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KRA Corporation

Final Report

Review of the CMHS Mental Health Care Provider Education in HIV/AIDS Program

Submitted to:

Martha Ann Carey, Ph.D., R.N.
Government Project Officer
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Contract No. 280-95-0005

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June 14, 1996

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Summary

Summary

This report presents findings from a review of the Center for Mental Health Services' (CMHS) Mental Health Care Provider Education in HIV/AIDS Program from its inception in 1986, then under the auspices of the National Institute of Mental Health, through 1994. The Mental Health Care Provider Education in HIV/AIDS Program supports the provision of state-of-the-art training for 1) traditional mental health care providers (e.g., psychiatrists, psychologists, nurses, social workers); 2) other first line providers of mental health services (e.g., primary care physicians, medical students); and 3) nontraditional providers of such services (e.g., the clergy and other spiritual providers, alternative health care workers). The Program also supports the development and dissemination of curricula and teaching materials for providing training on the mental health aspects of HIV/AIDS, and promotes the establishment of linkages with other AIDS organizations and training programs, including the Health Resources and Services Administration (HRSA) AIDS Education and Training Centers (AETCs). Overall, the goal of the Program is to improve access to appropriate and adequate mental health services for people living with HIV/AIDS and for their families and partners.

The review of the Mental Health Care Provider Education in HIV/AIDS Program examines the activities and outcomes of 27 projects funded by the Program, and provides recommendations for future Program planning with respect to the establishment of research objectives and methods for conducting ongoing evaluation of Program initiatives.

The specific goals of this study were:

- to review the Mental Health Care Provider Education in HIV/AIDS Program
- to identify how project effectiveness could be examined
- to review the Program's effectiveness in meeting its goals
- to recommend directions the Program should take to continue responding to the HIV/AIDS epidemic.

Methods utilized for conducting the review of the Program included consultation with a panel of experts in the field of training and evaluation, discussions with key personnel from projects funded by the Program, review of materials and reports produced by the projects, and review of the research literature on the evaluation oftraining programs and on the mental health aspects of HIV/AIDS.

As a whole, the Mental Health Care Provider Education in HIV/AIDS Program has made many contributions to our Nation's ability to respond to the HIV/AIDS epidemic. Foremost among these is the training of tens of thousands of mental health service providers representing the full spectrum of assistance to persons infected with HIV and their families. Individuals attending training are likely to, have increased their knowledge about the mental health aspects of HIV/AIDS, their

willingness to serve HIV-infected individuals, and their confidence that they can effectively serve this population. Furthermore, the funding that organizations received through this Program has served as a catalyst for systemic changes within teaching institutions and hospitals, for the development of alliances among mental health service providers, as well as for alliances among mental health service providers and other public and private agencies.

The CMHS Mental Health Care Provider Education in HIV/AIDS Program is now at a critical juncture in its history. Findings from this review indicate that there are strong continuing needs for HIV/AIDS training. For example, training needs differ in different parts of the country as the scope and spread of the epidemic changes. Different segments of the mental health care provider continuum have varied needs, including basic introduction to mental health aspects of HIV/AIDS and its transmission and prevention, particularly in areas of recent arrival of the epidemic. In other places, training is needed in very specific and sophisticated aspects of assessment or treatment. Throughout the mental health care provider system, continuous updates of knowledge and treatment modes are needed, as the affected population groups change and as new treatments are developed.

A pressing need at the Program level may be to obtain systematic knowledge about the efficacy of various approaches to training mental health providers. For example, what training practices/techniques are most effective for which kinds of providers, for what kinds of subject matter, in what kinds of contexts? A key to developing this knowledge is research on some longer-term consequences of the training, particularly changes in practice behavior and the resulting changes in satisfaction and quality of life for recipients of services. Further, there may be a continuum of outcomes that are related to different types and intensities of training, from initially calming providers' fears of contagion to modeling detailed strategies for treating neuropsychiatric complications of AIDS.

The first step in planning for the future of the Mental Health Care Provider Education in HIV/AIDS Program is the identification of the key questions and priorities that CMHS wants the Program as a whole to address, and the intended roles of individual projects among these priorities. After key directions are established, a second step is to identify which evaluation and assessment strategies are needed for which questions. Finally, attention must be given to the roles of the individual training projects and of the Federal program office to allow the greatest impact from the resources available for the Program.

Chapter 1

Introduction

Chapter 1

Introduction

Backaround

As the incidence and prevalence of Human Immunodeticiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) continue to climb, mental health care providers can expect to find increasing numbers of individuals with HIV/AIDS among their client populations. These individuals, along with their families and partners, have a broad range of psychosocial needs, and often require assistance in coping with the psychological impact of the disease. Further, research and clinical experience have yielded increasing evidence that HIV infects the brain, resulting in central nervous system impairment and neuropsychiatric complications such as dementia. Formal as well as informal providers of mental health services are also in front-line contact with populations most at risk for HIV/AIDS. Persons from these populations, including injecting drug users and their partners, gay and bisexual men, sex workers, members of racial and ethnic minority groups, the homeless, adolescents, and individuals with serious mental illness, are in need of culturally sensitive and age-appropriate information and assistance to change high-risk behaviors or to maintain low-risk activities.

When the AIDS epidemic first emerged during the 1980's, many health care providers were unwilling to treat individuals with AIDS because of fears about contagion, fears of being ostracized, or negative stereotypes and attitudes they held towards population groups such as gay and bisexual men and injecting drug users. In addition, few providers were sufficiently knowledgeable about the neuropsychiatricand psychosocial complications of AIDS to be confident that they could provide appropriate treatment and counseling to infected individuals. These issues created a tremendous need for professional education and training to address providers' lack of basic knowledge of the disease as well as their emotional responses and fears. In some communities, and among some provider groups, these needs still exist today. Further, as HIV spreads to new populations and new information emerges about the nature of the disease, its treatment, and associated mental health issues, providers are continually in need of updated and specialized types of training.

The CMHS Mental Health Care Provider Education in HIV/AIDS Program

The Center for Mental Health Services (CMHS), a component of the Substance Abuse and Mental Health Services Administration (SAMHSA), is the Federal agency responsible for providing national leadership in improving the country's mental health services delivery system. As part of its mission, the agency works to increase the availability and accessibility of comprehensive mental health services for people living with, or at risk for, mental disorders, including individuals with HIV/AIDS.

Within CMHS, the Mental Health Care Provider Education in HIV/AIDS Program supports the development of model educational approaches for training mental health care providers to address the psychological and neuropsychiatric aspects of HIV/AIDS. This Program was first established in 1986 under the auspices of the National Institute of Mental Health (NIMH). It existed at various

times as a contractual and as a grant program, and was moved to CMHS when the agency was established by Congress in 1992. Currently, the Program supports 12 grants and has contracts with 4 professional associations. [1]

The overall goal of the Mental Health Care Provider Education in HIV/AIDS Program is to improve access to appropriate and adequate mental health services for people living with HIV/AIDS and for their families and partners. Towards this end, the Program supports the provision of state-of-the-art training for 1) traditional mental health care providers (e.g., psychiatrists, psychologists, nurses, social workers); 2) other first-line providers of mental health services (e.g., primary care physicians, medical students); and 3) nontraditional providers of such services (e.g., the clergy and other spiritual providers, alternative health care workers). The Program also supports the development and dissemination of curricula and teaching materials for providing training on the mental health aspects of HIV/AIDS, and promotes the establishment of linkages with other AIDS organizations and training programs, including the Health Resources and Services Administration (HRSA) AIDS Education and Training. Centers (AETCs).

The Program Review

In 1995, CMHS contracted with KRA Corporation (KRA) to conduct a review of the Mental Health Care Provider Education in HIV/AIDS Program from its inception in 1986 through 1994. During those years, 28 different organizations received funding to develop and implement training projects.* A list of these organizations, along with a depiction of the years during which each project was funded, is presented in Exhibit 1.

