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OBTAINING INFORMED CONSENT: PSYCHIATRIC NURSES' KNOWLEDGE AND PRACTICE AT FEDERAL NEURO-PSYCHIATRIC HOSPITAL ENUGU, NIGERIA

Chinwe S. F. Ezeruigbo[1], Easter Osuchuchu[2], Michael O. Elom[2], Chinelo Vincent[3], Nneka Ubochi[4], Peace Iheanacho[4]

Abstract: Background: Within a psychiatric care setting, informed consent is the voluntary acceptance of a plan for medical care by a competent patient after full disclosure of the care plan, its risks, benefits, and alternative approaches. This implies that the patient must have full information about any treatment options and must be competent to make the needed decisions. Objective: To assess psychiatric nurses' knowledge and practices of obtaining informed consent. Research Method: The study used a quantitative, descriptive cross-sectional survey design. Data were collected from a random sample of 99 nurses selected from a total of 131 nurses of different professional cadres working in the hospital, by means of a structured questionnaire constructed by the researchers. Data were analyzed using descriptive statistics. Results: Respondents' score on Knowledge of Informed Consent was above average (15.06 ± 2.671 out of a possible total score of 25). Likewise, their score on the disclosure of full information to psychiatric patients before treatment was well above average (6.01 ± 2.198 out of a maximum possible score of 8). However, respondents' score on the practice of obtaining Informed Consent was below average (2.41 ± 0.940 out of a maximum possible score of 5). Conclusion: Though a majority of the participants indicated good knowledge of informed consent, there was no corresponding correct practice of obtaining informed consent from patients in the hospital.

Keywords: informed consent, Nigeria, ethics, psychiatric health

Obtención de consentimiento informado: conocimiento y práctica de enfermeras de psiquiatría En El Hospital Federal de Neuropsiquiatría Enugu, Nigeria

Resumen: Antecedentes: En un establecimiento de cuidado de la salud mental, el consentimiento informado es la aceptación voluntaria de un plan de cuidado médico de un paciente competente después de haber recibido información completa del plan, sus riesgos, beneficios y alternativas posibles. Esto implica que el paciente debe tener información completa acerca de las opciones de tratamiento y debe ser competente para realizar las decisiones necesarias. Objetivo: Evaluar el conocimiento y la práctica de obtención de consentimiento informado de enfermeras de psiquiatría. Método de investigación: El estudio usó un diseño de encuesta transversal cuantitativo y descriptivo. Los datos fueron recolectados de una muestra al azar de 99 enfermeras seleccionadas de un total de 131 de diferentes grupos profesionales que trabajan en el hospital, mediante un cuestionario estructurado desarrollado por los investigadores. Los datos se analizaron mediante estadística descriptiva. Resultados: El puntaje de los encuestados sobre el conocimiento de consentimiento informado fue mayor del promedio (15.06 ± 2.671 de un posible puntaje total de 25). De la misma forma, su puntaje sobre la entrega de información completa a los pacientes de psiquiatría antes del tratamiento fue bastante mayor que el promedio (6.01 ± 2.198 de un máximo posible de 8). Sin embargo, los puntajes de los encuestados sobre la práctica de obtención de consentimiento informado fue por debajo del promedio (2.41 ± 0.940 de un máximo posible de 5). Conclusión: Aunque una mayoría de los participantes indicó un buen conocimiento del consentimiento informado, no hubo en correspondencia una práctica correcta de obtención de consentimiento informado de pacientes en el Hospital.

Palabras clave: consentimiento informado, Nigeria, ética, salud mental

Obtendo consentimento informado: conhecimento e prática de enfermeiras psiquiátricas no Hospital Federal Neuro-Psiquiátrico Enugu, Nigéria

