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Mental health training experiences among Haitian healthcare workers post-earthquake 2010

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Abstract

Background—After the 2010 earthquake in Haiti, the large number of persons with major limb damage, amputations, shock, trauma, anxiety and depression placed a severe strain on mental health (MH) services.

Purpose—This qualitative study describes the impact and acceptability of a Mental Health Training Program (MHTP) implemented in the north of Haiti after the earthquake.

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Author contributions

RC: Concept development, coordination of contributors, manuscript draft, data collection and analysis. CW: Conduct data collection, review transcription of collected data, and manuscript draft. EM: Data entry, coordinate and lead data analysis, and manuscript draft. DA: Conduct literature review, draft and editing of background manuscript. GN: Manuscript review and contribution (critical revision). VM: Manuscript review and contribution (critical revision). NP: Manuscript review and contribution (critical revision)

Conflict of interest statement

The authors report no real or perceived vested interests that relate to this article (including relationships with pharmaceutical companies, biomedical device manufacturers, grantors or other entities whose products or services are related to topics covered in this manuscript) that could be construed as a conflict of interest.

Supporting information

Additional Supporting Information may be found in the online version of this article at the publisher's web-site:

Appendix S1 Focus group semi-structured guide

Methods—A total of 113 healthcare workers (HCWs) participated in a training program designed to build local MH care capacity. The training curriculum draws on literature related to MH and the impact of the Haiti earthquake. Two focus groups were conducted with 16 HCWs; discussions centred on the personal and professional impact and acceptability of the training program.

Discussion—Results demonstrated that the MHTP changed the HCWs' perceptions about MH issues and provided them with the knowledge and skills to respond to growing community MH needs. Acceptability of the MHTP was related to the content covered, to the delivery mode of the content and to the cultural appropriateness of the program.

Conclusions—Disasters of different types will continue to occur and to impact MH in communities around the world. MH training will allow nurses to quickly and effectively respond to disasters. A coordinated emergency plan that is subject to frequent review, rehearsal and evaluation is also essential.

Keywords

Disaster; Earthquake; Haiti; Healthcare; Mental Health; Prevention; Training; Trauma

Introduction

The earthquake that impacted Haiti on 12 January 2010 was catastrophic in scale. According to Budosan & Bruno (2011), '222 653 people were registered as dead, and 310 928 wounded. More than 1.5 million were in need of basic assistance, and 660 000 people were displaced' (p. 225). The disaster increased the need for health care to address serious injuries as well as acute and chronic medical conditions caused or exacerbated by the earthquake and its aftermath (Pan American Health Organization 2011). The large number of persons with amputations placed a severe strain on existing mental health (MH) services, in addition to the demands related to shock and trauma (Caron 2010; Lecomte & Raphaël 2010; Safran et al. 2011; World Health Organization 2010a). Symptoms of anxiety and depression continued to appear weeks and months after the earthquake and affected victims of all ages (Pietrangelo 2010). Several issues made the provision of MH services difficult after the earthquake. These included: lack of Haitian healthcare workers (HCWs) trained in MH care, lack of adequate infrastructure and cultural taboos associated with seeking MH services (Khouri et al. 2012; Safran et al. 2011).

Background

MH in Haiti

In Haitian culture, MH is believed to be rooted in the interface of the natural and supernatural worlds (Khouri et al. 2012). It is uncommon for Haitians to discuss MH issues, as these are not acknowledged as an illness and instead are viewed as a punishment (Dubois 2012; Kiev 1961; Pedersen & Baruffati 1985; Safran et al. 2011). Depression or anxiety, for example, may be seen as the consequence of not paying homage to a familial 'guardian angel' (or a *lwa*) who is upset (James 2008; Khouri et al. 2012; Sterlin 2006; World Health Organization 2010b). Someone with MH problems may be stigmatized, called 'crazy', 'stupid' or 'possessed', and labelled 'non-functional' or 'worth-less'. There is a belief that the angry spirit who caused the illness may harm anyone who makes contact with the ill person (Carrazana et al. 1999; Desrosiers & St. Fleurose 2002; James 2008; World Health Organization 2010a).

