REIMAGINING CRISIS SUPPORT

MATRIX, ROADMAP AND POLICY

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Roadmap

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My home is situated on the aboriginal territory of Mohawk and Abenaki communities. I acknowledge their living cultures and those who remain on this land.

Deepest thanks to my life partner Diana Signe Kline for asking me to explain the 'mind maps' and for her art that invites us to go deeper; to Lu Han for multi-leveled support and many generative conversations; to Beatriz Pérez Pérez and Hege Orefellen for their comradeship in pushing the edges of survivor knowledge; to Lu Han, Beatriz Pérez Pérez, Brookes, an anonymous Mad person, Irit Shimrat, Jeannette Kah Le Guil, Jen Padron, Bethany Brown, Erveda Sansi, Beatriz Tarancón Sánchez, Stephanie Wooley, and Ann Campbell for their comments on one or more drafts of this material; to Max Dashú for the layout tutorial and to Lu Han, Diana Signe Kline, and Sophie Cheung for feedback on layout. The finished work is entirely my responsibility.

This book is for everyone who is interested in crisis support that does not depend on mental health discourse or practices.

It is for human rights defenders working on legal capacity reform, deinstitutionalization/independent living, and the abolition of involuntary commitment.

It is for everyone who has been psychiatrized and wants to repair the damage personally and politically; for everyone who still needs support and needs to not be re-victimized.

It is for activists in every social justice movement and revolutionary movement that envision a just, equitable and solidarity-based future.

It is for state officials, policymakers and human rights mechanisms charged with implementing and monitoring the Convention on the Rights of Persons with Disabilities.

It is for academic institutions, independent scholars, the legal profession, journalists, and communities engaging in social practice and theory.

INTRODUCTION

I began talking about the need to de-medicalize crisis support in September 2018 after learning from lawyer Alberto Vásquez that the Peruvian legal capacity reform, which remains the clearest and most advanced in its fidelity to the Convention on the Rights of Persons with Disabilities, left only one basis for involuntary mental health interventions outside the context of criminal proceedings – as involuntary hospitalization in situations characterized as a medical emergency.

The application of the CRPD to medical emergencies is itself a dimension of legal capacity reform that has to be fulfilled. The standard of 'legal capacity at all times' and 'best interpretation of will and preferences' (when it is not feasible to determine the person's will) could suffice for actual medical emergencies – say, when a person is unconscious and could bleed to death, to justify lifesaving treatment notwithstanding the non-manifestation of consent or refusal.

But in the context of psychiatry I was concerned that the CRPD would be incorrectly applied, in particular that the obligation to respect a person's manifestation of will at all times including in situations of emergency or crisis would be ignored, and the criterion of 'best interpretation' invoked when it was not warranted.

The framing of crisis as a medical emergency implies a need for urgent medical intervention and assumes the appropriateness of such intervention. For this reason, especially in light of the legacy of psychiatry as segregation and coercive control, it was highly likely that psychiatrists would view situations where the person is unclear or ambivalent about what she needs, struggling to express new and difficult feelings and perceptions, or reacting strongly against the presence of a psychia-

trist or mental health worker, as a failure to manifest her will, and that they would proceed with medical intervention as the default course of action without ascertaining that the person welcomes such a response. Forced interventions would thus be likely to continue, requiring case-by-case redress after the fact.

It was clear that the challenge to a medical narrative had to be incorporated into the CRPD normative framework. It could not be left to a debate about the type of services to be offered.

The stimulus to take on the topic of crisis support in greater depth was a conversation I had with Israeli human rights advocate Sharon Primor at a conference in Hong Kong in April 2019. Our dinner companions enjoyed watching us spar, as she challenged me to set out positive policy as an alternative to forced psychiatry. I started to write a list of the needs in crisis situations and the kinds of responses that would have to be in place for comprehensive policy to take the place of the medical coercive psychiatric system. I posted some notes on Academia.edu (under the title 'Towards Positive Policy') as a draft for people to comment on, and out of this developed the skeleton concept of de-medicalized crisis support based on Article 12 (support for decision-making) and Article 19 (support for practical necessities of living in the community).

The premise of de-judicialization came a few months later during a conversation with Michelle Funk of the World Health Organization and Catalina Devandas, Special Rapporteur on the Rights of Persons with Disabilities, about what a legislative framework might look like for de-medicalized crisis support. It became clear to me that there cannot be any legislative framework that treats crisis support as a mandated action in response to defined situations; to do so would carry over the managerial approach of mental health legislation that is incongruent with providing support as act of respect and solidarity among fallible individuals who are all vulnerable in their shared humanity. Crisis support needs to be made available as a positive entitlement of the individual, in the same manner as other disability-related support such as personal assistance, to bring to full fruition the social model of disability for people with psychosocial disabilities.

This paper presents a framework for crisis support based in the social model of disability, and then branches out into exploration of broader social change and actions that can help to bring about this crisis support – de-medicalized and de-judicialized – on the ground. It began as narrative of an initial graphic representation that one colleague calls a mind map, which was to be developed into a hyperlinked website with text and references on the various components. The two-part mind map, which differs in some particulars from the outline of this paper, is attached here as Appendix I.

The concept in skeleton form is found in the paper, 'Positive policy to replace forced psychiatry, based on the CRPD', and was presented in an even more pared-down version in a one-page intervention at the 2019 CRPD Conference of States Parties; the latter is also attached, as is a related essay, 'Discernment as process, not precondition'.

I use the term 'crisis' as a shorthand, understanding that it is problematic – similar to 'psychosocial disability', it can be misunderstood as a euphemism for the old paradigm of mental illness. I use the term in two ways. First, it allows me to think about the complex social situation that is happening when anyone thinks about invoking psychiatric commitment, with the differing motivations and perceptions of all concerned. That use of the term starts from the problem I am aiming to solve - what is going on when this happens and what can we do instead? How can we divert the good motivations into a different channel, while rejecting violence, segregation and making anyone an outcast from community or from intersubjective relations? This is a social crisis that has personal as well as political dimensions for everyone involved.

Second, sometimes though not always the person who is targeted for such intervention has been experiencing her own sense of urgency and distress. Understanding this urgency and distress as crisis allows us to reframe it apart from the question of whether anyone is trying to violate her human rights. This is a personal crisis that has social and political dimensions.

In view of the social and interpersonal dimensions of crisis, whether we start out understanding it from the social or the personal point of view, community is both the background of any crisis and a participant in it. This does not mean that the community around a per-

son has any ownership of her personal crisis or her decisions. It means that there is potentially a restorative or transformative justice need in relation to the social (including interpersonal) and political dimensions.

Justice and healing cannot be led by mental health professionals. On the contrary, that sector needs to make reparations for its profound violation of the fabric of community through its violent practice of psychiatric commitment and forced intervention with drugs and electroshock, practices that subjugate and terrorize its victims and render society as a whole vulnerable to its political and ideological influence. The first step is to end the violations and step aside; the mental health sector cannot be either directly or indirectly in charge of a new paradigm.

This paper is itself a bridge between different ways of engaging with the traumatic events that led me to bear witness as a survivor of psychiatric violence – from law and policy generated deductively from the necessity for abolition, to a more situated practice that ultimately blends seamlessly with a need for radical change in all areas of society. This is in one sense intersectional but in another an expression of an underlying universality that converges from many directions.

I have written most of the paper during the globally shared yet vastly disparate and isolating world of the COVID-19 pandemic and, in the US, an uprising against racist police violence and other systemic racism, known as the Movement for Black Lives. Crisis support has received attention since it is apparent that police responses to someone experiencing personal crisis can be life-threatening. The concept of social-model crisis support presented here dovetails with that serendipitous national conversation that draws on theory and practice of the prison abolition movement and psychiatric survivor movement, as well as with the human rights framework for robust equality that is set out in the CRPD.

BASIC PREMISES

CRISIS SUPPORT

Crisis is the last bastion of defense for involuntary mental health hospitalization and treatment. Even people who are allies of human rights falter when it comes to what they imagine to be the 'hard cases'. 'What about a person who is psychotic?' they ask. 'What about a person who is a danger to self or others?'

There is widespread agreement among disability human rights defenders that long-term, residential institutionalization of people with any kind of disability is wrong. But the residual power is defended, accompanying the residual belief that surely there must be some period of time for which confinement is necessary and appropriate, for some people in some situations.

Some governments have shortened the time limits for involuntary hospitalization in psychiatry. Italy is widely cited as an example of 'deinstitutionalization' and is sometimes wrongly believed to have eliminated involuntary commitment. In fact, Law 180 of 1978 initiated residential deinstitutionalization, which was completed only in 2000, for large-scale institutions, with small institutions still common). Italy also continues to allow short-term involuntary hospitalization, and practices of mechanical restraint, sedation and long-acting injection of drugs continue unabated.

New Zealand, similarly, has a two-week limit to involuntary psychiatric admissions.

Thanks to their reforms of legal capacity, Peru and/or Colombia may become the first countries to entirely abolish legalized involuntary hospitalization. This breakthrough will happen if the implications of full legal capacity are applied consistently in domestic law and practice

to treatment and hospital admissions in the mental health context, but whether that step will be taken is as yet uncertain.

Too many of our would-be allies fail to appreciate the life-altering harm done in the short term by these practices that constitute arbitrary detention, torture and other ill-treatment in the psychiatric system. They do not see the degrading label and status of 'mental patient' for what it is: a social construct that makes scapegoating acceptable.

They cannot imagine the alternative to these practices – understandably, as even survivors may feel it is their fault it happened, or that it was unavoidable.

Short-term authorization for involuntary admissions, particularly those on an 'emergency' basis and those based on the criterion of 'danger to self and/or others' (which overlap with each other) relate to situations that we can characterize as a personal crisis and/or an interpersonal or social crisis.

Despite the fact that non-coercive responses to crisis are both required by human rights norms and exist both as common-sense practices by families and friends, and as developed alternatives to the existing system, the question of 'what to do instead' has preoccupied some human rights advocates.

A conceptual model that gives an alternative account of crisis and the needs relating to its social and personal dimensions, based in a social model of disability, can move us past these obstacles. Such a model should be able to guide policy formulation on the large scale and the conduct of particular practices, by individuals and communities and by any organized support providers.

DE-MEDICALIZATION

De-medicalization means that everyone has the chance to understand themselves without the overlay of jargon that can be alienating.

Plain language is both necessary and sufficient to define and describe the phenomena that are mysterious within ourselves, that may need our attention and care and the solidarity of others.

Medical framing is conducive to hierarchical practices, because one person is posited to be an expert about another person's inner world. Both the reductionist discourse of biopsychiatry and the softer objectification in psychological or psychodynamic theories take away narrative control from the living human being. In doing so they also remove the basis for her agency.

Some people find medical diagnosis helpful to understand themselves. Some find psychiatric drugs helpful as a tool to manage distress or unusual states of consciousness that can be overwhelming. Some find therapy and counseling from professionals to be helpful. In seeking to respect the agency of each person in navigating life with all its challenges, we need to hold these truths alongside the systemic critique of medicalization in all its forms.

Medical framing cannot be the basis for crisis support, while at the same time the agency of individuals with regard to medical discourse and practices should be respected.

De-medicalized crisis support should not correct any terminology people use about themselves. Supporters should not make any assumptions or conclusions about what that person is experiencing based on such terminology. This includes psychiatric diagnosis as well as trauma, spiritual emergence, coming to terms with one's identity, or

any other narrative that sets the terms for how a person wants to engage with supporters. Construction of meaning about what is going on, about one's needs, about insights and knowledge to be acted on or shared with others, belongs to the person concerned.

With respect to drugs, de-medicalization implies setting aside the point of view that drugs are a medical treatment or a way of containing a crisis in order to make it manageable. Psychiatric drugs are no more and no less than mind-altering substances that might be used, with due caution, for the effects they produce. That is how they are being used now by people who have found them effective tools for well-being, with or without the cooperation of their prescribers. Supporters should not encourage a person to use drugs to manage her own feelings, thoughts or energy but should call in a prescriber if requested. For some people the very idea of psychiatric drugs is tantamount to annihilation, and supporters should be cautious and sensitive to avoid re-traumatization by suggesting a prescription.

Supporters should be aware of and prepared to share self-calming techniques if welcomed. However, they need to understand that personal crisis is simply what is going on for a particular person at this juncture of her life. It is not a condition that is bad or that needs to be suppressed in and of itself.

We need to pay attention to the legacy of serious violence and abuse at the hands of medicalized mental health services that make many people especially sensitive to the medicalization of mental, emotional and social phenomena. For those who have been so traumatized, medicalization is an alienating feature of any service or support practice and can be a barrier to them being able to use it.

The technologies of control developed and used against mad people have been recognized internationally as forms of torture and arbitrary detention. These include detention and control by others on grounds of disability, aggression against the body and mind through restraints, solitary confinement, subjection to neuroleptic drugs and electroshock against a person's will or without her prior free and informed consent, and other degrading and inhuman conditions of confinement. These circumstances are naturally experienced as punitive and the rationalization that they are intended as benevolent medical treatment is a kind of gaslighting that amounts to psychological torture.

DE-JUDICIALIZATION

De-judicialization means that crisis support creates no legal relationship between an individual and the state.

Crisis support is not an intervention by the state in a person's life or freedom.

It does not require a legal mandate to intervene, as it respects the person's will and preferences, boundaries, and articulation of what she needs, at every stage of the interaction. It does not require a rule-of-law apparatus similar to that which currently regulates involuntary hospitalization and treatment. That apparatus will be rendered obsolete and should be demolished along with the involuntary measures themselves.

De-judicialization counteracts the habit of judicializing madness – making it a matter for state intervention (both obligatory protection by the state acting in a paternalistic role, requiring counter-protection to limit the state's exercise of that coercive power). It also counteracts the emphasis in legal capacity reform on formalized arrangements to support decision-making, communication and manifestation of the person's will and preferences.

With respect to crisis, advance directives have been suggested as the appropriate means to provide support for the exercise of legal capacity. Advance directives allow people to anticipate future support needs and set out their plans and preferences for when and how supporters should respond. Yet this is not a complete or satisfying answer. Most people cannot anticipate a crisis before it happens and even those who have experienced one and think it might happen again may not want to anticipate the future. Advance directives can contribute to med-

icalization by encouraging people to think of themselves as perpetually vulnerable and to understand support as containment. Even for those who use this tool and find it valuable, advance planning is at best an imperfect anticipation of a future circumstance that cannot be fully known when the plan is made.

Another formal approach to legal capacity support in relation to crisis posits that crisis fits within the criteria for making a 'best interpretation' of the person's will and preferences. This is generally incorrect and must be treated with extreme caution. 'Best interpretation of will and preferences' is a term of art meaning an interpretation of indirect evidence – such as past choices, beliefs and values communicated to others – when it is entirely impossible to know a person's will through her direct communication. The paradigmatic situation calling a 'best interpretation' is a state of coma. In contrast, crisis requires paying close attention to understand what an individual is communicating – keeping in mind that this communication may include refusal and rejection – not treating her as if she is non-communicative.