Resumo: Background: Em um ambiente de cuidados psiquiátricos o consentimento informado é a aceitação voluntária de um plano para cuidado médico, por um paciente competente, depois da apresentação integral do plano de tratamento, seus riscos, benefícios e abordagens alternativas. Isso implica que o paciente deve ter informação completa sobre quaisquer opções de tratamento e deve ser competente para tomar as decisões necessárias. Objetivo: Avaliar conhecimento e práticas de enfermeiras psiquiátricas ao obter consentimento informado. Método de Pesquisa: O estudo utilizou um desenho de levantamento transversal descritivo, quantitativo. Os dados foram coletados de uma amostragem aleatória de 99 enfermeiras selecionadas de um total de 131 enfermeiras de diferente quadros profissionais trabalhando no hospital, por meio de um questionário estruturado construído pelos pesquisadores. Os dados foram analisados usando estatística descritiva. Resultados: O escore dos respondentes no Conhecimento do Consentimento Informado esteve acima da média (15.06 ± 2.671 de um escore total possível de 25). Da mesma forma, seus escores na apresentação de informação completa para pacientes psiquiátricos antes do tratamento esteve bem acima da média (6.01 ± 2.198 de um escore máximo possível de 8). Entretanto, o escore dos respondentes na prática de obter Consentimento Informado esteva abaixo da média (2.41 ± 0.940 de um escore máximo possível de out 5). Conclusão: Embora a maioria dos participantes indicou bom conhecimento do consentimento informado, não houve prática correta correspondente em obter o consentimento informado dos pacientes no hospital.

Palavras chave: consentimento informado, Nigéria, ética, saúde psiquiátrica

[1] Department of Nursing, Ebonyi State University, Abakaliki, Nigeria.
Correspondence: chinwe.ezeruigbo@yahoo.com

[2] Department of applied biology, Ebonyi State University, Abakaliki, Nigeria.

[3] Department of Nursing, Imo state University, Nigeria.

[4] Department of Nursing, University of Nigeria, Enugu Campus

Introduction

Informed consent is an integral part of the principle of ethics in the treatment and care of patients, especially psychiatric patients*(1)*. It has been suggested that it is the most common ethical protection in clinical research and treatment*(2)*. By definition, informed consent is the process whereby explicit information is provided to a patient or an experimental subject that would be relevant for them to decide on whether or not to have a particular treatment or to participate in a particular experiment*(3)*. Put more succinctly, it is defined as the voluntary acceptance of a plan for medical care by a competent patient after the physician adequately discloses the plan, its risks, benefits, and alternative approaches*(4)*. From this definition, it is clear that informed consent deals with fundamental issues such as the rights, autonomy, confidentiality, freedom of the patient or subject with respect to treatment or participation in research. Hence, it has far-reaching implications in healthcare research and patients' treatment*(5)*.

Due to the obvious fundamental nature of informed consent and its enormous implications in medical care and proper treatment of patients, it is a mandatory medical practice in most countries, for health care providers to obtain informed consent from patients before the initiation of any treatment, be it invasive or otherwise*(2)*. Nevertheless, the obtaining of informed consent from psychiatric patients, especially in less developed regions, like Africa, can present dilemmas most times; especially when the individuals involved have impaired mental cognition or worse still when there is reason to fear that such persons may harm themselves or others*(2,6-8)*. Are there situations in which medical practitioners can use restraints, apply certain treatment procedures on psychiatric patients or subject them to not-so-pleasant conditions for any reason, without their consent? Ahmet Göktaş*(9)* suggests that there are; and that physical restraint and other processes that may be undertaken without the patient's informed consent may, in fact, be beneficial. However, care must be taken in the application as there may be complications that may lead to unwanted outcomes*(8,10)*. It has along this line been advised that surveillance based on standards of application must be in place in situations where procedures not requiring informed consent of the psychiatric patient are to be instituted*(11,12)*.

The complexities associated with informed consent protocols in psychiatric situations where patients may be incompetent to give consent due to their illness*(13)* constitute challenges to the practice of obtaining informed consent. The unapparent nature of the model proffered by Ahmet Göktaş equally imposes some difficulties on the knowledge and practical side, especially on the part of the legal implications. This is especially the case in the African context where illiteracy, demographic and cultural dichotomies (such as age group, marital status, religion, employment status), and deficiencies in public health facilities pose a major challenge*(14)*.

Given the ethical and legal implications of the application or non-application of informed consent, especially in the field of psychiatry, it is pertinent that all healthcare professionals, particularly nurses should have a working knowledge of the concept*(15)*. In addition, nurses are responsible for taking care of psychiatric patients 24 hours a day. The inexcusable place of nurses in the discourse is amplified by the persistent push for nurses to become more active in working with clients and their families in order to encourage clients to participate actively in decision making*(16)*. Hence, their thorough knowledge of basic psychiatric concepts such as those associated with the legal and ethical aspects of informed consent is vital. This knowledge is equally required to enable psychiatric nurses to handle the dilemma which is usually thrown up by the application of informed consent*(17-19)*. This study was conducted to appraise the knowledge and practice of psychiatric nurses in the Federal Neuro-Psychiatric Hospital, Enugu.

