

HIV Counselling, Testing and Referral Services in  
Mental Healthcare Settings in Kolkata- a Provider  
Perspective

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**Declaration:**

I hereby certify that, the work embodied in this dissertation entitled “HIV Counselling, Testing and Referral Services in Mental Healthcare Settings in Kolkata- a Provider Perspective” is then result of original research and has not been submitted for any degree in any other university or institution.

Thiruvananthapuram  
25<sup>th</sup> June'04

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## **ABSTRACT**

### **Background:**

Studies say that mentally ill people are 4 to 22 times at higher risk of HIV infection than general people due to their type and status of mental illness, opting for unsafe sexual practices, substance uses etc. So need of adequate HIV Counselling, Testing or Referral services are recommended which may be different from case to case. Providers' adherence to standard principles particularly in mental healthcare settings is under researched. In this background, our study explored adherences and barriers in providing services in mental healthcare settings of Kolkata, capital of the state of West Bengal, located in northeast part of India.

### **Objectives:**

1. To describe and assess adherence to HIV Counselling, Testing and Referral services on the part of the providers.
2. To explain a few barriers in HIV Counselling, Testing and Referral services.

### **Methodology:**

All public mental healthcare settings were selected. NGOs were selected based on consents of Head of the Departments (HOD) from an available list. Respondents were selected based on their consents from selected settings. We used pre-tested semi-structured interview schedules on providers (psychiatrists, psychologists and others). HIV Risk Assessment Scores were computed. Scores of 12 selected variables (S12) and Total Score (TS) were also computed. Different qualitative opinions about barriers were captured from expert opinions. Head of the Departments were interviewed to explore resources influencing HIV related services. Statistical significance was assessed at p value of 0.05 using SPSS version 11.

### **Results:**

There were 52 providers, 10 HODs, 13 experts from 14 settings (9 public and 5 NGOs). Client's STD history, partner's STD history and ever injection histories of drugs with any needles were 'Always' assessed by 17(32.7%), 16(30.8%) and 17(32.7%) providers respectively. Mean HIVRAS were 8.35, 12.23 and 10.25 for psychiatrists, psychologists and others. Providers from public and NGO settings had mean HIVRAS 8.81 and 12.81 respectively. It is around 50-60% of total maximum possible scores. For scores like S12 and T12, psychologists and NGO as setting performed better than psychiatrists or public setting respectively. NGO providers are approximately 6-8 times more likely to score higher in HIVRAS, S12 or TS compared to public setting providers. Training status, setting variety or specialty variety had statistically significant relation with HIVRAS. Adherence to HIV counselling and testing issues varied from provider to provider or setting to setting. Out of 52, 78.84% providers considered poor insight, 50% considered dual illness as common barriers in providing services. Confidentiality was counted to be very good by 42.23% providers. Time constraints due to patient rush were another barrier. Poor coordination and poor gender orientation among providers were important. Expert groups considered that stigma was a barrier due to its either addition, subtraction or predominance impact on seeking services due to dual illness of mental morbidity and HIV. Ethical conflicts on validity of informed consent given by mentally ill person, arranging mandatory HIV testing for high-risk groups and disclosing test result hasten appropriate services. There were no guidelines for providers, which could help them taking appropriate decisions.

### **Conclusions:**

Inadequate adherence in standard principles in settings of Kolkata might place clients in a more vulnerable situation enhancing their risks of HIV infection. Improperly dealt barrier issues might affect adherence to services from providers. There is need to develop standard guidelines which is culturally sensitive and regionally appropriate to overcome barrier issues to enhance adequacy of HIV services.

## **Chapter-1**

### **INTRODUCTION**

HIV/AIDS epidemic is now a major challenge to public health professionals. After the small pox eradication initiative, no other disease has received so much public health attention as this epidemic. Prevention and control of the epidemic is brought with numerous complexities. Mental illness and HIV/AIDS are related to each other. The challenge of disease control is multifolded and complicated when we consider HIV/AIDS and mental illness together.<sup>1,2</sup>

Most patients with severe mental illness are not well connected to the health care system.<sup>3</sup> Psychiatrists and other mental health care providers are frequently involved in a primary care giver role in lives of these patients.<sup>3</sup> Most middle and low-income countries including India devote less than 1% of their health expenditure to mental health. It indicates that community care facilities, and treatments for the mentally ill are negligible. Mental healthcare settings should have intradepartmental or interdepartmental coordination with adequately trained professionals to provide adequate services to mentally ill persons to prevent spread of HIV infection.

#### **1.1 HIV/AIDS and Mental Health Disorders as Global Public Health Challenges**

Threat from susceptible people poses greater burden than people living with HIV/AIDS in the world. There are 42 million people living with HIV/AIDS worldwide. 38.6 million of them are adults (above 18 years old), 19.2 million are women and 3.2 million are children under the age of 15 years. Five million new infections occurred in the year 2002.<sup>4</sup> Among them 4.2 million are adults of which 2 million of them are women. 3.1 million people died of HIV/AIDS related causes in 2002.<sup>3</sup> Sub-Saharan Africa has the highest number of HIV positive individuals (29.4 million people living with HIV/AIDS) followed by South and South-East Asia (6 million).<sup>4</sup>



450 million people worldwide suffer from mental, neurological or behavioural problems at any given time.<sup>3</sup> These problems are increasing day by day. Mental health problems are common to all countries, leading to immense human suffering, social exclusion, disability and poor quality of life. Mental illness also increases mortality, morbidity and affect economic and social costs. Many of these factors pose further vulnerability towards HIV infection. One in every four persons who are seeking healthcare services has at least one mental, neurological or behavioural disorder.<sup>3</sup> Most often these are neither diagnosed nor treated. Mental problems affect and are themselves affected by HIV/AIDS.

Research on HIV and other STDs often focuses on those who are most vulnerable, including men who have sex with men, injecting drug users, and commercial sex workers. Researches, conducted in both Europe and the USA suggest that persons living with severe mental illness are vulnerable to HIV infection, with infection rates ranging from 4% to 23%, which is much higher than those reported for the general population.<sup>2</sup>

Total loss of QALY due to HIV/AIDS or mental health problems contributes to a significant loss of human resources to the world. Countries like South Africa and India with large number of HIV/AIDS victims and mental illness sufferers contributes significantly to this total QALY loss of the world. A study in USA by Phillips KA et al predicts that if routine HIV testing identifies infected individuals one year earlier, it would have gained US\$22000 per QALY.<sup>5</sup>

## **1.2 HIV/AIDS and Mental Health Disorders – Burden to India**

The annual round of HIV Sentinel Survey was conducted in 320 sites in all the states and Union Territories in August-October, 2001 in India. The study included 135 sites in STD clinics, 170 sites in antenatal clinics, 13 sites for Injecting Drug Users (IDUs) and 2 sites for Men who have Sex with Men (MSM). The point estimate for year 2001 was 3.31 million HIV

infections in adult population (15-49 yrs. age group). The estimates for 1998,1999 and 2000 were 3.5 million, 3.7 million and 3.9 million infections respectively. <sup>6</sup> These numbers may be only the tip of the iceberg.

A recent study in primary healthcare settings in South India reveals that of the total patients coming there, 22.4 % have mental disorders; 9.1% has depression, 8.5% has anxiety disorders, and 1.5% have alcohol disorders. <sup>7</sup>

H.C. Ganguli analyzed fifteen epidemiological studies on psychiatric morbidity in India in 2000. The national prevalence rates for 'all mental disorders' were 70.5 (rural), 73 (urban) and 73 (rural + urban) per 1000 population. Prevalence of schizophrenia is 2.5/1000. Prevalence of schizophrenia seems to be consistent across cultures and over time. Urban morbidity in India is 3.5 percent higher than the rural rate.<sup>8</sup> (Ref Table I)

Table: I *Prevalence of five mental disorders (Rate/1000 population) in India*

	Urban	Rural
Schizophrenia	2.5	3.6
Depression	33.7	15
Anxiety neurosis	16	7
Hysteria	3.1	3.7
Mental retardation	9	-

Source- Indian Journal of Psychiatry, 2000, 42 (1), 14-20

Compared with few states in India, West Bengal has higher prevalence of mental disorders. Urban area has more prevalence than rural areas. (Ref Table II).

Table II: *Rural and Urban Morbidity (Rate/1000 population: All Mental Disorders)*

Region	Investigator	Rate Rural	Rate Urban	Morbidity Ratio Rural to Urban (Rural=100)
West Bengal	Nandi et al. (1980)	142	207	100: 146
U.P.	Sethi et al. (1972, 1976)	039	073	100: 185
U.P.	Dube (1970)	018	025	100 : 139

Source- Indian Journal of Psychiatry, 2000, 42 (1), 14-20

In this background, our study explores the HIV counselling process in mental healthcare settings in Kolkata, a metro city in West Bengal. It will capture best scenario, as it is an urban

location. It has huge patient drainage from all northeast part of India and having maximum providers located around.

We, in India have hardly any data to comment exclusively on prevalence of HIV/AIDS among mentally ill people. Prevalence data of psychiatric morbidity without HIV/AIDS itself is poor. What proportion of mentally ill people are also suffering from HIV/AIDS, is very much under researched. In India, HIV is expanding at an alarming rate. One study investigated the prevalence of HIV infection among psychiatric patients in South India. It found that 3.4% of 2139 inpatients were HIV infected.<sup>9</sup> A second study investigated 59 patients admitted to a state psychiatric hospital. Majority of them have high-risk partners.<sup>10</sup>

High prevalence of HIV infection among mentally ill population shocks many people. Examples of severe mental illness are schizophrenia, manic-depressive psychosis, and psychotic depression.<sup>2</sup> They occur in the prime of life and frequently disrupt normal patterns of work and cause extreme psychological distress. The consequences are high rates of alcohol and substance use and practices of unsafe sex. Disapproval of these activities as on the part of clients and avoidance in providing specific services from providers have fostered a situation in which risk behaviours are largely ignored<sup>2</sup> and HIV continues to spread among them in India.

*In this context our literature review explains why HIV Counselling, Testing and Referral services are important in mental healthcare settings. It talks about impact of barriers in providing services to mentally ill people.*

## **Chapter-2**

### **LITERATURE REVIEW**

*Studies have been conducted in primary care settings or obstetric care settings as to explore how providers are adherent to HIV cares. Several studies have been conducted to explore risk behaviours of mentally ill people in outpatients and inpatients of psychiatry departments. Limited researches on the content and process of HIV Counselling, Testing and Referral services specifically in mental healthcare settings on the part of providers are available. Our review explores principles and adherence of HIV Counselling, Testing and Referral Services with special emphasis in relevance to mental healthcare providers and settings.*

#### **2.1 Correlates of Sexual Activity, Substance Use and HIV Risk Among Mentally ill People**

Eleven studies of 2873 predominantly hospital-based psychiatric patients in New York City, Baltimore, and Columbia, South Carolina, conducted in 1997, indicate that average HIV infection rate among adults with severe mental illness is 7.8 percent, nearly 20 times the rate of estimated incidence (0.4 percent) for the general population.<sup>11</sup> Another study done in New York says that for severely mentally ill, rate of HIV infection ranges from 0.4% to 22.9%.<sup>2,11</sup> Across studies, psychiatric patients with identified comorbid alcohol or other drug use disorders have a significantly higher rate of infection than those without use of alcohol or drugs.<sup>11</sup>

Drug injection confers important risk. Even use of non-injected drugs or alcohol alone may result in substantially higher risks of infection than the average rate. Patients with alcohol or other drug use disorders may be members of social networks where sex and drugs combine to

create vulnerability to sexually transmitted HIV infection.<sup>11</sup> HIV infection is also significantly related to type of substance use ( $p < 0.03$ ).<sup>11</sup>

There may be hypersexuality in certain psychiatric illnesses. Patients may lack the social skills or access to condoms necessary to practice safer sex. While illegal drug use is common among psychiatric patients, only a small number report any recent IV drug use.<sup>11</sup> Many, however, report having sex with intravenous drug users. Psychiatric patients often demonstrate poor judgment and impulsive behavior when selecting a sexual partner. (Ref. Annexure 4)

A study conducted in South India (1998-2000) provides evidence regarding the prevalence and correlates of HIV-risk behaviour of psychiatric inpatients in South India.<sup>12</sup> It shows statistically significant differences among men and women in respect to their risk behaviours (Ref. Table III).

Table III: *HIV Risk Behaviours by Gender: Indian Psychiatric Inpatients*

Risk Factors by gender for patients reporting high risk sexual behaviour			
<i>Risk Behaviours</i>	<i>Males (n=99)</i>	<i>Females (n=26)</i>	<i>p value</i>
Sexually Transmitted Infection	21(21%)	15(58%)	<0.001
Multiple Partner	64(65%)	12(46%)	Not significant
Exchanging sex for money	9(9%)	7(27%)	<0.05
Exchanging money for sex	65(66%)	0(0%)	<0.001
Partner has risky sexual behaviours	87(88%)	23(88%)	Not significant

Source: *International Journal of STD & AIDS* 2003; 14: 532-538

Predictors of high-risk behaviours of HIV infection are identified as younger age, non-diagnosed schizophrenia, being single, and substance use. Definition of serious mental illness, which is mostly related to HIV infection, varies. But they typically incorporate information on diagnosis, disability, and illness duration. The category usually includes schizophrenia and bipolar disorder, as well as recurrent major depression and personality disorders.<sup>12</sup>

If we can identify an HIV positive person one year earlier through routine HIV testing we can save US\$22000 per QALY.<sup>5</sup> A meta-analytical review of 27 published articles from 1985-1997, shows that HIV counselling and testing services appear to provide effective means for secondary prevention for HIV positive individuals, but it is not effective for primary prevention among uninfected individuals.<sup>13</sup> Kathryn A. Phillips et al conducted a study to claim that routine testing is most cost-effective in primary settings at an incremental cost of US\$4200 per infection identified.<sup>5</sup>

## **2.2 Principles of HIV Counselling, Testing and Referral Services**

We have described these principles taking references from CDC revised guidelines on HIV Counselling, Testing and Referral Services and NACO (National AIDS Control Organization) guidelines, India. This section talks about general principles that may look irrelevant to some extent for mentally ill persons.

### ***HIV Counselling***

HIV counseling basically includes providing information on HIV/AIDS, mode of transmission and its prevention aspects.<sup>14,15</sup> Clients should receive help to identify the specific behaviors putting them at risk for acquiring and transmitting HIV. They should be enabled to commit steps to reduce this risk. Prevention counseling can involve one or more sessions.

### ***HIV Testing***

#### Pretest counselling

A person's request for HIV testing or declining for testing should be honoured. A counsellor should always- (1) Explore risks and discuss reasons for the test. (2) Provide information about HIV infection and testing; including the meaning of positive & negative test results, and the

impact of the window period on test result (3) Discuss risk reduction (4) Maintain anonymity of testing. (5) Discuss potential benefits and harms of being tested (6) Discuss the confidentiality of test results (7) Assess the window period by identifying the most recent risk event. (8) Obtain and record informed consent <sup>14,15</sup>

Post-test counselling:

HIV test results are given only in person. A counsellor should – (1) Assess the patient's understanding of the test result. (2) Encourage the patient to express feelings and reactions (3) *Disclose negative result providing information on need for repeat testing.* (4) Reassess risk and make aware regarding risk-reducing strategies.<sup>13,14</sup> (4) *Disclose Positive result with* assessment of the psychological response to being HIV positive, plan to overcome adverse psychological reactions, arrange reassurance about the person's immediate safety, arrange for medical follow-up and if possible, review transmission modes and risk-reduction strategies and arrange for partner notification, if necessary.<sup>14,15</sup>

***HIV Referral***

Clients should receive or be referred to medical services for screening, treatment, and prevention of opportunistic infections or related HIV-conditions (e.g., cervical cancer). Also they should look for co-infection with communicable diseases (e.g., TB, STDs, and hepatitis B, C).<sup>13</sup> Female clients who are pregnant or of childbearing age should receive or be referred to reproductive health services to prevent perinatal transmission, and provide appropriate care based on established treatment <sup>13</sup> Clients who use drugs or alcohol should receive or be referred to substance or alcohol abuse prevention and treatment services.<sup>14,15</sup>

### **2.3 Guidelines of HIV Prevention for People with Mental Illness: a Special Need**

Successful intervention with mentally ill patients is complex, and requires offering help in a supportive, non-judgmental, and positive environment. For patients to avoid high-risk behaviour, they need information and skills. It may require case-to-case special attention based on client's mental status and type of illness.

*Centers for Disease Control and Prevention* recommends universal precautions, implementation and interpretation of HIV antibody testing, and prevention of the sexual transmission of HIV with total confidentiality to reduce stigma attached to it.<sup>14</sup> Routine test or risk assessment is recommended where HIV prevalence is <1 % or for the high risk groups irrespective of clinical symptoms. So mentally ill people should come under this group.

*The Mental Health Global Action Programme* developed by WHO in 2001 provides a coherent strategy to focus upon forging strategic partnerships for sustainable capacity building for mental health action in countries.<sup>3</sup> But the strategy approach has not specifically addressed the challenges of dual issues of HIV and mental illness when they occur together.

