

# **Sexual Health Program**

## **HIV/AIDS and Mental Illness Project Report** **Training for Health Care Professionals Working in Mental Health Area**

**June – Dec 2001**

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# HIV/AIDS and Mental Illness Training Project

## 1. Background

The current National HIV/AIDS Strategy<sup>1</sup> notes “the increased number of people living with HIV/AIDS who are experiencing problems associated with poor mental health, ranging from AIDS-related dementia to depression induced by the complexities of living with HIV/AIDS.”, and the need to “ensure access to mental health services for people living with HIV/AIDS and experiencing mental health problems”. In addition, some people with mental disorders are particularly vulnerable to HIV infection because they lack the ability to understand risks and/or to control their behaviour.<sup>2</sup>

During the development of the current WA HIV/AIDS Treatment and Care Plan, issues were raised with regard to the treatment and care of people living with HIV/AIDS who have mental health problems. In response to the strategies proposed within the Plan, the Sexual Health Program funded the Western Australian AIDS Council Inc. (WAAC) to assess the needs of people with mental disorders and mental health professionals with regard to HIV/AIDS education and prevention, and treatment and care. One of the components of the analysis examined the extent and appropriateness of health care provider education and training about HIV/AIDS. The findings supported the need for organised training for mental health staff regarding issues pertinent to HIV/AIDS and mental illness.

The need for training in the area of HIV/AIDS and mental illness for health professionals has been identified in other jurisdictions. The Victorian HIV Psychiatry Consortium produced a training package *HIV/AIDS and Mental Illness*. Targeting mental health workers, general HIV nurses and psychosocial disability support workers, several hundreds of health professionals have attended the half-day training session. The package was adapted for this training project with changes to make it relevant to WA.

In early 2001, the Sexual Health Program received funding through the Best Practice Quality Management Program for the project “*HIV/AIDS and Mental Illness: training for health care professionals working in the area of mental health*”. The project commenced in June 2001.

### ***Project Objectives***

The project targeted mental health workers and related health care providers working in metropolitan and rural community mental health teams and psychiatric institutions. The project aimed to assist the target group in gaining

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<sup>1</sup> Commonwealth Department of Health and Aged Care. *Changes and Challenges. National HIV/AIDS Strategy 1999-2000 to 2003-2004*. Commonwealth of Australia 2000.

<sup>2</sup> Health Department of WA 1998. *Mental Health, HIV and AIDS – Policy Statement*.

an increased level of understanding of HIV/AIDS and mental illness issues, such as:

- Epidemiology of HIV infection
- Appreciation of HIV dynamics
- Clinical manifestations of HIV infection
- Drug therapy and associated benefits and risks
- Factors which influence coping with HIV infection
- Factors which may contribute to suicidal ideation in patients with HIV
- Treatment problems in severely mentally ill
- Possible psychiatric and neuro-psychiatric sequelae of HIV infection
- Barriers to prevention
- Community services and support for patients with HIV and their families and carers

It was intended to provide training to 100-120 mental health workers and related health care providers. The project also attempted to raise knowledge and skills and provide training for mental health workers and related health care providers in the assessment of HIV/AIDS risk behaviours in people with mental illness.

## 2. Project Implementation

### 2.1 Workshop

In May 2001 the Director and senior staff from the Communicable Disease Control Branch met with Professor George Lipton, the Director of Mental Health Division, to outline the proposed project. Professor Lipton expressed strong support for the project. The project had conducted seven workshops between July and November with a total of 120 participants (see following table). Five of these were in metropolitan areas and two in rural regions as seen in the following table: -

<b>Date</b>	<b>Location</b>	<b>Presenters</b>	<b>Participant No.</b>	<b>Evaluation Forms Received</b>
10/7/01	Grace Vaughan House Shenton Park	Mr Paul Grech Dr Helena Piirto Dr Chris Heath Mr Tony Cichello Ms Diane McKay	27	23
12/7/01	Department of Health East Perth	Mr Paul Grech Dr Helena Piirto Dr Mina John Mr Tony Cichello Mr Frank Farmer	23	21
12/9/01	Osborne Park Hospital	Mr Ken Wong Dr Helena Piirto Dr Mina John Ms Diane McKay	14	10

<b>Date</b>	<b>Location</b>	<b>Presenters</b>	<b>Participant No</b>	<b>Evaluation Forms Received</b>
22/10/0	Alma St Centre Fremantle	Mr Ken Wong Dr Mina John Ms Trish Langton Mr Graham Brown	19	16
7/11/01	Swan District Hospital	Mr Ken Wong Dr Helena Piirto Dr Mina John Ms Diane McKay	12	11
21/11/01	Bunbury SouthWest Mental Health Service	Mr Ken Wong Dr Caryl Barnes Dr Tiffany Mould Ms Diane McKay	11	9
22/11/01	Geraldton CentralWest Mental Health Service	Mr Ken Wong Dr Tiffany Mould Dr Thubarahalli Raghu Mr Cipri Martinez	14	7
<b>Total:</b>			<b>120</b>	<b>97</b>

Adopting the format originally developed by the Victorian HIV Psychiatry Consortium, the training workshops included presentations from a psychiatrist, immunologist (HIV specialist) and an HIV positive person.

