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**Washington State Program of Assertive Community Treatment (PACT)**  
**Program Standards**  
**(FINAL) 4-16-07**

**I. Introduction**

The Program for Assertive Community Treatment (PACT) is a person-centered recovery-oriented mental health service delivery model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation, and recovery for persons who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and have not benefited from traditional outpatient programs.

The important characteristics of PACT programs are:

- PACT serves individuals with severe and persistent mental illness who also experience difficulties with daily living activities and tasks and because of the limitations of traditional mental health services, may have gone without appropriate services. Consequently, this consumer group is often over represented among individuals who are homeless or are in jails and prisons, and have been unfairly thought to resist or avoid involvement in treatment.
- PACT services are delivered by a group of transdisciplinary mental health staff who work as a team and provide the majority of the treatment, rehabilitation, and support services consumers need to achieve their goals. The team is directed by a team leader and a psychiatric prescriber and includes a sufficient number of staff from the core mental health disciplines, at least one peer specialist, and a program or administrative support staff who work in shifts to cover 24 hours per day, seven days a week and to provide intensive services (multiple contacts may be as frequent as two to three times per day, seven days per week, which are based on consumer need and a mutually agreed upon plan between the consumer and PACT staff). Many, if not all, staff share responsibility for addressing the needs of all consumers requiring frequent contact.
- PACT services are individually tailored with each consumer and address the preferences and identified goals of each consumer. The approach with each consumer emphasizes relationship building and active involvement in assisting individuals with severe and persistent mental illness to make improvements in functioning, to better manage symptoms, to achieve individual goals, and to maintain optimism.
- The PACT team is mobile and delivers services in community locations to enable each consumer to find and live in their own residence and find and maintain work in community jobs rather than expecting the consumer to come to the program. Seventy-five percent or more of the services are provided outside of the program offices in locations that are comfortable and convenient for consumers.
- PACT services are delivered in an ongoing rather than time-limited framework to aid the process of recovery and ensure continuity of caregiver. Severe and persistent mental illnesses are episodic disorders and many consumers benefit from the availability of a longer-term treatment approach and continuity of care. This allows consumers opportunity to recompensate, consolidate gains, sometimes slip back, and then take the next steps forward until they achieve recovery.

## II. Definitions

*Program of Assertive Community Treatment (PACT)* is a self-contained mental health program made up of transdisciplinary mental health staff, including a peer specialist, who work as a team to provide the majority of treatment, rehabilitation, and support services consumers need to achieve their goals. PACT services are individually tailored with each consumer through relationship building, individualized assessment and planning, and active involvement with consumers to enable each to find and live in their own residence, to find and maintain work in community jobs, to better manage symptoms, to achieve individual goals, and to maintain optimism and recover. The PACT team is mobile and delivers services in community locations rather than expecting the consumer to come to the program. Seventy-five percent or more of the services are provided outside of program offices in locations that are comfortable and convenient for consumers. The consumers served have severe and persistent mental illness that are complex, have devastating effects on functioning, and, because of the limitations of traditional mental health services, may have gone without appropriate services. There should be no more than 10 consumers to one staff member on each urban team and no more than 8 consumers to one staff member on each rural team.

*Activities of Daily Living Services* include approaches to support and build skills in a range of activities of daily living (ADLs), including but not limited to finding housing, performing household activities, carrying out personal hygiene and grooming tasks, money management, accessing and using transportation resources, and accessing services from a physician and dentist.

*Clinical Supervision* is a systematic process to review each consumer's clinical status and to ensure that the individualized services and interventions that the team members provide (including the peer specialist) are planned with, purposeful for, effective, and satisfactory to the consumer. The team leader and the psychiatric prescriber have the responsibility to provide clinical supervision which occurs during daily organizational staff meetings, treatment planning meetings, and in individual meetings with team members. Clinical supervision also includes review of written documentation (e.g., assessments, treatment plans, progress notes and correspondence).

*Comprehensive Assessment* is the organized process of gathering and analyzing current and past information with each consumer and the family and/or support system and other significant people to evaluate: 1) mental and functional status; 2) effectiveness of past treatment; 3) current treatment, rehabilitation and support needs to achieve individual goals and support recovery; and 4) the range of individual strengths (e.g., knowledge gained from dealing with adversity or personal/professional roles, talents, personal traits) that can act as resources to the consumer and his/her recovery planning team in pursuing goals. The results of the information gathering and analysis are used to: 1) establish immediate and longer-term service needs with each consumer; 2) set goals and develop the first person-centered treatment plan with each consumer; and 3) optimize benefit that can be derived from existing strengths and resources of the individual and his/her family and/or natural support network in the community.

*Consumer* is a person who has agreed to receive services and is receiving person-centered treatment, rehabilitation, and support services from the PACT team.

*Co-Occurring Disorders Services* include integrated assessment and stage-based treatment for individuals who have a co-occurring mental health and substance use disorder. This type of

treatment is based on a harm reduction model (vs. a traditional or abstinence-only substance abuse treatment model).

*Crisis Assessment and Intervention* includes services offered 24 hours per day, seven days per week for consumers when they are experiencing crisis.

*Daily Log* is a notebook, cardex, or computerized form which the PACT team maintains on a daily basis to provide: 1) a roster of consumers served in the program; and 2) for each consumer, a brief documentation of any treatment or service contacts which have occurred during the day and a concise behavioral description of the consumer's clinical status and any additional needs.

*Daily Organizational Staff Meeting* is a daily staff meeting held at regularly scheduled times under the direction of the team leader (or designee) to: 1) briefly review the service contacts which occurred the previous day and the status of all program consumers; 2) review the service contacts which are scheduled to be completed during the current day and revise as needed; 3) assign staff to carry out the day's service activities; and 4) revise treatment plans and plan for emergency and crisis situations as needed. The daily log and the daily staff assignment schedule are used during the meeting to facilitate completion of these tasks.

*Daily Staff Assignment Schedule* is a written, daily timetable summarizing all consumer treatment and service contacts to be divided and shared by staff working on that day. The daily staff assignment schedule will be developed from a central file of all weekly consumer schedules.

*Family and Natural Supports' Psychoeducation and Support* is an approach to working in partnership with families and natural supports to provide current information about mental illness and to help them develop coping skills for handling problems posed by mental illness as experienced by a significant other in their lives.

*Individual Treatment Team (ITT)* is a group or combination of three to five PACT staff members who together have a range of clinical and rehabilitation skills and expertise. The ITT members are assigned by the team leader and the psychiatric prescriber to work collaboratively with a consumer and his/her family and/or natural supports in the community by the time of the first person-centered treatment planning meeting or thirty days after admission. The core members are the primary practitioner, the psychiatric prescriber, and at least one clinical or rehabilitation staff person who shares case coordination and service provision tasks for each consumer. The ITT has continuous responsibility to be knowledgeable about the consumer's life, circumstances, goals and desires; to collaborate with the consumer to develop and write the treatment plan; to offer options and choices in the treatment plan; to ensure that immediate changes are made as a consumer's needs change; and to advocate for the consumer's wishes, rights, and preferences. The ITT is responsible to provide much of the consumer's treatment, rehabilitation, and support services. ITT members are assigned to take separate service roles with the consumer as specified by the consumer and the ITT in the treatment plan.

*Individual Therapy* includes verbal therapies that help people make changes in their feelings, thoughts, and behavior in order to move toward recovery, clarify goals, and address stigma. Supportive therapy and psychotherapy also help consumers understand and identify symptoms in order to find strategies to lessen distress and symptomatology, improve role functioning, and

evaluate treatment and rehabilitative services. Current psychotherapy approaches include cognitive behavioral therapy, personal therapy, and psychoeducational therapy.