De-judicialization means that crisis support is provided as a community service mobilized in response to an individual's call for assistance. When a person requests support for herself, it should be quickly provided without hesitation. Calls requesting support for someone else need to be approached carefully to explore whether the individual is experiencing a crisis from her own point of view and whether she is interested in receiving support of any kind, whether practical, or in communicating or making decisions. The person making such a call can also be offered personal support if she needs it. Conflict de-escalation and violence prevention should be made available impartially to all concerned.

DE-MEDICALIZED, DE-JUDICIALIZED CRISIS SUPPORT AND RESPONSE TO CONFLICT

Crisis support can be cultivated as a skill within families and communities, by everyone or by members who take that on as a vocation. It can also be developed as a public service. Individuals can use the principles of crisis support to navigate the hard times as their own best friend.

Crisis support should be made available on-call, 24/7, by people who demonstrate the ability to attend to others' needs without exercising control over them. Supporters should be trained in good practices and ethics, de-medicalization, and awareness of political, social and cultural contexts that are likely to impact people as the background for crisis and affect how they can get what they need. Maintaining the availability of support as a public service should be the responsibility of the state or other entity that exercises a coordinating and policy role in a particular territory. Communities, families (including families of choice), friendship networks, and mutual support groups, should also practice support to the best of their abilities, paying attention to the same traits and capabilities that are desired in support as a service. Self-support skills can be complementary to others' support, and for some people may be primary.

Support is not a mental health service, and might be aligned most closely with restorative or transformative justice – mobilizing community to tend to a person who is in pain, understanding that pain needs the strength of community to create mutual resilience and knowledge.

This is true even when a person does not want others' engagement but still needs their solidarity to refrain from making things worse.

Support is also linked to restorative justice in that crisis can entail confronting the impact of one's own past choices and the full extent of harm experienced from others' actions. Supporters' role in relation to this dimension of crisis is as empathetic witnesses, it is not up to them to direct a confrontation.

Response to conflict overlaps with crisis support, and both need to be addressed in conjunction. In order to avoid judicialization of crisis, the principle of solidarity needs to be understood as both governing principle and interface between the two functions.

Outreach to offer support is part of the support role, in response to a call requesting such outreach or on the supporter's own initiative. As stated above, this has to be approached carefully without any preconceptions or expectations.

Support has an immediate dimension and a more protracted one. Crisis that prompts a call for support might be the culmination of a long-term irresolvable dilemma. A dangerous living environment and deep unhappiness in oneself can be two sides of the same coin, each of which could carry immediate and longer-term needs.

Reaching out for support, or accepting support that is offered, means taking a risk. Supporters should honor the agency that this requires and meet it with due respect for its dignity.

Crisis support, like personal assistance in independent living or support for exercising legal capacity, can be whatever a person can design and work out with her supporters. The following details address issues that arise from current practice and expectations.

Personal support.

Crisis support starts with simple empathy for another human being. It includes the creation of an accepting space for the person to know and articulate her needs or simply to be without interference or hostility. It includes communication assistance, advocacy and accompaniment to get her needs met from any social services or community resources.

It includes practical support to get her basic needs met, such as food, sanitation, water, shelter, comfort, and physical health. This has to be done in ways that the person finds acceptable, and is always subject to her refusal.

Support can include healing modalities such as massage, Reiki and acupuncture, as well as guidance in calming and centering oneself. It can include dance, music, art, poetry, journaling, philosophical discussion, gardening, walking, crying and laughing, prayer, watching TV, taking a break, doing ordinary things.

Supporters should make psychiatric drugs available, via an authorized prescriber, to those who request them. But drugs should not be used as an easy way out due to their harmful properties and interference with personal agency and subjectivity. Herbal preparations and choice of foods for their energetic properties are less harmful means for changing mood and mental activity by ingesting medicine, and should not be overlooked for those who want such relief.

Conflict de-escalation and responding to violence.

The social dimension of a crisis may call for conflict de-escalation and intervention to stop violence, in addition to personal support for any or all of those involved. There may be a number of people experiencing the crisis at a personal level, it might be the culmination of a bad relationship or power struggle.

When one person is experiencing intense distress that becomes a personal crisis, those around her might want support for their own feelings. Household members, close friends and family, have to work out how to meet their mutually conflicting needs. Support should be provided to all parties who want it, as well as help with conflict resolution if all accept that help.

Skilled de-escalation and anti-violence intervention are needed where conflict has become violent, including where police have been called and police may have initiated the violence. Conflict resolution and de-escalation skills are also called for in relation to social and economic disputes.

When there is a need for both conflict resolution or de-escalation and personal support for one or more people involved in a conflict,

these roles should be separated if feasible. Supporters, even in a brief interaction with someone they do not have a previous relationship with, should maintain confidentiality and be accountable to the individual they are supporting. De-escalation and conflict resolution imply impartiality towards everyone involved.

Police presence represents an escalation and should be avoided. If they are on the scene for any reason, they should de-escalate their own presence and impact, and avoid the use of lethal force. There should be clear and enforceable legal duties and restrictions to constrain police action with de-escalation as the guiding principle.

All those responding to calls for personal support or situations of violence and conflict are obligated to respect and serve everyone on an equal basis. They should avoid any kind of profiling, scapegoating or assumptions based on race/ethnicity, disability, or sex. With regard to sex, they should avoid normalizing aggression by men as a manifestation of masculinity or shaming women who are aggressive as insufficiently feminine. With regard to disability, they should practice accessible communication that listens for intention while accepting diversity of expression and manifestation.

Self-harm and suicide.

Self-injury or suicidality is not an occasion for intervention by the state.

Suicide and self-injury may be reactions to intolerable conditions of life for which the state bears some responsibility. The state, and ultimately the international community, is obligated to ensure dignified conditions of life. However, these acts are ultimately and deeply personal.

The question of safety needs to be addressed from the person's own perspective, providing supports that she needs to be safe from outside threats as she understands them. People need to be able to talk about suicide and explore their feelings, needs, beliefs and values thoroughly without being censored. Self-harm and suicidality should be approached with empathy, including support for harm reduction.

A suicidal attempt in progress should be met with non-judgmental support for the person as a unique human being whose life is worthy and who ultimately bears responsibility for that life, even in making a fi-

nal irreversible choice to end it. Unsuccessful attempts should be treated as any other medical emergency, acting to preserve life and health subject to the person's refusal if she is in a position to communicate her will.

DECISION-MAKING SUPPORT FOR PERSONAL CRISIS

A crisis by definition entails a dilemma. It usually requires both immediate and longer-term decision-making, including both discernment and action. Support for discernment and for taking action is a non-medical way to conceptualize an important part of the support required to respond to personal crisis. Together with practical support, and complemented by conflict resolution, decision-making support is proposed as a basis on which to develop policy and programs for de-medicalized, de-judicialized crisis support.

Decision-making support is at the heart of what it means to proactively engage with the person's exercise of agency in respect to the crisis itself. This engagement can only be by invitation, but at the same time it is as natural as breathing and part of what we do in everyday life. The sensitivities required to engage in this dimension of support are not reducible to a training course or set of legal obligations. Nevertheless we need to talk about it and create it as a living new paradigm.

Here I set out elements of decision-making support relevant to crisis for immediate and longer term needs that are drawn from reflection, theory and practice in the survivor movement, feminism, peer support, restorative justice and other sources. The elements are listed as a group and then elaborated with references to some of the source material.

1. Natality – celebrating the emergence and renewal of life.
2. Reflective and active phases of decision-making – discernment and action.
3. Warm regard, solidarity, being trustworthy.
4. Openness to personal rhythms, time frames, trajectories.
5. Presencing, witnessing, 'attending,' appreciative inquiry, 'hearing into speech'.
6. Nothing off-limits – hard choices, risks and responsibility, intense pain, all can be witnessed and moved through.
7. Invitation to make meaning together, without expectation and accepting rejection.
8. Support to convey information or choices, and to defend against unwanted disclosure or self-explanation.
9. Scaffolding – what do you need right now, provisional belief, one day at a time.
10. Respect for boundaries and confidentiality, no reporting to authorities.
11. Personal metaphors for inner actions, practices of decision-making that create a pathway.
12. Spiritual and cultural resonances; political, social, ecological and economic context; individual and historical traumas; dialectic of justice and healing.

    Corollary: respect for particularity of culture and for separatisms that deny access to outsiders
13. Negotiating different logics, community building as risk and transformation

1. Natality – celebrating the emergence and renewal of life.

Each new human being represents a unique subjectivity and agency that is brought into the world. With each breath we take we re-experience that newness and participate in the renewal of life.

Hannah Arendt viewed 'natality' along with 'plurality' as the conditions of human life and political action. Natality connotes birth itself, and the welcoming as new of each new human being.

Han Dong urges a process of labor to give birth to something new, in contrast to the energy created by combat.

Second-wave feminism in the U.S. ruptured women's subjugated relations with men, the patriarchal family, and patriarchal authority in academia, medicine, religion, and the state. This rupture was necessary as women created new connections with one another and gave birth to themselves as whole.

As a first principle, natality reminds us that in every moment life greets us with new possibilities. The challenge is to consciously withstand and engage in the labor process.

2. Reflective and active phases of decision-making – discernment and action

Discernment is a process in which we all engage implicitly when confronting a dilemma, and we can make this process more deliberate by turning our attention inward to know our needs and choices more clearly. In this sense, discernment is practiced regularly by some religious communities, but it does not need to be religious or spiritual in nature.

We have also confronted discernment as a judgment exercised against us to restrict our autonomy. Psychiatrists, courts and other authorities have been legally empowered to measure our discernment against theirs and restrict our freedom when there is a discrepancy. The weaponizing of discernment understood as a trait or characteristic that can be found wanting in a person is contrary to human rights and has to be set aside.

Understanding that every person has the capacity for discernment means never giving up on anyone and never imposing one's own meaning on them.

3. Warm regard, solidarity, being trustworthy

'Warm regard' is a willingness to meet the person in her best light, seeing her as worthy. It is drawn from the work of Soteria House as

recounted by Voyce Hendrix in his book-length description. Warm regard is also implied in mutual support groups.

By 'solidarity' I mean to convey the sense of looking with someone and not at her. Leslie Feinberg's novel Stone Butch Blues describes the protagonist visiting her friend in an asylum, who has been severely traumatized and no longer speaks. She looks out the same window that her friend is seated in front of and comments, 'it's not much of a view'. Entering into the friend's viewpoint gains her attention and they have a brief conversation. When the friend turns away the protagonist understands that it is her choice and her need.

For 'being trustworthy' I have in mind the Personal Ombud program in Skåne, Sweden (PO-Skåne), which builds trust by ensuring that the person being served retains control over the terms of the interaction.

Being trustworthy is opposite to positing trust as a characteristic desired in a support relationship. A show of trust should never be demanded; trust fluctuates and cannot be measured or ascertained.

4. Openness to personal rhythms, time frames, trajectories

Openness to personal rhythms, time frames and trajectories is a time-related dimension of natality and solidarity. It means respect for the person's leading of her own process, choice of whether and when and how to engage, definition and expression of needs, going inward and going outward.

This element is derived from Soteria, PO-Skåne, and peer support practices including Intentional Peer Support (IPS). IPS is an egalitarian approach to support based on mutual respect and acceptance of diversity. It rejects pathologizing narratives and hierarchical practices.

5. Presencing, witnessing, 'attending,' appreciative inquiry, 'hearing into speech'

Witnessing and 'presencing' is an expression of solidarity as being actively receptive to what the other is communicating. It means

bearing witness to another's pain or joy or truth, whatever is being communicated and however the communication is happening.

That is drawn from both Soteria and experience of the lesbian-feminist community.

'Appreciative inquiry' is from IPS. It means actively seeking to know the other person's truth by asking questions, with sensitivity to how the questions are being received and respect for the choice to deflect, not answer, or disengage.

'Hearing into speech' is widely invoked to characterize feminist consciousness-raising. Nelle Morton, who first described this collective power, contrasts women's active hearing of each other with mental health 'techniques' that direct and interrupt the emergence of new meaning.

Sarah Hoagland calls on lesbians to 'attend' to one another in crisis, drawing on women's tradition of midwifery that assists a natural process.

However named, the interest and willingness manifested by the supporter complements the potential of natality that can only be realized through the agency of the person in crisis.

6. Nothing off-limits – hard choices, risks and responsibility, intense pain, all can be witnessed and moved through

When we are facing hard things, it helps to have comrades who face it with us and acknowledge all parts of the struggle with compassion. This is true when confronting authoritarian repression and police violence; it is also true when deep unhappiness leads a person to want to end her life.

In the survivor community, some mutual support groups make a commitment to not call police or emergency services on anyone, honoring each person's responsibility for her own life.

7. Invitation to make meaning together, offering in vulnerability to be accepted or refused

Sometimes there is a need for collective meaning because our lives

are interconnected. Other times someone else's participation can help find a way out of frustration or deadlock.

It is an invitation and not an expectation: no one can stake a claim on our suffering as the source of their own and require us to shift focus to their pain.

Collective meaning may remain elusive or simply be rejected by one or another person. Everyone might circle back and find common ground later on, or there may be lingering regrets that remain unresolved.

This element is related to 'appreciative inquiry' and a general principle for active engagement of supporters.

8. Support to make known any relevant information or choices, and to refrain from disclosure or self-explanation

A person's crisis as it plays out in the world may involve her with a lot of people and situations that can be confusing and overwhelming. Supporters, whom she accepts to communicate with and relate to, can help her to make her needs known and to take the space, time, accommodations and attending that will serve her best.

This is a relatively prosaic, instrumental or transactional element, drawn from peer advocacy and other support for the exercise of legal capacity. It is 'transactional' in the sense of being limited in nature and not part of a formalized ongoing support relationship.

9. Scaffolding – what do you need right now?, provisional belief, one day at a time

Whatever the crisis entails, there's no quick fix. But you need something to get you through to the next day. Where are you going to sleep and how are you going to eat? How will you settle down and sleep or make it through a wakeful night? How can you move in any direction if you can't imagine where to go?

It can help to find something to use as a provisional map, a provisional step forward even if it is only for the immediate future. This can be an attitude or belief you choose to adopt, an idea that

might work (but that you don't need to act on right away), or a set of practices and traditions.

12-step programs are the obvious reference for this element. Feminists and survivors of psychiatry have made their own versions of 'steps' for accepting one's life and moving beyond present limitations.

Some cultural traditions and rituals can serve a similar purpose and connect us to deeper meaning and community.

We may also find that we 'make the road by walking' and it is enough to see what is immediately in front of us, as it unfolds.

