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IPS Newsletter Fall 2014

Featured Artwork by
Lorraine Nicholson

Currently at art school in Scotland studying digital film-making and photography, I am living the dream I never imagined would ever materialize. Ironically, major depression put me on the threshold of my authentic path in life just 10 years ago and made me reframe what was most important in my life. I naturally and instinctively turned to art as an emotional channel in my recovery journeys in order to try to make sense of what I had been through.

Over the course of a few years and at the instigation of others saying that I had the potential to help others have hope, a fully illustrated poetry book came together entitled "The Journey Home" which was published in 2010 and continues to sell worldwide. It reveals through powerful images and words what my depression laid bare, namely my soul. It also makes real the lived experience of recovery as defined by an individual.

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In this Issue

What is Intentional Peer Support (IPS)?

Intentional Peer Support is a way of thinking about and inviting powerfully transformative relationships among people. Practitioners learn to use relationships to see things from new angles, develop greater awareness of personal and relational patterns, and support and challenge each other in trying new things.

Moving Towards

As Intentional Peer Support grows, there is an ever-increasing body of people and organizations embracing IPS as a way of being in relationship and working with one another. There is work afoot to develop IPS for children and young adults (if you're interested in this, please contact Eva Dech at eva@intentionalpeersupport.org), and a growing interest in justice, corrections and forensic settings; housing and employment organizations; domestic and family violence; and other disability and family interest groups.

In the past year, IPS has held a number of pay-per-seat trainings for both the core and facilitator's training. The number of facilitators is expanding, and many types of IPS learning communities are growing around the world. Also, a number of research initiatives are underway and under development—so an exciting range of options abound right now (send a blank email to IPSresearch-subscribe@googlegroups.com if you would like to be a part of that discussion). We look forward to working more closely with you all in the future!

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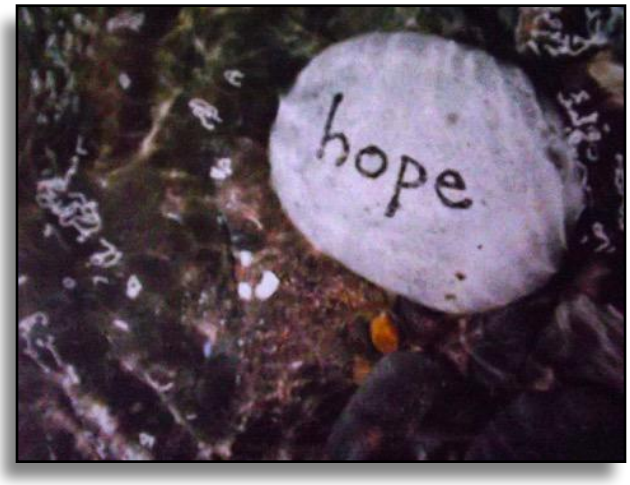
Seeing the Person

Moving beyond force and traumatization for people in crisis

By Chris Hansen

In a number of Western nations, mental health policy-makers have committed to the reduction and eventual elimination of the use of seclusion and restraint. Both empirical research and anecdotal evidence show that "coercive interventions cause traumatization and re-traumatization…coercive or traumatizing settings do NOT foster hope, healthy relationships, pro-social behaviors or trust" (NASMHPD, 2005).

Yet every year, billions of dollars are spent worldwide on forcibly treating people in the mental health system by a medical profession who is committed to the primary precept of 'First Do No Harm'. Even where the constraints of legislation state that people must be treated when deemed a danger to themselves and/or others, and in the least restrictive setting possible, the imbalance of power created between a medical system and people with very little power creates a dynamic whereby coercive interventions become an easy way to deal with a difficult situation. It would be fair to say that in many cases the mental health system feels stretched, overworked, and under-resourced, but lack of resources in our societies do not justify abuse, traumatization and/or a violation of a person's human rights in a non-justice setting.



