DECARCERATING CARE
THE EVOLUTION OF MENTAL HEALTH SURVEILLANCE

Institute for the Development of Human Arts

Decarcerating Care:
The Evolution of Mental Health Surveillance

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Closed Caption Transcript

>> JESSIE ROTH: Welcome again to Decarcerating Care: The Evolution of Mental Health Surveillance. My name is Jessie Roth and I am the director of the Institute for the Development of Human Arts. For a brief visual description, I am a white woman with dark brown hair and glasses. I have a big bun, dark headphones, and I'm wearing a black shirt. There are houseplants behind me, and a little light coming in through my window. It's a great honor to welcome you to the fifth installment of this ongoing talk series that we've been doing.I will start with brief opening slides so we can get started. We can go to the next slide.

Just a couple of quick notes on accessibility. We have live closed captioning available. You should be able to turn that on. We have a team of ASL interpreters joining us. We aim to provide visual descriptions whenever possible as well. On tech, we have a team. Sun is in the chat if you have questions. We are recording this event to share with registrants later. We want to invite you to join the conversation in the chat. Feel free to share thoughts and reactions and resources. We won't be able to answer all of the questions that come up but we save them and hope to engage with them beyond this evening.

A few quick words about the Institute. We're a community of current/prior mental health service users and survivors and activists coming together to transform mental health care. We're advancing at critical, scalable, effective approaches. What makes us unique is we integrate experiential and academic knowledge, challenging power dynamics and the view of professionals as the ones holding knowledge.

Here are community agreements. Shared expertise and wisdom: Everyone brings their own expertise to the conversation. We all can gain from and respect each other's various expertise. Collective liberation: Overcoming oppression aids everyone's liberation. It is our responsibility to challenge various forms of prejudice. We educate in the spirit of solidarity, and

hold each other accountable without criticizing who they are as people. Listen like allies: We respect a wide diversity of choices and perspectives, even when we disagree, and we don't judge or invalidate other people's experiences.

To give you an idea of what to look forward to, I'm going to pass it to Selima in a moment. We will have intros from our panelists, a discussion, and then a Q&A. So it's my honor to introduce you all to Selima, our moderator this evening. I'm excited to hear from her and our other lovely panelists. Thank you again, all, for being here.

>> SELIMA JUMARALI: Good evening everyone, my name is Selima Jumarali. I use she/her pronouns. I am a brown-skinned, Indo-Guyanese, femme person with round cheeks and black dark curly hair. I am wearing an emerald green top, big gold earrings, sitting in front of a gray wall. I am a fifth year PhD candidate in clinical and community psychology at the University of Maryland-Baltimore County. I acknowledge that I am calling in from unceded land in Baltimore, Maryland. It's my honor to be a moderator with these beautiful hearts and brilliant minds – both our panelists and all of you. I am here with deep gratitude and warm reminders for us to hold each other with compassion, care, and abundance. Take care of ourselves and take what we need as we need it.

I also enter thinking of all those resisting oppression around the world, particularly the queer, trans and women activists in iran fighting for freedom and bodily autonomy, and those fighting the occupation and ethnic cleansing in Palestine.

Welcome officially to the fifth installment series of Decarcerating Care, a discussion series born in 2020 amidst the ever-evolving COVID-19 global pandemic, and racial uprisings in response to the police murder of George Floyd. As Black organizers and activists called for the defunding of police, IDHA launched this discussion series and joined the conversation to critique the notion we should replace cops with care, raising awareness of the historical and present day harms of the psychiatric industrial complex. I'd like to extend appreciation to the IDHA committee of organizers, staff, and interns who worked behind the scenes to make this happen, and who supported us with tech, logistics, and to our interpreters and captioners tonight.

Tonight's theme is the evolution of mental health surveillance where we will expose and unpack the pernicious shape shifting of carceral logics of control, carcerality, and disposability within the mental health arena. Psychiatry and psychology have wielded the medical model to spread the myth that the natural diversity of our minds and bodies to be categorized and assigned value. This myth is leveraged to uphold the white supremacist capitalist hierarchy and establish false binaries of "good/bad", "healthy/ill" "normal/deviant and pathological." The false binaries teach us that people on the "wrong" side can be disposed of, whether in jails, or prisons, or asylums.

But we know the truth. Humans are resilient, dynamic, and responsive. What the medical system may call "symptoms," some of us call normal and natural responses to living under oppressive forces that limit our self-determination, interpersonal connection, and social, political, economic freedom. Tonight, our spectacular panelists will review the historical roots of mental health surveillance and their inextricable ties to white supremacy, capitalism, and ableism. They will expose present-day interactions and manifestations of mental health surveillance to help us all sharpen our critical analysis and differentiate "reformist reforms" from true abolitionist

practice. FInally, they will uplift ongoing resistance to these harms and ground us in centering liberation and healing as we translate tonight's learning into action, Again, we invite you to engage in this conversation by using the chat to share your thoughts, feelings, and reactions – as well as any resources for continued learning and growth.

It is now my pleasure to invite the panelists to introduce themselves. A friendly reminder to share your name, pronouns, visual description, and how you feel about rising surveillance and carcerality in the mental health system and how this relates to your work. We'll start with Azza.

>> AZZA ALTIRAIFI: This is Azza. It's great to be here. I use she/they pronouns. I am a Black, femme-presenting person wearing glasses, gold earrings and a necklace, a forest green cardigan, and a pink floral print headscarf. Visible behind me are various framed art prints and my bookshelf. By day, I am a senior policy manager at a movement support organization. I am a mad, disabled organizer and strategist. Lately my work has focused at the intersections of disability justice, carceral abolition, and labor organizing. Those are the perspectives, experiences, and domains of struggle I'll be drawing on today. Apologies, I am having an issue with my computer. I will go on mute here and try to address this and come back on.

>> SELIMA JUMARALI: Please take your time. We will move to TL.

>> TALILA "TL" LEWIS: Selima, I think all of us are trying to get grounded. Could you slowly repeat the question?

>> SELIMA JUMARALI: Absolutely. For introduction, you can share your name, pronouns, and visual description, as well as how you're entering the conversation. What are your feelings about the rising surveillance and carcerality in mental health, and how does that impact your work? Give us a brief taste of what's to come in the conversation this evening.

>> TALILA "TL" LEWIS: OK. I am a Black, genderfluid person, pretty gender-neutral presenting today, with my favorite black sweater that comes up my neck with lots of different materials. A black beanie, seafoam colored shirt under it. I'm seated on a couch in front of a white wall. I'm on unceded Tongva land.

I am queer, Black, multiply disabled. I am an abolitionist social justice engineer; that is the best way I can explain it. I'm a community attorney and organizer. I co-founded an organization called HEARD, which is an abolitionist organization that focuses on sporting deaf, disabled, incarcerated folks. That's all forms of incarceration. I may or may not talk about that at all today. Like the specific work. It depends on how things go about.