*The National Institute of Mental Health* adopted new priorities to address the AIDS epidemic among people with severe mental illness.<sup>16</sup> Besides prevention and treatment, the priorities emphasize the need for a fuller understanding of the extent and social organization of sexual and drug use behaviour. Simply by asking, providers can learn their clients' HIV-related risks and service needs and appropriately address them to reduce the human and economic costs of the AIDS epidemic.<sup>3</sup> But these have little been adopted in mental healthcare settings.<sup>16</sup>

*National Institute on Drug Abuse (NIDA)*, USA has provided few key considerations as to conduct risk assessment counselling for drug users. Steps are calm and cool interview



environment, rapport building with clients, ensuring confidentiality, befriending and administering the assessment.<sup>17</sup>

A few specific guidelines from a manual “*Prevention of HIV Infection in Mentally Ill People for mental health professionals*” by Meg Kaplan et al are helpful for mental health providers.<sup>1</sup>

#### **Guidelines for sessions on substance users**

Mental Healthcare Professionals should provide specific knowledge on up-to-date information about HIV and AIDS. This includes facts about transmission and testing. This enables clients to develop coping skills. Cultural issues like religion, rearing practices, family styles, stigma may influence the level of comfort that patients have in discussing sex. In addition, socioeconomic status may affect a person’s propensity to use substances.<sup>1</sup>

Sessions are identified to be one of the best ways of providing HIV information to mentally ill people that bring about significant changes in their risk behaviours. The sessions are planned for participants of both sexes, in 10 or more weekly or biweekly meetings. The length may vary. We need to use two group leaders, one female and one male, when possible. Same-sex providers should work with same-sex sub-groups. Reinforcement, compliments and phrases such as “That’s a good point” are essential. Assessment of his or her feelings, encouraging each member to participate is important. Providers should use a ‘Feeling Thermometer’. This technique allows participants to assess and discuss their feelings by metaphorically taking their emotional temperature. Placing a bowl of condoms where patients can privately take their own is the best approach. Materials like Handouts, AIDS Knowledge Questionnaire, and Sex Word Synonym Sheets are to be distributed.<sup>1</sup>

## **2.4 Barriers in HIV Counselling, Testing and Referral Services among Mentally Ill**

### *Controversies in dealing with HIV/AIDS and Mental Illness together*

There are controversial issues like duty of a provider to counsel, duty to treat, to provide information on safe sexual activity in mental healthcare settings. Issues like mandatory testing have drawn attention of policy makers and care givers. Ethical rights of patients and responsibilities of health care providers are crucial in providing HIV services. Protection of HIV infected people who are mentally ill from discrimination due to illness versus rights of people who are susceptible earns particular emphasis to remain safe. We cannot mention a uniform guideline in national or international level particularly addressing above controversies in mental healthcare settings.<sup>2</sup> There are variations in adherence and practices among providers based on their own ethical values and perceptions.<sup>18, 19, 20</sup>

### *Ethical conflicts (Mandatory Testing, Informed Consent, Confidentiality)*

Public rhetoric over mandatory testing versus ethical issues raised by few due to the spread of HIV among the seriously mentally ill is not a simple issue.<sup>2</sup> Issues have been debated within the professionals for over a decade across countries. Some experts feel that the benefits of early detection and treatment are insufficient to justify the intrusiveness of mandatory testing and the distress it will impose.<sup>2</sup> Counselling and confidentiality protections in disclosing positive HIV status in the mental health system are arguably considered to be inadequate to overcome benefits of disclosing it out. Services are increasingly expected to be "consumer driven," with meaningful client participation in decisions; clients and providers can differ in their values and beliefs. Value issues may grow in significance in provider roles. Boundary issues affect everyday practice in all settings but may operate differently in mental health care in ethical ground.<sup>18,19,20</sup>

Obtaining informed consent involves educating, disclosing advantages and disadvantages of testing for HIV, listening, answering questions and seeking permission to proceed through each step of counselling and testing. To give consent, patient must be deemed competent and understand the purposes, risks, harms and benefits of being tested, as well as those of not being tested person's consent must be voluntary.<sup>14, 15</sup> Providers have the opportunity to take decisions based on their own views and perceptions. Mc KAY, Mary M et al are trying to assess the changing trend of informed consent among mentally challenged people for doing HIV research before, during and after research period and also the factors that shape these changes. But we need to wait for the outcomes.<sup>21</sup> Great harm may result from careless breach of a patient's trust. Physicians are responsible for ensuring that their nursing and support staff respect the confidentiality of information obtained during testing for HIV and counselling.

### *Stigma*

Depending upon client's type and status of illness, substance use, even caste and education, stigma may be perceived differently or stigma may have different effects on people in respect to transmission of HIV. When the stigma arising from HIV/AIDS is superimposed on stigma arising from mental health problems, things become more complicated. Stigma may have powerful consequences like depression, lack of self worth and despair. For fear of disclosure, people are reluctant to seek for counselling or treatment.<sup>22</sup>

## **2.5 Mental Healthcare Providers: How much adherent?**

The Mental Healthcare Providers Education in HIV/AIDS Programme (MHCPE), which is a part of Federal Substance Abuse & Mental Health Service Administration (SAMHSA), USA is an initiative to educate mental healthcare providers on HIV/AIDS issues.<sup>16</sup>

The mental health profession remains an untapped resources within the community and mental healthcare settings for addressing HIV/AIDS prevention and early detection.<sup>16, 23</sup> HIV/AIDS continue to present major challenges for mental health professionals.<sup>16</sup>

Screening for risk factors may also suffer because professionals are reluctant to bring up HIV with psychiatric patients; often out of well-meaning concern for the patients.<sup>2</sup> They may overestimate the anxiety caused by taking a sexual history. They may feel that discussing sexual behavior can worsen psychiatric symptoms. They may assume patients' sexual histories to be unreliable and see little point in obtaining them. Yet there is evidence that patients give reliable information and that many clients welcome the opportunity to discuss sexual issues.<sup>2</sup> Providers have adequate opportunity to become friendly and to provide sexual health information, as clients spend long time with them due to chronic mental illnesses.

Mental healthcare professionals are increasingly called for providing HIV information to their clients. These practices among providers are possible to bring through effective training on HIV and mental health issues.<sup>16, 23</sup>

Studies have been conducted in USA to explore the adherence, knowledge and practices of healthcare providers like physicians, gynaecologists, obstetricians or social workers & nurses either in their hospitals, private clinics or in the community services and social workers. But limited may be mentioned as to address quality and quantity aspects of HIV related Counselling, Testing or Referral services specifically in mental healthcare settings. A study done by James Walkup et al, 1998 in New York conducted to assess HIV risk assessment related practices by the providers. It revealed that out of 53 psychiatry departments studied, 47% conducted HIV risk assessment, 6% reported that they provide all information to all

patients. Commonest practice is to provide information to high-risk group only. 34% provide information to selected individuals. Information providers were doctors and nurses.<sup>24, 25</sup>

## **2.6 HIV/AIDS Care Preparedness in Mental Healthcare Settings in India**

National AIDS Control Organization, India has provided with guidelines as how to manage HIV counselling, testing or referral services in the general population. Indian Council of Medical Research has prioritized HIV/AIDS as a research agenda. But there is a big gap between appropriate attention taken for people with mental health problems and specific services needed in respect to their HIV/AIDS counselling, testing and referral support.

Experience within India and several other developing countries have shown that VCTC (Voluntary Counselling and Testing Centre) helps people to cope with their HIV infection, to get access to care and to plan for the future.<sup>26</sup> Realizing the importance of the voluntary counseling and testing centers, National AIDS Control Organization (NACO) has decided to expand the net work of voluntary counseling testing centers up to the district level. There are total of 142 VCTC s in India in 2000.<sup>15</sup> Review could not identify any special attention for mentally ill people in NACO guidelines.

Government of India is yet to develop any standard guidelines as how to provide counselling or assess risks for substance users. There is scarcity of government agency to provide guidelines for mental healthcare professionals. Mental Health Act'87 of our country is yet to be upgraded to develop guidelines to address HIV services among mentally ill people.

## **Chapter-3**

### **RATIONALE and OBJECTIVE:**

#### **3.1 Rationale of the Study:**

We understand that dual problems of mental illness and HIV/AIDS together pose more challenges to the public health initiative. We are not truly prepared to combat the complexities arising out of dual illnesses. A few studies have estimated prevalence and psychiatric morbidity or risk behaviours of clients in mental healthcare settings. But we need to know the context of HIV Counselling, Testing and Referral services as on the part of the providers in mental healthcare agencies in Indian context. We need to understand shape and pattern of barriers in providing services. How do conventional HIV healthcare barriers are different here?

West Bengal has higher prevalence of psychiatric morbidity than many other states in India. Urban population has a higher prevalence than rural. The sample frame of this study is the providers of mental healthcare in Kolkata. It is a metro city having huge variations of people coming from different parts of northeast India. It has a permanent citizenship of 1 crore 15 lakhs. Varieties of providers are there. Settings are public, private/NGO providing treatment, or counselling services to mentally ill persons. This sample frame may be suitable to reflect the situation.

Study findings may draw attention of providers, academicians, HODs of NGOs or policy and decision makers of in mental health services in the state of West Bengal.

#### **3.2 Objectives:**

- *To describe and assess adherence to HIV Counselling, Testing and Referral services on the part of the providers*
- *To explain a few barriers in HIV Counselling, Testing and Referral services*

## Chapter-4

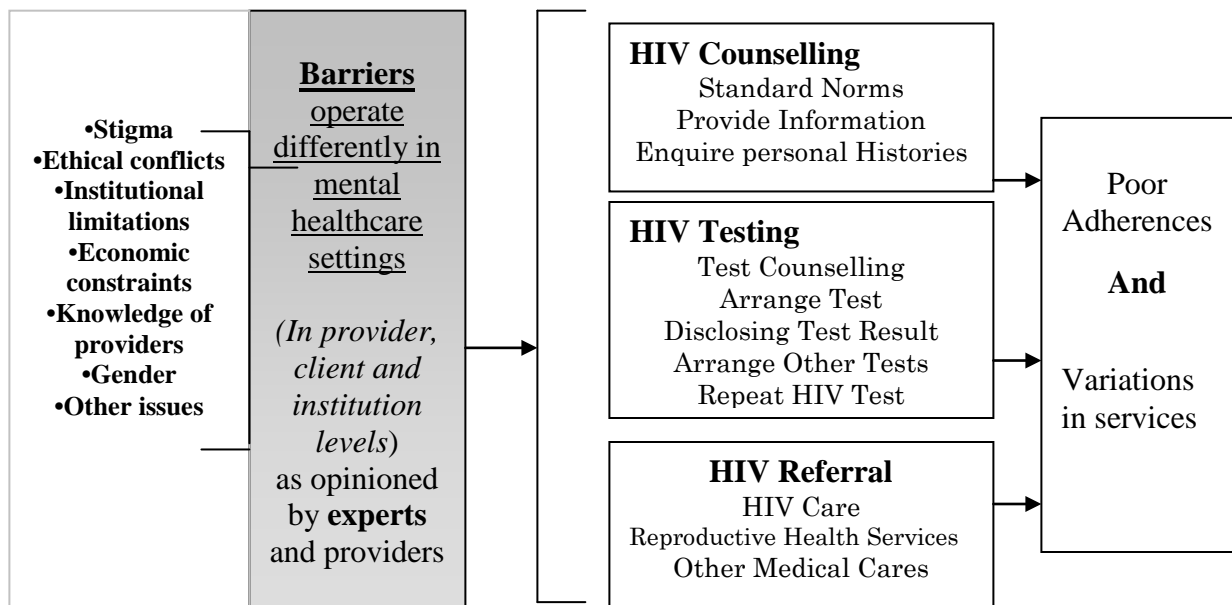
### METHODOLOGY

#### 4.1 Conceptual Framework:

*HIV Counselling* includes components like following standard norms of counselling, HIV risk assessment, providing HIV information, providing prevention information, risk reduction, or enquiring personal histories. *HIV Testing* includes HIV test counselling, arrange for testing, disclosing test result, doing other relevant tests, repeat tests when necessary. And *HIV Referral* includes HIV care, other reproductive cares, associated medical illness care.

While providing these services, mental healthcare providers face barriers like stigma, ethical conflicts, institutional limitations, gender etc.

We conceptualize that barriers affect services, rendered by providers operate in provider, client or institutional level. Outcome is compromise in quality and adherence to services.



## **4.2 Operational Definitions:**

Mental healthcare setting: Institutions providing cares to mentally ill persons including substance users

Mentally ill person: A person who comes to mental healthcare settings for seeking any kind of care are operationally defined as mentally ill person. They are in age group of 15 years to 60 years. Clients have been visiting settings at least since last 3 months.

Providers: Psychiatrist, Psychologist, Physician, Head of the Department and Expert

HIV Counselling: It includes standard norms of counselling, HIV risk assessment, provide HIV information, providing prevention information, risk reduction, or enquire personal histories.

HIV Testing: It means HIV ELISA testing and relevant ones for knowing status of a suspected person. The decision to adopt this test in a clinical or non-clinical setting should be based on several factors, including- (1) Client preferences and acceptability (2) Confidentiality (3) Likelihood of client returning for results (4) Ease of sample collection.

HIV Referral: Typical Referral needs are medical evaluation, care, and treatment in the same institute or from other institute where facilities are available.

## **4.3 Study Design:**

It is a cross sectional study looking into HIV Counselling Testing and Referral services as on the part of providers of maximum possible typologies. It contains both quantitative and qualitative approaches.

## **4.4 Study Setting:**

Our study setting is in Kolkata. Kolkata is a metro city and capital of West Bengal. It is located in northeast part of India. Kolkata along with its suburban areas has approximately a permanent citizenship of 1 crore 15 lakhs. Settings included Psychiatry Hospitals, Psychiatry Department



of General Hospitals, Psychiatry Department of Homeopathic Medical Colleges, and NGOs. There are allopathic, homeopathic institutes providing mental healthcare services. There are 9 public settings with OP and inpatient facilities, approximately 6 private hospitals with only OP facilities and 7 NGOs with OP and inpatient facilities for providing mental healthcare services.

#### **4.5 Respondents:**

They are Psychiatrists, Psychologists or Physicians. Head of the Departments (HOD) were psychiatrist, psychologist or administrator.

#### **4.6 Sample size:**

In a recent mental healthcare conference in November '02, total number of registered providers was 137. We consider 33% of them will be good representative. So required number is 46. Total number of providers interviewed is 52. 10 Head of the Departments and 13 experts were interviewed. Ultimate sample size comes 52(45% of total expected number of providers). 9 of the HODs are mental health care providers. HODs are people other than 52 respondents.

#### **4.7 Sampling Method: Selection of Setting:**

All public Medical College Hospitals, Psychiatry Hospitals, Homeopathic Medical Colleges Hospitals in Kolkata were selected. Lion share of the patient turn over is served by public settings. Private hospitals were approached. Most of the HODs there did not consent to provide information. We excluded private hospitals from our study. We had a list of NGOs working on mental health services. They were selected based on consent of HODs.

#### **4.8 Sampling Method: Selection of Provider:**

The researcher went to different institutions. Among the then providers on duty, whoever gave consent, was selected for interview. Head of the Departments were selected through a prefixed appointment over telephone. Experts were selected from providers who already gave interviews

for 1<sup>st</sup> set of schedule (*schedule details explained below*) and on the basis of years and variety of experiences, setting varieties, qualifications and their conveniences. We tried to capture maximum possible typologies.

#### **4.9 Promotion of the Study:**

Permissions from the Director of Medical Education, Government of West Bengal were sought by 30<sup>th</sup> November'03 before data collection, which started from 1<sup>st</sup> Jan'04.

#### **4.10 Study Period:**

Data collection- 1st January '04 to 31<sup>st</sup> March'04. Data analysis- 1<sup>st</sup> April'04 to 5<sup>th</sup> June'04

#### **4.11 Preparing Instrument:**

##### *Development of Interview Schedules*

(1) Interview Schedule I for *Providers* - A semi-structured interview schedule for providers addressing HIV Counselling, Testing and Referral services was prepared (see Annexure I). The promotional period needed helps from psychiatrists, HIV consultants and a Bio-Statistician. 1<sup>st</sup> part was HIV Risk Assessment. It has been developed from a standard instrument, '**Brief HIV Screener (BHS)**.' The BHS is a 10-item questionnaire that has been validated for use in health care settings to screen for HIV-related risk behaviours of clients. The BHS is internally consistent (Kuder± Richardson-20 coefficient<sup>0.73</sup>) and able to discriminate between low- and high-risk groups. It is a self-administered questionnaire for clients. 1<sup>st</sup> interview schedule containing 'HIV Risk Assessment' portion contains 10 questions to be asked to providers having three options (Always, Sometimes and Never). Each item of these 10 from BHS has been reversed to probe into a provider to know their adherence with little modification.

(2) Interview Schedule II for *Head of the Department* - One semi-structured interview schedule addressing adequacy and quality aspects and infrastructures available.

(3) Interview Schedule III For *Experts* –Semi-structured Interview schedule addressing pre-identified barrier issues was developed in consultation with Medical Anthropologist.

#### **4.12 Pre-testing procedures:**

Pre-testing was done from 10<sup>th</sup> to 18<sup>th</sup> December'03 in a Psychiatry Department in a Medical College. Interview Schedule-I was pre-tested on 2 Psychologists (1 male and 1 female) and 1 Psychiatrist (1 female). The Interview Schedule II was pre-tested on H.O.D. of an NGO. Interview Schedule III was pre-tested upon a Psychologist from a detoxification centre. Necessary corrections were made based on the feedback.

#### **4.13 Interview Procedures:**

Researcher being a medical doctor and having previous experiences in HIV/AIDS had additive advantages to effectively probe during interviews. Interviews were conducted in a separate room. For HOD, it was in their office rooms. For experts, either it was in their work place or houses depending on their conveniences. Full confidentiality and privacy was maintained. Average times needed for Interview Schedule I, II and III were 20 minutes, 35 minutes and 50 minutes respectively.

#### **4.14 Ethical Consideration:**

Any provider who was requested for interview had the right not to participate or discontinue the interview at any point of time. The Directorate of Medical Education, Government of West Bengal, released order to conduct the study. Concerned HODs gave written permissions. The researcher could not compensate opportunity cost of respondents. But they happily cooperated, as it was an academic research and a new area to them. Prior to each interview the consent form was read. Verbal consent was taken. Purpose of the interview was mentioned. Assurance of confidentiality was assured.

