STANDARDS OF CARE

Los Angeles County Commission on

HIV

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MENTAL HEALTH SERVICES

EXECUTIVE SUMMARY

SERVICE INTRODUCTION

Mental health treatment for people living with HIV attempts to improve and sustain a client's quality of life.

Mental health services include:
- Mental health assessment
- Treatment planning
- Treatment provision
    - Individual psychotherapy
    - Family psychotherapy
    - Group psychotherapy
    - Psychiatric medication assessment, prescription and monitoring
    - Drop-in psychotherapy groups
    - Crisis intervention
    -

All interventions must be based on proven clinical methods and in accordance with legal and ethical standards.

SERVICE/ORGANIZATIONAL LICENSURE CATEGORY

Providers of mental health services include licensed practitioners and unlicensed practitioners who practice under the supervision of a licensed mental health professional and as mandated by their respective licensing bodies. Psychiatric treatment services are provided by medical doctors board-eligible in psychiatry. All prescriptions shall be prescribed solely by physicians licensed by the state of California.

SERVICE CONSIDERATIONS

General Considerations: HIV/AIDS mental health services are short-term or sustained therapeutic interventions provided by mental health professional for clients experiencing acute and/or ongoing psychological distress

Client Intake: Client intake is required for all patients who request or are referred to HIV services. The intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation.

Crisis Intervention: Crisis intervention is an unplanned service provided to an individual, couple or family experiencing biopsychosocial distress. These services focus on reversing and stabilizing crisis-related deterioration of functioning.

Mental Health Assessment: Mental health assessment is completed during a collaborative face-to-face interview in which the client's biopsychosocial history and current presentation

are evaluated to determine diagnosis and treatment plan. Reassessments are indicated when there is significant change in the client's status, or when the client re-enters treatment.

Informed Medication Consent: Informed consent is required of every patient receiving psychotropic medications. The consent must include: medication benefits, risks, common side effects, side effect management and timetable for expected benefit.

Treatment Plans: Treatment plans are developed in collaboration with the client and outlines the course of treatment. It begins with a statement of problems to be addressed in treatment and follows with goals, objectives, timeframes and interventions to meet the goals.

Treatment Provision: Treatment provision consists of ongoing contact and clinical interventions with (or on behalf of) the patient necessary to achieve treatment plan goals. Treatment provision includes: individual psychotherapy, family psychotherapy, conjoint psychotherapy, group psychotherapy, psychiatric medication assessment, prescription and monitoring, drop-in psychotherapy groups and crisis intervention.

STAFFING REQUIREMENTS AND QUALIFICATIONS

Providers of professional mental health services will be, at a minimum, master's- or doctoral-level graduate students in counseling, marriage and family therapy, nursing (with specialized mental health training, psychiatry, psychology, or social work.

HIV/AIDS psychiatric treatment services are provided by medical doctors board-eligible in psychiatry. A psychiatrist may work in collaboration with a psychiatric resident, or registered nurse (RN). While state law govern prescription of medication, it is recommended that physicians licensed as such by the state of California shall prescribe all prescriptions for psychotropic medication. If an NP is utilized to provide medications, he or she must do so according to standardized protocol and under the supervision of a psychiatrist.

Programs ensure access to appropriate services.

All staff hired by provider agencies will possess the ability to provide developmentally and culturally appropriated care to clients living with and affected by HIV. All clinical staff will have previous experience or training utilizing appropriate treatment modalities in practice.

MENTAL HEALTH SERVICES

SERVICE INTRODUCTION

Mental health treatment for people living with HIV attempts to improve and sustain a client's quality of life. Counseling and psychotherapy have been shown to be helpful in alleviating or decreasing psychological symptoms that can accompany a diagnosis of HIV. Psychiatric treatment for people living with HIV attempts to stabilize mental health conditions while improving and sustaining quality of life. Evidence based psychiatric treatment approaches and psychotherapeutic medications have proven effective in alleviating or decreasing psychological symptoms and illnesses that may accompany a diagnosis of HIV. Often, people living with HIV have psychological illnesses that pre-date their infection, but have been exacerbated by the stress of living with a chronic illness.

Mental health services include:

- Mental health assessment
- Treatment planning
- Treatment provision:
  - Individual psychotherapy
  - Family psychotherapy
  - Conjoint psychotherapy
  - Group psychotherapy
  - Psychiatric medication assessment, prescription and monitoring
  - Drop-in psychotherapy groups
  - Crisis intervention

All programs will use available standards of care to inform clients of their service and will provide services in accordance with legal and ethical standards. Maintaining confidentiality is critical and its importance cannot be overstated. All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for information disclosure.

The Los Angeles County Commission on HIV and the Division of HIV and STD Programs (DHSP)—formerly referred to as the Office of AIDS Programs and Policy (OAPP)—have developed this standard of care to set minimum quality expectations for service provision and to guarantee clients consistent care, regardless of where they receive services in the County.

Recurring themes in this standard include:

- The provision of mental health treatment services should be a collaborative one.

- Providers are asked to "start where the client is."
- Treatment decisions are made collaboratively, based on the needs identified in the mental health assessment.
- Providers must be experienced, well trained and knowledgeable regarding the needs of a culturally complex treatment population.

This document represents a synthesis of published standards and research, including:

- *Mental Health Services Contract Exhibit,* Division of HIV and STD Programs (DHSP)
- *Mental Health Services,* Psychiatric Treatment – Contract Exhibit, Division of HIV and STD Programs (DHSP)
- *Practice Guidelines for the Treatment of Patients with HIV/AIDS,* American Psychiatric Association, 2001.
- *Mental Health Practice Guidelines for Treatment of People Living with HIV/AIDS,* Mental Health Task Force, Los Angeles County Commission on HIV and Division of HIV and STD Programs (DHSP), 2002.
- Standards of care developed by several other Ryan White Title 1 Planning Councils. Most valuable in the drafting of this standard were Boston, MA (2004); Baltimore, MD (2004); and San Antonio, TX (2005).