Khouri et al. (2012) investigated explanatory models of mental illness in Haiti's Central Plateau. Through 10 focus groups and 31 key informant interviews, they found that beliefs

in supernatural forces were not major barriers to pursuing MH treatment. Rather, major obstacles identified by the participants were a lack of treatment resources and lack of HCWs trained in MH, especially in rural Haiti.

Before the 2010 earthquake, information on MH professionals in Haiti was limited and inconsistent (Rose et al. 2011). There were only 0.2 psychiatrists per 100 000 people (Rose et al. 2011), and only 23 psychiatrists, 10 psychiatric nurses, 50 psychologists and a number of social workers, all of whom were working at two public psychiatric hospitals in Port-Au-Prince (Budosan & Bruno 2011). Availability of MH services outside of Port-Au-Prince is limited (Rose et al. 2011). Widespread networks of traditional practitioners (e.g. herbalists, religious healers) are used by many people when faced with a MH problem. This lack of MH professionals underscores the need for MH training of nurses in Haiti.

MH training program

To help address MH care issues in Haiti after the earthquake, a Mental Health Training Program (MHTP) was implemented by the University of Miami (UM) School of Nursing and Health Studies, the UM School of Education and Human Development, and the UM Miller School of Medicine. The MHTP was designed to provide Haitian HCWs with the knowledge and skills to respond to growing MH needs in Haiti. The aims of the MHTP were: (1) to increase capacity of local health professionals to triage and to provide basic MH services, (2) to promote sustainability of local MH service capacity by training a cadre of MH trainers, and (3) to evaluate the MHTP's acceptability and success in improving MH care. The MHTP is grounded in a community empowerment framework that facilitates capacity building and empowers communities to address their own problems (Laverack & Labonte 2000). The project was implemented in Cap-Haitien in partnership with the Ministry of Health in the north of Haiti and L'hôpital Justinien in Cap-Haitien. Though the northern area of Haiti was not impacted directly by the earthquake, it was flooded with evacuees from Port-au-Prince and the surrounding vicinity.

Culturally tailored interventions and training are more effective than interventions and training designed for other populations (Griner & Smith 2006). The MHTP was developed by Dr Guerda Nicolas, a Haitian psychologist who was part of the UM team and who has worked with the Haitian people. The program was designed to be culturally appropriate for HCWs in Haiti (Nicolas et al. 2009a,b) and addresses MH in the context of Haitian culture (e.g. content, group discussions). The MHTP was implemented by Haitian professionals in Haitian Creole, the predominant language of all participants.

The MHTP is a 40-h program conducted over five sessions with groups of 25–30 HCWs. A total of 113 nurses, physicians, social workers and other HCWs were trained over a period of 6 months (April to September 2011). All the participants completed the entire training. Participants received a pro-rated stipend based on the distance they travelled to the training program in Cap-Haitien.

The MHTP participants met in a community location that was easily accessible to HCWs coming from urban or rural areas in the north. Role play, participatory sessions and discussions were used to deliver the program content. Participants developed a better understanding of common MH symptoms and experiences (e.g. anxiety, depression, trauma, grief) and of the manifestation of these symptoms across different ages, genders and cultures in Haiti. They also learned effective coping and adaptation strategies to manage stress. The training sessions were conducted in Haitian Creole by two Haitian psychologists, one Haitian psychiatrist and a Haitian nurse. After completing the MHTP, participants reported that they were satisfied with the training (95.8%) and that the training had met their expectations (100%) (Cianelli 2012).

After each training cycle, three to five participants were selected to serve as trainers for subsequent training cycles. Selection criteria to serve as trainers were: demonstrated leadership, teaching ability and MH knowledge (post-training), and willingness to serve as a trainer. Thirteen HCWs were selected to become trainers. They received 8 additional hours of training for this purpose.