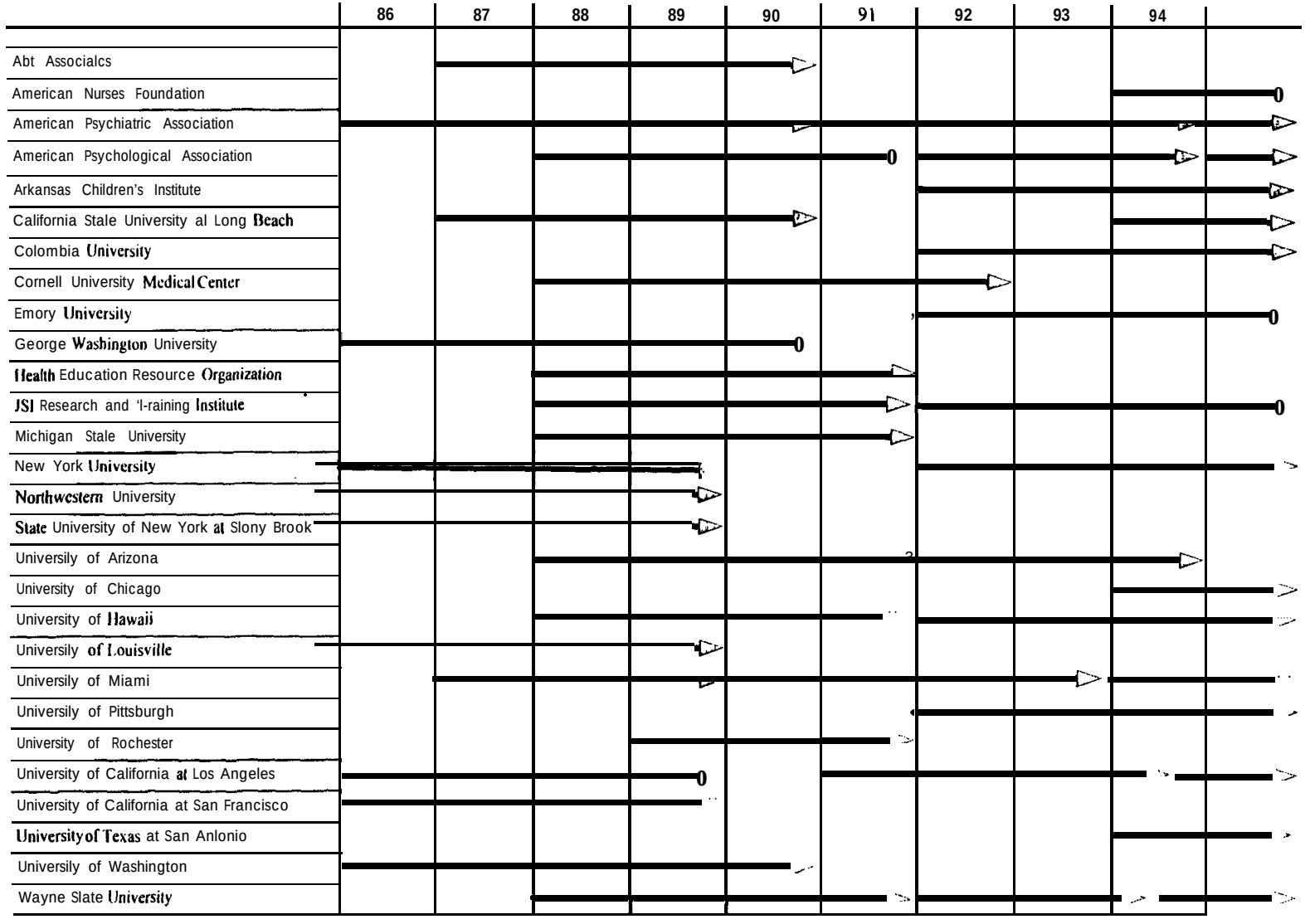
The specific objectives of KRA's contract were the following:

- to review the Mental Health Care Provider Education in HIV/AIDS Program
- to identify how project effectiveness could be examined
- to review the Program's effectiveness in meeting its goals
- to recommend directions the Program should take to continue responding to the HIV/AIDS epidemic

[1] Professional associations with contracts include the American Nurses Foundation, American Psychiatric Association, American Psychological Association, and National Association of Social Workers.

[2] Throughout this report, we refer to the Mental Health Care Provider Education in HIV/AIDS Program as "the Program." Grants and contracts funded by the Program are referred to as "projects." Some organizations were awarded grants and/or contracts during several different funding cycles. For purposes of this study, however, we considered instances where an individual organization received funding over multiple funding cycles as one project.

Exhibit I: Organizations Funded to Implement HIV/AIDS Training Projects (FY 86 - FY 94)*



*Arrows indicate different funding cycles

As part of KRA's review, the activities of funded projects were examined with two purposes in mind: 1) to document what was accomplished and what was learned from the nearly 10 years of funded projects, and 2) to recommend ways to apply lessons learned from the history of the Program to guide future planning for CMHS. In particular, issues raised for future planning included the identification of areas where targeted program initiatives may be developed to address unresolved questions identified by the current study, and practices CMHS can implement to provide for ongoing evaluation of the Program at the Federal and local levels.

A number of factors posed challenges to conducting this type of review. Although individual projects shared the overall Program goals described earlier, they adopted multiple and varied approaches to achieving them-projects responded to needs present within their own communities in determining training approaches, provider groups targeted for training, and the contexts in which training was provided. Also, though most of the projects conducted some sort of evaluation of their effectiveness, their primary focus was on training delivery, and therefore few resources were devoted to examining outcomes. extending beyond individual training events. A lack of uniform data on projects funded during the years covered by the study was particularly problematic. In some cases, written records from projects not currently receiving funding were no longer available, having been disposed of or archived. Additionally, projects did not collect or report data to NIMH or CMHS in a uniform fashion. Thus, aggregation of information across projects (such as data on the total number of providers trained) was not feasible in this review.

Given these issues, a variety of strategies was utilized in conducting the review in order to maximize our ability to interpret data that were collected. These strategies included:

- **Consultation with a panel of experts.** A panel of 11 experts was convened to provide input on the focus and design of the review. The panel consisted of individuals with expertise in the areas of HIV/AIDS training and program evaluation, and an individual representing the HIV/AIDS community. A list of panel members and their affiliations is presented in Appendix A.

- **Telephone discussions with key personnel from funded projects.** Efforts were made to contact individuals within all 28 of the organizations funded to implement training projects during the years 1986 to 1994. Key personnel included project directors/principal investigators,[3] project managers, and project evaluators. The topics covered during telephone discussions included projects' development and implementation, target populations, training approaches, training content, and evaluation methods and findings. A copy of the topic guide used in conducting these discussions is included in Appendix B.

- **Review of written documentation of project activities.** Whenever possible, we sought to obtain (either from CMHS or from project directors) written materials documenting activities of the funded projects. These materials typically included

[3] In general, projects that were funded as contracts had project directors, while those funded as grants had principal investigators. Since some organizations were funded at different times as grants or as contracts, we use the term project director in order to maintain consistency throughout the report.

grant applications, projects' quarterly and final reports, evaluation reports, and data collection instruments.

- **Review of relevant research literature.** Recent publications were reviewed on topics including the mental health needs of individuals with HIV/AIDS, continuing education and training for health care providers, the evaluation of training programs for health care providers, and the evaluation of HIV/AIDS specific training programs.

A list of the source and type of information that was available from each project is presented in Exhibit 2. Overall, we were successful in obtaining information, through written documentation and/or telephone discussions, from 27 of the 28 projects targeted for inclusion in this review.

The remainder of this report presents our findings and recommendations from the review of the CMHS Mental Health Care Provider Education in HIV/AIDS Program. Chapter 2 discusses the implementation and activities of funded projects. In Chapter 3, methods and findings from project evaluation efforts are reviewed. Finally, in Chapter 4, we discuss the extent to which the overall Program is meeting its goals, and we present issues for CMHS to consider in future Program planning to ensure that the Program is able to continue to respond to the mental health needs presented by the HIV/AIDS epidemic.

* * * *

Exhibit 2: Data Available for Projects Funded (FY 86 - FY 94)

	Funded Organization	No Information Available	Written Material Only	Telephone Discussion Only	Written Material and Telephone Discussion
1	Abt Associates			x	
2	American Nurses Foundation				x
3	American Psychiatric Association				x
4	American Psychological Association				x
5	Arkansas Children's Institute				x
6	California State University at Long Beach			x	
7	Columbia University .				x
8	Cornell University Medical Center			x	
9	Emory University				x
10	George Washineton University			x	
11	Health Education Resource Organization			x	
12	JSI Research and Training Institute				x
13	Michigan State University				x
14	New York Universitv				x
15	Northwestern University				
16	State Universitv of New York at Stonv Brook			x	
17	University of Arizona		x		
18	University of Chicago				x
19	University of Hawaii		x		
20	University of Louisville			x	
21	University of Miami				x
22	University of Pittsburgh		x		
23	University of Rochester				x
24	University of California at Los Angeles				x
25	University of California at San Francisco			x	
26	University of Texas at San Antonio				x
27	University of Washington				x
28	Wayne State University				x
		14 %	3 (11%)	8 (29%)	16 (57%)

*Project staff no longer at the university

Chapter 2

Review of Project Implementation and Activities

Chapter 2

Review of Project Implementation and Activities

This chapter summarizes information gathered about the implementation and activities of the 27 projects from which data were collected in this review of the Mental Health Care Provider Education. in HIV/AIDS Program. The discussion is organized around the following topic areas:

- Organizational settings of funded projects
- Geographic target areas for training
- Target populations for training
- Strategies for recruiting trainees
- Needs assessment strategies
- Training approaches
- Training content
- Curriculum development and dissemination
- Interagency collaboration
- Facilitators and barriers to project implementation and operation

Brief descriptive information on each of the 27 projects is presented in Appendix C.

Organizational Settings of Funded Projects

Projects were located in a variety. of organizational settings, most commonly within university departments (e.g., departments of public health, departments of social work) or medical schools. Other projects were housed in hospitals, medical centers, research organizations or professional organizations. One project was housed within a community-based training organization.

Geographic Target Areas for Training

Funded projects were located in communities with high incidence of HIV/AIDS (e.g., New York City, Los Angeles, San Francisco), as well as in communities where the disease was still relatively rare (e.g., Hawaii, Arkansas). Some projects targeted their whole state or several states for training, while other projects focused training efforts primarily within their organization or local community. The professional organizations (e.g., American Psychological Association) generally considered

their target areas to be nationwide. Exhibit 3 displays the areas of the country targeted by at least one training project during the years included in this study.

