Note

Answering the Call: How Reconfiguration of the Nation's Mental Health Crisis Call Line Can Facilitate Reimagination of Community Well-Being and Public Safety

Lucy Chin∗

When the 988 Suicide and Crisis Lifeline went live in Summer 2022, communities across the country began to confront the question of how this new, expanded behavioral health resource would integrate into the country's preexisting, emergency response systems. The program seemed to promise the solution to an increasingly visible problem—as communities demanded changes in how we respond to emergent situations, the national government announced a solution that promised to significantly expand our mental health emergency response system. This sort of shift presents a once-in-a-generation opportunity to implement innovative policy measures that provide meaningful mental

∗ J.D. Candidate 2024, University of Minnesota Law School. This note reflects years of learning from and collaborating with community organizers in St. Louis, Missouri and, truly, would not have been possible but for the work that I was lucky enough to do with the DRT Coalition. Community coalitions such as this one are pushing for neighborhoods that serve all of us, and I am immensely grateful for the time I was able to spend working alongside such committed and thoughtful individuals, who have informed my approach to lawyering and to life. I am also indebted to numerous individuals who supported me once the writing process began. First, thanks to my Faculty Advisor, Professor Elizabeth Bentley, who provided a listening ear and insightful encouragement throughout the entire process. Next, thanks to Volume 107 editors Calvin Lee and Jackie Cuellar for informing and improving the first drafts of this piece. Next, to the entire *Minnesota Law Review* Volume 108 staff and editing team—and, in particular, to Ryan Liston, Pat Ebeling, Evan Dale, Nick Grossardt, Mary Fleming, Toph Beach, Benjamin Albert Halevy, Nolan Meghrouni-Brown, Tiger Rost, Chloe Chambers, and Layla Mahmood—for the care and attention that you put into this piece, and for the patience you had with my writing process. Finally, to my dear friends; to my mom, Robin, and my sister, Jessie; and to my partner, Erik—you all keep me grounded and make me feel like I can take on any challenge. Thank you endlessly. Copyright © 2024 by Lucy Chin.

health resources to a wide array of people across the country, while at the same time actually responding to the demands of grassroots organizers that have been thinking about the same issues.

This Note, using the Lifeline as a central case study, is concerned with the question of what community response in the face of acute behavioral health challenges and severe mental illness can and should look like across the country. This Note advances the argument that, though the Lifeline may present a promising infrastructure, to achieve a person-centered, non-carceral, and high-quality system, police officers must be removed from behavioral health response calls. Beginning with a description of the nation's approach to behavioral health crisis response programs in order to illuminate how we arrived at today's status quo, and then exploring the shifting and expanding role of police officers in the context of behavioral health crises, this Note uses the Lifeline as a case study for how to implement a nationwide behavioral health response system that operates separate from police officers.

INTRODUCTION[1]

In the United States, approximately 129 people die by suicide every day,[2] making suicide one of the leading causes of death across the country.[3] One of the strongest risk factors for attempt or death by suicide is the presence of mental health issues.[4] Today, there is a high prevalence of serious mental illness[5]

1. Before diving into this urgent topic, it is important to provide a brief content warning. This Note discusses suicidal behavior, death by suicide, police misconduct, and fatal state violence. The Author recognizes that these topics, separately and/or in conjunction with one another, can be difficult to read about. The Author's goal in including descriptions of these topics is to illuminate the relationship between such experiences and the policy choices that created the systems which allow such violence to persist. The legal system has played, and will continue to play, a pivotal role in the types of behavioral healthcare that are available nationwide, and it is critically important for lawyers to engage with difficult moments that shed light on just how far the American public safety system has to go to develop a system that respects and honors the individuals reaching out for help across the country.

2. National Suicide Hotline Designation Act of 2020, Pub. L. No. 116-172, § 2(1), 134 Stat. 832, 832 ("According to the American Foundation for Suicide Prevention, on average, there are 129 suicides per day in the United States.").

3. *Suicide*, NAT'L INST. OF MENTAL HEALTH (May 2023), https://www.nimh.nih.gov/health/statistics/suicide [https://perma.cc/KYF7-HPWE] ("[I]n 2020: [s]uicide was the twelfth leading cause of death overall in the United States, claiming the lives of over 45,900 people."); *see also 988 Appropriations Report*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. 4 (Dec. 2021) [hereinafter *SAMHSA Appropriations Report*], https://www.samhsa.gov/sites/default/files/988-appropriations-report.pdf [https://perma.cc/M7VD-KJ8H] ("In 2019, there was approximately one death by suicide every 11 minutes in the United States. There were nearly two and a half times as many suicides (47,511) as there were homicides (19,141).").

4. *E.g.*, M.K. Nock et al., *Mental Disorders, Comorbidity and Suicidal Behavior: Results from the National Comorbidity Survey Replication*, 15 MOLECULAR PSYCHIATRY 868, 868 (2010) ("[P]sychological autopsy studies suggest that more than 90% of people who die by suicide have a diagnosable mental disorder, with similar figures reported among clinical samples of suicide attempters." (footnote omitted)).

5. *Road Runners: The Role and Impact of Law Enforcement in Transporting Individuals with Severe Mental Illness, A National Survey*, TREATMENT ADVOC. CTR. 1 (May 2019) [hereinafter *Road Runners*], https://www.treatmentadvocacycenter.org/wp-content/uploads/2024/01/Road-Runners.pdf [https://perma.cc/Q9MV-RED3] ("Approximately 8.3 million Americans have a severe mental illness such as schizophrenia, severe bipolar disorder or major depression with psychotic features. Almost half of these people are untreated on any given day." (footnote omitted)).

and rates of suicide continue to surge.[6] Yet, consistent and high-quality options for treatment of severe mental illness and reduction in suicidal behavior remain limited.[7] This creates a situation in which people are left without support until they find themselves in emergent and high-risk situations.[8] Many of those individuals, left without other options, avail themselves of emergency medical services and crisis lifelines.[9] Unfortunately, our society's general emergency response system remains under-resourced and ill-equipped to deal with specialized mental health issues and suicidal behavior.[10] 911 traditionally dispatches armed law enforcement officers who have a highly limited range of services that they can provide to individuals in distress,[11] and, until recently, municipalities did not train officers on how to deal with individuals who were calling because of behavioral health crises.[12] Furthermore, there is a well-documented history of police reacting with violence, inappropriate constraints, and use of force—sometimes lethal—when an individual is dealing with severe mental illness.[13] Overall, police are thought to escalate

6. S. REP. NO. 115-213, at 1–2 (2018) ("According to the National Center for Health Statistics, suicide rates in the United States have surged to their highest levels in nearly 30 years. The overall suicide rate rose by 24 percent from 1999 to 2014." (footnote omitted)).

7. *See* Maddy Reinert et al., *The State of Mental Health in America 2023*, MENTAL HEALTH AM. 8 (Oct. 2022), https://mhanational.org/sites/default/files/2023-State-of-Mental-Health-in-America-Report.pdf [https://perma.cc/T68Z-ETCN] ("28% of all adults [in America] with a mental illness reported that they were not able to receive the treatment they needed.").

8. *Road Runners*, *supra* note 5, at 1 ("Faced with limited community treatment options and a dire shortage of psychiatric inpatient beds, those in need of mental health treatment may not receive it until a crisis occurs and law enforcement intervenes.").

9. *See id.* ("Approximately one-third of individuals with severe mental illness have their first contact with mental health treatment through a law enforcement encounter.").

10. See *infra* Part I.B for a discussion of the historic disinvestment in the country's public mental healthcare system.

11. See *infra* Part I.B for a discussion of the United States' 911 emergency dispatch system.

12. See *infra* Part II.A for a discussion of recent updates to police training on behavioral health.

13. Nicholas Turner, *We Need to Think Beyond Police in Mental Health Crises*, VERA INST. OF JUST. (Apr. 6, 2022), https://www.vera.org/news/we-need-to-think-beyond-police-in-mental-health-crises [https://perma.cc/6R4V-VNQW] ("In 2021, at least 104 people were killed after police responded to someone 'behaving erratically or having a mental health crisis.'").

rather than address root issues that may prompt someone to reach out for help, signaling a fundamental mismatch.[14]

While many of these interactions take place without media attention or public scrutiny, some examples have gained a high-profile and illustrate the tragic dynamics that can be at play between the police and the mentally ill. One such example is the experience of Ms. Stacy Kenny. On March 31, 2019, Sergeant R.A. Lewis of the Springfield Police Department in Springfield, Oregon, fatally shot Ms. Kenny.[15] Ms. Kenny, who was diagnosed with schizophrenia, had voluntarily pulled over after she noticed that a police car was following her[16] and then called 911 to request clarity on why she was being followed.[17] She was on the phone with the emergency dispatcher, who also reached out to notify the responding officers of Ms. Kenny's concern.[18] Rather than heeding the warnings sent out by the dispatcher, which the officers claim not to have heard,[19] they assumed Ms. Kenny had violent and aggressive intentions, shooting her multiple times when she began to flee.[20] After the altercation, the officers were recorded saying: "We are all okay. Bad guy down."[21] Though her

14. For a discussion of general police practices and how such practices impact outcomes during behavioral health calls, including calls for suicide, serious mental illness, or substance abuse, see *infra* Parts I.B and II.