The purpose of this study was to describe the personal and professional impact and acceptability of the MHTP among Haitian HCWs who participated in the Cap-Haitien training sessions. This information will be used to improve and refine the MHTP for continued use in Cap-Haitien, as well as to implement the model throughout Haiti.

Methods

Design

A qualitative descriptive approach was used to elicit information from focus group participants. A qualitative descriptive method is indicated when descriptions of the phenomena are desired directly from the source. This methodology allows the researcher to remain closer to the data and to the meanings that participants attribute to their experiences. Transcribed narratives serve as the vehicle of communication from which an interpretive structure for the data may be derived (Sandelowski 2000).

Focus groups provide rich information about participants' common experiences (Duggleby 2005; Freeman et al. 2001; Van Eik & Baum 2003). In this study, focus groups were used to gather information from HCWs who had participated in the MHTP. The researchers obtained information through group discussion using a semi-structured focus group guide (Supporting Information Appendix S1).

Ethical issues

This study was approved by the UM's institutional review board. All participants signed an informed consent form prior to participating in the focus groups.

Setting and participants

HCWs who had completed the MHTP were recruited from two hospitals in Cap-Haitien and from community health centres in surrounding rural and urban areas. To be eligible to participate in the trainee focus group, participants were required to: (a) be a HCW, (b) reside and work in northern Haiti, (c) have completed the MHTP, and (d) be willing to participate in the study. Potential participants were approached by a Haitian staff member and provided a brief description of the study to determine their interest in participating. Once participants were screened for inclusion criteria, participation in one of the trainer/trainee focus groups was scheduled.

Data collection

Two focus groups were conducted with eight MHTP trainers in one group and eight MHTP trainees in the other group. The groups were held in a Cap-Haitien community centre and were led by a bilingual (English and Haitian Creole) coinvestigator experienced in facilitating focus groups. Both groups were conducted in Haitian Creole, the preferred language of the participants. Refreshments were provided prior to the focus groups to allow time for participants to speak informally with the facilitator.

The consent process was completed prior to beginning each focus group. First, the facilitator provided each potential participant with a consent form. She then read the form out loud while the trainees and trainers followed along. Next, they were provided additional time to

read the consent form on their own. After all the potential participants had sufficient time to read the form, they were provided with an opportunity to ask questions about the study and the focus group process. Any questions or concerns were addressed by the group facilitator. Participants then signed the consent form to indicate their agreement to take part in the study.

The facilitator conducted the semi-structured focus groups using a 15-item discussion guide. The items were based on the literature review and on information provided by the team that implemented the MHTP. Participants responded to questions that assessed the impact of the training, the extent to which its goals were attained and future directions for the training program (e.g. Item 3: *What are the most important aspects of the MHTP that you would like to highlight?* Item 5: *How has this training impacted you?* Item 12: *What are the potential barriers to expanding this training in Cap-Haitien and in the North area? How can we overcome these barriers?* Item 15: *What are some other needs in the community?*). Follow-up questions were used to stimulate discussion.

Each 60-min focus group was recorded using a digital recorder to facilitate the transcription process. Extra precautions were taken to ensure that the transcribed data were linguistically accurate as well as to protect the participants' privacy. Because of the linguistic complexities of written Haitian Creole, the audio recordings were translated and transcribed directly into English by a trilingual (English, French, Haitian Creole) native Haitian interpreter. To help ensure accuracy and fidelity of transcriptions, the native Haitian co-investigator (also trilingual) reviewed the transcribed focus group data while listening to the Creole audio recordings.

Data analysis

This study used qualitative content analysis to identify and define the major themes that emerged from the focus groups. Content analysis is used to recognize, code and categorize patterns from text data (Patton 2001; Sandelowski 2000). More specifically, when analysing the transcripts directed content analysis was used. This approach is recommended when there is prior literature related to the phenomenon of interest that can benefit from further description (Hsieh & Shannon 2005).