Mr Paul Grech, Coordinator of the Victorian Consortium, was invited to conduct two training workshops with metropolitan mental health workers and to conduct a session with advanced trainee psychiatrists. The workshops were conducted as planned in the metropolitan areas, but training for advanced trainee psychiatrists could not be organised due to scheduling problems.

The project officer had met with a number of key stakeholders to raise issues related to HIV/AIDS and mental illness and to gain their support for the project. Meetings had been held with WA AIDS Council, Silver Chain, HIV Case Management, Professor David Greensberg of Forensic Psychiatric Services, Dr Aaron Groves and Ms Karen Dickenson of Metropolitan Mental Health Service, Dr Helen Slattery of Postgraduate Training in Psychiatry, Ms Michelle Kosky of Health Consumer Council, Dr Mark Rooney of Eastern Regional Mental Health Service, Ms Leanne Sultan of Northern Regional Mental Health Service, and Professor George Lipton and Ms Penny Libscomb of the Mental Health Branch. Almost all had expressed their support for this project, acknowledging that training in this area was timely. However, a small number of people had voiced their concern that there still seemed to be a lack of evidence to support the argument that training in this area was urgently needed.

## Workshop Training Manuals

Two manuals were developed by the Victorian HIV Psychiatry Consortium for the workshop. These included the Basic Education Training Manual which contains background information including HIV epidemiology; clinical aspects of HIV; HIV dynamics; antiretroviral drugs; coping with HIV; HIV and neuropsychiatry; HIV infection and chronic mental illness; barriers to HIV prevention among people with mental illness; medico-legal issues; and support services. The Sexual Health Program had purchased the copyright of these manuals to be used for training purpose in WA.

While most of this information was applicable to WA, to make it relevant to WA service providers, changes were made to sections related to HIV epidemiology, medico-legal information (see *appendix 1*) and support services. These included WA HIV/AIDS data, relevant sections of WA Mental Health Act (1996) and Guardianship and Administration Act (1990), and local support services. Consultation was made with relevant staff and service providers regarding these changes. In particular, staff from Mental Health Division, Legal and Legislative Services and the Office of Public Advocate were consulted in regard to the WA Mental Health Act (1996) and the Guardian and Administrative Act (1990).

Although this process took some time to finalise as it involved different legislation and how it could be applied by staff, the section on medico-legal information was at the end approved by Professor Lipton, Chief Psychiatrist, for the purpose of training for mental health staff. The manual was sent to workshop participants prior to the workshop as targeted staff had varying levels of understanding of issues pertinent to HIV/AIDS and mental illness. This manual served to provide them with background information particularly for those with little or no knowledge in this area.

Another manual used was the Workshop Manual which was a compilation of Power Point presentation slides and case studies, which included Schizophrenia and HIV/AIDS, AIDS Related Dementia, Risk Assessment and HIV/AIDS in Women, and Medical Aspects (a case where a working nurse with co-morbidity of HIV and mental illness). The manual was distributed at the beginning of the workshop.

### **2.2. HIV Risk Assessment Form– Sexual and Drug History**

Some respondents to the needs analysis, conducted before the project, indicated that identification of individuals who practice high-risk behaviours had not been included in their training or there was no formal or standardised way to do this. Staff at Royal Perth Hospital have proposed the production of an HIV/AIDS risk assessment tool to improve assessment of risk behaviours in people with mental illness.

An HIV Risk Assessment form (see *appendix 2*) with screening questions pertinent to sexual and drug-using history was proposed by this project to be used by mental health service providers. Mental Health Service Regional Directors (North, East, South, South-West and Central-West) were contacted for this request and the proposed form was sent for their consideration.

Meanwhile Professor Lipton had expressed support for this discussion with mental health service directors, in determining whether the form should be adopted as a routine screening instrument.

Directors of all regions except South West responded to the Project Officer in regard to this as follows:

- Eastern Regional Director reported that identification of risk taking behaviour was a part of normal history taking, and that the form was a good research tool but was of limited value in clinical practice by staff. It was also advised that there was the reluctance to add another questionnaire as a part of standard practice as routine outcome measures would be introduced soon.
- Central West Regional Manager advised that the matter needed to be discussed among his management staff, and that with staff shortage and changes decision might not be made until 2002 as to whether the form would be adopted as standard policy and procedure.
- Southern Regional Director advised that he had passed the request on to program and service managers for their information and to directly liaise with the Project Officer.
- Northern Regional Director initially advised that the issue would be discussed at their management meeting and that outcome would be reported.
- The Rural Services Coordinators had also been contacted through its Chair, who expressed his concerns about the questions, suggesting that it might be more appropriate if the form was used after rapport had been built with clients. The matter was to be further discussed among rural service providers.

