THE PROBLEM WITH 988:

HOW AMERICA'S LARGEST HOTLINE VIOLATES CONSENT, COMPROMISES SAFETY, AND FAILS THE PEOPLE

SAFE HOTLINES

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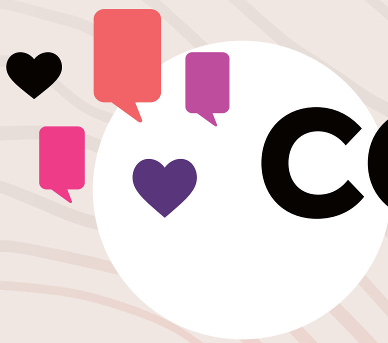

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EXECUTIVE SUMMARY

This report aims to be a source of clarity about dimensions of hotlines that are often hidden from public knowledge, including the unique pipeline from hotlines to harmful emergency interventions involving police and psychiatric hospitalization.

TRIGGER WARNING: This report discusses suicide and suicidal ideation, self-harm, mental illness, violations of consent, police violence, physical and sexual assault, racism, transphobia, forced psychiatric intervention, and death. Some quotes from study participants use profanity.

This report addresses critical issues related to suicide and crisis hotlines in the United States, particularly focusing on the 988 Suicide and Crisis Lifeline. Though originally intended as a safe and confidential support service, many crisis hotlines, including all crisis centers within the 988 network, have evolved to adopt policies and practices that compromise the safety, privacy, and autonomy of those seeking help. This report aims to be a source of clarity about dimensions of hotlines that are often hidden from public knowledge, including the unique pipeline from hotlines to harmful emergency interventions involving police and psychiatric hospitalization.

The first section of this report, **How 988 Operates: A Guide to Hotline Policies and Practices**, provides an overview of how 988 hotlines operate, with a specific focus on non-consensual interventions and the lack of transparency surrounding the practice. The second section, **Policing and Criminalization: Why Cops Don't Belong in Care**, explores the connection between hotlines and law enforcement in crisis response. The third section, **Forced Hospitalization: A Jail By Another Name**, analyzes experiences of psychiatric hospitalization – a potential outcome of a hotline call – with a specific focus on involuntary and coercive experiences. The fourth section, **Help-Seeker Privacy and Location-Tracking Technology**, examines the issues of geolocation and the use and misuse of hotline users' data. Finally, this report concludes with a discussion of **Recommendations** for hotlines guided by the input of people who have sought support from suicide and crisis hotlines.

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* *For the purpose of this report, "mental health" is used as a colloquial umbrella to encapsulate a broad range of emotional or psychological experiences that vary from what is perceived as normative. There are many other valid ways of understanding one's self outside of this Western framework through various spiritual, cultural, and trauma-related interpretations.*

Central to this report is an awareness that the perspectives of **help-seekers**, especially those with marginalized identities, are underrepresented – or entirely absent – in both research efforts and the development of hotline policy. This report centers the voices of help-seekers in its analysis, building on original research data from **210** survey responses and **26** interviews with people who have lived experiences of **mental health*** crises. The survey collected reports on both helpful and harmful impacts of hotline use and other forms of crisis care, perspectives on emergency interventions, and how the threat of non-consensual intervention affects help-seekers. The interviews explored hotline users' experience of hotline conversations, as well as non-consensual interventions and psychiatric hospitalizations initiated by a hotline call. This original data offers a multifaceted understanding of crisis hotline users' experiences, adding to the existing knowledge of crisis hotlines, crisis intervention, and the mental health care system more broadly. *For more information on the original survey and interview research design, see Appendix A.*

In tandem with the lived experiences of help-seekers, this report brings together existing research and a diverse catalogue of policy documents to provide a clearer image of the current hotline landscape. The report concludes with concrete recommendations to transform crisis hotlines in ways that center life-affirming, transparent, and consensual crisis support. Primarily informed by help-seekers, we call for increased investment in non-punitive, consent-driven crisis care and the end of non-consensual interventions.

KEY FINDINGS:

1. **988 Suicide and Crisis Lifeline:**
   The creation and funding of the 988 Lifeline presents a major opportunity to improve the quality and efficacy of crisis intervention services. However, the new Lifeline is missing the mark on providing crisis care that is safe, consensual, and effective. Instead, 988 has systematized the use of non-consensual interventions and has obscured information about this practice from public view. Efforts to obtain data from 988 administrators have been largely unsuccessful, with officials refusing to disclose critical information about the frequency and outcomes of emergency interventions.

2. **Non-Consensual Interventions:**
   This report exposes the negative consequences that can result from emergency interventions, especially those that violate consent. These consequences can include forced hospitalization, police involvement, physical violence, and long-term psychological harm. Non-consensual interventions can lead to traumatic outcomes, particularly for marginalized groups, including Black, Brown, LGBTQ+, disabled and low-income individuals.

3. **Help-Seeker Needs:**
   This analysis illuminates the perspectives of help-seekers, who too often are ignored in the creation of hotline policy. Help-seekers' experiences and needs are centered in the discussion of current harmful practices and inform recommendations for improving suicide and crisis hotlines.

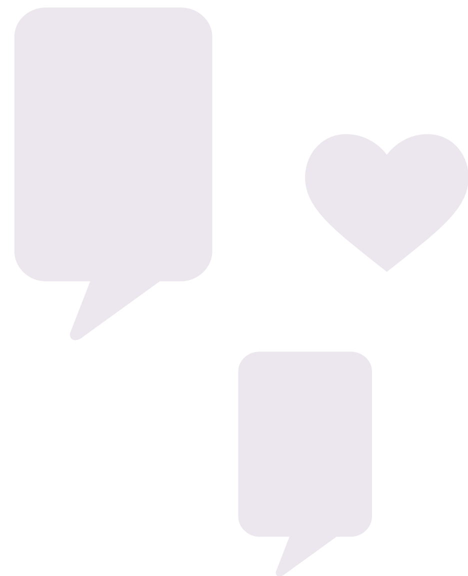
RECOMMENDATIONS:

1. **Policy Change:**
   The findings in this report emphasize the need to end non-consensual interventions, suicide risk assessments, law enforcement collaboration, and the use of forced and coercive psychiatric hospitalization. This report further advocates for policies that prioritize informed consent, transparency, and increased accountability to the needs of help-seekers.

2. **Training and Support:**
   Help-seekers highlight the importance of and need for improved training for hotline operators to better understand and support individuals in crisis, particularly those from marginalized communities.

3. **Investment in Non-Punitive Crisis Care:**
   This report recommends increased funding for alternative crisis support systems that do not involve law enforcement or forced psychiatric interventions.

The report concludes with a strong call to action for transforming crisis hotlines into truly safe and supportive resources. By centering the experiences and needs of help-seekers, especially those from vulnerable populations, the report advocates for a more humane and life-affirming approach to mental health crisis care. **Everyone deserves safe and effective care during experiences of crisis, and approaches to crisis support that center the needs of help-seekers are within reach.** We hope that this report will provide readers with the knowledge to envision better solutions, as well as the determination and direction to make them a reality.



INTRODUCTION

Suicide hotlines originally began as a unique form of support rooted in human connection: a space to share and be heard in a vulnerable moment. One of the first suicide hotlines in the United States started in the early 1960s and consisted of a single phone in the basement of a tattoo parlor in San Francisco's Tenderloin District. The founder, Bernard Mayes, envisioned a service that offered "unconditional listening" from an "anonymous ear."[1] This community-based model of support gave people a space where they could talk openly about their reality without the fear of being institutionalized or the threat of social and legal punishment. Over 60 years later, suicide and crisis hotlines remain a space that neither close friends nor mental health professionals can replicate. In a context where high-quality care is regularly denied to survivors of trauma, people with psychiatric diagnoses, and those who are experiencing life-interrupting challenges, suicide and crisis hotlines fill a major gap in social support.

While suicide and crisis hotlines have continued growing in popularity, the promise of anonymous and safe support has all but disappeared. In the United States, the majority of crisis hotlines have adopted policies and practices that violate the privacy, trust, autonomy, and safety of people who are reaching out for support.

In a far cry from their safe and effective origins, many suicide and crisis hotlines have become entrenched in a system that links crisis response to police, prisons, and psychiatric hospitalization. These hotlines now play a major role in initiating **emergency interventions** for people in crisis, and most disturbingly, are able to do so without consent.

Though emergency interventions can occur voluntarily or involuntarily, this report draws specific attention to the practice of **non-consensual intervention**, a potential consequence of contacting crisis hotlines that is both hidden from help-seekers and understudied in existing research. Non-consensual intervention is the process through which an emergency response occurs without a help-seeker's knowledge or consent. Non-consensual interventions can include both the initial response of emergency responders at a help-seeker's location and any additional interventions that take place from there, such as incarceration or forced hospitalization. Non-consensual intervention also includes instances where a help-seeker may be coerced into consenting to an emergency response. Crisis hotlines employ non-consensual interventions by initiating processes for sending emergency responders – often law enforcement – to the location of a help-seeker perceived to be at risk of harming

themselves or others. Although often framed as necessary for the safety of an individual or their community, in reality, non-consensual interventions set the stage for traumatizing experiences that can exacerbate crises and decrease trust in hotlines.

In the United States, non-consensual interventions pose an enormous threat to people in crisis, particularly Black and Brown people, LGBTQ+ people, disabled people, poor people, and those at the intersections of these and other marginalized identities. Encounters with emergency responders, especially law enforcement, too often escalate to physical violence, psychiatric hospitalization, incarceration, and even death.[2-3] In fact, emergency interventions, even those that start out consensually, can quickly become non-consensual as dynamics of race, gender, and perceptions of risk play out between emergency responders and people experiencing crisis. The repercussions of these interventions can mean long-lasting emotional, financial, and physical injuries – conditions that prolong and exacerbate crisis and thoughts of suicide. Non-consensual interventions are often condemned by people who have experienced them,[4-5] but U.S. policymakers and crisis hotline administrators have ignored these voices and continue the practice. Rather than centering the well-being of help-seekers, non-consensual interventions center the subjective perceptions of hotline operators and the legal liability of hotlines themselves.

Recently, with the creation of the largest hotline network in the United States, the issue of safety and consent on crisis hotlines has grown all the more urgent. In 2022, the U.S. government introduced the 988 Suicide and Crisis Lifeline, transitioning the former ten-digit number for the National Suicide Prevention Lifeline into a new three-digit dialing code: **988**.[6] Presented as an easy-to-remember alternative to 911, the 988 Lifeline has been promoted as a way to divert calls related to psychological and emotional crisis away from law enforcement.[7] 988 has been celebrated as an advancement for the mental health system, as its introduction expanded the Lifeline into a systematized network with over 200 crisis centers providing access to 24/7 crisis response and resources.[8] To date, federal funding made available for the rollout

While suicide and crisis hotlines have continued growing in popularity, the promise of anonymous and safe support has all but disappeared.

of 988 has invested almost $1.5 billion into suicide prevention and crisis response.[9]

While 988 represents a significant expansion of crisis care, it also represents an expansion of location tracking capabilities and non-consensual practices in social support services. 988 policymakers have adopted and defended the practice of non-consensual intervention, disregarding the voices of hotline users, psychiatric survivors, human rights organizations, and crisis care experts who condemn the practice.[10] In addition to defending non-consensual intervention, 988 administrators have advocated to increase the surveillance of hotline users, asking the federal government to grant the Lifeline unprecedented location tracking capabilities.[11] Simultaneously, the Lifeline has avoided calls for transparency and maintained secrecy around the number of non-consensual interventions their hotlines are initiating and the negative consequences that help-seekers have faced as a result. Undeterred by the contradiction of the life-threatening harms that can be caused by non-consensual interventions, 988 officials continue to make claims that the use of these interventions allows them to better achieve their goal of providing "life-saving services."[12]

Since its creation, the 988 Suicide and Crisis Lifeline has increased its reach to the U.S. public through a national marketing campaign. In this campaign, 988 regularly advertises itself as a "private" and "confidential" resource for people in crisis, offering a safe space to discuss one's struggles.[13] Not included in this advertising is any disclosure about the possibility of emergency interventions, which can include law enforcement, and in particular that such interventions can occur without a help-seeker's knowledge or consent. In spite of efforts by advocates and survivors of non-consensual intervention, 988 officials have continued to obscure the policies and practices that render their advertising misleading and dishonest. This lack of transparency has meant that the public is largely unaware of the potential negative consequences of calling 988.

Despite good intentions in its design, in reality, 988 has created another pipeline for people experiencing crisis to come into contact with potentially unwanted and unhelpful interventions. These interventions can ultimately harm, traumatize, and discourage people from reaching out for help. The next section examines the policies and practices in place that enable 988 to initiate non-consensual interventions on help-seekers.

CHAPTER 1

HOW 988 OPERATES: A GUIDE TO HOTLINE POLICIES AND PRACTICES

"I need genuine human connection. I need validation. I need compassion and empathy and people who are trained to offer that."

The suicide and crisis hotline landscape in the United States is made up of national, local, and grassroots hotlines.* These hotlines operate within a convoluted patchwork of regulatory bodies, disjointed policies, and inconsistent practices. Within this landscape, the most expansive and well-funded hotline is the 988 Suicide and Crisis Lifeline, self-described as "a national network of local crisis centers."[1] Over 200 crisis centers participate in the 988 network, including formerly independent hotlines. Since the inception of the three-digit crisis line in 2022, these centers have received over 10 million calls, texts, and chats in just two years.[2]

One major incentive for independent hotlines to join the 988 network is access to both state and federal funding. To date, the Department of Health and Human Services (HHS) reports that nearly $1.5 billion has been allocated to the 988 Lifeline.[2] This increased funding presents a massive opportunity for crisis hotlines to improve the quality of their services and help more people than ever. However, joining the 988 network comes at a cost – all hotlines within the 988 network are contractually obligated to employ emergency interventions for help-seekers who are labeled as "**imminent risk,**" with or without their consent.[3]

* *For the purpose of this report, the term crisis hotline is used to generally describe suicide and crisis call centers, warmlines, peerlines, helplines, etc*

Hotlines outside of the 988 network are ineligible for 988 funding. For many grassroots hotlines that provide crisis care without the threat of non-consensual intervention, the consequences of being excluded from this funding include significant barriers to their growth, reach, and capacity, and a risk of being eclipsed entirely. As 988 expands its network, drawing in crisis care providers, funders who support suicide prevention efforts, and formerly independent hotlines, the existence of non-punitive alternatives in the U.S. is under threat.

Ironically, one of the key factors driving the introduction of 988 was the hope that it would decrease help-seekers' contact with police. Many advocates for 988 presented the three-digit line as a solution to concerns about the high rates of incarceration, violence, and trauma experienced by people in crisis and the substantial barriers to accessing support.[4-6] However, the implementation of 988 has in many ways resulted in a strengthening of the relationship between mental health crisis care and carceral systems, putting even more help-seekers at risk of harmful interventions.[7]

RESISTING TRANSPARENCY: 988 DODGES REQUESTS FOR PUBLIC DATA

For this report, the research team made several attempts to gather missing data regarding 988 hotline operations. While the Lifeline publicly shares performance metrics that include the total number of calls/texts/chats received and answered,[8] the only figure they provide on emergency interventions across their network comes in the form of an often-repeated talking point: "Less than two percent of 988 Lifeline calls involve emergency services."[9] Nowhere on their website – or in any material they make available to the public – is the actual number of 988 calls annually that result in emergency interventions, the reasons for triggering emergency interventions, or the number of interventions initiated without the help-seeker's knowledge, request, consent, or collaboration.

In an effort to fill the gaps in information and provide greater transparency for hotline users, our research team solicited 988 officials for data about emergency interventions using Freedom of Information Act (FOIA) requests and data request forms. Additionally, the research team also examined publicly available documents with partial figures about 988-initiated emergency intervention rates. The research team sent FOIA requests to the Substance Abuse and Mental Health Services Administration (SAMHSA), the federal body that oversees 988, on July 16, 2022 and June 16, 2023. FOIA requests were also sent to the Department of Health in California and Florida regarding government-funded hotlines in the 988 network.* Additionally, data request forms were sent to several national hotlines affiliated with the 988 network, including The Trevor Project, the Veterans Crisis Line, and, 988's administrator, Vibrant Emotional Health. *For a more in-depth report of what our FOIA requests and survey form entailed, please refer to Appendices C and D.* Most hotlines did not fill

* *California and Florida 988 centers were examined in particular because these states have some of the largest 988 centers that handle significant call volume and receive significant funding. Furthermore, the information laws in these states suggested that data should be shared upon request.*

out the data survey, and Vibrant in particular employed a variety of tactics to rebuff the researchers' efforts at gaining information. Vibrant's tactics included changing points of communication, offering to send information and never doing so, and denying the existence of requested data. Despite months of repeated follow-up requests, the only 988-affiliated hotline that completed the data request form was The Trevor Project. *For a breakdown of the data provided by The Trevor Project, please refer to Appendix E.*

For their part, SAMHSA acknowledged the FOIA requests in July 2024, two years after the first request was submitted. In their reply, the agency provided only partial responses that contained no information about 988-initiated emergency interventions. To date, 988 and its administrators have refused transparency about the total number of emergency interventions they are initiating, the demographics of whom they initiate interventions on, the number of interventions that are non-consensual, and the outcomes of these interventions, including police interaction and psychiatric hospitalizations.

Notably, 988 crisis centers are required to participate in data collection efforts by SAMHSA and Vibrant, including collecting data about "crisis encounter outcomes and satisfaction of the help seeker and the crisis counselor."[10] Centers are further required to "maintain all contact records for a minimum period of three years." 988 centers are also contractually required to have follow-up procedures in instances where an emergency intervention has been initiated. This follow up includes confirming whether or not emergency services made contact with the help-seeker.[3] In cases where a crisis center is unable to confirm that emergency services made contact with a help-seeker, they are required to take additional steps to further assess risk and/or provide services. These additional steps can include providing the help-seeker's contact and address information to law enforcement or a mobile crisis team (when available) to perform "safety checks"* until the status of the individual can be confirmed. With these data collection and follow-up requirements in place, one can reasonably conclude that 988 officials do indeed possess information about the context and outcomes of the emergency interventions they are initiating; they are simply refusing to be transparent about it.

The fact that the public is unable to access information related to a taxpayer-funded public service is, in itself, a considerable concern. For help-seekers, the transparency of this information is crucial for making informed decisions about if, when, and how to use hotline services. For taxpayers and donors to nonprofit hotlines, this information is further crucial for understanding the full impact of their financial contributions to these mental health services. Transparent and trustworthy data is key to understanding what works, what does not, and what can be improved across the industry. As 988 continues to expand toward its stated goal of being the central hub for triaging all crisis care in the United States, the need for full transparency has never been more urgent.

* *also known as "welfare checks" or "wellness checks,"safety checks give police legal cover to enter someone's home unannounced and without a warrant. This type of entry can include breaking down doors or windows which can be traumatizing and financially costly for help-seekers who are often left responsible for repair costs.*

THE 988 LANDSCAPE

The 988 Suicide and Crisis Lifeline is operated by a complex web of public and private stakeholders, with different bodies involved in 988's funding, administration, and day-to-day operations. At the federal level, 988 is overseen by the Substance Abuse and Mental Health Services Administration (SAMHSA), a branch of the U.S. Department of Health and Human Services.[10] SAMHSA provides funding, national requirements, guidelines, and recommendations for behavioral crisis care policy and practice. Under contract to SAMHSA is Vibrant Emotional Health, a New York-based nonprofit that serves as the administrator of the 988 network. Vibrant is the entity which provides and oversees the specific policy requirements, guidelines, and operating recommendations for the 200+ crisis centers currently in the 988 network. On the state and local level, 988 centers can be administered by for-profit companies, nonprofits, and state health departments.

Policies and practices vary widely between different 988 crisis centers. While some 988 policies are required by SAMHSA or Vibrant, others are given only as guidelines.[10] This leaves individual crisis centers to create their own systems and procedures within these recommendations. For example, all 988 centers are required to establish and maintain formal collaborative relationships with local law enforcement, 911 **Public Safety Answering Points** (PSAPs), and **Mobile Crisis Teams** (MCTs) in their area.[3] However, how that happens is up to individual crisis centers, and depends on the specific emergency response services available in each county or municipality. Examples of ongoing collaboration between crisis centers and emergency services include shared trainings between 988 staff and 911 PSAPs, regular data-sharing with emergency service agencies, and written memorandums of understanding that formalize the relationship between 988 centers and emergency responders.[11-12] Some 988 centers are even "co-located" with 911 PSAPs, meaning that they operate in the same office as the 911 PSAP for their area.[13]

To further complicate matters, crisis hotlines also implement and adhere to policies and practices specific to accreditation.[14] Crisis hotline accreditation is offered by various regional bodies, as well as two national/international accreditors, the American Academy of Suicidology (AAS) and the International Council of Helplines (ICH). These hotline accreditation bodies each provide their own requirements, guidelines, oversight, and evaluation of hotline policy and practice in exchange for a certificate of

The disjointed policy landscape of crisis hotlines in the United States, including within the 988 network, means that help-seekers can have vastly different experiences depending on the crisis center they reach. In some cases, the number of emergency interventions initiated by crisis hotlines varies significantly from hotline to hotline.

accreditation. Though accreditation is not required to operate a hotline, it is an industry norm that can increase a hotline's credibility with the public and provide an advantage in funding opportunities.[15]

The disjointed policy landscape of crisis hotlines in the United States, including within the 988 network, means that help-seekers can have vastly different experiences depending on the crisis center they reach. In some cases, the number of emergency interventions initiated by crisis hotlines varies significantly from hotline to hotline.[16] This high variability raises concerns about whether inconsistencies in policy and training may lead to some centers being more likely to trigger interventions on help-seekers.

