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**HIV COUNSELING, TESTING AND REFERRAL  
SERVICES IN MENTAL HEALTHCARE SETTINGS  
IN KOLKATA - A PROVIDER PERSPECTIVE**

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## **HIV Services in Mental Healthcare settings**

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# **HIV COUNSELLING, TESTING AND REFERRAL SERVICES IN MENTAL HEALTHCARE SETTINGS IN KOLKATA- A PROVIDER PERSPECTIVE**

## **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 multi-folded 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 healthcare system.<sup>3</sup> Psychiatrists and other mental healthcare 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 indicating 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.

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>

About 450 million people worldwide suffer from mental, neurological or behavioural problems at any given time.<sup>3</sup> 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 to HIV infection. About 25% of those seeking healthcare services

have 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>

## **About This Paper**

The annual round of HIV Sentinel Survey was conducted in 320 sites of India (135 STD & 170 ante natal clinics, 13 Injecting Drug Users (IDUs) and 2 Men having Sex with Men (MSM)) in August-October, 2001. The point estimate (2001) was 3.31 million (3.9 million in 2000) HIV infections in adult population (15-49 yrs. age group).<sup>6</sup> In primary healthcare settings, 22.4% of patients had mental disorders; 9.1% depression, 8.5% anxiety, and 1.5% alcohol disorders.<sup>7</sup> National prevalence rate for 'all mental disorders' in 2000 was 73 per 1,000 population (rural 70.5, urban 73).<sup>8</sup> Prevalence of schizophrenia was 2.5/1000.<sup>9</sup> Urban morbidity is 3.5% higher than the rural rate. West Bengal state has higher prevalence of mental disorders with urban areas having higher prevalence. This paper explores the HIV counselling process in mental healthcare settings in Kolkata, a metro city in West Bengal state. The city has huge patient drainage from all northeast part of India and has more providers too.

Although the number of studies on this topic is limited, available studies indicated that the prevalence of HIV infection among psychiatric patients was 3.4%.<sup>9</sup> Similarly, majority of patients admitted to a state psychiatric hospital was found to have high-risk partners.<sup>10</sup> Severe mental illnesses such as schizophrenia, manic-depressive psychosis, and psychotic depression occur in the prime of life and disrupt normal life 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 and HIV continues to spread among them in India.<sup>2</sup>

## **Rationale**

Dual problems of mental illness and HIV/AIDS together pose challenges to the public health initiative. But, the system is 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?

## **Objective**

The main objective of this paper is to assess the adherence of and barriers to HIV counselling, testing and referral services on the part of the providers.

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

The rate of HIV infection among mentally ill patients was found to be in the range of 0.4% – 22.9% (0.4% for general population).<sup>2,11</sup> Use of alcohol or other drugs was found to influence the rate of infection.<sup>11</sup> Drug injection confers important risk. Even use of non-injected drugs or alcohol may result in substantially higher risks; sex and drugs combine to create vulnerability to sexually transmitted HIV infection ( $P < 0.03$ ).<sup>11</sup> Hyper-sexuality is prevalent in certain psychiatric illnesses; they lack social access to condoms necessary to practice safe sex. Illegal drug use is common among psychiatric patients, but only few reported any recent IV drug use.<sup>11</sup> Many, however, report having sex with intravenous drug users and psychiatric patients often demonstrate poor judgment and impulsive behaviour while selecting a sexual partner. A study of psychiatric inpatients conducted in South India (1998-2000) showed statistically significant differences among men and women in respect to their risk behaviours.<sup>12</sup>

## **Barriers to HIV Counselling, Testing and Referral Services Among Mentally Ill**

HIV counselling and testing services provided effective means for secondary prevention for HIV positive individuals, but it is not effective for primary prevention among uninfected individuals.<sup>13</sup> HIV counselling basically includes providing information on HIV/AIDS, mode of transmission and its prevention aspects.<sup>14,15</sup> Clients should receive help to identify specific behaviours putting them at risk for acquiring and transmitting HIV. They should be enabled to

commit steps to reduce this risk. Counsellors are required to perform certain tasks during counselling.<sup>13-15</sup> According to them, clients using drugs or alcohol should receive or be referred to substance or alcohol abuse prevention and treatment services.<sup>14,15</sup>

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. Various agencies have developed certain guidelines of HIV prevention for people with mental illnesses.<sup>3,14,16,17</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> They should provide specific knowledge on up-to-date information about HIV and AIDS including facts about transmission and testing thus enabling the clients to develop coping skills.