10. Respect for personal boundaries and confidentiality, no reporting to authorities

Support is never coercive. This element links to the ability to face hard things and the nature of support as facilitative attending.

The description of practice by PO-Skåne is the best guide for respecting the person's will and preferences in the context of outreach to offer support, and for maintaining confidentiality and absence of hierarchy throughout a support engagement.

11. Personal metaphors for inner actions and practices that create a pathway

One reason I use the approximation term 'crisis' is that no one describes what she is going through in the same way. Mental health systems standardize descriptions through the language of diagnosis, symptoms, treatment, even 'coping skills'. But we often have our own rich internal guidance in the form of images, metaphors, words we use to describe things to ourselves. It is worthwhile to become aware of these and of how we use them.

The inner world is not an object for analysis or appropriation or mobilization in the service of anything other than itself. If someone brings her inner world into conversation with others, it is still her world and needs to be respected as such.

12. Spiritual and cultural resonances; political, social, ecological and economic context; relational and historical traumas; dialectic of justice and healing

Corollary: respect for particularity of culture and for separatisms that deny access to outsiders

Worry and fear are part of life as we know it. Money, home, food, water, political violence and corruption, incarceration, rape, ecocide; good and evil, destiny and meaning, death and life, occupy our thoughts and feelings and being. Personal crisis may be the acute impact of world-historical tragedies in a person's life. A crisis that appears to be purely individual may be contextualized by such events or by the relative privilege to remain distanced from them.

We need to be sensitive to spiritual awakening with or without a cultural context and potential community, to political commitments and upheavals and their impact on participants and bystanders. This is where personal crisis can take on social meaning and lead to confrontation with the state, even once states have abolished forced psychiatry by law. Whether on a large or small scale, there may be a need for transformative justice that is invoked by an individual's manifestation of suffering.

Cultural rituals exist for the transformation of historical or personal trauma. These rituals may be in plain sight without being recognized as having transformative potential, such as the Passover seder in my own tradition. Making meaning through one's own culture's transformation rituals heals the alienation imposed by genocides and dislocations, and affirms in oneself the gifts passed down from ancestors.

13. Community-building as risk and transformation, negotiating different logics

Home is not where they have to take you in, it's where, in fact, they do take you in and you have a place. Your state can make you stateless and deport you. Your family can put you under guardianship and/or have you transported to psychiatry.

Finding home can't be done as a beggar or as an imperialist. It is a decision to be with others and be oneself. It requires a mutual

willingness to be in community together with our differences, without getting all our needs met in one space.

'Negotiating different logics' as used by Maria Lugones refers to the experience of racially subordinated people whose actions have one meaning to themselves and another to those who subordinate them. (Thanks to Sarah Hoagland for that reference.)

Where there is difference, especially but not only with subordination, there is also difference about how to understand the difference, how to work with it or work around it, whether and how to communicate about it. Working out differences, if we care to do this, is not linear but a multidimensional whole evolving through time.

When I was locked up I would not have named what I was going through as 'crisis'. Nevertheless, if someone had reached out to me in the ways I'm describing, it would have been meaningful to me and supported me to find a way out that did not smash me to bits.

Being locked up blasted me out of my original dilemma, in the same way that a parent hits a child who's crying and says 'I'll give you something to cry about'. But I could have been led to wisdom by wise people, more gently, instead of being victimized by foolish people doing evil that I would have to unwind for myself, heal and, if appropriate, forgive.

When I use the term 'crisis' here, I am trying to convey a deeper meaning simply of mystery. We are referring to experiences that can't be named in sound-bites and need to be protected from jargon, yet need solidarity. This goes beyond the situations where forced psychiatry is threatened. Along with the abolition of any lawful basis for forced psychiatry in domestic law, we need to equilibrate those personal and social crises that are being labeled as, or attributed to, madness or mental illness, with those that aren't.

Having a conversation from the standpoint of solidarity can bridge the gap of communication and the sense of otherness that psychiatry intensifies.

MATRIX

HUMAN RIGHTS UNDERPINNING THIS FRAMEWORK

The conceptual model in this paper is derived from the inherent logic of the Convention on the Rights of Persons with Disabilities. It is based primarily in Articles 12 and 19 – the right to legal capacity as a person before the law, and the right to live independently in the community.

The Convention is a comprehensive human rights treaty, and human rights is a discourse that expresses what we can claim from one another and from the state, as a matter of the dignity and worth of every human being. Crisis experiences as we have theorized them are embedded in life – in the personal, social, economic, cultural and political situation of the person concerned.

Looking at crisis, and support needs related to it, as they relate to substantive provisions of the CRPD, including Articles 12 and 19, grounds the conceptual model in the framework of international human rights law. This helps to provide a foundation for its proper understanding and implies a call to action based on states parties' obligations to implement the Convention.

LEGAL CAPACITY

Legal capacity is the concept that has been created to construct a relation between individual human beings and the legal system of a state.

It refers to the power that an individual has to hold rights and duties within that system, to operate that system by one's own actions, and to invoke the effects of that system by performance of certain ceremonial or formal acts.

CRPD Article 12 guarantees legal capacity without discrimination based on disability. This includes the recognition that skill in making decisions cannot be measured and must not be used as a reason to restrict the legal effect given to a person's decision-making.

Legal capacity has an extended dimension that protects personal autonomy up to the point where it might be lawfully limited by the state or through ordinary interactions of give and take with other individuals. This extended dimension is both a function of the cultural meaning of legal recognition as an agent (as a responsible adult with public and private powers who inhabits her choices and can be held accountable for breaches of duty towards others) and a direct consequence of the potential for many interactions and transactions of daily life to engage legal rights and duties, even if we rarely invoke the law in these matters. This extended dimension can be understood as part of the right to legal capacity protected by the CRPD.

Disabled people, as well as children, older people, women, members of subordinated social classes, indigenous peoples and cultural or religious minorities, have historically not been accorded full legal capacity. Although they were recognized as having some of the same rights and duties as those with full capacity (non-disabled adult men of

the elite classes), they were not permitted to engage the system by their own acts, or this power was limited in scope. People subjected to chattel slavery were systematically deprived of their legal capacity and not accorded rights or redress as subjects of the law.

Through movements for human rights, democracy, and equality, slavery was abolished by law and most restrictions on legal capacity have been removed. The CRPD established equal legal capacity for people with disabilities, countering prejudices and stereotypes that equated 'capacity' with ability, particularly with respect to cognition and judgment. The CRPD upholds the natural will of any person and calls for safeguards to protect everyone's engagement with legal rights and duties based on the principle of universal design, as well as personalized supports, accessible communication and reasonable accommodations, in order to improve the legal system's usability by a wider range of people in a way that meets their needs and reflects their own choices.

While it is clear that social, economic and political inequalities and oppression severely limit the options available to different individuals, their opportunity to exercise choice, and the skills, knowledge and level of comfort they bring to engagement with the legal system, formal equality before the law, including disability-related access measures, is an important component in dismantling systems of oppression. In the Roadmap section we will address more of the social and economic context.

Although children are not yet fully integrated into the unitary system of legal capacity established by the CRPD, it may be possible to do so by adding the element of guidance in the developmental process of maturation to the safeguards and supports that states are required to develop in relation to the exercise of legal capacity. Education and training for legal capacity could be useful to children and should also be provided to adults in appropriate ways, just as supports for exercising legal capacity should be generally available.

CRPD considers both guardianship regimes and forced treatment regimes in mental health to be restrictions of legal capacity that take away a person's right to engage the legal system by her own will and choices, and allow others to make choices that profoundly affect the person's life: even decisions about her own body like ingesting psychotropic drugs or undergoing sterilization or electroshock. These regimes

include the deprivation of liberty using the power of involuntary admission to hospitals and institutions delegated to medical personnel or to courts, or by accepting the consent of guardians or family members to represent that of the person concerned, whose own decision is denied legal validity. All these practices violate the right to legal capacity.

In contrast, CRPD sets out a positive entitlement of support for exercising legal capacity that allows people to seek help with making decisions, understanding information or communicating their choices, without having anyone else take over for them or act against their will.

This support regime is one way to address the needs people may have in crisis situations.

In crisis, it can be hard to make decisions because we feel like the stakes are high, there may be no answer that feels good or right or safe, and we don't know which way to move. A crisis by definition entails a dilemma, and usually requires both immediate and longer-term decision-making, including both discernment and action. Support for discernment and for taking action, dealing with both immediate and longer-term needs, is a non-medical way to conceptualize an important part of the needs that emerge in crisis situations, for the purpose of developing policy and programs for de-medicalized, de-judicialized crisis support.

This type of support is informal in the sense that it does not need to involve formal registration of supporters or a written agreement setting out the scope of support. In a crisis, what's important is meeting the person where she is, both literally and figuratively, engaging with her ethically, and respecting her choices. Ethical guidelines for crisis supporters, and holding them accountable for acts of abuse or bad faith, are the appropriate safeguards; legal formality serves no purpose and is likely to be counterproductive. Formalizing a legal agreement in the midst of a crisis itself is inadvisable, and while a formal agreement could be used for pre-planned crisis support, this might lead to a managerial approach and discourage flexibility and attunement to the present moment.

Support for making decisions takes many forms. It includes prayer and divination, not only linear rationality.

Support can also be a personal practice of befriending oneself. None of us exist in total isolation — even a hermit has a history and culture, even a person who has lost her memory had past experiences. Solidarity is always necessary in crisis at least to the extent of respecting a person's chosen solitude, and potentially checking in to assist with basic needs if that is welcomed.

INTEGRITY

Integrity means wholeness – each person's physical and mental wholeness as an organism, as a human being, as a person. The right to respect for integrity acknowledges the incommensurability of one human being with another.

Sometimes 'moral' integrity is also included in the human right to integrity of the person – meaning one's own subjective conscience. That is a good addition because it brings in the impulse of self-reflection, contemplation, and potential to observe conflict within oneself or within a whole that one belongs to (community, country, nation) and resolve it through justice and healing.

CRPD Article 17 guarantees the right to respect for physical and mental integrity, highlighting the obligation to refrain from aggression against a person's mind or body. Persons with disabilities are entitled to this respect on an equal basis as others; wholeness is inherent in any human being, to be respected, and can also be understood as a subjective state of inner harmony that a person might seek to attain.

No one else can know another person's need for healing, though they might empathize with her apparent or expressed suffering. It is a violation of integrity to impose any intervention on another person even with good intentions for her to heal. Good practices require the healer to ask permission before any physical or energetic touch, or any conversation or relationship that has a purpose of healing another person.

Healing or contemplative practices, on our own or with a trusted guide or community can aid us in our process of evolving as a whole being, and/or of resolving inner conflicts or seeing things in our lives and the world from a new perspective.

Healing that supports our integrity can be closely related to discernment and to the possibility of action that restores a right relationship to oneself and others.

LIVING INDEPENDENTLY IN THE COMMUNITY

The right to remain at home, to maintain one's connections to the world and not be placed in a detention setting during a crisis, is crucial to re-situating crisis as part of the life we share in common.

The articles of the CRPD that govern these rights are Articles 14, on liberty and security of the person, and 19, on living independently and being included in the community.

Article 14 prohibits disability-based detention and requires non-discrimination, including reasonable accommodation, when persons with disabilities are detained by state authorities for any reason. Persons with disabilities can be subject to arrest and detention on the same grounds as other persons, but disability itself is not a lawful reason for detention. Involuntary holds on mental health grounds are contrary to the CRPD because they are based on the medicalization of psychosocial disability as the threshold factor for detention. No additional factors or criteria can legitimize this detention as viewed under the CRPD.

Article 19 protects the right to choose where and with whom to live, and to choose one's living arrangement. It also provides for support that a person may need to care for herself and conduct her life at home and in the community. Support can also be provided to prevent isolation. Community spaces and services must welcome people with disabilities and adapt to their needs.

Articles 14 and 19 add to the sphere of personal autonomy protected by Article 12 (legal capacity) by ensuring the space to carry out one's life in privacy and freedom and to have the support needed to do

so. Individuals have the right to direct supporters and should have the opportunity to design supports to meet their specific needs. Supporters must respect personal autonomy and integrity in all ways, including when support is provided as part of any permanent or temporary living arrangement.

Crisis support includes support for the practical aspects of managing life when you might be emotionally very sensitive, focused inward, or simply kept busy with the demands of a fraught situation. Housing or food insecurity, domestic violence, sexual violence or exploitation, job loss, end of an intimate relationship, deaths and illnesses of close people, precarity of income, confront people with practical needs that can lead to a life crisis. A crisis that starts from within (e.g. crisis of purpose and meaning, eruption of past trauma, or a source within or beyond the self that may never be fully known) can have implications for practical life that are far-reaching.

Practical crisis support could involve help with household tasks and navigating the community (the kind of tasks typically done by a personal assistant), navigating service systems and financial and legal issues (the kind of tasks done by knowledgeable advocates), and/or emotional support to get through the days and to confront difficult tasks. It could include going to a crisis respite center or a spiritual or healing retreat, or otherwise finding a place to go that feels safe, comfortable and nurturing.

Navigating legal and financial issues or service systems during a crisis overlaps with support for exercising legal capacity in those areas. Transactional support for exercising legal capacity in relation to a discrete legal act or proceeding, including support during police investigations and criminal trials, should be available with the flexibility to meet needs of people in crisis, in case it is not possible or desirable to postpone the matter.

Emotional support and support to prevent isolation overlap with support for healing and for discernment about any aspect of a crisis (which similarly falls under the right to legal capacity). Someone experiencing crisis may want to be left alone, may want someone around all the time, or some combination. Preventing isolation means respecting the person's wishes about the degree of contact and connection, so that

community remains available to her; respecting chosen solitude while maintaining awareness and solidarity in case she reaches out.

OTHER SUBSTANTIVE RIGHTS

The issues explored here are illustrative, taking some common experiences as examples to round out a description of personal crisis and related support needs using human rights discourse. The references are to articles of the CRPD.

Right to housing and subsistence (Art 28)**.**

Insecure housing and subsistence can expose us to many dangers and a high level of stress and anxiety. This constitutes a crisis in itself.

Right to freedom of expression and communication (Art 21)**.**

In a crisis what we may need most is to be listened to, or to find the means to express ourselves.

Right to practice art, music, science, spirituality, religion and other aspects of culture (Art 30).

Creativity can be stymied or blocked, we feel as if the well has run dry. Or we are struggling to discover and express something new, to solve a mathematical or philosophical problem, to integrate knowledge that comes from deep intuition or another dimension.

We may need to heal cultural wounds larger than ourselves. This includes de-colonization and reconnecting with culture and land and origins.

Right to sexuality, relationships, parenting, family (Art 23).

Loneliness, feeling unsatisfied with relationships, struggling with sexuality, coming out as lesbian/gay or bisexual, intense feelings for another person, end of a relationship, birth of a child, abortion, miscarriage, challenges in parenting, abuse or conflicts within a family - all can lead to personal crisis or emerge as underlying themes as a crisis unfolds.