How am I entering this conversation? I have so many things on my brain that it's hard to get one thing out. That is because we are dealing with what I call the medical carceral industrial complex. The connections between all of these sites of control, surveillance, and incarceration are impossible for me to separate. As it so too is impossible for me to separate how ableism influences all of our lived experiences as marginalized people and how all of us experience the grunt of ableism regardless of our disability status. I will be talking about that. In particular, Black and Indigenous people, regardless of disability status, are detrimentally impacted by ableism. I think I'll be talking about that. I think that gets to what you asked us. Go ahead.

>> SELIMA JUMARALI: Thank you, TL. Next can we have Yana introduced?

>> YANA CALOU: Hi, my name is Yana Calou. I'm an olive-skinned genderqueer person wearing a nose ring and a black bowler hat over dark brown curly hair that's short in front and long behind. I am wearing a mustard colored shirt and I'm in front of a bright yellow door and gray wall. I work at a crisis hotline that is divested from the police. I'm the Director of Advocacy there at Trans Lifeline, leading our Safe Hotlines campaign that is aimed at getting police out of hot lines.

My experience as a non-binary and light-skinned, mixed-race, Brazilian-American person informs how I approach movement work and my experience of going through mandated reporting as a child, struggling with mental health issues personally and as someone who's involved with my father's mental health crisis that involved police and psychiatric hospitalization, I think it informs my work and my commitment to abolitionist crisis supoort that doesn't rely on this infrastructure.

I am honored to be learning and organizing community with you all today. I hope to connect some of the ways that carcerality and surveillance have been constructed as care. I want to share some ways we are seeing surveillance, policing, and the denial of agency operating in the crisis hotline landscape as billions of dollars are being spent on new federal infrastructure for this, specifically around crisis hotlines that engage in non-consensual interventions, which means the sending of police or emergency responders to the caller's location without their knowledge or consent. I'm joining you on unceded Lenape, lands known as Brooklyn, New York.

>> SELIMA JUMARALI: Thanks so much, Yana. Next, Idil.

>> IDIL ABDILLAHI: Good evening. Is my camera on? Thank you for having me. I'm thankful to be speaking with all of the brilliant speakers this evening. Thank you very much. I use she/her pronouns. I'm a Black woman with a bald head. I am wearing pretty dope square black glasses, like one of my other panelists. I am wearing a headset so I have earphones on and small silver earrings. I have a taupe lipstick from MAC and I am wearing a black hoodie. I have a gold necklace with a pendant that says my name, I-D-I-L. I am sitting with a blurred background on a black chair. I am speaking from Treaty 13 in so-called Canada. I am an educator at Toronto Metropolitan University. I work in the School of Disability Studies. I am cross appointed to the School of Social Work as well.

To briefly respond to your question, Selima, thank you so much for it. I feel a sense of urgency to respond to this particular question. Often, as I think some of my other panelists have already discussed today, there is a seemingly disparate conversation for many people around care and carcerality. For me the discussion is one that is about carcerality first, that then goes on to think about how we discipline, contain, and confine people through ideas of prescribed pathology.

These conversations are interlinked for me. They are connected. Ultimately, they have a foundation around social order, discipline, control, loss of autonomy for individuals. I come to this conversation firstly as a Black woman who has lived and been through these spaces, who

has worked with individuals, who has survived these spaces personally, and is now beginning to think about how we truly begin to frame decarcerality in the context of prescribed pathology for particular kinds of people: Black people, queer people, trans people, working class people, and so forth.

I want to think about those ideas today particularly and think about how fundamentally it is the control of those of us who are living with mental health issues that are not identified that are seeking to be controlled. To me, I think the bigger picture is one about carcerality and containment and not so much one about care. I think it's important for us to undergird this framing of this conversation in that. In the apprehension of livabilities, in the containment of lives, and ultimately in how it is that we think about how care manifests in the context of those who are most impacted by some of these discussions.

I come to this conversation with these ideas in mind. Hopefully to speak about them as they reverberate through multiple systems, not just ultimately the mental health system. Many of us don't come to that system without first being engaged in another system. I want to think about the continuum of these carceralities across lives, and how they manifest differently in different bodies and across different lived experiences. Blackness, transness, compounded disabilities, indigeneity, etc. This is Idil and I'm done speaking for now, thank you.

>> SELIMA JUMARALI: Thank you so much, Idil. My heart is reeling from what you have shared. Last but not least. Shawna.

>> SHAWNA MURRAY-BROWNE: Hey, this is Shawna Murray-Browne. As a visual description, I am also wearing dope frames as described by Idil. They are blue rectangular-esque frames. I have red lipstick. I'm a Black woman with brown skin and twisted hair coming down my right side. I have a tan shirt, a white curtain in the background, with a peek of a yellow wall, my favorite color. I'm speaking from a land also known as Baltimore City, which is unceded land. I am really happy to be here.

I have been trained as a clinical social worker. I have practiced as an integrative psychotherapist, both in private practice and in juvenile detention and residential treatment. I have been an organizer here in this city of Baltimore. I'm a healer and a person that sits at the feet of my elders to contend with the realities and wisdoms of the African spiritual tradition. The things coming up for me now are this intersection of the experience that I find myself often having to find space for other people, to bring together the personal and "professional." This conversation brings up, for me, urgency and breath, simultaneously.

Urgency, what comes up for me is the stories of my brother, mother, and father. They have all either been killed as a result of carceral systems, or they are struggling with substance use and abuse, as a result of harms done by the so-called mental health, so-called justice systems. I also come as a person that holds liberatory healing space for Black women and femmes in leadership, navigating the in between, the radical intersections of trying to do liberation work while working in systems. And also holding space for those that are mental health practitioners, human service professionals, our administrators, organizers, etc., about what it means to decolonize therapy for Black folks.

I plan to bring all of that, but really zoom in on what it can mean for us to provide and move through the world from a liberation-focused healing perspective; to give voice to the both/and experiences of those working in the system, but are from our own community and have unique experiences. And just giving light to some of the things that I think are often left unsaid. I'm happy to be here.

>> SELIMA JUMARALI: I'm taking a deep breath after that. Thank you, Shawna, and all the panelists. As you know, over the last 2-3 years we have faced multiple pandemics, a range of social uprisings, political and economic crises, and other cataclysmic social changes. In this time of the past 2-3 years, what has the most salience for you in terms of how it's impacted you, your movement work, or your community? Whether that's a particular event or dynamic. This is to everyone. Anyone can start.

>> IDIL ABDILLAHI: This is Idil speaking. I'll go ahead and start from my vantage point. My camera is off. There is an image of me on a Toronto subway with my hand on my head, a scarf, green jacket, my bald head, and lipstick. That's what you see on the screen.

Speaking from the so-called Canadian context, and for many, I take George Floyd's death as an international, global, marker. Before his murder, there was also a suspicious death of an Indigenous Black young woman; Regis Korchinski-Paquet. The country I live in didn't apprehend, take up, make urgent her death in the same way as George Floyd's death. Regis's mother called 911 for mental health support for her daughter that day. She ended up dead off of a balcony. The family and community are still awaiting information on what happened that day.

