ALTERNATIVE CRISIS RESPONSES

from a Disability Justice lens

PROJECT LETS

NO COPS IN CRISIS

Building our capacity to respond to community members during crises through a Disability Justice lens

Today's Agenda

01 — Peer Support from a DJ lens

02 — Change In + Out of the System

03 — Breakout Rooms

05 — Skill-Building: Crisis Response

ACCESS IS A PRACTICE

#AccessIsLove

Please use the space you are in as you need or prefer. This includes: rocking, flapping, stimming, sitting down, standing up, laying on the floor, moving around, stepping in and out of the room, etc. If you have additional access needs, please DM us.

This content is heavy. Though it is critically important to be able to have these conversations & know tools to address crises, it can be triggering and uncomfortable. If you need to step back at any time, please do so.

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BASELINE VALUES

- Abolition of prisons, police & institutions is a requisite for all forms of justice
- Disabled people have always and will always exist
- Proximity to disabilities does not equate to having disabilities
- Disability is expansive and fluid
- Ableism forms and informs every systemic oppression that exists
- Everyone deserves the dignity of risk
- Disability is a natural part of the human experience
- There is nothing wrong with being Disabled

From the teachings of Talila "TL" Lewis, Dustin Gibson, & Stefanie Lyn Kaufman-Mthimkhulu

PEER SUPPORT FROM A DJ LENS

"Disability Justice was built because the Disability Rights Movement and Disability Studies do not inherently centralize the needs and experiences of folks experiencing intersectional oppression, such as disabled people of color, immigrants with disabilities, queers with disabilities, trans and gender non-conforming people with disabilities, people with disabilities who are houseless, people with disabilities who are incarcerated, people with disabilities who have had their ancestral lands stolen, amongst others."

service provider

abolitionist

service provider **abolitionist**

Just because someone is Disabled, neurodivergent, or has "lived experience" doesn't mean they have an anti-oppression and liberation-based analysis. People with "lived experience" can be oppressive in a way that feels worse than systemic oppression, because you expect the system to be oppressive, not your so-called peers. What really matters is experience and shared values. ***I don't care if you share my experience if you are complicit in my oppression and that of others.*** *" - Leah Harris*

our experiences
our diagnoses
our labels
our "treatment"
our options for healing
our access to resources
our bodyminds

are politcal

What is safety?

Safety means different things to different people. In the mental health system, safety typically means agreeing not to do anything to hurt yourself or someone else.

Being treated through a lens of constant assessment and evaluation to determine your potential to harm yourself/others **can actually decrease someone's ability to take care of themselves.**

This type of treatment leads folks to be treated like ticking time bombs, and creates a **huge power discrepancy in relationships** (for example: if I say I'm suicidal, I may lose my autonomy and be held against my will; but if I don't, I'm not getting the full care I need).

What is safety?

Imagine you get a text from a friend who says they don't feel safe. The most common way (and the way we'd like to avoid at all costs) people respond, is through a **fear-based framework.** We become afraid and let our fear drive impulsive reactions that can cause the person in crisis to shut down, or face further trauma.

What is safety?

Real safety exists is in the context of culturally respective, mutually responsible, trusting relationships.

This means: no judgments or assumptions!

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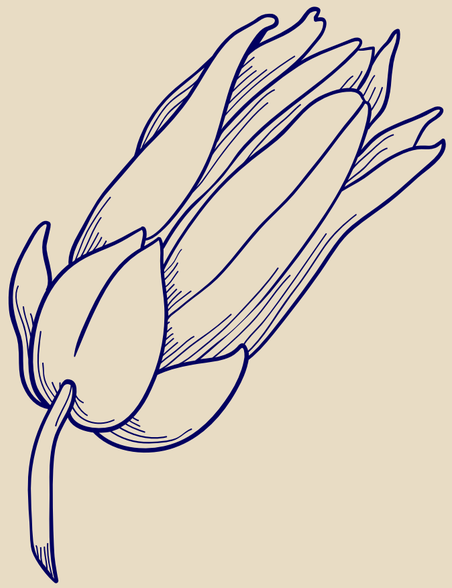
Example: Hearing + Communicating with Voices

FEAR-BASED FRAMEWORK:

- You need to take medication to stop the voices.
- Are you safe? Will you sign a contract?
- People aren't supposed to hear voices, that's not normal.
- You’re just saying this to get attention.



