Yale RebPsych 2020

 "Critical Mental Health and Liberation Psychiatry - Decolonized,

 Community-Based Approaches to the Mental Health Industrial Complex”

 Thursday, October 15th, 2020

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"Critical Mental Health and Liberation Psychiatry - Decolonized, Community-Based Approaches to the Mental Health Industrial Complex"

Presenters: Stefanie Lyn Kaufman-Mthimkhulu & Xochi Cartland

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Nientara Anderson: For those tuning in, we're giving a few minutes for others to join. Then we'll get started.

How does everyone feel about starting now?

Welcome, everyone, to Reb Psych 2020: Decolonizing Mental Health. I am Nientara Anderson and I'm here with Marco Ramos. We are psych students and on the committee of Reb Psych. We want to acknowledge we are on stolen land. We are realizing that other Indigenous people have stewarded these lands. We honor and respect the ongoing relationship between people and the land.

Marco Ramos: This aims to explore what it means to decolonize mental health today. We talked about rethinking addiction last week. We'll drop a recording of that into the chat.

Tonight, we're delighted to introduce our series looking at decolonized approaches to the mental health industrial complex.

We have Stefanie Lyn Kaufmann-Mthimkhulu and Xochi Cartland with us today. They work with Project LETS. Their work specializes in building peer-support collectives and non-carceral structures. They have led many trainings for students, practitioners, and helped with policy creation.

Stefanie comes with lived experience and working with incarcerated peoples. Xochi is a student coordinator of the transformative justice program at Brown. Their primary interest is in building grassroots structures to reduce harm outside of institutions. We look forward to them sharing with us.

A bit of housekeeping. We'll hear the workshop first and then have time for discussion. Please share the chat function to share questions. We will monitor that. We have live and recorded closed captioning. The directions to access that are in the chat.

Recordings and a transcript will be distributed. With that, I'll turn it over to our presenters. Virtual round of applause.

Stefanie Lyn Kaufmann-Mthimkhulu: We are so excited to be here. A few notes from us: We are strong believers in practicing access-centered practices. I'd like to echo that there are captions available. Do what you need to do to be present in this space. If you're in bed, doodling, headphones or not, that is fine with us. Be present in the capacity that feels best for you.

Just a few content warnings and notices. We will be talking about the history of psychiatry, specifically violence against Black, Indigenous, and marginalized folks. These topics may be difficult to hear. Take a step back if you need and revisit the recording when that feels best for you.

Decolonization is a big term with different meanings to different people. It's moving back to an Indigenous approach, centering Indigenous knowledge. I know we all come with different understandings, so please center on that. With that, in this workshop, our understanding of Indigenous folks is not limited to folks indigenous to Turtle Island. We believe liberation is across borders and boundaries, centered globally. We will talk about experiences and practices outside of a United States focus.

Xochi and I acknowledge privilege here. So many have been disconnected from practices and traditions, and we are privileged to study practices similar to and different from our cultures.

I want to acknowledge some healers I've worked with. I was first a patient and then working alongside [names], a group of Sangomas.

Xochi Cartland: Hello, welcome. I am sitting outside in a gorgeous setting, in Puerto Rico. It is a huge privilege to have access to share and learn this information. I want to name my teachers. I have learned transformative justice from many [listing names.] I am Mexican Indigenous. My father's family came on the Mayflower.

This is not something that's an abstract, it affects all on a deep and personal level. We all have to work actively in decolonization. We have to practice it. With that, we're ready to get started.

Stefanie Lyn Kaufmann-Mthimkhulu: I am a white, Puerto Rican, Jewish, femme-ish person. I am wearing glasses and a t-shirt.

We have a lot of content here. We'll try to get through it all. Please ask questions as we go. If it fits, we'll try to address it as we go. We'll talk about the boundaries of psychiatry and about the history. It's a very non-complete history, though. We will pick important points but there's so much more. We'll be talking about Indigenous-centered understandings. We'll talk about carceral logics and how the conception of diversity, madness, and neuro-divergence has been linked to the carceral state of the United States.

We'll end with healing practices and focus on liberation, care, and support outside of institutions, and professionalized settings.

I want to start with something I learned from Dustin Gibson, an organizer in the disability justice space. It's about centering people. We can talk very abstractly, but it's about real people. Real bodies, real minds.