## **Controversies and Ethical Conflicts**

There are controversial issues like duty of a provider to counsel, treat, and to provide information on safe sexual activity in mental healthcare settings. Ethical rights of patients and responsibilities of healthcare 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>

Issues concerning mandatory testing and ethical issues have been debated for over a decade. Benefits of early detection and treatment appear to be insufficient to justify the intrusiveness of mandatory testing and the distress it will impose.<sup>2</sup> 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 healthcare 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> Changing trend of informed consent

among mentally challenged people for doing HIV research before, during and after research period and the factors that shape these changes are being analysed now.<sup>21</sup>

## **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>

## **Mental Healthcare Providers: How Much Adherent?**

The mental health profession remains an untapped resource within the community and mental healthcare settings for addressing HIV/AIDS prevention and early detection.<sup>16,23</sup> Screening for risk factors may suffer because professionals are reluctant to bring up HIV with psychiatric patients; often out of well-meaning concern for the patients; discussing sexual behaviour can worsen psychiatric symptoms.<sup>2</sup> However, providers have adequate opportunity to become friendly and to provide sexual health information, as clients spend long time with them.

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 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.<sup>24, 25</sup>

## **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

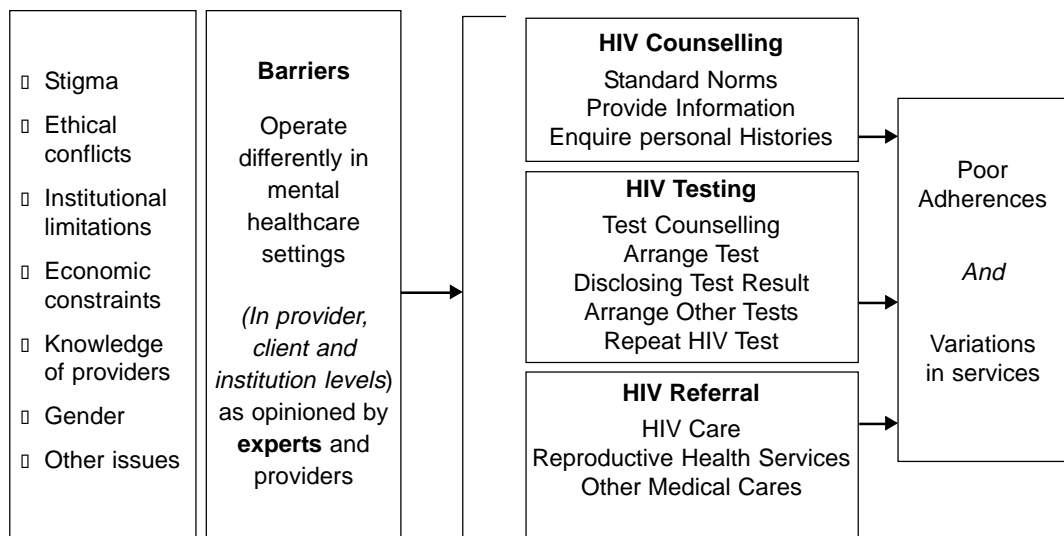
counselling and testing centres, National AIDS Control Organization (NACO) has decided to expand the net work of voluntary counselling testing centres up to the district level. There are total of 142 VCTC s in India in 2000.<sup>15</sup> Review could not identify any special attention for mentally ill 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.

### CONCEPTUAL FRAMEWORK

HIV counselling includes components such as adherence to standard norms, risk assessment, provision of information, risk reduction, or enquiry into personal history. HIV testing includes test counselling, arrangement for testing, disclosure of test result, conduct of other relevant tests and repeat tests when necessary. HIV referral includes HIV care, and reproductive and associated medical illness care. While providing these services, providers face barriers like stigma, ethical conflicts, institutional limitations, gender etc affecting their services (Chart-1).

**Chart- 1. Conceptual framework for the study**





## **Operational Definitions**

*Mental healthcare setting* - Institutions providing care to mentally ill including substance users

*Mentally ill person* - A person (15 to 60 years) coming to mental healthcare setting for seeking any kind of care

*Providers* - Psychiatrist, Psychologist, Physician, Head of the Department and Expert

*HIV counselling* - Includes standard norms of counselling, HIV risk assessment, provide HIV information, providing prevention information, risk reduction, or enquire personal histories.

*HIV testing* - Means HIV ELISA testing and other relevant tests to know status of a suspect

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

## **METHODS**

### **Study Design**

This was a cross sectional study looking into HIV counselling, testing and referral services of the providers of all possible typologies. It contained quantitative and qualitative approaches.

### **Setting**

This study was conducted in Kolkatta, capital of the state, West Bengal. It is a metro city with 11.5 million population and a migrant population of varying characteristics. The state of West Bengal has a higher prevalence of psychiatric morbidity than many other Indian states and urban population has a higher prevalence than the rural. Government and non-government sectors provide treatment and/or counselling services to mentally ill persons. There are 9 public providers with outpatient (OP) and inpatient (IP) facilities, 6 private hospitals with only OP and 7 Non-Government Organisations (NGOs) with OP and IP facilities for mental healthcare.

### **Sampling**

The respondents were psychiatrists, psychologists or physicians. Heads of the department were psychiatrist, psychologist or administrator. Attendance of a mental healthcare conference held in 2002 revealed that there were 137 registered providers. It was decided to include at least 33% of them (about 45) in the study and so, 52 were included in the study; in addition, there were 10 heads of department. All public (Medical College, Psychiatry, and Homeopathic

Medical College), private and NGO hospitals in Kolkata were listed. All public hospitals were included, but private ones were excluded as their heads did not agree. Those NGO institutions consented were included. Those personnel on duty and provided consent were interviewed. Heads of departments were interviewed after pre-fixed appointment. Experts were selected from providers who already gave interviews for 1<sup>st</sup> set of interview schedule; selection was based on qualification, experience, and setting. Interviews were conducted during January – March 2004.

