Institute for the Development of Human Arts

Decarcerating Care: Taking Policing out of Mental Health Crisis Response
September 14, 2020

Closed Captions Transcript

>>JESSIE ROTH: Hi everybody. I'm Jessie Roth, the co-director of the Institute for the Development of Human Arts. I'm going to give you a quick couple of intro slides here before we kick off the discussion. Thank you so much everybody for joining us.

We have been really blown away by the response to this event and now we are honored to have I think close to a 1,000 people joining us. I wanted to start by doing a quick visual description of myself. I'm a white woman with brown hair, I have my hair in a bun, wearing headphones, and sitting with a couple of my houseplants behind me.

So welcome to Decarcerating Care, taking policing out of mental health crisis response. And just to tell you a little bit about the Institute to kick ourselves off here. We are a community of current and prior mental health service users and survivors, psychiatrists, psychologists and other clinicians, as well as activists and artists who have all come together with the goal of transforming mental health care. We do this through collaborative education and community development, through events like this, with the goal of advancing critical, effective and scalable alternative approaches to mental health.

What makes IDHA unique is the way we integrate both experiential knowledge and academic knowledge, challenging the idea that only those who work in the field of mental health, or as professionals, are the experts. With the goal of shifting power dynamics that traditionally privileges professional experience. There is an image here on the screen of one of our members giving a speech at a conference for peer specialists in New York City.

A couple of community agreements for this evening. The first is shared expertise and wisdom. So, we acknowledge that everyone brings their own expertise to this conversation and that we can all gain from and respect each other's various expertise. The second is collective liberation. So, 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 we are as people. And finally, we listen like allies. We respect a wide diversity of choices and perspectives, even when we disagree, and we don't judge or invalidate anybody else's experience.

A couple of quick notes on accessibility. We do have closed captioning available so in your webinar view you can click the closed caption button, there is a screenshot to show you where that is located. We also are joined by two ASL interpreters who will be swapping out throughout the event. And finally, wherever possible we aimed to provide visual descriptions like a did at the beginning.

>>ASL INTERPRETER ANDREW TOLMAN: This is Andrew, one of the ASL interpreters. I'm seeing a lot of comments that are saying that the ASL interpreters are not visible currently and I've explained how to pin it, but a lot of people are saying they cannot see yet. So, I want to assure we can double check that before moving forward.

>>JESSIE ROTH: Sure. So -- let's see. So people can see the interpreters now that I've stopped sharing my screen. I will just leave the interpreters visible, I will just read the last couple of quick notes. We are almost through the slides anyway.

The first is that we are recording this event, as you can see, and we will share with the registrants later. Please feel free to submit any questions you have for the panelists using the chat, you can also use the chat to share any thoughts and reactions. We likely will not get to all questions this evening but we will save the chat and hope to engage with the content on an ongoing basis.

The way tonight will work as I'm about to pass over to our moderator for the evening, Noah Gokul, an IDHA member and the moderator for the evening. Then we will hear from our amazing panelists and dive into a discussion. So once again thanks so much everybody for joining us.

>>NOAH GOKUL: Thank you so much Jessie and wow, we are at 1,000 people that feels very historic. My name is Noah Gokul, I use he/him pronouns. I'm a young Brown man of Indo Caribbean and white descent, wearing a black shirt and a white turtleneck underneath. My hair is up in a bun, I have a green bun and behind me I have my work and keyboard.

I really want to welcome everyone to our event Decarcerating Care, taking policing out of mental health care. It is such an honor to moderate this panel of such terrific folks. I want to thank all the folks, particularly all the IDHA folks and co-organizers of this event: Sascha DuBrul, Jessie Roth. We put a lot of love, time, and energy into this event to make this happen. I really want to thank our esteemed panelists who are giving us a range of perspectives on how to create community-based alternatives to cops.

I'm going to read a little bit about our event and ground us. Having this range of perspectives and embracing complexity aligns with the intentions of IDHA. I want you to know that the people who put this event together are coming from a place of love and care. Care for our communities, care for ourselves, and care for our world. And part of that care looks like justice for those who have not been cared for, and it looks like a transformation of what care

looks like. Taking policing out of mental health crisis response means understanding that the mental health care system has its own form of policing people's bodies and minds and it has been used to exert control over Black bodies, not unlike the prison system.

Caring for distressed individuals is not handcuffing people and putting them in hospitals and other confined spaces and labeling them disordered. I'm sitting here in Portland, Oregon, right now, a town filled with smoke from increasing wildfires, rampant police violence on protesters, in the middle of a pandemic with so many struggling people. So we have to be really clear that crisis is way more complex than a disease or disorder. And people in crisis reflect a world that is in crisis.

We are deeply inspired by the Black Lives Matter movement and the subsequent calls to defund the police. Within the conversation of reallocating funds toward mental health, there are a ton of people and experiences that are so often left out. And those who know the carceral nature of our mental health care system. And today we bring in some of those voices.

So I will just have our panelists introduce themselves. I'm really really excited to have them on this. I'm going to start off with Stefanie who is a really really brilliant mind in this topic. And then we will go in order of Stefanie, Asantewaa, Tim, Stella, and then Neil. I will let Stefanie join us, thank you all for joining.

>>STEFANIE LYN KAUFMAN-MTHIMKHULU: Thank you Noah. Hi everyone, thank you for being here. My name is Stefanie, I use she/they pronouns, and for a visual description I'm a white femme-ish presenting person with dark blonde hair, some facial piercings, and I have a blue T-shirt on that says ‘the future is accessible.’ My favorite. Little bit about me, I am a queer, gender-queer, disabled, mad, autistic, neurodivergent psych survivor. With a lived experience of psychiatric incarceration, specifically for the purposes of this panel, so coming to this really as a peer. Someone who is providing support and advocacy services for others but also having that same lived experience myself.

Some of y’all also may know me from Project LETS, I’m the director Project LETS and we are a national grassroots organization led by and for folks who have lived experience with what is called mental illness, madness, disability, trauma, and neurodivergence. Our focus at Project LETS is building transformative peer support collectives and community mental health care structures that exist outside of, and do not depend on, state-sanctioned systems of quote “care.” Which we know really replicate a lot of the very violent aspects of the prison-industrial complex, and are trapping our folks inside of the systems that are meant to cage and kill us. So with multiply-marginalized folks and communities to provide access, political education, and the resources we need to survive and thrive.

I'm really excited to be here in this conversation today. Personally, I've had a lot of lived experiences with the conflation of treatment and punishments, which I think we will talk about today. And just the pathologization of very logical responses to harm and violence, and things that are happening in our world that then become disordered within us. I think a lot of our panelists have similar experiences with that, so I’m excited to talk about that. As well as some pretty harmful experiences, losing my bodily autonomy and my self-determination. I've experienced police brutality, and as I mentioned incarceration and forced medication. So I'm really committed and dedicated to building these alternative systems that are based in mutuality

and respect, and am excited to hear my brilliant badass panelists talk about all of this more today. I will pass it onto the next person. Thank you all for having me and thanks to IDHA for organizing this event.

>>ASANTEWAA BOYKIN: Hello my name is Asantewaa. Pronouns she/her/hers. I am the daughter of Valerie Boykin and the granddaughter of Bertha Brandy. I'm wearing a gray shirt and some really neat bantu knots in my hair. I'm also one of the co-founders of the Anti-Police Terror Project and a founder of Mental Health First, which is a mobile crisis response team that is independent of police. I hope what I can bring to the conversation is the introduction of new ideas around what these systems look like. I think our job now is to divest from the systems, while simultaneously building our own systems. So I hope to bring those ideas here to this table. I'm also an ER nurse and I've worked in inpatient psychiatric care for a decade or more.

>>TIM BLACK: My name is Tim, I use he/him/his pronouns. I'm a white male wearing some glasses, I have a brown and black plaid shirt on, and behind me is a white wall with some framed pictures and a couple of jackets hanging up. I came to work with the CAHOOTS mobile crisis response program in Eugene Oregon in 2010, where I served as a crisis worker for about five years before transitioning to a role as the administrator of the program.

In addition to the work in the field as part of that mobile crisis response, I also have several family members who have been touched by substance use and abuse as well as mental health. I myself have come in today to this conversation with lived experience, specifically around PTSD. This is a really exciting opportunity to engage in a conversation with a lot of different perspectives, and similar and different to Asantewaa, CAHOOTS is a mobile crisis program. But we are integrated into the public safety system, so there's going to be some really – I'm just really excited to talk about it.

But as we really look at what Public Safety means without enforcement, we need to be looking at: what are the types of first responses that we can bring in that are going to be able to respond to crises? That are going to be able to respond to the underlying issues that allow that crisis to exist in a community? And the way we've been approaching it across the US has not been working and so part of my work is I talk to cities across the US about how they can really transform their crisis response and really evaluate where that fits in, whether that works with existing systems or not. This is just a tremendously powerful conversation to be having. Thanks for this opportunity tonight.

>>NOAH GOKUL: Thank you Tim. Can we hear from Stella?