We have an image of Zachary Bear Heels. He was 29 and Indigenous. He was taken in 2017 by police after being reported for erratic behavior. He was murdered after being tased and punched multiple times. An autopsy stated he didn't die from shocks or punches, but from "excited delirium". That term has no grounding or basis in medicine, but is used to blame Black, Indigenous People of Color for their own deaths, stating basically that they got so worked up they died. This removes the locus of responsibility from the people who murdered him.

We have Saraya Rees, a person who is Black biracial. She was incarcerated for this. She was abruptly taken off her psychiatric meds by her doctor. This was a year ago.

The crisis prevention team threw on the ground and arrested her for arson and attempted murder of her family members. She was coerced into answering questions, and her family was unable to see her for weeks. She was sentenced to 11 years in kid prison, where she is being routinely physically harassed. I encourage people to look her up. I'm going to take a moment to let people process that.

I know this is heavy content. We encourage people to share in the chat what brings you here so we can have some interaction with you. This was supposed to be a more interactive workshop, but we are where we are.

Xochi Cartland: None of this material is being handled lightly. We're both committed to doing work in a more empathetic way that's rooted in community. Please know that we feel that pain with you.

Stefanie Lyn Kaufman-Mthimkhulu: Psychiatry is colonial legacy, but it's still ongoing, which I feel is important to recognize, and it doesn't account for the multitude of injuries through colonization. It further amplifies the harm done by the carceral system.

China Mills has talked about colonial psychiatry as a medicalized colonizing of lands, people, bodies and minds.

I think it's also important to note that while these are linked, these are also dual processes. Some populations have experienced both colonization and psychiatrization. As we move into this, there has been a global undertaking to frame an increasing number of experiences globally of violence in psychiatric terms.

I think it's important to note that this is something that after folks began engaging in these violent practices, they needed some justification. There was a perception that Indigenous people were innocent and child-like, the noble savage myth, and could not be mentally ill.

Conversely, Black folks were perceived as being inherently mentally ill. For both peoples, the solution was colonization, so they could "evolve." The thought process for colonization was different but the solution remained the same, that bringing civilization to them will heal them and help them evolve.

I also want to make note of some of the contrasting values that occur within western cultures and Indigenous cultures globally. Thinking about things like domination, competition, a belief in an objective truth, and of course individualism, in Western cultures, prioritizing individuals over community.

It's also a belief that being interdependent, which we all are, is shameful.

On the Indigenous side, they emphasize cooperation, collectivism, mutual aid, one with nature, and so on.

Xochi Cartland: Thank you so much for that, Steph. This is obviously an incomplete timeline, but we'll start with pre 1417 and the conception of mental illness, rooted in people exhibiting non-normalized behavior and coming together to support them.

In 1417, the first psychiatric hospital opened in Spain, and I want to note that that's a primarily white country.

Dualism, that body and mind are not the same thing . . . the idea was that the body and the mind were inherently different, and we start to see this divide between psychiatry and other forms of medicine. There's this huge emphasis on individuality, that there's something wrong with your neurochemistry, not that this is something normal, normal responses to harm under white supremacy.

The Quakers were the first to use solitary confinement. We see literal torture, lack of freedom, restriction of movement, things like that.

In 1851 there was a eugenicist who coined this term. He didn't understand why enslaved Africans wanted to escape, and this was used as a way to excuse colonialism and enslavement.

The next is dysaesthesia aethiopica, which was a theory proposed to explain "laziness" in African Americans. They were seen as 10x the chance to have mental illness. The theory was that enslavement was the proper place for Black Americans, and enslavement was a proper cure for this mental illness. We need to interrogate how this was used to uphold white supremacy.

Stefanie Lyn Kaufman-Mthimkhulu: When Black slaves were recaptured, labor was often used as the "treatment." We continue to see that up to now, this conflation of treatment and punishment.

Xochi Cartland: We also want to talk about hysteria, which comes from the Greek and means uteruses. We want to honor because of the way this was rooted in perceptions of gender, this primarily affected people who present as femmes, but this could affect anyone with a uterus. This was a way of policing women.