*Initial Assessment and Person-Centered Treatment Plan* is the initial evaluation of: 1) the consumer's mental and functional status; 2) the effectiveness of past treatment; 3) the current treatment, and rehabilitation and support service needs, and 4) the range of individual strengths that can act as resources to the person and his/her IIT in pursuing goals. The results of the information gathering and analysis are used to establish the initial treatment plan to achieve individual goals and support recovery. Completed the day of admission, the consumer's initial assessment and treatment plan guides team services until the comprehensive assessment and full person-centered treatment plan is completed.

*Medication Distribution* is the physical act of giving medication to consumers in a PACT program by the prescribed route which is consistent with state law and the licenses of the professionals privileged to prescribe and/or administer medication (e.g., psychiatric prescribers, registered nurses, and pharmacists).

*Medication Error* is any error in prescribing or administering a specific medication, including errors in writing or transcribing the prescription, in obtaining and administering the correct medication, in the correct dosage, in the correct form, and at the correct time.

*Medication Management* is a collaborative effort between the consumer and the psychiatric prescriber with the participation of the IIT to carefully evaluate the consumer's previous experience with psychotropic medications and side-effects; to identify and discuss the benefits and risks of psychotropic and other medication; to choose a medication treatment; and to establish a method to prescribe and evaluate medication according to evidence-based practice standards.

*PACT Primary Practitioner* leads and coordinates the activities of the individual treatment team (IIT) and is the IIT member who has primary responsibility for establishing and maintaining a therapeutic relationship with a consumer on a continuing basis, whether the consumer is in the hospital, in the community, or involved with other agencies. In addition, he or she is the responsible team member to be knowledgeable about the consumer's life, circumstances, and goals and desires. The primary practitioner develops and collaborates with the consumer to write the person-centered treatment plan, offers options and choices in the treatment plan, ensures that immediate changes are made as the consumer's needs change, and advocates for the consumer's wishes, rights, and preferences. The primary practitioner also works with other community resources, including consumer-run services, to coordinate activities and integrate other agency or service activities into the overall service plan with the consumer. The primary practitioner provides individual supportive therapy and provides primary support and education to the family and/or support system and other significant people. In most cases the primary practitioner is the first IIT member available to the consumer in crisis. The primary practitioner shares these service activities with other members of the IIT who are responsible to perform them when the primary practitioner is not working.

*Peer Support and Wellness Recovery Services* include services which serve to validate consumers' experiences, provide guidance and encouragement to consumers to take responsibility for and actively participate in their own recovery, and help consumers identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce consumers' self-

imposed stigma. Such services also include *counseling* and support provided by team members who have experience as recipients of mental health services for severe and persistent mental illness.

*Person-Centered Treatment Plan* is the culmination of a continuing process involving each consumer, their family and/or natural supports in the community, and the PACT team, which individualizes service activity and intensity to meet the consumer's specific treatment, rehabilitation, and support needs. The written treatment plan documents the consumer's strengths, resources, self-determined goals, and the services necessary to help the consumer achieve them. The plan also delineates the roles and responsibilities of the team members who will work collaboratively with each consumer in carrying out the services.

*Psychiatric and Social Functioning History Time Line* is a format or system which helps PACT staff to organize chronologically information about significant events in a consumer's life, experience with mental illness, and treatment history. This format allows staff to more systematically analyze and evaluate the information with the consumer, to formulate hypotheses for treatment with the consumer, and to determine appropriate treatment and rehabilitation approaches and interventions with the consumer.

*Psychotropic Medication* is any drug used to treat, manage, or control psychiatric symptoms or disordered behavior, including but not limited to antipsychotic, antidepressant, mood-stabilizing or antianxiety agents.

*Service Coordination* is a process of organization and coordination within the transdisciplinary team to carry out the range of treatment, rehabilitation, and support services each consumer expects to receive per his or her written person-centered treatment plan and that are respectful of the consumer's wishes. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

*Shift Manager* is the individual (assigned by the team leader) in charge of developing and implementing the daily staff assignment schedule; making all daily assignments; ensuring that all daily assignments are completed or rescheduled; and managing all emergencies or crises that arise during the course of the day, in consultation with the team leader and the psychiatric prescriber.

*Social and Community Integration Skills Training* includes services to support social and interpersonal relationships and leisure time activities, with an emphasis on skills acquisition and generalization in integrated community-based settings.

*Stakeholder Advisory Groups* support and guide individual PACT team implementation and operation. Each PACT team shall have a Stakeholder Advisory Group whose membership consists of at least 51 percent mental health consumers and family members. It shall also include community stakeholders that interact with persons with severe and persistent mental illness (e.g., homeless services, food-shelf agencies, faith-based entities, criminal justice system, the housing authority, landlords, employers, and community colleges). In addition, group membership shall represent the local cultural populations. The group's primary function is to promote quality PACT programs; monitor fidelity to the PACT Standards; guide and assist the administering agency's oversight of the PACT program; problem-solve and advocate to reduce barriers to PACT implementation; and monitor/review types of and trends in consumer and family grievances and complaints. The

Stakeholder Advisory Group promotes and ensures consumers' empowerment and recovery values in PACT programs.

*Supported Education* provides the opportunities, resources, and supports to individuals with mental illness so that they may gain admission to and succeed in the pursuit of post-secondary education, including high school, GED, and vocational school.

*Symptom Management* is an approach directed to help each consumer identify and target the symptoms and occurrences of his or her mental illness and develop methods to help reduce the impact of those symptoms.

*Transdisciplinary Approach* specifies that team members share roles and systematically cross discipline boundaries. The primary purpose of this approach is to pool and integrate the expertise of team members so that more efficient and comprehensive assessment and intervention services may be provided. The communication style in this type of team involves continuous give-and-take among all members (inclusive of the consumer and, if desired, his/her family/other natural supports) on a regular, planned basis. The role differentiation between disciplines is defined by the needs of the situation rather than by discipline-specific characteristics. The transdisciplinary approach can be contrasted with the multidisciplinary approach in which team members independently carry out assessments and implement their own section of the treatment plan, rather than in a cross-disciplinary, integrated fashion, which also serves to actively involve the consumer in their own assessment and treatment.

*Treatment Plan Review* is a thorough, written summary describing the consumer's and the IIT's evaluation of the consumer's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last person-centered treatment plan.

*Treatment Planning Meeting* is a regularly scheduled meeting conducted under the supervision of the team leader and the psychiatric prescriber. The purpose of these meetings is for the staff, as a team, and the consumer and his/her family/natural supports, to thoroughly prepare for their work together. The group meets together to present and integrate the information collected through assessment in order to learn as much as possible about the consumer's life, his/her experience with mental illness, and the type and effectiveness of the past treatment they have received. The presentations and discussions at these meetings make it possible for all staff to be familiar with each consumer and his/her goals and aspirations and for each consumer to become familiar with each IIT staff person; to participate in the ongoing assessment and reformulation of strengths, resources, and service needs/issues; to problem-solve treatment strategies and rehabilitation options; and to fully understand the treatment plan rationale in order to carry out the plan for each.

*Vocational Services* include work-related services to help consumers value, find, and maintain meaningful employment in community-based job sites as well as job development and coordination with employers.

*Weekly Consumer Contact Schedule* is a written schedule of the specific interventions or service contacts (i.e., by whom, when, for what duration, and where) which fulfill the goals and objectives in a given consumer's person-centered treatment plan. The IIT shall maintain an up-to-date weekly consumer contact schedule for each consumer per the person-centered treatment plan.