15. Michael Gennaco, *Independent Critical Incident Review and Analysis of the Officer-Involved Shooting Death of Stacy W. Kenny*, OIR GRP. 1 (2021), https://kennyfamilycomplaint.files.wordpress.com/2021/03/springfield-kenny-report-final.3.12.21.pdf [https://perma.cc/3YCS-LTQ7].

16. *Id.* at 4 ("At about 9 p.m. on March 31, 2019, Stacy W. Kenny was driving in the City of Springfield when Officer Kraig Akins started to follow her (without emergency lights), and Kenny immediately pulled over to the side of the street.").

17. Kimberly Kindy et al., *Fatal Police Shootings of Mentally Ill People Are 39 Percent More Likely to Take Place in Small and Midsized Areas*, WASH. POST (Oct. 17, 2020), https://www.washingtonpost.com/national/police-mentally-ill-deaths/2020/10/17/8dd5bcf6-0245-11eb-b7ed-141dd88560ea_story.html [https://perma.cc/LH3Y-DD8J] ("Kenny, who had been diagnosed with paranoid schizophrenia, begs an emergency operator to explain why she's been pulled over.").

18. Gennaco, *supra* note 15, at 5 ("[D]ispatch announced via radio that Kenny was on the phone with a 911 operator.").

19. *Id.* ("Sergeant Lewis observed Kenny talking on her cell phone but neither he nor any other responding officer claimed to have heard this radio transmission.").

20. *Id.* at 6 n.5 (noting that Sergeant Lewis fired six rounds at Kenny, with five of them striking Kenny—three in the torso and two in the head).

21. Kindy et al., *supra* note 17.

family did receive a settlement from the police department, the officers were not criminally charged and the police department did not find the officers in violation of any regulations.[22]

Ms. Kenny's story is not one that arose from a call to the 988 Suicide Hotline, specifically. Nonetheless, the police response and Ms. Kenny's ultimately fatal interaction with law enforcement parallel the type of experience that might be possible for someone calling a hotline service. Her experience illustrates what is at stake when we send police into these sorts of situations. And it calls to mind countless other individuals whose only "crime" was being in the wrong place at the wrong time while experiencing a behavioral health crisis.[23] Officers on the scene only saw Ms. Kenny's conduct in the moment, regarding her behavior as non-compliant and erratic rather than as a symptom of a medical episode. To the police officers, Ms. Kenny's conduct justified their decision to smash out her window, attempt to pull her from the vehicle, and punch her in the face when she failed to comply.[24]

Ms. Kenny's outreach to emergency services, which she initiated to seek an explanation for why she had been pulled over in the first place, also failed to protect her from violent reactions by the police officers on site.[25] The responding officer killed Ms. Kenny instead of de-escalating the situation or utilizing non-violent tactics to ensure compliance. The incident is even more alarming considering the fact that Ms. Kenny's mother and

22. *Id.* ("The Kenny family received a $4.55 million settlement in July from the city of Springfield — the largest lawsuit settlement involving police in Oregon's history. The officers were not criminally charged. The department cleared the officers of any wrongdoing, saying they did not violate any laws or department policies."); Gennaco, *supra* note 15, at 1 (characterizing the settlement as "believed to be the largest dollar settlement in Oregon history for a police shooting case").

23. See *infra* Part II, for examples of police/community interactions that resulted in harm to community members because of officers' conduct.

24. Gennaco, *supra* note 15, at 5 ("Officer Akins approached the driver's side window of Kenny's vehicle, directed Sergeant Lewis to 'smash out the windows' and immediately began breaking out the driver's side window. After Officer Akins smashed the driver's side window, he ordered Kenny to come out of the vehicle and show him her hands. Officer Akins said he then attempted to pull Kenny from her vehicle by her hair and, after being unable to do so, punched her 7 to 13 times in the face.").

25. Kindy et al., *supra* note 17 ("Amid screaming and rustling sounds, police officers smash the windows on her red Nissan, Taser her twice, punch her in the face more than a dozen times and try to pull her out by her hair.").

father met with the Springfield Police Department to notify police of their daughter's diagnosis,[26] attempting to avoid this exact outcome by providing situational awareness in the event police officers interacted with Ms. Kenny.[27]

Though a single example, this case is representative of a much broader pattern. Specifically, it illustrates the failure of our public safety system to effectively respond to individuals dealing with suicidal behavior, severe mental illness, and behavioral health crises.[28] Each incident of law enforcement misconduct against callers facing mental health issues represents a failure of our public safety system. And such incidents illustrate just what is at stake as the federal government considers adjustments to the national mental healthcare network.[29] In the face of any emergent mental health crisis or suicidal episode, individuals deserve to be treated with respect and compassion, rather than being criminalized and subject to use of force by the very individuals they call upon for support and protection. This is why it is critically important for behavioral health hotlines to operate

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26. Gennaco, *supra* note 15, at 4 ("Several months prior to the officer-involved shooting, Kenny's parents had met with a Springfield officer to advise that their son Patrick Kenny had a history of schizophrenia, that he had not been taking his medication for approximately six to eight weeks, that he was engaging in odd behavior, that he was not hostile, [and] that neither he nor any family member possessed firearms . . . ."). Note that Patrick Kenny transitioned to Stacy Kenny and had begun identifying as a woman after this conversation. *Id.* at 4 n.3.

27. *Id.* at 4 ("[Ms. Kenny's parents] were alerting law enforcement so that law enforcement would have situational awareness and react appropriately, were they to encounter [her].").

28. This idea—that public safety infrastructure as it currently operates is not equipped to provide the best response in the context of behavioral health calls—is a central assertion of this Note and, as such, is explored in further detail throughout. See *infra* Part II, for a specific discussion of this topic and for case law exemplifying the negative outcomes that arise.

29. Though, in this case, Ms. Kenny did not reach out to a suicide or behavioral health crisis lifeline, her call is the type that may have been routed to a mental health call lifeline. If it had been, the sort of response that she received from the call taker (e.g., de-escalation or brief assessments to identify and understand the source of Ms. Kenny's concern) and the way that the call-taker may have engaged other state services' (e.g., sending behavioral health responders to mediate between Ms. Kenny and law enforcement officers) could have been very different. This idea is explored in further detail *infra* Parts III and IV.

with at least some degree of independence from law enforcement officials.[30]

The most recent iteration of the national behavioral health care telephone hotline is the 988 Suicide and Crisis Lifeline (the Lifeline).[31] The Lifeline represents a new chapter in the nation's approach to dealing with suicidal behavior and severe mental illness by providing "24/7, free and confidential support for people in distress" as well as "prevention and crisis resources" for individuals calling for themselves or as a concerned third-party.[32] Even though calling the Lifeline will not immediately solve everything for someone who is suffering from severe mental illness, there is hope that the Lifeline will align caller outreach and service provision,[33] potentially diverting callers away from the criminal-legal system and towards long-term, holistic service interventions.[34]

Improvements of this sort within the existing national network is possible and could have a profound impact on

30. *E.g.*, Kathleen Giunta, Note, *Slaying the Serpents: Why Alternative Intervention Is Necessary to Protect Those in Mental Health Crisis from the State-Created Danger "Snake Pit,"* 30 J.L. & POL'Y 497, 523–31 (2022) (explaining how cities across the United States are thinking about and implementing community-based alternatives for when individuals seek support during a behavioral health crisis).

31. *988 Suicide & Crisis Lifeline*, 988 SUICIDE & CRISIS LIFELINE [hereinafter Lifeline Homepage], https://988lifeline.org [https://perma.cc/5ENT-X65R] ("The 988 Lifeline is a national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week in the United States.").

32. *Id.*

33. *SAMHSA Appropriations Report*, *supra* note 3, at 1 ("The creation of 988 is a once-in-a-lifetime opportunity to strengthen and expand the Lifeline and transform America's behavioral health crisis care system to one that saves lives by serving anyone, at any time, from anywhere across the nation. Preparing the Lifeline for full 988 operational readiness will require a bold vision for a system that provides direct, life-saving services to all in need *and* links them to community-based providers uniquely positioned to deliver a full range of crisis care services. SAMHSA sees 988 as the linchpin and catalyst for a transformed behavioral health crisis system in much the same way that, over time, 911 spurred the growth of emergency medical services in the United States.").

34. *See 988 and the Research Behind Suicide Hotlines,* COLUM. UNIV. IRVING MED. CTR. (July 13, 2022), https://www.cuimc.columbia.edu/news/988-and-research-behind-suicide-hotlines [https://perma.cc/ECH8-ETZQ] ("It's also hoped that 988 will reduce law enforcement involvement in mental health crises, diverting people in crisis away from jail and connecting people in crisis with folks who have experience with people in mental health crises.").

communities across the country.[35] However, the transformative outcomes promised with this Lifeline are not automatic.[36] Rather, such outcomes will depend largely on the willingness of the federal government to remove police and law enforcement from the national behavioral health care infrastructure and invest in non-carceral service providers. In fact, this Note argues that, given the current landscape of policing, success of the Lifeline depends on such a commitment. Broadly, this Note is concerned with the question of what community response can and should look like across the country in the face of acute behavioral health challenges and severe mental illness. Ultimately, this Note will advance the argument that, though the Lifeline may present a promising infrastructure, to achieve a person-centered, non-carceral, and high-quality system, police must be removed from the behavioral health responder system. And with increased attention to and investment in this system, now is an ideal time to implement such innovations. Indeed, doing so allows the United States to move closer to a system where situations like the one experienced by Ms. Kenny's family, and countless other families, become aberrations instead of a risk that we accept as standard.

