

Montana Standards for Programs of Assertive Community Treatment
Adapted in 2011 from
National Program Standards for ACT Teams
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ACT Program Standards

The *Montana Standards for PACT* guide PACT team start-up and implementation by clearly defining the minimum program requirements. Successful PACT model implementation and demonstrated improvements in client outcome are best accomplished by close adherence and strong fidelity to the PACT Standards. In addition, the PACT Standards emphasize that PACT is a client-centered, recovery-oriented service delivery model.

These program standards are used to establish costs and reimbursement, and are used for monitoring program fidelity. In addition to these standards, programs must adhere to all related federal laws and regulations, and all applicable Montana statutes and administrative rules.

I. Introduction

Assertive Community Treatment (ACT) is a client-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 disabling mental illnesses, have severe symptoms and impairments, and have not benefited from traditional outpatient programs.

The important characteristics of assertive community treatment programs are:

- PACT serves clients with severe disabling mental illnesses that are complex, have devastating effects on functioning, and, because of the limitations of traditional mental health services, may have gone without appropriate services. Consequently, the client group is often over represented among the homeless and in jails and prisons, and has been unfairly thought to resist or avoid involvement in treatment.
- PACT services are delivered by a group of multidisciplinary mental health staff who work as a team and provide the majority of the treatment, rehabilitation, and support services clients need to achieve their goals. Many, if not all, staff share responsibility for addressing the needs of all clients requiring frequent contact.
- PACT services are individually tailored with each client and address the preferences and identified goals of each client. The approach with each client 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 client to find and live in their own residence and find and maintain work in community jobs rather than expecting the client to come to the program.
- PACT services are delivered in an ongoing rather than time-limited framework to aid the process of recovery and ensure continuity of care.

II. Definitions

Assertive Community Treatment (PACT) is a self-contained mental health program made up of multidisciplinary mental health staff persons who work as a team to provide the majority of treatment, rehabilitation, and support services clients need to achieve their goals. The clients served have severe disabling mental illnesses that are complex, have devastating effects on functioning, and, because of the limitations of traditional mental health services, may have gone without appropriate services.

PACT Service Coordination (Case Management) is a process of organization and coordination within the multidisciplinary team to carry out the range of treatment, rehabilitation, and support services each client expects to receive per his or her written individualized treatment plan and is respectful of the client's wishes. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

PACT Service Coordinator (Case Manager) is the team member who has primary responsibility for establishing and maintaining a therapeutic relationship with a client on a continuing basis. In addition, the service coordinator leads and coordinates the activities of the individual treatment team (ITT).

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

Client-Centered Individualized Treatment Plan is the documentation of a continuous process involving each client and the PACT team, which individualizes service activity and intensity to meet client-specific treatment, rehabilitation, and support needs. The written treatment plan details the client's self-determined goals and the services necessary to help the client achieve them. The plan also delineates the roles and responsibilities of the team members who will carry out the services.

Daily Organizational Staff Meeting is a daily staff meeting held at least five times per week and 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 clients; 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.

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 core members are the service coordinator (case manager), the psychiatrist, and one clinical or rehabilitation staff person who backs up and shares case coordination tasks and substitutes for the service coordinator when he or she is not working. The individual treatment team has continuous responsibility to:

- 1) be knowledgeable about the client's life, circumstances, goals and desires;
- 2) collaborate with the client to develop and write the treatment plan;
- 3) offer options and choices in the treatment plan;
- 4) ensure that immediate changes are made as a client's needs change; and
- 5) advocate for the client's wishes, rights, and preferences.

Initial Assessment and Client-Centered Individualized Treatment Plan is the initial evaluation of:

- 1) the client's mental and functional status;
- 2) the effectiveness of past treatment; and
- 3) the current treatment, rehabilitation, and support service needs.

The results of the information gathering and analysis are used to establish the initial treatment plan to support recovery and help the client achieve individual goals.

Medication Distribution is the physical act of giving medication to PACT program clients by the prescribed route that is consistent with state law and the licenses of the professionals qualified to prescribe and/or administer medication (e.g., psychiatrists, registered nurses, and pharmacists).