*Wellness Management and Recovery Services* are a combination of psychosocial approaches to working with the consumer to build and apply skills related to his or her recovery, including development of recovery strategies, psychoeducation about mental illness and the stress-vulnerability model, building social support, reducing relapses, using medication effectively, coping with stress, coping with problems and symptoms, and getting needs met within the mental health system and community.

### III. Admission and Discharge Criteria

#### A. Admission Criteria

Individuals must meet the following admission criteria:

1. Severe and persistent mental illness listed in the diagnostic nomenclature (currently the Diagnostic and Statistical Manual, Fourth Edition, or DSM IV, of the American Psychiatric Association) that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. Individuals must have a primary mental health diagnosis. Individuals with a sole diagnosis of a substance use disorder, mental retardation, brain injury or Axis II disorders are not the intended consumer group for PACT services. Individuals who have not been able to remain abstinent from drugs or alcohol will not be excluded from PACT services.
2. Significant functional impairments as demonstrated by at least one of the following conditions:
  - a. Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.
  - b. Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).
  - c. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).
3. Continuous high-service needs as demonstrated by at least one of the following:
  - a. High use of acute psychiatric hospitals (e.g., two or more admissions per year) or psychiatric emergency services.
  - b. Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).
  - c. Co-occurring substance use disorder of significant duration (e.g., greater than six months).
  - d. High risk or recent history of criminal justice involvement (e.g., arrest and incarceration).

- e. Significant difficulty meeting basic survival needs or residing in substandard housing, homelessness, or at imminent risk of becoming homeless.
  - f. 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.
  - g. Difficulty effectively utilizing traditional office-based outpatient services or other less-intensive community-based programs (e.g., consumer fails to progress, drops out of service).
4. Documentation of admission shall include:
- a. The reasons for admission as stated by both the consumer and the PACT team.
  - b. The signature of the psychiatric prescriber.

## **B. Discharge Criteria**

1. Discharges from the PACT team occur when consumers and PACT staff mutually agree to the termination of services. This shall occur when consumers:
  - a. Have successfully reached individually established goals for discharge and when the consumer and program staff mutually agree to the termination of services.
  - b. Move outside the geographic area of PACT's responsibility. In such cases, the PACT team shall arrange for transfer of mental health service responsibility to a PACT program or another provider wherever the consumer is moving. The PACT team shall maintain contact with the consumer until this service transfer is completed.
  - c. Demonstrate an ability to function in all major role areas (i.e., work, social, and self-care) without requiring ongoing assistance from the program for at least one year without significant relapse when services are withdrawn.
  - d. Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable person-centered treatment plan with the consumer.
2. In addition to the discharge criteria listed above based on mutual agreement between the consumer and PACT staff, a consumer discharge may also be facilitated due to any one of the following circumstances:
  - a. Death.
  - b. Inability to locate the consumer for a prolonged period of time.
  - c. Long-term incarceration.
  - d. Long-term hospitalization where it has been determined based on mutual agreement by the hospital treatment team and the PACT team that the consumer will not be appropriate for discharge for a prolonged period of time.
3. If the consumer is accessible at the time of discharge (i.e., according to circumstances listed under III.B.1 above), the team shall ensure consumer participation in all discharge activities, as evidenced by documentation as described below:



- a. The reasons for discharge as stated by both the consumer and the PACT team.
  - b. The consumer's biopsychosocial status at discharge.
  - c. A written final evaluation summary of the consumer's progress toward the goals set forth in the person-centered treatment plan.
  - d. A plan developed in conjunction with the consumer for follow-up treatment after discharge.
  - e. The signature of the consumer, the consumer's primary practitioner, the team leader, and the psychiatric prescriber.
4. When clinically necessary, the team will make provisions for expedited re-entry of discharged consumers as rapidly as possible and will prioritize them on the admission and/or waiting list.

***Policy and Procedure Requirements:*** The PACT team shall maintain written admission and discharge policies and procedures.

#### **IV. Service Intensity and Capacity**

##### **A. Staff-to-Consumer Ratio**

Each PACT team shall have the organizational capacity to provide a minimum staff-to-consumer ratio of at least one full-time equivalent (FTE) staff person for every 10 consumers (not including the psychiatric prescriber and the program assistant) for an urban team. Rural teams shall have the organizational capacity to provide a minimum staff-to-consumer ratio of at least one full-time equivalent (FTE) staff person for every 8 consumers (not including the psychiatric prescriber and the program assistant).

##### **B. Staff Coverage**

Each PACT team shall have sufficient numbers of staff to provide treatment, rehabilitation, crisis intervention and support services 24 hours a day, seven days per week.

##### **C. Frequency of Consumer Contact**

1. The PACT team shall have the capacity to provide multiple contacts per week with consumers experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment, or having significant ongoing problems in daily living. These multiple contacts may be as frequent as two to three times per day, seven days per week and depend on consumer need and a mutually agreed upon plan between consumers and program staff. Many, if not all, staff shall share responsibility for addressing the needs of all consumers requiring frequent contact.
2. The PACT team shall have the capacity to rapidly increase service intensity to a consumer when his or her status requires it or a consumer requests it.
3. The PACT team shall provide a mean (i.e., average) of three contacts per week for all consumers. Data regarding the frequency of consumer contacts shall be collected and reviewed as part of the program's Continuous Quality Improvement (CQI) plan.

##### **D. Gradual Admission of Team Consumers**

Each new PACT team shall stagger consumer admissions (e.g., 4-6 consumers per month) to gradually build up capacity to serve no more than 80-100 consumers on any given urban team and no more than 42-50 consumers on any given rural team.

## V. Staff Requirements

### A. Qualifications

The PACT team shall have among its staff, persons with sufficient individual competence and professional qualifications and experience to provide the services described in Section VIII, including service coordination; crisis assessment and intervention; recovery and symptom management; individual counseling and psychotherapy; medication prescription, administration, monitoring and documentation; substance abuse treatment; work-related services; activities of daily living services; social, interpersonal relationship and leisure-time activity services; support services or direct assistance to ensure that consumers obtain the basic necessities of daily life; and education, support, and consultation to consumers' families and other major supports. The staff should have sufficient representation of the local cultural population that the team serves.

### B. Team Size

1. The **urban program** shall employ a minimum of 10 to 12 FTE transdisciplinary clinical staff persons, including 1 FTE team leader and 1 FTE peer specialist on the team.
2. The **rural program** shall employ a minimum of 7 to 8 FTE transdisciplinary clinical staff persons, including 1 FTE team leader and 1 FTE peer specialist on the team.

### C. Mental Health Professionals on Staff

Of the minimum 10 to 12 FTE transdisciplinary clinical staff positions on an urban team, there are a minimum of 8 FTE mental health professionals (including one FTE team leader). Of the minimum 7 to 8 FTE transdisciplinary clinical staff positions on a rural team, there are a minimum of 4.5 FTE mental health professionals. Mental health professionals have: 1) professional degrees in one of the core mental health disciplines; 2) clinical training including internships and other supervised practical experiences in a clinical or rehabilitation setting; and 3) clinical work experience with persons with severe and persistent mental illness. Mental health professionals include persons meeting Washington State WAC requirements and operate under the code of ethics of their professions. 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 nurse); and registered occupational therapists.