SERVICE/ORGANIZATIONAL LICENSURE CATEGORY

Providers of mental health services include licensed practitioners and unlicensed practitioners who practice under the supervision of a licensed mental health professional and as mandated by their respective licensing bodies. HIV/AIDS mental health psychiatric treatment services are provided by medical doctors (MDs) board-eligible in psychiatry. A psychiatrist may collaborate with a psychiatric resident or registered nurse/nurse practitioner (RN/NP) under the supervision a medical doctor board-eligible in psychiatry. All prescriptions shall be prescribed solely by physicians licensed by the state of California.

After a diagnosis of HIV, psy-chiatric and psychological treatment is often necessary.

Licensed Practitioners:

- **Licensed Clinical Social Workers (LCSW):** LCSWs possess a master's degree in social work (MSW). LCSWs are required to accrue 3,200 hours of supervised professional experience in order to qualify for licensing. The Board of Behavioral Science Examiners regulates the provision of mental health services by LCSWs.
- **Licensed Marriage and Family Therapists (LMFT):** LMFTs possess a master's degree in counseling. LMFTs are required to accrue 3,000 hours of supervised counseling or psychotherapy experience in order to qualify for licensing. The Board of Behavioral Science Examiners regulates the provision of mental health services by LMFTs.
- **Nurse specialists and practitioners:** Registered nurses (RNs) who hold a master's degree as a nurse practitioner (NP) in mental health or a psychiatric nurse specialist (PNS) are permitted to diagnose and treat mental disorders. NPs may prescribe medications in accordance with standardized procedures or protocols, developed and approved by the supervising psychiatrist, NP and facility administrator. Additionally, the NP must furnish and order medications under a psychiatrist's supervision.

  To qualify for prescribing medications, NPs must complete:
  - At least six months of psychiatrist-supervised experience in the ordering of medications or devices
  - A course in pharmacology covering the medications to be furnished or ordered

RNs who hold a bachelor's degree are permitted to provide psychoeducational services but are not allowed to diagnose or treat mental disorders independently. Nurses and NPs are regulated by the California State Board of Nursing.

- **Psychiatrists:** Psychiatrists are physicians (medical doctors or MDs) who have completed an internship and psychiatric residency (most are three years in length). They are licensed by the state medical board, which regulates their provision of services, to practice independently. They are certified or eligible for certification by the American Board of Psychiatry. They have ultimate clinical authority but function collaboratively with multidisciplinary teams, which may include psychiatric residents or NPs. They initiate all orders for medications.

  They provide HIV/AIDS mental health treatment services as follows:
  - Examination and evaluation of individual patients
  - Diagnosis of psychiatric disorders
  - Medication treatment planning and management
  - Medical psychotherapy
  - Supervision of allied health professionals through a defined protocol
  - Participation and leadership in interdisciplinary case conferences including signing off on diagnoses and treatment plans

- **Psychologists:** Psychologists possess a doctoral degree in psychology or education (PhD, PsyD, EdD). Psychologists are required to accrue 3,000 hours of supervised professional experience in order to qualify for licensing. The Board of Psychology regulates the provision of mental health services by psychologists.

Unlicensed Practitioners:

- **Marriage family therapist (MFT) interns; psychological assistants, post-doctoral fellows and trainees; and social work associates:** Interns, assistants, fellows, and associates are accumulating supervised experience as part of their preparation for licensing or certification. They have completed graduate work in counseling, psychology or social work. These providers require direct supervision by a licensed mental health practitioner as mandated by their respective licensing bodies.
- **Marriage family therapist (MFT) trainees and social work interns:** Trainees and interns are in the process of obtaining their master's degrees and completing the necessary practicum or field work in a site approved by their academic institutions. Trainees and interns require direct supervision by a licensed mental health practitioner at the approved site as mandated by their respective licensing bodies.

DEFINITIONS AND DESCRIPTIONS

Crisis intervention services are unplanned services provided to an individual, couple or family experiencing biopsychosocial distress. These services focus on reversing and stabilizing crisis-related deterioration of functioning.

Mental health assessment is completed during a collaborative face-to-face interview in which the client's biopsychosocial history and current presentation are evaluated to determine diagnosis and treatment plan. Reassessments are indicated when there is significant change in the client's status, or when the client re-enters treatment.

Treatment plans are developed in collaboration with the client and outline the course of treatment. A treatment plan begins with a statement of problems to be addressed in treatment and follows with goals, objectives, timeframes and interventions to meet these goals.

Treatment provision consists of ongoing contact and clinical interventions with or on behalf of the patient necessary to achieve treatment plan goals. Treatment provision includes:
- Individual psychotherapy
- Family psychotherapy
- Conjoint psychotherapy
- Group psychotherapy
- Psychiatric medication assessment, prescription and monitoring
- Drop-in psychotherapy groups
- Crisis intervention

HOW SERVICE RELATES TO HIV

There is a variety of connections to care.

At the end of 2013, approximately 60,050 people were estimated to be living with HIV infection in Los Angeles County. Los Angeles County comprises 40% of the total AIDS cases in the state of California (Epidemiologic Profile of HIV in Los Angeles County, 2013)

Recent studies have indicated that over one–third of patients presenting in HIV primary care clinics met screening criteria for one or more mental health disorders and over 40% of these patients were not receiving any psychiatric treatment (Israelski et al., 2007). Another study similarly found that 56% of patients attending HIV clinics screened positive for either posttraumatic stress disorder (PTSD), acute stress disorder (ASD) or depression and over half of those screening positive were not receiving any psychiatric treatment (Soller et al., 2011). When all DSM IV-TR diagnostic categories are combined, between one-third and one-half of HIV-positive persons suffer from a current mental disorder (Klinkenberg & Sacks, 2004).

Comorbid mood disorders negatively impact health-related quality of life (HRQoL) in HIV positive adults (Sherbourne et al., 2000). Comorbidities, both medical and psychiatric, were associated with deterioration in most dimensions of HRQoL for HIV-positive men (Jia et al, 2007). Untreated mental illness has also been shown to result in worse outcomes for treatment of HIV infection and substance use disorders (Altice et al., 2010).

