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Full Length Research Paper

As I See It: The Cry of the Community Psychiatric Nurse in Ghana

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Background: Community Psychiatric Nurses (CPNs) play a crucial role in the public health delivery system in Ghana. In general, mental health care in Ghana is largely underdeveloped with limited resources, including skilled personnel to improve quality of care. This study sought to explore the needs and challenges of CPNs in the discharge of their duty. **Materials and Methods:** An exploratory descriptive qualitative design was adopted in this study. A total of thirteen (13) CPNs were purposively sampled and data gathered through semi-structured interviews using an interview guide. Data was analyzed thematically yielding descriptive results of some of the barriers and challenges encountered by CPNs in Ghana. **Findings:** The major challenges of CPNs included: inadequate logistical support; irregular supply of medications; stigmatization of the CPN; assaults from patients and limited support from families and caregivers leading to relapse of patients. **Conclusion:** Psychiatric nurses are integral members of the community health delivery team; however, the work of the community psychiatric nurse in Ghana presents a challenge both in terms of personnel and logistics. Furthermore, quality community psychiatric nursing care requires collaboration with other multidisciplinary teams, including the social worker, families and caregiver.

Key words: Community Psychiatric Nurse, Experience, Challenges, Barriers.

INTRODUCTION

The environment, in which psychiatric patients are managed, has an impact on both the patient's behaviour and the outcome of treatment. In the past when patients were institutionalized, their aggressions were managed largely by medication, however, the hospital setting maybe too restrictive and thus leading to violence and aggression. Following de-institutionalization, community care was perceived therapeutic and rehabilitative leading to improved quality of life (Lichtigfeld & Gillman, 2000).

In Ghana, Community Psychiatric Nursing was introduced in 1973. It was based on a therapeutic community in one of the wards at the Accra Psychiatric Hospital. The trial stage of this programme encountered numerous relapses among discharged patients, leading to re-admissions. Consequently, psychiatric out-patients' clinics were established in various parts of the country to support discharged patients in the community (Department of Psychiatry, Medical School, 2003).

According to (2007), Community Psychiatric Nursing as a branch of professional nursing that utilizes both human and natural resources in the promotion and maintenance of

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mental and physical health. The CPN 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 CPNs' Unit of the hospital for follow-ups. This is done in order to facilitate continuity of care in the communities. The duties performed by the CPNs include home visits, creating awareness and promoting mental health in the community, identifying and managing cases, and referral of cases to psychiatric hospitals for treatment.

However, community mental health care in Ghana grapples with many challenges. According to Asare (2003), as at 2003, there were 132 CPNs working in all ten regions of the country, but some regions may have just one or two CPNs. The nurses were not equitably distributed throughout the country, and only 52 districts out of the then 110 were covered by at least one CPN.

In spite of their contributions to health care delivery, the public is not aware of the existence of CPNs as a critical health human resource in the communities (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 already seemingly neglected mental health care in the country.

The roles of the CPNs are multiple in the health care delivery system. CPNs in Ghana perform a unique role in the discharge of their duties both within the communities they serve, as well as the hospitals. There are two hundred and sixty (260) Community Psychiatric Nurses in Ghana with only sixty-eight (68) in the Greater Accra Region while the remaining ones are serving in various parts of the country. The reason for this low number is associated with a number of trained nurses, non-availability of risk allowances or insurance cover for injury in the course of their work, and lack of interest by community psychiatric nurses due to stigma (Bukari, 2007).

Community care is crucial in mental health treatment and rehabilitation; community care makes patients feel part of the community and thus reduces stigma. However, observation of the CPNs revealed that, they face some challenges in the discharge of their duties in Ghana such as wrong home addresses and thus making home, tracing of patients' difficult, assaults by patients, inadequate transportation, and shortage of staff, low morale and non-compliance with medications by clients leading to relapses and readmissions. Despite these challenges, limited empirical studies have investigated the experiences of community psychiatric nursing in Ghana. The objective of this study was to unearth the challenges CPNs experience in the discharge of their duties. Uncovering the challenges would help the CPNs in Ghana to be able to identify areas of concerns with regard to knowledge and professional development to further advance community psychiatric nursing practice. It was also envisaged that data generated through this inquiry may constitute the base for future research.

MATERIALS AND METHODS

Research Design

As little is known in this area, the study adopted an exploratory descriptive qualitative design. In order to achieve the objective of this study, the researchers explored the experiences of community psychiatric nurses in Ghana.

Research Setting

The research was conducted in Accra involving all the community Psychiatric Units in the Accra Metropolis. About 60% of CPNs are located within the Accra Metropolis. In Accra, all the CPNs meet for a case conference once a week where they submit their weekly and quarterly reports to the Regional Headquarters. Similarly, on a yearly basis, these reports are compiled and sent to the National Headquarters of the Ministry of Health for budgetary planning purposes.