Target Populations far Training

As required by NIMH/CMHS, all projects included both traditional and non-traditional providers of mental health services in their target populations for training. Exhibit 4 lists the various types of providers targeted for training by one or more of the projects reviewed.

Traditional mental health care providers and other first line providers of services. Projects generally followed NIMWCMHS guidelines in terms of targeting traditional providers of mental health services, including psychologists, psychiatrists, social workers, and nurses. Most projects, particularly those housed within medical schools and hospitals, also provided training to students (e.g., medical or nursing students) and other individuals likely to be first-line providers of mental health services (e.g., interns, psychiatric residents).

Non-traditionakproviders of mental health services. Many of the projects reviewed provided training to all levels of hospital staff, especially those staff who came in direct contact with individuals with HIV/AIDS (e.g., nursing aides). Similarly, training events conducted within inpatient mental health facilities often were provided to the entire staff. Most projects also identified the clergy as one of their target groups. As the nature of the HIV/AIDS epidemic changed and moved beyond the gay male and intravenous drug-using population, projects found it necessary to increase their efforts to target non-traditional providers, such as school counselors and other groups working specifically with women, children, and minority populations.

Strategies for Recruiting Trainees

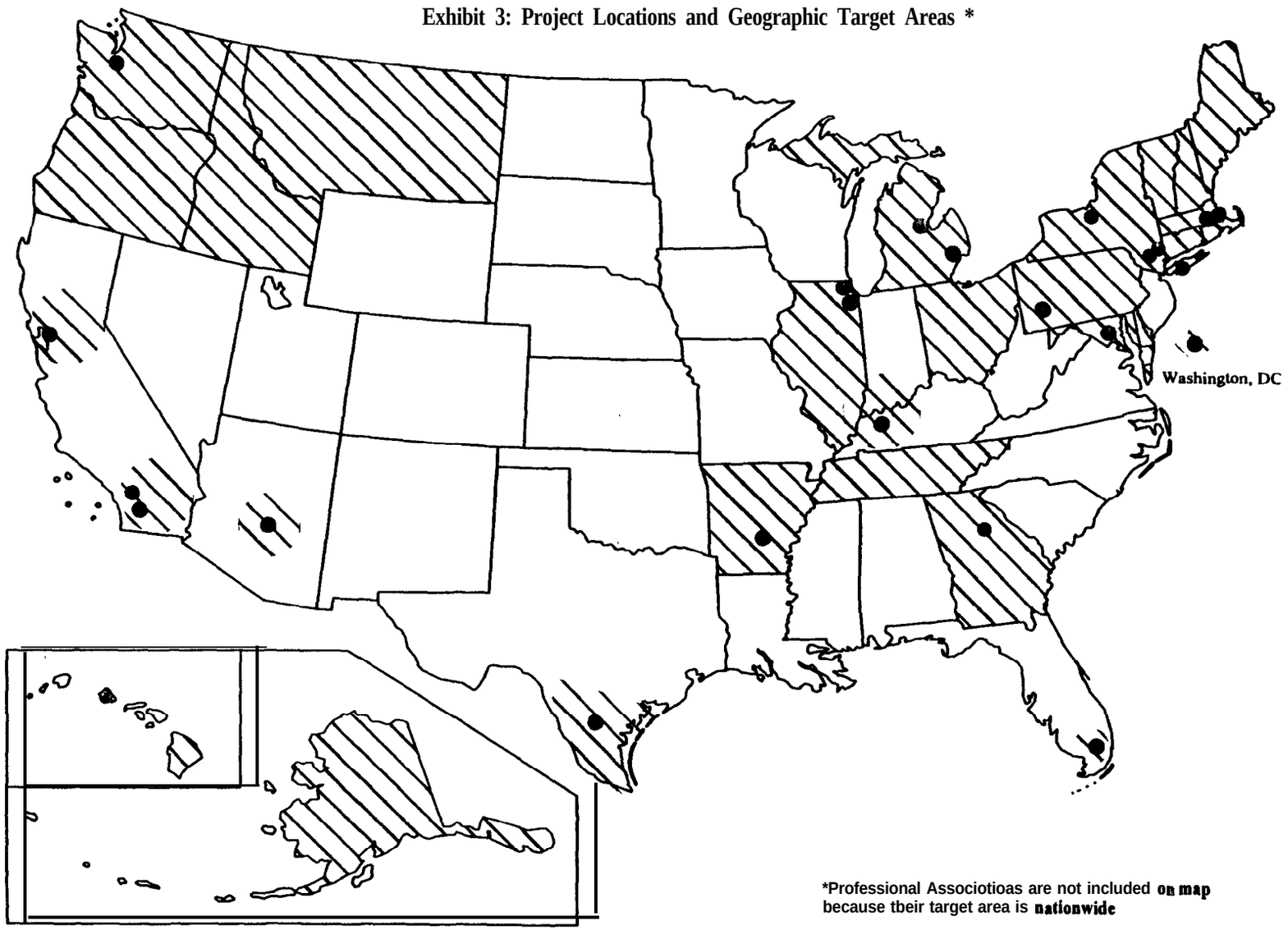
The most common strategy adopted by projects to recruit trainees was the use of mailings (brochures, calendars of events, flyers) to community-based organizations (CBOs), hospitals, and professional and pastoral associations. Most projects also advertised in newsletters, newspapers and journals. Professional associations recruited through local affiliates and by advertising in their bulletins. Some projects established liaisons with AIDS organizations and obtained membership in local HIV/AIDS consortia to facilitate recruitment efforts. Several projects also offered continuing education units (CEUs) and continuing medical education (CME) credits as a means of recruiting trainees. Projects affiliated with medical centers and schools offered their trainings to medical students and residents as part of their coursework or rotations.

Needs Assessment Strategies

Needs assessment activities were cited by project directors as being crucial to developing appropriate training interventions for the communities they served. In general, needs assessment strategies were found to focus on two purposes: determining the target population for training and determining training content.

Determining the target population for training. Projects differed in their approaches to determining their target population. While some projects did not conduct formal needs assessments

Exhibit 3: Project Locations and Geographic Target Areas *



*Professional Associotioas are not included on map because tbeir target area is nationwide

Exhibit 4: Provider Groups Trained

Traditional Mental Health Care Providers	Other First-Line Providers of Mental Health Services	Non-Traditional Providers of Mental Health Services
• Psychologists • Psychiatrists • Social workers • Nurses • Case managers • Family therapists	• Physicians • Dentists • Psychiatric residents • Residents (general) • Physician assistants • Psychology students • Medical students • Dental students • Social work students • Public health students • Nursing students • Health aides • Nursing aides	• Pastoral/clergy • Teachers • Women's foundations • Female service providers • Para-professionals • Homemakers • Hospital administrators • Firefighters • Chemical abuse and rehabilitation counselors • HIV counselors • Mental health counselors • Practicing caregivers • Respiratory therapists • Healers • Bartenders • Counselors (general) • Therapy aides • Hematologists • Lab technicians • Phlebotomists • Secretaries • Patient advocates • Health care educators • Supervisory personnel (hospitals, treatment facilities, etc.)

(either because they felt that NIMI-KMHS specified exactly whom they were to target, or they felt that all provider groups in their community were in need of training), other projects developed instruments and feedback forms to conduct needs assessments. These were typically distributed to different agencies within-the projects' target areas. Projects also consulted with advisory boards, committees, or CBOs to determine provider groups in need of training. Overall, projects emphasized their focus on staying responsive to changes in the types of providers being affected by the HIV/AIDS epidemic in their communities.

Determining training content. Most of the projects conducted some type of needs assessment to develop training topics and content. Strategies included asking agencies where training would be conducted to specify topics of interest, and consultation with steering committees and advisory boards representing a cross section of the target population and community agencies. Participants in training events were frequently asked to indicate areas in which they would like or need additional training.

Training Approaches

Overall, projects employed three general approaches to the provision of training: direct training of providers, training-of-trainers, and provision of clinical experience and training. Within individual projects, it was typical to find that more than one of these approaches was utilized, and that different approaches were used with different populations of trainees.

Direct training of providers. Virtually all of the projects used the direct training format. The direct trainings most often took the form of lectures; group discussions, presentations by panels of persons with AIDS (PWAs), case study analysis, and audio/visuals. Length of direct trainings provided ranged from 1 hour to 5 days. Most projects had very flexible curricula with modules that could be taught independently of other modules. This allowed the projects to tailor the content and length of trainings to the knowledge and skill level of their trainees, as well as their schedules. The focus of the direct training included making trainees feel more comfortable talking to clients with HIV/AIDS, disseminating state-of-the-art knowledge, skills building, fostering positive attitudes towards clients with HIV/AIDS, and identifying and reducing fears about the disease.

Training-of-trainers. Almost half the projects reviewed utilized a training-of-trainers strategy for some of their work. The overall focus of this approach was to train individuals who would later provide training to others. In doing so, the projects also focused on teaching new skills and knowledge, and on helping trainees to develop appropriate attitudes and beliefs. Training-of-trainer formats most often took the form of discussions, particularly with PWAs, lectures, case study analysis and audio/visuals. A few projects also used role playing and anecdotal stories. The length of training-of-trainer sessions was generally from 1 to 3 days. One of the professional organizations had a staff member available to provide technical assistance to trainees from its training-of-trainers program when they returned to their communities to develop their own training programs.

