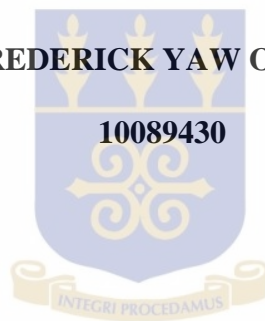


**SCHOOL OF NURSING
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA
LEGON**

**EXPERIENCES OF COMMUNITY PSYCHIATRIC NURSES IN THE
DISCHARGE OF THEIR DUTY: A STUDY IN THE ACCRA METROPOLIS**

FREDERICK YAW OPARE



**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN
PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF
MPHIL NURSING DEGREE**

JULY, 2013

DECLARATION

I, Frederick Yaw Opere hereby declare that this thesis is the outcome of my own study undertaken under the guidance of Dr. Mrs. Patience Aniteye, School of Nursing, University of Ghana, Legon and Mr. Gladstone Fakor Agbakpe, Department of Psychology, Methodist University College. References made from other researchers and writers have been duly acknowledged. None of the materials contained in this thesis have been presented either wholly or partially to any institution for a degree.

.....

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.....

Date

We, the underlisted accept this thesis as conforming to the required standard



.....

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Date

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(Supervisor)

.....

Date

Experiences of Community Psychiatric Nurses

DEDICATION

I dedicate this work to my lovely family Mercy, Ena, Nuna and Klenam. Thank you for your support, love and patience. Also, to Reverend Joseph Abbotsi for believing in me and my good friend, Maame Amponsah for her continuous prayers for me.



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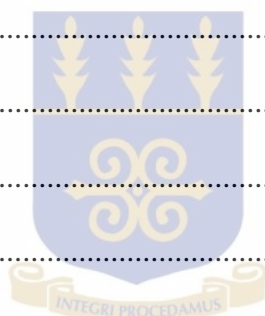
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LIST OF ABBREVIATIONS

APNA	American Psychiatric Nurses Association
APNM	Association of Psychiatric Nurse Managers
CMHN	Community Mental Health Nurse
CNS	Clinical Nurse Specialist
CPN	Community Psychiatric Nurse
GP	General Practitioner
NP	Nurse Practitioner
PMH-APRN	Psychiatric Mental Health Advanced Practiced Registered Nurse
PMHN	Psychiatric Mental Health Nurse
WHO	World Health Organisation

ABSTRACT

This study sought to explore the experiences of Community Psychiatric Nurses (CPNs) in the discharge of their duty. An exploratory descriptive qualitative design was used in this study. The study was conducted in the Accra Metropolis. Thirteen participants working in the six districts of the Community Psychiatric Units of Ayawaso, Osu-Koltey, Ablekuma, Okai-koi, LEKMA, and Ashiedu-Keteke in the Accra Metropolis were used. Purposive sampling method was used to select participants with more than 3 years working experience from each Community Psychiatric Unit. A semi-structured interview guide was the tool for data collection. The major findings included difficulty locating the homes of patients due to poor home addresses and transportation, limited logistical support and irregular supply of medications. Also, there were stigmatization of the CPN, assaults from patients and the negative attitudes of relatives of patients which led to relapses. Participants had the expectation that risk allowances should be given in the event of any injury sustained whiles working. They also emphasized the need for recognition from their employers, support from stakeholders as well as Training and certification of CPNs. Various coping strategies such as reducing stigma, religion, self-motivation and reduction in home visits were employed to deal with the challenges. Based on these findings, recommendations were made to help address the challenges of the Community Psychiatric Nurses in the Accra Metropolis. Among them were: the employer and management of the various health care facilities should provide the CPNs with transport to facilitate access to their clients in the community. There should be media involvement in educating the general public on mental health issues to reduce the stigma of mental health and mental illness. The Ministry of Health in collaboration with stakeholders should embark on the training and certification of CPNs for their recognition.

CHAPTER ONE**1.0 Introduction**

Psychiatric Mental Health Nursing (PMHN) is a specialty within nursing. Psychiatric mental health registered nurses work with individuals, families, groups, and communities, assessing their mental health needs. The PMHN develops a nursing diagnosis and plan of care, implements the nursing process, and evaluates it for effectiveness (APNA Annual Activity Report, 2009). Psychiatric Mental Health Advanced Practice Registered Nurses (PMH-APRNs) offer primary care services to the psychiatric-mental health population. PMH-APRNs assess, diagnose, and treat individuals and families with psychiatric disorders or the potential for such disorders using their full scope of therapeutic skills, including the prescription of medication and administration of psychotherapy. PMH-APRNs often own private practices and corporations as well as consult with groups, communities, legislators, and corporations (APNA Annual Activity Report, 2009).

Advanced practice registered nurses (APRNs) apply the nursing process to assess, diagnose, and treat individuals or families with psychiatric disorders and identify risk factors for such disorders (APNA Annual Activity Report, 2009). They also contribute to policy development, quality improvement, practice evaluation, and healthcare reform. The practice of the psychiatric mental health nurse (PMHN) as a Clinical Nurse Specialist or Nurse Practitioner is considered an advanced specialty in nursing. APRNs practice as Clinical Nurse Specialists (CNSs) or Nurse Practitioners (NPs) and their training prepares them to work as professors, researchers, or administrators (APNA Annual Activity Report, 2009). According to the Association of Psychiatric Nurse Managers (APNM) (2003), up to the 1960s the activities of psychiatric nurses in Ireland were based in hospitals. The introduction of the new psychotropic medicines significantly influenced the

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decision to discharge some patients into the community to be cared by nurses who had cared for them in hospitals. While more and more patients were discharged into the community, the nature of psychiatric nursing care did not change much until the mid-1980s, unlike in the UK, where it happened almost a decade earlier. Sheridan (2000) described the year 1984 as a “watershed” in the history of psychiatric nursing services in Ireland. This was mainly due to the publication of the policy document: *Psychiatric Services Planning for the Future* (Department of Health, 1984). This policy provided the much needed momentum for the significant shift towards community care. However, the necessary changes in curriculum and training to equip nurses for their substantially more community-based role did not follow (Sheridan, 2000). The psychiatric nursing profession, however, was instrumental in developing the changing role of psychiatric nurses in the community (Sheridan, 2000). This was fuelled by changes in other countries and in response to the needs of patients and the context in which nurses operated.

Prior to the 1960s, psychiatric nurses’ role in Ireland was mainly custodial. This changed as there was a pressing need to rehabilitate patients who were discharged into the community. According to the new policy, psychiatric nurses in their community were to finally relinquish their custodial role in favour of a therapeutic one (Sheridan, 2000). However, the extent to which nurses’ roles were therapeutic or the way they perceived their therapeutic role was not known.

In the 1960s, because of the then de-institutionalisation movement, much of the care provided by hospitals was shifted to the community (Johnson, 2000). It was estimated that the readmission rate for discharged patients was approximately 40-50 percent within a year of discharge from the hospital (Vasudeva, Kumar & Sekhar, 2009). In New York State for example, more than 60 percent of all admissions to the state hospital were readmissions and for many patients, re-hospitalisation had become a way of life. Mentally ill persons who had been admitted, treated and discharged home were subjected to problems leading to relapses.

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The environment in which psychiatric patients are treated has an impact on both the patient's behaviour and the outcome of treatment. In the past when patients were institutionalized, their aggressive outbursts were strikingly diminished. Before the process of de-institutionalization occurred, psychiatric hospitals often had to deal with unruly, aggressive patients. As a result, it is acceptable that Community Psychiatry will have much to offer in curbing such abnormally aggressive outbursts. (Lichtigfeld & Gillman, 2000).

According to the Department of Psychiatry, University of Ghana, Medical School, in the early years of the 18th century, mentally ill persons were segregated and incarcerated with common criminals in Ghana. In 1888, the colonial government passed a legislative ordinance to provide custody for lunatics. The old high court in Victoriaborg, Accra was converted to an Asylum. In 1904, the total number of the mentally ill persons had risen to one hundred and four (104) but the facility was inadequate. In 1906, the present Accra Psychiatric Hospital was built and one hundred and ten (110) patients were admitted and they were supervised by sixteen (16) untrained nurses and a visiting doctor. In 1951, the first African Psychiatrist a Gambian doctor named Forster, was appointed to the Asylum. He started using chemical means to restrain the patients. After two years of opening, the population doubled and the hospital became crowded. In spite of additional extensions and establishment of other facilities, overcrowding continues to confront the hospital today. It soon became evident that one hospital could not provide services for the country with a population of over six (6) million so the first president of Ghana, Doctor Kwame Nkrumah expanded the hospital and established the Adome resettlement project for the chronically ill patients. Later the Ankafu Psychiatric Hospital was built in 1966. The two hospitals could still not accommodate the increasing number of patients reporting for treatment. In 1974, the Pantang Psychiatric Hospital was unofficially opened to ease the

congestion in the two previous hospitals (Department of Psychiatry Medical School, 2003).

Community Psychiatric Nursing, a component of the psychiatric nursing management provided for the patients who are treated and discharged was introduced. It was introduced in 1973 by a World Health Organisation (WHO) nurse named Pearl Alderson as a pilot project based on a therapeutic community in one of the wards at the Accra Psychiatric Hospital. Some nurses underwent orientation in the programme. The programme went on well and patients in the programme recovered within shorter periods. However, when given trial leave, the patients would readily relapse and be re-admitted. To remedy the situation, the therapeutic community programme was extended into the communities where the illness started. In 1981, psychiatric out-patients' clinics were established in some districts and regional capitals to assist discharged patients in the community (Department of Psychiatry Medical School, 2003).

Bukari (2007) defines Community Psychiatric Nursing as a branch of professional nursing that utilizes both human and natural resources in the promotion and maintenance of mental and physical health. The Community Psychiatric Nurse acts as a bridge between the hospital and the community. For instance, at the Accra Psychiatric Hospital, patients on admission who are discharged are referred to the Community Psychiatric Nurses' Unit of the hospital for their particulars to be duly filed before going home. This is done in order to facilitate continuity of care in the communities. The duties performed by the Community Psychiatric Nurses include home visits of discharged psychiatric patients, creating awareness and promoting mental health in the community, identifying and managing cases, referring cases to the next level of care, providing after-care services (including outpatient care in the districts and regions (Bukari, 2007).

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Community mental health care exists in Ghana; however, it is not well developed. According to Asare (2003) there were 120 Community Psychiatric Nurses (CPNs) working in all ten regions of the country, but some regions may have just one or two CPNs. The nurses were not distributed evenly throughout the country, and only 70 districts out of the then 170 were covered by at least one CPN. To become a CPN, a psychiatric nurse has to train for three to six weeks on the job after their completion of the mental nursing course but without a certificate.

In spite of the roles performed by the Community Psychiatric Nurse, the public is not aware of the existence of these resource persons (Bukari, 2007). As a result, mentally ill persons are often sent to the Psychiatric Hospitals to seek health care which may lead to admissions and therefore a heavy burden on the nurses. Montia (2007) in his study of the discharge rate of psychiatric patients revealed that seven hundred and thirty-six (736) patients from the Accra and Pantang Psychiatric Hospitals were well enough to go home. He also showed that in 1990, one thousand eight hundred (1,800) destitute persons were sleeping openly in the streets of Accra, 70% of whom were ex-patients of the mental hospitals. The assessment also found that 60% came from various parts of Ghana while 20% were from neighbouring countries for example, Togo, Niger, Burkina Faso, Ivory Coast, and Mali. These discharged patients are often cared for by community psychiatric nurses. This underscores the role of the community psychiatric nurses in the discharge of health services.

According to Cowen (2005) Community Psychiatric Nurses now focus their attention almost entirely on people with enduring mental illnesses and undertake case management roles in community teams. Many nurses have now been trained in the use of psychosocial interventions and there have been particular advances in the training of nurses in medication management.

The role of the Community Psychiatric Nurses are multiple and important in health care given the WHO definition of health as a “state of complete physical, mental and social wellbeing of an individual and not merely the absence of disease or infirmity”. Their needs and challenges need to be explored through a scientific research and the current study was designed to fulfill this purpose.

1.1 Statement of the Problem

There are three major psychiatric hospitals in Ghana namely the Accra Psychiatric Hospital, the Ankaful Mental Hospital and the Pantang Mental Hospital (Mind Freedom, 2005). There are however, psychiatric wings or units attached to all the general hospitals and the Polyclinics in the Greater Accra Region and these have contacts with Pantang and Accra Psychiatric Hospitals but these hospitals are located in the southern part of Ghana. As such, all patients have to be brought from the middle and northern parts of the country for treatment thus creating congestion in these few hospitals. To decongest these Hospitals, community care becomes important. Available statistics from the Accra, Ankaful and Pantang Psychiatric Hospitals between 2007 to 2012 showed the following:

Table 1.1: Distribution of patients by record at the Accra Psychiatric Hospital

ITEM	2007	2008	2009	2010	2011	2012
ADMISSION	2939	2152	3918	3648	3626	3921
DISCHARGE	3001	3505	1800	2925	2873	3565
READMISSION	1111	1041	1796	1757	3390	2076

Table 1.2: Distribution of patients by record at the Ankaful Psychiatric Hospital

ITEM	2007	2008	2009	2010	2011	2012
ADMISSION	1569	1507	1534	1425	1290	710
DISCHARGE	1543	1558	1634	1347	1190	735
READMISSION	273	536	562	394	337	274

Table 1.3: Distribution of patients by record at the Pantang Psychiatric Hospital

ITEM	2007	2008	2009	2010	2011	2012
ADMISSION	1318	1415	1636	1539	1401	594
DISCHARGE	1282	1407	1735	1105	1325	557
READMISSION	639	689	806	730	601	282

The above figures clearly show that discharged patients from the psychiatric hospitals must be followed up by the Community Psychiatric Nurses in order to facilitate continuity of care thus preventing relapses and re-admissions. This therefore makes the work of the community psychiatric nurses important.

Community Psychiatric Nurses in Ghana perform a unique role in the discharge of their duties both within the communities they serve, as well as the hospitals. According to Bukari, (2007), recent statistics indicate that there are two hundred and sixty (260) Community Psychiatric Nurses in Ghana with only sixty-eight (68) in the Greater Accra Region whiles the remaining are serving in various parts of the country. The reason for this low number is associated with non-certification of the practitioners, non-availability of risk allowances or insurance for the injured in the course of their work, and lack of interest by some mental health nurses to go into community psychiatric nursing (Bukari,

2007). Furthermore, families of persons with mental illness tend to neglect their relatives because of stigmatization of mental patients. Stigmatization, and lack of understanding of mental illness in the country, is a major problem that worsens mental illnesses (Bukari, 2007).

Additionally, an observation of the community psychiatric nurses revealed that, they face some challenges in the discharge of their duty such as wrong home addresses hence making home tracing of patients' difficult, uncooperative relatives of patients, inadequate transportation, shortage of staff, low morale and non-compliance to medications by clients leading to relapses and readmissions.

A recent publication in the *Daily Graphic*, January 13th, 2011 by Adam captioned “600 face ejection at the Accra Psychiatric Hospital” pointed out that about 600 patients who had been treated and cured of their mental illnesses at the Accra Psychiatric Hospital had been discharged home to reconcile with their relatives. This was an attempt to decongest the wards and ease the heavy burden on the nurses. To facilitate the integration of the discharged patients into the community, the community psychiatric nurses' work becomes important. Community care is critical in mental treatment; community care makes patients feel a part of the community, instead of being chained in hospitals.

In spite of the important role the community psychiatric nurses play, the researcher could not find any study about them in the Ghanaian society therefore no scientific statement can be made in the Ghanaian context. In view of this, the researcher seeks to explore the experiences of Community Psychiatric Nurses in the discharge of their duty in the Accra Metropolis.

1.2 Purpose of the Study

The purpose of this study was to explore the experiences of Community Psychiatric Nurses in the Accra metropolis.

1.3 Objectives of the Study

The objectives of the study were to:

- describe the experiences of Community Psychiatric Nurses.
- identify the expectations of Community Psychiatric Nurses.
- identify challenges faced by Community Psychiatric Nurses.
- describe strategies used by Community Psychiatric Nurses to deal with the difficulties.

1.4 Research Questions

The study sought to find answers to the following research questions:

- What are the experiences of Community Psychiatric Nurses?
- What are the expectations of Community Psychiatric Nurses from their employers?
- What challenges do Community Psychiatric Nurses face in their work?
- What are the strategies used by Community Psychiatric Nurses to deal with the difficulties?

1.5 Significance of the Study

As there is paucity of research in this area in Ghana, the researcher sought to obtain information about the experiences of the Community Psychiatric nurses. This will enable the community psychiatric nurses in Ghana to be able to identify areas of concern with regard to knowledge and development required to further advance Community Psychiatric nursing practice.

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It is also envisaged that data generated through this inquiry will contribute towards building this information base, future research and pave the way for other nurses who may wish to pursue research in the field of Community Psychiatric Nursing.

Also the findings of the study will illumine the needs of community psychiatric nurses (including training needs) and issues concerning their certification. This would help enhance job satisfaction and recognition for the nurses.

1.6 Definition of Terms

Community Psychiatric Nurse: A Registered Mental Nurse who supervises the management of discharged mentally ill persons and their relatives in the community.

Experience: The challenges, frustrations or difficulties undergone or faced during community psychiatric practice.

Mental Patients: Anybody with a history of a mental disorder who has been discharged home and receiving care from a community Psychiatric Nurse.

CHAPTER TWO**LITERATURE REVIEW****2.1 Introduction**

In reviewing the literature, databases were used. Major among them were PubMed, Hinari, JSTOR, nursing journals and abstracts. Literature was also sought from different journals. The key words for the search were “Community Psychiatric Nursing”, “Experiences of Community Psychiatric Nurse”, “Role of the Community Psychiatric Nurse”. Not much work has been done in this area hence most of the research works reviewed were based on clinical work.

The review on research work related to the experiences of community psychiatric nurses in the discharge of their duty was divided into four key areas. These were 1. The kinds of experience Community Psychiatric Nurses go through. 2. The expectations of Community Psychiatric Nurses from their employers, 3. Challenges Community Psychiatric Nurses face in their work, 4. Strategies used by Community Psychiatric Nurses to deal with the difficulties.

Community psychiatric nursing is well established as a profession in many countries across the world (WHO 2007). Research is mostly UK-based but increasing in other countries (Bellali & Kalafati 2006, Elsom, Happell & Manias, 2007, Holst & Severinsson 2003, Wallace, O’Connell & Frisch, 2005).

Community Psychiatric Nursing refers to a treatment philosophy based on the social model of psychiatric care that advocates that a comprehensive range of mental health services be readily accessible to all members of the community.

2.2 Experiences of the Community Psychiatric Nurse

Olofsson and Norberg (2001) conducted a study on the experiences of coercion in psychiatric care as narrated by patients, nurses and physicians in Canada. The aim of the study was to increase understanding of psychiatric patients', nurses and physicians experiences of coercion, in relation to their own and other parties' experiences. Seven triads of patients, nurses and physicians narrated their experiences of the same coercive event. Twenty-one interviews were analysed focusing on narrative elements. The results of the study pointed out that the nurse and physician narratives showed that they felt unable to connect with patients, while the patients mentioned that they wanted more human contact with nurses and physicians. All the three parties expressed the belief that interpersonal relationship and human contact were important. The nurses and physicians stated that knowing the patient made them feel easier about using coercion and that their actions were less violating for the patient. The patients stated that human contact alleviated their feeling of discomfort and made them feel more secure when subjected to coercion.