However, there was no further response from these regions and services to the project regarding this matter, though further attempts had been made by the Project Officer to check if further action had been taken.

### **2.3 Postgraduate Training in Psychiatry**

To explore the scope of workforce development for mental health professionals especially those working in psychiatry, discussion was held with Dr Helen Slattery, the Director of Postgraduate Training in Psychiatry, regarding the feasibility of adopting the distant education model developed and delivered by the Victorian HIV Psychiatry Consortium. This model included a distant education manual which contained in-depth materials of the following topic areas: -

- Epidemiology of HIV Infection and Prevention of HIV transmission;
- HIV treatments;
- Central Nervous System Infections and other Neurological Complications;
- Psychiatric Disorders and HIV/AIDS: An Overview;
- Depression and HIV/AIDS;
- Mania and HIV/AIDS;

- HIV Related Cognitive Impairment and HIV Dementia;
- Chronic Mental Illness and HIV/AIDS;
- Medico-legal Issues/Considerations;
- Psychological Issues.

After reviewing the manual Dr Slattery advised that lectures in such specialised areas were programmed in Third Year for Postgraduate Training in Psychiatry. Due to the wide range of areas that needed to be covered, at most one afternoon would be devoted to the subject matter discussed. Dr Slattery advised that the decision was to have a lecture on HIV/AIDS delivered by Dr Helena Piirto in 2002.

#### **4. Workshop Evaluation**

Workshop evaluation was conducted at the end of each workshop, with participants returning evaluation forms (*see appendix 3*) which were distributed at the beginning of the workshop. Altogether ninety-six evaluation forms were returned out of one hundred and twenty participants. Information was gathered in regard to the background of participants, their comments on the education training manual provided to them for background reading, and their comments on the workshop. It should be noted that most evaluation forms were returned with some questions unanswered. As such the total number of responses to each question did not equate the total number of forms received.

#### **Participant Information**

Out of ninety (90) respondents indicated their roles at work, 50 were clinician, 13 were team leader/coordinator, 7 were from case management<sup>3</sup>, 7 were from management, 5 were student/graduate students, and 8 did not indicate specific roles.

Regarding primary employment, ninety three (93) participants responded with the majority of them working in Community Mental Health (42), others were from Inpatient Psychiatry service (17), HIV/AIDS and Related services (16), Psychiatric Emergency/Acute Assessment (7), and "Other" (11).

There were ninety-one (91) responses to the question of Site of Service, with the majority being Metropolitan (76), Rural (13) and Other (statewide) (2).

Ninety four (94) participants indicated their Discipline, with close to half being Psychiatric Nurse (41), and the rest spread among Occupational Therapist (11), Psychologist (13), Social Worker (10), HIV Support Worker (6), Psychiatrist (4), Clergy/Pastoral Worker (4), Allied Health Aide (1) and unspecified (3).

Respondents were also asked the number of patients/clients known to be HIV positive. Out of ninety-three (93) responses, 37 indicated that they had none,

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<sup>3</sup> This refers to the case management of clients with HIV/AIDS and/or mental illness by clinicians, not the Case Management Program which deals with specific HIV/AIDS cases.

28 had HIV positive clients in the past, 21 had current positive clients and 7 had positive clients past and present.

## Training Manual

Respondents were asked to provide feedback, on a scale from 1 to 5 indicating strongly disagree to strongly agree, on the education training manual had they had the opportunity to read it. The following table summarises their responses: -

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree	Total No. of Responses
1. The Training Manual was a useful source of information.	0	0	5	37	34	76
2. The Training Manual helped me to achieve the stated objective.	0	2	5	49	13	69
3. The Training Manual presented the information in a manner that was able to be understood.	0	2	6	36	28	72
4. The Training Manual helped me understand the critical facts about HIV/AIDS.	0	4	1	39	28	72
5. The Training Manual gave me a better understanding of HIV/AIDS and mental illness.	0	3	2	40	27	72
6. The Training Manual will be a useful resource tool in the future	0	1	2	37	32	72

The majority of respondents indicated that the Training Manual helped them have a better understanding of HIV/AIDS and mental illness. They also agreed that it would be a useful tool for future reference.

The respondents were further invited to comment on the Training Manual in terms of the suitability of information included. Although the majority of the respondents did not provide information to these questions, there were some useful suggestions which had been adopted by the project. For instance, WA HIV/AIDS data was included in the Training Manual for participants of workshops conducted after July.

