



## Program of Assertive Community Services (PACT)

### Service/Program Definition

*Program of Assertive Community Services (PACT) entails the provision of an array of services delivered by a community-based, mobile, multidisciplinary team of professionals, paraprofessionals and peer specialists. PACT multidisciplinary teams provide acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation, and support. The team provides assistance to Members to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and provide assistance in helping the individuals served to become better integrated into the community. Services are provided in the community and are available, as needed by the individual, 24 hours a day, seven days a week, 365 days a year.*

PACT teams comply with the following National Program Standards\*:

*\*These National Standards for PACT Teams, June 2003, were developed with support from the U.S. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Community Support Branch, through grant # SM52579-4. The ACT Standards is a companion document to A Manual for ACT Start-Up: Based on the PACT Model of Community Treatment for Persons with Severe and Persistent Mental Illnesses, written with support from the National Alliance for the Mentally III Assertive Community Treatment Technical Assistance Center.*

### Program Components

The program provides emergency services 24 hours per day, seven days per week, 365 days a year to all Members enrolled in the program. These services are intended to be the first level of crisis intervention whenever needed by the Member. The program provides these services by phone, and face-to-face if warranted by the Member's presentation, during the program's operating hours. After hours, the program provides an emergency phone number that accesses a clinician either directly or via an answering service. Both during and after operating hours, the responding clinician provides a brief assessment and intervention by phone. Based upon this assessment, the provider may refer the Member, if needed, to an Emergency Services Program (ESP) for an emergency evaluation. An answering machine or answering service directing callers to call 911 or the ESP, or to go to a hospital emergency department (ED), is not sufficient. Symptom assessment, management, and individual supportive therapy will be provided to help Members recover and manage symptoms and impairments. This component is to include, but not be limited to, the following:

Ongoing assessment of the Member's symptomatology and the Member's response to treatment

Mental health and substance abuse education

- Psychopharmacological education (efficacy and side effects)
- Symptom-management efforts directed to help each client identify the symptoms and occurrence patterns of his or her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen their effects
- Psychological support to Members, both on a planned and an as-needed basis, to accomplish personal goals and to cope with the stresses of day-to-day living
- The program will provide for medication evaluation, prescription, and documentation.
- When clinically indicated, medication monitoring and/or medication administration will also be provided.

The team psychiatrist will:

- assess each Member's mental illness symptoms and behavior and prescribe appropriate medication;
- regularly review and document the Member's symptoms of mental illness as well as his or her

response to prescribed medication treatment;

- educate the client regarding his or her mental illness and the effects and side effects of medication prescribed to regulate it; and monitor, treat, and document any medication side effects.
- All team members will assess and document the Member's symptoms and behavior in response to medication and will monitor for medication side effects.

The team program will establish medication policies and procedures that identify processes to:

- record physician orders;
- order medication; arrange for all client medications to be organized by the team and integrated into Members' weekly schedules and daily staff assignment schedules;
- provide security for medications (i.e., long-term, injectable, daily, and longer-term supplies) and set aside a private designated area for set up of medications by the team's nursing staff; and
- administer medications to team Members.

Substance abuse service will include, but not be limited to, individual and group interventions to assist members to:

- identify substance abuse, effects, and patterns;
- recognize the relationship between substance abuse and mental illness and psychotropic medications;
- develop motivation for decreasing substance abuse;
- achieve periods of sobriety and stability; and
- develop connections to self-help groups such as Double Trouble and Dual Recovery programs.

Work-related services will be provided in collaboration with clubhouses to help Members find and maintain employment in community-based job sites that will include, but not necessarily be limited to, the following:

- Assessment of job-related interests and abilities, through a complete education and work history assessment, as well as on-the-job assessments in community-based jobs
- Assessment of the effect of the Member's mental illness on employment, with identification of specific behaviors and symptoms that interfere with the Member's work performance, and supportive therapy to reduce, eliminate, or help Members cope with symptoms/behaviors
- Development of an ongoing employment rehabilitation plan to help each Member establish the skills necessary to find and maintain a job
- On-the-job or work-related crisis intervention
- Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation

Services to support activities of daily living in community-based settings will be provided, including individualized assessment, problem solving, side-by-side assistance and support, skill training, ongoing supervision (e.g., prompts, assignments, monitoring, encouragement), and environmental adaptations to assist Members to gain or use the skills required to:

- carry out personal hygiene and grooming tasks;
- perform household activities, including house cleaning, cooking, grocery shopping, and laundry;

- find housing that is safe and affordable through relationships with local housing authorities, housing alliances, and local landlords;
- develop or improve money-management skills;
- use available transportation (maximize transportation services available through Medicaid); and
- have and effectively use a personal physician and dentist (e.g., annual physicals, etc.).