Subsequently, we had the well-known murder of George Floyd in Minneapolis. The world, including Canadian institutions, organizations, and corporations – so many made statements and acknowledgements were made of the events surrounding George Floyd's murder. Here in Canada, we also had the death of D'Andre Campbell. These are all Black people. Prior to that, we had several other deaths that were all connected to calls to 911 and police. For me, there are two simultaneous things happening: the acknowledgement of Black death is connected globally to me. Then there's the refusal of the local. To quote Dr. Ronaldo Walcott in Black Like Who?

Something happens here, meaning here in so-called Canada where we live, where Black people die here, Black people are shot by police here. Yet, for some reason that death doesn't resonate. Yet, for some reason the death of Black people living here and now and in this place and in this time doesn't appeal to people, particularly Canadians in the way we discussed the relationship between Canada and the U.S. We know these borders are fictitious but something is happening here. What's happening is there is a particular kind of racist prioritizing of death, of imperialist and American focus on death, mental illness, that isn't taken up in a way it would happen in Berlin. I was there recently. There is not a rapid taking up of the death of Black people across borders, globally.

For me, what ends up happening – the impact is really thinking about how we take up the deaths of Black people across globes because it is happening everywhere. How do we take up the fear of madness, of difference, the fear of disorderly-ness, the fear of the unknown. Especially in the context of the Black body, the context of the refusal of unlivability, the interruption that happens when people don't know what's happening to their family member.

When we are uncertain about who to call and how to call. Right?These are the first resonances that I have. We value lives differently in different spaces and places and community, etc..

Also in the last two years, there's been an uptick in conversations around madness and mental health that have come up in the context of neoliberal discussion about a contextual pandemic, of which has left out and left behind those of us for whom this is a consistent reality. My other panelists have talked about how we are working in systems that acknowledge a kind of appropriate madness or mental health illness, one that is approachable or manageable. One brought on by something we all experience. Not one that is our sustained life. I worry about the watering down, neoliberal conversation. The f'd up-ness of this romanticized mental health and mental illness. That's not what many of us are talking about. What's the impact of that?

And as we sort of see this uptick, new discussion about mental health, this opened discussion. It's important for us to know that the carcerality that brings us to this discussion today is not the folks we are talking about. And so I want to insert and impregnate us with this discussion this evening. I'll leave it here, I'll leave it here and pass it onto the next panelist.

>> SELIMA JUMARALI: Thank you so much. Would anyone else like to respond or build off of these comments?

>> TALILA "TL" LEWIS: I know this question was meant to be an entree so I want to share a lesson learned for myself, coming to you now from an identity as a former distance runner. One thing we learn is that pacing is critical. Not just in the individual race, but in various aspects of the race, as well as our preparation for the race and our general existence. Runners are runners all the time. It doesn't pause because you're not running. You have to be mindful of your presence, your body and mind, everything. Almost all the time.

I think, for me, it's acknowledgement of the freedom struggles that we're presently in and that our ancestors kind of handed off to us. It's a generational marathon. Our role in the struggle is just our role. To maintain perspective on your place in the grander struggle is really important. It's also critical to organize in a way that acknowledges our humanity, our independence, and our "love-rage." It's almost impossible to disconnect. Love-rage, rage-love. But then there's joy. Leaving space and acknowledging humanity, interdependence, love-rage, and joy, in our organizing. All of this needs to be included in organizing. When doing our work in earnest and in a principled way, it has an impact on the people moving the work, and it's important to acknowledge that.

It's also important to think about organizing in ways that leave maps. Thinking about the specific directions a person might need to go or avoid to find their way home or away from danger. We want to leave maps with instructions and meals and jokes and art and warnings and descriptions. That way, if we get tired and we have that laid out, the next person doesn't have to begin from where you began. Also, keeping in mind you can lose your memory during the work. Part of acknowledging our humanity is recognizing you won't be where you are all the time. People need to find you wherever you might be. Someone has to be able to come along, share a secret word to convince that they're on your right team, and then help you find a way with others to get you to the finish line. Thanks.

>> SHAWNA MURRAY-BROWNE: I had to look at my notes – I have so much going on! That's what paper is for. A few things I want to put out around what's most salient, specifically, aligns with some things my colleagues and panelists have shared. We're specifically looking at the roles, positioning, and consideration of people who consider themselves human service professionals, therapists, and the like.

One thing is, a common conversation or statement expressed by folks in the field of social work, of therapy, the "helping professions" is: I just want to help people. That is totally appropriate for us, having been socialized with a particular way of viewing what help can look like, to stand there. However, I think it's important to consider that working within institutions alone won't get us to our liberation. One of the underlying things that's important to contend with is, there's a difference between social change and social justice. Anyone who has heard me speak for longer than an hour has heard me say this. Social justice usually exists within the confines of the structure and usurps and waters down what grassroots work has shown to be necessary and important.

Village building, relationship building requires us to shatter the distance between personal and professional to a certain extent. Alliance building and reconnecting with yourself as a person in community, in line with what TL just articulated about the importance of honoring your humanity, is so important. If you're a therapist or social worker, but you don't have any grassroots engagement in your locale, I would ask: who are you working with collectively and collaboratively if you don't know your people? That's the first thing.

Organizing and positioning for actual power building so that when we are in communal space and doing radical imagination, where we're imagining what things can be like, we're playing an inside-outside game. Cool, cool, I'm going to write the notes as sparsely as possible, and I'm going to do the connection and heart work and deep communing with people in community. Last thing before I pass the mic, is the importance of not only embodiment to be able to access radical imagination – I had to take a bath to get back in myself and my body – and also this critical consciousness raising around having the eyes to see. How do we cultivate the eyes to see what's in front of us, rather than ruminating on what's happening on our phone and screens?

>> AZZA ALTIRAIFI: There is so much coming up for me now. I so, so appreciate what you shared, TL. I have to name, I am so honored to be on a panel with TL who is a teacher, close friend, and comrade and lives what was shared through action and words. Deep gratitude for those lessons. Over the past year and change, one thing that's really come through COVID being the extraordinarily catastrophic event it's been and the mass death and disablement it's generated. For those who know me well, you may see me move and speak differently. I am one of many disabled by long COVID and I'm trying to navigate and understand this new embodied experience.

One of the primary ways I've come to understand how these systems operate together is this. So much of the way we distinguish between disabilities, and what constitutes disabled and what doesn't constitute disabled as far as the state is concerned, is entirely tethered to one's productivity. If someone can be exploited through their capacity to produce wage labor in this routinized and time-regulated way in which the labor market is organized, then your disability status is not all that germane. All the state is concerned about is the accumulation of capital.

What is going to serve the interests of capital? If capital can be served through exploiting you as a worker, they will do that. The moment your disability starts to be something that cannot be accommodated, shaped, or fit into this routinized way that labor is organized, those people are shoved out of the labor market. They are institutionalized and become sites of extraction in surveillance of capital in those settings, or they are pathologized and incarcerated…where they become sites of exploitation in service of capital.