>>STELLA AKUA MENSAH: Hi. Can folks hear me? Hi my name is Stella Akua Mensah. My pronouns are she/her/hers, and I am a Chicago-born peer support specialist, writer, artist, performer, transformative justice advocate, and psychiatric survivor. I am a Black light-skinned, half-white woman with short, brown hair and a green and red button up, in a room with many things on the wall behind me, colorful little items, and some yellow curtains. And I'm so thrilled to be here, it’s extremely exciting.

A little bit more about me. Like I said, I'm a peer support specialist so at the moment, I primarily work with homeless women in Boston, that's where I'm currently based. So I provide peer support-based advocacy, largely drawing on my experiences as a multiple trauma survivor,

psychiatric survivor, a person who has briefly experienced homelessness actually immediately following my psychiatric incarceration some years back. And I also serve as an advocate for folks that I support as they navigate the very terrible and carceral systems that extend also to shelter, which I think is also sometimes left out of the conversation – the carceral nature of homeless shelters as well.

My background largely in regards to peer support and my advocacy and activist work, that element of my life, is largely in transformative justice. So I started an initiative at Brown University, where he graduated in 2017, transformative justice was a very lifesaving framework for me and really is at the root of most of what I do and think about. And really to me is like my sort of pathway to liberation. So in addition to those things, I'm a writer and artist at the intersection of memoir and political thought, as well as magical realism and other forms of creative writing.

So in terms of being on this panel today, like I said I'm a psychiatric survivor. This might be a term some folks are familiar with, it's a word that I use that a lot of folks used to describe themselves indicating that I've survived psychiatric torture and abuse. And in my case also sexual assault within psychiatric incarceration settings, forced drugging, various forms of torture. And as a result, I'm very personally attached to this cause. And truly as an abolitionist, I think that psychiatric abolition needs to be also at the center of our conversations as I don't think that psychiatry and psychiatric abuse are really – it's really like a sister issue or system to police and prisons. I really think that actually is more of a subcategory of police and prisons and all of these are examples of state-controlled. And I'm really thrilled to be having this conversation. Thank you.

>>NOAH GOKUL: Thank you so much Stella. And last but not least...

>>NEIL GONG: Hi everybody my name is Neil Gong. Thanks so much to IDHA for having me and all of you for being here, this is such an important conversation we are having. I use he/him pronouns. For visual description, I'm an Asian-American man with long black hair and a beard, wearing a maroon shirt, set against a yellow wall behind me. I am also showing off my face mask from the Mission Graduate Employees Organization. The graduate students are on strike right now. I'm sitting in solidarity with them, I'm a sociologist at the University of Michigan. They are striking now for both a healthy campus reopening, and also a remaking of the campus relationship with police.

I'm an academic, I do research and I teach and I research community mental health care and inequality. I'm currently writing a book that looks at intensive community mental health services for the rich and the poor in Los Angeles. Which means I spend a lot of time shadowing case management teams, public mental health services, and the public safety net and then looking on the other side of town at elite services for wealthy people and what that means.

Another part of my research is on the history of psychiatric care in the United States and specifically psychiatric deinstitutionalization. So how we went from a system that locked people up in state hospitals to one that often abandons vulnerable people to the streets or locks them up in jails. And this is probably what I'll most be focusing on today, addressing some lessons that history holds for our current moment. Because that is a history of activists and policymakers successfully defunding an oppressive system, but not actually getting the promised

reinvestment in community resources and care. I think this is very important to think through and think with, as we try to remake systems today learning us both to opportunities and some pitfalls as we work to reallocate police funding.

I have a recent piece on this, linked on the webpage called “How defunding abusive institutions go wrong, and how we can do it right.” It’s in the LA Review of Books. I came to this work mostly because of bad experiences friends and family had with mental healthcare, either being ignored and not having access to care, or getting treatment that messed people up more. For a long time, I thought my role in this would be becoming a clinician. After college I worked a brief time on a community mental health and housing team in New York City. And I was just continually amazed at how broken the system was and I had all these questions. Why are so many people with psychiatric disabilities precariously housed or coming off the streets? Why are so many people locked up in jail and how did we get here?

Part of this I had already been questioning after working with the Icarus Project, a radical peer-based mental health support network, and they exposed me to ideas from the mad pride movement, psychiatric survivors’ movement, and other attempts to rethink what it is we are talking about when we talk about mental illness or madness, or psychiatric disability. And between the experiences working in this broken public system and working with groups like the Icarus Project, I realized I was more interested in and better suited to try to address these more systems-level issues than becoming a therapist. So that is how I ended up as a sociologist working on these issues. So I will mostly be talking about the historical roots of some policy failures related to de-institutionalization, and how that may inform what we do today. Glad to be here.

>>NOAH GOKUL: Thanks to all our panelists. I really just want to highlight again the diverse perspectives everybody is coming with here that really is going to show the complexity of the topic that we are talking about today. So I just want to get into it and start with this first question.

I've been on webinars that are on this topic of replacing mental health care with cops. And so, we are going to really identify the question: what is left out of the mainstream narrative about social workers replacing cops? What is left out of this conversation when we talk about this? I'm definitely calling on Stefanie, Stella, and Neil who may have thought about this question and have interesting things to share. Feel free to jump in whoever wants to start.

>>STELLA AKUA MENSAH: This is Stella speaking if it's alright if I jump in. So as a neurodivergent abolitionist, I fundamentally think when we talk about the evolution away from police involvement in mental health crisis response, I think fundamentally we really need to accept before any other work that we can do, to really transform what is happening. We need to accept the history of psychiatry and social work as tools of social control. It is so important for us to educate ourselves and each other and challenge ourselves and each other to see that it is not really a reductive way to describe psychiatry and social work honestly.

If we look at diagnoses like drapetomania, basically it was a diagnosis in antebellum slavery to describe Black enslaved folks who wanted to run away. So it is a diagnosis explaining the mental disease that was quote unquote “going on” that could possibly compel a Black enslaved person to want to run away from their torture camp. I think it's important to keep in

mind that this was not that long ago. And I think we often do this thing in our culture and in systems of mental health and also how we view the world and view healthcare, where we are like that was a long time ago, then there was a period of the asylum, and then there is now. And these are utterly separate eras and periods of time.

And I think when we think about psychiatry, we need to look back to those kinds of diagnoses and understand the foundation of something is extremely relevant to its current functioning. It is inextricably valid and not only relevant, but fundamental. If we think about the torturous nature of the asylum, which we can all pretty much get on the same page about, and then bring it to the present.

Think about the mounds of anecdotal and quantitative evidence about people's current experiences, both on psych wards and in appointment-based relationships with social workers and other therapists. We can see there is a base level desire to control, correct, drug, discard and even torture those at the bottom of the social hierarchies created by white supremacy and colonialism. And the element of torture, correction, drugging, discarding – they are not accidental byproducts, or incidental byproducts of, or casualties I guess, accidents within attempts to care. It's important for us to challenge ourselves to see that maybe this is at the core of the intention of the systems. So I think when we accept this is not only our history but are our current reality. The asylum is not dead. There are tons of us, myself included, psychiatric survivors who have experienced torture on psych wards that is akin to the torture experienced in asylums.

I wish I could say that we were beyond that but we just are not. And I think it is valid for folks who have good experiences on psych wards to describe those experiences in their own language. That is very necessary and vital. I also think we need to prioritize these stories. If we accept this is our current reality, we can see that psychiatrists and those in alignment with psychiatry are police officers of a slightly different form. And I think something that is helpful in seeing how this is the case is thinking about how we are now addressing systemic racism and white guilt in the mainstream. This is a tiny bit more accessible to folks now at the current moment during the uprising that is occurring. That is very vital. And inevitable.

If people can accept, and I'm seeing a lot of people around me accepting that even though antebellum slavery happened a long time ago, kind of, not that long ago, but happened a significant amount of time ago, its ramifications are still rampant systemically and in our psyches especially in the psyches of white people, in a way that requires ongoing lifelong work. Then I don't see why we cannot extend that same logic to the reality that psychiatry's torturous and eugenicist roots are still systemically rampant and present in our psyches in ways that require ongoing lifelong work to unlearn and dismantle.

And I think that culturally, we make a lot of excuses and qualifications for psychiatric quote unquote "treatment." As opposed to something like systemic racism. And I think we really need to understand that, or challenge ourselves to see that systemic ableism, eugenics, asylums, thinking, is in our psyche. We have to unlearn it. That takes rigorous work in the same way that white people learning white supremacy that is internalized takes rigorous work.

And then coming back to the question of social workers, at its core, being involved. I think that social workers, I don't think it's a stretch to say that social workers are already kind of

a form of police and that isn't to say that there are not good ones. I think there is more potential for a social worker to do good care work and dismantle the system from inside than there is for a police officer. But I can already see how social workers coming in for mental health crisis response instead of cops will be a slight step toward abolition at best, and at worst, an ineffective kind of publicity stunt for the state and state control.