Mental health services for people living with HIV have been demonstrated to have a positive influence on primary care, in entry (Messeri, et al., 2002; Conviser & Pounds, 2002), utilization and retention (Lo, MacGovern & Bradford, 2002; Conviser & Pounds, 2002). HIV-positive patients with psychiatric disorders are less likely to discontinue highly active antiretroviral therapy (HAART) if they are receiving consistent mental health treatment. Possible factors for this relationship include co-located HIV and mental healthcare that encourage treatment coordination and medication adherence (Himelhoch et al., 2009). Adherence to treatment for HIV, substance use, and comorbidities can be enhanced through a range of interventions: counseling, contingency management, supervised therapy (DOT), medication-assisted therapy, and integrated health service delivery (Altice et al, 2010). Improvement in mental health problems for people living with HIV can lead to improved health-related quality of life (Elliot, Russo, & Roy-Byrne, 2002).

Medication-assisted therapy enhances adherence to antiretroviral therapy, treatment for comorbidities, and retention in HIV care, while decreasing HIV risk behaviors (Altice et al.

2010). A recent study of persons living with HIV found that greater mean psychotropic medication adherence was significantly associated with greater antiretroviral medication adherence (Cruess et al., 2011).

Mental health favors adherence to antiretroviral drugs which slow the progression of illness, prevent medical complications and improve quality of life (Repetto and Petitto, 2008). Psychopharmacological treatment is effective and can improve psychiatric problems in HIV-infected individuals (Repetto and Petitto, 2008).

SERVICE COMPONENTS

Mental health services for people living with HIV are provided by mental health professionals, psychiatrists, psychiatric residents, or RNs/NPs under the supervision of a psychiatrist for those patients experiencing acute and/or ongoing psychological or psychiatric distress. Services include mental health assessment; development of a treatment plan; psychotherapeutic treatment provision; psychiatric treatment provision; and crisis intervention.

While it is generally the case that a client receiving mental health services will be registered and enrolled in a medical care coordination program, circumstances may arise under which a client must be seen immediately to mitigate a crisis that requires stabilization. In such cases, once a client has been stabilized they should be referred to a medical care coordination program within three working days.

STANDARD	MEASURE
Clients seen in crisis who are not currently enrolled in a medical care coordination program will be referred to one within three working days of stabilization.	Record of linked referral on file in client chart

MENTAL HEALTH ASSESSMENT

All clients receiving mental health treatment should already be engaged in medical care coordination services and have an up-to-date, comprehensive assessment, performed by the medical care coordination team, on file. In order to reduce client assessment burden, mental health providers will utilize this existing assessment as a tool to inform their treatment plans.

To supplement the domains covered in the medical care coordination assessment, mental health providers as defined above will include the following key components in their assessments:

- Detailed statement of the client's current presenting problem, focusing on mental health related issues
- Detailed mental health treatment history, including psychotropic medications
- Mental status exam
- Complete five axis diagnosis utilizing the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

Persons receiving crisis intervention or drop-in psychotherapy groups only do not require these full assessments. For clients receiving crisis intervention, a brief assessment of the presenting issues must be on file. The assessment shall support the mental health treatment modality chosen. A progress note referencing actual date(s) of assessment, time spent,

and, if the assessment was not completed, plans to complete will be included in the client file. Assessments will be signed and dated by the mental health provider conducting the interview. If this provider is unlicensed, the assessment will be cosigned by the licensed mental health clinician supervising that unlicensed provider.

Reassessments shall be conducted as driven by client need, when a client's status has changed significantly or when the client has left and re-entered treatment, but at a minimum of once every 12 months.

Mental health assessments should be completed after two sessions, but no longer than 30 days. If an assessment cannot be completed within 30 days, the reason for this delay must be stated in the progress notes.

Clients who present for mental health treatment without a medical care coordination assessment on file should be referred to this service within three working days.

In such cases, mental health providers must expand the scope of the mental health assessment to include (at minimum):

- Detailed statement of client's presenting problem, focusing on mental health issues
- Detailed psychiatric or mental health treatment history, including psychotropic medications
- Substance use history
- Family, relationships and support systems (including physical, sexual and domestic violence history; living conditions and environment)
- Cultural influences (including church affiliation, religious and spiritual belief systems; sexual orientation and gender roles; and discrimination)
- Education and employment history
- Legal history
- General and HIV-related medical history and health (including appetite, diet, sleep and exercise)
- Current medications
- Medication adherence
- HIV risk behavior, disclosure practices and harm reduction
- A detailed assessment of the client's feelings about his/her HIV status and its perceived impact on his/her health and well-being
- Mental status exam
- Complete five axis diagnosis utilizing the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

STANDARD	MEASURE
Mental health assessments will be completed within two visits, but in no longer than 30 days.	Completed assessment, in client file to include (at minimum): • Detailed mental health presenting problem • Psychiatric or mental health treatment history • Mental status exam • Complete DSM five axis diagnosis
Clients not currently enrolled in a medical care coordination program will be referred to one within three working days of stabilization.	Record of linked referral on file in client chart.

STANDARD	MEASURE
"Expanded" assessment (for clients without a medical care coordination assessment on file) should be completed within two visits, but in no longer than 30 days.	Completed assessment, signed and dated in client file to include (at minimum): • Statement of client's presenting problem • Psychiatric or mental health treatment history • Substance abuse history • Family, relationships and support systems • Cultural influences • Education and employment history • Legal history • General and HIV-related medical history • Medication adherence • HIV risk behavior, disclosure practices and harm reduction • Mental status exam • Complete DSM five axis diagnosis If assessment is not completed in 30 days, reason for delay to be documented in progress note.
Reassessment is ongoing and driven by client need, when a client's status has changed significantly or when the client has left and re-entered treatment, but at a minimum of once every 12 months.	Progress notes or new assessment demonstrating reassessment in client file.
Assessments and reassessments completed by unlicensed providers will cosigned by licensed clinical supervisor; if completed by unlicensed psychiatric provider, assessment will be cosigned by a medical doctor board-eligible in psychiatry.	Cosignature on file in client record.

TREATMENT PLANS

Mental health assessments and treatment plans should be developed concurrently, however treatment plans must be finalized within two weeks of the completion of the mental health assessment. Treatment plans must be developed by the same mental health provider that conducts the mental health assessment.

