Baltimore City Health Department
Ryan White CARE Act, Title I
Quality Improvement Program (QIP)

Standards of Care Comparative Analysis:
Mental Health

December 2002

Prepared by:

*T*raining *R*esources *N*etwork
Alan Drucker, PhD
Susan Thorner, MA
Cheryl Nesbitt
Lori DeLorenzo, RN, MSN
Jeffrey Menzer, RN, ACRN

Comparative Analysis of Mental Health Standards of Care

Section 1. Process

The Baltimore EMA Standards of Care (EMA Standards) related to the delivery of mental health services for adults[1] were compared with standards from three different sources: The American Psychiatric Association's Practice Guideline for the Treatment of Patients with HIV/AIDS[2]; The Institute for Clinical Systems Improvement (ICSI)[3]; and the Texas Implementation of Medical Algorithms (TIMA)[4].

An extensive search for relevant treatment guidelines to be utilized in this comparison was conducted using multiple databases. This search revealed that the only national organization to have published guidelines specific to the mental health treatment of persons with HIV/AIDS is the American Psychiatric Association.

Since the Baltimore EMA Standards state that treatment for specific psychiatric symptoms/conditions/disorders should be provided in accordance with other published practice guidelines, a search was conducted to identify resources with published treatment guidelines for a variety of psychiatric conditions covering the spectrum of mood disorders (e.g., Major Depression and Bipolar Disorders), psychotic disorders (i.e., Schizophrenia), anxiety disorders (e.g., Panic Disorder, Generalized Anxiety Disorder, Post-Traumatic Stress Disorder), and cognitive disorders (i.e., Dementia). Several such practice guidelines were identified. From this list of practice guidelines, the list was subsequently narrowed to include guidelines that were evidence-based with documentation and a rating schema for the quality of the evidence, and to those agencies which had guidelines published for several psychiatric conditions.

Unfortunately, the practice guidelines that were available for review were all written with a target audience of psychiatrists, primary care physicians, physician assistants, nurse practitioners, or mental health practitioners (psychologists, social workers, or nurse clinicians). All of the guidelines that were reviewed focused heavily on pharmacological treatment(s) of mental disorders, and none provided much detail regarding psychotherapy interventions.

No treatment guidelines specific to the provision of mental health treatment to children and adolescents with HIV/AIDS could be identified. Some practice guidelines for the psychiatric treatment of children and adolescents were identified. However, these were specifically directed toward child psychiatrists and related to psychopharmacological treatment. The practice

---

[1] Greater Baltimore HIV Health Services Planning Council, *Standards of Care for Health Services and Support* Services, Section 4, September 1999.

[2] The American Psychiatric Association's Practice Guideline for the Treatment of Patients with HIV/AIDS is available on the American Psychiatric Association's website (www.psych.org)

[3] The Institute for Clinical Systems Improvement has several clinical guidelines available on their website (www.icsi.org)

[4] The Texas Implementation of Medical Algorithms (TIMA) has clinical algorithms and treatment guidelines available on their website (www.mhmr.state.tx.us/centraloffice/medicaldirector/TIMA.html)

guidelines that were found for child and adolescent mental health services did not generally have applicability to the Baltimore EMA Standard of Care for Mental Health Services to Children and Adolescents. Therefore, no comparative analysis was performed with respect to those standards.

The results from the comparative analysis for the three practice guidelines selected are presented in Table 1. Column 1 outlines the EMA Standard of Care, Column 2 outlines the American Psychiatric Association's Practice Guideline for the Treatment of Patients with HIV/AIDS, Column 3 outlines the Institute for Clinical Systems Improvement guidelines, and Column 4 outlines the Texas Implementation of Medical Algorithms guidelines. Column 5 presents the strengths and/or weaknesses of the Baltimore EMA Standards of Care, and Column 6 presents recommendations for consideration to revise the Baltimore EMA Standards of Care based upon the results of this comparative analysis.

Section 2. Summary of Comparative Analysis

The Baltimore EMA Standards of Care for Mental Health Services are comprehensive. Strengths of the EMA Standards included the emphasis on the use of a multidisciplinary team for evaluation and treatment of persons with HIV/AIDS, the explicitness of the documentation expected for mental health treatment evaluations, and the emphasis placed on providing continuous counseling for reducing HIV-transmitting behaviors and substance abuse.