The vibrator was used to treat hysteria, so sexual abuse was also tied to this as women were forcible penetrated without their consent in the name of a cure.

Hysteria was used to explain people who could not "cope" with their forced trauma of assimilation. They called that an irrational response to what was actually a very normal response to abuse and trauma.

Stefanie Lyn Kaufman-Mthimkhulu: Something that continues to come up with the experiences we have, you might be thinking this is the past and it's not so bad anymore, or we don't do XYZ anymore, but the reality is that an institution and practice cannot and should not ever be divorced from its history. We have to reckon with that. If that manifests in marginalized folks being fearful of engaging in treatment, that's totally valid. Some of these things are very much still present.

Xochi Cartland: And taking accountability will never happen unless they acknowledge the legacy. We won't be talking about things like forced sterilization. Those are ways in which medicine is still being weaponized against black and brown bodies.

This is very much ongoing. Ignoring it will not serve our liberation.

Stefanie Lyn Kaufman-Mthimkhulu: I really recommend this book about the abusive history toward African Americans.

So we see this theme of Blacks and indigenous folks of inherently being inferior, and western civilization being necessary to make them whole.

In 1889, we have the great confinement, primarily in Europe. Anyone considered to be an other is institutionalization to "protect" society from degenerates.

We are moving to the early 19th century. We have Freud, who we just can't get into right now. He brings talk therapy. Darwin, who brings eugenics in the form of looking at biological idealism. These are shaping psychiatry in a specific way: to value some traits more than others.

A lot of people don't know about the "Ugly Laws", not repealed until 1974. This looked at people deemed "unsightly or unseemly." It targeted disabled folks as well as Black and Indigenous folks. It was illegal to be in public.

We have a pattern of using pseud-science. It pathologizes survivors and resistance to violence and oppression by white patriarchy.

We have the words of Holmes: "Three generations of imbeciles is enough." This has never been overturned. This is literally still law. This is around the compulsory sterilization of the "unfit."

From 1939 - 1945, about 300,000 people were killed in psychiatric hospitals in Germany and Austria under the Nazi regime. It started in the 1920s. They were experimenting on disabled folks. Alfred Hotch co-published a treaty about "permitting the destruction of unworthy life." This was the blueprint for the Third Reich.

In 1980, trans folks were officially classified as having "gender identity disorder." Hysteria wasn't declassified until this time.

So biological idealism is blossoming into psychology to justify oppression.

Xochi Cartland: This was all legal. There are many things active in psychiatry today. That doesn't mean they're not harmful or abusive. Forced admittance, sterilization, medication, and slavery, yes. I am familiar with protocol. I understand the limitations and that it is active genocide. Legal doesn't mean it's OK.

We're talking about . . .

Stefanie Lyn Kaufmann-Mthimkhulu: This is an asylum for "insane Indians" in South Dakota. It was the only Indigenous asylum of its time. We know many people were there for reasons that had nothing to do with mental illness. They had physical impairments and disabilities, arguing with agents, refusing to give up their spiritual practices, and refusing to let their children be sent away.

I'm going to read from a book I'll talk more about: Children were straight-jacketed and chained to beds, lying quietly in their own excrement. One girl was chained to a steaming radiator. He found calm, well-behaved, mentally healthy patients who had been locked away for up to three years. He found every window locked and barred.

They had hired attendants from local farms who made decisions about restraint of patients. The decisions weren't up for review.

So that's another example of the violence Indigenous folks have faced, the violence of pathology and being pathologized and losing freedom. Renée, the author of the book, says they, the Indigenous folks, were engaged in acts of resistance without using that terminology. Families would "share the burden" of a person experiencing mental distress to avoid utilizing institutions.

Xochi Cartland: We're going to talk about the Central Lunatic Asylum for the Colored Insane, a facility founded in Virginia in 1870. It was the only asylum for African Americans until they were integrated in the 20th century.

It was created after slavery had theoretically ended in parts of the country. It was used as another way to get labor from Black folks. Racism shaped the treatment and the attitude of the care providers. There are reports of patients incarcerated for talking back to police officers or bosses, homelessness that was a direct result of being enslaved, or not getting off the sidewalk for a white man.

The case reports that were released, there are comments referring to specific patients, like "old useless harlot." Many comments centered around whether a patient was "useless" or "useful." One patient was said to have attempted to kill every white man.