Treatment plans are developed collaboratively with the client to determine the course of treatment and are required for persons receiving all mental health services, excluding drop-in psychotherapy groups and crisis intervention services. Treatment plans will be updated on an ongoing basis, but at a minimum of every six months. Treatment plans will be reviewed and revised at a minimum of every 12 months. Treatment plans will be signed and dated by the mental health provider and the client. If the mental health provider is unlicensed, the treatment plan will be cosigned by the licensed clinical supervisor. Treatment plans completed by unlicensed psychiatric providers must be cosigned by a medical doctor board-eligible in psychiatry.

Mental health providers will continue to address and document existing and newly identified treatment plan goals. A copy of the treatment plan shall be provided to the client.

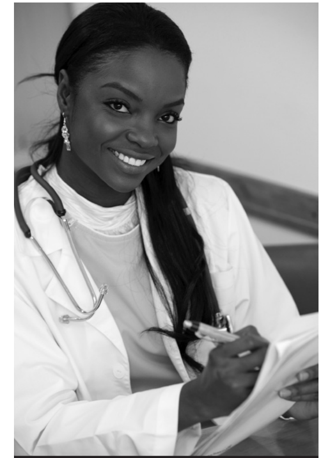
Treatment plans should include (at minimum):

- A statement of the problems, symptoms or behaviors to be addressed in treatment.
- Goals (desired outcomes) and objectives (measurable change in symptoms or behaviors)
- Interventions proposed
- Appropriate modalities to address the identified problems
- Frequency and expected duration of services.
- Service referrals (e.g., day treatment programs, substance abuse treatment, etc.)

STANDARD	MEASURE
Mental health assessments and treatment plans are developed concurrently and collaboratively with the client. Treatment plans must be finalized within two weeks of the completion of the mental health assessment and developed by the same mental health provider that conducts the mental health assessment.	Completed, signed treatment plan on file in client chart to include: • Statement of problem • Goals and objectives • Interventions and modalities • Frequency of service • Referrals
Review and update treatment plan on an ongoing basis, but at a minimum every six months.	Documentation of treatment plan update in client chart.
Review and revise treatment plan not less than once every twelve months.	Documentation of treatment plan revision in client chart.
Assessments and reassessments completed by unlicensed providers will cosigned by licensed clinical supervisor; those completed by an unlicensed psychiatric provider will be cosigned by a medical doctor board-eligible in psychiatry.	Cosignature in client record.

TREATMENT PROVISION

Client intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation. When possible, client intake will be completed in the first contact with the potential client. (Programs will assess individuals in crisis to determine what other interventions are appropriate, either within the agency, or by immediate referral.)



Treatment Plans are developed with the client.

All modalities and interventions in mental health treatment will be guided by the needs expressed in the treatment plan. Practitioners shall be knowledgeable about outcome research and utilize clinically proven treatment for their client's presenting problems. Treatment shall conform to the standards of care recognized within the general community and supported by clinically published research for the client's condition. Psychiatric service providers shall adopt and follow performance standards as set forth in The Practice Guideline for Treatment of Patients with HIV/AIDS, American Psychiatric Association, Washington, DC, 2001. Programs providing psychiatric services shall be responsible for obtaining and maintaining staff, facility and referral systems in compliance with American Medical Association standard guidelines.

Ongoing psychiatric sessions: Mental health treatment should include counseling regarding knowledge of modes of transmission, prevention, risk and harm reduction strategies (as well as root causes and underlying issues related to increased HIV transmission behaviors). Substance abuse, treatment adherence, development of social support systems and community resources as indicated by the client's circumstance are important areas to be explored. Focus should also be placed on maximizing social and adaptive functioning. The role of and—when present in a client's life—spirituality and religion should be understood and utilized as a strength when present. If clients begin to deteriorate physically, emotional distress can be relieved by helping them prepare for disability, even death. For the client whose health has improved, exploration of future goals including returning to school or work is indicated. When a signed release has been completed, sources of support and care can be recommended to significant others and family members.

The provision of specific types of psychotherapy (behavioral, cognitive, post-modern, psychodynamic) is guided by the individual client's need and based on published practice guidelines and research. For those clients on psychotropic medications, side effects of these agents should be assessed at each visit, along with the provision of education regarding such

medications, within the scope of the provider's practice. As indicated, these clients will be referred back to the prescribing physician for further information.

Individual counseling/psychotherapy: Individual counseling or psychotherapy may be either short- or long-term in duration, depending on the needs outlined in the treatment plan. Short-term or brief therapy usually lasts up to 12 sessions and can be most useful when client goals are specific and circumscribed. Longer-term therapy provides a means to explore more complex issues that may interfere with a client's quality of life. Even in the case of longer-term therapy, specific, short-term, mutually defined goals are recommended to focus treatment and measure progress.

Family counseling/psychotherapy: A family may be defined as either the family of origin or a chosen family (Bor, Miller & Goldman, 1993). The impact of HIV on the family system can be enormous. The overall goal of family counseling/psychotherapy is to help families improve their functioning, given the complications of living with HIV. Interventions with the family system can be especially effective in helping children and caregivers with behavioral problems and symptoms.

Couples counseling/psychotherapy: This modality is most appropriate where the presenting problem is dissatisfaction or conflict within a relationship that impacts a person living with HIV. In cases of domestic violence, couples counseling should not begin until the provider determines the appropriateness of this modality based upon the progress both parties have made in individual or group treatment and the fact that current violence is no longer a risk. If these criteria are not met, members of such couples should be referred for individual or group treatment.

Group psychotherapy treatment: Group treatment can provide opportunities for increased social support vital to those isolated by HIV.

While groups may be led by a single leader, significant benefits arise when utilizing two co-facilitators:

- Fewer group cancellations due to facilitator absence
- Increased chance that important individual and group issues will be explored
- Members have the opportunity to witness different skills and styles of the therapists
- Increased opportunity to work through transference relationships

Group treatment can be provided in a variety of formats.

Psychotherapy groups (either open or closed) must be part of an individual's treatment plan, with progress being recorded in the individual's chart.

- **Closed psychotherapy groups** typically require a process for joining and terminating. Closed groups usually have a set number of group members (between six and ten). This format provides an opportunity to build group cohesion and for members to take part in active interpersonal learning. These groups can be time limited or ongoing, issue specific or more general in content.
- **Open psychotherapy groups** do not require ongoing participation from clients. The group membership shifts from session to session, often requiring group leaders to be more structured and active in their approach. These groups can be especially useful to clients requiring immediate support, but unsure about making a commitment to ongoing treatment.

