King County

Program for Assertive Community Treatment (PACT)

Two-Year Outcomes

Department of Community and Human Services
Mental Health, Chemical Abuse and Dependency Services Division

Prepared by
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Executive Summary

King County implemented the Program for Assertive Community Treatment (PACT) to reduce psychiatric hospital and jail use for up to 180 individuals who are among the most frequent utilizers of these systems. The PACT is a federally-recognized evidence-based practice that provides comprehensive, individualized assistance to people with severe and persistent mental illness. The PACT incorporates a team approach, a low staff to client ratio, and services provided 24 hours a day, seven days a week in the community in a time-unlimited, flexible manner. King County operates two PACT Teams (downtown/north and south/east). With PACT and other similar programs, King County continues its efforts to reduce the cycles of psychiatric hospitalizations, jails, and homelessness that often accompany serious and persistent mental illnesses through providing a supported housing model tailored to the needs of clients with the most complex needs.

The purpose of this report is to present two-year outcomes for participants who entered the PACT program during its first two years of operation.

Results

The PACT began enrolling participants in July 2007. Ninety-four people enrolled during the first year of the program and 80 during the second year. In both cohorts, participants were:

- 67 percent male
- Nearly two-thirds White/Caucasian
- Over four-fifths diagnosed with schizophrenia spectrum disorders
- At least half complicated with co-occurring substance abuse
- 53 percent referred from state hospitals, though 81 percent had psychiatric hospitalizations during the prior year
- One-third with incarcerations during the year prior to enrollment.

Participants who entered during the second year had similarly strong one- and two-year outcomes to those who entered during the first year. Specifically, the participants showed:

- High program retention – 93 percent of the first-year cohort and 86 percent of the second-year cohort were retained in the program for at least one year. About three-quarters were still in PACT after two years.
- Psychiatric hospital admissions dropped by about half during the first year following admission with slight additional reductions during the second year following admission.
- No significant changes in jail bookings or jail days.

- Increased average income after one year in the program remaining stable during the second year. Nearly all individuals had a stable source of income after one year in the program.

- More apparent alcohol and drug use, but more movement toward active treatment.

Recommendations

The program continues to be highly successful in retaining participants and participants showed significant reductions in psychiatric hospitalizations. These findings are in line with research regarding PACT programs nationally that show the most consistent impacts of the program are in reducing hospitalization.

The current report continues the recommendations made in the report of outcomes for the first six-month cohort:

- Continue processes in use that help retain individuals in the program and reduce hospitalizations.

- Increase focus on treatment for substance use, as more individuals are using drugs and alcohol.

- Increase attention to reducing incarcerations for the subset of individuals at risk for incarceration.

- Increase access to innovative supported employment services to increase the likelihood that participants will obtain employment.

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Background

The Program for Assertive Community Treatment (PACT) provides evidence-based, comprehensive, individualized assistance to people with severe and persistent mental illness. The PACT helps individuals who experience significant difficulties with maintaining stable community living situations, relationships, work and/or school because of a severe and persistent mental illness. The PACT is intended for individuals who have been frequently hospitalized or incarcerated due to mental illness or show severe functional impairments related to mental illness. King County operates two PACT teams with a target enrollment, when full, of 90 clients per team.

More than 25 research studies demonstrate the effectiveness of PACT in reducing hospital stays and improving housing stability while being more satisfactory to consumers and their families than standard care. The PACT is an evidence-based practice listed with the federal Substance Abuse and Mental Health Services Administration. The PACT is funded by the Division of Behavioral Health and Recovery in Washington State.

Purpose of this Report

This report presents two-year outcomes for participants who entered during the first two years of the PACT program.

Program Description

King County operates two PACT teams. Downtown Emergency Service Center (DESC) PACT assists individuals living in downtown, as well as north Seattle and King County. The south/east team, operated by Navos, helps people in south/east King County. Each team has 90 spaces allotted for PACT participants.

Services

The PACT involves:

- Team Approach – PACT teams consist of a psychiatrist, nurses, chemical dependency specialist, employment specialist, social workers, and peer specialists working together to help PACT consumers achieve their goals. The team meets daily.

- Low staff to client ratio – a team consists of 10-12 direct care staff serving about 90 consumers.

- Fixed Point of Responsibility – rather than sending consumers to a variety of providers for assistance, the team provides most, if not all, the services an individual needs.

- In Vivo Services – staff provide most services in the community where the help is needed.

- Time Unlimited – services are provided as long as they are needed. There is no fixed timeline.

- Flexible Services – services are based upon the individual needs/goals of each consumer with the ability to provide multiple contacts each day.

- 24/7 Crisis Services – services are available when they are needed.

- Assertive engagement (i.e., persistent and active approaches to treatment participation).

Fidelity to evidence-based PACT is monitored by Washington State Division of Behavioral Health and Recovery and by the Washington Institute for Mental Health Research and Training.

