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Abstract

The dominant narrative in much of the world, but especially the West, is that public safety and security are provided by policing. Psychotherapy invests in this dominant narrative via its reliance on emergency services provided by the state, such as 911 and police, to pursue the safety of clients and the larger society. However, the long-documented history of oppressive systems of policing suggest that these dominant narratives operate to protect powerful groups while surveilling and policing marginalized people, but particularly Black and Brown communities. As such, critical and abolitionist movements have rejected the idea that policing provides safety and have sought out alternative methods for ensuring community wellness and safety. Although the field of psychology has broadly expressed interest in growing its critical lens and interrupting systems of power, very little has directly addressed how carceral logics influence psychotherapy practice, and how this influences the client's sense of safety in therapy. This manuscript argues for an abolitionist approach to informed consent and safety planning in psychotherapy to address the disparate ways that clients, and especially marginalized clients such as Black and Brown people, experience psychotherapy's traditional use of systems of policing and state authority. Clinical illustrations are provided and future directions are discussed.

*Keywords***:** abolition, psychotherapy, safety planning, informed consent, liberation psychotherapy

Clinical Impact Statement: Question: This manuscript addresses whether there are alternatives to the way that psychotherapy traditionally centers police and 911 services during

informed consent and safety planning. Findings: Clinicians can use the recommendations offered in this paper to restructure their informed consent and safety planning procedures to address the disparate experiences of authorities that clients, especially marginalized clients, may have. Meaning: This manuscript offers a new approach to informed consent and safety planning that utilizes abolitionist ideologies and builds a network of personal and community support systems. Next Steps: Future research should empirically investigate this approach as well as seek out other abolitionist approaches to psychotherapy.

Decentering the Use of Police: An Abolitionist Approach to Safety Planning in Psychotherapy

> We desperately need therapists who are abolitionists. So many of us can't tell our therapists that we have suicidal thoughts because we fear the police will get sent to our house. It's terrifying to see your therapist as a cop (#DepressedWhileBlack, 2021).

The 2020 police murders of Breonna Taylor, Tony McDade, George Floyd, and many other Black and Brown people have added attention and energy to worldwide movements for the liberation of Black and Brown people. With the violence resulting from police presence becoming more visible in popular media, the call for an abolition movement has also gained energy (Kaba, 2020). The modern movement for abolition invokes the lineage of the abolition movements to end enslavement and Jim Crow, and today reflects the drive to replace the oppressive systems of prisons and police with life-affirming institutions like housing and health care (Kaba, 2021). Despite the new momentum for abolition, calls to "defund the police" are still unpopular (Pew Research, 2020; Taylor, 2020), which is likely the result of many factors, including the dominant social narratives that inspire rejection of the "other" (Davis, 2005; Freire, 1970; Kendi, 2016), manufacture fear and insecurity (Davis, 2005), and legitimize armed police as the protectors of the masses (Davis, 2016; Vitale, 2017).

Psychotherapy occupies an important role in its maintenance and expression of powerful cultural and social narratives (Sue et al., 2019) and thus has a role in how it responds to issues of safety and trauma related to policing and other carceral logics, which are beliefs rooted in policing and incarceration that encourage one to export social concerns and social problems to the state, instead of learning to rely on one's community for healing and accountability (Ziyad, 2021). Policing and other forms of state authority have a presence in most psychotherapy

practices in U.S. society due to the need to maintain client safety. At the onset of therapy, clients are informed about the limits of confidentiality and when and how emergency services will be utilized to ensure client safety and the safety of the public if the therapist is concerned about client statements during therapy. Emergency services provided by the state, such as 911 and police, are also used to perform welfare checks to ensure and maintain client safety when risk is indicated. Moreover, clients are often provided emergency contacts, such as 911 and police, to maintain their own safety outside of the therapy hour. Unfortunately, these practices to ensure client welfare are rooted in carceral logics, which historically have protected White and wealthy communities while policing and surveilling marginalized communities, and therefore may inadvertently perpetuate state-based trauma and violence against marginalized people, and especially Black and Brown people. Extensive research has documented the negative mental health impacts that come with increased police interaction for Black people in the U.S. (McLeod et al., 2020). This manuscript offers an alternative strategy for maintaining client safety and welfare informed by an abolitionist framework. Clinical materials and illustrations are offered for therapists to decenter the use of emergency services provided by the state, such as 911 and police, to maintain client safety and welfare, particularly for Black, Brown, and other marginalized clients.