#### 4.15 Variables:

##### In Interview Schedule I and II

###### ***Independent variables:***

<i>Type of settings</i>	Public or NOG, Psychiatry or Other
<i>Type of providers</i>	Psychiatrist, Psychologist, Others including Physicians
<i>Age of providers</i>	No in years
<i>Sex of providers</i>	Male or Female
<i>Experiences of providers in years</i>	Mental illness, research, HIV/AIDS or Counselling
<i>Training on HIV/AIDS</i>	Formal training/workshop on HIV/AIDS, if attended
<i>Resources available</i>	Number & type of providers, duty hours, and person-time
<i>Barriers</i>	Adherence to adequate and quality services

###### ***Dependent variables:***

<i>Adherence to HIV Risk Screening</i>	Adherence to query items
<i>HIV Risk Assessment Score (HIVRSA)</i>	Total score of a provider from 10 Risk Assessment Queries in BHS
<i>Score from 12 variables (S12)</i>	Total score from 12 selected variables
<i>Total Score (TS)</i>	Sum score of HIVRAS and S12
<i>Adherences to HIV Counselling, Testing &amp; Referral services by providers</i>	% of adherence of providers from setting varieties on specific questions on counselling, testing or referrals
<i>Variations of services among providers</i>	Differences in services across settings or providers
<i>Performances of providers</i>	Quality items in counselling, scores

##### In Interview Schedule III

###### ***Independent variables:***

<i>Stigma</i>	As a barrier to provision of services from providers, client, or institutional level
<i>Ethical conflicts</i>	Questionable validity of informed consent of doing HIV testing on mentally challenged, dilemma in disclosing HIV status
<i>Institutional limitations</i>	Resources, guidelines and coordination
<i>Economic constraints</i>	Impact when dual diagnosis of mental illness and HIV together?
<i>Knowledge of providers</i>	Preparedness of providers for HIV counselling, testing cares
<i>Gender</i>	Impact on services for being male or female

###### ***Dependent variables:***

- Adherence of providers to HIV Counselling, Testing and Referral Services
- Compliance to HIV Counselling, Testing and Referral Services from clients

#### 4.16 Scope of Other Data Collection Methods:

Observation might be a suitable method to tally what the providers say and what they do. It will be unethical to interfere as a researcher into confidentiality and privacy of a mentally ill person who is sharing experiences about his/her sexuality with a counsellor. *Participating* as a client

with the provider in counselling needs more time and preparation to perform. So we restricted ourselves to information provided by providers and experts.

#### **4.17 Organization and Analyzing the Data**

##### *Scoring and grouping of selected variables*

In our study, any question from BHS having answer 'Always', 'Sometimes' or 'Never' stands for scores 2, 1 and 0 respectively. If every client of 15 to 49 years of age, in his/her last 3 months' visits to the setting, has been asked the specific question at least once, it is 'Always'. If any one is left, it is 'Sometimes'. If no one is asked, it is 'Never'. It has 10 questions. Total score ranges from 0 to 20. We have coded individual provider score as **HIVRAS**.

*Score for other variables in schedule1:* Always-2, Sometimes-1, Never-0. If options are Yes and No, then it is 1 and 0 respectively.

*HIV Risk Assessment Score grouping:* Score > 10(median) is 'high score' and < or =10 is 'low score' (HIVRAS).

*12 selected variables score (S12) grouping:* For 12 selected, important variables (n=12), all providers answered. We have scored it and added together to find '12 variable total score' (S12). Score = < 7(median) is 'low score' and >7 is 'high score'. These 12 variables are counselling on needle syringe exchange, harm reduction, consent on sexual health, information on HIV in OPD, information on prevention of HIV, approach of counselling, use of checklist, counselling before and after HIV testing, provide all information on referral and assessing ability & willingness to be referred.

*Total Score grouping (TS)[TS = HIVRAS+S12]:* Score >16(median) is 'high score' and < =16 is 'low score'.

*Data from Interview Schedule I and II were entered in SPSS 11.10 version. Some qualitative data were analyzed manually. Data from Interview Schedule III were analyzed through phases of editing, interpreting, categorizing & coding. For gender as a barrier we used Gender Analysis Framework of Liverpool.*

*Extracts of qualitative data:*

Extracts were used to identify variations in opinions. The intent is to identify and categorize opinions and locate idiosyncrasies. Somewhere verbatim has been quoted.

*Statistical Methods used for Quantitative Data*

Independent Samples t- test, Chi-square, One-Way-Anova, Binary and Multiple Logistic Regressions are used whenever appropriate to calculate statistically significant associations at 0.05 level.

*Description and Assessment tool:*

We have selected variables of services from CDC guidelines on ‘HIV Counselling, Testing and Referral services’, ‘Training Module for Mental Health Professionals’ by Meg Kaplan et al’2003 and ‘Guidelines For Administering The HIV Risk Assessment’, NIDA Risk Behaviour Assessment Questionnaire, (revised April 1998). HIV Risk Assessment has been assessed by the HBS that we described earlier. Adherence is described in % and assessments through % and different scores.

*For describing adherence we have taken two categories- types of setting (Public or NGO) and types of provider (psychiatrist, psychologist and others) to capture variations.*

## Chapter-5

### RESULTS

#### 5.1 Characteristics of Settings:

The study was conducted in 14 mental healthcare settings in Kolkata. Out of them 2 institutes are exclusively psychiatry hospitals, 5 are psychiatry departments of Medical College Hospitals, 2 are Out Patient Departments (OPD) of Homeopathic Hospitals, 3 are Counselling Centres, and 2 are Detoxification Centres. Out of 14, 9 institutes are public and 5 institutes are Non Governmental Organizations (NGO).

The psychiatry hospitals provide exclusively psychiatry services along with primary health care for their clients. Psychiatry Departments of General Hospitals provide psychiatry services, but send clients to adjacent departments for primary healthcare. Homeopathic institutes provide counselling services and primary healthcare services. NGOs provide both psychiatry services and primary healthcare services. All public institutes are located mostly around central Kolkata. NGOs, except one, are located at peripheral Kolkata. 4 Allopathic Medical College Hospitals have HIV Testing facilities.

We give a very brief overview of the resources available to the 10 institutes where we met 10 Head of the Departments (HOD) [Table 1]. On an average, public settings serve 218 patients and NGOs serve 69 patients per day in OPD. Expected average duty hours of providers in public setting and NGOs are 9.57 and 6.66 hours respectively. Public & NGO settings on an average provide 0.42 & 0.36 expected Provider- OPD-Hours per patient per day respectively.

*Table 1: Provider Resources in 10 Departments of Mental Healthcare Settings*

	Public (n=7)				NGO (n=3)			
<i>Characteristics</i>	Psychiatrist	Psychologist	Nurse	N	Psychiatrist	Psychologist	Nurse	N
<i>No of Providers</i>	79	25	66	170	13	6	22	41

## 5.2 Characteristic of Respondents:

Respondents are providers, Head of the Departments (HOD) and experts.

### Providers (n=52)

We recruited 52 providers for interviews on HIV Risk Screening, adherence to counselling norms, HIV testing procedures and referral services. 36 (69.3%) respondents belong to public setting and 16(30.7%) providers belong to NGOs. NGO settings are Counselling Centres, Substance Use and Detoxification Centre

There are 31 psychiatrists (59.6%), 13 psychologists (25.0%), 6 physicians (11.5%) and 2 others (3.8%). [Table 2]

Table2: Characteristics of 52 Providers

	N (%)		N (%)
<b>Characteristics</b>		<b>Characteristics</b>	
<i>Sex</i>		<i>Age</i>	
Female	23(44.2)	=<30 years	15(28.8)
Male	29(55.8)	31-38 years	11(21.2)
		39-56 years	26(50.0)
<i>Job Description</i>		<i>Experiences in years</i>	
Psychiatrist	31(59.6)	=<7 years	26(50.0)
Psychologist	13(25.0)	>7 years	26(50.0)
Physician	6(11.5)		
Other/Counsellor	2(3.8)		
<i>Practice location</i>		<i>HIV training</i>	
Public	36(59.3)	Yes	13(25.0)
NGO	16(25.0)	No	39(75.0)
<i>Qualification</i>		<i>Psychiatrist</i>	
MD/DPM in Psychiatry	31(9.6)	Regular Employee	19(61.29)
MA/PhD Psychology	12(23.1)	Post Graduate Trainee	12(38.71)
MBBS/MD Physician	1(1.9)		
BHMS Physician	5(9.6)	<i>Psychologist &amp; Physician</i>	
Others	2(3.8)	Regular Employee	21(100.0)
		Post Graduate Trainee	0(0.00)

These others (n=2) included two counsellors - one Ex-Injecting Drug User in an NGO and one Ex-Heroine-User. They work in NGOs in substance use programmes.

7 years is the median of experiences of providers. Only 13 providers have any kind training or working experiences in HIV/AIDS to some extent. None of the providers served as HIV/AIDS



expert or Anti Retroviral Therapy (ART) treatment giver except one NGO (MBBS) physician provider.

Head of the Departments (HOD) (n=10)

None of the HODs are from 52 providers who were chosen for interview with interview schedule I. 7 HOD s are from public settings. Three of the public settings and three NGOs have inpatient facilities. All settings have outpatient facilities. Out of 10 HODs, 6 are psychiatrists, 2 are psychologist/counsellor, 1 physician and 1 administrator.

Experts (n=13)

Majority has experiences of more than 10 years in the relevant field (n=9 i.e. 69%). Six (46.1%) experts have clinical and counselling experiences in metal illnesses. Five have clinical experiences in HIV/AIDS. One expert has research experiences in HIV/AIDS. Six out of 13 are psychologists (46.1%) and 5 are psychiatrists (38.5%). [Ref. Table 3]

Table 3: Characteristics of 13 Experts

Characteristics	Psychiatrist (N)		Counsellor (N)		Physician (N)	Other (N)
<b>Type of setting</b>						
Public	4		2		1	0
NGO	1		4		0	1
<b>Qualification</b>						
MD/DPM	5		0		0	0
MA/PhD/MSW	0		6		0	0
BHMS	0		0		1	0
Other (Ex Drug User)	0		0		0	1
<b>Experiences &gt;10 years</b>	9					
<b>=&lt;10 years</b>	4					
Variety of experiences	Clinical in mental illness	Clinical in HIV/AIDS	Research in mental illness	Research in HIV/AIDS	Counselling in mental illness	Counselling in HIV/AIDS
	6	5	6	1	6	5

We have described characteristics of settings and 3 groups of respondents. In the following sections we put an overview of the content and context of these services in settings giving emphasis on setting and respondent varieties to capture variations. We focus on independent and dependent variables as mentioned in methodology section.

### 5.3 HIV Counselling

*Public setting providers take sexual health histories of their clients as a mandatory part in detailed history sheets. It takes approximately 30-45 minutes. They conduct HIV counselling or HIV Risk Screening of their clients only when they consider that client is under risk. NGO providers serve their clients in HIV/AIDS or substance use programmes. Risk assessment part is taken care of through group counselling, focus group discussion (FGD) and family meetings in NGO settings.*

#### 5.3.1 Adherence to HIV Risk Screening

NGO settings have a few guidelines to address the issues of HIV among their clients. They are programmatic in approach, where as public settings have more of clinical orientation. None of the public setting adopts separate strategy to address HIV issues among their clients. In public setting Risk Assessment or Counselling services are provided as and when required, only if a provider finds client to be high risk. NGO providers try to explore risk status of all clients. Interviews revealed out that there is no existing terminology of HIV Risk Screening among providers. But they assess risks through informal ways. Only 4 people in public settings use checklist for screening.

Out of 10 specific questions from 'HBS' instrument; *we have highlighted providers' 3 most priority query items as **bold** numbers under heads of 'Always', 'Sometimes' and 'Never'.*

*Out of 52 providers, client's STD history, partner's STD history and ever injection history of drugs with any needles are 'Always' assessed by 17(32.7%), 16(30.8%) and 17(32.7%) providers respectively. Out of 52 providers, number of sexual partners, client's STD history, and ever injection histories of drugs with any needles are 'Sometimes' assessed by 38(73.1%), 34(65.4%) and 33(63.5%) providers respectively. [Table4]*

Table4: HIV Risk Screening by all providers (n=52)

HIV Risk Screening Queries	Always Asked		Sometimes Asked		Never Asked	
	n	%	n	%	n	%
Number of sexual partners	11	21.2	<b>38</b>	73.1	3	5.8
History of anal sex	3	5.8	32	61.5	17	32.7
STD history of partner	<b>16</b>	30.8	26	50.0	10	19.2
History of STD	<b>17</b>	32.7	<b>34</b>	65.4	1	1.9
Paid money for having sex	11	21.2	23	44.2	<b>18</b>	34.6
Got money for giving sex	9	17.3	26	50.0	17	32.7
Ever injection with needles	<b>17</b>	32.7	<b>33</b>	63.5	2	3.8
Injection history of partner	6	11.5	27	51.9	<b>19</b>	36.5
History of sex with MSM	6	11.5	30	57.7	16	30.8
Use of condom for anal sex	12	23.1	17	32.7	<b>23</b>	44.2

Denominator- all clients seeking care as per operational definition of mentally ill person

*Out of 52 providers, use of condom for anal sex, injection history of partner and whether paid money for sex is 'Never' assessed by 23(44.2%), 19(36.5%) and 18(34.6%) providers respectively. Providers are in general far away from mandatory HIV screening of their clients. Significantly poor percentages of providers are 'Always' adhered to probing risk related questions during counselling, those may help them reducing their risk behaviours.*

*Psychiatrists, were adherent 'Always' for 3 most priority risk assessment queries like STD history of client, STD history of partner and ever injection of drugs with needles in 22.6%, 22.6% and 19.4% cases respectively. Psychologists 'Always' enquired about ever injection of drugs with needles, number of sexual partners, STD history of clients in 66.7%, 53.3% and 46.7% cases respectively [Table 5].*

Across types of providers, psychologists are more adhered in asking specific questions related to risks. Psychologists are more adhered to appropriate questions in respect to efficacy of transmission. For example, psychologists never ask about use of condom for anal sex in 20% cases compared to psychiatrists (51.6%). There are also variations in asking most frequent questions among psychologists, psychiatrists and other groups. [Table5]

Table 5: Adherence to HIV Screening queries across type of providers

Queries	ALWAYS n (%)			SOMETIMES n (%)			NEVER n (%)		
	PsyD	PsyC	Oth	PsyD	PsyC	Oth	PsyD	PsyC	Oth
No sexual partner	2(6.5)	8(53.3) ●	<b>1(16.7)</b>	26(83.9) ●	7(46.7)	<b>5(83.5)</b>	3(9.7)	0(0)	<b>0(0)</b>
History of anal sex	0(0)	2(13.3)	<b>1(16.7)</b>	20(64.5)	11(73.3) ●	<b>1(16.7)</b>	11(35.5)	2(13.3)	<b>4(66.7)</b>
STD history	7(22.6) ●	7(46.7) ●	<b>3(50.0)</b>	24(77.4) ●	7(46.7)	<b>3(50.3)</b>	0(0)	1(6.7)	<b>0(0)</b>
STD history partner	7(22.6) ●	6(40.0)	<b>3(50.0)</b>	17(54.8)	7(46.7)	<b>2(33.3)</b>	7(22.6)	2(13.3)	<b>1(16.7)</b>
Paid money for sex	4(12.9)	6(40.0)	<b>1(16.7)</b>	14(45.2)	6(40.0)	<b>3(50.0)</b>	13(41.9) ●	3(20.0) ●	<b>2(33.3)</b>
Got money to give sex	3(9.7)	4(26.7)	<b>2(33.2)</b>	15(48.4)	9(60.0) ●	<b>2(33.3)</b>	13(41.9) ●	2(13.3)	<b>2(33.3)</b>
Ever inj. by needles	6(19.4) ●	10(66.7) ●	<b>1(16.7)</b>	23(74.2) ●	5(33.3)	<b>5(83.30)</b>	2(6.5)	0(0)	<b>0(0)</b>
Inj. history of partner	2(6.5)	4(26.7)	<b>0(0)</b>	14(45.2)	9(60.0) ●	<b>4(66.7)</b>	15(48.4)	2(13.3)	<b>2(33.3)</b>
Sex with MSM	2(6.5)	4(26.7)	<b>0(0)</b>	18(58.1)	9(60.0) ●	<b>3(50.0)</b>	11(35.5)	2(13.3)	<b>3(50.0)</b>
Condom for anal sex	5(16.1)	6(40.0)	<b>1(16.7)</b>	10(32.3)	6(40.0)	<b>1(16.7)</b>	16(51.6) ●	3(20.0) ●	<b>4(66.7)</b>

PsyD- Psychiatrist, PsyC- Psychologist, Oth- Others include Physicians and other 2

Denominator- all clients seeking care as per operational definition of mentally ill person

### 5.3.2 Scores: (HIVRAS, S12 and TS)

We are describing 3 types of scores –HIVRAS, S12 and TS. We describe scores across settings and providers. We have looked for associations with age, sex, provider variety, years of experiences, training status.

#### Distribution of HIV Risk Assessment Scores, S12 scores and Total Scores (TS)

Table6: HIVRAS, S12 and TS Details

		HIVRAS Details	S12 Score Details	Total Score Details: TS
Mean		9.61	6.40	16.02
Median		10.00	7.00	16
Mode		6.00	7	13
Std. Deviation		4.08	1.97	5.26
Minimum		3.00	1	5
Maximum		18.00	10	26
Percentiles	50	10.00	7	16.00
	75	13.00	8	19.75

HIVRAS- Total HIV Risk Assessment Score, S12- Total score from selected 12 variables, TS- Total Score of HIVRSA & S12

Type of providers and scores

Psychologists got higher scores in HIVRA, S12 and TS [Table 7]. Mean score for all providers is 9.61.