I think there is an argument we made for social workers being crisis responders as a brief evolution or stage of the movement toward abolition of state-control. But for that to be pulled off, it would need to be thought of as a stage, not the end goal. Not like our salvation. And I worry that won't happen because the nature of psychiatry and social work is it involves that state control element. So I'd rather bypass that altogether and go straight to the stage where peers are the crisis responders.

Which is happening. And I'm excited to hear from Asantewaa, Allison, Tim, Carla, as well as Stef and Neil about this topic. And I do want to briefly say that I really believe that the abolition of state control needs to be a process and an evolution. It's good for us to hold and honor that this is a huge task because systems of power and control and surveillance and punishment of the bad and strange seems to have precedence that date back fairly close to the beginning of human history. So this is an intensely difficult and challenging work and undoing something so old and fundamental as to how our worldviews are organized as state control is nothing short of apocalyptic. When I think of apocalyptic as in the fall of the empire.

So looking to indigenous folks worldwide, but certainly indigenous Americans and some of the discourse I've seen about how colonialism and genocide were already the apocalypse for indigenous folks. I feel like it will take another apocalypse in the form of the fall of the Empire to create the kind of world I think we deserve to live in. So I want to honor the difficulty of this work, and I do want to honor that this is a world that we need to look intensely to indigenous communities to create and its formation needs to be largely led by indigenous people worldwide.

>>NOAH GOKUL: I want to jump in here, thank you so much, that was an amazing grounding. I'm really looking forward to hearing from what other folks have to say. But thank you so much, that was amazing. It feels like we are almost that apocalyptic moment right now, with the smoke and COVID and everything. Other folks want to jump in on this? Stefanie?

>>STEFANIE LYN KAUFMAN-MTHIMKHULU: Thanks Noah. Just want to echo what Stella just said, thank you for that. At its core, abolition...it means no cages. It is not like let's get rid of the prisons and the jails, but keep the psychiatric incarceration and the nursing homes and the group homes. And the court ordered ECT. We cannot pick and choose here. It means we are tearing it all down. And when talking about abolition we need to be very clear.

We are not doing this work and embarking on this journey and working towards liberation only to shift from one system of policing to another. Which is what really Stella just described. And I think for me, when I think about this question in general, what we want to be doing is transforming our relationships to neurodivergence, to madness, to disability, to mental illness whatever term you use. We are working to completely reimagine a different approach. We want to do this differently, grounded mutuality, and reciprocal respect, in equalizing power dynamics. So when I'm thinking about social workers replacing police and the mental health care system

getting more involved in this carceral role, Stella said it best, like we already are. It already is carceral. We have to make that jump logically.

To be part of the carceral state really for me, we are thinking about systems that are containing people. Taking away their locus of control, offering surveillance, isolating folks from their communities, limiting freedom. And we know that the mental health care system works in collaboration and partnership with police. That is kind of a fundamental aspect of it. And we can even think about the similarities between incarceration in a prison and incarceration in a psychiatric facility, thinking about the limited access to outside and fresh air, and sunlight. Use of restraints, whether physical or chemical restraints. The law-enforcement transport aspect of it. The limited accountability. All those aspects are mirrored in these systems so that is what I'm picking about, as well as this wanting to make clear that we know that both prisons and psychiatric institutions and mental healthcare in general can produce disability. It can produce madness as a result of, as Stella mentions, this trauma.

Thinking about isolation, solitary confinement, all of that. So as Stella and I have discussed a lot, can social workers do good in communities? Yes, but like the police, this is not about a few bad apples. It's about a really pervasive and unrelenting nature of systemic racism, ableism, classism, and the upholding of white supremacy that we know was the foundation of social work. And we can look back at indigenous families that have been torn apart. Black families have been torn apart by social workers acting as this gatekeeper of who is meeting standards and who is not, and what that power looks like.

So I think as Stella mentioned when you are talking about having a good experience with mental health care or psychiatric treatment, that is a privilege. We are talking about having the privilege to have had that good experience and we need to really be centering folks who have lived experience. The last thing I want to say on this is that it is not about, for me at least, abolishing mental health care. We want people to get healing and have access to resources. But it needs to be informed, it needs to be voluntary and healing-centered. I really think about peer support as an abolitionist offering. We are going to build systems of care and support for each other but are not going to punish people, we are not caging people in distress, forcibly medicating them, this about reciprocal, culturally respectful relationships that I believe, if we don't center peers in our responses to what we are trying to build now, we are just shifting one system of policing in for another.

>>NOAH GOKUL: Yes, yes. And I just want to say that a lot of the stuff that both of you just said, one of the things that really helped us ground this event was the article that both of you put out, abolition must include psychiatry. Such an amazing frame for this event so thank you. Neil Gong, one of our panelists, just put out an article recently called how defunding abusive institutions goes wrong, and how we can do it right. So I'm just going to call on Neil, what do we leave out of this conversation when it comes to replacing social workers with cops?

>>NEIL GONG: I really appreciate what Stella and Stefanie had to say here, they really got at an important point. This is one of the core points that gets left out is the way that social work and mental health care in psychiatry can essentially be policing. I want to say a few things about that briefly before I turned to some of my main points.

I'm absolutely on board with the critique of mainstream psychiatry, that its long history has always had an element--we may diverge on how fundamental we think it is to the enterprise-- of social control, that can often be aligned with, or directly is policing. At the same time, and you both alluded to this, in building something else, we still want people to have access to whatever tools could be useful for them. So to me, the reframe is maybe: what can we re-appropriate from even a corrupt system? Are there things we can still hold onto the expertise, the experience, the things that have worked for people and make sure they have access to that in empowered, voluntary kinds of way.

So if a person wants access to a social worker to help them advocate whatever system is in front of them, or a therapist of different sorts, or medication, we want them to have access to someone who can meet them in an egalitarian manner. One person I can think of in psychiatry, Joanna Moncrieff, has this idea of how people don't actually get informed consent even when they think they are, because they are not given access to the full range of side effects, or the fact that very often doctors, have no idea how certain meds work what kind of affect it is going to have a people. But you can imagine a prescribing practice or social work practice that is much more aligned with those ideals of informed consent and it being voluntary.

We have to figure out how to hold onto the tools the people have and found useful. Re-appropriate them for a new system. This question of how we do this, what the transition stages look like, how to not get trapped in the transition stage? These are big questions I think for lots of different kinds of movements. Really important to talk about.

The things I want to talk about from this article that Noah mentioned are less about police versus social workers per se, but about this issue of systems change. I would like to take us through the last time we transformed a major social control institution through defunding and what that meant for vulnerable people. As Stella was saying, it is not as though people – you know, the asylum disappeared, but in some sense it didn't. There are still all kinds of carceral spaces people are locked up in. But I'm going to focus on this moment.

Psychiatric deinstitutionalization is, on the one hand, a story of civil liberties victories, but also movements being co opted and people being abandoned. When abolitionists talk about "it's not just destroying, it's actually rebuilding," one of the things with psych deinstitutionalization is we closed a lot of oppressive places but did not actually replace them with community services that were supposed to happen. In the 1950s, the United States had more than 600,000 people in psychiatric confinement, deprived of fundamental rights, often locked away indefinitely.

As people have noted, this is often bound up in racism, sexism or ableism. Or simply families not knowing how to contend with difference. So activists wanted the closure of these kinds of oppressive state hospitals and then getting reinvestment into high-quality community resources. What we ended up getting from politicians like Ronald Reagan was the closing of the state hospitals, but actually not getting that reinvestment in the community.

Remember that very often, politicians are not going to close something down because they believe in liberation for people. It's because it's a way to cut budgets, to not have to spend money. State hospitals were expensive. And given related Reagan-era cuts to public housing and other forms of welfare services a lot of people ended up being released to the streets. And

later on in many cases people having crisis are going to end up being picked up by police, which is of course the topic we are focused on today.

If I restate that as something of a lesson for us today, it is that defunding campaigns can be co-opted and essentially turned into a form of austerity politics by people who just don't want to pay taxes. This is not to blame what happened with deinstitutionalization on activists but it is a warning, because we are in a pandemic-driven fiscal crisis. And we may see something similar, where we get access to cuts to police and prison budgets, but this coming primarily from fiscal constraints. And we will never actually see community investment unless we hold people's feet to the fire.

The priority really has to be on investing and coming up with alternatives. So defunding alone is at best, a half victory and it can even be detrimental, and here's what I mean:

Another part of the story of deinstitutionalization, there was quite a bit of backlash. In the 1980s, as we are seeing more and more people with psychiatric disabilities on the streets, or in jails, the public starts blaming this on deinstitutionalization, even though what is really at play is these further cuts to the welfare state, and the rise of things like broken windows policing. There is this phrase “people are dying with their rights on,” they should have never been released, we need to bring back the asylum.

So this is something of a lesson for today. Failures in systems change can be attributed to botched reform ideas and efforts, rather than underfunding. When it is really the underfunding that is causing this. And so today, we are in this pandemic-ravaged economy and that means there is likely going to be a spike in economic-related crimes because people are trying to survive. There's likely going to be a spike in mental health crises. And the risk is that the public is going to blame this on: say we actually defund the police, but don't come up with a system to deal with all of the pain and suffering people are going through.