Drop-in groups can also be offered as a mental health service, as long as at least one of the leaders of the group is a mental health provider as defined in this standard.

- **Drop-in groups:** do not have an ongoing membership. Instead of a psychotherapeutic focus, these groups focus on such functions as providing topic-specific education, social support and emotional encouragement. As such, they do not require inclusion in a client's treatment plan, nor is a full mental health assessment required to access this service.

Psychiatric evaluations, medication monitoring and follow-up: Psychiatrists shall use clinical presentation, evidence-based practice guidelines and specific treatment goals to guide the evaluation, prescription and monitoring of appropriate medication.

For medication monitoring and follow-up, visit frequency should be at a minimum:
- Once every two weeks in the acute phase
- Once every month in the sub-acute phase
- Once every three months in the maintenance phase

For those patients on psychotropic medication, side effects of these agents shall be assessed at each visit, along with the provision of education regarding their medications. In addition, these patients should regularly be counseled about the importance of adherence to psychotropic medications.

The American Psychiatric Association (2001) suggests the following general pharmacologic treatment guidelines, especially for those patients with symptomatic HIV disease:
- Use lower starting doses and titrate more slowly.
- Provide the least complicated dosing schedules possible.
- Concentrate on drug side effect profiles as a means to avoid unnecessary adverse effects.
- Be aware of drug metabolism/clearance pathways to minimize drug-drug interactions and possible organ damage.

In general, refills shall not be written beyond three months of the last psychiatric visit. However, exception can be made in special circumstances or when the stability of the client warrants less frequent monitoring. Such exceptions shall be documented in client progress notes.

Psychiatrists must coordinate the provision of psychiatric care with primary care medical clinics and other related providers. Regular contact with a patient's primary care clinic and related providers will ensure integration of services and maintain care continuity.

STANDARD	MEASURE
Interventions and modalities will be determined by treatment plan.	Treatment plan signed and date by mental health provider and client in client file.
Practitioners will use outcome research and published standards of care, as appropriate and available, to guide their treatment.	Progress note signed and dated by mental health provider detailing interventions in client file.

STANDARD	MEASURE
Treatment, as appropriate, will include counseling about (at minimum): • Prevention and transmission risk behaviors, including root causes and underlying issues related to increased HIV transmission behaviors • substance abuse • treatment adherence • development of social support systems • community resources • maximizing social and adaptive functioning • the role of spirituality and religion in a client's life • disability, death and dying • exploration of future goals	Progress note signed and dated by mental health provider detailing counseling sessions in client file.

Psychiatrists coordinate care with medical clinics and other providers.

Documentation: Treatment provision should be documented through progress notes and include the date and signature of the mental health provider. If the provider is unlicensed, progress notes will be cosigned by the licensed clinical supervisor. For unlicensed psychiatric providers, progress notes will be cosigned by a medical doctor board-eligible in psychiatry.

Progress notes for individual and family/conjoint psychotherapy will include:

- Date, type of contact, time spent and interventions/referrals provided
- Results of interventions and referrals
- Progress toward treatment plan goals
- Newly identified issues/goals
- Client's responses to interventions and referrals.

In the case of psychotherapeutic groups, progress notes will include:

- Date, time and length of the group
- Record of attendance
- Issues discussed and interventions provided relative to the group process and each individual participant.

In the case of drop-in groups, progress notes will include (at minimum):

- Date, time and length of group
- Record of attendance
- Issues discussed and interventions provided.

In the case of evaluations, medication monitoring and follow-up, progress notes will include:

- Date, type of contact, time spent
- Treatment plan including current medical and psychotropic medication and dosages
- Progress towards psychiatric treatment plan goals
- Interventions and patient's response to interventions
- Referrals provided (e.g., psychotherapy, neuropsychological assessment, case management, medical services, etc.)
- Results of interventions and referrals
- Documentation that the provider has addressed existing and newly identified goals

STANDARD	MEASURE
Progress notes for individual, family and conjoint treatment will document progress through treatment provision.	Signed, dated progress note in client chart to include: • Date, type of contact, time spent • Interventions /referrals provided • Progress toward Treatment Plan goals • Newly identified issues • Client response

STANDARD	MEASURE
Progress notes for group psychotherapy will document progress through treatment provision.	Signed, dated progress note in client chart to include: • Date, time and length of group • Record of attendance • Issues discussed • Interventions provided
Progress notes for drop-in groups will document treatment provision.	Signed, dated progress note in client chart to include: • Date, time and length of group • Record of attendance • Issues discussed and interventions provided
Progress notes for psychiatric services will document progress through treatment provision.	Signed and dated note to be placed in the client file including: • Date, type of contact, time spent • Treatment plan including current medical and psychotropic medication and dosages • Progress towards psychiatric treatment plan goals • Interventions and client's response to interventions • Referrals provided • Results of interventions and referrals • Documentation of provider's addressing existing and newly identified goals
Progress notes completed by unlicensed providers will be cosigned by licensed clinical supervisor. Notes completed by an unlicensed psychiatric provider will be cosigned by a medical doctor board-eligible in psychiatry.	Cosignature on file in client record.

Informed Medication Consent: Informed consent is required of every patient receiving psychotropic medications.

This consent indicates that a patient has been told about and understands:

- Medication benefits
- Risks
- Common side effects
- Side effect management
- Timetable for expected benefit

An Informed Medication Consent will be signed by both the patient and psychiatrist on the date that the medication is prescribed. A new Informed Medication Consent will be signed and date by the patient and psychiatrist when a new medication is prescribed. If the psychiatric provider is unlicensed, the assessment will be cosigned by a medical doctor board-eligible in psychiatry.

STANDARD	MEASURE
An Informed Medication Consent will be completed for all patients receiving psychotropic medications.	Completed, signed, dated Informed Medication Consent on file in client chart to indicating the patient has been told about and understands: • Medication benefits • Risks • Common side effects • Side effect management • Timetable for expected benefit
A new Informed Medication Consent will be completed whenever a new medication is prescribed.	New Informed Medication Consent on file in client chart.
Informed Medication Consents completed by unlicensed providers will be cosigned by medical doctor board-eligible in psychiatry.	Cosignature on file in client record.