Medication Management is a collaborative effort between the client and the psychiatrist/APRN with the participation of the Individual Treatment Team (ITT) to:

- 1) carefully evaluate the client's previous experience with psychotropic medications and side-effects;
- 2) identify and discuss the benefits and risks of psychotropic and other medication;
- 3) choose a medication treatment; and
- 4) establish a method to prescribe and evaluate medication according to evidence-based practice standards. The goal of medication management is client self-medication management.

Program of Assertive Community Treatment (PACT) is the name of the original assertive community treatment program, Mendota Mental Health Institute, Madison, Wisconsin, that developed the ACT model and conducted two controlled research studies which substantiated ACT model effectiveness for adults with severe and persistent mental illnesses compared to traditional mental health service delivery.

Recovery does not have a single agreed-upon definition. “The overarching message is that hope and restoration of a meaningful life are possible, despite serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society.” (*Mental Health: A Report of the Surgeon General, 1999, p 97*)

Stakeholder Advisory Groups support and guide individual PACT team implementation and operation. The Stakeholder Advisory Group promotes and ensures clients’ empowerment and recovery values in assertive community treatment programs.

III. Admission and Discharge Criteria

A. Admission Criteria

The following criteria are to be used by a PACT team in selecting clients “in the greatest need” of PACT services:

1. Clients with severe disabling mental illnesses 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.
2. Clients with significant functional impairments as demonstrated by at least one of the following:
 - a. Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community, or persistent and recurrent difficulty performing daily living tasks without 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. (In Montana, emphasis is placed on the criteria in sections a above and c below.)
 - c. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).
3. Clients with one or more of the following problems, which are indicators of continuous high service needs (i.e., greater than eight hours per month):
 - a. High use of acute psychiatric hospitals or psychiatric emergency services.
 - b. Intractable severe major symptoms (e.g., affective, psychotic, suicidal).
 - c. Coexisting substance abuse disorder of significant duration.
 - d. High risk or recent history of criminal justice involvement.
 - e. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or 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.

B. Discharge Criteria

Discharge from PACT occurs when a client and program staff members mutually agree to the termination of services. This may occur when a client:

1. Has successfully reached individually established goals for discharge.
2. Has successfully demonstrated an ability to function in all major role areas without ongoing assistance from the program, without significant relapse when services are withdrawn, and when the client requests discharge.
3. Moves outside the geographic area of PACT responsibility. In such cases, the PACT team shall arrange for transfer of mental health service responsibility to another provider and maintain contact with the client until this service transfer is implemented.
4. Declines or refuses services and requests discharge, despite the team's best efforts to develop an acceptable treatment plan with the client.

IV. Service Intensity and Capacity

A. Staff Coverage

Each PACT team shall have sufficient numbers of staff to provide treatment, rehabilitation, and support services 24 hours a day, seven days per week, as described in **Hours of Operation and Staff Coverage** below.

B. Frequency of Client Contact

1. The PACT team shall have the capacity to provide multiple contacts a week with clients 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.
2. The PACT team shall have the capacity to rapidly increase service intensity to a client when his or her status requires it or a client requests it.
3. The PACT team shall provide at least three face-to-face contacts per week for each client.

C. Gradual Admission of Team Clients

Each new PACT team shall stagger client admissions (e.g., 6-8 clients per month) to gradually build up capacity to serve no more than 70 clients on any given 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; symptom assessment and 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 clients obtain the basic necessities of daily life; and education, support, and consultation to clients' families and other major supports.

B. Team size and Professional Staff

The PACT Team shall employ a minimum of 10 FTE multidisciplinary clinical staff to serve **up to** 50 clients, and 12 FTE multidisciplinary staff to serve **up to** 70 clients as outlined in the below table:

Montana Staffing Requirements

	50 clients	70 clients
Team leader*	1 FTE	1 FTE
Psychiatrist / APRN	16 Hours**	20 Hours**
Nurse	2 FTE	2 FTE
Peer Specialist	.5 FTE	.5-1 FTE
Vocational Specialist	1 FTE	1 FTE
Substance Abuse Specialist	1 FTE	1 FTE
Master's level MH Professional	1-2 FTE	2-3 FTE
Other level	2-3 FTE	3-4 FTE
Administrative Assistant	1 FTE	1 FTE

* May also serve as prescriber

** Direct and indirect hours

D. Required staff

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 psychiatrist or psychiatric APRN.
2. **Psychiatrist / APRN:** A psychiatrist or psychiatric APRN, who works on a full-time or part-time basis for a minimum of 20 hours per week for every 70 clients. The psychiatrist / APRN provides clinical services to all PACT clients; works with the team leader to monitor each client's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic and medical services.