In general, the EMA Standards were found to exceed the recommendations of the APA Practice Guidelines for Treatment of Patients with HIV/AIDS. While the APA Practice Guidelines provide a great deal of background education regarding HIV/AIDS, it is difficult to identify specific recommendations. The APA Practice Guidelines did identify a few issues that were not specifically addressed in the EMA Standards of Care. For example, the APA Practice Guidelines reference the identification of the cultural and religious/spiritual background of patients as part of the complete evaluation.

One main deficiency of the EMA Standards of Care is the lack of specificity with respect to actual treatment guidelines. This is clearly a difficult task to achieve, as the mental disorders that commonly are associated with HIV/AIDS are quite diverse. The EMA Standards provide excellent detail with respect to the evaluation and formulation of a differential diagnosis, but does not address the actual provision of treatment with the same specificity.

Conversely, the Institute for Clinical Systems Improvement practice guidelines and the Texas Implementation of Medical Algorithms practice guidelines are limited in their utility by virtue of the lack of specificity for individuals with HIV/AIDS. Neither of these organization's practice guidelines address many of the unique issues that confront those providing treatment to individuals with HIV/AIDS infections. For example, neither set of guidelines address potential medication interactions with antiretroviral medications, nor do they address treatment of psychiatric syndromes that have primarily medical origins (e.g., cerebritis, medication induced depression/anxiety, etc.)

Another short-coming of the treatment guidelines reviewed was the lack of incorporation of psychotherapy into the treatment recommendations. The EMA Standards do make an effort to incorporate counseling and psychotherapy into the treatment schema. However, they also do not provide specific guidance as to the types of psychotherapy that might be indicated or any specific standards for assessing the efficacy of such treatment for the individual with HIV/AIDS.

Section 3. Preliminary Recommendations

The recommendations that result from the comparative analysis are presented in detail in Table 1, Column 6.

The Baltimore EMA Standards for Mental Health Treatment would benefit from further development of standardized treatment recommendations for major diagnostic categories. Within the comparative analysis are several recommendations that may serve to guide the process of developing such treatment recommendations. For clarity, these recommendations are reported here.

1) Basic treatment algorithms should be developed for each of the following general diagnostic categories: psychosis, depression, bipolar disorder, anxiety, dementia/cognitive disorders, and delirium. Such treatment algorithms should provide specifics as to appropriate treatment based on symptom severity and acuity of the psychiatric syndrome.

2) Treatment algorithms should be developed that address the multidisciplinary treatment team approach by providing specific recommendations that would apply to each of the following treatment modalities: pharmacotherapy, psychotherapy, pastoral care, and case management.

3) Guidelines should include greater specificity regarding the interaction of the mental health treatment team with the patient's Primary Care Physician and medical treatment team. A section may need to be added which would specifically address communication between the medical and mental health treatment teams to ensure coordination of care.

Table 1. Comparison between Baltimore EMA's Standards for Adult Mental Health Services and National Professional Associations

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
1.0 Mental health and psychiatric care for persons with HIV should reflect competence and experience in evaluation, formulation, and diagnosis as well as in evidence-based therapeutics, using contemporary practice guidelines where available.	"All psychiatrists need to have an adequate fund of knowledge about HIV/AIDS. …Optimum management of patients at high risk for HIV infection uses a wide range of psychiatric skills such as comprehensive diagnostic evaluations, assessment of possible medical causes of new-onset symptoms, initiation of specific treatment interventions, and a keen understanding of psychodynamic issues…."	These guidelines do not specifically address the provision of treatment for individuals with HIV/AIDS. There are several different guidelines for various settings (e.g., treatment by mental health professionals, treatment by Primary Care clinicians, different diagnostic conditions.) Each set of guidelines clearly identifies the target treatment audience.	These guidelines are specifically written for use by psychiatrists and/or Primary Care Physicians for treatment of various psychiatric disorders. They are not specific to HIV. These are examples of the evidence-based therapeutics and contemporary guidelines to which this standard refers.	S: The standard is intended to ensure that the mental health services received by persons with HIV are of the highest quality and is supported by medical evidence as being effective.	No recommendations.
1.1 An initial evaluation must be conducted prior to the initiation of any treatment. This evaluation must be conducted by a licensed mental health professional working as part of an interdisciplinary team. This team must consist at a minimum of: a psychiatrist and any of the following professional: A psychologist, social worker, or mental health clinical nurse specialist.	"The development of a psychiatric treatment plan for patients with HIV infection requires thoughtful and comprehensive consideration of the biopsychosocial context of the illness [I]. "	These guidelines do not discuss the evaluation that should be performed prior to initiating treatment. The guidelines assume that a diagnosis has been made, or that the presenting symptoms strongly indicate the presence of the condition for which the guideline was written. These guidelines identify the target audience for whom the guidelines were written (e.g., psychiatrists, Primary Care Physicians, clinical nurse specialists in mental health, licensed social workers, psychologists.) The guidelines	These guidelines do not discuss the evaluation that should be performed prior to initiating treatment. The guidelines assume that a diagnosis has been made, or that the presenting symptoms strongly indicate the presence of the condition for which the guideline was written. Guidelines exist for the treatment of Schizophrenia, Bipolar Disorder, and Major Depression. As these guidelines are specifically written to address pharmacotherapy of these	S: The importance of a thorough evaluation prior to decisions regarding treatment is identified. S: The need for a multidisciplinary treatment approach is identified. W: The standard mandates a psychiatrist to be a part of the multidisciplinary treatment team when it is often the Primary Care Physician who	Consideration should be given to rewording the definition of the multidisciplinary team. RECOMMEND: "This team must consist of the following: either a psychiatrist or the Primary Care Physician, Physician's Assistant, or Nurse Practitioner, AND any of the following: a psychologist,