Those structures of confinement and incarceration are themselves tools of class war, ableism, and anti-Blackness, as are the ways people are facing the threat of death and violence in their workplaces, and why we're seeing a huge resurgence of labor militancy in this moment. It calls on us to really confront the fact that disability and ableism has to be central to any analysis of class struggle or what it takes to completely and totally abolish capitalism, address the undergirding structures of anti-Blackness that form the basis of systems of mental health, carcerality, and surveillance that we are gathered to talk about. I think those sorts of connections and how enmeshed those structures are became clear to me and especially radicalizing me as I've been navigating COVID and long COVID in my case in particular.

>> SELIMA JUMARALI: Thank you so much, Azza. You can see in the chat that people are feeling what you are saying. The energy is rising. I want to turn it back to you to ground us. What are some of the present-day dynamics that echo these historical roots of surveillance against mad, disabled, neurodivergent people. Just to bring us into how we can be clear about those parallels. As TL was saying, in this freedom journey, we are not starting from the beginning, we are building off of our ancestors' work. If you could comment on present day dynamics that echo historical surveillance.

>> AZZA ALTIRAIFI: Will do. Sometimes the pace of my speaking fluctuates. Please let me know if I'm going quickly for interpreting and access reasons.

>> SELIMA JUMARALI: Pause. I see that interpreter Erin has their hand up.

>> INTERPRETER: It's a reminder to watch your pace and be sure you are breathing into your words. It makes it more accessible for the interpreters and the folks listening as well.

>> SELIMA JUMARALI: Thank you for that reminder. Please go ahead, Azza.

>> AZZA ALTIRAIFI: I am echoing that gratitude. Thank you. To restate the question, tracing those historical roots that help us understand the context for the structures that we have today. I would start by first understanding the history of the development of medical authority and confinement in this country. They are very entangled.

If we go way back to the systems of chattel slavery that is one of the first systemized structural places where you see a few things happening. One, you see medical authority being used in order to justify and legitimize this brutal institution of chattel slavery. Folks may be familiar with "diagnoses" like drapetomania which was a manufactured description of an illness by someone named Samuel Cartwright that claimed Black people are predisposed to be enslaved and in servitude and if they had drapetomania it would make them want to escape their confinement, and that is disabling.

As a consequence, people were using medical authority as a way to try and justify the systems of oppression that were used to extract labor through violence and brutalization. Even after chattel slavery is formerly, for the most part, legally ended after the 13th amendment is ratified, you still see that practice. It is reproduced and replicated. You start to see that the development of medical authority becomes entangled with using these captive populations as a way to develop their understandings of medical diagnoses and how to form diagnostic criteria.

That understanding is important for recognizing the ways that hierarchy within the medical industrial complex is originated and reproduced and how it's entangled with the forms of oppression and sanism and ultimately the mass tools of surveillance that seek to encode and embed the social control function over people who are marginalized. The other piece that is important is the dimensions around labor that I was talking about earlier. You also see both during the period of chattel slavery and immediately afterwards, the development of something called "work therapy." The development of work therapy is happening at the same time that you begin to see this shift towards work as punishment.

I think there's a lot of research and understanding that people were moved into what was called a convict leasing program. That was such a contributor to the mass incarceration of Black and brown, poor and disabled folks who were in many ways even more vulnerable in a convict leasing program because people who are incarcerated are being leased out, they are having their labor extracted. There is no incentive to care about their well being because there is a consistent supply of labor through the program.

On the other hand there is also the development of these big asylums that are becoming mass warehousing institutions for anyone whose behaviors were deemed as not normative, anyone who engaged in struggle, or challenged the status quo, or on the margins of society etc. These people were institutionalized in huge numbers in these asylums that started implementing work therapy programs. People would be forced to labor and that labor would be described as having a therapeutic quality.

I bring that up because folks may have seen but there was a recent investigative project done by Reveal that looked at some 300 programs currently operating today that are “drug treatment” facilities for people with substance abuse disorders. Part of the program compels people to labor uncompensated. They describe the labor as having therapeutic value to justify their confinement and that extraction for profit. Some of that labor is done to maintain the institution itself, much as what we see in jails and prisons. A lot of it is done through contracts and used by Walmart, Avalon Bay for folks who may be familiar with their capture of housing, and other big companies like Exxon Mobil. Many benefit from the labor extracted by the people confined within these sorts of institutions.

It reveals how people are subject to these kinds of forces of incarceration, confinement, brutalization, in service of capital; how the development of medical authority in this country is entangled with that so that people within that system become agents of a broader effort by the state to exert control over marginalized groups, and particularly Black and Indigenous bodyminds; and how today the expansion of surveillance technologies, and the way that carceral logics are reproduced well beyond the walls of jails and prisons, is just a continuation of that history.

As we think about and are engaged in abolitionist struggle, and principled struggle, we have to contend with that past in order to make sure that the kinds of organizing and interventions we are pursuing do not simply replace one kind of authority for another, but instead totally transform our conditions, build power in our communities, and create systems and networks of care that are not built in hierarchy but on interdependence and the recognition of each of our inherent value and the recognition that those of us most impacted have wisdom that should be valued in the development of these networks of care and aid.

>> SELIMA JUMARALI: Thank you. I want to invite us all into a breath after what you just shared. Yes, we need to contend with the past. I want to pass to TL now to talk about the links between ableism, racism, and classism, and how they play out in the mental health system and how communities are resisting in the present day.

>> TALILA "TL" LEWIS: Hey. This is TL. I'm trying to figure out where to start. I'm going to start where I didn't want to start but I want to give concrete examples first, to help people associate the theory with what we are actually talking about. A lot of this is from the past, but I get into eugenics as present. Bear with me. I want to invite people to pay attention to the similarities, connections, and overlays between Black codes, Indian removal, and Indian appropriation acts; Jim Crow, public charge laws, unsightly beggar ordinances, anti-vagrancy laws, and convict leasing and vendue systems. I will drop a link in the chat because it's not a word that we actually use very frequently. One moment, please.

I only have access to hosts and panelists; I'll ask you all to share it beyond. I also want people to pay attention to the interchangeable and often indistinguishable sites where those people targeted by those laws and systems inevitably find themselves, often cyclically so. For examples, plantations were prisons. Pens. People were held in pens. Stockades, privately owned and operated homes, houses of correction (i.e. jails/prison). Poor houses, workhouses, poor farms, homeless shelters, asylums, county infirmaries, prison, prison hospitals, reservations, boarding and residential "schools," orphanages, and even the military among other places.

The stated purposes of these institutions and practices always include positive spins, like aid, treatment, cure, rehabilitation, correction, vocational skill development or proving, the list continues. All of these spaces are carceral, regardless of their euphemistic name or stated benevolent rationale or claim. And if we want to rhyme, anyone paying close attention can peep the game. Right? It's clear. The people in all of these places I just named, with the exception of the military, used to be called "inmates" in those spaces. The laws and practices and geographies and conditions of these purging places make it clear the aim has always been to maintain control over value-less, surplus, ungovernable populations and land to expand and protect white-colonial power and capital. That's where I'll begin.