NON-CONSENSUAL INTERVENTIONS

All hotlines within the 988 network are required by the 988 Suicide and Crisis Lifeline Safety Policy to initiate emergency interventions.[3] The process of these interventions is multi-faceted, but always begins when a help-seeker is assessed to be at **"imminent risk"*** – a status assigned by hotlines when an individual is perceived to be at risk of harming themselves or others. These interventions often involve sending law enforcement, emergency medical services (EMS), or mobile crisis teams (MCTs) to a help-seeker's location, and can result in criminalization, forced psychiatric hospitalization, and other harmful or traumatizing experiences. Even when a help-seeker refuses an emergency intervention, 988 is authorized to initiate the process of location tracking and emergency response without consent. **Non-consensual intervention** by a crisis hotline describes the process in which crisis hotline workers initiate an emergency intervention on a help-seeker **without their knowledge or consent.**

According to 988, emergency interventions occur in less than 2% of all calls to the Lifeline.9 However, available data suggests this is a significant underestimation. A study released in 2022 by the NRI, a national organization that collects and analyzes data on public behavioral health systems, revealed emergency intervention figures significantly higher than the often-repeated "2% or less."[16] The study included information on the outcomes from 988 centers and non-988 crisis centers in 31 states. In the states that reported data about emergency interventions, an average of 3.6% of calls resulted in law enforcement being dispatched (21 states reporting), 16.9% of calls resulted in mobile crisis units being dispatched (25 states reporting), and 1.9% of calls resulted in EMS being dispatched (17 states reporting). Strikingly, the state reporting the highest number of law enforcement interventions initiated by crisis hotlines placed this figure at an astonishing 17.3%. This data suggests that the actual number of emergency interventions being initiated by 988 is likely far higher than what SAMHSA and Vibrant are currently disclosing to the public.

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* *A term to denote when a caller is believed, via a hotline operator's assessment, to be at risk of harming themselves or others. Once a caller is deemed to be at imminent risk, hotlines within the 988 network are required to initiate further interventions.*

TABLE OF DATA REPRESENTED IN NRI'S BEHAVIORAL HEALTH CRISIS SERVICES: TECHNOLOGY AND METRICS 2022

Table 1:

Crisis Call Center Outcomes Being Tracked by States, 2022

CRISIS CALL CENTER METRICS	NUMBER OF STATES REPORTING	AVERAGE	MEDIAN	MINIMUM	MAXIMUM
Percentage of calls that are successfully resolved during the call	30	80.0%	84.8%	15.1%	99.0%
Percentage of calls that resulted in Mobile Crisis being dispacted	25	16.9%	7.0%	0%	99.0%
Percentage of calls that resulted in Law Enforcement being dispatched	21	3.6%	2.0%	0%	17.3%
Percentage of calls that resulted in Emergency Medical Services (EMS) being dispatched	17	1.9%	1.1%	0%	6.0%
Percentage of calls that were transferred to 911	16	2.3%	1.2%	0%	10.0%

The reach and potential consequences of emergency interventions should not be minimized. Since 988 was launched in July 2022, the Lifeline has received over 10 million calls.[2] Even if 988's stated 2% statistic is correct, that impact lands at over 200,000 emergency interventions initiated by 988 centers in the past two years alone. Within our research, participants who experienced emergency responses initiated by crisis hotlines detailed encounters of police violence, discrimination, involuntary hospitalization, forced medication, and physical and sexual assault. *For more information on the impacts of interventions, see the Policing and Criminalization and Forced Hospitalization sections.* The extent and severity of these consequences illustrate how emergency interventions initiated by crisis hotlines can expose help-seekers to institutional violence and devastating outcomes that can worsen crisis.

In the case of non-consensual interventions, participants highlighted how experiencing these interventions can compound distress by stripping a help-seeker of their agency and consent in a vulnerable moment. In our study, one interview participant shared, **"I feel like a lot of crisis comes from feeling a lack of agency and a lack of autonomy. [...] so knowing that there is your last piece of autonomy to latch onto and it's always fucking snatched away for some reason."** Our study participants emphasized that a hotline's use of non-consensual interventions and the possibility of location tracking, police involvement, and/or psychiatric hospitalization posed a looming threat during hotline conversations that impacted their ability to be honest and vulnerable. For some, the possibility of an unwanted emergency intervention meant that they avoided calling hotlines altogether. For those who experienced the harms of non-consensual interventions, the consequences lasted well beyond their hotline conversation.

Hotlines and their regulators justify the practice of non-consensual interventions as part of their imperative to provide "life-saving services."[17] This reasoning, however benevolent the intention, ignores the many ways that non-consensual interventions can cause life-altering and sometimes lethal harm. In addition to the violence that many of our participants described experiencing during interventions, they also identified numerous long-term consequences, including intensified thoughts of suicide, job loss, financial instability, and increased familial and interpersonal conflict. While proponents of non-consensual interventions claim that the benefits of these interventions outweigh the harms, existing research offers little to no evidence to support this argument. Information on both the frequency and outcomes of non-consensual interventions is largely unpublished, and the data that does exist is frequently concealed by crisis centers.

Many people who have survived non-consensual interventions, including participants in our study, firmly oppose the practice. One participant shared, **"I think not having non-consensual – what do they call it? – rescue. I really think other organizations could learn from that. Because it is like there's this threat [...] that is behind the conversation that makes it really hard to be vulnerable."**

In opposition to the practice of non-consensual intervention, participants we interviewed called for greater emphasis on **informed consent** throughout hotline conversations. Informed consent was framed by many callers as essential for building trust in hotlines and improving the quality of support provided by them. In the case of emergency interventions, informed consent requires:

- Explicit disclosure of the possibility of interventions at the start of all hotline interactions
- Fully informing help-seekers of both potentially positive and negative impacts of emergency interventions
- Increased transparency about the process used to determine that an individual is at "imminent risk," including if risk assessment questions are mandatory
- A commitment to only utilize emergency interventions with the full, ongoing consent of help-seekers

Though emergency interventions are not the outcome of all hotline calls, the frequency of the practice, the lack of transparency surrounding it, and the harms reported by people and communities who have experienced non-consensual interventions demand greater attention. An important starting point is increasing awareness of the practice itself and how hotline calls can result in the initiation of an intervention.

"I think not having non-consensual – what do they call it? – rescue. I really think other organizations could learn from that. Because it is like there's this threat [...] that is behind the conversation that makes it really hard to be vulnerable."

-PARTICIPANT

988'S "SAFETY" ASSESSMENT

In the mental health field, suicide **risk assessments** are evaluations conducted to assess an individual's likelihood of attempting suicide. For 988 hotlines, operators are trained to assess for the possibility of suicide on every call, text, and chat.[3] As part of this process, 988 operators are required to ask all help-seekers some version of the questions: "Have you had any thoughts of suicide in the past few days, including today?" and "Have you taken any action to harm yourself today?" If an individual answers yes to either question, the 988 operator is then required to conduct a further assessment to determine whether the help-seeker is at imminent risk of harm. Should the operator determine the help-seeker is at "imminent risk," they are required to initiate an emergency intervention.

In several studies, suicide risk assessments have been shown to be misleading, innaccurate, and an inadequate tool for predicting suicide.[18-20] In a meta-analysis of 50 years of research on risk assessments, suicide risk assessments conducted by a trained health professional were shown to be no more accurate at predicting future suicide than random guessing by someone with no training or by flipping a coin.[21-22] Furthermore, a 2018 review of risk assessment and suicide prediction methods reinforced that suicide risk categorization often leads to concerningly high rates of false positives while failing to pre-emptively flag many fatalities who were considered low risk.[23] Despite these findings and others that underscore the ineffectiveness of risk assessments, 988 continues to utilize this practice.

"Are you in danger of hurting yourself or others today?' is generally the script that I'm familiar with, something of that sort. It's really frustrating 'cause I struggle with chronic suicidality, but it's not dangerous. It's in order to prevent it from becoming dangerous that I call these hotlines. But it just sucks that less-trained folks hear the word 'suicide' and they become like, activated to behave in a certain way. And it's just like, oh my God, this is my time to call you. Why do I have to take care of you now?"

-PARTICIPANT

In response to critiques about their suicide risk assessments, 988 has rebranded its process of risk assessment as a **"safety assessment."**[3] This safety assessment upholds the same intention and principles as the formerly-titled risk assessment, with the most substantial change in this transition being the name. According to the 988 Suicide Safety Policy, the new safety assessment "reinforces the need to ask all contacts about suicide and to assess immediate risk while remaining firmly committed to the Four Core Principles of Suicide Assessment originally identified in the Lifeline Risk Assessment." These Four Core Principles include Desire, Intent, Capability, and Buffers:

- **Desire:** an individual's desire to die by suicide
- **Intent:** a well developed plan to die by suicide that an individual has already taken some steps toward
- **Capability:** an acquired ability to inflict self-harm; may include a history of suicide attempts, a history of self harm, emotional dysregulation, current intoxication, and available means
- **Buffers:** any resource an individual might already have in their lives that could act as a support to help them feel less like harming themself or taking their own life

Notably, these four principles are designed to evaluate a person's suicide risk based on desire and ability to act on suicidal thoughts. This type of assessment does not limit the initiation of an emergency intervention to instances when a suicide attempt is actively in process, but actually widens the scope for potential interventions to situations where desire, intent, and ability is present. Given the inaccuracy of risk/safety assessments, it is important to underscore that thinking about suicide, knowing how one might complete suicide, and having the means to go through with it are not reliable indicators of emergency or a need to initiate an emergency intervention. This type of assessment, as reflected by several of our participants, leaves room for significant misinterpretation, putting individuals who live with suicidal thoughts at higher risk of non-consensual interventions. Describing their experience, one participant said, "'Are you in danger of hurting yourself or others today?' is generally the script that I'm familiar with, something of that sort. It's really frustrating 'cause I struggle with chronic suicidality, but it's not dangerous. It's in order to prevent it from becoming dangerous that I call these hotlines. But it just sucks that less-trained folks hear the word 'suicide' and they become like, activated to behave in a certain way. And it's just like, oh my God, this is my time to call you. Why do I have to take care of you now?"

In addition to being unreliable in determining risk, risk/safety assessments can prevent help-seekers from receiving the kind of support they actually want and need. Many participants in our study felt that these assessments derailed or detracted from receiving the support they were seeking. One participant shared, "[The call] kind of got sidetracked onto whether or not it was an emergency. [...] I understand the need to ask that question, but I also felt like, in the moment, when I was going through something, I kinda felt very misunderstood that the questions were being asked. And that kind of made me a little scared, actually." Commenting further on the reality of risk/safety assessments being barriers to care, another participant said, "I think people shouldn't be turned away, or be consistently road-blocked from talking about what they need to talk about and diffusing a crisis. If they have that barrier of, 'We have to ask you these questions first, or else we're not going to talk to you,' I think that's awful. I think that anybody should be able to reach out and talk, even if they're unwilling to answer all of the questions about their safety. 'Cause some people can't do that. Some people aren't in the space to do that, and they shouldn't be denied support because of it."

For some participants, risk/safety assessments discouraged them from wanting to continue a hotline call or call a hotline altogether. One participant shared: "If someone's gonna ask me if I'm safe and I'm actively feeling suicidal, [...] it doesn't feel helpful to ask me that. Because it gives me the message that, 'We just want you to say that you're safe so that we can feel better. We don't actually care about what's going on for you.' And those are the calls that I might hang up on."

Participants also shared that risk/safety assessments felt like a defining moment that could lead to harmful outcomes. One participant described these assessments as "this gate that you have to pass in order to receive the help. There's the fear of, 'If I don't pass this gate correctly, it will lead to coercing.'" These experiences point to the reality that for many help-seekers, risk/safety assessments also create fear and anxiety about a potentially unwanted loss of agency.

"If someone's gonna ask me if I'm safe and I'm actively feeling suicidal, [...] it doesn't feel helpful to ask me that. Because it gives me the message that, 'We just want you to say that you're safe so that we can feel better. We don't actually care about what's going on for you.' And those are the calls that I might hang up on."

-PARTICIPANT

Because these assessments introduce the threat of an emergency intervention, our participants also reported having to play a balancing game between disclosing and withholding information to successfully navigate their calls. One participant shared: "I always have to preface my calls with, 'No, I'm not a danger to myself or others,' even if I am actively suicidal, so they don't call the cops. [...] But then you have to communicate that you're in just the 'right amount' of danger so that they don't hang up or deprioritize your call." Here, communicating "the right amount of danger," as opposed to *too much* danger, indicates the participant's intentional prevention of an emergency intervention that could be triggered by the assessment.

An additional issue with 988's risk/safety assessment is the wrongful conflation of self-injury with suicide and an overemphasis on self-harm as an indicator of suicide. If a help-seeker answers yes to 988's required question of "Have you taken any action to harm yourself today?" operators are instructed to then "assess immediate safety and determine if there is a [suicide] attempt in progress."[3] Our study participants offered another perspective, reflecting that a history of self-harm did not necessarily predict future suicide, and that focusing excessively on self-harm distracted from help-seekers' actual needs.

When asked about self harm-related risk/safety assessment questions, our participants expressed that these questions did not align with their actual experiences. One participant disclosed that questions about self-harm were irrelevant because for them, self-harm did not indicate a desire to commit suicide. However, they felt unable to reveal information about their self-harm due to the assumptions that could be drawn between the two. They stated, "[Self-harm] was something that I was dealing with at the time, and I was like, I probably shouldn't mention that because of the assumptions. [...] It's also not always suicidal and a different type of coping mechanism... for me." Another participant reflected that having the ability to talk about certain things or feelings related to self-harm would be supportive and helpful, yet these questions are currently only used as a tool to initiate potentially harmful interventions. They shared, "Of course I felt like hurting myself. [...] Of course I want to be honest and to be able to talk about those feelings. I think it would be really helpful for me to have acknowledged how I was actually feeling in those moments, but I just know that if you say yes to those questions [about self-harm] – those questions aren't to have a supportive conversation. It's like those questions are to involuntarily hospitalize you or call the police on you or do something that isn't helpful and is really traumatizing and harmful."

Several of our participants expressed support for the removal of risk/safety assessments from 988 hotlines. One participant suggested that risk/safety assessments be something that people could "opt out of so they can just be heard." Another participant added, "Wanting to know if somebody's safe is great, but making it also a requirement? There are some people who are like, 'I don't wanna talk about my safety. I just wanna talk about why I'm here today.'" This participant

also questioned the relevance of assessment questions, saying, "'How long have you been feeling this way?' is kind of a normal question to ask. Not super invasive, but, like, 'Have you ever, uh, attempted suicide?' or stuff like that, that's so useless and just triggering."

It is clear from existing research and our participants' experiences that risk/safety assessments are neither helpful nor accurate. The consequences of maintaining the use of risk/safety assessments can range from help-seekers feeling dismissed and unsupported, to the unnecessary initiation of emergency interventions that can be "traumatizing and harmful" and erode public trust in crisis hotlines more broadly.

> ***"I always have to preface my calls with, 'No, I'm not a danger to myself or others,' even if I am actively suicidal, so they don't call the cops. [...] But then you have to communicate that you're in just the 'right amount' of danger so that they don't hang up or deprioritize your call."***
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> **-PARTICIPANT**

THE ROLE OF THE HOTLINE OPERATOR

Suicide and crisis hotlines are primarily staffed by a mix of trained volunteers and paid staff, sometimes including social work or counseling students, clinicians, and other licensed mental health care providers. Within the 988 network, hotline operator training can vary widely by crisis center and by state. Individual crisis centers can develop, practice, and evaluate their own training policies and protocol, as long as they attend to 988's minimum requirements, including: completing a safety assessment when a help-seeker reports thoughts of suicide; preventing suicide by any available measures; and working with emergency services when the caller is at imminent risk and will not or cannot secure their own safety.[3]

The hotline operator plays a critical role in initiating emergency interventions. Hotline operators start the process of risk/safety assessments, make the determination of imminent risk, and initiate the emergency response. The level of risk that a hotline operator perceives and conveys to a 911 operator when initiating an emergency intervention can have profound consequences. Research has shown that when 911 operators overestimate risk, they prime law enforcement to approach situations with more aggressiveness.[24] Because of this potential for harm, it is critical not to underestimate the role of the hotline operator in the process of emergency interventions.

According to 988's Suicide Safety Policy, an indicator of imminent risk is that "the risk must be present in the sense that it creates an obligation and immediate pressure on center staff to take urgent actions" such as initiating an emergency intervention.[3] The issue with this criteria is that it is dependent on the subjective nature of an operator's sense of obligation or "pressure," rather than the help-seeker's wants and needs. This primes the triggering of emergency interventions based on a hotline operator's internal narrative or anxiety, which can be dependent on beliefs and emotions informed by individual life experiences, socialization, and implicit biases.

Our participants reported being especially aware of operator anxiety and having to manage operators' emotions in order to avoid emergency interventions. This typically shifted the dynamic of hotline conversations to the help-seeker focusing on the emotions of the operator instead of the intended opposite dynamic. One participant likened this shift to "a performance and a reassurance," while another participant explained that "it becomes about managing [the operator's] emotions and their concerns. It also becomes about, 'Are they going to flag me up the line to their supervisor? Do I have to worry about someone coming to my location? Do I have to worry about the cops being called? Am I gonna be able to stay in my own home and keep my liberty?'" Another participant shared concerns about operators who may misinterpret what they share and be "trigger-happy" or quick to initiate an emergency intervention. This emotional labor on the part of the person in crisis was not only an added barrier to receiving adequate support, but also an additional layer of stress and anxiety during a vulnerable moment.

"it becomes about managing [the operator's] emotions and their concerns. It also becomes about, 'Are they going to flag me up the line to their supervisor? Do I have to worry about someone coming to my location? Do I have to worry about the cops being called? Am I gonna be able to stay in my own home and keep my liberty?'"

–PARTICIPANT

Our participants also reflected a desire for more hotline operators with shared lived experiences and increased training around working with people of various identities and cultural backgrounds. Participants expressed that without proper training, operators may act upon biases and assumptions that can be unhelpful or even harmful. Reflecting on a negative experience they had on a hotline call, one interviewee stated, "I feel like the operator was culturally insensitive. I'm from, I can just call it a diverse background, and maybe my accent and the way I express my feelings might be different to the way the operator needs me to express the feeling. So I feel like the operator might not understand different cultural backgrounds, how people express their feelings." Another participant made a concrete suggestion in response to operator biases, saying, "There needs to be

ongoing training and ongoing community. And also, connection to the disability justice movement, and also diversity, like racial diversity and gender diversity, like those trainings as well, because people's experiences are so intersectional. And your experience is gonna be different from my experience just based on how we look and how people treat us based on how we look. And you wanna have a worker on the phone or on text who's aware of those and isn't inadvertently perpetrating more bullshit."

Further elaborating on a desire for cultural and identity competence, many participants commended the unique helpfulness of peer support. **Peer support*** was described as creating more understanding and trust in the conversation. One participant shared their recommendation for more hotlines to transition to peer support models:

"Something that would be really helpful for me on hotlines is more involvement with peer support. I would only really call, for me, hotlines that I felt like I could trust had people on the other side who have maybe, it's not like everyone has to go through every single part of the same experience as me, but just trusting that people on the other end that have their own experiences with the mental health system, neurodivergence, trauma, transness. Some of those things would be crucial for me feeling like I could actually trust and talk about things that were going on in my life and sort of not just be met with a link to like, 'here's five ways you can do a grounding exercise,' 'cause I think that felt very inadequate for the things that I was going through at the times I would call hotlines."

Beyond shared identity and cultural competence, help-seekers expressed needing to feel a baseline connection with the operator, with connection being one of their main reasons for contacting a hotline. Yet many participants in our study spoke to a lack of human connection between the individual operator and caller. One participant expressed, "I need genuine human connection. I need validation. I need compassion and empathy and people who are trained to offer that." Many participants expressed feeling their interactions were robotic or lacked human connection, and that this often led to further negative impacts from their hotline experience. Another participant shared, "There wasn't a real humanness in that call, and I feel like it kinda escalated my crisis too."

Participants further discussed the importance of operators following the caller's lead without rushing to solutions or making assumptions about help-seeker's needs. When describing negative experiences with operators, participants pointed out that these operators often led the conversation and asked unhelpful questions or offered unhelpful information. Participants suggested that operators explicitly ask what type of support help-seekers want or need and shift their approach to match. This necessitates being present with help-seekers without trying to fix their behaviors and instead

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* *A term to denote when a caller is believed, via a hotline operator's assessment, to be at risk of harming themselves or A peer is considered one with shared lived experience, identity, and values.*

listening to understand their experience. One participant emphasized the need for operators to approach hotline calls with openness, stating: "I'm a big proponent of meeting people where they're at and just asking people what they need, because everybody's needs are different, you know? Like, one day, I may need to just yell and scream, [...] just get all of the feelings out and just talk about what's going on. And sometimes I might just need somebody to talk to me about trans joy or the good things that are happening. Really just asking people what they need. And if they don't know, just trying stuff out, you know, really being curious and open to really whatever somebody might need."

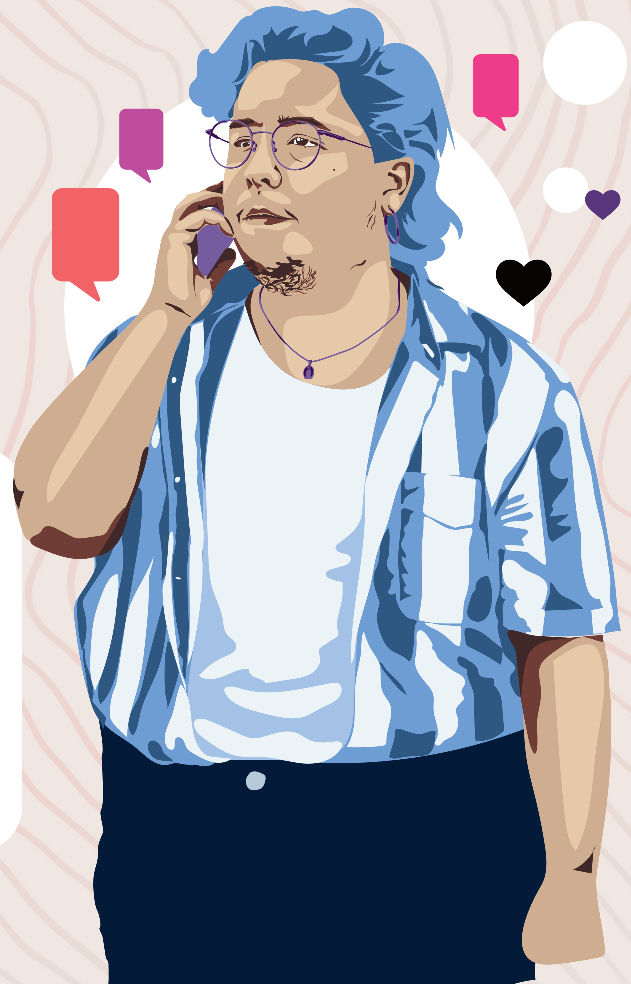
The role of the hotline operator is particularly important as it is their decision that initiates the process that can expose help-seekers to a variety of direct and indirect harms. The next section will elaborate on the specific threats and harms of law enforcement in mental health crisis response, popular "alternatives" that have not yet divested from police, and help-seekers' demands to remove law enforcement from mental health care entirely.