Housing

Most consumers entering PACT are without stable housing. Unique among PACT teams in the state, King County's PACT teams benefit from a partnership with their local housing authorities to provide affordable housing to PACT participants. With the assistance of rental housing subsidies from the King County Housing Authority and the Seattle Housing Authority, King County Regional Support Network PACT teams are able to place consumers in private market apartment units, where the client pays no more than 30 percent of his or her income in rent and utilities. Team members work with participants to learn basic skills of cooking, grocery shopping, and maintaining a clean home.

Eligibility Criteria

To be eligible for PACT, a person must have a referral from a state or local hospital, local jail, outpatient service provider, or intensive residential and community support program within the King County public mental health system and screened by the PACT team for the following criteria:

1. Primary mental health diagnosis with priority given to people with schizophrenia, other psychotic disorders, and bipolar disorder.

2. Functioning impairment as indicated by significant difficulty with at least one of the following:

   a. Maintaining consistent employment at a self-sustaining level

   b. Consistently carrying out the homemaker role (e.g., meals, washing clothes, etc.)

   c. Consistently performing daily living tasks (e.g., obtaining medical or legal services, avoiding common hazards, meeting nutritional needs, maintaining personal hygiene)

   d. Performing daily living tasks, except with significant support or assistance

   e. Maintaining safe living situation (e.g., forgetting stove, unsanitary, evictions, etc.).

3. Continuous high-service needs as demonstrated by at least one of the following:

   a. High use of psychiatric hospitals (e.g., two or more admissions or emergency services/yr)

b. Persistent or recurrent severe major symptoms (e.g., affective, psychotic, suicidal)
c. Co-occurring substance use disorder greater than six months duration
d. High risk or recent history of arrests or incarceration
e. Significant difficulty meeting survival needs or in substandard housing, 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
g. Requires residential or institutional placement if more intensive services not available
h. Difficulty utilizing office-based outpatient services or other less-intensive programs.

4. Residence in King County or a plan to move to King County in near future.
5. Be at least 18 years of age.
6. Ability to live in independent or semi-independent housing with programmatic supports.

Participant Characteristics

PACT Team Enrollment

Enrollment in PACT was somewhat greater for the DESC team during the first year but the same as the south/east team during the second year as shown in Table 1.

Table 1. PACT Enrollment

	First Year Cohort 7/07-6/08	Second Year Cohort 7/08-6/09
DESC	51 (54%)	40 (50%)
South/East (SE)	43 (46%)	40 (50%)
Both teams	94 (100%)	80 (100%)

PACT Referral Sources

Table 2 shows that the state hospital refers the most PACT participants.

Table 2. Referral Sources

	First Year Cohort (n=94)		Second Year Cohort (N=80)[1]	
State hospitals/Program for Assertive Living Skills (PALS)	50	53%	37	47%
Residential treatment facility – Long Term Rehabilitation (LTR)	13	14%	17	22%
Community hospital	8	9%	15	19%
Community mental health agency	12	13%	5	6%
Intensive outpatient treatment program	5	5%	2	3%
Other	6	6%	2	3%

*2 missing/unknown; % taken from 78

Demographics

About two-thirds of PACT participants are male (67 percent both years). Participants in the first year cohort had an average age of 43.3 years (SD=12.3) with range 20 to 66 years old. The second year cohort was similar with an average age of 41.8 years (SD=12.6) and range of 22 to 66 years.

Nearly two-thirds of PACT participants are White/Caucasian. African American/Blacks comprise the largest non-white group, as shown in Figure 1 and Table 3.

Figure 1. PACT Participant Ethnicity
(first two years N=174)

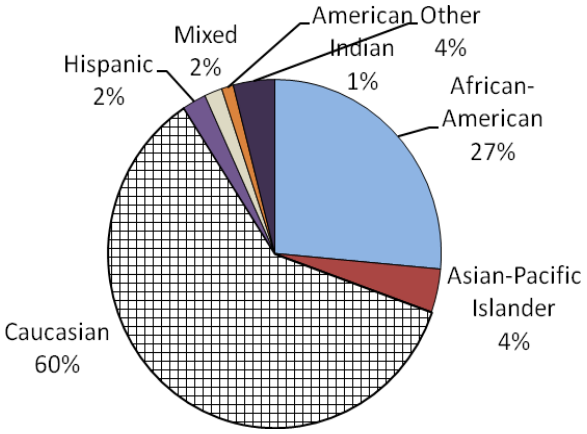


Table 3. Participant Ethnicity

Ethnicity	First Year Cohort (N=94)	Second Year Cohort (N=80)
Caucasian	53 (56%)	52 (65%)
African-American/Black	27 (29%)	19 (24%)
Asian-Pac Islander	5 (5%)	2 (2%)
Mixed	2 (2%)	1 (1%)
Hispanic	1 (1%)	3 (4%)
American Indian	1 (1%)	1 (1%)
Other	5 (5%)	2 (2%)

Diagnoses

As Figure 2 and Table 4 show, most PACT participants had a schizophrenia spectrum diagnosis (e.g., schizophrenia, schizoaffective, other psychotic disorder).