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
Non-licensed providers may also provide services under the supervision of appropriately licensed providers.		do not address the use of multidisciplinary treatment teams.	conditions, they are intended only for physicians or others licensed to prescribe psychotropic medications. The guidelines do not address the use of a multidisciplinary team in providing treatment.	may be prescribing psychotropic medications and a psychologist, social worker, or mental health clinical nurse specialist who has conducted the assessment and is providing mental health intervention.	social worker, mental health clinical nurse specialist, or Marriage and Family Therapist. Non-licensed providers may also provide services under the supervision of appropriately licensed providers."
The evaluation must consist of the following:					
1.1a History, chief complaint, present illness, past psychiatric history, family history, social and personal history substance use history medical history, review of systems, current and recent medication, and pre-morbid personality.	"Specific tasks that constitute the psychiatric management of patients with HIV/AIDS include the following: establishing and maintaining a therapeutic alliance; collaboration and coordination of care with other mental health and medical providers; diagnosing and treating all associated psychiatric disorders; facilitating adherence to the overall treatment plan; providing education about psychological, psychiatric, and neuropsychiatric disorders; providing risk reduction strategies to further minimize the spread of HIV; maximizing psychological and	These guidelines do not include details regarding the components of a history that should be obtained during an evaluation.	These guidelines do not include details regarding the components of a history that should be obtained during an evaluation. "It is assumed that a comprehensive psychiatric evaluation, a complete general medical history, and relevant diagnostic tests are completed prior to entry into any treatment algorithm."	S: The standard is very specific regarding the components of the assessment that should be included. W: Issues of culture, religious/spiritual beliefs that might affect treatment are not addressed.	Include an assessment of the patient's cultural, religious, and/or spiritual beliefs, which might affect treatment.

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
	social/adaptive functioning; considering the role of religion/spirituality; preparing the patient for issues of disability, death, and dying; and advising significant others/family regarding sources of care and support."				
1.1b Complete mental status evaluation: appearance and behavior, talk, mood, vital sense, self attitude, suicidal risk, homicidal risk, abnormal beliefs (delusions, overvalued ideas), perceptual disturbances (hallucinations, illusions), obsessions/compulsions, phobias, panic attacks.	Not addressed in the guidelines.	These guidelines do not include the components of a mental status examination that should be included in an evaluation.	These guidelines do not include components of a mental status examination that should be included in an evaluation. "It is assumed that a comprehensive psychiatric evaluation, a complete general medical history, and relevant diagnostic tests are completed prior to entry into any treatment algorithm."	S: The standard is specific as to the elements that constitute a complete mental status examination.	No Recommendations
1.1c Cognitive assessment: level of consciousness, orientation, memory, language, praxis, executive (may substitute the Mini-Mental State and Verbal Trails Test)	"When seeing a patient in consultation, it is important to gather history about cognitive or motor symptoms and conduct a mental status screening examination to determine whether neurocognitive deficits are present." "The widely used Mini-Mental State is not sensitive in picking up early HIV-Associated cognitive motor	These guidelines do not address the cognitive examination of patients.	These guidelines do not address the cognitive examination of patients. "It is assumed that a comprehensive psychiatric evaluation, a complete general medical history, and relevant diagnostic tests are completed prior to entry into any treatment	S: Specifics elements to be included in the cognitive assessment are outlined. W: The Mini-Mental State is not sensitive in detecting early HIV-associated cognitive motor symptoms. Other	Delete the parenthetical clause regarding use of the Mini-Mental State and Verbal Trails Test. Recommend use of the following screening tests instead of the Mini-