This Note proceeds in four parts. Part I describes the nation's approach to behavioral health crisis response programs, first by tracing the federal government's expanding interest in supporting suicide prevention efforts that led to the creation of

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35. *See, e.g.*, Jon Gerberg & Alice Li, *When a Call to the Police for Help Turns Deadly*, WASH. POST (June 22, 2022), https://www.washingtonpost.com/investigations/interactive/2022/police-shootings-mental-health-calls [https://perma.cc/5YGE-7BBJ] (illustrating how traditional 911 calls have led to violent encounters between psychologically distressed callers and law enforcement); Drew Desilver et al., *10 Things We Know About Race and Policing in the U.S.*, PEW RSCH. CTR. (June 3, 2020), https://www.pewresearch.org/fact-tank/2020/06/03/10-things-we-know-about-race-and-policing-in-the-u-s [https://perma.cc/RPF6-9LJB] (showing a pattern of violent encounters between Black communities and law enforcement).

36. *See* Press Release, U.S. Dep't of Health & Hum. Servs., HHS Secretary: 988 Transition Moves Us Closer to Better Serving the Crisis Care Needs of People Across America (Sept. 9, 2022), https://www.hhs.gov/about/news/2022/09/09/hhs-secretary-988-transition-moves-us-closer-to-better-serving-the-crisis-care-needs-of-people-across-america.html [https://perma.cc/KU2N-9T72] ("'Our nation's transition to 988 moves us closer to better serving the crisis care needs of people across America,' said HHS Secretary [Xavier] Becerra . . . . '988 is more than a number, it's a message: we're there for you. The transition to 988 is just the beginning. We will continue working towards comprehensive, responsive crisis care services nationwide to save lives.'").

the initial suicide prevention lifeline, and second by looking at the landscape of other public services available to respond when emergent behavioral health crises occur. The goal of this Part is to understand the systemic and conceptual considerations that inform (and constrain) the national approach to providing robust mental health care services. Next, Part II explores the ways that police are often involved in responding to behavioral health crises, including both the shortcomings associated with their involvement and efforts to hold them accountable when misconduct arises. Part III then analyzes the specific elements of the Lifeline with an eye towards the gaps that exist between the stated objective of the Lifeline and current best practices. Finally, Part IV concludes by articulating recommendations that could help realize a Lifeline that actually addresses the core issues inspiring individuals to call the Lifeline in the first place. The recommendations advanced are each oriented towards community-based, individualized, and non-carceral solutions based on the core belief that it is both morally right and legally justifiable to remove police from behavioral health response and, instead, invest in alternative responders. Indeed, doing so may improve outcomes for stakeholders across the spectrum, including not just callers and their families, but law enforcement officers as well.

I. UNDERSTANDING THE NATIONAL APPROACH TO BEHAVIORAL HEALTH CRISES

Across the country, service-providers and community organizations acknowledged the groundbreaking nature of a new three-digit mental healthcare crisis number.[37] The reaction signaled recognition of the expanded objective and service landscape, which is significant in light of a system historically

37. *Compare Statement Regarding the National Suicide Hotline Designation Act Receiving Congressional Approval*, VIBRANT EMOTIONAL HEALTH (Sept. 21, 2020), https://www.vibrant.org/988-statement-congress [https://perma.cc/VL42-KVK5] ("Vibrant Emotional Health . . . knows from experience that a national three-digit phone number will expand access to needed crisis services, increase the effectiveness of suicide prevention efforts, help reduce the stigma around mental health, and, ultimately, save lives."), *with* Michelle Harven, *The Concerns Looming over the 988 Mental Health Hotline*, WAMU (Aug. 16, 2022), https://the1a.org/segments/the-concerns-looming-over-the-988-mental-health-hotline [https://perma.cc/3C9Y-L3TW] (discussing some of the shortcomings of the 988 hotline, and expressing critiques and concerns that are held by local mental health services providers).

plagued by chronic underinvestment.[38] The resource's name change alone is noteworthy. The original service, the National Suicide Prevention Lifeline, is now called the Suicide and Crisis Lifeline, a shift that purposefully seems to cast a wider net.[39] The Frequently Asked Questions page of the website, in fact, now indicates that the call line is not only for suicide-related calls but for "people experiencing suicidal, substance use, and/or mental health crisis, or any other kind of emotional distress."[40] The answer to the subsequent question goes on to explicitly clarify that the Lifeline is not only for suicide-related crises.[41]

Why has the Substance Abuse and Mental Health Services Administration (SAMHSA) expanded the Lifeline in such a way? And, why is such an expansion worthy of attention and scrutiny? The answer to both questions may, at least in part, lie in communities that helped to usher in this change. The transition was influenced by communities who relentlessly shed light on the fact that the current approaches to behavioral health calls fail to

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38. Andrew C. Hanna, Note, *Municipal Liability and Police Training for Mental Illness: Causes of Action and Feasible Solutions*, 14 IND. HEALTH L. REV. 221, 232–33 (2017) ("As a result of deinstitutionalization, from 1955 to 1980, the resident population of mental health facilities fell from 559,000 to 154,000. In 1955 there was one bed in a psychiatric ward for every 300 Americans compared to one for every 3,000 today. . . . Because community health programs meant to replace institutionalization were either inadequate or lacked sufficient funding, for many, '[t]he default hospital has become the emergency room.' Even when community health programs are available, many individuals either lack coverage within their insurance or lack coverage completely. Nearly a third of individuals with mental illness were either denied coverage by an insurance company or an insurance company deemed such care not medically necessary, and a staggering number of people have not sought care at all." (second alteration in original) (footnotes omitted)).

39. *See The Lifeline and 988*, 988 SUICIDE & CRISIS LIFELINE, https://988lifeline.org/current-events/the-lifeline-and-988 [https://perma.cc/HLV8-G7HQ] (noting the transition from the National Suicide Prevention Line).

40. *988 Frequently Asked Questions,* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (June 15, 2023) [hereinafter *988 FAQs*], https://www.samhsa.gov/find-help/988/faqs [https://perma.cc/L38D-B4ZN] (answering the question: What is 988?).

41. *Id.* ("Is 988 only for suicide-related crises? What about substance use crises? The 988 Lifeline responds 24/7 to calls, chats or texts from anyone who needs support for suicidal, mental health, and/or substance use crisis, and connects those in need with trained crisis counselors. There are many reasons that people connect with the 988 Lifeline. Some examples in addition to thoughts of suicide are feeling overwhelmed with anxiety, sexual orientation worries, drinking too much, drug use, feeling depressed, mental and physical illness, loneliness, trauma, relationships, and economic worries.").

provide equitable, high-quality services to all callers[42] and who articulated reimagined expectations of how behavioral health calls should be dealt with when emergency responders are sought out or dispatched to a scene.[43]

This Part briefly traces the history of suicide prevention and behavioral health response in our country—focusing both on legislative and community-based approaches—to contextualize the importance of the recent shift in service provision and explain the role that police officers play in default operations. By understanding how police became such an instrumental part of the behavioral health crisis network, one can more easily understand the reasoning and urgency that exists in shifting key features of the Lifeline's infrastructure as expansion continues.

A. GOVERNMENTAL EFFORTS TO ADDRESS SUICIDE PREVENTION

The first nationwide Lifeline arose after decades of organizing that endeavored to shed light on the important role that a centralized resource could play with respect to mental health crises across the country. The Note turn to this history next.

42. *E.g.*, Bryan Castro, *Can You Please Send Someone Who Can Help? How Qualified Immunity Stops the Improvement of Police Response to Domestic Violence and Mental Health Calls*, 16 HARV. L. & POL'Y REV. 581, 592 (2022) ("In the past year, 1,422 [persons with significant psychological conditions] have died via gunshot wound by the hands of the police. That number constitutes 22% of all people who have been shot and killed by the police. Similarly, an accounting of the people who were shot by the police in the state of Maine between 2000 and 2011 found that nearly half of all victims had [a serious mental illness]. A study of all people killed by police between 2005 and 2013 showed that 60% of them had a [significant psychological condition] that contributed to the incident. The risk of being killed by police during an incident is 16 times higher for [persons with significant psychological conditions] than the average member of the public." (footnotes omitted)); *see also infra* Part II (discussing the shortcoming endemic to systems that rely on law enforcement officials to intervene and solve calls where the primary issues relate to behavioral health, suicide, or substance abuse).

43. *See, e.g.*, *One Million Experiments*, INTERRUPTING CRIMINALIZATION & PROJECT NIA (2022), https://millionexperiments.com/search [https://perma.cc/58GJ-K88X] (exploring snapshots of community-based projects that expand ideas about what keeps communities safe across the country, many of which directly build upon calls to minimize police functions and reallocate public safety funding to police alternatives).