EXPLORATION-BASED FRAMEWORK:

- What does the voices mean to you? What are they saying?
- How does it make you feel to communicate with them?
- What has been helpful about it? What has been hurtful about it?
- If you could describe what this has been like for you, what would you say?
- What support do you need from me?

INSIDE OR OUTSIDE OF THE SYSTEM?

Does it...

- reduce funding to the mental health system?
- increase funding for community-based, peer-led supports?
- center folks with lived experience?
- challenge the notion that forced psych treatment increases safety?
- reduce tools/tactics/technology the MH system has at its disposal?
- reduce the power and scale of the mental health system?

“Recent critiques of solitary confinement and supermax facilities (the solitary incarceration of people in a cell the size of a closet for twenty- three hours a day for months and sometimes years) call for screening for mental health issues and the release of those with such issues from these types of confinement. Such advocacy could be a great case of coalition between prison abolitionists and disability/madness activism. **But calling for certain populations to be released from jails and prisons often sends them to be reincarcerated in other institutions** or by other means, including by forced drugging or by indefinite detention in detention centers, psychiatric hospitals, or psych forensic units.”

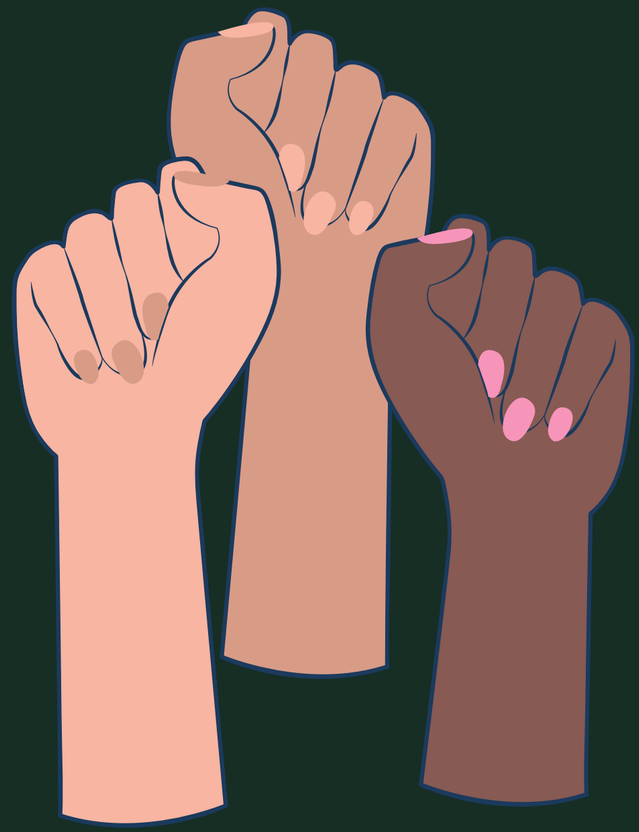
Liat Ben-Moshe

Institutionalized peer support has had a positive impact in many peoples lives for sure, but from a larger standpoint, the institutionalization of peer support has ultimately demobilized the very social justice movement from which it was birthed.

Brooke Feldman: The Co-option and Oppression of a Social Justice Movement: Professionalized Peer Support Services

Do I...

- have true power in the system?
- feel equally valued as other roles in the system?
- have opinions, ideas or beliefs that are silenced?



In psychiatric settings, a patient who doesn't cooperate with their treatment plan is called "non-compliant." We become non-compliant when we refuse to accept the narratives of racial capitalism, and it's through non-compliance that we dream another world into existence.

Madness, Disability And Abolition: Healing In Autonomous Communities

CRITICAL SKILL BUILDING

How do we respond to harm/crises? What are our pre-sets?


Yolo Akili
@YoloAkili
Your desire to *snap* someone out of their depression, or psychosis— may be more about your own discomfort & anxiety about controlling someones mental state. Instant able-bodied cognition can not be and is not the goal of peer support. The goal is to create communities of care.