3. **Nurses:** 2 FTE nurses are required at least one of whom is a Registered Nurse. Registered nurses will provide medical assessment and services as well as treatment and rehabilitation services.
4. **Master's Level Mental Health Professionals:** A minimum of 2 FTE master's level or above mental health professionals.
5. **Vocational Specialist:** One or more individuals with training and experience in supported employment &/or vocational rehabilitation with a minimum of a bachelor's degree in rehabilitation/vocational counseling and/or certification in rehabilitation counseling, shall be designated the role of vocational specialist. The vocational specialist has the responsibility to develop, direct, and provide work-related services, including assessment of the effect of the client's mental illness on employment, and to plan and implement an ongoing employment strategy to enable each consumer to obtain and retain a job.
6. **Substance Abuse Specialist:** One or more individuals with licensing as an addiction counselor and having training and experience in substance abuse assessment and treatment shall be designated the role of substance abuse specialist.
7. **Peer Specialist:** A minimum of one peer specialist on a team. A person who is or has been a recipient of mental health services for severe disabling mental illness holds this position. Peer specialists are fully integrated team members who provide highly individualized services in the community and promote client self-determination and decision-making. Peer specialists also provide essential expertise and consultation to the entire team to promote a culture in which each client's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities.
8. **Remaining Other Staff:** The remaining staff may be bachelor's level and paraprofessional mental health workers who carry out rehabilitation and support functions.
9. **Program/Administrative Assistant:** 1 FTE program/administrative assistant who is responsible for organizing, coordinating, and monitoring all non-clinical operations of ACT, 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 calls and coordinating communication between the team and clients.

VI. Program Organization and Communication

A. Hours of Operation and Staff Coverage

1. The PACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week. Staff persons are regularly scheduled to provide the necessary services on a client-by-client basis (per the client-centered comprehensive assessment and individualized treatment plan) in the evenings and on weekends. PACT team staff who are experienced in the

- program and skilled in crisis-intervention procedures shall be on call and available to respond to clients by telephone or in person.
2. When a team does not have sufficient staff numbers to operate an after-hours on-call system, the team may arrange coverage through a reliable crisis intervention service. The team must communicate routinely with the crisis intervention service to obtain information from the previous evening and to alert the crisis-intervention service to clients who may need assistance and to provide effective ways for helping them.
 3. If availability of the PACT psychiatrist / APRN during all hours is not feasible, alternative psychiatric backup will be arranged.

B. Place of Treatment

Each team shall provide 75 percent of service time in the community in non-office-based or non-facility-based settings. Data regarding the percentage of client contacts in the community will be reported and reviewed to verify that this standard is being met.

C. Staff Communication and Planning

1. The PACT team shall conduct **daily organizational staff meetings** at least 5 days per week and 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 in writing:
 - A roster of the clients served in the program, and
 - For each client, a brief documentation of any treatment or service contacts that have occurred during the last 24 hours and a concise, behavioral description of the client's status that day.
 - b. The **daily organizational staff meeting** includes a review of the treatment contacts which occurred the day before and provides a systematic means for the team to assess the day-to-day progress and status of all clients.
 - c. During the **daily organizational staff meeting**, the PACT team shall also revise treatment plans as needed, plan for emergency and crisis situations, and add service contacts to the daily staff assignment schedule per the revised treatment plans.
2. The PACT team shall conduct **treatment planning meetings** under the supervision of the team leader and the psychiatrist / APRN. These treatment planning meetings shall:
 - a. Convene at regularly scheduled times per a written schedule set by the team leader.
 - b. Occur and be scheduled when the majority of the team members can attend, including the psychiatrist / APRN, team leader, and all members of the ITT.
 - c. Require individual staff members to present and systematically review and integrate client information into a holistic analysis and prioritize problems.
 - d. Occur with sufficient frequency and duration to make it possible for all staff:
 - 1) to be familiar with each client and their goals and aspirations;

- 2) to participate in the ongoing assessment and reformulation of problems;
- 3) to problem-solve treatment strategies and rehabilitation options;
- 4) to participate with the client and the ITT in the development and the revision of the treatment plan; and
- 5) to fully understand the treatment plan rationale in order to carry out each client's plan.

