

Center for Mental Health Services Session Reporting Form

Instructions

Instructions to Agency Staff/Trainers

The Center for Mental Health Services (CMHS) is committed to improving the mental health services delivered to HIV/AIDS affected populations and requests that you complete the attached Session Reporting Form. This form requests descriptive information on the education/training session and must be completed by agency staff or trainers at the end of each training session. The information collected will enable CMHS to evaluate the effectiveness of the effort in meeting its objectives to provide state-of-the-art information to a diverse mixture of training participants. CMHS and the sponsoring agency intend to use the information gathered from the evaluation to improve the quality of training and to ensure continued funding for HIV/AIDS provider education programs.

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions and completing the survey form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 2-1057, Rockville, Maryland, 20857. An agency may not conduct or sponsor and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0195.

Thank you, your help is appreciated.



Session Reporting Form (SRF)

Note: This is to be completed by a project administrator.

Form Approved
OMB. No. 0930-0195
Exp. Date XX/XX/XXXX

Date: _____ / _____ / _____
month day year

CMHS Site ID # _____ Session Number _____

Trainer ID# _____

Title of Training or Conference _____

Instructions: Please respond to the items by filling in the appropriate oval using a No. 2 pencil or dark blue or black pen.

Correct

Incorrect

1. Language Spoken During Session (*Please choose only ONE*)

- English Spanish Both

2. Total Number of Participants in Session: _____

3. Type of Curriculum Used (*Mark the single best answer*)

- General curriculum CMHS Ethics curriculum Substance Use and HIV
 Adherence curriculum CMHS "The Brain and Behavior" curriculum Neuropsychiatric curriculum
 Other Specialized curriculum _____

4. Workshop Length (actual hours of training): hours _____ minutes _____

5. Language of Evaluation Forms (*Please choose only ONE*)

- English Spanish Both

6. Co-sponsoring Organizations (*Mark all that apply*)

- None College or University State/Local Drug/Alcohol Department
 AIDS Education and Training Centers Community Health Center Hospital/Hospital-Based Clinic
 Area Health Education Center State/Local Health Department CBO providing AIDS services
 State/Local Office of Mental Health Chemical Dependency Program Professional Association
 Health Professions School Other _____

7. Please indicate the primary and secondary topics to be covered during training (*Circle "1" for primary, "2" for secondary*).

- | | | |
|--|--|--|
| 1 -- 2 Mental health aspects of HIV | 1 -- 2 Legal and ethical issues | 1 -- 2 Children and HIV |
| 1 -- 2 Treatments for HIV disease | 1 -- 2 HIV counseling and testing issues | 1 -- 2 Taking a substance use history |
| 1 -- 2 Adherence to treatment issues | 1 -- 2 Women and HIV | 1 -- 2 Severe mental illness |
| 1 -- 2 Neuropsychiatric aspects of HIV | 1 -- 2 Prevention of HIV infection | 1 -- 2 Taking a sexual history |
| 1 -- 2 Culturally competent practices | 1 -- 2 Working with affected family/significant others | 1 -- 2 Other sexually transmitted diseases |
| 1 -- 2 Substance abuse issues | 1 -- 2 Adolescents and HIV | 1 -- 2 Perinatal HIV transmission |
| 1 -- 2 Epidemiology of HIV/AIDS | 1 -- 2 Sexual orientation/sensitivity | 1 -- 2 Older adults and HIV |
| 1 -- 2 HIV disease progression | | 1 -- 2 Other (<i>specify, e.g., spirituality, rural populations</i>) |
| 1 -- 2 Pharmacological issues | | |

For neuropsychiatric curricula only:

- | | |
|---|---|
| 1 -- 2 Central nervous system complications of HIV | 1 -- 2 Psychological factors affecting HIV medical status |
| 1 -- 2 Cognitive and other mental disorders associated with HIV | 1 -- 2 Psychopharmacology and drug-drug interactions |
| 1 -- 2 Other _____ | 1 -- 2 Assessment/diagnosis of neuropsychiatric complications |