Figure 2. PACT Participant Diagnoses
(first two years N=175)

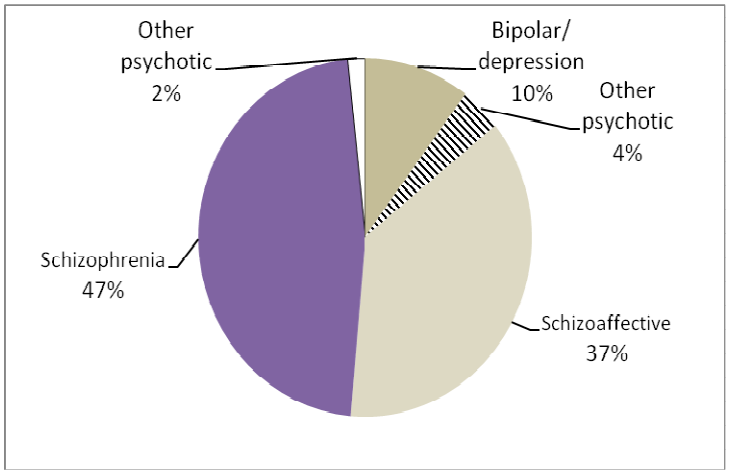


Table 4. PACT Participant Diagnoses

Diagnosis	First Year Cohort (N=94)	Second Year Cohort (N=80)
Schizophrenia	46 (49%)	36 (45%)
Schizoaffective	33 (35%)	32 (40%)
Bipolar/depression	9 (10%)	9 (11%)
Other psychotic	3 (3%)	3(4%)
Other	3 (3%)	0 (%)

Homelessness

Ten of the first year cohorts (11 percent) were reported to be homeless just prior to PACT enrollment. Including the 46 additional individuals who came directly from Western State Hospital (WSH) and who would otherwise be homeless upon discharge (four individuals were reported as both homeless and referred from WSH); there were 56 homeless individuals at enrollment (60%). Four of the second year cohorts (5%) were reported to be homeless just prior to PACT enrollment. Including 36 additional individuals who came directly from WSH (one was reported as both homeless and referred from WSH); there were 40 homeless individuals at enrollment (50%).

Income Source

About four-fifths of the first year participants (n=76; 81%) and second year participants (n=64; 80%) had a stable income source (i.e., Supplemental Security Income [SSI], Social Security Disability Insurance [SSDI], General Assistance Unemployable/General Assistance Expedited [GAU/GAX]) at the time of enrollment.

High-Service Needs

Table 5 shows reasons for needing intensive service as assessed at the point of referral to PACT. The most common reasons reported were severe symptoms, high hospital use or residing in a facility and being able to be in a more independent setting if intensive services are provided.

Table 5. Reasons for High Service Need

High service need as indicated by at least one of the following...	First Year Cohort (N=94)[1]	Second Year Cohort (N=80)
a. Persistent or recurrent severe major symptoms (e.g., affective, psychotic, suicidal)	72 (77%)	49 (61%)
b. High use of psychiatric hospitals (e.g., 2+ admissions or emergency services/year)	63 (67%)	48 (60%)
c. 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	55 (59%)	58 (73%)
d. Requires residential or institutional placement if more intensive services not available	53 (56%)	40 (50%)
e. Significant difficulty meeting survival needs or in substandard housing, homeless	50 (53%)	41 (51%)
g. Imminent risk of becoming homeless (e.g., repeated evictions or loss of housing)	46 (49%)	28 (35%)
f. Co-occurring substance use disorder greater than six months duration	48 (51%)	40 (50%)
h. High risk or recent history of arrests or incarceration	40 (43%)	38 (48%)

[1]One missing from first year cohort; two missing from second year cohort - %s taken from 93 and 78 respectively

Functioning Impairment

Table 6 shows the types of functioning impairment participants were reported to have at the time of referral to the program. Most PACT participants have impairment in community living tasks and employment, about half show impairment in homemaking roles and daily living skills. Fewer show safety concerns.

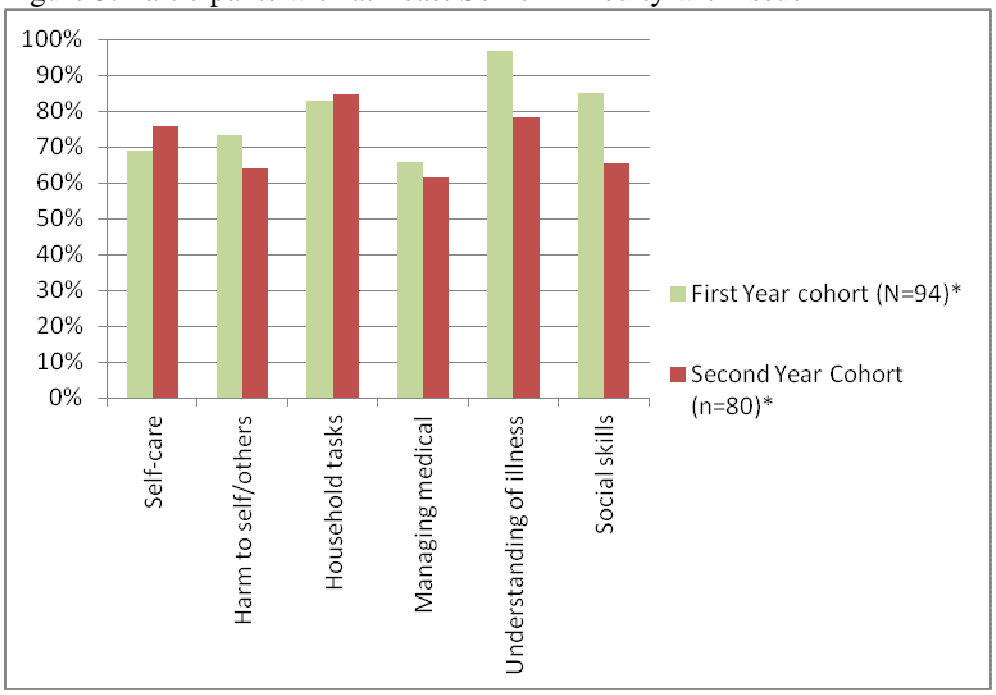
Table 6. Functioning Impairment Due to Mental Illness