Provision of clinical experience and training. For projects providing clinical experience and training, the focus was on giving trainees information and experience to prepare them to work with HIV/AIDS clients without feeling uncomfortable or fearing exposure to the disease. Some projects used clinical experience with medical students and interns (grand rounds and rotations for residents),

and focused on integrating this aspect of training into the medical and graduate school curricula. Additionally, projects provided onsite advanced training to psychiatrists, mental health professionals, and staff members of mental health organizations.

Training Content

Training content varied widely both within and across projects. Projects typically adjusted the content of training for different training events and provider groups. Across the board, however, topics covered by the projects tended to fall into six general categories. These were:

- "HIV/AIDS 101" (e.g., modes of transmission)
- Psychosocial aspects of HIV/AIDS (e.g., dealing with death and dying)
- Neuropsychiatric aspects of HIV/AIDS (e.g., AIDS-related dementia)
- Specific skill development (e.g., how to take a sexual history)
- Legal and ethical issues related to HIV/AIDS (e.g., confidentiality issues)
- HIV/AIDS among specific populations (e.g., the seriously mentally ill)

A comprehensive listing of training topics covered by one or more of the projects is presented in Exhibit 5.

Curriculum Development and Dissemination

In addition to directly providing training and clinical experience, projects also developed and disseminated training curricula and other teaching materials. The professional associations, specifically the American Psychological Association and the American Psychiatric Association, both developed curricula that were widely disseminated to other projects. These curricula were composed of teaching "modules" that could be adapted for different training events. Several projects also developed videotapes that could be utilized to foster discussion during training sessions. Approximately one-third of the projects reviewed indicated that they attempted to disseminate products they had developed (including training manuals, curricula, and videotapes). Recipients of these products included State and local agencies, foreign countries, Federal agencies and projects funded by those agencies (e.g., HRSA AETCs), universities, and medical schools.

interagency Collaboration

The projects developed a wide variety of collaborative relationships which they regarded both as major extensions of their resources and as valued outcomes in and of themselves. Collaborative activities included both formal collaborations (e.g., collaborations involving written agreements or transfer of funds), as well as informal ones.

Exhibit 5: Topic Areas Covered by HIV/AIDS Training Projects

"HIV/AIDS 101"	Psychosocial Issues	Skill Building
• Modes of transmission • Course of illness • Epidemiology of HIV/AIDS • Incidence/prevalence of HIV/AIDS • Protecting self and others • Other prevention issues	• Death and dying • Anxiety and depression • Family issues; dealing with friends/partners • Counseling patients with HIV/AIDS • Substance abuse and HIV/AIDS • Crisis intervention • Case management • Psychosocial assessment • Stress reduction • Models for counseling • Avoiding burnout • Empowering HIV+ patients • Psychosocial aspects of clinical care • Spirituality issues • Cultural issues, including cultural sensitivity towards: Homosexuals, Women, African-Americans, Hispanics, mentally ill • Talking about sex and sexuality • Women's issues • Adjusting to different cultures and populations • Sexism • Homophobia • Psychological stages of HIV/AIDS • Behavioral problems • Introducing alternative lifestyles	• Diagnostic skills • Diagnostic and clinical therapeutic guidelines • Teaching medical students how to take a sexual history • Dealing with mentally ill, HIV/AIDS infected patients • Doing patient and self needs-assessments • Teaching safe sex • Referrals to community based resources • Health habits, and infection prevention • Pre- and post-testing and counseling • Dual and triple diagnoses • Early intervention • How to run a focus group • How to talk about sex • Development of a drop-in-group • Impact of cultural institutions on attitudes toward HIV/AIDS • Prevention of HIV/AIDS among substance abusers • How to train others
Legal/Ethical Issues	**Neuropsychiatric Issues**	**Other Specific Topics**
• Reporting HIV/AIDS • Partner notification • Corporate policies toward HIV/AIDS infected employees • Confidentiality issues • Ethical issues involved with HIV/AIDS • Medical insurance • Suicide • Homelessness	• Brain disorders resulting from HIV/AIDS • Management of dementia and delirium • Introduction of psychotropic drugs • Psychiatric manifestations • Central nervous system • Pathogenesis	• Adolescents and AIDS • Human aspects of HIV/AIDS • Children and HIV • Infants and HIV • Women and reproductive health • School based prevention • HIV and the developmentally disabled • Changes in sexuality as a result of aging

Formal collaborations. The majority of projects established formal collaborations with at least one other agency or organization, including HRSA-funded AETCs, universities, medical schools and hospitals, state and local health departments, Ryan White Projects, local AIDS clinics, national research centers, and institutes and seminaries. Services provided by formal collaborators included access to trainers and trainees, access and linkages to the community, curriculum development, evaluation, recruitment, access to databases, space, and refreshments. Services that projects provided to their collaborators included educational oversight, evaluation, funding, training, information and materials, transportation, aftercare planning and services, and supervision of interns.

Informal collaborations. Informal collaborating agencies included local substance abuse organizations, community-based organizations, health organizations, hospitals, hospital associations, health departments, universities and colleges, HRSA-funded AETCs, and research centers. The informal collaborating agencies provided the following services: networking, mailings, advice, trainees, linkages to the community, recruitment, referrals, trainers, and connections to PWAs. The projects typically provided training and consultants to the informal collaborating agencies.

Facilitators and Barriers to Project Implementation and Operation

Overall, project directors did not cite major problems in getting their projects implemented, nor in ongoing operations. Most projects felt that support for the training efforts from key people facilitated project. implementation and operation. These key people ranged from Program administrators at the Federal level, to health departments and departments of infectious diseases at the State level, and community agencies, university administrators, and CBOs at the local level.

One barrier identified by several projects was the fact that some agencies, schools, or organizations within their community were resistant to training because of taboos against discussing issues such as homosexuality and intravenous drug use. This was particularly problematic in some of the rural communities. Recruitment of physicians to participate in the trainings was also a common problem cited by projects. One project in particular had a difficult time recruiting psychiatrists who were not currently treating AIDS patients. The projects developed various strategies to deal with recruiting physicians and psychiatrists. One project used psychiatrists to do outreach to other psychiatrists. Another project experimented with different days of the week for training and found that the Thursday-Friday combination worked well. Another project spent a considerable amount of time marketing specifically to physicians.

Recruitment of qualified trainers was another problem cited by several projects. This issue was addressed by networking with steering committees, advisory panels, and other community representatives. Other projects cited the lack of good evaluation tools and lack of sufficient time and funding to conduct formal evaluation as a barrier. Networking with other training projects proved helpful in obtaining evaluation materials, and projects generally opted to do short-term rather than long-term outcome evaluations in order to conserve funds.

* * * *

Chapter 3

Review of Project Evaluation Efforts and Findings

Chapter 3

Review of Project Evaluation Efforts and Findings

All of the projects we reviewed conducted some form of evaluation to assess their effectiveness. By and large, evaluation efforts focused on examining participant satisfaction with training, and on short-term outcomes for training participants (i.e., outcomes that could be measured immediately following a training intervention). A few projects attempted to assess longer term outcomes for participants by conducting followup assessments at periods ranging from 1 month to 1 year following a training intervention.

Because the projects viewed their role as being one of training delivery (as opposed to knowledge production), evaluation efforts primarily served the purpose of providing continuous monitoring of project efforts. For example, analysis of demographic data and numbers of training participants were used to determine whether certain types of individuals or provider groups were not being reached. Similarly, participant satisfaction data were utilized to assess the perceived usefulness and relevance of training provided, as well as the appropriateness of different aspects of training interventions (e.g., content, approach, length, training setting, training materials). Results could then be used to plan and modify future training events. Frequently, participants were also asked to indicate whether they had any unmet training needs or areas in which they desired additional training. This not only provided projects with information about the adequacy of their current efforts, but also allowed them to keep abreast of emerging needs within the community or among different provider groups.

Overall, very little was evaluated in terms of changes in providers' practice or impacts on the recipients of services following training provided by the projects. Examining these types of impacts is both expensive and time consuming, and would likely require more controlled studies than those performed by the projects we reviewed. Projects' resource commitments to evaluation were typically small, whether assessed as the portion of project budget allocated to evaluation, or as the percentage of an evaluator's time committed to the project. However, most project directors viewed assessment of their projects' long-range impacts on provider behavior and recipients of services to be important, and indicated a desire to do so if sufficient funds were available.

Short-term Outcomes for Training Participants

The types of outcomes assessed for participants immediately following training interventions generally reflected projects' overall goals (i.e., to increase trainees' knowledge, comfort, or skills in dealing with HIV/AIDS). The most common method for assessing these outcomes was via pre- and post-tests comprised of self-report scales or inventories developed by the projects. Following are the areas in which a majority of projects reported outcomes for training participants. It should be noted, however, that a more extensive review and analysis Would be required in **order to verify** the validity of the findings reported.

- **Knowledge/understanding of HIV/AIDS.** Knowledge gains for participants were reported in terms of increases in general knowledge of HIV/AIDS, the psychological sequelae of HIV/AIDS, biopsychosocial aspects of HIV/AIDS, legal/ethical issues, and prevention strategies. Some projects also included "familiarity" as a knowledge indicator (e.g., familiarity with the mental health referral system for persons with HIV/AIDS; familiarity with resources in the community).

