opment of local user focused monitoring groups can be useful in this respect. Independent service users/survivors groups from other localities may also have a role to play here.
- One of the greatest potential barriers to effective and enjoyable user involvement is fragmentation. Organisations and services can keep user involvement activities in separate pockets reducing the overall impact. Local service user groups can sometimes fail to find ways to collaborate and again this reduces the total energy going into change and probably reduces the goodwill among organisational leaderships for promoting further user involvement developments.

Sources

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Laurie Ahern, Peter Stastny and Chris Stevenson

INTAR
The International Network Toward Alternatives and Recovery[1]

The International Network Toward Alternatives and Recovery was founded in 2003 by a group of U.S. practitioners and advocates in mental health recovery, including world renowned psychiatrists, people who have recovered from mental distress, psychologists, family members and other mental health

1 This chapter represents exclusively the personal views of the authors, and should not be construed as a statement by the organization or any other participant in the 2004 & 2005 INTAR meetings. Acknowledgment: The authors wish to thank Will Hall and Kim Hopper for their helpful comments regarding this manuscript.

professionals (www.intar.org). The international organization grew out of the shared experience and expert body of research that demonstrates a strong need to promote non-medical humane, non-coercive ways of helping people in emotional crisis. INTAR is a key international organization dedicated to advancing the knowledge and availability of alternative approaches for individuals experiencing severe mental distress.

In an era of so-called "evidence-based treatments" and "best practices," people who experience extreme states of mind, traditionally labeled mental illness, are still being subjected to predominantly bio-medical and involuntary treatments, often including repeated or prolonged hospitalizations, high dosages and multiple combinations of powerful psychiatric drugs, along with a lack of recovery-oriented services and opportunities in the community. People treated with traditional mental health services, and their families, have become increasingly more disillusioned with the results of conventional psychiatry and seek alternative practitioners and forms of assistance. The research literature supports their skepticism. A recent review of the literature demonstrates that a considerable percentage (40-60%, depending on the study) of individuals who experience a psychotic episode would recover without neuroleptics if they participate in active psychosocial treatment, while short- and long-term damage from these drugs is very common (Aderhold & Stastny, 2007). This greatly increases the need to amplify and search for alternative approaches that enable individuals to recover without undue harm to their bodies and minds.

Individually, INTAR members have experienced substantial success in advancing self-help programs and alternate clinical approaches that help put the person's distress into context, thereby respecting and acknowledging the entirety of the person and the experience. As a result, the work of INTAR members has assisted people to regain control over their lives without debilitating treatments meant to cure them. One INTAR member, a recovery researcher, described the drastic difference in outcomes when a non-medical, person-centered approach is used to help a person through distress:

> Take two wonderful, happy, smart young men. Both were in college, living on their own—testing the waters—testing themselves. New friends, new freedoms, new loves, new ideas, new temptations—new everything. Both had the world at their feet and were

limited only by their own imaginations of what their lives might be about, might become.

Then crash.

Jack is a child I have known for his entire lifetime. I watched him take his first steps and say his first words. I watched and I'm still watching.

Karl I met just months ago. The parallels between these two young men are eerie—yet the outcomes so different—so frighteningly different.

Crash, crash, crash. It seems to happen at that age. Eighteen to mid-twenties. And it happened to Jack and Karl.

Jack was at a college in New England and Karl was in school out on the West Coast. When Jack was 15 years old, he and a friend were car-jacked at knife-point. Even though they caught the man—and he was sentenced to seven years in prison—Jack never seemed to quite get over it. He would not stay alone in his house at night, always locked his car doors no matter where he was going, and would not travel without a cell phone.

Karl told me about a time when he was an exchange student in high school, how he had been held up—mugged—alone in a foreign country—and had never been so terrified in his life.

Jack has always wanted to be a journalist and Karl, he told me that music has been his passion since as long as he could remember. Both had such high hopes, such big dreams. Only one dreamer remains. The other dreamer died with his dreams when he was labeled "mentally ill."