1. Required among the mental health professionals are: 1) on an urban team, a minimum of 3 FTE and a maximum of 5 FTE registered nurses and 2) on a rural team, a minimum of 1.5 FTE and a maximum of 2 FTE registered nurses (for either team, a team leader with a nursing degree cannot replace one of these FTE nurses).
2. Also required among the mental health professionals are: 1) on an urban team, a minimum of 4 FTE master's level or above mental health professionals (in addition to the team leader); and 2) on a rural team, a minimum of 2 FTE master's level or above mental health professionals (in addition to the team leader).

#### D. Required Staff

The chart below shows the required staff on urban and rural teams.

Position	Urban	Rural
Team leader	1 FTE	1 FTE
Psychiatric prescriber	16 Hours for 50 Consumers	16 Hours for 50 Consumers
Registered Nurse	3 – 5 FTE	1.5 – 2 FTE
Peer Specialist	1 FTE	1 FTE
Master's level*	4 FTE	2 FTE
Other level*	1 – 3 FTE	1.5 – 2.5 FTE
Program/Administrative Assistant	1-1.5 FTE	1 FTE

(1 FTE Vocational Specialist and 1 FTE Chemical Dependency Specialist may be included within either the “Master’s level” or “Other level” staffing categories above.)

The following provides a description of and qualifications for required staff on all PACT teams.

1. **Team Leader:** A full-time team leader/supervisor who is the clinical and administrative supervisor of the team and who also functions as a practicing clinician on the PACT team. The team leader has at least a master's degree in nursing, social work, psychiatric rehabilitation or psychology, or is a psychiatric prescriber. The team leader must be a Mental Health Professional (MHP) as defined by the WAC 388-865-0150. A formally waived MHP may also be considered for this position (per WAC 388-865-0265).
2. **Psychiatric Prescriber:** A psychiatric prescriber may include a psychiatrist or a psychiatric nurse practitioner/clinical specialist in psychiatric-mental health nursing (per WAC 246-840-300). The psychiatric prescriber works on a full-time or part-time basis for a minimum of 16 hours per week for every 50 consumers. The psychiatric prescriber provides clinical services to all PACT consumers; works with the team leader to monitor each consumer's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic and medical services.
3. **Registered Nurses:** All registered nurses shall be licensed in the State of Washington and meet the definition of an RN per Washington State RCW 18.79.030(1). On an urban team, a minimum of 3 FTE and a maximum of 5 FTE registered nurses are required. On a rural team, a minimum of 1.5 FTE and a maximum of 2 FTE registered nurses are required. A team leader with a nursing degree cannot replace one of the FTE nurses.
4. **Master's Level Mental Health Professionals:** On an urban team, a minimum of 4 FTE master's level or above mental health professionals (in addition to the team leader) are required. On a rural team, a minimum of 2 FTE master's level or above mental health professionals (in addition to the team leader) are required. On both rural and urban PACT

teams, 50% of master's level professionals (i.e., 2 on urban teams and 1 on rural teams) shall meet the requirements of an MHP as defined by the WAC 388-865-0150.

5. ***Chemical Dependency Specialist:*** One or more team members with 1) at least one year of training in substance abuse assessment and treatment, or 2) at least one year of supervised experience and 40 hours of training in substance abuse assessment and treatment shall be designated the role of chemical dependency specialist. Preference will be given to people who have experience in working with individuals with mental illness.
6. ***Vocational Specialist:*** One or more team members with training and experience in vocational services shall be designated the role of vocational specialist, with preference given to a master's degree in rehabilitation counseling or at least one year of experience in employment services (e.g., job development, job placement, supported employment). Preference will be given to people who have experience in working with individuals with mental illness.
7. ***Peer Specialist:*** A minimum of one FTE peer specialist is required on either an urban team or a rural team. The Peer Specialist must be certified by the Washington State Peer Counselor Certification Program within 1 year of employment by the PACT team. A person who is or has been a recipient of mental health services for severe and persistent mental illness holds this position. Because of their life experience with mental illness and mental health services, the peer specialist provides expertise that professional training cannot replicate. Peer specialists are fully integrated team members who provide highly individualized services in the community and promote consumer self-determination and decision-making. Peer specialists also provide essential expertise and consultation to the entire team to promote a culture in which each consumer's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities.
8. ***Remaining Clinical Staff:*** The remaining clinical staff may be bachelor's level and paraprofessional mental health workers who carry out rehabilitation and support functions. A bachelor's level mental health worker has a bachelor's degree in social work or a behavioral science, and work experience with adults with severe and persistent mental illness. A paraprofessional mental health worker may have a bachelor's degree in a field other than behavioral sciences or have a high school degree and work experience with adults with severe and persistent mental illness or with individuals with similar human-services needs. Those paraprofessionals may have related training (e.g., certified occupational therapy assistant, home health care aide) or work experience (e.g., teaching) and life experience.
9. ***Program/Administrative Assistant:*** The program/administrative assistant (1-1.5 FTE in an urban setting or 1 FTE in a rural setting) is responsible for organizing, coordinating, and monitoring all nonclinical operations of PACT, including managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for consumer and program expenditures; and providing receptionist activities, including triaging calls and coordinating communication between the team and consumers.

***Policy and Procedure Requirements:*** The PACT team shall: 1) maintain written personnel policies and procedures for hiring; 2) establish core staff competencies, orientation, and training; and 3) maintain personnel files for each team member containing the job application, copies of credentials or licenses, position description, annual performance appraisals, and individual orientation and training plan.

## **VI. Program Organization and Communication**

### **A. Hours of Operation and Staff Coverage**

#### **1. Urban Teams**

- a. The PACT team shall be available to provide treatment, rehabilitation, crisis intervention, and support activities seven days per week. For urban teams, this means:
  - i. Regularly operating and scheduling staff to work two eight-hour shifts with a minimum of 2 staff on the second shift providing services at least 12 hours per day weekdays.
  - ii. Regularly operating and scheduling PACT staff to work one eight-hour shift with a minimum of 2 staff each weekend day and every holiday.
  - iii. Regularly scheduling PACT staff on-call duty to provide crisis services and deliver services the hours when staff are not working. MHP's on the PACT staff who are experienced in the program and skilled in crisis-intervention procedures shall be on call to provide back-up to on-call staff and be available to respond to consumers by telephone or by going out to see consumers who need face-to-face contact.
  - iv. Regularly arranging for and providing psychiatric backup all hours the psychiatric prescriber is not regularly scheduled to work. If availability of the PACT psychiatric prescriber during all hours is not feasible, alternative psychiatric backup should be arranged (e.g., mental health center psychiatric prescriber, emergency room psychiatric prescriber).

#### **2. Rural Teams**

- a. Rural teams with 7 or more clinical full time equivalents: The PACT team shall be available to provide treatment, rehabilitation, crisis intervention, and support activities seven days per week. For rural teams with seven or more full time clinical staff, excluding the program assistant and prescriber, this means:
  - i. Regularly scheduling PACT staff for a minimum of 10-hour shift coverage on weekdays and six- to eight-hour shift coverage on weekends and holidays. In addition to the minimum specifications identified above, staff are regularly scheduled to provide the necessary services on a consumer-by-consumer basis (per the comprehensive assessment and person-centered treatment plan) in the evenings and on weekends. The number of staff per shift may be driven by consumer need.
  - ii. Regularly scheduling PACT staff on-call duty to provide crisis services and deliver services the hours when staff are not working. MHP's on the PACT team who are experienced in the program and skilled in crisis-intervention procedures shall be on call to provide back-up to on-call staff and be available to respond to consumers by telephone or be available to respond to see consumers who need face-to-face contact
  - iii. In addition to the use of on-call PACT staff, the team may arrange for coverage through a reliable crisis-intervention service as long as there is a mechanism by which the rural team communicates routinely with the crisis-intervention service (i.e., at the beginning of the workday to obtain information from the previous evening and at the end of the workday to alert the crisis-intervention service to clients who may need assistance and to provide effective ways for helping them)

and the on-call PACT staff are available to see consumers face-to-face when necessary and/or if requested by the crisis-intervention services provider.