Significant difficulty in functioning regarding at least one of the following…	First Year Cohort (N=94)[1]	Second Year Cohort (N=80)
a. Maintaining consistent employment at a self-sustaining level	88 (94%)	72 (90%)
b. Consistently performing community living tasks (e.g., obtaining medical or legal services, avoiding common hazards; meeting nutritional needs; maintaining hygiene)	70 (74%)	54 (68%)
c. Consistently carrying out the homemaker role (e.g., meals, washing clothes, etc.)	53 (56%)	43 (54%)
d. Performing daily living tasks except with significant support or assistance	48 (51%)	29 (36%)
e. Maintaining safe living situation (e.g. forgetting to turn off stove; unsanitary conditions)	26 (28%)	18 (22%)

[1]One missing from first year cohort - %s taken from 93 and 78 respectively

Additional data regarding functioning were collected to describe more fully the severity of impairment in domains that could affect community placement. As shown in Figure 3, at least two-thirds of participants needed some prompting or assistance with the domains noted.

Figure 3. Participants with at Least Some Difficulty with Issue



*One missing from first year cohort; two missing from second year cohort - %s taken from 93 and 78 respectively

Two-Year Outcomes

Following are two-year outcomes for the first two years of PACT participants, that is, individuals who entered the program between July 1, 2007 and June 30, 2009.

Retention and Exit Reasons

Nearly all first-year participants (n=87; 93%) were retained in the PACT program for at least one year. Twelve of the second-year participants exited prior to one year (n=69 retained; 86%). The one year retention rate in our study is at the high end of the 78-85 percent rates found in other PACT programs (Bond, McGrew, & Fekete, 1995; Herinckx, Kinney, Clarke, & Paulson; 1997). Two-year retention was 76 percent and 73 percent for the two cohorts.

Reasons for exiting the program are listed in Table 7. The most common reason for exiting is a long-term hospitalization. Numbers are too small to detect any differences across years or cohorts.

Table 7. PACT Exit Reasons

Exit Reasons	First Year Cohort (N=94)		Second Year Cohort (N=80)		Total all years (N=174)
	Exits within **one** year of admission	Exits within **two** years of admission	Exits within **one** year of admission	Exits within **two** years of admission	
Long-term hospitalization		3	3	4	10
Needed more intensive services	3	4	1	1	9
Moved out of area	1	1	4	1	7
Changed program or agency		1	2	2	5
Refused additional services	1	3			4
Lost to contact			1	1	2
Died	1	2		1	3
No longer met criteria (primary substance use)		2			
Long-term incarceration	1			1	2
Total	7	16	11	11	45

Psychiatric Hospitalizations

As shown in Table 8, psychiatric hospital admissions were reduced by about half for both cohorts during the first year following admission and were reduced slightly more during the second year. These reductions were statistically significant. The number of people who had no hospitalizations nearly tripled within the first year following admission and stayed constant during the second year. It is noteworthy that we see such a dramatic reduction in hospitalizations (and increase in the proportion of people without hospitalization), as pre-enrollment hospitalizations were suppressed due to many of the individuals with no hospitalization (19%) coming from cost-intensive, structured residential programs that reduced their likelihood of hospitalization.

Note that this analysis includes all individuals in the cohort, regardless of whether they exited from the PACT program. As such, results are conservative and would likely be even stronger if people who had exited were removed from the analysis as many of these individuals exited due to long-term hospitalizations.

Table 8. Change in Psychiatric Hospitalizations

Psychiatric Hospitalizations	First Year Cohort (N=94)			Second Year Cohort (N=80)		
	Pre	Post 1st yr	Post 2nd yr	Pre	Post 1st yr	Post 2nd yr
Total hosp admissions	253	124	108	154	87	83
Total hosp days	17639	4088	5221	14271	2460	4275
Average hosp admissions	2.7 (2.8)[1]	1.3 (1.9)*	1.1 (2.1)*	1.9 (1.9)	1.1 (1.8)*	1.0 (1.8)*
Average hospital days	187.7 (140.4)	43.5 (74.9)*	55.5 (96.5)*	178.4 (141.9)	30.8 (56.8)*	53.4 (105.6)*
No hospitalizations	18 (19%)	50 (53%)	49 (52%)	15 (19%)	46 (58%)	50 (63%)