So not having the lived experience of being enslaved have the right to view that as non-normative behavior. Sometimes there is an assumption in psychiatry that, because of your training, you have insights into people who have experienced things you never have. This is so rooted in white supremacy. These institutions were as well.

They were really just creating a working force here. Let's move on.

Stefanie Lyn Kaufmann-Mthimkhulu: I want to add, as Xochi mentioned, some other notes: Patients were there for refusing to let a white man pass, talking back to a police officer, homelessness as a result of being stolen from ancestral lands. There is one story about Caleb Burton, and he was said to be delusional and insane as a result of being emancipated after the war.

Xochi Cartland: There is an intersection between mental health systems and the carceral system. This is surveillance, control, eugenics. People are restrained in environments under the guise of safety. We know that is not true. It exists in mutually respectful and inclusive states.

Disabled people are more likely to be killed by police. It's also important to say that the majority of people killed are Black, Indigenous, Trans. This functions off of capitalism.

Disabled people are worth more money to the state in hospitals and jails than they are on disability benefits. This is saying we are such an individualized society that we see people in these terms. It turns the job of someone meant to help people into someone who cares about a person as property or an asset.

People who were previously in asylums got shuttled off to prisons when funds for asylums ran out. In the United States now, there are three times more disabled and mentally ill folks in jail than in hospitals. They shouldn't just be incarcerated in hospitals either.

We see how the legal system criminalizes neuro-divergence and non-normative behavior. People are dying as a result of police brutality. There are people with power and people who are disenfranchised by incredible violence.

We also need to understand the ways that prisons produce mental illness. They are disabling experiences. I was hospitalized for suicidal ideation, and I promise you I was more suicidal when released than when I went in. Not having access to my own clothing, having male guards after I'd been abused, these are all ways the system creates more violence.

Stefanie Lyn Kaufman-Mthimkhulu: There's a doctor who is always on CNN, doing medical correspondence, and after our president went for his joy ride in the car with the secret service members in their PPE, she tweeted that Trump was her patient she would restrain him and put him on psychiatric hold. We can see how there's this criminalization act, using these methods as a method of control. I'm not in favor of our president, but I'm also not in favor of using the medical system in this way.

I'm sure that many people in the medical profession would not welcome that link to carcerality.

Xochi Cartland: [Reading screen]

Stefanie Lyn Kaufman-Mthimkhulu: We're not going to have time to go over this. I encourage you all to look it up. The blog is "Leaving Evidence" at Wordpress. She has mapped out the medical industrial complex for us, showing the interconnectedness of control, exploitation, ableism and so on.

As I mentioned, I think it's critical to have a global context when speaking about liberation and talk about the profit gained from medicalizing distress. The U.S. has found it very profitable to persuade others that they express distress in the same way we do in this country. They deny local realities of distress.

[Reading quotations from China Mills] [On screen.]

We're at 6:50pm. Xochi, we're so right on our timing. You're going to get recordings, slides, and we're going to move through this as best we can. If you need to log off before we're finished, that's fine.

This is a group of folks from Rwanda. I want to read a quote from Andrew Solomon talking about his time there with traditional healing methods. He's quoting someone speaking with him in Rwanda.

"We had a lot of trouble with western mental health workers who came here after the genocide. Their practice did not involve being outside in the sun. There was no music. There was no sense that everyone had taken the day off so the whole community could come together and lift you to joy. There was no acknowledgement that the distress was something that could be cast out. Instead, they put people in dingy rooms and had them talk about bad things that had happened to them. We had to ask them to leave."

I think the podcast is called The Moth, and the episode is in the chat.

Xochi Cartland: We want to define mental health as the ability to have justice. Think about how different that is from your current conception of mental health. Justice is unfortunately denied to so many of us.

Stefanie Lyn Kaufman-Mthimkhulu: The World Health Organization defines mental health as a state of well-being in which a person can work productively and make a contribution to their community, which sounds like an advertisement for capitalism. It's not good. We encourage people to have a personal definition of what mental health means to you.

Xochi Cartland: It's linked to the idea that if you don't produce, you don't have value.

Stefanie Lyn Kaufman-Mthimkhulu: Fanon is coming, don't worry. I got a question in the chat.