Policing as a Dominant, yet Limiting Narrative of Safety

Dominant or master narratives were first introduced by French philosopher Jean-Francois Lytotard (1984) and are popular scripts that control how some social processes are enacted and epistemologically validated (Stanley, 2007). Sociology, history, and criminology research suggest that policing has widely been accepted as the dominant narrative to explain how public safety can be achieved (Chazkel et al., 2020; Harcourt, 2001; Nuño, 2013; Seigel, 2017; Wilson,

2000). These dominant narratives are installed by appealing to popular ideals in the U.S. such as equality using colorblind language and the appearance of neutrality (Alexander, 2010). The dominant narrative of the police as provider of safety is further entrenched by institutional rhetoric of risk, security, and fear of the other (Davis, 2005; Freire, 1970; Kendi, 2016; Vitale, 2017). While used throughout U.S. history, this institutional belief was brought to popularity via the "law and order" rhetoric of the late 20th century (Alexander, 2010; Wacquant, 2009). Despite the well documented connection between policing and the racist and classist social hierarchies they uphold in the United States, as well as the relative ineffectiveness of policing in terms of preventing and solving crime (especially for Black and Brown people), most people in the U.S. continue to believe in the colorblind rhetoric that police exist to protect and serve all people (Chazkel et al., 2020; Gilmore, 2008; Goldberg, 2019; Kaba, 2021; Seigel, 2017 Vitale, 2017).

However, views of policing vary greatly by social identity. White people generally endorse far higher trust in police, and the gap between White people's and Black people's trust in police is currently at an all-time high of 34% (Gallup, 2020). Research suggests that police bring feelings of safety to White people and people who live in wealthier neighborhoods (Peck, 2015; Schuck et al., 2008). Further, research suggests that White people have more positive interactions with police, view them more positively, and believe more strongly in their legitimacy (Schuck et al., 2008, Wu & Sun, 2009). Scholars posit that racial disparities in police perception attitudes are true for White youth as well (Fine & Cauffman, 2015; Fine et al., 2020). These positive White attitudes reflect many writers and scholars who suggest that police have, throughout U.S. history, existed to protect White people, White property, and White ideology (Davis, 2016; Goldberg, 2019; Kaba, 2021; Khan-Cullors, 2017; Seigel, 2017; Vitale, 2017).

Policing and Identity

Throughout U.S. history, policing has always been disproportionately applied to People of Color to monitor and control their lives and squash potential uprisings in ways that preserve the existing class and race-based hierarchies (Alexander, 2010; Fagan et al., 2016; Jones-Brown, 2007; Kendi, 2016; Seigel, 2017; Vitale, 2017). Van de Veer et al. (2012) conducted a series of controlled experiments and found that police presence did not change citizens' sense of safety, and even had the potential to increase fear. Other studies have examined this phenomenon across racial groups and found that Black civilians report significantly higher rates of fear of police than White people, as well as less safety for adults (Brunson & Miller, 2006; Schuck et al., 2008) and youth (Nordberg et al., 2016). Further, fear increases significantly in areas that are targeted for "broken windows" style policing (Hinkle & Weisburd, 2008), which is a policing strategy that targets low-level infractions with heavy police presence and often violent enforcement, primarily in segregated communities inhabited by People of Color (Vitale, 2017). The fear of police that many people have, especially People of Color, is supported by both statistical facts of the increased likelihood of unarmed People of Color to be killed by police (Vitale, 2017; Wertz et al., 2020) as well as academic studies that show police officers are more likely to shoot unarmed Black targets than White ones (Correll et al., 2007; Eberhardt et al., 2004; Peruche & Plant, 2006), and use less force against White suspects (Kahn et al., 2016). In one study, the dehumanization process engaged in by police predicted the use of force against Black children (Goff et al., 2014).

While policing is often racialized, gender, sexuality, documentation status, and ability type are also important identifiers that determine the treatment from and experience of the state. Research suggests that many other overlapping and intersectional experiences of suffering exist in this space, such as policing against members of the LGBTQ+ (Lesbian, Gay, Bisexual,

Transgender, Queer, and other gender and sexuality expressions not represented by cisgender or heterosexual identities) community (Mallory et al., 2015; Owen et al., 2018; Sklansky, 2008), the broad web of state-sanctioned violence against the immigrant community (Chavez-Dueñas et al., 2019; Sun & Wu, 2018), policing against people with disabilities (Brink et al., 2011; Perry & Carter-Long, 2016), and police-perpetrated sexual violence (Barker, 2020; Ritchie, 2017; Stinson et al., 2015). Attending to the intersectional nature of experiences with police multiplies the importance for therapists to de-center the use of police and the state in psychotherapy.

Of particular concern for psychotherapists are police interactions with individuals with mental health concerns. Approximately 25% of people killed by police have mental health concerns, compared to the general population of about 4.2%, and these numbers were even higher for Black people with mental health issues (Saleh et al., 2018). Police officers perceive people with mental health concerns as more dangerous and out-of-control (Watson et al., 2004). They also tend to be less trusting and express more anger towards people with mental health concerns (Watson et al., 2004), which highlights a severe risk for increased use of force based on the common police perception that an encounter could turn violent at any time (Vitale, 2017). Therefore, it seems plausible that perceptions of police and the actual safety they provide for people may differ as a function of social factors and identities. As such, it is problematic that the practice of safety planning and management in psychotherapy relies so heavily on the use of policing.

