
**ANOTHER WAY OF AVOIDING
THE "SINGLE MODEL TRAP"**

PATRICIA KRAMER,
WILLIAM A. ANTHONY,
E. SALLY ROGERS,
& WILLIAM A. KENNARD

PATRICIA KRAMER, ACSW, IS PROGRAM SUPERVISOR, ADMH, FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES.

WILLIAM A. ANTHONY, PH.D., IS EXECUTIVE DIRECTOR, CENTER FOR PSYCHIATRIC REHABILITATION, AND PROFESSOR, REHABILITATION COUNSELING PROGRAM, SARGENT COLLEGE OF HEALTH AND REHABILITATION SCIENCES, BOSTON UNIVERSITY, BOSTON, MA.

E. SALLY ROGERS, SC.D., IS DIRECTOR OF RESEARCH, CENTER FOR PSYCHIATRIC REHABILITATION, AND RESEARCH AND ASSOCIATE PROFESSOR, REHABILITATION COUNSELING PROGRAM, SARGENT COLLEGE OF HEALTH AND REHABILITATION SCIENCES, BOSTON UNIVERSITY, BOSTON, MA.

WILLIAM A. KENNARD, M.S. IS PARTNER, BOSTON CENTER FOR PSYCHIATRIC REHABILITATION, MARLBORO, MA.

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Another way to end the "model wars" (Hughes & Clement, 1999; IAPSRs, 1998) is to take what works best from different models and blend them. At two different sites, practitioners being trained to deliver ACT received additional training in the psychiatric rehabilitation and case management technology that had been previously developed at Boston University. Feedback from the practitioners indicated that the blending of these two "models" was helpful and additive. A 4-year period of data collection at one site using a simple pre-post test design showed inpatient days were reduced by about 90% for 80 individuals who were considered to be high utilizers of inpatient services. It appears that the integration of separately developed model approaches bears further study.

In numerous publications and speeches (e.g., Hughes & Clement, 1999; IAPSRs, 1998) IAPSRs has taken a position against mental health departments and managed care organizations adopting as policy the use of a single model of rehabilitation. In critiquing this "single model trap" Hughes and Clement (1999) give examples of the following models:

...clubhouse programs, lodge programs, intensive psychiatric rehabilitation treatment (Anthony), skill development (Lieberman), peer support programs, assertive community treatment programs...transitional employment, supportive employment, and individual placement and support (Drake). (p. 1)

As new initiatives continue to grow and evolve into what some would call program models, they begin to reach be-

yond their initial focus and incorporate other ingredients of change. This can result in the blending of models that originated from very different sources with a very different history. The contributions of each are creatively melded and the combined intervention that emerges uses the unique features of each separate initiative. The present study is an example of the combination of two initiatives that appear to blend particularly well together: 1) the ACT program initially developed by Stein and Test (Stein, Test, & Marx, 1975) and 2) the psychiatric rehabilitation practitioner technology initially developed by Anthony and his colleagues (Anthony, Cohen, & Vitalo, 1978).

ACT is essentially a program model, with a structure most unlike the way programs are usually organized in mental health. Basic to the ACT program

model are the essential principles around which the program is structured (Phillips et al., 2001). However, the ACT program's need for competent practitioners, as well as its increasing focus on rehabilitation within the ACT model makes the psychiatric rehabilitation personnel training technology (Anthony, Cohen, Farkas, & Gagne, 2002) especially appropriate for programs structured on the ACT model.

This particular study provides an example of the feasibility of integrating psychiatric rehabilitation technology into an Assertive Community Treatment program (ACT). Of particular concern was how the staff would perceive the training in these two technologies. Using a survey specifically designed to ascertain this information, practitioners were queried about their training experiences in these two "models." In addition, at one site outcome data was collected to make sure that the blended program was getting the expected reduction in hospital days.

The ACT programs at both sites contained all the basic elements of the ACT program model: multi-disciplinary teams, 24-hour service availability, services that are ongoing and unlimited in duration, assertive outreach, and in vivo treatment and rehabilitation (Phillips et al., 2001). Specifically, the rate of practitioners to service recipients was no more than one to ten. Each of the ACT teams was multi-disciplinary and included people recovering from severe mental illnesses. ACT training was initiated during the start-up period for each team and was delivered in a team setting. The training incorporated information regarding the ACT model, such as its history and development; demonstrations of effectiveness; unique characteristics; specific organizational

structure, process and communication tools; record keeping methods; team building; and service initiation. The importance of vision and values reflecting a philosophy of recovery, consistent with that of the psychiatric rehabilitation technology, was incorporated as a basis for team operation and service delivery. Training was conducted utilizing both a classroom setting, during the initial month of start-up, with practical on-site "at elbow" experience being used over the next 5 months.