"Something that would be really helpful for me on hotlines is more involvement with peer support. I would only really call, for me, hotlines that I felt like I could trust had people on the other side who have maybe, it's not like everyone has to go through every single part of the same experience as me, but just trusting that people on the other end that have their own experiences with the mental health system, neurodivergence, trauma, transness. Some of those things would be crucial for me feeling like I could actually trust and talk about things that were going on in my life and sort of not just be met with a link to like, 'here's five ways you can do a grounding exercise,' 'cause I think that felt very inadequate for the things that I was going through at the times I would call hotlines."

-PARTICIPANT

CHAPTER 2 | POLICING AND CRIMINALIZATION: WHY COPS DON'T BELONG IN CARE

"I have actively avoided calling 988 since it's come out because of the people who have shared that [they] called 988 and the cops showed up. I don't need the cops when I'm having emotional distress."



Through the practice of emergency interventions, suicide and crisis hotlines have created a distinct pathway for help-seekers experiencing psychological or emotional crisis to come in contact with law enforcement. In recent years, the role of law enforcement in mental health crisis response, as well as the broader criminalization of people with psychiatric diagnoses, has gained significant public attention. This awareness has been driven in large part by Black organizers and activists confronting police violence against people of color, as well as disability justice activists confronting police violence against people with disabilities. Today, many advocates, policymakers, and mental health professionals recognize that police are often greater sources of violence and trauma than effective support for people in crisis. In 2018, the American Public Health Association released a formal policy statement recognizing police violence as a public health issue, emphasizing a need for greater investment in community-based mental health programs.[1] Racial justice and human rights organizations such as the ACLU,[2] Mijente,[3] and the NAACP[4] have made similar calls for change. Following the George Floyd uprisings in 2020, several

professional behavioral health organizations also formally acknowledged the issue of police violence,[5] with some encouraging a movement away from relying on police in mental health crisis response.[6]

While police budgets have continued to increase over the past several decades,[7] there has been a significant lack of state and federal investment in community-centered mental health support. This disparity in funding has resulted in an overreliance on police as the primary response to mental health crisis.[8-9] Even subtle reforms to crisis response have continued to rely on and invest in law enforcement, including questionably-effective Crisis Intervention Training (CIT) programs.[10-11] When funding is invested in non-police crisis intervention, large amounts are allocated to short-term solutions, such as creating more psychiatric beds,[12-13] which do little to meaningfully address the root causes of distress and trauma. This trend is reflective of a landscape that offers few resources to confront the social and economic factors that often cause or exacerbate crises. As a result, many individuals experiencing emotional distress, suicidal thoughts, and/or psychological diagnoses are subject to violence, stigma, and perpetual marginalization. These experiences are compounded when the crisis is rooted in intersections of poverty, racism, disability, and gender- and sexuality-based discrimination.

The process of mental health crisis response can vary significantly from one jurisdiction to another based on municipal budgets, agency size, contractual agreements, and available services. In many jurisdictions, law enforcement responds to nearly all mental health-related emergency calls, even if there is no threat of violence or concern about criminalized activity.[8-9] In very few cases, mental health-specific alternatives such as mobile crisis teams are available; however, these options are not always completely separate from police. As a result, many mental health-related emergency calls – including when 911 is contacted by 988 or another crisis hotline – are ultimately routed to police.

The continued involvement of police in mental health crisis response is perpetuated in part by the stereotype that people in crisis are violent, even though research has found that people with psychiatric diagnoses are far more likely to be victims of police violence during law enforcement encounters.[14] Studies have estimated that people perceived to have a mental illness are sixteen times more likely to be killed by law enforcement[15] and at least one in four – and potentially up to half – of people killed by police have a perceived mental illness.[16] In our study, one participant disclosed that their friend was killed by

"The first sort of non-negotiable thing for me is all hotlines really need to firmly commit to never calling the cops, having no entanglement with police whatsoever."

-PARTICIPANT

police during a mental health crisis, reflecting how such violence devastates families and communities and erodes trust in purported systems of care.

Existing research, including our study on hotline users' perspectives, has suggested that the relationship between crisis lines, 911, and law enforcement is not clear to the broader public.[17] Because the interconnectedness of crisis lines and police still remains obscure, many help-seekers do not realize that calling 988 could lead to an encounter with the police. Several of our interview participants echoed this confusion, describing a lack of awareness about the connection between police and hotlines at the time of their hotline call, and some still not knowing about this relationship at the time of the interview.

Participants who did know about the possibility of police intervention largely came to this knowledge either through personal experience or through the experience of a friend or family member. One participant described the result of their hotline call, saying, "I didn't know [what] was happening until I heard sirens, and I yelled back to my now-ex, and was like, 'Did you call the cops?' He was like, 'No. Why would I have called the cops?' And then I put it together in my brain exactly like – I was still on the phone [with the hotline]. And then I hung up the phone immediately." As other participants shared similar anecdotes, they also emphasized a desire for change in the nature of hotlines' relationship to law enforcement. One participant shared, "It's time for change [from using police in interventions]. You know, we have so many other tools in our toolbelt as a society. It's time for us to do a better job."

HELP-SEEKERS WANT LAW ENFORCEMENT OUT OF MENTAL HEALTH CRISIS RESPONSE

One of the most consistent themes in our interviews was the opposition to police-based responses to mental health crisis. The vast majority of interviewees expressed wanting hotlines to sever their relationship with law enforcement and wanting to remove police from mental health crisis response more broadly. One interviewee stated, "The first sort of non-negotiable thing for me is all hotlines really need to firmly commit to never calling the cops, having no entanglement with police whatsoever."

Many participants identified having the police called on them as one of their top concerns when using hotlines. One interviewee stated, "I have actively avoided calling 988 since it's come out because of the people who have shared that [they] called 988 and the cops showed up. I don't need the cops when I'm having emotional distress." Participants emphasized how police presence would not make them feel safer during moments of crisis and would feel more like an active threat. Another participant expressed this sentiment, saying, "I don't think the police should be having anything to do with mental health crisis or emotional distress. […] I think that we need mental health workers who are not partnering with police. Because you shouldn't be looking at losing your freedom because you're in an emotional crisis. […] There just needs to be a separation of mental health and police. It's completely inappropriate to have police interfacing with emotional distress."

Within our study, 88% of survey participants who responded that they were unlikely to contact a hotline in the future expressed not wanting to interact with emergency responders, including police, as a reason.

Study participants who indicated...

Not wanting to interact with emergency responders as a reason for not contacting hotlines in the future, by demographic group

VARIABLE	FULL SAMPLE (N=210)	TRANS (N=106)	POC (N=117)	NONPHYS DISABILITY (N=152)	PHYS DISABILITY (N=59)
Why participants were unlikely to contact hotlines in the future	75	47	46	61	21
Do not want to interact with emergency responders, including police	66 (88%)	43 (91.49%)	40 (86.96%)	58 (95.08%)	20 (95.24%)

Many interviewees also highlighted the specific threat that police pose to communities of color, LGBTQ+ people, and disabled people, particularly during an experience of crisis. Reflecting on the experiences of marginalized communities, one interviewee emphasized, **"You know, a lot of people do not have any type of safety with the police. So they would never call the police or want the police to 'help them' because you can't trust what the police would do."** Police violence disproportionately impacts not only people perceived to have a mental illness, but also people of color and gender-diverse people. Studies have shown that Black and Latine people with assumed or diagnosed mental illnesses are far more likely than their "healthy" peers to be killed by law enforcement—even in cases where the police were called not because of an illegal act, but to help someone access psychiatric treatment.[18-20] In the 2016 U.S. National Transgender Survey, over half (58%) of respondents reported experiencing mistreatment during interactions with police, including being verbally harassed, physically assaulted, or sexually assaulted.[21]

Existing research has shown that experiences of police brutality are associated with both short- and long-term mental health consequences. One study found that exposure to police killings of unarmed Black people was associated with more days of poor mental health among Black Americans in the general population, with the largest effect 1-2 months after exposure.[22] This impact of police violence on mental health is particularly concerning considering that suicide rates have increased among Black Americans in recent years.[23] Looking at longer-term outcomes, one study found that people who experienced police brutality had higher likelihood of having unmet need for mental health care than those who had *not* experienced police brutality.[24] In the same study, those who experienced police brutality were more likely to feel mistrust in medical institutions and feel less respected in health care settings.

The experiences of our study participants supported these patterns. Participants described interactions with police that ranged from unpleasant to violent, including experiencing threats of violence from law enforcement, having weapons pointed at them, and being intimidated into consenting to searches of their living space. One interviewee described a particularly violent instance where they were not only called homophobic and transphobic slurs during their interaction with the police, but also sexually assaulted by one officer. They reflected how this traumatic encounter influenced their ability to advocate for themselves for the rest of the interaction, saying, **"The specific cops that had showed up were so transphobic and violent towards me that there was no chance of me feeling any sort of safety enough to ask questions, get information, give consent to anything that happened."** Other participants shared similar experiences, describing how aggressive behavior from law enforcement – including being tackled or restrained – stripped them of their agency. Describing their feelings after being restrained by police during an intervention, one participant said,

"There's not really a lot of ability to refuse or question any sort of interventions that were happening at that point. Once the cops showed up, basically everything became out of my control about what the next steps were going to be. [...] My preferences were not listened to."

Even when participants did not experience physical violence or harm from law enforcement, many described their interaction with police as coercive and threatening. For many interviewees of color, the threat of police violence shaped every aspect of their interaction. Describing their thought process when a white officer showed up to their home and asked to come in, one participant said: "I'm like, 'You know what? No, I'm not gonna let this man in,' 'cause when you let the police in, just the power imbalance is a thing. I was like, you know what? I'm not — if this situation turns violent or whatever for whatever reason – I'm not gonna be the next Black, trans person shot in their home for being mentally ill." This same participant described how law enforcement used coercive language to push them into going to the hospital, saying that they could either go voluntarily or be involuntarily taken in by the police. This example is particularly worrying in that it showcases how emergency interventions can present a help-seeker with a false illusion of choice that offers coercion rather than consent. Notably, even participants who did not report any kind of negative interaction with police, the vast majority of whom were white, reflected that

"I don't think the police should be having anything to do with mental health crisis or emotional distress. [...] I think that we need mental health workers who are not partnering with police. Because you shouldn't be looking at losing your freedom because you're in an emotional crisis. [...] There just needs to be a separation of mental health and police. It's completely inappropriate to have police interfacing with emotional distress."

-PARTICIPANT

they would prefer not to experience a police-based response.

CRISIS RESPONSE REFORMS: THE CONTINUATION OF POLICE INVOLVEMENT

In response to police violence and subsequent calls for change, various reforms have developed to shift the role of police in mental health crisis response. Most of these approaches have stopped short of completely removing police from crisis response. These approaches have been divided broadly into three models: **crisis intervention teams** which entail crisis response training for police officers (CITs), **co-response** involving emergency response from both police and mental health professionals, and **mobile crisis teams** (MCTs) composed of non-police first responders (e.g., social workers, counselors, EMTs, case managers, crisis workers, peer supporters).[25] The terminology used to describe these models is often blurred in professional use; for example, "mobile crisis team" is at times used to refer to both co-response (with police) and non-police crisis teams. However, these categories reflect varying levels of police involvement in crisis response, with CITs remaining grounded in police-based response and MCTs generally entailing little to no police involvement. The key models are described below to provide a fuller picture of how crisis response largely continues to rely on and invest in law enforcement to varying degrees.

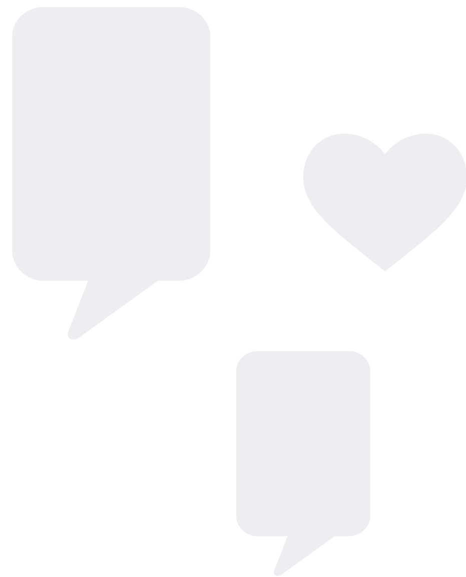
Crisis Intervention Team (CIT) programs primarily focus on providing police officers with specialized training in mental health crisis response. The 40-hour training aims to increase officers' understanding of mental health conditions and symptoms, develop de-escalation skills and practices, and promote knowledge and awareness of community mental health resources.[26] Evaluations of the efficacy of CIT programs have been highly variable, and understanding the outcomes of this model is further limited by the lack of research centering the experiences and insights of survivors of law enforcement interventions.[10] While studies have suggested that CIT-trained officers are more likely than non-CIT-trained officers to provide referrals to mental health services, findings on the influence of CIT on use of force or arrest rates have been more mixed.[27-28] For example, one study found that CIT training may help to reduce arrest rates.[29] However, the same study found that CIT-trained officers were more likely to transport individuals to a mental health facility, which could result in involuntary commitment, another form of incarceration. While some findings suggest that officers who underwent CIT training self-report that they would be less likely to use force during crisis response,[30-31] existing data has not shown that CIT actually reduces the use of force in practice.[10] Furthermore, existing research suggests that CIT training

does not adequately address officers' stigma towards people with perceived mental illness.[32]

Regardless of questionable effectiveness, CIT training does little to mitigate the fear of police that many individuals have, especially those from marginalized communities.[33] Even when police officers do not escalate an already traumatic situation, their very presence can escalate the experience of crisis. Without deeper interrogation of the social frameworks that criminalize mental health and suicide, this model reflects only a superficial attempt to change approaches to crisis response.

Another crisis intervention model known as **co-response** uses an interprofessional team in response to psychological or suicidal crisis, generally including both mental health professionals (e.g., social workers, psychiatric nurses) and law enforcement officials who have undergone specialized crisis response training.[34] The logic of the interprofessional model is that the presence of a mental health specialist will facilitate de-escalation. In theory, all co-response efforts share the broad similarity of pairing law enforcement with mental health professionals. However, the help-seeker experience of this response can vary. For example, co-response models can involve law enforcement officers and mental health professionals traveling together to the site, arriving at the site separately, or staggering their arrival, with the mental health professional joining after initial screening by law enforcement.[35] Evaluations of the experiences of those on the receiving side of these responses have found that

Even when police officers do not escalate an already traumatic situation, their very presence can escalate the experience of crisis. Without deeper interrogation of the social frameworks that criminalize mental health and suicide, this model reflects only a superficial attempt to change approaches to crisis response.



help-seekers prefer the idea of a co-response model to a police-only response.[36] Still, studies examining the outcomes of co-response interventions have found mixed results. For example, one study found that individuals who experienced intervention from a co-response team were less likely to be arrested after a 911 call than those who experienced a police-only response.[37] This study, however, did not find significant differences in longer-term involvement in the criminal punishment system. Findings on the outcome of psychiatric hospitalization were also inconsistent, with some studies pointing to increases in hospitalization and others finding decreases after co-response interventions.[38-39]

In the case of crisis hotline-initiated interventions, co-response can still be problematic, especially in non-consensual interventions where a help-seeker has no expectation of police and crisis team workers arriving at their home, school, or work. In our study, several interviewees raised concerns about these models of crisis response, noting that some seemingly "non-police" mobile crisis teams do still work with law enforcement. One interviewee stated, "I think there's some times that there is not enough informed consent or transparency about the risks or who else [crisis teams] might be working with." This interviewee suggested implementing teams of community health workers or peer supporters that are not affiliated with the police.

Finally, a growing number of cities and states have implemented **mobile crisis teams** (MCTs) composed of non-police first responders to respond to mental health-related calls. The structure and organization of mobile crisis teams can take various forms.[40] They are generally operated by community organizations, hospitals, or health departments, and can be staffed by social workers, counselors, EMTs, nurses, and peer supporters, among others.[41] MCTs can have substantial system-level benefits, including reduced psychiatric hospitalization when compared to police-based interventions.[42-43] However, the types of calls that are eligible for diversion to mobile crisis teams can vary, often meaning that police continue to play a significant role in crisis response even when mobile crisis teams are available. For example, in New York City's B-HEARD MCT model, NYPD officers respond to "emergency situations involving a weapon and imminent risk of harm to self and others," maintaining their role in many mental health crisis situations.[44] The most recent data from B-HEARD reported that the team responded to only 25% of all 911 mental health calls, and only 55% of the calls were even eligible for a B-HEARD response.[45]

The continued role of police in "imminent risk" situations is particularly concerning when considering the numerous examples of people in crisis who were killed by police when they were perceived to be or actually holding a weapon.[46-47] In these cases, police officials have publicly used the claim of "fearing for their life" in order to justify denying individuals their due process and inflicting violence on people and their communities.[48] Though diverting calls to mobile crisis teams can reduce the involvement of police in some mental health-

related calls, the probability remains high that those labeled “imminent risk” will still experience police response.

Beyond their role in the immediate experience of intervention, law enforcement and other emergency responders are regularly involved in transporting people in crisis to hospitals for psychiatric evaluation and treatment, or to jails. While existing research often presents hospitalization as a favorable outcome to incarceration in jails, the experience of hospitalization exposes help-seekers to a variety of other harms, including coercive treatment, physical and chemical restraint, and neglect and abuse from medical staff. The following section explores the harmful impacts of psychiatric hospitalization with attention to specific consequences experienced by help-seekers with marginalized identities.

CHAPTER 3

FORCED HOSPITALIZATION: A JAIL BY ANOTHER NAME

"Every time I asked, 'What happens if I don't do this?' it's 'We'll sedate you.' Okay, so I have to."

In addition to potentially exposing people in crisis to the threat of police, crisis hotlines also serve as a pipeline to unwanted psychiatric interventions, including forced hospitalization and forced medication. Many calls for crisis response reform center a demand for mental health professionals to replace police as the primary first responders for crisis calls. However, this approach reflects an assumption that mental health professionals will provide more appropriate, humane, and less-coercive support. These proposals overlook the interconnectedness of the mental health and criminal punishment system, and often fail to consider the ways that the mainstream mental health system also perpetuates violence, inequities, and oppression. While mental health professionals may not be carrying guns and handcuffs, they still hold and use numerous tools of force and coercion, including the threat of involuntary psychiatric hospitalization and court-mandated medication and treatment.

The terms "involuntary commitment," "civil commitment," and "forced" or "involuntary hospitalization" all describe a process through which people who are considered to pose a danger to themselves or others are held in a hospital without their consent.

Across the U.S., law enforcement officials and mental health professionals most commonly hold the power to initiate an involuntary hospitalization.[1] However, the process of hospital admission for suicidal thoughts and behavior and mental health crisis varies from state to state. Involuntary commitment typically involves a short-term detention, usually lasting three to four days,[1] which can be extended into a longer-term detention that can last weeks, months, or years.[2] Variation across states, in both the legal process of involuntary hospitalization and data reporting practices, makes it challenging to collect large-scale figures on the frequency of forced hospitalization. However, available data estimates that the number of inpatient civil commitments is in the hundreds of thousands annually, with 24 states recording a total of 591,402 involuntary detentions in 2014.[3]

Though there is a legal distinction between "involuntary" and "voluntary" hospitalization, in reality, both can be highly coercive. In our study, even participants who identified as being admitted "voluntarily" reported experiences of coercion in the hospital setting. One interviewee emphasized that they **"signed a bunch of papers telling [hospital staff] they could do all kinds of things,"** but ultimately only did so because they felt unable to say no. The participant shared, **"Every time I asked, 'What happens if I don't do this?' it's 'We'll sedate you.' Okay, so I have to."** The coercive dimensions of such experiences reveal that even hospital admissions that are labeled as "voluntary" can be involuntary in practice. While much of the existing research groups together people who were classified as voluntarily and involuntarily hospitalized, studies find that coercive experiences have more layers of negative effects in comparison to voluntary experiences.[4] For example, perceived coercion during hospital admission has been found to increase the risk of suicide attempts after discharge,[5] underscoring how consent during psychiatric treatment can impact suicidal thoughts and behaviors.

Numerous mental health and human rights organizations have condemned forced psychiatric commitment and other coercive psychiatric practices. One of the most prominent statements against forced treatment is the Convention on the Rights of Persons with Disabilities (CRPD), released by the United Nations in 2006.[6] The Human Rights Indicators on the CRPD advocate for the elimination of forced psychiatric treatment, as well as practices of seclusion and restraint in medical settings.[7] To date, 186 countries, excluding the United States, have ratified the CRPD, making the U.S. among a global minority.[8] In 2023, a report published by the World Health Organization (WHO) and the United Nations (UN) pointed to "the limited evidence to support the success of coercion in reducing the risk of self-harm, facilitating access to treatment, or protecting the public." The report further underscored that "coercion can inflict severe pain and suffering on a person, and have long-lasting physical and mental health consequences which can impede recovery and lead to substantial trauma and even death."[9] Both the UN and the WHO have condemned the practice of involuntary and coercive psychiatric treatment, naming the practice as a violation of human rights and "the right to

health." In response to forced and coercive medical practices, organizations such as the World Network of Users and Survivors of Psychiatry emphasize the importance of approaches rooted in protecting the rights and centering the voices of people living with psychosocial disabilities.[10]

CONSEQUENCES OF PSYCHIATRIC HOSPITALIZATION FOR HELP-SEEKERS

Research on experiences of psychiatric hospitalization have found that harmful and abusive experiences in the hospital setting are alarmingly common.[11] Several of our interviewees described harmful and violent events that they experienced and/or witnessed while in the hospital, including forced sedation, being strip-searched, racial and/or gender-based discrimination from hospital staff, and sexual advancements from other patients. One participant shared about the challenge of containing emotional responses in light of these abuses, saying, "If you show too much anger, then you're likely to get subdued, either physically with restraints or with a shot to make you go unconscious." Existing research reinforces these accounts. When asking patients whether they had experienced the type of forceful treatment in psychiatric settings that is supposed to be used as a "last resort," one study found that 65% of patients had experienced handcuffed transport, 59% of patients had experienced seclusion, 34% had experienced restraint, and 29% had experienced physical takedowns.[11] In the same group, 63% of patients witnessed traumatic events, 31% experienced physical assault, and 8% experienced sexual assault.