Table7: Mean Score of providers

Mean Scores								
HIVRAS			S12			TS		
PsyD	PsyC	Oth	PsyD	PsyC	Oth	PsyD	PsyC	Oth
8.35	<b>12.23</b>	10.25	6.19	<b>7.31</b>	5.17	14.55	<b>19.54</b>	16.0

*PsyD- Psychiatrist, PsyC- Psychologist, Oth- Others including Physicians, HIVRAS- Total HIV Risk Assessment Score, S12- Total score from selected 12 variables, TS- Total Score of HIVRSA & S12*

Individual HIVRAS has statistically significant association with types of providers (Psychiatrist-0, Psychologist-1, Others-1) ( $p=.000$ ) through One-Way ANOVA test. Association between type of provider (psychiatrist or not) and HIVRAS is not statistically significant ( $p=0.576$ ). Type of providers has no statistically significant relationship with S12 ( $p=0.303$ ). Its association with TS is significant ( $p=0.047$ ). Similarly association between type of provider (psychologist or not) and TS is only statistically significant ( $p=0.025$ ). Doing binary logistic regression between HIVRAS and S12, we see that those who got higher score ( $>10$ ) in HIVRAS, are 2 times more likely to score higher in S12 ( $>7$ ) ( $p=0.001$ ). We adjusted for experiences, sex, age, training status and settings. OR became 0.212 ( $p=0.036$ ).

Table 8: HIVRAS and sex of providers

	HIVRAS		S12		TS	
	0-10	>11	0-7	>7	0-16	>16
Number of Male (%)	18(58.1)	11(52.4)	20(55.6)	9(56.3)	17(63.0)	12(48.0)
Number of Female (%)	13(41.9)	10(47.6)	16(44.4)	7(43.8)	10(37.0)	13(52.0)
	P=0.686		P=0.963		P=0.278	

Associations between sex and HIVRAS, S12, TS are not statistically significant [Table 8]

Perception of gender having role to provide HIV information in OPD has no statistically significant association ( $p=0.645$ ) with sex.

**Table 9: Experiences and HIVRAS**

	HIVRAS: n (%)		S12: n (%)		TS: n (%)	
	0-10	=>11	0-7	>7	0-16	>16
0-7 years	16(51.6)	10(47.6)	16(61.53)	20(76.92)	15(55.6)	11(44.0)
>7 years	15(48.4)	11(52.4)	10(38.47)	6(23.08)	12(44.4)	14(56.0)
	P=0.777		P=0.229		P=0.405	

Associations between years of experiences (= or less than 7 years) and HIVRAS, S12, TS are not statistically significant [Table 9]. Mean scores of HIVRAS, S12 and TS for (0-7) years of experiences are 9.34, 6.54 and 15.88 respectively. They are 9.88, 6.27 and 16.15 respectively for providers whose experiences are more than 7 years.

Age versus HIVRAS, S12 and TS

Mean age for public providers are 39 years. It is 34 years for NGO providers. The following age groups in the table show no significant relationship with HIVRAS (p=0.267).

**Table10: Age Group versus HIVRAS**

Group Score	Age group				Total	P= 0.267
	0-10	0-29	30-38	>=39		
>11	8	5	18	31		
	6	7	8	21		
	14	12	26	52		

Calculation for association between age and S12 or TS has P values 0.242 and 0.464 respectively indicating no statistically significance.

Type of settings and scores

**Table11: Type of settings and scores**

Score Group	HIVRAS		Score Group	S12		Score Group	TS	
	Public N (%)	NGO n (%)		Public n (%)	NGO n (%)		Public n (%)	NGO n (%)
0-7	29(80.6)	7(43.8)	0-16	23(63.9)	4(25.0)	0-10	26(72.2)	5(31.3)
>8	7(19.4)	9(56.2)	>17	13(36.1)	12(75.0)	>11	10(27.8)	11(68.2)
	P=0.005			P=0.020			P=0.010	

Associations between type of settings (public or NGO) and HIVRAS, S12, TS are statistically significant [Table 11]. Associations between HIVRAS, S12 & TS with settings varieties Psychiatric Hospitals, Psychiatry Dept. of General Hospital and NGOs are statistically significant with respective p values 0.003, 0.083 and 0.006.

Mean HIVRAS are 8.19 and 12.81 in public and NGO settings respectively. HIVRAS (mean) scores are 9.81, 7.81 and 12.81 for Psychiatric Hospitals, Psychiatry Dept. of General Hospital and NGOs, respectively. Mean scores of S12 and TS for public settings are 5.89 and 14.50 respectively. They are 7.40 (S12) and 20.50(TS) for NGOs.

#### Variations in Individual Risk Assessment Scores

In One-Way-ANOVA analysis, individual HIV Risk Assessment Scores of providers showed significant association with institution variety (Psychiatry Hospital-public, General Hospital – public and NGO) ( $p=0.000$ ) or institution variety (public and NGO)( $p=0.010$ ). For TS doing One-Way-ANOVA, we got statistically significant variations among mean scores of above three types of settings (Psychiatry Hospital-public, General Hospital –public and NGO) with p value 0.000. For S12, p value was 0.122.

We did Independent-Sample- t- tests for HIVRAS, S12 and TS with age group (0- up to 38 years, 1- more than 38 years), sex (0-male, 1-female), type of settings (0- psychiatry hospital and psychiatry dept of general hospital, 1- others), type of provider (0- psychiatrist, 1- others) and experiences (0- up to 7 years, 1- more than 7 years) and training in HIV/AIDS (0- trained, 1- not trained). Significant associations were found between HIVRAS, S12 and TS with type of settings with respective p values 0.001, 0.031 and 0.001. Total Score, TS is significantly associated with type of provider ( $p=0.016$ ).

#### Role of gender

Mean HIV Risk Assessment Score (HIVRAS) for male and female providers are 9.27 and 10.04 respectively. Association of HIVRAS with sex is not statistically significant ( $p=0.686$ ). Perception of gender having role in HIV counselling is 59.6%. We calculated to see no statistically significant association between perception of gender having role in HIV

counselling (yes=1, No=2) with HIVRAS (p=0.400), with providing HIV information in OPD (p=0.645), with sex (p=0.573), age group (<= 38 years and above, p=0.258), settings (public or NGO, p= 0.512), reported very good confidentiality (p= 0.208), HIV Training status of providers (p=0.332). HIVRAS (High- 11-20, Low 0-10) of individual providers is significantly associated with provider's HIV/AIDS training status (p=0.014). But mean HIVRAS of trained and not-trained providers are 11.69 and 8.92 respectively.

#### Scores in quartile distribution among providers and settings

25<sup>th</sup>, 50<sup>th</sup> and 75<sup>th</sup> percentiles of HIVRAS are 6,10 & 13 respectively. If we plot providers in 4 quartiles of HIV Risk Assessment Score distribution graph, psychiatrists are located in 2<sup>nd</sup> quartile (mean score is 8.35), psychologists are in end of 3<sup>rd</sup> quartile (mean score 12.23) and others (including physicians) remain at the beginning of 3<sup>rd</sup> quartile.

25<sup>th</sup>, 50<sup>th</sup> and 75<sup>th</sup> percentiles of S12 are 5,7 and 8 respectively. For S12 score distributions (mean score 6.19), psychiatrists remain scattered in 2<sup>nd</sup> quartile, psychologists in early 3<sup>rd</sup> quartile (mean score 7.31) and others in 2<sup>nd</sup> quartiles (mean score 5.17).

On the other hand for Total Score (TS) distribution; again psychologists remain in the end of the 3<sup>rd</sup> quartile (mean score 19.54). Psychiatrists and others remain in 2<sup>nd</sup> quartile having their mean scores 14.55 and 16 respectively. Here 25<sup>th</sup>, 50<sup>th</sup> and 75<sup>th</sup> percentiles of TS are 12.25, 16 & 19.75 respectively. *Score ranking in descending order is -psychologists, psychiatrists and Others.*

#### Training on HIV/AIDS and Quality of Counselling

HIV Risk Assessment Score (High- >=11, Low 0-10) of individual providers is significantly associated with provider's HIV/AIDS training status (p=0.014) [Table 12].



*Table 12: HIV/AIDS Training Status and HIVRAS*

		HIV Training Status of Providers		Total	P value
		Trained (n)	Not Trained (n)		
HIVRAS	0-10	4 (30/77%)	27(69.23%)	31	.014 Pearson Chi-square (2-sided)
	>=11	9(69.23%)	12(30.77%)	21	
Total		13(100.00%)	39(100/00%)	52	

We calculated association between training status and few other variables like providing HIV information in OPD, counselling both times for HIV testing, assessing personal histories, counselling about client’s willingness and ability to be referred, taking personal histories etc through chi-square methods. Training status of HIV/AIDS of the providers is only significantly associated with their counselling for willingness and ability of client to be referred (p= .048). Training status is also significantly associated with type of settings (public and NGO) (p=0.010). [Table 13]. We see that NGOs have more trained persons.

Trained and untrained psychologists have mean HIVRAS 14.71 and 8.16 respectively. Trained and untrained psychiatrists have mean HIVRAS scores are 8.40 and 8.16 respectively.

*Table 13: HIV/AIDS Training Status and Settings*

	Public	NGO	Total	P value 0.010
No of providers trained in HIV/AIDS	7(19%)	10 (63%)	17 (33.05%)	
No of providers not Trained in HIV/AIDS	29(81%)	6 (37%)	35(63.95%)	
Total	36(100%)	16(100%)	52(100%)	

In public settings, trained and untrained providers have mean scores 8.71 and 8.70 respectively. Where as in NGOs, mean HIVRAS is 15.16 and 11.60 respectively. It means that training has a positive impact on bringing better quality HIV counselling, but mostly for NGO settings and providers.

**Multiple Logistic Regression**

*We stressed on categorical variables (significant in chi-square calculations) like HIV training status, type of settings, speciality and did multiple logistic regressions for HIVRAS, S12, TS looking for adjustment with other variables like age, experiences etc [Table 14].*

*Adjusted Odds Ratio for setting variety to HIVRAS, S12 and TS adjusted for training, speciality in psychiatry are 8.037, 8.092 and 6.385.*

**Table 14: Training, Age, Experiences, Setting and Provider Variety.**

	HIV Service Scores of Providers								
	HIVRAS			S12			TS		
	Un Adj. OR	Adj. OR	95% C.I. of Adj. OR	Un Adj. OR	Adj. OR	95% C.I. of Adj. OR	Un Adj. OR	Adj. OR	95% C.I. of Adj. OR
Training	5.062	0.244	0.058-1.023	1.00	1.434	0.313-6.560	0.309	0.375	0.085-1.652
Setting	8.666	8.037	1.376-46.937	5.362	8.092	1.421-46.096	8.665	6.385	1.259-32.309
Sp.Psychiatry	.605	0.381	0.069-2.115	1.769	0.557	0.103-3.232	3.636	1.515	0.360-6.369

Training- Trained in HIV/AIDS or not, Setting-Public or NGO, Sp Psychiatry- Specialist in Psychiatry or not

*The findings mean that NGO setting providers are approximately 8, 8 & 6 times more likely to have higher scores than public setting providers, remaining adjusted for training or speciality.*

### **5.3.3 Adherence to HIV Counselling Norms and Providing Information**

In this section we will describe how far the providers are adhered to HIV counselling norms across settings. Here we particularly asked providers about % of their adherence to few technical issues in respect to the client’s risk group. For example, if client is a drug user, whether they are asking and providing information on harm reduction, needle syringe exchange, type of substance use etc. These questions may not be applicable for others.

#### *Difference in HIV Counselling Norms Across Settings*

Only one provider in public setting told that he does not take any special attention for HIV counselling. All providers in NGOs opt for client’s consent while taking their sexual histories. In public settings, 30.56% are not adhered to this principle. More than 90% providers in all settings maintain good confidentiality and more than 80% of providers approach their clients through rapport building for probing into sexual histories. But significant proportions (26.1%) of public providers are not adhered to pretest/posttest counselling in HIV Testing. [Table 15]

*Table 15- Difference in HIV Counselling Norms across settings*

<i>Item (no of respondents)</i>	Yes: n (%)		No: n (%)	
	<i>Public</i>	<i>NGO</i>	<i>Public</i>	<i>NGO</i>
Special attention taken (52)	<b>35(97.2)</b>	16(100.0)	1(0.03)	0(0.0)
Consent for sexual histories (52)	25(69.44)	15(81.25)	<b>11(30.56)</b>	3(18.75)
Maintain Good Confidentiality (52)	35(97.20)	15(93.08)	1(2.80)	1(6.92)
Counselling approach (52)			-	
Direct related question	6(16.7)	2(12.5)		
Rapport and then ask	30(83.3)	14(87.5)		
Gender has role in counselling (52)	<b>22(61.1)</b>	9(56.3)	14(38.9)	7(44.7)
Opt for mandatory family counselling (52)	32(88.9)	15(93.8)	4(11.1)	1(7.2)
Special care to schizophrenia, bipolar disorders (47)	<b>22(61.1)</b>	8(72.7)	14(38.9)	3(27.3)

NGO providers less likely comply with the fact that gender has any role to play in providing HIV counselling (56.3%) compared with public providers (61.1%). NGO providers are more likely to seek special attention in HIV counselling for clients (72.7%) suffering from schizophrenia or bipolar disorders compared to public providers (61.1%). The difference between public and NGO about their practice of specialized counselling (yes/no) for schizophrenia or bipolar disorders is not significant (p=0.627).

*Difference in providing HIV Information across settings*

85.70% providers in NGO counsel their substance user clients for detoxification compared with 69.40% cases in public settings.

*Table16: Providing HIV Information and Prevention Message*

Item (no of respondents)	Provide Information: Public		Provide Information: NGO	
	Yes n (%)	No n (%)	Yes n (%)	No n (%)
HIV Information in OPD (52)	35(97.20)	1(2.80)	14(87.5)	2(12.50)
Counsel HIV Transmission (52)	28(77.80)	8(22.20)	14(85.71)	2(14.29)
Counsel HIV Risk Reduction (52)	33(91.7)	3(8.30)	15(93.8)	1(6.20)
HIV Risk Prevention (52)	35(92.10)	3(7.90)	13(92.85)	1(7.15)
Counsel on Detoxification (50)*	<b>25(69.40)</b>	11(31.60)	12(85.70)	2(14.30)
Type of Substance Use (52)*	<b>33(91.70)</b>	3(8.30)	16(100.00)	0(0.00)
Ask Injecting Behaviors (52)*	<b>28(77.80)</b>	8(22.20)	15(93.80)	1(6.20)
Ask Tattoo Behaviours (51)*	9(25.00)	<b>27(75.0)</b>	8(53.30)	7(46.70)
Seek Occupational Expo (52)	32(88.88)	4(11.12)	13(92.85)	1(7.15)
History of Blood Transfusion (52)	32(88.90)	4(12.10)	15(93.10)	1(6.90)
Needle Syringe Exchange (52)*	28(77.8)	8(22.20)	14(87.50)	2(12.50)
Counsel on Harm Reduction (52)*	18(50.0)	<b>18(50.0)</b>	10(62.5)	6(37.5)

\*Denominator- clients who are substance users

100% of NGO providers counsel their clients about their type of substance uses, which is linked to HIV transmission, but public providers counsel 91.70% substance user clients. 62.5% NGO providers are giving Harm Reduction counselling to substance users, where as in public

setting it is 50%. NGO providers more frequently ask (53.30%) about tattooing behaviours than public (25.00%).

*Enquiring personal histories of clients by providers*

Assessing the personal histories of clients has positive forces for HIV transmission. NGOs are on average more adhered to these aspects. Details are in Table 17.

*Table 17: Adherence of Providers into personal histories of clients*

<i>Query Item</i>	<i>Compliance: Yes</i>		<i>Compliance: No</i>	
	<i>Public</i>	<i>NGO</i>	<i>Public</i>	<i>NGO</i>
Assess client's awareness about HIV/AIDS	28(77.8)	15(93.8)	8(22.2)	1(6.2)
Ask about marital status	32(88.9)	15(93.8)	4(11.1)	1(6.2)
Ask about the locality they belong	20(55.6)	10(62.5)	16(44.4)	6(37.5)
Provide HIV information in indoor	24(77.4)	7(77.8)	7(22.6)	2(22.2)
Occupation and income	34(94.4)	15(93.8)	2(5.6)	1(6.2)

NGO providers are more enthusiastic to probe into a client's personal histories that may enable them to build up better rapport and effective communication.

**5.3.4 Health Education Materials Used in HIV Counselling**

5 out of 5 NGOs have adequate number of health education materials like handouts, pamphlets, posters, pictorial books etc for their clients those they distribute on regular basis. On the other hand public settings do not have any for educating their clients. A few posters from Health and Family Welfare Department have been displayed on the walls of hospitals of 4 public settings to aware people on HIV/AIDS. They have no specific educational materials or health educator for mental healthcare settings. 5 out of 5 NGOs serving substance users have separate posters for injecting drug users, substance users and alcoholics to disseminate information.

**5.3.5 HIV/AIDS or Substance Use Sessions for Clients**

5 out of 5 NGOs have provisions of group counselling and sessions where the clients interact and share their experiences. Substance user/injecting drug users meet together in a meeting

with a group leader for the counselling session. Usually clients under acute stages of mental illness or high following their substance use are encouraged to attend daycare centres. There is no separate strategy to control and make an unattentive, talkative or violent client productive in a session. It entirely depends on a counsellor's individual ability to deal with the situation and his/her ethical perceptions. In none of the public setting do providers conduct separate sessions for groups of clients. They only provide individual counselling. Out of seven public allopathic settings, three do not have even any counsellor for individual counselling.