The choice of this part of Africa is justifiable both in the Nigerian and African contexts. In Nigeria, the Federal Neuro-Psychiatric Hospital, Enugu is one of the six in the country of over 200 million people. The hospital was established in 1962 for mental health issues and the mentally challenged. It is a national and regional mental health resource. The reference area of the hospital covers the South Eastern zone comprising of 5 out of the 36 states in the country. This implies that patient

traffic in the hospital is roughly 14 percent. The recent increase in substance abuse in the South Eastern zone and the associated rise in the level and complexities of mental illness, no doubt has the tendency of increasing the pressure on nursing care and complicating further, the process of obtaining informed consent in psychiatric situations*(20)*. According to a report from the United Nations Office on Drugs and Crime (UNODC), drug use in the zone has a prevalent rate of up to 13.8 percent, which makes it the third-highest in the country after South-South and southwest zones 20. A study on the knowledge, and practice of obtaining informed consent, using Federal Neuro-Psychiatric Hospital Enugu is expected, therefore, to make a significant contribution to the literature.

Materials and Methods

The design was a descriptive cross-sectional survey design carried out to determine knowledge and practices of obtaining informed consent. The study setting was the Federal Neuro-Psychiatric Hospital, Enugu. It is a 150 bedded hospital with a 131 nursing staff capacity distributed by cadre as follows – 11 Deputy Directors of Nursing Services (DDNS) /Assistant Directors (ADNS) of Nursing Services, 43 Chief Nursing Officers (CNOs), 21 Assistant Chief Nursing Officers (ACNOs), 3 Principal Nursing Officers (PNOs), 45 Senior Nursing Officers (SNOs), and 8 Nursing Officers (NOs). The hospital provides general, emergency, community, forensic, mental retardation, substance abuse, child and adolescent, geriatric, and consultation-liaison psychiatric services. The study targeted all 131 nursing staff of the institution. Stratified and simple random sampling techniques were used to draw up a sample of 99 nurses of the hospital across all cadres who were on various shifts.

The instrument for data collection was a researcher constructed structured questionnaire to assess knowledge and practices of obtaining consent among psychiatric nurses within the study setting. The instrument has two parts (2), the demographic and informed consent sections. The demographic section sought information on age, sex, religion, marital status, educational qualification, years since graduation from higher institution of learning, cadre/designation, work experience of participants and comprised of 8 items. The informed consent section assessed participants' knowledge and practice of informed consent in terms of institutional guidelines and extant laws, substituted consent, voluntarism, competency/capacity, disclosure, understanding, decision, privacy, standard of care, civil responsibility, and nurses' general role and consisted of 22 items.

A pilot test was conducted to test the clarity of the items and the operability of the instrument and it was found to be clear and operable. Experts were consulted to ascertain the validity of the questionnaire. Reliability was established using Kuder-Richardson formula (KR20) which came out to be 0.89.

Approval for the study was sought and obtained from the relevant authorities in the institution. Informed consent of the participants was sought and obtained prior to data collection. Questionnaires were administered to 99 staff of the hospital by the investigator at three different shifts daily for two weeks. On average it took 30 minutes to complete the questionnaire. Confidentiality of the participants, who were free to withdraw from the study at any point it became necessary, was maintained throughout the study.

The data were then transferred to SPSS version 24 where descriptive and inferential analyses were carried out.