Each experimented with drugs for the first time in college—Jack went to a concert and tried LSD. Karl started smoking marijuana with the band he formed in college. Pandora's box was now open. Paranoia and fear trickled in, replacing logic. Men were after them, people were talking about them. They could not sleep, they could not eat. Fear was the dominating factor in their lives. The drugs were gone, the high was over, the trip had ceased—but the demons remained.

Jack called home and Karl's friends called his parents. This is where the road divides. This is where the similarities end. This is

where one has a breakdown and the other has a breakthrough.

Jack's mother knew he was frightened. She told him to leave college and come home. She felt she needed to help him feel safe again—the only way to bring him out of this fearful place.

Karl's parents told him to come home. They too knew he was frightened, needed help. They brought him to the best psychiatrist. He was hospitalized. He was medicated. He was told he had a chemical imbalance of the brain. He was labeled. He was told that college was too stressful for him. He could never return. He tried to commit suicide. He lived, but his dreams, his dreams died.

Jack's mother and friends stayed home with him, listened to the fears. He went off caffeine, ate healthy foods and took long, warm baths. He had acupuncture, massages, and found a therapist who did not label him. They took walks together, they talked. Slowly, very slowly, he felt safe enough to come back. And then they worked on why he left, why this reality was so frightening that he needed to leave it in the first place.

Jack—well, Jack is back living at college. He started working out and he now volunteers in a home for mentally retarded adults. He told me several things since his breakthrough: "This is the most painful thing I have ever experienced in my life and I would not wish it on anyone—but I would not change a thing. Better I deal with these issues now than wait until I'm 40 or 50. I feel stronger than I ever have. I've learned so much about myself, I still have fears but I control them—they no longer control me."

Karl—who once dreamt of being a musician—called me after he walked home from his last day at the day treatment program. "I saw a sign on a restaurant window—they were looking for a dishwasher. Do you think I could handle that?"

The participants in the INTAR meetings expressed a common belief. In their research, practices or advocacy they try to provide safe, caring and non-stigmatizing assistance to those in crisis or emotional distress. Although the work of INTAR participants from around the world is as diverse as the countries they are from, they espouse the same values and can frequently demonstrate better outcomes than traditional psychiatric treatment. During the first

international INTAR summit held in the U.S. in November 2005, practitioners from Canada, Finland, Germany, Ireland, U.K., Austria and the United States came together to share information, research findings and their own personal experiences in non-medical approaches in helping people in extreme emotional states. As one INTAR member stated:

> It is our experience that even people diagnosed/labeled with the most severe mental illness can lead independent and self-directed lives without lifelong psychiatric treatment. When you look at a person's life experiences and history rather than looking at these problems as a disease people can get better.

Over the course of the three-day summit, INTAR members found affirmation for what they knew (i.e., for the values and beliefs that guide their individual work). Specifically, these include, among others:

- to do no harm
- create safe spaces
- no coercion
- accepting people's thoughts and feelings
- appreciation of altered states
- accepting different or unusual ways of being
- attempting to understand context but also accepting the limits of such understanding
- inspiring hope and possibility
- integrate self-determination
- reframing
- protection of human rights and dignity
- and bearing witness.

The second international summit in Ireland produced a network of work groups to explore a variety of practices/processes. The most important outcome of both summits was the conviction that there is a critical and pressing need to continue the work of the group and to continue sharing information on alternative practices and approaches.

To that end, the participants in the third international summit in Canada in May 2007 focused on formulating concrete ways in which INTAR could disseminate the groups' collective experience and knowledge to a wider audience. Additionally, INTAR held a public panel discussion at Malaspina Uni-

versity in Nanaimo, British Columbia, which again demonstrated the public's hunger for alternatives to traditional mental health services.

What are the Opportunities and Challenges for Promoting Alternatives through the Work of INTAR?