Sometimes a group of providers in public settings pay attention to their clients during counselling. It is more due to academic reason. There are postgraduate students in psychiatry. As a part of their learning, they take histories of their clients in details. Teachers teach them taking client as a case for study. There is scope for multiple providers in counselling or treating a patient together. It may improve quality of care.

Interview with an Ex-drug user revealed that in several places of Kolkata, these substance user groups meet together in NA (Narcotics Anonymous) meetings to share their feelings. Non-narcotics are not allowed to participate in these meetings. They share their crises, sexual behaviours, drug use behaviours or many ethical conflicts in their lives with their colleagues seeking suggestions and help from each other.

*In the next section we will be describing overall HIV Testing and Referral services across settings. We will also talk about other test provided to clients who are advised for HIV ELISA.*

#### **5.4 HIV Testing and Referral Services**

*Earlier we have provided some information on HIV Testing and Referral procedures. Here we describe other relevant findings related to adequacy of testing and referral process. Percentages are given for clients who are considered to be under risk as perceived by the providers. All clients need not be asked for HIV testing. How much are they adhered in testing or referring if it is a client with risk?*

Testing arrangement and referral basically depend upon the client and his or her relatives accompanying him/her or family members. 2 institutions provide vehicle for carrying their inpatients to referral centres for HIV Testing or related illnesses. For inpatients, apart from doctors or psychologists, nurses have no role in providing HIV Test counselling services to their clients. In none of the NGO settings, there are provisions for arranging HIV testing from the institute itself. Where as 3 of the public settings, which are also State Medical Colleges, have attached VCTC and HIV ELISA testing facilities attached. In NGO settings, Social Workers play significant roles in follow up or finding out non-reporting clients at their house. NGOs even contact non-reporting clients through telephones. Data flow is poorly managed in both the settings with better adherence to confidentiality in NGO settings. For maintaining database or reporting to the appropriate authorities for HIV positive cases, NGOs are more generous. When public settings maintain records for report submission, NGOs have research interests too.

##### *Adherence to HIV Testing and Referral services among providers*

Table 18 shows that psychologists are adequately adhered to norms on counselling services before (100.0%) or after HIV Testing (80.0%). They also provide all information while

referring clients to outside facilities (87.5%). They counsell family members (100%) and ask clients to give feedback (100%). They are careful to provide HIV risk reduction information (85.71%). They perform better than psychiatrists in above contexts. Psychiatrists do advise HIV testing for high-risk groups (96.77%). They also arrange Hepatitis B or Hepatitis C tests for high-risk groups. [Table 18]

Interestingly, physicians (both allopathic and homeopathic) more depend on symptomatic presentations for HIV Testing (75%). They depend on VDRL or blood RE tests for assessing risks of HIV first and then go for HIV ELISA (adherence is 25%). HODs opinioned that relying on VDRL for HIV infection may delay actual diagnosis leading a client towards advanced state of AIDS.

Table 18: Adherence to HIV Testing and Referral services among providers

Item	Psychiatrist (n=31), Psychologist (n=13), Others (n=8)		
	Psychiatrist % of adherence	Psychologist % of adherence	Others % of adherence
<b>HIV Testing and Counselling</b>			
Prescribe HIV ELISA Test	16/31=51.61	NA	2/8=25.00
Basis for HIV Test -Symptomatic	21/31=67.74	NA	6/8=75.00
Basis for HIV Test -High-risk group	30/31=96.77	NA	4/8=50.00
Basis for HIV Test -Above both	20/31=64.55	NA	4/8=50.00
Risk reduction for HIV positive	14/20=51.85	6/7=85.71	1/3=33.33
Repeat ELISA in (-ve) and explain <i>Window Period</i>	14/24=51.83	6/10=60.00	1/3=33.33
Counsel before HIV Testing	27/31=87.09	10/10=100.00	4/6=75.00
Counsel after HIV Testing	22/31=70.96	10/10=100.00	4/6=75.00
Counsel to give feedback	26/31=83.87	16/16=100.00	5/8=62.50
Counsel family members of HIV + individuals	13/31=41.93	13/13=100.00	5/8=62.50
<b>Other Tests</b>			
Advise Hepatitis. B & Hepatitis C test	26/31=83.87	NA	1/8=12.25
Advise for VDRL Test	21/31=67.74	NA	6/8=75.00
Advise Blood RE	15/31=48.38	NA	4/8=50.00
Prescribe Urine RE	13/31=41.93	NA	1/8=12.25
<b>HIV Referral</b>			
Counsel for Cancer Cervix for HIV+ women	3 cases out of 4	Refd. by doctor	NA
Counsel for services in HIV+ pregnant women	4 out of 5 cases	Refd. by doctor	NA
Ask HIV+ for Anti Retroviral Therapy	12/15 =80.00	Refd. by doctor	1/2=50.00
Provide all information when referred	18/31=58.06	7/8=87.5	3/8=37.50
Refer outside for specialized counselling	28/31=90.32	10/13=76.92	6/8=75.0
Assess client's ability & willingness to be referred	26/31=83.87	6/7=86.15	2/8=25.0

[NA- Not Applicable- provider never got scope to serve in that category. Denominators in columns mean number of applicable respondents who ever faced such situation]

NGO providers are better performer in respect to client’s ability and willingness assessment, referral for ART or even seeking feedback services [Table 19]. NGO providers are less adherent (87.0%%) to HIV Test counselling than public setting providers. HODs of NGOs commented that they adopted referral strategies rather than stressing more on test counselling at their own settings. They try to stress on risk assessment. NGOS have more mean HIVRAS.

Table 19: Adherence to HIV Testing and Referral Services across settings

Item of adherences	PUBLIC SETTING (%)	NGO SETTING (%)
Prescribe HIV Testing	20/36= <b>55.55</b>	4/16=25.00
Assess client’s ability & willingness to be referred	21/36=58.33	11/16= <b>68.75</b>
Risk reduction for HIV positive	13/20=65.00	9/11= <b>68.75</b>
Repeat HIV ELISA in (-ve) and explain <i>Window Period</i>	25/36=69.44	14/16= <b>87.50</b>
Counsel before HIV Testing	34/36= <b>94.44</b>	14/16=87.50
Counsel after HIV Testing	34/36= <b>94.44</b>	14/16=87.50
Ask HIV+ for Anti Retroviral Therapy	10/16=62.50	9/9= <b>100.00</b>
Provide all information when referred	12/30=40.00	8/13= <b>61.53</b>
Counsel for feedback	28/36=77.77	14/16= <b>87.50</b>
Counsel Family members of High Risk Group client	32/36=88.88	15/16= <b>93.75</b>

Denominator- asking questions for clients under risks or HIV+

We found that. Interviews identified poor coordination between psychiatrists and psychologists while referring them outside either for testing and or seeking treatment from referral centres. Psychiatrists directly refer clients outside with out mandatory counselling processes from psychologists. With in same institutions, they work independently, not as a group.

### 5.5 Resources, Conduct and Performances of providers – at a Glance across settings

10 settings where HODs were interviewed are grouped into three-Psychiatric Hospital, Psychiatric Department of General Hospital and NGOs to capture variations. We consider that HIVRAS, S12, TS will be our performance indicators. Adherence to FGD, use of IEC materials, Family Meetings, Narcotic Anonymous (NA) meetings can reflect the quality aspects also. [See Table 20]



Adherence to quality aspects like group counselling, sessions, providing IEC materials, research, and feedback mechanism through social workers, sending reports to appropriate authority are performed by NGOs. In score distributions, ascending order is psychiatry departments of general hospitals, psychiatry hospitals and then NGOs. NGOs have minimum expected provider-hours per day (69.33). Interviews with HODs revealed that their specific programmatic approaches explain better adherence to quality or adequacy aspects.

*Table 20: Performances of providers – at a Glance across settings*

<b>Settings</b>	<i>Psychiatry Hospital</i>	<i>Psychiatry Dept. of Gen. Hospital</i>	<i>NGO</i>
<b>Resources</b>			
No of institutions	2	5	3
Total no of providers	17	56	33
Total number of average patients in OPD	185	232	69
Average expected OPD hours/day	8.5	6.8	6.66
Expected total provider-hours/day	144.5	380.8	69.33
<b>Conduct</b>			
Clinical Psychiatry (1)	Yes	Yes	Yes
HIV Counselling (2)	Yes	Yes	Yes
HIV Referral (3)	Yes	Yes	Yes
Primary health Care (4)	Yes	No	Yes
<b>Performance</b>			
<i>Average OPD patient seen/day in OPD</i>	<i>185</i>	<i>232</i>	<i>69.33</i>
<i>Number of service items offered</i>	<i>4</i>	<i>3</i>	<i>4</i>
<i>Individual Counselling Services</i>	Yes	Yes	Yes
<i>FGD</i>	No	No	Yes
<i>Group Counselling Services by providers</i>	No	Yes	Yes
<i>IEC Stuffs</i>	No	No	Yes
<i>Family Meetings</i>	No	No	Yes
<i>NA Meeting</i>	No	No	Yes
<i>Condom distribution</i>	No	No	No
<i>Reporting to State AIDS Society</i>	No	No	Yes
<i>Research</i>	No	PG Student Research	Yes
<i>Feedback Mechanism from Client</i>	Voluntary	Voluntary	Social Worker
<b>Mean Scores</b>			
<b>HIVRAS</b>	9.81	7.81	12.81
S12	6.56	5.92	7.40
TS	16.38	13.73	20.50

*In next section, we will discuss a few specific barriers influencing services in different settings as perceived by experts in provider, client or institutional levels. Here we tried to describe diverse opinions of experts emphasizing why providers cannot provide adequate services*

## **5.6 Barriers in HIV Counselling, Testing and Referral Services**

### **5.6.1 Provider Opinions**

73.01% out of 52 providers think that poor acceptance from clients, 78.84% think poor insight, 50% consider dual illness together are performing as most common barriers in providing services. 25% people identified more expenses due to dual illness as a barrier. Confidentiality was counted to be very good as perceived by 42.23% of providers. Time constraints and more patient rush were identified as other barriers. 13.46% providers spend maximum 4 minutes time, 53.84% spend 5-10 minutes time and 32.70 % provide spend more than 10 minutes time for rapport building with their new clients to start sexual health counselling. A few providers are not aware of the fact that there is VCTC in their own institute and they are sending clients out side for HIV testing. Lack of proper coordination among providers was identified as another barrier.

### **5.6.2 Expert Opinions**

*A few specific issues, as mentioned in 4.14 section under 'Variables' portion in interview schedule III have been described to explain barriers in providing services in mental healthcare settings in Kolkata from opinion data of 13 experts. The focus of the descriptions emphasizes why and how providing HIV services are different in clients who mentally ill. We have captured idiosyncracies of opinions to describe providers' difficulties to overcome barriers.*

#### **5.6.2.1 Stigma**

*When one-sided stigma coming from HIV/AIDS is superadded with another stigma coming from mental health problems, things become more complicated. Due to fear of stigma people are reluctant to seek counselling or treatment. Ultimate effect on stigma as a result of HIV and*

*mental illness together is sometimes additive, sometimes subtractive or having no relation. Depending upon client's illness variety, type of substance use, highness, even caste and education, stigma may be perceived differently.*

**Stigma: Substance users versus psychiatric illness**

Majority believes that stigma is more with substance users than those who are only psychiatrically ill. “We deal substance user as a client, not as an addict. We use the term ‘use’ not ‘abuse’. Substance use is a disease. NOG providers in two settings collaborate Kolkata police in their campaigns to reduce stigma in the community. Reducing stigma out of substance use needs special care for counselling. “So we stress on enhancing self-esteem of the client to reduce perceived stigma.”

**Stigma: at individual, family and community level**

Family members of an HIV positive person are stigmatized. “When mental illness is mixed with HIV, think no one will marry any girl from that family. Community perceives the stigma due to the notion of poor morale of the individual or family.”

Opinion of a Psychologist	Opinion of a Psychiatrist
<p>“Stigma for inpatient is nil as we can maintain 100% confidentiality. It is maximum in outpatient department.”</p> <p>“Outpatient will perform all tests e.g. thyroid test, blood routine tests; what ever we say. They come back with all reports other than HIV test result at hand. It’s simply due to stigma.”</p>	<p>“In indoor environment, stigma is much more due to fear of isolation from others. Neighbouring patients may know my status.”</p> <p>“In inpatient, sending blood for test is not a problem. Send blood to laboratory, do the test. Things are not in patient’s hand.”</p>

Experts think that when HIV infection is due to occupational exposure such as accidental needle injury or due to blood transfusion, his/her self-esteem is good; stigma is obviously less in that case. The client may have depression due to disease process. But he/ she has very little stigma. ‘Counselling among them gives better result to improve mental status.’ Majority

believes that stigma is more, if HIV infection is due to sharing of needles in injecting drug users.

Stigma is also attached with an institution's type of services. For example, psychiatry hospital may be known as 'Pagla Garad' ('Pagla' means mad and 'Garad' means asylum) to common people. Institute itself is stigmatized. People are stigmatized in their ideation level in the notion that mentally challenged people are mad and some nonhuman species.

"Stigma is maximum in a closed environment where information transmits informally like a volatile substance e.g. spirit." When a center is known as care and support organization for HIV/AIDS and mental illness, people may be stigmatized. Client will be reluctant to come there seeking care. "So *recoding* of name is necessary. A halfway home may be alternative to solve this problem. Jail has become *correctional home*"

11 out of 13 experts feel that stigma should be overcome at the provider level. Adequate orientation and training of providers are needed on stigma.

**Stigma: influenced by types and status of mental illness**

13 out of 13 experts commented that perception of stigma due to HIV/AIDS is dependent on type and status of mental illnesses. If a patient is suffering from mania, he/she does not perceive stigma as a barrier to seek care. Because of his/her elated mood, he/she is forward enough to perform further risky behaviours, smart enough to seek cares or even does not bother to take services. "Neither of the attitude is attached with stigma."

"Stigma is least or nil when client has mental retardation." It depends upon client's IQ level.

100% of the experts think that stigma is mostly related with the level of insight in an individual. Where as in the family or community level, it has nothing to do with the individual's perception. "But community or family response is important as they have direct or indirect impact on the individual."

One expert commented, “Loss of libido due to long anti-psychotic drugs is the commonest cause of non-compliance to therapy or sexual health counselling. It is not type of illness or stigma etc you are more worried about.”

**Stigma: Effect of Socioeconomic status**

One expert categorically ranked perceived stigma level. She told that higher middle class people have money, but ‘stigma is much more than money’. For middle class people both money and stigma are equal force playing role in seeking care. Where as for lower middle class people both stigma & money play very strong roles affecting HIV or mental healthcare seeking behaviours.

Many of the experts told that stigma has nothing to play around education. Highly educated people are arrogant, noncompliant to advices. It is very difficult to bring changes in their attitudes among themselves. “If education is middle standard, expected that you will get good result. They are able to understand and are not so stubborn like highly educated people.”

There are not much variations of perceived stigma among different castes or religions. “Not necessarily more orthodox people will have more stigma due to HIV/AIDS or mental illness. But tribal people have least stigma attached even during counselling, testing or referrals.”

**Stigma: Effect of Gender**

“If husband is HIV positive and mentally ill, among family members, wife is affected and stigmatized. But if wife is HIV positive & mentally ill, husband is not much stigmatized. Husband can hide the status and may even be adhered to counselling or safe practices. He can opt for sex from outside. Wife cannot.”

**Stigma: Impact from HIV/AIDS & mental illness together**

Addition effect- 10 out of 13 believes that effect is additive. Family members just let the patient die being totally frustrated irrespective of their economic condition. These reactions may be

due stigma which comes from the idea that the person has no morale. Mental illness means madness to the people. When both these things are mixed together in a person, naturally stigma is increased. Effect is additive.

Subtraction effect- Stigma may be reduced. Many experts think that if patient suffers from mania, perception of stigma is less. This patient is least concerned about stigma and will seek all supports, as he/she does not bother concern about surroundings. Here effect is subtractive.

Neither subtraction nor addition- “There is no question of addition or subtraction. Stigma arising from two sources is two different elements. They are heterogeneous. One is attached with notion of morality; another is due to some disease. They cannot be added or subtracted. Each works through their own way.”

Predominance affect- Few experts feel that people has become more conscious. Mental illness is considered as a disease to be very common. So stigma is less. Where as STD/HIV/AIDS related stigma only would work, and HIV stigma becomes predominant.

*Framework: Stigma affecting provision of cares from opinion data (majority)*

<b>Aspects</b>	<b>Effect on stigma</b>	<b>Outcome: seek HIV services</b>
Substance use	More stigma than mental illness	Substance users seek less HIV services
Stigma from dual illness	More, Less or No relation	Varies case to case
Discrimination	More stigma	Less access
Gender	Men less than women	Women seek less services than men
IQ	More IQ more stigma	More IQ- less access
Insight	Good insight more stigma	Insight good- access poor
Inpatient versus outpatient	Stigma more for poor confidentiality	Varies from incidence to incidence
Family or community support	Family/community perceive stigma	Individual-varies case to case Community- support withdrawn
Economic status	Inverse relation with income	Inverse with perceived stigma
Education	Proportional to educational level	Inverse with perceived stigma
Provider’s stigma	More stigma due to poor concern	Less services provided by providers

### 5.6.2.2 Ethical conflicts

Often times, providers fall in dilemma what to be done, who should be given priority or how a HIV positive status to be disclosed to the client or his/her family members. It is difficult to break the breach of confidentiality. How much a provider can rely on client's consent?