  Most projects developed their own inventories (true/false, multiple choice) for assessing knowledge gains. Specific questions could be modified depending on the content of the training provided. One project indicated that an instrument available through the American Red Cross was particularly useful in assessing changes in basic HIV/AIDS knowledge among peer educators and counselors.

- **Attitudes toward persons at risk for or with HIV/AIDS.** Projects reported changes in attitudes or beliefs including reduced anxiety about HIV/AIDS; decreased homophobia; increased acceptance of homosexuals, injecting drug users and HIV-positive individuals; increased respect for HIV-positive individuals; and increased empathy.

  An inventory for assessing trainee attitudes-the Orthogonal Scales of AIDS Attitudes for Use with Health-Care and Social Service Providers-was developed by staff from the project at California State University at Long Beach. This inventory was later utilized by a number of other training projects as well. It is comprised of six subscales of Likert scale-ratings. The subscales are designed to assess fear of contagion, compassion towards persons at risk for or with HIV/AIDS, acceptance of homosexuality, acceptance of injecting drug users, willingness to provide care to persons at risk for or with HIV/AIDS, and respect for confidentiality.

- **Comfort or willingness to care for individuals at risk for or with HIV/AIDS.** Most project evaluations also included questions specifically related to this issue, and reported increases both in trainees' comfortableness and willingness to treat clients with HIV/AIDS.

Immediate outcomes of training interventions which were assessed less frequently (but which are perhaps more closely linked to eventual changes in behavior or practice) included the following:

- **Behavioral intent.** Trainees from some projects reported that as a result of the training they would use more AIDS-specific diagnostic procedures, attempt to raise awareness about HIV/AIDS among their co-workers and patients, and see more HIV-positive clients in their practices.

- **Perceived skill competencies.** Some projects asked trainees to provide self-ratings of how comfortable and how confident they felt engaging in certain practices emphasized during training. Trainees reported increases in skills such as taking a

sexual history and communicating with patients, and referring patients to other treatment sources.

- **Actual skill competencies.** A few projects (primarily as part of clinical training) made use of techniques such as videotaping trainees practicing clinical skills and obtaining ratings on trainees from professors and staff supervisors to document increases in certain skills as the result of training.

Long-term Outcomes for Training Participants

Few data were available to document long-term outcomes for trainees, although several projects were in the process of conducting followup studies at the time this review was performed. Two general outcomes being assessed included the retention of gains or changes documented immediately following training, and changes in practice behavior. Measures of changes in practice behavior included both increases in numbers of persons at risk for or with HIV/AIDS counseled or cared for by trainees, and the application of knowledge and skills obtained during training. Although these outcomes were primarily being assessed via self-report, a few projects also indicated that they were attempting to obtain reports from supervisors in trainees' workplaces regarding whether knowledge and skills were being utilized.

Anecdotal Findings About Project Effectiveness

Many project directors relied on anecdotal- or non-quantifiable outcomes as evidence for the effectiveness of their projects. Some of these indicators included trainees referring other providers to the project for training, calls received by the project requesting case consultation, hospital patients reporting receiving better care from hospital staff after they had been trained, and supervisors at inpatient facilities reporting increased condom usage among patients following staff training.

A consistent finding in this review of the Program was that projects were likely to have substantial impacts beyond the outcomes assessed for individual trainees (these impacts are sometimes referred to as secondary outcomes), yet such impacts were not systematically evaluated. They frequently included:

- Systemic changes within the funded organization and at the community level (e.g., increases in communication and collaboration)

- Development of policies related to HIV/AIDS within the funded organization or in workplaces where training was provided (e.g., confidentiality policies, policies regarding treatment of individuals with HIV/AIDS)

- Leveraging of additional funding for training mental health care providers in HIV/AIDS (e.g., grants from States, counties, or private organizations)

- Contributions by project staff to the research literature on mental health aspects of HIV/AIDS and its treatment and prevention.

As part of this review, a bibliography was compiled of contributions to the research literature made by project staff as a result of the funding received under the Mental Health Care Provider Education in HIV/AIDS Program. The bibliography is presented in Appendix D.

Barriers Encountered in Conducting Project Evaluations

As previously mentioned, many of the project directors indicated that they lacked sufficient funds to conduct more extensive evaluation of the their projects. In addition, several other issues were cited as barriers to conducting evaluations or to interpreting evaluation findings. These included:

- Availability of adequate instrumentation
- Identification and availability of an evaluator with substantial knowledge in the area of HIV/AIDS
- Time constraints on having participants complete evaluation forms, particularly after brief training events, or when training events were co-sponsored by another organization
- Difficulty getting trainees to mail back followup assessments
- "Non-findings" on indicators of behavior change attributable to insufficient time elapsed between training and followup assessment, or to the presence of institutional barriers preventing trainees from implementing changes in their places of work
- "Non-findings" on indicators of knowledge or attitude change attributable to self-selection biases and ceiling effects (e.g., having participants in training who were already knowledgeable and already willing to work with individuals with HIV/AIDS)

Discussion

The review of project evaluation efforts revealed that projects were successful in using evaluation as a tool to inform their training delivery, and to revise their programs to address emerging needs. Overall, however, the evaluations conducted by projects were too limited in scope and methods to provide extensive findings about project outcomes or impacts. While some projects explored potentially useful measurement instruments or strategies, most project directors indicated that sufficient resources were not available to conduct more comprehensive evaluations. A few projects also endeavored to use the various assessment tools to compare the effectiveness of different modes of training (e.g., half-day vs. full-day). However, these types of judgments were more often made based on informal feedback from project staff or trainees.

In order to document the long-term outcomes of training, including changes in provider behavior and impacts on clients receiving services, it will be necessary to invest more time and resources in project evaluation. Examination of the types of barriers to evaluation cited by projects also reveals

that they would likely benefit from the availability of technical assistance, as well as the opportunity to network among each other around the issue of evaluation.

* * * *

Chapter 4

Conclusions and Recommendations

Chapter 4

Conclusions and Recommendations

Is the Program Meeting Its Goals?

The CMHS Mental Health Care Provider Education in HIV/AIDS Program has made many contributions to the Nation's ability to respond to the HIV/AIDS epidemic. Foremost among these is the training of tens of thousands of mental health service providers representing the full spectrum of assistance to persons infected with HIV and their families. Training participants are likely to have increased their knowledge about the mental health aspects of HIV/AIDS, their willingness to serve HIV-infected individuals, and their confidence that they can effectively serve this population. The Program served as the catalyst for systemic changes within health care and teaching institutions, and for developing alliances among mental health service providers and among these providers and other community organizations. Finally, the Program has contributed to the development and dissemination of techniques, as well as curricula and other training materials, for training mental health service providers about HIV/AIDS.

While there are strong beliefs among project staff (as well as some limited empirical evidence) that the Program has effectively trained a full range of mental health care providers, the very nature of the HIV/AIDS epidemic creates a need for ongoing and continually updated modes of training. These training needs can be attributed to:

- Changes in the populations infected with and affected by HIV/AIDS
- Different provider groups having first-line access to these new populations
- Emerging information about the disease itself
- Significant changes expected in the mental health care delivery system (e.g., the shift to managed care)
- Behavioral issues related to compliance with new treatment protocols (e.g., protease inhibitors)

Further, much more definitive evidence is needed concerning the behavioral changes in trainees that can be expected from different types of training, and when the trainees return to practice in various settings. We also have little documentation regarding a number of potential Program impacts of substantial interest, including the following:

- Utilization of disseminated materials and curricula
- Increases in client access to services
- Increases in client satisfaction with services provided by trainees

Examining these impacts poses challenges to the individual projects and CMHS as well, While a majority of projects indicated that they would welcome additional resources for the purpose of examining the longer-term impacts of training interventions, some of these impacts are not easily quantifiable. Additionally, CMHS must address the issue of whether the collection of uniform data across projects (even in the form of project outputs, such as number of providers trained), is desirable. These issues are raised in the final sections of this report as questions for CMHS to consider in future Program planning.

Future Directions

The CMHS Mental Health Care Provider Education in HIV/AIDS Program is now at a critical juncture in its history. Needs assessments and feedback from project trainees and project partners indicate there are strong continuing needs for HIV/AIDS training, per se, in addition to research/evaluation needs. These needs have been described in previous chapters, in relation to the multiple factors involved in the HIV/AIDS epidemic. For example, training needs differ in different parts of the country as the scope and spread of the epidemic changes. Different segments of the mental health care provider continuum have varied needs, including basic introduction to mental health aspects of HIV/AIDS and its transmission and prevention, particularly in areas of recent arrival of the epidemic. In other places, training is needed in very specific and sophisticated aspects of assessment or treatment. Throughout the mental health care provider system, continuous updates of knowledge and treatment modes are needed, as the affected population groups change and as new treatments come "on line."

A pressing need at the Program level may be to obtain systematic knowledge about the efficacy of various approaches to training mental health providers. For example, what training practices/techniques are most effective for which kinds of providers, for what kinds of subject matter, in what kinds of contexts? A key to developing this knowledge is research on some longer term consequences of the training, particularly changes in practice behavior and the resulting changes in satisfaction and quality of life for recipients of services. Further, there may be a continuum of outcomes that are related to different types and intensities of training, from initially calming providers' fears of contagion to modeling detailed strategies for treating neuropsychiatric complications of AIDS.

