

The Single Model Trap PRA Board Approves Position Statement

All too often a state will choose a single model of rehabilitation as the only rehabilitation service which is funded. While the designated model changes from state to state, the negative consequences for other rehabilitation services are depressingly familiar. Recently there has been an upsurge of the “single model trap.” At the November, 1998 meeting the PRA Board of Directors took a position against the endorsement of a single model. The full text will be sent to all Organizational Members and is available upon request by other members. The paper will be widely disseminated to state mental health directors, state Medicaid directors, managed care organizations and the mental health specialty press, as well as to our members. The following excerpts from the position statement outline the concerns and the alternatives.

Because of our deep roots in the various models of rehabilitation, the PRA Board of Directors is deeply concerned about the unintended negative effects of choosing one and only one model of rehabilitation and community support for inclusion in a state or managed care continuum of services. The body of research in rehabilitation demonstrates that those who participate in rehabilitation are significantly more likely to improve their level of functioning, to reduce both number and days of hospitalization, and to gain employment. But there is not sufficient research to demonstrate that any one model is more effective than any other model for all people in all settings. **There is no magic model for all people with serious mental illness.**

When the decision to use a particular model of rehabilitation is made at a policy level rather than at a provider, practitioner or consumer level, there are a number of unintended negative effects. By offering only one approach we limit consumer choice and the likelihood of meeting individual needs. As time passes a certain level of dissatisfaction grows because one model, no matter how effective it may be, does not serve all persons with serious mental illness. Some states then abandon one approach and are convinced the next model is the magic answer. And the cycle begins again to the detriment of consumers, providers and the state.

If the funding stream is designed for a single model rather than for rehabilitation services in general, the situation becomes untenable. This is akin to reimbursing only behavioral psychotherapy or only Stelazine for medication. We would never consider such limitations in any other mental health services at the policy level. The provider is forced to provide an inflexible service and innovation is stifled. The ability to respond to new interventions, community needs, funding issues, changes in the environment, and system changes is limited. And consumers lose the opportunity to choose the approach that best meets their needs.

Another unintended effect of emphasizing a single model over effectiveness is the lack of attention to building an infrastructure to support quality rehabilitation services. For far too long, every model of rehabilitation has been underfunded; staff members have received insufficient training; agencies do not have the infrastructures to track outcomes; and few standards have been put in place. It is easier to blame a model as insufficient, than to address these more expensive but ultimately more effective infrastructure issues.

What is the Alternative?

Models are crucial to guide good practice and program development. But providers must have the flexibility to decide which combination of models best fits the needs of consumers, the local community and the agency. The typical rehabilitation agency uses more than one model and creates different services to meet the varying needs of those requesting services. Most importantly, every consumer needs the freedom to choose what approach best meets his or her needs and choose to again as needs change over time.

How do we ensure quality without mandating a single model? PRA recommends the following approaches at a policy level:

- **Every state needs a funding system which allows for the reimbursement of psychiatric rehabilitation services in general and promotes a diversity of approaches.** Narrow, model-based definitions of services in funding regulations almost always have a stifling effect and do not ensure quality services. Service definitions need to be specific enough to differentiate between more medical model services (such as day treatment and partial hospitalization) and rehabilitation, but broad enough to encompass all models of rehabilitation and case management.
- **Outcomes, performance indicators and consumer satisfaction are far more effective ways of monitoring quality of rehabilitation services than mandating a model of care.** By monitoring and using outcomes information a state is far more likely to ensure quality rehabilitation services than by mandating models of care.
- **Build an infrastructure of support for staff and agencies.** It is nothing less than a miracle that so many good people have struggled with low pay, insufficient training and insufficient guidance to provide excellent rehabilitation services. Our best teachers have been consumers, family members and our peers. PRA has worked since its inception to develop the standards tools needed to ensure practitioners are well trained and competent. We urge states and managed care organizations to the structural issues of quality rehabilitation.

Conclusion

Models of rehabilitation are designed to promote good practice. And that is where the promotion of models belongs - at the level of practice, not policy. True consumer choice requires a diversity of rehabilitation services to best meet the changing needs of each consumer over time. PRA urges states, managed care organizations, and advocacy groups to avoid the single model trap and instead concentrate on the development of an infrastructure to promote quality rehabilitation services and to track outcomes.