This is a quote from Renee Linklater about decolonization. [Reading quotation] [On screen.]

She talks about how diagnoses are really one marker of a journey. I want us to think critically about what it means to be given a diagnosis by an institution that upholds the status quo. I saw a comment about how gender dysphoria has been reclassified so you get accommodations and surgeries . . . it's important to recognize the limitations of a diagnosis.

PTSD is one of the only diagnoses that implies that something has happened to you. Linklater talks about residential school syndrome and a PTSD like response to being put in a residential boarding school as an Indigenous person. She asks who it is who's really sick in that relationship.

One way we can decolonize the system is by calling things by their accurate names. We're implying that things need to be treated medically as opposed to something that needs to be treated spiritually.

Xochi Cartland: There are also useful things about psychiatry. I want to mention that. I thing the important thing to name is that psychiatry was not created to cure people. It was created to control and monitor people. It's important to think about what the system was created to do.

A bit more about Renee Linklater. She has a very holistic way of asking why we are focusing on individuals when it's really about relationships, to others and to the world.

We won't heal from trauma unless we acknowledge that. I'm thinking about the collective trauma I'm experiencing with everything going on with ICE, for example. It's not a trauma that will be individually fixed by psychiatry.

I think when psychiatry wants to go into intergenerational trauma, it's also the memory and the resilience that guides us, and that we have to tend to.

There's also this idea of parallel realities to treat psychosis. In many cultures, talking to your ancestors is a very important spiritual practice, one that in the United States you can be hospitalized for. Is the reality you're experiencing not a reality just because it's not what most people experience?

There's the idea of ethnostress. This is the idea that they are symptoms of dehumanization from colonization.

We need to discover the source of the soul wound in some traditions, and that happens outside of colonization. The idea with colonization is so centered around the idea that some lives are worth more than others, but the idea of Indigenous healing strategies are vastly different. We are all related, and connected. That is vastly different than white, Western approaches.

Stefanie Lyn Kaufmann-Mthimkhulu: There was a comment in chat about how not everything applies to everyone, and can be harmful. We're saying, many people with different spiritual practices and understandings of their minds and how they work can be pathologized. They believe they see or hear things that other people don't.

If you have a Black friend who feels they may be surveilled by the government after going to protests, sometimes this is pathologized and they are told, no that's not happening. This is incredibly harmful. Some people may have experiences that are treated through medicine and therapy; we want to broaden the approach to different conceptions. But we don't want to say that's the thing to use for everyone.

Xochi Cartland: We have a medicine wheel here. There are many Indigenous folks who use this. The people of the Dagara Nation in West Africa and in Turtle Islan, or north America. The shared ideas is that wellness can't happen until all of these quadrants are aligned. We need to think about and criticize how psychiatry focuses only on the mind. Never was I asked about my food or housing security, and those were not secure many times. That contributes to my wellness.

Stefanie Lyn Kaufmann-Mthimkhulu: After being in community with other disabled folks, when talk about the body comes up, it is typically dismissed. I had a spinal infection that was dismissed as a psychosomatic effect of my neuro-divergence. It was dismissed until someone finally found it.

That's important. When we take the body into account, it can show up as dismissing somebody's experiences.

Fanon - incredible. We cannot do him justice, so we're just highlighting him and his book. He introduced sociodiagnostics. It's an indictment of colonialism. He says it's a disease that distorts human relations and renders everyone "sick."

There were studies done about the layout of the cerebral structures of the North African that were responsible for them being seen as "lazy/inept/impulsive." I think this is a very useful tool and framework of his. We can't understand psychological problems and distress outside of the conditions of oppression that led to them.

That's why I have problems with this talk about mental illness coming on because of COVID. It's like, you're having a hard time dealing with this so we should treat you individually. It's not black and white, but we need to think about it.

If it is society that is sick, society needs to be replaced. (Fanon).

This is Ignacio Martin-Baro. He was murdered by the CIA in El Salvador. He was critical of western psych. He developed some useful, critical frameworks. Namely, we have to be critical about social and emotional issues that impact health. He linked social justice as a form of mental health care. He talks about four main critiques.