1. Bringing Federal Attention to the Importance of Suicide Prevention

It is now well understood that addressing death by suicide and severe mental health crises requires varied approaches and long-term commitment from a wide array of institutions.[44] Yet, such multifaceted efforts have not always been as ubiquitous as they seem today. In the United States, concerted efforts to raise awareness around suicide prevention coalesced in the mid-1950s.[45] By the 1990s, resulting from continued community-based advocacy, the issue gained federal attention when the Senate and House of Representatives passed resolutions publicly affirming that suicide was a national problem and should be a national priority.[46]

Catalyzed by the congressional resolutions and grassroots organizing that came before, a group of practitioners came together for a "national consensus conference on suicide prevention"—now considered "the founding event of the modern suicide prevention movement."[47] Key framing documents followed,[48] the most important of which was the National Strategy for Suicide Prevention (NSSP). The NSSP became known as the "first

44. *See generally Suicide Prevention Interventions and Treatments*, AM. FOUND. FOR SUICIDE PREVENTION, https://afsp.org/suicide-prevention-interventions-and-treatments [https://perma.cc/PF9V-V8YN] (describing the various best practices and methodologies that service providers use in suicide prevention treatment).

45. U.S. Surgeon Gen. & Nat'l Action All. for Suicide Prevention, *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*, U.S. DEP'T OF HEALTH & HUM. SERVS. 96 (2012) [hereinafter *2012 National Strategy*], https://www.ncbi.nlm.nih.gov/books/NBK109917/pdf/Bookshelf_NBK109917.pdf [https://perma.cc/6TVK-RAUC] ("In 1958, the first suicide prevention center in the United States opened in Los Angeles, California, with funding from the U.S. Public Health Service.").

46. *Id.* ("Suicide became a central issue in the United States in the mid-1990s, when survivors of suicide loss saw the need to mobilize attention and the political will to prevent suicide in the nation. . . . [Their] efforts resulted in two Congressional Resolutions—S. Res. 84 and H. Res. 212 of the 105th Congress—recognizing suicide as a national problem and suicide prevention as a national priority."); *see also* S. Res. 84, 105th Cong. (1997) (enacted) (recognizing that any interventions addressing suicide prevention must be multifaceted and that the development of accessible and affordable mental health services should be pursued, while simultaneously paying attention to public education and de-stigmatization); H.R. Res. 212, 105th Cong. (1997) (enacted) (same).

47. *2012 National Strategy*, *supra* note 45, at 96.

48. For a timeline of key programmatic development and research publications, see *id.* at 94–100.

attempt in the United States to prevent suicide through a coordinated approach by both the public and private sectors."[49] It is "designed to be a catalyst for social change with the power to transform attitudes, policies, and services" and to "lay[] out a framework for action and guide[] development of an array of services and programs yet to be set in motion."[50]

While the 2001 version of the NSSP informed several programmatic and legislative efforts to address suicide prevention, as the scale of research and resources evolved, so too did advocates' and service providers' desire to expand the suicide prevention infrastructure.[51] The new National Strategy, published more than a decade later, "reflect[ed] advances in suicide prevention knowledge, research, and practice," was intended to inform contemporary suicide prevention actions in the United States through the mid-2020s.[52] Both the original and updated NSSP reports continue to provide a reference point for organizers engaged in federal, state, and local advocacy, informing programmatic and legislative efforts across the country.

2. Early Programmatic and Legislative Efforts to Bolster Support for Suicide Prevention

While framing documents published by regulatory agencies, private non-profit organizations, and public-private coalitions continue to play a significant role in educating the public and demonstrating the need for additional research, these documents have also facilitated practical victories in the areas of legislation and federal programming. Two major legislative efforts

49. *National Strategy for Suicide Prevention: Goals and Objectives for Action,* U.S. DEP'T OF HEALTH & HUM. SERVS. 27 (2001), https://www.ncbi.nlm.nih.gov/books/NBK44281/pdf/Bookshelf_NBK44281.pdf [https://perma.cc/AT6Q-D5WX].

50. *Id.*

51. Continued engagement with this issue inspired a revised National Strategy. *See 2012 National Strategy*, *supra* note 45, at 10–11 (describing research progress and initiatives that followed the 2001 NSSP).

52. *Id.* at 11.

are grant programs that target populations disproportionately impacted by suicidal behaviors: young adults[53] and veterans.[54]

Other federal interventions inspired by the 2001 NSSP include: the establishment of the National Suicide Prevention Lifeline in 2001,[55] the creation of the Suicide Prevention Resource Center in 2002, and the creation of the National Violent Death Reporting System in 2002.[56] And, motivated by a call in the NSSP for "the development of comprehensive state suicide prevention plans," now almost every state in the country has established such a plan, which includes annual funding commitments and the development of coalitions responsible for advancing program elements.[57]

The Lifeline is of particular import because it is the primary resource providing coverage for anyone, at any time, across the entire United States, rather than targeting a certain population limited by either demographics or geography.[58] The Lifeline "serves as a central switchboard, seamlessly connecting callers to a crisis center geographically nearest" to them.[59] The resource also includes a website with resources and a chat program,[60]

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53. *See* Garrett Lee Smith Memorial Act § 520E, 42 U.S.C. § 290bb-36 (directing SAMHSA to awards grants and cooperative agreements to state, non-profit, and Tribal organizations for the purpose of developing youth suicide prevention programs); *see also 2012 National Strategy*, *supra* note 45, at 98 (characterizing the Act as "the most important legislative accomplishment in the field of youth suicide prevention," which "created the first significant federal grant program directed specifically at suicide prevention").

54. Joshua Omvig Veterans Suicide Prevention Act § 3, 38 U.S.C. § 1720F (establishing a program designed to reduce and prevent suicide among veterans); *see also 2012 National Strategy*, *supra* note 45, at 98 (explaining that the Act "supported the development of a comprehensive program to reduce the incidence of suicide among veterans" by "direct[ing] the Secretary of the U.S. Department of Veterans Affairs (VA) to implement a comprehensive suicide prevention program for veterans").

55. In July 2022, the National Suicide Prevention Lifeline was renamed the 988 Suicide and Crisis Lifeline. *See supra* note 39.

56. *2012 National Strategy*, *supra* note 45, at 99.

57. *Id.* at 99–100.

58. *About*, 988 SUICIDE & CRISIS LIFELINE, https://988lifeline.org/about [https://perma.cc/RFA7-SL4E].

59. *2012 National Strategy*, *supra* note 45, at 99.

60. The main 988 Suicide & Crisis Lifeline website promotes itself, not just as a way to connect people with the call center, but also as a space for sharing prevention and crisis resources, and best practices for professionals across the country. *Lifeline Homepage*, *supra* note 31. The Lifeline website also includes

partnerships with social networking websites,[61] and an internally-operated text service that can provide same counseling services as the phone-based service.[62] Given national and local investments in the Lifeline, the new resource has enormous potential. However, it also has certain vulnerabilities, which are of particular and renewed relevance given the Lifeline's recent transition and the expansion that policymakers expect as a result.[63]

From the wide-ranging federal efforts that have cropped up in the past several decades, to the establishment of a number of advocacy groups interested in addressing the ongoing challenge of suicidal behavior, it is clear that our nation's conception of suicide and severe mental illness has expanded over time.[64] Yet, while national commitments and heightened awareness are positive signs of equitable access for individuals across the country, these decisions do not stand alone in shaping the landscape of services available to individuals facing mental health crises. Other entities that work within the framework set by federal government decisions are law enforcement officers, who—across most of the country—have become key members of our nation's emergency response structure.

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an online chat feature that provides crisis counseling, which people may use instead of the call or text line. *See 988 Lifeline Chat and Text*, 988 SUICIDE & CRISIS LIFELINE, https://988lifeline.org/chat [https://perma.cc/6EQD-H7M2].

61. *2012 National Strategy*, *supra* note 45, at 99.

62. *See 988 Suicide and Crisis Lifeline*, FED. COMMC'NS COMM'N (Nov. 30, 2022), https://www.fcc.gov/988-suicide-and-crisis-lifeline [https://perma.cc/9YW5-D6GX] ("By calling or texting 988, you'll connect with mental health professionals with the 988 Suicide and Crisis Lifeline").

63. *See SAMHSA Appropriations Report*, *supra* note 3, at 6 ("[Between 2018 and 2020], the overall volume of Lifeline contacts – including calls, chats, and texts – has remained above 3 million each year ."); *id.* at 8 ("[T]he volume of encounters with the Lifeline . . . is expected to increase to 7.6 million by the end of the first full year of 988 implementation in July 2023, more than a two-fold increase over 2020 volume.").

64. *See, e.g.*, *Public Perception of Mental Health and Suicide Prevention Survey Results*, HARRIS INSIGHTS & ANALYTICS, LLC 6–11 (Sept. 2022), https://suicidepreventionnow.org/static/executive-summary-2022-9c5a59e0f8016f1803570b11cfd3cb29.pdf [https://perma.cc/48HD-X2SF] (detailing how Americans' knowledge, attitudes, and understanding of mental health support and suicide prevention have changed over time).