- iv. Regularly arranging for and providing psychiatric backup all hours the psychiatric prescriber is not regularly scheduled to work. If availability of the PACT psychiatric prescriber during all hours is not feasible, alternative psychiatric prescriber backup should be arranged (e.g., mental health center psychiatric prescriber, emergency room psychiatric prescriber).
- b. Rural teams with less than 7 clinical full-time equivalents: The PACT team shall be available to provide treatment, rehabilitation, crisis intervention, and support activities seven days per week. For rural teams with less than seven full time clinical staff, excluding the program assistant and prescriber, this means:
    - i. Regularly scheduling staff for at least 8 hour shift coverage on weekdays;
    - ii. Through the use of the *Daily Organizational Staff Meeting* and the *Daily Staff Assignment Schedule*, adjusting schedules and providing staff to carry out the needed service activities in the evenings or on weekend days when necessary;
    - iii. Regularly scheduling staff on-call duty to provide crisis services and deliver services the hours when staff are not working. PACT team staff who are experienced in the program and skilled in crisis-intervention procedures shall be on call and available to respond to consumers by telephone or in person.
    - iv. When a rural team does not have sufficient staff numbers to operate an after-hours on-call system, the staff should provide crisis services during regular work hours. During all other hours, the team may arrange coverage through a reliable crisis-intervention service. The PACT team shall rotate cell phone/pager coverage 24/7 to be available for face-to-face contacts and shall arrange with the crisis-intervention service to be notified when a face-to-face contact is needed. The rural team communicates routinely with the crisis-intervention service (i.e., at the beginning of the workday to obtain information from the previous evening and at the end of the workday to alert the crisis-intervention service to clients who may need assistance and to provide effective ways for helping them).

## B. Place of Treatment

Each urban team shall set a goal of providing 75 percent of service contacts in the community in nonoffice-based or nonfacility-based settings, while each rural team shall set a goal of providing 85 percent of service contacts in the community in nonoffice-based or nonfacility-based settings. Data regarding the percentage of consumer contacts in the community will be collected and reviewed to verify that goals are being met as part of the program's Quality Improvement (QI) plan.

## C. Staff Communication and Planning

1. The PACT team shall conduct **daily organizational staff meetings** at regularly scheduled times per a schedule established by the team leader. These meetings will be conducted in accordance with the following procedures:
  - a. The PACT team shall maintain a written or computerized **daily log**. The daily log provides:

- i. A roster of the consumers served in the program, and
    - ii. For each consumer, a brief documentation of any treatment or service contacts that have occurred during the last 24 hours and a concise, behavioral description of the consumer's status that day.
  - b. The **daily organizational staff meeting** shall commence with a review of the daily log to update staff on the treatment contacts which occurred the day before and to provide a systematic means for the team to assess the day-to-day progress and status of all consumers.
  - c. The PACT team, under the direction of the team leader, shall maintain a **weekly consumer contact schedule** for each consumer. The weekly consumer contact schedule is a written schedule of all treatment and service contacts that staff must carry out to fulfill the goals and objectives in the consumer's person-centered treatment plan. The team will maintain a central file of all weekly consumer schedules.
  - d. The PACT team, under the direction of the team leader, shall develop a **daily staff assignment schedule** from the central file of all weekly consumer schedules. The daily staff assignment schedule is a written timetable for all the consumer treatment and service contacts and all indirect consumer work (e.g., medical record review, meeting with collaterals, job development, treatment planning, and documentation) to be done on a given day, to be divided and shared by the staff working on that day.
  - e. The daily organizational staff meeting will include a **review by the shift manager of all the work to be done that day** as recorded on the daily staff assignment schedule. During the meeting, the shift manager will assign and supervise staff to carry out the treatment and service activities scheduled to occur that day, and the shift manager will be responsible for assuring that all tasks are completed.
  - f. During the **daily organizational staff meeting**, the PACT team shall also revise person-centered treatment plans as needed, anticipate emergency and crisis situations, and add service contacts to the daily staff assignment schedule per the revised treatment plans. This meeting is held on a daily basis in addition to the regularly scheduled treatment planning meetings.
2. The PACT team shall conduct person-centered treatment planning meetings under the supervision of the team leader and the psychiatric prescriber. These treatment planning meetings shall:
  - a. Convene at regularly scheduled times per a written or computerized schedule maintained by the team leader.
  - b. Occur and be scheduled when the consumer and the majority of the team members can attend, including the psychiatric prescriber, team leader, and all members of the ITT. These meetings may also include the consumer's family and/or natural supports, if desired and available.
  - c. Require individual staff members to present and systematically review and integrate consumer information into a holistic analysis and work with the consumer and ITT to establish priorities for services.
  - d. Occur with sufficient frequency and duration to make it possible for all staff to be familiar with each consumer and their goals and aspirations and for each consumer to become familiar with ITT staff; to participate in the ongoing assessment and reformulation of strengths, resources, and service needs/issues; to problem-solve

treatment strategies and rehabilitation options; to participate with the consumer and the ITT in the development and the revision of the person-centered treatment plan; and to fully understand the treatment plan rationale in order to carry out the plan with each consumer every 180 days.

#### **D. Staff Supervision**

Each PACT team shall develop a written policy for clinical supervision of all staff providing treatment, rehabilitation, and support services. The team leader and psychiatric prescriber shall assume responsibility for supervising and directing all staff activities. This supervision and direction shall consist of:

1. Individual, side-by-side sessions in which the supervisor accompanies an individual staff member to meet with consumers in regularly scheduled or crisis meetings to assess their performance, give feedback, and model alternative treatment approaches;
2. Participation with team members in daily organizational staff meetings and regularly scheduled treatment planning meetings to review and assess staff performance and provide staff direction regarding individual cases;
3. Regular meetings with individual staff to review their work with consumers, assess clinical performance, and give feedback;
4. Regular reviews, critiques, and feedback of staff documentation (i.e., progress notes, assessments, treatment plans, treatment plan reviews); and
5. Written documentation of all clinical supervision provided to PACT team staff.

***Policy and Procedure Requirements:*** The PACT team shall maintain written program organization policies and procedures, including required hours of operation and coverage, staff communication and planning, emphasis on team approach, and staff supervision, as outlined in this section.

### **VII. Assessment and Person-Centered Treatment Planning**

#### **A. Initial Assessment**

An initial assessment and treatment plan shall be done the day of the consumer's admission to PACT by the team leader or the psychiatric prescriber, with participation by designated team members.