## **Instruments**

A semi-structured interview schedule was used for the providers. First part of the schedule was related to HIV risk assessment developed from a standard instrument 'Brief HIV Screener (BHS).' BHS is a 10-item questionnaire validated for use in healthcare settings to screen for HIV-related risk behaviours of clients. This self-addressed questionnaire was internally consistent (Kuder ± Richardson - 20 coefficient  $\hat{=}$  0.73) and was able to discriminate between low- and high-risk groups. Questions related to risk assessment included three reply options - always, sometimes and never. Each one was reversed to probe into their adherence. A semi-structured interview schedule addressing adequacy, quality, and infrastructures available was used for the heads. Schedule for the experts was developed with the help of a Medical Anthropologist and included issues concerning barriers.

## **Pre-testing**

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.

## **Ethical Consideration**

Provider 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.

## Variables

The dependent variables were adherence to risk screening, risk assessment score (total score from BHS risk assessment queries), another score from 12 variables, adherence to counselling, testing & referral (% of providers), service difference across settings/providers, and provider performance (quality scores). The independent variables were type, setting, age, sex, and experience of the provider, training on HIV/AIDS, resource availability (no. of providers, duty hours and time use), barriers, stigma, ethical conflicts, institutional limitations, economic constants, knowledge and gender of the client.

## Data Analysis

'Always', 'sometimes', and 'never' were given respective scores of 2, 1 & 0. Total score ranged between 0 and 20. Individual provider score was coded as HIVRAS. Scores > 10 meant 'high score', and = 10 meant 'low score'. Regarding the other questions, the replies of 'yes' and 'no' received scores of 1 and 0 respectively. The '12 variable score (S12)' of > 7 was 'high score' and = 7 was considered 'low score'. Twelve variables were 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. HIVRAS and S12 were added to find the total score (TS). A total score of 16 was considered 'high score'.

Quantitative data were entered in SPSS 11.10 version. Independent samples t-test, Chi-square, One-Way-Anova, Binary and Multiple Logistic Regressions were used whenever appropriate to calculate statistically significant associations at 0.05 level. Qualitative data were analyzed through phases of editing, interpreting, categorizing & coding. For gender as a barrier we used Gender Analysis Framework of Liverpool. Extracts were used to identify variations in opinions. The intent is to identify and categorize opinions and locate idiosyncrasies. Somewhere verbatim has been quoted.

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.

## **RESULTS**

### **Characteristics of Settings**

The study was conducted in 14 mental healthcare settings in Kolkata - 2 psychiatry hospitals, 5 psychiatry departments of Medical College Hospitals, 2 OP departments of Homeopathic Hospitals, 3 Counselling Centres, and 2 Detoxification Centres. Nine were public and 5 NGOs. Psychiatry hospitals provided exclusively psychiatry services along with primary healthcare. Psychiatry departments provided psychiatry services, but sent clients to other departments for primary healthcare. Homeopathic institutes provided counselling and primary healthcare services. NGOs provided both psychiatry and primary healthcare services.

Public setting served 218 patients while NGOs served 69 patients per day in OP department. Average duty hours of providers in public setting and NGOs were 9.6 and 6.7 respectively. Time available to a patient was 0.42 hours and 0.36 hours in public and NGO settings. There were 79 psychiatrists, 25 psychologists, and 66 nurses in the public setting whereas there were 13 psychiatrists, 6 psychologists, and 22 nurses with the NGOs.

### **Characteristic of the Respondents**

There were 52 providers - 36 (69.3%) from public setting and 16 (30.7%) from NGO (Counselling, substance use and detoxification centre). Thirty one (59.6%) were psychiatrists, 13 (25.0%) psychologists, 6 (11.5%) physicians, and 2 (3.8%) others. Among the providers interviewed, 44.2% were women, 28.8% were below 30 years (50.0% above 38 years), 50.0% had more than 7 years experience, and 25.0% had HIV training, Ten (7 public sector and 3 NGO) heads of department were interviewed; 6 were psychiatrists, 2 psychologists/counsellors, 1 physician and 1 administrator. Besides, 13 experts (from the list of 52 physicians included) were interviewed. Six had clinical and counselling experiences in mental illnesses; 5 had clinical experiences in HIV/AIDS while 1 had research experiences in HIV/AIDS. Following sections bring out an overview of the content and context of the services in the public and NGO settings.

### **HIV Counselling**

Public setting providers took sexual health histories of their clients as a mandatory part in detailed history sheets; it took about 30-45 minutes. They conducted counselling or risk screening of their clients only when they considered that client was under risk. NGO providers served their clients in HIV/AIDS or substance use programmes. Risk assessment was done through group counselling, focus group discussion (FGD) and family meetings.