VII. Client-Centered Assessment and Individualized Treatment Planning

A. Initial Assessment

An initial assessment and treatment plan is completed the day of the client's admission to PACT.

B. Comprehensive Assessment

Each part of the assessment area is to be completed by a PACT team member with the skills and knowledge in the area being assessed. The assessment is based upon all available information, including that from client interview/self-report, family members and other significant parties, and written summaries from other agencies, including police, courts, and outpatient/inpatient facilities, where applicable.

The comprehensive assessment includes evaluation in the following areas that is presented at the first treatment planning meeting:

- a. **Psychiatric History, Mental Status, and Diagnosis:** The psychiatrist / APRN is responsible for completing the psychiatric history, mental status, and diagnosis assessment.
- b. **Physical Health:** A registered nurse is responsible for completing the physical health assessment.
- c. **Use of Drugs and Alcohol:** The substance abuse specialist is responsible for completing the use of drugs and alcohol assessment.
- d. **Education and Employment:** The vocational specialist is responsible for completing the education and employment assessment.
- 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.
- f. **Activities of Daily Living (ADL):** Occupational therapists, nurses or other staff members with training to do the assessment and who have interest in and compassion for clients in this area may complete the ADL assessment.
- g. **Family Structure and Relationships:** Members of the client's individual treatment team (ITT) are responsible to carry out the family structure and relationships assessment.

C. Individualized Treatment Planning

Treatment plans will be developed through the following process:

1. The treatment plan is developed in collaboration with the client, and the family or guardian when feasible and appropriate. The client's participation in the development of the treatment plan is documented. Together the PACT team and the client assess the client's needs, strengths, and preferences and develop an individualized treatment plan.
2. Individual treatment team members are responsible to ensure the client is actively involved in the development of treatment and recovery goals. With the permission of the client, PACT team staff members involve pertinent agencies and members of the client's social network in the formulation of treatment plans.
3. Each client's treatment plan identifies his or her problems, strengths/weaknesses, and specific measurable goals. The treatment plan clearly specifies the approaches and interventions necessary for the client to achieve his/her individual goals and identifies who will carry out the approaches and interventions.
4. The following key areas should be addressed in every client's treatment plan:
 - a) psychiatric illness or symptom reduction;
 - b) housing;
 - c) activities of daily living (ADL);
 - d) daily structure;
 - e) meaningful activity or employment; and
 - f) family and social relationships.

The service coordinator (case manager) and the individual treatment team, together with the client, are responsible for reviewing and rewriting the treatment goals and plan whenever there is a major decision point in the client's course of treatment.

VIII. Required 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 client will be assigned a service coordinator (case manager) who coordinates and monitors the activities of the client's individual treatment team and the entire PACT team. The primary responsibility of the service coordinator is to work with the client to write the 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 client's needs change, and to advocate for the client's wishes, rights, and preferences. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

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 with PACT and

will be provided in conjunction with the local mental health system's emergency services program as appropriate.

C. Symptom Assessment and Management

This includes:

1. Ongoing comprehensive assessment of the client's mental illness symptoms, accurate diagnosis, and the client's response to treatment.
2. Psycho-education regarding mental illness and the effects and side effects of prescribed medications.
3. Symptom-management efforts directed to help each client 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.

D. Medication Prescription, Administration, Monitoring and Documentation

1. The PACT team psychiatrist/APRN shall:
 - a. Establish an individual clinical relationship with each client.
 - b. Assess each client's mental illness symptoms and provide verbal and written information about mental illness.
 - c. Make an accurate diagnosis based on the comprehensive assessment which dictates an evidence-based medication pathway that the psychiatrist will follow.
 - d. Provide education about medication, benefits and risks, and obtain informed consent.
 - e. Assess and document the client's mental illness symptoms and behavior in response to medication and shall monitor and document medication side effects.
2. All PACT team members shall assess and document the client's mental illness symptoms and behavior in response to medication and shall monitor for medication side effects.