NVIVO (9) was used to conduct the analysis and to facilitate data storage. Two research team members, working independently, read through and coded each transcript. A codebook and coding sheet were developed to facilitate coding.

Broad categories emerged from the coding process. Three final themes were identified and agreed upon through consensus among four research team members. The three emergent themes described below were: (1) personal impact of the MHTP, (2) professional impact of the MHTP, and (3) acceptability of the MHTP. Within each group, saturation was achieved with these themes as the limits of the phenomena were reached.

Findings

Participant demographic characteristics

The majority of the 16 participants were women (83.3%), with a mean age of 36 ± 10.0 years (range = 24–54 years). Eight participants (50%) were single, 5 (31.3%) were married and 3 (18.7%) were in a relationship. Two participants (12.5%) reported working with no salary, 3 (18.7%) worked part-time, 8 (50.0%) worked full-time and 3 (18.7%) worked in multiple locations or sites. Eight (50%) participants were nurses, 6 (37.5%) were physicians and 2 (12.5%) were in other professions. Only one of the participants had formal training in

MH. There is no formal licensing board for practitioners in the Haitian MH system, and no regulations governing MH practice.

Many participants talked about how the MHTP had influenced their perception of the healthcare system's capacity, before and after the earthquake, to meet the MH needs of their communities:

Let me start by saying that taking care of patients with mental problems is fairly new. It's only after the earthquake in 2010, when it became evident that many people were suffering from the trauma caused by this catastrophe, that mental health was recognized as an important aspect of healthcare. Let's consider Cap-Haitien that has a population of 225 000 people! Only one psychiatrist is assigned to serve the patients with mental illnesses. The psychologists who are present on the ground belong to the AIDS program, not to the general population.

Lack of MH infrastructure and limited access to providers were cited as the most significant barriers for those in need of MH services.

Professional impact of the MHTP—Many HCWs discussed how participation in the MHTP had provided them with more specialized skills in identifying and addressing MH issues:

We learned from this training that those patients with mental problems need ... psychological and moral support. That's why we take more time now to talk to patients. We noticed that the rate of success is now higher with this method. We now offer a quality service that combines medicine with moral and psychological support. We have more tools to address and solve problems. Again, this training allows us to give a quality service to the population. We would like [the training] to continue.

Several participants who had been selected to be future MHTP trainers described changes they had seen in their practice sites that they attributed to the MHTP:

But in the emergency room where I work ... nurses take more time with patients. They give me more insight about patients, if they see that a patient needs more help they would not give up until they make sure that I take care of this patient. I am not saying they didn't care about the patients before. But this focus on dialogue, support, follow-ups was simply not there. I believe the same is true for the other departments at the hospital. I would therefore advise that the rest of the personnel also receive this training.

Focus groups also allowed us to explore participants' views on the implications of the MHTP for their practice. Several participants used metaphors and anecdotes to illustrate how concepts learned in the training program could be applied to practice: 'I think that the training we received ... is like the rain pouring on a thirsty land. This community needed such a program.'

The training has developed our ability to listen. When the patient notices that you are listening to him, he is more willing to trust you. Before, we did not pay close attention to what the patient was saying. I think this attitude frustrated them and made their situation worse. Conversely, if they see you are sharing their concerns, they will become friendlier.

Participants' confidence levels when working with patients with MH issues increased after participating in this training:

Everyone who talked earlier agrees that this training brings our knowledge of mental health to another level. Now, when we meet with a patient, we make sure that he understands that we are here for him, for his well-being, and not only to give him medicine for pain or for depression, to take his blood pressure or send him to take a test. Now, we see the patient as someone who might have fear, anxiety, who needs someone to talk to. Furthermore, this training has also improved the atmosphere in my home. When my husband comes home and acts in a way that is not normal, instead of arguing, I try to find the reasons behind his behavior. Is it a work-related problem? Is it a money issue? I try to put myself in his shoes, so I can come up with a solution. This is the same with the patient. Is it a physical problem or a psychic problem that has repercussions on the physical?