Policing in a Therapeutic Context

Not unlike the larger U.S. society, the practice of psychotherapy has historically viewed and centered police as an effective means to provide personal and public safety. Suicide prevention research began to flourish in the 1960's (Furlong, 1970), which resulted in the

recommendation to utilize third parties to ensure safety for clients deemed to be high-risk (Farberow et al., 1970). The proliferation of crisis call centers—who routinely utilized police or other authorities to forcibly remove suicidal clients from dangerous situations (Roberts & Grau, 1970)—grew alongside the burgeoning psychotherapeutic practice of involving third parties for suicidal clients (Furlong, 1970). The collaboration between police and crisis centers and the new focus on training police in mental health response (Barocas, 1971) eventually brought police into other realms of mental health during this period (Furlong, 1970). Many clinicians began embracing the methods of crisis intervention teams at the suggestion of the American Association of Suicidology (Comstock, 1979). In the wake of Tarasoff v. Regents of the University of California (1976) and the 1977 Haines case in Canada (Haines v. Bellissimo, 1977), where the court ruled that therapists have a duty to take all reasonable steps to prevent or reduce the risk of suicide, the APA began drafting language in 1979 to change Principle 5 in their *Ethical Standards* to include language about "clear and imminent danger" to the client or others (Eberlein, 1980). These multiple changes in the world of psychology came together to permit the assumption that therapists should involve police and other authorities in psychotherapy during times of crisis.

Psychotherapy is infused with carceral logics, which assume that exporting people's pain and problems (e.g., suicidality) to state authorities (Ziyad, 2021) is an element of best practices. Literature reviews around safety planning suggest that utilizing police during safety planning is a relatively common occurrence in therapy (Murray et al., 2015). Research in the field often assumes that police are experts in safety or that they must be involved in safety planning procedures (Fiorillo et al., 2011; Murray et al., 2014). Police are often sent to do "welfare checks" on clients who are perceived by the therapist to be at increased risk and have missed an

appointment, even though there is no research supporting the clinical effectiveness of police welfare checks (Vitiello & Moseley, 2021). Utilizing police as "welfare" responders in people's homes neglects the fact that many clients might not experience this as care, but instead be subjected to fear, intrusion, loss of privacy, criminalization/incarceration, feelings that one's rights have been violated, and reduced desire to discuss important therapeutic issues or suicidality in the future (Wortzel et al., 2019a, Wortzel et al., 2019b).

Wortzel et al. (2019b) examined data from the National Suicide Prevention Lifeline and found that in over 99% of cases, using the 911 system was unnecessary for a rescue without caller collaboration. Thus, the use of police for welfare checks has far greater potential risks than benefits. Involuntary hospitalizations are another situation where police are assumed to be shared experts in offering care and safety for vulnerable clients (Fiorillo et al., 2011). The vast increase in police handling people during involuntary hospitalizations in recent years (e.g. a 2021 study from Rosen & Travers showed that one state had a 77% increase in police transports for mental health concerns over a seven year period) is gravely concerning given the research suggesting that police often fail to provide quality care to the most vulnerable.

Recently, scholars have critiqued the inefficacy of policing in the therapeutic context and suggest increased police training as a solution (McLeod et al., 2020; Vitiello & Moseley, 2021). This approach unfortunately disregards decades of abolitionist scholarship that has shown that attempting to solve harmful policing via training ignores the failed history of past attempts to improve training and only further inscribes the legitimacy and power of police (Hinton, 2017; Murakawa, 2014; Schrader, 2019; Vitale, 2017). When dealing with police presence in the mental health field, assumptions are often made that more training for police who deal with people with mental health concerns results in better outcomes (Richmond & Gibbs, 2020).

However, this approach does not acknowledge the more than 50 years of failed history for training police in mental health care, or the ways that utilizing police in our field in the first place only reinscribe their legitimacy and future harmfulness (Rodriguez, 2020).

Psychotherapists cannot assume that working with and mentioning the police or other authorities is a neutral politic in their psychotherapy practice. If therapists are serious about their intention to provide therapy that is anti-racist, anti-classist, and anti- to all the "-isms" of social domination inherent in carceral logics, then they must develop practices that reflect resistance to the structures and institutions that have led to the dispossession of marginalized people in the first place. It is imperative that therapists relinquish the assumption that acknowledging the possibility of police presence in the course of psychotherapy is inconsequential or that its meaning is equal between clients. Psychotherapists must also be aware of their history as practitioners and researchers, which despite good intentions, includes an uninterrupted stretch of elitism and maintenance of the status quo—a social order that has been violent and harmful towards those with less access to social power (Prilleltensky & Stead, 2013). One practice that may be useful in disrupting the status quo and increasing a sense of power for clients within psychotherapy is to approach safety planning from an abolitionist perspective.