The risk is that people are going to, the public is going to blame on activists and defunding the police, rather than societal conditions that are really driving what is happening. This is actually already a Trumpian rhetorical strategy you are seeing. So this is the danger of defunding without sufficient reinvestment to actually tackle social problems at the roots. It can bring such a strong backlash that you hear people say “no, we need mass incarceration and more police than ever.”

Concretely that means we have to prepare for problems with new systems we build, especially in a bad economy like this and we have to have real answers if people do demand a return to harsh enforcement. So those are two things I would like us to keep in mind as we envision how we make this alternative system.

>>NOAH GOKUL: Thank you Neil. And I think that is that your perspective really adds such a good foundation and bringing in that history. I really appreciate it. From hearing from the three panelists we have had, it’s clear that bringing in the social workers, and it is bigger than just kind of having an immediate crisis response, and that there are so many historical reasons why we really need to find a complex solution for these problems.

So I really want to bring in: what are people doing right now to create alternatives. Because I think that is a huge part of this conversation. So having these conversations about

defunding the police and reallocating that money to alternatives. With us today are two panelists who represent alternatives to police and mental health crisis response. So what do these programs look like? I'm going to pass the baton over to Asantewaa and Tim if you want to talk about your programs.

>>ASANTEWAA BOYKIN: Thank you. My husband just brought me coffee, God bless him. So we created Mental Health First and I would like to start off with this. First I think it probably exists in a lot of our communities organically, where those of us who historically are mistrusting of police and policing, we tend to create our own underground, for lack of better term, systems. Where we agree to take care of each other.

So we begin to ask ourselves the question: why can't we build out something similar to what exists organically in our own communities and make it available to the larger community? Hence this is how we came up with Mental Health First. And we began to build a framework because we are not the first folks to think outside of the box, to think outside of the current medical-industrial complex and the psychiatric-industrial complex.

We are not the first to do it but we definitely wanted to do it in a way where there was absolutely no police involvement. Because the folks that we were trying to capture were folks who were historically mistrusting of police and policing. We knew at some point the safety question would have to be answered. And I'm recalling the first question around: what do social worker models look like? I had a recent experience where some folks in Dallas were asking us questions like how do we build this out? What do we do?

At the end of the day, they added an EMT to their team, they had a social worker, but also the social workers were echoing back to the city we don't feel safe responding, so we still need an officer on our team. I would just say these social worker models still have to be divorced from police and policing. So if they are the type of social worker that does not feel safe approaching someone who may not be in our shared reality, then quite frankly they are probably in the wrong profession.

Here in Sacramento we have a social worker that essentially wears a police uniform that has the word social worker on the back, so we cannot incorporate social work in a way that is like, oh look we have social workers. But then those social workers are essentially police. And when somebody has not experienced our shared reality, or has this historical mistrust of police and policing, I can't tell the difference between one person wearing a bullet proof vest and another one. So essentially, they all look like police, which is going to escalate the situation matter how you look at it.

Anyone having thoughts around, how do we create something different, I would just say look at the frameworks that already exist. Look at the places like CAHOOTS that have longevity and have been successful in creating these programs and influencing other programs around the country, and in some ways including ours. Look at what is already being done, look at the demographics of your city, look at the high-utilizer list if there's one available, and what are those folks lacking and try to answer those questions.

The first thing we did as a team once we assembled ourselves. We just asked, what could we build if money was endless? We called it our dreaming session and we had to taper it down and go back to, what is accessible to us? Right now in this moment?

And Mental Health First is what we built. Our framework is super simple. Our primary goal is just to mitigate the immediate crisis and hopefully help that person come to their own next step. Our framework does not sweep in and tell people what they need or how they need it. We call it self-determined crisis management. Being simple is just getting a person from one place to another. This place where they feel unsafe to this place where they feel safe. And if that safe place is in an emergency room, then we soft handoff to an emergency room. If that next safe place is their sisters house, we take them to their sister's house. And then if they want to we will call him back. If not, we tell them to call us back when you feel the need.

I recall an instance a couple weeks ago where there was a person who called us and was looking to get literally from one place to another, and that next safe place was an emergency room. I will never forget this sentence, he said if I call 911 they will fuck me up. And that resonates because when these are the folks that are supposed to keep you safe, get you the help that you need. So that you can get healthcare. When there is a hesitancy in anyone's process because they feel may be harmed. It speaks to where we really are. We can talk about it, we can defund the police and say. This is what we need: abolition abolition abolition.

But we have to be really, really clear about where we are in this moment. And who are the folks who need the services the most, and if we still have an existence where someone feels like it they call 911 – and not just police, literally EMS. I work in an ER, and not to down those folks. But some of the privileges that exist amongst the culture of first responders is disgusting. I wish I could explain or give examples without really violating HIPAA or down talking firefighters, EMS, but sometimes I have, in the ER, I've seen people treated so inhumanely that I wonder if we really have lost our souls as an entire species.

Just because of the way that somebody presents, whether that be their skin color, because they are unhoused, or perhaps they are under the influence. So we not only have to change the culture and mental health specifically, but also actively work and change the culture inside of our healthcare system. Also with the understanding these systems were not built for us. These systems were built for white landowning males, and we have to deconstruct them and build them absent of the roots that are steeped in white supremacy.

>>TIM BLACK: Asantewaa touches on something really vital to what we are talking about here, and that is what happens when crisis emerges and the need goes unmet. Whether that need is safety, getting a bandage changed. Getting connected to treatment services and a sense of community. Whatever it is, there is a need that is going on and when we cannot meet that need, or overcome those barriers imposed on us by others, that's when that crisis emerges.

In Eugene and Springfield, we have been approaching our mobile crisis response in a similar but different way. The CAHOOTS program, an acronym which stands for crisis assistance helping out on the streets. Our mobile crisis response program sends out teams where you have an EMT alongside a crisis worker. We don't use clinical social workers, we don't recruit folks who have that higher level of credentialing, because we're not going out to place

holds on folks. We're not doing dialogistic work in the field. It would be a dismissal of the person and experience they are having to engage in any diagnostic work in that movement.

As we talk about how you can have a first responder system that is out there and really responding to the underlying issues to that crisis, rather than encroaching from enforcement, like you see with traditional infrastructure in the form of police departments. CAHOOTS model presents an opportunity to talk about the whole system, not just mental health and medicine, but looking at that intersection of those two things.

By bringing in that EMT to our response, we are able to do a lot of harm around reduction. We are able to open the door to folks, maybe they don't have the vocabulary to say I've been experiencing depression for the last six months. But if they know they can reach out to the EMT and say you know my stomach has been hurting, experiencing loss of appetite, I can't hold stuff down, we start to open that door and find ways for people to come in and engage in conversation that feels accessible and safe to them.

I want to make sure we are all on the same page because some folks can go Google and learn about CAHOOTS and I would be remiss if I assumed everyone had the same background I do. So we are in Eugene and Springfield, like I said we have a crisis worker and EMT that are paired together. We have 24/7 coverage in our metro area which has about 250,000 folks. And all of our calls for service, every crisis, comes through the traditional public safety program. Which means the point of access is to call the Public Safety non-emergency number because we are not an emergency ambulance service. That means that CAHOOTS crews are being dispatched over the same priority channels and Public Safety as patrol. As the police.

That means that our unarmed civilian first responders are going out without pepper spray, without tasers, without a vest on, wearing a T-shirt and hoodie that looks nothing like traditional public safety apparatus. That means that all of our calls are being broadcast on a system where officers are hearing where our teams are going and to address that perception of how unsafe these responses can be, we view that radio as part of our system of safety, that is that resource we can reach out to in these moments where things to escalate beyond our ability or control. But those situations are very rare. We had 24,000 calls for service last year and only needed to call for support 300 times.

That is 300 times where someone was going through something so profound that we needed extra support to maintain their safety and the safety of others. And rare situations that resulted in getting someone to the hospital because we really needed to utilize those traditional systems to get that person into a better place in the moment.

We are able to divert thousands of calls from police contact each year, and a lot of it has to do with having a system that has really been developed, the CAHOOTS response system has been developed to respond to all situations, not just mental health presentations, not just suicidal subjects. But when somebody calls and says I don't have any place to go tonight, CAHOOTS is going out to talk to them. Or if someone says there is this person sleeping in the doorway of my business, it is CAHOOTS coming out to get that person connected to services as opposed to enforcing a trespass order.

As we talk about all these different alternatives and options, we are in this transitional moment and right now, the system of using that dispatch, of using those traditional public safety tools as a point of access for CAHOOTS is a step in the right direction. But even within our own community, we see that using that public safety non emergency number means that we are only available to folks who feel comfortable, who feel it is safe for them to call and request our services through the public safety system. So as we engage with our partners in this process, and that includes law enforcement, that includes EMS and the fire department. One thing we are really prioritizing right now is: how can we make ourselves more accessible?