- **Informed Consent**

*Aspects of conflicts regarding informed consent as barrier identified are-* (1) Type and status of mental illness (2) Need for consent every time (3) Significant other for invalid consent. We have presented it in the following Table 21.

*Table 21: Dilemma in opinions in arranging or disclosing test result*

Opinion Category	Psychologist	Psychiatrist
<i>Type &amp; status of mental illness</i>	<p>“The patient’s rationality, judgment should be assessed to declare validity of the consent. I feel to continue giving therapy rather being more interested to seek consent as a provider.”</p> <p>“You cannot rely...they may give or refuse consent in their highness.”</p>	<p>“Consent given by a mentally challenged person is inconsistently inconsistent in validity.”</p>
<i>Need of consent every time</i>	<p>“Why are you all worried about consent? Do not always consider law. Law will never betray you. As a provider do which is best for your client. But assure good confidentiality.”</p>	<p>“Irrespective of mental status of the client, inform the client. Do not bother if it is understood or not. Record the reaction of the client. Mention that patient is unconscious. Your work is over. With out valid consent, you can do testing for greater right of the people surrounding.”</p>
<i>Significant others for an invalid consent</i>	<p>“Apart from the client’s consent, you have to rely on the first significant member. You have to look the thing from legal point of view in this age of ‘Consumer Protection Laws’.”</p>	<p>“The breach of confidentiality may be broken to sexual partner rather than to the family members.”</p>

- **Mandatory HIV Testing**

*There have been significant responses from experts in government settings recommending for mandatory HIV testing. But a few from NGOs opinioned that prevention of the contact persons*

*is preferable than mandatory testing. Mandatory testing is recommended in circumstances where client is in high-risk group, for a person being raped, performed unsafe sex with high-risk partner or being injured (with history of blood exchange through injury) by a person with known positive status.*

- **Risk group of the client**

Majority agrees that HIV testing should be mandatory for high-risk groups like IDUs, highly promiscuous, manic or dementia patients; and also contacts persons of high-risk groups. Difference in opinions was on how to arrange a mandatory testing. 8 experts feel that testing should be done taking consent through pretest counselling of mentally ill person. The consent can be taken only when the patient is stabilized after providing counselling or treatment. If all cares fail to cure the acute stage of the client, we can opt for mandatory testing even though patient is not mentally sound.

- **Guidelines**

13 out of 13 experts feel that there are no guidelines as how to deal controversial issues. So definite guidelines can help them. One expert also felt that in this age of ‘Consumer Protection Act’, there should be definite guidelines to protect the providers. 7 out of 13 experts feel that there will be ethically no violation of rights as the greater right of more susceptible population may overcome the questionable individual right through mandatory testing.

*Table 22: Expert opinion data*

Against mandatory HIV testing	In favour of mandatory HIV testing
“You cannot violate individual’s right doing a mandatory testing if the client denies. It is his/her body. He/she will take decision. Better you prevent the people who are in contact. Knowing status does not solve the problem rather aggravates the problem. Getting consent is possible.”	“Can you empower women having a schizophrenic husband who forcefully wants to have unsafe sex? Can you empower the wife to use condom. No counselling can work. I do not know the solution. Male promiscuity is an open secret. So do tests mandatory, otherwise, they will escape from doing test”



- **Disclosing HIV status**

Majority feels that HIV test result to the mentally sound person is much different with mentally challenged person. In mental healthcare settings, results are not disclosed. They send patients to VCTC to adjacent medical colleges.

- **Impact of having HIV positive result**

Cognitive changes on a client knowing his/her HIV+ status are (1) Disbelief (2) Acceptance (3) Stigma (4) Change in life style (5) Anger (6) Aggressive (9) Suicidal ideation. In every step of disclosing test result, for a mentally challenged person, the next day cognitive and behavioural aspects are not predictable. There are experiences where providers feel lost as how to deal situations. [Ref Table 23]

*Table 23: Barriers in disclosing HIV status and dealing outcomes*

<b>HIV Testing Services</b>	<b>Barriers</b>	<b>Outcomes</b>
Provide test result	Stigma, Mental status	Discrimination, Isolation Depression, Suicide
Explain what result means	Questionable cognitive functions	? Unsafe sex or risk reduction
Assessment of further risk	Truthfulness of client	Individual Risk –differs?
Counselling	Poor Acceptance	Doubt on compliance
Partner notification	Poor cooperation, Stigma	Avoidance

*From expert opinions we find that these outcomes are related with poor compliance to services.*

*Providers do not know when and how to disclose HIV test result.*

### **5.6.2.3 Institutional Limitations**

There was uniformity in the idea that space; privacy or confidentiality is not up to the level for all public settings. Also the way data or information flow is least scientific considering the confidentiality issues.

Available institutional facilities are inadequate. While dealing mental illness and HIV services together, there should be unmet facilities of counselling, testing or minimum referral services at the institution itself. This aspect has been identified as great constraints to provide cares.

Stigma, reluctance or poor family supports or even total withdrawal are the barriers for a client to access cares, then referral services from outside, again pose another threat hastening compliance to services.

While at the institution level particularly for public settings, poor client doctor ratio was significant barrier. Experts think that less patient rush may improve quantity and quality of services. Research works have been totally ignored. “Other than medical professionals, nurses and health workers may be trained and utilized for routine counselling.”

13 out of 13 experts feel the necessity of training, refreshing trainings, orientation programmes as to facilitate the HIV counselling, testing process.

One expert has an idea of starting ‘Half Way Home’ to enhance acceptance of HIV services. Otherwise institutional stigma will hasten people to come to the institution seeking cares.

“An institution itself can be stigmatized because of its type of services such as mental illness or STD/HIV/AIDS.”

Few experts firmly believe that there is strong inertia among providers to come out of their psychiatric clinical orientations and to provide services to meet present public health need. It is big lacunae from the providers.

One Homeopathic expert provider commented that they have adequate drugs in Homeopathy for mental illnesses. But they do not have separate psychiatry wings. They treat mentally challenged people in the medicine OPD itself. The principal of a Homeopathic Institute told that the Directorate of Homeopathic Medical Services has taken imitative to start separate infrastructure for psychiatry patients.

Most of the clients never give feed back when they are advised for HIV testing. They can be traced in the field if adequate number of social workers is available.

“There is no cooperation and coordination among different varieties of providers. Like psychiatrists are doing sexual health counselling without consulting with the psychologists. It is never an integrated approach.”  
“For each disease under national control agenda there should be separate doctor in our public setting to look into. It may enhance accountability of that person. One psychiatrist for HIV/AIDS, another Tuberculosis... like that.”

### **5.6.2.3 Economic constraints**

One expert told, “...clients are not able to afford their conveyance to addiction centres though we provide medicines and lunch for the day. Conveyance counts 35% of the total costs. No donor will pay for conveyance of the client to come to the detoxification center.” Providers sometimes take help of voluntary organizations. When patients are unable to afford the psychiatric drugs, they send them to government institutions for drugs free of cost. NGOs are providing mental healthcare services at least maintenance charges.

“If Rs. 1 is spent for psychiatric care in a hospital, 40 paise are for drugs, 40 paise for hospital costs, 9 paise for transport, 1 paise for psychiatrist and 10 paise for opportunity cost.”

One expert opinioned that non-adherence to mental healthcare services are not only due to costs. “Most important is loss of libido. This part we never consider. Here they loose urge of sex and try to substitute with fantasy and multiple partners even practise unsafe behaviours.”

### **5.6.2.4 Knowledge of providers**

Providers are not oriented towards HIV services, rather mostly oriented to clinical psychiatry or clinical psychiatric counselling rather than HIV. Many providers are not upgraded. They are not user or friendly with Internet. So they cannot avail online journals and rely on printed textbook information available to them.

### **5.6.2.5 Gender**

*For being man or woman there are differences in available resources, access to resources, control over resources and bargaining power over resources available.*

***Susceptibility to HIV infection:***

“Virginity is not a factor today. Adolescents go for unsafe sex. They come for counselling. We see them very tensed about knowing their HIV status.” 3 experts think that young women are vulnerable due to promiscuity of their husbands. An injecting drug user may insist his wife to have drugs. Providers can do little in such cases.

***Patterns of illnesses:***

Depression is more in women often associated with libido. So risk behaviours are less. Mania is more in men leading them more vulnerable to HIV infection. There is no practice of gender and disease specific counselling process for HIV. “Mental Health Act is not quite good to help us to address HIV issues or how to take different actions for a man or women. We know men are more powerful than women.”

***Responses to illness:***

There is inhibition mostly from women to talk freely. They are shy. Men discuss HIV sexual practices frankly. Men are more frank with women counselors. They consume less time for befriending. Women are more adherent to treatment and support “If a person is HIV positive and mentally ill, family members just throw them away to die. If client is a woman, I think negligence is far more in our society.”

Inhibition is there even to provide adequate response to a woman from a male provider. “As a women counselor, sometimes I feel unsafe in sexual health counselling. A patient may become erotic and scratch me. Patient feels that ‘I am dying, let others also die.’ Where is my safety?”

### 5.6.2.6 Other Issues

#### Private practice:

Many psychiatrists or psychologists were busy with their private practices paying very little time for their OPD or indoor patients. Even in the private settings, scope of HIV Counselling remains very limited. Services are more clinical psychiatry oriented.

#### Information asymmetry:

One expert feels that this gap in demand and supply of services is mostly due to lack of awareness among clients. Clients sometimes develop apathy for the providers if the providers become inquisitive about their sexual health aspects. Clients cannot understand the necessity of asking sexual histories when they come for psychiatric problems. Allopathic providers think that clients from Homeopathic institutions reach them at late stage when the mental illness has progressed and intervention would have been preferred earlier. ‘Semantics’ used by providers may have different meanings to a client in their different cultural contexts. For example, ‘masturbation’ is called ‘hasta-moithun’ in Bengalee language. It is a gentle man’s language. Most of the clients may not understand it. Where as some local slang language better communicates with local people. There is need to develop a *book of code languages* which is culturally and regionally appropriate.

#### Untapped potential:

Using the same resources available the experts feel that quality and quantity of cares both can be enhanced through guidelines, training and orienting providers. Also other paramedicos should be trained and be absorbed with in the services to facilitate cares. “Counselling for HIV is not technically a big thing.” Majority believes that nurses, health workers and social workers may be attached with in this process.

## **Chapter-6**

### **DISCUSSION**

#### **6.1 HIV Risk Screening and Counselling Aspects:**

Providers are not 'Always' adhered to HIV risk screening of clients irrespective of their mental status. They inadequately probe into homosexual histories ('Always' anal sex history -5.8%, and MSM history-11.5%) or clients' compliance of condom uses during anal sex ('Always'-23.1%). Unsafe anal sex has more HIV transmission efficacy than unsafe vaginal sex. Partner's sexual history is less stressed upon. Providers 'Always' take history of partner's STD or drug injection history in 16% and 11.5% cases respectively. Neither in public nor NGO settings specifically for substance users or Injecting Drug Users, mandatory sexual health counselling, harm reduction or needle syringe exchange counselling are not practised in 100% cases. There are several substance users who chat on Internet through yahoo messenger in NA room meant for them. The interview revealed that there are enormous scopes for substance users to talk about their sexual practices, to have sexual relationships and sharing needles for injections among narcotic groups. Providing appropriate information to substance users may have positive externalities through anonymous information sharing.

Providers assess risks when they think that a client has significantly high risks. James Walkup et al in New York conducted a study "HIV Risk Assessment Related Practices' where providers in psychiatric settings are only adhered to HIV screening for high-risk group clients only.<sup>24</sup> Study by Michael Rivard et al in Quebec, Canada shows that physicians or gynaecologists-obstetricians are screening HIV related information from their clients in 5.8% to 32.7% cases when they talk about their STD histories.<sup>26</sup> Studies say that mentally ill people are 4 to 22.9 times at more risk for HIV infection than general people.<sup>2</sup> So mandatory HIV risk screening may be expected. Poor adherence to HIV screening ultimately poses a client to greater

vulnerability. Only 4 out of 52 providers use checklist while screening their clients or talking about risk reduction. It obviously means that in a busy setting, providers may forget certain relevant topic during counselling with a client. American Psychiatric Association's guidance for mental healthcare professionals to opt for mandatory HIV screening of clients and counselling of family members remains debatable since a decade. Mental healthcare providers have adequate opportunity to probe client's sexual history in details due to the fact that clients spend lot of time with them due to their chronic illnesses. Studies show that mental illness is not necessarily associated with poor adherence to counselling or therapy.<sup>2, 27</sup> Using the scope of befriending, they can probe into their sexual histories. So more patient rush in out patient department may not be sufficient cause to justify poor adherence to HIV services.

## **6.2 Interpretations of scores (HIRAS, S12 and TS):**

HIV Risk Assessment score distribution shows that psychologists have maximum mean score (12.53) in compared to psychiatrists (8.35) and others (10.25). For S12 and TS, psychologists have highest scores as well (7.31 and 19.54). In score quartile distributions, psychologists remain in the 3<sup>rd</sup> quartile for HIVRAS; psychiatrists are in 2<sup>nd</sup> quartiles and others in early 3<sup>rd</sup> quartiles. NGOs remain at higher quartiles in HIVRAS, S12 or TS compared to public settings. Counselling centres remain in higher quartiles than psychiatry hospitals or psychiatric department of general hospitals. It justifies their counselling related professional variety and orientation towards probing for counselling aspects of a client rather than providing clinical care for which psychiatrists are responsible. But our interviews with experts or HODs explored out that there is poor coordination among varieties of providers with in the same institute. Psychologists may mandatorily provide pretest or posttest counselling for HIV testing. Where as psychiatrists directly send their clients to VCTC or outside centres with out opting for mandatory counselling from counsellors available in their own settings. Some providers are not

even aware of availability of HIV testing facilities or VCTC in their own settings. Poor coordination should not be the barrier against unmet necessity of service provisions. There remains untapped potential and idle capacity already available. Utilizing same resources through better organization and improved coordination among providers and departments within same institute, performance may be improved. For example NGO's better performance in respect to their adherence and quality items are explained by their objective and target oriented approaches. They have specific budgetary allocations, fixed by donors in different heads.

HIVRAS of providers are significantly associated with their S12 scores. Doing binary logistic regression with HIVRAS and S12, we found that those who got higher score (>10) in HIVRAS, are 5 times more likely to score high (>7) in S12. So these 12 items may be accepted as standard query list in HIV counselling process. Standard practice of better HIV screening performer remains better performers for S12 item enquiries.

One big controversy came out of our study. Doing multiple logistic regressions we found that only setting variety seems statistically significant with HIVRAS, TS and S12 (Adjusted OR with 95% C.I. are respectively 8.037[1.376-46.937], 8.092[1.421-46.096] 6.385[1.259-32.390]), adjusted for training and speciality in psychiatry. While our adjusted odds calculations for different scores indicate NGO's better quality adherence, NGOs lag behind in a performance indicator i.e. 'OPD Provider Hours' (69.33 OPD for NGO, compared with 380.8 and 145.5 for psychiatry dept and psychiatry hospitals respectively). NGO providers are more adhered to HIV counselling, testing or referral services compared with public setting in respect to standard principles, getting better average scores. This comparative poor utilization of NGO services has been explained by the NGO HODs through their poor provider client ratio (2.1 in NGO, 2.98 in public), poor budget and adverse geographical locations. A few NGOs take little



service charges amounting Rs. 5 to 10 as maintenance fess from their clients. We have to consider the fact that our public settings under the study are located in central Kolkata. Public settings have more confidence on client's side due their affiliation with government, client's perceived genuinity about providers, their huge space infrastructures and better awareness among people about their service varieties. More number of patients seen per day in OPD in public settings has enhanced their 'OPD Provider-Hours'. Where as counting the quality aspects of services for every client, NGOs are more qualitative and adherent to standard principles.

### **6.3 Barriers in HIV Counselling, Testing and Referral services:**

Coming into barrier issues as evidenced by expert groups, we see that stigma, ethical conflicts, institutional barriers are playing important roles in providing HIV Counselling, Testing or Referral services. Though experts described gender as an important barrier, we could not find statistically significant difference in gender perceptions among providers across their sex or experiences neither with training status. Good confidentiality is maintained in public settings (97.2%) at higher proportions compared to NGOs (87.5%). Our findings suggest that in NGOs, providers counsel in separate room. Where as in public settings clients are standing in a row. Maintaining higher confidentiality may be related with differences in provider's perceptions or reporting bias. For taking consent to start sexual counselling, NGO providers are more adhered to norms 81.25% compared to public being (69.44%). In taking special attention for schizophrenic or bipolar disorder clients (NGO: 72.7%, Public: 61.1%, P= 0.627) NGOs are staying ahead of public. Item queries like type of substance use, detoxification, harm reduction; needle syringe exchange and enquiring personal histories are better in NGOs (ranges from 53-100%), compared to public settings (25-90%). NGO providers are also adhered to group counselling, sessions, distributing IEC materials among clients, distributing condoms among

clients through confidentiality. They are generous to do research works, data analysis too. This may be due to their programmatic approaches and better orientation. They are bound to submit reports to donors and need segregated data. In public settings, there lies lot of flexibilities.