An Abolitionist Approach to Safety Planning in Psychotherapy

A critical psychology lens is necessary to attend to the ways that psychotherapists uphold systems of power such as policing, and whether there are other, more effective ways to provide safety to people who live with mental health concerns without using state authority. Vast research and theory already exist that advocate for more liberatory approaches to psychology where the most marginalized people in society are centered and empowered so that the profession of psychology and those they work with are collaboratively challenging the systems

that allow psychological unwellness to exist in the first place (Comas-Díaz & Torres Rivera, 2020). The research and theory in fields like critical and liberatory psychology cover these issues in much greater detail but are beyond the scope of the present paper (Martín-Baró, 1994; Montero & Sonn, 2009; Prilleltensky & Austin, 2009). Liberation psychology insists that our practices as psychologists center those with the least access to power and that we critique and resist traditional assumptions within Western psychology—many of which endorse systems of power—which have been crafted and maintained by powerful people and systems (Comas-Díaz & Torres Rivera, 2020; French et al., 2020). In describing the deideologizing method, Torres Rivera (2020) writes, "…the liberation psychologist must study and analyze the dominant messages in light of the experiences of those living on the margins (p. 45)." Therefore, the powerful system of policing and the ways it is utilized in psychotherapy must be critiqued in order to move towards a more critical and liberatory psychotherapy. This paper offers an example of one simple, critical, abolitionist approach to psychotherapy that is applicable to the practice of every therapist: informed consent and safety planning.

Informed Consent

Informed consent is the process of the therapist conveying in a comprehensible manner any information that is likely to have a bearing on the client's decisions about whether to participate in therapy (Blease et al., 2018). The goal is to maximize the client's understanding and agency towards the treatments they are undergoing. Even though research supports effective informed consent practices as integral to positive psychotherapy outcomes (Crawford et al., 2016; Snyder & Barnett, 2006), informed consent is often not given sufficient attention in psychotherapy, and meaningful opportunities to promote agency and enhance the therapeutic relationship are missed (Barnett et al., 2007; Goddard et al., 2008). Prior research offers evidence

for the process of informed consent as a ripe opportunity to facilitate a positive therapeutic relationship.

While a robust safety plan is not needed for most clients, a de facto safety plan occurs in most informed consent processes via the limits of confidentiality. This happens when the therapist discusses the limits of confidentiality around suicidal or homicidal thoughts, danger to dependent adults, danger to children, and their subsequent need to call the proper authorities if any of these scenarios arise (Younggren & Harris, 2008). Given the robust evidence of the divergent ways that clients with various social identities experience the state and especially police, these conversations in therapy will likely have a meaningful impact on the client's feelings of safety, trust, and buy-in to therapy. Moreover, in the case that police are utilized in the course of therapy to maintain safety for Black and Brown or other marginalized clients, the risks may far outweigh the benefits. Finally, the therapist can use the informed consent time to discuss the possibility of welfare checks and the client's preference for how police are or are not utilized. Researchers suggest that this is another opportunity to increase transparency, autonomy, and nurture the therapeutic relationship from the onset of therapy, while hopefully eliminating the need for police to be involved in welfare checks in the future (Vitiello & Moseley, 2021; Wortzel et al., 2019b).

Safety Planning

Effective therapeutic risk management techniques such as safety planning have been shown to contribute to the development of a positive therapeutic relationship (Gysin-Maillart et al., 2016; Simon & Shuman, 2009). Therefore, it is possible that collaboratively constructing a safety plan that de-centers the police and other state mechanisms is not only important for physical safety but is also an important relationship-building step during early sessions that can

serve to support the therapeutic alliance and gather information about the important figures of safety in the client's life (or lack thereof; Borges et al., 2019). For example, if the client is unable to list individuals who they would feel safe contacting, or if they list a friend but not a family member, then those are all potentially important pieces of clinical information. These conversations can also communicate the therapist's awareness of structural racism, classism, ableism, and other -isms within policing and other systems of authority and their impacts on mental health. Clients with minoritized identities often do not feel like their issues can be understood by their therapist, which leads to poorer therapy outcomes (Davis et al., 2018). This is a direct and real way that every therapist can acknowledge systemic inequities in the lives of their most marginalized clients.

By acknowledging systemic inequities early on in therapy, therapists can lay the groundwork for future liberation psychology-focused interventions where the therapy locates unwellness and necessary interventions outside of the individual and within the oppressive systems that limit the client's access to opportunities and resources (Haddock-Lazala, 2020). Therapists can allow the client to decide how they want to be in relationship with these powerful, and often harmful systems, given their vastly divergent understandings and experiences of them. For some, this will include a preference for calling 911, police, and other authorities. However, as we have shown, it is dangerous to assume that this is the preferred or only method, especially when working with clients who have been dispossessed by systems of power.

One practical way to interrupt the harmful patterns of utilizing powerful state-sponsored institutions for safety, that every therapist can do, is an abolitionist approach to informed consent and safety planning. The informed consent and safety planning process that begins in the first session should include the acknowledgement that not all people prefer to call the authorities in

times of emergency using 911, which usually brings police presence. The therapist can follow this acknowledgement with alternatives that include: 1) building a list of people and/or organizations that can be utilized in times of emergency. This might include family and friends but can also include community members; and 2) building a list of community organizations who can respond to emergencies and assist in times of suicidal ideation or other severe mental health concerns. This might include local crisis responders who can provide mental health support, basic physical needs such as food, and transportation to safe locations. For the second alternative, the psychotherapist should be fluent in their local resources and have already built relationships with the local organizations and individuals that can provide safety. For example, the therapist should be in relationship with the local mutual aid, housing coalition, non-police crisis response, food bank, suicide hotline, domestic and sexual violence support, and other relevant organizations. These relationships will not only offer the client more options during informed consent and safety planning but are invaluable for clients who need assistance meeting basic needs throughout the course of therapy when the therapist wants to offer more than a referral to a social worker.