The psychiatric rehabilitation technology training, also delivered in the context of the ACT team environment, was done over a period of 9 months (Farkas & Anthony, 1989). With special attention being given to the needs of an ACT team in its application of the technology, the combination of classroom and field experience was once again used. Total practitioner and supervisory training time in psychiatric rehabilitation practitioner technology was approximately 380 hours. The focus of the training was on preparing practitioners to assist people with psychiatric disabilities in choosing, getting, and keeping their desired living environment and preferred social activities. Due to resource limitations, lesser training emphasis had to be placed on people's vocational and educational goals. Psychiatric rehabilitation technology was used to assess and develop people's readiness, set goals, determine those skills and supports that were needed to move toward their goals, and to provide the needed support and/or instruction for individuals to become competent in their chosen environmental areas.

Trainee Satisfaction. All the teams were comprised of individuals with many years of experience in the mental health

and/or substance abuse field (although none had previously practiced on an ACT team or received training in the psychiatric rehabilitation technology). Among the team members on each team were one or more people with severe mental illness, a number of whom had Bachelor's degrees in various areas. None of these individuals had previously been a provider of services before. Additionally, each team had among its staff individuals with Master's degrees in Psychology, Social Work and/or Nursing; Bachelor's degrees in Human Services and Nursing; as well as Licensed Practical Nurses. All teams also had either a part-or full-time psychiatrist as part of their staff, although the psychiatrists were not available for much of the training. A 10-item training survey was developed to assess the trainees' perception of the training, particularly with respect to the blending of two ostensibly different approaches.¹ Seventy-three percent of the trainees completed the survey. Of these returned surveys, 93% of the trainees reported experiencing no conflict between the two "models"; 75% reported that the training in the two "models" helped them be better prepared to deliver services to the individuals they were serving; 100% indicated that there were not any parts or learnings from either of the two types of trainings that contradicted each other; 93% responded that they would recommend this blended training and practice to other ACT teams.²

Program Evaluation Data. We were able to collect consumer outcome data at one of the sites as a check to see if the ACT program was obtaining the expected effects, particularly with respect to hospitalization data on a group of people who had been high utilizers of inpatient services (Bustillo, Lauriello, Horan

1 Copies of the actual trainee satisfaction form used are available from the senior author.

2 Responses to each survey question are available from the senior author.

Table 1—Baseline and Follow-up Data for One ACT Site

	YEAR 1 BASELINE	YEAR 2	YEAR 3	YEAR 4
Average number of days hospitalized				
Patients enrolled directly from the state hospital	365	26	17.5	17.1
Patients enrolled directly from the community	147	26	21	17.1
Independent living rates*	0%	25.9%	33.8%	53.5%
Social involvement**	0%	41.3%	62.2%	78.8%
Work status				
Full-time employment	0%	1.6%	0%	0%
Part-time employment	0%	11.0%	13.5%	15.6%
Volunteer work	0%	4.8%	9.5%	8.1%
Educational activity***	0%	4.6%	9.5%	8.1%

* Defined as living on their own or with a significant other and having rent or mortgage responsibilities.

** Defined as utilizing the PEER Center in the community or the drop-in center at the state hospital.

*** Defined as participation in school, GED, training, or educational programs.

& Keith, 2001). Baseline and 3 years of follow-up data were collected on the first 80 persons served by one of the sites. Individuals enrolled into this ACT program had to have a DSM III-R Axis I diagnosis considered by the state to be a severe and persistent mental illness, a minimum of two or more hospital admissions within the last 12 months, or a recent (i.e. within the last 18 months) discharge from the state hospital, current residency at the state hospital, or on a waiting list status for admission to this state hospital. Of the 80 enrollees, 25 came directly from the state hospital; 55 people had received their most recent inpatient services from the community hospital. Referrals to the ACT program were made by state hospital staff, by staff at acute care facilities, and by community case managers. Both the referred person and the ACT program staff had to agree that the program was an appropriate choice before services could begin.

While a randomized study was impossible due to funding and political constraints, it was possible to collect simple proxy measures of people's community functioning. Hospitalization days were collected from agency records one year prior to program involvement and for the next three years. Records were also analyzed for measures of independent living status, social involvement, employment and education. Table 1 presents data for this 4-year period. All individuals who were rehospitalized while living in the community were admitted to a community hospital. The evaluation data with respect to hospital days seem consistent with ACT findings.

CONCLUSIONS

As services to people with severe mental illnesses continue to evolve and grow, we must look at new ways to use our existing knowledge and technolo-

gies. The present study shows the potential of producing a new generation of interventions by combining the ingredients of separately developed approaches. The value in heretofore developed model approaches may be in the uniqueness each brings to the process and outcome table. We would suggest a line of empirical inquiry that looks at how various best practice models can be effectively integrated, potentially resulting in better outcomes for service recipients and a more satisfying practice for practitioners.

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