Is it going to continue to serve us to be part of that traditional service of dispatch, or can we accomplish the same outcomes without reliance on that system? And I think, the last thing I want to highlight is that we are really trying to work ourselves out of a job here. You talk to anybody on the CAHOOTS team, we don't want this to be a needed service in another 30 years. If a community is able to apply restorative justice, community mediation, violence interruption, decriminalized homelessness, and drug use. If we are able to provide compassionate and adequate voluntary resources for folks, we envision ourselves getting to a place where this just is not a necessary service. That is our goal. That is ultimately what we are trying to do. We want to get to a point where we don't need CAHOOTS anymore, but we also are trying to be realistic and recognize we are not going to get there tomorrow.

>>NOAH GOKUL: Thank you Tim. And we have an audience question and I think that both of you who just answered might be good folks to talk about this question. Someone had a question: how do we address liability concerns for mental health providers and community organizations might endure when they are responsible for meeting the needs of persons experiencing mental health emergencies? What supports are needed for these organizations to not rely on law enforcement as a safety net?

>>TIM BLACK: On one level it starts with how you are talking about folks. Really again, 24,000 calls for service last year, and we only ran into situations we couldn’t de-escalate 300 times. That says that by and large, these unarmed civilian first responders are going out and having a lot more success and a lot of safer interactions than counterparts with guns, badges, with the tools of enforcement at their disposal.

And that communication is not just using the right words, it is not just being mindful of pronouns or holding space for somebody. It's really recognizing how much cumulative fatigue goes into meeting your basic needs and addressing anything you have going on a deeper level. It is really recognizing how the direction of the wind, what the weather has been like for the last few days, can inform how this person is going to respond to you, and really again looking at the whole person, looking at how physical health informs behavioral health, and vice versa. How the culture and the systems we've grown up with inform how we interact moving forward. And there is this constant perception of danger and that liabilities is our biggest concern.

Why is it that as soon as we start to talk about a different type of response, there is this perception of danger? This perception of othering, instead of really looking at it through the lens of, these are our neighbors that we’re trying to support, there's this other thing out there, this unknown entity and because I don't understand it it's unsafe. If we can start to really give providers opportunities to really hear more of that first hand, lived experience. If you can provide opportunities for peer support workers, folks with lived experience to be the providers, by

identifying non-traditional approaches, I think we can start to steer the conversation away from liability.

Where's the conversation in liability for every traffic stop? That police are engaging in? We are not having conversations about liability insurance related to the use of chokeholds. So why is it that we have to talk about liability before we can start to talk about first responder reform?

>>ASANTEWAA BOYKIN: I would like to echo what Tim said around making sure that it is peers, not just responding, but also creating the best practices. It takes a lot more than a degree and something to say, this is how this should work. I know in MH First we had a peer counsel, folks that had all kinds of interactions with the healthcare system, with the mental health care system, and also with police and policing informing what our best practices look like. That would be step one, we really have to listen to the folks that have the lived experience.

I also think, and I don't like the term destigmatize. I think we have to normalize these things that naturally exist in our communities. We have to normalize someone who may not be in a shared reality as us. We have to normalize folks dealing with depression. Because I think currently the way our system is set up, is when these folks are not behaving “normally,” they can just be disappeared. There is a number to call they can be disappeared and you don't have to look at them anymore, right? That should definitely not be the case.

As we move about and start to create non-medical-industrial complex, non-police responses, I hope folks get more comfortable dealing with our neighbors. We have looked at 911 call databases in Sacramento and not 50% of the calls are needing police. Under 50% of the calls actually need police. So how are we going to continue to organize the police out of these spaces? A lot of it is just encouraging folks to talk to their neighbors, no matter how they come because a lot of the calls are neighbors’ disputes, noise complaints, mental health calls.

So we have to shift from needing this person with the gun to mediate our conflicts and helping us disappear our neighbors so we don’t have to deal with them, and really encourage folks to begin to have conversations just period across the board.

>>TIM BLACK: This reminds me of something that happens on CAHOOTS a lot. One type of call CAHOOTS will respond to is a welfare check for a “subject down.” Someone who is not up and walking. It could be they are taking a seat, or trying to get some shuteye after being up all night trying to find a safe place to be. Very frequently these calls will come in, one caller unable to confirm whether or not they are conscious and breathing. And what that says, is this person saw something, thought I should call so that issue can be as said, disappeared.

But they are not even willing to take the steps necessary, the literal steps necessary, to get close enough to see whether that person that they are so concerned about and want resources to go out to, they are not actually willing to take the literal steps to see that person is breathing. To determine whether this is a medical emergency or not, let alone what is your name, how are you doing? Do you need anything?

A lot of this is about I think obviously white fragility, being unwilling to recognize we live in a broken system. It really is a disconnect from our neighbors, our community. When we start

to have those conversations and engage with people, you learn the name of that person living in the tent around the corner from you, it is not just a problem that needs to get disappeared. Joe is really struggling today. We need to really be able to build those connections and relationships, we have our neighbors and community that are going to empower us to make any sort of real, meaningful, lasting change.

>>ASANTEWAA BOYKIN: I know we have good Samaritan laws but do we need bad Samaritans laws. You don't call us until you check a pulse? Don't call us until you say hi.

>>NOAH GOKUL: Yeah, I mean that does not sound like a ridiculous thing at all to me. So thank you so much. I really want to come back to this interesting conversation and of course this is related. I'm really interested in centering our conversation within the Black Lives Matter movement and how policing crisis response and psychiatry has an effect on Black folks.

The question I have is for everyone, and this is just to really name this, but what role does the larger Black Lives Matter movement play in the work that you are doing? We have about 15 minutes for that. Suggest reminding folks that I'm going to be keeping time if you see me on the screen it means maybe two minutes left. So yeah what is the work that you are doing have to do with what role doesn't have to play the larger Black Lives Matter movement?

>>STELLA AKUA MENSAH: I think it's impossible to separate the evolution towards abolition of psychiatric violence from the abolition of white supremacist structures and white supremacy. Like I mentioned earlier, you know, I think the ways that Black people have always been pathologized in this country just for having feelings. Which of course like Black women experience more than anyone. Black trans women. There are so many intersections that make particular folks more and more vulnerable to abuse by the systems.

But thinking about that book, the protest psychosis, which I think a lot of people look to is a great example of how Black folks historically just being resistant to systemic violence and protesting and being revolutionaries on any scale has been grounds for us to be considered psychotic. I think it's just very important for us to think about this looming threat of psychiatric incarceration if you are a Black person who is resisting the system. So not only are psychiatric cages vital to tear down, I think in addition to more typical prisons, largely because of how they mass incarcerate Black folks in this country.

Also, there is a very present threat, this happens every day, this is largely part of my experience, of psychiatric harm. Yeah just for resisting, we are considered psychotic. And I think not only that, but I think it's also important to think about how so much of the divergent behavior that neurodivergent folks like myself have exhibited at times. Neurodivergent behavior that Black folks in this country are often incarcerated for.

First of all, what is it divergent from? What is normal, and why is normal defined by whiteness? And respectability and palatability. But also there are such logical experiences of divergence that come out of so much inherited ongoing trauma. So not only is it absurd to label Black resistance as insane. It's also absurd for us not to take into account how racial trauma and anti-Black trauma and white supremacy create divergence that can get to the point of distress and pain, not just divergence in the sense of resistance but also distress. It makes

sense and it is valid to respond to trauma by not being respectable or palatable. So yeah lots of sorry scattered thoughts about the intersection of Black Lives Matter with this topic.

>>ASANTEWAA BOYKIN: I think the words Black Lives Matter is a phrase that I think most of us can get behind, right? I think that one of the biggest things that the Black Lives Matter movement is they kind of centralized that messaging, even though when you think about the Black Lives Matter movement, there are several organizations across sectors from grassroots to nonprofit, the whole gamut. I think what they've done is give us some centralized messaging that is palatable even to folks that don't have a taste for it, it's palatable.

I think also what I've noticed is folks have been watching the patterns. What we understand is that, I think it is somewhere around 70-75 folks who were murdered by police were those that were in the midst of a mental health crisis. I think that those similarities cannot be ignored. So then folks began to have these conversations. Well why is that?

That is because the police are showing up. Guns are showing up and not care. Obviously, these folks would subsequently be harmed at greater numbers, which is one of our goals. Is just to decrease police contact so that our folks are not murdered. Because if the police are not showing up then they cannot shoot them. I would encourage folks, the media does a very poor job, at really stating what is happening on the ground and they use this blanket term Black Lives Matter. And in one sense, it offers folks that are on the ground a certain amount of protection. And also it erases some work of folks that have been doing work for over decades. So it is a double-edged sword but I'm really excited to see that sentiment of Black Lives Matter moving to defund the police. Now that we have the sentiment out of the way and understand that Black lives in fact do matter, whatever going to do about it? We're going to defund the police, we're going to defend Black lives. So I'm really excited to see sentiment move into something that is more of an action.