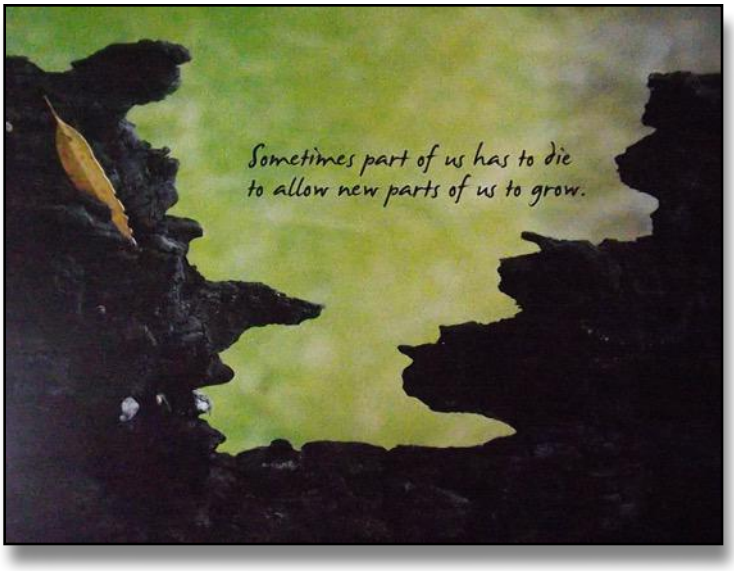
Statistics reveal that 51-98% of public mental health clients in a U.S.setting have been exposed to trauma and that most have multiple experiences of trauma (Muesar et al., in press; Muesar et al., 1998, Goodman et al 1997). This fact has only recently begun to inform how we respond to people in treatment, let alone in emergency situations. While it seems obvious that actions like forced treatment, seclusion and restraint are re-traumatizing, there are other considerations in developing responses that are more trauma-informed.

Power and control are the defining features of abusive relationships. Our challenges, then, are to:

- See a person's way of being in the world as a logical response to past experiences, rather than as symptoms of an 'illness'
- Build trusting relationships which are mutually responsible and negotiated, and

- Listen in a way that makes room for a person's stories and history

Susan had been a recipient of mental health services for most of her life. She had been diagnosed with bipolar disorder and because of her history, was told to expect periodic episodes of mania. She was in and out of hospitals regularly. One summer she came to a crisis alternative. She described not sleeping, racing thoughts, images of death and blood, and an urgency about running into the woods with a knife. Rather than responding with control, the worker shared some of her own experiences with these desperate feelings and asked Susan if something had happened to her during a summer. Susan went on to tell the story of an August where she had been kidnapped, held in an outhouse, and repeatedly raped. When she had finally been released she ran through the woods for a long time, not knowing where she was or what she should do. Many years later, just before August, when she finally brought it up to her psychiatrist, she was told to put the past behind her. That's exactly what she did, always one step behind her. Out of her sight but not out of her experience.



When Susan was able to understand her reactions as normal responses to what had happened, she slowly understood her current feelings contextually. This pain now has meaning for her. It is her history and her experience and she has begun to transform it. She now helps others develop plans and strategies to move through crises differently or even to prevent them all together.

One research study (Onken et al., 2002) concluded "Participants reported that [hospital] settings cause them to lose living skills and re-traumatise them. The lack of access to the outside world gives the sense of being locked away... People lose a sense of being a citizen and a community member. Physical and emotional abuse and the abuse of power and authority in hospitals is detrimental…"

"I was force treated because I was supposed to go to support groups and counseling as part of my probation. The reason I wasn't going was because I was too afraid to cross the street. The experiences I had in hospital made me too afraid make my own decisions, so back into hospital I went, and I lost my kids. If only someone had offered to help me find a solution" (user/survivor of psychiatry interviewed for the purposes of this paper).

Another user/survivor tells a story of multiple tragic losses and stresses that left her feeling that suicide was the only viable solution*:*

"In hospital I was treated as though I deserved to be punished. People treat their animals better than many psychiatric patients are treated. Any self-respect I had quickly disappeared. As a result of a rather long hospitalization I lost my well-paid management job, custody of one of my children, my friends and social supports, and ended up having to rely on benefits, the food-bank and other charities. It has taken me many, many years to regain my sense of self, and to this day I still struggle with the sense of shame and 'otherness' this experience created. The sad thing is that if someone had lent me a caring ear and helped me to see the options, none of this would have happened" (user/survivor of psychiatry).

The best-intentioned use of coercion can lead to irreparable damage:

"I was forced into hospital, held down and drugged. I now have post-traumatic stress and flash-backs from that time that are worse than any 'diagnosis' I was given before then. I would far rather have been sent to the police station and borne the consequences of a person who had violated the law than treated as person who is unable to reason" (user/survivor of psychiatry).

The widely-held view that coercive treatment potentially saves lives and protects society is a form of social control that fails to acknowledge the cost and the damage to the individuals concerned. It also overlooks the number of people who as a result can't find a way out of the mental health system ('chronic mental patients') and the countless other social problems forced treatment creates.

What are the alternatives to force?