While hospitalization may prevent suicide attempts during the actual period of containment within a facility, a variety of studies have found a connection between hospitalization and increases in both short- and long-term suicide risk.* Evidence from a U.K.-based study suggests that the lifetime suicide risk for people who have experienced psychiatric hospitalization is highest immediately following their discharge.[12] Researchers in Denmark found a similar peak in suicide risk just after discharge, adding that women were 246 times more likely and men were 102 times more likely to die by suicide during the week after their release.[13] Similar patterns hold for adolescents. A U.S.-based study that followed a group of adolescents for six months after psychiatric hospitalization found that 18% of participants attempted suicide over the course of the follow-up period, and 36% experienced a suicide event (including both suicide attempts and emergency interventions to prevent an attempt).[14]

Participants interviewed for our study not only reported stronger feelings of suicidality after their hospitalization, but also described changes in the nature of their thoughts of suicide. For one participant who was hospitalized after a suicide attempt, their negative experience of hospitalization made them determined to use a more lethal method of suicide in the future. "I never had a concrete plan until after that happened," they reflected. "Then I immediately had a concrete, fail-proof plan, because that was

* *In part because of the lack of publicly-available data on inpatient hospitalization in the U.S., many of these studies have been conducted internationally. However, because the mistreatment and coercion experienced by psychiatric patients in inpatient settings is a global concern, their findings can still be informative.*

never gonna happen again. If anyone ever tried to call anyone on me again, I had my failsafe, and I was going to get out of there in a casket, or, you know, they were gonna arrest me quickly. It was never going to happen again. And that's true to this day. I still have that plan. I don't like that I have that, but I do." Within our study, of the survey participants who expressed that they were unlikely to contact a hotline again, 80% expressed not wanting to be psychiatrically hospitalized as a reason.

Study participants who indicated...

Not wanting to be psychiatrically hospitalized
as a reason for not contacting hotlines in the future, by demographic group

VARIABLE	FULL SAMPLE (N=210)	TRANS (N=106)	POC (N=117)	NONPHYS DISABILITY (N=152)	PHYS DISABILITY (N=59)
Why participants were unlikely to contact hotlines in the future	**75**	**47**	**46**	**61**	**21**
Do not want to be psychiatrically hospitalized	**60** (80%)	**39** (82.98%)	**38** (82.61%)	**53** (86.89%)	**20** (95.24%)

In addition to increasing or intensifying suicidal thoughts, the experience of hospitalization has been found to have lasting negative effects on psychiatric survivors' psychological well-being more broadly. One U.K.-based study of adults who were hospitalized found that almost half demonstrated symptoms of post-traumatic stress disorder in relation to their hospitalization.[15] Several of our interviewees echoed these findings, describing increased short- and long-term mental health challenges after their experience of hospitalization. One participant said their hospitalization resulted in **"a lot more emotional and mental distress in the next couple weeks, just because I was already in a pretty acute state of crisis, and that just really pushed me over to the edge,"** noting that they also experienced flashbacks of their hospitalization for a long time.

Many participants in our study also emphasized the lack of therapeutic support they received during their hospitalization. Recounting their experience of a 72-hour hold, one participant described only interacting with the psychiatrist one time, and being offered a coloring sheet to pass the time in the ward's common room. They reflected, **"There really wasn't anything therapeutic going on, or really much supervision happening. [...] There were a lot of other people there who had also either recently been in crisis or were currently in crisis. And I saw most of them not getting any care, and that was probably the most distressing part."** Another participant summarized the imbalance of support and harm in their experiences of hospitalization, concluding, **"In general, I've found psychiatric hospitals to be more harmful than helpful."**

Among the participants surveyed and interviewed for this report, those who had experienced psychiatric hospitalization also highlighted numerous financial consequences of their hospitalization, many of which have been understudied in existing research. Several interview participants spoke to the economic consequences of their hospitalization, including loss of employment and unexpected ambulance and hospital bills. Participants expressed that these financial tolls continued to affect them long after their hospitalization. One participant recounted having to contact their supervisor before going to the hospital to let them know that they were unsure when they would be able to return to work, then being in the hospital for so long that they were unable to return to work after being released. Reflecting on their current situation, they noted, **"I had to move back in with my mother. And to this day, I still haven't been able to find another job."**

Another participant shared that because financial stress was part of why they had been in crisis, their hospitalization only exacerbated their problems: **"I was just begging with [the police]. I was like, 'Listen, the reason why I'm struggling, it's not gonna make it easier. If I'm hospitalized in an inpatient way, that means I'm gonna miss my shift at work tomorrow. [...] If I can't do my job, I can't pay rent, and then I'm**

gonna be homeless again.'" This particular experience challenges the common belief that hospitals provide reprieve from crisis, underscoring how hospitalization can exacerbate the conditions under which a person might have thoughts of suicide. Furthermore, hospitalization rarely addresses the root causes of crises, including financial struggles,[16] lack of access to safe housing,[17] inaccessibility of non-crisis medical care,[18] and countless other examples of structural issues and systemic failures.[19-21]

Beyond the financial consequences of hospital interventions, experiencing psychiatric hospitalization can create significant barriers to accessing treatment in the future. Studies have found that people who experienced involuntary hospitalization report greater hesitance to seek even voluntary outpatient treatment out of fear of experiencing coercive treatment.[22] Relatedly, people who have not directly experienced involuntary hospitalization can be affected by the knowledge that it could happen to them. For example, a study of individuals who concealed suicidal ideation from their therapist found that almost half would be more open about their thoughts of suicide only if the threat of hospitalization was reduced or controlled (e.g., direct communication around what would trigger hospitalization, a promise from the therapist to not report suicidal ideation).[23] Taken together, these findings underscore that psychiatric hospitalization, especially when involuntary, can not only be a traumatic and abusive experience, but is also ineffective in promoting longer-term well-being.

"I was just begging with [the police]. I was like, 'Listen, the reason why I'm struggling, it's not gonna make it easier. If I'm hospitalized in an inpatient way, that means I'm gonna miss my shift at work tomorrow. [...] If I can't do my job, I can't pay rent, and then I'm gonna be homeless again.'"

-PARTICIPANT

IDENTITY-SPECIFIC CONSEQUENCES OF PSYCHIATRIC HOSPITALIZATION

While psychiatric hospitalization can be harmful to any person, studies have found that people of color, minors, transgender people, and other marginalized populations experience disproportionate mistreatment at each step of the process of hospitalization. One study of patients admitted to an inpatient psychiatric unit found that Black, Latine,* and Asian patients were all more likely to be involuntarily admitted than white patients, with Black patients being the most likely to be admitted involuntarily.[24] Furthermore, other studies suggest that force and coercion shape the experiences of people of color even when they are admitted voluntarily. In psychiatric hospital settings, non-white patients have reported higher levels of perceived coercion than white patients.[25] Several of our research participants described how their race influenced the quality of care they received while hospitalized, with one participant noting that they "received more respect and care and attention" when their white friend was visiting them, which disappeared after their friend left.

> ***"I think the first time I was inpatient, they had some phlebotomist who had never drawn blood on a human before besides their classmates, and they were using us as their practice."***
>
> **-PARTICIPANT**

Minors also confront uniquely harmful consequences of forced hospitalization in both short- and long-term contexts. One study of youth admitted to a state psychiatric hospital documented widespread practice of restrictive interventions (i.e., use of physical restraints or seclusion).[26] The study found that Black youth, as well as youth who were admitted involuntarily, experienced a higher number of restrictive interventions. In another study, three-quarters of the young people who were interviewed reported that involuntary hospitalization negatively affected their sense of trust in others, particularly mental health providers.[27] Many described longer-term impacts on their engagement with mental health services, including concerns about disclosing suicidal thoughts and fears of hospitalization to providers.

Intersections of identity and socioeconomic status also shape experiences of psychiatric hospitalization, often reflecting and reinforcing existing social inequalities. Several of our participants illustrated the ways that these disparities manifest. One interviewee described that they were taken to a facility that was known to be of lower-quality than the one that their white peers

* *The cited study categorizes this group of participants as "Hispanic." This report, with understanding of the discriminatory legacy of the term, has opted to use the gender-neutral term Latine instead.*

were taken to. Explaining the incident, the interviewee shared, "All the people I knew who were white who had gone through something at that school had been taken to [the better hospital], and I think there was maybe, like, an assumption that I might have been on Medicare or Medicaid ... or that I might not have had insurance or something that would prevent me from, you know, being able to access care at [the better hospital]." Another interviewee described receiving inferior treatment during their hospitalization at a facility in a lower-income area, noting, "I think the first time I was inpatient, they had some phlebotomist who had never drawn blood on a human before besides their classmates, and they were using us as their practice." This experience is reminiscent of numerous past and present-day examples of people with marginalized identities being denied access to quality health care and used as training and test subjects.[28-30]

Transgender people also experience unique challenges in hospital settings, with many having to navigate medical staff that lack competency in caring for trans patients. One study on the experiences of transgender and gender-diverse people hospitalized for a suicide attempt or suicidal ideation found that over half of the survey respondents reported that their treatment was unhelpful.[31] This was especially true for people who were hospitalized involuntarily, as those who voluntarily sought hospitalization were more likely to experience treatment as helpful. More broadly, transgender people also commonly report a lack of access to gender-affirming care, medication, and resources in most hospital settings. In a survey of 6,450 transgender and gender non-conforming people, 50% of trans people reported having to educate their medical providers about trans-affirming care.[32] This reality is particularly relevant to crisis response and mental health care, as studies show that delaying or denying access to trans-affirming health care can be a significant source of psychological harm for transgender patients, including increasing suicidality.[33]

> ***"[The hospital stay] was an awful experience for me, 'cause being a trans person, being someone of color, and being gaslit by some of the staff, especially towards the end."***
>
> **-PARTICIPANT**

The people we interviewed also highlighted several forms of gender-based discrimination that they experienced during their psychiatric hospitalization, including being misgendered, deadnamed (being referred to by a name that a person no longer uses), and not being asked if they wanted to room with or be strip-searched by a person of a particular gender. One participant shared, "[The hospital stay] was an awful experience for me, 'cause being a trans person, being someone of color, and being gaslit by some of the

staff, especially towards the end." Another participant, who identified as non-binary at the time of their hospitalization, highlighted both the lack of attention to their gender identity and the lack of gender-neutral facilities, saying, "I wouldn't have been okay staying in the room with men or women at the time. I would have been like, 'I don't belong to either of these places.' Because I would have been afraid to stay with the men because of how I presented. And I'm uncomfortable staying with the women. But no one asked me how I identified."

For transgender people, in addition to navigating the immediate impacts of institutions, a history of involuntary psychiatric hospitalization can obstruct access to gender-affirming medical care in the future. At the time of this report, in order to approve gender-affirming surgery and hormones, most health insurance companies, hospitals, and doctors require written proof from a mental health provider that a transgender individual has been diagnosed with gender dysphoria,* has the ability to make fully informed decisions, and has no other mental diagnoses that could account for their experience of being transgender.[34-35] In cases where transgender people have a history of psychiatric hospitalization, health care providers can use that history to question and deny a person's capacity to consent to surgery, hormones, and other gender-affirming procedures. Additionally, should the experience of hospitalization result in psychiatric diagnoses, these diagnoses can be used to deny future gender-affirming care on the basis that these diagnoses explain an individual's transgender identity.[36] This is reflective of a long history of medical institutions pathologizing transness and forcing people to operate within an illness-based framework for their experience.[37-38] This oppressive approach means that the experience of involuntary hospitalization can have especially harmful repercussions for transgender people, whose root causes of suicidality often include gender dysphoria, marginalization, discrimination, and familial and societal rejection.[39-40]

The short- and long-term harms that can be caused by forced hospitalization reveal yet another problematic dimension of mental health crisis response that can actually increase an individual's risk of suicide. The breadth and severity of these consequences illustrate how emergency interventions from crisis hotlines can expose help-seekers to institutional violence and devastating, sometimes life-altering, outcomes. Despite the harms of forced hospitalization and other forms of involuntary care, the 988 network continues to embrace policies and protocols that utilize non-consensual interventions. As a result, help-seekers

* *Originally applied as a psychiatric diagnoses, Gender Dysphoria, in both medical contexts and common use, refers to the experience of distress as result of incongruence between a person's sex assigned at birth and their gender identity.*

in crisis may be subjected to extensive harm based on interventions that they may not have consented to receive in the first place. This reality underscores the need for humane, non-violent, and non-coercive options for people in crisis, rather than further investment in systems that perpetuate trauma, abuse, and harm. The following section explores call, text, and chat routing, geolocation, the lack of transparency in 988's data use policies and practices, and help-seekers' calls for increased clarity, consent, and the end of non-consensual location tracking and emergency response.

> ***"All the people I knew who were white who had gone through something at that school had been taken to [the better hospital], and I think there was maybe, like, an assumption that I might have been on Medicare or Medicaid ... or that I might not have had insurance or something that would prevent me from, you know, being able to access care at [the better hospital]."***
>
> **-PARTICIPANT**

CHAPTER

4 | HELP-SEEKER PRIVACY AND LOCATION-TRACKING TECHNOLOGY

“I have actively avoided 988 because I know that [...] they do link to location and cops. So that’s something that I don’t feel is a resource that I can take advantage of, and will not take advantage of. I don’t think that they’re necessarily transparent about [their use of police intervention].”

Suicide and crisis hotlines are often touted as a discreet and anonymous resource for people experiencing suicidal thoughts or emotional crisis. The 988 Suicide and Crisis Lifeline specifically promotes itself as a “confidential” and “private” resource for people in distress.[1] In fact, to address concerns potential hotline users have about confidentiality, 988’s messaging guide encourages communications that emphasize that “988 interactions are private and confidential.” In reality, 988 regularly violates the privacy, confidentiality, and safety of help-seekers. The clearest and most disturbing example of this comes in the form of policies that require all hotlines within the 988 network to employ non-consensual interventions for help-seekers labeled “imminent risk.”[2] The process of non-consensual intervention includes a violation of consent at every step: sharing information from hotline conversations without a help-seeker’s consent, initiating processes to track and trace a help-seeker’s physical location without their knowledge, and sending law enforcement and other emergency responders to a help-seeker’s location without their awareness.[3]

It is critical to note that hotlines exist in a regulatory gap where current privacy protections, like those for personal health information, do not apply. While many hotlines promise confidentiality and anonymity, legally, these terms have

loopholes which allow hotlines to track, trace, store, and share help-seeker information with a range of government, legal, and commercial entities. Nonprofits such as individual hotlines and 988's administrator, Vibrant Emotional Health, typically fall outside of existing data privacy protection laws. For example, in order to be considered legally protected health information, personal health data has to be collected by a health professional.[4] Most hotline calls are answered by a mix of staff and volunteers, many of whom are not health providers and therefore are not legally required to keep health data confidential. To date, the United States federal government has yet to pass broad or comprehensive data privacy legislation.

Crisis hotlines also operate with very few regulations or oversight when it comes to transparency about data use and confidentiality. Many hotlines use vague language when it comes to definitions of and exceptions to confidentiality and privacy. Often, they bury this information within lengthy privacy policies, terms of service statements, and website FAQs (Frequently Asked Questions). This leaves help-seekers largely uninformed about how their personal information can be used and obscures the circumstances in which their privacy can be breached; for example, in cases where crisis hotlines are sharing help-seeker data with AI companies.[5]

A prominent example of the sharing of confidential help-seeker data is the transmission of information between 988 and 911 when hotlines initiate emergency interventions.[6] This information sharing enables 911 operators to determine a help-seeker's physical location and to dispatch law enforcement and other emergency responders. On their website, in marketing materials, and in media coverage, 988 minimizes their role in initiating location tracking by relying on the technicality that 988 itself is not the agency that currently has **geolocation*** capacity – even though their crisis centers initiate the process. Meanwhile, 988 administrators on all levels have lobbied for the hotline network to have in-house geolocation capacity.[7] Officials from SAMHSA, Vibrant, the National Emergency Network Association (NENA), and other stakeholders have emphasized precise location tracking for 988 as a necessary move toward "saving lives."[8-9] If granted, this shift would give all 200+ crisis centers in the 988 network full access to the precise location of every single 988 caller, texter, and chat user. This possibility raises urgent questions and concerns about data privacy, use, storage, breaches, and the technical requirements for the expansion of 911 technology to nonprofit organizations and private companies.

MAJOR RED FLAGS: 988 HOTLINES AND AI DATA SHARING

One of the most alarming developments in regards to the use, and potential misuse, of help-seeker data is the emergent relationship between suicide and crisis hotlines and artificial intelligence (AI) technology. In 2021, an egregious example of hotlines sharing user data was uncovered when an internal whistleblower at the Crisis Text Line (CTL)

* *Geolocation is the process of using technology to determine a precise location of a device, which can include x (longitude), y (latitude), and z (vertical) coordinates.*

shared that CTL had been selling help-seeker data to its for-profit subsidiary, Loris.ai.[5] At the time, the CEO of CTL was also the founder and CEO of Loris.ai.[10] The revelation brought to light Loris.ai's use of CTL's data to create AI software that trains and guides customer service representatives in ways it described as "more human and empathetic."[5] CTL claimed that they had full consent to share data from every texter who connected to the hotline because users agreed to their Terms of Service and Privacy Policy. As a result of public concern and media pressure, CTL released a statement in 2022 saying the company had stopped both the data-sharing practice and relationship with Loris.ai.[11] Legally, however, there is no federal law explicitly prohibiting hotlines from selling or sharing user data – data that most help-seekers assume is private.

For their part, 988 is vague about how and when they collect and store help-seeker data. It is unclear when information is being stored, including recorded hotline conversations and text/chat transcripts, for how long, or if help-seekers have any power to request the deletion of these records. However, the Lifeline does offer help-seekers assurances of "confidentiality," saying that "information about callers/chatters/texters will not be shared outside the 988 Lifeline without documented verbal or written consent from the person seeking help, except in cases where there is imminent risk of harm to self or someone else, or where otherwise required by law."[6] Additionally, in their Terms of Service for Chat and Text, 988 states, "Any information provided by you or collected on you will not be shared or disclosed with any third party."[12] Notably, in stark opposition to their assurances of confidentiality, the language 988 uses to shield the Lifeline of risk and liability is specific and clear. The Terms, Conditions, and Privacy Statement in 988's Terms of Service for Chat and Text notes that by using the Lifeline, help-seekers are submitting information at their own risk.[12] The statement goes on further to say, "Vibrant Emotional Health expressly disclaim all warranties of any kind, whether express or implied and make no warranty that Lifeline Chat or SMS texting will a) meet your requirements; b) be uninterrupted, timely, confidential, secure, or error-free; or c) meet your expectations."

Concerningly, in at least one instance, a national provider of 988 services is making hotline user data available to a for-profit company for the development of AI technology. In May 2023, Lyssn.io, a self-described "AI powered behavioral health and human services technology company," revealed a project partnership with Protocall Services, explicitly naming the goal of enhancing "quality assurance for 988 & crisis care."[13] Protocall Services is a private company that acts as "a SAMHSA-contracted national backup provider for 988 and [administers] the primary 988 line for the State of New Mexico." In the announcement, Lyssa.io described the partnership's focus as the development of AI-technology meant to give hotline workers feedback on their use of risk assessments, safety planning, and the quality of their conversations with help-seekers.

Unlike the privacy policy provided by 988, Protocall's privacy policy on the website for New Mexico's 988 hotline states that the company can "collect, store, use, or transfer" help-seeker data, including name, address, demographics, financial details, geolocation data, and personal health

information.[14] The protection Protocall offers for this data includes an assurance that personal information will only be shared in an aggregated, unidentifiable form, or they will "take commercially reasonable steps to notify you if legally permissible." It remains unclear if and how Protocall's sharing of hotline user data with Lyssn.io will meet 988's assurances not to share private help-seeker information with third parties "without documented verbal or written consent."[6]

OPAQUE AND INSUFFICIENT: 988'S DISCLOSURES ON DATA-SHARING FOR EMERGENCY INTERVENTIONS

This issue of data use transparency within 988 is particularly apparent in its efforts to obscure and minimize information about how and when help-seeker data is used to initiate emergency interventions. Buried far down in its website FAQ, 988 offers basic information about the process that initiates emergency intervention, what information gets shared with emergency responders, and the fact that confidentiality and privacy can be compromised once emergency responders are sent to a help-seeker's location.[6] Nowhere in the FAQ is there an explanation that hotline operators can share any identifying information the help-seeker provides with 911 operators – including disclosures about where they work, live, or go to school.[3]

In a further missed opportunity for transparency, 988 hotline operators are not required to disclose the possibility of information sharing for the purpose of location tracking and emergency intervention. For example, help-seekers who access 988 via chat are given no warning that their location could be tracked via their IP address or that emergency responders could be sent to their location depending on what they share. The only transparency help-seekers are offered before initiating a 988 chat comes in the form of a pre-chat survey that asks them to tick a box of consent, agreeing to a link for the Chat and Texting Terms of Service (ToS).*[12] There is no requirement to read or even click on the link for the ToS in order to move forward in accessing 988 services. If a chat user does visit the ToS before agreeing, it states: "Any information provided by you or collected on you will not be shared or disclosed with any third party. We do, however, reserve the right to disclose any personal information to the authorities at our sole discretion and as required by law." Nowhere in the ToS does 988 disclose the conditions under which help-seeker data will be shared to initiate emergency interventions or that it can happen without the help-seeker's consent. However, within these ToS, 988 is clear to state that "in no event shall Vibrant Emotional Health be liable for any special, incidental, consequential, or indirect damages."