>>NEIL GONG: I just want to say briefly the Movement for Black Lives has done a phenomenal job of containing a very intersectional lens that brings people together, a big tent, showing how various kinds of struggles are interconnected. But they've also shown that by centering Black lives, and the needs of the most vulnerable, you end up with analyses and approaches to concrete change that will benefit everyone. The fact we're even talking about mental health system reform or transformation in the way we are right now for everybody is a large part because of BLM. It’s exciting, things are on the table that were not there before.

One thing I want to highlight and I’m so excited to see in this conversation today, is trying to think in a very complex way about how race and criminalization play out. A lot of radical mental health spaces have traditionally been very white, and you end up with these divides. People are maybe talking about one side of the carceral spectrum, which is institutionalization in psychiatric hospitals, whereas you have other folks, often less advantaged communities, often people of color and specifically Black communities, where that is less the threat. It is more the threat of the jail cell. And those have been in some cases separate conversations. It’s so important right now that comes together and we are trying to figure out: how do we move forward with all of that.

>>STEFANIE LYN KAUFMAN-MTHIMKHULU: Thanks for that Neil. Want to echo what folks said and add some thoughts. I really believe if we were doing work around policing, crisis

response, anything to do with mental health, we have to be centering the folks who are the most marginalized, the most targeted by systems of oppression. And the violence at the hands of the medical system, prison industrial complex etc. And think about how policing in and of itself, as Stella was mentioning, is impacting the psyches, the minds, the bodies, of Black folks. How that creates trauma and disability. This is a nonnegotiable. As long as these institutions exist, we will not be able to center and prioritize healing and liberation.

We know that disabled, neurodivergent folks are 16 times more likely to die in a police encounter. We know that over 50% of folks killed by police are disabled, particularly Black and Indigenous folks. I want to uplift Black scholars and organizers that I've learned from, Talila Lewis, Dustin Gibson, Azza Altiraifi, Imani Barbarin, Leroy Moore. Definitely encourage folks to check them out if you don't know their work.

I want to uplift what Stella said about how we have to contend with the history of psychiatry, the history of mental health care and to those roots. Like why were they built? What was the original purpose? If we look at the report of the Virginia Central Lunatic Asylum for colored insane in 1870, they were writing in their charts that the cause of psychosis was freedom. Black folks not wanting to work for free. This is the history. Stella mentioned drapetomania. I also want to uplift “excited delirium,” which is a term that has no medical grounds or basis but is consistently used for neurodivergent Black folks who were murdered by police. We see this with Natasha McKenna and with Elijah McClain, essentially blaming these folks for their own deaths because they are neuro- divergent or mentally ill.

The term is excited delirium, basically they got so worked up and excited because of their mental illness that they had a heart attack and died. And not wanting to point to what has happened to cause that. There are studies that show that young Black boys may have the same exact symptoms as young white boys, yet the Black kids are diagnosed with oppositional defiant disorder and the white ones are diagnosed as autistic, and we see how that plays out for folks.

So for me taking a lot of how ableism is really the foundation of every system of oppression, and ableism and racism work together in a very specific and intertwined way for Black disabled folks that we cannot look at that separately. It has to be looked at collectively. And this is something that TL talks about a lot of their work.

My last point that I want to make is just that if we are white and doing this work, we have to be partnering with, centering, uplifting the initiatives and goals of Black disabled organizers and organizations. For example, folks are saying registries, not okay we don't need, police don't need a list of who is autistic and who is not. Police training doesn't work. We have to stop highlighting that as a solution. When folks say that over and over again we have to listen to that and center that in the work. I am going to stop there.

>>NOAH GOKUL: Thank you everyone and I really am so appreciative to really ground this conversation in the Black Lives Matter movement and centering Black folks. And I'm so glad that this event is being recorded so I can come back because my brain is boggling all around and there is so much happening.

And so I really want to get to a question that I think a lot of folks are thinking about and this is for everyone. How do we take what you are doing and use it to inform things on a national

level? What can we do to make this something that is nationwide? What is your vision of that? If you don't have a program you are working in, what is your vision of that? This is a question for everyone so does anybody want to kick things off?

>>TIM BLACK: One thing that is a significant barrier for nearly every community is that funding. Where'd you get that seed money to get this thing started? Everybody wants to hear about okay, how much this is going to save us, what is our return on investment? This perception that it is capitalist systems that are going to bail us out.

Whether it is reliance on the nonprofit industrial complex, or looking to create a municipal program that is going to go out and do these responses. We have to recognize that funding is going to be a barrier, and so something that could help nationwide is talking to your local elected at the federal level to support passage of the CAHOOTS act, which was introducing Congress a couple weeks ago, and would provide that pilot funding for communities to implement this programming without having to empty their own coffers right away.

But at the same time doing this on a national level, we need to recognize there's not going to be one single approach that works in every community. As we talk to other cities that want to look to replicate the CAHOOTS model, if that's what they think is going to best serve their community, we are constantly saying this needs to be something informed by the folks you want to serve. This is a program that needs to be signed by your community because that is who it's serving. We cannot expect a program in white, liberal, west coast college town of Eugene to have the same results in Cincinnati or Tampa.

So as we look at really changing the landscape of public safety, of creating crisis response systems that are not part of those existing systems of oppression and marginalization, we need to recognize there's not going to be a one-size-fits-all approach that is going to make this work. Every community is going to have to build something and design something unique to that community's needs, if we are ever going to be successful in the type of change we are talking about.

>>NEIL GONG: I want to second everything Tim is saying. I think funding is a big part and we don't want to get into the mindset of, yeah does this intervention save us money? That is a losing battle. I saw that with Housing First, where initially you get Republicans on board by saying that “if we give this person who is a high service utilizer housing, then you will save money.” It might work when but what about giving other people housing? You've already given up any moral political argument for why that matters, you just make it about money.

An important thing for us to contend with is even if we defund police, that money is significant. But it is still not going to be enough to do the kinds of things we want in the world. We have to get out of this tax neutral frame where it is just about taking money from the bad things and putting it to the good things.

We have Jeff Bezos, we have billionaires, we should be talking about taking a lot of their resources and giving them to other people. We have to get out of this mindset. Yes, defund police and reallocate resources, but that will not be enough. We have to look at other ways of getting revenues through taxes and other kinds of mechanisms.

>>ASANTEWAA BOYKIN: I would say on a micro level, talk to your neighbors. Say hi. Get to know them. Right? Utilize the frameworks that exist on your block. If your neighbor is a painter and you need some painting, holler at your neighbor first before you call the corporate painter folks. I think that one of our best tools is relationships. If we begin to build those relationships across the fence, eventually we will not need outside intervention.

And also, if you are a healthcare worker or mental health care folks, or if you are in school, actively decolonizing your practice. I've been a nurse a long time and every now and then I have to check in with myself and to be like, why don't I like this particular set of patients? The drunk entitled white guy, like I have to literally take a deep breath and treat him the exact same way that I would anyone else because that is part of decolonizing our practices.

Identifying those biases we have within ourselves. If you are in the state of California, AB 2054 has passed the Senate, this will take tax dollars and allocate them to community first responding programs. If you have the time, tweet Gavin Newsom, tell him to sign it. For some reason he wants this bill under the Department of Corrections, which is against everything that the bill is outlining.

And also when we talk about how do we solve mental health crisis, how do we solve homelessness, substance abuse disorder? Practical solutions work. We solve homelessness with housing. We solve mental health crises by providing mental health care. So as you're going about your day talking to folks and decolonizing your practice and talking to your neighbors, if you find someone who has some power in their hand and they are like what do we do? Talk practical solutions. Also I know there's a lot of conversation around defunding the police. We have to talk about what that really means. Like how much do officers make, and if we equate that to how much how many resources even to the one officer.

If the officer makes $80,000 per year, you can employ two mental health care workers for that amount of money. They deserve a lot more. But that is two folks for the price of one man with a gun. Who actually is not going to fix the problems so talking about the defund the police conversation in a way that is tangible and that makes sense. So that as those folks were not so palatable to it, can kind of understand where we are coming from when we say these dollars would be better used in other spaces.

>>STEFANIE LYN KAUFMAN-MTHIMKHULU: Thank you for that. I definitely want to uplift the notion that real safety does not exist in the context of liability concerns or constant surveillance, and constant evaluation. It exists in relationships. And we know that. There is data that shows that folks who are experiencing domestic violence, or who have just experienced sexual assault, the vast majority are not going to turn to the criminal legal system, to outside folks. Folks are going to reach out to folks they feel safe with they have comfort with. Which is why tools like pod-mapping by Mia Mingus, the Bay Area Transformative Justice Collective, Such an incredible tool to figure out who was in my pod? If I'm experiencing harm causing harm, who can I call on? Who are some movable folks that I need to actually put some effort into building relationships with so that I can have them in my pod.