We tend to focus on biology. We mentioned that western psychology also focuses on the individual. Hemostatic - he says, question the status quo. Revelation may be needed, that's a saying of his. Ahistorical. If 200% more Black Americans are diagnosed with schizophrenia, does that mean they have more schizophrenia or is something else going on, with Black men in particular. They are diagnosed much more frequently.

There is a political reason why psychiatry has been ahistorical. To medicalize suffering is to take away the political responsibilities about what that means to people. We have to be clear about that.

This is one of my favorite graphics. A Pacman is talking to a therapist saying, I see dead people. This is normal abnormality - talking about symptoms over context.

There were high levels of anxiety during the El Salvadoran war. Is that mental illness, or is that a normal reaction to an abnormal context or situation? Is it harmful, or is it an accurate depiction of your context? That's something only you can determine or decide. We don't apply this to everyone, just want to introduce this relational concept.

Lastly, I want to highlight Dr. Sama Jabr. There's a great article - Palestine's Head of mental health services says PTSD is a western concept. That's the title.

What is sick, again? The context or the person? She says, in Palestine she sees many reactions are normal reactions to a pathogenic context.

We talk about PTSD by saying, you're safe. The event is over. You're not there. But what does it mean to face ongoing trauma? For Black Americans, that's constant. There is no "you're safe." I think in the United States we ignore that reality of ongoing trauma.

One of my other favorite quotes is by Hussein Bulhan. Psychiatry, like any therapy, should be the meeting of two free people.

What time is it? We're going to spend a few minutes going over examples of community healing. Strategies and approaches.

A few disclaimers: I and Xochi believe we have the ability to support our healing in community. Oftentimes we've lost the ability to do this as things become outsourced and professionalized or medicalized, monetized. Birth and death used to happen within the community. We want to look to other strategies that prioritize culture.

And not everyone tied to a specific culture is tied to it or identifies with its healing. There has been a concerted effort to ensure that people were stripped of their traditional spirituality and healing. The religious freedom act of 1978, for example, legalized American Indigenous rights to their spiritual practices and beliefs.

There are many things to think of. There are practices of chaining mentally ill folks, globally. In certain parts of South Africa, a child's disability might be seen as evidence of a parent's bad behavior, particularly the mother. So harm can occur within community and institutions.

Here is a quote: There is something about communal movement, music, and singing that can restore inner equilibrium disturbed by trauma. (Body Keeps the Score)

One example I'm personally familiar with are sangomas, who typically approach mental health from a community based framework. There are some who specialize in divination. They'll have a variety of bones and shells and you blow into the bag, and they roll out the bones and objects. They also use plants and herbs, soul retrievals, processes where if you're personally or a family member of being cursed by some spirit, you bring money and wine to the spirit and build them a home. It's an example of a dialogue with the illness.

There's a group of grandmothers in Zimbabwe who created and operate the Friendship Bench. They are primary care providers who help people with what we might call lower level mental health issues, like depression and anxiety. They have a local term that translates into "thinking too much." They have also developed a diagnostic guide that incorporates their spiritual beliefs. These grandmothers will come and wait for people to come and speak to them and it has been found to be beneficial for folks.

Xochi Cartland: I'm happy that people are participating, but please watch your use of language, and please do not put traumatizing language relating to the harm that other people have experienced.

Stefanie Lyn Kaufman-Mthimkhulu: I'm seeing someone mention not speaking about traditional healers who engage in harmful practices. We gave the disclaimer that there are practices harmful in both institutions and in communities. You're absolutely right. It's not that community solutions are 100% great. But we want to highlight some things that people may not be aware of.

Xochi Cartland: I want to echo that. There have been times I've been harmed by traditional methods of healing. The difference for me is that I wasn't forcibly injected or disappeared in those situations. Harm by institutions happens at an alarming rate. There was a very good study and one of the quotes that stuck with me was that they would rather die than put in a psychiatric institution again. It's important to understand proportionally what tends to harm people, especially people of color and marginalized folks.

I want to talk about traditional healers in Mexico. It's rooted in identifying what is troubling your spirit and using somatics and ways of connecting with the Earth to treat the illness in an integrative way. It's often not called an illness at all.

Stefanie Lyn Kaufman-Mthimkhulu: I want to highlight two efforts happening in the U.S.