Svedberg, Hallstrom and Lutzen (2000) undertook a qualitative study on the experience of community psychiatric nurses on the morality of treating patients with depot neuroleptics in Sweden. The aim of the study was to gain an understanding of the meaning that community psychiatric nurses attach to their everyday interactions with patients on depot neuroleptic treatment situations. Nine experienced community psychiatric nurses were interviewed using semi-structured, open-ended questions. Data analysis was done by the phenomenological descriptive method. Four themes were identified which highlighted aspects of the moral meaning of treating patients with depot neuroleptics: 1. 'benevolent justification' occurs when nurses perceive that the patient's welfare is at stake; 2. 'inability to advocate the patient's best interest'; this occurs when

nurses feel they are at a disadvantage; 3. 'accomodative interactions' also occur when nurses are able to respond to a patient's expressed needs; and 4. 'acceptable advocacy' occurs when physicians are sensitive to nurses' suggestions on patients' treatment. The findings from the study indicated that treatment care planning involving both patients and nurses is essential to enhance patients' autonomy, which is a precondition for satisfactory interactions. The study illumined the meaning that nurses give to administering depot neuroleptic injections to patients in the context of community psychiatric clinics. The phenomenon of major concern was identified as the moral aspect of the interactions with individual patients in the treatment situation.

Mccardle, Parahoo and Mckenna (2007) in their study indicated that, increasingly people with mental health problems in Ireland and in the U.K, are receiving mental health services in the community. The aim of the study was to identify the predominant approaches to care used by community psychiatric nurses and the theoretical bases of their practice. One hundred and sixteen questionnaires out of 203 sent to community psychiatric nurses throughout Ireland were returned, giving a response rate of 57.1%. In addition, 33 home visits by 13 community psychiatric nurses were observed. The findings showed that over 96% of the sample were in full-time employment; most (71.4%) worked a 5-9 weekly shift; 31% had a post registration counselling qualification, and about a quarter were based in hospitals. The average caseload size was 61 and the service was predominantly a closed referral one. The main client care activities were: assessment of clients' medication management, health promotion, and client and family support. From the researchers' observations, there was no evidence of community psychiatric nurses practising cognitive, behavioural therapy or family therapies to any greater extent. The study however provides baseline data for monitoring trends in community mental health

nursing in Ireland, and for informing future policy regarding service provision and training of community psychiatric nurses.

Badger and Nolan (1999) researched into General Practitioners'(GP) perceptions of community psychiatric nurses in primary care in Birmingham in the United Kingdom. The study results revealed that, the management and responsibility for the care of people with mental health problems in the community is increasingly being assumed by General Practitioners (GPs) and primary care personnel. According to the researchers, as primary care groups evolve, so must their expertise in managing people with a wide range of mental health problems. It is expected that all mental health professionals will participate in this development, although it is likely that community psychiatric nurses will be the largest professional group involved, with a significant part to play in the shaping, management and delivery of mental health services. The researchers indicated that to date, there has been little research into how community psychiatric nurses are perceived by other primary health care professionals. The study sought to provide insight into how GPs assess the contribution of community psychiatric nurses in primary care. Overall, the results of the study suggested that the GPs view community psychiatric nurses favourably and consider that they have an important role to play. Greater involvement in primary care raises issues about the education and preparation of community psychiatric nurses, their professional development and supervision needs.

O'Brien (2000) conducted a study in Scotland with the aim of constructing an interpretation of the experience of nurse-client relationship in the context of community psychiatric nursing. Hermeneutic phenomenology formed the framework of the study. Shared conversations were conducted with five (5) experienced community psychiatric nurses and five (5) clients. Themes of 'Being there', 'Being concerned', 'Establishing and Facilitating transition were identified from the nurses' conversations. This thematic

structure was used to illuminate the centrality of the nurse-client relationship, and to articulate the skills that are involved in establishing and maintaining the relationship with clients with mental illness.

Barlow (2006) carried out a study to determine the perceptions of the role of the community psychiatric nurse. The researcher's aim was to use a small-scale study to explore the self-perceived differences between contributions of community psychiatric nurses and other members of a multidisciplinary community mental health team for older people. Four community psychiatric nurses and five (5) other professionals completed questionnaires consisting of a series of open-ended questions in order to collect qualitative responses. The questionnaires were analysed on a thematic basis. The results of the study indicated that community psychiatric nurses' skills' seemed to be recognised and valued by their multidisciplinary colleagues. However, the community psychiatric nurses did not appear to appreciate this; the attributes identified by community psychiatric nurses were not always the same as those identified by their colleagues. The researcher pointed out that there did not appear to be any consensus among the community psychiatric nurses, yet their colleagues seemed to feel that the community psychiatric nurses' role was reasonably clear.

2.3 Expectations of the Community Psychiatric Nurse

Reda (1995) carried out a study on staff perception of their roles during the transition of psychiatric care into the community. The objective of the study was to investigate the staff's experiences involved in the process of the transition of 20 non-demented long-stay psychiatric patients. Staff members expressed satisfaction from working outside the hospital. They believed that the patients' condition and their quality of life had improved and that they were likely to achieve successful resettlement after a lengthy process of

rehabilitation. However, staff members considered their roles as demanding and involved a lot of domestic activities. They therefore recommended gradual and slow preparation for patients, and an educational programme for the public as well as appropriate preparation and continual professional support for staff.

Johnson and Montgomery (1999) conducted a study on chronic mentally ill individuals reentering the community after hospitalization in Canada. The aim of the study was to explore the experiences of persons reentering an urban community after hospitalization for mental illness using a qualitative study. The sample consisted of five men and three women, aged from early 30s to mid-50, mostly diagnosed with schizophrenia, and who had had several hospitalizations within the previous year. Most returned to places where they had lived before, frequently to boarding homes for former psychiatric patients. Most of them lived alone. Each participant was interviewed shortly before discharge and one to two times in the community. Tape-recorded interviews were analyzed according to the “Giorgi” method. Three themes emerged from the data, related, respectively, to the hospital and its environs remaining a focus of the participants’ lives, the added burden of social and financial conditions, and the presence of goals which nevertheless had barriers to their achievement. Contrasts were drawn with the findings of an earlier study, in which there was found a much stronger sense of discharge marking a new beginning. The findings not only add to the knowledge about what it is like for chronic mentally ill individuals to live outside hospital, but also raise questions about the influence of particular diagnoses, community characteristics in adjustment overtime.

Adam, Tilley and Pollock (2003) conducted a study on what people with enduring mental disorders value about CPNs and CPN services in Scotland. The study involved the qualitative analysis of interview data which sought the views of people with enduring mental disorders regarding services provided by CPNs and what these people value in

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working with CPNs. Thirteen people took part in semi-structured interviews, and data were analyzed using strategies including thematic analysis. The main finding was that people value their interpersonal relationship with CPNs. This relationship has a specific function in the individual's overall social network. The CPN-person relationship forms the context of 'purposeful talk', and is shaped and developed through the talk. It provides comfort and a greater sense of confidence with which people can cope with daily life. A valued feature of the personalized relationship with CPNs is continuity, associated with regularity of contact with CPNs, accessibility (both physical and emotional) and respect for commitment to people as individuals. The finding further interprets CPNs, as they appear in these accounts given by people with enduring mental disorders, as 'beings-between', bridging symbolically the worlds of hospital and community. They are figures between 'friends' and professionals, to whom people who have been ill can relate and show feelings which would, if otherwise expressed, compromise participation in the community. CPNs help sustain people experiencing 'illness in the context of life' and enhance their potential for participation in the community. In doing so they contribute to public health, viability of sustaining relationships and personal care, which is valued at the micro-level of interaction, depends on support at the meso-level by managers, and at the macro-level by policy makers and funders. The study recommended that health service managers who play a key role in instigating and managing service changes should engage in regular dialogue with CPNs about the impact of change on the ability of CPNs to sustain relationships with people. The adaptability of CPNs to the situation and the person in the situation needs to be facilitated, not compromised, by the requirements of record keeping and accounting systems. Practice described in this study indicates the possibility of CPNs relating to the person in ways consistent with a 'community development approach'.

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Kelly, Long and Mckenna (2001) revealed that since the early 1990s, clinical supervision has been the subject of debate by nurses, academics and practitioners. This debate has encouraged the adoption of clinical supervision by the profession throughout the United Kingdom. Their aim was designed to redress this information deficit. The current position of clinical supervision in relation to community psychiatric nursing in Northern Ireland was explored and evaluated. A survey approach was adopted in collecting data from community psychiatric nurses in Health and Social services trusts in Northern Ireland. Data was obtained relating to practice of clinical supervision and to attitudes of community psychiatric nurses, their managers and supervision. Further results indicated that there was support for clinical supervision and that it was being implemented within community psychiatric nursing in Northern Ireland, although not in all cases. However, the findings indicated that serious education and training deficits exist, and the importance of the interface between managerial and clinical supervision was emphasized. The issues of providing effective education and training in supervision skills, and the uncertainty that was highlighted regarding fundamental concepts underpinning clinical supervision have implications for nursing practice, education and management.

Hannigan (1997) conducted a study on the challenge for community psychiatric nursing and posed the question “is there a future in primary health care”? pg 753. He stated that the growing debate surrounding the role of the community psychiatric nurse in the United Kingdom is reviewed. Issues which have attracted significant interest and which formed the focus of the author’s article were the prioritization of community psychiatric nurse services, community psychiatric nurse attachment to primary health care, and the effectiveness of clinical interventions. The requirement for community psychiatric nurses was how to concentrate services on people experiencing severe and enduring mental health problems. Innovative and effective clinical social interventions for this client group

were beginning to disseminate into everyday community nurse practice. Problem-solving family interventions, cognitive therapies and case management were three such examples. The past, present and possible future role for community psychiatric nurses working in primary health care settings with people experiencing non psychotic mental health problems was an important focus of the authors who thus concluded that there is a foreseeable future role of community psychiatric nurses in primary care.

Wells, Bergin, Gooney and Jones (2009) conducted a study on views on nurse prescribing. The study reported on the views of community mental health nurses on nurse prescribing. Data were gathered through a 13-item questionnaire administered to 103 members of the Association of Community Mental Health Nurses in Ireland. The results of the study indicated a distinct difference of view between male and female community mental health nurses, with female nurses having greater reservation towards the desirability of nurse prescribing in relation to educational preparations and impact on professional relationships. Overall, only 17% of respondents favoured being supervised in their prescribing practice by their consultant psychiatrist. The authors concluded that there is ambivalence towards prescribing in this important group of nurses which may need to be taken into account if nurse prescribing is to be successfully implemented within the Irish mental health service context.

Bellali and Kalafati (2006) researched Greek psychiatric care reforms: new perspectives and challenges for community mental health nursing. The purpose of the study were reportedly two fold; firstly, to explore the main issues of psychiatric care reform in Greece and outline the operating structures of psychiatric care and rehabilitation. Secondly, the research sought to explore the implementation of mental health services such as supervisor-therapist, liaison coordinator-crisis interventionist and counselor-trained within the context of a multidisciplinary therapeutic team. Given that the multiple

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professionals were involved in mental health care in primary care, issues of their roles were likely to be crucial to the effective implementation of care reforms by the new workers. Moreover, there is evidence of ambiguity in the roles of different mental health professionals in primary care, relating to the problems they manage and the treatments they provide. The researchers believed that more emphasis needs to be given to the mental health nursing specialty in Greece, because the vast majority of patients requiring mental health care should have care as the psychiatric structures at the community are continuously developing.

Holst and Severinsson (2003) conducted a study to examine factors that may have an influence on the collaboration between the health care professionals in a psychiatric hospital and two community psychiatric health service departments. Interviews were conducted with three psychiatric nurses, one medical practitioner, one health and social manager and one cultural worker from each community; thus a total of nine informants. The transcribed interview texts were analysed by means of qualitative content analysis. The main findings of the study showed that community psychiatric nurses felt a need for more systematic interdisciplinary collaboration. The existing collaboration was characterized by ad hoc meetings. In addition, the need for information about their colleagues' professional competence was reported. The respondents called for a more regular forum for professional guidance and coordination in relation to particular client cases in order to improve the quality of psychiatric care. There was also a need for collaboration within community health care and a link to psychiatric hospital care in order to better evaluate the outcomes of care provided. The authors concluded that the lack of continuity in the collaboration between health care professionals may affect the quality of community health services because continuity is a vital component of care.

2.4 Difficulties Faced by Community Psychiatric Nurses

A study was conducted by Simpson (2005) on factors that either facilitate or constrain the ability of community psychiatric nurses, in their role as care co-ordinators, to meet service users' and carers' needs. A multiple case study of seven sectorised community mental health teams was employed over 2 years using predominantly qualitative methods including participant observation, semi-structured interviews and document review. The data were collected in one National Health Service Trust in South England between 1999 and 2001. The findings revealed that additional duties and responsibilities specifically associated with the care co-coordinator role and multidisciplinary working, combined with heavy workloads, produced 'limited nursing', whereby community psychiatric nurses were unable to provide evidence-based psychosocial interventions that are recognized, to reduce relapse amongst people with severe mental illness.

Fourie, McDonald and Bartlet (2005) conducted a study on the role of registered nurse in an acute mental health inpatient setting in New Zealand. The study sought to compare the perceptions that registered psychiatric nurses have about their roles with their actual practice. A qualitative descriptive exploratory study design was used. The study observed nursing practice on three selected wards and used focus group interviews to establish from registered nurses what they perceived their roles to be. Findings from the study showed that many of the nursing roles related to delivering care from a crisis management perspective, covers aspects such as assessment, stabilization of symptoms and discharge planning. The participants also believed that the therapeutic relationship was a fundamental role in inpatient care. Nurses used any opportunity such as kitchen organization, medications, or dealing with a challenging patient to make it a reality. This study highlighted the complexity of the roles that nurses performed and went some way to give expression to what at times seem as invincible practices.

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Olofson and Jacobson (2001) studied 18 involuntarily hospitalized psychiatric patients who narrated their experiences of being subjected to coercion and their thoughts on how to prevent the coercion. A qualitative content analysis identified recurring themes, which were incorporated in two core themes describing the participants' experience. The core theme: "Not being respected as a human being" included most of their narrated experiences, described in the themes "Not being involved in one's own care", "receiving care perceived as meaningless and not good", and "Being an inferior kind of human being". The core theme "Being respected as a human being" included a minor part of the narrated experiences and how the participants wanted things to be, described in the themes "Being involved in one's own care", "Receiving good care", and "Being a human being like other people". The participants' plea for respect was discussed in relation to the ongoing deinstitutionalization of psychiatric care and the need for attitude changes in care and community leading to the treating of mentally disordered people with more respect.

Crichton (2001) conducted a study on risk perceptions of mental health nurses which had been found to be most stressful and problematic at a large Mental Health Trust in North England. Findings of the study indicated that risks were related to the nature of the client group. Nursing staff relied heavily on intuition and past experience in risk situations, and some of the most commonly occurring situations also produced the most stress. The subject of risk is one about which mental health nurses feel strongly and have considerable trepidation, because of the consequences of making mistakes and the conflicting demands placed upon them by society and by their senior colleagues. The researcher suggested the need for all staff to undertake risk management and risk assessment training and this should be updated at least every three years.

Parry-Jones, Grant, McGrath, Caldock, Ramcharan and Robinson (1997) carried out a study on stress and satisfactions of care management practice among three distinct groups

of front-line workers: social workers, community nurses and community psychiatric nurses. The results of multiple regression analyses, corroborated by qualitative data implicate an increased workload in general and administrative work in particular, combined with reduced opportunities for client contact, as the main sources of stress. Being able to control or shape those factors impinging on the experience of stress and job satisfaction appears to lie at the heart of the dilemma. Practice and policy implications are considered.

Largerstrom, Hansson and Hagberg (1998) carried out a study on the relationship between nursing work and low-back problems in Sweden. The aim of the study was to estimate the risk of physical, psychosocial, and work organizational exposure factors that may lead to low-back problems. In addition, the study reviewed and evaluated reported ergonomic intervention, with the object of decreasing the prevalence and incidence of low back problems among nurses. The findings from the study showed that a considerable number of studies of nursing staff have shown the connection between lifts and transfers of patients on one hand and low-back problems on the other. Furthermore, factors in nursing work that may be significant in this connection are staff density and work satisfaction. In this study the single individual factor that was related to low-back problems was “history of back problems”.

Edwards, Burnard, Coyle, Fothergill and Hannigan (2000) in their study revealed that there is a growing body of evidence that suggests that many community mental health nurses experience considerable stress and burnout. The aim of this review was to bring together the research evidence in this area for community mental health nurses working within the U.K. Seventeen articles were identified in the literature, 7 of which looked at stress and burnout for all members of community mental health teams and the remaining 10 focused on community mental health nurses. The evidence indicates that those health

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professionals working as part of community teams experienced increasing levels of stress and burnout as a result of increased workloads, increased administrative duties and lack of resources. For community mental health nurses specific stressors were identified which included increases in workload and administrative duties, time management, inappropriate referrals, safety issues, role conflict, role ambiguity, lack of supervision, not having enough time for personal study and National Health Service reforms, general working conditions and lack of funding and resources. Areas of future research are described and the current study of Welsh community psychiatric nurses was mentioned. This review had been completed against a background of future significant changes in the health service. In the Mental Health field, specific new initiatives will have a significant impact on the practice of community mental health nursing. A new National Framework for Mental Health along with a review of the Mental Health Act (1983) will help to shape the future practice of Mental Health Nursing. These findings have implications for policy. In the current study, the researcher determined what community psychiatric nurses go through in their work. The research might also inform policy in Ghana.

Moylan and Cullinan (2011) carried out a study in the United States aimed at examining assault and injury in relation to a nurse's decision to restrain. The researchers pointed out that ethical standards and current law demand that acute care psychiatric patients be treated with respect, using the least restrictive interventions. Unfortunately as restraint use has decreased, assault and injury of mental health care workers has increased. Violence against those working in acute care psychiatric facility is a serious global issue. The findings revealed that in a sample of 110 nurses from five institutions, 80% of the nurses were assaulted, 65% had been injured and 26% had been seriously injured. The injuries included fractures, eye injuries and permanent disability. Nurses who had been injured decided to restrain later in the progression of aggression than those who had not been

injured. There is paucity of research in Ghana highlighting what community psychiatric nurses encounter in their work. This study set out to illumine this area.

Thompson, Powis and Carradice (2008) reported on a study that explored community psychiatric nurses' experience of working with people who self-harm. Interpretative Phenomenological Analysis was used with 8 experienced community psychiatric nurses who participated in semi-structured interviews. The participants described struggling to conceptualize self-harm behaviours and generally reported finding working with people who self-harm stressful particularly in terms of managing the emotional impact upon themselves and the boundaries of their professional responsibilities in relation to risk management.

According to Poster (1996), in an effort to understand beliefs and concerns about work safety and patient assault, a multinational survey of 999 nursing staff members working in psychiatric facilities across the United States, Canada, United Kingdom and South Africa was carried out. Although the majority of the sample (78%) reported being physically assaulted at least once during their careers, 62% responded that they felt safe in their work environment most of the time. Significant differences were found among the nurses with regard to beliefs about adequacy of staffing, safety of the physical environment, admission of assaultive patients, expectations about being victims of assault, overall level of safety, and taking legal action against a patient. A significant difference in attitudes was also found among nursing staff members, who reported previous assaults. The nurses believed that assaults are expected events in their work with psychiatric patients.