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
	symptoms. Alternative screening examinations have been proposed that identify symptoms more likely to be present with subcortical dementia. Psychiatrists should become familiar with the available screening examinations for cognitive motor impairment that are more specific for subcortical symptoms." "…psychiatrists should administer a baseline screening examination on every patient with HIV infection and plan to readminister the test on a regular basis as part of the treatment plan. If there is evidence of early cognitive impairment, formal neuropsychological testing is useful to more comprehensively document cognitive dysfunction as well as areas of relative cognitive strength."		algorithm."	tests are identified which are more specific for HIV-associated cognitive disorders. W: The APA Guidelines suggest that a baseline neurocognitive screening be completed and that this should be repeated at regular intervals and/or if symptoms emerge which indicate possible HIV cognitive impairment. The Baltimore EMA standards do not require this.	Mental State: Mental Alteration Test, HIV Dementia Scale, and Executive Interview Test. Would suggest that all patients receiving psychiatric treatment have the above three tests performed at baseline and repeated annually or as clinically indicated by emerging symptoms of cognitive impairment.
1.1d Laboratory assessment, as clinically indicated.	Guidelines recommend laboratory assessments based upon clinical indications from history and/or exam.	"There are no definitive studies which support recommendations for or against routine laboratory or medical screening." "No studies have ever shown that routine medical screening in those presenting with major depression in the outpatient	The guidelines make occasional comments regarding the usefulness of monitoring the serum levels of tricyclic antidepressants. Otherwise, they do not make recommendations regarding laboratory assessments that should be	S: The guideline encourages consideration of appropriate laboratory testing. W: The standard does not address the issue of psychological	Include psychometric and neuropsychological testing as clinically indicated.

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
		setting yields benefit." "Studies have demonstrated that the yield of thyroid function studies is minimal for patients with or without fatigue as a prominent symptom." (*NOTE:* These guidelines are written for the general treatment of psychiatric disorders, not specific to individuals with HIV. The above statements are probably not applicable to persons infected with HIV, since medical etiology for many psychiatric symptoms is actually quite common and laboratory evaluation is more likely to be indicated based upon clinical presentation, stage of HIV disease, and other factors.)	completed prior to initiating treatment. "It is assumed that a comprehensive psychiatric evaluation, a complete general medical history, and relevant diagnostic tests are completed prior to entry into any treatment algorithm."	or neuropsychological testing which may be indicated for some patients.	
1.1e Multi-axial differential diagnosis leading to final diagnostic formulation.	Guidelines identify several categories of psychiatric disorders that are commonly identified in persons with HIV. The guidelines specifically state, "Psychiatric disorders associated with HIV/AIDS should be accurately identified and treated." "The more common diagnoses found in association with HIV/AIDS are dementia and	These guidelines emphasize use of the DSM-IV diagnostic criteria and description of the diagnoses on the basis of the multi-axial schema of DSM-IV. The guidelines also emphasize the use of modifiers for the general diagnosis (e.g., Major Depression would be modified as atypical, post-partum, seasonal pattern, melancholic,	These guidelines assume that a final diagnostic formulation has been made, and that the patient being treated has the diagnosis for which the treatment algorithm is intended.	S: The use of the DSM-IV schema of using the multi-axial system for characterizing and diagnosing conditions is encouraged. S: The standard reminds clinicians to create a differential	No recommendations.

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
	the spectrum of cognitive disorders; delirium; mood disorders; substance use disorders; anxiety disorders; psychotic disorders; adjustment disorders; sleep disorders; disorders occurring in infants, children, and adolescents; and HIV-associated syndromes with psychiatric implications."	psychotic, or catatonic.)		diagnosis and to reduce this to a final diagnostic opinion.	
1.1f A plan of care with specific measurement treatment goals through the use of appropriate outcome assessment. The treatment plan must include input from the client.	Not addressed in the APA Guideline.	The guidelines address specific areas related to treatment planning not addressed by the Baltimore Standards, including appropriateness of the level or intensity of care (e.g., inpatient treatment v. outpatient treatment). It also provides specific treatment recommendations with regard to the indicated treatment based upon the severity of the illness. The guidelines state, "treatment should involve agreement between the patient and his or her provider (primary care or psychiatry) involved in managing this condition." The treatment guidelines also stress the importance of patient and family education regarding their illness and treatment to be included as a component of the	The guidelines provide the treatment plan in an algorithmic manner with respect to treatment with psychopharmacologic agents. "Treatment Goals: 1) The ultimate goal in the acute phase of treatment (0-12 weeks) is achieving symptomatic remission and full return of psychosocial functioning. The prevention of relapse and recurrence is the essential goal of the continuation and maintenance phases of treatment."	S: The standard is in accordance with generally accepted practices, and exceeds the APA Guidelines, which do not address this issue. Input from the patient is an important element that empowers the patient to actively participate in his/her own treatment.	Suggested revision : "A plan of treatment with measurable goals stated in terns of behaviors and/or symptoms. The treatment plan must identify the method that will be used to assess progress towards the treatment goals. The treatment plan must include input from the client."