[1]standard deviation in ()
*statistically significant change from 'pre' - p<.05 based on t-tests and Wilcoxon rank sum

Jail Incarcerations

As shown in Table 9 and Figures 4 and 5, jail bookings and days did not significantly change for either cohort. However, the proportion of individuals with no bookings increased somewhat. It should be noted that most PACT participants had no bookings prior to PACT admission, largely because most were living in closely supervised housing situations or state hospitals that did not provide participants an opportunity to be arrested. The more limited housing supervision and increased community independence of PACT gave participants a much greater opportunity to be arrested and incarcerated, yet we did not see a significant increase in incarcerations. Thus, the PACT program may be serving a 'protective' function in preventing incarcerations that might not occur with a less intensive program.

Table 9. Change in Jail Incarcerations

Jail Incarcerations	First Year cohort (N=94)			Second Year Cohort (N=80)		
	Pre	Post 1st yr	Post 2nd yr	Pre	Post 1st yr	Post 2nd yr
Total jail incarcerations	56	75	49	48	34	50
Total jail days	1781	1721	1283	1371	706	1782
Average jail incarcerations	.60 (1.1)[1]	.80 (1.8)	.52 (.98)	.60 (.98)	.43 (1.1)	.63 (1.5)
Average jail days	18.9 (49.9)	18.3 (50.4)	13.7 (37.5)	17.1 (46.6)	8.8 (29.1)	22.3 (62.8)
No jail incarcerations	60 (64%)	67 (71%)	65 (69%)	52 (65%)	61 (76%)	63 (79%)

[1]standard deviation in ()
*statistically significant change from 'pre'- p<.05 based on t-tests and Wilcoxon rank sum

Figure 4. Hospitalizations and Jail Bookings

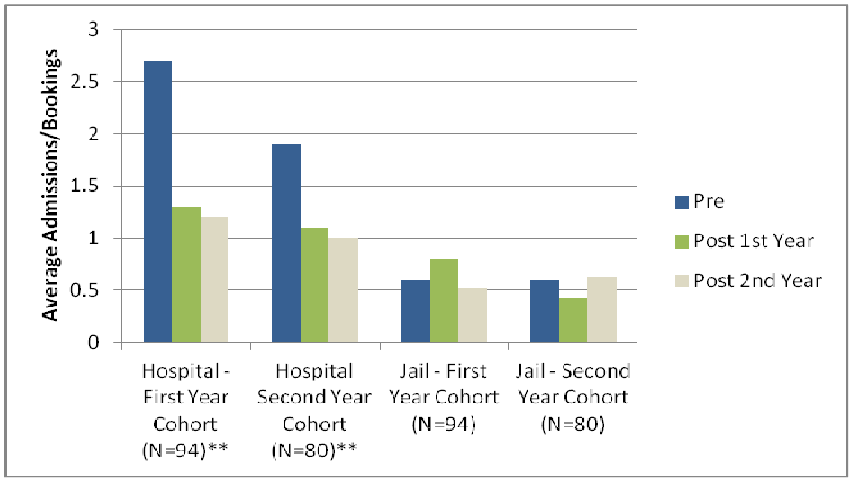
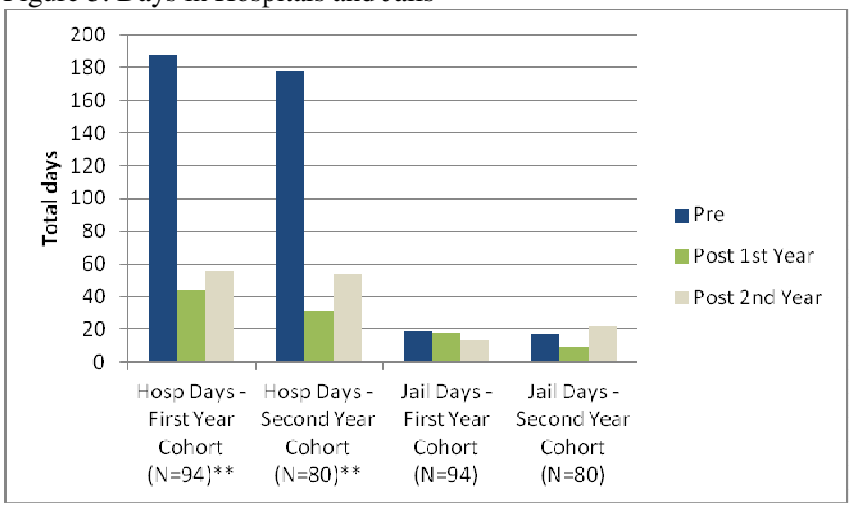


Figure 5. Days in Hospitals and Jails



Substance Use

Table 10 shows relatively low substance use at enrollment. This may be due to most participants being referred from institutional settings in which substance use was suppressed, staff having little chance to observe substance use behavior, and ratings based largely on client self-report, which is not the most reliable assessment method. Indeed, about half of PACT participants are noted by clinicians at the time of referral to have a longstanding co-occurring substance use disorder (see Table 5).