Results

The sample size for this study (96 nurses) represents 73% of the total number of nurses in the hospital (131). However, 99 copies of the questionnaire were shared and ninety-six (96) were returned hence, the return rate was 97.0%. The mean age of the nurses was (29.29 ± 9.08) and 52.3% of them were below 36 years old. The participants were mainly: female (79.2%), married (64.6%), Christian (97.9%), had Registered Psychiatric Nursing as the highest education (68.8%), had spent less than 6 years since graduation, (67.7%), had less than 6 years of working experience (65.6%). 37.5% of them were Senior Nursing Officers (SNOs) and 21.8% were Chief Nursing Officers (CNOs)

Table 1: Socio-Demographic Characteristics of the Participants

Socio-Demographic Characteristics	Frequency	Percentage
Age group		
<=25yrs	44	45.8
26-30yrs	23	24.0
31-35yrs	10	10.4
36-40yrs	7	7.3
40yrs & Above	12	12.5
Age Range = 19 – 56Years Mean = 29.29 Years Std. Dev. = 9.08		
Gender		
Male	20	20.8
Female	76	79.2
Religion		
Muslim	2	2.1
Christian	94	97.9
Marital Status		
Married	62	64.6
Single	34	35.4
Highest Level of Education		
Registered Psychiatric Nursing Certificate	66	68.8
Bachelor's Degree	20	20.8
Masters	2	2.1
Others (HND, Student Nurse, O Level)	8	8.3
Year of Graduation		
Less than 6yrs	65	67.7
6-10yrs	13	13.5
11-15yrs	10	10.4
16-20yrs, above 20yrs	8	8.3
Job Status		
DDNS/ADNS	5	5.2
CNO	27	28.1
ACNO	15	15.6
PNO	4	4.2
SNO	36	37.5
NO	9	9.4
Years of working experience		
Less than 6yrs	63	65.6
6-10yrs	13	13.5
11-15yrs	13	13.5
16-20yrs, above 20yrs	7	7.3
Years of working Experience Mean = 8.09Years Std. Dev. = 3.65		

Table 2: Knowledge of Procedures that require signed Informed Consent

Items	Yes (%)	No (%)	I don't Know (%)	Not Certain (%)
1. Admission	70 (72.9)	14 (14.6)	9 (9.4)	3 (3.1)
2. Administration of drugs	77 (80.2)	11 (11.5)	7 (7.3)	1 (1.0)
3. ECT	90 (93.8)	3 (3.1)	3 (3.1)	0 (0.0)
4. Self-care	63 (65.6)	23 (24.0)	9 (9.4)	1 (1.0)
5. Wound dressing	72 (75.0)	16 (16.7)	7 (7.3)	1 (1.0)
6. invasive diagnostic procedure	88 (91.7)	4 (4.2)	4 (4.2)	0 (0.0)
7. HIV test	80 (83.3)	11 (11.5)	5 (5.2)	0 (0.0)
8. Anesthesia	90 (93.8)	1 (1.0)	4 (4.2)	1 (1.0)
9. Blood transfusion	84 (87.5)	6 (6.3)	4 (4.2)	2 (2.1)
10. Surgeries	92 (95.8)	1 (1.0)	2 (2.1)	1 (1.0)
11. Research studies	78 (81.3)	12 (12.5)	5 (5.2)	1 (1.0)

Table 2b: Knowledge of the processes/ components of Informed consent

1.	Informed Consent is regulated by law	62 (64.6)	1 (1.0)	32 (33.3)	1 (1.0)
2.	Informed consent is obtained solely to provide protection to HCP	50 (52.1)	27 (28.1)	10 (10.4)	9 (9.4)
3.	Is there any legislation governing the process of gaining informed consent for treatment?	71 (74.0)	12 (12.5)	8 (8.3)	5 (5.2)
4.	Do you explicitly know your institution's guidelines on obtaining consent	74 (77.1)	13 (13.5)	5 (5.2)	4 (4.2)
5.	Mental disorder prevents a person from knowing/ understanding what he or she consents to?	77 (80.2)	10 (10.4)	3 (3.1)	6 (6.3)
6.	Are you aware of the consequences of not obtaining informed consent?	91 (94.8)	3 (3.1)	1 (1.0)	1 (1.0)
7.	For consent requiring signature detailed patient information can be provided by the interviewing practitioner or the nurse?	70 (72.9)	17 (17.7)	7 (7.3)	2 (2.1)
8.	Consent of any kind can be waived in an emergency if the patient is in danger to self or others?	79 (82.3)	9 (9.4)	3 (3.1)	5 (5.2)
9.	Capacity/competence, information and voluntary nature of the decision constitute are the three major elements of legally valid consent?	79 (82.3)	7 (7.3)	6 (6.3)	3 (4.2)
10.	Is there a need to obtain informed signed consent with every intervention such as grooming?	55 (57.3)	33 (34.4)	6 (6.3)	2 (2.1)
11.	Does signing on admission for mentally ill patients cover interventions to be carried out during hospital stay?	63 (65.6)	23 (24.0)	5 (5.2)	4 (5.2)
12.	Should only necessary information be provided to patients before obtaining informed consent?	69 (71.9)	23 (24.0)	3 (3.1)	1 (1.0)
13.	Once a diagnosis of mental illness is made, a surrogate or health care decision takes precedence.	74 (77.1)	14 (14.6)	4 (4.2)	5 (4.2)
14.	For the mentally ill, surrogate or mental health worker decides on participant's involvement in research.	69 (71.9)	14 (14.6)	7 (7.3)	6 (6.3)