## Workshop

Participants were also asked to provide feedback, on a scale from 1 to 5 indicating strongly disagree to strongly agree, on the workshop conducted. The following table indicates their responses to the statements provided: -

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree	Total No. of Responses
1. The workshop covered issues that were topical.	1	2	4	39	45	91
2. The discussions were informative and a worthwhile use of time.	1	4	8	44	41	98
3. Presenters were knowledgeable and presented	1	4	5	31	50	91

their material clearly.						
4. The workshop will help me to respond more effectively to persons with HIV/AIDS.	1	6	8	43	31	88
	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree	Total No. of Responses
5. The method of presentation was useful.	2	5	7	53	24	91
6. The workshop last the right length of time. a. It needed to be longer 15 b. It needed to be shorter 11	4	18	13	39	15	89
7. I'd recommend attendance at this workshop to other mental health professionals.	1	2	6	33	50	92

It appeared that the vast majority of the participants approved the workshop in terms of the issues covered, presentation format and the knowledge and presentation skills of the presenters. It's also encouraging to see that a high number of participants felt strongly about recommending the workshop to other mental health professionals.

Respondents were finally invited to add further comments in regard to their expectations of the workshop and whether issues should have or not have been covered in the workshop. Most of the respondents did not make any further comments. Of those who did the majority indicated that their expectation of being informed in the area of HIV/AIDS and mental illness had been met, though a few suggested that more "cutting-edge information" should have been included.

## 6. Discussion and Conclusion

This training project primarily aimed to increase the level of knowledge and skills in the area of HIV/AIDS and mental illness for mental health and related professionals. The workshops conducted by and large achieved this as reflected by the evaluation made by participants. The number of staff that participated in training has met the stated objective of the funding agreement. The ongoing discussion with mental health service management, in regard to the planning and delivery of workshops, standardised risk assessment and workforce development for postgraduate psychiatry training, had placed the issues regarding HIV/AIDS and mental illness on the agenda of mental health service providers.

The implementation of the project, however, had witnessed a very challenging time for mental health services across WA with restructures and staff changes. This often resulted in the issues being addressed by this project not seen as a priority by service providers. Staff changes in more than one region made it difficult for the project officer to have continued strategic planning with service providers. Initiatives at times were forced to be abandoned under such circumstances.

To maximise the opportunity for mental health staff to access the training workshop, the project officer liaised closely with local service providers to identify suitable venue, time and date for the workshop. Most service

providers had been supportive and cooperative. However, there were occasions when a lengthy period of time was required to even get an agreed date from the staff liaising with the project officer. The lack of available presenters, immunologist/medical officers and psychiatrists who had HIV/AIDS experiences, added challenges to the whole process. There were times that when the workshop was finally delivered, the target participants originally registered did not attend as they had gone for a regular team meeting instead. This was hugely disappointing for the project considering the time and resources taken to organise the workshop.

While most service providers welcomed the delivery of training workshop for their staff, there was no indication that among them there would be continued workforce development program in the area of dual diagnosis of HIV/AIDS and mental illness and its implications for service providers and clients. The high prevalence<sup>4</sup> of co-morbidity of HIV/AIDS and mental illness needs to be addressed by mental health service providers with responding strategic planning in workforce development. This requires sustained efforts and cooperation from service providers working in both mental health and HIV/AIDS and related services.

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<sup>4</sup> Coghlan R, Lawrence D, Holman CDJ, Jablensky AV (2001). *Duty to Care : Physical illness in people with mental illness*. Perth: The University of Western Australia.

## Appendix 1. Medico-legal Issues

### MENTAL HEALTH ACT (1996)

The Act can only be used when there is a mental illness present. Note whilst the involuntary provisions of the Mental Health Act (Act) can be used to address issues of psychiatric treatment and medical treatment, the Act does not cover financial issues. These can only be dealt with, using the appropriate parts of the Guardianship and Administration Act.

#### SECTION 26

Section 26 of the Act sets out criteria that must be met before a person can be detained in an authorised hospital or be made subject to a Community Treatment Order (CTO).

A person should only be made an involuntary patient if :-

(a) The person has a mental illness requiring treatment;

The Act defines mental illness: “a person has a mental illness if the person suffers from a disturbance of thought, mood, volition, perception, orientation or memory that impairs judgement or behaviour to a significant extent”.

(b) The treatment can be provided through detention in an authorised hospital or through a community treatment order and is necessary in order to-

(i) Protect the health or safety of that person or any other person;

(ii) Protect the person from self-inflicted harm, which includes serious financial harm, lasting or irreparable harm to any important relationship resulting from damage to the reputation of the person among those with whom the person has such relationships and serious damage to the reputation of the person; or

(iii) Prevent that person doing serious damage to property; and

(c) The person has refused or is unable to give consent to treatment, and

(d) The treatment cannot be adequately provided in a way that would involve less restriction of the freedom of choice and movement of the person than would result from the person being an involuntary patient.

• It is important to note that Section 4 (2) of the Act lists the following behaviours, which by themselves are not sufficient when determining if a person is mentally ill -

(a) holds, or refuses to hold, a particular religious, philosophical, or political belief or opinion;

(b) is sexually promiscuous, or has a particular sexual preference;

(c) engages in immoral or indecent conduct;

(d) has an intellectual disability;

(e) takes drugs or alcohol;

(f) demonstrates anti-social behaviour.