The first step in planning for the future is the identification of the key questions and priorities that CMHS wants the Program as a whole to address, and the intended roles of individual projects among these priorities. After key directions are established, a second step is to identify which evaluation and assessment strategies are needed for which questions. Finally, attention must be given to the roles of the individual training projects and of the Federal program office to allow the greatest impact from the resources available for the Program.

Establishing Program Objectives

There are a number of considerations to be taken into account by CMHS in identifying and prioritizing the objectives for the Program, and specifying the appropriate roles for research and evaluation in relation to the objectives. This discussion identifies some dimensions of the underlying

issues and the advantages and disadvantages of several alternatives, without making firm recommendations for specific courses of CMHS action. Following are some major prioritizing questions.

> *Should the Program have as its major thrust: a) knowledge generation about the effectiveness and long-term impacts of different types of training; b) the development of new trainingprocedures and materials: or c) the dissemination and application into a large-scale training community of new knowledge and techniques concerning mental health aspects of the HIV/AIDS epidemic itself?*

These diverse emphases are not mutually exclusive for either the Federal Program or individual projects, but they do carry different implications for activities to be funded and priorities between research and training delivery. A knowledge generation emphasis about training implies that a much larger proportion of funding and staff activity than at present would be placed on research and evaluation. These resources would be needed to develop, test and share the measuring tools needed to assess the diverse potential outcomes of training; to develop appropriate data collection designs (usually comparative) to evaluate the effectiveness 'of training; and to carry out the actual data collection and analyses needed to address the effectiveness issues identified in the design stage. Many of the project directors of current and past projects expressed interest in conducting such studies, but did not have funding for this purpose.

Perhaps the major emphasis of current projects is on the second thrust: developing training methods and procedures that are appropriate for diverse circumstances and types of providers. Decisions about "appropriateness" are based primarily on the immediate feedback from participants and the judgments of the training staff, who often have extensive experience with AIDS patients and the HIV epidemic. Their experiential wisdom and descriptive information about their developmental work in training is often shared among a growing network of training providers in conferences, through personal consultations, by exchanging training materials, and via publications. Many project directors expressed strong support for the continuation and expansion of this work, as the HIV epidemic spreads.

A third thrust of the CMHS Program could be the dissemination of new knowledge and intervention strategies about HIV/AIDS itself, rather than about methods of training. Many of the current projects are already doing this informally, because their staff members and training consultants are among those who are "on the front line" in developing and applying the treatment strategies. CMHS might want to make this emphasis more systematic, perhaps by adapting some aspects of the Agency for Health Care Policy and Research (AHCPR) procedures for clinical guideline development and dissemination. This might involve, for example, periodic review and consensus panels among those developing and testing treatment strategies to identify effective new interventions that should be disseminated to other providers via the network of CMHS-funded training centers.

A mix of these three strategies might be most appropriate for the future of the Program. Using a dissemination strategy, some funding could be allocated toward identifying and gaining consensus about the needed mental health treatment strategies for HIV/AIDS. The current and future network of training centers would be responsible for disseminating these recommended interventions, as well as meeting other training needs in their geographic regions, and documenting their activities via a

standard set of data elements. Some projects could be provided with additional resources, perhaps via a separate funding mechanism, to undertake more fundamental evaluation and followup of elements of the training itself, and to generate increased knowledge about the processes and effectiveness of training.

What questions about the Program and the individual projects does CMHS wish to answer from evaluation efforts?

This planning issue has implications for the types of evaluative data that individual projects might collect and that are needed nationally for describing the Program as a whole. For example, detailed followup and comparative studies may be needed via project-level evaluation to examine the persistence of changes in knowledge and attitudes among providers who attend training, the changes in practice behavior associated with diverse types of training, or any changes in quality of life for persons with HIV/AIDS that flow from their providers' experiences in training. However, less detailed project-level data collection would be needed to address accountability questions such as how many "trainings" were provided each year (e.g., defined as a person attending a training event, to avoid the data aggregation problem from the same person attending multiple training events during a year). In essence, CMHS would need to assess, for each of a number of potential questions about training, whether the answers are needed from all projects, perhaps only from a cluster of projects doing similar types of training, or from only one project doing intensive evaluative research on that issue.

What resources can CMHS invest to collect information on the longer-term outcomes of these projects?

Trade-offs among the varied Program emphases and types of data collection involve resource allocations, of course. It is frequently expensive to conduct impact evaluations of the effectiveness of complex change strategies, such as training. In particular, little evaluative information is now available on the longer-term outcomes of training; such studies require substantial resources. They may need resources that are equal to or greater than the cost of the training itself, for planning, data collection from recipients (and from relevant comparisons), and analyses for the evaluation. For this reason, such evaluation should be devoted only to key questions of central importance, when answers are needed to make sure that training resources are being spent on effective activities. To assure the wisest use of resources, full impact evaluation efforts should be linked with other knowledge coming from diverse sources, such as the evaluation work of other agencies conducting training and basic research literature on the assumptions underlying that type of training (e.g., the uncertain links between changing attitudes and changing behaviors).

Are there emerging issues and/or developments in knowledge about HIV/AIDS that need to be addressed nationally?

This consideration underlies a potential Program emphasis on the dissemination of new knowledge or training approaches via the network of funded training centers. Such issues could include new knowledge about the mental health aspects of HIV/AIDS, new knowledge about effective adult education techniques, changes in the health care delivery system (such as the shift to managed care), or other similar issues arising nationally that may require local training adaptations. The project staff

are frequently on the front line of identifying these emerging issues. With the advice of experts in the field, CMHS would need to delineate the specific emerging issues and new knowledge to be addressed via this strategy.

What are CMHS' research and training roles with respect to the roles of other agencies?

Future CMHS priority setting depends on having a clear division of responsibilities among Federal agencies concerned with HIV/AIDS, and between the Federal and State levels. As the key Federal agency working to foster mental health systems change, the CMHS mission in regards to HIV/AIDS provides leadership for training in its mental health aspects, as distinct from HRSA's focus on physical health care for AIDS clients. Although States and local agencies might be expected to supply some resources for the actual training for their staff members, it would be inefficient to have each State independently doing knowledge synthesis and consensus building only for itself. Similarly, the research toward new knowledge about the effectiveness of training and the developmental work to create new training strategies and techniques ought to be Federally funded, with results shared among all the States. Thus, even in an era of resource limitations, CMHS' roles with respect to HIV/AIDS training seem to be a fundamental part of its mission.

What responsibilities does CMHS have to develop performance indicators for this Program under the Government Performance and Results Act (GPRA)?

Data collection and evaluation plans for the Program ought to be designed so they are supportive of CMHS' overall responses to the GPRA requirements. As these plans and responses are still being formulated within CMHS, it is not feasible for us to comment on these linkages. However, it is critically important that both types of planning-for the HIV/AIDS training program and for GPRA—be done with full awareness of the Program priorities and data collection requirements being planned within the other stream of activities. For example, if "knowledge generation" about training effectiveness is selected as a key priority of the HIV/AIDS training program, then the production of knowledge outcomes (e.g., publications, research reviews and syntheses, etc.) could become a key outcome indicator, rather than the extent of training provided.

Selecting Research Strategies

After the major Program and project priorities are established, the next set of concerns is the selection of the Program/project research and evaluation activities that will best address the specific questions within each priority. Following are some issues to be considered.

What research/evaluation planning activities should take place if a knowledge generation focus is chosen?

For this emphasis, additional planning will be needed, first, to summarize what is already known with what degrees of rigor (in the area of training for adult professional development); then, to prioritize future research issues and the designation of how individual project emphases will be selected. Should the research issue be nominated as a part of an investigator-initiated grant proposal and award process or should research issues be selected *apriori*, with funding allocated among key

research questions? Further, if more than one project is examining the same issue, joint development of key data collection instruments and procedures will be needed to assure comparability of results across projects. A Federal-level evaluator or technical assistance provider may be needed to assist in the implementation of the evaluation and/or the analysis of the results.

If a knowledge generation focus is desired, CMHS will need to decide whether all projects have to participate in addressing the same research question, or whether separate projects could address different issues. If a mix of Program emphases is selected, should all projects participate in some way in a knowledge generation focus? Or can sufficient knowledge be generated by a subset of the projects, perhaps competing for a pool of funds separate from what is allocated to training development or knowledge dissemination?

What research/evaluation activities should take place if a training development focus is chosen?

Even with this focus, a systematic set of data elements should be collected from each project to provide accountability at the Federal level for funding decisions and responsiveness to national concerns about Program activities. Efforts in this direction have recently been expanded by CMHS, and should continue to be developed. For example, standard definitions may need to be available for some terms in the national reporting format, to be certain that all projects are using them with the same meaning. (For example, what is meant by "clinical teaching" vs. "case studies"; what is the distinction between a "conference/symposium" and a "workshop"; are "cultural factors" a different content area from "minority issues"?) After collection, the Federal data should be quickly summarized, with the summary report made available to multiple stakeholders, especially the projects themselves, to provide feedback and added motivation for continued high quality local data collection.