We may need to make space for a liberation of righteous energy in our lives as we politicize rape, femicide, normalized male aggression and compulsory heterosexuality.

Right to safety from violence and abuse (Art 16).

Violence or abuse in any context creates harm on many levels that needs sensitive response and support. Pay attention to the possibility of violence or abuse in unexpected contexts, including psychiatric violence and police violence, as well as sexual violence, intimate partner violence, parent-child violence. Help to ensure the person's safety in the immediate situation by respecting her choices about whom to involve or allow to be present in her space. Conflicts about common housing have to be resolved in a way that ensures safety and does not place the burden of dislocation on abuse victims unless that is their preferred option.

Right to bodily comfort and health (Arts 17 and 25).

Physical health conditions can result in alterations in energy or consciousness that may be hard to distinguish from manifestations of a personal life crisis and that may also carry emotional or spiritual meaning. The possibility of conditions related to blood sugar, thyroid, heart, autoimmune diseases, hormonal cycles, effects of medications, recreational substance use, injuries, or other aspects of physical health should be taken into account in case a physical health crisis may require treatment. This is not intended to legitimize psychiatric classifications or any speculative diagnosis that attributes emotional distress or unusual perceptions or beliefs to physical pathology, which is entirely contrary to the premise of de-medicalized crisis support.

Serious physical conditions and the needs associated with them can affect many parts of a person's life and contribute to life crisis. At-

tending to these needs, including supportive end-of-life care, is part of the totality of what crisis support may include.

Being able to ground oneself in the body and sensory experience, including breathing and meditation, can help to ease stress associated with any crisis and release a sense of urgency about dilemmas that aren't easily or immediately resolved.

On the other hand, bodily awareness can also be acutely uncomfortable when one's sensitivity is heightened.

Right to advocacy and political participation (Arts 4.3 and 29).

People labeled as mad have been denied a collective voice by layers of custom and legislation, both through exclusion from political process (such as the right to vote and be elected, and the right to form associations) and through simply being assumed to have nothing meaningful to say.

A personal crisis can hold political and social meaning, and people have a right to express their political views on any subject. Political and social discourse should refrain from labeling anyone as 'mad' or 'mentally ill' and should respect diversity in communication.

Right to education and right to work (Arts 24 and 27).

Personal crisis can interfere with a person's ability to concentrate on work or carry out responsibilities. There should be accommodations to allow us to stay connected with work or school and resume activities as able, if the person wants to do so and it is not an undue burden on the workplace or educational institution. Issues of vocation, performance, job loss, conflicts or abuse at work or school, can also figure in a person's experience of personal crisis as dilemmas requiring discernment and/or action.

DUTIES TOWARD OTHERS

The rights to liberty (art 14) and access to justice (art 13) are implicated as guarantees against unfairness in the state's enforcement of its laws. Personal crisis may be the context in which conflicts take place that result in law enforcement involvement, or conversely, conflicts with other persons or with the law may result in a life crisis. Police violence and aggression and systematic discrimination by police and penal systems has a profound traumatic impact on individuals and communities.

The international human rights framework upholds the principle that all people have duties towards one another, as a necessity for the creation of community in which each person can flourish. Nevertheless, there is no mechanism for direct accountability of individuals for most breaches of human rights norms. Both the definition of these duties and their enforcement are left to processes under the control of states: civil lawsuits and the criminal justice system, both of which raise concerns of equitable access and substantive fairness.

The mediation of the state creates tension between the value of community and the means used to uphold it - the use of force and punishment against individuals by the state as a corporate actor (i.e. a supra-individual actor created and maintained through cooperation, hierarchy and/or violent domination). The criminalization of particular conduct is never a straightforward enforcement of mutual duties within a human rights framework; criminalization may serve ends that are discriminatory or otherwise oppressive.

Human rights has not (yet?) moved to take an abolitionist stance towards detention either as punishment for a crime or on other grounds that are not ruled out as arbitrary under international law (as is the case

with involuntary psychiatric hospitalization). Instead, human rights norms specify procedural and substantive guarantees that states are obligated to follow when carrying out detentions governed by their domestic legislation, including but not limited to criminal arrest and imprisonment. The positive obligation imposed on states to provide protection and remedies against interpersonal violence and other serious harms underscores the needs of victims to have somewhere to turn for violence prevention and accountability, but reinforces police and prison systems which are inherently flawed, inequitable and often ineffective from the standpoint of victims as well as those charged with criminal conduct.

A person who is experiencing intense emotions or unusual perceptions might be victimized or might break laws or victimize others during that period of time. Traditionally these occurrences were dealt with by coercive, paternalistic and medicalized measures (such as guardianship, the insanity defense and psychiatric incarceration) that removed the person from moral agency as a victim or as a suspected offender. Instead, CRPD calls for people in this situation to be treated as the social and legal equals of other members of the community, providing them with communication accessibility and accommodations for divergence in any proceedings that need to take place. Support should be available for exercising legal capacity in police stations and courtrooms, and this can include communication assistance and advocacy for accommodations.

Restorative or transformative justice practices can function either as a state-authorized diversion from police and courts, or as an entirely separate alternative in the hands of the community. These measures, developed initially by indigenous communities, are designed to strengthen community ties that have been damaged through victimization, by working collectively to repair harm done and reminding those who have harmed others of their place in the community with mutual dependencies and responsibilities. Such community-based practices are especially relevant where state violence and discrimination have seriously breached the public trust and there is an urgent need for transformative options. It is important to make sure that community justice processes are fair and equitable and take account of both power inequalities and differences in culture or personality that may impede understanding.

CRPD does not allow for anyone to be declared incapable of being held criminally responsible. Judges and juries should be able to take into consideration the totality of factual circumstances, including subjective perceptions and motivations, that may negate culpability under a disability-inclusive standard applicable to all persons. Any such negation of culpability must amount to a true acquittal and not lead to diversion into psychiatric incarceration or other forms of paternalistic control. Restorative or transformative justice practices are based on cooperation rather than an adversarial finding of guilt, but need to ensure the ability to contest facts if they are to replace state-based processes. These practices must also avoid the tendency to replace punishment with paternalistic control, in order to comply with the CRPD and to build inclusive community.

IMPLEMENTATION: LEGISLATIVE REFORM

CRPD requires states parties to abolish the practice of forced treatment and hospitalization in the mental health system, which requires law reform. The state must repeal legislative provisions that authorize these practices, which are mostly contained in mental health laws but can also be found in the areas of criminal procedure, legal incapacity, family law, and health law. Complementary reforms are also needed to ensure the right to full legal capacity and the applicability of free and informed consent to hospital admissions and all treatment or support services including in a situation of emergency and crisis.

It is not advisable to use mental health legislation as a positive vehicle to set out policy or establish programs for crisis support or to address comprehensively the rights and support needs of persons with psychosocial disabilities. The reason is that we need an entirely new paradigm. Similarly to how CRPD practitioners reject the retooling of guardianship as a support practice and insist on an entirely new practice of support with its own duties and infrastructure, we need to reject the retooling of mental health legislation and insist on a framework for crisis support that is built up from a social model of disability, enshrined in the CRPD, that understands support as solidarity in the exercise of autonomy.

What kind of legislation, if any, would be useful as a framework for enacting the repeal of mental health involuntary commitment and treatment laws, shifting funding and policy to de-medicalized support measures including crisis support, and undertaking complementary

funding and policy transformations related to the social, economic and political problems that contextualize personal crisis?

The answer will necessarily be different in every country, given the diversity of legal systems, resources (not only financial but also strengths and capabilities of state, civil society, communities), and the kinds of social, economic and political problems faced by the country as a whole and its internally diverse populations.

My vision here draws on successful legal capacity reforms in Latin America and law reform initiatives for independent living and decarceration in the United States.

Legal capacity reform.

The first approach to consider is legal capacity reform, which has emerged as a fulcrum for ensuring personal autonomy of persons with disabilities in all spheres of life. Legal capacity reform is directly relevant both to the abolition of involuntary measures in the mental health system and to creating and funding a positive entitlement for informal decision-making support outside the health framework. As recognized by the UN Committee on the Rights of Persons with Disabilities, forced mental health treatment as well as guardianship is a regime of substitute decision-making incompatible with the Convention. The reform in Colombia included repeal of legislative provisions authorizing involuntary institutionalization, but it is uncertain whether this has entirely removed legal authority for such measures in the mental health system. In Peru, advocacy to abolish the small scope remaining for involuntary measures in psychiatry has focused on harmonizing mental health regulations with the comprehensive legal capacity reform. Neither country's reforms addressed involuntary mental health diversion related to criminal proceedings. Despite these imperfections the reforms in Peru and Colombia have brought us closer to abolition than any other approach actually implemented.

By implementing the state's obligation to provide support in exercising legal capacity, such reforms can provide a policy anchor and entitlement to decision-making support for crisis. This kind of support should be addressed on its own terms, as a particularized need that predominantly takes the form of a service provided by on-call person-

nel rather than either a formalized arrangement or a natural support pre-existing in the person's life.

The link between decision-making support and practical support for the tasks of daily life, also needed at times of crisis, is not an obvious fit within legal capacity reform. On the one hand, practical support creates the conditions for everyday survival and well-being that allow for harder decision-making to be less impeded by stress. Everyday life also requires decision-making that a person may or may not want support with. Costa Rica's reform combines support for independent living with support in exercising legal capacity, however it is flawed by its categorical assignment to one or the other based on the type of disability and paternalistic approach to legal capacity support as a safeguard. The impulse to combine the two kinds of support is worth considering so long as it is not limited in those ways.

Right to live independently in the community.

The second approach to consider is legislation centered on the right to live independently in the community, which would then have to incorporate repeal of involuntary measures in the mental health system along with comprehensive legal capacity reform.

The Disability Integration Act, proposed in the United States Congress but not yet enacted, would create an enforceable right to receive supports and services in the community for any person with a disability who has such needs and who is institutionalized or at risk of institutionalization. In order to qualify for funding as community-based support, services would have to meet detailed criteria that emphasize freedom of choice, personal privacy and autonomy, including the freedom from coercion and restraint, and full access to and integration with the surrounding community.

The supports and services covered by DIA are described in terms of practical domains and include many that are relevant to personal crisis, in particular: assistance with household tasks, communication and interpersonal relations, travel and community participation, as well as emotional, cognitive and decision-making support. Emergent and intermittent needs of individuals who meet the criteria must be covered in addition to long-term needs. Municipalities must ensure that housing

is 'sufficiently available' to persons with disabilities that is affordable, accessible and not contingent on accepting any other service or support.

The legislation is flawed; most importantly, it does not contain the language necessary to abolish involuntary hospitalization and treatment by stating an intent to override state-level provisions authorizing those practices. Even if non-coercive crisis support could be developed under the 'emergent needs' category, and individuals who are involuntarily committed could claim a right to receive non-coercive community support instead, there would be no right to simply be left in peace and shut one's door. Another flaw is the requirement that an individual be institutionalized or at risk for institutionalization in order to qualify for community-based supports and services. This suggests that needs perceived to be low-level will not qualify, and reinforces institutionalization for higher-level needs (or coercive control) as a default paradigm.

The virtue of DIA as a model for legislation on the entitlement to crisis support is that its framework actually contemplates such needs inclusively as part of the right to live independently in the community.

- Supports related to emotional and social needs are included within comprehensive disability rights legislation, and described in ordinary language for the most part.
- No separate 'mental health' section, and no designation of any support as a mental health service or requirement that it be performed by or under the supervision of a mental health professional.
- Crisis support as an on-call service could be developed and funded as support to meet 'emergent' or 'intermittent' needs.
- Includes the simple economic and social right to have the state ensure the availability of affordable housing that is not tied to services.
- The overall framing comes from the independent living movement, and it reflects a social model of disability in the sense of a right to social solidarity that respects autonomy.

These elements would need to be combined with repeal or override of involuntary hospitalization and treatment provisions, along with comprehensive legal capacity reform and criminal procedure reform. There would also need to be systematic deinstitutionalization that goes beyond an option given to individuals to find their own solution.

Even in its current form, DIA has real potential if it were to be enacted in the US context. Mainstreaming the support needs of people with psychosocial disabilities into an independent living model can begin to change the paradigm for social response to crisis, distress and unusual thoughts and perceptions. But the realization of this potential will depend on the details of regulations and programming that will be developed if the bill becomes law. It will be especially important to ensure that crisis support is fleshed out in that process and that it remains within the independent living framework and is not outsourced to the mental health sector.

Decarceration.

The third approach to consider starts where the other two fall short: situating crisis support and the abolition of forced psychiatry in relation to a drastic reduction in the state's carceral and repressive apparatus. Both legal capacity reform and independent living legislation start from the premise that services are to be provided based on free and informed consent; coercive control is an incompatible intrusion to be rejected. This means that the role of police and the criminal justice system in controlling people with disabilities and other marginalized groups is pushed into the background; criminal procedure reform remains an afterthought and restorative or transformative justice is not part of the picture.

An exciting blueprint for decarceration legislation was developed in 2020 by the Movement for Black Lives, bringing into a single comprehensive vision the demands of Black communities to be free from police violence and to rebuild community infrastructure and services. The draft BREATHE Act calls for dismantling the most repressive and unnecessary police agencies and practices; investing heavily in the social and economic needs of communities that have experienced high rates of incarceration, police violence and racial discrimination; promoting the development of community-controlled safety and accountability

measures; and reparations for mass incarceration, police violence, slavery and its legacy, violations of indigenous sovereignty, and other racial discrimination.

The BREATHE Act includes spaces of involuntary commitment among the carceral spaces to be drastically reduced in population, and provides large amounts of seed funding for communities to develop alternatives to policing. That even drastic reduction of involuntary commitment is being contemplated, if not abolition, speaks to a deep vein of community organizing in which disabled people of color have drawn attention to intersectional issues that threaten their lives from both directions: it is not enough to reduce police presence and assign mental health personnel to respond to people believed to be experiencing a crisis; the nature of that response itself has to be changed. While the BREATHE Act has not been introduced in the legislative process, it remains a visionary statement emerging from the protests of 2020 and decades of prison abolition and anti-police violence organizing. As such many of its components are already part of local advocacy and projects, including an agenda to stop police from shooting people with disabilities and provide crisis support instead of a law enforcement response. Some community mutual aid initiatives are in place that include crisis support along with economic mutual aid, violence prevention and de-escalation, and transformative justice.

The flaws in this approach are significant. It does not challenge the role of mental health services as the presumptive providers of crisis support, nor does it take a definitive stance that mental health involuntary commitment and involuntary treatment are among the carceral practices that are to be eliminated through legislative abolition rather than merely reduced. The BREATHE Act does not address legislative reform needed in other areas specific to disability either, in particular legal capacity reform and reform of criminal procedure to eliminate incarceration in forensic psychiatric institutions based on incompetence to stand trial or an insanity verdict.