• The assessment of whether or not a person has a mental illness requiring treatment and whether or not the other criteria in Section 26 are met will always be made by a psychiatrist.

## Appendix 1. Medico-legal Issues

### *SECTIONS 59 MEDICAL (NON-PSYCHIATRIC) TREATMENT*

- Where an involuntary patient is willing to accept medical treatment, it is important to obtain informed consent from the patient. An involuntary detained patient can consent to medical treatment and then be discharged (in which case they will no longer be an involuntary patient), granted leave but remain an involuntary patient or made subject to a CTO and be referred for medical treatment.
  
- Where an involuntary patient or mentally impaired defendant is unable to give informed consent, *Section 119 (3) of the Guardianship & Administration Act* allows a medical practitioner to provide medical treatment if the patient is incapable of consenting to treatment, if the patient is a person for whom a guardian could be appointed under the Act (whether or not a guardian has been appointed) and if consent is given by the first in order of priority of the following persons:
  - (a) a guardian of the person needing the treatment;
  - (b) the spouse of the person needing the treatment;
  - (c) a person who, on a regular basis, provides or arranges for domestic services and support to the person needing the treatment but does not receive remuneration for doing so;
  - (d) a person who is the nearest relative (*other than the spouse, defined as first in order of priority of child (18 years or over); step child (18 years or over); parent; foster parent; brother or sister; grandparent; uncle or aunt; nephew or niece*) of the person needing the treatment and who maintains a close personal relationship with the person needing the treatment;
  - (e) any other person who maintains a close personal relationship with the person needing treatment; or
  - (f) a person prescribed in the regulations.
  
- Where a patient is refusing treatment for a medical condition, it is imperative to also establish whether there is an underlying mental illness or whether it is a rational choice by someone who is fully aware of all his or her options. However, Section 110 of the Act allows an involuntary patient or a mentally impaired defendant to be given non-psychiatric medical treatment if they are not capable of giving consent (ie lack capacity) and it has been approved by the Chief Psychiatrist or his/her delegate. Such medical treatments generally involve surgery requiring a general anaesthetic. An involuntary patient receiving medical treatment may also be given concurrent psychiatric treatment other than psychiatric treatment referred to in Section 108 (deep sleep therapy; insulin coma or sub-coma therapy; psychosurgery).
  
- Electroconvulsive therapy is not to be performed on an involuntary patient or a mentally impaired defendant who is in an authorised hospital unless it has been recommended by the treating psychiatrist and the recommendation approved by another psychiatrist.

## **Appendix 1. Medico-legal Issues**

### **GUARDIANSHIP & ADMINISTRATION ACT (1990)**

The Act may be used when the person has:

- (a) a mental disability, as defined by this Act, and is unable to make reasonable judgements in respect of matters relating to his or her property and financial affairs; or
- (b) is incapable of looking after his or her own health and safety, unable to make reasonable judgements in respect of matters relating to his or her person, and in need of oversight, care or control in the interests of his or her own health and safety or for the protection of others.

The Guardianship and Administration Board may make an Administration order in (a) and/or a Guardianship order in (b).

- The *Act* defines a “mental disability” as including an intellectual disability, a psychiatric condition, an acquired brain injury and dementia.
- As a result of the disability must lack competence to make reasonable judgements in respect to matters relating to his/her affairs - Section 43 (1) (b) or Section 64(1).
- Must be a current (not speculative) need.
- Must be no less restrictive way of dealing with the issue other than by appointment of a Guardian or Administrator.

#### ***GUARDIAN***

- Decision in areas of health and lifestyle – limited or plenary.
- Disputes between carers and proposed represented person, termination of life decision.
- Sterilisation (joint consent of the Guardianship and Administration Board and guardian appointed).

#### ***ADMINISTRATOR***

- Decision re financial / legal affairs.

#### **LESS RESTRICTIVE ALTERNATIVES**

- Whilst well and competent can appoint your own alternative decision-makers.

Finances – Enduring Power of Attorney (financial).

#### **ENDURING POWER OF ATTORNEY**

Whilst competent, appoint an Attorney to manage your financial affairs, should you not be able to, or subsequently incapable (eg. dementia) of managing your affairs. To validly execute Enduring Power of Attorney you need:

- Enough memory to know what your financial and legal affairs are (know full extent of what you are entrusting to Attorney).
- Understanding that in granting the Power the Attorney, they (the nominated Power of Attorney) can do anything you can do yourself.

## Appendix 1. Medico-legal Issues

- Understanding that the Power endures i.e. if they become incompetent / unacceptable, Attorney can continue to act (not so with general Power of Attorney).
- Understanding that, whilst competent you can revoke it.
- Understanding that the Power does not undergo any audit / financial scrutiny by external agency.
- If Attorney under power is incompetent / corrupt, then can be referred to Guardianship and Administration Board for revocation of the power pursuant to Section 109(1) of the Guardianship & Administration Act on the grounds that no longer in best interests of donor of power for this to continue.