B. POLICE AND LAW ENFORCEMENT'S ROLE IN COMMUNITY-BASED CRISIS RESPONSE

One of the very first lessons generally impressed upon children by American society is that if one finds oneself in any sort of emergency, they should call 911. Individuals are taught that doing so will activate a fast, effective, and appropriate response no matter the concerns or emergency situation.[65] However, the American emergency response structure has faced technical challenges in quickly dispatching responders to callers.[66] And, specifically in the context of behavioral health crisis calls, the United States still has a system wherein individuals who call on traditional emergency services for mental health crises are more likely to be met with armed law enforcement officials than individuals trained in behavioral health, de-escalation, and social service resource provision.[67]

One reason that this is undesirable is because police officers have had limited tools at their disposal when responding to mental health crisis calls[68]: they may transport a person to the hospital voluntarily, transport a person to the hospital involuntarily

65. For historical overviews of the 911 and emergency medical service systems in the United States and critical perspectives on conventional crisis responses, see generally Eric Rafla-Yuan et al., *Decoupling Crisis Response from Policing — A Step Toward Equitable Psychiatric Emergency Services*, 384 NEW ENG. J. MED. 1769 (2021); Katrina Feldkamp & S. Rebecca Neusteter, *The Little Known, Racist History of the 911 Emergency Call System,* IN THESE TIMES (Jan. 26, 2021), https://inthesetimes.com/article/911-emergency-service-racist-history-civil-rights [https://perma.cc/SX5V-FT58]; S. Rebecca Neusteter et al., *The 911 Call Processing System: A Review of Literature as It Relates to Policing*, VERA INST. OF JUST. (July 2019), https://www.vera.org/downloads/publications/911-call-processing-system-review-of-policing-literature.pdf [https://perma.cc/Y4FV-2QDG].

66. Neusteter et al., *supra* note 65, at 5 (noting that, despite the advantages of a nationwide emergency response system, 911 "is still far from perfect" and describing various infrastructural challenges that plague the current 911 dispatch system).

67. *See Road Runners*, *supra* note 5, at 1 ("Law enforcement officers are thus often on the front lines of psychiatric care, charged with responding to, handling and even preventing mental illness crisis situations.").

68. Giunta, *supra* note 30, at 520–22 (characterizing the standard law enforcement perspective as forcing compliance and noting that such an approach is not always possible in situations where an individual is dealing with serious behavioral or mental health issues).

for a mental health evaluation,[69] or conduct a welfare check and leave the caller in the location where the check took place.[70] In some cases, these options have expanded with the implementation of police-mental health collaboration programs.[71] However, even these seemingly collaborative responses remain constrained by law enforcement operating procedures and, oftentimes, fail to get at the root cause of a caller's issue.[72]

69. Celia Goble, Note, *Social Workers to the Rescue?: An Urgent Call for Emergency Response Reform*, 48 FORDHAM URB. L.J. 1021, 1040 (2021) ("The state may use short-term, emergency involuntary mental health holds for individuals who present a danger to themselves or others, as authorized by the Supreme Court in *O'Connor v. Donaldson*. Every state permits the police to detain individuals who present a danger to themselves or others, but the laws regarding initiation of mental health holds vary from state to state. Despite their lack of in-depth mental health training, the police are authorized to initiate emergency holds in 38 states, while mental health practitioners are only authorized to do so in 31 states. . . . While the rationale behind such policy differs from state to state, the police are often the sole emergency responders to mental health crises." (footnotes omitted)); *see also, e.g.*, Hyer v. City & County of Honolulu, 654 F. Supp. 3d 1111, 1129 (D. Haw. 2023) (explaining that, according to state statute, responding police officers were required to take the individual into custody and transport him to a psychiatric facility following a police psychologist's determination that he was "imminently dangerous to self or others").

70. *Calling 911 and Talking with Police*, NAT'L ALL. ON MENTAL ILLNESS, https://www.nami.org/Your-Journey/Family-Members-and-Caregivers/Calling-911-and-Talking-with-Police [https://perma.cc/88TJ-BLVP]; *see also* Joseph McKechnie, Note, *A Community Caretaking Policy: Why Mental Health Professionals Should Respond to Welfare Checks When No Exigencies Are Present*, 55 CREIGHTON L. REV. 227, 244–45 (2022) ("Community caretaking duties [conducted by police officers] are usually civil actions, which include performing welfare checks when requested. . . . Police departments have developed policies and standards on how to best handle these types of situations." (footnote omitted)).

71. Police-Mental Health Collaborations are "law enforcement-based program[s] that enable[] officers to respond appropriately and safely to people with mental illnesses," and include, most prominently, programs like crisis intervention trainings and referral networks between local mental health service providers and law enforcement officers. *Learning: Police-Mental Health Collaboration (PMHC) Toolkit*, BUREAU OF JUST. ASSISTANCE, https://bja.ojp.gov/program/pmhc/learning [https://perma.cc/X36F-RPDH].

72. Giunta, *supra* note 30, at 520–21 ("While a [Co-Response Team] approach requires a mental health practitioner to complete this assessment, a [Crisis Intervention Team] approach—or alternative jurisdictional approach—requires an officer to perform the mental health assessment, which can lead to a mixed outcome depending on the effectiveness of [Crisis Intervention Team] training in that jurisdiction, among other factors. While some officers may benefit from and utilize these training lessons, there is not clear evidence of the training's success . . . ." (footnote omitted)); *see also Hyer*, 654 F. Supp. 3d at

Furthermore, disparate outcomes depending on the identity of the caller persist.[73] That an individual is houseless, dealing with a behavioral health crisis, Black, or a member of another marginalized community, should have absolutely no bearing on one's likelihood to survive a call for emergency services. However, it does[74]—a factor that should remain top of mind as the Lifeline expands across the country and municipalities face questions about what public entities should be responsible for expanded services.

The American conception of police officers shifted drastically throughout the 1960s as law enforcement replaced comprehensive social services providers and public welfare networks—particularly in urban, Black neighborhoods.[75] Framed as "community policing," the passive presence of officers increased in schools, on public transportation, and throughout heavily trafficked public spaces in order to preempt criminal conduct.[76] From this community policing project, police officers began to establish themselves as key players in a wide variety of social problems, no longer just focused on responding to crime, and instead

1129–37 (reviewing the facts of the case and illustrating how even officers who were a part of the React Team, a specialized training program, were constrained in the options they had when responding to an individual's behavioral health crisis).

73. *E.g.*, Taleed El-Sabawi & Jennifer J. Carroll, *A Model for Defunding: An Evidence-Based Statute for Behavioral Health Crisis Response*, 94 TEMP. L. REV. 1, 8–11 (2021) (describing the harm caused by excessive use of force by police and illustrating the disparate impact of use of force against Black persons, other persons of color, and individuals with behavioral health concerns).

74. *See id.*; *2021 Police Violence Report*, MAPPING POLICE VIOLENCE, https://policeviolencereport.org/policeviolencereport2021.pdf [https://perma.cc/E7LQ-9U6E] (illustrating disproportionate police use of force against people of color); Rafla-Yuan et al., *supra* note 65, at 1770–72 (recounting incidents involving officer use of force against individuals experiencing mental health crises). Worth noting also is that this issue is exacerbated by the lack of behavioral health resources and treatment available to individuals before moments of crisis. *See, e.g.*, *Road Runners*, *supra* note 5, at 1 (describing the reality that law enforcement is more likely to be the first intervention for people who need mental health treatment).

75. ELIZABETH HINTON, FROM THE WAR ON POVERTY TO THE WAR ON CRIME 9 (2016) ("For those neighborhoods lacking comprehensive rehabilitative or social welfare programs, when law enforcement and criminal justice institutions became the last public agencies standing, the police were the service that could be summoned when help was needed.").

76. *Id.* at 99.

existing in spaces that were previously not a part of the criminal-legal landscape.[77]

Though this change arose from the problematic notion that certain communities required police intervention to prevent crime, contemporary community policing presents a very different brand. Today, community policing is defined as "a philosophy that promotes organizational strategies that support the systematic use of partnerships and problem-solving techniques to proactively address the immediate conditions that give rise to public safety issues," emphasizing collaboration with residents to "co-produce public safety."[78] Offices across the country have community policing programs that attempt to improve relations between law enforcement and the communities they police, a project which is premised on the necessity of passive police presence that came out of efforts in the 1960s.[79]

One of the areas where community policing has taken significant hold is as a part of the emergency response system. At the same time that police were expanding their role in community service provision, investment in institutions that provided support for those facing mental health challenges were shrinking.[80] Now it is more likely that when one calls for help

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77. *See, e.g.*, HANNAH L.F. COOPER & MINDY THOMPSON FULLILOVE, FROM ENFORCERS TO GUARDIANS: A PUBLIC HEALTH PRIMER ON ENDING POLICE VIOLENCE 164–66 (2020) (identifying community policing as a "pillar of reform," but acknowledging that criticisms of the practice exist); MARIAME KABA & ANDREA J. RITCHIE, NO MORE POLICE: A CASE FOR ABOLITION 140 (2022) ("[W]hen our organizing focuses exclusively on the more visible violence of police, it can keep us from identifying and addressing the subtle ways that the logics of policing are embedded in social policy.").

78. *Practices in Modern Policing: Community Participation and Leadership*, INT'L ASSOC. OF CHIEFS OF POLICE 1 (2018), https://www.theiacp.org/sites/default/files/2018-11/IACP_PMP_Community%20Leadership.pdf [https://perma.cc/TA8S-G5ZN].

79. *Id.* at 5–17 (describing various community policing initiatives in cities across the United States).