The impact of the training transcended professional practice; participants reported that it had significant personal impact as well.

Personal impact of the MHTP—Personal impact of the MHTP was described not only in terms of HCWs' personal lives, but also in terms of their personal development as healthcare providers:

I hear testimonies from people that establish a clear difference in our behavior before and after the training sessions. They all point to one direction: the change in our mindset. We are more open to dialogue; we attach more importance to communication. The impact on the patients, and therefore on the community is evident.

Participants also described the larger societal and community benefits to be derived from increasing local MH capacity: '... it would be great if we could continue with this program, because with more trainers on the ground to detect and help people who are mentally challenged, the society will be better off.'

One strategy for maximizing community impact was to target vulnerable groups for training and capacity building through the train-the-trainer model:

We have to target several social groups that exist in the northern region, continue with the training of each of those groups. If we put in place a training session for those groups, not only will it allow this training to last, but also more and more people will be trained. That will have a positive impact because until now only a few groups have been contacted or involved in this effort to spread this idea of mental health that is so important in our community. I have to correct myself by saying that some groups have been indirectly contacted because some participants in the training session belong to those groups. But we don't know, once they get home, if they apply the principles or the lessons learned in those sessions. As I said before, we have to contact those groups if we want this program to last and to cover the rest of the country.

Acceptability of the MHTP—All participants recognized the need for increased MH services, and several discussed barriers to accessing existing services, including stigma and culturally influenced perceptions of MH: 'In our culture, what really matters is the physical aspect of healthcare, not the mental aspect. Therefore, our training was incomplete until now. With this training, we are able to help patients who are sick not only in their body (physically) but also in their mind (psychologically).' Another participant said, '... in our country, when you talk about mental health, people already categorize you as "crazy". They go so far as to say that all mental health workers are also "crazy".'

Participants drew parallels between physical and MH training:

I think we should motivate more people to learn about mental health. This topic is really neglected in our country. For instance, if there is a training on cholera, a lot of people will participate because they know cholera is a very dangerous illness that can kill people very quickly. But for mental health, it's different. Because they don't have any physical symptoms, they think they are not sick. And yet, their state of health would require them to seek help from a psychologist or a professional who received this training. So, more motivation is essential.

HCWs described several barriers to the acceptability of MH problems:

One of the biggest barriers I could think of is the fact that people have some false beliefs regarding mental health, beliefs that come from ignorance, misinterpretation. The only way you can bring those people to see mental health as a real issue is to divulgate the good news, give some examples of the benefit they can get by accepting to receive a training in mental health.

Participants were not only motivated to participate actively in the MHTP, but also were readily engaged to apply knowledge in practice: 'To repeat a French saying: the more I have, the more I want to have. I really think that the training I received is just the beginning, and there is more to come. It's like we are climbing a ladder. When we get to the middle of the ladder we still are not satisfied because we want to get to the top. I am really hungry for "knowledge".'

For those selected to become trainers, the additional skill set that allowed them to teach the new content was essential for capacity building: 'As a participant in a training session, the first concern you have when you finish is to apply on the ground what you have learned. As a trainer, it's different. You must be able to transfer the knowledge that you acquired. This requires another approach, another level of competency.'

I think knowledge is a durable good, conversely to money that can be lost quickly. What you learn today will last forever. I would like this training to continue not only in Cap-Haitien, but through the whole country because anxiety is everywhere, especially after the earthquake. People who do not know much about mental health care think of those symptoms as "unnatural". For those beliefs to go away, they have to know more about this topic.

All participants acknowledged that MH was a neglected issue nationally. They agreed that capacity building for HCWs, as well as the expansion of MH training capacity, was needed.

Discussion

The study findings contribute to the knowledge base on MH training among HCWs in Haiti. Given the lack of research on MH in Haiti, it is essential to improve our understanding of the personal and professional impact and acceptability of the MHTP. This knowledge will help us implement the MHTP in other parts of Haiti as well as in other countries.