Knowledge of Informed Consent

Table 2 shows the results of participants' responses to questions about their knowledge of procedures that require signed and Table 2b presents the result on knowledge of the processes and components of obtaining informed consent. An overwhelming majority of the participants (63% - 92%) affirmed knowledge of IC in 24 out of 26 items on "knowledge of informed consent." On available legislation on IC, 74% knew that there was legislation governing the process of gaining informed consent for treatment whereas, 77.1% reported that they explicitly knew their institution's guidelines on obtaining informed consent. Most of the participants (94.8%) were aware of the consequences of failing to obtain informed consent. A majority of the participants (83.2%) correctly identified that capacity/competence, full information disclosure, and voluntary nature of the decision constitute the three major elements of legally valid consent. However, in contrast to the need to disclose full information as a major element of informed consent, most participants (71.9%) believed that only necessary information should be provided to patients before obtaining informed consent. Unfortunately, more than half (52.1%) of the study subjects felt that informed consent is obtained solely to provide protection to Health Care Personnel (HCP).

On the issue of capacity, most of the participants correctly affirmed the following: that mental disorder prevents a person from knowing/understanding what he or she can consent to (80.2%); that consent of any kind can be waived in an emergency if the patient is in danger to self or others (82.3%); signing on admission for mentally ill patients covers interventions to be carried out during hospital stay (65.6%), once a diagnosis of mental illness is made, a surrogate or health care decision takes precedence (77.1%) and that for the mentally ill, surrogate or mental health worker decides on participant's involvement in research (71.9%). Interestingly, participants' mean score on the knowledge scale (15.06 ± 2.671) was well above average (total possible score was 25). This shows that the study subjects were mostly very knowledgeable about obtaining informed consent with regards to psychiatric patients.

Practices of Obtaining Informed Consent

Results of the assessment of research subjects on "Practices of Obtaining informed consent" are shown on Table 3. Here, the mean practice score was 2.41 ± 0.940, which is below average (maximum possible score was 5). It shows that knowledge of informed consent did not translate to actually practicing it. It also shows that far a less number of participants correctly practiced obtaining informed consent than affirmed knowledge of it. Thus, on appraisal of participants' practice of obtaining informed consent, only a little above half of the study sample (54.2%, 56.3% and 57.3%) reported that they adhered to three out of five items used for appraising practice of obtaining informed consent while well above half

Table 3: Practices of Obtaining Informed Consent

Item	A (%)	B (%)	C (%)	D (%)
Practice of obtaining informed consent for medical procedures in mental Health Care				
1. I inform patients about every procedure to be carried out	61 (63.5)	23 (24.0)	1 (1.0)	11 (11.5)
2. I answer patient's questions regarding procedures	54 (56.3)	26 (27.1)	2 (2.1)	14 (14.6)
3. I explain the consequences of intervention refusal	52 (54.2)	24 (25.0)	1 (1.0)	19 (19.8)
4. Based on my knowledge I assist patients to choose and consent to intervention	60 (62.5)	27 (28.1)	8 (8.3)	1 (1.0)
5. I ask patients to explain his understanding of the procedures, risk and benefits of the intervention	55 (57.3)	23 (24.0)	12 (12.5)	6 (6.3)