80. HUM. RTS. WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 19–20 (2003), http://www.hrw.org/reports/2003/usa1003/usa1003.pdf [https://perma.cc/DX4J-8JMM] ("Beginning in the early 1960s, states began to downsize and close their public mental health hospitals, a process called 'deinstitutionalization.'"). And, while this downsizing arose as the result of scrutiny around poor conditions to which patients were subjected, the community-based mental health centers that were envisioned as replacement resources for the hundreds of thousands of former patients did not come to fruition, resulting in a "[c]hronically underfunded" mental health system that "does

(irrespective of the actual type of emergency one is facing), a police officer will be a part of the default response.[81] Police as first responders may not seem inherently problematic and, in some cases, may be lauded as a good use of the resource that is meant to *protect and serve* a community. However, inherent issues with the system of policing mean that even well-intentioned and specialized officers may not be equipped to respond to calls concerning severe mental health crises and suicidal behavior, and yet serve as gatekeepers to the type of care that a caller receives.[82] This relationship has been the source of some of the most high-profile examples of state-sanctioned violence enacted by police officers and presents one of the most persistent barriers to

not reach and provide mental health treatment to anywhere near the number of people who need it." *Id.* at 20.

81. Castro, *supra* note 42, at 591 ("Police receive high amounts of mental health related calls. Data from the New York City Police Department shows that their officers respond to an estimated 400 calls related to mental health per day, or 12,000 per month. These numbers increased for ten years in a row before dropping for the first time in 2019 . . . . An Arizona police department reported more calls regarding [serious mental illness] than about crimes like burglaries or auto theft." (footnotes omitted)).

82. *See* Hanna, *supra* note 38, at 236–37 ("As more individuals with mental illness come into contact with police officers and police departments struggle to acquire adequate training, results can be deadly. Recent data from the first six months of 2015 shows that of the 462 people killed by police, 124 were 'in the throes of mental or emotional crisis.' In most of these incidences, police weren't contacted in response to a crime. Rather, most calls involved family or caretakers calling the police because of an escalating situation. . . . These types of interactions are so common that police officers have been dubbed 'street corner psychiatrists.' More than half of the shootings involved departments that had not provided training for dealing with the mentally ill to their officers." (footnotes omitted) (first quoting Wesley Lowery et al., *Distraught People, Deadly Results*, WASH. POST (June 30, 2015), https://www.washingtonpost.com/sf/investigative/2015/06/30/distraught-people-deadly-results [https://perma.cc/GU75-GAWW]; and then quoting Amy C. Watson & Beth Angell, *The Role of Stigma and Uncertainty in Moderating the Effect of Procedural Justice on Cooperation and Resistance in Police Encounters with Persons with Mental Illnesses*, 19 PSYCH., PUB. POL'Y, & L. 30, 30 (2013))); *see also* McKechnie, *supra* note 70, at 246 ("Welfare checks also present police with difficult situations, which require them to make split second decisions to gain control of the situation. Police must balance officer safety and the threat an individual may pose in these instances. Far too often officers perceive a threat and respond with deadly force." (footnotes omitted)). Even if officers don't respond with deadly force, per se, they may unnecessarily detain individuals, leading to involvement with the criminal legal system. *See id.* ("[T]he National Alliance on Mental Illness has found that two million people each year with mental illness are booked into jails across America . . . .").

implementing innovative reform that reimagines public safety in the context of mental health care crises.[83]

The system that currently predominates in American society might seem reasonable given that local governments have limited resources, and that law enforcement is a well-established source that could respond to those needs. However, it only seems that way because policy choices over many years have rendered such an outcome the only viable option.[84] The next Part examines discrete examples of police/community member interactions in the context of behavioral health crises, which arose within the context of standard operating procedures. It explores families' and victims' attempts for accountability when these interactions have gone poorly. And it showcases just why the system that arose from the history described above is so deeply unsatisfying and in need of immediate transformation.

II. SHORTCOMINGS OF LAW ENFORCEMENT AS FIRST RESPONDERS

As the role of police officers in responding to behavioral health crisis calls has expanded, so too have examples illustrating issues endemic to the structure that currently exists. Police officers have never been equipped to provide robust mental health care or brief treatment services.[85] Rather, their fundamental role concerns ensuring compliance with and punishing people for violation of criminal statutes.[86] When such competing

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83. For reasons that police are ill-equipped to handle such calls, as well as some of the reasons that, nonetheless, they remain a part of crisis response systems, see *infra* Part II.

84. Hanna, *supra* note 38, at 232–33 ("The move to deinstitutionalize individuals with mental illness has contributed greatly to the number of their encounters with the police. . . . With fewer psychiatric beds available in hospitals across the country and many individuals either being denied treatment or unable to secure adequate funding for treatment, police officers are increasingly relied upon by the families of individuals with mental illness to respond to crises arising from a mental illness. . . . This inadequacy in health care has led mental health professionals to assert that persons who would previously have been treated within the mental health system are being dealt with by the criminal justice system instead." (footnotes omitted)).

85. *See supra* Part I.B (describing how law enforcement came to have a significant role in behavioral crisis first response and the shortcomings associated with this history).

86. *Cf.* El-Sabawi & Carroll, *supra* note 73, at 6 ("Law enforcement has become the proverbial 'first responder' as their responsibilities swelled to 'fill the

elements lead to harm by an officer, accountability measures are limited, leaving communities worse off than before the interaction began.[87] The following Sections explore these issues in turn, thus exemplifying reasons that regulators who are building out the Lifeline's infrastructure should significantly limit the formal role of law enforcement as first responders for Lifeline calls.

A. POLICE DEPARTMENTS ARE FUNDAMENTALLY ILL-EQUIPPED TO RESPOND EFFECTIVELY TO BEHAVIORAL HEALTH CRISIS CALLS

Municipal police departments fundamentally exist to ensure that people are complying with laws.[88] And, oftentimes, individuals that are facing mental health crises or suicidal ideation who have the police dispatched without their consent or awareness are not complying with, or perhaps are not able to comply with, laws because of cognitive overwhelm.[89] These situations create

gap' in America's disjointed and, at times, nonexistent systems for healthcare and human services. This leaves law enforcement stretched problematically thin, tasks them with rendering services that officers are not trained to provide, and often places the provision of those essential services in conflict with law enforcement's *primary mission* to ensure the public's safety." (emphasis added)).

87. *See* Castro, *supra* note 42, at 587 ("Public trust in the police can decrease after a display of police use of force. A study found that after the police beating of a man went viral, the police received about 17% fewer 911 calls the following year because people dealt with their problems themselves."); Goble, *supra* note 69, at 1049 ("Communities lose faith in the police after incidents of officer-involved fatalities. In areas where these incidents occur, fewer people make calls to 911, reducing officers' ability to perform their crime investigation and prevention roles." (footnote omitted)); *National Suicide Prevention Lifeline: Policy for Helping Callers at Imminent Risk of Suicide*, NAT'L SUICIDE PREVENTION LIFELINE 15 (Dec. 2010), https://988lifeline.org/wp-content/uploads/2016/08/Lifeline-Policy-for-Helping-Callers-at-Imminent-Risk-of-Suicide.pdf [https://perma.cc/C9DR-ZUBT] ("[F]ear of potential police intervention can prevent individuals from feeling safe in discussing their suicidal thoughts with others, including crisis line helpers. Involving the police in jurisdictions where they have not developed specialized services for persons with mental illness can have more invasive, nontherapeutic results than jurisdictions that do have such services.").

88. El-Sabawi & Carroll, *supra* note 73, at 6 (acknowledging "that the range of responsibilities assumed by law enforcement has far exceeded their central organizational purpose of ensuring public safety through the enforcement of the law").

89. The police interaction with Ms. Kenny recounted earlier is a tragic example of this. *See* Gennaco, *supra* note 15, at 4–6 (noting Ms. Kenny's unusual actions during the sequence of events); Kindy et al., *supra* note 17 ("Kenny

tremendous risk and have led to many instances of unnecessary violence and lethal use of force.[90] Despite the belief that law enforcement officers will arrive at the scene and be able to solve any range of issues that arise—their presence being better than no response at all, some might say—this assumption has proven unfounded.[91] In reality, what actually exists is a fundamental mismatch between what callers to emergency services or the Lifeline need and what police officers are able to provide.

Some municipal police departments, recognizing this gap, have begun to integrate policies and training in order to support officers that may find themselves responding to such situations.[92] While a growing number of police departments have

called the 911 operator, saying she was confused about why officers were pulling her over."). Cognitive overwhelm was one of the concerns behind establishing the shorter 988 Lifeline number. *See 988 and the Research Behind Suicide Hotlines*, *supra* note 34 (noting that 988 may reduce law enforcement involvement in mental health crises, reducing the use of jail).

90. Hanna, *supra* note 38, at 238 ("Because of the particular challenges that individuals with mental illness create and law enforcement's unfamiliarity with such symptoms, verbal abuse and belligerence are often misunderstood as disrespect and may '...provoke an officer to respond more punitively.'" (alteration in originally) (quoting Linda A. Teplin, *Keeping the Peace: Police Discretion and Mentally Ill Persons*, NAT'L INST. OF JUSTICE 12 (July 2000), https://www.ojp.gov/pdffiles1/jr000244c.pdf [https://perma.cc/B97W-44KP])); Giunta, *supra* note 30, at 522 ("Further, the presence of 'co-occurring disorders' muddles the mental health assessment phase of the [Crisis Intervention Team] or [Co-Responder Team] approach, since it may not be clear to an officer whether the behaviors are caused by mental health crisis or something else, like substance abuse. Co-occurring disorders may greatly influence the decision-making process of an officer in determining [how to engage with an individual]." (footnote omitted)). *See also infra* Part II.B (providing examples of negative outcomes that have arisen as a result of police encounters).