One particular method that can be used for resource building and crisis preparation is called "pod mapping" (see Figure 1), which was developed by the Bay Area Transformative Justice Collective to help visualize who and what your support networks are in times of need (BATJC, 2016). Pod mapping was developed because people had been referring to “the community” as their source of support, which was too vague or differentiated to be operationalized for many people. Constructing pod maps helps people to be more specific and intentional about building networks of people and organizations who will actually show up when help is needed. Building pod maps also helps build collective power, since after time and

consistent practice, there is an increased awareness of the number and types of support that exist in the previously vaguely understood "community." This method can be harnessed by the therapist and offered as a tool for clients who want to build support networks outside of state authority. A more robust discussion about pod mapping and safety planning can be found elsewhere (Barnard Center for Research on Women, 2020). While we use pod mapping in our clinical illustration, we acknowledge that it is only one tool and may not work for everyone. We encourage therapists to be creative and courageous in building non-police response systems into their practice, whether or not they utilize this particular tool.

Clinical Illustration

In order to encourage practitioners to move towards tangible change in their practice, we provide a sample informed consent excerpt that can be edited for providers' own use when discussing limits of confidentiality [Figure 2], as well as clinical examples to illustrate an abolitionist approach to informed consent and safety planning. The first clinical example illustrates the use of an abolitionist approach to safety planning during an initial session with a client. The following dialogue is based on a real conversation between one of the authors and a client and has been de-identified and heavily disguised throughout so that it will not be recognizable to anyone, including the client.

Therapist: *Now that we've discussed the limits of confidentiality, it will be helpful if we talk about what will happen if a crisis occurs and we do need to break confidentiality. Because people have varying needs for safety in times of crisis, it is important that we establish a safety plan that is unique to you before progressing too far in our work. As stated above, if I believe there is an imminent threat of serious physical harm to yourself, we will need to take protective actions. While we hope*

these scenarios never happen, now is our time to lay out a plan that makes you feel comfortable and safe, just in case. Many people choose to involve friends, family members, community members, or organizations before they involve authorities, which can include the hospital and police. One way I like to document this is via "pod mapping," which is a tool that was developed out of mutual aid groups in San Francisco to visualize who and what are your support networks in times of need. We'll fill out the basics of this together and can come back to it in future sessions if you find it useful and want to expand on it. Let's start with your name in the middle.

Client: *OK, that sounds good* [Fills out name in middle of pod map].

Therapist: *Starting with the bold circles around the middle, in the case where you are thinking of harming yourself and can't guarantee your safety, who would you like to call? It's OK not to fill them all in. It will also help to write a brief description of what they might be able to offer underneath their name. For example, someone might be best when you're feeling drawn towards harmful substance use, while another person might be best when you need a safe place to stay that night.*

Client: *OK, I think I want to put my grandpa down first. He will always pick up the phone right away if I need something, and he believes depression is real, so I know I can go there. Then my brother too, he's a recovering alcoholic, so I know he gets it in some ways. Maybe one more would be my old boss. She was there when I had all my breakdowns and she never judged me, she still checks in on me too like once every couple weeks, so I know she would be willing to talk and help. I can't think of anyone else.*

Therapist: *This looks great, three is a wonderful start. Once we finish the rest of our paperwork, I'll prepare the release of information for the folks you listed here including their contact information. It will also be important that you eventually speak with them about their placement here in your pod map network since their consent is important. Do you feel comfortable speaking with them, or would you like to discuss this more with me first?*

Client: *Yeah, that's no problem, they all know I'm here today and what I've been going through.*

Therapist: *Great, I'm very glad you're open with them. It's also possible that I would need to contact someone if I am worried about your well-being during a time when we aren't in session. Maybe this would happen if you've missed a couple sessions and I can't get in touch with you. Traditionally, many therapists might call the police to do a welfare check, but I'd like to check with you to see if you'd prefer me to contact the folks on your pod map first?*

Client: *Yeah definitely, I'd prefer you call my grandpa first, then my brother. You can try my old boss but she lives like an hour away. I don't really need the police knocking on my door.*

Therapist: *OK, great, it sounds like you'd prefer authorities only be involved as a last resort.*

Client: *Yeah, I'd say that's true. Do I need to fill in these dotted line circles?*

Therapist: *Good question. The dotted line circles are for people that you don't yet feel close enough to but might in the future. Maybe as we continue working together, if you find this pod map useful, you'll want to add new people, but we'll save that for future work.*

Client: *OK cool.*

Therapist: *And finally on our pod map, there are the bigger circles in the corners and around the edge. These are for the organizations we have in the community who are available in times of crisis. Have you ever used a crisis mental health support before?*

Client: *When I was a teenager, I used to call this suicide hotline when I couldn't talk to my parents. They were always really nice to me and it seemed to help.*