#### **B. Comprehensive Assessment**

Each part of the assessment area shall be completed by each respective team specialist and/or a PACT team member with skill and knowledge in the area being assessed. A team member with training and interest in the area does each part and becomes the specialist in that particular area with the consumer. The assessment is based upon all available information, including that from consumer interview/self-report, family and/or natural supports, and written summaries from other agencies, including police, courts, and outpatient/inpatient facilities, where applicable. A comprehensive assessment shall be initiated and completed within one month after a consumer's admission according to the following requirements:

1. In collaboration with the consumer, the ITT will complete a psychiatric and social functioning history time line.
2. In collaboration with the consumer, the comprehensive assessment shall include an evaluation of the following areas:



- a. ***Psychiatric History, Mental Status, and Diagnosis:*** The psychiatric prescriber is responsible for completing the psychiatric history, mental status, and diagnosis assessment. (Using information derived from the evaluation, a psychiatric prescriber or a clinical or counseling psychologist shall make an accurate diagnosis listed in the American Psychiatric Association's DSM IV.) The psychiatric prescriber presents the assessment findings at the first treatment planning meeting.
  - b. ***Physical Health:*** A registered nurse is responsible for completing the physical health assessment. The registered nurse presents the assessment findings at the first treatment planning meeting.
  - c. ***Use of Drugs and Alcohol:*** A team member with experience and training in dual diagnosis substance abuse assessment and treatment is responsible for completing the drug and alcohol assessment. The chemical dependency specialist presents the assessment findings at the first treatment planning meeting.
  - d. ***Education and Employment:*** A team member with experience and training in vocational assessment and services is responsible for completing the education and employment assessment. Included in this area is the assessment of community inclusion and integration as it relates to education and employment. The vocational specialist presents the assessment findings at the first treatment planning meeting.
  - e. ***Social Development and Functioning:*** A team member who is interested and skillful in attainment and restoration of social/interpersonal skills and relationships and who is knowledgeable about human development is responsible for completing the social development and functioning assessment. Included in this area is the assessment of the individual's social and interpersonal inclusion and integration within the community. The team member who does the assessment presents the assessment findings at the first treatment planning meeting.
  - f. ***Activities of Daily Living (ADL):*** Nurses and other clinical staff with training or experience in this area (e.g., occupational therapists) are responsible to complete the ADL assessment. Other staff members with training to do the assessment and who have interest in and compassion for consumers in this area may complete the ADL assessment. The team member who does the assessment presents assessment findings at the first treatment planning meeting.
  - g. ***Family Structure and Relationships:*** Members of the consumer's IIT are responsible to carry out the family structure and relationships assessment. The staff members working with the family present the assessment findings at the first treatment planning meeting.
  - h. ***Strengths and Resources:*** Members of the consumer's IIT are responsible for engaging the consumer in his or her own narrative in order to identify individual strengths and resources as well as those within the individual's family, natural support network, service system, and community at large. These may include: skills, talents, personal virtues and traits, interpersonal skills, interpersonal and environmental resources, cultural knowledge and lore, family stories and narratives, knowledge gained from struggling with adversity, knowledge gained from occupational and parental roles, spirituality and faith, and hopes, dreams, goals, and aspirations.
3. While the assessment process shall involve the input of most, if not all, team members, the consumer's psychiatric prescriber, primary practitioner, and IIT members will assume responsibility for preparing the written narrative of the results and formulation of the psychiatric and social functioning history time line and the

comprehensive assessment, ensuring that a psychiatric and social functioning history time line and comprehensive assessment are completed within one month of the consumer's admission to the program. After the assessment formulation is complete, the IIT will solicit feedback from the consumer and obtain their signature indicating their degree of participation in the assessment process. A copy of the signed assessment shall be made available to the consumer.

4. The primary practitioner and IIT members will be assigned by the team leader in collaboration with the psychiatric prescriber by the time of the first treatment planning meeting or thirty days after admission.

### **C. Person-Centered Treatment Planning**

Person-centered treatment plans will be developed through the following treatment planning process:

1. The person-centered treatment plan shall be developed in collaboration with the consumer and his/her preferred natural supporters, and/or guardian, if any, when feasible and appropriate. The consumer's participation in the development of the treatment plan shall be documented. The PACT team shall evaluate together with each consumer their needs, strengths, and preferences and develop together with each consumer a person-centered treatment plan. The treatment plan shall identify individual service needs; strengths and capacities; set specific and measurable long- and short-term goals for each service need/issue; establish the specific approaches and interventions necessary for the consumer to meet his/her goals, improve his/her capacity to function as independently as possible in the community, and achieve the maximum level of recovery possible (i.e., a meaningful, satisfying, and productive life).
2. As described in Section VI, PACT team staff shall meet at regularly scheduled times for treatment planning meetings. At each treatment planning meeting the following staff should attend: the team leader, the psychiatric prescriber, the primary practitioner, IIT members, the peer specialist and all other PACT team members involved in regular tasks with the consumer. PACT staff shall make every effort to ensure that the consumer and his/her family and/or natural supports (if desired by the consumer) are in attendance at the treatment planning meeting.
3. IIT members are responsible to provide the necessary support to ensure the consumer is actively involved in the development of treatment (recovery) and service goals and participation in the treatment plan meetings. This may include offering of peer-based coaching and/or skills training around his/her role in developing their own person-centered treatment plan. With the permission of the consumer, PACT team staff shall also involve pertinent agencies and members of the consumer's social network in the formulation of treatment plans.
4. Each consumer's treatment plan shall identify service needs/issues, strengths/ weaknesses, and specific measurable goals. The treatment plan must clearly specify the approaches and interventions necessary for the consumer to achieve the individual goals (i.e., recovery) and identify who will carry out the approaches and interventions.
5. The following key areas should be addressed in every consumer's person-centered treatment plan unless they are explored and designated as "not of current interest" by the consumer: psychiatric illness or symptom reduction; housing; ADL; daily structure and employment; family and social relationships; physical health; and other life areas, goals and

aspirations as identified by the consumer (e.g., community activities, empowerment, decision-making). The consumer's own words are reflected in the treatment plan.

6. The primary practitioner and the ITT, together with the consumer, will be responsible for reviewing and rewriting the treatment goals and plan whenever there is a major decision point in the consumer's course of treatment (e.g., significant change in consumer's condition or goals) or at least every 180 days. Additionally, the primary practitioner shall prepare a summary (i.e., treatment plan review) which thoroughly describes in writing the consumer's and the ITT's evaluation of his/ her progress/goal attainment, the effectiveness of the interventions, and the satisfaction with services since the last treatment plan. The plan and review will be signed or acknowledged by the consumer, the primary practitioner, ITT members, the team leader, the psychiatric prescriber, and all PACT team members. A copy of the signed person-centered plan is made available to the consumer.

***Policy and Procedure Requirement:*** The PACT team shall maintain written assessment and treatment planning policies and procedures incorporating the requirements outlined in this section.

## **VIII. Core PACT Services**

Operating as a continuous treatment service, the PACT team shall have the capability to provide comprehensive treatment, rehabilitation, and support services as a self-contained service unit.

Services shall minimally include the following:

### **A. Service Coordination**

Each consumer will be assigned a primary practitioner who coordinates and monitors the activities of the consumer's ITT and the greater PACT team. The primary responsibility of the primary practitioner is to work with the consumer to write the person-centered treatment plan, to provide individual supportive counseling, to offer options and choices in the treatment plan, to ensure that immediate changes are made as the consumer's needs change, and to advocate for the consumer's wishes, rights, and preferences. In most cases, the primary practitioner is also the first staff person called on when the consumer is in crisis and is the primary support person and educator to the individual consumer's family. Members of the consumer's ITT share these tasks with the primary practitioner and are responsible to perform the tasks when the primary practitioner is not working. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

Service coordination will incorporate and demonstrate basic recovery values. The consumer will have ownership of his or her own treatment. The consumer will be expected to take the primary role in person-centered treatment plan development, play an active role in treatment decision making, and be allowed to take risks, make mistakes and learn from those mistakes.