CRISIS INTERVENTION

Crisis intervention is an unplanned service provided to an individual, couple or family experiencing psychosocial stress. Such services are provided in order to prevent deterioration of functioning or to assist in the client's return to baseline functioning. Crisis intervention can be provided face to face or by telephone. It is imperative that client safety is assessed and addressed under these crisis situations. Crisis intervention services may occur as often as necessary to ensure client safety and maintenance of baseline functioning.

Crisis intervention services are documented through progress notes which shall include the date and signature of the mental health provider. If the provider is unlicensed, progress notes will be cosigned by the licensed clinical supervisor.

Crisis Intervention progress notes require the following documentation:

- Date, time of day and time spent with or on behalf of the client
- Summary of the crisis event
- Interventions and referrals provided
- Results of interventions and referrals
- Follow-up plan.

STANDARD	MEASURE
Crisis intervention services will be offered to clients experiencing psychosocial stress.	Progress note to detail reasons for crisis intervention services.
Client safety will be continuously assessed and addressed when providing crisis intervention services.	Progress note to detail safety assessment.
Progress notes will document crisis intervention services.	Signed, dated progress note in client chart to include: • Date, time of day and time spent • Summary of crisis event • Interventions and referrals • Results of interventions and referrals • Follow-up plan
Progress notes completed by unlicensed providers will be cosigned by licensed clinical supervisor.	Cosignature on file in client record.

UTILIZING INTERNS, ASSOCIATES AND TRAINEES

A significant portion of mental health services are provided by interns, associates and trainees (IATs). While this process expands capacity by developing a well-trained workforce and provides increased access through cost effective services, extra care must be taken to ensure that high quality, ethical counseling and psychotherapy services are maintained.

Programs utilizing IATs will give thoughtful attention to:

- **Training:** Programs utilizing IATs will provide an orientation and training program of no less than 24 hours of instruction focusing on the specifics of providing HIV mental health services. This orientation/training will be completed before IATs begin providing services.
- **Case assignment:** IATs will only be assigned cases that are appropriate to their experience and scope of practice. Additionally, IAT should not be assigned cases that require an intervention that is longer term than the IAT's internship. Such cases should be referred to staff clinicians or referred out.
- **Supervision:** Programs will provide IATs with clinical supervision in accordance with all applicable rules and standards. Supervisors, or other appropriate mental health staff will be available to IAT at all times that they are providing direct services to clients.

IATs will explicitly inform their clients of their intern status at the beginning of treatment. A document that acknowledges IAT status and details the case supervisor's name will be signed by the client and IAT and placed in the client record. The issue of termination/transition/transfer (due to a therapist's IAT status) will be addressed at the beginning of the assessment, at treatment inception and revisited six weeks prior to IAT termination.

IATs will consult with the clinical supervisor prior to the termination/transition intervention with a client. As part of the termination process, the IAT and client will discuss the client's treatment accomplishments, challenges, preference for future treatment and treatment recommendation. As is true throughout the treatment process, the clinical supervisor will provide oversight for the termination/transition process and cosign the IAT documentation.

While every effort should be made to ensure that IATs will not provide services for clients whose treatment plans extend past the internship term, it is recognized that in some cases, clients require unanticipated additional and/or ongoing treatment to meet the stated goals of their treatment plans. In such cases, special care must be given to the transfer of these clients.

Programs will endeavor to transfer IAT clients immediately to another clinician or outside program.

In the event that a client must be placed on a waiting list for transfer to another clinician or IAT, programs will provide the following options for ongoing monitoring and crisis care:

- **Telephone contact:** Existing mental health staff or IAT will attempt contact at least twice a month to every client on the transfer waiting list in order to monitor current mental status and assess for emergent crises.
- **Transition group:** All clients on a transfer waiting list will be offered the opportunity to attend a transition group or another existing support group in order to monitor current mental status and assess for emergent crises.
- **Crisis counseling:** Utilizing both monitoring mechanisms noted above, all clients on a transfer waiting list will be informed of the availability of crisis counseling designated for them on an as needed basis

Programs will complete a Client Transfer Form (CTF) detailing the transfer plan for each IAT transfer.

STANDARD	MEASURE
Programs using IATs will provide an orientation and training program of no less than 24 hours to be completed before IATs begin providing services.	Documentation of training/orientation on file at provider agency.
IATs will be assigned cases appropriate to experience and scope of practice and that can likely be resolved over the course of the IAT's internship.	Record of case assignment on file at provider agency.
Programs will provide IATs with clinical supervision in accordance with all applicable rules and standards.	Record of clinical supervision on file at provider agency.
IATs will inform clients of their status as an intern and the name of the supervisor covering the case.	Internship notification form, signed by the client and the therapist on file in client chart.
Termination/transition/transfer will be addressed at the beginning of assessment, treatment inception and six weeks prior to termination.	Signed, dated progress note confirming termination/transition/transfer on file in client chart.
At termination the IAT and client will discuss accomplishments, challenges and treatment recommendations.	Signed, dated progress detailing this discussion on file in client chart.
Clients requiring services beyond the IAT's internship will be referred immediately to another clinician	Signed, dated CTF on file in client chart.

STANDARD	MEASURE
All clients placed on a waiting list will be offered the following options: • Telephone contact • Transition group • Crisis counseling	Signed, dated CTF that details the transfer plan on file in client chart.

TRIAGE/REFERRAL/COORDINATION

In certain cases, clients will require a higher level of mental health intervention than a given agency is able to provide. Mental health providers are responsible for referring these clients to additional mental health services including neuropsychological testing, day treatment programs and in-patient hospitalization. Referrals to other services including case management, treatment advocacy, peer support, medical treatment and dental treatment will also be made as indicated. Because many clients receiving mental health services are also diagnosed with co-occurring substance abuse disorders, careful consideration and referral to appropriate substance abuse treatment services are critical. Also vital is the coordination of mental health care with all of the above listed services, especially, primary care medical clinics. Regular contact with a client's primary care clinic and other providers will ensure integration of services and better client care.