Therapist: *Wonderful, it sounds like the hotline was a good resource, and that's another layer of support we can utilize. We are fortunate to have a couple local community groups and organizations who are available for crises. I wonder if you've heard of [name of local mobile crisis response]? They have a 24/7 hotline as well as mobile services where they send mental health professionals to your location if you're having a crisis. If you'd like to include them in our plan, I'd be happy to tell you more about them or we could call them together to get a feel of who you would be talking to.*

Client: *That sounds good, we can include them.*

Therapist: *Finally, have you seen information about [local neighborhood mutual aid/peer professional support team]? They formed specifically to serve local people who prefer not to interact with authorities and can provide mental health support, substance use support, as well as basic first aid in times of crisis.*

Client: *Yeah that sounds really cool, I'd actually like to list them first before the hotline people. But let's keep my individual contacts first on the list.*

Therapist: *Great, that gives us a nice robust list. Finally, I'll fill in a few numbers and websites for mental health crisis support that are not local but are still able to help in times of crisis, and I'll make a copy of this that you can take home with you. I wonder what it was like for you to build out your pod map with me?*

In the first clinical example, the therapist and client explore several layers of support in just a couple minutes, thus expanding the menu of options during a time of crisis while decentering the traditional assumptions about utilizing the police and other authorities. This requires a bit of extra work for the therapist, including some research, awareness, and investment in the various community organizations outside of state authority. The therapist also learns about the client's preferences around utilizing authority services only as a last resort. While not communicated explicitly, it is possible that the client is slowly building additional trust with the therapist, given their openness and adaptiveness to the client's preferences for crisis preparation. If the client has experienced negative interactions with police, medical responders, or mental health therapists in the past, this process was likely even more beneficial for the therapeutic bond. The client also has new awareness about community resources that might be helpful if the therapist is ever out of reach and the client needs support from home. Finally, the client opened some interesting lines of future therapeutic inquiry, such as listing a grandparent but not a parent, as well as not listing any friends.

The second clinical example illustrates how to utilize the pod map for the same client during a time of crisis. This excerpt is from session six following the client reporting active suicidal ideation and an inability to maintain their safety. The following dialogue has been de-identified and heavily disguised throughout so that it will not be recognizable to anyone, including the client.

Therapist: *It sounds like you've thought a lot about how you might attempt to end your life today, and I'm feeling very concerned for your safety if you leave our session today without some additional support.*

Client: *It's too much, doc.*

Therapist: *I hear how hopeless this feels for you. The depth of your feeling tells me that this might be a time when we involve someone from your support network to ensure that you can be safe tonight so you can get the support you deserve. Do you remember when we did the pod mapping in our first session?*

Client: *Yeah, I do.*

Therapist: *I think you mentioned you saved a copy of it on your phone, but just in case you can't find it, I have one in my desk as well, let's take a look at it together. In your inner circle, you have your grandpa, brother, and your old boss. Is someone here a good person to call and ask for support now?*

Client: *My grandpa. I don't know what to say to him though. I mean, he knows about my depression, but I don't know how to ask him for help. Can you call?*

Therapist: *Of course. Can we call together and have it on speakerphone? If it's alright with you, I will explain that you're feeling very hopeless and we could really use his support to ensure you won't harm yourself tonight. I'll get the conversation going and then you can jump in and speak with him.*

Client: *Thank you, that's fine.*

[After phone call]

Therapist: *I'm really glad you were able to be so open with your grandpa. While we wait for him to arrive, I'm going to give you an extra copy of your pod map. Remember*

you not only have two others in your trusted network around your name, but you also have the bubbles on the outside. The crisis response team can send a counselor to your home location if you need, or the peer response group can do the same if you'd like a peer instead of a mental health professional. The phone numbers and websites around the edge are always there as well. I wonder if you feel different now that we've involved other layers of support?

Client: *I mean, I still feel pretty numb and hopeless. But I'm less scared of what I might do to myself tonight—that's a good thing, I guess.*

In the second clinical example, the therapist and client are already prepared to handle a safety crisis for the client. Through earlier discussions and pod map preparation, there are no questions about who the client wants to involve in their treatment, how to contact them, and at what point authorities might be called. The therapist and client are also learning how to ask for help in a healthy way. The client's grandfather is likely far better able to care for the needs of the client than state authorities because of his love and accountability to the client, and the client's agency and trust with the therapist are protected. The process of working with a client who is feeling suicidal without involving the state illustrates an abolitionist approach to well-being, one where we can learn to rely on each other instead of the systems that have dispossessed so many, especially Black and Brown people. Fostering this kind of collective inter-reliance and accountability is foundational to healthy relationships and communities that are moving towards true liberation (Kaba, 2021). This approach encourages a network of people to learn to embrace our role in each other's pain, accountability, and healing. Carceral logics encourage us to export those tasks to the state, but an abolitionist ideology allows us to imagine a new future that is

more collective, inter-reliant, and equitable in its distribution of resources and safety (Ziyad, 2021).