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
		treatment plan.			
1.1g Practice guidelines for specific conditions/situations/disorders, such as those published by the American Psychiatric Association or the American Psychological Association should inform the treatment plans.	"Treatment decisions must balance standard recommendations for psychiatric conditions against the medical stage of HIV illness and up-to-date information about available medical interventions targeted at the underlying HIV infection." "There are no data to suggest that the psychotherapeutic management of patients with HIV infection should be different from that of other patients."	These guidelines would be examples of the "Practice guidelines for specific conditions/situations/disorders" which is referenced in this standard. There are various guidelines available from the ICSI addressing such disorders as Major Depression, Bipolar Disorder, Schizophrenia, Panic Disorder, and others.	These guidelines would be examples of the "Practice guidelines for specific conditions/situations/disorders" which is referenced in this standard. The guidelines available from this source address the following disorders: Major Depression; Bipolar Disorder; Schizophrenia.	W: Specific treatment guidelines for individual diagnoses are not provided. Available practice guidelines may vary dramatically in quality, ease of implementation, recommendations, and focus of treatment.	Specific treatment guidelines should be developed by the Baltimore EMA for the "specific conditions/situations /disorders" to which this refers, or that the standard be reworded as follows: Treatment will conform with the standards of care recognized within the general community and supported by clinically published research for the client's condition.
1.2 Follow-up visits to provide or monitor treatments and to assess progress toward meeting care plan goals.					
1.2a Visit frequency averaging every week to two weeks for patients with active symptoms working toward a short-term goal. For those whose symptoms are in	No guidance is offered with respect to recommended visit frequency.	These guidelines offer no specifics regarding the frequency with which patients should be seen.	These guidelines are quite specific as to the frequency of follow-up visits for monitoring of medications. Treatment is divided into three phases: acute phase, continuation phase, and	S: The standard provides guidance for the level of intensity of treatment for those with active symptoms working toward a treatment goal, and	Modify by dividing treatment into phases and establishing appropriate frequency of visits within each phase of

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
remission, bit remain on psychotropic medicines, visits averaging every three months are necessary.			maintenance phase. These phases are defined as correlate with a certain percentage of symptom resolution.	for patients receiving medication management services only. W: The standards do not allow for individuality of treatment needs. W: The visit frequency which would be appropriate for patients with sub-acute or chronic problems are not addressed. W: The visit frequency for medication management for patients with unstable or acute symptoms are not outlined.	treatment and dependent upon the type of treatment being provided. The treatment stages best suited for this would be: acute phase/symptomatic phase; sub-acute/continuation phase; maintenance phase. For psychotherapy visits, frequency would be minimum of: once per week in acute phase, once every month in sub-acute phase, and once every three months in maintenance phase. For medication management, visit frequency would be minimum of: once every other week in acute phase, once every two months in sub-acute phase, and once every 4 months in the maintenance phase.