Building care webs, building complex safety plans. I have Stella’s crisis plan, Stella is going to have mine soon, working on it. But actually share those documents so the people in your life know how they want to be responded to if they enter into a crisis. And I think I also want

to add this is possible. I work with so many folks who because of the professionalization of what is happening, we have inherently lost the ability to respond to conflict, to anything really, in community. We outsource everything. And privatized and monetized, and we inherently have the skills and the capacity and capability to respond.

Learn about de-escalation. Reach out, read, study. This is as much about learning skills as it is about political education. They cannot exist without each other, has to be happening together. We can learn about this and become better. And also just knowing nothing about us without us is a long-standing motto of the disability rights, independent living movement. So thinking about how we are the experts of our own body-minds and folks who are in this to support us, whether you are a social worker regardless of your politics, you always need to defer to us.

We are the experts, and whether that means being really clear about what you're reporting requirements are so that people can make informed decisions. If you are operating a crisis line and you engage in active rescue, be clear about that so folks can decide how they want to engage with your services. I think, yeah, I want to highlight what folks have said about a lot of this is really about shifting the problem elsewhere. Disappearing people so we don't have to deal with them, and we need to unlearn that and unlearn what we have known and heard our entire lives and have been socialized to understand that disabled people, mentally ill folks, neurodivergent folks are burdens.

We are not burdens, we are deserving of love, care, in our communities. We don't need to outsource it and that does not require changing one thing, as folks have said. It's not just about defunding the police. This is about radically shifting our relationship to everything. Which also requires dismantling capitalism. It is a lot of moving pieces that have to happen together and one thing is not going to solve it all. We need everyone to be working to create those solutions.

It's not just going to be one program. It's not just going to be CAHOOTS, or one thing that happens. We all have to be playing a part in building the world that we want to see that folks want to live in that provides compassionate care and truly helps people in the way that we want to be helped.

>>STELLA AKUA MENSAH: I would love to jump in if there is still time on this question.

>>NOAH GOKUL: Yeah maybe two minutes.

>>STELLA AKUA MENSAH: I really love what folks have said in response to this question. I want to echo Asantewaa, what you said about relationships being our number one tool. And I utterly agree, I think the first thing I would say in terms of spreading this work nationally, internationally, is that we need to really evolve back into actively our interconnectedness and fundamental communal nature as being -- that is what we need and along with that, is using peer support models as wisdom to look to in teaching ourselves and modeling for each other how community can look. Because peer support is largely about using your lived experience, as well as your increasing empathic skills in life to support one another in mutuality.

It really is the crux of what community means, and so like Stefanie mentioned earlier the notion of peer support is an abolitionist tool because it is something that as it spreads and spreads, we will not need these systems of control and correction that we feel that we need now. When it comes to community care, I think it's important to keep in mind that care has to mean meeting people's needs on their own terms. And a lot of folks asked in the chat, what we do in situations when people are rejecting care that they feel they need. It would be great if we could address that later on. If possible.

I utterly believe that the world in which like all care is actually care, by which I mean it is on the terms of the people receiving I, and it feels like care to them, as well as a world in which we don't do things not consensually. There will be so much less suffering and fewer crises.

I do know that becomes a question, that question comes up a lot around what we do in situations when someone doesn't have the insight. There is so much there, but I still think that consent has to come first. Doing that work internally and in our communities, decolonizing ourselves, decolonize your practice, learn about crisis intervention. Do that work and reading around Transformative Justice. And if you are a practitioner, a medical practitioner, holding yourself and colleagues accountable to harm and abuse that happens within medicine because I think that is something that has largely been an issue in this conversation is doctors having impunity.

So I think yeah, holding selves and colleagues accountable for harm as we decolonize ourselves, learn from people with lived experience. Spread peer support, really go back to our communal nature as human beings. And also, I am so excited to keep seeing local mobile crisis responses that are independent of the state popping up more and more around the country and I think that eventually that has the potential to really ultimately create a web of care. That will evolve us out of our current state.

>>NOAH GOKUL: Thank you so much Stella and I mean I feel like you've already answered this question but we had someone from the audience who had a question, how should those social justice-oriented students and social work school or medical school strive to reconcile being great clinicians or social workers with police abolition? Is it possible to have both?

So what about these social work students, and there are a lot of social workers also on this call as well. How do they reconcile being part of the system? Is it possible to have both? Anybody can jump in.

>>STEFANIE LYN KAUFMAN-MTHIMKHULU: I'll jump in. I think it's really hard. I think because as many people have mentioned in the chat, the way in which there are liability standards if you do if you don't report certain things, you might lose your license. That inherent structure sets things up to dismiss the patient as the expert.

There is always this inherent power dynamic that is really difficult and I know I talked with a lot of social workers who have lived experience and feel and identify as peers, but are very discouraged from sharing that in a professional capacity with folks. For me, the best experiences I've had with mental health professionals has been folks who are open to talking

about their experiences. Being incarcerated, being pathologized. I need that to have a relationship with a professional, and I would encourage folks to push the boundary on that.

I already mentioned being very up front and clear about what your reporting requirements are. I've worked with folks who hold a lot of space to talk about suicide and suicidal ideation and recognize the difference between having suicidal ideation and having the intent, means, and plan to actually accomplish that suicide. And if you don't hold space for that, people are not going to be honest. They are going to be terrified to open up so I think it's really on you as a provider to be very very clear about that. And to offer a different solution to folks.

If you want to talk about something, maybe word the third person or whatever that looks like to really establish those guidelines in those boundaries. I also think you have to be aware of the issues within your profession. Like it does not help anyone to say, well I understand and I do this in my work. It is the system. Is a systemic problem which means that your individualized desires or how you approach it is not enough?

I was speaking to a social work student who was like we don't ever talk about disability and they are pushing to bring in disability justice organizations and folks to speak to social workers. You need to be uplifting actual people with lived experience again in the classroom, in settings, so inviting folks to come in and talk really. My main word of wisdom here is to be very honest and open that the field and profession has a lot of issues. And that we need to be including peers again in the solutions and the work that we're doing and recognizing the limitations of your profession. And where those boundaries come in and where they live.

>>ASANTEWAA BOYKIN: If I could add I just wrote down a few things. I would say question everything you are learning. Absolutely everything with the understanding that all of our practices around medicine are just steeped in white supremacy. And also challenge the idea of whiteness and maleness as a normalcy. And everything that diverts from that is abnormal. One thing as a Black woman going through nursing school, I was just I'm going to die, I'm just going to get everything. Because the framework is I am 50% more likely to lose a child, with no other explanation other than I was born in a female body and in Black skin. So just challenging that white maleness as a normalcy.

And also there's an entire movement around dismantling the DSM. I think it was Stefanie who brought up how young Black males are being diagnosed with this oppositional disorder yet when white young men have the same behavior, he is still a well-meaning child. And we think about Dennis Dillon Wolfe getting McDonald's and Antonio Thomas being murdered. And that thing. So dismantling and at best decolonizing the DSM. As you're going through your practices just kind of do your studies, just understand that this practice you are studying is steeped in white supremacy and we have to challenge every single time it shows up.

>>NOAH GOKUL: I'm looking at the time and there's just so much to talk about. I wish that we could spend another half hour just talking about other stuff. I think that one of the things that someone in the audience asked, I think maybe someone has already touched on this but maybe we can bring it up again. What about the psych hospitals? What happens to psych hospitals? What does that look like in this new vision of mental health care?

>>STEFANIE LYN KAUFMAN-MTHIMKHULU: I can start, I would love Stella to jump in. As Noah mentioned Stella and I just co-authored a piece called abolition must include psychiatry. I think they are gone. I don't think they are here.

Neil talked a bit about deinstitutionalization and the various ways that it was sort of realized, some state hospitals closed, but we still have a thriving system of incarceration. We still have asylums. They have not gone anywhere. I think Stella and I have talked about this, about how there are parts and aspects to psych wards that we might want to take out and repurpose and figure out why that helps some folks. The structure of it, being able to go somewhere else and have structure. That is really helpful for me.

Amazing. Folks have done incredible work with peer respite centers. There are about 14 and the entire nation. They are completely underfunded and they are amazing, there's been a lot of data that has shown that peer respite centers, which are basically homes that are non-medical centers that are staffed and led by people with lived experience who are providing these short-term stays. And really socially-minded, healing-centered, trauma informed aspects of care. And we need to have us everywhere.

And we need to figure out what aspects of these institutions may be helpful in certain capacities. Take it out and repurpose it, but things need to be voluntary. We are getting rid of restraints, chemical restraints, physical restraints. This loss of autonomy and self-determination is really at the heart of this institution. And I really believe in a future in a world where they no longer exist. Under any name. The ability for someone to put me in an institution against my will no longer exists.

>>STELLA AKUA MENSAH: I'm just jumping in and fully second everything that Stefanie mentioned and described. As I made very clear I'm an abolitionist. I utterly believe that psych wards need to be abolished completely. Not repurposed under a different name. Goes absolutely hand in hand with the abolition of prisons and even the call to defund the police. And I do think it's great calling attention to the alternatives that exist right now and what we can do right now as we simultaneously work towards abolition. Which I think has to be like sister processes.