Study Population

The target population was all CPNs working in the Psychiatric Units of the various Hospitals and Polyclinics in the Accra Metropolis. The criteria for inclusion were CPNs who have had more than three years working experience. Whereas the criteria for exclusion were newly qualified mental health nurses who were assigned the roles of Community Psychiatric Nursing.

Sampling Technique

Purposive sampling method was used to select 13 CPNs from the research area comprising six sub-metro-districts (Ayawaso, Ashiedu Keteke, Okaikoi, LEKMA, Ablekuma and Osu-Klottey) of the Accra metropolis. Participants were recruited through the Regional Coordinator of the CPNs at the in-service training unit of the Accra Psychiatric Hospital. At least two (2) participants each were selected from the six (6) sub-metro districts in the Accra metropolis. Data collection stopped when it was realized that the study participants were saying almost the same thing, thus 'saturation' of data.

Data Gathering Instrument

A semi-structured interview guide was used to collect data. The interview guide was piloted to established validity and reliability with five participants outside the study area. Interviews were audio taped with participants' consent. Field notes were recorded which consisted of observations and non-verbal communications.

Characteristics of the Sample

The characteristics of the sample obtained included the sex, age, marital status, and educational level, and religion, number of children and place of residence of CPNs. 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 respectively, all within the Accra metropolis in the Greater Accra Region. One participant mentioned that he had five children, three stated three children each, three of the participants cited two children each and two of the participants also mentioned one child each while the remaining four did not have any children.

Ethical Considerations

Ethical Clearance was obtained from the Institutional Review Board of the Noguchi Memorial Institute for Medical Research, University of Ghana, Legon. In collecting data, the researchers' approval letters were sent to all the relevant authorities of the Community Psychiatric Units of the various Health facilities in the Accra metropolis where the study was done. In addition, verbal consent was obtained from the participants prior to the interview and they were assured of confidentiality. The CPNs were assured that their names would not be identified when reporting or sharing any information. Pseudonyms were used in all written and oral presentations of the interviews conducted. Interviews were audio taped and recorded with the consent of the participant. 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 interview data. Notes, transcripts and audios were all securely kept to protect participant confidentiality.

Data Analysis

Although data analysis was done concurrently with data collection, overall, all recorded interviews were transcribed verbatim and analyzed thematically; emerging themes were identified and these were arranged into categories with their corresponding sub-themes. Themes were cross-checked with participants to ensure agreements. In reporting the findings, participant's quotes were used to validate the themes.

FINDINGS

The findings of this study, yielded a range of themes and sub-themes regarding community psychiatric nurses' experiences working in the Accra metropolis, Ghana. These included:

Barriers to community psychiatric care

The barriers to community psychiatric care that emerged from this study comprised of both psychosocial and services related.

Service related barriers

Regarding the service related barrier, the corresponding sub-themes identified included logistic constraints and medications shortages. Logistics and medications are very essential for the work of the CPNs. They help facilitate

effective delivery of mental health care in the community. However, their limitations created significant challenges for the CPNs. Some of the participants mentioned that they had problems with office spaces to work, lack of transport and supplies including medications. Participants expressed various concerns, including:

"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. 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 the office accommodation is that which is not encouraging"

(Cann, 32 years)

"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 drugs we have challenges with it, it has not been forthcoming. 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)

Psychosocial Barriers

Psychosocial barrier expressed by participants related largely to stigma. All the CPNs interviewed cited the stigma associated with being a psychiatric nurse. Participants reported that even health professionals and other community members refer to them as "mad nurses". They felt that they were poorly respected by society and thus 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:

"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 are you 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 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)

"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 us 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)

Stigma of Association

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

"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 behaviour. 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 the client will tell you I'm not taking the food and then you ask why....."ah! These 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), sometimes 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 to them; that they don't fight us or injure us. They see us to be superhuman 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)

Attitudes of Family Members

The attitudes of families and caregivers showed that they had no regard for their mentally ill relatives and the nurses. Patients appeared to have lost all their rights accorded as human beings. Some relatives referred to them as "mad people" connoting "useless people". Some relatives and carers did not see why they should spend time on mental health patients to get them to take their medication. They acted as though the health professionals owned the patients and were solely responsible for their welfare.

"They do so because they are fed up with the patient's behaviour. If you have been able to go to the house and educate the patient's relatives to make sure that the 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)

"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 maybe the person is asked to take the medication, maybe 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 madman to take, what's the benefit to buy medicine for a mad person?' These are some of the comments you hear.

(Betty, 32 years)

Feelings of frustration

The participants highlighted situations that generated feelings of frustration in them in the course of their work. The major problem that demoralized them was the lack of recognition of families and carers as well as the general public. They (participants) believed they are important in that they look after people and more so patients and thus deserve some respect.