## Adherence to HIV Risk Screening

NGO settings had a few guidelines to address the issues of HIV among their clients and they were programmatic in approach. Public settings had more of clinical orientation and none adopted separate strategy to address HIV issues among their clients. Risk assessment or counselling were provided as and when required but only if a provider found the client to be high risk. NGO providers tried to explore risk status of all clients. Interviews revealed that there was no existing terminology of HIV risk screening among providers. But they assessed the risks through informal ways.

As indicated by Table-1, 17 (32.7%) of the providers 'always' assessed the client's STD history, 16 (30.8% assessed partner's STD history, and 17 (32.7%) assessed ever injection history of drugs with any needles. Vast majority of the providers 'sometimes' assessed these three whereas about 20% of the Psychiatrists and over 45% of the Psychologists 'always' assessed all the three. About 35-45% never assessed use of condom for anal sex, injection history of partner and whether paid money for sex.

**Table-1. HIV Risk Screening by Providers (N = 52)**

HIV risk screening queries	Number (%) of providers asking the query		
	Always	Sometimes	Never
Number of sexual partners	11 (21.2)	38 (73.1)	3 (5.8)
History of anal sex	3 (5.8)	32 (61.5)	17 (32.7)
STD history of partner	16 (30.8)	26 (50.0)	10 (19.2)
History of STD	17 (32.7)	34 (65.4)	1 (1.9)
Paid money for having sex	11 (21.2)	23 (44.2)	18 (34.6)
Got money for giving sex	9 (17.3)	26 (50.0)	17 (32.7)
Ever injection with needles	17 (32.7)	33 (63.5)	2 (3.8)
Injection history of partner	6 (11.5)	27 (51.9)	19 (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)	23 (44.2)

## **HIV RAS, S12 and TS Scores**

The average HIVRAS score was found to be 9.6 (range 3–18), S12 score was 6.4 (range 1–10) and average total score was 16.0 (range 5-26). In all the cases, median was very close to the mean. Psychologists had the highest (12.2) HIVRAS score, S12 score (7.3) and total score (19.5) followed by others in HIVRAS score (10.3) and total score (16.0) and by psychiatrists in S12 score (6.2); total score of psychiatrists was 14.6. HIVRAS score was significantly (one-way ANOVA test,  $P = 0.00$ ) different for different type of providers. Total score too was significantly ( $P = 0.05$ ) different for different type of providers. However, type of providers had no significant ( $P = 0.3$ ) influence in case of S12. Binary logistic regression between HIVRAS and S12 indicated that those who receiving higher HIVRAS score ( $> 10$ ) were 2 times more likely to score higher S12 score ( $> 7$ ) ( $P = 0.001$ ). Odds Ratio after adjusting for experience, sex, age, training status and settings was 0.21 ( $P = 0.04$ ).

Sex of the provider did not influence the scores ( $P = 0.28 - 0.96$ ). Similarly, experience was found to have no influence ( $P = 0.23 - 0.78$ ) on the scores. Age too failed to have any significant ( $P = 0.25 - 0.46$ ) influence on the scores. However, the score was significantly ( $P = 0.01 - 0.02$ ) different for public and NGO settings. NGOs had a HIVRAS score of 12.8 against 8.2 in public setting ( $P = 0.01$ ). S12 score was 7.4 for NGO against 5.9 for public sector and total score was 20.5 for NGOs while it was 14.5 for public settings. Within the public sector, psychiatric hospitals had a higher score ( $P = 0.003$ ) compared to psychiatric department within the hospital.

## **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) ( $P = 0.00$ ) or institution variety (public and NGO) ( $P = 0.01$ ). For total score, One-Way-ANOVA suggested statistically significant ( $P = 0.00$ ) variations among mean scores of the three types of settings. However, it was not true for S12 ( $P = 0.21$ ).

Independent-Sample-t-tests for HIVRAS, S12 and TS with age (0 for  $\leq 38$  years, 1 for  $> 38$  years), sex (0 male, 1 female), type of settings (0 psychiatry hospital and psychiatry dept., 1 others), type of provider (0 psychiatrist, 1 others) and experience (0 for  $\leq 7$  years, 1 for  $> 7$  years) and training in HIV/AIDS (0 for trained, 1 for not trained) indicated significant associations between the scores and type of settings ( $P = 0.001 - 0.03$ ). Total Score was significantly ( $P = 0.02$ ) associated with the type of providers.

## Role of Gender

Mean HIV Risk Assessment Scores (HIVRAS) for male and female providers were 9.3 and 10.0 respectively. Association of HIVRAS with sex was not statistically significant ( $P = 0.69$ ). However, 59.6% of the providers perceived that gender had a role to play and this perception had no influence over the HIVRAS score ( $P = 0.40$ ). Similarly, provision of HIV information in OPD ( $P = 0.65$ ), sex ( $P = 0.57$ ), age ( $P = 0.26$ ), settings ( $P = 0.51$ ), confidentiality ( $P = 0.21$ ), and HIV training status of providers ( $P = 0.33$ ) had no significant association with HIVRAS score. However, providers' training status was significantly ( $P = 0.01$ ) associated with the 'high' (score of 11-20) or 'low' (score of 0-10) status of HIVRAS; mean HIVRAS scores for trained and not-trained providers were 11.7 and 8.9 respectively.