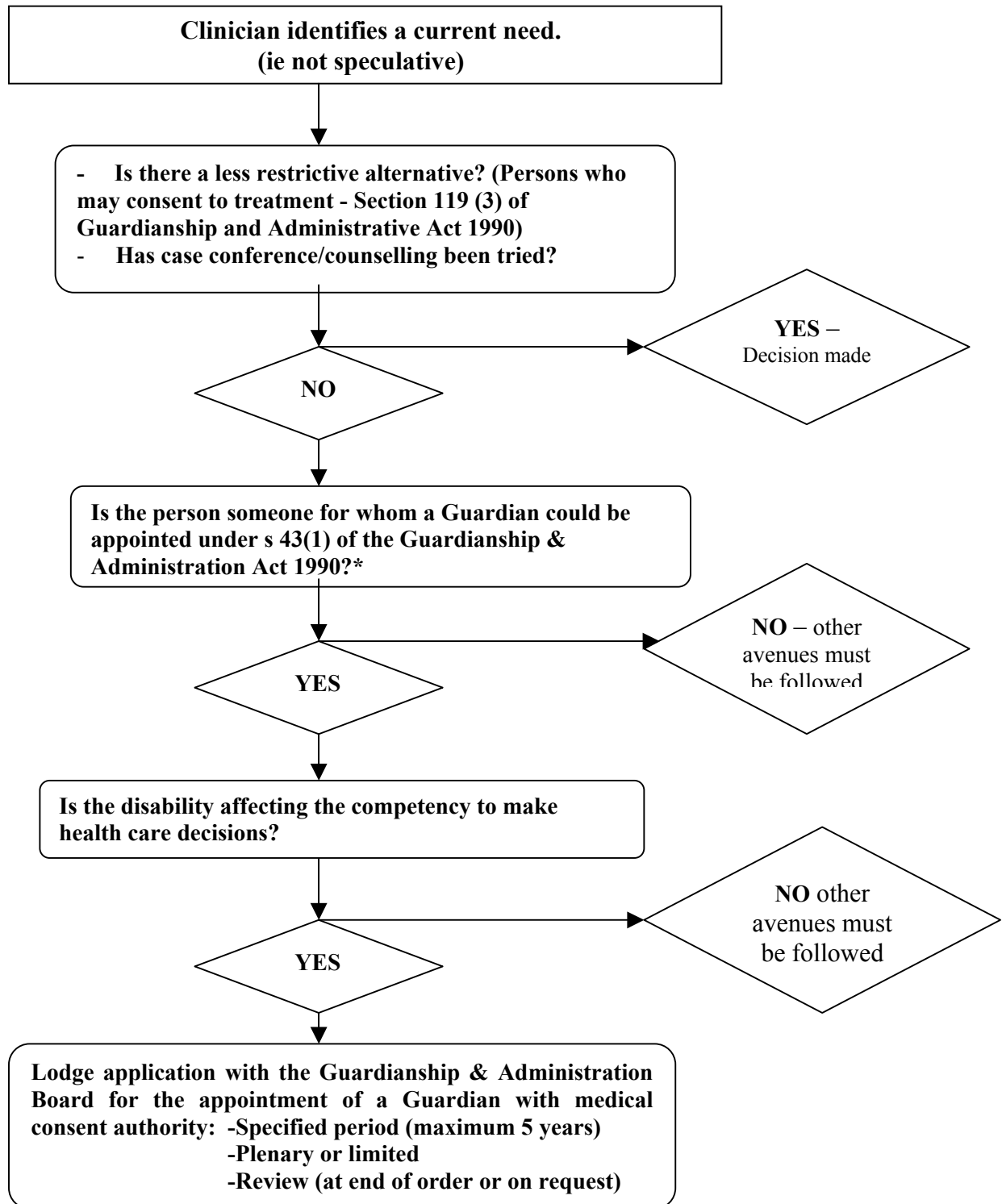
(The following appears in the Workshop Manual.)

- **Mental Health Act (1996) and Guardianship & Administration Act (1990)**  
(Refer to medico-legal section in Basic Education Training Manual)
  - The Mental Health Act sections referring to involuntary treatment can only be used when there is a mental illness present as per Section 26 criteria. Section 109 notes that an involuntary patient, or a mentally impaired defendant, who is in an authorised hospital, may be given psychiatric treatment without his or her consent.
  - The Guardianship and Administrators Act is used when the person has a decision-making disability as defined by the Act. It provides for the appointment of a Guardian for adults who need assistance in their personal affairs and for the appointment of an Administrator of the estates of persons who need assistance in their financial affairs.
  - When an individual is admitted as an involuntary patient as per section 26 criteria of the Mental Health Act – he or she may be given psychiatric treatment without his or her consent except for Electroconvulsive Therapy (unless the therapy is given as emergency psychiatric treatment ss.(104, 113) and Psychosurgery.
  - Where an involuntary patient is not capable of giving consent to treatment, then non psychiatric medical treatment may be given if the Chief Psychiatrist or delegate so approves in writing unless:  
***The Guardianship and Administration Board has appointed a Guardian with medical decision-making authority (section 45 (2)(d) G&A Act).***
  - ECT is not to be performed on an involuntary patient unless the treating psychiatrist has recommended it, and the recommendation is approved by another psychiatrist. ECT may be given as Emergency Psychiatric Treatment if the treatment is necessary to save the person's life or to prevent the person from behaving in a way that can be expected to result in serious physical harm to himself/herself or any other person. Emergency psychiatric treatment may be