Key: A = As much as necessary; B = Necessary; C = As time permits; D = In detail

Table 4: Practice of Full information disclosure

S/N	Item	Freq. (%)
	Key elements of information looked out for before patients signs the consent form include the following:	
1	Complete explanation of the procedure or treatment	89 (92.7)
2	Names and qualifications of major persons performing and assisting in the procedure	74 (77.1)
3	Description of the anticipated pain and/or discomfort, serious harm, including death, that may occur	78 (81.3)
4	Communicate that other supportive care will be discontinued if he or she refuses the procedure/ treatment.	70 (72.9)
5	Communicate that he or she may not be able to refuse the procedure/ treatment after the procedure has begun	71 (74.0)
	When there is no signed consent before procedures such as ECT:	
	I ask the practitioner if the patient has been informed.	74 (77.1)
	I inform the patient and assist the patient to sign the form	74 (77.1)
	I do nothing because it is not a nursing duty	43 (44.8)

of the sample (63.5% and 62.5%) reported that they adhered to the remaining two items.

Practice of Full information disclosure

Participants' responses to whether they disclose full information to psychiatric patients on treatment procedures or any other necessary decision taken on their behalf, as a vital element of obtaining informed consent are shown in Table 4. An overwhelming majority of the participants responded in the affirmative to questions bordering on whether they disclose full information to their patients prior to carrying out any decisions on them. Responding to 7 out of 8 items, between 72% and 92% of respondents affirmed that they always disclose full information to psychiatric patients about treatment procedures before the treatment. Here, as in the case of knowledge, the mean score was well above average (6.01 ± 2.198) (out of a maximum possible score of 8) This indicates that disclosure of full information to psychiatric patients was being practiced and was recognized as a major component of obtaining informed consent from the patient.

Influence of sociodemographic variables on the practice of obtaining informed consent

No significant difference was found between the different strata of each demographic variable with respect to their knowledge of informed consent except in the case of years of work experience. There was however, a significant difference (P = 0.021) between participants with less than 6 years of work experience and the rest of the strata in the "years of work experience" demographic variable.

Relationship between Socio-Demographic Characteristics and Knowledge of informed consent, Practices of obtaining Informed Consent and Information Disclosure

Table 6 shows the correlational analyses. None of the demographic variables correlated with the knowledge of Informed consent, Practice of obtaining informed consent and Disclosure of full information in the study. For instance, the demographic variables did not correlate with knowledge of Informed consent, thus: Gender (r = 0.099; P = 0.337); Level of education (r = 0.035, P = 0.736); number of years since graduation from higher institution of learning (r = 0.210, P = 0.040); Job status (r = -0.016, P = 0.876) and Years of work experience (r = 0.113, P = 0.271).

Discussion

The study shows that majority (63% - 92%) of the participants were knowledgeable about informed consent with an above average mean score of 15.06 ± 2.671 out of 25. This result corroborates the findings of previous studies*(21,22)* though there have been reports of lack of knowledge of

Table 5: Comparison of the influence of Socio-demographic on Knowledge of obtaining informed consent at Federal Neuropsychiatric hospital, Enugu

Variable	N (%)	Mean	SD	t/F-Value	P-Value
Age group					
<=25yrs	44 (45.8)	15.41	2.31	0.819	0.516
26-30yrs	23 (24.0)	14.61	3.04		
31-35yrs	10 (10.4)	14.00	3.27		
36-40yrs	7 (7.3)	15.57	2.07		
40yrs & Above	12 (12.5)	15.25	3.02		
Gender					
Male	20 (20.8)	14.55	2.93	0.930	0.337
Female	76 (79.2)	15.20	2.60		
Religion					
Muslim	2 (2.1)	12.50	4.95	1.898	0.172
Christian	94 (97.9)	15.12	2.62		
Marital Status					
Married	62 (64.6)	14.84	2.63	1.232	0.270
Single	34 (35.4)	15.47	2.73		
Highest Level of Education					
Registered Psychiatric Nurse	66 (68.8)	15.00	2.65	0.374	0.772
Degree	20 (20.8)	15.45	2.89		
Master	2 (2.1)	13.50	3.54		
Others (higher national diploma,etc)	8 (8.3)	15.00	2.39		
Year of Graduation					
Less than 6yrs	65 (67.7)	14.72	2.63	1.511	0.217
6-10yrs	13 (13.5)	15.15	2.54		
11-15yrs	10 (10.4)	16.20	3.08		
16-20yrs,above 20yrs	8 (8.3)	16.25	2.32		
Job Status					
*DDNS/ADNS	5 (5.2)	15.80	1.48	1.181	0.325
CNO	27 (28.1)	15.26	2.97		
ACNO	15 (15.6)	14.60	2.97		
PNO	4 (4.2)	17.75	2.87		
SNO	36 (37.5)	14.67	2.48		
NO	9 (9.4)	15.06	2.77		
Years of working experience					
Less than 6yrs	63 (65.6)	14.60	2.77	3.386	0.021
6-10yrs	13 (13.5)	16.38	1.66		
11-15yrs	13 (13.5)	16.46	2.33		
16-20yrs,above 20yrs	7 (7.3)	14.14	2.41		