Methods for dealing with extreme distress

When people experience states of extreme emotional distress, regardless of cause, attempts to negotiate and engage are strained by the tear in usual use of language and communication (Pearce, Littlejohn, 1998). Understanding that crisis events are full blown flights of fright, no matter what the presenting story may be, grounds the supporters in understanding that the first priority is to help the person feel welcome, safe and heard. Contradiction, challenge or refutation build unhelpful power dynamics, and create relationships that are embedded in pathology and lead to secrecy and control. Rather, it becomes essential in the early stages of engagement to allow a person to talk about their perception of the experience in as much detail as is necessary without having it labeled, assessed, or interpreted. Loren Mosher, from the Soteria project (Mosher in Warner, 1995), describes this not as a "treatment or a cure but rather a phenomenologic approach, attempting to understand the psychotic person's experience and one's reaction to it, without judging, labeling, derogating or invalidating it" (pg.113).

Mobile response:

In difficult situations, leaving one's home can be unsettling and often confusing. On the other hand, staying home can be dangerous and frightening. Mobile teams can be useful in de-escalating situations as well as providing a normalizing response, much like what communities used to do. Well-trained mobile teams are able to engage with people while taking context into consideration, and can even provide in home longer term supports as needed.

Alternative programs:

There are a variety of models that provide a short-term community around the person in distress. The focus of these projects is on relationships, strengths, and recovery. There is little attention paid to diagnosis but rather to each person's phenomenological experience.

Crisis Planning:

Prevention can mean anything from developing early education to helping people create their own crisis plans proactively. When people are allowed the time and the non-judgmental atmosphere to talk about the things they have been through, they can often begin to identify some of the things that helped them learn and grow from particular situations and they can also begin to identify the things that have kept them stuck in old patterns and old ways of relating to people.

Planning for emergencies and times of crisis is an effective method of enabling people to make their own rational choices in advance about the intervention, types of support and resources that they want and that work for them.

The Convention on the Rights of Persons with Disabilities is dedicated to ensuring the equitable inclusion and opportunities of ALL people in our communities, no matter what their 'difference'. We need to commit to alleviating pain, suffering and exclusion rather than creating it. Endorsement of forced treatment perpetuates an under-class of people whose human rights are offered as sacrifices for the "good of society". Condoning a continuation of these practices is an indictment on the aspirations of the United Nations.

We need a world that values and includes all, and is committed to providing the support and resources we need to enable us all to live well in our communities.

References available online HERE

www.intentionalpeersupport.org

An excerpt from "Stranger"

Full article available at www.madinamerica.com/2014/08/stranger/

By Steven Morgan

Three days later I am at Treatment. Here the walls are further apart, the air has more space to breathe, the floors squeak a little less and the mattresses are wrapped in cotton instead of plastic. But mostly it smells different. Yes, I smell institution—the detergent on the linens, the pink handsoap, the stale paper in self-help books; but it's nothing like the rotten scent—the chemical humidity—that hangs in Stabilization, one I swear thickens more by the day with each patient sucking it in and coughing it out.

There is also sunlight in this wing, albeit dulled through the frosted windows. And high ceilings with skylights that create the ambience of an airport. One feels less like a sick person in here and more like a customer. Which isn't to say you're treated like one—or at least that if you are, it's as a customer attempting to return an un-returnable item…forever.

I am standing in the grand central room. In the middle is the employee headquarters, a large octagon marked off by waist-high countertops. Inside are open-air stations and filing cabinets that the employees fiddle with endlessly, always bending over and gesturing to one another with the resentment of being watched ("Why is everything always setup in the *patient's* favor?" they groan). There is no glass like at convenience stores, but those countertops are just a hair longer than striking distance.

It's medtime. A voice over the intercom drops from the sky, "Medications. Line up for medications." We heed the call and gather single file. If aliens invaded at this moment and this was the first image they saw—thirty of our mis-shaped bodies aligned before two clean figures dressed in white, our cheeks watched closely as we swig back plastic shot glasses—what would they *see*?

Mine are vanilla hexagon, lip-stick red tube, two faded bluejean circles, and an unabashedly golden egg. Call them Lithium, Abilify, Effexor, and Ativan. In one fell swoop they are me. It's in the moment that I swallow that I feel hope. Though I can't get out now, I did in fact check in to this place, and this is why right here: I talked to my doctor, I read the pamphlets, I aced the quizzes on pfeifer.com, and I'm here to collect on their wager that flowing white robes in lime grass fields are a balanced chemical away. That's what a particular kind of desperation will do.