1. they are the expert of their own bodymind
2. you don't know everything and you cannot do it alone
3. getting other people + resources involved should never come at the expense of compromising the autonomy of the person in crisis

BUILDING A CRISIS + SAFETY PLAN

- **What are your guidelines?** [Ex: Do not reach out to my family under any circumstances]
- **What does a crisis look like for you?**
- **What is the plan?** What do you need during a crisis? What helps you? What should others suggest? *[can have different parts for different states]*
- **Timelines** for taking action
- **Worst case scenario** [places you would go, what to do if you are incarcerated]

PRIORITIES IN A CRISIS SITUATION

Safety + Stabilization

Trying to support someone who is actively unsafe, escalated, or in the midst of a crisis is not the time to start asking questions. You need to develop a mutual framework for trust, and work to help stabilize this person and ensure their safety. Think: what steps will you take to prevent the crisis from further escalating?

Needs Assessment/Core Need

Once the individual has been grounded/calmed a bit, you can begin a needs assessment. You can ask about things like: their location, physical aspects (water, food), and what they need in this movement to move to a place of safety (even if only temporary). There is also often a core need that individuals have, and if you can determine that it will be useful moving forward in your support.

De-escalation

What steps will you take to further stabilize the people involved in the crisis? What relational supports and other resources are needed in the moment to do this? How can you keep this person in a "cool" and safe place? Let them lead the conversation, ask the right questions, don't make assumptions, and work to not re-trigger them.

Long-Term Planning

How are you working with the people involved in the crisis to develop a longer term support plan as a way to prevent future crises from happening? This may be a longer, more on-going conversation. You may consider a "warm handoff" to another resource, so this person doesn't feel like they're being abandoned by a support resource.

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Have you made sure basic needs are met? (example: food, sleep)

Have you checked if they have an existing provider or support system?

Have you asked them what they need?

Have you tried de-escalating the situation?

Is there an existing crisis and safety plan, or Psychiatric Advance Directive?

Have you assessed the risk of suicide or harm (intent, means, plan)?

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Is there an existing crisis and safety plan, or Psychiatric Advance Directive?

Have you created and held space to just talk about their experiences, emotions and suicide without judgement?

Have you assessed the risk of suicide or harm (intent, means, plan)?

Have you sought out urgent, community based crisis resources?

Have you made sure basic needs are met? (example: food, sleep)

Have you checked if they have an existing provider or support system?

Have you asked them what they need?

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Have you made sure basic needs are met? (example: food, sleep)

Have you checked if they have an existing provider or support system?

If you do involve others: Do you have a plan to reduce harm as much as possible?

CN: DISCUSSION OF SUICIDE

SUICIDE

Thoughts of suicide does not mean imminent risk

There is so much space between thinking of death/suicide and actually having the plan and means to act on those thoughts. When we automatically assume someone is in imminent danger, we involve other systems that can strip autonomy from the individual. Regardless, we need other ways to support folks who do have a plan, means, and intent that are voluntary and non-coercive.

Studies show risk of suicide increases afer being released from a psych hold

Many clinical providers and the general public believe that safety for someone in a mental health crisis truly means being locked up. We know better than that.

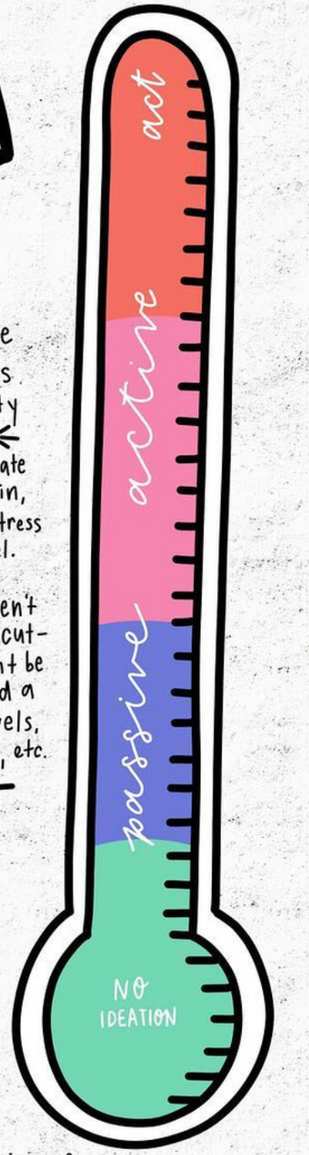
We keep each other safe

How can we support suicidal folks in our communities? Can we take rotating shifts to care for the person? Can we organize a meal train? Send art supplies? Crowdfund for material resources? Support them in leaving their current environment for a period of time? What does that person truly need in this moment, and how can we act on our understanding of safety as relational + being in community?