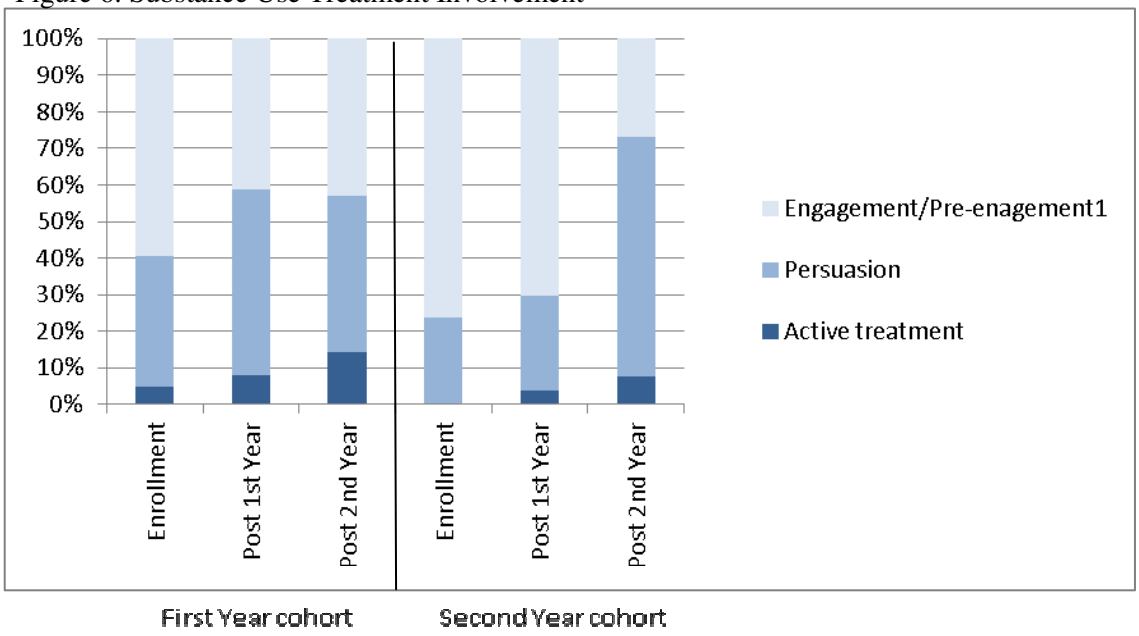
Table 10 also shows that slightly more participants were using alcohol and drugs after one year in PACT than at the point of enrollment. The same, or somewhat fewer for the first year cohort, were using drugs or alcohol after two years in the program. Note that the number of participants in the first and second year post-admission is reduced due to individuals exiting the program.

Table 10. Substance Abuse or Dependence

Number (and %) with Abuse or Dependence	First Year Cohort			Second Year Cohort		
	At enrollment N=94	Post 1st Year N=87	Post 2nd Year N=71	At admission N=80	Post 1st Year N=69	Post 2nd Year N=58
Alcohol	13 (14%)	30 (34%)	20 (28%)	7 (9%)	8 (12%)	8 (14%)
Other drugs	15 (16%)	24 (28%)	20 (28%)	8 (10%)	13 (19%)	13 (22%)

Figure 5 shows that, of participants who were using drugs or alcohol, there is some movement over time along the “stages of change” continuum toward active treatment.

Figure 6. Substance Use Treatment Involvement



[1]Definitions of treatment involvement: Active treatment – engaged in treatment, discussing use and reduced use; Persuasion – regular contact with case manager, discussing use or attending group, Engagement- irregular contact with case manager; Pre-engagement - no contact with case manager

Income Stability

At admission, 81 percent of the first year cohort and 84 percent of the second year cohort had some source of income, while 91 percent and 97 percent respectively had income after one year, improving to nearly all individuals after two years. Consistent with this pattern, average income also rose from baseline to the first year post-admission and again by the second year post-admission, as seen in Table 11.

Table 11. Change in Income

	First Year Cohort			Second Year Cohort		
	At admission N=94	Post 1st Year N=87	Post 2nd Year N=71	At admission N=80	Post 1st Year N=69	Post 2nd Year N=58
#/% No income	N=18 (19%)	N=6 (7%)	1 (1%)	13 (16%)	2 (3%)	0 (0%)
Total income	Ave.=$572.2	Ave.=704.9	Ave=823.1	Ave=$595.1	Ave=$804.1	Ave=$821.5

Summary

Participants who entered during the second year had similarly strong one- and two-year outcomes to those who entered during the first year. Specifically, the participants showed:

- High program retention – 93 percent of the first year cohort and 86 percent of the second year cohort were retained in the program for at least one year. About three-quarters were still in PACT after two years.

- Psychiatric hospital admissions dropped by about half during the first year following admission, with slight additional reductions during the second year following admission.

- No significant changes in jail bookings or jail days.

- Increased average income after one year in the program, remaining stable during the second year. Nearly all individuals had a stable source of income after one year in the program.

- More apparent alcohol and drug use, but more movement toward active treatment.