2.5 Strategies used by Community Psychiatric Nurses in Dealing with Difficulties

Hummelvoll and Severinsson (2001) carried out a study in Australia which aimed at exploring mental health professionals' reflection on their work on an acute psychiatric

ward. Data were collected using participant observation and interview methods. Three core themes were identified from a qualitative hermeneutic analysis. The first core theme, coping with uncertainty, revealed a dialectical pattern of the factors contributing to thriving and strain in the working situations. The second core theme, caring for the patient, included the caring process, patients' pathway to acute psychiatric care, as well as the patients' needs and roles on the ward. The third core theme, coping strategies, included five different methods: the primary nursing system, concealed versus integrating, milieu therapy, seclusion and medical orientation model. It was concluded that good mental health care is a result of collaboration between health professionals and the health services. The study emphasized the need for establishing structures that will enable collaboration to take place. Consequently, this may contribute to enhancing the care of the patient and their families.

Burnard, Edwards, Fothergill and Coyle (2000) conducted a study in Wales on community mental health nurses' experiences of stress and burnout related to their work and their coping strategies. The total population of community mental health nurses in Wales was surveyed (N=614) and 301 (49%) responded. The questionnaire booklet contained a number of validated instruments to measure stress, burnout, and coping, together with a demographic questionnaire. These questions were asked in order to determine the community mental health nurses' own views of the sources of stress in the workplace, and to investigate which methods they use to cope. The findings from the study revealed that the most frequent stressors included perceived workload, excessive paperwork and administration, and a broad spectrum of client-related issues. Coping strategies that community mental health nurses reported using, included peer support, a range of personal strategies such as relaxation, and belief in self and supervision. The authors concluded that a range of factors such as organizational pressures and factors

related to working with patients are important in determining stress levels, and that informal rather than formal support methods are the preferred methods of coping.

Johnson, Niedens, Wilson and Swartzendruber (2012) reported that research indicates that a community-integrated response to dementia crisis can reduce negative consequences attributed to crisis including increased caregiver burden, increased health care costs, and premature institutionalization. The Neuropsychiatric Inventory Questionnaire and Geriatric Depression Scale were used to measure the impact of Neuropsychiatric symptoms and Bridge interventions on patients and care givers. The results revealed significant reduction in patient anxiety, depression, resistance to care, impulsive behaviour, verbal outbursts, and wandering. Care givers reported a significant reduction in anxiety, apathy, resistance to care, and less distress over patient neuropsychiatric symptoms. Care givers also reported increased confidence in managing difficult behaviours.

Davidson and Campbell (2007) conducted a study on coercion in the field of community-based mental health care and treatment. The researchers argued that the lack of a critical understanding of the concept and how it is used by practitioners and agencies can have serious repercussions for the rights of service users. A quasi-experimental, longitudinal design was used to test some of the ideas about coercion by comparing the activities of assertive outreach and community mental health teams in Northern Ireland, particularly the key ideas of perceived coercion, workers' strategies and engagement with services. The findings were that assertive outreach appeared to be more successful at reducing perceived coercion, minimising the need for coercive strategies, engaging high-risk clients and reducing inpatient bed use. The researchers maintained that there is a need for greater transparency in the way that practitioners use coercive measures and more explicit guidance is required in this crucial area of mental health practice.

2.6 Conclusion

The main aim of this chapter was to review literature on the experiences of Community Psychiatric Nurses in the discharge of their duty. The review revealed a number of challenges such as limited logistical support, assaults from patients, stigmatization of the CPN as well as their training needs which impacted negatively on the work of the CPNs. To deal with these challenges, various coping strategies such as reduction in stigma, self-motivation and reduction in home visits were employed. This study sought to explore these experiences in the Ghanaian context.

CHAPTER THREE**METHODOLOGY**

The purpose of this chapter was to present the methodology that was used in the study.

This includes the research design, research setting, target population, inclusion and exclusion criteria, sample size and the sampling technique, data gathering tool, data gathering procedure and field notes, data analysis, methodological rigour and ethical considerations.

3.1 Research Design

An exploratory descriptive qualitative design was used for the study. The reason for choosing this design was that very little has been done in this area in Ghana and that has motivated the researcher to investigate the experiences of community psychiatric nurses in the discharge of their duty. Qualitative inquiry is most often used to describe a phenomenon about which little is known to capture meaning (data are collected in the form of feelings, behaviours, thoughts, insights and actions rather than in the form of numbers) and to describe a process rather than outcome (Mayan, 2001 p.5). A qualitative approach allows the researcher to use naturalistic methods. That is he/she places emphasis on understanding the human experience as it is lived, generally through careful collection and analysis of narrations. The researcher acquires information directly from those experiencing it (Polit & Hungler, 1995).

3.2 Research Setting

The research was conducted at the Community Psychiatric Unit at the Accra Psychiatric Hospital. The Accra Psychiatric Hospital was formerly known as the lunatic asylum located on the Castle Road at Adabraka-Accra in the Osu-Klottey constituency of the Greater Accra Region. It is adjacent to the Holy Spirit Cathedral and directly opposite to

the Adabraka Polyclinic. It was built in 1904 and officially commissioned in 1906 with four wards to accommodate 200 patients. With the passage of time the number of patients increased, so the facility was modified and an extension was made to it and later the name was changed to Accra Psychiatric Hospital with a bed capacity of 600. As of August, 2012 the hospital had 21 wards (7 female wards and 14 male wards), a community psychiatric unit, and an in-service training unit for community psychiatric nurses and staff strength of 350. It has 3 psychiatric consultants, 6 medical assistants, 300 nurses and paramedical staff. The O.P.D, has 12 consulting rooms and a reception. All patients that come to the hospital pass through the reception before being distributed to the consulting rooms. In like manner, patients who are treated and discharged go through the community psychiatric unit before going home in order to facilitate continuity of care.

There are community psychiatric nurses in all the ten regions of Ghana. All of them are attached to the Community Psychiatric Units of the various Polyclinics and health facilities. There are ninety-two (92) community psychiatric nursing districts in the country. In the Accra metropolis for instance, on Fridays, all the Community Psychiatric Nurses meet at the Regional Headquarters for a Case Conference where they read their weekly reports. On quarterly basis the community psychiatric nurses submit reports to the Regional Headquarters in the region where they are located. On yearly basis all the reports from the Community Psychiatric Units in the Regional Headquarters' are compiled and sent to the National Headquarters of the Ministry of Health.

3.3 Target Population

A target population is the entire aggregate of cases about which the researcher would like to make a generalization (Polite & Hungler 2001). For this study, the target population

was all Community Psychiatric Nurses working in the Psychiatric Units of the various Hospitals and Poly clinics in the Accra metropolis.

3.4 Inclusion Criteria

The criteria for inclusion were Community Psychiatric Nurses who have had more than three years working experience.

3.5 Exclusion Criteria

The criteria for exclusion were newly qualified mental health nurses who were assigned the roles of Community Psychiatric Nursing.

3.6 Sample Size and Sampling Technique

Purposive sampling method was used to select participants for this study. Purposive sampling is a non-probability method in which the researcher selects study participants on basis of personal judgement about which ones will be most representative (Polit, Beck & Hungler, 2001).

The researcher recruited 13 community psychiatric nurses from the research area, that is the Community Psychiatric Units in the various health facilities in the six districts (Ayawaso, Ashieduketeke, Okaikoi, LEKMA, Ablekuma, Osu-Klottey) of the Accra metropolis. The researcher recruited at least two (2) participants each from the six (6) districts in the Accra metropolis. One other participant who met the inclusion criteria and was willing to take part in the study was included. Data collection stopped when it was realized that the study participants were saying almost the same thing. The recruitment of participants was done through the Regional Coordinator of the Community Psychiatric

nurses after a thorough explanation regarding the study had been done at the in-service training unit of the community psychiatric nurses at the Accra Psychiatric Hospital.

3.7 Data Gathering Tool

Semi-structured interview guide (Appendix B) was the tool used for data collection. This was developed based on the research questions. An audiotape was used to collect and capture data. Field notes were recorded which consisted of observations that were made during the interviews.

3.8 Data Collection Procedure

Permission was sought by the researcher from relevant authorities of the Community Psychiatric Units of the various Health facilities in the Accra metropolis where the study was done after making available to them a permission letter (Appendix D) and an Ethical Clearance Certificate (Appendix E). Interviewing each participant lasted between 45 to 90 minutes. Probing questions were asked where answers provided were not clear or understood. Interviews were audio taped and recorded with the consent of the participant and later transcribed verbatim. The interviews focused on their experiences as Community Psychiatric Nurses and were conducted in the English language. The Community psychiatric nurses were approached directly by the researcher to ask if they would participate. Once a person agreed to consider participating, he/she was briefed on the research topic, objectives and the purpose of the study using the information sheet. The participant was then asked if he/she had any questions for clarification. Once all questions and concerns were addressed, he/she was given the consent form and asked to sign to indicate that the informed consent was understood.

3.9 Field Notes

A notebook was used for taking key notes of participants' daily responses and observations made about non-verbal responses of the participants so as to confirm or cross check the results of the study. Stern, (1985) noted that field notes assist in developing subsequent interview questions, deciding future settings for the study and making theoretical sampling decisions. Field notes also guide the researcher to ask relevant questions and particularly assist to validate the information being gathered to make it credible and trustworthy.

3.10 Data Management

The audio tape, field notes of all interviews and relevant materials were kept under lock and key in a cabinet in the researcher's office.

3.11 Data Analysis

All aspects of the data including interviews, field notes and diary entries were analysed to provide the rich information from the community psychiatric nurses about their experiences in the discharge of their duty. Data analysis was done concurrently with data collection using latent content analysis (Mayan, 2001).

Latent content analysis is the process of organizing and integrating narrative qualitative information according to emerging themes and concepts (Polit, Beck & Hungler, 2001). It involves the process of identifying, coding and categorizing primary patterns found in the data. The researcher read the transcripts several times to completely understand what the participants were saying. By reading and re-reading the transcripts, the researcher "immersed" himself in the data and completely "listened" to the data. The data was then coded using a carefully developed thematic code frame (Appendix F). After coding, the

data was categorized by grouping the data with similar meaning under given names. These categories were then analysed to discover relationships between them so that the meaning of the data emerged and this provided understanding of the interviews.

3.12 Methodological Rigour

Rigour in qualitative research refers to the trustworthiness of the research findings. Guba and Lincoln as cited in Sandelowski (1996) suggested four factors relating to the test of rigour. These included credibility, fittingness, auditability and confirmability.

In this study, credibility was achieved by a review of the pilot interviews by the thesis committee members in order to critique the quality of the interview and determine the adequacy of the researcher's interview questions and skills. All potential and inherent biases, feelings, personal beliefs and values about the researcher were identified. This was done to recognise and minimise personal judgement. All documents, field notes, personal journals and diaries were discussed with the supervisors.

Fittingness in qualitative research refers to the extent to which the reader is able to transfer the findings of the study situations to other settings (Mayan, 2001). In this study, direct quotes from participants and description of the setting in which the phenomenon was described was used to determine if it would fit into similar contexts.

An audit trail is a systematic collection and documentation of the decision trail that was used by the researcher. This allows an independent auditor to determine whether or not he/she will come to similar conclusions about the data (Polit, Beck & Hungler, 2001). As part of the audit trail, methods of coding, categorisation of data, as well as field notes and personal notes were kept and made available for scrutiny by the supervisory committee members to see if they could come to similar conclusion with the same data.

Confirmability refers to the objectivity of the data, such that two or more independent people would agree with the data's relevance or meaning (Polit, Beck, & Hungler 2001). Strategies that were used to facilitate the confirmability of the study included a well-documented audit trail in addition to the procedures outlined whereby members of the research committee scrutinised the data and any relevant supporting documents.

3.13 Ethical Considerations

Ethical clearance was sought from the Institutional Review Board of the Noguchi Memorial Institute for Medical Research, University of Ghana, Legon. The protection of human rights was ensured throughout the course of study. The Community Psychiatric Nurses were approached directly by the researcher to ask if they would participate. Once a person agreed to consider participating, he/she was briefed on the research topic, objectives and the purpose of the study using the information sheet. Each participant was then asked if he/she had any questions for clarification. Once all questions and concerns were addressed, he/she was asked to sign the consent (Appendix C) form to indicate that the informed consent was understood. This indicated his/her voluntary willingness to participate in the study. All participants were informed that despite signing the consent form, they could withdraw from the study at any time.

Confidentiality and privacy of participants was addressed. The community psychiatric nurses were assured that their names would not be identified with any of the comments. Pseudonyms were used in all written and oral presentations of the study. Typed transcripts and signed consent forms were stored in a cabinet separate from each other. Audiotapes, transcripts and the consent forms will be kept for at least five years. The only people who had access to the transcripts and the tapes were the supervisory committee and the researcher.

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A letter was written to the Community Psychiatric Unit of the Accra Psychiatric Hospital asking for permission to do the research (Appendix D). In addition, an information sheet as well as informed consent form (Appendix C) was included in the package to the authorities of the Community Psychiatric Units of the various health facilities in the Accra metropolis where the research was conducted. The information sheet gave detailed information of the processes involved in the study.

CHAPTER FOUR**FINDINGS****4.1 Introduction**

The purpose of this study was to explore the experiences of Community Psychiatric Nurses (CPNs) in the Accra metropolis. Thirteen CPNs were interviewed about their experiences in the discharge of their duty. During the analysis of the data, themes were identified and these were arranged into categories with their corresponding sub-themes. The themes obtained from the interview data were presented using the CPNs own verbal accounts. This was done in relation to the objectives of the study. In the ensuing sections, the sample's characteristics are presented followed by the thematic findings.

4.2 Characteristics of the Sample

The characteristics of the sample obtained included the Community Psychiatric Nurses' sex, age, marital status, educational level, religion, number of children and place of residence. There were three males and ten females who participated in this study and their ages ranged from 26 to 60 years. All the participants were CPNs with various academic and professional qualifications. Six of the participants were registered mental health nurses with an additional qualification from the university, three were registered mental health nurses and the remaining four were enrolled mental health nurses. All participants were Christians. Ten of them were married and three were single. The participants' place of residence were as follows: Nima 441, Zeenu-Ashaiman, Roman Ridge, Darkuman Official Town, Ridge near the Hospital, West Legon, Mataheko, Mamprobi, Teshie, Darkuman, Abeka Lapaz, Nungua barrier and Teshie, all within the Accra metropolis in the Greater Accra Region. One participant mentioned that he had five children, three stated three children, three of the participants cited two children and two of the

participants also mentioned one child while the remaining four did not have any children (Appendix A).

4.3 Thematic Findings

The thematic findings have been grouped into major themes and under each of these major themes were sub-themes. Direct quotes from participants were used to support the themes that emerged. The themes and their corresponding sub-themes are enumerated in table 4.1.

Table 4.1: Thematic Findings

THEMES	SUB-THEMES
1. BARRIERS	<p>a. Service related:</p> <ul style="list-style-type: none"> • Home Visits / Reaching the patients / Access to patients / Transport • Inadequate logistics / Supplies / Medications • Lack of security / Legal backing <p>b. Psychosocial:</p> <ul style="list-style-type: none"> • Stigmatization / Name calling of CPNs • Stigma of association • Attitude of family members • Feelings of frustration
2. CHALLENGES	<ul style="list-style-type: none"> • Assaults from patients • Additional responsibility of CPNs • Health concerns • Apathy of health consumers • Problems of relapse
3.SUPPORT	<ul style="list-style-type: none"> • Risk allowance • Need for recognition • Stakeholders' involvement • Trust / Confidence
4. TRAINING / CERTIFICATION	<ul style="list-style-type: none"> • Lack of training
5. COPING STRATEGIES	<ul style="list-style-type: none"> • Reducing stigma • Religion • Self- motivation • Reduction in home visits

4.4 Barriers

One of the major themes identified in exploring the experiences of the CPNs was Barriers. These barriers included service related and psychosocial barriers. Service related barriers were those attributes associated with the work of CPNs that constrained them in various ways, whereas the psychosocial barriers were those psychological and social factors that acted as limiting factors to the work of the CPN. CPNs perform numerous roles in the community which included home visits (which are normally undertaken by more than three CPNs at a time), case finding and referral, health education and counseling services. In the course of carrying out these responsibilities, they faced many challenges that militated against the effective delivery of health care to their clients.

4.4.1 Service Related Barriers

Home visits emerged as one of the barriers under the service related barriers. The CPNs complained of poor home addresses which made it difficult in locating the homes of their patients. They also complained that relatives of patients refused to see them and at times, lack of transportation prevented them from rendering effective care to their patients. This was expressed in various ways by the CPNs:

Sometimes, we collect the landmarks from the data they have written in their folders. Sometimes we take it from there and when we pick it from there, we are able to get the real information. Somebody will say P.O Box 10 in the folder but you cannot trace P.O Box 10 therefore you have to go to the patient and by establishing rapport with the patient on the ward and when the patient sees that you are nearer him on the ward, and you give him a nice reception, he chooses to accept you so when he opens his arms for you he gives you the right direction to his house. Some of these patients also because of their condition if you go to their house they would not like to see you for people to know that they are suffering from this condition, especially people working in big big companies are another area of concern to them. They feel that when people get to know that they are mentally ill people, they will look down upon them and even their jobs, they may lose their jobs. So some of them will not open up, they will tell you I don't want you to come to my house.

(Andy, 56 years)

For effective home visiting, transport was needed to convey the CPNs to homes of the mental patients. Lack of transportation was cited as a problem. In addition, the CPNs were sometimes subjected to inhumane treatment by patients and relatives during home visits:

Me for instance, on Mondays we do go for home visits and most of our clients live very far and when you write for T &T, nobody minds you. You have to walk; at times you are left at the mercy of the rain and this scorching sun. you will go and my brother, if you go to the house of these clients too, at times you are welcome, at times too hmmm, the kind of insults that would be rained on you, the kind of embarrassment.....People sometimes go to the extent of pouring urine, faeces and a whole lot of things that is anything that they lay hands on, they will just pour it on you and tell you not to come to the house again.

(Betty, 32 years)

In some instances CPNs were obliged to use their own money to pay for transportation to patients' homes as shown:

Yes, the clients, for most of them we know their homes so it's.....Ayawaso is a very large area, one of the biggest sub-districts so we usually divide it. We sometimes divide it according to the political divisions, east, west, central, north and you know the home visit is such that one person cannot go even 2 CPNs are not advisable to go. Usually we go in 3 or 4. Transportation has always been a problem so we use our own money so that when we come back, we write for reimbursement so they refund the money back to us. We are supposed to be provided with a vehicle, but we don't have and the challenge there is when you go with current transportation fares and you write for reimbursement, management will tell you, this is too much, we can't pay all because we are paying other units and department as well so we can't pay you. This means that part of your salary is what you used for the work which is not supposed to be so has been taken off. Meanwhile you went to the home and gave the patient money just to buy food before the patient can take the medication. So it makes the home visiting a challenge that is the transport aspect of it.

(Cann, 32 years)

In some cases, addresses provided by patients and relatives were wrong making home visits a daunting task:

No, no! Sometimes they give us wrong addresses that is why we always try to sit with the clients on the ward and seek their support as to how they will direct us to where we can find them. It's not easy sometimes; it is even the transportation to the area. Sometimes too the reception in their homes is not suitable. Sometimes too when there is a problem in the house we try to sit the relative or anybody with the patient down, talk to them for a lengthy time and when they accept us and the patient then we know we have done our job and we go back to our various homes.

(Diana, 56 years)

Overall, home visiting was associated with myriads of problems. In addition to exposure to harsh weather conditions, houses were difficult to locate due to poor street addresses, no transportation is provided and sometimes relatives and patients were harsh to the CPNs.