For site use only:

PLEASE TURN OVER

8. Instruments administered (Mark all that apply)

- Participant Feedback Form
- Site-specific forms: if yes, number of different forms. _____

9. Involvement of Disclosed HIV-positive Individuals in Training (Enter numbers for each)

Trainer (s) _____ Guest Speaker(s) _____ Panelist (s) _____ Video (s) _____
Other _____

10. Face-to-Face Education Strategies/Methods employed. If this is distance learning, skip to Question 12.

(Please indicate approximate time spent in hours and minutes on each period. The total time should equal length listed in questions 4.)

Case Studies	_____ . _____	Panel Discussion	_____ . _____	Small Group "Breakouts"	_____ . _____
Grand Rounds	_____ . _____	Role Play	_____ . _____	Interactive Exercises	_____ . _____
Lecture	_____ . _____	Self-Instruction	_____ . _____	Structured Discussions	_____ . _____
Question and Answer	_____ . _____	Videos	_____ . _____		
Other	_____ . _____				

11. Educational Materials Distributed to Trainees during Face-to-Face Sessions (Mark all that apply)

- Pamphlets
- Copies of overheads/slides
- Articles
- Case studies
- Resource lists/directories
- Chart notes
- Books
- Curriculum materials
- Video tapes
- Worksheets
- Prevention resources
- Other _____

12. Distance Learning Modality/Method (Mark the single best answer)

- Telephone conference - interactive
- Telephone conference - Non-interactive
- Video conference - interactive
- Video conference - Non-interactive
- Web-based training, excluding materials downloaded from web sites
- Other, please specify _____

13. Participants were asked to complete the following knowledge gain sections (Mark all that apply)

- Entire form
- Questions 1 to 20
- Special Populations and Issues
- HIV-Related Conditions and Treatment Aspects
- Transmission and Prevention

THANK YOU FOR PARTICIPATING

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Center for Mental Health Services Participant Feedback Form

Instructions

The training you are attending is funded by The Center for Mental Health Services (CMHS), a Federal agency with a mission to improve mental health services delivered to HIV/AIDS affected populations. CMHS requests that you complete the attached form in order to assist in assessing the effectiveness of the effort in meeting its objectives to provide state-of-the-art information to a diverse mixture of training participants. CMHS and the sponsoring agency intend to use the information gathered from this feedback to improve the quality of training and to ensure continued funding for HIV/AIDS provider education programs.

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Completion of the feedback form is voluntary. **All information gathered from the form is anonymous. It is important that you fill in the Anonymous Unique Identifier at the top of the form. This identifier will be used to match your responses from this form with responses from other forms that you may complete as part of this training.** Please use a pen or pencil to darken each circle completely. Return the completed form to the place designated by the training staff.

Thank you, your help is appreciated.

Adherence Participant Feedback Form

*This survey will help us evaluate and improve the training program.
Completion of the feedback form is voluntary.*

Form Approved
OMB No. 0930-0195
Exp. Date xx/xx/xxxx

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Instructions: Please respond to the items by filling in the appropriate oval using a No. 2 pencil, dark blue or black pen.

Correct

Incorrect

1. Anonymous Unique Identifier: This permits training sites to determine if you have attended multiple trainings.

// /
 Last 4 digits of social security number month day
Date of Birth

2. Reasons for attending training (Mark the SINGLE BEST answer):

- CMEs/CEUs Knowledge/skill development
 Friend/family with HIV Other: _____
 Job requirement

3. Gender: Male Female

4a. Are you of Hispanic or Latino descent or origin?