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
1.2b The provision of supportive and educational counseling, at all visits. This should include counseling regarding the prevention of HIV-transmitting behaviors and substance abuse, as clinically indicated	"It is often the psychiatrist's role to educate other clinicians and patients about the neuropsychiatric complications of HIV infection and to initiate and encourage treatment of current or emergent psychiatric disorders." "Psychiatrists are obligated to assess the risk for HIV transmission from their HIV-infected patients to others and provide risk reduction counseling. This task should be a long-term treatment priority, since many HIV-infected individuals continue risk behaviors. Risk assessment should be repeated when there are changes in the patient's clinical status or social situation, such as the onset of binge drug or alcohol use or new sexual relationships." "Psychiatric treatment of patients with HIV infection should include active monitoring of substance abuse, since it is often associated with risk behaviors that can lead to further transmission of HIV [I]."	"Patient education is essential for successful treatment… Education objectives include: 1.) Provide basic information on the causes, diagnosis, treatment, and management of (the condition). 2) Empower patients to help manage their illness in conjunction with their clinician. 3) Involve the family in educational efforts unless contraindicated." These guidelines do not address the issues of counseling and/or education regarding prevention of HIV-transmitting behaviors and substance abuse since these guidelines are not intended to address HIV/AIDS specifically.	These treatment guidelines do not address the issue of providing supportive and/or educational counseling. These guidelines do not address the issues of counseling and/or education regarding prevention of HIV-transmitting behaviors and substance abuse since these guidelines are not intended to address HIV/AIDS specifically.	S: The need to provide supportive and educational counseling for persons with HIV is recognized. It specifically addresses risk reduction counseling and substance abuse avoidance. The standard is consistent with the APA Guidelines with respect to these two areas. W: The standards do not address other areas that might require supportive and/or educational counseling, such as: treatment adherence; lifestyle modification; development of social support systems; resource identification.	Suggest expanding this to include provision of counseling for treatment adherence, lifestyle modification, development of social support systems, and identification of other community resources as indicated by the client's circumstances.
1.2c The provision of specific types of psychotherapy (e.g. interpersonal.	"There are no data to suggest that the psychotherapeutic management of patients with HIV infection should be different from	The guidelines mention that "psychotherapy may be elected instead of, or in addition to, pharmacotherapy" for mild to	These guidelines do not address the type(s) of psychotherapy that would be indicated based on	S: The standard links the provision of therapy with identified treatment goals.	Suggest identifying specific forms of counseling which are indicated for

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
behavioral, psychodynamic, cognitive) as indicated by the clinical situation, based on practice guideline recommendations, and linked to specific treatment goals.	that of other patients. Many clinicians use a variety of approaches (e.g., both time-limited and longer-term individual and group psychotherapy) and psychotherapeutic models (e.g. cognitive behavior, supportive, interpersonal, or psychodynamic/psychoanalytic)."	moderate levels of the condition. However, the guidelines do not address the type(s) of psychotherapy that would be indicated based on research evidence of efficacy, nor do the guidelines identify specific goals of psychotherapy.	research evidence of efficacy, nor do the guidelines identify specific goals of psychotherapy. "At baseline and throughout treatment, possible psychosocial interventions, including psychotherapy, should be considered to optimize treatment. The protocol allows for the addition of psychotherapy if clinically indicated based on individual patient situations."	W: No specific practice guidelines to which it refers are identified.	various conditions based upon treatment guidelines. For example: Depression/Anxiety – Cognitive Behavioral or Interpersonal Therapy Psychosis – Social Rehabilitation Personality Disorders – Cognitive Behavioral or Dialectic or Interpersonal Therapy
1.2d The prescription and monitoring of appropriate psychotropic medications is indicated by the clinical situation, evidence-based practice guideline recommendations, and linked to specific treatment goals. Psychotropic medications must be	The need to establish and maintain an ongoing therapeutic relationship is covered in Section III.B.1.a – Establish and maintain a therapeutic alliance.	These guidelines serve as examples of the evidence-based guideline recommendations referred to in the Baltimore EMA standard. These guidelines do not require that a psychiatrist be the prescribing physician.	These guidelines serve as examples of the evidence-based guideline recommendations referred to in the Baltimore EMA standard. These guidelines do not require that a psychiatrist be the prescribing physician.	S: Encourages patients to develop ongoing relationships with the psychiatrist prescribing psychotropic medications. W: Specific treatment guidelines are not referenced.	Suggest altering the wording to allow that non-psychiatrists may prescribe psychotropic medications (e.g., Primary Care Physicians, Physician Assistants, or Nurse Practitioners).