Limitations and Future Considerations

Critiquing the status quo method of safety planning and informed consent might mean rejecting the widespread practice of focusing on authorities during safety planning. However, abolition is a project of not just tearing down oppressive systems, but building up new, life-affirming alternatives to replace them (Kaba, 2021). Du Bois (1935) described how slavery was never truly abolished without the construction of new economic, educational, legal, and other means for formerly enslaved people to fashion prosperous new lives. Truly democratic institutions that grant full agency and power to oppressed people were needed to materially change the conditions of oppression: thus, his term “abolition-democracy.” Davis (2005) agrees with Du Bois’ (1935) analysis and extends it to modern day with the necessary abolition of the prison industrial complex (PIC), wherein the violent and racist institutions of policing and jails must be replaced with things that the PIC has stripped from vulnerable communities such as education, health care, and housing (2005). An abolitionist approach to psychotherapy must not just challenge the focus on authorities during safety planning, but also construct new, life-affirming options that build networks of care, power, and agency for the client.

In our example, this is modeled by building out the pod map, and should also include robust discussions around community and relationship building. This is not to say that these are simple psychoeducational conversations that can happen in the first session to replace safety planning. These should be ongoing conceptualizations held by a psychotherapist with a liberatory lens. Just as informed consent should be a process and not a single discussion (Blease et al., 2016), liberatory therapy interventions should be ongoing. Importantly, we must remember

that psychotherapy is not liberatory unless the client leaves with a greater sense of agency and connectedness to others, which helps promote the power that comes from greater political and social autonomy (Kivel, 2017). During informed consent and safety planning, these conversations about connectedness can begin with simple questions about the client's community. Where do they go for safety? Who do they think of first in times of crisis? Do they feel that they have options? While in the initial session, therapists may be able to build a list of people or community resources who they can contact before the authorities in times of crisis, the longer-term goal here is to ensure that clients feel certain that they have several options for safety and security. Since many people do not feel this from state-sponsored institutions, it should be part of the therapist's role to facilitate finding solidarity and care within the client's community and social circles. As mentioned above, this might start from the therapist's references to local organizations and individuals who are focused on building solidarity at the community level. The result of these conversations should always be that the client feels more agentic and in solidarity with others who are building social and political power to resist the mechanisms of oppression that harm them.

We also acknowledge that referrals to community organizations will be far easier in some locations than others. Certainly, therapists in rural areas might have a harder time because of lower population, less density, and less organizing activity than in more urban areas. For these therapists where minimal local organizing happens, it might be appropriate to think about the benefits of building or facilitating these groups as an alternative to receiving resources from state-sponsored institutions. As we have shown, people have very divergent experiences with powerful systems, and some might not realize there are other options because of how dominant institutional narratives function to limit imagination and activity that challenges the status quo

(Souto-Manning, 2014). Many models exist for how to create community solidarity from the ground up (Spade, 2020), and everything from mutual aid organizations to Freirean conscientization group therapy offerings are tangible places to begin for therapists who are interested in building out their liberation psychology practice and enhancing the community work that they exist within. The client in the clinical example presented was able to list and utilize a level of support that might be considered "average" for the people who come into psychotherapy. Certainly, there will be clients who have smaller networks and some who cannot name a single person for their trusted support system on the pod map. In these cases, the dotted bubbles can be utilized more directly, and therapeutic work can focus on building healthy relationships where people in the dotted circles might move closer to the middle where support can be relied upon. Even without this, safety planning should include the outer bubbles of the pod map and offer the option to utilize community resources and other mental health support before authorities are involved.

Finally, we acknowledge that regardless of a psychologist's liberatory intent, laws and regulations exist that restrict what is allowed in certain situations. We do not advocate for breaking laws or disowning one's ethical commitment to keeping clients safe. Instead, we advocate to expand our lens of what it means to provide safety for our clients and to recognize how differently many marginalized clients experience authority. Through an abolitionist lens, we can imagine a world with many more options than what is the current common practice. Through this lens, we can also begin to rely on each other and our communities for safety instead of authorities, thus contributing to a liberatory and abolitionist practice.

Future empirical research should test the theory of best-practice abolitionist psychotherapy of safety planning and informed consent proposed herein. Process and outcome

research could examine the importance of this early-session intervention to see how it affects the therapeutic alliance, trust, feelings of safety, and client-perceived measures of cultural competence in the therapist. The present paper only looks at one possibility for implementing abolitionist principles in psychotherapy via informed consent and safety planning. There are certainly copious other ways that abolitionist principles can be implemented within psychotherapy, and the field would be well-served to explore all of these in depth.

Conclusions

This paper advocates for an abolitionist approach to informed consent and safety planning. We explored the critical academic literature that understands policing as a powerful institution that inflicts great harm on many Black and Brown clients, in addition to many other intersecting and marginalized identities. We have critiqued psychotherapy's embrace of policing and state authority in its utilization during informed consent and safety planning, and how this approach lacks a liberatory, critical psychology lens. We proposed alternative processes that de-center the use of police in psychotherapy and utilized the Bay Area Transformative Justice Collective's (2016) pod mapping tool to show how therapists can facilitate safety planning outside of state power during therapy. It is our hope that the clinical examples provided in this paper offer a practical way for therapists to critique and reimagine the traditionally taken-for-granted process of safety planning and informed consent in psychotherapy. An abolitionist approach can ensure safety and well-being for all clients, most especially Black and Brown and other marginalized clients, who have been historically targeted and harmed by systems of state power traditionally employed by psychotherapy practices, such as 911 and the police.

