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IAPSRS has a very strange niche in Washington. We are, first of all, an international association working on many national issues. We are a provider organization that acts more like an advocacy organization, which means that our peer provider organizations have a hard time understanding many of our stands and policies, and our peer advocates are not sure what to do with our advocacy efforts. We represent professionals in mental health who absolutely believe that every person with a mental illness can recover. And we believe that every kind of treatment or rehabilitation that is not in partnership with that consumer directing the process will not be effective. It does put us in a rather strange position at times. And I would like to believe we're breaking new ground so that other professional/provider organizations will see the light. I will be delighted when the day comes when we'll have this kind of meeting and see that the host of provider organizations who are so important to be providing treatment across the United States will all be represented here.

For many years we've been working on many of the issues [covered in the plank report]. I was delighted to be in Oregon; it fed my soul. I realized IAPSRS was even more in sync than I thought with many of those positions.

We have a strong statement opposing involuntary outpatient commitment. We oppose it, first, because it violates the rights of every person with a mental illness in this country; second, because there is very little evidence that it's effective; third, because the process of commitment can often be traumatic to people. IOC as it's currently being discussed in our state legislatures and media reinforces stigma and very wrong assumptions about mental illness and violence. These things are not acceptable.

Two stands IAPSRS has taken are, first, opposition to IOC, and, second, to absolutely oppose any presentation in the media or in any policy arguments that distorts mental illness and the connection to violence in order to pass IOC.

That is such a destructive process. I've brought with me our policy paper on this; we have disseminated it broadly. We also have a consumer committee that has helped us look at policies and recommend changes, to bring both IAPSRS and the whole field to be as open to partnership with consumers as possible. We have produced a set of guidelines for every psychiatric rehabilitation program in the field which talks about the role of consumers as partners, in governing bodies and as staff. It addresses issues such as getting lower levels of pay than people who come to those positions with other types of background, and looking at discrimination within the mental health field and how important it is to address that. We are proud of these policy guidelines and are doing work to think about how we infuse them into the system. We have developed some multicultural principles, which we again are very proud of, to sensitize programs across the country to how important it is to have cultural competence, to be able to speak in the language and hear people in the perspective and culture they're coming from.

We also have developed a code of ethics. I bring this up to assert that any practitioner in psychosocial rehabilitation must address the stigma and discrimination that they see in their communities and cannot, should not, and it's an ethical violation to contribute to stigma in any way.

We're tackling stigma within the mental health professions. For example, a national training seminar is being offered that was helping therapists and practitioners develop more competence in working with folks who were particularly difficult, such as people with borderline personality disorder. The brochure was meant to be funny, and listed 10 dehumanizing characteristics, such as blood type: B negative, etc. We have gotten several bodies to pull their CEUs from this national training program. The last thing anyone needs is to go to a practitioner who blames you for being a challenge. The practitioner should not be a barrier in the process. We are developing a zero tolerance policy for stigma within the mental health profession.

We also are developing a credentialing program for psychosocial rehabilitation practitioners. It's a little scary because we're becoming just like all those other [accrediting] guys. We worked hard to be sure that consumer practitioners have every opportunity to become credentialed, that requirements are inclusive, not just based on things that create barriers, such as degrees, and that experience is the most important factor, not education. In many places you can get a Ph.D. and come out knowing very little about mental illness.

Many of you have put an enormous amount of volunteer time into programs that hasn't been reimbursed. We recognize that that is as valuable as any other kind of training. We recognize that peer support programs are an essential part of the service delivery system. We have many peer support programs that are members of IAPSRS. We hope that will grow over time.

We also have developed an outcome system to see how people are doing over time. Typically, they look at things like remission of symptoms. But we look at, are folks able to stay out of the hospital, have a job, have a decent income? We look at, what is your perception of the quality of services you're receiving? That outcomes tool kit has been disseminated to thousands of programs and is going into a software system. We're using that with psychosocial rehabilitation programs to see if they're helping people move on. Psychosocial rehabilitation should not be where people stay for the rest of their lives; it is a step along the way. We have developed practice guidelines for the field, but some things we think are different. For every program, for every person receiving your services, it says, you should be developing advance directives, or a relapse prevention plan. We have also said it is essential that psychosocial rehabilitation programs address stigma right up front and talk about it in the programs with people.

Mental illness is not the major barrier; it is poverty, lack of education, trained helplessness, the hopelessness people feel when they have been told, year in and year out, that you cannot be responsible for your own life. Psychosocial rehabilitation programs should work with people to change those things.

I know we don't always get it right. But one of the things I look for, and I have experienced with so many of you in this room, is that we truly respect and listen to each other, that we have a dialogue to developing better services, and more rights.

We have worked on the Work Incentives Improvement Act, which will change work incentives mostly with SSDI and provide a way for people to go to work without losing health insurance. This has been a major priority for four years. We're working on implementation. Every person should have the opportunity to go back to work if that's what you desire and that's what is good for you.

We have an open door: Keep working with us, and we'll keep working with you. With all of us together, we can make a huge difference over time.