STANDARD	MEASURE
As needed, providers will refer clients to full range of mental health services including: • Neuropsychological testing • Day treatment programs • In-patient hospitalization	Signed, dated progress note to document referrals in client chart.
As needed, providers will refer to other services including case management, treatment advocacy, peer support, medical treatment and dental treatment	Signed, dated progress note to document referrals in client chart.
Providers will attempt to make contact with a client's primary care clinic at a minimum of once a year, or as clinically indicated, to coordinate and integrate care. Contact with other providers will occur as clinically indicated.	Documentation of contact with primary medical clinics and providers to be placed in progress notes.

CLIENT RETENTION

Programs will strive to retain clients in mental health treatment. A broken appointment policy and procedure to ensure continuity of service and retention of clients is required. Follow-up can include telephone calls, written correspondence and/or direct contact, and strives to maintain a client's participation in care. Such efforts shall be documented in the progress notes within the client record.

STANDARD	MEASURE
Programs will develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency
Programs will provide regular follow-up procedures to encourage and help maintain a client in mental health treatment.	Documentation of attempts to contact in Progress Notes. Follow up may include: • Telephone calls • Written correspondence • Direct contact

CASE CONFERENCES

Programs will conduct monthly multidisciplinary discussions of selected patients to assist in problem-solving related to a patient's progress toward mental health treatment plan goals and to ensure that professional guidance and high-quality mental health treatment services are being provided. Active clients shall be considered for case conference at least once every six months. All members of the treatment team available, including case managers, treatment advocates, medical personal, etc., are encouraged to attend. These discussions assist mental health providers in problem-solving and monitoring related to a client's progress toward treatment plan goals. Documentation of case conferences shall be maintained within each client record in a case conference log.

Case conference requires the following documentation:
- Date of case conference
- Name of case conference participants
- Name of client(s) discussed
- Issues and concerns identified
- Mental health follow-up plan
- Clinical guidance provided and verification that such guidance has been implemented

STANDARD	MEASURE
Interdisciplinary case conferences will be held for each active client at least once every six months	Case conference documentation, signed by the supervisor, in client record to include: • Date, name of participants and name of client • Issues and concerns • Follow-up plan • Clinical guidance provided • Verification that guidance has been implemented

CASE CLOSURE

Case closure is a systematic process for discharging clients from mental health services. The process includes the completion of a case closure summary to be maintained in the client record. Clients are considered active provided they receive mental health services at least once within a one-year period.

Case closure will be initiated if the patient does not receive mental health services or is unable to be contacted within a one-year period.

Case closure may occur when the patient:
- Successfully attains psychiatric treatment goals
- Relocates out of the service area
- Becomes eligible for benefits or other third-party payer (e.g., Medi-Cal, medical insurance, etc.)
- Has had no direct program contact in a one-year period
- Is ineligible for the service
- No longer needs the service
- Discontinues the service
- Is incarcerated long term
- Utilizes the service improperly or has not complied with the client services agreement
- Has died

Case closure summaries (CCS') will include the date and signature of the mental health provider. If the provider is unlicensed, the case closure summary will be cosigned by the licensed clinical supervisor. For unlicensed psychiatric providers, the CCS must be cosigned by a medical doctor board-eligible in psychiatry.

CCS' require the following documentation:

- Course of treatment
- Discharge diagnosis
- Referrals
- Reason for termination
- Documentation of attempts to contact the client, including written correspondence and results of these attempts (For those clients who drop out of treatment without notice)

STANDARD	MEASURE
Programs will develop case closure criteria and procedures.	Case closure criteria and procedures on file at provider agency. Cases may be closed when the patient: • Successfully attains psychiatric treatment goals • Relocates out of the service area • Becomes eligible for benefits or other third-party payer (e.g., Medi-Cal, medical insurance, etc.) • Has had no direct program contact in a one-year period • Is ineligible for the service • No longer needs the service • Discontinues the service • Is incarcerated long term • Utilizes the service improperly or has not complied with the client services agreement • Has died
Regular follow-up will be provided to clients who have dropped out of treatment without notice	Documentation of attempts to contact in progress notes.
A CCS will be completed for each client who has terminated treatment	Client file will include signed and dated CCS to include: • Course of treatment • Discharge diagnosis • Referrals made • Reason for termination
CCS' completed by unlicensed providers will be cosigned by licensed clinical supervisor. For unlicensed psychiatric providers, the CCS must be cosigned by a medical doctor board-eligible in psychiatry.	Cosignature on file in client record

STAFFING REQUIREMENTS AND QUALIFICATIONS

Providers of professional mental health services will be, at a minimum, master's- or doctoral-level graduate students in counseling, marriage and family therapy, nursing (with specialized mental health training), psychiatry, psychology, or social work.

HIV/AIDS psychiatric treatment services are provided by medical doctors board-eligible in psychiatry. A psychiatrist may work in collaboration with a psychiatric resident, or RN/NP. While state law governs prescription of medication, it is recommended that physicians licensed as such by the state of California shall prescribe all prescriptions for psychotropic medications. If an NP is utilized to provide medications, he or she must do so according to standardized protocol and under the supervision of a psychiatrist (Please see Service/Organizational Licensure Category.)

All staff hired by provider agencies will possess the ability to provide developmentally and culturally appropriate care to clients living with and affected by HIV. All clinical staff will have previous experience or training utilizing appropriate treatment modalities in practice.

All hired staff will participate in orientation and training before beginning treatment provision. Licensed providers are encouraged to seek consultation to address clinical, psychosocial, developmental, and programmatic issues, as needed. If providers are unlicensed, they must be clinically supervised in accordance with the requirements of the licensing board of their respective professions. Graduate-level interns must be supervised according to the requirements of their respective programs and to the degree that ensures appropriate practice.

Practitioners should have training and experience with HIV/AIDS related issues and concerns. At a minimum, providers will participate in eight hours of continuing education or continuing medical education (CME) on the topics of HIV and mental health issues every two years.

Practitioners providing mental health services to people with HIV should possess knowledge about the following (at a minimum):

- HIV disease process and current medical treatments
- Medication interactions (for psychiatrists)
- Psychosocial issues related to HIV/AIDS
- Cultural issues related to communities affected by HIV/AIDS
- Mental disorders related to HIV and or other medical conditions
- Mental disorders that can be induced by prescription drug use
- Adherence to medication regimes
- Diagnosis and assessment of HIV-related mental health issues
- HIV/AIDS legal and ethical issues
- Knowledge of human sexuality, gender and sexual orientation issues
- Substance abuse theory, treatment and practice

Finally, practitioners and staff must be aware of and able to practice under the legal and ethical obligations as set forth by California state law and the their respective professional organizations.