4.4.2 Inadequate Logistics, Supplies and Medications

Logistical supplies and medications were very critical for the work of the CPNs. They help facilitated effective delivery of mental health care in the community. However, the lack or inadequacy of the supplies created some challenges for the CPNs. Some of the participants mentioned that they had problems with office accommodation, transport and supplies including medications. The participants narrated this in different ways. One such narration was:

Some of the challenges; office accommodation is one. Ayawaso we are privileged that we have at least this small space you know equipped for us but most of the units I can't speak of what they have so accommodation is one big challenge to us because like this place we have 5 CPNs but we get occasionally 20 student nurses joining us and you can't even fix them anywhere because that is happening all over the place because most of the district directors are not into psychiatry, they don't see the benefit of community psychiatry. So they just put it in the corner they get. But we are privileged because we get the full support from our management; it's just that office accommodation is that which is not encouraging.

(Cann, 32 years)

Another participant who was not happy with logistical supplies reiterated that:

Sometime ago, not quite long we were talking about even a TV set to keep our clients watching when they are waiting because the number of clients we have is large but we were refused. I mean nothing tangible was given to us as an answer. Again another time, we requested for a refrigerator, up till now we have not been given. Last time, we asked for a shelf so that we can keep our folders on it because sometimes we have to bend and so on and it's affecting us. We were told to send all the files to records. Some of our clients have lost their ID cards so if they get there that means when they are coming for review it would be a difficult thing to handle.

(Gina, 56 years)

A participant who felt embittered about the lack of financial allocation, medications and concern from management to assist with their operations had this to say:

Then also, right in the facility where you work too, when they are sharing or allocating funds they hardly allocate some to us because we are not generating any funds to the clinic and so it's like you are rather feeding on what other people are generating and so when you have any concern, it is the last to be addressed or even ignored because they don't see the need in giving you logistics to work with, if at the end of the day you don't bring in any income or revenue to run the clinic. Also it is the drug; we have challenges with it, it has not been forth coming. You see at one point in time we have it in stock and at other times it's not there and clients have to go and buy and it's expensive and so it makes them relapse here and there which makes the work quite cumbersome because at one time the client will be fine and at another time, he relapses.

(Hilda, 30 years)

The participants had a lot of challenges to complain about in relation to their work. Apart from the lack of office accommodation, it appeared what they needed to make working conditions suitable for them were also not provided. The CPNs believed that because their services do not generate income, their needs were intentionally ignored. They further believed that the medications they needed to give to the patients which were not regularly stocked was the main cause of relapse among the patients.

4.4.3 Lack of Security / Legal Backing

Another theme that emerged as a service related barrier was the lack of legal backing. Most of the CPNs commented during the interview that there is no law protecting them in the course of their work. They could be assaulted by relapsed patients or their relatives without any compensation. They also mentioned lack of certification for the work they do. Narrations of this included:

As a CPN, right now we don't have any insurance. If you go to any patient's home and he beats you, hurts you, he wounds you free. There is no claim that the government will say this and this and this so I'm giving you this.

(Andy, 56years)

Another participant said that a mentally ill person had rights and could be unpredictable, that is, capable of doing anything to the nurse at any point in time because his mind is disturbed. But the nurse has no such right despite the training they had received as health care professionals:

They say clients' rights but you the nurse you have no rights. The client is seen to be suffering from the mind and anything they feel like doing, they do it at any point in time. So you the nurse who have been trained to be taking care of the mentally ill will continue to receive slaps from your clients but have no right to slap back. The very moment you slap back, your pin is being collected and you cease to be a nurse again.

For example, if you go to a house and a client tells you I don't want to see you there again. You don't have to go because there is no law protecting you but the client's right is there. He says don't visit me so you don't have to go and if you force and go and something happens, it is your own palaver.

(Betty, 32 years)

Another participant also explained:

Hmmm, this job, from the policy level community psychiatry itself, its establishment is like, the thing was planned within the psychiatric community so that there is the need for the clients to be followed up to ensure quick recovery and also to decongest the hospital so that clients can be managed in their own homes. So it is not something that is from the policy level; we are nurses but the actual community psychiatric implementation didn't have any license for us to go into the community. But we felt that the psychiatric set up realized that it will help with the recovery of the client that is why they started this community psychiatry. The legal backing is a way that we can just go and bring the mentally ill from the community to the hospital. We don't have that power but if somebody comes to the hospital and we follow up the patient, it is God who is protecting us because of the recovery of the client. Legal backing ensures that we can be rejected or accepted by the client; but there is no license that community psychiatry has to empower us to enter a client's home; we don't have that power.

(Elsie, 60 years)

Community psychiatric nurses did not appear to be comfortable or safe working in the communities. They felt they needed a mandate to empower them to carry out the home visits and render care to psychiatric patients in their homes. In their view, they had no such authorization and thus if they were assaulted by their patients, they were not eligible

for any compensation. They thought their lives were endangered due to lack of this mandate. Overall they did not feel safe and protected by any law or policy.

In addition, they felt marginalized since some patients could and did stop them from visiting their homes for follow-up. This, in their view bridges continuity of care; they also felt they were a brand of health professionals who had no certificates or any rights accorded their duties.

4.5 Psychosocial Barriers

Having described the service-related constraints of CPNs, the ensuing section presents the psychosocial barriers to effective community psychiatric work.

4.5.1 Stigmatization and Name Calling of CPNs.

All the CPNs interviewed cited the element of stigmatization. Some of them reported that health professionals as well as community members refer to them as “mad nurses”. They felt that they were poorly respected by society and also the work they do is not appreciated. They reportedly felt that colleagues and community members ridiculed them and did not see why they should be given needed resources to do their work. Visiting “mad people” in their homes was perceived by many as a useless undertaking. The area of grave concern regarding CPNs’ stigmatization was that people whom they thought should know better were the ones that ridiculed them most and even shunned them. Some cited general nurses as the cadre of health professionals who stigmatized them the most.

Most of the participants during the interview mentioned that they had been stigmatized which was a source of great worry. Some of them recounted their experiences:

Ooh! When they see us the only description for us is “the mad nurses are here”. Sometimes when we request for a vehicle to go for home visits the response is that “why you are people worrying yourself over mad people who have been allowed some parole at all, is it necessary to visit them in their homes? In fact you people

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have so much time at your disposal. We don't have vehicles, why don't you sit somewhere?" As if the work is not important.

(Fanny, no age)

Another participant put it this way:

What I will say is that sometimes the way that your fellow colleagues treat you in the field especially the treatment from the general side; that is, the general nurses, the way they treat you, like they call you names because they brand you as using a twi term which is literally translated to mean mad nurses. It is like sometimes, it creates a barrier between we and the general nurses because we feel that they are in the field so they should understand so it's like you don't want to go to them because they also don't want to come to you. So maybe if there is something that you need to communicate together or liaise to do something it becomes a problem because of the tag that they have placed on us.

(Irene, 32 years)

4.5.2 Stigma of Association

Most of the participants indicated that certain derogatory remarks were made about them by other colleague health workers, patients' relatives and the general public because of their association with the mentally ill in the course of their work. Narrations portraying this were:

Sometimes they say that we the psychiatric nurses we behave like our clients because at times you come and somebody is depressed, the person says okay let's dance, you have to dance so that the person too will feel happy. Go to the ward and you will see a nurse dancing with a client but if the client should be in the house to tell the relatives to dance with them, the response will be, "get away from me with that your silly behavior. Why should I dance when I don't feel like?" But you know the client is not in his or her right sense, so this is what the mind is telling her.....I need somebody to dance with me, just dance with the person. At times you go to the ward, I have experienced so.....I have been a victim of such instances but client will tell you I'm not taking the food and then you ask why....."ah! This enrolled nurses they have poisoned it then come and let's eat". So I do eat from the same bowl with the client. So when you are eating the person also takes the food especially new clients, when they bring them, because of the change of environment, "ah! Is that it as for this food I can't eat it". Why won't you eat? "Ah! You mean this food? It's not nice, then I will ooh!.....taste it and see". "Ah! This food is nice". So when the client sees you eating, he will eat.

(Betty, 32 years)

A participant noted:

(Laughs), some even in our health institutions; our own colleagues that is health professionals in other disciplines of health see us as mentally ill people and they even say it. They say “ooh! Those mad nurses”. That is the way they see us. People also wonder how we are able to manage the mentally ill because of their aggressive behaviours and the way they walk about in town. They are surprised at the way we manage and relate with them; that they don't fight us or injure us. They see us to be super human beings who are able to tame aggressive mental patients. Sometimes they even say that if we are not mentally sick we wouldn't be able to work with them.

(Elsie, 60 years)

This was what a participant had to say:

Let me start from the hospital. From the hospital the psychiatric nurse is being stigmatized by our own colleague nurses and some people who work in the clinic because of the clients that we see. We are sometimes not included in some of the things that they do; their workshops for example they don't include us. Sometimes too you have to talk a lot before we are being put in some of the workshops that are done in the clinic. In the society, some see us as being mentally ill ourselves that is why we are able to see people who are mentally ill. They say because we work with them it means we also have a problem, that's why we are able to work with them. But some people also appreciate us when they see that you helped them.

(Fanny, no age)

Due to their nursing of mental patients, CPNs were also regarded as mentally ill themselves. They reported that they were often said to behave just like their patients. Some of the participants described how they were accused of eating, dancing and behaving as their patients do. It was asserted that they must be mentally ill themselves given the way they were able to manage mental patients without being harmed. Whilst some perceived them as mentally ill, others thought they had exceptional attributes that enabled them to care for aggressive patients.

4.5.3 Attitudes of Family Members

According to the participants, the attitudes of family members of mental patients showed that they had no regard for their mentally ill relatives and those who care for them. Mental patients appeared to have lost all respect accorded human beings and some

relatives regarded and referred to them as “mad people” connoting “useless people”. Health professionals were treated as if they owned the mental patients. Some patients’ relatives did not see why they should spend time on mental patients to get them to take their drugs when this was a difficult task to perform. The patients do not reason well and sometimes they refused to take their drugs and made unreasonable comments to these relatives. These relatives failed to see and understand that the patients were sometimes irrational. They personally took the comments their ill relatives made and refused to help them. They acted as though the health professionals owned the patients and were solely responsible for them.

Narrations related to this included:

They do so because they are fed up with patient’s behavior. If you have been able to go to the house and educate the patient’s relatives to make sure that patient takes his medications and somebody has to volunteer to do that for you for the patient ensuring that early morning he takes the medication then patient says I’m not going to take it, I won’t drink the medication again, you take the medication yourself. When the person who is trying to help the patient to take the medication is fed up puts the medication there and then he will not even go near the patient again. He will call me and say that’s your patient we are fed up, he can roam the streets we don’t care. That’s what at times they tell us.

(Andy, 56 years)

A participant said:

They don’t even want to... The thing is they think once you have been admitted into the psychiatric hospital, meaning there’s nothing good that will come out of you. That is it, so that when you go and may be the person is asked to take the medication, may be when the person came to the hospital the medicine wasn’t there and is being prescribed for them to go and buy, Ah! Are we to use our own money to buy medication for a mad man to take, what’s the benefit to buy medicine for a mad person? These are some of the comments you hear.

(Betty, 32 years)

Another participant narrated that:

Yes, yes because sometimes when you get to a client’s home like this if the relatives are not able to understand you well they will tell you, that’s your member, they don’t even regard you as a nurse. They will tell you all kind of nasty things to make you angry; they seem as if you are rather the relative of the client so they will tell you that, that’s your man over there. It is so painful to see relatives of clients behave like this towards you the nurse.

(Diana, 56 years)

Not all relatives disregarded CPNs during their home visits. Some relatives of mental patients warmly received and related well with the CPNs. They cooperated and collaborated with the CPNs to jointly care for the mentally ill relatives.

Participants who believed that people said a lot of good things about their care for the mentally ill persons in the community had this to say:

Okay, most people, a lot of people say good things about us. They are happy about it and they normally even say that we are really doing well because we get the time to come and visit the clients in their various homes, checking whether they have medications, we encourage them to take it. Some people congratulate us for that; others too do not want to see us at all. They said the mental illness that their ward is suffering from is spiritual, something related to spiritual so they normally send them to prayer camps and they don't need the hospital treatment. But others too will accept the medication and at the same time send them to the prayer camps.

(Laura, 32 years)

A participant maintained during the interview that there were some family members of patients who appreciated the work of the CPNs and were happy when they saw them and thus had good working relationships with them:

Well some appreciate what we do on home visits and home tracing, the way they receive us, you can see that they are happy, they have got someone who is helping them to take care of a relative who is mentally ill and then for some too the comment goes like this, "that is your person sitting down there, you can go to him", something like it's you who appreciate taking care of them so he or she is there so go and see him; so some appreciate and others do not.

(Gina, 56 years)

4.5.4 Feelings of Frustration

The participants commented that they experienced feelings of frustration in the course of their work which affected them psychologically. The CPNs highlighted on situations that generated feelings of frustration in them. The major problem that demoralized them was lack of recognition from relations of the patients they saw as well as the general public. They believed they were important in that they look after human beings and more so mentally ill people who most people cannot understand or manage. Yet, other workers

whose works are not as difficult as theirs have better conditions of service and are highly respected. Furthermore, some CPNs became dejected when their patients relapsed despite the follow up visits and health education. This was because they felt all their efforts had not yielded any dividends. On the other hand, they became happy when they saw their clients responding well to treatment and coping well in their communities.

A participant said:

Sometimes it demoralizes us. You feel you are in a bad field like you are in a bad institution you didn't choose the right profession. People are working in the banks and they are feeling relaxed all the time in an air condition, getting huge salaries and you who is caring for somebody- human beings..... Somebody taking care of paper and you taking care of human beings, nobody cares about you.

(Andy, 56 years)

A participant who was not happy about the way things were going had this

to say:

I feel very sad when I see such things and it hurts me because after all the education that I gave and then at the end of the day I see that I still lose my clients, it's very disturbing. It looks like you are not really doing your work which is very disturbing.

(Fanny, no age)

Others said they liked their job and were willing to do more but certain constraints did not permit them which made them feel bad:

At times, you feel bad because what you wish or how you want to work is not like that, how you want it is not like how you are getting it so at times you feel something. You wish to do more but at times it seems there are few cracks somewhere. You feel down hearted because how you want to work but it's not like how you are working.

(Jane, 32 years)

Another participant said she felt happy when her clients were in good health while at home but when they relapsed she felt unhappy:

The thing is when I go on home visits and I see those clients happy in the house I'm also happy but when you go and they have relapsed, it means all the effort you are making is of no use. That one it becomes something else, you wish you were not in that service may be being on the ward so that when they discharge them nobody does the follow-up, it is we the CPNs who do the follow-up to see what is

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going on there so when you go and it's like the client has relapsed compared to when the person was on the ward, it becomes frustrating and you wish to be on the ward or change from being a CPN into another field.

(Betty, 32 years)

A participant commented that if there was an improvement in clients' conditions there was work fulfillment. On the other hand if the patients were showing signs of relapse, it created feelings of frustration:

I love my job and I'm glad when I see that my clients are doing well, so when some of them are not doing well, I feel I'm not getting the fulfillment I need in my job. That is why it makes me feel bad when the clients are not doing well.

(Fanny, no age)

4.6 Challenges

In this section, one major theme on the experiences of the CPNs was challenges. CPNs faced multitudes of challenges in the course of their work. A number of sub-themes were identified under this theme. One of such sub-themes was assault.

4.6.1 Assaults from Patients

Participants narrated some of their experiences as assaults from patients during home visits. Some CPNs had been slapped by patients during home visits to check on patients' welfare. Others had been threatened and chased out with cutlasses with warnings not to come to their homes. One CPN indicated that she was almost raped but for the timely intervention of a food vendor. This was expressed in various ways:

There are times when we go to the patient's homes to give the modocate injections to calm them at home at the request of their relatives before then the patient had slapped some of us. Presently an E.P church watchman whose wife was misbehaving sent the woman to the psychiatric hospital and was to be given injection modocate as prescribed by the doctor. The man came to my end here and went. When we went the man thought it was our business and not part of his business. It's so bad watching us, not knowing that the patient was aggressive. So when the injection was drawn we were able to talk to the patient to turn so that the injection was given. After giving the injection the patient slapped me.

(Andy, 56 years)

A participant gave an account of how she was almost butchered by a patient because the patient had warned that he did not want to be visited by nurses since he was not sick:

Just recently we went to a client's house. That client warned us not to come there again but for the nature of our work, you can't say you won't go there again but anytime we are in that vicinity we pass there. So I just went knocked and there was no response so I knocked again and I heard somebody responded "who is it?" I said "auntie nurse" "ooh okay! Then wait for me I'm coming". The person just went and had it not been for somebody in the house, that guy was having machetes, he would have butchered me. So like when the lady saw it she just shouted "whoever is there should go" and all of us have to go back. It was a residential estate too, you know that kind of environment, very quiet so if the lady wasn't around, I personally would have been butchered because he had warned us not to come there again because he thought he was not sick.

(Betty, 32years)

Another participant reported that on some occasions during home visits they sometimes met patients who were relapsed and attempted to attack or rape them:

During home visits and home tracing, sometimes we go in and meet a client who is relapsed, sometimes they attack us. At one time I was nearly raped, so that morning the woman just told hmmm.....she sells boiled beans and fried plantain and after finishing everything, she was about to take her things and leave the house when she remembered that she had left something behind and wanted to come and pick the item, not knowing that the delay was what saved me from being raped by a client. It so happened that client father had died in the morning of that day and the people in the house had sent the corpse to the morgue so they all left except the food vendor who could not go with them; it was there that the woman was around to help else the client would have done what he wanted to do.

(Gina, 56 years)

4.6.2 Additional responsibility of CPNs

The majority of the participants during the interview said that they felt obliged to take up certain responsibilities such as giving money for food, transport fares and buying medications for patients which should be performed by patients' relatives:

Sometimes you go to a patient's home and they will demand money from you. Somebody will tell you I haven't got money to buy food to eat before taking the medication. So you are coming here to inform me to take my medication? What do I eat before the medication? Things like these and we want our patients to take the medications. Sometimes we dip our hands into our pockets to get some kenkey for the patients before giving the medication to the patient to take.

(Andy, 56 years)

At times you go to the homes of these clients and you have to dip your hands into your pocket and buy food for them because they tell you "I only take my medication unless I eat" and you also want them to take their medication, so you have to buy food for them. Give them pocket monies. As you go there the relatives will say ooh! For the past one month, two weeks, he hasn't bathed. When we talk to him it doesn't work. We have to go there and persuade this client. At times we have to fetch the water, put it in the bath house and then beg the client to go and bathe. In fact it's interesting, at times you go and they tell you he doesn't brush his teeth, he doesn't do this, you go there as if you are on the ward. Okay what do you want to use? I want brush, today I won't take chewing stick, I won't take the sponge, I want toothbrush. Then you ask the relatives "does this client have? No. Then what are you doing? This one will say I don't have money. So you the CPN will have to buy it for the client making sure that the client brushes his teeth.

(Betty, 32 years)

For some of the homes, when we visit they tell you they haven't eaten so they can't take their medications. So we give out money or we buy food for them. At times we go to the homes and find a child of a client who is sick. You cannot just see the client and come back, so we send the sick child to the hospital for treatment. Sometimes we give them food when they come for review. Some other times they demand transport fares and we give.

(Elsie, 60 years)

Another participant explained:

At times we use our own money even when you go to clients you have to give out money for the person to buy food and sometimes when there is shortage of drugs, we again use our money to buy for them because for some conditions like epilepsy they will start getting frequent fits when they don't have drugs and it's something you cannot see them go through, so we are compelled to buy the drugs for them.