Regarding informed consent of a client as a barrier in counselling or testing, we find dilemma among providers in their perceptions. Validity of consent does not become a barrier for HIV testing among most of the providers in public settings. It is same for opting mandatory HIV testing for high-risk group as to protect the greater rights. Opinions of waiting to get a valid consent till a violent client becomes calm and judgmental through admission, treatment etc for arranging HIV testing may be justified as a valid argument with certainty that inpatients are not going to be affected and client's confidentiality is to be protected. Protection of wife or any other sexual partner from infected person is debatable. Disclosing test result does not solve the issue or reduce total social cost. Benefit of mandatory testing, not waiting for valid consent or disclosing test result to person concerned irrespective of mental status must overcome the possible benefits of by not doing these. Study done by David J Moser et al argues that 80% of the subjects with schizophrenia and 96% of the HIV positive clients demonstrated adequate capacity to consent for hypothetical circumstances.<sup>20</sup> Use of McArthur Instrument for Intelligence Assessment for validity of consent has become into practice in many countries. Where as in our context the issues remain as on the part of providers own views and perceptions. There is lack of concern about ethics in dealing these issues among providers. We do not know how providers deal situations. Rather it goes haphazard. It indicates the need of training, orientation of the providers in respect to their dealing dilemma issues how to arrange, when to arrange tests or when to disclose or to whom to disclose test results keeping breach of confidentiality intact in mentally challenged people.

Stigma has been perceived differently among providers playing role as a barrier in service provision. Stigma, which is predominant out of dual illnesses, may dominate the client in seeking cares. Additive and subtractive opinions need evidence to be proved. Mental illness has been accepted as a disease. HIV/AIDS is more attached with morale of an individual in our social belief. So HIV/AIDS related stigma perhaps might dominate the other. Contrarily, we like to express one expert's opinion- 'No more stigma can influence a wife, when her husband becomes HIV positive after his 10 years of illness from schizophrenia. She has lost all charms and has stopped to dream in life out of her husband's long illness.' Information of a HIV positive status 'spreads like volatile substance in closed environment' and 'stigma is much more in inpatient department than outpatient.' It obviously stands because of provider's lack of concerns, with no available guidelines at hand as how to deal such issues and message transmits faster affecting the privacy of a client. Stigma is perceived differently across cultures and to be dealt differently through culturally appropriate prevention strategy.

*Role of Gender in HIV Counselling:*

Study by Sharma et al in South India indicates gender-based difference in HIV risk behaviours such as exchanging money for sex. In linkage to gender based discrimination, to have or give sex for money has much role to play around power dynamics in our country context that may place women more vulnerable to HIV. Our study got no statistical significance between provider's gender perception having role in provision of HIV care with confidentiality, and sex of providers. In a study by Michael Rivard et al in Quebec , Canada shows that gender is a more important variable in sexual risk assessment than their speciality.<sup>26</sup> Women enquired more frequently about their number of sexual partners, condom use etc than the male practitioners. In their study, general practitioners avoided screening as they felt that clients are not at risk of HIV/STD or they were worried about patient discomfort, fear of offending their

patients etc.<sup>26</sup> In our study we see that providers are only adhered to ask such questions only if they consider the client to be high risk. Its public health implication is that there may remain hidden high-risk sexual behaviours remaining unexplored as on the part of the clients, if not explored through routine screening process. It is important to explore and raise question about gender sensitiveness of providers that may adversely affect the quantity and quality of cares.

#### **6.4 HIV/AIDS Training Status of Providers and its Implications:**

HIV/AIDS training status of providers have much public health implications to our context. Training status of the providers is significantly associated with HIV Risk Assessment Score of providers. Where as training status is not significantly associated with gender perceptions. Training status is statistically significant in association with provider's probing into client's ability and willingness to be referred. Training status is significantly associated with type of settings (Public versus NGO). Trained personnel in NGO and public settings are 37.5% 19.4% respectively. We considered a person to be HIV/AIDS trained if they attended any formal course of training or workshop in last 5 years. Study by Michael Wolf et al shows that physicians who are trained or prior experiences in HIV/AIDS are 3.1 times more like to have public health role to provide HIV services than those who are not trained.<sup>23</sup> Their study found no significant association of providing HIV services to their clients with the age, gender of the providers. We have similar findings to some extents. Among psychologists (n=13), who got training, their mean score of HIVRAS is higher (14.75) compared to untrained (11.11). NGOs have more % of trained personnel, who got higher HIVRAS (15.16) than those who are not trained (11.40). Our study findings have significant relationship between HIV/AIDS training and HIV/AIDS related services provided. It has implications for local public health policy. Adequate number of providers is not trained or trained are not adequately differing from untrained. It indicates poor quality or adequacy of training received by few providers.

#### **6.5 Preparedness for HIV related services:**

With adequate preparation, these professionals can make difference in adequacy and quality of services provided. While our findings suggest significant variations among public versus NGO setting practices, it is not expected. HIV/AIDS preparedness should be uniform having adequate interdepartmental coordination to combat the public health challenge. Beyond it, preparedness includes at least availability of local public health policy to address the issue adequately and standard guidelines to providers in dealing dilemma situations. Study by Karen McKinnon et al shows that mental healthcare agencies are requesting for adequate training for their providers who are working with people with severe mental illness, training on substance use disorders.<sup>29</sup> For equipped preparedness of our agencies training is essential to serve better and reduce barriers to the service provisions. Their study also has found out the efficacy of training intervention. Agencies with high substance use disorder caseloads (HSUDC) are more likely to provide HIV Risk Assessment (HSUDC: 67.7%, LSUDC: 46.9%;), Risk Reduction (HSUDC: 61.3%, LSUDC: 43.8%) services than agencies with low substance use disorder caseloads (LSUDC).<sup>29</sup> Agencies with high substance use caseloads are distributing more educational materials (74.2%) than those with low substance use caseloads (62.5%).<sup>29</sup> Their study finds that trained staffs are more likely to be comfortable, providing more quality and quantity cares than not trained agencies. Mental healthcare agencies irrespective of their caseloads are seeking for training about HIV/AIDS. This is also our finding from HODs and experts. They unanimously feel that training is must for their providers. Providers lack orientation towards HIV/AIDS. In our study experts and HODs have identified lack of training as one of the most important barrier in provider level.

## **6.6 Strengths and limitations:**

One researcher who has working experiences in both HIV/AIDS and mental healthcare programmes conducted data collection. Pre-tested instruments were used. The study includes 52 providers, 10 HODs and 13 experts (from 52 providers). Total 62 sample size rounds to 41% of maximum expected 150 mental healthcare providers in Kolkata might still capture majority of variations. Kolkata is a metro city having huge variations of clients in respect to their culture, economic condition, religion etc. Our study can serve as a pilot initiative at least to facilitate a further more comprehensive research.

Still we have to acknowledge that our study is from providers' perspectives. There is scope of reporting bias. Verification from clients, observations or participatory researches could have minimized that problem. The study could not match between supply or demand sides of services. Here lies a limitation for extrapolation of findings. The private clinics and institutions in Kolkata were not included. Still NGO providers may be accepted as not for profit private providers. Most of the private providers are public providers too. So by recruiting public providers, we may not miss much of private variations. Statistical analyses for associations might be affected by small sample size. Our study did not explore the issues of sexual abuse or coercion from the providers or experts.

## **6.7 Conclusions:**

Providers are not always adhered to HIV risk screening of their clients irrespective of their mental status or variety of illnesses. So providers may overlook hidden risks lying on them. Very limited use of checklist for risk assessment may lead providers missing a significant topic to explore. None of the provider groups or institution groups lies in 4<sup>th</sup> quartile in any of score distribution. HIVRAS, S12 and TS of either settings range from 50-60% of the maximum

possible score. Across providers, scores are also close to 50% of the maximum possible except for psychologists who are little above 60%. Unfortunately stigma reduction strategy is lacking in either setting. Poor concern of ethical issues among providers makes HIV services more on their perception and judgment. Poorly dealt barriers may place clients under more vulnerability. Inadequate gender concern among providers is another domain in linkages to vulnerability. Argument can be raised on practices of any settings or of any providers to be accepted as a model effectively addressing the challenges of HIV/AIDS epidemic in mentally ill group in terms of their preparedness. There remains lot of scopes for quality improvement through training, orienting and developing definite guidelines.<sup>30, 31</sup>

## **6.8 Recommendations:**

These may help providers of our study, West Bengal State AIDS Control Society; HIV/AIDS care services organizations, policy-making bodies, educators in continued medical education.

### *(A) Recommendations for Near Future*

- Provide Checklist to providers for HIV Risk Assessment
- Training and orientation of providers, informal Post Graduate Training module
- Interdepartmental coordination in the same institute
- Improve database, its flow and analysis
- Further comprehensive research to match demand and supply of HIV services

### *(B) Recommendation for Distant Future*

- Strategies to buildup intersectoral coordination
- Mental health care programme -culturally sensitive and regionally appropriate
- Develop guidelines addressing barriers to deal HIV/AIDS and mental illness together

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**Annexure: 1: Instrument**

Item no 

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Date 

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**HIV Counselling, Testing and Referral services in  
Mental Healthcare Settings in Kolkata-a Provider  
Perspective**

**INTERVIEW SCHEDULE I FOR SERVICE PROVIDERS**

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Information provided by you will be kept strictly confidential. Neither individual's  
nor institution's name will be taken in study findings.  
It will be only used for research purposes.

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*Principal Investigator*

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## INFORMATION ABOUT SERVICE PROVIDER

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*Before I start the interview, have you any question that you want to know? Please ask me.*

---

**AGE:**  YEARS

**SEX:**  M  F

**Designation:**

Psychiatrist	<input type="checkbox"/>	General Duty Medical Officer	<input type="checkbox"/>
House Officer	<input type="checkbox"/>	HIV Consultant	<input type="checkbox"/>
Counsellor	<input type="checkbox"/>	Others (Please mention)	<input type="checkbox"/>
Nurse	<input type="checkbox"/>		

**Years of experiences:**  Years

**Qualification:** MBBS  PG Psychiatry  PG Psychology  Nursing   
BHMS

**DO YOU HAVE ANY SPECIAL TRAINING ON HIV/AIDS?** YES  NO

## COUNSELLING

### Risk Assessment Queries Used

Please read carefully the following questions. Tick the most appropriate one, which best suits your services, related to HIV/AIDS. We are interested to know what care you provide, not what should be provided. Suppose the patient is coming to you since last one year and you have counseled him/her several times. Please ask me if, any clarification you need.

1. How often do you ask them about no of their sexual partners?

Always  Sometimes  Never

2. How often do you ask about history of anal sex any time with their sexual partners?

Always  Sometimes  Never

3. How often do you ask them about use of condom when having anal sex?

Always  Sometimes  Never

4. How often do you take history of sexually transmitted disease?

Always  Sometimes  Never

5. How often do you ask whether, they got money or drugs from anyone to have sex with them?

Always  Sometimes  Never

6. How often do you ask whether they had paid money or drugs to have sex with someone?

Always  Sometimes  Never

7. How often do you ask about ever injection of street drugs, steroids, or vitamins with a needle?

Always  Sometimes  Never

8. How often do you ask them about their sexual partners whether have ever injected street drugs, steroids, or vitamins with a needle?

Always  Sometimes  Never

9. How often do you ask about any sexual partner been men who have sex with men?

Always  Sometimes  Never

10. How often do you take history of sexual partners ever having sexually transmitted disease, such as gonorrhoea, syphilis, chlamydia, genital warts, or genital herpes

Always  Sometimes  Never

---

### MORE ABOUT COUNSELLING

---

HERE YOU ARE REQUESTED TO PROVIDE INFORMATION ONLY RELATED TO HIV/AIDS. YOU MAY CONSIDER CIRCUMSTANCES WHERE YOU COUNSEL MENTALLY ILL PATIENTS MR./MS. A, B, C ETC. YOU MAY CHOOSE MORE THAN ONE ANSWERS.

---

1. *Do you think that mentally ill persons need any special attention in HIV counselling?*

Yes  No

2. *Do you go for any consent before you start HIV counselling?*

Yes  No

3. *How do you approach your patient in the beginning for HIV counselling?*

General question  Directly related question  Rapport & then ask

4. *How much time can you spend for making rapport with your new client on an average?*

< 5 minutes  5 to 10 minutes  > than 10 minutes

5. *How frequently do you provide information to mentally ill patients about HIV/AIDS in OPD?*

Always  Sometimes  Never

6. *Do you provide information to all inpatients about HIV/AIDS?*

Yes  Sometimes  Never

7. *What are the information that you provide to your client?*

Risk of transmission  Prevention  Risk Reduction

8. *What other issues do you seek to know from your patients as on the part of risk?*

Type substance uses  Injecting behaviors  Tattoo   
Mother to child transmission  Occupational exposure  Blood transfusion

9. *Do you ask Injecting drug users about the followings?*

Needle syringe exchange  Detoxification  Harm Reduction

10. *Do you opt for family counselling for your patients who are at risk?*

Always  Sometimes  Never

11. *What among the following personal histories do you consider while counselling them?*

Occupation  Marital Status  Awareness HIV  Residence

12. *Do you take special attention for counselling when patients suffer from schizophrenia, bipolar disorders and severe illness?*

Yes  No

13. *Do you use any checklist for risk assessment or risk reduction?*

Yes  No

14. *DO YOU FEEL THERE IS ANY DIFFERENCE WHILE YOU ARE COUNSELLING A MAN AND A WOMAN?*

Yes  No

15. *If yes, why is there such difference?*

Poor confidentiality  Social norms  Other (pls. Mention)

16. *Do you send your client outside for specialized counselling?*

Always  Sometimes  Never

17. *How much confidentiality can you maintain during counselling, record keeping? (Please ignore discussion with your colleague for purpose of service provision)*

Very good  Good  Poor

18. *Can you please name some barriers against counselling mentally challenged persons in your setting, which you may not face if you are dealing with a mentally sound person?*

---

### **HIV TESTING**

---

Please think only circumstances where you consider testing for mentally ill people. You may choose more than one.

---

1. *What are the mandatory investigations you suggest to your high-risk patients in your setting?*

Blood RE  Urine RE  VDRL   
HIV ELISA  Western Blot  Nothing

2. *When do you counsel suspected patients for HIV testings?*

Before testing  After testing  Both   
Advise to test with out counselling

3. *What is the basis for your advice to go for HIV testing?*

High risk group  Symptomatic of AIDS  Both  Other

4. *Do you always counsel a HIV negative test result person to repeat testing and explain window period?*

Yes  No

5. **DO YOU COUNSEL FOR RISK REDUCTION IN HIV POSITIVE INDIVIDUALS?**

Yes  No

6. **Do you counsel family members of a HIV positive person?**

Always  Sometimes  Never

7. **Do you counsel your HIV positive patient for Anti Retroviral Therapy?**

Yes  No

8. **Can you please name some barriers against HIV Testing for mentally challenged persons in your setting?**

---

**REFERRAL**

You may consider circumstances where you refer your patients Mr./Ms. A, B, C, D etc outside seeking any kind of further care including HIV testing.

1. **What are the circumstances when you refer patients outside?**

Testing Not available  Treatment not available  Better care   
Other (please mention)

2. **Do you provide all information (address, cost of investigation, type of provider) to your patient when you refer them outside? (If anyone of these two is no, tick No)**

Yes  No

3. **Do you counsel your client to give feed back when you refer them outside?**

Yes  No

4. **How frequently do you counsel them to go for other tests like Hep. B, Hpe.C , Syphilis ?**

Always  Sometimes  Never

5. **How frequently do you assess a client's ability and willingness to be refereed?**

Always  Sometimes  Never

6. **Where do you send your HIV positive pregnant client for referral care?**

Obstetrician  HIV treatment expert  Never came across

7. **Did you anytime send your HIV positive women for referral care to gynecologist or medicine practitioners?**

Yes  No

8. **Can you please name few barriers in you HIV referral services, which you may not face if you are dealing with a mentally sound person?**

**Thank you very much for sparing your valuable time**

---

Item no:

Date:

**HIV Counselling, Testing and Referral services in  
Mental Healthcare Settings in Kolkata- A PROVIDER  
PERSPECTIVE**

**INTERVIEW SCHEDULE II FOR HEAD OF THE DEPARTMENT**

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Information provided by you will be kept strictly confidential. Neither individual's  
nor institution's name will be taken in study findings.  
It will be only used for research purposes.

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*Principal Investigator*



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**INFORMATION FROM THE HEAD OF THE INSTITUTION/ DEPARTMENT**  
I need this information to get an idea about the infrastructure available in your  
setting in respect to HIV counselling, testing and referral services in your  
setting.

---

*Do you want to ask me something before I go for the interview?*

---

**1. Institution:**

- (A) Public  Private
- (B) Psychiatric Hospitals  Academic Institution   
NGO  Counselling Center   
Jail Hospital  Private Clinic
- (C) If treatment centre
- Allopathic  Homeopathic  Ayurvedic
- (D) OPD care  Indoor  Both
- (E) How many patients do your institute serve per day?
- (F) How long is a duty hour on average per day per provider?  Hours
- (G) How many providers are there in your setting?
- Total no of doctors  No of psychiatrists  No of Counsellor  No of nurses
- (H) How many beds are there for mentally ill people in your setting (if inpatient facilities)
- 
-

## Record keeping

---

1. Do you keep records of your patients whom do you think that they are at risk of HIV Infection?

Yes  No

2. If yes, what kind of records?

Resister note book  Computerized  Nothing

3. Do you analyze data time to time?

Yes  No  Don't know

4. How frequent?

Half yearly  Yearly  More than 1 year

5. Why do you analyze data?

Own interest  Donor's report  Research

---

## Reporting and Feedback

1. Whom do you report about a person at HIV risk or person with HIV?

WBSACO  DHS  Other  Do not report

2. How do you get feed back from a patient you referred for testing or better care?

Voluntary  Contact by telephone  Fieldworker visits their house

3. What percentage of all referred patients give you feed back?

---

## Adequacy and Quality aspect

---

1. Do you consider that mentally challenged people need special attention in care of HIV Counselling, testing and Referral? A. Yes  B. No

**IF YES and FACILITIES AVAILABLE:** 1. Can you please describe HIV Counseling services in your setting? 2. Can you please describe HIV Testing services in your setting? 3. Can you please describe HIV Referral services in your setting? It includes counselling, treatment and cares for other reasons also, e.g. STD, cardiac problem. It includes the whole person recovery process. 4. In what way mentally challenged people can be taken special attention in regard to HIV Counselling, Testing and Referral services?