I'm going to come back to my other beginning. In "america", people have come to understand most things through the lens of whiteness, wealth, colonial and imperial power systems. That makes it easy to dismiss and difficult to see oppressed people's humanity. I talk about humanity a lot. Humanity is particularly relevant here because so much of what disability actually is, is just humanity. So much of ableism is a humanity heist. Heist, it's theft. The theft of certain people's humanity, of those deemed unworthy, undesirable – Black, Indigenous, uncivil, and so on and so forth.

The maintenance of perpetual inequity and domination we experience on this stolen land requires a comprehensive and nimble and timeless approach. It has to prioritize, normalize, commodify, and obscure ableism and eugenics. To that end, settle colonizers have found an immortal accomplice in ableism. This is an ideology and practice that does the following six things for the interpreters sake:

(1) Continuously other-izes and devalues people and communities. (2) Creates dominant and subordinate groups. (3) Pits possessed and subjugated communities against each other. (4) Moves undetected and unnamed through and across communities, spaces – often confused with or named as some other oppression all together. (5) Leveraged to maintain widespread, "pre-ordained" inequity, ruling and violence. It can be used to justify any and all manner of commodification, pathologization, criminalization, extraction, and exploitation.

I'll wrap up because I know I'm close to time. I have to figure out the last thing to share. I think it is this. One way to think about ableism is having a patho-criminalizing function. I put together pathologizing and criminal, or criminalizing. You can switch the order if you prefer. Specifically in settler-colonizing, capitalist societies. The function of ableism in our societies is to nullify, objectify, and problematize – thing-ify – oppressed people to distract from the actual problem. That's capitalism, imperialism, authoritarianism, oppression, impoverishment, and the list continues. Ableism fashions the distraction that Toni Morrison warned us about – that keeps its objects perpetually clamoring towards an everlasting one-more-thing, to prove they are not nothing and not everything. They are just human.

Ableism compels the timeless, hallowed, haunting chorus: "Ain't I a woman? I am man. Black Lives Matter." Ableism is why Baldwin's equation rejected ableism when he told students in 1963, at the high school where his nephew went. He said: "The measure of one's dignity depends on one's estimation of one's self. It doesn't depend – as so many in this country seem to believe – on someone else's estimate." With that, I think I'll pause and invite someone else to share. Thank you.

>> SELIMA JUMARALI: Thank you, TL, that was a word. I'm breathing this all in and feeling it in my body. I invite us all to do the same. I don't think anyone could've put it better - ableism is a humanity heist, a theft. There are so many ways in which these past dynamics continue to cycle and recreate themselves to present day iterations, like you said, to assert control and uphold white settler colonialism. The patho-criminalizing function you describe makes me think of how mental health care is considered to be expanding and increasing access, and hiding the function of also increasing surveillance and control. Yana, can you talk about the rollout of 988 as an example of a border pattern of services that purports increasing access but still leads to confinement, control, and surveillance.

>> YANA CALOU: Thank you, Selima. As soon as TL said "patho-criminalizing", I thought about how suicidality enters the state penal codes and how individual mental illness instead of seeing it as a normal response to unlivable conditions gets both criminalization and pathologized at the same time. Super helpful framing.

I want to say, 988 is built as this effort to separate out mental health calls from 911. I don't think it's not well-intententioned to get care to more people. But we need to think about

what that care is to people. The answer to getting cops and 911 for a mental health response is not forced care, predicated on racialized, gendered, classed, and ableist notions of mental illness anyway. Before we dive into the carceral surveillance and privacy concerns of 988, I want to name that the mental health model relies on ignoring pain and that suicidality is a very normal response to not having what we need to be okay – culturally, spiritually, financially, emotionally. And they've needed to ignore and deny that response in order to subjugate, and treat us as just unwell people who are deserving of access to treatment. And to say "stigma" is actually the problem.

The field of suicidology is a place that really and critically produces and maintains sanism because I see, over and over, the ways that lived experience is repeatedly tokenized in the suicide prevention landscape where users of crisis services are just "unreliable narrators," and doing any kind of research on survivor's experiences of non-consensual intervention is labeled as: well, they were in a crisis so they don't know what was happening, or they can't say what this experience was like for them. Which is really the opposite of centering survivor experiences and what we want to happen and deserve to happen when we need support.

988's overall practices are very much in line with all crisis hotline practices in this country. The transition of 988 is important because of the funding that's attached to it. It's really just created a new number for people to call, rather than overhauling the system and funding for that number. The system that exists relies on non-consensual interventions. It fits into the system of trying to get people more care without focusing on actual prevention, and it carries out the state's paternalist response to saving lives, which means: someone else gets to decide what a crisis is, what risk is, what immediate danger is – rather than you.

It means a 72-hour hold, it means ER visits people can't afford, forced medications – many of which, when applied involuntarily, have been shown to increase suicide rates in the year post-discharge. So suicide prevention is not prevention, it's a patchwork of institutional responses that happen after-the-fact that don't actually get at why this is happening, and actually make this worse.

At Trans Lifeline, we struggle with the same things other hotlines deal with. There is no emergency infrastructure within the U.S. that we can actually rely on. The lack of non-carceral emergency infrastructure is not a crisis line's fault. All crisis lines, I believe, whether they're associated with police or not, want more emergency resources to support their callers with. In practice, 988 is not working to divest from police and 911. They're actually cementing it. If they wanted to divert calls from police, they wouldn't be doing what I'm about to tell you they're doing.

They're not working to end the harms of surveilling Black and Brown communities; they're expanding it. There's no such thing as a non-consensual interaction without that surveillance technology. The capacity to geolocate a caller is key. You can't send a cop to someone's job, or school, or home, or location if they don't tell you where that place is, unless you figure out where they are, without them telling you. Once someone else defines the crisis event itself for you, and imminent risk is defined by a person who is not in community with you or connected to you in the ways Shawna is talking about, and who has expertise that takes away from the person actually experiencing this. This is what is happening.

I want to clear up the confusion about surveillance technology on 988 because I'm watching crisis hotlines complain about all the misinformation out there circulating about call tracing and geolocation. Some say, we don't do this. But crisis hotlines have brought this about due to lack of transparency about the issue. Currently, 988 and crisis hotlines like Crisis Text Line and Trevor Project don't geolocate callers themselves, but they do geolocate callers through the process and thus engage in non consensual intervention. If they choose to engage in this, the hotline you call can provide a phone number or IP address, if you're chatting. The 911 safety point or center that corresponds with that center can get involved. But all the talking points are “we don’t geolocate.”

What’s important is that this year 988 has requested the expansion of the same surveillance technology as 911. You can watch the FCC hearing from this May, in which the heads of 988 and 911 claim that 911 is preparing for increased mental health calls due to 988. The head of 911 across the country claimed that 911 and 988 are married, and 988 does not exist without 911. But all the public talking points are saying it is diverting mental health calls from the police.

