереднього навчання з кризової інтервенції, самооцінки компетентностей, організаційної підтримки, бар'єрів та освітніх потреб. Пункти самооцінки оцінювалися за п'ятибальною шкалою Лайкерта від 1 – зовсім не погоджуюся до 5 – повністю погоджуюся. Дані були опрацьовані методами описової статистики: абсолютні та відносні частоти, середні значення і стандартні відхилення. Для орієнтовної перевірки відхилення середніх значень від нейтрального рівня шкали було використано одновибірковий t-критерій відносно значення 3.

Результати. З особами, які постраждали від воєнної або міграційної кризи, регулярно працювали 34 респонденти (23,9 %), а час від часу – 55 респондентів (38,7 %). Певну форму контакту з такими особами загалом зазначили 139 респондентів (97,9 %). Кризову інтервенцію особі, яка постраждала від воєнної або міграційної кризи, неодноразово надавали 46 респондентів (32,4 %), а один раз або кілька разів – 52 респонденти (36,6 %). Сертифіковане навчання з кризової інтервенції пройшли лише 2 респонденти (1,4 %), короткий курс або тренінг – 22 респонденти (15,5 %), тоді як 57 респондентів (40,1 %) не проходили такого навчання. Найвищі середні оцінки були отримані за пунктами щодо здатності надати базову психологічну першу допомогу (M = 4,44) та знання, куди скерувати людину в кризі для подальшої професійної допомоги (M = 3,91). Нижчими були оцінки готовності працювати з особами, які пережили воєнну травму або вимушену міграцію (M = 2,37), а також оцінка організаційної підтримки на робочому місці (середнє значення області = 2,64). Найчастіше респонденти називали

мовний бар'єр і високе психологічне навантаження працівників (по 62,7 %), нечіткі компетенції окремих професій (59,2 %) та нестачу подальших спеціалізованих послуг (58,5 %). Зацікавленість у подальшому навчанні з кризової інтервенції висловили 136 респондентів (95,8 %). Одновибіркові t-тести підтвердили, що впевненість у психологічній першій допомозі та скеруванні до подальшої допомоги була статистично вищою за нейтральний рівень, а готовність до роботи з воєнною травмою, вимушеною міграцією і частина організаційних умов – нижчими.

Висновки. Результати свідчать про середній і нерівномірний рівень готовності фахівців першого контакту до надання кризової інтервенції в умовах воєнних та міграційних криз. Респонденти почуваються впевненіше в базовій підтримці та скеруванні до подальшої допомоги, але менш впевнено в роботі з воєнною травмою, вимушеною міграцією, інтенсивними емоційними реакціями та в умовах недостатньої організаційної підтримки. Практичне значення результатів полягає у потребі в систематичному навчанні, супервізії, методичних алгоритмах, профілактиці професійного вигорання, мовно й культурно доступній допомозі та посиленні міжсекторальної співпраці. Кризова інтервенція має розглядатися як складова громадського здоров'я та підготовленості системи до психосоціальних наслідків надзвичайних ситуацій. Отримані дані можуть бути використані для розробки навчальних програм, стандартів першого контакту та практичних рекомендацій для служб, які працюють з особами, постраждалими від кризи.

Ключові слова: психологічна перша допомога, психосоціальна підтримка, біженці, готовність фахівців, організаційна підтримка, супервізія, профілактика вигорання, громадське здоров'я.

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