## Impact of Training and Setting

Twenty fifth, 50<sup>th</sup> and 75<sup>th</sup> percentiles of HIVRAS were respectively 6, 10 and 13. Plotting of providers in 4 quartiles of HIVRAS distribution graph located the psychiatrists in 2<sup>nd</sup> quartile (mean score 8.4), psychologists in end of 3<sup>rd</sup> (score 12.2) and others (including physicians) at the beginning of 3<sup>rd</sup>. Twenty fifth, 50<sup>th</sup> and 75<sup>th</sup> percentiles of S12 were 5, 7 and 8 respectively. For S12 score distributions (score 6.2), psychiatrists were in 2<sup>nd</sup> quartile, psychologists in early 3<sup>rd</sup> (score 7.3) and others in 2<sup>nd</sup> (score 5.2). For Total Score (TS) distribution; psychologists were in the end of 3<sup>rd</sup> quartile (score 19.5). Psychiatrists and others (scores 14.6 & 16) were in 2<sup>nd</sup>. Twenty fifth, 50<sup>th</sup> and 75<sup>th</sup> percentiles of TS were 12.3, 16 & 19.8 respectively.

HIV Risk Assessment Score (High = 11, Low 0-10) of individual providers was significantly (Pearson Chi-square 2-sided test,  $P = 0.01$ ) associated with provider's HIV/AIDS training. NGO had more trained providers compared to the public setting ( $P = 0.01$ ). Associations between training status and few other variables like providing HIV information in OP department, counselling both times for HIV testing, assessing personal history, counselling about client's willingness and ability to be referred, taking personal history, etc. through Chi-square methods found that the training was significantly ( $P = 0.05$ ) associated only with the counselling for willingness and ability of the client to be referred. Trained psychologists had higher (14.7) HIVRAS compared to the untrained (8.2). However, it was not the case in the case of trained psychiatrists (8.4 and 8.2 respectively). In public settings, trained and untrained providers had the same mean score of 8.7 whereas it was 15.2 for trained and 11.6 for untrained provider in NGO setting. In other words, training had positive impact on the performance only in the case of NGO setting. Adjusted Odds Ratio for setting (public or NGO) adjusted for training, speciality in psychiatry were 8.0, 8.1 and 6.4 respectively for

HIVRAS, S12 and TS (Table-2). In other words, NGO providers have 6-8 times higher scores than public providers.

**Table-2. Impact of Training, Setting and Specialty on the Scores**

Attribute	HIV service scores of providers								
	HIVRAS S12 TS			S12			TS		
	OR	Adjusted		OR	Adjusted		OR	Adjusted	
		OR	95% C.I.		OR	95% C.I.		OR	95% C.I.
Training	5.06	0.24	0.06-1.02	1.00	1.43	0.31-6.56	0.31	0.38	0.09-1.65
Setting	8.67	8.04	1.38-46.94	5.36	8.09	1.42-46.10	8.67	6.39	1.26-32.31
Psychiatry	0.61	0.38	0.07-2.12	1.77	0.56	0.11-3.23	3.64	1.52	0.36-6.37

Training – Trained in HIV/AIDS, Setting – Public/NGO, Psychiatry - Specialist in Psychiatry

## HIV Counselling Across Settings

Over 90% providers in all settings maintained confidentiality and about 80% approached their clients through rapport building for probing into sexual history. However, 26.1% of public providers did not adhere to pre-test/post-test counselling in HIV Testing. Only one provider in public setting told that he did not take any special attention for HIV counselling. All providers in NGOs and 69.5% of public providers opted for client's consent while taking their sexual history. Over 70% of NGO and 61.1% of public providers sought special attention in HIV counselling for clients suffering from schizophrenia or bipolar disorders ( $P = 0.063$ ).

About 85% of NGO providers and 69.4% of public providers counselled their substance user clients for detoxification (Table-3). All NGO providers and 91.7% public providers counselled their clients about the type of substance use, which is linked to HIV transmission. Higher proportion (53.0%) of NGO providers asked about tattooing behaviours. However, majority (above 75%) of public and NGO providers asked about clients' awareness about HIV/AIDS, marital status, occupation and income. All the NGO providers and none of the public providers had adequate number of health education materials like handouts, pamphlets, posters, pictorial books etc for distribution among the clients. However, few posters of Health and Family Welfare Department on HIV/AIDS have been displayed in public hospitals. All NGO providers had separate posters for injecting drug users, substance (ab)users and alcoholics.