Our concerns about the data and its use and the privacy and the surveillance with literally one nonprofit getting the expansion of 911 surveillance technology without any stipulations or oversight about how the location data will be used, and without letting callers know that is happening, is pretty terrifying. That request is still sitting in the FCC and Congress. It hasn't happened yet. But what’s happening now is crisis hotlines are claiming not to geolocate, while still doing so in partnership with 911, and they are not being transparent about the fact that they have actually asked for it.

I want to thank the work of Rob Wipond, a Canadian journalist who has done a lot of the work on the transparency of lifeline calls that go to 911 and police. What's frustrating is that this is a taxpayer-funded program that isn't actually letting us know how the money is being spent, and how many calls are going to police each year.

Across crisis hotlines and tech services utilizing this we see agencies being removed from people and agencies saying it would discourage callers to have that transparency. We must listen to people who have survived interventions and what they are saying about what's helpful and what's harmful. We need a definition of safety that understands the clear harm and lack of effectiveness in carceral and criminal interventions.

Across crisis hotlines and tech services that utilize non consensual interventions, we are seeing these logics of sanism used to remove the agency of people seeking help. Agencies claim that transparency about those surveillance practices would discourage callers and stop people from getting help – and that’s the reason for taking away that transparency. We must listen to people who have survived those interventions and what they are actually saying about what is helpful and what is harmful. And we need a definition of safety that is an abolitionist definition of safety that understands the very clear harm and lack of effectiveness in carceral medical and criminal interventions.

Our current infrastructure of 911, EMS, fire, police, police-led crisis intervention teams, mobile crisis teams that just take the psych assessment to you and force you into psychiatric hospitalization – this is what is justifying broader surveillance to non-consensually intervene

faster. That is not what we need. It's not what trans people say we want, it's not what people of color are saying we want, or what disabled people say we want. Burying that information continues to erode this trust that the help we seek during crisis will actually be supportive.

I think that 988 funding could play a key role in demanding emergency infrastructure that doesn't rely on the police and forced hospitalization, and that those funds could actually divert calls from police by funding crisis support that does not work with police, rather than deepening that partnership with them and expanding the use of police surveillance technology for their own operations. We can demand a model of suicide prevention that starts with putting money into people's hands so we all have a safe place to live, free healthcare that centers our agency, good food, good water, and supportive schools. That's what makes people have lives that we can live.

At Trans Lifeline, we started the Safe Hotlines campaign during the pandemic to center this vision inspired by the work of Black organizers who mobilized after George Floyd's murder to lead movements to defund police departments and abolish family policing across the country. After two trans people were murdered by police this summer within weeks of each other in the midst of so called "mental health crises," Maddie Hofmann and Aaron Lynch, we are really interested in centering survivors and listening to the experiences of people who have been non consensually hospitalized because the logics of sanism don't allow those narrators to be reliable. If you want to share your story of experiencing a non-consensual intervention or if you want to sign the crisis caller bill of rights demanding the kinds of safety, agency, and transparency you would want during a time of need, you can find those links that are being shared. Part of what we are doing is learning more about survivor experiences. If you want to participate in a paid study with experiences using crisis hotlines or non-consensual you can participate in this. I'll also share my contact information so people can get in touch. Thank you so much.

>> SELIMA JUMARALI: Thank you. I know Yana from this study that they are just describing. We really want to learn about people's experiences. I will be doing my dissertation study on the psychiatric hospitalization experiences among LGBTQ people of color in hopes to advocate for the need for alternatives. This is a perfect segue to turn to you, Idil, to talk about the role that academic institutions and research can play in expanding surveillance and control, and how these academic systems intersect with others to reinforce the carceral state.

>> IDIL ABDILLAHI: Thank you so much, this is a great question. I think there are a few prongs that we have to take up. One of the first prongs for me is the idea that in general, students who are experiencing mental health issues and/or other disability-related issues have to register and let an institution know that that is their lived experience in order to get access within the classroom space. I think about that, again in the context of being in so-Canada, and what that means in an institutional-academic relationship.

For me, and probably for many disability justice scholars and sanism scholars and people who support individuals that are living in those situations, we all know that ultimately we don't all have the same access in order to request access from an institution. If you have a history of being one of the people that Azza described in the history of mental health from the foundational perspectives of pathology and race, to go into what TL described around class and broader ideas of ableism, to then go into responses of what Shawna shared in terms of how practitioners respond, and then when Yana described in terms of the community responses.

When we think about all of these relationships, it also is based on a particular disclosure of our health status that institutions ultimately don't require. Right?

If we think about it from the vintage point that I speak from, in the Canadian context in Ontario, in Toronto specifically, there are particular kinds of legislative and policy initiatives that suggest students shouldn't have to disclose certain things in order to get access and space in a classroom. When I think about the first relationship with academia, I think about how we treat the individuals that show up in our spaces and in our classroom. How do we let them know that they are allowed? That they are supposed to be, and that the space that we garner in order to teach them “help other people,” how do we enact or embody that in those educational and teaching spaces in a way that is fundamentally helpful to the broader wellbeing of individuals? That means queer trans individuals, Black individuals, Indigenous individuals, people living with mental health issues and so forth.

We know that institutions are here to police, to discipline, and to have people act and respond in spaces, places, and ways that we expect as appropriate. From the front end position, I think about what we expect students to do to get access in a classroom. In and of itself that is extremely colonial, extremely carceral, and problematic. Then I think about the other cases around all of the discipline. Psych discipline, social work, psychology, occupational health, I could go on. Nursing, nutrition. They tell us that racialized people, Black people, fat people, poor people, people without access, are the actual pathology that we are supposed to correct. These are inherent.

I want to go back to what Azza described as poor houses. If you are not able to be a commodity within systems, what does that mean for the systems that are supposed to produce how we understand the individual. When I go into the idea of research, ultimately, when we are in disciplines are to correct. Right? The idea is that we are to make something better; to make people whole and to not be unwell. When we think about the context in which our studies are designed, the expectation is we are looking to find a cause and effect. If we give you the 988 or the 119 number in the Canadian context, we assume that is supposed to alleviate or do something differently.

I will touch briefly on some of what Yana said, which isn’t the academic piece but I think it's important to speak to. In the Canadian context, we spoke about post-George Floyd. What do we do with these types of calls? People talked about redirecting those calls to mental health service providers. Except it was still a 911 call. Ultimately, it is the police who get to determine the risk and the severity of that call. If a person is having a mental health call and there's a weapon involved, for example, irrespective of who you call – if there’s a knife, pair of scissors, or plastic fork involved – that is a 911 call, regardless of having called the other number. Not only that but historically, in the Canadian context these aren't new numbers to call.

Like Shawna described, social work outworks itself all the time. It has peer workers, which in and of itself is its own problem. The academy helped create the idea of a peer worker. That's important to talk about. The peer worker is never the person with the “worst clinical diagnosis.” Right? I'm using air quotes on the screen. It is not the person that has “particular kinds of criminal charges,” which then allows them to be a participant in society in a particular kind of way.