Now it's time to smoke. The pack I checked in has been traded for coffee and excuses to loiter in the smoking cage. Everyone knows the employees keep a stash behind the counter, but you have to sway them into giving up such leverage. Fortunately, at this time of day, coffee has kicked me into a formidable charmer (the brochures call this Rapid Cycling). I look for a vulnerable employee who must have kids my age and therefore cannot possibly say No (they call this Manipulation). Back and forth yackity yack, a flash of the devil's smile, she hands me two cigarettes—reluctantly, telling me these will be my last, then launches into tiny sermons about tobacco and mental health that are also posted in bold fonts on the bulletin board (and in those brochures).

The doorway between the hospital and the smoking cage marks two worlds. On the inside I am notes in cursive. On the outside I am a friend. We congregate, six of us men—the women have to smoke in a separate cage—something about tobacco calling back a rite of camaraderie. Here we laugh.

Read the full article "Stranger" here: www.madinamerica.com/2014/08/stranger/

Join our mailing list for updates and our newsletter

We're on Facebook! Please visit our Facebook Page

Check out the IPS Learning Community on Facebook for online discussions

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Intentional Peer Support

By Megan Powell
IPS Core Class Melbourne, Australia 2014

From helping to learning,
an inquisitive journey.

There's two of us involved in this,
we're sharing this relationship.

I want to learn and build a connection,
let's take some time for reflection.

About what's happened to you,
where you've come from your worldview?

I'll share back so we understand.
A relationship where we both know where we stand.

Moving towards fostering hope.
Rather than moving away from what's causing us
not to cope.

If we disconnect that's ok,
we can reconnect in another way.

Say straight up that it's not working.
Name the feeling and say it's hurting.

Being open and honest will always come first.
To ignore a disconnect can be the worst.

Realise my judgement and try to understand,
that my feelings are valid but so are theirs.

I will feel discomfort from time to time,
but sitting with that is definitely fine.

Building trust to enhance our connection.
Allowing the conversation to take any direction.

Validating feelings, somebody has listened.
A button was pressed but try to withstand

A natural reaction of our flight or flee,
and be willing to name the feeling in me.

Where did that opinion originate, how was it
formed?
When listening to you I'm willing to learn.

I won't always feel the same,
but to close my mind would be a shame.

I'd miss so much, you would be reluctant.
I want to allow you the chance to vent.

There are so many truths that exist.
With an open mind you more likely not to resist.

If what we see is what we do, and what we do is
what we get.
When focusing on the illness our strengths we
forget.

If we see we are sick, treatment is what we seek,
We are bound to get treated as if we are weak.

If we see a problem, an answer is what we need,
And help is what grows from this planted seed.

But when capable is what I see, I'm more likely to achieve,
And get a sense of accomplishment, which is what I really need.

Our language is important and can imply who's in power.
Be careful of assumptions and watch each of us flower.

Medications and diagnosis may very well help,
But really doesn't allow for me to see my sense of self.

Listen with curiosity and don't assume we know.
Question with sensitivity and we begin to grow.

What lies above the surface can often be misleading.
Dig beneath the surface is what is really needed.

To uncover a richer story than what is being told,
Uncover feeling buried deep and a story will unfold.

We can do this by saying I wonder, or help me understand.
How did you learn or what's making you so scared.

Apologising can mend the connection when it's broken.
You just need to realise what can come when these words are spoken.

How would you like it to be or what can we do to get there.

When realising these simple things an experience is shared.

We are not looking to fix or focus on solving problems,
But unearthing possibilities that move us towards what we're wanting.

Take care of the relationship and not each other.
Maintain the connection to learn and to discover.

This relationship needs to work for both of us.
When a power struggle arises this will diminish trust.

Let's talk and negotiate what we both expect.
When something is not working, it's ok to check.

Both our boundaries are clearly defined,
and understanding that over time these can always be refined.

Being treated and managing their illness is a mental health outcome.
Peer support is creating what they want by learning about them.

Tell me what you see, feel and need and I will do the same.
This relationship is ours to share and not to place the blame.

I'll practice my thinking and what I've been show.
Discover their belief system but hold onto my own.

I know it's not easy and time will tell,
If IPS has been learnt and if I'm doing well.

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Youth and Young Adult IPS Planning Committee

What is IPS?