Psychiatrists shall comply with existing laws regarding confidentiality, informed consent and client's rights, and shall conform to the standards and guidelines of the American Medical Association and the American Psychiatric Association regarding ethical conduct, including:

- **Duty to treat:** Practitioners have an ethical obligation not to refuse treatment because of fear or lack of knowledge about HIV.
- **Confidentiality:** Maintenance of confidentiality is a primary legal and ethical responsibility of the psychiatric practitioner.
- **Duty to warn:** Serious threats of violence against a reasonably identifiable victim must be reported. However, at present, in California, a person living with HIV engaging in behaviors that may put others at risk for HIV infection is not a circumstance that warrants breaking of confidentiality. Physicians, however, may notify identified partners who may have been infected, while other mental health providers are not permitted to do so.

Mental health service providers are advised to seek legal advice when they are unsure about particular issues and the legal/ethical ramifications of their actions.

STANDARD	MEASURE
Provider will ensure that all staff providing psychiatric treatment services will be licensed, supervised by a medical doctor board-eligible in psychiatry, accruing hours toward licensure or a registered graduate student enrolled in a counseling, social work, psychology or marriage and family therapy program.	Documentation of licensure/professional/student status on file.
It is recommended that physicians licensed as such by the state of California shall prescribe psychotropic medications.	Documentation of licensure on file.
New staff will complete orientation/training prior to providing services.	Documentation of training on file.
Mental health staff are trained and knowledgeable regarding HIV/AIDS and the affected community.	Training documentation on file maintained in each personnel record which includes: • Date, time and location of the function • Function type • Name of the agency and staff members attending the function • Name of sponsor or provider • Training outline, meeting agenda and/or minutes
Programs will provide and/or allow access to ongoing staff training and development of staff including medical, psychiatric and mental health HIV-related issues.	Training documentation on file maintained in each personnel record which includes: • Date, time and location of the function • Function type • Name of the agency and staff members attending the function • Name of sponsor or provider • Training outline, meeting agenda and/or minutes
Licensed staff are encouraged to seek consultation as needed.	Documentation of consultation on file.
Treatment providers will practice according to California state law and the ethical codes of their respective professional organizations.	Chart review will ensure legally and ethically appropriate practice.
Psychiatric treatment providers will possess skill, experience and licensing qualifications appropriate to provision of psychiatric treatment services	Resume and current license on file.
Unlicensed professional psychiatric and mental health professionals will receive supervision in accordance with state licensing requirements. DHSP will be notified immediately in writing if a clinical supervisor is not available.	Documentation of supervision on file.
Mental health service staff will complete documentation required by program.	Administrative supervisor will review documentation periodically.

ADMINISTRATIVE SUPERVISION

Programs will conduct client record reviews to assess that all required mental health documentation is completed properly in a timely manner and secured within the client records. Client record review will require the following documentation:

- Checklist of required documentation signed and dated by the person conducting the record review
- Written documentation identifying steps to be taken to rectify missing or incomplete documentation
- Date of resolution of omitted required documentation

STANDARD	MEASURE
Programs shall conduct record reviews to ensure appropriate documentation.	Client record review, signed and dated by reviewer on file to include: • Checklist of required documentation • Written documentation identifying steps to be taken to rectify missing or incomplete documentation • Date of resolution for omissions

UNITS OF SERVICE

Unit of service: Units of service defined as reimbursement for mental health treatment are based on time spent providing, documenting and receiving consultation/supervision for direct treatment.

- ***Individual psychotherapy units:*** Calculated in hour increments per counseling session.
- ***Family/conjoint psychotherapy units:*** Calculated in hour increments per counseling session
- ***Group psychotherapy units:*** Calculated in hour increments per each client in attendance in a counseling session.
- ***Drop-in group psychotherapy units:*** Calculated in hour increments per each client in attendance in a counseling session.
- ***Crisis intervention units:*** Calculated in hour increments per counseling session.
- ***Psychiatric diagnostic service units:*** Calculated in hour increments per psychiatric session.
- ***Medication evaluation units:*** Calculated in hour increments per psychiatric session.
- ***Psychotropic medication provision units:*** Calculated in hour increments per psychiatric session.
- ***Medication monitoring units:*** Calculated in quarter-hour increments per counseling session.

Number of clients: Client numbers are documented using the figures for unduplicated clients in a given contract period.

OTHER RESOURCES

Professional Organizations:

- Board of Behavioral Science Examiners – http://www.bbs.ca.gov
- Board of Psychology – http://www.dca.ca.gov/psych California Medical Board – http://www.medbd.ca.gov/
- California State Board of Nursing – http://www.rn.ca.gov/index.html
- Board of Behavioral Science Examiners – http://www.bbs.ca.gov
- Board of Psychology – http://www.dca.ca.gov/psych

Ethical Codes:

- American Psychological Association — http://www.apa.org/ethics
- California Association of Marriage and Family Therapists – http://www.camft.org/about/ethicsi.html
- National Association of Social Workers — http://www.naswdc.org/PRAC/standards/standards.htm
- American Psychiatric Association — http://www.psych.org/psych_pract/ethics/ppaethics.cfm

- American Psychological Association — http://www.apa.org/ethics
- California Association of Marriage and Family Therapists — http://www.camft.org/about/ethicsi.html
- National Association of Social Workers — http://www.naswdc.org/PRAC/standards/standards.htm

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CCS	Case Closure Summary
CME	Continuing Medical Education
CTF	Consent Transfer Form
DHSP	Division of HIV and STD Programs
DSM	Diagnostic and Statistical Manual of Mental Disorders
EdD	Doctoral Degree in Education
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
IATs	Interns, Associates and Trainees
LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
MD	Medical Doctor
MSW	Masters Degree in Social Work
NP	Nurse Practitioner
PhD	Doctor of Philosophy
PNS	Psychiatric Nurse Specialist
PsyD	Doctoral Degree in Psychology
RN	Registered Nurse
STD	Sexually Transmitted Disease