Recommendations

The program continues to be highly successful in retaining participants and participants showed significant reductions in psychiatric hospitalizations. These findings are in line with research regarding PACT programs nationally that show the most consistent impacts of the program are in reducing hospitalization.

The current report continues the recommendations made in the report of outcomes for the first six-month cohort:

- Continue processes in use that help retain individuals in the program and reduce hospitalizations.

- Increase focus on treatment for substance use, as more individuals are using drugs and alcohol.

- Increase attention to reducing incarcerations for the subset of individuals at risk for incarceration.

- Increase access to innovative supported employment services to increase the likelihood that participants will obtain employment.

Program for Assertive Community Treatment (PACT) Service Detail for Open Enrollments July 2007 through Feb 2011

Definitions

This report provides service detail information for individuals who entered PACT from its inception, July 2007 to February 2011, which is the last month for which we could analyze a full year's worth of service data. Participants are divided into three groups to keep comparability with other reports:

First Year cohort – July 2007-June 2008 (n=94)
Second Year cohort – July 2008-June 2009 (n=80)
Third Year Plus cohort – July 2009- February 2011 (n=66)

This report describes services between the PACT start date for a given individual and one year subsequent to that date – earlier if the person exited prior to one year. Days not in hospitals and jails (not available for services) were subtracted to provide a figure for days in the community during the PACT benefit.

Funding Caveats

State PACT funding was reduced in 2010, resulting in the loss of one FTE staff person for each PACT team. In addition, Homeless Grant Assistance Program (HGAP) monies were time-limited and ended at the close of 2010 resulting in the loss of a housing liaison position (split between the two teams). The full funding amount was restored in 2011, but Medicaid is now a substantial portion of funding creating a 'cap' on non-Medicaid services. The restored funding was used to hire a part-time housing support person at each program in 2012.

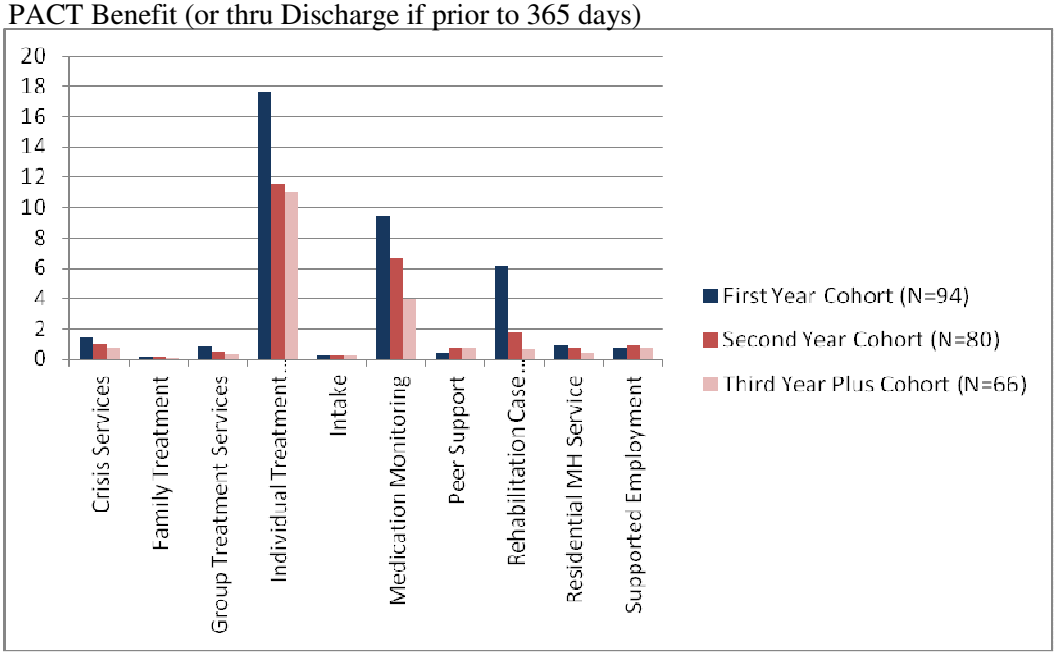
These changes in funding have led to changes in service patterns in addition to the staffing changes noted above. Reduced non-Medicaid services in the mental health system as a whole has meant that it is more challenging to transition participants away from PACT to less intensive service packages. Further, staff vacancies have meant that existing staff are spread thinner, resulting in less service per participant. Along these lines, supervisory staff has often been called upon to fill in direct service roles. They and mental health clinicians also must provide housing support, which reduces their time to focus on their clinical areas of expertise. These issues should be taken into account when reviewing the service detail results below.

Service Detail Results

Figure 1 shows the average number of service encounters per 30 days in the community during the first year of a person's PACT benefit (or less if discharged prior to 365 days). Note that averages were calculated for people who had at least one encounter of the given service category. Table 1 indicates how many people in each cohort had at least one encounter of the given service category. The figure shows that Medication and Individual Treatment Services were the most common. It also shows that each new cohort receives fewer average service encounters per person. This could be due to individuals in later cohorts needing less service. It could also suggest that as the programs

filled, staff were stretched thinner and fewer service hours were provided to each individual. As noted above, funding reductions have compounded this problem.