Other issues that will need to be resolved include whether there should be expanded funding for individual project evaluation; whether funding should be provided for additional opportunities for local project evaluators to interact, and to share methods, instruments and findings; and whether a Federal technical assistance/facilitation contract would be helpful to assist local evaluation and evaluators.

What research/evaluation activities should take place if a focus on the dissemination of new knowledge is chosen?

As indicated above, this emphasis would require a process for identifying what new issues or knowledge-based findings are available and need to be disseminated, perhaps using a consensus development mechanism. Staff or contractor support is likely to be needed to translate a panel's discussion and consensus into well formatted and appropriately worded materials for use in training. Some decisions would be needed about the extent of evaluation to be encouraged or required from each training project, in its dissemination of the Federally produced guidelines. With this emphasis, it may be desirable to conduct a multi-site evaluation, including all projects engaged in disseminating a specific set of findings, to assess the effectiveness of the training at the local level. Or national technical assistance may be needed to assist the implementation of intended dissemination, its local evaluation and analysis of the results.

How can CMHS use the research/evaluation efforts of the various participants to keep the projects responsive to changes in knowledge about the mental health aspects of HIV/AIDS, developments in treatment, and about changes in the populations they are trying to serve?

Articulating this issue reminds us that the use of research and evaluation findings is not automatic, but requires a continuing effort from both Federal and local program managers. With careful planning, as recommended here, attention to new developments in this field could be built into the Program as a part of its knowledge synthesis. Support is likely to be needed for regular local needs assessments and to demonstrate that project changes are made in response to national guidelines and consensus developments. CMHS may need to fund needs assessments as part of local project activities, particularly if local developments and priorities are different from those identified nationally. As evaluations are conducted and/or new types of training are developed locally, it is essential for projects to have opportunities to interact and/or technical assistance to assure quality and comparability of results. Quick feedback of results is a key to continued and thoughtful application of the findings.

Roles of the Program and the Projects

Finally, the breadth of the research and training issues involved and the limited resources likely to be available to the Program make it critical that careful consideration be given to the most appropriate roles of both the Federal Program and the individual projects. Both are needed to assure the highest possible yield from research and evaluation activities. Therefore, decisions will need to be made on the following issues:

Is a Federal evaluation of the CMHS Mental Health Care Provider Education in HIV/AIDS Program, conducted by a single research contractor, a desirable option at this time?

As this Program review has documented, the overall Program addresses a wide variety of provider needs with a vast array of training program strategies, topic contents, and intended outcomes. One Federal "impact" evaluation, employing a common research design and the same set of measures across all sites, would not seem feasible without major modifications in local project activities to fit within the evaluation protocol. We do not believe that such an evaluation would be a desirable expenditure of resources for the knowledge gained from it. Instead, we would recommend selecting more well specified evaluative questions from among the array of issues identified here, using the strategies discussed above.

However, we do strongly support the value of the Federal descriptive data set now being developed by CMHS to collect and summarize certain standard data elements across all projects. Continued work on these efforts should help to provide the basic descriptive data about projects that is needed nationally, and to document changes in Federal Program efforts over time. Such monitoring data are also likely to provide the data needed for some key performance measures for GPRA. In addition, continued periodic meetings of project directors and staff are useful for sharing information and new training strategies.

What should the roles of the projects be in relation to research and evaluation?

These roles are highly interdependent with the Program priorities selected by CMHS, for the relative emphases among knowledge generation about the effectiveness of training, developing training methods and procedures, and the dissemination of new knowledge and HIV/AIDS intervention strategies via training of providers. With different priorities, the roles of local projects might differ, ranging from being relatively independent in their design of project activities and evaluation to requiring modified local project designs to contribute to national research priorities. Local involvement in expanded evaluation activities might retain all control of evaluation and data collection design at the project level, versus rather passive participation in a contractor-designed Federal evaluation, versus collaboration with other similar projects in designing and executing a multi-site evaluation. Whatever priorities are chosen Federally, we urge the continued strong contribution of the expertise that has been developed within the local projects, for this expertise is critically important to designing feasible and effective new Program efforts.

What should the roles of the CMHS Program be?

This analysis of potential future directions has emphasized the pivotal roles for the Federal Program staff in providing guidance concerning Federal priorities. After priorities are articulated, decisions concerning resource allocation among different purposes and players will strongly influence the feasibility of carrying out those priorities. For example, the Program could continue to let local projects determine the directions of most activities within broad guidelines, or could specify some project intervention and evaluation designs, based on overall research objectives identified with the assistance of the relevant stakeholders. The feasibility of implementing diverse priorities may depend on whether CMHS provides funding earmarked for evaluation, provides a Federal evaluation coordinator/technical assistance contractor, provides additional funding to projects for needs assessments, and/or facilitates interaction among projects about evaluation issues via electronic networking and face-to-face workshops.

While local projects are likely to resist too-rigid Federal direction that restricts what they can do, they are willing and anxious to participate in collaborative research efforts that will expand the extent of knowledge about training for all those involved. Their common goal is to contribute to the ultimate usefulness of provider training toward more responsive mental health services to those affected by the HIV/AIDS epidemic.

* * * *

Appendix A

Expert Panel Members

Expert Panel Members

John R. Anderson, Ph.D.
Director, Office on AIDS
American Psychological Association

John A. Bonnage, Ph.D.
Consultant, HIV/AIDS Education and Training of Psychiatrists
American Psychiatric Association

Pam Reid Duffy, R.N., Ph.D.
Director, AIDS Education Project
University of Arizona

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Associate Professor, Behavioral Medicine Unit
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James P. Halloran, Jr., R.N., M.S.N.
Project Manager, HIV/AIDS Education and Training for Psychiatric/Mental Health Nurses
American Nurses Foundation

Vivian H. Jackson, ACS
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National Association of Social Workers

Jurgis Karuza, Ph.D.
Buffalo Geriatric Education Center

John A. McLaughlin, Ed.D.
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Julia H. Rose, Ph.D.
Geriatric CARE Center
Fairhill Institute for the Elderly

Paul R. Sathrum
Project Coordinator, HIV/Comprehensive School Health
National Education Association

Mary Ann Scheirer, Ph.D.
Independent Consultant

Appendix B

Topic Guide for Telephone Discussions with Project Staff

Topic Guide for Telephone Discussions with Project Staff

Part I: Project Implementation and Activities

A. Background Information

- During what years was the project funded?
- Names of current and/or former Project Directors
- In what type of organization was the project housed?
- Prior organizational experience in HIV/AIDS professional education and training
  Probe: dates and funding sources (e.g., HRSA)
- Was any additional HIV/AIDS-related funding received during or after the NIMH/CMHS project was implemented?
  Probe: dates andfunding sources
- What needs were the organization responding to in applying for funding from NIMH/CMHS to implement the HIV/AIDS training project?
- Geographic target area for project
  Probe: Did the target area change over time?
- Training settings
  Probe: urban, inner city, suburban, rural
- Project objectives
  Probe: Didproject objectives change over time?

B. Collaborative Activities

- Did the project establish any *formal* collaborative relationships with other organizations/agencies/projects providing professional education or services in the field of HIV/AIDS'?
  Probe: names of organizations/agencies/projects
  Probe: services provided to the project by the collaborator
  Probe: services project provided to the collaborator

- Did the project establish any ***informal*** collaborative relationships with other organizations/agencies/projects providing professional education or services in the field of HIV/AIDS?
  Probe: names of organizations/agencies/projects
  Probe: services provided to the project by the collaborator
  Probe: services project provided to the collaborator

C. Project Implementation

- Were any problems encountered during implementation of the project?
  Probe: types of problems; severity and persistence of problems
  Probe: strategies used to overcome problems; how successful were these strategies
  Probe: factors that helped to get the project up and running

D. Project Operation

- Were there any problems in continued operation of the project?
  Probe: types of problems; severity and persistence of problems
  Probe: strategies used to overcome problems; how successful were these strategies

- (If applicable) Was the project able to continue operation after the NIMH/CMHS funding ended?

E. Target Population for Professional Education

- What was the target population for the training provided by the project?
  Probe: discipline, organizational affiliation, student/residency status, practice environment
  Probe: methods used for deciding on the appropriate target population
  Probe: involvement of members of the target population in the development of the training and/or the development of curriculum/methods

Methods used to recruit participants for training

How successful was the project in recruiting the numbers and types of participants targeted for training?

What personal demographics were collected from training participants?

- Were records kept of the number of trainees that attended each training event?
  Probe: Were methods utilizedfor tracking individual participation in more than one training event?

F. Instructional Methods and Formats

- What types of training approaches were employed?
  Probe: direct training ofproviders; training-of-trainers; clinical experience

- Description of training provided
  Probe: length of training (in hours or days); focus or purpose of training; topic areas covered; instructional methods utilized
  Probe: background of instructors who provided training

G. Development and Dissemination of Materials and Curricula

- What types of materials were developed by the project for use in training events?

- Were these materials disseminated outside of the project?
  Probe: target audience(s) for products disseminated
  Probe: methods utilizedfor dissemination
  Probe: effectiveness of dissemination methods
  Probe: Is there any evidence that products were utilized by recipients outside of the project?

- Did the project make use of materials or curricula developed by other training projects funded by the Mental Health Care Provider Education in HIV/AIDS Program?