(Jane, 32 years)

It appeared family members of some mental patients shirked their responsibilities onto the CPNs. Although the duty of the CPN was to carry out a home visit and ensure that clients were doing well and taking their medications they were entreated by relatives to buy food or medications for the patients. They sometimes had to assist the clients at home with activities of daily living such as bathing and oral toileting in addition to providing some of their needs.

4.6.3 Health Concerns

Some of the participants complained of problems which were health related. In their view, the harsh nature of their work was having a negative impact on their health. One respondent attributed her health problems to the extensive walking they do due to lack of transportation. She made reference to other colleagues who were having certain health problems; the problems were all orthopaedic in nature, as the quotes depict:

Too much working also affects our health; some of us have developed pains in our back, waist and spondylosis because we do a lot of walking just to save money and do other things but not spend so much money on transportation hence our health. My wish is for the clients to get total recovery.

(Elsie, 60 years)

A participant had this to say:

Sometimes you yourself become stressed up and things start jamming up. The way things should go becomes bizarre in your life. Due to this work I have a problem with the left side of my waist. Doctor told me because you are not the heavy type that is why you are not really seeing what is happening. Well after the X-ray and a CT-Scan were done, I have to go to Korle-bu for orthopaedic care, and I have now been referred to the Neuro Surgeon; there's a test that I have to do but I cannot afford it. So for now there are some duties that I cannot perform because of that problem at the back of my waist because if I perform those duties, it means I will worsen the situation and I have 4 more years to go on retirement so they have to help me so that the problem will not become worse.

(Gina, 56 years)

4.6.4 Apathy of Health Consumers

Participants maintained that patients and their relatives' lack of interest in health education made them feel that they were not doing much for their patients which affected them psychologically.

A participant reported that sometimes when the patients were discharged home they were influenced by their peers who were drug addicts to continue using drugs even if they did not have money to buy. This, the CPNs considered thwarted their efforts in the delivery of health care to their patients:

There are these stubborn patients who are drug addicts and who join bad friends when they go back. There are so many times we organize programmes in his

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community for these patients to know but immediately we leave the community they call the patients because they want the monies for their drugs, and somebody who is on drugs will do everything to get the money to buy the drugs and they also make profits when the patients come to them to buy the drugs.

(Andy, 56 years)

Another participant was of the view that the education they gave to clients and the general public was not heeded to. This she thought was as a result of society's reluctance to discourage certain unhealthy practices that led to frequent relapses and readmissions to the psychiatric hospital. Much as they tried to assist patients to take charge of their lives relatives of patients dissociated themselves from them because they thought they could not waste their resources on their mentally sick relatives:

We know that most of the times our education falls on deaf ears because even if the client is willing to stop the society in which we are is encouraging it and so at any point in time you see clients coming to you that he wants to stop. We try to bring him on the right path but he goes back to the same people and because relatives are not ready to bring the person to himself and embrace him or her as part of the family who is just sick at a point and mix well but they think you are a wasted person, the family does not get anything from you so they can't waste their resources on you so that is how come we end up with the ghettos. We go there also with the intention of seeing whether the other people there can also be included in our care. But often it doesn't work because they have become like hardened people in the thing and they are like, we have been doing this for years and what you are talking about we don't experience it. So it makes it a bit difficult.

(Hilda, 30 years)

A participant commented that in the area where she practices, the people were not receptive to learning because most of them were illiterates. Therefore educating them posed a challenge since they continued to hold onto their old beliefs and did not want to depart from it. This is depicted by the quote:

For my area the experience I will say I have in my community is that the community people don't like learning, I don't know it is because it has been an old township and it's like most of the people are not well educated; they don't want to go to school. So it's like getting information across to them is difficult. It's like they have one belief and they are holding unto it even if you want to let them know that these beliefs are not good and they need to change it, they don't want to change it.

(Irene, 32 years)

4.6.5 Problems of Relapse

Relapse of patients was a major drawback cited by the vast majority of participants.

Participants commented that there were bouts of relapse experienced by patients. The relapses were attributed to negligence by relatives with respect to supervision of patients to take their medicines. Sometimes the medicines were not purchased for the patients for lack of funds. When the medicines were available and the patients refused to take them the relatives sometimes got fed up to encourage the patients to take their drugs. Sometimes patients did not take their drugs because they needed to eat before they did so and relatives complained they did not always have money to look after the patients.

When patients relapsed due to failure of taking the drugs, they reportedly got hallucinations and “saw” the nurses as snakes, lions or witches and trees thereby refusing their care:

Some of these issues happen sometimes and some of the patients may not take their medications, the relatives may also not supervise the patient to take his medications, because they don't have time for them. So for about 3 days or 4 days he hasn't taken his medications so there may be experiences of relapse and when the patient is experiencing relapse and you visit the person, the patient sees you as when the illness was coming. You know some of these patients see us as snakes, animals, lions, witchcraft when the onset of the illness is coming. He doesn't take his medications and gets relapsed and these signs start to set in again and he sees things chasing him, sees individuals as something different. So when he sees you and he relapses he doesn't want you to come nearer to him.

(Andy, 56 years)

Another participant noted that patients did better whiles on admission as compared to when they were discharged to the community. The reason was that, during hospitalization he was fed three times in a day and also supervised to take his medications. The healthcare providers also understood them and were ready to listen to them. This was in contrast to the situation they encountered in the community. In the community, some of the patients' relatives denied them food and attention and instead made derogatory remarks about them and their ill health which often led to relapse:

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The thing is when you go to the hospital, there are some people who were admitted as young as when they were in their infancy and they are grown as at now and are still there. The thing is with those clients when they are there, they are okay because in the morning he will take his breakfast, afternoon take his lunch and in the evening his super. But when the person goes to the house, that kind of attention is not there, the food itself is not there for the client to take. Everybody neglects him so the person does well on the ward than in the house. Anything he does as a normal being as we are, he may say something and you will be annoyed but he being a psychiatric patient what he says For all you know what the person says may be right. Ooh! Get away with your mad talk. So that kind of utterances alone piss them off.....ooh! get away with you silly behavior, you mad man. So it's like the person goes away and one or 2 weeks time the person relapses and brought back to the hospital.

(Betty, 32 years)

A participant remarked that most relatives of patients believed that mental illnesses have spiritual influences and did not believe that orthodox drugs could treat them. They would rather seek spiritual intervention by going to prayer camps, churches or shrines. In effect, they left their sick persons there when they realized that their conditions had become worse rather than sending them to the hospital:

Most of them feel that the disease is spiritual; they don't believe that it can be treated with medication. Although we give them medication, most of them believe it is spiritual so will rather take the patient to church so when it becomes worse they leave you there; Prayer camps, shrines etc. and that's where they leave the clients. Instead of bringing them to the hospital for treatment; they take their medication for some time and they think they are not seeing any improvement so they will rather go somewhere else.

(Fanny, no age)

Another participant stated that most patients who were drug addicts were being neglected by their family members on the premise that they did not deserve to be part of them. As a result of this the patients preferred to associate with their peers who introduced them to the use of drugs since they were well accepted by those people:

Most of our clients, because of the conditions which they are suffering from; substance abuse or drug addicts, they are relatives of families which have neglected them in such a way that they think they don't deserve to be part of the household and so they also find refuge in their colleagues who also welcome them especially in the company where they feel welcome. So you find them in the company of some friends who introduced them to the drugs. So when you go to the house you don't meet them, people will just direct you to the place where you will

find them and when you go there you find them in the company of those people. Yet you go there and educate them but the influence is still there.

(Hilda, 30 years)

4.7 Support

According to the participants, support was necessary for the integration and rehabilitation of the mentally ill in the society. CPNs' expectation for the success and sustenance of community psychiatric nursing was that the Ghana Health Service (GHS), other stakeholders, the family members of patients and the society needed to collaborate to ensure smooth integration. Since they believed the care and supervision of the mentally ill patients largely rested on them, they thought they should be given risk allowances and other incentives.

4.7.1 Risk Allowance

The majority of CPNs during the interview indicated that their work was risky and thus expressed the need for compensation from their employers for their hard work and in the event of any injury sustained in the course of work:

Formerly there was a risk allowance, the meager risk allowance given to mental nurses. When we were fighting for a good sum of allowances, they stopped that one. All other nurses also came in and said they are nurses and they are also at risk. So this risk allowance was removed. If the government had listened to the mental nurses a little it would have even raised the salaries of a mental nurse higher than the general nurse. Looking at the risks involved when dealing with a mental patient which would have been an incentive to us. Because some of us don't get the incentives, those who are fed up with it this way leave the country and go outside to look for greener pastures outside the country.

(Andy, 56 years)

One participant expressed:

I will expect that.....like we don't even have a risk allowance when it comes to such things but the work is full of risks. It's only psychiatry but I think we are exposed to the bigger risks because the person is being shunned by society and you are going to embrace the person. So whatever happens, it is your business. So I will expect that they pay attention to the field and give incentives to encourage

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people, personnel to come to the field to make the work easier to make it less stressful because it's like a kind of work for a few people to do which is difficult.

(Hilda, 30 years)

Another participant described the environment where she worked as dangerous but without any compensation when injuries occurred:

The environment in which we work is bad with our clients and most of the time we get attacks from patients. I have been attacked several times at the Accra Psychiatric Hospital but it's like there is no compensation or risk allowance so that if a patient breaks your leg for instance, nobody cares about it because it had happened. So all those things ought to be put in place.

(Irene, 32 years)

The participants expected that, given the dangerous nature of their work, their employers (Ghana Health Service) would appreciate the potential risks involved and offer a form of compensation to them. This failure on the part of GHS was a bone of contention amongst them. They were unhappy about this omission. What worsened their situation is the apparent lack of recognition.

4.7.2 Need for Recognition

Participants maintained that there was the need for their employers, relatives of patients and the society to offer them some recognition in order to facilitate effective community psychiatric care services.

One participant complained that though psychiatry is a public health issue, it is not recognized as such since they often heard people in authority comment that the CPNs did not do anything except to say they were going on home visits. Besides, they sometimes heard people say they were mere community nurses and did not even have certificates. Furthermore, they wished that their employer realized the importance of community psychiatry work and treat them like any other health care providers:

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Yes, for our employers, well I personally will like them to see psychiatry and mental conditions as a major public health concern which I doubt they are seeing it as such. Once they are able to see it like that then they will know the importance of community psychiatric nursing because for most of them at the top, you hear them say as for the CPNs they don't do anything, they just come and tell us they are going on home visits and that kind of things. I don't know where they get that perception from but that is what we hear often. So for me, I will like them to see psychiatry as a public health issue as it is, and then treat the CPNs equally as they do to the public health nurses But the moment they stop to see psychiatry as a public health issue then they tends to relegate us also to the level that is degrading to us. Some people don't even believe that we are certificate holding nurses, they say ooh they are mere community nurses.

(Cann, 32 years)

Another participant reiterated that the health sector should focus on psychiatry as an important aspect of health but it had been relegated. Just as the focus had been on the treatment of other diseases such as HIV, psychiatric conditions should be accorded the same attention as HIV for people to be interested in it. Though psychiatry is a public health concern, it is not recognized as such. CPNs work hard to keep mental patients off the streets but their efforts are not recognized. They therefore expected to be wholly accepted and integrated into the health care delivery system:

The health sector itself should accept psychiatry as one of the important aspects of health just as they treat any other disease like HIVs and the others and everybody is interested in it, we also want psychiatry to come to the limelight as even the first and the foremost because without the brain the whole body cannot work properly. If the brain is diseased or the brain is not working well, the whole body is also not correct, immediately you will be devastated. So we should also be accepted as an important area so that the total health of the individual, right from the mind to other parts of the body must be met by the individual as well as the general population. So the field must be treated as another important area. Like public health activities which are always the first and foremost and everything concerning it, because psychiatry is also a public health concern as well. If we don't have sound people in the general population then the country is not safe if mental patients are allowed to roam our streets and nobody cares about psychiatry and mental illness, we can see that our streets will be littered with a lot of mental patients. Right now as we speak, people are saying that these people why won't you come and catch them to the mental hospital which is not so but we must be treated very well. We are also part of the health care system. So the health institutions and corporate bodies must also accept us wholly and integrate us into the health care delivery system for the total health of individuals and the society.

(Elsie, 60 years)

A participant narrated that it appeared psychiatry was not part of the health sector because for a long time it had been marginalized. Less attention was given to the field because no revenue was generated as compared to other fields of health services. Consequently they lacked infrastructural development making the work unfavorable. The focus of the Health ministry and the GHS was on other hospitals and not the psychiatric hospitals:

Hmmm, like for a long time psychiatry has been sidelined. It's like much money is not pumped into psychiatry because they feel we don't generate anything but the others give some money so they tend to pay attention to those places more than they pay attention to us. Most of the time, you hear there is renovation at Korle-bu, there is renovation in Komfo Anokye Hospital, there is renovation at Ridge Hospital, but we don't hear anything like Pantang Hospital or Accra Psychiatric Hospital or Ankaful Psychiatric Hospital. There haven't been renovations since they were built. So it's like they have.....the general side have a good environment to work. But if you can go to the Accra Psychiatric hospital now, you see the conditions under which nurses are working is very bad. So they should try as much as possible to put this infrastructural development plan into action so that we can have a good working environment so that if you come to work you feel at home to work more.

(Irene, 32 years)

4.7.3 Stakeholders' Involvement

Participants were of the view that involvement of key stakeholders including NGOs, relatives of patients and significant others in the society could help support the care of the mentally ill in the community and their rehabilitation.

A participant reported that they were seen as workers who generated no funds for the hospital hence did not get support from anywhere. They were unlike the public health nurses who continued to enjoy the benefits of some funding agencies because they were seen to be working through the programmes they organize for the public:

You know the public health nurses are enjoying the benefits of some international funding sometimes and all those things organize programmes for patients or for their clientele or the public from the Global funds. They get the malaria support but when it comes to psychiatry, aside Basic Needs and Mind Freedom, which for about 3 or 4 years now I haven't even heard of, nobody and Basic Needs have a clear thing..... they are supporting outreach services and education and they have their sustainable livelihood. Aside that nothing comes from anywhere to support. So even if as a unit you want to embark on a programme or something, that you have to source for funds from the hospital management which of course you are not going to get because you don't generate anything for the hospital;

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everything that we do here is free. So if you want to go in for money from management, it is a challenge further because you don't put back anything into the coffers. But for public health as I said Global fund will give them money for say one week, let's do a programme on malaria education, another one will say let's do I.T for one week and they receive monies as such . People see them as working more than seeing CPNs working. So that when they see us as such and then we start enjoying those benefits they might not come to us directly, we will use them for the work but then that will sell our services as CPNs.

(Cann, 32 years)

Another participant was of the view that support from stakeholders for example, employers or trainers of skilled labour would help engage discharged mental patients to acquire skills. This they thought could go a long way to help them earn a living thereby assisting with their integration and rehabilitation:

That is may be the client is able to sew dresses or he could do jobs like carpentry for instance, we sit with their relatives and try to look for a carpentry workshop where we try to talk with the boss over there and the necessary arrangement made so that if they are able to mature after going through that apprenticeship at that place they proceed with that. If it were like seamstress we try to engage them where we can get the relatives to find out if they have sewing machine so that the client can use at the seamstresses' workshop so that we talk with the boss over there for the patient to be accepted so that even if he is not able to work all the day, the days that she is able the boss there will be able to cope with her and try to teach her to learn to sew.

(Diana, 56 years)

One participant viewed acceptance of community psychiatric care by the Ministry of Health and the public as an important aspect of the health delivery system as the number one support. She also emphasized on the provision of transportation or transport allowances to facilitate their work in the various communities. In addition, it was noted that they should be provided with logistical support such as office accommodation for counseling and also for their comfort:

The number one support is acceptance from both the health ministry and the general public need to recognize mental health as an important area in the health care delivery system. There should also be financial support from the institutions that we are. More so, transportation should be provided so we can move into the various communities and do a lot of work. There could also be transport allowances that can take us round to do whatever we want to do in order to meet the health needs of our clients. A proper office set up for counseling and other services ought to be provided to facilitate the comfort of staff and clients in the

course of the work for the satisfaction of everybody and other logistics that will make the work more interesting.

(Elsie, 60 years)

4.7.4 Trust and Confidence

The participants reported that some of the relatives of patients expressed satisfaction, trust and confidence in the care they received. A participant mentioned that during home visits to check on the welfare of their patients, they were perceived by patients' relatives as parents to the patient such that they confided in them as and when necessary. This, they claimed was an indication that patients and their relatives had confidence in them and the work they do. He also reported that there were times when relatives instead of sending their relapsed persons to the hospital for treatment would rather report to the CPNs for their attention:

Sometimes some of the homes we visit some see us as being the father to the client. The least thing they come to report to you and this we also want even though they do have confidence in us, the confidence shouldn't be that any little thing they come to report to us to intervene. There are times when the patient will relapse and instead of taking him to the hospital they will say that is your man, your patient we cannot control him so take him away.

(Andy, 56 years)

Another participant remarked that some relatives of patients expressed confidence in them and were willing to support in caring for their sick persons to enhance recovery. This served as a source of encouragement for them. Some of the relatives also encouraged frequent visits by the CPNs.

Between the client and the relatives, some are not good and some are happy to assist even for the client to recover. Some, it is not good at all but some are very good, very encouraging. Some help us by encouraging us to be visiting them. In fact we have lots of clients in our catchment area; a little above 600. So sometimes it takes us a long time going round to visit a client before you get to another. At times they call and ask, it's been a long time you visited our brother or sister at home. Such places when you go, you feel happy, it strengthens you; you meet some who are ready to help their sick relative to come out of their difficulties.

(Gina, 56 years)

The same issue was narrated as follows:

I will say that when it comes to the care of our clients, they see that we are doing a fantastic job. They appreciate our work and this is the encouraging part of our work. They try as much as they can to even give us new clients especially those that are not on medication, when we go there, they introduce them to us. But those who don't know we are trying as much as we can to reach them and try to give them some health talks. The few people that we reach appreciate our work. But the larger majority I will say because they don't know much about it they don't care or they don't see the importance.

(Hilda, 30 years)

4.7.5 Relatives' Support for Integration

Participants were of the view that when the relatives of patients were involved in the care of their mentally sick persons it would assist with their integration into the society and their rehabilitation.

A participant mentioned that their work was not easy; sometimes tracing the homes of their clients posed a challenge. When relatives of patients were counseled to understand the patients and accept them, they enjoyed good health. Also, when the relatives assisted with the care of their sick persons by meeting their daily needs CPNs appreciated these efforts:

The work is not easy, it is not sometimes easy at all even tracing the homes is a serious job and if you are able to settle the case with the relatives and he is accepted and they are moving on well, he feels very very sound. If you remove somebody, one person from the hospital and now the relatives are now taking care of the patient as their own so when the patient needs money they will give if he needs food they will do. Every support that the patient will need at home even to see us they will also help.

(Andy, 56 years)

Another participant remarked that she wanted the relatives of patients to relate well with one another in order to prevent frequent relapses. When clients and their relatives have a good interpersonal relationship, the incidence of mental breakdowns would be controlled:

I want all the relatives to be in good terms with the clients so that kind of frequent relapses will not be there. When you go and the client is happy and the family members are happy for the client, I don't think that this client will relapse except a few ones whiles some of them do get it occasionally.

(Betty, 32 years)

The participant commented that relatives of patients should assist the CPNs to facilitate the integration of patients into the society to help curb the stigma of mental illness.