Services to support social, interpersonal relationship, and leisure-time skill training will be provided to include supportive individual therapy (e.g., problem solving, role-playing, modeling, and support); social-skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities. These activities structure Members' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support required to:

- improve communication skills, develop assertiveness, and increase self-esteem as necessary;
- employ self-help recovery strategies/approaches;
- develop social skills, increase social experiences, and develop meaningful personal relationships;
- relate to landlords, neighbors, and others effectively; and
- familiarize themselves with available social and recreational opportunities and increase their use of such opportunities.

The program will provide education, support, and consultation to Members' families and other major supports, with the Member's agreement or consent, including:

- education about the Member's illness and the role of the family in the therapeutic, ongoing communication and collaboration process;
- intervention to resolve conflict; and
- ongoing communication and collaboration, face-to-face and by telephone, between the team and the family.

*Staff Requirements:* The following minimum staffing configuration must be met in each of the Program of Assertive Community Treatment teams:

- A 1:10 staff-to-client ratio.
- A full-time team leader/supervisor, who is the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team. The team leader has at least a master's degree in nursing, social work, psychiatric rehabilitation, or psychology, or is a psychiatrist.
- A psychiatrist on a full-time or part-time basis for a minimum of 20 hours per week for 60 Members. The psychiatrist provides clinical services to all Members, works with the team leader to monitor each Member's clinical status and response to treatment, supervises staff delivery of services, and directs psychopharmacological and medical treatment.
- Each client will be assigned a primary case manager who coordinates and monitors the activities of the individual treatment team and has primary responsibility to write the treatment plan, to provide individual supportive therapy, to ensure immediate changes are made in the treatment plans as Members' needs change, and to advocate for client rights and preferences. The primary case manager is also the first staff person called on when the client is in crisis and is the primary support person and educator to the individual Member's family. Members of the Member's individual treatment team share these tasks with the case manager and are responsible for

performing the tasks when the case manager is not available.

- The Member's psychiatrist, primary case manager, and individual treatment team members will be assigned by the program director within a week of admission.
- PACT will maintain a minimum of 10 to 12 FTE mental health professionals on an *urban team*, or a minimum of three FTEs on a *rural team* (including the team leader). These mental health professionals will have professional degrees in one of the core mental health disciplines: clinical training, including internships and other supervised practical experiences in a clinical or rehabilitation setting, and clinical work experience with persons with serious mental illness. They are licensed or certified per the applicable Massachusetts regulations. Mental health professionals include: persons with master's or doctoral degrees in nursing, social work, rehabilitation counseling, or psychology; diploma, associate, and bachelor's nurses (i.e., registered nurses); and registered occupational therapists. The following are required among the mental health professionals:
  - On an *urban team*, at least three FTE registered nurses and on a *rural team*, at least one FTE registered nurse (For either team, a team leader with a nursing degree cannot replace one of these FTE nurses.)
  - One or more staff mental health professionals designated for the role of vocational specialist, preferably with a master's degree in rehabilitation counseling

Remaining clinical staff may be bachelor's level and paraprofessional mental health workers who carry out rehabilitation and support functions.

- The team must include one to two FTE consumer advocates/peer specialists to provide peer counseling to motivate and encourage Members, provide consultation to the team, and serve as a link among individual Members, consumer groups, and the program. The consumer advocates/peer specialists will have significant experience as a mental health services consumer and demonstrate significant recovery.
- The team must include a program assistant (1:1.5 FTE in *urban setting* or .5:1 FTE in *rural settings*) who is responsible for organizing, coordinating, and monitoring all non-clinical operations of the program, including: managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for client and program expenditures; and providing receptionist activities, including triaging call and coordinating communication between the team and Members.
- The team will maintain written personnel policies and procedures as well as personnel files for each team member, containing job applications, copies of credentials or licenses, job descriptions, annual performance appraisals, and orientation and training plan.

*Service, Community and Collateral Linkages:* All programs will maintain a referral and resource guide for self-help groups and other community resources.

#### Process Specifications

- The PACT team will conduct Daily Operational Meetings (DOM) under the supervision of the team leader and the psychiatrist.
- The treatment team DOM will be held 3-5 times per week at regularly scheduled times.
- The team will meet to develop written individualized client-centered treatment plans.
- An initial assessment and treatment plan will be completed by the team leader or the psychiatrist, with participation of designated team members at the time of the Member's admission to the

program.