91. Even welfare checks may still lead to volatile outcomes. Sarah DeGue, et al., *Deaths Due to Use of Lethal Force by Law Enforcement: Findings from the National Violent Death Reporting System, 17 U.S. States, 2009–2012*, 51 AM. J. PREVENTATIVE MED. S173, S180 (2016) ("The findings indicate that one in five (21.7%) legal intervention deaths were directly related to issues with the victim's mental health or substance-induced disruptive behaviors. These include incidents in which LE contact was initiated in response to a call from someone concerned about the victim's safety or behavior due to mental illness or situations in which dangerous/erratic behavior by the victim during a police encounter was attributed to mental illness or acute substance use.").

92. Goble, *supra* note 69, at 1044 (noting that there are over 2,700 Crisis Intervention Training programs across the country currently utilized). *See also* Kindy et al., *supra* note 17 (noting that a decline in fatal shootings of the mentally ill "coincides with an expansion in new police training that teaches officers

begun to implement the Crisis Intervention Model, an oft-touted criminal justice reform that includes "forty hours of training provided by mental health clinicians, client and family advocates, and police trainers,"[93] this training is disproportionately minor compared to the complexity of such calls.[94] Furthermore, though popular, crisis intervention training is not ubiquitous, so benefits of the training are not distributed evenly across all police departments.[95] And, even officers that go through specialized training to deal with individuals in mental health crises may fail to implement lessons learned, attempting to control and restrain individuals as opposed to approaching the situation with a holistic perspective or attempting to de-escalate the situation and connect someone with specialized care.[96]

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better ways to approach people with mental illnesses," but also noting that completion of these trainings does not necessarily guarantee success). As an example, the Houston Police Department has a training program that specifically addresses the use of tasers and mental health, but that training may not be front of mind for officers when they are reacting to what they perceive as an imminent danger and are seeking control in an unfamiliar situation. *See, e.g.*, Khansari v. City of Houston, No. H-13-2722, 2015 U.S. Dist. LEXIS 145969, at *5–8 (S.D. Tex. Oct. 28, 2015).

93. Amy C. Watson & Anjali J. Fulambarker, *The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners*, 8 BEST PRACS. IN MENTAL HEALTH 71, 73 (2012).

94. *See* Castro, *supra* note 42, at 592 ("Training seems disproportionately low compared to the high amount of time the police spend responding to mental health related calls. In 2004, a survey of police departments in Pennsylvania showed that about half of the officers did not feel like they were qualified to handle [persons with significant psychological conditions]. A DOJ study of 664 state and local police departments showed that 90% of them had [severe mental illness] as a topic in their academy curriculum. The same study showed that those academies devoted 10 hours of total training involved [significant psychological conditions]. By contrast, the recruits received 71 hours total on firearm skills." (footnotes omitted)).

95. According to the National Alliance on Mental Illness, over 2,700 communities have CIT trained officers. However, with 18,000 police municipalities in the country, only a small percentage have received this training overall. *Crisis Intervention Team (CIT) Programs*, NAT'L ALL. ON MENTAL ILLNESS, https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs [https://perma.cc/G5GA-C63U].

96. *See, e.g.*, Timpa v. Dillard, 20 F.4th 1020, 1025 (5th Cir. 2021) (describing death by police after a mental health episode, despite advance notice that the call was for crisis intervention and specific restraint procedures that were not followed); Hyer v. City & County of Honolulu, 654 F. Supp. 3d 1111, 1117–18, 1131 (D. Haw. 2023) (describing the death of an individual acting erratically and the presence of a crisis negotiation team that decided the victim could not

Additionally, even in situations where police officers recognize the need for mental health treatment instead of a criminal charge or detainment, officers must physically restrain individuals in order to—oftentimes involuntarily—transport them to a hospital for the provision of services.[97] Compared to behavioral health responders that are often able to do brief mental health assessments without relocation,[98] conduct common in law enforcement encounters increase the danger for all parties and render the interaction adversarial, focused on compliance as opposed to treatment.[99] Furthermore, in cases where constraint and transport is "required," police must only have probable cause,[100] thus allowing them to easily justify physically aggressive behavior.

Such practices demonstrate one side of this issue: police officers' functions are misaligned with the usual needs of an individual calling for help in the context of behavioral health crises and legal standards create no incentive for police to prioritize treatment and care provision over compliance. However, this is not the only reason that reconsideration of officers' role is necessary. In cases where families or victims seek accountability for harm arising from these problematic policies, police are protected by legal doctrines that interpret conduct in these situations relying on the same frameworks as those used in non-

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reasonably communicate with officers); *Khansari*, 2015 U.S. Dist. LEXIS 145969, at *5–8 (describing vision loss of a victim to a taser deployed by officers who had both crisis intervention techniques training and refresher courses).

97. *See, e.g.*, *Hyer*, 654 F. Supp. 3d at 1118 ("The police consulted with a police psychologist about Hyer's bizarre and threatening behavior. The police psychologist instructed the officers to detain Hyer for a mental health evaluation. The process of attempting to implement the police psychologist's order lasted for over six hours.").

98. *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit Executive Summary*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. 4 (2020), https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf [https://perma.cc/BDK5-DZML] (recommending the "least invasive intervention," as opposed to forced institutionalization, when possible).

99. *See supra* notes 68, 85–87 and accompanying text (describing typical police involvement as primarily attempting to gain control of the situation at hand, either through compliance or use of force).

100. Putman v. Harris, 66 F.4th 181, 185 (4th Cir. 2023) ("Although Putman wasn't a criminal suspect, officers may seize a person for an 'emergency mental health evaluation,' so long as they have probable cause." (quoting Barrett v. PAE Gov't Servs., Inc., 975 F.3d 416, 429 (4th Cir. 2020))).

behavioral health crises contexts, making accountability, and subsequent policy change, near impossible to achieve.

B. WHEN POLICE CAUSE HARM, ACCOUNTABILITY THROUGH LEGAL MEANS IS NEAR IMPOSSIBLE TO ACHIEVE

Section 1983 provides the procedural device by which most plaintiffs bring forward cases that attempt to enforce substantive provisions of the Constitution.[101] Specifically, this statute protects individuals from public officials "who, under color of any statute, ordinance, regulation, custom, or usage" deprive them "of any rights, privileges, or immunities secured by the Constitution and laws."[102] In *Monell v. Department of Social Services of the City of New York*, the Supreme Court expanded their conception of viable Section 1983 claims, allowing litigants to sue police departments and municipalities for unconstitutional policies and practices, in addition to targeting the conduct of individual employees alone.[103] Usually, individuals who have suffered at the hands of police officers or family members bringing suit on a decedent's behalf allege—among other claims—excessive force in violation of the Fourth Amendment,[104] unreasonable seizure in violation of the Fourth Amendment,[105] and substantive[106] or procedural[107] due process infringements in violation of the Fourteenth Amendment.

These cases are brought infrequently and are generally considered very difficult for plaintiffs to win.[108] Nonetheless, the cases that are brought forward are worth paying attention to because they may inspire alternative policy interventions or

101. *E.g.*, Crumpton v. Gates, 947 F.2d 1418, 1420 (9th Cir. 1991).

102. 42 U.S.C. § 1983. *See also* Castro, *supra* note 42, at 593 (describing § 1983 litigation in the context of police misconduct).

103. Monell v. Dep't of Soc. Servs., 436 U.S. 658, 690–91 (1978).

104. *See, e.g.*, *Putman*, 66 F.4th at 185; Hyer v. City & County of Honolulu, 654 F. Supp. 3d 1111, 1126 (D. Haw. 2023); Carlson v. Fewins, No. 1:08-CV-991, 2010 WL 11424724, at *6 (W.D. Mich. Dec. 23, 2010); Bloom v. Palos Heights Police Dep't, 840 F. Supp. 2d 1059, 1064 (N.D. Ill. 2012); Khansari v. City of Houston, No. H-13-2722, 2015 U.S. Dist. LEXIS 145969, at *11 (S.D. Tex. Oct. 28, 2015); Timpa v. Dillard, 20 F.4th 1020, 1028 (5th Cir. 2021).

105. *See, e.g.*, *Hyer*, 654 F. Supp. 3d at 1126; *Carlson*, 2010 WL 11424724, at *6; *Khansari*, 2015 U.S. Dist. LEXIS 145969, at *11.

106. *See, e.g.*, *Bloom*, 840 F. Supp. 2d at 1064.

107. *See, e.g.*, *id.* at 1065.

108. Castro, *supra* note 42, at 583 (describing obstacles to suing the police, which results in only about one percent of victims suing).

increase the visibility of poorly conceived standard operating procedures.[109] As such, the Subsections below provide examples of how plaintiffs use Section 1983 to attempt to hold police officers accountable, how courts often avoid finding fault, and how such gaps justify regulatory changes on the part of the federal government to affirmatively interrupt this cycle.

1. Assessing Reasonability of Officer's Conduct: *Hyer v. City and County of Honolulu*

The Fourth Amendment[110] is generally regarded as protecting an individual from unreasonable conduct by police officers. Specifically, the Fourth Amendment protects from unreasonable seizures, which "occur[] when an officer uses physical force or a show of authority" to terminate one's freedom of movement.[111] An alleged violation of one's Fourth Amendment rights may occur in the context of an emergency response scenario if an individual feels that their independence was obstructed without cause. In such cases, the court considers whether the officer's conduct was reasonable[112]—a balancing test exemplified in *Hyer v. City and County of Honolulu*.