**Table-3. Supply of Information in Public and NGO Settings**

Information/counselling item	No. of providers (%)	
	Public	NGO
About HIV in OPD	35 (97.20)	14 (87.5)
HIV transmission	28 (77.80)	14 (85.71)
HIV risk reduction	33 (91.7)	15 (93.8)
HIV risk prevention	35 (92.10)	13 (92.85)
Detoxification*	25 (69.40)	12 (85.70)
Type of substance use*	33 (91.70)	16 (100.00)
Injecting behaviours*	28 (77.80)	15 (93.80)
Tattoo behaviours*	9 (25.00)	8 (53.30)
Occupational expo	32 (88.88)	13 (92.85)
History of blood transfusion	32 (88.90)	15 (93.10)
Needle syringe exchange*	28 (77.8)	14 (87.50)
Harm reduction*	18 (50.0)	10 (62.5)

\* Among substance users

### **HIV/AIDS or Substance (ab) Use Sessions for Clients**

All NGOs and none of the public setting had provisions for group counselling/sessions where the clients interacted and shared their experiences. Substance/injecting drug users meet with a group leader for the counselling session. Clients with acute mental illness or high substance use were encouraged to attend day-care centres. Four out of 7 public providers offered individual counselling. However, some group sessions were organised for academic purpose.

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

## **Testing and Referral Services**

Testing and referral depended upon the client and his/her accompanying relatives. Two institutions provided vehicle for carrying the inpatients to referral centres for HIV testing or related illnesses. Except doctors or psychologists, nurses did not provide test counselling services. None of the NGOs had provisions for testing while 3 public settings, which are also State Medical Colleges, had VCTC and HIV ELISA testing facilities. NGO social workers played significant role in following up or finding the non-reporting clients. Data was poorly managed in both settings with better adherence to confidentiality in NGO settings. NGOs maintained the database and reported the HIV positive cases to the appropriate authorities. NGOs had research interests too.

Table-4 shows that psychologists adequately adhered to norms on counselling services before or after HIV Testing. They also provided all information while referring clients to outside facilities and counselled family members and clients to give feedback. They were careful to provide HIV risk reduction information. They performed better than psychiatrists. Interestingly, 75% of physicians (both allopathic and homeopathic) depended more on symptomatic presentations for HIV Testing and on VDRL or blood RE tests for assessing risks of HIV first and then go for HIV ELISA. Heads of departments opined that relying on VDRL for HIV infection might delay actual diagnosis leading a client towards advanced state of AIDS.

NGOs and public settings performed more or less equally in assessing client's ability and willingness for referral (59-69%), risk reduction for HIV positive (65-69%), counselling before and after HIV testing (88-94%), counselling family members (89-94%) and counsel for feedback (78-88%). Public providers scored higher (55.6%) than NGOs (25.0%) in prescribing HIV testing whereas NGOs scored well (61.5%, public sector 40.0%) in providing all information when referred and in asking for ART for HIV positive clients (100.0%, public sector 62.5%). Interviews found that there was a poor coordination between psychiatrists and psychologists in referring clients outside for testing or treatment. Psychiatrists directly referred the clients without mandatory counselling processes from psychologists.

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 (69.3) per day. Interviews with HoDs revealed that their specific programmatic approaches explain better adherence to quality or adequacy aspects.

**Table-4. Adherence to HIV Testing and Referral Services**

Item	No. of providers adhering (%)		
	Psychiatrist N = 31	Psychologist N = 13	Others N = 8
Prescribe HIV ELISA Test	51.6	NA	25.0
Basis for HIV Test -Symptomatic	67.7	NA	75.0
Basis for HIV Test –High-risk group	96.8	NA	50.0
Basis for HIV Test –Above both	64.6	NA	50.0
Risk reduction for HIV positive	51.8	85.7	33.3
Repeat ELISA in (-ve) and explain Window Period	51.8	60.0	33.3
Counsel before HIV Testing	87.1	100.0	75.0
Counsel after HIV Testing	71.0	100.0	75.0
Counsel to give feedback	83.9	100.0	62.5
Counsel family members of HIV + individuals	41.93	100.0	62.5
Advise Hepatitis. B & Hepatitis C test	83.9	NA	12.3
Advise for VDRL Test	67.7	NA	75.0
Advise Blood RE	48.4	NA	50.0
Prescribe Urine RE	41.9	NA	12.3
<b>HIV Referral</b>			
Ask HIV+ for Anti Retroviral Therapy	80.0	NA	50.0
Provide all information when referred	58.1	87.5	37.5
Refer outside for specialized counselling	90.3	76.9	75.0
Assess client's ability & willingness to be referred	83.9	86.2	25.0

NA- Not Applicable/ Available

## Barriers in HIV Counselling, Testing and Referral Services

Diverse opinions of experts/providers emphasizing why providers cannot provide adequate services are summarised here; fifty two providers and 13 experts were interviewed for this purpose. Majority (73.0%) of providers thought that poor acceptance from clients, poor insight (78.8%), and dual illness (50.0%) were the most common barriers in providing services. Expenses, time constraints, more patient rush, and lack of coordination among providers were identified as other barriers. About one-third of the providers spent over 120 minutes for rapport building with new clients before starting sexual health counselling. Few providers were unaware of VCTC in their own institute and they sent clients to out side for HIV testing.