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
provided under the supervision of a psychiatrist. Clients must have the opportunity to develop ongoing relationships with the psychiatrist(s) prescribing their psychotropic medication(s).				W: Prescription of psychotropic medication should in part be linked to specific symptoms, and monitoring of medication should reflect progress toward symptom resolution and/or prevention of symptom reoccurrence. (As opposed to "treatment goals".) W: The standard is specific to psychiatrist, while Primary Care Physicians, Physician Assistants, or Nurse Practitioners may prescribe psychotropic medications.	Recommend that Informed Consent for treatment with psychotropic medications be documented in the medical record. Recommend rewording so that medication monitoring reflects assessment of progress to resolution of presenting symptoms and/or prevention of symptom reoccurrence.
1.2e Medication side effect assessment and teaching for patients on psychotropic medications.	"General guidelines, particularly for patients with symptomatic HIV disease, include 1) using lower starting doses and slower titration, 2) providing the least complicated dosing schedules possible, 3) focusing on drug	These guidelines present a comprehensive chart of the commonly used medications and their adverse effect profiles. However, the guidelines do not offer any specifics as to how often an	These guidelines imply that adverse effects of medications should be assessed at each visit. Adverse effects of medications are one of the criteria that determine the	S: Standard is recognizes that patients should be informed about the medication(s) prescribed, and that the clinician should	Revise the wording to state: Medication side effects are assessed at each visit. Potential medication interactions are

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
	side effect profiles to avoid unnecessary adverse events (e.g., anticholinergic effects from tricyclic antidepressants, leukopenia from carbamazepine), and 4) maintaining awareness of drug metabolism/clearance pathways to minimize drug-drug interactions and possible end organ damage." "Although some drug-drug interactions may be only theoretical, it is prudent for clinicians to explain these concerns during the informed consent process of psychotropic prescribing. Because of the extent of comorbid substance abuse among some HIV patients, a general warning of the possible interactions of combining antiretroviral agents, psychotropic medications, and recreational drugs are often indicated."	assessment of side-effects should occur, how to manage adverse effects, or what education patients should receive regarding their medication and/or adverse effects of their medication.	recommendations for the next course of action in the treatment protocol. The guidelines do not address patient education regarding psychotropic medications.	assess for adverse effects of medication(s). W: The need to obtain and document informed consent from the patient for treatment with psychotropic medications is not outlined. W: Assessment of potential medication interactions is not addressed and frequency with which this should occur is not delineated.	assessed at each visit. Patients are provided education regarding their medication, including: name of medication, reason being prescribed, expected benefits, possible adverse effects, and alternative treatments.
1.2f Monitoring of progress toward care plan goals through the use of appropriate outcome assessment, which must include input from the client.	Not addressed in the guideline.	"Assessment includes evaluation of symptoms, work or school attendance and productivity and quality of interpersonal interactions." The guidelines include examples of some patient self-rating instruments and physician	The guidelines monitor treatment progress based upon percentage of symptom resolution. The guidelines include screening tools that are completed by the patient to monitor improvement in	S: Ensures that treatment progress is evaluated and considers the client's own assessment of progress. W: No specificity as	Recommend that assessment of treatment progress toward treatment goals be documented at each visit.

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
		administered rating instruments to objectively document treatment response.	conjunction with the clinical interview. There is also an objective scale by which to rate the severity of adverse effects of medications, if present.	to how often progress towards treatment goals should be conducted. W: No provision to document identified barriers to attaining treatment goals. W: No provision for modification of the treatment plan as clinically indicated.	Recommend that barriers to treatment progress be identified and documented at each visit. Recommend that treatment plan be updated whenever clinically indicated.
1.2g Reassessment of each client's case and care plan at least every three months.	Not addressed in the guidelines.	This standard is not addressed in the treatment guidelines.	The guidelines do not specifically address this issue. However, the guidelines identify "Critical Decision Points" throughout the course of treatment. These Critical Decision Points require that the clinician assess the patient's progress in treatment. These decision points occur within three-month intervals.	S: Specific with regard to minimum frequency of treatment care plan review. W: Does not address who is responsible for this review. W: Does not specify that client's input should be included in this reassessment.	Suggest identifying the individual(s) with responsibility for ensuring this is accomplished. Suggest requiring that the treatment plan and treatment goals are reviewed with the patient at least every three months, and that the patient provides input regarding any changes to the treatment plan.
2.0 HIV mental health providers must show	"Issues of confidentiality should be reviewed with the patient, and	This standard is not addressed in these guidelines.	This standard is not addressed in this guideline.	S: Compliance with licensing and	No Recommendations.

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
compliance with the following standards regarding: a. licensure and qualifications of care providers; b. confidentiality and regard for patient rights; c. access, cultural appropriateness and continuity of care; and d. quality of care improvement efforts.	the patient should be asked to consider the psychiatrist's role in assisting with the process of disclosure of HIV status to appropriate persons. …it is important to discuss with the patient whether he or she wants to extend the treatment relationship to include selected communication with the family or significant other(s). …the psychiatrist should be aware of transference and countertransference feelings as well as personal attitudes about HIV infection and how the patient acquired the virus."			confidentiality standards are required.	
2.1a All staff delivering mental health services will possess current organizational and professional licensure.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	S: Standard addresses licensure requirements.	No Recommendations.
2.1b Non-licensed staff or trainees delivering mental health services will receive professional supervision of the care they are providing to individual clients by a licensed mental health provider.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	S: Standard addresses supervision issues.	No Recommendations.
2.1c All staff delivering mental health	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	This standard is not addressed in these	S: Requirements for past experience	No Recommendations.