Nevertheless, the reform demands of the Movement for Black Lives have put a spotlight on the need for reimagined crisis support by re-humanizing all victims of police violence and seeing them as members of our communities who deserve solidarity. It is too soon to know

how far this will take us, but it is a useful angle on both intersectional conversations.

Synthesis.

Each of the three approaches discussed highlights a different perspective on the abolition of forced psychiatry and reimagining of crisis support. None of them centers this project in itself but rather situates it as a necessary dimension of some other affirmative social purpose: legal capacity reform, entitlement to support for independent living, decarceration. When we center the abolition of forced psychiatry and reimagining of crisis support, there is a tendency to devolve into reforming or replacing mental health legislation. That can put us back at the starting point reacting against the status quo and replicating it rather than actually imagining something new.

It would be ideal to combine legal capacity reform, entitlement to support for independent living, and society-wide decarceration. Decarceration, in particular, requires us to pay attention to the wide social, economic and political context of every country; this context is relevant to legal capacity and independent living as well but can remain hidden if reforms are made that reinforce social stratification.

It remains premature to try and coalesce the elements into a single package that could serve as a template for model legislation. The 'iterative' process that we are engaged in as a global, diverse, intersectional movement will continue to evolve in response to challenges and opportunities posed in specific countries and global conversations.

IMPLEMENTATION: REPARATION

Official acknowledgment that human rights violations have taken place can begin to create a new narrative and ensure that the state and civil society have common ground from which to change attitudes and practices.

In this case, reframing starts with acknowledgement that psychiatric violence and segregation are rooted in discrimination, and that this cannot be excused despite its being pervasive in modern societies and having deep roots in many cultures including globally dominant ones.

Such a process has to make space for victims to tell their stories publicly and privately, for the stories of psychiatric violence to become a collective trouble and not one that individuals struggle with alone. These stories implicate good and evil, abuse and trust, betrayal and forgiveness, rage and internalization of violence. All the stories are different and implicate everything conceivable: armed conflict, displacement, rape, sex industry, racism, sexism, poverty and more.

This is not a forum for debate, nor does it aim to reconcile victims of psychiatry with those who have harmed them. It is a space for the whole of society to confront the violence enacted by medical professionals and the state against those selected out as mad, a selection often intersectional with race; sex; class; sexual orientation; physical, sensory or intellectual disability; age; and other kinds of discrimination. Contributions of survivors should be welcomed and prioritized both as testimonial evidence and as calls to action with implications for concrete measures of transformative justice including policy going forward. The

complex history of those who have both been victimized and perpetrated violations against others needs to be acknowledged.

State responsibility for its role in perpetuating and failing to stop systemic violence should be expressed through collective and individual measures of reparation, beginning with satisfaction (unequivocal statement of abolition as state policy/acknowledgement of nature and scope of violations/restoring the status and dignity of survivors as reliable witnesses) and guarantees of non-repetition (immediate halt to involuntary hospitalization and treatment/enactment of laws and decrees to prevent it from being reintroduced). Space for individual and collective grief and memory needs to be created by and for survivors, with a secondary educational function towards the community.

Individual measures of reparation should be tailored to circumstances and needs, and not get mired in bureaucracy. They of course begin with the restoration of liberty, legal capacity and the means to live independently in the community of those who are currently under any kind of institutionalization or coercive regimes. They can also include assistance to withdraw from drugs and/or to heal the body from their long-term effects, restitution of property, return to job or compensation for lost wages, reinstatement in school, and other measures of restitution and rehabilitation (understanding rehabilitation as personalized assistance needed to heal or repair the harmful impact of the human rights violations in one's life). Personal harm should also be compensated financially and acknowledged in other forms meaningful to the individuals concerned.

Individualized measures take time to address; this is no different from other large-scale human rights violations. The effort must be made to restore individuals to their full human rights rather than shifting them from institutions to the community while still in the guise of 'mental health patients'. Necessary policy, administrative structures and financial appropriations are needed, including those that invoke economic justice at the global level as well as within countries, as the implementation of human rights obligations and not donor-controlled or donor-conditioned charity.

Liability of perpetrators will be difficult to impose, given the widespread acceptance of abusive systemic psychiatric practices within

international as well as domestic law prior to the CRPD. Some meaningful accountability process is needed, and requires careful design, since the number is quite large of those who have set in motion a process of hospitalization or treatment that is involuntary in law or in fact, or who participated in carrying it out, as well as those who participated at the level of policymaking and administrative responsibility.

Victims' rights and the right to truth requires that investigation and accountability processes be set in motion in response to any accusation by a victim or witness, to uphold the right of access to justice. Investigation and disclosure of the truth of systemic violations in each locality and setting should also be undertaken by independent monitoring mechanisms that include victims of violations and do not include anyone employed in mental health services.

A process should also be established whereby everyone who has worked in the coercive system is vetted, offered training, and required to demonstrate requisite capabilities to be eligible to continue working in any kind of support role, including within conventional mental health services. They should not work in a support role while any accountability process is pending against them.

The feasibility of reparations, and its nature and meaning, will differ from one country to another. Some states may welcome the framework of reparations to justify and secure the appropriation of funds for direct economic and social assistance to victims of institutionalization. In others, the acknowledgement of state responsibility for human rights violations entailed by reparations will be viewed as an infringement of state sovereignty and rejected. These nuances need to be considered in advocating and planning a reparations initiative. Irrespective of the country, reparations processes should not be under the control of the mental health sector or any other service sector, amount to a shift to 'community-based mental health services' or aim for reconciliation within a 'human rights in mental health' framework.

Reparations for psychiatric violence can be difficult to address if other serious systemic human rights violations persist unchallenged. One option is to combine reparations for multiple systemic human rights violations in an intersectional manner, or else to address them sequentially.

If it is not politically feasible to institute reparations in a country, as much as possible of the agenda should be instituted as a simple transformation of policy without invoking the reparations framework as such. Nevertheless, the right to remedy and reparation, including a fair process to hold perpetrators accountable, belongs to all victims under international law, and at least those violations taking place subsequent to the CRPD entry into force for a particular country are fully subject to this norm.

One option is for the United Nations and regional intergovernmental organizations to initiate a process of transformative justice in collaboration with survivors. This can be done in connection with the promotion of deinstitutionalization, as deinstitutionalization under the CRPD includes the abolition of involuntary hospitalization and treatment and should confront the truth and impact of psychiatric violence. Such a process must remain outside the auspices of any health sector mechanisms or agencies. It should be based in the CRPD and its implications for international norms on torture and arbitrary detention, set within an intersectional global context addressing all relevant economic, social, cultural, civil and political rights, self-determination of peoples, the right to development and the right to peace.

ROADMAP

WHAT WILL IT TAKE TO PUT THIS INTO PRACTICE?

The Roadmap takes as a starting point the human rights framework of the CRPD, and asks what is necessary to create the conditions for those rights to be fulfilled.

The first three chapters of the Roadmap return to the themes of de-medicalization and de-judicialization in a higher-order sense of envisioning what kind of society could include the kind of crisis support we want, as part of its social fabric. What would society have to look like, in order for crisis support to be integrated into ordinary social, cultural and economic life, to not be always struggling against countervailing values and practices that cause intense distress and have the potential to distort crisis support practices, making them revert back to the medicalized and judicialized status quo?

These three chapters - Democratize Knowledge (Diminishing the power of psy disciplines and industries); Build Community Accountability (Diminishing the repressive apparatus of the state); and Strengthen Communitarian Values - begin with intuition and personal experience to find a way in to the issues presented, along with theoretical and political constructs, rather than, as in the Matrix section, using the logic of human rights discourse as a scaffolding.

These pieces point beyond the question of crisis support itself, understanding crisis as an expression of tensions that go beyond the individual and the nature of crisis as opening windows on new knowledge, whether that knowledge manifests itself immediately or requires a lifetime to bring to fruition (and irrespective of how broad or narrow may be its implications). Theorizing social vision from a focal point of what is needed to allow people to experience crisis without the baggage of exclusion and harm, converges with other social movements and visions of a just and equitable way of living.

The fourth chapter of the Roadmap introduces tools to promote a proper implementation of crisis support and an end to forced psychiatry and other abuses. The fifth chapter presents a mapping of values

that situate the author's approach to crisis support in relation to diversity and to paying attention to one another at micro- and macro-levels. This mapping is intended as both an argument that certain values and perspectives should be taken into account in reimagining crisis support as part of a larger social justice vision, and as an example of the kinds of values that any of us might bring to the work of reimagining crisis support.

DEMOCRATIZE KNOWLEDGE

DIMINISH THE POWER OF PSY DISCIPLINES AND INDUSTRIES

Back against the wall, some other person reaches out and pulls us up or we find that we are alone and have to fight our way out with whatever we have. We may struggle again and again with the same thing, we may never find the equilibrium or happiness we're looking for. Every decision matters, even giving up is not final so long as we are alive, and suicide is a choice though it can be a terrible and even spur-of-the-moment mistake. Or, giving up is acceptance and willingness to face what is next, to live with the limitations of body or circumstances or our own failings.

Other people relate to our anguish, our struggles and histories, as outsiders. They may care deeply, they may be involved in our lives and mutually interdependent, or primarily dependent on us as children are. But they cannot live our lives, they cannot struggle with our angels or demons or nightmares or regrets.

That is no different when it comes to psychological and psychiatric professionals. They can only support our struggles as caring outsiders, if they have skills that allow us to relax and the humility to be sensitive to our hurts and not make them worse. They have no magic, only theories and techniques that may be harmful or helpful, and if we're lucky, native talent for empathy and kindness. At worst they are egotists who cultivate our dependence on them, narcissists who abuse us for their own gratification, torturers who look on callously when we suffer and who give the orders to torture us again and again.

This is not a picture that those professionals like to see of them-

selves, but it is a truth that society has to confront. If we cannot face the harsh reality unvarnished, along with the good that exists, we participate in ongoing injustice. Given the structural power of psychiatry as a medical profession with the delegated state power of detention - combining social and economic power with the legalized use of force - justice requires an emphasis on the harsh reality so as to eradicate the hierarchical power relations that sustain it.

Some survivors and allies work for the abolition of psychiatry as a medical profession, saying that it is not science and never can be science, and it is therefore illegitimate to call it medicine or give it any credibility as a basis of expertise. They view the fight against psychiatry's human rights violations as only part of the fight to abolish psychiatry itself.

Use of mind-altering drugs to feel better, including the management of this use by prescription, can be done without psychiatric diagnosis or the existence of psychiatry as a medical specialty. Psychopharmacology deals with specialized knowledge of how these drugs work on and for the brain and consciousness, and can develop approaches that are respectful of the toxicity and potency of those substances, the alterations they cause to brain structure and functioning, and their adverse effects on the brain and other organ systems. Neurology can continue to study the workings of the brain, including its relationship to emotions and consciousness, but the concept of psychopathology would be gone.

Suffering and unusual states of consciousness, patterns and habits and responses to trauma and abuse, can be studied through psychology and other academic and non-academic methodologies, without aiming for a definitive account or classification. Philosophy, anthropology and literature all have some worthwhile angles to approach this dimension of life, and both ordinary people and traditional wisdom keepers have their own accounts that not only make sense of their own lives but offer more general principles. Academic and professional knowledge needs to be in dialogue with everyday life and community knowledge; people and communities need to exercise critical thinking as part of their political and civic practice, to take responsibility for their own judgment and their participation in collective action.

The democratization of knowledge, both theoretical and practical, is not limited to psy disciplines or to academia. It is a transfer of

power that we should promote in all spheres of life, and particularly in relation to public affairs and criticism. This is a dimension of any movement for social justice, including the movement against psychiatric oppression, that both counters internal elitism and seeks to end hierarchical official knowledge production.

Peer support is one dimension of democratization in the anti-psychiatric oppression movement but it is neither the sum total of that democratization nor is it limited to a particular community defined by having experienced psychiatric diagnosis. Our personal experience is necessary to fight back from being against that wall, to collectively redefine and reimagine ourselves and lead others into a new vision. Peer support has been crucial in evolving both political values and agendas of the movement, and popular support practices that are egalitarian and mutual and that anchor the work of reimagining crisis support outside mental health discourse.

But not all of us are interested in peer support focused on distress or unusual perceptions as such; some of us find mutual support in other contexts and communities we are involved in - religious, spiritual, political, cultural - and bring our full selves to that, integrating the meaning of being a survivor of psychiatry, for example, into the collective life of those communities. In addition, some of the most powerful conversations happen in and across the gray areas of experience and identity, where we do not need to be bound to an identity-based definition and instead come together based simply on a particular experiential background and unity of purpose. All of this is necessary to promulgate survivor knowledge throughout society as a whole.

Survivor knowledge encompasses more than understanding oneself and relationships, more than being an expert on crisis or madness. It means many things according to the particular insights that each survivor draws from her life, her political commitments and situated opportunities for theory and practice. Survivor knowledge can contribute to restorative justice, to feminism, to houseless people's movements, to inclusive development and more. This democratization of knowledge, in many directions at once, is needed to restore balance to our unequal societies, and to undo the hegemonic power of psychiatric discourse and practices in all our lives.

BUILD COMMUNITY ACCOUNTABILITY

DIMINISH THE REPRESSIVE FUNCTION OF THE STATE

Law and morality.

Mea culpa. What are culpability and blame, and (why) do we need them? What purpose do they serve?

Culpability justifies punishment in the form of a criminal sentence (as retribution), which also is said to serve other purposes related to preventing future crimes by that person or another (deterrence, incapacitation, and rehabilitation).

Legal guilt depends not only on doing an act that is prohibited according to law (actus reus), but having a culpable mental state (mens rea) at the time. The culpable mental state is defined factually rather than morally, most often as intent to do the prohibited act or knowledge that a set of facts obtained. The question of moral culpability, in the sense of having done an unjustified wrong, is both assimilated to legal guilt and left to its margins.

Intent to kill a human being, as the mens rea defined for murder, in the absence of self-defense or some other justification or excuse, serves as a proxy for the judgment of moral blame and sets the rule for legal culpability. Yet there can be reasons to kill that call into question the definition of self-defense as limited to imminent danger, such as to escape long-term abuse by an intimate partner. We need some other

framing (e.g. an argument to expand how we understand self-defense in a context of coercive control) in order to avoid the moral incongruence of blaming the person whom we see as the true victim. Such a re-framing is political, invoking the resistance to sex-based structural oppression, and adherence to the original legal doctrine is equally political as it rejects the relevance of sex-based structural oppression and resistance to a premise of criminal law. While any legal system depends on some kind of balance between legal rules and their application to individual cases, the question of moral justice is particularly acute in criminal law because it results in punishment, yet moral justice remains subjective and political, requiring some determination of the merits of conflicting claims that go beyond the interested parties in a particular case.