## Stigma

When stigma from HIV/AIDS is superadded with that of mental health problems, things become more complicated. Due to fear of stigma, people were reluctant to seek counselling or treatment. Ultimate effect on stigma from HIV and mental illness was found to be additive, 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.

Majority of experts believed that stigma was more with substance users than those who were only psychiatrically ill. "We deal substance user as a client, not as an addict. We use the term 'use' not 'abuse'. NGO providers in two settings collaborated with Kolkata police in their campaigns to reduce stigma in the community as reducing stigma from substance use needs special care for counselling. "We stress on enhancing self-esteem of the client to reduce perceived stigma." Family members of an HIV positive person were 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 maintain 100% confidentiality. It is high in outpatient department."</p> <p>"Outpatient will perform all (e.g. thyroid, &amp; blood routine) tests; whatever we say. They come back with other reports than HIV test result. 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 thought that when HIV infection is due to occupational exposure (accidental needle injury, blood transfusion, etc.), his/her self-esteem is good; stigma is obviously less in that case. The client may have depression due to disease process. But (s)he 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 high in a closed environment where information transmits informally like a volatile substance e.g. spirit." When a centre 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". Eleven out of 13 experts felt that stigma should be overcome at the provider level. Adequate orientation and training of providers are needed.

All 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 attitudes is attached with stigma." "Stigma is least or nil when client has mental retardation." It depends upon client's IQ level.

All experts thought that stigma is mostly related to the level of insight in an individual. "But community/family response is important as they have direct/indirect impact on the individual." "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 you are worried about."

### **Effect of Socioeconomic Status and Gender on Stigma**

One expert told that upper middle class people have money, but 'stigma is much more than money'. For middle class people both money and stigma are equal force in seeking care

whereas for lower middle class people, both stigma & money play very strong role affecting HIV or mental healthcare seeking behaviour. Many experts told that stigma was not related to education. Highly educated people are arrogant, and are noncompliant to advices; it is difficult to bring change in their attitudes. There are not much variations of perceived stigma among different castes/religion. "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."

"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**

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. Many experts thought 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.

At the same time, some others felt that "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." Few others felt that people have become more conscious and mental illness is considered as a common disease. So, STD/HIV/AIDS related stigma only would work, and HIV stigma is predominant.

### **Ethical Issues**

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? Aspects of conflicts regarding informed consent are presented in Table-5.

Opinion Category	Psychologist	Psychiatrist
Type& status of mental illness	<p>“Patient’s rationality/judgment should be assessed to declare validity of the consent. As a provider, continue giving therapy than seeking consent.”</p> <p>“You can’t rely. They consent or refuse in their highness.”</p>	<p>“Consent given by a mentally challenged person is inconsistently inconsistent in validity.”</p>
Need of consent every time	<p>“Why are you all worried about consent? Do not always consider law. Law will never betray you. As a provider do what is best for your client. But assure good confidentiality.”</p>	<p>“Irrespective of mental status, inform the client. Don’t bother whether it is understood or not. Record his/her reaction and mention that patient is unconscious. Without valid consent, you can do testing for greater right of the people.”</p>
Significant others for an invalid consent	<p>“Apart from 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 opined that prevention of the contact persons is preferable to 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 (blood exchange) by a person with known positive status.

## Risk Group of The Client

Majority agreed 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.

However, 8 experts felt that testing should be done after pre-test counselling as consent can be taken only when the patient is stabilized through counselling/treatment. If all types of care fail to cure, one can opt for mandatory testing even when the patient is not mentally sound.

## **Guidelines**

All experts felt that there are no guidelines as how to deal controversial issues. One of them felt that in the age of 'Consumer Protection Act', there should be definite guidelines to protect the providers. Half of them felt that there would be no violation of rights as the greater right of the susceptible population may overcome the individual right through mandatory testing.

## **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. One expert had 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."

## **Economic Constraints**

One expert told, "...clients are not able to afford their conveyance to (de)addiction centres though we provide medicines and lunch for the day. Conveyance accounted for 35% of the total cost. When patients are unable to afford the psychiatric drugs, they send them to government institutions for drugs free of cost. NGOs provided mental healthcare services at lesser 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 opined 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.”

## **Gender**

There were differences among men and women in the availability of and access to resources. “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.

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.”

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 counsellor, 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?”

## **Other Issues**

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.

One expert felt 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 Bengali. Most of the clients may not understand it. At the same time, local slang language better communicates with local people. There is need to develop a book of code languages which is culturally and regionally appropriate.

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 paramedics 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.

## **DISCUSSION**

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

Providers did not sufficiently adhere to HIV risk screening of clients irrespective of their mental status. They inadequately probed into homosexual histories or clients' compliance of condom use during anal sex. Unsafe anal sex has more HIV transmission efficacy than unsafe vaginal sex. Partner's sexual history was less stressed upon. Only 16% and 11.5% of providers respectively most often took history of partner's STD history and drug injection. Neither public nor NGO setting practised mandatory sexual health counselling, harm reduction or needle syringe exchange counselling all the time for the substance abusers. Interviews revealed that there was enormous scope 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 had significantly high risks. A study on "HIV Risk Assessment Related Practices" revealed that providers in psychiatric settings adhered to HIV screening for only high-risk group clients.<sup>24</sup> Another study in Quebec, Canada showed that physicians or gynaecologists/obstetricians screened HIV related information from 5.8% - 32.7% of their clients when they talked about their STD history.<sup>26</sup> Studies found that mentally ill people are 4 – 23 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 few providers in the present study used checklist while screening their clients or talking about risk reduction. It 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.