Intentional Peer Support is a way of thinking about and inviting powerfully transformative relationships among people. Participants learn to use relationships to see things from new angles, develop greater awareness of personal and relational patterns, and to support and challenge each other as we try new things. In a highly interactive environment, participants learn the IPS tasks and principles, examine assumptions about who they are, and explore ways to create mutual relationships where power is negotiated, co- learning is possible, and support goes beyond traditional notions of 'service'

The purpose of this committee is to develop youth and young adult involvement in IPS, including:

- Being a part of the planning effort to build peer support opportunities for youth
- Identifying youth/young adults involved in peer support cross-systems and college campuses
- Collaborating with Youth Groups
- Building, promoting and supporting youth and young adults in peer support

To get involved please contact: Eva Dech at eva@intentionalpeersupport.org

Thank you in advance for considering working with us on this important effort!
IPS Management Team

"As peer support in mental health proliferates, we must be mindful of our intention: social change. It is not about developing more effective services, but rather about creating dialogues that have influence on all of our understandings, conversations, and relationships." – Shery Mead, Founder of IPS

intentional peerSUPPORT
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Upcoming IPS Core Training

Clearwater, Florida

20 miles west of the Tampa airport

December 15th—19th, 2014

Sheraton Sand Key on the beach
www.sheratonsandkey.com

Cost of Registration: $850

REGISTER HERE

Registerations accepted on a first-come, first-serve basis, so please register early!

For further inquiries:
info@intentionalpeersupport.org

Please see Page 2 below for Travel and Accomodation Information


IPS Training 2014

What is Intentional Peer Support?

IPS is a way of thinking about and creating powerful and transformative peer support relationships. It is a process where both people use the relationship to look at things from new angles, develop greater awareness of personal and relational patterns, and support and challenge each other in trying new things. IPS is used across the world in settings ranging from peer-run respites to traditional mental health services. We come from a history of grassroots alternatives that focus on the possibilities that emerge when relationships become mutual, explorative, and conscious of power.

About the IPS Core Training

Our Core Training is a 5-day introduction to the IPS framework and is designed to have you practicing right away. In a highly interactive environment, participants learn the tasks and principles of IPS, examine assumptions about who they are, and explore ways to create mutual relationships in which power is negotiated, co-learning is possible, and support goes beyond traditional notions of "service." IPS is all about opening up new ways of seeing, thinking, and doing, and here we examine how to make this possible. Our Core Training is for anyone interested in peer support and has been widely used as a foundation training for peers working in both traditional and alternative mental health settings. Specific topics covered include:

The Four Tasks: Connection, Worldview, Mutuality, Moving Towards * The Three Principles: From Helping to Learning, Individual to Relationship, Fear to Hope * Looking at language and story * Listening differently and with intention * Understanding trauma worldview and re-enactment * Rethinking old roles and ways of relating * Working towards shared responsibility in relationships * Examining power and privilege * Negotiating boundaries and limits * Navigating challenging scenarios * Understanding crisis as an opportunity * Using co-reflection to sustain values * Creating social change

"IPS offers a way of being in the world – whether or not we're working in conventional or alternative mental health – which is congruent with a healing and recovery-based community. It can be life-changing. It was for me." - Participant, IPS Core Training 2014

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Travel and Accomodation Information

Registration Fee
Registration is $850 and covers training, manuals, and lunch on each training day. Hotel accommodations, breakfast and dinner, and travel arrangements are the responsibility of applicants.

Registrations can be made here. If you are registering for someone else, please put the participant's name in the "Order Notes" section, which is next to "Billing Details" on the checkout page. Also, if you are registering more than one person, please indicate the name of each participant in that same section.

Location
The IPS Core Training will be taking place from December 15th—19th at the Sheraton Sand Key (www.sheratonsandkey.com) in Clearwater, Florida. The nearest major airport is Tampa International Airport, which is about 20 miles away.

Please plan to arrive in Clearwater on Sunday, December 14th in order to begin at 9:00am on Monday, December 15th. Training is from 9:00–4:30 from Monday–Thursday, and 9:00–3:00 on Friday.

Hotel
Participants are offered a discounted rate of $129 per room at the Sheraton Sand Key, where the training will be held. **In order to receive the discounted rate, you must book by 11/28/14**. Please make your hotel reservations directly by calling 800-456-7263 and asking for the discounted "Intentional Peer Support" rate.

Shuttle
There is a shuttle service from the Tampa airport to the Sheraton Sand Key operated by Super Shuttle. It's $25 each way per person. Reservations cab be made by calling 800-258-3826, or at the baggage claim. Taxi services cost about $55 each way.

IPS Training 2014