Any attempt to formulate a higher-order principle as to how we should calibrate the adjustment of legal rules to accommodate change based on recognition of systemic injustice would depend on the ability of the operators of the justice system to identify systemic injustice and distinguish it from the reintroduction of oppression or from conflict that doesn't amount to a political question. Any principle that calls for calibration in light of individual circumstances without being guided by consideration of systemic bias and structural oppression is doomed to reproduce such oppression; hence the tensions between feminism and restorative justice, including that women fare worse than men in restorative processes (as may also be true in criminal justice) both as victims and as accused persons (as found by Australian scholars Kathleen Daly and Janice Stubbs).

The irresolution between moral and legal culpability recalls the Hart-Fuller debate about the relationship of law and morality – must law be moral in order to be recognized as law, or are they entirely independent? What are the implications of taking one position or the other?

The relationship between law and morality is necessarily imperfect as morality is subjective, inter-subjective and contestable, while law asserts itself with finality and imposes consequences. Restorative justice attempts to re-integrate them, to merge healing and justice in an outcome that strengthens a community in its mutual sense of belonging, interdependence, and responsibilities to and for one another's dignity and well-being. Restorative justice comes in large part from indigenous communities pushing back against colonizers' legal systems that dispropor-

tionately criminalize members of these communities, and creating new forms of justice that incorporate their traditional values and practices. These practices bridge the public-private divide as to the definitional aspects of law and morality, accountability and consequences, rather than limiting community members to the role of jurors within a pre-defined set of alternative outcomes. Interested parties too have a more pro-active role and more options than in a criminal trial – the accused to speak honestly and work to repair the harm done by her actions rather than maintaining a self-protective silence and separation from the community, and the victim to participate as a protagonist for creative justice rather than serving a limited agenda of exemplary punishment. On the other hand, it is a shortcoming of many restorative justice practices that they do not provide for dispute about either the act that took place or its wrongfulness, but rather depend on a willingness of the accused person to confront an undisputed harm she has committed. Victims also may prefer the backing of the state when they are seeking justice against powerful members of their own community (which is only effective if the state does not align itself with those powerful individuals).

The role of the state.

Culpability and blame, though they are the rationale for the consequential aspect of law enforcement, cannot be the real motivation for the repressive apparatus of the state. That apparatus, which includes police at national and local levels, private security industries or militias operating in conjunction with state forces or tolerated by them (if not at war with them), the military, and the intelligence and counter-insurgency agencies, as well as jails and prisons and other detention settings, not only enforces laws, but governs and controls the population. The functions attributed to the penal system – retribution (vengeance), deterrence (intimidation), incapacitation (coercive control) and rehabilitation (indoctrination) – characterize the repressive apparatus as a whole, and need to be questioned rather than taken for granted.

The strength or weakness of a central state varies greatly from one country to another. How we deal with that state, and what it means to build community accountability, necessarily varies. We may need to proceed slowly and understand our own capabilities. It cannot be a question of fighting a strong state head-on, in the absence of effective

power to prevail, but of raising questions and developing ways of dealing with accountability that satisfy the needs of victims, communities, and of accused persons for fairness and proportionality.

Community accountability – starting from within.

In thinking about community accountability, we might start with good memories of times when we were corrected in our conduct, by a teacher or a parent. Correction is pointing out the standards that we are expected to live by. When effective, it works not so much by appealing to the desire to please an authority figure, but because it appeals to something we recognize in ourselves as being right, congruent with how we want to live and conduct ourselves. It might be how to write an essay, how to perform a martial arts technique, how to face injustice with dignity. We ourselves have to be prepared to stand up for correct performance in others, when we are instructing them or when there is a boundary we have a right to set.

In a pluralistic society, correction among adults (and increasingly between adults and children as well) is a negotiation, a question of balance to which each of us has to bring our honest values and beliefs along with our humility. We have to distinguish political and moral conflict from correction that appeals to a standard that is shared or that the other person can readily identify with and accept. The failure to acknowledge this difference leads to power struggles.

I do not believe that punishment has a correctional effect, contrary to the terminology used by the penal system. It may be that morality and moral judgment as such is not the point, only moving towards shared values that discourage aggression and predation and can counter them effectively.

To the extent that we can make this work, madness (e.g. the insanity defense) becomes irrelevant as does the need to determine culpability as the basis for sanctions such as public shaming or imprisonment. Legal culpability serves to justify the exercise of power over a person, and does nothing to promote solidarity and mutual forbearance. Situations of adversity imposed as punishment may lead to a rude awakening that allows a person to see the error of her ways and seek to make amends; However, it can be hard to distinguish such an impact from fear-based

compliance and internalization of shame and a sense of inferiority, seeking to appease those who are exercising power and control.

It is not conducive to democratic values to inculcate shame and inferiority in the members of any society, which inevitably falls on those who are already hierarchically subjugated. Such a system creates the specific hierarchy of those who impose coercive power (prison/institution staff) and those who are required to obey (inmates) and exercises a disciplinary function on those who can remain outside these relations but are affected by having to avoid them. Democracy depends on equality to allow everyone to have the humility and confidence (at the personal level) and the security and freedom (at the collective level) to communicate honestly in debates about the public good and actions to promote and defend it.

It is hard to imagine living this way, to give up the disempowering fear that only the state and its specialized functions can deal with the hard situations. It is easy to imagine rampant predation and that we will have to reinvent the state to bring persistent violators (who? and according to whom?) under control. The state might have a different character if it is used as an instrument of collective action and organization rather than as an instrument of hierarchical class power; it is also painfully obvious that it is difficult if not impossible to maintain community values and democracy when exercising state power, or any organized power asserted over territory and the people living there.

I am thinking - as so many have done before me - about the Haudenosaunee/Iroquois confederacy Great Law of Peace, which resolved violent conflict in a process that included both women as peacemakers and the transformation of a war leader into a peace leader. That society and the Great Law as a model for political organization inspired political thought by Europeans and US settlers, including socialism, feminism, the UN charter and the United States Constitution. The last is bitterly ironic as the instrument of settlers that consolidated their territorial control as a state in opposition to indigenous sovereignty, also legitimizing slavery and denying any political role to settler women. Reversal of these processes of domination - none of which has been fully accomplished - is needed to transform violence within US society, as a prerequisite for creating fair justice for interpersonal harms.

STRENGTHEN COMMUNITARIAN PRACTICES

Community is about how each of us relates to the whole. It starts with solidarity, not submergence. It doesn't require us to give up our individuality or change our personalities. It requires us simply to look around, see where we appreciate others' contribution to our lives and create reciprocity consciously or unconsciously to keep the circle going. It includes forbearance as well as engagement.

Solidarity economy.

Recently I was reading the book Aceptamos Túmin, which describes the development of a community currency in a small town in Mexico. Their purpose was to build a solidarity economy of, by and for poor people, taking back the power of circulating value in the form of currency from the state and multinational corporations as a first step to collective and individual economic empowerment. In working towards a solidarity economy, they also instigated pride in local heritage, particularly indigenous heritage, and had to face challenges of trusting one another and responding to breaches of trust in a way that kept up the process of building trust rather than destroying it.

Their response to breaches of trust inspired me in writing the previous piece on community accountability, and reading about solidarity economy also led me to reflect on what in my own life draws on similar values. I thought about the farmer's market that my wife and I attend

regularly to buy a week's worth of vegetables along with meats, cheese, eggs and other foods, year-round. We deeply value and appreciate the ability to buy fresh local produce and the farmers' diligence and capability and commitment to providing what they can even in our northern winters: kale, bok choi, chard and spinach keep us well-fed. We know we are providing them with needed income and buy as much there as we can, in preference to the supermarket. During this pandemic we are all taking care with social distancing, and the produce farmers have developed protocols for food-washing and packaging; we are keeping each other healthy and allowing this market to keep functioning.

We need to be deliberate and practical as well as visionary in our actions. Some of us are called to defend the earth and water by occupying pipelines, some are called to be farmers or restore a small plot of land, some of us care for a parent or spouse or child full-time. Some of us may not feel we are contributing enough or in the right way. Solidarity starts with whatever we can do, wherever we are already exercising reciprocity in our lives, where we nurture a whole beyond the parts, where we accept the ebbs and flows of relationship that include forbearance as well as giving and receiving. It has to move outward and beyond these beginnings, to develop political analysis and act with courage and deliberateness to challenge inequality and cooperate with others to do so with greater strength.

Care and forbearance.

For some of us forbearance comes naturally and others find it a challenge. The pandemic has been teaching us forbearance through social distancing, teaching us the difference between necessary and unnecessary engagement with one another, teaching us to value and cherish what is necessary, to find ways to maintain it in some form, and allowing us to set aside what is not only unnecessary but a kind of noise that actually prevents us from relating more deeply with our own lives.

The cooperation we are practicing now is very different from how 'supported decision-making' is usually thought of. This is not an ethic of care based on a paradigm of infancy as helpless and utterly dependent, needing and glorifying motherhood as the only power allowed to women under patriarchy – a rather terrifying notion of motherhood

as the power to withhold that is nevertheless kept in check, sacrificing oneself to negate and tame that power as it is not really allowed after all.

It is closer to the shared reciprocity of a community of adults and children, female and male, old and young, human and the natural world (conveyed beautifully by Robin Wall Kimmerer), into which infants are born and find their own way while their care is part of the community and not separated out into a replication of cruelty and domination. Motherhood matters, more as responsibility than as power, as indigenous North American scholars such as Patricia Monture-Angus and white feminists inspired by their indigenous neighbors (Sally Roesch Wagner, writing about first-wave feminist Matilda Joslyn Gage) have written about women's role in those cultures. But even here we may hear 'responsibility' from within a patriarchal mindset as duty without power. The meaning that I understand from these writers is an ability to care that comes out of the fabric of community in which women themselves are cared for, not only by mothers who are similarly cared for and value daughters as full human beings, but in a texture of relationship in which everyone has a place and everyone is needed.

We should not imitate cultures that are not our own or smother anyone with benefactions. To begin, we have only to reach out and give something we have that someone else needs. Can we take groceries to an older neighbor who has to stay indoors, donate money to funds for unemployed domestic workers, facilitate a connection between friends to give each one what she needs?

There is a next step necessary here.

Many members of our communities are struggling to meet our own needs – as healthcare workers coming home exhausted and barely able to care for ourselves, mothers who have no respite from childcare duties, anyone trapped with an abusive spouse. When and how do they ask to get their own needs met, when everyone is struggling and no one can or will take their place? Mutual aid projects try to share the burden yet the glaring inequality and exploitation of the 'essential work force' of the pandemic - in underpaid care work, production of goods and services necessary to sustain life and health, and in industries that states have supported to continue functioning in the interest of capitalist economy - are a dirty underside of the value that some of us are finding in balancing forbearance with necessary engagement. The extra unpaid

care work falling on working women when children, men and women stay home full-time has made it impossible to ignore the unequal burden of such care work that a feminist movement has not eliminated.

Those of us who can prioritize our own needs are in a fundamentally different position than those whose choices are drastically constrained, and we have no social bonds or ethical systems in place to redistribute responsibility among all members of the community, much less to restructure the public priorities that distribute constraints unequally. Public disempowerment and weak social and ethical bonds reinforce one another along class, sex and racial lines, all at the same time; such factors along with age and disability make it starkly less likely that a person will survive a collective crisis. There are actions we can take individually to mitigate the harms done by inequality but in order to fundamentally change the exploitation underlying the way we live, we have to mobilize and strategize collectively, confronting the personal risks and seeking value beyond our individual comfort.

What is value?

What do we in fact value?

Some of us are finding our gifts in the pandemic year – from writing in solitude and connecting with new people in casual, easy ways over the internet to learn and enjoy company, to sharing spiritual messages, to enduring necessary pain and discomfort beyond what we thought we were capable of. We are finding our limitations and boundaries, our needs and the dimensions and exact quality of our suffering. We are aware of our mortal vulnerability, there is no way to know which visit outside will catch us unawares and there is no reason to dwell on it beyond taking the necessary precautions.

The question is, how much of this mindfulness is useful to humanity and how much is a temporary grace for the middle classes to take time out before returning to the market economy and its depredations? Is there enough left of human capability to come together and move us into a future that is politically, economically and socially democratic and communitarian at the international, national and local levels?

Art can be a practice of community - as we learned from stories of people singing out of their windows in Italy and, in Iran, writing poetry on banners also hung from their windows.

Political advocacy creates community and also divides people ideologically. It can also lead to dishonesty, power struggles and violence. In hierarchical political systems - including nation-states and the United Nations - advocates fight to win. The consideration of burning bridges vs maintaining good relationships can moderate rhetoric and de-escalate conflict but can also lead to over-caution and fear-based decision-making.

Setting out points of unity can allow a wide range of people and groups to work to advance all together, rather than competing for places of honor or ranking. Yet such points of unity will inevitably exclude those who disagree with them, while those who want to move faster or look beyond to the next cutting-edge issue will be unsatisfied.

Care and nurturing of the earth and the natural world is necessary to life - human and non-human. It is an act of solidarity that creates community with the non-human world and allows us to sustain the human one. Women I know who practice small-scale organic farming and restoration of damaged land are building a sustainable present and future. Others practice citizen science and environmental advocacy to sustain habitat of pollinators against industrial development, or to shrink the fossil fuel industry and nuclear energy.

Consciously moving towards a subsistence-oriented economy is another way to build community. Living with enough and giving away the rest, sharing rather than hoarding what we have, means creating the bonds with others that allow us to trust in communal rather than personal wealth. Valuing our own contributions to the collective good and taking them seriously also supports community by maintaining balance and perspective.

TOOLS

Principles of de-medicalization and de-judicialization.

These ideas have been introduced thoroughly in the Basic Premises. It is necessary to revisit them here except to note that as principles, they can be a frame of reference to summarize the vision of crisis support based in a social model of disability.

We need to make a leap from a society that isolates individuals and segregates them to impose social control in the name of treatment, to one that accepts the full range of human diversity in our communities, homes, workplaces, and public life, and that holds out real support for people who are experiencing extreme states of distress, discomfort and unusual states of consciousness that are causing them distress or fear or confusion. We need to find ways out of conflict that don't require anyone to subordinate herself to a correctional or therapeutic system designed to fix her as a flawed human being; we are all flawed, can all use some humility and some self-respect. At the same time, we need to dismantle systematic violence - sexual, economic, political and otherwise - so that we can all flourish. We need to see each other in ourselves and ourselves in each other, and act accordingly.