But of course people still have crises and need their needs met. Respite centers are amazing, I think such an excellent alternative. There's a place called the living room in Framingham Massachusetts for folks who live in the Massachusetts, Boston area. Very cool innovations happening in alternatives, in spaces that feel safe for people to process what they are dealing with. And spaces that feel healing.

I think we also cannot underestimate the efficacy and power of self and community created spaces that make us feel good. Personally in my crisis plan, something I mention is that if I feel like I'm in crisis, I need to be in a space like a garden or a particular room or apartment of a friend that I know feels good and nice for me. In addition to that, folks experience the need for creative expression when dealing with crises. Or maybe they need centers on discussion. Talking to their friends, talking things out, processing. Naming for ourselves, what would help me feel better? And using that notion. When people are in crisis, it's because there are core needs often not being met.

If folks have core needs that are not being met, how do we of course on a systemic level but also on a micro level meet those needs? Where is loneliness pulling a role in this crisis? Where is a recent trauma playing a role? Where is not feeling heard and needing to be hurt by their friends more. All of these things can help us design healing spaces that are not psych wards. Respite care is a great thing off point for that design.

>>NOAH GOKUL: All right you all. Well thank you so much. I have chills right now. I feel it just cast a spell into the world and this is the spell that is going to magically dismantle oppression. This is just part of that magical spell. I'm just enthralled with all of your work and your answers today. I really thank you for bringing all of who you are to this space.

We are just at the top almost to 8 o'clock and we actually have two folks coming together who are going to join us just for a few minutes to talk about the work they are doing. They are from the Correct Crisis Intervention Today, CCIT and it is a New York City-based organization doing advocacy work. We are going to welcome Carl Rabinowitz and Allison Wilens to just speak briefly about that.

>>CARLA RABINOWITZ: Thank you so much for including me, this is Carla Rabinowitz, the project coordinator of CCIT NYC, fighting to transform New York City's response to mental health crisis. For all the reasons you mentioned, a few years ago we came up with a model that has one peer de-escalator and one EMT responding to crisis calls. We picked two of the places in New York City that had the most number of calls and we are working to get that funded.

We know that CAHOOTS has been around but Toronto, Los Angeles, Portland, San Francisco are all going to models of one peer, one EMT, and one clinician. A lot of people are saying this cannot work in New York City, but New York City already has a model called transitional services of New York lead model where they have one peer and one clinician. They handle 3,000 calls, the response time is six minutes and only 3% of their calls, very few have to take someone to hospital. We don't want arrest, or police or hospitalization.

The other thing is we define peer broadly. Very broadly. Maybe someone else can talk on that. If you are interested our website is CCITNYC.org. If you like the model of having a peer de-escalator and an EMT, go to the website and get the event page and take action. You can also see the proposal page. I just want to say thank you. For your time.

>>ALLISON WILENS: Hi thank you everyone I'm Allison Wilens, they/them, long brown hair, red collared shirt, lavender plant, book about mushrooms in the background. On Leni-Lenape land.

I’m going to talk fast, reach out if you want to talk more about topics I’m going to raise. I'm thankful to IDHA for having us, and to these panelists who have all personally inspired a lot of my work. So I'm a harm reductionist, a prison abolitionist, EMT, and peer responder. I participated for five years in a crisis support model for people who use drugs that is similar to the CCIT NYC model using EMTs and peers. Through that work we kept thousands of people from going to the ER or jail and avoiding transport at all.

We need to decriminalize all altered states, whether induced through a drug or not. Altered states are often of a medical nature. Overdose is preventable, all overdoses are

preventable. Over half a million people have died of overdose in the US alone in the last decade. We need to fund a harm reduction response for that, but we also need to fund, we also need decriminalization and safe supply. People only died because the drugs they're taking are poison and that is something preventable. If you went to the pharmacy and your drugs are poisoned, you would be upset about that. It is a very reasonable ask for us to provide that to people.

The knowledge that I have comes from the wisdom of people who used drugs in these communities, it's a harm reduction model, and some concerns that have informed that are concerns about people who are criminalized when they access these kinds of state systems, so the larger conversations we are having around, whether pursuing legislative model or funding models outside, around data sovereignty, not having surveillance be a condition of receiving resources.

Many people who use drugs are neurodivergent and are people who are using drugs within that context. We need solidarity, there are no single issues. People need people you cannot solve one at a time. The original ambulance service was invented by Black folks who were self-organizing in Pittsburgh to serve their community. We are far from those radical roots but we can get back there. The work of Project LETS is very inspirational to me in that regard.

I want to talk about oversight versus over credentialing, because I want to uplift my lived experience as a neurodivergent person, but realize that in talking to healthcare providers that is traumatic for me and exhausting. And we should be paying peers for that. If a system is complicit in violence, you're not doing people with lived experience a favor by including them. They are doing you a favor, compensate them for the time to talk to you and the time it takes them to recover from the ableism you've not learned to unpack.

If someone is resisting care, it's not the right type of care. You are not paying enough attention to what they need. We also need labor movement for healthcare workers, where they are peers, or EMTs, or nurses. Settings matter, most ERs I've been to are designed in a way that exacerbates stress due to sensory sensitivity. We ought to replace fluorescent lights, get some dimmers or something, seriously, we need one to one attention.

Stop requiring surveillance as a condition for receiving resources. Especially in the context of when reparations are really in order. Be transparent about everything about your process, allow yourselves to be held accountable. Neurodivergent people are not asking permission for agency or telling you that we have at. We are organizing the support systems that allow us to self-determine, we are reckoning with the violence against us, you need to stop killing us. We cannot delay these kinds of solutions because of public opinion. We have to commit to educating the public about all of our issues. We have to make it sustainable to iteratively build a world where it is safe to fall apart.

Systems that are not ableist out-compete and out-produce ableist ones. You don't get to make out of this life without being disabled. We're early adopters, it's in your best interest to learn from us. This idea we're going to solve mental health crisis, we actually might not, there might always be mental health crisis. My goal is actually not to eradicate that, it's to provide the safe containers.

We have to stop pretending we can have perpetual adolescence and understand our role in the larger ecology, the role of death and resource reallocation in that ecology. You can study fungal networks about this, at lower stages of complexity and emergent organizing is most efficient at higher stages, there needs to be mediation between those emergent nodes while acting autonomously.

Regarding liability, assuming responsibility, self-determination is a participatory process. The shadow of being free is that we are also responsible. We have to put plans in place to de escalate crisis before they get to an emergency point, but for a lot of crises, emergency response isn't necessary. When it is, we actually do have to talk about liability and who is responsible. Is it the owner of the space, the person, responder, the city? We need to negotiate these things and form new agreements.

I want to end by saying, I want to challenge us when we say we are not ready for this yet. We have to check ourselves. Are we coming from a survivor or provider perspective? And our own unresolved feelings about the complexity of the moment and our roles in these systems?

>>NOAH GOKUL: Thank you so much Allison. Thank you so much. I really appreciate you coming in and really make sure to check out this organization. We only have a few more minutes. I really just, before I pass to Jessie, I want to plug that this was a free event and IDHA really tries to make sure these events are free for everyone. You can donate to this event and make sure that more awesome events like this are happening. We want to make sure we are paying all our panelists well and we had to upgrade our zoom level for this event. Would appreciate if people are able to support, throw some funds our way. Thanks so much to everyone for participating today. I'm going to pass it over to Jessie to end us.

>>JESSIE ROTH: Thank you so much Noah and the hugest of heartfelt thanks to everybody, could we actually have all of our panelists turn their videos back on and interpreters so I can see everybody's faces. This was an incredible conversation, I am moved almost to tears over here, really humbled by all the wisdom that we have in the Zoom room, including everybody in the chat, which we will save. So a quick note on the follow-up. We will be sending everyone who registered the recording, as well as the transcript from the closed captions, the anonymized chat, and all of the links and resources that have been shared.

A huge thank you to our incredible ASL interpreters, I don't know how they kept up with some of this conversation. Thank you also to our closed captioner. And before we go, I have one last announcement, which is that this event has been in the works, being organized for a couple of months now, and really the goal of building to IDHA's fall training series. So actually as of now 8:00 PM Eastern, we have just launched our fall class online, so I am going to stick the link here in the chat. It is called Healing Systems: models tools and strategies to transformative health care.

Essentially, it responds to the fact that so much of the training that folks get when entering the mental health system, or if you are just are supporting people informally in your community, we tend to focus on the individual and often of course pathologizing the individual -- this three-part series is going to focus on the systems that intersect with our mental health. The first class is going to be about macro systems of oppression and how those intersect with

mental health. The second about relational systems, including a deep dive into open dialogue. And finally the last class will be about internal family systems and somatic practice, and about our own body transformation. So check out the link I will stick it there, one more time. Now that is in the chat. So yeah registration is open, the first class is October 24 and we would love to have as many as you join us as possible. To close it out, Noah any last words? Thanks everyone for being here.

>>NOAH GOKUL: You all are amazing and just take care of yourself in these hard times and we will win.