We think about the academy, we think about remedies to academic problems, disciplinary problems, and not life problems. When we come back to what is the issue on some of these calls, like I said earlier in the introduction, how do you feel about the response and carcerality to mental health in this time? My response to that is I feel like what we have to ultimately think about is: what happens when we are asking individuals to respond to mental health issues, yet that's not actually what we are asking people to respond to. We are asking them to respond to a kind of out-of-order-ness. Rankness. It's a kind of madness. Right?

For many people, Black people, queer people, Indigenous people, trans people, we don't understand these things as everyday life responses to what's happening around individuals. What we do, rather, is say, “is it the pandemic causing this? Is it a life experience causing this?” When people want to end or complete their lives by virtue of something horrible happening – or are there some of us that live passively with suicidal ideation every day for all of our lives? For many people living with those experiences and mental health issues every day, you are having a 911 call every day – in the Canadian context, that means you're having a criminal offense every day. Suicidality is illegal, it is a criminal offense.

So if you're feeling every day like you can't go on any longer and call a hotline – whether it’s 119, 988 – the idea of that is that there's still a logic saying, “you shouldn't be having this particular experience you're having.” How do we take up the ails of social and political life that have us make those responses? And what are we tallying? What kinds of data are we collecting? The data of the call to the hotline, or are we actually collecting and assessing the impact of the pain and trauma individuals are feeling that lead them to make that call?

When I talk about the prescription of pathology and incarceration, that is the everyday life for those of us toiling and experiencing a certain kind of trauma. There is tabulation and calculation. They're often collecting neo-liberal interventions to what these experiences are, but not the reality of what those experiences are. If they did, it would say, nobody wants to call 911. If your cousin, sister, mother, brother, and partner could actually contact another number and not have their entire embodiment and life taken apart, then they would.

But it is those of us who are being seduced by these ultimately reformist ideas that we're all on the call seeking to refuse. We don't want these things, right? Ultimately, in my Canadian context, wanting to end your life can get you a sentence. That's the thing. I want to insert this context. I think it’s important. That’s the thing. When you call for support for your family member and they end up dying; when you seek support for a family member and you're scared because you don't know what will happen to them, the truth is that call will lead to incarceration. And then add in what my panelists have talked about in terms of class, race, intersected ability, ableism, etc. etc.

We have to acknowledge the carceral and pathology relationships across all disciplines and fields. We also have to acknowledge how the academy reproduces its own police. In certain institutions, you're supposed to report your colleague when they come to work unkempt or disorganized on the job or appearing to exhibit behaviors like this. So we're normalizing a particular type of carcerality in these interactions. We know where those end up and lie. People whose hair can’t rest back or be flattened enough, people who don’t smile enough, people who look different, people whose gender expression lands differently in those institutions.

I see one minute left. Ultimately: We don't need more data. We know what happens to people living with mental health issues. We know what happens to Black and Indiegnous people. We know what happens when people end up incarcerated in systems. We need to think about why we demand more data while people are experiencing damage in their everyday lives. Right? We have the answers, we need to do something differently. That is the actual urgency that is before us. I'll end there.

>> SELIMA JUMARALI: Thank you so much. I'm so sorry to have to call time. I want to hear more and talk about more, and I also want to get to hear from Shawna. You're right; we don't need any more data. The information is there and has been passed on for generations. We don't have to rely on the white supremacist written data to tell us what's true. Let's now learn what liberation healing looks like.

>> SHAWNA MURRAY-BROWNE: Thank you. I am full! I am writing copious notes here. I will be taking breaths throughout because I do speak fast.

A few things I'd like to share and will put forth in sections to help me and everyone else. I want to start with points and decision making that therapists, practitioners, caseworkers, "mandated reporters" – decision points where we invite surveillance in and we have decisions to make. It's required for us to be thoughtful. I will then respond to a comment made long ago, a question in the chat that was specific to the "narrative" of mandated reporters. I will speak to that directly because I think it's necessary for this conversation. Then I hope to share an example of how we might utilize some of the tenets of liberation-focused healing, a framework I've created in alignment with generations of wisdom of folks across the country and world, and into a praxis. We'll see how I do; I'll try! Stay with me.

I think it's important to get really grounded in where we are making decisions about inviting in surveillance and where it lies. This is true, both inside systems where we are enacting harm reductionist practices. That is super important. It's also true in outside systems – is that a thing? Outside of working with institutions where we might still be under some control. That's licensed professionals that might be navigating spaces. Then we have folks who may decide to completely relinquish their affiliation with licensure because they are working with abolition. When someone steps into the role as a professional, they are connecting themselves from community. It requires us to have to "other" "those we serve." That is why there are certain outlines around self-disclosure, which gets in the way of deep connection. So bearing this in mind, dance with me.

First, I have to contend with myself and how I receive information. For example, if I'm at a supermarket and there is a a person who is clearly frustrated, maybe knocking things over, and someone in the building knows I'm there, who I am, and knows I'm a social worker. I'm required to participate in the carcerality of our systems by reporting. So there's information I have to assess in myself, and that's my positioning as me, myself, an abolitionist, a Black woman, and a social worker who's licensed.

Second, all practitioners need to be super clear about the difference between the code of conduct that guides work, and the "code of ethics." Why is this important? Those two things are not the same. The code of ethics informs how a social worker or professional – and I'm speaking as a social worker in a field of many other care providers – the code of ethics guide

tells me what's expected of me to be able to call myself a social worker without getting in any trouble. The code of conduct is all about legality. That means if I don't follow things in the code of conduct instructions, I could have my license revoked. Or, if I don't act in alignment with my particular code of conduct, I could be punished. To make that clear, the carceral system impacts those of us on the receiving end of services, but also those who are navigating, serving, and offering up services. I can't go into all of this, but I want to label it for eyes to see.

Three, insurance. In order to make your services “accessible,” you get on insurance panels. But what kind of information is being gathered there? To be able to offer certain services and support in a therapeutic setting, if someone is taking insurance, they have to be diagnosed and get a label, while information on you is also being reported to a larger system. I'm not as versed as Yana in all the multiplicity of ways surveillance works, but this is a large data system that feeds the medical industrial complex, that guides and supports, and can be accessed.

The daily decisions that practitioners make around referrals. Say I'm someone's therapist and I decide they need “anger management.” Maybe this is mandated. I have to make a decision. Will I send them to the hospital where an anger management program is being provided, or will I call on the grassroots organization that has certain things offered already to support this person holistically? That requires a certain level of community connection.

Five, notes and records. The mantra in the human service sector is, “if it's not written down it didn't happen.” That is, we're supposed to write down everything that's stated and if we don't, we could be penalized. If we need support – I used to work in a residential treatment center. If I need support for my “client” (a term I don't like but using now), I need to justify the recommendation for the support by noting things in my records. These are the same records that can be pulled years later. I served folks as youth who later ended up in the adult prison system, and they still cite notes from when they were in my care.