- Yes No

4b. Race: (Select one or more)

- White
 Black or African American
 Asian
 American Indian or Alaska Native
 Native Hawaiian or Other Pacific Islander

5. How much formal schooling have you received?

- (Please choose only ONE)
- Less than high school M.D.
 High school/GED Doctoral Degree (non-M.D.)
 Associate Degree M.D. & Doctoral Degree
 Bachelor's Degree Other Professional Degree
 Master's Degree Other: _____

6. What facility BEST describes the primary setting where you work? (Please choose only ONE)

- Academic Institution Long-term Care Facility
 Community Based Organization Non-hospital Mental Health Clinic/Agency
 Correctional Facility Private Practice
 Home Health/Visiting Public Health Agency/Clinic
 Hospice Religious Organization
 Hospital Mental Health Clinic/Unit Substance Abuse Treatment
 Other Hospital Clinic/Unit Not working
 Other Hospital Clinic/Unit Other: _____

7. Which geographical description BEST describes where this facility is located?

- Urban Suburban
 Rural Not Applicable

8. Which of the following describe your work at the facility identified in Item 6 above? (Mark all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Administrator/Supervisor | <input type="checkbox"/> Physician (not a Psychiatrist) |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Clergy/Pastoral Worker | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Counselor | <input type="checkbox"/> Social Worker (BSW,MSW) |
| <input type="checkbox"/> Faculty/Teacher | <input type="checkbox"/> Student |
| <input type="checkbox"/> Health Educator | <input type="checkbox"/> Volunteer/Buddy |
| <input type="checkbox"/> Nurse (LPN, RN, APN) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Outreach Worker | |

9. Do you provide services directly to HIV-positive individual(s)?

- Yes No

A. If YES, in what capacity? (Mark the SINGLE BEST answer)

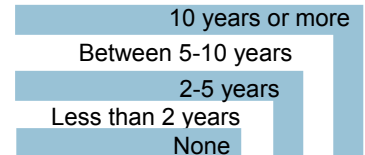
- | | |
|---|---|
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Physician (not a Psychiatrist) |
| <input type="checkbox"/> Clergy/Pastoral Worker | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Counselor | <input type="checkbox"/> Social Worker (BSW,MSW) |
| <input type="checkbox"/> Educator | <input type="checkbox"/> Student (specify) _____ |
| <input type="checkbox"/> Nurse (LPN, RN, APN) | <input type="checkbox"/> Volunteer/Buddy |
| <input type="checkbox"/> Outreach Worker | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Psychiatrist | |

B. If NO, what is your main job/capacity? (Mark the SINGLE BEST answer)

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Administrator/Supervisor | <input type="checkbox"/> Researcher |
| <input type="checkbox"/> Clergy/Pastoral worker | <input type="checkbox"/> Student |
| <input type="checkbox"/> Faculty/Teacher | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Health Educator | <input type="checkbox"/> Other: _____ |

10. Do you provide direct services to family members/significant others of HIV-positive individual(s)?

- Yes No



11. Please indicate the number of years that you have provided service in the following areas:

- | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| <u>Direct</u> HIV-related clinical mental health services (e.g., therapy)..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <u>Other direct</u> services to HIV-positive individuals (e.g., primary health care)..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <u>Any other</u> HIV-related assistance to HIV-positive individuals (e.g., driving someone to an appointment)..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

PLEASE TURN OVER

Ethics Participant Feedback Form

This survey will help us evaluate and improve the training program.
Completion of the feedback form is voluntary.

Form Approved
OMB No. 0930-0195
Exp. Date xx/xx/xxxx

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Correct



Incorrect



1. Anonymous Unique Identifier: This permits training sites to determine if you have attended multiple trainings.

_____ // _____ / _____
Last 4 digits of social month day
Date of Birth

2. Reasons for attending training (Mark the **SINGLE BEST** answer):

- CMEs/CEUs Knowledge/skill development
 Friend/family with HIV Other: _____
 Job requirement

3. Gender: Male Female

4a. Are you of Hispanic or Latino descent or origin?