First of all, practitioners in alternative methods are very busy making sure that they can sustain themselves and their organizations. They have little time to promote their own approaches on the world psychiatric stage, much less engage in general advocacy to promote humane alternatives of many kinds. It is quite characteristic of many alternatives that they remain the sole example of their generally quite successful approach. For example, after 15 years of operation, there is still only one substantial Windhorse program in operation (in Northampton, MA), with three much smaller programs in Vienna, Austria; Lambsheim near Ludwigshafen, Germany; and Boulder, CO. The Runaway House in Berlin is still the only example of its kind in Germany, and probably in the world. Related approaches have been established in New Hampshire (Stepping Stone). A family-outreach program that does not espouse the medical model has been established in Toronto, Canada, but so far has not been replicated elsewhere. With INTAR, there is the possibility that these efforts will cross-fertilize and their positive results will become disseminated to a wider audience, thus encouraging further dissemination.

It is also possible that these often fairly insular approaches require charismatic leadership for their own successes, and that such leadership cannot be easily transplanted. Windhorse and the Runaway House have taken many years and a highly dedicated group of people to become relatively firmly established. It is possible that the necessary ingredients (beyond charismatic leadership) of these approaches can be identified and disseminated more easily. The obstacles that alternatives are facing in most communities have less to do with the lack of buy-in to the principles they are espousing, but are rather tied to a whole host of economic disincentives that are exceedingly difficult to overcome. In the USA, for example, hospitals and psychiatric emergency departments have totally cornered the market on crisis intervention, especially in urban communities (with few notable exceptions: San Francisco and San Diego, CA). This is the primary reason why programs such as

SOTERIA that provide non-hospital, largely drug-free interventions for individuals experiencing psychosis, have rarely been replicated successfully. It is our hope that organizations such as INTAR can affect a turning of the tide by affirming that there are safe and effective alternatives to hospital-based/biomedical interventions.

How Will INTAR Synthesize Charisma and Successful Alternatives to Traditional Psychiatry for More General Consumption?

INTAR embodies wisdom, creativity and practical experience, but without being self-congratulatory. The group is not homogeneous; it represents diversity in hearts and minds and language. The group has hands across oceans and a shifting population; as new alternative projects come on board, that adds to the diversity. Through this, INTAR is a spring of richness. Thus far, INTAR functions in a supportive and formative way. It breathes life into and feeds the soul of those who are fighting the good recovery fight, whether experts by experience or those offering a service, or those who are in both positions. The people who constitute INTAR make human to human connections and talk about their different treatment alternatives. As the group works with a flattened hierarchy—we all have expertise but there is no single expert—there is a pattern of operation—tentative, deeply respectful, tolerant and patient. There is a sense of the group "feeling its way in the light."

It remains a challenge to galvanise a loose collective towards producing outcomes. But much is at stake. If there is no concerted effort to proffer rational arguments for these and many other successful alternatives, then they are fated to remain the exceptions that prove the rule: hospitals and psychiatric drugs will remain the only available options for individuals experiencing acute psychiatric problems. Peer support and psychotherapy will be seen as nothing more than adjunctive interventions that are likely to be priced out of the market, especially for people considered to have serious psychiatric conditions. Holistic alternatives and techniques will remain the purview of rich self-payers and never reach the vast majority of those who could benefit from them. Therefore, an organization like INTAR must lead the way in providing the following essential services:

1. Creating and strengthening a world-wide network of like-minded providers of non-traditional mental health services.
2. Developing and disseminating an evidence base that derives from the collective experiences of non-traditional mental health programs.
3. Working in conjunction with other advocacy organizations, such as MindFreedom International and Mental Disability Rights International, to promote the widespread availability of effective alternatives.
4. Creating an international network of consultants who would be available for individual and organizational consultations, through discussion forums, mailing lists, video-links and other means of real-time communication.
5. Engaging with major professional and family organizations that are traditionally opposed to alternative treatments, but that are equally committed to finding ways of helping people who eschew the prevalent methods of mental health systems.

Source

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Peter Lehmann and Maths Jesperson

Self-help, Difference in Opinion and User Control in the Age of the Internet

Self-help and its facilitation and promotion are of fundamental interest for (ex-) users and survivors of psychiatry. Without the enhancement of self-help resources there will never be any progress in therapy or in recovery or in the ability to live a self-determined life. This is the message of organised (ex-) users and survivors of psychiatry from all over the world. Self-help is also the foundation for self reflection about the so-called symptoms of mental