In our study, participants expressed frustrations and struggles when it came to hotlines being vague and not transparent with these policies and protocols. One participant stated, **"I think another frustration I have is the ways that hotlines represent themselves to the public in terms of advertising for 988, for example.**

* *The Electronic Privacy Information Center (EPIC) calls this method of disclosure the "notice and choice" framework (also known as "notice and consent"). This ubiquitous online privacy method has been shown to be all but void of the possibility of obtaining meaningful consumer consent under non-crisis conditions. For more information, see Levine, S. (2024). Toward a Safer, Freer, and Fairer Digital Economy. https://www.ftc.gov/system/files/ftc_gov/pdf/20240417-Reidenberg-Lecture-final-for-publication-Remarks-Sam-Levine.pdf*

[...] It's very unclear, if you look at most of the promotional materials for a lot of hotlines, that they are entangled with a carceral system. It's not clear on most of the messaging on the websites that they do call the cops. You have to search pretty deeply into their [...] frequently asked questions or terms and conditions." Another participant expressed confusion and lack of clarity around hotlines' location services and feeling unable to ask for clarity, questioning, "Do [hotline operators] have location services where they can find out where I am even if I don't tell them? Like, none of that was made clear at all, and I felt like, if I asked, it would seem like I'd be incriminating myself, so I didn't want to ask."

The vast majority of our participants believe that hotlines should always be transparent about emergency response (70.48%) and geolocation (71.77%). One participant explained that hotlines should be very "upfront" about their policies in these areas, so that "if you want to or need to lie, you can." This emphasis on not being able to tell the truth due to hotline practices was echoed by many participants throughout the study. Beyond simple transparency, 61.9% of participants believe help-seekers should always be able to opt out of geolocation and nearly 70% of participants believe that hotlines should always inform callers when emergency services have been dispatched. These figures were even higher for participants from marginalized communities. These findings overwhelmingly demonstrate that our participants believe that help-seekers deserve true transparency when using crisis hotlines, including the ability to deny permission for hotlines to track their physical location.

"I think another frustration I have is the ways that hotlines represent themselves to the public in terms of advertising for 988, for example. [...] It's very unclear, if you look at most of the promotional materials for a lot of hotlines, that they are entangled with a carceral system. It's not clear on most of the messaging on the websites that they do call the cops. You have to search pretty deeply into their [...] frequently asked questions or terms and conditions."

-PARTICIPANT

Study participants' perspectives on...

Hotline transparency regarding emergency response by demographic group

VARIABLE	FULL SAMPLE (N=210)		TRANS (N=106)		POC (N=117)		NONPHYS DISABILITY (N=152)		PHYS DISABILITY (N=59)	
	N	%	N	%	N	%	N	%	N	%
Hotlines should be transparent about: **hotline emergency response use**	**210**		**106**		**117**		**152**		**59**	
Always	**148**	70.48%	**93**	87.64%	**93**	79.49%	**121**	79.61%	**49**	83.05%
Most of the time	**28**	13.33%	**5**	4.72%	**12**	10.26%	**17**	11.18%	**5**	8.47%
Sometimes	**30**	14.29%	**7**	6.60%	**10**	8.55%	**11**	7.24%	**4**	6.78%
Never	**4**	1.90%	**1**	0.94%	**2**	1.71%	**3**	1.97%	**1**	1.69%
Hotlines should be transparent about: **dispatch of emergency responders**	**210**		**106**		**117**		**152**		**59**	
Always	**146**	69.52%	**88**	83.02%	**89**	76.07%	**114**	75%	**47**	79.66%
Most of the time	**38**	18.10%	**12**	11.32%	**18**	15.38%	**19**	12.50%	**8**	13.56%
Sometimes	**21**	10.00%	**5**	4.72%	**9**	7.69%	**15**	9.87%	**4**	6.78%
Never	**5**	2.38%	**1**	0.94%	**1**	0.85%	**4**	2.63%	**0**	0.00%

Study participants' perspectives on...

Future crisis hotline usage
by demographic group

VARIABLE	FULL SAMPLE (N=210)		TRANS (N=106)		POC (N=117)		NONPHYS DISABILITY (N=152)		PHYS DISABILITY (N=59)	
	N	%	N	%	N	%	N	%	N	%
Why participants were unlikely to contact hotlines in the future	**75**		**47**		**46**		**61**		**21**	
Do not want to be psychiatrically hospitalized	**60**	80.00%	**39**	82.98%	**38**	82.61%	**53**	86.89%	**20**	95.24%
Do not want to share my personal difficulties with a stranger	**26**	34.67%	**18**	38.30%	**14**	30.43%	**21**	34.43%	**8**	38.10%
Do not want to interact with emergecy responders, including police	**66**	88.00%	**43**	91.49%	**40**	86.96%	**58**	95.08%	**20**	95.24%
Do not want my geographic location to be identified without my permission (e.g., being geolocated)	**46**	61.33%	**30**	63.83%	**24**	52.17%	**42**	68.85%	**16**	76.19%

988'S LOCATION TRACKING CAPABILITIES

In its current state, 988's in-house location capability is largely limited to the use of **area code** and **zip code routing**.[15] Area code routing uses the first three digits of a phone number to direct a call or text to the nearest 988 center. In order to facilitate area code routing, all 988 centers are required to be equipped with caller ID.[16] The process of routing by area code is applied to all 988 texts, wireless calls, and calls from VoIPs (Voice over Internet Protocol, such as WhatsApp, Zoom, Signal, and some phone providers) that are not attached to a fixed address.[17] When a call is made from a landline phone or VoIP attached to a fixed address, the call is simply routed based on that address. Online chats are routed via zip (or postal) code, which help-seekers are required to provide in a pre-chat survey. 988 centers equipped for chat also have access to callers' IP addresses, a unique string of numbers or characters used to identify each device connected to the internet.[18] In "imminent risk" cases, 988 operators can share IP addresses with 911 in order to determine a help-seeker's location.

988 uses area code and zip code routing to further their goal of connecting all help-seekers to crisis centers in their area. In a web page titled "Vibrant's Position on Geolocation for 988," the Lifeline's administrator cites a belief that help-seekers can receive better resources and follow-up care, and potentially "build a trusting connection" more quickly with hotline operators when connected to local crisis centers that may better understand their contexts.[19] However, location routing by area codes, zip codes, and IP addresses does not always connect help-seekers to a center in their area. High call volume, a lack of local 988 centers, or a disruption in service can mean that help-seekers are routed randomly to one of 14 designated national backup centers.[8] Additionally, area codes can be misleading for location data, as many people keep their mobile phone numbers when they move to other cities or states. If a help-seeker is reaching out for support while traveling, the use of area code routing can lead to delays in localized service. For example, if someone with a Texas area code calls from Virginia, they would be automatically routed to the crisis center closest to their Texas area code. In these instances, callers would need to be rerouted to a crisis center in their area, causing a longer wait time.

The 988 Suicide and Crisis Lifeline cites delays and inaccuracies in service, as well as the need for the exact location of individuals for purposes of emergency interventions, as reasons why 988 should be granted in-house **geolocation** capacity.[19]

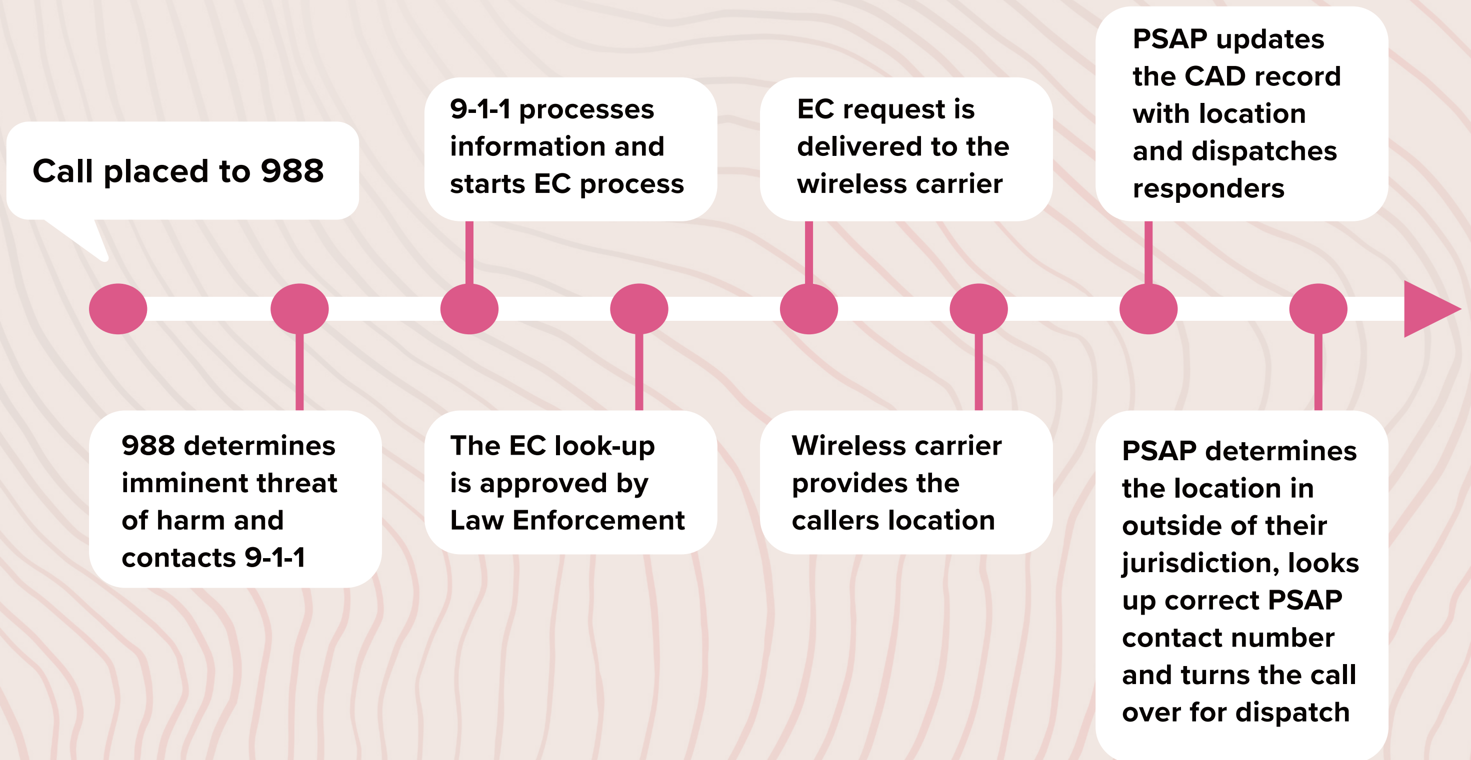
GEOLOCATION: A TECHNICAL OVERVIEW

In order to utilize technology that tracks a help-seeker's precise location, most hotlines in the 988 network must connect with a 911 **Public Service Answering Point** (PSAP). Since all calls to 911 are assumed to be an emergency, once a crisis hotline has engaged 911 regarding a help-seeker, geolocation immediately becomes the standard operating procedure.[21-22] In some areas, such as South Carolina, local 988 hotlines have partnered with private companies in order to facilitate location tracking without solely depending on 911.[23]

In most cases, the hotline operator is the first step in the process of initiating geolocation and emergency intervention. When a hotline operator determines that a help-seeker is at imminent risk, they are required to escalate the call to a hotline supervisor, who then contacts a 911 operator.[21-22] Once contact has been made, the crisis center supervisor gives the 911 operator all identifying information available about the help-seeker, including their area code or IP address and any personal details the hotline operator received during the conversation. This information is then used, along with geolocation, to send police and/or other emergency responders to the help-seeker's location.

The 911 operator begins the process of location tracking by determining the type of technology the help-seeker is using. For landline calls, phone numbers are tied to a fixed address and the 911 operator simply types the phone number into a database to retrieve the address.[17] In the case of mobile phone calls, VoIPs, and online chats, 911's location-tracking technology relies on mobile phone carriers and internet service providers to report their customer's precise location. Mobile providers can use a process known as device-based hybrid location to automatically activate "emergency mode" on a mobile device, which turns on all location-sensing capabilities, including GPS, Wi-Fi, Bluetooth, and any applications that have location services, whether or not the caller already has them turned on.[7] The Federal Communications Commission (FCC) requires that all mobile phone carriers and internet service providers report precise location data that conveys the x (longitude), y (latitude), and z (vertical) coordinates of the help-seeker to the 911 operator.[23] The x and y coordinates must be accurate within a maximum of 50 meters. The inclusion of the z coordinate, which indicates the vertical location of the caller in a multi-floor building, is a newer requirement and must be accurate within a three-meter radius for 80% of wireless calls. In the case of non-consensual intervention, a help-seeker is not always informed that the 911 location tracking process has happened until police or other emergency responders arrive.

911'S LOCATION-TRACKING PROCESS



When the call or text is coming from a mobile phone, the 911 operator begins a process known as an Exigent Circumstances (EC) Look-Up in order to contact the caller's mobile service provider (MSP) and request the device's precise location. Currently, most states require law enforcement approval of an EC Look-Up request before it is sent to the caller's MSP. After approval (if necessary), the EC Look-Up is sent to the MSP, which collects data from the caller's device to determine their location. Wireless provider activates DBH to activate "emergency mode" on the caller's device. Both Google and Apple have developed DBH capability for all recent smartphones, meaning that DBH is used for the majority of wireless calls that 911 geolocates. According to David Furth, Deputy Director of Homeland Security, we should think of DBH as "Google Maps on steroids." The MSP directs the geolocation data from the caller's device to the automatic location information (ALI) database, which is accessible to the 911 operator who initiated the EC Look-Up. The operator is then able to query the ALI database to retrieve the caller's precise location for dispatch. This process, sometimes called a location bid, can be manual or automatic and can be repeated throughout the call if the caller's location changes.

If the precise location of the caller matches the jurisdiction of the PSAP that initiated the EC Look-Up, the 911 operator is able to dispatch law enforcement and/or emergency services to that location. If the location data does not match the jurisdiction of the originating PSAP, the 911 operator will need to look up the correct PSAP and transfer the location data there for dispatch. This process can take anywhere from 15-20 minutes and upwards of several hours due to the variability of state and local statutes and protocol that govern it, as well as older PSAP technology and outdated processes of some MSPs (for example, a requirement that ECs be faxed).

Currently, most 911 PSAPs operate using Legacy 911 technology. However, 911 is in the process of transitioning to Next Generation 911 (NG911), which performs the same geolocation functions with the addition of advanced technology that includes the capacity for voice, text, video, and multimedia communications.[7] NG911 will also transmit geolocation data to 911 PSAPs with each call in the form of a validated address (including floor, room, apartment, or office) rather than the current practice of coordinate-based location.[28] Until recently, obtaining an exact and validated address was only possible with landline numbers. At present, not all 911 PSAPs with Legacy 911 systems operate using the same technology, and the NG911 rollout has been slow, costly, and inconsistently applied across the nation.

988'S ATTEMPTS FOR IN-HOUSE GEOLOCATION

Shockingly, 988 administrators have asked the federal government to grant the Lifeline unprecedented geolocation capabilities, including **automatic dispatchable location**.[19] Automatic dispatchable location automatically transmits precise location data of every incoming call, including a verifiable address and, for multi-level buildings, the floor, apartment, or office number within three meters of the device used to make the call, text, or chat.[25] The automatic dispatchable location process can be repeated as many times as necessary throughout a call, in the event a caller is on the move. Should this capacity be granted to 988, all 200+ crisis centers in the 988 network, as well as 988's nonprofit administrator, Vibrant Emotional Health, would gain access to the exact location of all 988 users. NENA has suggested that the technology built for NG911 could be easily used for 988,[9] but other stakeholders have cast doubt on whether this is truly possible given technological inconsistencies that exist state to state and the vast differences in regulations between 911 and 988.[17] *For a further discussion of regulatory concerns, please reference Appendix E. For their part, Vibrant has recommended that all 988 crisis centers be redesignated as PSAPs in order to bypass current regulations that restrict geolocation data transmission to 911.*[8]

Officials from SAMHSA, NENA, and 988 itself have touted geolocation capacity for 988 as a necessary move to provide "life-saving services."[7] As stated on their website, Vibrant believes that the benefits of providing 988 with in-house location-tracking capabilities "outweighs any associated costs."[19] These costs include the life-changing harms that can be caused by emergency interventions, including physical harm, financial devastation, increases in suicidal thoughts, and death.

In May 2022, the FCC held a forum on 988 and geolocation, which primarily focused on the technical feasibility and cost considerations of 988 gaining automatic dispatchable location capabilities.[7] The majority of stakeholders in attendance voiced or implied support for granting 988 geolocation capabilities and were largely concerned with how best to move it forward. However, one panel, which included several mental health professionals and multiple

suicide attempt survivors, challenged this sentiment. This panel of experts pointed to the harms and deaths caused by non-consensual intervention and hospitalization, as well as how institutional racism and other types of oppression influence outcomes relate to non-consensual intervention. They also emphasized how anti-trans, anti-immigration, and anti-abortion legislation could lead to further persecution of a help-seeker if a forced intervention led to criminalization, family separation, and/or incarceration. Despite this caution, the vast majority of presenters throughout the forum advocated in favor of moving forward with pursuing in-house geolocation for 988.

While acknowledging a range of outstanding and complex issues including privacy, legal, technical, and financial considerations, the FCC has stated that "transmitting geolocation information, including dispatchable location information, with 988 calls would have significant benefits," specifically more accurate call routing and faster dispatch of emergency services when perceived to be necessary.[17] However, to date, the FCC has not announced any concrete plans to move forward with implementing in-house geolocation or automatic dispatchable location capability for 988. Instead, in May 2024, the FCC introduced a proposal to require all wireless carriers to implement **georouting** for 988: routing an incoming call based on the closest cell tower or wire-center boundary without transmitting the precise location.[27]

Georouting provides the same streamlining benefits as geolocation while mitigating many of the harms that more precise geolocation can pose. According to a September 2023 press release from the FCC, 988 has already successfully completed the first round of testing a georouting method that directed non-live calls to 988 crisis centers based on cell tower location and wire-center boundaries.[28] Since the completion of this initial test, FCC Chairwoman Jessica Rosenworcel has said that they hope to build on this foundation and has made a public appeal to the wireless industry and related associations to identify and develop a georouting solution for 988.

Georouting, unlike geolocation, has the potential to better support help-seekers by connecting them to local services without violating their privacy or introducing the threat of non-consensual intervention and the possibility of harm.

SURVEILLANCE ≠ SAFETY

Crisis hotlines' use of geolocation and non-consensual intervention poses a significant threat to the safety and well-being of help-seekers, especially those from marginalized communities. For some of our research participants, the threat of harm that accompanies location tracking and non-consensual intervention meant engaging in precautionary measures to protect their privacy. One participant stated, **"I use a Google Voice number now that I can turn off Caller ID on because I did have the police sent to my house once, on accident."** Other research participants reported abruptly ending hotline calls if they feared that an

operator could be initiating the process of geolocation. For example, one participant stated, "I remember hanging up too often. Usually, when I would call, and I'm a repeat caller throughout my life, but especially in adolescence I would hang up a lot, especially when they would ask questions about location. I was really nervous about cops coming."

For some research participants, the threat of geolocation and non-consensual intervention dissuaded them from using hotlines altogether. One participant shared, "I have actively avoided 988 because I know that [...] they do link to location and cops. So that's something that I don't feel is a resource that I can take advantage of, and will not take advantage of. I don't think that they're necessarily transparent about [their use of police intervention]." Of the participants who had used crisis hotlines in the past, 62.79% reported that they would not be comfortable sharing their level of suicidality or distress with a hotline if they knew their location could be tracked. Of the surveyed participants who reported being "unlikely" or "very unlikely" to use hotlines in the future (35.71%), 61.33% cited concerns about geographic location tracking as a reason for not using hotlines in the future.

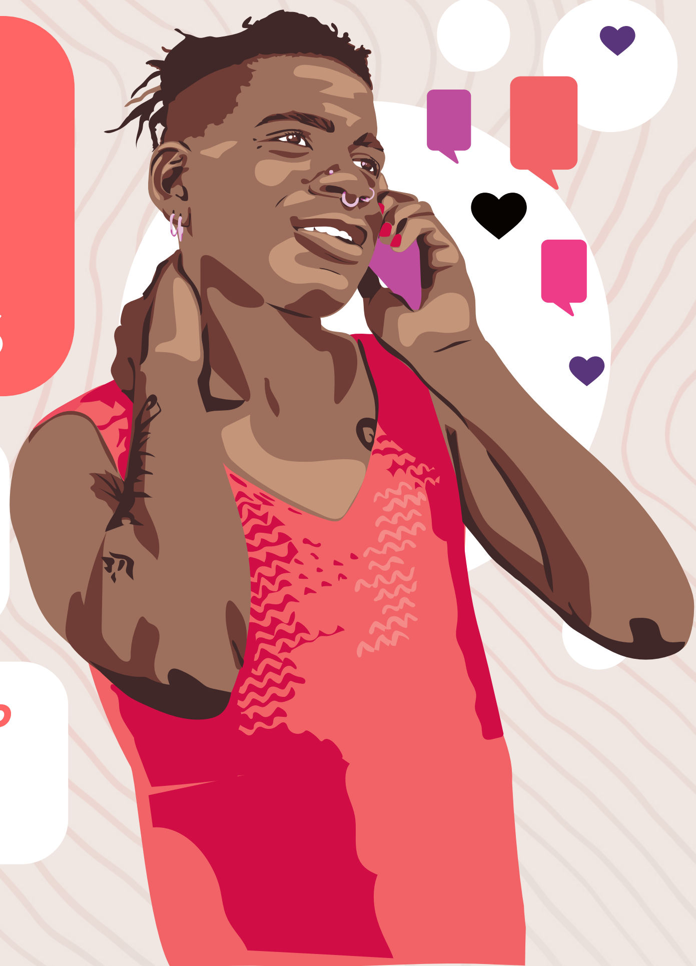
Study participants' perspectives on...