*DDNS = Deputy Director of Nursing Services /ADNS = Assistant Director of Nursing Services; CNO= Chief Nursing Officer, ACNO =Assistant Chief Nursing Officer, PNO = Principal Nursing Officer, SNO = Senior Nursing Officer, NO

Table 6: Relationship between Socio-Demographic Characteristics and (Knowledge of informed consent, Practices of obtaining Informed Consent and Information Disclosure) N = 96

		Knowledge		Practice		Information Disclosure	
Characteristics	Freq. (%)	R	P-Value	R	P-Value	R	P-Value
Age Group							
<=30yrs	67 (69.8)	-0.041	0.691	-0.022	0.831	0.044	0.679
>30yrs	29 (30.2)						
Gender							
Male	20 (20.8)	0.099	0.337	0.116	0.262	-0.071	0.501
Female	76 (79.2)						
Religion							
Muslim	2 (2.1)	0.141	0.172	0.064	0.535	-0.059	0.574
Christian	94 (97.9)						
Marital Status							
Married	62 (64.6)	0.114	0.270	-0.069	0.503	0.013	0.904
Single	34 (35.4)						
Highest Level of Education							
Below First Degree	66 (68.8)	0.035	0.736	0.051	0.622	-0.088	0.404
Degree & Above	30 (31.3)						
Year of Graduation							
<=10yrs	78 (81.3)	0.210	0.040	-0.069	0.508	-0.028	0.789
>10yrs	18 (18.8)						
Job Status							
* ACNO & Above	47 (49.0)	-0.016	0.876	0.065	0.531	-0.172	0.101
Below ACNO	49 (51.0)						
Years of working experience							
<=10yrs	76 (79.2)	0.113	0.271	-0.079	0.448	-0.179	0.088
>10yrs	20 (20.8)						

*ACNO= Assistant Chief Nursing Officer

informed consent among some research subjects*(23-26)*. Furthermore, from the legal and ethical perspective, an overwhelming majority of the participants (94.8%) indicated awareness of the consequences of failing to obtain informed consent, an indication of a knowledge of the legal and ethical dimensions of informed consent*(21)*. Also, participants who indicated that they disclose full information to patients as part of their practice of obtaining informed consent were in the majority (72% - 92%) with a well above average mean score of 6.01 ± 2.198. This finding indicates that most of the respondents have a favorable attitude towards disclosure of full information to the patients as a major element of obtaining informed consent. This agrees with the findings of other studies*(21,23)*. However, a little more than half of the participants (54.2% - 62.5%) affirmed that they actually practiced obtaining informed consent correctly, with a below average mean score of 2.41 ± 0.940. This shows that knowledge of informed consent did not translate to actual correct practice in the hospital. Indeed, Table 8 shows that knowledge of informed consent had a negative, weak correlation with the practice of obtaining informed consent (r = -0.152, P =

0.141). Thus, a far less number of participants actually practiced informed consent than the number that affirmed knowledge of it and this is also in agreement with some reports*(23,27)* in the literature, though some other studies show contrary findings to the present one, to the effect that knowledge actually translated to practice of informed consent in the management of psychiatric patients in those other studies*(21)*.

Contrary to reports in the literature, 6 age, gender, educational qualification and job status did not differ significantly (P>0.05) in relation to knowledge of informed consent (Table 5). However, there was a significant difference (P<0.05) between those with less than 6 years of experience and those with more than 6 years of experience with respect to knowledge of informed consent, with the former having more knowledge of informed consent than the latter. This finding is in contrast to the findings of Sailaxmi Gandhi et al., where more years of experience was reported to have conferred more knowledge of informed consent than less years of experience*(6,28)*. However, the present finding could be due to the fact that those with less than 6 years' work experience formed the majority (65.6%) of the participants. This large discrepancy in number may explain the significant difference between those with less than 6 years of work experience and the other strata in relation to their knowledge of informed consent, and not necessarily because less years of work experience conferred more knowledge of informed consent than more years of work experience.