Utterances that suggested rejection that could precipitate relapses should also be avoided:

The relatives should also help us so that this client will be well integrated into the family and the community as a whole and that kind of stigma should also be eliminated because the person has been admitted, the least thing the person does then “the condition has resurfaced, as for this one, it is madness proper” this kind of utterances should stop because when you start saying those things, it puts the clients off. They say I’m mad so nobody wants to listen to me; no one wants to care for me, why won’t I go to where I want? This is why we are getting a whole lot of suicide because the client feels rejected.

(Betty, 32 years)

Another participant expressed that relatives of patients should visit their sick persons regularly while on admission to enhance speedy recovery just as they visit physically ill patients in other hospitals. Showing love and acceptance to their mentally ill persons by involving them in decision making in the family and other social activities promotes a feeling of acceptance:

When there is no division our clients will also be happy and will be well in time because it’s like somebody goes to the hospital and a relative will be visiting the fellow regularly while one at the mental hospital will not receive visitors at all. When you compare that one, the sickness will be the same. But those at the psychiatric hospital; the length of stay will be prolonged while those at the general side, because they see their relatives always, chat with them and when they need other things they give them, they should apply the same principles to those who are mentally ill at the hospital and then when they go home too they should accept them into their midst when there is any gathering you won’t see anybody isolated. They should involve them in any decision making at home including family meetings.

(Diana, 56 years)

A participant commented that relatives of patients should not leave their sick persons to their fate. They should accompany them to the hospital for periodic medical check-ups, supervise their medications and demonstrate a caring attitude towards their spouses or children, if any. This would assure the person that someone cares about him and would make him receptive to pieces of advice.

Okay, what the relatives can also do about this situation is that, when somebody is mentally ill, the person should not be left alone, they should accompany them to the hospital for periodic medical check-ups, see to their medication that they are taking them, help them by supervising them to take their medication. If there is a wife or husband they should be interested in the management of their spouses or their children because if you show interest in what the person is about it helps the person to know you are interested in him. So when the person knows you are interested in him, whatever advice or help you want to give the person, he will be ready to do it because the person sees that you also have time for him or her.

(Fanny, no age)

4.8 Training / Certification

In this section, training and certification are discussed. Training and certification of community psychiatric nurses are prerequisites for practising as a CPN. The training enhances the psychomotor skills of the CPN to ensure effective Community mental health practice whereas certification ensures job security, self-confidence and a legal backing. The majority of CPNs in Ghana reportedly do not have formal training and certification in community psychiatric nursing. According to the CPNs interviewed, there is a three months orientation programme for all categories of newly qualified nurses. After the orientation programme, registered mental health nurses who express the interest to join the CPNs are recruited.

4.8.1 Lack of Training

The vast majority of the participants disclosed that they did not have any formal training in Community Psychiatric Nursing. Some maintained that there should be training and certification of CPNs so that they are given their due recognition:

The thing is when you.....what they tell you is that what we are doing is illegal because we don't have the certificate or what qualifies you to be a CPN. We are trained as psychiatric nurses we are not CPNs but doing the work of CPNs so I think they have to organize some workshops for us or do some upgrading for us so that we get our certificate so as to enable us operate very well.

(Betty, 32 years)

A participant said:

As part of the rotation, I was to do a 3 months community psychiatry practical, so I was sent to the Metro-Head Directorate where the CPN leadership is and there, I think that initially I joined the Osu Klotey Sub-districts that is Adabraka polyclinic, now Ridge OPD for 2 weeks for the field work and learn how they put together their reports. After the 2 weeks, we were then asked to come for another 3 months. There I opted for Ayawaso because at Adabraka, there was an issue there so I opted for Ayawaso. So for the 3 months that I came to Ayawaso, I met the leadership and they took me on rounds and then taught me the nitty-gritty of community psychiatry. The home visits, how to trace a home, how to react when you get to the home and meet an aggressive patient and all those things for 3 months.

(Cann, 32 years)

Another participant also said:

It is not an established course that we did so that the certificate will identify us as CPNs. We only had orientation for 3 months just to go in and do this job; so psychiatric nurses were selected, that is those who were interested in the community work. Some had 3 months orientation on the job without certificate.

(Elsie, 60 years)

It's like all of us don't have the certificates to show on CPNs, we all did psychiatric nursing and got posted to the field. We for instance, it was right after school, N.T.C and we were pushed into community psychiatry so it's like we are now learning but some had the opportunity to be on the wards before they came so they had a little bit of training before they started work in the community as CPNs.

(Martha, 26 years)

A participant was of the view that a community psychiatric nursing school should be established:

Also, I will be very glad if community psychiatric nursing training school is established to train CPNs be it under graduate or post graduate or let's say it can be fresh like the way we train general nurses or mental nurses. If something like that can be done for the country I think it will go a long way to help us improve upon the mental health situation in the country.

(Irene, 32 years)

The CPNs felt inadequate and dissatisfied. Since they do not have certificates as CPNs, they felt they were practising psychiatric nursing in the communities without a formal legal backing or mandate. One thought workshops should be organized for them and another thought a CPN school should be established.

4.9 Coping Strategies

In this section coping strategies used by CPNs to enable them work are discussed. Despite the numerous challenges faced by the CPNs, they were determined to continue to work by developing coping strategies to strengthen them as they cared for the mentally ill persons in the community. The strategies they developed are now discussed in turns.

4.9.1 Reducing Stigma

In the findings presented earlier in this chapter, stigmatization was cited as one of the major barriers that had negative impact on their work. There was a large measure of stigma of association; since they cared for mental patients, they were also perceived as mentally deranged to some extent. This perception society holds about them immensely demoralized them. Yet, they were committed to their jobs and employed some strategies to help them withstand what community members mete out to them.

Most of the participants during the interview said that they disguised themselves during home visits as a strategy to mitigate the effects of stigma associated with their work:

When you are a client and I'm in a mufti and come to visit you, nobody would know I am a nurse. You see society brand them as mad people which our clients detest so much. You see not wearing uniforms on visiting clients is a way of providing privacy, so when I come in mufti nobody knows I am a nurse. I come and then I chat, at times maybe you are in a compound house, nobody knows you are sick there then you in your uniform like this may be 3 or 4 people appearing in the house, wow! People may begin to think that ah! What is happening that people in nursing uniforms are coming to this man for, what is wrong with him? Has he done something? But if I'm in mufti, people might think that I'm a friend, relative or a colleague. So when we come there, we don't even disclose our identity unless it gets to a stage that somebody has to know.

(Betty, 32 years)

In the interest of the patients' integrity, the CPNs hid their identity during home visiting.

This was also to ensure privacy and confidentiality as well as to ward off gossiping.

Disclosure was based on their discretion and was only done when it was necessary.

Another participant said:

Our reason for wearing mufti is the negative thought about mental illness. The clients or relatives feel ashamed that nurses in uniform are following them because of the condition that they have. A lot of them who do not have insight into the condition and the way they are brought to the hospital and in an aggressive mood and dirty in appearance are accompanied by their relatives in that same condition. When they are recovering and they realize it and are able to recollect what happened, it gives them some sort of bad feelings that they said certain things and so when they come back to their normal senses they regret. For us also, we are protecting the clients, we don't want eyes to be following us that nurses are visiting a particular patient in his house because if it happens that way, they display themselves which makes some people to know that there is a mental patient in that house. So it is a way of protecting the clients such that people might not say that there is a mad person in this house and nurses are following him. We protect our clients such that we take them as relatives or friends whom we are visiting; meanwhile we are doing our professional work. The second issue is to protect our clients and make our self not to be so conspicuous, glaring or display ourselves in public such that our clients will feel respected in a way that public eyes will not be following us that, nurses are following this mad person or coming to visit them. We are protecting our patients; that's the main reason.

(Elsie, 60 years)

In this participant's view, hiding their identity during home visiting of mental patients was a way of protecting the integrity of their patients. "Mad people" are not respected in the Ghanaian society thus the CPNs reportedly wore mufti rather than uniforms so that community members did not wonder why the home visiting was being carried out.

The same issue was narrated as follows:

We don't wear uniforms when we are going on visits because of the stigma, we wear only mufti. What we normally do is where we find our clients especially on Tuesdays we go to Accra Psychiatric Hospital and see if we have clients in our catchment area then we take their landmarks for tracing. In taking their landmarks, we are very sure of what we take because it will give you the direction to the client's home and not whereby you go and ask; I want this person or lady who lives here or there but if you get the right landmarks, you go straight to the person's house. We even take telephone numbers in addition. So all these information helps us to get to the client's house without asking, so this one too prevents stigma.

(Jane, 32 years)

But we do explain to them that, we come in house attire, we don't come in uniforms so we don't think there is anything wrong with that because nobody will think that we are nurses. So some people agree and others too do not, so we think it is the stigma attached to mental illness and that is why some of them do that.

(Laura, 32 years)

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Okay, at times we have our name tags in our bags so when we show it to them that we are from this hospital and that we are nurses but not Witnesses and do not have any bad intentions or anything like that but we are here to visit our clients and that's why we are here, they do accept it.

(Laura, 32 years)

Some of the participants highlighted measures they took to further ensure that no one knew that their clients were mental patients in order to avoid stigmatization. One of the measures was that they made sure they knew exactly where the patients lived so that they avoided asking people since streets in Ghana are not all labeled and it was common practice to ask people for direction when one got lost. They used important land marks to locate the houses of their clients. They also collected and kept telephone numbers of relatives so they asked for directions from relatives and not community members. Furthermore, they did not wear their name tags but rather kept them concealed in their bags and only showed them to relatives of their clients in cases where they were mistaken as Jehovah's Witnesses visiting homes for discussions of their doctrine.

4.9.2 Religion

Some of the participants said that they used religious beliefs to console themselves concerning the challenges they encountered in their work. The CPNs trusted God as the source of grace, help, abundance and mediator. They reportedly did all they could to help the patients and expected that God would reward them:

But the bible says give and it shall be given unto you. So sometimes we take consolation that when we give, our Father also see us through. So we find consolation in the bible. We do that for some of these patients anticipating a reward not from the same patient but from God.

(Andy, 56 years)

Another participant said:

Most of them are demoralizing because it is difficult to accept whatever we are proposing or suggesting that we make but we don't do these things with the authorities but with the families and those concerned. Mostly it's demoralizing but the challenges are there and by the grace of God we are managing, we contain them.

(Elsie, 60 years)

4.9.3 Self-Motivation

Despite the multitude of challenges faced by the CPNs, they continued to care for the mentally ill. Participants narrated that they encouraged themselves in order to boost their morale for the demands of the work:

The thing is with this kind of nursing, if you really have that kind of heart. Hmmm, if you are the tolerant type, you can do it because you go, they slap you the next time you are there again you won't say because the client slapped me or the client poured urine on me, I won't go. Some people would not go but if you really have the interest for the job and the client as well you will by all means go.

(Betty, 32 years)

Honestly speaking nowadays when I'm going on visits I don't feel like I used to during the initial stages when I started it. Now when I go..... Now I've seen that no matter what you do some people will by all means love you others too will hate you. So when you go and that day everybody welcomes you, then it's a good day for you. If you go and that day they won't accept you, just take it like that and then you go elsewhere may be that place they will accept you.

(Betty, 32 years)

Others expressed negative emotions regarding their job as CPNs but continued to render care by encouraging themselves:

It is painful but all the same we have taken it as our job so we try our best to do it because it's like if nobody is giving you any satisfaction, you don't put your mind on that thing. You have to give yourself another time so that it doesn't hurt you more, if it hurts you, you can't go out every day to help clients but if you are able to send it somewhere you will be visiting your clients at home.

(Diana, 56 years)

Another participant said:

Well I have not regretted that I have done this work and have gotten into this condition. I'm happy that God has given me the life to continue. I accept the situation as it is in the mean time and hopes that something better will come some day.

(Elsie, 60 years)

Another participant said that they hoped to be noticed one day since they continued to do their best in terms of educating the public and conducting home visits to check on clients. She however, indicated that she was happy that some of the clients were in good health:

We are still striving still doing our part and hope to be noticed one day. I'm still doing my best through education, visiting my clients; the number that I can visit at a time. So I take it cool and I'm happy at least some of my clients are doing well.

(Fanny, no age)

A participant explained:

We don't feel happy, we are not encouraged but the reason why we don't stop is that whenever there is any danger they quickly run to us. That is why we think that for us to prevent the danger from coming let's go to them and be doing what we can because if not at the end of the day they will come back to us in a worst state where we might not be able to help them and might end up losing the life of that client. So even as much as it is difficult we don't feel reluctant to help. We try our best to offer them the little that we can.

(Hilda, 30 years)

The CPNs reported that they were not recognized for the work they do even though they thought their work comes with dangers and weariness. They were reportedly demoralized for lack of recognition and job satisfaction. Even though some of them felt sad and hurt, they could not complain because in their view no one gave them a listening ear. They tried to ignore their inner sentiments of sadness and moved on with their work. Some were invigorated by seeing their clients doing well; others hoped that one day their work would be appreciated. One CPN sought higher education to upgrade herself.

4.9.4 Reduction in Home Visits

Participants mentioned that sometimes they had to reduce the number of home visits as a means of dealing with the challenges they encountered in terms of financial constraints and lack of transport:

What we do is that because of the financial constraint, usually we restrict the number of visits that we embark on normal working days. But increase the number of visits when we do have student nurses around. So when we have students around, we get an excess of 20. So when we get an excess of say 13, 14 or even 8 students, we share them among the staff because we are 5 and then each one will take one sub- district so it becomes cost effective because we have had a lot of students so we can do more visits within a short time frame. But when the students are no more here, we reduce the impact of what we do.

(Cann, 32 years)

One participant noted:

Yes, yes if you are supposed to visit about 10 clients a day and there is no money, we can only do about 4 or 5 because that is how far my money can take me.

(Hilda, 30 years)

Another participant said:

The T & T, if you are not paid for it and you don't have money too, may be you are supposed to do let's say 10 or 15 home visits because of that you have to cut it to say 10 because the clients it is not easy to get to all the clients since they are living apart. We are supposed to see enough clients but because of that you reduce the number so those who could not be visited, you have to extend their visit to next time. Meanwhile they may be in need of some form of help, you can't tell and you may not know. May be days or weeks later, they can also have the share of their visit. You see, our area is quite large so we have clients, we may decide to go and visit let's say this week we go to one place, the next week another and things like that. So if you are not able to finish let's say Bubiashie next week you don't go to Bubiashie but other places before we come back to Bubiashie again which may take a long time. The result is that other clients get deprived.

(Jane, 32 years)

A participant said:

At times it's like you draw your own itinery with regards to what you want to do with the clients but because there is no T & T, you have to leave this and cover a different thing because the means is not there for you to get to that place because at the end of the day, you are supposed to work.

(Martha, 26 years)

CHAPTER FIVE**DISCUSSION OF FINDINGS**

The purpose of the study was to explore the experiences of Community Psychiatric nurses in the discharge of their duty in the Accra metropolis. Various experiences that the participants go through were critically examined after conducting thirteen in-depth interviews.

The participants provided narratives regarding the experiences of CPNs in the course of their work. The findings of this study revealed five major themes and their corresponding sub-themes which were discussed. The major themes and their sub themes were as follows:

Barriers, of which there were two types; service and psychosocial related barriers. The service related barriers were home visits, inadequate logistics, supplies and medications and lack of security or legal backing. The psychosocial barriers were stigmatization and name calling of CPNs, stigma of association, attitudes of family members and feelings of frustration.

Another major theme that emerged from the data was challenges. The corresponding sub-themes were assaults from patients, additional responsibility of CPNs, health concerns, apathy of health consumers and problems of relapse.

A third major theme that also emerged from the data was support. The sub-themes in relation to this major theme were risk allowance, need for recognition, stakeholders' involvement, trust and confidence and relatives' support for integration.

Also, training and certification was identified as a major theme and the only sub-theme was lack of training.

Finally, coping strategies as a major theme also emerged from the data and its corresponding sub-themes were reducing stigma, religion, self-motivation and reduction in home visits.

In the ensuing discussion of the data, barriers were the first to be discussed. This was followed by challenges, support, training and certification and lastly coping strategies.

5.1 Barriers

5.1.1 Service Related Barriers

One major finding that accounted for the experiences of the CPNs was barriers which have been divided into service related and psychosocial barriers. Home visits emerged as a service related barrier. The participants indicated that poor home addresses of their clients and absence of street names made it difficult to locate the homes of their clients. Besides, relatives of some of their clients refused them entry; lack of transport also prevented them from carrying out effective health care to their clients. This finding supports the assertion made by Holst and Severinsson that the lack of continuity in collaboration between health care professionals may affect the quality of community health services because continuity is a vital component of care. This means that CPNs encountered difficulties in an attempt to ensure continuity of care for the discharged mentally ill patients in the community which could be associated with the poor mapping of communities, lack of compromise on the part of relatives of patients and transport.

5.1.2 Lack of Security and Legal Backing

Lack of security and legal backing was identified as another service related barrier. Participants for example, reported that they lacked insurance against assaults from

patients during home visits and thus risked being injured without due compensation and legal backing from the government.

5.1.3 Inadequate Logistics, Supplies and Medications

Another service related barrier was inadequate logistics, supplies and medications. The participants reported that they had problems with office accommodation, transport, and other supplies including medications. They mentioned that limited office space could not accommodate a large number of staff on some occasions especially when there were student nurses in their facility. Also, they lacked entertaining facilities such as television set to keep clients at rest when they reported for reviews; storage facilities such as refrigerator and book shelves to keep patients' folders were also mentioned. Others cited poor allocation of funds and irregular supply of medications and sometimes complete lack of medications. This finding supports Mid-Ghana Baseline Report (2011) in which it was reported that there is inadequate office space and lack of mental health care providers to offer the optimum level of health care services. Basic psychotropic and anti-epilepsy medicines exist for treating most of the mental disorders and epilepsy but availability in adequate quantities and their regularity remains a challenge. The current findings also support the findings of Adam (2008) who showed that medicines used in treating mental disorders in Ghana are too old and are causing serious side-effects to patients. Other drugs available at the pharmacy are of poor quality and reportedly smuggled into the country. Based on the above findings, it is important that new psychotropic drugs are made available at community psychiatric units of the various health facilities. Having discussed the service-related barriers, the psychosocial barriers are now highlighted in the next section.

5.2 Psychosocial Barriers

5.2.1 Stigmatization and Name Calling of CPNs

Participants indicated that there were psychosocial related barriers they encountered in the course of their work. One of such experiences was stigmatization and name calling. This they mentioned was a source of great worry to them. Some stated that they were described as carers of mad people and were discouraged from carrying out home visits. A few mentioned that other colleague health workers looked down upon them thus creating an artificial barrier between them. This finding differs from the findings by Barlow (2006) who carried out a study aimed at determining the perceptions of the role of the Community Psychiatric Nurse. Findings of the study revealed that community psychiatric nurses skills seemed to be recognized and valued by their multidisciplinary colleagues. However, the CPNs did not appear to appreciate this; the attributes identified by the CPNs were not always the same as those identified by their colleagues. The researcher pointed out that there is consensus among the CPNs, yet their colleagues seemed to feel that the CPN's role was reasonably clear.

5.2.2 Stigma of Association

Another psychosocial barrier was stigma of association. Participants observed that certain derogatory comments were made about them by other health workers, patients' relatives and the society attributable to their constant interaction with mental patients because of the work they do. Some mentioned that they often heard comments such as "psychiatric nurses behave like their clients". Others said that people wondered how they were able to manage the mentally ill if they themselves were not mentally ill. This finding is similar to study findings of Nagel (2010) who argued that courtesy stigma is a reality among mental health nurses not by their association to society's view of mental illness in general.