Future crisis hotline usage
by demographic group

VARIABLE	FULL SAMPLE (N=210)		TRANS (N=106)		POC (N=117)		NONPHYS DISABILITY (N=152)		PHYS DISABILITY (N=59)	
	N	%	N	%	N	%	N	%	N	%
Of people who have used crisis hotlines, whether they would feel comfortable sharing degree of suicidality, distress or crisis with a crisis hotline if they knew their location could be tracked	**86**		**54**		**51**		**73**		**31**	
Unsure	**8**	9.30%	**6**	11.11%	**6**	11.76%	**6**	8.22%	**2**	6.45%
Yes	**24**	27.91%	**7**	12.96%	**11**	21.57%	**19**	26.03%	**7**	22.58%
No	**54**	62.79%	**41**	75.93%	**34**	66.67%	**48**	65.75%	**22**	70.97%

5 CHAPTER

A BETTER SYSTEM IS POSSIBLE: CONCLUSION & RECOMMENDATIONS



"If you wanna fix a hotline, you have to fix the whole system."

"988 has a profound opportunity to center policies and practices that promote consent and connection."

Suicide and crisis hotlines are one of the most accessible forms of mental health services available in the United States. Crisis hotlines, and in particular the 988 network, present a major opportunity to provide help-seekers with support that centers consent and self-determination. However, under current practices, 988 hotlines are missing the mark on providing life-affirming care and are instead exposing help-seekers to potentially harmful and life-changing consequences. **Help-seekers deserve crisis support that is consistently high-quality, relevant, and consensual.** Furthermore, the public deserves transparency about the impact of crisis services, especially when that impact can mean serious and life-altering consequences. As 988 continues to grow, receiving more funding and broadening its reach, the need to protect the privacy, autonomy, and well-being of help-seekers has never been more urgent.

In our study, help-seekers are clear on several fronts: In order to be helpful and effective, suicide and crisis hotlines, including all hotlines in the 988 network, must commit to transparency, informed consent, and peer support. Furthermore, hotlines must divest from harmful interventions that set the stage for help-seekers to be criminalized, detained, and/or hospitalized. These sentiments echo long-standing demands from survivors of suicide attempts, psychiatric hospitalization, and law enforcement violence, and remind

us that recovery does not happen in the isolation of a jail cell or a hospital bed.

988 has a profound opportunity to center policies and practices that promote consent and connection. Without changes to center the lived experiences and recommendations of hotline users and eliminate the harms posed by non-consensual interventions, 988 hotlines run the risk of being insufficient, harmful, ineffective, and eventually losing the trust of the people they aim to support. The following is a summary of recommendations to improve suicide and crisis hotlines, and some further recommendations to transform the mental health system overall.

Hotlines must end unhelpful and harmful practices, including:

- Ending the use of non-consensual interventions and establishing consent-driven, request-only transfer and emergency dispatch policies
- Ending all collaboration with law enforcement
- Ending the use of coercive practices to initiate emergency interventions, including the use of pressure or threats to convince help-seekers to agree to emergency intervention
- Ending mandatory risk/safety assessments, and all assessments that can result in the initiation of non-consensual interventions

Hotlines must incorporate and center practices of informed consent, including:

- Fully informing help-seekers about the process of emergency intervention, including location tracking and the potential outcomes (e.g., hospitalization, medical bills, police interaction, criminalization)
- Acquiring informed and ongoing consent from a help-seeker before initiating any type of emergency intervention
- Acquiring informed and ongoing consent from a help-seeker before collecting and/or sharing their identifying information
- Creating transparent and easily accessible systems for help-seekers to be notified of data collection and be able to opt-in or out
- Implementing a system where help-seekers can, with full knowledge, opt into geolocation, easily allowing help-seekers to opt out of the threat of emergency intervention

Hotlines must increase transparency about policies, practices, and hotline intervention outcomes by:

- Publicly disclosing data on the annual number, not percentage, of call/chats/texts that end with emergency interventions being initiated, how many of those interventions are occurring without help-seeker consent or collaboration, and the outcomes of those interventions
- Demonstrating total transparency about the use of emergency services, the potential for non-consensual intervention, and the possibility of geolocation in: all marketing materials, at the start of and during hotline conversations, and in easily-viewable, accessible language on websites, apps, chatbots, and greeting/hold recordings

- Immediately alerting help-seekers anytime an emergency intervention has been initiated
- Making explicit to help-seekers which questions, if any, are mandatory
- Providing clarity about when and how help-seeker data, including call/text/chat recordings and transcripts, is being used, stored, and transmitted
- Explicitly and forthrightly sharing practices and policies of data collection – including providing clarity about when and how help-seeker data and call/text/chat recordings and transcripts – is being used, stored, and transmitted

Hotlines must create and implement robust operator training protocols that:

- Center the recommendations of hotline users, suicide attempt survivors, and psychiatric survivors, especially those from marginalized groups
- Educate operators about the potential for an increased risk of suicide as a result of emergency responses, including the potential for abuse and harm by police and medical staff
- Develop human connection skills that prioritize curiosity, cultural competency, empathy, and validating the experience of the help-seeker without judgment
- Teach hotline workers how to provide personalized and relevant support by following the lead of help-seekers
- Grow understanding about suicidal thoughts, self-injury, and other stigmatized behaviors, without trying to correct these behaviors unless requested by a help-seeker
- Educate operators about non-police, non-carceral alternatives that may be available for emergency support (peer respites, enlisting chosen family to support in home, etc)
- Teach hotline operators to manage their biases, anxieties, fears, and discomforts during hotline interactions

Suicide and crisis hotline administrators and regulators must further increase accountability to taxpayers, private funders, and help-seekers by:

- Instituting clear policies that protect hotline user information, such as formal reviews of data use practices and accountability measures for improper storage or use of help-seeker data
- Implementing corrective measures for crisis centers that violate help-seeker privacy
- Implementing annual reviews of transparency and consent practices

While suicide and crisis hotlines are an accessible and popular mental health resource, they represent only one dimension of a larger system that requires significant transformation in order to provide safe, helpful, and consensual support to help-seekers. As one of our participants said, "If you wanna fix a hotline, you have to fix the whole system." Many of our study participants pointed to the need for larger

structural change in the mental health system, including addressing lack of accessibility to mental health care due to financial cost, with one participant stating, "We need to really completely restructure how we pay for mental health services and health care in this country. [...] It's leaving people stranded and to die, quite literally."

Furthermore, participants pointed to a fundamental need for a systematic shift toward crisis prevention instead of simply crisis response. One participant stated, "A lotta folks who are in crisis are in crisis because it's like systems aren't meeting their needs. People don't have food. People don't have a lot of things." These sentiments reflect a growing understanding that crises cannot be reduced to individual experiences but must be considered and addressed amidst larger systemic inequities. Providing life-affirming care to people in crisis requires investment in community-based solutions that reject entanglement with carceral systems. Therefore, crisis care necessitates structural changes, including investing in communities to meet material needs (e.g., housing, food, health care) and dismantling systemic harm in all forms (e.g., racism, transphobia, ableism).

The mental health system as a whole must:

- End all non-consensual and coercive practices, such as involuntary hospitalization, forced treatment, and physical restraints
- End all collaboration with law enforcement and the criminal punishment system
- Invest in non-carceral peer support, including peer-led respites, non-911 affiliated hotlines, and MCTs that don't utilize police or forced psychiatric hospitalization
- Be free for help-seekers, as financial stress is a common cause of initial crisis and costly interventions often exacerbate financial stress
- Address the root causes of crises, rather than simply reacting to crises
- Be attuned to and support identity-specific needs and experiences
- Acquire the informed and ongoing consent of help-seekers, including before initiating interventions

A better mental health care system is possible and we have the ability and opportunity to realize it. Creating crisis intervention systems that are truly supportive for all communities means shedding harmful policies and practices and creating new structures informed by the actual needs of the community. In doing so, we can move closer to a world where the holistic needs and wellness of all people are realized and all people can thrive. Radical change is necessary, and we hope this report has provided meaningful direction to provide the care that help-seekers truly want, need, and deserve.

GLOSSARY

Automatic Dispatchable Location: An automatic transmission of the precise location data, including a verifiable address and, for multi-level buildings, the floor, apartment, or office number within three meters of the device used to make the call, text, or chat

Carceral: Relating to prisons, policing, and criminalization

Co-response: Emergency response from both law enforcement and mental health professionals

Criminal Legal System / Criminal Punishment System: Alternative terms used in place of the criminal justice system as a more accurate way to describe the carceral system within the United States that is comprised of state sanctioned policing, punishment, trafficking, incarceration, exploitation, torture, and violence against community members

Broadly, an experience of heightened distress

Crisis Intervention Team: A 40-hour program that is intended to provide police officers with specialized training in mental health crisis response

Device-Based Hybrid Location: A tool to locate callers that uses multiple sensors to calculate the exact location of a wireless call. This happens through a mobile provider activating "emergency mode" on a caller's device which turns on all location-sensing capabilities including GPS, wifi, bluetooth, and any apps that have location services, whether or not the caller already has them turned on

Emergency Dispatch: A procedure where a PSAP/911 operator sends out an emergency response team, usually police, firefighters, or emergency medical services, to a caller's location

Emergency Intervention: A procedure where emergency personnel such as police, firefighters, or emergency medical services arrive on site to respond to a reported safety crisis

Forced Hospitalization / Involuntary Hospitalization: Also called civil commitment, a non-consensual process where an individual is held in a psychiatric institution against their will to receive treatment for a perceived mental health condition or for posing a danger to themselves or others. These holds are usually at minimum 72 hours, and can be initiated by police, mobile crisis teams, mental health professionals, and/or a judge

Geolocation: A precise location tracking process through GPS or IP addresses that identifies, locates, and tracks the whereabouts of a connected device with x (longitude), y (latitude), and z (vertical) coordinates when possible

Georouting: Also sometimes referred to as location-based routing, georouting is the process of routing an incoming call based on the closest cell tower or wire-center boundary to the caller. Georouting is distinct from geolocation because it does not determine a caller's precise location with x, y, z coordinates. It is also distinct from general call routing, which instead utilizes the caller ID's area code or IP address

Help-Seeker: One who is seeking support during a distressing moment, such as an emotional or psychological crisis

Hotline: A call, text, and/or chat based service that is often intended to provide free and confidential support

Hotline User: One who uses a hotline's services, which includes callers, texters, and chatters

Hotline Operator: One who is the front interfacer with the hotline's callers, texters, and chatters

Hotline Worker: One who works for a hotline, including operators, consultants, and supervisors. Not all hotline workers interact directly with callers

Imminent Risk: An assessment used by hotlines such as the 988 network to assess whether a caller poses a risk of causing harm to themselves or others

Informed Consent: An ongoing relationship between a provider and a help-seeker in which a provider (or operator) fully discloses the impacts, including risks, of a procedure, intervention, or interaction while providing alternative options; and the help-seeker, with full awareness of all the impacts, expresses ongoing consent with the explicit option to opt out at anytime without consequence or coercion

Mental Health / Mental Illness: A medicalized interpretation of the root of one's emotional or psychological distress or variance from what is perceived as normative. A mental illness can be self-identified or given a psychiatric diagnosis. Mental health is a Western framework that is often portrayed as the only option for making meaning of one's experiences and relies on a reductive binary of healthy vs unhealthy.

Mobile Crisis Team (MCT): Mobile crisis teams are typically run by community mental health agencies and are made up of mental health providers such as social workers, nurses, therapists, or psychiatrists. These teams are dispatched to a help-seeker's location and are intended to de-escalate a crisis, provide support resources, and determine whether the intervention requires escalation. MCTs are not always alternatives to emergency responders or police, as they can still be accompanied by police and/or call police and emergency services after arriving.

Non-Consensual Intervention: The process through which an emergency response occurs without a help-seeker's knowledge or consent. Non-consensual interventions can include both the initial response of emergency responders at a help-seeker's location and any additional interventions that take place from there, such as incarceration or forced hospitalization. Non-consensual intervention also includes instances where a help-seeker may be coerced into consenting to an emergency response

GLOSSARY

Peer: One with shared lived experience, identity, and values

Peer Support: Mental health crisis support that is by and for peers

Public Service Answering Point (PSAP): A center for 911 and emergency services

Risk Assessment: A process used by hotlines to assess a caller's likelihood to harm themselves or others. Assessments typically consist of a series of questions around an individual's desire, intent, and capability to harm, as well as any buffers to deter a caller from enacting harm.

Safety Assessment: 988's has evolved its risk assessment model to safety assessment, where a hotline operator assesses whether a caller will harm themselves or others. Similar to a risk assessment, a safety assessment consists of a series of questions around an individual's current desire, intent, and capability to harm themselves or others.

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APPENDICES

APPENDIX A: SAFE HOTLINES PROJECT RESEARCH DESIGN

In spring of 2022, a group of researchers with various backgrounds in community organizing, crisis response, surviving psychiatric hospitalization, and academia came together to design a mixed methods research project for the Safe Hotlines project. The purpose of the survey was to learn about the experiences of people who have sought support in the U.S. during difficult mental health situations, including a crisis, distress, and/or suicidality. We were interested in learning about help-seeking experiences from any source or resource, including emergency responder interventions. Our expanded focus was on people's experiences and opinions using crisis hotlines or lifelines of any kind.

The survey included an informed consent page, eligibility page, and a demographics section that all respondents were invited to complete. After completing those questions, people who indicated they sought help during a mental health crisis in the past five years were presented with follow-up questions about where they sought help. They could indicate whether they sought help from a crisis hotline, their personal network, community and alternative care, professional care (such as therapists, psychiatrists, or doctors), or 911/emergency responders. This was a "check all that apply" question. For each type of resource they sought help from, they received follow up questions about the quality and helpfulness of the care along with any harm or negative outcomes that resulted from seeking help.

Respondents who sought help from crisis hotlines were presented with additional questions about their experiences with hotlines. Respondents who opted not to seek help during a mental health crisis were presented with questions to gauge their reasons why they did not seek help. Any respondent who did not seek help from a crisis hotline was presented with questions about their reasons they did not contact a hotline. All respondents, whether they sought help in the past or not, were presented with questions about their opinions of the utility of hotlines and their willingness to seek help from hotlines in the future.

SURVEY PHASE 1 (FALL 2022)

After receiving Institutional Review Board approval from American University (IRB-2023-23), the Safe Hotlines research team launched the online survey using Qualtrics survey software in November of 2022.

Anyone was eligible to take Phase 1 of the survey as long as they were at least 18 years old; experienced a difficult mental health situation, significant distress, suicidality, or crisis in the last five (5) years; were in the U.S. during this experience or these experiences; and felt they might be unable to cope with their feelings or circumstances without outside help. Our goal for our sample size was 210.

To distribute the survey, the team shared the link via email, text, and social media, relying on word-of-mouth to gather participants. Embedded in the survey requirements were two quotas: ensure at least half of the sample identify as a person of color and ensure at least half of the sample have sought help from a crisis hotline in the past five years.

People who completed the survey (and consented to receive the gift card) were eligible to receive a $40 Target gift card via email. As survey responses came in, research team members followed a "quality assurance protocol" to verify the validity of responses before sending a list of verified survey IDs to another team member who manually emailed gift cards for survey completion. Survey responses were not linked to respondent contact information during the quality assurance or data analysis processes.

Survey respondents who sought help from a crisis hotline were eligible for a follow-up interview (see Interview Phase section below for more information). If they indicated they were willing to participate in the Interview Phase, they entered their contact information. This information was saved separately from the survey responses, linked only by an automatically generated Qualtrics ID number.

Shortly after launch the team paused data collection due to the realization that the survey was receiving spam or fraudulent responses.

QUALITY ASSURANCE PROTOCOL & DATA COLLECTION PAUSE

Prior to launching the survey in November of 2022, the research team took the following steps to prevent spam or fraudulent responses:

- Added CAPTCHA verification
- Added six "attention check" questions
- Added manual inspection quality assurance (QA) protocol
- At least twice daily, team members were to manually inspect surveys (with a focus on attention check questions and open-ended question content)
- Made sure informed consent had language that indicated there was a quality assurance protocol and not all who complete survey will receive compensation (but did not add specifics about what we were looking for to prevent spam responses being made valid)
- Created Google Form to track QA process
- Compensation was only to be provided once marked as valid

After identifying spam and fraudulent responses in the sample in Survey Phase 1, the team paused data collection and implemented a new quality assurance points system. The QA team added the following indicators to inspect including time stamp, IP addresses (to check for duplicates), demographic consistency, email

address (many of the fraudulent responses had the same email format), contradictory responses, and open-ended responses. Prior to relaunching the survey for Survey Phase 2, the team added additional attention check questions, changed the URL for the survey, and did not post on social media. Instead, researchers used a targeted snowball sampling process through sharing the survey only to known networks and asking these networks not to share the survey publicly but only with their known networks.

After implementing the new quality assurance protocol on Phase 1 responses, the team removed 171 fraudulent responses (58%). There were 124 valid survey responses.

SURVEY PHASE 2 (SPRING 2023)

In Phase 2 of the survey, the eligibility criteria was modified due to the quota sampling strategy of ensuring at least half of the sample identify as a person of color and at least half of the sample have sought help from a crisis hotline in the past five years. People could take the survey as long as they were at least 18 years old; identified as a person of color; experienced a difficult mental health situation, significant distress, suicidality, or crisis in the last five (5) years; were in the U.S. during this experience or these experiences; and felt they they might be unable to cope with your feelings or circumstances without outside help. Our goal for our sample size was 210.

As mentioned in the QA protocol, the survey was not distributed publicly or via social media, but to known networks via email and text. After implementing quality assurance protocol on Phase 2 responses, the research team removed 27 fraudulent responses (24%). There were 86 valid surveys in Phase 2.

The final sample from both survey phases includes 210 valid surveys. Reasons for removal (n=198) were: ineligible; did not finish the survey; contradictory/inconsistent responses; duplicate IP addresses; or did not pass the attention check questions.

INTERVIEW PHASE (SUMMER 2023)

Interview respondents were purposefully selected to ensure a diverse sample of crisis hotline help-seekers. Mental health and crisis support resources were provided. Selected respondents received an email invitation to participate with a Calendly scheduling link to select a time and interviewer. The interview took place via Zoom. Interviews were recorded to the Zoom cloud for transcription purposes. Recordings were deleted after verifying the accuracy of the transcriptions.

At the start of each interview, participants were informed that they could take a break or stop at any time and did not need to answer any questions they did not want to. Interviewers checked-in with participants throughout the interview on how they were doing. Participants were offered optional and free peer support resources, including a peer support session after the interview. The offered peer support resources and sessions were disclosed as not part of the research study and that no data would be collected in these sessions.

Interview participants were asked questions about their experiences calling crisis hotlines including how they were treated, what information or resources they received, and how they chose to call the hotline they called. They were also asked to share what an "ideal" hotline experience might look like and anything else they would like to share about their experiences contacting hotlines.

Participants were also asked whether they experienced "an intervention" when they contacted a hotline. An intervention is any hotline experience that involves police or emergency medical responder involvement, regardless of whether they wanted these services. Some hotlines may also refer to an intervention as a "wellness check" by local authorities. Participants were asked follow-up questions about the utility, helpfulness, or any resulting harms they experienced if they indicated they received an intervention. If they had not received an intervention, they were still asked their opinions about the types of interventions that may result from a hotline call.

Lastly, participants were asked about their experiences with seeking help from other resources (such as their personal network, professional care, community and alternative care, or 911). They were invited to discuss what was most helpful to them, what resources they wished existed, and where they might advise a friend to seek help after their experiences.

Interview participants received a $100 Target gift card after the interview.

QUANTITATIVE DATA ANALYSIS

Full demographics for the final analytic sample of $N = 210$ are provided in Appendix B. Most participants were between the ages of 25-35 ($n = 124$ or 60.78% of the sample), followed by 18-24 (42 or 20.59%), 36-45 (26 or 12.75%), 46-55 (9 or 4.41%), and 56+ (< 5 or < 2.38%). A total of 106 participants (52.74%) were trans and 117 participants (55.71%) were people of color; presented in alphabetical order, racial diversity in the sample was as follows: Asian (15 or 7.14%), Biracial or Multiracial (34 or 16.19%), Black (40 or 19.05%), Black-Indigenous (< 5 or < 2.38%), Black-Latine (< 5 or < 2.38%), Indigenous (< 5 or < 2.38%), Indigenous-Latine (< 5 or < 2.38%), Latine (16 or 7.62%), Middle Eastern or North African (< 5 or < 2.38%), white (87 or 41.43%). 6 participants (2.86%) chose not to share their race. In terms of lived experience with disability, 152 (72.38%) had lived experience with a non-physical disability and/or neurodiversity and 50 (29.06%) had lived experience with physical disability.

This report contains only descriptive statistics from the dataset, with each variable captured by a single item on the survey. All analyses were conducted in Statistical Package for the Social Sciences (SPSS) Version 28. Analyses were first run for the full sample, followed by separate analyses for four subsamples: trans people, people of color, people with lived experience with non-physical disability and/or neurodiversity, and people with lived experience with physical disability. Unless otherwise specified, percentages refer to the number of participants who endorsed an item divided by the total number of participants in

the sample/subsample. However, for some variables, percentages reflect the number of people who endorsed an item divided by the number of participants for whom the item was applicable (e.g., items about experiences calling hotlines use the number of participants who have used hotlines as the denominator). Any additional variations in denominators reflect participants missing data (e.g., participants choosing to skip that particular item). Within the text of the report, subsamples for reported statistics are specified explicitly. Within tables, the denominator used for each calculation can be found in bold at the top of each set of reported percentages.