It's about building a world worth living in

In the current context of our society, it makes sense for people to be suicidal. That is a reasonable response to the harm, violence, oppression (etc.) faced by so many people--especially those who are multiply marginalized. Though not everyone may directly link their suicidality to social factors/causes, there is enough evidence + lived experience to support social solutions being impactful.

THERE ARE DIFFERENT TYPES OF SUICIDAL IDEATION



NOTE

ALL of these types + levels of suicidality are =VALID= & doesn't dictate the level of pain, intensity, & distress you may feel.

♥

These also aren't always clear cut- someone might be moving around a few, "skip" levels, fall in between, etc.

SUICIDE ATTEMPT

attempts to kill self, either initiating made plan or impulsively

SUICIDAL with PLAN & INTENT

has a specific plan (how, when, where) and intends to carry it out → Ex. "I am going to overdose tomorrow at home."

SUICIDAL INTENT (no plan)

intends to kill self but doesn't have a specific plan → Ex. "I think I'm going to kill myself, but not sure when."

SUICIDAL THOUGHTS (method, no plan or intent)

has an idea of how they would do it, but no specific plan or intent → Ex. "I've thought about overdosing, but I'm not going to."

SUICIDAL THOUGHTS (no intent/plan)

thinking about killing self, but no details & no intention to act → Ex. "I should just kill myself." "I wish I could just kill myself."

THOUGHTS OF MORBIDITY

thinking about own death & dying, but not specifically by self → Ex. "I wish I wouldn't wake up" "I wish I were dead."

RANDOM INTRUSIVE THOUGHT*

passing thought, curiousity → Ex. "What if I just jumped?" when waiting for train *different if person has chronic suicidality

NO THOUGHTS

SOURCED FROM lived experience & columbia-suicide severity rating scale

@ALYSERURIANI

ALTERED STATES

Slow down and recognize that you are probably not in danger simply because someone is behaving in an unconventional way.

Unconventional does not equal dangerous

It is also important to validate that their reality is real for them if that's what they need to hear. **It profoundly escalates things to repeatedly tell someone who is having their own reality experience that it's not 'real'.** It is gaslighting because their reality experience is extremely real for them. While your reality (as the observer) may be different and perhaps shared with more people, that does not erase the fact that their experience is real.

ALTERED STATES MANNERS

Dive In + Join Them

Be present in the moment. Dive in. Ask questions. Engage. Don't fight back, challenge, and try to prove them wrong. Don't assume your reality is the only "correct" one.

Honor Spiritual Beliefs + Non-Medicalized Perspectives

If someone thinks they're receiving spiritual messages, validate that they are spiritually powerful and that there is so much you don't know. If they think they need to constantly create art and that they're going to be famous, validate that they are talented and remember that it makes sense within productivity-obsessed capitalism for someone to feel they need to produce content prolifically. Many people view their altered states outside of a medical context or framework.

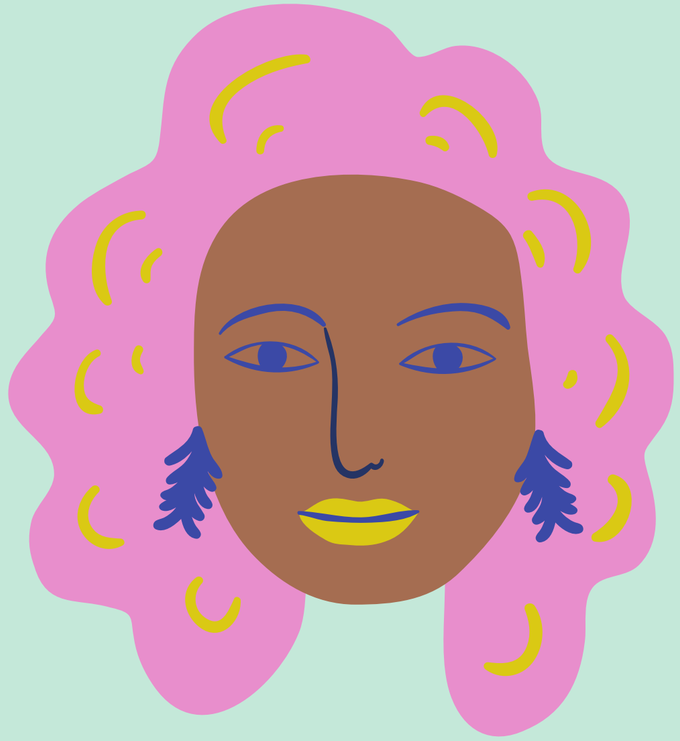
Don't Assume It's Paranoia

For example: if someone (especially a negatively racialized person) is talking about surveillance, validate that because of the type of world we live in! Remember that this can be understood not as simply a delusion but as an extrapolation of the reality of a surveillance state. **These mental states extrapolate real things.**