Mental Health First is a mobile crisis response that has peers involved, nurses, mental health workers who are available for conflict resolution and for domestic violence. They are doing great work.

I don't know how many of you know about peer respite centers, but they are non-medicalized houses where people can go if they're in psychiatric distress. A study was done in California that shows that people who checked in to peer respites were 70% less likely to use emergency or psychiatric inpatient services.

That is all we have for content. Thank you all for bearing with us. I'm very happy to see the discussion in the chat, and I'm happy that people are sharing experiences. I think Xochi and I both don't want to come across as saying one thing or the other is the solution. It's going to require many solutions, different people working together, doctors working with traditional healers, to get people the care they need and want.

Xochi Cartland: And the goal is self-determination in the options that people have, not just to have more options. At no point did I have any autonomy over my treatment. It was something done to me. We want autonomy in every aspect of this process. That's the goal.

Stefanie Lyn Kaufman-Mthimkhulu: Absolutely. There are a couple of questions in the Q&A. If you want to submit a question, please do. Xochi and I will not be able to address everything right now, but we'll take some time and put together a Google doc of responses. So feel free to send them in and we'll get to them.

Nientara Anderson: We're also putting a link to a feedback form in the chat. We'd really like to hear your input.

Stefanie Lyn Kaufman-Mthimkhulu: Can you address why using social workers to do the work of police with the mentally ill is not enough? We need to further grapple with policing and how it's white supremacy bullshit, generally . . .

Xochi Cartland: This is my favorite question. Why are social workers not enough? Because they are mandated reporters. They still work in the carceral system. If we ask them to replace police, they will take over surveillance, monitoring, and the other roles of police.

It also legitimizes the carceral state. Looking at a case like the Minneapolis State department is important. They were among the most progressive police departments in the United States, and George Floyd still happened.

The Justice Collective has great resources, and we highly recommend them.

Stefanie Lyn Kaufman-Mthimkhulu: In the chat, I linked an article I wrote about this very topic.

Somebody asked about how to bring these topics up with your universities and strategize around these issues on campus.

That's actually part of how this was born. When I was a student at Brown, faced with the very carceral way that higher education handles mental health issues on campus, basically you're viewed as a liability. There's an extremely violent system of behavioral management and teams of folks who will monitor or force treatment on people, and dictate what kind of care you need while you're a medical student if you have a crisis or a documented history of mental illness.

Project LETS has chapters around the country on different campuses, and if you're interested in getting involved with that, you can check our website.

[Reading question] "I have a question. I’m a psychiatry resident working on an inpatient psychiatry unit with many people involuntarily hospitalized. I agree that involuntarily hospitalization is NOT just or therapeutic. But I have patients who need a level of community care and support which just doesn’t exist right now. Some of these people aren’t able to take care of themselves when the leave independently. Do you have advice for what I can try to do for someone who needs community support when the infrastructure doesn’t yet exist?"

Xochi Cartland: That's a good question. We lack the resources.

What preventative work are we doing? I notice people don't have access to community in a harmful way, you might notice. So how are we addressing that? We can do pod mapping, make a crisis plan with them, identify who they would be comfortable sharing with.

And the crisis plan shouldn't be, call 911. It's what can you do in the moment.

Did I freeze? OK. Project Lets talks about doing work outside of the carceral state. We need to be creating systems there. Look for how we can uplift each other's work and connect.

I think it's about advocating for your patients to the extent you can, and emphasizing de-escalation. Don't use chemical or physical restraints when you can. Emphasize humanity. There are things you can do in the moment to support autonomy and respect.

Nientara Anderson: This was an amazing kick off to Reb Psych. Thank you, attendees, for being here and sharing with us. I'm going to drop the feedback form into the chat and thank both of our presenters for being here tonight and sharing knowledge, experiences, and presence with all of us.

Please come to the next event, on 10/22/20 at the same time. You can register and share it with your friends. We look forward to seeing folks at subsequent events. This has been a great start.

Stefanie Lyn Kaufmann-Mthimkhulu: Thank you for being here and thank you for moderating. Thank you to the captioners for giving access.

Nientara Anderson: Thank you to Kyle, Christy, and Jason. We appreciate y'all. Goodnight, everyone.

[End of webinar.]