The last thing is the day to day decision making. Who are we communicating with? In the chat someone put “medical necessity.” We have this burden of proof. I put that as a frame as I go to this explanation. Why won't practitioners decide not to participate in mandated reporting? The question was whether we need to illuminate the mandated reporting narrative. First thing there is, it is not a narrative. I wrote here: mandatory reporting is the illusion of power for the practitioner to have over the people. It's illusory in the way we might feel if a police officer is in the space. It's also an illusion of power for the practitioner themselves. It is the manifestation of the creation of separation. If I'm a mandated reporter and you're not, if you do something I have to let you know that I have the ability to report.

>> SELIMA JUMARALI: I want to remind you to breathe as you're talking.

>> SHAWNA MURRAY-BROWNE: You're right. Thanks for that.

The last thing is that it is not a narrative. It is a guideline. As a social worker who decides to maintain my license, it is something that hangs over my head day to day. There are a few things I want to invite us as a collective, and as practitioners, to contend with about how we can navigate this space that really has an impact on anyone's livelihood. If I didn't have my license, you probably wouldn't know who I was. I wouldn't be able to eat. I would not have access to certain resources. My skills might not be acknowledged within the space that I currently work.

That is not to say that people who divest from licensure do not have those things, but for me and my line of work at the intersection of liberation and reform, I need my license in order to have a voice in those spaces. Likewise many folks need some support in those spaces.

The liberation-focused healing framework is a framework that came out of me seeking to navigate the child welfare system, working in sex abuse investigations, of being really irritated in school as a MSW and presently as a doctoral candidate. It is something that I first embodied, and then when my community called me to share what I was doing, I created the framework to articulate my day to day decision-making. I will share some components and some ways we might apply it. I might not be able to share all of it. I do provide a full fledged training that Selima mentioned earlier. That is Decolonizing Therapy for Black Folks. Next month, we'll have open enrollment. I'll make sure you all have the link.

The major tenets of the framework are informed by through Black radical tradition; by liberation psychology; by African-centered psychology, and by concepts of social identity developmental; and by wisdoms of ancient and traditional healing technology. What it would require – I was thinking of someone I hold dear that I held space for when he was 16 in a residential treatment center. We'll call him Tristan. Tristan lived in Baltimore. His mom struggled with addiction. He often got in fights in school and was found selling drugs on the corner in the city of Baltimore.

His introduction to surveillance happened at both sites: the school system with the social worker and the police on the corner in the neighborhood where he lived. After several incidents where they were tracking him – talking to his grandma, trying to address these things – he was eventually arrested. They moved him into a residential treatment center. They stated that he could not be managed safely in the home. In my care it looked like this for Tristan. He went to a school for residential treatment and I was his therapist. He would often break things. He would throw things at the white folks in the system. I would be called to de-escalate. Some of the decision-making I had to make is an example of liberation-focused thinking within a system.

Here's an example. Basically there was a way that he had to navigate himself in order to get permission to go home, to leave the location. I would allow a space for the use of hip hop and writing in the therapeutic space, our private space. He could cuss, he could scream. I had a pillow with boxing gloves that he could hit as long as we had understanding about what was considered safe and allowable. That is an example of utilizing his own cultural orientation to support him and put his own experiences into words.

As he was able to engage in those spaces, it was important for me to connect his grandma to grassroots political organizing outside of the institution. I might be advocating for Tristan inside the institution, but I needed grandma to be able to cultivate the political prowess to advocate for herself and her grandson out of the institution. I encouraged her so that she could raise her own critical consciousness. The only thing I'll add because I'm pretty sure I'm out of time, it is super important that practitioners do this rooted village cultivation. That is a tenet in the framework. That is when you connect with your people in community. Not as a volunteer, not as a helper. Not “Hi, my name is Shawna Murray-Browne, LCSW-C,” but as a genuine connection with folks in communion. To learn more about that, connect with me later.

>> SELIMA JUMARALI: Thank you so much, Shawna. I highly encourage people to check out Therapy that Liberates and Decolonizing Therapy for Black Folks. It is enlightening and heartening as someone working within systems. I think it's also helpful for those working outside of systems. I'm super conscious of time and want to honor the closing time that we've promised you all. Saying out loud to panelists, we will skip the last couple of questions and move into closing.

I invite all of the panelists and our audience members and community to share if there are any people, movement, art, music, or stories that you would like to uplift as we close this space. Please drop it in the chat. I will pass it to Jessie to share some exciting news of a new series being launched by IDHA. I want to extend deep gratitude to everyone here this evening, to the organizers and facilitators, and please stay tuned for Jessie's exciting announcement. Thank you all.

>> JESSIE ROTH: Thank you Selima and thank you everyone for the conversation. It's a lot to think about. I'm definitely feeling pushed up against time but I'm looking forward to keeping the conversation going and saving the comments I see coming in from the panelists here. If we could put up a slide, we do have a really exciting announcement if folks have a couple of minutes. Let's pause while we wait for it to come up. I'm seeing the gratitude and energy in the chat. Thank you. Great.

I'm really excited to share that we have just launched IDHA's fall 2022 and spring 2023 virtual training series. I want to uplift a whole lot of gratitude to the training community at IDHA who put in so much love, intention, and care to make this series possible. Crossroads of Crisis: Dreams & Strategies for Collective Care. You can visit the link in the chat. Part of the reason I'm excited to share this is that a lot of the threads from tonight are going to continue to be woven into this series over the next 8 months. It is the longest virtual series we have organized. We'll go from November to June. To read a few themes, we have the Crisis Industry, Building Communities to Meet Crisis, Creating a Crisis Toolkit, Re-Orienting to Emergency, and a lived experience showcase at the end. I want to keep this brief but I want to share the excitement because we are building a web.

The links are in the chat. Registration is open and will be open on a rolling basis. The first class is November 13. That said, we have a really exciting early bird special. Because the class is so long, we wanted to give you registration options. We are offering early bird for the first time. You can save an additional 10% on a full series registration by using the code EARLY10. That is going for the next week. You can also tap into a bundle of self-paced courses from our last two series if you're interested.

This is a preview. Crisis as Catalyst had classes like Grounding in Grief, Making Sanctuary as Decolonial Practice, and Ancestral Healing. You can have them included if you tap the early bird. We just finished adapting our spring 2022 series, Cultivating Community. You can get those included as well. I think the details will be in the chat for you. Just a final note now to say that a lot of thought and care has gone into creating this. We would be super honored to have you join us for part or the entire series. We designed it intentionally as a series and it will be a beautiful, rich learning journey from now into next summer. With that I think there's one more slide.

In terms of event follow-up, you'll get a follow-up email from us in the next couple of days with the recording of this event, links from the chat, including resources you have shared to further enrich our conversation here, and ways to stay in touch with IDHA and your panelists. You can tag us on social media and follow us. In closing, you can take down this slide. I want to mention again, the gratitude. I encourage you to turn your video on if you can. Thank you to Selima for moderating this rich, rich conversation. Thank you to the panelists, I will be thinking about this for a long time. Thank you to the access team of ASL interpreters and captioners. The organizers of the Decarcerating Care Committee – and all of you. It's beautiful to see the ongoing conversations of the past few years. An invitation to stay in dialogue and community with you all. ‘Til next time, thank you.