### **B. Crisis Assessment and Intervention**

Crisis assessment and intervention shall be provided 24 hours per day, seven days per week. These services will include telephone and face-to-face contact. The local mental health system's emergency services program as appropriate will provide adjunctive crisis intervention and ITA investigation services as is clinically indicated. Whenever possible, a representative from the PACT team will be present to support the PACT consumer when external crisis responders are involved with the consumer.

Each PACT consumer will have an individualized, strengths based crisis plan. As with the treatment planning process, the consumer will take the lead role in developing the crisis plan.

### **C. Symptom Management and Psychotherapy**

Symptom Management and Psychotherapy shall include but not be limited to the following:

1. Psychoeducation regarding mental illness and the effects and side effects of prescribed medications, when appropriate.
2. Symptom management efforts directed to help each consumer identify/target the symptoms and occurrence patterns of his or her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects.
3. Psychotherapy, including individual supportive therapy and cognitive behavioral approaches.
4. Generous psychological support to consumers, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to recover.

### **D. Wellness Management and Recovery Services**

Wellness Management and Recovery Services shall include but not be limited to the following:

1. Defining and identifying the consumer's recovery goals within the consumer's frame of reference.
2. Developing strategies for implementing and maintaining the identified recovery goals.
3. Psychoeducation and providing the consumer with practical information about mental illness and the consumer's diagnoses and experiences with mental illness.
4. Skills training and practice in how to develop social supports.
5. Skills training for the consumer in understanding and implementing the stress vulnerability model.
6. Skills training for the effective use of medication.
7. Skills training for defining relapse, identifying triggers for relapse and strategies for reducing relapses in frequency and severity.
8. Skills training for identifying individualized stressors and coping positively with those stressors.
9. Skills training for identifying and coping with individualized symptoms.
10. Skills training and practice for getting consumer's needs met within the mental health system, including empowerment and self-advocacy.
11. Direct assistance with learning and practicing new skills as they are developed.

### **E. Medication Prescription, Administration, Monitoring and Documentation**

1. The PACT team psychiatric prescriber shall:
  - a. Establish an individual clinical relationship with each consumer
  - b. Assess each consumer's mental illness symptoms and provide verbal and written information about mental illness. The psychiatric prescriber will review that information with the consumer, and as appropriate, with the consumer's family members or significant others.
  - c. Make an accurate diagnosis based on direct observation, available collateral information from the family and significant others and the comprehensive

- assessment. The diagnostic work-up will dictate an evidence-based medication pathway that the psychiatric prescriber will follow.
- d. Provide to the consumer, and as appropriate, the consumer's family and/or significant others, practical education about medication, including benefits and risks of various medication strategies. The prescriber will obtain informed consent from the consumer for all medications prescribed.
  - e. In collaboration with the consumer, assess, discuss and document the consumer's mental illness symptoms and behavior in response to medication and shall monitor and document medication side effects.
  - f. Provide psychotherapy, including individual supportive therapy, psychoeducation, symptom management, and cognitive behavioral approaches.
2. All PACT team members shall assess and document the consumer's mental illness symptoms and behavior in response to medication and shall monitor for medication side effects. Observations will be reviewed with the consumer.
  3. The PACT team program shall establish medication policies and procedures which identify processes to:
    - a. Record physician orders.
    - b. Order medication.
    - c. Arrange for all consumer medications to be organized by the team and integrated into consumers' weekly schedules and daily staff assignment schedules.
    - d. Provide security for medications (e.g., 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.
    - e. Administer medications per state law to team consumers.

#### **F. Co-Occurring Disorders Services**

1. PACT consumers will receive a comprehensive chemical dependency assessment during the first month of treatment. The assessment will include:
  - a. Substance use history.
  - b. Parental and familial substance use summary.
  - c. Effects/impact of substance use.
  - d. Functional assessment: role played by substances in the consumer's life.
  - e. Consumer strengths.
  - f. Social support network (including both users and people who support recovery)
  - g. Consumer's self-identified goals and aspirations
2. PACT consumers will receive integrated, stage-based treatment that is non-confrontational, considers interactions of mental illness and substance abuse, and has consumer-determined goals. Treatment will follow a harm reduction model. This shall include but is not limited to individual and group interventions in:
  - a. Developing motivation for decreasing use.
  - b. Developing skills to minimize use, recognition of negative consequences of use, and if consumer chooses, adoption of an abstinence goal for treatment.
  - c. Engagement (e.g., empathy, reflective listening, avoid argumentation)

- d. Assessment (e.g., stage of readiness to change, consumer-determined problem identification)
- e. Motivational enhancement (e.g., developing discrepancies, psychoeducation)
- f. Active treatment (e.g., cognitive skills training, community reinforcement)
- g. Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans)

#### **G. Education Services:**

##### ***Supported Education:***

Supported education related services are for PACT consumers whose high school, college or vocational education could not start or was interrupted. Services provide support to enrolling and participating in educational activities.

- 1. Strengths-based assessment of educational interests, abilities and history.
- 2. Pre-admission counseling to determine which school and/or type of educational opportunities may be available.
- 3. If, indicated referral to GED classes and testing.
- 4. Assistance with completion of applications and financial aid forms.
- 5. Help with registration.
- 6. Orientation to campus buildings and school services.
- 7. Assessment of learning style and study skills.
- 8. Early identification and intervention with academic difficulties.
- 9. Linking with academic supports such as tutoring and learning resources.
- 10. Assistance with time management and schoolwork deadlines.
- 11. Supportive counseling.
- 12. Information regarding disclosing mental illness.
- 13. Advocating with faculty for reasonable accommodations.

#### **H. Vocational Services:**

These include work-related services to help consumers value, find, and maintain meaningful employment in community-based job sites as well as job development and coordination with employers. Services include but are not limited to:

- 1. 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.
- 2. Assessment of the effect of the consumer's mental illness on employment with identification of specific behaviors that help and hinder the consumer's work performance and development of interventions to reduce or eliminate any hindering behaviors and find effective job accommodations.
- 3. Job development activities.
- 4. Development of an ongoing employment rehabilitation plan to help each consumer establish the skills necessary to find and maintain a job
- 5. Individual supportive therapy to assist consumers to identify and cope with the symptoms of mental illness that may interfere with their work performance.
- 6. Development of a consumer-driven, on-the-job or work-related crisis intervention plan. The plan will identify early triggers for intervention.
- 7. Provision of on-the-job or work-related crisis intervention services.

8. Work-related supportive services, such as assistance with resume development, job application preparation, interview support, grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation.

**I. Activities of Daily Living Services**

These include services to support activities of daily living in community-based settings include individualized assessment, problem solving, skills training/practice, sufficient side-by-side assistance and support, modeling, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist consumers to gain or use the skills required to:

1. Find housing which is safe, good quality, and affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, and decorating; and procuring necessities (such as telephones, furnishings, linens)
2. Perform household activities, including house cleaning, cooking, grocery shopping, and laundry
3. Carry out personal hygiene and grooming tasks, as needed
4. Develop or improve money-management skills
5. Use available transportation
6. Have and effectively use a personal physician and dentist

**J. Social and Community Integration Skills Training**

Social and community integration skills training serve to support social/interpersonal relationships and leisure-time skill training and 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 to structure consumers' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support required to:

1. Improve communication skills, develop assertiveness, and increase self-esteem, as necessary
2. Develop social skills, increase social experiences, and where appropriate, develop meaningful personal relationships
3. Plan appropriate and productive use of leisure time
4. Relate to landlords, neighbors, and others effectively
5. Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities

**K. Peer Support Services**

These include services to validate consumers' experiences and to guide and encourage consumers to take responsibility for and actively participate in their own recovery, as well as services to help consumers identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce consumers' self-imposed stigma. Peer Support and Wellness Recovery Services include:

1. Peer counseling and support services, including those which:
  - a. Promote self-determination and
  - b. Encourage and reinforce choice and decision making.
2. Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery.
3. “Sharing the journey” (a phrase often used to describe consumers’ sharing of their recovery experience with other peers).
4. The Peer Specialist will serve as a consultant to the PACT team to support a culture of recovery in which each consumer’s point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, support, and community activities.