Suspend Judgment

Acting horrified and demanding hallucination content when someone talks about hearing voices, especially on command, is not okay. There isn't a valid reason to assume the person is dangerous just because they are hearing voices. Also, asking for a live play-by-play, demanding details when a type of hallucination is mentioned, etc. is crossing the line.

De-escalation should come from a place of empathy and patience, and if we decide to do it we should be willing to collaborate with the person in crisis, not just tell them what to do.



BASICS OF DE-ESCALATION

- Focus on helping them access physical and emotional safety. Ask them what they need from you to be able to trust your help.

- Work with them to help them get what they need as opposed to telling them what they should be doing

- Keep their voice & choice centered in your interactions (**“Can you tell me what you need?”** or **“What usually helps you when you feel like this?”** or **“Here are some resources we can connect with, what feels best for you?"**

- Consider power dynamics around historical oppression that may be present due to identities such as race/ethnicity/gender or past experiences of trauma. Also, consider if there is someone else that may be able to better respond based on shared identity and experiences.

DE-ESCALATION DO'S + DON'TS

DO

- Try to understand and reflect on what the person is experiencing and what they're communicating about
- Ask simple questions, one at a time, and use plain language
- Be direct! Ask if they're considering killing themselves, if they have tools or plan. Ask if they're comfortable enough sharing that plan or getting rid of the tools. Ask if they have already executed their plan.
- Ask what will help them to feel safe and in control, offer choices
- Keep space for you or the person to easily exit the room

DON'T

- Blame, accuse, lie (about who you are, what you can do for them, who you are getting involved)
- Demonstrate disbelief about their experience
- Make demands
- Use a loud voice
- Threaten or criticize; whisper or laugh
- Make decisions/involve others without consent or informing the person of your actions
- Say mantras that are not tangible or specific (the best is yet to come)

"More often than not if an individual in a mental health crisis grabs something as a weapon it's gonna be in self defense because they're scared or experiencing paranoia. Sometimes you can say, 'I see you're holding a knife in your hand, are you feeling scared right now?' or 'Can you trust me enough to put that knife down while we talk?' or 'I know you won't hurt anybody but I'm concerned there are other people around who may think you'll hurt somebody so can you put it down?'" Shannon Benaitis

Community Resources

When responding, consider all options before engaging with potentially violent, abusive, or deadly "resources"

Pod Mapping

Pods are a great way of identifying individuals in the community who can show up during a crisis moment.

Peer Respite Centers

Only about 13 peer respite centers exist in the US, but they have been shown to reduce the "need" for psych hospitalization/incarceration, and are peer-led.

"Soft Holds"

If a community member is feeling like they can't keep themselves safe, consider setting up rotating shifts of folks who can come and stay with/spend time with them.

Mobile Crisis Response

Some communities have MCR teams that can respond to crises or do "checks." Make sure to research the MCR before you use, as some work with police.

A good support network is the single most powerful protection against becoming traumatized After an acute trauma, survivors require: presence of familiar people, faces, and voices; physical contact; food; shelter and a safe place; time to sleep. Our attachment bonds are our greatest protection against threat.

IF POLICE GET INVOLVED:

Details can make a difference for harm reduction

If you are able to give information about the person and situation beforehand, it **may** make a difference during the response.

If it's safe: use your body as a barrier between EMTs/cops and the person

This can help slow the process down, and give the person a chance to go voluntarily as opposed to being forcibly restrained and medicated against their will.

Acknowledge the harms

When you call 911 you risk: force, coercion, detention, deportation, trauma, isolation/solitary confinement, sexual violence, loss of job/house/child/privacy, death; Bringing in force and coercion is always an escalation to what is going on, and should always be seen as a last resort.

Why am I calling? What are my intentions? What needs are being met? Whose needs are being met? Mine or the person who needs support? Is it about my own fear or my compassionate concern for the other person? Am I actually in danger? Are they actually in danger?