The reason that social, economic, and political change needs to happen in order to make the leap to de-medicalized, de-judicialized crisis support is that our crises, our unusual states of consciousness, our distress do not happen in a vacuum. We are political, economic, sexual, social, emotional beings and our crises, distress, inner and outer voices, spiritual crises and messages, come from our lives. To de-contextualize these phenomena from life is the essence of the medical model and has to be rejected. At the same time, to treat these phenomena as some kind

of social or communal property, as a target for intervention irrespective of the will of the individual concerned, is the essence of judicialization – while understanding ourselves as deeply and inescapably interconnected, we are also each separate beings of intelligence and conscience, with mutually unknowable perceptions, thoughts, sensations and emotions. If we are aiming to rejoin the public and private domains of life, this does not mean subordinating one to the other but understanding the difference between personal and collective agency and accountability. Our solidarity respects the entirety of everyone's personhood and engages with them at private or public levels depending on the nature of the relationship and respecting a choice to disengage.

Pilot projects.

Pilot projects demonstrate the feasibility of a concept, test it out in practice.

Social model crisis support in one sense does not need a pilot project, since we have so many practices existing as alternatives to or within the mental health system that function more or less in this way already. What is the purpose of calling for pilot projects, how would these projects differ from what we already have?

There are two ways that it makes sense to demonstrate the potential of social model crisis support. First, if a project project would help to create a social and legal environment that rejects the option of compulsory hospitalization and treatment, either based on the 'danger' standard or any other one, as diversion from criminal justice, or in the form of pressure by family members and service providers. This means that a pilot project cannot be only the creation of a good support practice (or framework for requesting and providing support), it has to have a legal and administrative policy component as well. For example, a project could secure the cooperation of government, police, courts, and psychiatric system in a particular locality so as to place a moratorium on involuntary commitments and make the public aware of the reasons behind this decision based in solidarity and human rights. Information would have to be disseminated widely so that anyone can exercise the right to not be intervened with against her will and to have support as needed, and do not attempt to coercively intervene with anyone in her supposed 'best interest' but instead seek need support for herself and/or call for

inclusive conflict de-escalation and violation interruption should it become necessary.

The second way a pilot project would be relevant is to take as a starting point the premise that crisis support can be understood outside mental health discourse as implementation of Articles 12 and 19 of the CRPD – making available decision-making support for immediate and long-term navigation of dilemmas that constitute the crisis, and practical support for living in the community during this period of time when it may be difficult to take care of one's basic needs alone. This is a way of seeing crisis that de-medicalizes, de-judicializes and re-configures it as simply a crisis in living that has personal, interpersonal, social, cultural, political and economic dimensions as they affect an individual's life. It encourages and propitiates solidarity and makes punitive, repressive or hostile responses unreasonable and counterproductive. It gentles our responses to one another and promotes give and take, seeing the full humanity of a person who is both suffering and making choices.

Advocacy/shield programs.

Solidarity includes practices that resist the state's power to mobilize violence and coercive control against people experiencing crisis. This can be done using powers the state itself recognizes as protective, such as appointing a proxy who agrees to abide by your wishes, if the law allows for this proxy (or a designated support person) to refuse any mental health hospitalization or treatment on your behalf. This tool should be used with extreme caution in any legal system where you cannot revoke the proxy and act for yourself at any time, including most of our legal systems where we can be deemed incompetent.

The strongest protection of this nature exists in Germany, where it is possible to refuse examination as well as hospitalization or treatment through an instrument known as the PatVerfü. It is binding against ordinary coercive measures in the mental health system and can be protective though not binding against an examination to impose security measures through criminal procedure legislation. More common in other parts of the world are advance directives or designated decision-makers that can refuse particular 'treatments' but not hospitalization - these are of limited value since the psychiatric system can impose

detention, a harm in itself, and also use detention to coerce compliance with medication or electroshock.

Protective resistance can also be done by lawyers either as public defenders or pro bono, using the full extent of the ordinary law available as well as constitutional law and international human rights norms whenever it is possible to do so. Abolitionist lawyers (a phrase taken from the prison abolition movement but equally applicable here) work zealously to defeat arbitrary detention and torture one case at a time. They should avoid strategies or arguments that seek exceptional treatment for individual cases; as human rights defenders they need to be mindful that guarantees of non-repetition for the individual client will usually require systemic change that overturns the regime of involuntary commitment as a matter of law. Strategic human rights litigation from a survivor perspective is needed everywhere to complement political advocacy and provide leadership in the legal field.

Mobilization and cooperation of activists can also make a difference. This can be in the form of public campaigns on a particular case, such as MindFreedom Shield has done on occasion. Friends can intercede with the institution and provide some context to re-humanize the person to institutional personnel; at times it has been possible to get people released by giving them a temporary place to stay in our homes. It can also help to be present in court, testify as witnesses if appropriate or write statements of support. All such advocacy has to respect the choices of the person concerned regarding privacy and strategies.

Working together to participate in UN reporting processes (country reviews by the CRPD Committee or other treaty bodies, or by other states through the Universal Periodic Review) can help to shape systemic advocacy at the national level. Activists can use these processes to advance already-existing national advocacy campaigns or to figure out and initiate new directions for campaigning based on the CRPD.

Victims can also use the individual complaints mechanisms of the UN – the CRPD Optional Protocol if ratified by the country where the violations occurred, or UN Special Procedures and the Working Group on Arbitrary Detention, which are universal. The decisions or views of these mechanisms, communicated directly to the state and also made public, can help to exercise pressure in a particular case. Making such complaints can also generate a body of jurisprudence applying hu-

man rights norms that can be valuable for domestic and regional courts that have enforcement power, which the UN mechanisms themselves do not have. In order to use these procedures effectively, it is necessary to research their advantages and disadvantages - pay particular attention to the requirement to exhaust domestic remedies in order for a complaint to be admitted under the Optional Protocol. Victims can use these mechanisms on their own or be represented (with their consent) by lawyers or advocates.

Publicity can influence public opinion and create a more receptive environment for change, along with organizing and educational activities. It is an important dimension of advocacy so long as it respects the wishes of victims with respect to privacy and strategies. Media and social media campaigns can be used in relation to court cases and complaints made to UN mechanisms, as well as the country review process and follow-up advocacy. Journalists can play an important role in investigating and publicizing human rights violations, and in amplifying the demands of the survivor movement as a marginalized group that has legitimate claims on human rights and solidarity.

Evaluate existing support practices.

The social model of crisis support I propose here does not exist in a vacuum. Besides the logic of the CRPD and contemplative reflection it has been inspired by existing philosophies and practices in and beyond the survivor movement. Intentional Peer Support, in particular, understands autonomy and mutuality in ways congruent with the CRPD, as Chris Hansen was the first to notice.

The World Health Organization is finalizing a set of materials that establishes criteria for good practices in mental health, including non-coercion, and evaluates particular services accordingly. One might dispute the criteria or evaluations; it is not a given that such a project has positive value. But even if it does, such a project only makes sense within a frame of reference that holds constant the existence of mental health services and discourse as a way of approaching state policy regarding support to understand and relieve our emotional suffering and navigate unusual states of consciousness and life crisis.

The social model of crisis support, in contrast, views our suffering, states of consciousness and crisis as speaking for themselves and offering opportunities for connection and inner work (contemplation) that do not need to be limited to the individualized focus of psychiatry and psychotherapy, or to subject our interpersonal and social (and political, economic and cultural) needs to the discipline of targeted intervention – which is the risk of practices based in family therapy and of the discourse of 'social determinants of mental health'. Our crisis, or madness as some would put it, opens out into the wide world and stops being a limitation in our lives when we get to the bottom or center, which is at the same time the point of connection.

I tentatively want to suggest that our movement of people who have experience of these difficult states of being ('peer' movement, 'mad' movement etc.) develop its own criteria for evaluating practices of social-model support, which could begin with the principles of de-medicalization and de-judicialization. The principle of de-judicialization encompasses non-coercion of any kind and also the need to make support available without need of a formal legal instrument to designate a supporter and without any other legally mandated response to crisis except that it be made available to all those who call on them, without turning anyone away, and works with the person and never against her. The principle of de-medicalization means that psychiatric terminology and concepts are not invoked, that experiences and feelings are allowed to speak for themselves. These principles do not capture all the positive features we may want, especially those related to social, economic, spiritual, political 'wide world' dimensions of our lives. They are only a place to start.

LINK OUR DIVERSE STORIES

Each of us will have a different starting point for situating oneself in the world, in relation to other people's stories, and in relation to diversity itself. What follows is a matrix of values that defines my own mapping. Readers are invited to explore connections and disconnections with my set, and to consider their own.

Lesbian ethics. The autonomous existence of women as intelligent, political, moral beings creating culture is the key premise of the women's liberation movement or second-wave feminism. This entails cultivating our connections with one another that can include awareness of sexual energy between women and making primary life commitments to other women. Lesbian ethics, from the book of that name by Sarah Hoagland, represents a lesbian-centric stance on interpersonal relationships and affirms the value of looking deeply at our lives as lesbians to strengthen ourselves and our communities.

Lesbian ethics points to a principle of female autonomy that is required to restructure patriarchal societies. The choices women make as individuals, in partnerships, in larger groups and collectives, at every level of social, economic, political and cultural organization, cannot be ruled by men; rather the dependency of men and society as a whole on women's choices and labor needs to be acknowledged and respected.

Decolonization. Decolonization seeks to reverse the historical and present practices of colonialism including in its settler form (as in the United States). It requires us to face the violence of ongoing settler domination

and be willing to engage in multi-leveled reparation without a pre-defined outcome.

Decolonization can include the reclaiming of one's own traditional healing practices and practices of community in which every person is valued, belongs, and can contribute. It includes practices that view distress and crisis as emerging within a social context of oppression rather than as individual pathology. It means that others have to honor the meaning of a community's worldview and practices in their own terms, without needing to reinterpret them within a dominant hegemonic discourse.

Decolonization is the responsibility of everyone, including those who are from the settler group. It means stepping back from assumptions of universality and becoming aware of one's actual relationships with others and relationships to land and any space.

Disability etiquette. The impoliteness of making an issue of someone's apparent disability or impairment is an important insight of the disability rights movement that needs to be extended to diverse behavior or communication. We want to make the world not only safe from psychiatric violence but also welcoming and safe from all interpersonal aggressions based in ableism.

Neurodiversity. Neurodiversity can be an alternative to pathologizing psychiatric diagnoses that accepts rather than stigmatizing diversity. It has been adopted primarily by people who have been diagnosed or identify themselves as being on the autism spectrum. The concept emphasizes diversity in neurological processes such as filtering information, and appeals to a sense of knowing oneself as unalterably different from the behavior and reactions expected to be typical and taken for granted by others. Since it grounds such diversity in the brain, neurodiversity would appear to accept some of the biomedical narrative of difference in mental and emotional functioning, while rejecting the judgment that equates difference with inferiority.

Diversity of distress. We all relate to distress in unique ways, which are at the same time shaped by cultural influences. The kinds of distress we experience, how we show it or hide it, the causes and contexts of our distress, are as unique as each person. Responding to one another's distress requires not only 'cultural competence' in a broad sense that we need to cultivate in support work, but a competence at the level of what I refer to as 'micro-diversity' – diversity that doesn't (yet?) have a reference point to be categorized. This relates to what Víctor Lizama calls the 'artisanal' nature of support work, which I understand as tailoring support to meet individual needs in approach, language, and kind of relationship established, as well as specific accommodations and tasks that the person may request.

Intimate solidarity. Being in a state of mind and emotion where all is not well, we need from other people both attention and inattention, the sensitivity and kindness to exercise forbearance and to offer kind words and presence with sincerity, for us to accept or not. We cannot escape the work required to make known our truths and choices; this can be postponed but ultimately it is the only way out of suffering. In a vulnerable state of being, there is intimacy whether we want it or not, we are visible to others when we have no choice about encountering them, and even if we try to protect ourselves this takes energy and can be stressful. The intimacy of such encounters has to be met with as much care and kindness as all of us can bring to it, being aware of our lives as part of a larger community and acknowledging how deeply and inescapably we affect one another. The redemption of any human being's pain is her own work (including the non-work and acceptance of not-knowing that is sometimes a bigger part of the journey), and solidarity is a shouldering together of as much of that work as we can with someone who needs it from us in a particular moment.

POLICY IMPLICATIONS

Readers have asked how the material in the Matrix and Roadmap translates into policy.

One burning question in my own mind for some time, has been the relationship that the movement of survivors/service users/mad people/people with psychosocial disabilities would envision between CRPD-compliant support practices and the mental health system. I have expressed the view here that crisis support should be reimagined and framed outside of mental health discourse and practices, and also that democratization of knowledge requires interplay between those who study any discipline formally and those whose knowledge is acquired through experience, practice, traditional or community sources that are outside academia and licensed professions of any kind. This premise is grounded in decolonization and the women's liberation movement as well as the survivor and disability rights movements. 'Nothing about us without us' was foundational to the successes of the CRPD in every respect.

I have come to understand the right relationship between different kinds of knowledge is a blurring of the lines that have created hierarchies as to what knowledge counts as authoritative and whose opinion counts about what is authoritative. That is what we did with the CRPD - as a mixed grouping of state delegates with and without disabilities and DPOs who had among us different levels of familiarity with law, human rights and policy, our work of treaty development resulted in a complex whole responsive to a multitude of human rights and justice needs. The near-universal level of ratification and its influence in international law and policy as a whole, including with respect to the norm requiring abolition of forced psychiatry, attests to its success with states and intergovernmental organizations as well as for the disability community.

I have also said above that the mental health system cannot be placed in charge of reparations or of the transformation of new policy. It makes no sense to attempt a right relationship with those who are still

abusing us - to do so would maintain the hierarchy and leave us in a marginal position, unlike our role in the CRPD where we led substantively as co-equals in the formative stage (the Working Group that met to draft a text in January 2004). Also, our relationship to states, while complex, was one we were willing to accept as the framework for human rights treaty development. We were not contesting the state as a form of political organization and exercise of sovereignty, and did not need to raise controversy about the state as such. The opposite is the case for mental health systems. Even if we consider that it is impractical and not necessarily desirable to eradicate all mental health discourse and practices, we do place all of that in question.

For that reason, my preferred approach with respect to mental health services is to diminish their presence and deny them a sphere of control over policy and practices of support for people experiencing crisis, distress and unusual perceptions. By framing the reimagining of crisis support in terms of supports based in a social model of disability, we point to particular needs of people experiencing crisis in particular, and promote the development of policy through a disability rights agency. As discussed in the section above on Legislation, such policy interfaces with legal capacity reform and support for decision-making, with independent living supports, and with measures to diminish the presence and violence of police and prisons and promote inclusive and fair community-run justice and safety initiatives.

Policy change has to start from the premise of abolition of compulsory hospitalization and treatment. This is a core obligation of an immediate character under international law. Some positive entitlements to support are also characterized as immediate obligations, include support to exercise legal capacity, which is part of the framework invoked in reimagining crisis support.