- Yes No

4b. Race: (Select one or more)

- White
 Black or African American
 Asian
 American Indian or Alaska Native
 Native Hawaiian or Other Pacific Islander

5. How much formal schooling have you received?

- (Please choose only **ONE**)
 Less than high school M.D.
 High school/GED Doctoral Degree (non-M.D.)
 Associate Degree M.D. & Doctoral Degree
 Bachelor's Degree Other Professional Degree
 Master's Degree Other: _____

6. What facility **BEST** describes the primary setting where you work? (Please choose only **ONE**)

- Academic Institution Long-term Care Facility
 Community Based Non-hospital Mental Health Clinic/Agency
 Correctional Facility Private Practice
 Home Health/Visiting Public Health Agency/Clinic
 Hospice Religious Organization
 Hospital Mental Health Substance Abuse Treatment Clinic/Unit
 Other Hospital Not working
 Clinic/Unit Other: _____

7. Which geographical description **BEST** describes where this facility is located?

- Urban Suburban
 Rural Not Applicable

8. Which of the following describe your work at the facility identified in Item 6 above? (Mark all that apply)

- Administrator/Supervisor Physician (not a Psychiatrist)
 Case Manager Psychiatrist
 Clergy/Pastoral Worker Psychologist
 Counselor Social Worker (BSW,MSW)
 Faculty/Teacher Student
 Health Educator Volunteer/Buddy
 Nurse (LPN, RN, APN) Other: _____
 Outreach Worker

9. Do you provide services directly to HIV-positive individual(s)?

- Yes No

A. If **YES**, in what capacity? (Mark the **SINGLE BEST** answer)

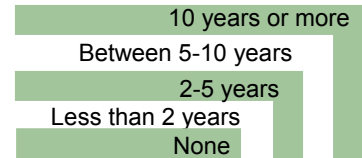
- Case Manager Physician (not a Psychiatrist)
 Clergy/Pastoral Worker Psychologist
 Counselor Social Worker (BSW,MSW)
 Educator Student (specify) _____
 Nurse (LPN, RN, APN) Volunteer/Buddy
 Outreach Worker Other: _____
 Psychiatrist

B. If **NO**, what is your main job/capacity? (Mark the **SINGLE BEST** answer)

- Administrator/Supervisor Researcher
 Clergy/Pastoral worker Student
 Faculty/Teacher Volunteer
 Health Educator Other: _____

10. Do you provide direct services to family members/significant others of HIV-positive individual(s)?

- Yes No



11. Please indicate the number of years that you have provided service in the following areas:

- Direct HIV-related clinical mental health services (e.g., therapy).....
Other direct services to HIV-positive individuals (e.g., primary health care).....
Any other HIV-related assistance to HIV-positive individuals (e.g., driving someone to an appointment).....

PLEASE TURN OVER

For the following questions, select a rating that reflects your degree of agreement with the statement presented.

	Strongly Agree				
		Agree			
			Neutral		
				Disagree	
					Strongly Disagree

12. This training session was well organized.....

13. The information/skills training was useful.....

14. I was satisfied with this training.....

15. I would recommend this training to others.....

16. The HIV-positive guest speaker/panel was important to my training experience (skip if not applicable to session).....

	Strongly Agree				
		Agree			
			Neutral		
				Disagree	
					Strongly Disagree

Already willing/capable/comfortable

17. As a result of this training, I am more comfortable treating and/or caring for HIV-positive and HIV-affected individuals.....

18. As a result of this training, I am more willing to treat and/or care for HIV-positive and HIV-affected individuals.....

19. As a result of this training, I am more capable of treating and/or caring for HIV-positive and HIV-affected individuals.....

20. My level of prior knowledge of the information/skills presented at this training was... Low Moderate High

To what extent has this training increased your HIV/AIDS knowledge/skills in the following areas: (Indicate if topic was not covered in training.)

Module I: Historical Perspective

		To a very great extent			
			To a great extent		
				To some extent	
					To a little extent
					Not at all

Topic not covered

20. Central nervous system complications of HIV.....

21. Cognitive and other mental disorders associated with HIV.....

22. Psychological factors affecting HIV medical status

23. Psychopharmacological and drug-drug interactions

24. Assessment/diagnosis of neuropsychiatric complications

25. My ability to respond to client concerns about new HIV treatments

26. Other _____.....

27. How will you use what you have learned in this training in your HIV/AIDS work?

28. How could this training be improved?

THANK YOU FOR PARTICIPATING!