Results demonstrated that the MHTP changed the HCWs perceptions about MH issues and provided them with the knowledge and skills to respond to growing community MH needs. The HCWs trained in the MHTP reported feeling empowered and ready to address MH issues in their practice. They also reported feeling ready to expand their work to other communities to help change the perception of MH issues in Haiti. These outcomes clearly reflect the community empowerment framework on which the MHTP is based (Laverack & Labonte 2000).

MH issues in the Haitian culture have been associated with supernatural or evil influences. As a result, the culture does not tend to recognize MH issues as illness (Dubois 2012; Kiev

1961; Pedersen & Baruffati 1985). This cultural understanding of MH issues has historically interfered with the development of MH prevention programs, as well as with the inclusion of MH essentials in the academic curriculum for nurses, physicians and other HCWs. Despite these culturally held beliefs and attitudes about MH, participants in the MHTP demonstrated that they were amenable to change.

Implications for nurses/MH workers

Implications for education and policy

The dearth of MH training was discussed by study participants, who lack appropriate knowledge, skills and resources to care for people suffering from MH issues. Mandatory MH education should be included in the academic curriculum for nurses and other HCWs, as well as in continuing education programs in every healthcare centre in Haiti. MH education will help Haitian HCWs to increase their knowledge, reduce their stigmatizing attitudes and increase their comfort in talking about MH with people in the community.

Research implications

Findings from this study can encourage the Haitian healthcare and scientific community to conduct further research to investigate cultural and other aspects of MH in Haiti, and to consider the widespread implementation of the MHTP across the country. The acceptability of the MHTP by the HCWs was related to the culturally sensitive approach integral to this program, to the specific content covered and to the format for delivery of that content. Thus, the MHTP is a program that can mobilize HCWs to serve as leaders and trainers in the MH field, with practical benefits for the health and MH of families and communities throughout Haiti. The importance of conducting research related to culture and MH is applicable to other countries that may confront problems similar to Haiti. Furthermore, the interdisciplinary nature of MH calls for collaborative research efforts nationally and internationally. Efforts in research can be directed to investigate strategies to build nursing networks in MH and disaster preparedness and response (World Health Organization 2006).

Conclusion and global implications

Although this paper focused on MH issues in Haiti, the findings may be applicable to other countries in the region. Disasters of different types will continue to occur and to impact MH in communities around the world. Nurses are the largest group of HCWs who respond to these catastrophic events. MH training can prepare them to quickly and effectively contend with disaster situations, and to recognize and address the immediate and longer term MH needs arising from these events. A coordinated emergency plan that is subject to frequent review, rehearsal and evaluation is also essential. Member states should develop a mechanism to ensure that nurses and midwives are involved at all levels in decision-making and strategic planning related to disaster nursing preparedness and response (World Health Organization 2006) as well as to build the capacity of nurses and midwives related to MH including this component in the curricula and in continuing education programs.

The train-the-trainer model provides an effective approach to train and maintain a critical mass of nurses with the capacity to provide MH care, and who are prepared to implement these skills in a disaster. By increasing disaster response awareness, nurses can develop appropriate interventions to combat the negative MH effects of a natural disaster. International and US experiences in disasters also stress the importance of nursing as a key component to respond effectively in these situations (Adams et al. 1999; Guscott et al. 2007; Nasrabadi et al. 2007; Yang et al. 2010). To improve acceptability, study findings stressed the importance of developing or adapting culturally sensitive training programs to be replicated in other settings nationally or internationally. Such training can position nurses as

leaders on the frontlines of care and support for individuals confronting MH health problems after a disaster, with practical benefits for the health and MH of families and communities.

Limitations

The results of the study reflect the perceptions of a subgroup of HCWs who resided in the north of Haiti; therefore, findings cannot be generalized to other HCWs in Haiti or in other countries. Additional research is needed to investigate the effectiveness and acceptability of MH care provided by the HCWs posttraining, and to assess the applicability and acceptability of the MHTP in other parts of Haiti and in other countries in the region.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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