Drawing on the research by others, the researchers pointed out that mental health nurses are often viewed by the public as corrupt, evil and mentally abnormal. This implies that there are ingrained misconceptions and myths that surround mental health nurses and the work they do. However, stigma is a big issue and in many African and Western societies. It is associated with mental illness as well as conditions such as leprosy, tuberculosis, HIV/AIDS and abortion. It is therefore necessary to demystify mental health care through intensive education, counseling and community psychiatric services.

5.2.3 Attitudes of Family Members

Another psychosocial barrier was the attitudes of family members. The participants remarked that relatives of patients were tired of patients' behaviour which had culminated in lack of concern for the patients and thus discouraged them from carrying out their mandated work in the community. Others stated that relatives of patients thought that patients had become a waste and there was no need to worry anymore about them, leading to neglect. A few participants mentioned that sometimes when they visited their clients, relatives of patients treated them with hostility. This finding supports the assertion made by Olofson and Jacobson (2001) who carried out a study on involuntarily hospitalized patients' narratives about being subjected to coercion and their thoughts on how to prevent coercion. The findings of the study revealed that a patient's plea for respect is essential in relation to the ongoing deinstitutionalization of psychiatric care and the need for attitude changes in care and community leading to the treating of mentally disordered people with more respect. Attitudes of family members towards their family member's mental condition could be addressed through health education to the public on the causes and management of mental illness and home care of the mentally ill.

5.2.4 Feelings of Frustration

Another psychosocial barrier was the feelings of frustration experienced by participants in their work. Some of the participants claimed it sometimes demoralized them and felt as if they were in a bad institution or did not choose the right profession. Others remarked that when they visited their clients and they were in good health, it made them feel happy but when they had relapsed, it meant that all the efforts made towards the client's recovery were of no use. A few mentioned that they felt sad and hurt when after all the education given they still find their clients in relapsed states. The findings support the study findings of Edwards, Burnard, Coyle, Fothergill and Hannigan (2000), who found in their study that those health professionals working as part of community teams experienced increasing levels of stress and burnout as a result of increased workloads, increased administrative duties and lack of resources. This means that feelings of frustration are peculiar to the work of the CPN. This problem can be addressed through support from relatives of patients, the employer and other stakeholders through a collaborative effort.

5.3 Challenges

5.3.1 Assaults from Patients

Further key findings showed that CPNs experienced challenges in their work. Some of such challenges were assaults from patients. Participants indicated that there were times when they became victims of physical attacks when treating patients in their own homes as a result of relapses. A participant gave an instance where she was warned by a patient not to be visited after chasing her out with a weapon. Another narrated how she was nearly raped by a patient during a home visit but for the timely intervention of a neighbour. This finding supports the findings of a study by Moylan and Cullinam (2011) who conducted a study on the frequency of assault and severity of injury of psychiatric

nurses in relation to the nurses' decision to restrain. The aim of the study sought to point out that ethical standards and current law demanding that acute care of psychiatric patients be treated with respect, using the least restrictive interventions. The finding showed that in a sample of 110 nurses from five institutions, 80% of the nurses were assaulted, 65% had been injured and 26% had been seriously injured. The injuries included fractures, eye injuries and permanent disability. This current finding is similar to that of Poster (1996) who conducted a study aimed at understanding the beliefs and concerns about work safety and patient assault of nursing staff working in psychiatric facilities across the United States, United Kingdom and South Africa. The finding showed that although the majority of the sample (78%) reported being physically assaulted at least once, 62% responded that they felt safe in their work environment most of the time. However, significant differences were found among the nurses with regard to beliefs about adequacy of staffing, safety of physical environment, admission of assaultive patients, expectations about being victims of assaults, overall level of safety and taking legal action against a patient. There was also a significant difference in attitudes found among nursing staff, who reported previous assaults. The nurses believed that assaults are expected events in their work with psychiatric patients. The implication is that the work of the CPN is risky and they must be given some form of insurance in the event that they sustain injuries in the discharge of their duty.

5.3.2 Additional Responsibility of the CPN

Another challenge that participants encountered in their work was additional responsibility of the CPNs. Most of the participants indicated that sometimes during home visits, patients demanded money from them to buy food to eat before they could take their medications. Others disclosed that apart from giving them money for food they

also coaxed their mental patients to bath and maintain their personal hygiene by fetching water for them. One participant mentioned that she had to buy medications for the patient because a condition such as epilepsy requires constant taking of medication so as to prevent frequent seizures. This finding is similar to the study findings by Fourie, McDonald, Connor and Bartlet (2005) who conducted a study on the role of the registered nurse in acute mental health inpatient care facility in New Zealand. Their study sought to compare the perceptions that registered psychiatric nurses have of their roles with their actual practice. The findings of their study showed that many of the nursing roles related to delivering care from a crisis management perspective, which covers aspects such as assessment, stabilization of symptoms and discharge planning. The study participants also believed that a therapeutic relationship was a fundamental role in inpatient care. Nurses used any opportunity such as kitchen organization, medications, or dealing with a challenging patient to make it a reality. The study further highlighted the complexity of the roles that nurses performed and went further to reveal what at times seemed an invisible practice. This suggests that the CPNs are confronted with financial difficulty out of their meagre salaries of which they have to support their clients. They need to be adequately rewarded for the work they do.

5.3.3 Health Concerns

Participants also indicated that health concerns, that is deterioration in health was another challenge that they were confronted with. A few participants stated that too much walking affected their health and had thus developed back and waist pain as well as spondylosis. A participant remarked that sometimes one became stressed up and life became bizarre and confusing with one not knowing what to do. They had developed health problems and were seeking treatment out of their meagre salaries. This finding supports the findings by Lagerstrom, Hansson and Hagberg (1998) who in a study reviewed the relationship between nursing work and low- back problems. The aim of their study was to estimate the risk of physical, psychosocial, and work organizational exposure factors that may lead to low back problems. Findings of the study pointed out that a considerable number of studies of nursing staff have shown the connection between lifts and transfers of patients on one hand and low back problems on the other. Factors in nursing work that may be significant in this connection are staff density and work satisfaction. The study further emphasized that the single individual factor that was related to low back problems was “history of back problems”. The implication is that CPNs do more than they are required to do with limited resources. They need to be supplied with adequate resources for their work and be fairly treated like any other nurse within the health ministry.

5.3.4 Apathy of Health Consumers

It was also found that apathy of health consumers is another difficulty that confronted the Community Psychiatric Nurses. Participants indicated that patients and their relatives’ lack of interest in the health education given by the CPNs was a source of worry to them. One participant remarked that there were some patients who were drug addicts but were easily influenced by their peers to continue taking the substance in spite of the health

programmes that were organized for them. Other participants observed that relatives of patients would intentionally lock up their mentally deranged relatives so that nobody could have access to them and refused them access to medical checkups. Another participant commented that she knew sometimes their education to the public fell on deaf ears because the communities rather encouraged unhealthy practices even when their victims wanted to end such practices. One other participant was of the impression that her community members did not like learning new things but would rather hold onto the old beliefs and did not want to change. The implication is that the general public had not well understood the concept of mental health. Intensification of public health education in the media in local languages on the causes and prevention of mental disorders should be carried out.

5.3.5 Problems of Relapse

An outstanding finding on challenge was the problems of relapse. Participants mentioned that their observations revealed that episodes of relapse experienced by patients were the result of neglect by relatives for lack of supervision of their medications, apathy and discrimination. One participant remarked that sometimes patients may not take their medications for a number of days because their relatives did not have time for them leading to relapses. Another participant indicated that relatives of patients believed that once the patient is admitted to the hospital and he is fed with breakfast, lunch and supper that was enough for him. But the person might have suffered neglect when he was in the house because the relatives might not have given him the care that he might have needed at home. Another participant mentioned that relatives of patients believed that the disease was spiritual and did not believe it could be treated with medications. They would therefore prefer to send the patients to churches, prayer camps or the shrines and leave

them there. This finding conforms to the claim by Lobelo (2004) who noted that the problem of relapse in psychiatric patients is global and that it is high in rural areas where services are not readily available. Lack of knowledge of psychiatric conditions and the management by family of patients play a part in psychiatric patients relapsing. Families reject their ill family members (patients) when they are in hospital, for what they did when their illness started; For instance, some patients assaulted people and stripped naked in the street. The family then dissociated themselves from the patient because of their behaviour. The implication is that society needs education on mental health issues and measures to reduce the rate of relapses of mental patients.

5.4 Support

5.4.1 Risk Allowance

Further findings revealed that adequate care of the mentally ill requires support. Risk allowance emerged as a support for the CPNs in their work. Participants requested that there should be some form of compensation from their employers for their hard work and in the event of any injury sustained in the course of their work. One participant indicated that formerly there was a risk allowance for mental health nurses but it was removed following agitation from other nurses. Looking at the risk involved in dealing with a mental patient, the risk allowance would have been an incentive to them. Others stated that psychiatric nursing is full of risks and if they have decided to embrace someone who is shunned by society it is important that attention be paid to the field and incentives be given to encourage people to join to make the work less stressful. A few participants indicated that the environment in which they work is bad and they sometimes got attacks from patients on several occasions but without any compensation or risk allowance. This finding supports findings of a study conducted by Crichton (2001) at a large Mental

Health Trust in North England on risk perceptions of mental health nurses. Findings of the study indicated that risks were related to the nature of the client group. Nursing staff relied heavily on intuition and past experience in risk situations, and some of the most commonly occurring situations also produced the most stress. The findings further revealed that the subject of risk is one about which mental health nurses feel strongly and have considerable trepidation, because of the consequences of making mistakes and the conflicting demands placed upon them by society and by their senior colleagues. The researcher stressed the need for all staff to undertake risk management and risk assessment training and this should be updated at least every three years. This means that CPNs should be given regular training on risk assessment and management and when necessary risk allowances be given. Also, they should be duly compensated in the event of any injury.

5.4.2 Need for Recognition

Findings of the study also revealed that the need for recognition as a form of support for the CPNs will be an important tool to facilitate the work of community psychiatric services. Some of the participants emphasized that they expected their employers to see psychiatry and mental conditions as a major public health concern so as to understand the importance of community psychiatric nursing and treat CPNs equally as public health nurses. Others mentioned that the health sector should accept psychiatry as one of the important areas of health care just as they treat any other chronic diseases such as HIV in which everyone seemed to show some interest. One participant reiterated that for a long time psychiatry had been marginalized, and given less funding because no funds are generated, however, those nurses who generate funds received support. This finding is similar to the findings by Hummelvoll and Severinsson (2001) who carried out a study

aimed at exploring mental health professionals' reflection on their work in an acute psychiatric ward. The findings revealed that good mental health care is the result of collaboration between health professionals and the health services. The study emphasized the need for establishing structures that will enable collaboration to take place. The result is that it will enhance the care of the patient and their families.

5.4.3 Stakeholders' Involvement

Participants mentioned that stakeholder's involvement including relatives of patients and significant others in the society could help support the care of the mentally ill in the community as well as their rehabilitation. Other participants were of the opinion that health care providers in public health receive international funding and support for health programmes such as malaria control but psychiatric health services lack such support. A few participants remarked that discharged patients in the community could be supported through apprenticeship training from self-employed persons to help them acquire skills to earn them a living and prevent relapses. One participant indicated that the number one support is for the health ministry as well as the public to accept and recognize mental health as an important area in the health delivery system. There should be adequate financial support and the provision of transport and transport allowances to enhance the work in the various communities. They also stressed on the provision of office accommodation for counseling services and other logistical supplies to make the work feasible. The findings from this study are similar to the findings of Bellali and Kalafati (2006) who carried out a study on Greek psychiatric care reforms: new perspectives and challenges for community Mental Health Nursing. The study aimed at exploring the main issues of psychiatric care reform in Greece and to outline the operating way of the new residential structures of psychiatric care and rehabilitation. Also, it aimed to focus on the

implementation of mental health nursing roles in the primary care services such as supervisor-therapist, liaison, coordinator-crisis interventionist and counselor-trained within the context of a multidisciplinary therapeutic team. Given that multiple professionals are involved in mental health care in primary care, issues of role are likely to be crucial to the effective implementation of new workers. Moreover, there is existing evidence of ambiguity in the roles of different mental health professionals in primary care, relating to the problems they manage and the treatments they provide. The findings of the study revealed that more emphasis needs to be given to the mental health nursing specialty in Greece, because the vast majority of patients requiring mental health care should have care as the psychiatric structures at the community are continuously developing. This means that after care services for the mentally ill is paramount in their rehabilitation and for successful integration in the society.

5.4.4 Trust and Confidence

Participants in this study mentioned that relatives of patients expressed trust and confidence in the care they receive from the CPNs. This, the CPNs considered as a form of support. One of the participants mentioned that when he visited the homes of some of their clients, he was seen as a “father” to the patient such that everything concerning the patient no matter how insignificant was reported. This was also appreciated as a sign of confidence reposed in them. Others remarked that some of the relatives of patients were hostile while others were happy to assist their sick relatives to recover to the extent that they sometimes encouraged regular visits by CPNs. Another participant commented that when it comes to the care of their clients, relatives saw them as doing good work and sometimes assisted them to find new clients especially those who were not on medication. This finding is in line with the views expressed by Adam, Tilley and Pollock (2003) who

conducted a study aimed at exploring the views of people with enduring mental disorders regarding services provided by CPNs and what these people value in working with CPNs. The main finding was that people value their interpersonal relationship with CPNs and this relationship has a specific function in the individual's overall social network. The CPNs' interpersonal relationship forms the context of a purposeful talk, and is shaped and developed through the talk. It provides comfort and a greater sense of confidence with which people can cope with daily life. A valued feature of the personalized relationship with CPNs is continuity, associated with regularity of contact, accessibility (both physical and emotional) and respect for commitment to people as individuals. This means that only few people value the work of the CPN and such people can be used as advocates to help educate the public on the importance of community psychiatric nursing.

5.4.5 Relatives' support for Integration

Another finding was that participants emphasized the need for the relatives of patients to assist with the integration of the mentally ill and their rehabilitation as an effective support system. One participant mentioned that it is not easy tracing the homes of patients and if a dispute is resolved between a client and their relatives following misunderstanding and he was accepted the patient felt well and sound. More so, it is helpful when patients are discharged from the hospital and the relatives offered the needed support such as feeding and financial assistance. Another participant emphasized that the relatives should help so that the client would be well integrated into the family and the community as a whole so as to help eliminate the stigma associated with mental illness. Other participants cited that where there is a strong family cohesion clients are also happy and recovery from mental condition is rapid. The participant further suggested visits by friends and relatives in order to promote family ties during periods of

hospitalization. A participant remarked that what relatives could also do about the situation was that when somebody is mentally ill the person should not be left alone but should be accompanied to the hospital for periodic medical check-ups, supervise their medications and domestic management for the person to feel a sense of belongingness. This finding supports the views shared by Johnson and Montgomery (1999) who studied the experiences of persons reentering an urban community after hospitalization for mental illness. The findings of the study have increased the understanding of what it was like for a group of individuals with chronic mental illness to reenter a large urban community after a period of hospitalization. The study further revealed that the participants did not perceive discharge from hospital as an opportunity to move forward with their lives. They had many difficulties caring for themselves, feeling cared for and feeling cared about when they left the asylum of the hospital. This means that informal care givers of the mentally ill lack understanding of home care of the mentally ill.

5.5 Training and Certification

5.5.1 Lack of Training

Another major finding was about the training and certification of CPNs. Training was identified as a need for the CPNs. Participants stated that there should be training and certification of CPNs in order to earn them CPN status recognition. One of the participants indicated that they were told that what they were doing was illegal since they do not have the certificate or what qualifies them as CPNs. Another participant mentioned that as part of their rotation programme, he only did a 3 month community psychiatry practical on the job where he learnt community psychiatric nursing. Other participants indicated that community psychiatric nursing is not an established course and lacks a certificate to identify them as CPNs. Only 3 months orientation programme on the job is

done and people are then selected to do the work based on personal interest. One participant suggested that a community psychiatric nursing school should be established, be it an undergraduate or post graduate institution in which registered mental health nurses would be trained. It was noted that all practising CPNs do not have a certificate to show as CPNs. After training as registered mental health nurses from the Nurses' Training College the nurses were pushed into community psychiatry. This finding supports the findings of Kelly, Long and Mckenna (2001) who revealed that since the early 1990s, clinical supervision has been the subject of debate by nurses, academics and practitioners. This debate encouraged the adoption of clinical supervision by the profession throughout the United Kingdom. The aim of the study was designed to redress this information deficit for nurses, their managers and supervision. The results indicated that there was support for clinical supervision and that it was being implemented within community psychiatric nursing in Northern Ireland, although not in all cases. The findings also indicated that serious education and training deficits existed, and the importance of the interface between managerial and clinical supervision was emphasized. The issues of providing effective education and training in supervision skills, and the uncertainty that was highlighted regarding fundamental concepts underpinning clinical supervision have implications for nursing practice, education and management. This means that community psychiatric nursing must have a training facility for its practitioners and also be provided with a legal backing. This calls for the need to inform policy makers to implement the Mental Health Act 846 (2012) to help establish a community psychiatric nursing college with the mandate to award certificates for practice.

5.6 Coping Strategies

5.6.1 Reducing Stigma

The study found that CPNs use various coping strategies to deal with the challenges of their work. Reducing stigma was a coping strategy employed by CPNs in managing some of the difficulties encountered in practice. Some of the participants indicated in the interviews that when they wore mufti to visit clients nobody got to know that they were nurses. Not wearing uniform to visit their clients was a way of providing privacy for the clients in order that people do not question the reasons for which nurses are visiting a particular person at home. Other CPNs mentioned that their reason for wearing mufti was due to the negative thoughts about mental illness. Clients and their relatives feel ashamed that nurses in uniforms are following them to their homes because of the condition they have. It was a way of protecting the clients so that people would not say that there is a mental patient in a particular house so nurses are following him. One participant stated that they sometimes kept their name tags in their bags and only showed it to the clients and their relatives during home visiting that they are nurses and have no bad intentions for visiting them. This was an attempt to reduce public suspicion and stigma.

5.6.2 Religion

Community psychiatric nurses also use religion as a coping strategy in their work. Participants commented that certain religious beliefs served as a consolation for the challenges they face in their work. Some of the participants mentioned that the bible says: “give and it shall be given unto you” so they often gave financial assistance to their clients. This inspired them with the hope that when they give, their Father (God) would compensate them. This finding supports the claim by Burnard, Edwards, Fothergill and Coyle (2000) who sought to explore mental health nurses’ experiences of stress and

burnout related to their work and their coping strategies. Their finding indicated that coping strategies that community mental health nurses reportedly used included peer support, a range of personal strategies such as relaxation and belief in self and supervision.

5.6.3 Self-Motivation

Participants also indicated that self-motivation was a coping strategy used by CPNs to deal with the demands of their work. Some participants stated that if a person is tolerant then that person can be a CPN since they sometimes received slaps from patients but continued to do the work. Other participants mentioned that they did not feel like going on home visits nowadays unlike when they started the work as CPNs but continued to encourage themselves that they cannot please everyone since not everybody appreciate what they do. A participant indicated that it is painful when there is lack of job satisfaction but they have accepted to do the work. Another participant remarked that they are still doing their part by continually visiting their clients, giving health talks and hope to be noticed one day. This finding is similar to the findings of Thompson, Powis and Carradice (2008) which reported on a study that explored community psychiatric nurses' experience of working with people who self-harm. The results showed that community psychiatric nurses struggle to conceptualize self-harm behaviours and generally reported finding working with people who self-harm stressful particularly in terms of managing the emotional impact upon themselves and the boundaries of their professional responsibilities in relation to risk management. The implication is that CPNs continue to offer health services in spite of the constraints of their work through personal encouragement. CPNs must be adequately motivated in their work in order that they meet the health needs of the mental patients.

