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Why might the 988 Suicide & Crisis Lifeline utilize any sort of intervention that may involve police?

The 988 Lifeline seeks to instill hope, sustain living, and promote the health, safety, and well-being of the people who use the service and the communities we serve. Since it is the primary mission of the 988 Lifeline to prevent the suicide of those who use our services, we must collaborate with people seeking help and the continuum of crisis and emergency services available in individual communities to take actions to secure the safety of those determined to have already acted on their thoughts of suicide or to be at imminent risk of suicide.

The 988 Lifeline expects that crisis counselors contact emergency services (911, police, sheriff) for assistance **only** in cases where the risk of harm to self or others is imminent or in progress and when a less invasive plan for the caller/texter's safety cannot be collaborated on with the individual.

We know that, for some individuals, having contact with emergency services can be traumatic and dangerous and that the impacts on historically harmed communities and individuals have and continue to be disproportionate and recommend whenever possible alternate options such as collaborating on a safety plan, utilizing mobile crisis teams, collaborating with the individual's loved ones or professionals, or supporting the individual to get to a crisis stabilization unit, emergency department, or urgent care.

While the impact of involuntary hospitalization and the questionable efficacy of a law enforcement response for suicide prevention is well-acknowledged, the reasons for taking actions to prevent a person's suicide, particularly when unable/unwilling to give consent, are still present. The 988 Lifeline maintains a commitment to life-saving services, outlined in the 988 Suicide & Crisis Lifeline Safety Policy (published in 2022 and updated in 2024; hereon referenced as Suicide Safety Policy), which stems from the following factors:

- Research has indicated that ambivalence about dying by suicide is typically present until a suicide is either avoided or a death occurs, and that ambivalence appears present when a person at risk chooses to call a service whose stated mission is suicide prevention;
- Research has shown that the distress associated with thoughts of suicide can impact an individual's cognitive functioning and prevent them from considering alternative actions that could reduce their psychological pain ("cognitive constriction");
- In addition to the impact of suicidal distress on cognitive functioning, a person's decision-making capability may be further impaired by psychosis or substance use.

Our policies addressing the use of emergency service intervention are supported by literature review and subject-matter expert clinical consensus from our Standards, Training, and Practices Committee. The policies are also in alignment with the practices of other suicide prevention organizations, such as the American Association of Suicidology (see AAS Crisis Center Accreditation Standards) and Lifeline Australia. To further demonstrate commitment to the use

of involuntary emergency interventions as a last resort, policy updates to the Suicide Safety Policy (2024) include:

- Requiring crisis centers to **investigate and prioritize alternative interventions to a 911 call.** To that end, crisis contact centers must collect information on all available local resources that could be used as alternate interventions to 911, and ensure that staff are guided on how to access such services. To the extent that no such alternatives exist in their coverage area, centers share with the 988 Lifeline their strategies for outreach/education efforts to public/private entities to address this need.
- **Engagement of local crisis and emergency services.** To the degree that there are no such alternatives to 911 in the community, crisis centers must make reasonable efforts to collaborate with community stakeholders (such as social justice, behavioral health advocacy, and provider organizations), public safety (911 and law enforcement entities), and public health authorities to promote the development of such services.
- Crisis counselor training will be required to include:
    - **The physical dangers associated with law enforcement responding to those experiencing mental health emergencies.** Crisis counselors must be educated on local protocols for engaging and transporting those in mental health and/or suicidal crises. They must also be reminded that police are armed and that violence resulting in physical injuries—up to and including death—can occur in police encounters with those demonstrating emotional disturbances. Education must address the active discrimination, stigma, and other harmful outcomes prevalent in police encounters with Black, Indigenous, and other people of color, as well as individuals within LGBTQI+ and disability communities. Such discrimination of these historically marginalized groups extends to the medical and criminal justice fields, where they are subject to disproportionate incarcerations and civil commitments. Education must reinforce the fact that there are inherent risks associated with any police involvement and that the decision to engage in such intervention on behalf of those at imminent risk of suicide may have additional negative consequences. Members of the population negatively impacted by such encounters must be included in the development of training efforts.
    - **The emotional impact of an involuntary intervention** can lead to both trauma and shame for the individual and the family unit/household and can deter those in need from seeking future crisis/mental health support. For some individuals, the reaction of family members, neighbors, or others in their home to the presence of police can result in additional emotional and physical risks beyond their immediate need (e.g., LGBTQI+ youth not out to their parents or people experiencing Intimate Partner Violence).
    - **The financial impact** that hospitalization can have on a caller when they are charged for an ambulance, ER visit, or inpatient services. Individuals held in emergency rooms for observation can also bear the financial impact of lost work days. Given that economic hardship can be a significant factor for some who consider suicide, the added impact of an unnecessary involuntary intervention could compound what may already be a contributing factor in an individual's depressed or suicidal state.

Suicide Safety Policy (2022 & 2024 versions) were arrived at through an expansive review of the literature, surveyed field practices, and consulted with two of 988 Lifeline's advisory committees - the Standards, Training, and Practices Committee (STPC) and the Individual and Family Lived Experience Committee (LEC). STPC membership incorporates experts in the field

of suicide prevention, crisis contact center training, and research, while the LEC is comprised of a diverse group of suicide prevention leaders with personal and professional connection to suicide prevention, representing (and reaching) high-risk groups, including communities of suicide attempt and loss survivors, Native American, and LGBTQI+ populations.