There can be many starting points to implement abolition - reparations, legal capacity reform, comprehensive legislation to implement the CRPD, deinstitutionalization, decarceration are examples discussed in this paper. While mental health reform is also a potential starting point, it has so far proved to be a poor one that results in empowering

both medicalization and the coercive and carceral powers of the mental health system.

If a state lacks the political will to proceed with abolition, that is an obstacle that civil society human rights defenders need to confront. The kinds of work described in the Tools section above can serve this purpose. It is important that advocacy for abolition be grounded in clarity of purpose and principles, so that it does not accept being put in a defensive posture or accepting terms set by opponents of our human rights and freedom.

Abolitionist advocacy, whether in the context of a state implementation initiative or a campaign to create the political will or obtain a favorable court ruling, needs to be well informed about the normative standards and the answers that the normative framework has given to common objections. For example, in delivering presentations I still hear the objection raised, as if it were new, 'but what about someone who is a danger to self or others?' The CRPD Committee has rejected this objection definitively in its Guidelines on Article 14 and there exist by now many resources from our movement to help explain this norm. Anyone questioning it needs to do the work of seeking out these resources and engaging in discussion with activists who are well grounded in this human rights advocacy. There is no excuse for setting aside the CRPD norms or characterizing them as unachievable aspirations. They originate from the survivor movement and reflect well-considered demands for justice.

Certain kinds of research can be helpful to support abolitionist campaigns but other kinds may be counter-productive. Human rights research to document the details and extent of formal and informal involuntary practices in mental health settings, the kinds of harm caused over the short and long terms to victims, the way that survivors fashion our lives in struggling to cope with these harms and finding strength and creativity, are all valuable to support abolition, reparations, survivors' healing and the creation of inclusive community. Research that asks the question 'is psychiatric coercion harmful?' is, on the contrary, offensive and insulting as it suggests that practices long acknowledged to be torture and arbitrary detention when done to non-disabled persons may be somehow beneficial to those who are labeled as mad. This supposition is dehumanizing and recalls a litany of dehumanizing medical practices

against colonized peoples, women and other marginalized groups including mad and (otherwise) disabled persons.

Research into the value of different support practices can also be useful. But in order to support abolition such research needs to be done from a standpoint critical of mental health discourse and practices rather than taking those disciplines, including their research norms, as the framework in which support practices are to be judged. Such research also needs to incorporate communitarian values and the aim of societal decarceration, as well as a feminist critique of the patriarchal institution of motherhood that isolates mothers (and by extension anyone providing care or support) and demands an impossible perfection from them.

The contention of this paper has been that we need, in addition to advocacy campaigns and research, an articulation of the meaning of crisis support within the logic of the CRPD to ground the formulation of policy within the framework of the human rights of persons with disabilities. Rather than make this an interface between the CRPD and the mental health system, we have deconstructed the need for crisis support into its components of support for decision-making and support for living independently in the community. A sub-theme of support for personal healing is also present along with the complementary development of community-led restorative/transformative justice and safety practices that are fully disability-sensitive including with respect to distress and unusual perceptions.

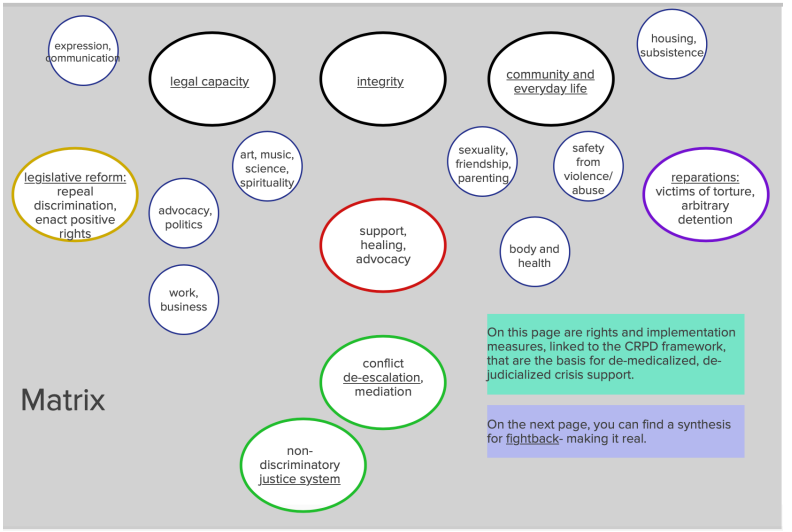
The use of paternalistic coercion based on risk assessment, which underlies involuntary commitment, is rejected as incompatible with the logic of Article 12 of the CRPD, as it is a form of substitute decision-making. Instead, concerns for a person's safety and well being can be affirmed while respecting personal autonomy on a non-hierarchical basis. The practice of harm reduction, promoted by disability justice activists in the US, supports people non-coercively to find their own best approach to reducing harm from risky conduct. I have made the point that safety should be viewed from the perspective of the person concerned, in solidarity, acknowledging her subjectivity and agency.

Readers, policymakers and especially DPOs, will have to consider whether my arguments are persuasive:

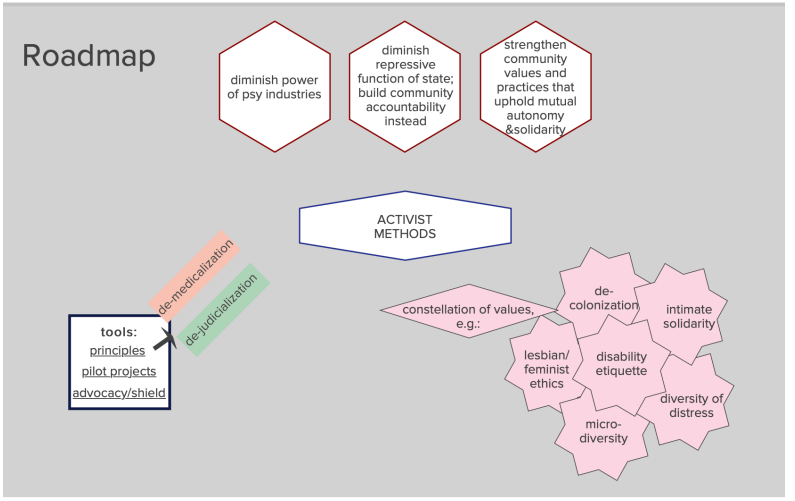
> Does the conceptualization of crisis support as support for decision-making and independent living in the community effectively complete the logic of the CRPD with respect to the abolition of involuntary commitment and treatment?
>
> Is this framework useful for the development of law and policy to eliminate involuntary commitment and treatment, and provide for a positive right to consensual support in personal crisis?
>
> What are the gaps or unfinished areas of this logic? What are the shortcomings of this approach?
>
> How might this approach be relevant to the policymaking body or advocacy group in which you work? How does it support, complement, and/or challenge initiatives you are engaged in?

APPENDIX I
MIND MAPS

De-medicalized, de-judicialized crisis support



De-medicalized, de-judicialized crisis support



APPENDIX II
KEY POINTS OF POSITIVE POLICY[1]

CRPD prohibits forced psychiatric interventions and calls for positive policy instead.

First, mental health crisis[2] must be removed from the category of medical emergencies, and recognized as personal and social in nature.

Second, instead of medical interventions like psychotropic drugs, or repressive ones like detention, we need two kinds of support. We need decision-making support tailored to crisis situations – not support to decide on treatment, but to deal with the situation that has become a crisis in the person's life.

We also need support to manage practical affairs during a crisis, and to maintain safety and well-being, according to the person's will and preferences – instead of labeling someone as a 'danger to self' and intervening against her will.

Third, to replace the label of 'danger to others,' we need police and justice systems that are fair towards people experiencing mental health crisis who are victims of crime or accused offenders, and we need access to conflict resolution for interpersonal disagreements. These functions must be de-linked from support, to differentiate their duty towards multiple parties, from the supporter's duty of loyalty to a single individual.

This policy complements states' immediate duty to abolish substitute decision-making and arbitrary detention. Non-coercive mental

1 Joint Intervention by the Center for the Human Rights of Users and Survivors of Psychiatry and the World Network of Users and Survivors of Psychiatry, CRPD Conference of States Parties 12th session, Roundtable 2, 12 June 2019.

2 When I wrote this statement, I used the term 'mental health crisis' to connect to a frame of reference that is widely understood, despite the phrase problematically invoking a discourse that is medicalizing and thus contrary to the point being made. I leave it intact to reflect the evolution of my thinking.

health services are one way to receive support, but they do not define our crises or play a supervisory role.

I welcome panelists' views on this approach, which situates mental health crisis fully within the social model of disability of CRPD.

APPENDIX III

DISCERNMENT AS PROCESS, NOT PRECONDITION[1]

In both continental and common law systems, the concept of discernment plays a central role as a factor that determines whether a person is considered to have or not have the capacity to make decisions or to exercise rights and duties for oneself. This use is contrary to CRPD Article 12 – it places conditions on the right to exercise agency, based on implicit or explicit assessment of a person's decision-making skills. The Committee on the Rights of Persons with Disabilities explains that a person's actual or perceived decision-making skills, sometimes also called 'mental capacity' (a problematic concept constructed by various questionable disciplines, not to be uncritically accepted as a fact about any person), cannot be used to restrict or deny a person's legal capacity to make decisions. Said another way, it amounts to a 'functional' approach to the deprivation of legal capacity, one of three approaches that are used to deny the legal capacity of people with disabilities.

Yet the concept of discernment has another facet, and another function. Discernment is also a process of contemplation engaged in by one or more individuals, to seek the inner truth of a situation and come to a resolution.[2] It cannot be measured or assessed objectively; its only end point is an inner sense of resolution, satisfaction or congruence, or a mutual sense of resolution, satisfaction or congruence when it involves more than one person. It's a concept used in some religious settings, and can imply a sense of sacred space or time, or simply a turning inward of attention. It can be a conversation or meditation, but might also take place over time by acknowledging a question or dilemma, or feeling of unease, and marking it to allow oneself to become aware of information

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1 Published in 2019 on academia.edu, (c) Tina Minkowitz.

2 Footnote added: The term 'activity' would be even better than 'process' to capture the meaning of discernment I promote. A process might still be objectified or intervened in, despite not being static. If it is a process, it is one that originates from the activity of a person or persons and is part of her or their personal or collective integrity.

that rises to the surface, or allowing a resolution to take form without conscious focused attention. When we mull things over, when we set aside a big decision for later, even when we simply think we are procrastinating, if our minds keep coming back to the problem and we become aware of the unease, all this can be how we use discernment.

Sometimes we balk at the bigness of a dilemma, or the way it presents itself as having no way out; something is unpalatable to us. A parent didn't love us and didn't make it right before they died; the only person who loved us is gone and will never come back; we were abused by the person we placed our trust in and we feel broken. Or we don't have the concepts or words, we just know we did something wrong, we failed, this is the end, our souls are gone or dead. Discernment can be developed and worked with in all these situations, patiently, slowly, paying attention to what comes up and what knits itself together, allowing attention to ebb and flow, in meditation or conversation or over long periods of time.

Discernment as a mutual process can work for conflict resolution if there is a sense of connection and mutual commitment or willingness to work things out. It does not even have to be polite, and can still keep being renewed even if harm has taken place, but does need to be based in a regard for the other person's individuality and needs having value as well as one's own. It is a process of seeking the truth of an interaction, the truth of who we are to one another and how the relationship can work or end.

Discernment can also be relevant to situations where the mind might be working very hard to find a way out; when we might be reacting strongly and making things more difficult for ourselves. Our friends might want to express concern and give us their perspectives – that can be helpful if they and we ourselves understand that it is our process of discernment and their perspectives are advisory – not a truth of 'consensual normality' that we should try to adhere to, but something for us to consider in our own worldview.

The understanding of discernment as a process, not a pre-condition, helps to complete the paradigm shift in legal capacity from substitute decision-making to supported decision-making regimes, which respect the person's autonomy, will and preferences at all stages including the decision about whether or not to use support. Discernment is

especially invoked against people with psychosocial disabilities and people with cognitive disabilities in pre-CRPD legal capacity regimes, to deprive us of legal capacity based on others' judgment of our faculty of judgment as well as our faculty of cognition. For people with psychosocial disabilities in particular, cognition is often not in question, and even the supposed criterion of rationality or linearity in decision-making is not really what is at issue – highly activated rationality can be just as likely to result in a mental illness label as highly active intuition or feeling (think of the 'paranoia' or 'obsessive-compulsive' labels). It is really our faculty of judgment or discernment – sifting through, parsing, judging, comparing, a critical faculty that itself can become imbalanced if over-emphasized – that is put into question, and this questioning of our discernment (also referred to as 'lack of insight' in mental health jargon) is the essence of meta-judgment leveled against us that constitutes 'madness' or 'mental illness' as a social construct.

For this reason, understanding discernment as a process is of value both for the general application of the paradigm shift on legal capacity to people with psychosocial disabilities and people with cognitive disabilities (e.g. ensuring our right to decision-making and providing access to meaningful support and accommodations in relation to legal proceedings, financial transactions, other legal acts or life decisions or everyday decisions), and for the shift I propose in my Positive Policy paper, which posits that mental health crisis itself should be reframed as an occasion for supported decision-making (similarly, ongoing mental health challenges can be so reframed), to replace the substitute decision-making paradigm of forced psychiatry. In particular, discernment as a deliberate paying attention or turning away from disturbing thoughts or emotions, allowing them to manifest to consciousness and allowing them to develop and change, is not what we lack that presumptively sane people have, it is a dimension of selfhood that we can deepen and cultivate (or become aware of, or trust to exist) in exactly those circumstances when it is most needed.

Discernment as a process is congruent with legal capacity as agency. It is the inward dimension of coming to a decision, as agency is the outward manifestation. Just as we respect agency and aim to support it, discernment too has to be respected and supported.

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Global movement of survivors of psychiatry, mad people, people with psychosocial disabilities

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Reimagining Crisis Support aims to change the conversation about personal crisis from mental health discourse to one based in a social model of disability and human rights.

Crisis support can be understood within a social model as support for making decisions and support to live independently in the community, as provided for in Articles 12 and 19 of the Convention on the Rights of Persons with Disabilities.

Complementary to crisis support, we need community-led conflict resolution and violence prevention measures that are open to all sides of a story and sensitive to intersecting axes of oppression including disability-based discrimination – a good fit with Articles 13 and 14 of the Convention.

Policy should be developed based on these premises to replace involuntary commitment laws and coercive paternalism with a solidarity-based response to human needs and uphold the human rights of people with disabilities.

Tina Minkowitz is a theorist and practitioner of international human rights law from a survivor of psychiatry perspective. She contributed significantly to the drafting of the Convention on the Rights of Persons with Disabilities and to its subsequent interpretation and application.

From 2002-2015, she represented the World Network of Users and Survivors of Psychiatry. Currently she is President of the Center for the Human Rights of Users and Survivors of Psychiatry, which she founded in 2009.