- A comprehensive assessment will be initiated and completed within one month after a Member’s admission.
- The following areas should be addressed in every Member’s treatment plan: symptom stability, symptom management and education, housing, ADL, employment and daily structure, family and social relationships, and crisis prevention strategies.
- The primary case manager and the individual treatment team will be responsible for reviewing and rewriting the treatment goals and plan whenever there is a major decision point in the Member’s course of treatment (e.g., significant change in Member’s condition) or at least quarterly.
- The revised treatment plan will be based on the results of a treatment planning meeting. Furthermore, the primary case manager will prepare a summary (i.e., treatment plan review) describing the Member’s progress since the last treatment planning meeting and outlining the Member’s current functional strengths and limitations. The plan and the review will be signed or acknowledged by the client, the primary case manager, individual treatment team members, the team leader, the psychiatrist, and all PACT team members.

**Criteria**

**Admission Criteria**

*The following criteria are necessary for admission to this level of care:*

1. The individual is age 18 and older.
2. The individual has symptoms consistent with a covered DSM-IV-TR diagnosis of Schizophrenia (295.xx) or chronic major mood disorder (296.xx) that have a Global Assessment of Functioning (GAF) score of 40 or under. Other mental health disorders maybe appropriate in conjunction with symptoms presenting as chronic and persistent and can reasonably be expected to respond to therapeutic intervention. Individuals with the primary diagnosis of substance use disorder, brain injury, or Axis II disorders are not candidates for PACT Treatment.

**AND**

*At least two of the following criteria:*

3. At least two psychiatric hospitalizations in the past 12 months or lengths of stay totaling over 30 days in the past 12 months that can include admissions to the psychiatric emergency services.
4. Intractable (i.e., persistent or very recurrent) severe major symptoms -- e.g., affective, psychotic, suicidal).
5. Co-occurring mental illness and substance use disorders with more than six months duration at the time of contact.
6. High risk or recent history of criminal justice involvement, which may include frequent contact with law enforcement personnel, incarcerations, parole or probation.
7. Literally homeless, imminent risk of being homeless, or residing in unsafe housing. **Homeless Individual (literally homeless)** is an individual who lives outdoors (street, abandoned or public building, automobile, etc.), or whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations (short-term shelter). **Homeless Individual (at imminent risk of being homeless)** should meet at least one of the following criteria: doubled-up living arrangement where the

	<p><i>individual's name is not on the lease, living in a condemned building without a place to move, arrears in rent/utility payments with no ability to pay, having received an eviction notice without a place to move, living in temporary or transitional housing that carries time limits, being discharged from a health care or criminal justice institution without a place to live.</i></p> <ol style="list-style-type: none"> <li>8. Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.</li> <li>9. Difficulty effectively utilizing traditional office-based outpatient services or evidence that they require a more assertive and frequent non-office based services to meet their clinical needs.</li> </ol>
<p><b>Psychosocial, Occupational, Cultural and Linguistic Factors</b></p>	<p>These factors may change the risk assessment and should be considered when making level of care decisions.</p>
<p><b>Exclusion Criteria</b></p>	<p><i>Any of the following criteria is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> <li>1. The individual manifests behavioral and/or psychiatric symptoms that require a more intensive level of care.</li> <li>2. The individual can be safely maintained and effectively treated with less intensive services.</li> <li>3. The symptoms of the individual are the result of a non-covered condition.</li> <li>4. The individual does not voluntarily consent to treatment and there is no court order requiring such treatment.</li> </ol>
<p><b>Continued Stay Criteria</b></p>	<p><i>All of the following criteria are necessary for continuing treatment at this level of care:</i></p> <ol style="list-style-type: none"> <li>1. The severity of the behavioral and emotional symptoms continues to require this level of intervention.</li> <li>2. The mode, intensity, and frequency of the interventions are consistent with the intended treatment plan outcomes.</li> <li>3. When clinically necessary, appropriate psychopharmacological evaluation has been completed and ongoing treatment is initiated and monitored.</li> <li>4. Individualized services and treatments are tailored to achieve optimal results in a time efficient manner and are consistent with sound clinical practice.</li> <li>5. The individual and significant others as appropriate participate in treatment to the extent all parties are able.</li> <li>6. There is documented evidence of active, individualized discharge planning.</li> <li>7. There is a documented active attempt at coordination of care with relevant providers when appropriate.</li> <li>8. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.</li> <li>9. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved or adjustments in the treatment plan to address lack of progress are</li> </ol>

	<p>evident.</p> <p>10. Care is rendered in a clinically appropriate manner and focused on individual's behavioral and functional outcomes as described in the discharge plan.</p>
<p><b>Discharge Criteria</b></p>	<p><i>Any of the following criteria is sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"> <li>1. The individual's treatment plan goals and objectives for this level of care have been met <b>and</b> a discharge plan with follow-up appointments is in place.</li> <li>2. The individual withdraws consent for treatment and there is no court order requiring such treatment.</li> <li>3. The individual's physical condition necessitates transfer to a more intensive level of care.</li> <li>4. The individual is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care.</li> </ol>