QUALITATIVE DATA ANALYSIS

Reflexive thematic analysis was used in order to explore and co-construct meaning from the individual interviews (N = 26). Zoom interview recordings were transcribed using an external transcription company. Transcripts were then finalized by research team members and checked for accuracy through a process of listening to the recording while reading through the transcripts to fix any errors. The research team followed the six phases of reflexive thematic analysis: (1) familiarization with data, (2) generating initial codes, (3) searching for themes among codes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the final report.

Data analysis began with finalizing transcripts as the coders read through the transcripts and familiarized themselves with the data. Then, the coders moved on to generating initial codes going line-by-line and using gerund/action coding for 18 of the transcripts. Initial codes that were significant or coming up across multiple interviews were then pulled out by the coders to form preliminary themes. Preliminary themes were formed by grouping together and breaking down these initial codes and phrases by meaning and ideas. Next, the auditor met with the coders to provide feedback and discuss the preliminary themes. The coders and auditor revisited that data and the research question together to discuss what participants intended to convey and what questions were being focused on. The new agreed upon thematic structure consisted of a total of five themes and nine subthemes. Coders then independently coded the remaining transcripts (n = 8) into the thematic structure to check for saliency; this revealed no new themes or subthemes and the thematic structure was finalized. Coders consistently met throughout the entire process to reflect and discuss their reactions, possible themes, and the way their positionality may be impacting the way they make meaning of participants' stories. The research team then began pulling quotes and producing the final report.

APPENDIX B: SAFE HOTLINES SURVEY DATA CHART

VARIABLE	FULL SAMPLE (N=210)		TRANS (N=106)		POC (N=117)		NONPHYS DISABILITY (N=152)		PHYS DISABILITY (N=59)	
	#	%	#	%	#	%	#	%	#	%
Age	**204**		**106**		**117**		**152**		**59**	
18-24	42	20.59%	24	22.64%	22	18.80%	30	19.74%	14	23.73%
25-35	124	60.78%	66	62.26%	72	61.54%	92	60.53%	29	49.15%
36-45	26	12.75%	13	12.26%	14	11.97%	19	12.50%	11	18.64%
46-55	9	4.41%	3	2.83%	7	5.98%	8	5.26%	3	5.08%
56-65	3	1.47%	0	0.00%	2	1.71%	3	1.97%	2	3.39%
Race	**210**		**106**		**117**		**152**		**59**	
Asian	15	7.14%	11	10.38%	15	12.82%	10	6.58%	4	6.78%
Biracial or Multiracial	34	16.19%	24	22.64%	34	29.06%	31	20.39%	13	22.03%
Black	40	19.05%	23	21.70%	40	34.19%	30	19.74%	14	23.73%
Black-Indigenous	2	0.95%	1	0.94%	2	1.71%	2	1.32%	1	1.69%
Black-Latine	3	1.43%	2	1.89%	3	2.56%	3	1.97%	0	0.00%
Indigenous	2	0.95%	2	1.89%	2	1.71%	0	0.00%	0	0.00%
Indigenous-Latine	1	0.48%	1	0.94%	1	0.85%	1	0.66%	0	0.00%
Latine	16	7.62%	10	9.43%	16	13.68%	13	8.55%	8	13.56%
Middle Eastern or North African (MENA)	4	1.90%	2	1.89%	4	3.42%	3	1.97%	1	1.69%
white	87	41.43%	30	28.30%	0	0.00%	59	38.82%	18	30.51%
Choose not to answer	6	2.86%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Cisgender	**203**		**106**		**117**		**151**		**58**	
Yes	89	43.84%	5	4.72%	37	31.62%	53	35.10%	16	27.59%
No	114	56.16%	100	94.34%	80	68.38%	98	64.90%	42	72.41%
Trans	**201**		**106**		**117**		**149**		**59**	
Yes	106	52.74%	106	100%	76	64.96%	92	61.74%	41	69.49%
No	95	47.26%	0	0%	41	35.04%	57	38.26%	18	30.51%
Gender nonconforming	**201**		**106**		**117**		**149**		**59**	
Yes	95	47.26%	77	72.64%	66	56.41%	81	54.36%	37	62.71%
No	106	52.74%	29	27.36%	51	43.59%	68	45.64%	22	37.29%
Sexual Orientation	**210**		**106**		**117**		**152**		**59**	
Asexual	15	7.14%	7	6.60%	10	8.55%	11	7.24%	5	8.47%

VARIABLE	FULL SAMPLE (N=210)		TRANS (N=106)		POC (N=117)		NONPHYS DISABILITY (N=152)		PHYS DISABILITY (N=59)	
Bisexual	39	18.57%	23	21.70%	22	18.80%	33	21.71%	15	25.42%
Gay	21	10.00%	18	16.98%	12	10.26%	18	11.84%	10	16.95%
Lesbian	22	10.48%	9	8.49%	9	7.69%	20	13.16%	4	6.78%
Pansexual	27	12.86%	20	18.87%	17	14.53%	25	16.45%	11	18.64%
Queer	79	37.62%	61	57.55%	50	42.74%	68	44.74%	28	47.46%
Questioning	4	1.90%	1	0.94%	4	3.42%	4	2.63%	1	1.69%
Straight	62	29.52%	11	10.38%	29	24.79%	32	21.05%	10	16.95%
Please specify (optional):	2	0.95%	1	0.94%	0	0.00%	2	1.32%	1	1.69%
Choose not to answer	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Physical Disability	**203**		**106**		**117**		**151**		**59**	
Yes	50	24.63%	34	32.08%	37	31.62%	46	30.46%	50	84.75%
No	144	70.94%	65	61.32%	76	64.96%	96	63.58%	0	0.00%
Chronic pain/illness	9	4.43%	7	6.60%	4	3.42%	9	5.96%	9	15.25%
Non-Physical Disability	**204**		**106**		**117**		**152**		**59**	
None	52	25.49%	14	13.21%	24	20.51%	0	0.00%	4	6.78%
Neurodivergence	29	14.22%	15	14.15%	16	13.68%	29	19.08%	6	10.17%
Mental Illness	56	27.45%	27	25.47%	37	31.62%	56	36.84%	16	27.12%
Mental Illness and Neurodivergence	67	32.84%	50	47.17%	40	34.19%	67	44.08%	33	55.93%
Types of support in last 5 years	**193**		**100**	**(Assumed)**	**112**	**(Assumed)**	**145**	**(Assumed)**	**56**	**(Assumed)**
911/Emergency Responders	28	14.51%	17	17.00%	15	13.39%	22	15.17%	15	26.79%
Professional Care	142	73.58%	84	84.00%	91	81.25%	113	77.93%	45	80.36%
Community & Alternative Care	88	45.60%	55	55.00%	53	47.32%	71	48.97%	30	53.57%
Personal Network	149	77.20%	83	83.00%	86	76.79%	113	77.93%	46	82.14%
Crisis Hotline	97	50.26%	60	60.00%	55	49.11%	80	55.17%	33	58.93%
Participant talked to someone/ received help via crisis hotline	**97**		**60**		**55**		**80**		**33**	
Yes	86	88.66%	54	90.00%	51	92.73%	73	91.25%	31	93.94%
No	11	11.34%	6	10.00%	4	7.27%	7	8.75%	2	6.06%
How helpful participants found the hotline	**86**		**54**		**51**		**73**		**31**	

VARIABLE	FULL SAMPLE (N=210)		TRANS (N=106)		POC (N=117)		NONPHYS DISABILITY (N=152)		PHYS DISABILITY (N=59)	
Very helpful	22	25.58%	10	18.52%	11	21.57%	19	26.03%	8	25.81%
Somewhat helpful	33	38.37%	22	40.74%	22	43.14%	28	38.36%	11	35.48%
Not helpful or unhelpful	13	15.12%	9	16.67%	8	15.69%	10	13.70%	5	16.13%
Somewhat unhelpful	11	12.79%	9	16.67%	5	9.80%	10	13.70%	5	16.13%
Very unhelpful	7	8.14%	4	7.41%	5	9.80%	6	8.22%	2	6.45%
Emergency response during hotline call	**86**		**54**		**51**		**73**		**31**	
Yes	17	19.77%	7	12.96%	6	11.76%	15	20.55%	6	19.35%
No	69	80.23%	47	87.04%	45	88.24%	58	79.45%	25	80.65%
Emergency response was police	**17**		**7**		**6**		**15**		**6**	
Yes	9	52.94%	5	71.43%	3	50.00%	8	53.33%	5	83.33%
No	8	47.06%	2	28.57%	3	50.00%	7	46.67%	1	16.67%
Emergency response was EMS	**17**		**7**		**6**		**15**		**6**	
Yes	9	52.94%	3	42.86%	2	33.33%	8	53.33%	3	50.00%
No	8	47.06%	4	57.14%	4	66.67%	7	46.67%	3	50.00%
Emergency response was fire department	**17**		**7**		**6**		**15**		**6**	
Yes	3	17.65%	2	28.57%	4	66.67%	3	20.00%	2	33.33%
No	14	82.35%	5	71.43%	2	33.33%	12	80.00%	4	66.67%
Emergency response was mobile crisis unit	**17**		**7**		**6**		**15**		**6**	
Yes	2	11.76%	1	14.29%	1	16.67%	2	13.33%	0	0.00%
No	15	88.24%	6	85.71%	5	83.33%	13	86.67%	6	100.00%
Emergency response was consensual	**17**		**7**		**6**		**15**		**6**	
Yes	11	64.71%	3	42.86%	4	66.67%	9	60.00%	2	33.33%
No	5	29.41%	4	57.14%	2	33.33%	5	33.33%	4	66.67%
Unsure	1	5.88%	0	0.00%	0	0.00%	1	6.67%	0	0.00%
Hotline operator informed caller about emergency services involvement	**17**		**7**		**6**		**15**		**6**	

VARIABLE	FULL SAMPLE (N=210)		TRANS (N=106)		POC (N=117)		NONPHYS DISABILITY (N=152)		PHYS DISABILITY (N=59)	
Yes, they informed me before I shared personal information about myself and my current situation	11	64.71%	3	42.86%	4	66.67%	10	66.67%	2	33.33%
Yes, but they informed me after I had already shared personal information about myself and my current situation	2	11.76%	1	14.29%	0	0.00%	1	6.67%	1	16.67%
No, they did not inform me	4	23.53%	3	42.86%	2	33.33%	4	26.67%	3	50.00%
How helpful was the emergency response after seeking help from the hotline	**17**		**7**		**6**		**15**		**6**	
Very helpful	2	11.76%	1	14.29%	2	33.33%	2	13.33%	0	0.00%
Somewhat helpful	9	52.94%	2	28.57%	2	33.33%	8	53.33%	2	33.33%
Not helpful or unhelpful	0	0%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Somewhat unhelpful	1	5.88%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Very unhelpful	5	29.41%	4	57.14%	2	33.33%	5	33.33%	4	66.67%
How harmful was the emergency response after seeking help from the hotline	17		7		6		15		6	
Very harmless	1	5.88%	1	14.29%	1	16.67%	1	6.67%	0	0.00%
Somewhat harmless	1	5.88%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Neither harmful or harmless	3	17.65%	1	14.29%	2	33.33%	3	20.00%	1	16.67%
Somewhat harmful	6	35.29%	0	0.00%	0	0.00%	5	33.33%	0	0.00%
Very harmful	6	35.29%	5	71.43%	3	50.00%	6	40.00%	5	83.33%
Results from crisis hotline help (check all that apply)	**85**		**54**		**51**		**72**		**30**	
The help I received was sufficient without engaging other resources	14	16.47%	9	16.67%	10	19.61%	11	15.28%	4	13.33%
The help I received made me feel more safe and/or calm	39	45.88%	27	50.00%	24	47.06%	33	45.83%	15	50.00%

VARIABLE	FULL SAMPLE (N=210)		TRANS (N=106)		POC (N=117)		NONPHYS DISABILITY (N=152)		PHYS DISABILITY (N=59)	
I was connected to helpful resources for mental health support in my area	21	24.71%	14	25.93%	17	33.33%	18	25.00%	11	36.67%
I felt heard and supported by the person I saw, spoke, or texted with	51	60.00%	30	55.56%	27	52.94%	42	58.33%	17	56.67%
None of the above	22	25.88%	16	29.63%	14	27.45%	19	26.39%	8	26.67%
Results from crisis hotline help (check all that apply)	**17**		**7**		**6**		**15**		**6**	
Involuntary outpatient mental health provider and/or assessment	1	5.88%	1	14.29%	1	16.67%	1	6.67%	1	16.67%
Voluntary outpatient mental health provider care and/or assessment	5	29.41%	4	57.14%	3	50.00%	5	33.33%	3	50.00%
Involuntary emergency room visit	2	11.76%	2	28.57%	2	33.33%	2	13.33%	2	33.33%
Voluntary emergency room visit	6	35.29%	5	71.43%	4	66.67%	6	40.00%	4	66.67%
Voluntary emergency responder support (police, EMS/paramedics, fire, or mobile crisis unit)	11	64.71%	3	42.86%	4	66.67%	9	60.00%	2	33.33%
None of the above	2	11.76%	1	14.29%	0	0.00%	2	13.33%	1	16.67%
Results from crisis hotline help (check all that apply)	**17**		**7**		**6**		**15**		**6**	
Forced medication	2	11.76%	2	28.57%	2	33.33%	2	13.33%	2	33.33%
Involuntary hospitalization, including psychiatric hospitalization or 72 hour psychiatric hold	3	17.65%	2	28.57%	2	33.33%	2	13.33%	2	33.33%
Voluntary hospitalization, including psychiatric hospitalization	7	41.18%	4	57.14%	3	50.00%	7	46.67%	3	50.00%
None of the above	7	41.18%	1	14.29%	1	16.67%	6	40.00%	1	16.67%
Results from crisis hotline help (check all that apply)	**17**		**7**		**6**		**15**		**6**	

VARIABLE	FULL SAMPLE (N=210)		TRANS (N=106)		POC (N=117)		NONPHYS DISABILITY (N=152)		PHYS DISABILITY (N=59)	
Identity-based discrimination in a hospital, clinic, or treatment center	3	17.65%	3	42.86%	2	33.33%	3	20.00%	3	50.00%
Emotional or verbal abuse from hospital, clinic, or treatment center staff	2	11.76%	2	28.57%	1	16.67%	2	13.33%	2	33.33%
Physical or sexual violence from hospital, clinic, or treatment center staff	2	11.76%	2	28.57%	2	33.33%	2	13.33%	2	33.33%
Threats of violence from hospital, clinic, or treatment center staff	2	11.76%	1	14.29%	1	16.67%	1	6.67%	1	16.67%
None of the above	12	70.59%	3	42.86%	3	50.00%	11	73.33%	2	33.33%
Results from crisis hotline help (check all that apply)	**16**		**7**		**6**		**14**		**6**	
Identity-based discrimination from police or other emergency responder	4	25.00%	4	57.14%	2	33.33%	4	28.57%	4	66.67%
Emotional or verbal abuse from police or other emergency responder	3	18.75%	3	42.86%	1	16.67%	3	21.43%	3	50.00%
Physical or sexual violence from police or other emergency responder	1	6.25%	1	14.29%	1	16.67%	1	7.14%	1	16.67%
Threats of violence from police or other emergency responder	4	25.00%	4	57.14%	3	50.00%	4	28.57%	4	66.67%
Arrest	1	6.25%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
None of the above	10	62.50%	2	28.57%	3	50.00%	9	64.29%	1	16.67%
Results from crisis hotline help (check all that apply)	**17**		**7**		**6**		**15**		**6**	

VARIABLE	FULL SAMPLE (N=210)		TRANS (N=106)		POC (N=117)		NONPHYS DISABILITY (N=152)		PHYS DISABILITY (N=59)	
Trauma reaction due to seeking this help (such as becoming more fearful of others, disruption in sleep, feeling hypervigilant, flashbacks or memories to the event)	5	29.41%	4	57.14%	2	33.33%	5	33.33%	4	66.67%
Temporary or permanent loss of guardianship of children	1	5.88%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Threats to have children removed from care	1	5.88%	1	14.29%	1	16.67%	1	6.67%	1	16.67%
Immigration detention and/or deportation	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
None of the above	10	58.82%	2	28.57%	3	50.00%	9	60.00%	1	16.67%
Results from crisis hotline help (check all that apply)	**15**		**6**		**6**		**13**		**5**	
School interruption due to seeking this help	2	13.33%	2	33.33%	2	33.33%	2	15.38%	2	40.00%
Loss of employment due to seeking this help	3	20.00%	2	33.33%	3	50.00%	3	23.08%	2	40.00%
Financial stress due to seeking this help	4	26.67%	2	33.33%	2	33.33%	3	23.08%	2	40.00%
None of the above	9	60.00%	3	50.00%	2	33.33%	8	61.54%	2	40.00%
Other	1	6.67%	1	16.67%	1	16.67%	1	7.69%	1	20.00%
Times contacted hotline last 5 years (since 2017)	86		54		51		73		31	
5 or more times	18	20.93%	12	22.22%	10	19.61%	16	21.92%	10	32.26%
2-4 times	45	52.33%	31	57.41%	32	62.75%	40	54.79%	16	51.61%
1 time	22	25.58%	11	20.37%	9	17.65%	16	21.92%	5	16.13%
Have not contacted a hotline in the past five years	1	1.16%	0	0.00%	0	0.00%	1	1.37%	0	0.00%
Participant received non-judgmental help during hotline support	**86**		**54**		**51**		**73**		**31**	

VARIABLE	FULL SAMPLE (N=210)		TRANS (N=106)		POC (N=117)		NONPHYS DISABILITY (N=152)		PHYS DISABILITY (N=59)	
Always	18	20.93%	9	16.67%	13	25.49%	13	17.81%	5	16.13%
Usually	38	44.19%	29	53.70%	24	47.06%	35	47.95%	14	45.16%
About half the time	20	23.26%	10	18.52%	9	17.65%	17	23.29%	9	29.03%
Seldom	7	8.14%	5	9.26%	4	7.84%	6	8.22%	3	9.68%
Never	3	3.49%	1	1.85%	1	1.96%	2	2.74%	0	0.00%
Participant received supportive help during hotline support	**86**		**54**		**51**		**73**		**31**	
Always	17	19.77%	9	16.67%	12	23.53%	14	19.18%	5	16.13%
Usually	36	41.86%	22	40.74%	19	37.25%	31	42.47%	12	38.71%
About half the time	15	17.44%	10	18.52%	9	17.65%	14	19.18%	8	25.81%
Seldom	15	17.44%	11	20.37%	8	15.69%	13	17.81%	6	19.35%
Never	3	3.49%	2	3.70%	3	5.88%	1	1.37%	0	0.00%
Participant received harmful help during hotline support	**86**		**54**		**51**		**73**		**31**	
Always	2	2.33%	2	3.70%	2	3.92%	1	1.37%	0	0.00%
Usually	10	11.63%	8	14.81%	6	11.76%	9	12.33%	5	16.13%
About half the time	15	17.44%	11	20.37%	9	17.65%	14	19.18%	8	25.81%
Seldom	26	30.23%	15	27.78%	11	21.57%	21	28.77%	9	29.03%
Never	33	38.37%	18	33.33%	23	45.10%	28	38.36%	9	29.03%
Participant received free of judgment help during hotline support	**86**		**54**		**51**		**73**		**31**	
Always	4	4.65%	1	1.85%	1	1.96%	2	2.74%	0	0.00%
Usually	6	6.98%	5	9.26%	3	5.88%	5	6.85%	4	12.90%
About half the time	13	15.12%	6	11.11%	6	11.76%	12	16.44%	5	16.13%
Seldom	29	33.72%	22	40.74%	15	29.41%	26	35.62%	13	41.94%
Never	34	39.53%	20	37.04%	26	50.98%	28	38.36%	9	29.03%
Participant received non-discriminatory help during hotline support	**86**		**54**		**51**		**73**		**31**	
Always	26	30.23%	12	22.22%	15	29.41%	21	28.77%	8	25.81%
Usually	23	26.74%	18	33.33%	13	25.49%	20	27.40%	9	29.03%
About half the time	15	17.44%	13	24.07%	11	21.57%	13	17.81%	7	22.58%
Seldom	17	19.77%	6	11.11%	8	15.69%	15	20.55%	7	22.58%

VARIABLE	FULL SAMPLE (N=210)		TRANS (N=106)		POC (N=117)		NONPHYS DISABILITY (N=152)		PHYS DISABILITY (N=59)	
Never	5	5.81%	5	9.26%	4	7.84%	4	5.48%	0	0.00%
Participant received help that was helpful during hotline support	**86**		**54**		**51**		**73**		**31**	
Always	13	15.12%	7	12.96%	10	19.61%	11	15.07%	5	16.13%
Usually	25	29.07%	16	29.63%	14	27.45%	20	27.40%	7	22.58%
About half the time	19	22.09%	12	22.22%	10	19.61%	17	23.29%	7	22.58%
Seldom	23	26.74%	14	25.93%	11	21.57%	21	28.77%	10	32.26%
Never	6	6.98%	5	9.26%	6	11.76%	4	5.48%	2	6.45%
If you knew your location could be traced by 911 by calling a crisis hotline in order to send emergency responders (police, EMS, fire, mobile crisis team), would you feel comfortable sharing your degree of suicidality, distress or crisis with a crisis hotline?	**86**		**54**		**51**		**73**		**31**	
Unsure	8	9.30%	6	11.11%	6	11.76%	6	8.22%	2	6.45%
Yes	24	27.91%	7	12.96%	11	21.57%	19	26.03%	7	22.58%
No	54	62.79%	41	75.93%	34	66.67%	48	65.75%	22	70.97%
Participant could choose type of services from hotline	**86**		**54**		**51**		**73**		**31**	
Unsure	14	16.28%	11	20.37%	10	19.61%	13	17.81%	5	16.13%
Yes	39	45.35%	20	37.04%	22	43.14%	32	43.84%	9	29.03%
No	33	38.37%	23	42.59%	19	37.25%	28	38.36%	17	54.84%
Participant could refuse services offered by the hotline	**86**		**54**		**51**		**73**		**31**	
Not sure	17	19.77%	11	20.37%	11	21.57%	15	20.55%	7	22.58%
Yes	21	24.42%	10	18.52%	11	21.57%	17	23.29%	6	19.35%
No	20	23.26%	13	24.07%	10	19.61%	18	24.66%	7	22.58%
Hotline use in future	**86**		**54**		**51**		**73**		**31**	
Yes, definitely	26	30.23%	11	20.37%	15	29.41%	19	26.03%	8	25.81%