Part II: Evaluation Methods and Findings

A. Data Collection

- Did the project collect pre and/or post information from training participants?
  Probe: what was measured and when (participant satisfaction; knowledge; attitudes; beliefs; skills)
  Probe: data collection methodology and instrumentation
  Probe: use of control or comparison groups

- How often were results of data summarized and/or reported?

- How was the information that was collected utilized by the project?

B. Outcomes for Participants in Training

- What differences in participants could be attributed to the training provided by the project?

  Did the project assess how participants applied knowledge and skills gained through the training?

  Probe: use ofparticipant action plans

C. Organizational Changes Attributable to the Project (Academic Institutions)

- What changes occurred within the university as a result of, or in connection to, the project?

  Probe: creation of courses, residencies, internship rotations, clinical preceptorships, programs of study; collaboration between university departments: development of university-wide policies and procedures related to HIV/AIDS

  Probe: permanency of changes

D. Organizational Changes Attributable to the Project (Non-Academic Organizations)

- What changes occurred within the organization as a result of, or in connection to, the project?

  Probe: development of affiliations between organizations; improved inter-organizational communication; improved inter-divisional communication; development of task-forces or committees; creation of HIV/AIDS facilities/clinics; development of new policies and procedures; development of new umbrella organizations within the community

  Probe: permanency of changes

E. Other Project Impacts

- Were there any other changes in the service delivery area as a result of the project?

- Were there any changes in the way mental health services are delivered to HIV/AIDS clients in the service delivery area as a result of the project?

Part III: Conclusion

- If the project were to be implemented again, would anything be done differently?
- Are there any issues for future Program planning that CMHS should be aware of?

Appendix C

Summary Information on Funded Projects

Summary Information on Funded Projects

Funded Organization: Abt Associates Inc.
Cambridge, Massachusetts
Contact Person: Vincent Scardino
Geographic Target Area: Boston metropolitan area
Training Approaches: Direct Training

Funded Organization: **American Nurses** Foundation
Washington, D.C.
Contact Person: **Sarah** Stanley, R.N.
Geographic Target Area: Nationwide
Training Approaches: Direct Training, Training-of-Trainers

Funded Organization: **American** Psychiatric Association
Washington, D.C.
Contact Person: Carol Svoboda, M.S.W.
Geographic Target Area: Nationwide
Training Approaches: Direct Training, Training-of-Trainers,
Clinical Experience (medical students)

Funded Organization: **American** Psychological Association
Washington, D.C.
Contact Person: John Anderson, Ph.D.
Geographic Target Area: **12 mid-sized cities nationwide (1988 - 199 1);**
Nationwide (1992 - Present)
Training Approaches: **Direct Training, Training-of-Trainers**

Funded Organization: **Arkansas Children's Institute**
Little Rock, Arkansas
Contact Person: **John Arruffo, M.D.**
Geographic Target Area: **Arkansas**
Training Approaches: **Direct Training**

Funded Organization:	California State University at Long Beach Los Angeles, California
Contact Person:	Fen Rhodes, Ph.D.
Geographic Target Area:	Los Angeles metropolitan area
Training Approaches:	Direct Training

Funded Organization:	Columbia University New York, New York
Contact Person:	Francine Cournos, M.D.
Geographic Target Area:	New York City and Statewide
Training Approaches:	Direct Training, Training-of-Trainers, Clinical Experience (medical students)

Funded Organization:	Cornell University Medical Center New York, New York
Contact Person:	Milton Viederman, M.D.
Geographic Target Area:	Cornell University Medical School and State of New York
Training Approaches:	Direct Training (medical students), Training-of-Trainers

Funded Organization:	Emory University Atlanta, Georgia
Contact Person:	J. Stephen McDaniel, M.D.
Geographic Target Area:	Atlanta and Statewide
Training Approaches:	Direct Training, Clinical Experience (medical students and residents)

Funded Organization:	George Washington University Washington, D.C.
Contact Person:	Jeffrey Akman, M.D.
Geographic Target Area:	Washington D.C., northern Virginia, southern Maryland
Training Approaches:	Direct Training, Training-of-Trainers, Clinical Experience

Funded Organization:	Health Education Resource Organization (HERO) Baltimore, Maryland
Contact Person:	Andrea Wilson
Geographic Target Area:	State of Maryland
Training Approaches:	Direct Training

Funded Organization:	JSI Research and Training Institute Boston, Massachusetts
Contact Person:	Steve Wroblewski
Geographic Target Area:	State of Massachusetts and New England
Training Approaches:	Direct Training, Train-of-Trainers

Funded Organization:	Michigan State University East Lansing, Michigan
Contact Person:	Terry Stein, Ph.D.
Geographic Target Area:	State of Michigan
Training Approaches:	Direct Training

Funded Organization:	New York University New York, New York
Contact Person:	Erline P. McGriff, Ed.D., R.N., F.A.A.N.
Geographic Target Area:	New York City, suburban Connecticut and New Jersey
Training Approaches:	Direct Training, Clinical Experience (medical students)

Funded Organization:	State University of New York at Stony Brook Stony Brook, New York
Contact Person:	Rose A. Walton, Ed.D.
Geographic Target Area:	Long Island
Training Approaches:	Direct Training, Training-of-Trainers

Funded Organization:	University of Arizona Tucson, Arizona
Contact Person:	Pam Reid Duffy, R.N., Ph.D.
Geographic Target Area:	Tucson and Phoenix metropolitan areas
Training Approaches:	Direct Training, Clinical Experience

Funded Organization:	University of Chicago Chicago, Illinois
Contact Person:	Larry S. Goldman, M.D.
Geographic Target Area:	State of Illinois
Training Approaches:	Direct Training

Funded Organization:	University of California at Los Angeles Los Angeles, California
Contact Persons:	Charles E. Lewis, M.D.
Geographic Target Area:	Los Angeles metropolitan area
Training Approaches:	Direct Training, Training-of-Trainers, Clinical Experience

Funded Organization:	University of California at San Francisco San Francisco, California
Contact Person:	Leonard Zegans, M.D.
Geographic Target Area:	San Francisco metropolitan area and surrounding rural areas
Training Approaches:	Direct Training, Training-of-Trainers

Funded Organization:	University of Hawaii at Manoa Honolulu, Hawaii
Contact Person:	Jane A. Waldron, Ph.D.
Geographic Target Area:	Hawaii and Pacific Islands
Training Approaches:	Direct Training

Funded Organization:	University of Louisville Louisville, Kentucky
Contact Person:	Roger A. Bell, Ed.D.
Geographic Target Area:	Louisville metropolitan area and southern Indiana
Training Approaches:	Direct Training, Training-of-Trainers, Clinical Experience

Funded Organization:	University of Miami Miami, Florida
Contact Person:	Sanford Cohen, M.D.
Geographic Target Area:	Miami metropolitan area
Training Approaches:	Direct Training, Clinical Experience (medical students)

Funded Organization:	University of Pittsburgh Pittsburgh, Pennsylvania
Contact Person:	Linda Frank, Ph.D., R.N.
Geographic Target Area:	State of Pennsylvania
Training Approaches:	Training-of-Trainers, Clinical Experience

Funded Organization:	University of Rochester Rochester, New York
Contact Person:	Judith Landau-Stanton, MB, ChB, DPM
Geographic Target Area:	State of New York
Training Approaches:	Direct Training

Funded Organization:	University of Texas at San Antonio San Antonio, Texas
Contact Person:	Cervando Martinez, M.D.
Geographic Target Area:	San Antonio metropolitan area and southern Texas
Training Approaches:	Direct Training, Clinical Experience

Funded Organization:	University of Washington Seattle, Washington
Contact Person:	Lewayne Gilchrist, Ph.D.
Geographic Target Area:	Alaska, Montana, Washington, Oregon, Idaho
Training Approaches:	Direct Training, Training-of-Trainers

Funded Organization:	Wayne State University Detroit, Michigan
Contact Person:	Ali M. Naqvi, Ph.D.
Geographic Target Area:	State of Michigan
Training Approaches:	Direct Training

Appendix D

Bibliography of Contributions to the Research Literature on Mental Health Aspects of HIV/AIDS

Bibliography of Contributions to the Research Literature on Mental Health Aspects of HIV/AIDS

The bibliography presented here represents a compilation of scholarly publications (journal articles, books, book chapters) published by project staff as the result of funding that organizations received from NIMH or CMHS through the Mental Health Care Provider Education in HIV/AIDS Program. Each entry in the bibliography is followed by a number, printed in bold, which identifies the project with which the author(s) was associated. A key to these numbers appears below.

KEY

1 Abt Associates
2 American Nurses Foundation
3 American Psychiatric Association
4 American Psychological Association
5 Arkansas Children's Institute
6 California State University at Long Beach
7 Columbia University
8 Cornell University Medical Center
9 Emory University
10 George Washington University
11 Health Education Resource Organization
12 JSI Research and Training Institute
13 Michigan State University
14 New York University
15 Northwestern University
16 State University of New York at Stony Brook
17 University of Arizona
18 University of Chicago
19 University of Hawaii
20 University of Louisville
21 University of Miami
22 University of Pittsburgh
23 University of Rochester
24 University of California at Los Angeles
25 University of California at San Francisco
26 University of Texas at San Antonio
27 University of Washington
28 Wayne State University

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