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Figure 1

Bay Area Transformative Justice Collective Pod Mapping

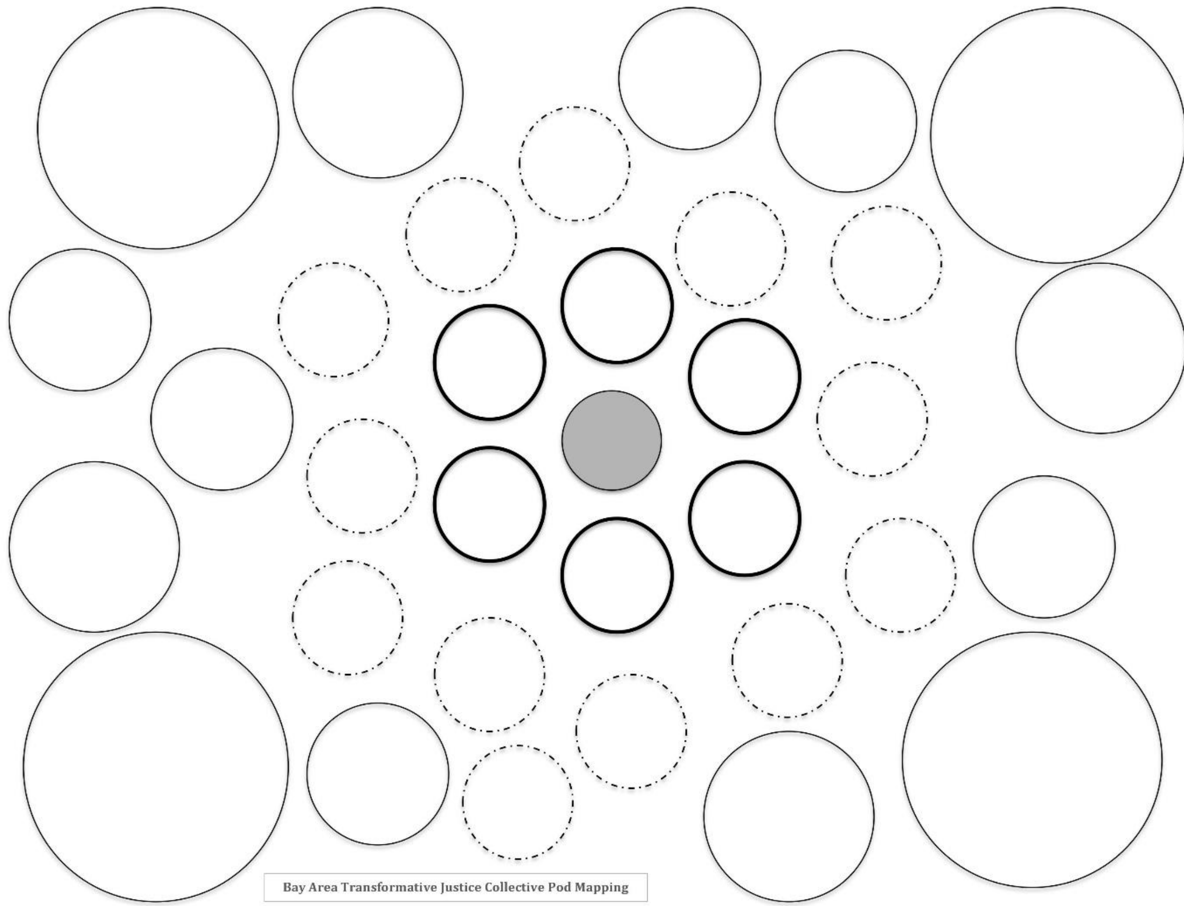

Figure 2

Informed Consent and Confidentiality Template

Confidentiality:
The privacy of communications between a client and a therapist is legally protected. We will protect your personal information and the material discussed during therapy as much as possible. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets legal requirements imposed by HIPAA and/or state law. However, in certain situations where there is reason to doubt the physical safety of certain parties, confidentiality may be broken. In the following situations, no authorization is required:

- The therapist has reasonable cause to believe that a child has been abused or if the therapist suspects that a dependent adult has been abused.
- If you (the client) communicate an imminent threat of serious physical harm to an identifiable victim, the therapist may be required to disclose information in order to take protective actions.
- If you communicate an imminent threat of serious physical harm to yourself, the therapist may be required to disclose information in order to take protective actions.

In an attempt to protect your confidential information as much as possible during the times of exception listed above, we will discuss your preferences for what outside parties you wish to involve when taking protective actions. Insofar as it is safe to do so, the therapist will honor your choices for who to involve in these exceptions to confidentiality, whether those are personal/community contacts or authorities such as 911, which often involve an ambulance and police. In the scenario when all other layers of support cannot guarantee your safety, the therapist will be legally required to contact local authorities. However, with thoughtful planning and preparation, this can be avoided in most situations, if you prefer.