given without any consent or approval that would be required if it was not emergency psychiatric treatment.

## Appendix 1. Medico-legal Issues

### SHOULD A GUARDIAN BE APPOINTED?



\* "Is the person incapable of looking after his or her own health and safety, unable to make reasonable judgments in respect of matters relating to his or her person, and in need of oversight, care or control in the interests of his or her own health and safety or for the protection of others."

## Appendix 2. HIV Risk Assessment Form

(Adapted from American Psychiatric Association and Victorian HIV Psychiatry Consortium)

### SEXUAL & DRUG HISTORY /HIV RISK ASSESSMENT<sup>i</sup>

This assessment is best carried out after first developing a level of rapport with your patient. It can be utilised by clinicians to guide them in identifying what factors they need to be aware of in assessing the level of HIV risk (if any) for their patient.

#### Status?

Male \_\_\_\_\_ Female \_\_\_\_\_

Married NO [ ] YES [ ]

Single NO [ ] YES [ ]

In Relationship(s) NO [ ] YES [ ]

#### Use of Alcohol?

Do you drink alcohol NO [ ] YES [ ]

If yes, type and frequency? \_\_\_\_\_

\_\_\_\_\_

Have you used any drugs? NO [ ] YES [ ]

Frequency/type? \_\_\_\_\_

\_\_\_\_\_

Ever used IV drugs? NO [ ] YES [ ]

Type? \_\_\_\_\_

Have you ever shared needles or other equipment? NO [ ] YES [ ]

#### Number of sexual partners?

One partner [ ] How long same? \_\_\_\_\_

More than one [ ] How many? \_\_\_\_\_

Sexually active with others? NO [ ] YES [ ]

Last sexual contact within the last

Last week [ ] last month [ ] last 6 months [ ] last year [ ] 1+ years [ ]

Frequency of sexual contact? \_\_\_\_\_

**Kind of partners?**

Same sex  Other sex  Both  Mostly which? \_\_\_\_\_

**Appendix 2. HIV Risk Assessment Form**

**Risk Prevention?**

Do you practice safe sex? NO  YES

Condom use?

Not relevant  Always  Mostly  Sometimes  Never

Other contraceptives? NO  YES

Specify which. \_\_\_\_\_

**Partner(s) Health?**

Do you know sexual health/history of partner? NO  YES

Any history of bisexual relationships? NO  YES

Any history of IV drug use? NO  YES

Partner ever tested for HIV? NO  YES

**Have you and/or your partners ever been involved in?**

Sex work NO  YES

Sex barter (for accommodation, drugs, cigarettes etc.) NO  YES

Comments-

\_\_\_\_\_

**History of sexually transmitted diseases?** NO  YES

If yes, which? \_\_\_\_\_

**Ever tested for HIV antibodies/AIDS test?** NO  YES

Results \_\_\_\_\_ year tested \_\_\_\_\_

**Concerned about HIV infection?** NO  YES

If yes, why? \_\_\_\_\_

**Knowledge about HIV/AIDS? (Tick all that apply)**

What it is  Transmission  Prevention  Nothing

**HIV education/testing needed:**

Sex Education  Contraception  HIV Testing

**Clinician:** \_\_\_\_\_

### Appendix 3. Evaluation Form

## PARTICIPANT INFORMATION

**Role:**

- |                                                  |                                                       |
|--------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Admin Support           | <input type="checkbox"/> Clergy/Pastoral Worker       |
| <input type="checkbox"/> Case Management         | <input type="checkbox"/> Clerical Officer             |
| <input type="checkbox"/> Clinician               | <input type="checkbox"/> Medical Officer              |
| <input type="checkbox"/> Graduate Student        | <input type="checkbox"/> Medical Receptionist         |
| <input type="checkbox"/> Team Leader/Coordinator | <input type="checkbox"/> Occupational Therapist       |
| <input type="checkbox"/> Management              | <input type="checkbox"/> Psychiatric Nurse            |
| <input type="checkbox"/> Student                 | <input type="checkbox"/> Psychiatric Services Officer |
| <input type="checkbox"/> Other _____             | <input type="checkbox"/> Psychiatrist                 |
|                                                  | <input type="checkbox"/> Psychologist                 |
|                                                  | <input type="checkbox"/> Registrar                    |
|                                                  | <input type="checkbox"/> Social Worker                |
|                                                  | <input type="checkbox"/> State Enrolled Nurse         |
|                                                  | <input type="checkbox"/> HIV Support Worker           |
|                                                  | <input type="checkbox"/> Other _____                  |