## **Interpretations of Scores**

Distribution of HIV Risk Assessment scores showed that psychologists had a mean score of 12.5 compared to 8.4 of psychiatrists and 10.3 of others; psychologists had 7.3 of S12 score and 19.5 of TS score. In score quartile distributions, psychologists remained in the 3<sup>rd</sup> quartile for HIVRAS, psychiatrists in 2<sup>nd</sup> and others in early 3<sup>rd</sup>. NGOs were at higher quartiles in HIVRAS, S12 or TS compared to public settings. Counselling centres were in higher quartiles than psychiatry hospitals or psychiatric departments 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 provide mandatory pre/post-test counselling for HIV testing whereas psychiatrists directly sent their clients to VCTC or outside centres without mandatory counselling in their own settings. Some providers were not even aware of the availability of HIV testing facilities or VCTC in their own settings. Utilizing same resources through better organization and improved coordination among providers and departments within the same institute is an option to performance.

HIVRAS of providers were significantly associated with their S12 scores. Doing binary logistic regression with HIVRAS and S12, it was found that those who got higher score (> 10) in HIVRAS were 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.

Multiple logistic regressions found that only setting variety was statistically significant with HIVRAS, TS and S12 (Adjusted OR, 95% CI were 8.04 [1.38 - 46.94], 8.09 [1.42 - 46.10] 6.39 [1.26 - 32.39]), adjusted for training and speciality in psychiatry. While the adjusted OR calculations for different scores indicated NGO's better quality adherence, they lagged behind in 'OPD Provider Hours' (69.3 compared to 380.8 and 145.5 for psychiatry dept and psychiatry hospitals respectively). NGO providers adhered more to HIV counselling, testing or referral services than public setting in respect to standard principles, and getting better average scores. This relatively poor utilization of NGO services has been explained by the NGO HoDs through their poor provider client ratio (2.1 in NGO, 3.0 in public), poor budget and adverse geographical locations. A few NGOs took 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.

## **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%). Findings of the present study found that providers in NGOs counselled in separate room while clients in public settings stood 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 81.3% compared to public being (69.4%). In taking special attention for schizophrenic or bipolar disorder clients NGOs (72.7%, Public 61.1%) had the edge but the difference was insignificant ( $P = 0.63$ ). Item queries like type of substance use, detoxification, harm reduction; needle syringe exchange and enquiring personal histories were better in NGOs (53 - 100%) compared to public settings (25 - 90%). NGO providers also adhered to group counselling, sessions, distributing IEC materials among clients, distributing condoms among clients through confidentiality. They also did research works,

and data analysis. This may be due to their programmatic approaches and better orientation. They submit reports to donors.

Regarding informed consent of a client as a barrier in counselling or testing, there was a dilemma among providers in their perceptions. Validity of consent was not 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. A study argued that 80% of the subjects with schizophrenia and 96% of 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 substarctive 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**

A study in South India indicated 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. Another study in Quebec, Canada showed 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 the present study, providers 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.

## **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 Vs 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. A study showed 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 was higher (14.8) compared to untrained (11.1). NGOs had more percentage of trained personnel, who got higher HIVRAS (15.2) than those who are not trained (11.4). 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.

## **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. In a study, it was showed that mental healthcare agencies requested for adequate training for their providers who are working with people with severe mental illness, training on substance use disorders.<sup>28</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>28</sup> Agencies with high substance use caseloads are distributing more educational materials (74.2%) than those with low substance use caseloads (62.5%).<sup>28</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.

## **Strengths and Limitations**

This study was carried out by a single researcher, who had working experiences in both HIV/AIDS and mental healthcare programmes. Pre-tested instruments were used. The study included 52 providers, 10 HoDs and 13 experts (from among 52 providers). The number of providers and HoDs amounted to 41% of 150 mental healthcare providers in Kolkata, a metro city having huge variations of clients in respect to their culture, economic condition, religion etc. This study can serve as a pilot initiative to facilitate more comprehensive research.

Still, it is necessary to acknowledge that this study was from providers' perspective. There is a scope for reporting bias. Verification from clients, observations or participatory researches could have minimized that problem. The study could not match between supply and demand sides of services. So, it is a limitation against the extrapolation of findings. Private clinics or institutions in Kolkata were not included. Still NGO providers may be accepted as not-for-profit private providers. Most of the private providers were public providers too. So, private variation was not missed much. Statistical analyses for associations might have been affected by small sample. The study did not explore the issues of sexual abuse or coercion from providers/experts.

## **CONCLUSIONS**

Providers did not always adhere 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>29, 30</sup>



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