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
services will either have specific experience in caring for HIV-infected clients or receive appropriate training.			guidelines.	working with HIV-infected clients or training are outlined.	
2.2a The provider organization will provide assurances and a method of protection of patient rights in the process of care provision.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	S: Expectation of patient rights are outlined.	No Recommendations.
2.2b The provider organization will provide assurances and a method of protection of patient confidentiality (in accordance with Maryland Annotated Code), with regard to medical information transmission, maintenance and security.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	S: Expectation of client confidentiality are outlined.	No Recommendations.
2.2c The provider organization will provide assurances regarding the provision of culturally appropriate care to their patients/clients. Specifically, the providers must have training or experience	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	S- The expectation of the provision of culturally appropriate care is outlined.	No Recommendations.

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
with caring for those groups most affected by the epidemic, such as gay men, African Americans, and substance using persons.					
2.2d The provider organization will provide assurances that mental health treatment services will be provided regardless of the sexual orientation of the client. Respect, confidentiality, and equal access will be assured.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	S: Standard addresses ADA requirements for delivery of services.	No Recommendations.
2.2e If unlicensed providers will be providing services, a formal letter of collaboration must detail the nature and type of supervision received by specific licensed providers.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	S: Expectations related to supervision of unlicensed staff are outlined.	No Recommendations.
2.3a The provider organization will provide clinical services in a timely fashion to all clients. Emergencies must be addressed within 2 hours of	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	S: Time frames for handling emergency situations are delineated.	No Recommendations.

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
notification of the provider. New client evaluations will generally be conducted within 10 working days of notification of the provider. Providers must consider providing access to their staff on a 24-hour basis.					
2.3b The provider organization must provide mechanisms for urgent care evaluation or triage.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	S: Mechanisms for urgent care evaluations or triage must be in place.	No Recommendations.
2.3c The provider organization will provide mechanisms to make available to its clients access, if clinically indicated, to the full range of mental health treatment settings including day programs, day hospitals, and inpatient psychiatric units.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	S: Access to a full range of treatment settings are to be made available to clients as clinically indicated.	No Recommendations.
2.3d The provider organization will provide mechanisms for continuity of mental health/psychiatric care to their clients in all settings	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	S: Continuity of care across treatment settings is expected.	No Recommendations.

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
in which they may receive care, including by limited to day programs, day hospitals, substance abuse programs, inpatient psychiatric units inpatient medical units, and chronic care units (nursing homes). Provision will be made for "off site" care if clinically necessary.					
2.3e The provider organization will develop and maintain linkages with substance abuse treatment service providers, so as to maintain care continuity for patients with dual diagnoses of substance abuse disorders and other mental disorders.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	S: Referral options for substance abuse are required.	No Recommendations.
2.3f The provider organization will develop and maintain linkages with primary medical care service providers, so as to maintain care continuity for patients receiving primary or specialty medical care.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	S: Referral options for primary medical care are required.	No Recommendations.

Column 1 **Baltimore EMA Standard**	*Column 2* **American Psychiatric Association**	*Column 3* **ICSI Health Care Guidelines: Mental Health Providers**	*Column 4* **Texas Medical Algorithm Project**	*Column 5* **Strengths and Weaknesses**	*Column 6* **Recommendations**
2.4 QUALITY IMPROVEMENT					
2.4a The provider organization will provide for methods to monitor for areas in need of improvement.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	S: A plan to monitor service is expected. W: The key components of a QI plan are not outlined.	Delineate the key components of a CQI plan.
2.4b The provider organization will provide for methods for the development of corrective action and the assessment of the effect of such actions, regarding areas in need of improvement.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	S: Ongoing improvement activities are required. W: The frequency for monitoring selected indicators are not outlined.	Outline the frequency for monitoring selected indicators.
2.4c Utilization review decisions will be clinically based on best practice and consistent with emerging national standards.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	This standard is not addressed in these guidelines.	S: Best practices and industry standards are to be used for the basis of utilization review decisions.	No recommendations.