**Primary Employment:**

- |                                                                      |  |
|----------------------------------------------------------------------|--|
| <input type="checkbox"/> Psychiatric Emergency /<br>Acute Assessment |  |
| <input type="checkbox"/> Community Mental Health                     |  |
| <input type="checkbox"/> Inpatient Psychiatric Service               |  |
| <input type="checkbox"/> HIV/AIDS & Related<br>Services              |  |
| <input type="checkbox"/> Other _____                                 |  |

Number of Your Patients/  
Clients who are known to be  
HIV+

- |                                     |       |
|-------------------------------------|-------|
| <input type="checkbox"/> None       |       |
| <input type="checkbox"/> Current    | _____ |
| <input type="checkbox"/> Previously | _____ |

**Site of Service or Practice**

- |                                       |       |
|---------------------------------------|-------|
| <input type="checkbox"/> Metropolitan | _____ |
| <input type="checkbox"/> Rural        | _____ |
| <input type="checkbox"/> Other        | _____ |

**Discipline:**

- |                                             |  |
|---------------------------------------------|--|
| <input type="checkbox"/> Allied Health Aide |  |
|---------------------------------------------|--|

## Appendix 3. Evaluation Form

# PARTICIPANT FEEDBACK- TRAINING MANUAL

For each question please circle the number that most closely reflects your opinion  
1 = Strongly Disagree    2 = Disagree    3 = Not Sure    4 = agree    5 = Strongly agree

### Answer the following only if you have read the Training Manual.

- |                                                                                              |   |   |   |   |   |
|----------------------------------------------------------------------------------------------|---|---|---|---|---|
| 1. The Training Manual was a useful source of information.                                   | 1 | 2 | 3 | 4 | 5 |
| 2. The Training Manual helped me to achieve the stated objectives.                           | 1 | 2 | 3 | 4 | 5 |
| 3. The Training Manual presented the information in a manner that was able to be understood. | 1 | 2 | 3 | 4 | 5 |
| 3. The Training Manual helped me understand the critical facts about HIV/AIDS.               | 1 | 2 | 3 | 4 | 5 |
| 4. The Training Manual gave me a better understanding of HIV/AIDS and mental illness.        | 1 | 2 | 3 | 4 | 5 |
| 6. The Training Manual will be a useful resource tool in the future.                         | 1 | 2 | 3 | 4 | 5 |

### **Please write your answers for the following questions.**

1. What, if anything would you change about the Training Manual?
  
  
  
  
  
  
  
  
  
  
2. Please list any important topics that should have been covered in the Training Manual.
  
  
  
  
  
  
  
  
  
  
3. Please list anything that should not have been covered in the Training Manual.
  
  
  
  
  
  
  
  
  
  
4. Any other comments?

## Appendix 3. Evaluation Form

# PARTICIPANT FEEDBACK - WORKSHOP

For each question please circle the number that most closely reflects your opinion  
1 = Strongly Disagree    2 = disagree    3 = Not Sure    4 = agree    5 = Strongly agree

### Answer this section if you have attended the Workshop.

- |                                                                                        |   |                          |   |   |   |
|----------------------------------------------------------------------------------------|---|--------------------------|---|---|---|
| 1. The Workshops covered issues that were topical.                                     | 1 | 2                        | 3 | 4 | 5 |
| 2. The discussions were informative and a worthwhile use of time.                      | 1 | 2                        | 3 | 4 | 5 |
| 3. Presenters were knowledgeable and presented their material clearly.                 | 1 | 2                        | 3 | 4 | 5 |
| 4. The Workshops will help me to respond more effectively to persons with HIV/AIDS.    | 1 | 2                        | 3 | 4 | 5 |
| 5. The method of presentation was useful.                                              | 1 | 2                        | 3 | 4 | 5 |
| 6. The Workshop lasted the right length of time                                        | 1 | 2                        | 3 | 4 | 5 |
| a. It needed to be longer.                                                             |   | <input type="checkbox"/> |   |   |   |
| b. It needed to be shorter.                                                            |   | <input type="checkbox"/> |   |   |   |
| 7. I would recommend attendance at this Workshop to other mental health professionals. | 1 | 2                        | 3 | 4 | 5 |

### **Please write your answers for the following questions.**

1. What were your expectations, if any, prior to attending the Workshop?
  
  
  
  
  
  
  
  
  
  
2. Were your expectations met?  
What would you change? - list any important issues that should have been covered in the Workshop.
  
  
  
  
  
  
  
  
  
  
3. Please list anything that should not have been covered in the Workshop.
  
  
  
  
  
  
  
  
  
  
4. Any other comments?