Figure 1. Average Number of Service Encounters Per Person Per Month in Community During First Year of PACT Benefit (or thru Discharge if prior to 365 days)



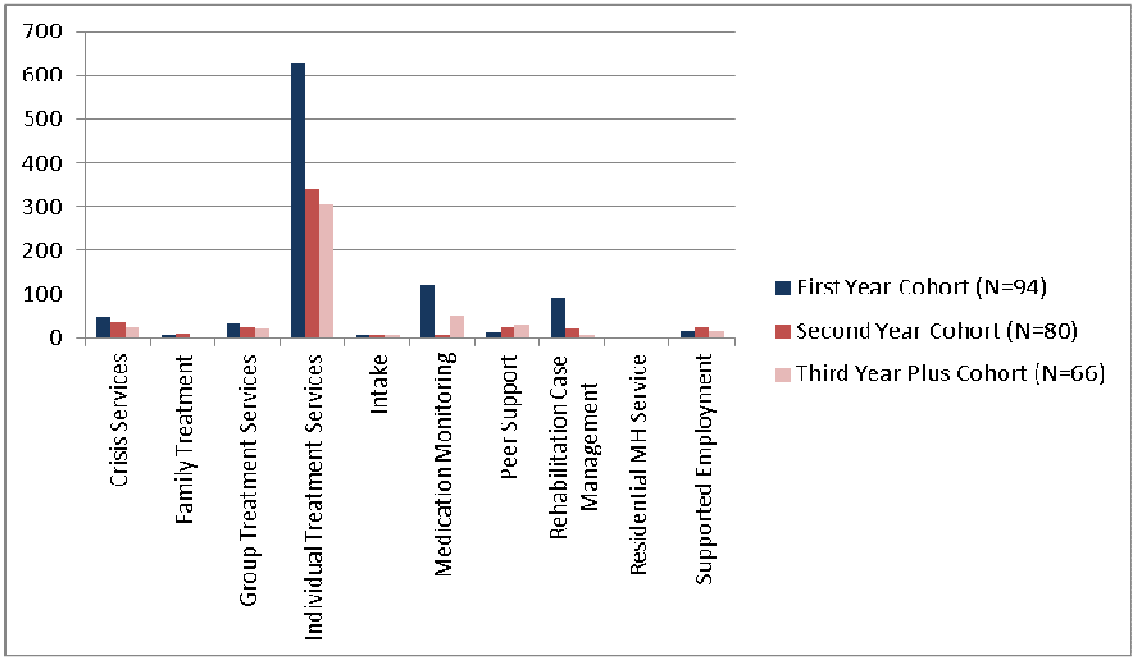
While all or nearly all participants receive intake, individual treatment and medication monitoring, the proportion of people who receive some other service is relatively low. The proportion of people receiving any crisis services, rehabilitation case management, group and family treatment, and supported employment has declined over the cohorts, while the proportion of people receiving peer support has grown substantially.

Table 1. Number and Proportion of PACT Participants Receiving ANY of Given Service Category

	First Year Cohort (N=94)		Second Year Cohort (N=80)		Third Year Plus Cohort (N=66)	
Individual Treatment Services	94	100%	80	100%	66	100%
Medication Monitoring	92	98%	80	100%	66	100%
Intake	78	83%	71	89%	62	94%
Crisis Services	70	74%	52	65%	41	62%
Rehabilitation Case Management	51	54%	40	50%	29	44%
Supported Employment	42	45%	25	31%	24	36%
Peer Support	30	32%	39	49%	44	67%
Group Treatment Services	41	44%	19	24%	22	33%
Family Treatment	15	16%	16	20%	5	8%
Residential MH Service	4	4%	1	1%	2	3%

Figure 2 shows the average service minutes per 30 days in the community during the PACT benefit within its first 365 days – or less if discharged prior to that point. Again, averages were calculated for people who had at least one encounter of the given service category. The pattern is similar to the figure above regarding service encounters.

Figure 2. Average Per Person Service Minutes Per Month in Community During First Year of PACT Benefit (or through discharge if prior to 365 days)



We also calculated the total number of service encounters across service categories – and divided it by 30 days-in-community during the benefit for each person. We then broke down the result into interpretable categories by agency and results are shown in Table 2.

Table 2. Total Service Encounters per Month in Community During First Year of PACT Benefit (or thru Discharge if prior to 365 days)

	First Year Cohort (N=94)		Second Year Cohort (N=80)		Third Year Plus Cohort (N=66)	
<once/week	1	1%	6	8%	6	9%
1 to <3/week	16	17%	22	28%	18	27%
≥3 to <7/week	36	38%	37	46%	36	55%
daily+	41	44%	15	19%	6	9%

Table 3 shows that two-thirds of the services were provided in the participant's residence over all the cohorts.

Table 3. Service Location

Location	% of services
Home	65%
Other community	18%
Office	14%
Inpatient psych	1%
ER	1%
Other (e.g., jail, residential, etc.)	1%

Figure 3 shows that services are well distributed across the days of the week over all the cohorts, though slightly fewer services occur on weekends.

Figure 3. Day of Service