VARIABLE	FULL SAMPLE (N=210)		TRANS (N=106)		POC (N=117)		NONPHYS DISABILITY (N=152)		PHYS DISABILITY (N=59)	
Probably	21	24.42%	15	27.78%	12	23.53%	19	26.03%	9	29.03%
Maybe/I'm not sure	20	23.26%	14	25.93%	13	25.49%	17	23.29%	5	16.13%
Probably not	15	17.44%	12	22.22%	8	15.69%	15	20.55%	8	25.81%
No, definitely not	4	4.65%	2	3.70%	3	5.88%	3	4.11%	1	3.23%
Help-seeker participant belief in transparency about hotline emergency response use	**86**		**54**		**51**		**73**		**31**	
Always	69	80.23%	49	90.74%	43	84.31%	62	84.93%	28	90.32%
Most of the time	11	12.79%	2	3.70%	5	9.80%	8	10.96%	2	6.45%
Sometimes	6	6.98%	3	5.56%	3	5.88%	3	4.11%	1	3.23%
Never	0	0%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Help-seeker participant belief in transparency about geolocation	**86**		**54**		**51**		**73**		**31**	
Always	72	83.72%	45	83.33%	44	86.27%	63	86.30%	28	90.32%
Most of the time	10	11.63%	5	9.26%	5	9.80%	7	9.59%	3	9.68%
Sometimes	4	4.65%	3	5.56%	2	3.92%	3	4.11%	0	0.00%
Never	0	0%	1	1.85%	0	0.00%	0	0.00%	0	0.00%
Help-seeker participant belief in transparency about dispatch of emergency responders	**86**		**54**		**51**		**73**		**31**	
Always	70	81.40%	49	90.74%	44	86.27%	60	82.19%	27	87.10%
Most of the time	10	11.63%	4	7.41%	6	11.76%	8	10.96%	4	12.90%
Sometimes	6	6.98%	1	1.85%	1	1.96%	5	6.85%	0	0.00%
Never	0	0%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Help-seeker participant belief in ability for opt-out of geolocation	**86**		**54**		**51**		**73**		**31**	
Always	61	70.93%	45	83.33%	40	78.43%	54	73.97%	25	80.65%
Most of the time	10	11.63%	5	9.26%	5	9.80%	9	12.33%	4	12.90%
Sometimes	11	12.79%	3	5.56%	4	7.84%	6	8.22%	1	3.23%
Never	4	4.65%	1	1.85%	2	3.92%	4	5.48%	1	3.23%
Future help-seeker contact of crisis line likelihood	**86**		**54**		**51**		**73**		**31**	
Very likely	14	16.28%	7	12.96%	9	17.65%	11	15.07%	8	25.81%

VARIABLE	FULL SAMPLE (N=210)		TRANS (N=106)		POC (N=117)		NONPHYS DISABILITY (N=152)		PHYS DISABILITY (N=59)	
Likely	22	25.58%	12	22.22%	10	19.61%	18	24.66%	6	19.35%
Neutral	24	27.91%	14	25.93%	15	29.41%	21	28.77%	7	22.58%
Unlikely	16	18.60%	13	24.07%	8	15.69%	14	19.18%	7	22.58%
Very Unlikely	10	11.63%	8	14.81%	9	17.65%	9	12.33%	3	9.68%
Why help-seeking participants would not contact hotline in the future	**26**		**21**		**17**		**23**		**10**	
Do not want to be psychiatrically hospitalized	20	76.92%	18	85.71%	14	82.35%	18	78.26%	10	100.00%
Do not want to share my personal difficulties with a stranger	6	23.08%	5	23.81%	4	23.53%	6	26.09%	3	30.00%
Do not want to interact with emergency responders, including police	23	88.46%	19	90.48%	15	88.24%	21	91.30%	10	100.00%
Do not want my geographic location to be identified without my permission (e.g., being geolocated)	17	65.38%	14	66.67%	9	52.94%	16	69.57%	10	100.00%
Other	8	30.77%	5	23.81%	4	23.53%	6	26.09%	2	20.00%
Why help-seeking participants would contact hotline in the future	**35**		**19**		**19**		**28**		**14**	
Support before, during, or after harming myself	9	25.71%	4	21.05%	2	10.53%	9	32.14%	4	28.57%
Support finding resources in my area	5	14.29%	2	10.53%	1	5.26%	3	10.71%	1	7.14%
Someone anonymous to talk to without judgment	18	51.43%	11	57.89%	8	42.11%	15	53.57%	8	57.14%
Free support during a difficult mental health situation	17	48.57%	11	57.89%	8	42.11%	14	50.00%	7	50.00%
Immediate/time sensitive support during a difficult mental health situation	25	71.43%	13	68.42%	9	47.37%	19	67.86%	9	64.29%
Other	1	2.86%	0	0.00%	0	0.00%	1	3.57%	1	7.14%

VARIABLE	FULL SAMPLE (N=210)		TRANS (N=106)		POC (N=117)		NONPHYS DISABILITY (N=152)		PHYS DISABILITY (N=59)	
Non-help-seeker participant belief in transparency about hotline emergency response use	**124**		**52**		**66**		**79**		**28**	
Always	79	63.71%	44	84.62%	50	75.76%	59	74.68%	21	75.00%
Most of the time	17	13.71%	3	5.77%	7	10.61%	9	11.39%	3	10.71%
Sometimes	24	19.35%	4	7.69%	7	10.61%	8	10.13%	3	10.71%
Never	4	3.23%	1	1.92%	2	3.03%	3	3.80%	1	3.57%
Non-help-seeker participant belief in transparency about geolocation	**123**		**52**		**66**		**79**		**28**	
Always	78	63.41%	42	80.77%	46	69.70%	59	74.68%	21	75.00%
Most of the time	19	15.45%	3	5.77%	7	10.61%	7	8.86%	3	10.71%
Sometimes	23	18.70%	5	9.62%	10	15.15%	10	12.66%	4	14.29%
Never	3	2.44%	2	3.85%	2	3.03%	2	2.53%	0	0.00%
Non-help-seeker participant belief in transparency about dispatch of emergency responders	**124**		**52**		**66**		**79**		**28**	
Always	76	61.29%	39	75.00%	45	68.18%	54	68.35%	20	71.43%
Most of the time	28	22.58%	8	15.38%	12	18.18%	11	13.92%	4	14.29%
Sometimes	15	12.10%	4	7.69%	8	12.12%	10	12.66%	4	14.29%
Never	5	4.03%	1	1.92%	1	1.52%	4	5.06%	0	0.00%
Non-help-seeker participant belief in ability for opt-out of geolocation	**124**		**52**		**66**		**79**		**28**	
Always	69	55.65%	38	73.08%	40	60.61%	53	67.09%	18	64.29%
Most of the time	18	14.52%	7	13.46%	11	16.67%	9	11.39%	2	7.14%
Sometimes	28	22.58%	5	9.62%	13	19.70%	13	16.46%	6	21.43%
Never	9	7.26%	2	3.85%	2	3.03%	4	5.06%	2	7.14%
Future non-help-seeker contact of crisis line likelihood	**124**		**52**		**66**		**79**		**28**	
Very likely	11	8.87%	2	3.85%	3	4.55%	5	6.33%	3	10.71%
Likely	27	21.77%	8	15.38%	14	21.21%	12	15.19%	3	10.71%
Neutral	37	29.84%	16	30.77%	20	30.30%	24	30.38%	11	39.29%

VARIABLE	FULL SAMPLE (N=210)		TRANS (N=106)		POC (N=117)		NONPHYS DISABILITY (N=152)		PHYS DISABILITY (N=59)	
Unlikely	26	20.97%	14	26.92%	15	22.73%	16	20.25%	3	10.71%
Very Unlikely	23	18.55%	12	23.08%	14	21.21%	22	27.85%	8	28.57%
Why non-help-seeking participants would not contact hotline in the future	**49**		**26**		**29**		**38**		**11**	
Do not want to be psychiatrically hospitalized	40	81.63%	21	80.77%	24	82.76%	35	92.11%	10	90.91%
Do not want to share my personal difficulties with a stranger	20	40.82%	13	50.00%	10	34.48%	15	39.47%	5	45.45%
Do not want to interact with emergency responders, including police	43	87.76%	24	92.31%	25	86.21%	37	97.37%	10	90.91%
Do not want my geographic location to be identified without my permission (e.g., being geolocated)	29	59.18%	16	61.54%	15	51.72%	26	68.42%	6	54.55%
Other	11	22.45%	8	30.77%	8	27.59%	10	26.32%	3	27.27%
Why help-seeking participants would contact hotline in the future	**38**		**10**		**17**		**17**		**6**	
Support before, during, or after harming myself	6	15.79%	3	30.00%	4	23.53%	4	23.53%	1	16.67%
Support finding resources in my area	17	44.74%	7	70.00%	9	52.94%	6	35.29%	3	50.00%
Someone anonymous to talk to without judgment	20	52.63%	7	70.00%	8	47.06%	9	52.94%	2	33.33%
Free support during a difficult mental health situation	27	71.05%	7	70.00%	13	76.47%	11	64.71%	2	33.33%
Immediate/time sensitive support during a difficult mental health situation	23	60.53%	6	60.00%	11	64.71%	11	64.71%	2	33.33%
Other	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%

VARIABLE	FULL SAMPLE (N=210)		TRANS (N=106)		POC (N=117)		NONPHYS DISABILITY (N=152)		PHYS DISABILITY (N=59)	
All participant belief in transparency about hotline emergency response use	**210**		**106**		**117**		**152**		**59**	
Always	148	70.48%	93	87.74%	93	79.49%	121	79.61%	49	83.05%
Most of the time	28	13.33%	5	4.72%	12	10.26%	17	11.18%	5	8.47%
Sometimes	30	14.29%	7	6.60%	10	8.55%	11	7.24%	4	6.78%
Never	4	1.90%	1	0.94%	2	1.71%	3	1.97%	1	1.69%
All participant belief in transparency about geolocation	**209**		**106**		**117**		**152**		**59**	
Always	150	71.77%	87	82.08%	90	76.92%	122	80.26%	49	83.05%
Most of the time	29	13.88%	8	7.55%	12	10.26%	14	9.21%	6	10.17%
Sometimes	27	12.92%	8	7.55%	12	10.26%	13	8.55%	4	6.78%
Never	3	1.44%	3	2.83%	2	1.71%	2	1.32%	0	0.00%
All participant belief in transparency about dispatch of emergency responders	**210**		**106**		**117**		**152**		**59**	
Always	146	69.52%	88	83.02%	89	76.07%	114	75.00%	47	79.66%
Most of the time	38	18.10%	12	11.32%	18	15.38%	19	12.50%	8	13.56%
Sometimes	21	10.00%	5	4.72%	9	7.69%	15	9.87%	4	6.78%
Never	5	2.38%	1	0.94%	1	0.85%	4	2.63%	0	0.00%
All participant belief in ability for opt-out of geolocation	**210**		**106**		**117**		**152**		**59**	
Always	130	61.90%	83	78.30%	80	68.38%	107	70.39%	43	72.88%
Most of the time	28	13.33%	12	11.32%	16	13.68%	18	11.84%	6	10.17%
Sometimes	39	18.57%	8	7.55%	17	14.53%	19	12.50%	7	11.86%
Never	13	6.19%	3	2.83%	4	3.42%	8	5.26%	3	5.08%
All participant future contact of crisis line likelihood	**210**		**106**		**117**		**152**		**59**	
Very likely	25	11.90%	9	8.49%	12	10.26%	16	10.53%	11	18.64%
Likely	49	23.33%	20	18.87%	24	20.51%	30	19.74%	9	15.25%
Neutral	61	29.05%	30	28.30%	35	29.91%	45	29.61%	18	30.51%
Unlikely	42	20.00%	27	25.47%	23	19.66%	30	19.74%	10	16.95%
Very Unlikely	33	15.71%	20	18.87%	23	19.66%	31	20.39%	11	18.64%

VARIABLE	FULL SAMPLE (N=210)		TRANS (N=106)		POC (N=117)		NONPHYS DISABILITY (N=152)		PHYS DISABILITY (N=59)	
Why all participants would not contact hotline in the future	**75**		**47**		**46**		**61**		**21**	
Do not want to be psychiatrically hospitalized	60	80.00%	39	82.98%	38	82.61%	53	86.89%	20	95.24%
Do not want to share my personal difficulties with a stranger	26	34.67%	18	38.30%	14	30.43%	21	34.43%	8	38.10%
Do not want to interact with emergency responders, including police	66	88.00%	43	91.49%	40	86.96%	58	95.08%	20	95.24%
Do not want my geographic location to be identified without my permission (e.g., being geolocated)	46	61.33%	30	63.83%	24	52.17%	42	68.85%	16	76.19%
Other	19	25.33%	13	27.66%	12	26.09%	16	26.23%	5	23.81%
Why all participants would contact hotline in the future	**73**		**29**		**36**		**45**		**20**	
Support before, during, or after harming myself	15	20.55%	7	24.14%	6	16.67%	13	28.89%	5	25.00%
Support finding resources in my area	22	30.14%	9	31.03%	10	27.78%	9	20.00%	4	20.00%
Someone anonymous to talk to without judgment	38	52.05%	18	62.07%	16	44.44%	24	53.33%	10	50.00%
Free support during a difficult mental health situation	44	60.27%	18	62.07%	21	58.33%	25	55.56%	9	45.00%
Immediate/time sensitive support during a difficult mental health situation	48	65.75%	19	65.52%	20	55.56%	30	66.67%	11	55.00%
Other	1	1.37%	0	0.00%	0	0.00%	1	2.22%	1	5.00%

APPENDIX C: FOIA REQUEST TO SAMHSA

The research team requested information in the public interest of understanding the aggregate data and emergency responder engagement data in suicide prevention among hotlines. This data is critical for the public to be able to make informed decisions with a full sense of agency when contacting a crisis hotline and knowing what to expect for themselves or loved ones.

We requested the following information from SAMHSA:

1. State Lifeline network centers self-reported call data submitted to Vibrant Emotional Health from forty-nine 988 State Planning Grant recipients
2. 13 California Lifeline network centers's daily, monthly, and quarterly self-reported call data to Didi Hirsh and Vibrant since July 16, 2022 to the present via 988 State Planning Grants
3. Lifeline center partner's self-reported call data from the following partners since July 16, 2022 to the present: Crisis Text Line, Veterans Crisis Line, The Trevor Project.
4. Vibrant 988 Network Agreement Contract

Additionally requested was all documentation (e.g. copies of spreadsheets, completed forms, PDFs, etc) related to 988 Lifeline Networks' data from July 16, 2022 (the day of 988's launch) to present, pertaining to:

1. Total number of incoming calls, chats, and texts
2. Total number of answered calls, chats, and texts
3. Total number of abandoned calls, chats and texts
4. Total number of calls, chats, texts that resulted in transfer to 911
5. Total number of calls, chats, texts that resulted in emergency rescue (including 911 dispatch, emergency dispatch, active rescue)

The research hotline data team also requested additional documentation or data pertaining to the number of the above calls, texts, or chats that led to emergency responder/911 interventions for a people classified as "imminent risk." The data team also requested data on involuntary "active rescue," as defined by Lifeline Network Agreement and 988 Lifeline.

APPENDIX D: DATA REQUEST QUESTIONS TO HOTLINES

Selected hotlines were sent a data survey that asked about call and text data, including the number of annual calls that engaged with 911 consensually and non-consensually. The survey also asked about each organization's technical capacity to determine callers' location; policies on disclosing 911 engagement to callers/texters; and policies, protocols, and practices on engaging 911. A sample of the survey is below:

- Organization name
- Who provides your organization with crisis hotline certification or accreditation?
- Is your organization part of the Lifeline Network
- Please describe the relationship/history between your organization and the Lifeline Network (988 or National Suicide Prevention Lifeline).
- Total answered calls during following years:
    - » 2017
    - » 2018
    - » 2019
    - » 2020
    - » 2021
    - » 2022 (through 10/31/22)
- Total answered calls that were classified as imminent risk (or highest risk category your organization used) during the following years
    - » 2017
    - » 2018
    - » 2019
    - » 2020
    - » 2021
    - » 2022 (through 10/31/22)
- Total answered calls that engaged emergency responders via 911
    - » 2017
    - » 2018
    - » 2019
    - » 2020
    - » 2021
    - » 2022 (through 10/31/22)
- Total answered calls that engaged emergency responders via 911 with caller knowledge, request, consent, or collaboration
    - » 2017
    - » 2018
    - » 2019
    - » 2020
    - » 2021
    - » 2022 (through 10/31/22)

- Total answered calls that engaged emergency responders via 911 without caller knowledge, request, consent, or collaboration (i.e. active rescue, involuntary rescue, emergency rescue)
    - » 2017
    - » 2018
    - » 2019
    - » 2020
    - » 2021
    - » 2022 (through 10/31/22)
- Would you like to offer more information for our research team to better understand and contextualize the provided numbers? Please also include any concerns or requests you have of our team.
- Total answered texts and chats during following years
    - » 2017
    - » 2018
    - » 2019
    - » 2020
    - » 2021
    - » 2022 (through 10/31/22)
- Total answered texts and chats that were classified as imminent risk (or the highest risk category your organization used) during the following years
    - » 2017
    - » 2018
    - » 2019
    - » 2020
    - » 2021
    - » 2022 (through 10/31/22)
- Total answered texts and chats that engaged emergency responders via 911
    - » 2017
    - » 2018
    - » 2019
    - » 2020
    - » 2021
    - » 2022 (through 10/31/22)
- Total answered texts and chats that engaged emergency responders via 911 with caller knowledge, request, consent, or collaboration
    - » 2017
    - » 2018
    - » 2019
    - » 2020
    - » 2021
    - » 2022 (through 10/31/22)

- Total answered texts and chats that engaged emergency responders via 911 without caller knowledge, request, consent, or collaboration (i.e., active rescue, involuntary rescue, emergency rescue)
  - » 2017
  - » 2018
  - » 2019
  - » 2020
  - » 2021
  - » 2022 (through 10/31/22)
- Would you like to offer more information for our research team to better understand and contextualize the provided numbers? Please also include any concerns or requests you have for our team.
- Please summarize your organization's guidelines, policies, and/or training, for 911 engagement (You will also have the opportunity to upload copies of these materials at the end of the survey).
- Please share or summarize your organization's guidelines, policies, and/or training for disclosing 911 engagement. (You will also have the opportunity to upload copies of these materials at the end of the survey)

APPENDIX E: THE TREVOR PROJECT'S VOLUNTARY DATA

The Trevor Project was the only 988-affiliated hotline that completed the Safe Hotlines' data request form around call data. The Trevor Project provided a breakdown of the number of calls received in 2020, 2021, and part of 2022, as well as a breakdown of number of calls that were classified as imminent risk, led to emergency responders, and of emergency response calls, how many were conducted consensually vs non-consensually. Below is a table with a breakdown of provided information:

	Total answered calls	Total calls classified as imminent risk	Total calls that engaged emergency responders	% of calls engaging emergency responders	Total calls engaging emergency responders without consent or knowledge	% of calls engaging emergency responders without consent or knowledge
2020	53,292	548	65	0.12%	35	53.85%
2021	84,257	1219	143	0.16%	83	58.04%
2022 (through 10/31/22)	127,599	1427	316	0.24%	152	48.10%

APPENDIX F: REGULATORY CONCERNS AND LEGAL FRAMEWORKS

In 2021, the Wireline Competition Bureau (WCB) of the Federal Communications Commission (FCC) issued its 988 geolocation report to Congress, which recognized concerns over technical challenges, caller privacy, and regulatory uncertainties.[1] One of the biggest outstanding regulatory questions surrounding 988 and geolocation is whether or not the FCC can also require mobile and internet service providers to transmit precise location data to 988 call centers under the existing legal framework or if new legislation would have to be passed in order to do so.

Location information constitutes a form of Customer Network Proprietary Information (CNPI), whose confidentiality is protected by the Telecommunications Act of 1996, which states that telecommunication carriers "shall only use, disclose, or permit access to CNPI as required by law or with the approval of the customer."[2] There are statutory exceptions for CNPI confidentiality, which allow the provisions of call location information to the following entities: "a public safety answering point, emergency medical service provider or emergency dispatch provider, public safety, fire service, or law enforcement official, or hospital emergency or trauma care facility, in order to respond to the user's call for emergency services."[3] 911-related legislation and FCC and National Emergency Number Association (NENA) regulations authorize 911 PSAPs to obtain automatic dispatchable location of a caller and dispatch 911 emergency services.[4] Once a crisis hotline has engaged 911, the call is considered an emergency, and therefore falls under the jurisdiction of NENA regulations, which allows for geolocation of the caller. Telecommunication carriers have questioned the FCC about the applicability of CNPI regulations and the Telecommunications Act to 988 precise geolocation, as crisis hotlines do not currently seem to qualify among the eligible providers and entities of emergency services.

The Wireless Communications and Public Safety Act defines emergency services as "9-1-1 emergency services and emergency notification services."[3] Currently, this definition excludes the non-police and non-EMS responses such as mobile crisis teams sometimes dispatched by 988. The question of consent is also unaddressed because the exception rule only applies in the situation of "a user's call for emergency services," which presumes active caller request (and thus consent) and disqualifies 988 calls for the exception rule. For one, in calls leading to non-consensual intervention, emergency services are called for not by the user, but by the 988 call-taker either unbeknownst to the help-seeker or against their wishes. In addition, calls where crises are de-escalated and resolved are not deemed as an emergency. The automatic transmission of location data from carriers to hotlines in a non-emergency situation is thus unwarranted without "the approval of the customer."[2] As these regulations are written in the context of public safety, the larger question remains whether individual mental health crisis, even when the risk of suicide is present, should be considered as an instance of public safety necessitating police response at all.

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