Participant Feedback Form

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 Friend/family with HIV Other: _____
 Job requirement

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4a. Are you of Hispanic or Latino descent or origin?
 Yes No

4b. Race: (Select one or more)

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5. How much formal schooling have you received?
 (Please choose only ONE)

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 Health Educator Volunteer/Buddy
 Nurse (LPN, RN, APN) Other: _____
 Outreach Worker

9. Do you provide services directly to HIV-positive individual(s)?

Yes No

A. If YES, in what capacity? (Mark the SINGLE BEST answer)

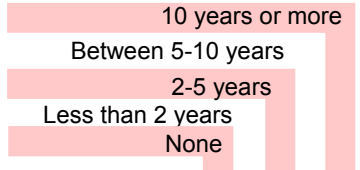
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 Clergy/Pastoral Worker Psychologist
 Counselor Social Worker (BSW,MSW)
 Educator Student (specify) _____
 Nurse (LPN, RN, APN) Volunteer/Buddy
 Outreach Worker Other: _____
 Psychiatrist

B. If NO, what is your main job/capacity? (Mark the SINGLE BEST answer)

Administrator/Supervisor Researcher
 Clergy/Pastoral worker Student
 Faculty/Teacher Volunteer
 Health Educator Other: _____

10. Do you provide direct services to family members/significant others of HIV-positive individual(s)?

Yes No



11. Please indicate the number of years that you have provided service in the following areas:

Direct HIV-related clinical mental health services (e.g., therapy).....

Other direct services to HIV-positive individuals (e.g., primary health care).....

Any other HIV-related assistance to HIV-positive individuals (e.g., driving someone to an appointment).....

PLEASE TURN OVER

For the following questions, select a rating that reflects your degree of agreement with the statement presented.

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

- 12. This training session was well organized.....
- 13. The information/skills training was useful.....
- 14. I was satisfied with the training.....
- 15. I would recommend this training to others.....
- 16. The HIV-positive guest speaker/panel was important to my training experience (skip if not applicable to session).....

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

Already willing/capable/comfortable

- 17. As a result of this training, I am more comfortable treating and/or caring for HIV-positive and HIV-affected individuals.....
- 18. As a result of this training, I am more willing to treat and/or care for HIV-positive and HIV-affected individuals.....
- 19. As a result of this training, I am more capable of treating and/or caring for HIV-positive and HIV-affected Individuals.....

20. My level of prior knowledge of the information/skills presented at this training was... Low Moderate High

To a very great extent
To a great extent
To some extent
To a little extent
Not at all

To what extent has this training increased your HIV/AIDS knowledge/skills in the following areas: (Indicate if topic was not covered in training.)

All Trainings

21. Psychosocial and/or mental health impact of HIV.....

Special Populations and Issues

- 22. Legal and ethical issues.....
- 23. Providing compassionate care to people from different cultures.....
- 24. Caring for special populations (e.g., women, gays, lesbians, people with severe mental illness).....
- 25. Caring for family and friends of HIV-infected individuals.....

HIV-Related Conditions and Treatment Aspects

- 26. How HIV affects the body.....
- 27. How HIV infection and AIDS are treated.....
- 28. Adherence to treatment.....
- 29. Other sexually transmitted diseases.....
- 30. Neuropsychiatric complications of HIV.....
- 31. Psychotropic and other drug interactions.....

Transmission and Prevention

- 32. Who is affected by the epidemic.....
- 33. Approaches for preventing HIV infection.....
- 34. HIV transmission.....
- 35. Counseling and testing issues.....
- 36. How substance use is related to HIV and AIDS.....
- 37. Perinatal transmission issues.....
- 38. Taking a sexual history.....
- 39. Taking a substance use history.....
- 40. Other _____

41. How will you use what you have learned in this training in your HIV/AIDS work? _____

42. How could this training be improved? _____

THANK YOU FOR PARTICIPATING!