Further, age, gender, educational qualification, job status, and years of experience were not associated with practice of obtaining informed consent as there was no significant difference (P>0.05) among the strata in each demographic variable and practice of informed consent*(6)*.

In variance with the findings of Elif Akyuz et al. *(2018)* who reported lack of awareness of institutional guidelines for the implementation of informed consent*(28)*, 74% of the respondents in this study knew that there was legislation governing the process of gaining informed consent from patients and 77.1% "explicitly know their institution's guideline for obtaining informed consent." It is understood that part of the reason for low informed consent practice among psychiatric nurses is lack of laid down procedures or legislation governing its application*(23)*. But in this study, despite the fact that majority of respondents acknowledged the existence of protocols for informed consent, however, knowledge of informed consent did not lead to its practice by majority of participants.

According to Ahmed Bait Amer, assessment of the capacity of a psychiatric patient to give informed consent is the biggest challenge in obtaining informed consent by MHP.2 In conformity with this concept, 83.2% of the respondents were of the opinion that capacity/competence, full information disclosure and voluntary nature of the consent constitute the three major elements of legally valid consent. On the issue of capacity to give informed consent, the findings of this study corroborate findings of other studies or opinions held by experts. For instance, most of the participants affirmed that: mental disorder prevents a person from knowing/understanding what he or she can consent to (80.2%); consent of any kind can be waived in emergency if the patient is in danger to self or others (82.3%)*(2,6,7,8)*; signing on admission for mentally ill patients covers intervention to be carried out during hospital stay (65.6%); once diagnosis of mental illness is made, a surrogate or health care decision takes precedence (77.1%)*(21,29,30)* and for the mentally ill, surrogate or mental health worker decides on participant's involvement in research (71.9%)*(21,29,30)*. From this finding, it is clear that the principle that incapacity/incompetence overrides a mental health patient's right for informed consent is universal among Mental Health Professionals. Nevertheless, it is worthy of note that a mentally challenged person may not necessarily be incapacitated to give an informed consent regarding any treatment*(2,29)*. It is therefore incumbent on the care-giver to conduct more than one mental state evaluations before deciding that the patient lacks capacity to give informed consent*(1,31)*.

However, in contrast to the assertion that it is pertinent to disclose full information as a major element of informed consent, most participants (71.9%) believed that only necessary information should be provided to patients before obtaining

informed consent. In line with this belief, up to 52.1% of the respondents obtained "informed consent solely to provide protection to Health Care Personnel (HCP)." This is similar to several other reports*(23,32-34)*. In contrast however, some other researchers hold that informed consent should be geared towards putting in place healthy communication between the health institution and that the informed consent should be designed for the protection of the patient too*(23,35,36)*. It has equally been demonstrated that lack of understanding of their roles and responsibilities sustains the belief by nurses that informed consent is solely for their protection*(23)*.

Conclusion

The study showed that psychiatric nurses' knowledge of obtaining informed consent was above average. It was also established that their understanding of the importance of the need to disclose full information to psychiatric patients concerning all decisions pertaining to their treatment and wellbeing and its legal and ethical dimensions was equally high. There was also indication of knowledge of the legal and ethical dimensions of informed consent with regards to psychiatric patients. However, it was found out that the knowledge was not associated with corresponding correct practice of obtaining informed consent as respondents' score to questions on practice of obtaining informed consent was below average. That is to say that knowledge did not translate to practice. Further, even though majority of the participants knew about the concept of full information disclosure, most of them indicated that only necessary information was actually provided to patients before obtaining informed consent; but this should not be so. Full information, and not some information must be disclosed to the patients before treatment or any other procedure are offered to them. It was a universal opinion among respondents that a psychiatric patient's right to informed consent is overridden by incapacity. However, there was no indication of awareness of the fact that a mentally challenged person is not necessarily incompetent to give informed consent before treatment and that, more than one mental health state test must be conducted on the patient to establish incapacity. There is therefore a dire need to readdress the ethical requirements and duties of a nurse towards upholding the highest standard of obtaining informed consent.

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