E. Co-Occurring Substance Abuse Services

Provision of stage-based treatment that is non-confrontational, considers interactions of mental illness and substance abuse, and has client-determined goals. This shall include but is not limited to individual and group interventions and facilitating the use of self-help groups and supportive recovery communities. **The Integrated Dual-Disorder Treatment book and fidelity scale provide relevant standards for PACT Co-Occurring Substance Abuse Services.**

F. Work-Related Services

Work-related services to help clients value, find, and maintain meaningful employment in community-based job sites and services to develop jobs and coordinate with employers.

G. Activities of Daily Living

Services to support activities of daily living in community-based settings include individualized assessment, problem solving, side-by-side assistance and support, skill training, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations.

H. Social/Interpersonal Relationship and Leisure-Time Skill Training

Services to support social/interpersonal relationships and leisure-time skill training include supportive individual therapy; 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 clients' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support.

I. Peer Support Services

Peer support services validate clients' experiences, and guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, peer support services help clients identify, understand, and develop strategies to reduce clients' self-imposed stigma.

J. Support Services

Support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not limited to:

1. Medical and dental services
2. Safe, clean, affordable housing
3. Financial and/or benefits counseling
4. Transportation
5. Legal advocacy and representation

K. Education, Support, and Consultation to Clients' Families and Other Major Supports

Services provided regularly under this category to clients' families and other major supports, with client agreement or consent, include:

1. Individualized psycho-education about the client's illness and the role of the family and other significant people in the therapeutic process.
2. Intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people.
3. Ongoing communication and collaboration, face-to-face and by telephone, between the PACT team and the family.
4. Introduction and referral to family self-help programs and advocacy organizations that promote recovery.
5. Assistance to clients with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to:
 - a. Services to help clients throughout pregnancy and the birth of a child.
 - b. Services to help clients fulfill parenting responsibilities and coordinate services for the child/children.

- c. Services to help clients restore relationships with children who are not in the client's custody.

IX. Billing Standards

PACT reimbursement is not available when a client is in another 24 hour service, i.e. MSH, MCDC, MSP, MWP, MMHNCC, acute-care hospital, group home, foster care, nursing home, county detention center or other 24/7 service.

X. Client Rights and Grievance Procedures

A. PACT teams shall be knowledgeable about and familiar with client rights including the right 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. File grievances or complaints

B. PACT teams shall be knowledgeable about and familiar with the mechanisms to implement and enforce client rights:

1. Grievance or complaint procedures under state law
2. Medicaid
3. Americans with Disabilities Act
4. Protection and Advocacy for Individuals with Mental Illness

C. PACT teams shall be prepared and provide clients with appropriate information and referral to the Protection and Advocacy Agency and other advocacy groups.

XI. Cultural Competence

Cultural competence is a set of congruent behaviors, attitudes and policies that enable a program to work effectively in cross-cultural or multi-cultural situations. The word "culture" is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious, economic, or social group. The word "competence" is used because it implies having the capacity to function effectively.

The program shall:

- a. Incorporate cultural awareness into the assessment and treatment of each consumer, asking each consumer about their cultural background and identity.
- b. Involve natural networks of support, such as family, community groups, and religious/spiritual organizations, in treatment planning for each consumer.
- c. Conduct regular organizational and individual self-assessments of cultural competence.
- d. Offer cultural competence training to staff in topics such as cultural awareness of groups commonly served by the program, culturally responsive communication and interviewing skills, and cultural beliefs about the causes of and treatment for illness.
- e. Include cultural competence in all program quality assurance and quality improvement activities.

XII. Stakeholder Advisory Groups

A. Each PACT team is encouraged to have a Stakeholder Advisory Group whose membership consists of mental health consumers and family members, as well as 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 should represent the local cultural populations. The group's functions may include promoting quality PACT programs; monitoring fidelity to the PACT Standards; guiding and assisting the administering agency's oversight of the PACT program; problem-solving and advocating to reduce barriers to PACT implementation; and monitor/review/mediate client and family grievances or complaints.

B. The stakeholder advisory group:

1. Promotes quality PACT model programs.
2. Problem-solves and advocates to reduce system barriers to PACT implementation.
3. Promotes and ensures client empowerment and recovery values in assertive community treatment programs.

XIII. Waiver of Provisions

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

The *Montana Standards for PACT Teams* is a companion document to [A Manual for ACT Start-Up: Based on the PACT Model of Community Treatment for Persons with](#)

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