"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)

"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)

Assaults from Patients

Participants narrated how they have to endure assaults from patients during home visits. Some CPNs had been assaulted by patients during home visits. Others escaped with threats and warnings not to come to their (patients') homes. This was expressed in various ways:

"There are times when we go to the patients' 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 an 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 killed 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 knocking 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 a machete, 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)

Financial burden

It was evident that some families and carers shirked their responsibilities. Although some of the duties of the CPNs include home visits to assist them with activities of daily living such as bathing and oral toileting, they were quite surprised that relatives and families expected them to be responsible for feeding and buying medication for the patients:

"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 won't 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! In 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 the chewing stick, I won't take the sponge, I want a tooth brush'. Then you ask the relatives "does this client have?" No. Then what are you doing? This one will

say 'I don't have the money'. So you the CPN will have to buy it for the client making sure that the client brushes his teeth."

(Betty, 32 years)

Relapse

Relapse of the patients was a major drawback cited by the vast majority of participants. A participant reported a significant number of patients relapse. Relapses were attributed to a range of factors including; negligence, lack of supervision, inability to afford prescribed medications and patients' refusal to adhere because they cannot take the medication on an empty stomach. This leads to worsening of mental state:

"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)

However, relapse was observed to be more prevalent among patients in community settings compared with in-patients. It was argued that in-patients were better supported and thus more compliant to treatment. In addition, patients are better fed in the hospitals where meals are provided:

"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 takes his lunch and in the evening his supper. 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 is 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 pisses them off.....ooh! Get away with you silly behaviour, you madman. 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)

DISCUSSION

The participants provided narratives regarding their experiences working as CPNs in Ghana. A major finding that emerged from the study related to barriers and challenges encountered by CPNs in the discharge of their duties. These barriers are either service related or psychosocial barriers.

The service related barriers

These include inadequate logistics and limited 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 any occasions, especially when there were student nurses in their facility. Others cited poor allocation of funds and irregular supply of medications and sometimes complete lack of medications. This finding supports the 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. Antipsychotic medication continues to play a crucial role in the management of people with mental disorders. However, findings from the study suggest that limited psychotropic medicines exist for management of the mental disorders. 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. Based on the above findings, it is important that new psychotropic drugs are made available at community psychiatric units of the various health facilities.

Psychosocial Barriers

The psychosocial barriers identified in this study are discussed below.

Stigma

Participants reported psychosocially related barriers, including stigma and derogatory names. The above mentioned was impacting on quality of care. Some stated that they were described as 'carers of mad people' which appears to be demotivating to staff. It was also observed that staff felt stigmatized by their fellow healthcare professionals who often undermine their work. This finding is in contrast with Barlow (2006) who observed that community psychiatric nurses' skills seemed to be recognized and valued by their multidisciplinary colleagues.

Another psychosocial barrier was a stigma of association with mental health patients. Participants observed that certain derogatory comments such as 'psychiatric nurses behave like their patients' were made by health workers, patients' families and carers as a result of

their association with mental health patients. Others wondered how CPNs were able to manage the mentally ill if they themselves were not mentally ill. This finding confirms study by 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. Studies (Currid, 2008; Halter, 2008) 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 (Rooney, 2009). 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, counselling and community psychiatric services.

Attitudes of Family Members

Another psychosocial barrier was the attitudes of family members towards mental health services. It was evident from the study that families and carers have an uncaring attitude towards patients. This attitude had culminated in a lack of concern for the patients and thus discouraged them (CPNs) 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) that 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 attitudinal changes in care and community leading to the treating of mentally disordered people with more respect. Attitudes of family members towards patients could be addressed through health education on the causes and management of mental illness and home care of the mentally ill.

Feelings of Frustration

Other important findings in the study related to feelings of frustration experienced by CPNs. Some of the participants claimed it sometimes demoralized them as if they were in a bad institution or did not choose the right profession. 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 a 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.

Assaults on Staff

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 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 also similar to that of Poster (1996) whose finding showed that although the majority of the psychiatric nurses reported being physically assaulted at least once, 62% responded that they felt safe in their work environment most of the time. 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.

Financial and other Burdens on CPN

Another challenge that participants encountered in their work was the 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. 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 about 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

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.

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. 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.

IMPLICATIONS FOR NURSING PRACTICE 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 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 attitudes in their practice area which may make them withdraw from other health care providers. Attitudes of family members may lead to feelings of rejection and dejection in the mentally ill culminating in

frequent relapses and readmissions creating congestion in the psychiatric hospitals.

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 for patients may lead to financial difficulties of the CPNs leading to feelings of frustration. 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. Thus a research can be conducted on the factors that influence the effective integration of the mentally ill in the society.

SUMMARY AND CONCLUSION

The findings of the study indicated that participants experienced some barriers as well as challenges. The barriers were serviced and psychosocially related. Regarding the service related barrier, the participants complained of inadequate logistics, supplies and medications as constraints to effective care delivery. As a psychosocial barrier, they included problems such as lack of office accommodation, transport and supplies including medications, stigmatization and name calling as well as the stigma of association, attitudes of family members and feelings of frustration. The challenges expressed by the participant were assaults from patients, health concerns, additional responsibility of the CPNs, and problems of relapse.

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