**L. Support Services**

Support services, to include skills training for accessing services, and providing direct assistance when necessary, to ensure that consumers obtain the basic necessities of daily life, including but not necessarily limited to:

1. Medical and dental services
2. Safe, clean, affordable housing
3. Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Vocational Rehabilitation, Home Energy Assistance)
4. Social service
5. Transportation
6. Legal advocacy and representation

**M. Family and Natural Supports’ Psychoeducation and Support**

Services provided under this category to consumers' families and other major supports with consumer agreement or consent, include:

1. Individualized psychoeducation about the consumer's illness and the role of the family in the therapeutic process
2. Individualized psychoeducation about the consumer's illness and the role of other significant people in the therapeutic process
3. Family intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people
4. Ongoing communication and collaboration, face-to-face and by telephone, between the PACT team and the family
5. Introduction and referral to family self-help programs and advocacy organizations that promote recovery
6. Assistance to consumers with their children, including individual supportive counseling, parenting training, and service coordination but not limited to:
  - a. Services to help consumers throughout pregnancy and the birth of a child
  - b. Services to fulfill parenting responsibilities and coordinating services for the child
  - c. Services to restore relationships with children who are not in the consumer’s custody



***Policy and Procedure Requirement:*** The PACT team shall maintain written policies and procedures for all services outlined in this section.

## **IX. Consumer Medical Record**

- A. The PACT team shall maintain a treatment record for each consumer.
- B. The treatment record is confidential, complete, accurate, and contains up-to-date information relevant to the consumer's care and treatment.
- C. The record shall accurately document assessments, treatment plans, and the nature and extent of services provided, such as a person unfamiliar with the PACT team can easily identify the consumer's treatment needs and services received.
- D. The team leader and the program assistant shall be responsible for the maintenance and security of the consumer treatment records.
- E. The consumer records are located at PACT team headquarters and, for confidentiality and security, are to be kept in a locked file.
- F. For purposes of confidentiality, disclosure of treatment records by the PACT team is subject to all the provisions of applicable state and federal laws.
- G. Consumers shall be informed by staff of their right to review their record and the process involved to request to do so.
- H. Each consumer's clinical record shall be available for review and may be copied by authorized personnel.

***Policy and Procedure Requirement:*** The PACT team shall maintain written medical records management policies and procedures.

## **X. Consumer Rights and Grievance Procedures**

- A. **PACT teams shall be knowledgeable about and familiar with consumer rights including the rights to:**
  - 1. Confidentiality
  - 2. Informed consent to medication and treatment
  - 3. Treatment with respect and dignity
  - 4. Prompt, adequate, and appropriate treatment
  - 5. Treatment which is under the least restrictive conditions
  - 6. Nondiscrimination
  - 7. Control of own money
  - 8. Voice or file grievances or complaints
- B. **PACT teams shall be knowledgeable about and familiar with the mechanisms to implement and enforce consumer rights. These include:**

Grievance or complaint procedures under:

- 1. WAC and RCW
- 2. Medicaid
- 3. Americans with Disabilities Act
- 4. Protection and Advocacy for Mentally Ill Individuals

- C. **PACT teams shall be prepared and provide consumers with appropriate information and referral to the Protection and Advocacy agency and other advocacy groups.**

*Policy and Procedure Requirement:* The PACT team shall maintain consumer rights policies and procedures.

**XI. Culturally and Linguistically Appropriate Services (CLAS)** United States. Dept. of Health and Human Services. Office of Minority Health. National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report. [Rockville, MD]: U.S. Dept. of Health and Human Services, 2001.

- A. PACT teams should ensure that consumers receive from all staff members, effective understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices. PACT teams will also make every attempt to ensure that consumers receive services in their preferred language and will make arrangements for interpreter services, if available.
- B. PACT teams should implement strategies to recruit, retain, and promote a diverse staff that are representative of the demographic characteristics of the service area.
- C. PACT teams should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
- D. PACT teams must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each consumer with limited English-proficiency at all points of contact, in a timely manner during all hours of operation.
- E. PACT teams must provide to consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- F. PACT teams must assure the competence of language assistance provided to limited English-proficient consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except by request of the consumer).
- G. PACT teams must make available easily understood consumer-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
- H. PACT teams should develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
- I. PACT teams should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, consumer satisfaction assessments and outcome-based evaluations.
- J. PACT should ensure that data on the individual consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and be periodically updated.
- K. PACT teams should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and consumer involvement in designing and implementing CLAS-related activities.
- L. PACT should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by consumer.

- M. PACT is encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.
- N. Special consideration shall be taken to insure that the abovementioned items A-M are appropriately and respectfully applied to Native American Consumers.

***Policy and Procedure Requirement:*** The PACT team shall maintain written Culturally and Linguistically Appropriate Services (CLAS) policies and procedures incorporating the requirements outlined in this section.

## **XII. Performance Improvement and Program Evaluation**

The PACT team shall have a performance improvement and program evaluation plan, which shall include the following:

- A. A statement of the program's objectives. The objectives shall relate directly to the program's consumers or target population.
- B. Measurable criteria shall be applied in determining whether or not the stated objectives are achieved.
- C. Methods for documenting achievements related to the program's stated objectives.
- D. Methods for assessing the effective use of staff and resources toward the attainment of the objectives.
- E. In addition to the performance improvement and program evaluation plan, the PACT team shall have a system for regular review that is designed to evaluate the appropriateness of admissions to the program, treatment or service plans, discharge practices, and other factors that may contribute to the effective use of the program's resources.

***Policy and Procedure Requirement:*** The PACT team shall maintain performance improvement and program evaluation policies and procedures.

## **XIII. Stakeholder Advisory Groups**

The PACT team shall have a stakeholder advisory group to support and guide PACT team implementation and operation. The stakeholder advisory group shall have at least 51 percent mental health consumers and family members and include other community stakeholders such as representatives from services for the homeless, consumer-support organizations, food-shelf agencies, faith-based groups, criminal justice system, housing authorities, landlords, employers, and/or community colleges. Group membership should also represent the local cultural populations and Tribal entities as applicable. The Stakeholder Advisory Group shall not have access to individually-identifiable consumer information without written consumer consent.

The stakeholder advisory group shall:

- A. Promote quality PACT model programs
- B. Monitor fidelity to the PACT program standards
- C. Guide and assist with the administering agency's oversight of the PACT program
- D. Problem-solve and advocate to reduce system barriers to PACT implementation
- E. Monitor types of and trends in consumer and family grievances and complaints, and make recommendations to the administering agency on how to improve services to reduce complaints and grievances

F. Promote and ensure consumers' empowerment and recovery values in PACT programs.

***Policy and Procedure Requirement:*** The PACT team shall maintain the written stakeholder advisory group policies and procedures, incorporating the requirements outlined in this section.

**XIV. Waiver of Provisions**

The PACT team may request of the PACT certification entity a waiver of any requirement of this standard that would not diminish the effectiveness of the PACT model, violate the purposes of the program, or adversely affect consumers' health and welfare. Waivers cannot be granted which are inconsistent with consumer rights or federal, state, or local laws and regulations.