Item no

Date

**HIV Counselling, Testing and Referral services in  
Mental Healthcare Settings in Kolkata- A PROVIDER  
PERSPECTIVE**

**SEMISTRUCTURED INTERVIEW FOR EXPERTS**

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**PREAMBLE:**

The purpose of this interview is to as much as I can learn and generate issues from your knowledge and experiences in HIV Counselling, Testing and Referrals, the issues you face, and how you deal with them. I want to express that; it is not any kind of evaluation. I have prepared a set of questions to ask you. However I would like to speak as freely as you wish.

*Do you want to ask me any question/s before we begin the interview?*

---

**1. Information about the expert:**

Please check all statements that describe your experiences. You may choose more than one options.

**a. Institution:**

- (A) Public  Private
- (B) Psychiatric Hospitals  Academic Institution
- NGO  Counselling Center
- Jail Hospital  Private Clinic
- (C) If treatment centre
- Allopathic  Homeopathic  Ayurvedic
- (D) OPD care  Indoor  Both
- (E) How many patients do your institute serve per day?

**b. Variety of experiences:**

Item	Variety	Tick	Years of experiences	That best describes your experience
1	Clinical experiences in mental illness			
2	Clinical experiences in HIV/AIDS			
3	Research experiences in mental illness			
4	Research experiences in HIV/AIDS			
5	Counselling experiences in mental illness			
6	Counselling experiences in HIV/AIDS			
7	Any other (please mention)			

---

## 2. Expert opinion

PLEASE MENTION YOUR OPINION TO EXPLAIN BARRIERS THAT DESCRIBE HOW SPECIFICALLY FOR MENTALLY CHALLENGED PEOPLE; HIV Counselling, Testing and Referral SERVICES ARE DIFFERENT FROM PEOPLE WITH SOUND MENTAL STATUS. YOU CAN THINK OF BEST & WORST PRACTICES WHILE GIVING FULL RANGE OF OPINION.

### a. Stigma and social norms

How has the fact that HIV testing positive or mental illness are stigmatizing to an individual affecting the way services are offered in your institution? What are the factors that help to reduce or enhance stigma? How have you organized services to mitigate this problem?

### b. Economic constraints

The fact is that mentally ill people often need long term counselling & treatment. How does it affect their adherence to HCTR services when you consider their income as a factor in between?

### c. Organizational limitations

As remaining on the part of your setting, how do you feel that the infrastructures or resources available here are adequate?

### d. Role of gender

Is the process of HIV Counselling different for men and women? Why? What are the processes of testing and referral? Are they different for men and women? Why? Does this influence the nature of referral you make? How?

### e. Ethical Conflicts

#### Informed consent

How does a mentally ill person valid give the informed consent for HIV Testing and counselling? How are this consent and process of taking consent different from a mentally sound person?

#### Mandatory HIV testing

Few people give the opinion of mandatory testing for severely mentally ill person. Do you think is it required? Why?

#### Disclosing HIV positive status out

1. Can you please explain me, if you feel there is some dilemma in letting a client know his/her positive HIV status? (For one example; Mr./Ms. A says- I may jump out of window to suicide, if I find I am HIV positive.)
2. How did you deal them?
3. What are your recommendations to overcome these dilemmas?

### f. Knowledge of providers

1. What is in your idea about competence in HIV counselling, testing and referral procedures on the part of providers in your setting?
2. How their knowledge, attitude and practices may be improved

## 4. Conclusion

- a. Do you have anything further to add, something my questions did not address?
- b. Do you have any comments that you would like to make about this interview?

---

Thank you very much for sparing your valuable time for the interview

**Annexure: 2:            Brief HIV Screener (BHS)**

**Developer(s):** Barbara Gerbert, Amy Bronstone, Stephen McPhee, Steven Pantila, and Michael Allerton

**Reliability:** KR-20 coefficient = 0.73 (Gerbert et al., 1998)

**Scale items:**

1. Have you had 2 or more sexual partners in the past 10 years?
2. Have you had anal sex (a man puts his penis into the anus of another person) with any of your sexual partners during the past 10 years?
3. How often have you used a condom when having anal sex in the past 10 years?
4. Have you ever had a sexually transmitted disease such as gonorrhea, syphilis, chlamydia, genital warts, or genital herpes?
5. At any time in the past 10 years, have you ever given money or drugs to anyone to have sex with you?
6. Have you ever had sex with someone so that they would give you money or drugs?
7. Have you ever injected street drugs, steroids, or vitamins with a needle?
8. Have any of your sexual partners in the past 10 years ever injected street drugs, steroids, or vitamins with a needle?
9. Have any of your sexual partners in the past 10 years been men who have sex with other men?
10. Have any of your sexual partners in the past 10 years ever had a sexually transmitted disease, such as gonorrhea, syphilis, chlamydia, genital warts, or genital herpes?

**FOR ITEM 3, USE RESPONSE CATEGORIES**

- a. Never (scored as 1)
- b. Sometimes (scored as 1)
- c. Always (scored as 0)
- d. Have not had anal sex (scored as 0)

**FOR ITEMS 1, 2, 4-6 USE RESPONSE CATEGORIES**

- a. Yes (scored as 1)
- b. No (scored as 0)

**FOR ITEMS 8-10 USE RESPONSE CATEGORIES**

- a. Yes (scored as 1)
- b. No (scored as 0)
- c. Don't know (scored as 0)

**References:**        *Development and testing of an HIV-risk screening instrument for use in health care settings. American Journal of Preventive Medicine, 15, 103-113.*

# HIV Prevention for People With Mental Illness

A Training Manual for  
Mental Health Professionals

Meg Kaplan PhD, Richard Herman MA,  
Francine Cournos MD, and Karen McKinnon, MA

Supported by funds from NYSOMH  
6<sup>th</sup> Edition, 2003

## **INTRODUCTION**

This training manual will help service providers conduct a prevention program for mentally ill patients at risk for HIV infection. It outlines 10 weekly sessions to be conducted with a group of 10 to 25 patients.

### **HIV Infection and the Psychiatric Patient**

Patients with severe mental illness may be at higher risk for HIV infection than the general population. Seroprevalence studies in New York City among severely ill psychiatric patients have found rates of HIV infection ranging from 4.0% to 19.4%. In most of these studies, women were as likely as men to be infected, and blacks had higher rates of infection than non-blacks.

Our research has shown that factual knowledge about AIDS among psychiatric patients is quite good. When asked 28 common questions about modes of infection and the consequences of HIV seropositivity, a group of 201 psychiatric patients answered correctly 82% of the time. Yet these same patients reported low rates of condom use.

Psychiatric patients often demonstrate poor judgment and impulsive behavior when selecting a sexual partner, and hypersexuality may be a symptom of certain psychiatric illnesses. Patients may lack the social skills or access to condoms necessary to practice safer sex. While illegal drug use is common among psychiatric patients, only a small number report any recent IV drug use. Many, however, report having sex with intravenous drug users.

### **Intervention with the Mentally Ill**

For patients to avoid high-risk behavior, they need information and skills, including:



- **Specific knowledge.**

Accurate, up-to-date knowledge about HIV and AIDS. This includes facts about transmission and testing.

- **Coping Skills.**

Patients must learn to negotiate safer sex behavior with their partners. They need help in being assertive, and in refusing to participate in unsafe sexual practices.

- **Emotional Awareness.**

The topic of AIDS is depressing and frightening, and patients must learn to be aware of the feelings the subject may elicit. They need help in recognizing, labeling, and controlling their emotional responses.

### **Goals for the Future**

Each session contains a section on goals for the future. This is to emphasize that whatever goals patients have will depend for their fulfillment on practicing safe sex.

### **Experiential Learning**

This manual uses an experiential learning model. This means that while ensuring that participants have ample information about HIV, the sessions focus on resistances to behavior change that are rooted in dysfunctional attitudes, beliefs, habits, and feelings.

For example, in our research study of 200 subjects, half of whom had been sexually active in the past 6 months, we found that 89% of active patients used condoms inconsistently or not at all, even though 92% of subjects believed that using a condom during sex helps prevent AIDS. This is one of the many clear pieces of evidence that knowledge by itself does not change behavior.

The techniques here are designed to confront unsafe behaviors and the motivations for them. They are intentionally repetitive to ensure that learning and practice can be transferred to each participant's life outside the sessions. Changes in attitude can follow changes in behavior: It is hoped that a person who learns to use condoms despite disliking them will eventually develop more positive attitudes toward their use.

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### **Sensitivity to Cultural Issues**

Frequently, mental health providers offer services to patients with a variety of cultural backgrounds. Many aspects of culture, such as religion, rearing practices, and family styles may influence the level of comfort that patients have in discussing sex. In addition, socioeconomic status may affect a person's propensity to use substances. It is therefore important for group leaders to realize that the patients' backgrounds will influence their ability to implement what they learn in the sessions.

Patients who use substances will need extra support in resisting peer pressure to use drugs if they live in an environment where they are exposed to drugs daily. In particular, it is frequently difficult for mentally ill patients to establish new peer groups in the face of continued pressure to use drugs.

Patients reared in a fashion that associates sex with shame or whose religion prohibits sex for anything other than procreation may have more difficulty with open discussions of sexual matters. These patients may need encouragement to give them "permission" to speak. However, even with permission, the patients may prefer to remain silent, and should not be pressured.

Group leaders should also remember that cultures vary in attitudes toward suffering. In some cultures, women are expected to "suffer with dignity." This attitude may affect a person's ability to set limits in abusive situations.

Leaders should remember that at times they may be asking patients to act in ways that run counter to expectations within the patients' culture. For example, in some cultures, women consider carrying a condom a sign of being promiscuous.

These are just some examples of the ways in which cultural issues may come into play. Group leaders should be attentive to these matters as they arise, and deal with them in an open, non-judgmental fashion.

## **PRINCIPLES AND TECHNIQUES**

Successful intervention with mentally ill patients is complex, and requires offering help in a supportive, non-judgmental, and positive environment. Providers who use this manual should always keep in mind the individual needs and unique stressors of individual patients.

### **Session setting**

The sessions are planned for participants of both sexes, in 10 or more weekly or bi-weekly meetings. The length may vary.

### **Group Leaders: Functions and Responsibilities**

1. Use two group leaders, one female and one male, when possible.
2. One group leader directs the activities.
3. The other leader monitors progress, offers feedback, and keeps the group focused on the task at hand.
4. Co-leaders switch roles regularly.
5. Same-sex leaders should work with same-sex sub-groups when possible.
6. Co-leaders should encourage all patients to participate, but it should be clear that the leaders have established control from the beginning. The leaders should direct activities, set the pace, and guide and encourage patient participation. They should allow patients who cannot tolerate the entire session a short break with the understanding they will return as soon as possible.

### **Key elements in Each Session**

In every session, regardless of the content, co-leaders should:

1. Reinforce positive behavior. Compliments and phrases such as "That's a good point" are essential.
2. Elicit group members' assessment of their feelings.
3. Encourage each member to participate.
4. Set an example by acting as a model for assertive behavior, both when role-playing and in group interactions. Allow quiet patients to remain so for as many sessions as they wish. Remember: They can learn just by listening.
5. Work toward increasing patients' own concerns about unsafe sexual behaviors and involvement in risky situations or with risky partners.
6. Build group cohesion by having group members share their experiences. Have members express appreciation for each other's contributions.
7. Be supportive and non-judgmental.

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8. Be persistent. If one approach doesn't work, try another.

9. Remember that patients from different cultures may have varying levels of comfort in discussing sex in a group setting, and may need more support and encouragement. Offer these patients more "space" and allow silence as a possible response.

### **Anonymous Questions**

It is essential that participants feel comfortable in asking any question they may have, and, for obvious reasons, not everyone will feel comfortable in asking all questions out loud. Therefore, hand out blank index cards 5 minutes before the end of every session, and encourage participants to write on them any question about sex or AIDS. Keep a box in which the cards can be deposited, and inform participants that the questions will be taken up next time. Then incorporate the answers to the questions into your plans for the next session.

### **The Feeling Thermometer**

Group leaders should use a Feeling Thermometer. This technique allows participants to assess and discuss their feelings by metaphorically taking their emotional temperature. The Feeling Thermometer ranges from 1 to 10, with 10 representing the highest level of discomfort, anxiety, or nervousness. 1 indicates total calm.

In each session, after reviewing the principles of the Feeling Thermometer with the group, the group leaders should go around the room asking everyone what their "temperature" is in response to a common experience, such as asking for a date with someone new. *Be sure that people respond with a specific number.* By using the same example for everyone in the group, each person will be able to see that people react with different levels of discomfort to the same situation. Remember that some cultures emphasize stoicism or machismo, which may make some patients less likely to report levels of anxiety accurately.

Frequent use of the Feeling Thermometer is important, *especially during role-plays*, and at other times during the session when the leader senses a level of strong emotion.

### *Condom Distribution*

*The most important tool for reducing the sexual transmission of HIV is condom availability. At many programs we have visited, condoms are only sporadically available. Also, patients often have to ask for each condom from a physician or a nurse. This is not good practice. While patients may not ask staff for condoms, they take them quickly when they are available freely out of the view of staff. We have found that placing a bowl of condoms where patients can privately take their own is the best approach.*

*Please call the Columbia University HIV Training Project at 1-212-543-5412 if you need help obtaining condoms.*

Annexure: 4



## GUIDELINES FOR ADMINISTERING THE HIV RISK ASSESSMENT

Adapted from the National Institute on Drug Abuse  
Risk Behavior Assessment Questionnaire, May 1984 (revised April 1988)

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### General Considerations for Interviewers

#### Interview Environment

The risk assessment should be conducted in a *quiet, private setting* that will encourage responses to sensitive questions. The setting should be as comfortable as possible for both the interviewer and respondent. Once the interview has begun, interruptions should be minimized. If the respondent needs to interrupt the interview, it can be completed in more than one sitting.

#### Rapport Building

Interactions between interviewer and respondent should be collaborative, positive, and pleasant. It is the interviewer's responsibility to take the lead in establishing this relationship. Be *friendly yet professional*. Approach the respondent with no preconceived ideas or opinions about his or her likely risk behaviors. Building good rapport takes patience as well as the ability to set aside your own emotional reactions from time to time. Don't frown, gasp, or laugh in response to an answer. Convey that there are no "right" or "wrong" or "bad" answers to questions.

Always allow the respondent time; *don't rush*. Remember that your purpose is to get good, accurate answers. Adjust your pace to that of the respondent.

Encourage the respondent to answer as many questions as possible. Some people say "I don't know" while they are trying to arrange their thoughts. Give the respondent time to think. Guiding the interview can be a challenge. While giving the respondent every opportunity to think through the questions you must also make sure that he or she doesn't go "off on a tangent." If this happens, try to steer the interview back on course with a gentle remark such as, "That's interesting, now what would you say about this question?"

If you sense that a respondent has not replied correctly or consistently to a question, or if he or she stumbles or hesitates, *always accept responsibility for faulty communication*. Your relationship with the respondent will be much more facilitative if you try to re-word any question the respondent has not understood or if you use an example to illustrate what you are trying to learn.

Some respondents may feel *threatened or uncomfortable by certain questions*. If the respondent seems hesitant, begin by simply repeating the question. If you sense that a respondent is feeling distress, you can use the *feeling thermometer* intermittently; that is, ask the respondent, "On a scale from 1 to 10, with 1 being the least anxious you've ever been and 10 being the most anxious, how are you feeling right now?" If the respondent is intolerably anxious, you can stop the interview and address his or her concerns. You can also help allay fears by assuring respondents that your purpose in asking these questions is to help them learn about their own intimate health-related behaviors, and by reminders about the confidentiality of their responses. In some cases, respondents may suddenly withdraw, even if the interview is apparently going well. Accept it graciously and naturally and reschedule the interview later.

Be prepared to answer respondents' questions relating to the assessment, but make it clear to respondents that you will do so at the end of the interview. This assures that respondents' answers are unbiased by the information you give, and also allows you to make appropriate referrals when you have

been asked something you cannot answer or when a respondent needs additional HIV-related services.

#### Ensuring Confidentiality

Providing the respondent an absolute assurance of confidentiality is essential to obtaining a good HIV risk history. This should be discussed at the very beginning of the interview and repeated at the end. Assure the respondent that all answers will be kept confidential, that you will not release the information you gather to any outside agency or authority without appropriate permission.

#### Administering the Assessment

It is important to remain alert throughout the interview, even when you have administered it several times and everything seems routine to you or the respondent. Some questions are appropriate for men only or women only, and you will sometimes pick up information that refers to a question that you have not asked yet. Ask the questions in the order in which they appear on the assessment form, even if the respondent has already provided information relevant to a question. You can use a lead-in such as, "You already talked about this a little, but I need to make sure I understood your response" and then ask the question as it appears.

A *probe* is an exploration for additional information from the respondent. If a probe is needed to clarify or expand upon an answer, probe by asking, "Is there anything else you would like to tell me about...?" Do not allow the respondent to probe you. Again, if a respondent asks you questions during the interview, take note of them and say you will be happy to try to answer them *after* the interview. Don't be afraid to tell a respondent that you don't know the answer to a question. Tell the respondent that you will do your best to find out the answer and get back to him or her, or refer them to someone in your referral network who can help. This referral network is extremely important to establish and to update regularly because you can't be expected to be an expert in everything.

#### Debriefing

How you end the interview is as important as how you begin it. Thank respondents for their frankness, and remind them that their answers will be kept confidential. Ask whether anything came up during the interview that was not clear or that they have questions about, and whether they would like a referral to any HIV-related programs or services offered at the mental health treatment site.