5.6.4 Reduction in Home Visits

It was also found in this study that reduction in home visits was another measure CPNs adopted to deal with the challenges of their work. Some participants mentioned that because of financial constraints they usually restricted the number of home visits that needed to be done. Other participants indicated that lack of transport or transport allowance did not allow them to cover areas that they had planned to visit. This finding is in line with the study findings of Simpson (2005) who studied Community Psychiatric Nurses and the care co-ordinator role. The study aimed at studying the illuminating factors that either facilitate or constrain the ability of CPNs, in their role as care co-ordinators, to meet service users' and carers' needs. The findings pointed out that additional duties and responsibilities specifically associated with the care co-ordinator role and multidisciplinary working, combined with heavy workloads, produced 'limited nursing', whereby community psychiatric nurses were unable to provide evidence-based psychosocial interventions that are recognized to reduce relapses amongst people with severe mental illness. This means that CPNs must be adequately resourced in terms of finance and transport to enable them visit their clients wherever they are in the community.

5.7 Limitation of the Study

In this study, the participants were not selected from all the community psychiatric units in the country but were selected from the community psychiatric units only in the Accra metropolis of the Greater Accra Region. The researcher was the sole person who carried out the study from his own perspective. It is likely that the researcher's background as a mental health nurse could have influenced the research process even though adequate steps were taken to reduce the risk.

CHAPTER SIX**SUMMARY, CONCLUSION AND RECOMMENDATIONS****6.1 Summary**

The study investigated the experiences of community psychiatric nurses in the discharge of their duty in the Accra metropolis. The objectives of the study were to determine the experiences of Community Psychiatric Nurses and their expectations, to identify challenges they face and to describe strategies they use to deal with the difficulties. Thirteen participants were purposively sampled and interviewed using a semi-structured interview guide. Informed consent was obtained before the interview. Content analysis was used to analyze the data. The findings of the study indicated that participants experienced two forms of barriers. The barriers were service related and psychosocial barriers. Regarding the service-related barriers, participants complained of poor home addresses which made it difficult for them to locate the homes of their clients. They also complained of relatives of patients' refusal to allow them access to the clients. Lack of transportation also prevents them from rendering effective care to their clients. Furthermore, inadequate logistics, supplies and medications were also identified. The participants mentioned that they had problems with logistics such as office accommodation, transport and supplies including medications. Lack of security or legal backing for their work was also a problem.

In relation to the psychosocial barriers, stigmatization and name calling of CPNs were prominent. In this instance, the participants mentioned that they had been stigmatized in various ways; this was a source of great worry. Stigma of association was another major issue of concern. Participants indicated that certain derogatory remarks were made about them by other colleague health workers, patients' relatives and the general public because of their association with the mentally ill in the course of their work. Participants also

complained about the attitudes of family members of the clients which led to patients' neglect and abuse; these abuses sometimes extended to them. Feelings of frustration were also identified among participants who claimed these are psychologically disturbing. Participants shared some of the numerous challenges associated with their work. One of such challenges was assault from patients during home visits. Sometimes they also took up additional responsibilities such as giving money to patients and or relatives for food, transport fares and buying medications for the patients. These responsibilities should be performed by patients' relatives.

Other challenges that participants experienced was health concerns such as deterioration in their health status. Apathy on the part of patients' relatives was also a problem; a situation where patients and their relatives showed a lack of interest in health education given by the participants. Participants also shared their experiences regarding problems of relapse. They expressed that there were episodes of relapse patients experienced due to relatives' negligence to supervise them to take their medications. Patients' relatives sometimes showed a lack of concern and discrimination.

As a form of support, participants expected that there should be compensation from their employers for their hard work and in the event of any injury sustained in the course of their work. Participants also expressed the need for recognition from their employers, relatives of patients and the society in order to facilitate effective psychiatric community care services. Participants were of the view that key stakeholders including NGOs, patients' relatives and significant others in the society could help support the care and rehabilitation of the mentally ill in the community. As a form of support for them, participants stated that some relatives of patients expressed satisfaction, trust and confidence in the care patients' received. The findings also showed that participants expressed the desire for the relatives' support for the integration of patients into society,

as a step towards their rehabilitation. Regarding training and certification, participants reported a lack of training and thus suggested that there should be training and certification of personnel in order to accord them the desired recognition.

In terms of coping strategies employed to deal with the challenges of their work, participants tried to reduce stigma by disguising themselves during home visits. Another coping strategy was the use of religion to console themselves. Self-motivation was also a strategy used to encourage themselves to cope with the demands of the job. The number of home visits they carried out was reduced in order to lessen their financial constraints and lack of transport.

6.2 Conclusion

The findings of the study indicated that the experiences of the community psychiatric nurses in the discharge of their duty in the Accra metropolis were as follows: difficulty locating the homes of their clients due to poor home addresses and transportation, limited logistical support and irregular supply of medications emerged as service related barriers. Also, stigmatization and name calling of the CPNs and the feelings of frustration that they go through were noted as psychosocial barriers to effective community care. Additionally, assaults from patients and the negative attitudes of relatives of patients leading to relapses were identified as challenges encountered in practice. Regarding support, participants had the expectation that risk allowances would be given in the event of any injury sustained while working. They also emphasized the need for recognition from their employers as well as support from stakeholders. Training and certification was mentioned as a need to ensure recognition. In view of all the challenges encountered by the CPNs, various coping strategies such as reducing stigma, religion, self-motivation and reduction in home visits were employed to mitigate their effects.

In the sections that follow, the implications of the study findings for the Community Psychiatric Nursing Practice and future research are presented. Finally, the recommendations made based on the study findings are outlined.

6.3 Implications for Nursing and Future Research

The findings of the study raised many issues that must be addressed in order to promote community psychiatric nursing. Inadequate logistics such as transport, office accommodation and irregular supply of medications can lead to low morale in the CPNs which can have a negative consequence on the effectiveness of community psychiatric services.

Stigmatization and name calling of CPNs can also affect their self-esteem and cause them to adopt defensive attitude in their practice area which may make them withdraw from other health care providers.

More so, physical assaults from patients can cause injuries, permanent disabilities and even deaths which may create human resource problems.

Additional responsibility of CPNs such as offering financial support to patients may lead to financial difficulties of the CPNs leading to feelings of frustration.

Apathy of health consumers may lead to inadequate knowledge on mental health issues which may further worsen the plight of the mentally ill, their relatives and the society at large.

Furthermore, stakeholders' involvement in the care of the mentally ill may help in the integration and rehabilitation of the patients thereby reducing the stigma of mental health and mental illness.

Training and certification of CPNs will help improve their self-confidence, enhance quality of care and ensure job security.

Findings from this study can also help inform policy makers (Nursing Administration) on mental health issues to address the challenges of CPNs. This may help improve upon the quality of mental health care delivery in Ghana.

The findings from this study suggest a number of avenues for future research. Selecting samples (CPNs) from other community psychiatric units in the various health facilities in the country and comparing their experiences may shed more light on the plight of CPNs.

Also, a research can be conducted on the factors that influence effective integration of the mentally ill in the community or society.

6.4 Recommendations

Based on the findings of this study, a number of recommendations were made:

- Relatives or any responsible family member of a patient should provide correct home addresses during admissions and after discharge. This is to enable CPNs to carry out after care services in the community with less difficulty in locating the homes of discharged patients.
- The employer and management of the various health care facilities should provide the CPNs with transport to facilitate easy access to their clients in the community.
- The Ministry of Health and management of the various health institutions should provide the CPNs with a well-furnished office accommodation in order to ensure privacy of their clients when providing counseling and other essential health care services.
- The Ministry of Health should ensure regular supply of potent psychotropic drugs to the CPNs so as to meet the demands of the patients and to prevent relapses.
- There should be media involvement in educating the general public on mental health issues to reduce the stigma of mental health and mental illness.

Experiences of Community Psychiatric Nurses

- Community psychiatric nurses should be adequately motivated to reduce the feelings of frustration.
- Risk allowances should be provided for CPNs in recognition of the risky nature of their work.
- Relatives of patients should be educated on home care of family members with mental disorders and how to cope with them to prevent relapses.
- The Ministry of Health in collaboration with other stakeholders should ensure the training and certification of CPNs in order for them to be recognized.
- CPNs should be encouraged to identify more effective ways of dealing with the challenges of their work in order to ensure effective delivery of health care.

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APPENDICES**APPENDIX A: DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS**

NAME	SEX	AGE (years)	MARITAL STATUS	EDUCATIONAL LEVEL	RELIGION	NUMBER OF CHILDREN	PLACE OF RESIDENCE
Andy	Male	56	Married	Enrolled Mental Health Nurse	Christian	5	Nima 441
Betty	Female	32	Married	Registered Mental Health Nurse	Christian	2	Zeenu-Ashaiman
Cann	Male	32	Married	Registered Mental Health Nurse with a bachelor's degree	Christian	1	Roman Ridge
Diana	Female	56	Married	Enrolled Mental Health Nurse	Christian	3	Darkuman Official town
Elsie	Female	60	Married	Enrolled Mental Health Nurse	Christian	3	Ridge near the Hospital
Fanny	Female	Nil	Married	Registered Mental Health Nurse with a bachelor's degree	Christian	2	West Legon
Gina	Female	56	Married	Enrolled Mental Health Nurse	Christian	3	Mataheko
Hilda	Female	30	Married	Registered Mental Health Nurse with a bachelor's degree	Christian	Nil	Mamprobi
Irene	Female	32	Single	Registered Mental Health Nurse with a bachelor's degree	Christian	Nil	Teshie
Jane	Female	32	Married	Registered Mental Health Nurse	Christian	2	Darkuman
Kanto	Male	30	Single	Registered Mental Health Nurse with a bachelor's degree	Christian	Nil	Abeka Lapaz
Laura	Female	32	Married	Registered Mental Health Nurse	Christian	1	Nungua barrier
Martha	Female	26	Single	Registered Mental Health Nurse with a bachelor's degree	Christian	Nil	Teshie

APPENDIX B: INTERVIEW GUIDE**Data Collection Instruments****Section A**

Demographic Data

Age

Sex

Marital Status

Number of children

Level of Education

Religion

Residence

Section B

Guiding questions

- How would you describe your work as a community psychiatric nurse?
- How is it like caring for the mentally ill in the community as a nurse?
- How would you describe the relationship between you and your clients/ family?
- What perceptions does the society have about you as a community psychiatric nurse?
- How would you like to be treated by your employers?
- What are some of the support you need to render effective services to your clients/ family?
- In which ways would you like to see your clients after rendering effective care to them?
- What are the challenges you face as a community psychiatric nurse?

Experiences of Community Psychiatric Nurses

- How do the challenges affect you?
- How do the challenges affect your work?
- What do you do to overcome the challenges that affect your work?
- How do you cope with the challenges that affect you?
- Do you have anything else to share with me?
- Thank you.

APPENDIX C: CONSENT FORM**Consent Form**

Title: Experiences of Community Psychiatric Nurses in the discharge of their duty: A study in the Accra Metropolis.

Principal Investigator: Frederick Yaw Opare

Address: School of Nursing, College of Health Sciences, University of Ghana, Legon.

P.O. Box LG 43 Legon

General Information about Research

The study seeks to explore and document the experiences of the community psychiatric nurses in the discharge of their duty. The study will generate new knowledge and offer relevant suggestions and recommendations which will help address some of the challenges of the Community Psychiatric Nurses in the Accra Metropolis. These suggestions will also help improve upon the quality of service delivery in the practice of Community Psychiatric nursing. All participants must be community psychiatric nurses. You have the free will to decide whether you want to take part in the study or not. If you agree, you will be given an agreement form and you will have to give your consent by signing the agreement form. You will be interviewed for at least 45 to 90 minutes. Interview will be scheduled at your convenience and it will be audio-taped.

Possible Risks and Discomforts

There is no risk associated in taking part in the study.

Possible Benefits

It is hoped that this study will provide a document which will shed light on the needs of community psychiatric nurses and thus help enhance job satisfaction and recognition.

Confidentiality

The venue and time for the interview will be such that no one will be able to hear what you say. Your name will not be mentioned during the recording of interview. If mentioned by accident it will be erased.

Your name will only be on the agreement form which will only be read by my supervisor and me. I will store any identifying information in a locked drawer to which I will have sole access. You are free to ask any question at any point during the interview for clarification.

Compensation

There would be no monetary gain for participating in the study; however, your effort will be much appreciated for taking part.

Voluntary Participation and Right to Leave the Research

You have the free will to decide whether you want to take part in the study or not. If you agree, you will be given an agreement form and you will have to give your consent by signing the agreement form. You are free to answer or not to answer any question I asked without penalty and also free to opt out of the study at any time if you wish.

Contacts for Additional Information

Other persons to contact for more information about the study in event of any doubt are:

Dr (Mrs) Patience Aniteye

School of nursing

College of Health Sciences

University of Ghana, Legon.

Tel. No.0244681352

Mr. Gladstone .F. Agbakpe

Methodist University College

P.O. Box DC 940

Dansoman

Tel. No. 0277137467

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.mimcom.org or HBaidoo@noguchi.mimcom.org .

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title (*Experiences of Community Psychiatric Nurses in the discharge of their duty: A study in the Accra Metropolis*) has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date


Name and signature or mark of volunteer

APPENDIX D: INTRODUCTORY LETTER

**SCHOOL OF NURSING
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA
LEGON**

Telephone: 021-513255 (Dean)
Ext. 6206
021-513250 } Secretary
028 9531213

Fax: 513255
E-mail: nursing@ug.edu.gh



P. O. Box LG 43
LEGON, GHANA

Our Ref:.....
Your Ref:.....

November 27, 2012

The Community Psychiatric Unit,
Regional Health Directorate,
Ghana Health Service,
P.O. Box 184,
Accra

Dear Sir/Madam,

**APPLICATION FOR SITE APPROVAL TO CONDUCT A RESEARCH AT THE COMMUNITY
PSYCHIATRIC UNIT, ACCRA PSYCHIATRIC HOSPITAL**

Title of Research: "Experiences of Community Psychiatric Nurses in the Discharge of
Their Duty: A Study in the Accra Metropolis"

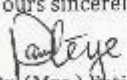
Researcher: Frederick Yaw Opare

This letter is to request your permission and assistance to conduct a study on the
experiences of Community Psychiatric Nurses in the Discharge of their Duty. The
researcher is an M'Phil student of the School of Nursing, College of Health Sciences,
University of Ghana, Legon. He is a Registered Mental Nurse and a tutor at the Ankaful
Nurses Training College with over 15 years working experience.

The participants will be Community Psychiatric Nurses.

Data collection will involve interviews with community psychiatric nurses at the Accra
Psychiatric Hospital between January and June 2013. Attached is a copy of the Ethical
Clearance Certificate from the Institutional Review Board of the Noguchi Memorial
Institute for Medical Research.

Thank you.


Yours sincerely,

Dr. (Mrs.) Patience Aniteye
Lecturer

APPENDIX E: ETHICAL CLEARANCE

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
Established 1979 A Constituent of the College of Health Sciences
University of Ghana

INSTITUTIONAL REVIEW BOARD

Phone: +233-302-916438 (Direct)
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E-mail: nirb@noguchi.nimcom.org
Telex No: 2556 UGL GH



Post Office Box F.G 581
Legon, Accra
Ghana

My Ref. No: DF.23
Your Ref. No:

14th November, 2012

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824 **IRB 00001276**

NMIMR-IRB CPN 022/12-13 **IORG 0000908**

On 14th November, 2012, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL : **Experiences of Community Psychiatric Nurses in the discharge of their duty: A study in the Accra Metropolis**

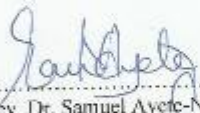
PRINCIPAL INVESTIGATOR : **Frederick Yaw Opare (MPhil Student)**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 13th November, 2013. You are to submit annual reports for continuing review.

Signature of Chairman: 
Rev. Dr. Samuel Ayete-Nyampong
(NMIMR – IRB, Chairman)

cc: Professor Kwadwo Koram
Director, Noguchi Memorial Institute
for Medical Research, University of Ghana, Legon

APPENDIX F: THEMATIC CODE FRAME

THEMES	CODE	DESCRIPTION
1. BARRIER	BAR	All that prevents the CPNs from rendering effective health care to discharged mental patients in the community.
a. Service related:	ser	All the factors pertaining to the GHS that prevent the CPNs from rendering effective care to mental patients in the community.
i. Home visits/ Reaching the patients/ Access to patients/ Transport	hov/rep/acp/tra	Problems and transport difficulties CPNs encounter during home visits home visits to mental patients.
ii. Inadequate logistics/ Supplies/ Medications	ils/sup/med	Scarce supplies and medications for mental patients use.
iii. Lack of security/ Legal backing	sec/leb	Lack of protection and legal backing for CPNs in their work.

Experiences of Community Psychiatric Nurses

b. Psychosocial:	pso	All the psychological and social concerns of CPNs about their work.
i. Stigmatization/ Name calling of CPNs	stg/nac	Derogatory comments from the society against the CPNs due to the work they do.
ii. Stigma of association	soa	CPNs being stigmatized because of their association with mental patients.
iii. Attitude of family members	aof	What family members think, do and feel in relation to their family member's mental condition; and also towards CPNs.
iv. Feelings of frustration	fof	Negative emotional expressions of CPNs in relation to difficulties they encounter in their work.
2. CHALLENGES	CHA	All the difficulties encountered by CPNs that limit effective health care provision to the mentally ill patients in the community.

i. Assaults from patients	afp	Verbal and physical attacks on CPNs by mental patients.
ii. Additional responsibility of CPNs	arc	CPNs taking up certain responsibilities which should be performed by patients' relatives.
iii. Health concerns	hec	Health problems experienced by CPNs attributable to the nature of their work.
iv. Apathy of health consumers	ahc	Lack of interest in health education by patients and their relatives.
v. Problems of relapse	por	Episodes of relapse experienced by mental patients due to negligence by relatives.
3. SUPPORT	SUP	All the inputs from employers and relatives of patients that will help facilitate effective community psychiatric nursing services.

i. Risk allowance	ria	Request made by CPNs as compensation for their hard work.
ii. Need for recognition	nfr	CPNs quest for recognition from employers, relatives and community members.
iii. Stakeholders involvement	shi	Expectations of CPNs in relation to the involvement of significant others and key stakeholders in the care of mental patients.
iv. Trust/ Confidence	tru/con	Expressions of confidence in CPNs (or its lack) by relatives of mental patients.
v. Relatives support for integration	rsi	Expectations of CPNs regarding relatives' involvement in integrating mental patients into the society or their rehabilitation.

Experiences of Community Psychiatric Nurses

4. TRAINING/ CERTIFICATION	TRA/CER	The quest for training and certification by CPNs.
i. Lack of training	Lot	The training needs of CPNs.
5. COPING STRATEGIES	COS	All the measures adopted by CPNs to deal with the challenges in their work.
i. Reducing stigma	res	Strategies employed by CPNs to mitigate the effect of stigma associated with their work.
ii. Religion	rel	Religious beliefs CPNs resort to, to help them cope with the challenges of their work.
iii. Self motivation	sem	Encouragements CPNs give themselves to boost their morale for the demands of their work.
iv. Reduction in home visits	rhv	Reducing the number of home visits CPNs need to undertake as a measure of dealing with the challenges there of.