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109. *Revisiting Who Is Guarding the Guardians?: A Report on Police Practices and Civil Rights in America*, U.S. COMM'N ON C.R., at vii (1981), https://www.ojp.gov/pdffiles1/bja/249021.pdf [https://perma.cc/8BQS-GR7C] (noting that police officer failures attract headlines, with the Commission in turn examining policies).

110. U.S. CONST. amend. IV ("The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no warrants shall issue, but upon probable cause, supported by oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.").

111. Castro, *supra* note 42, at 596.

112. *Id.* at 597 ("[A]ll claims of excessive force, regardless of whether it is deadly or not, in the context of a seizure, arrest or investigative stop are analyzed under the Fourth Amendment reasonableness standard. The court balances the 'nature and quality of the intrusion' with the governmental interest at stake in order to determine if the use of force was reasonable under the circumstances. This analysis requires a careful review of the 'facts and circumstances' of each case taking into account the government's interest in applying that force. Under *Graham* the plaintiff must show that the force used was excessive while considering: (1) the severity of the relevant crime, (2) whether the alleged suspect posed a threat to officers or others, and (3) whether the suspect resists arrest or takes flight . . . ." (footnotes omitted) (quoting Graham v. Connor, 490 U.S. 386, 395–96 (1989))).

In *Hyer*, a suit was brought on behalf of Steven K. Hyer, who was killed by officers after an extended attempt to detain Mr. Hyer while he was dealing with severe behavioral health issues.[113] Plaintiffs, on behalf of Mr. Hyer, asserted that officers engaged in excessive force in violation of Hyer's "federal constitutional right to be free from unreasonable seizures."[114] However, the court—using the *Graham* factors to interpret the officers' actions[115]—ultimately determined that the officers' behavior was reasonable given the circumstances.[116] This outcome obfuscates the expansive options of which the police could have availed themselves, and instead assesses their behavior through the narrow lens of standard law enforcement operating procedures. The reasonableness analysis that the court utilized isolates Hyer's dangerous and unlawful conduct from the underlying source of the conduct—a severe mental health issue—allowing the court to determine that officers' conduct, focused on controlling Hyer at any means necessary, was justified.[117]

Plaintiffs argued that "they wished police officers had called Hyer's father or used different tactics."[118] However, this did not translate to a cognizable issue to the court, which instead noted:

> The Ninth Circuit Court of Appeals has clearly explained that even where officers have alternative means available, police officers need not avail themselves of the least intrusive means of responding but

113. Hyer v. City & County of Honolulu, 654 F. Supp. 3d 1111, 1124 (D. Haw. 2023) ("The police efforts to gain control over Hyer, in order to take him in for a mental and medical examination, included a series of steps. The efforts made to take him into custody with his cooperation failed. His bizarre behavior escalated. A Taser was unsuccessful in disabling him long enough to detain him. The deploying of tear gas into his studio by two methods did not seem to affect him. He did not vacate the barricaded residence. An attempt to capture him by use of a canine takedown resulted in Hyer stabbing the dog with an arrow. Hyer then turned the compound bow and the arrow toward the officers and was shot as he attempted to load and shoot." (citation omitted)).

114. *Id.* at 1126.

115. *Id.* ("An excessive force claim is analyzed pursuant to the Fourth Amendment objective reasonableness standard set forth in *Graham v. Connor*. *Graham* requires the court to determine whether the officers' actions are 'objectively reasonable' in light of the facts and circumstances confronting them". (quoting *Graham*, 490 U.S. at 388)).

116. *Id.* at 1140–41.

117. Some circuits explicitly take into account an individual's mental or behavioral health issues. *See* Castro, *supra* note 42, at 597 ("The Sixth and Ninth Circuits take into account a person's [significant psychological condition] when evaluating use of force.").

118. *Hyer*, 654 F. Supp. 3d at 1137.

> need only act within a range of reasonable conduct. Arguments based on what the officers could have done do not create a genuine dispute of material fact.[119]

Again, the issue with this analysis is that it separates the court's understanding of excessive force from the behavioral health circumstances and greater context that give rise to the decedent's conduct, assessing one's behavior only in the exact moment of police interaction and failing to take into account anything except for compliance. As long as courts may narrow their focus in this way, individuals who bring these cases will continue to lose, which, in turn, reinforces a system where a wide range of law enforcement conduct is found to fit within the range of reasonable.

2. Prioritizing Discretion over Personal Autonomy: *Bloom v. Palos Heights*

Cases concerning police accountability may also be brought based on alleged violations of one's Fourteenth Amendment rights, claims exemplified in *Bloom v. Palos Heights*.[120] Specifically, *Bloom* concerns a situation in which police officers detained and transported S.B., a minor, to the hospital for psychological evaluation after a call was made to 911 and the caller reported to the responding police that S.B. was engaged in self-harming behavior and attempting suicide.[121] When officers arrived, they "removed S.B. from her home against her will, strapped her to a gurney and took her to the Hospital."[122] This conduct led S.B.'s mother to bring a variety of charges, all via Section 1983, against the individual officers, the police department, the fire district, and the individual who called 911.[123]

Particular to Bloom's case are her Fourteenth Amendment claims, which allege that the officers' conduct violated her substantive due process and equal protection rights. Her substantive due process allegation relied on her fundamental right to familial relations, which the court found unpersuasive.[124] On the

119. *Id.* (citation omitted).

120. 840 F. Supp. 2d 1059 (N.D. Ill. 2012).

121. *Id.* at 1063–64.

122. *Id.* at 1064.

123. *Id.* at 1064–65.

124. *Id.* at 1065 ("Protection of familial relations is indeed a fundamental right, but a brief separation of a parent from her child does not deprive the parent of her right to raise children.").

other hand, her procedural due process argument asserted that "upon arriving at the Hospital the Officers were required to complete an application to admit S.B." according to certain state statutes.[125] The court found that she misconstrued the statutes, which would have only required the officers to complete the application if they were attempting to facilitate "treatment of a person by a mental health facility as an inpatient."[126] Whereas Bloom's equal protection claims were based on her belief that "she could allege that one individual who posed a suicide risk was not taken to the hospital,"[127] the court did not agree that this theory alone created a viable argument, explaining that certain state actions require individualized assessment and, consequently, require discretion on the part of state actors.[128]

The court's finding that police officers should be granted discretion goes hand-in-hand with the perspective that state actors should only be held responsible when the state actors create the danger at issue.[129] When establishing that an officers' conduct amounts to state-created danger, plaintiffs must show that conduct shocks the conscience of a reasonable observer, which requires consideration of various factors.[130] With this high standard in mind, it is no surprise that plaintiffs like Bloom fail more often than they succeed. As with the Fourth Amendment claims described above,[131] courts generally prioritize officers' discretion and their professional expertise over claims concerning an individual's personal autonomy or unique needs. Such discretion allows officers to ignore important context and patterns that exist

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125. *Id.*

126. *Id.* at 1066.

127. *Id.* at 1067.

128. *Id.* at 1067–68 (citing Engquist v. Or. Dep't of Agric., 553 U.S. 591, 603 (2008)).

129. Castro, *supra* note 42, at 602 (discussing the affirmative action requirement of state-created danger).

130. *Id.* at 602 ("There is no specific definition for shocking the conscience, so a court must look at the facts of a specific case and determine whether it shocks the conscience. The defendant must affirmatively create the danger; the defendant's acts must be more than mere negligence; and there must be a factual connection between the acts and the harm. Further, the injury to the victim must have been a foreseeable consequence of the defendant's conduct and not just result from a possibility of harm to the general public. Lastly, the court takes into consideration whether through their acts, the defendants violated a state law or deviated from proper police training." (footnotes omitted)).

131. *Supra* Part II.B.1.

among individuals with behavioral health issues. And, as long as courts are unwilling to require more expansive thinking and engagement in behavioral health crisis situations, such lethal interactions and unsatisfying legal outcomes are likely to persist.[132]

3. The Qualified Immunity Affirmative Defense

Beyond courts' narrow interpretation of Section 1983 claims, police officers and municipal departments are also able to avoid legal accountability via the affirmative defense of qualified immunity. Qualified immunity, which according to one legal scholar "serves as a barrier to incentivizing police officers to do better when dealing with the public,"[133] was created by the Supreme Court in an effort to protect government officials from liability in the face of illegitimate lawsuits.[134] Courts use a two-step inquiry to determine if a government official is entitled to qualified immunity: "First, a court must decide whether the facts that a plaintiff has demonstrated make out a violation of a constitutional right. Second, the court must decide if the right at issue was clearly established at the time of defendant's conduct."[135] In applying the qualified immunity doctrine, courts have generally been highly deferential to police officers[136] and

132. *See* El-Sabawi & Carroll, *supra* note 73, at 5–6 ("The structural critiques existing in legal scholarship have largely acknowledged that the law permits racialized police violence and that this violence contributes to societal inequities, economic inequalities, and disproportionate power dynamics. Yet, the more 'persistent' legal framework for police reform argues that the institution of policing is socially desirable and essential in ensuring public safety and public order. . . . By supporting reforms that maintain the structural status quo (including the problematically broad scope of police responsibilities today), the legal [field] relegitimizes policing as an institution and sanctions the atrocities that continue to be conducted at the hands of that institution. There is a desperate need for strategic reconsideration of the scope of duties assigned to law enforcement." (footnotes omitted)).

133. *Castro, supra* note 42, at 584.

134. *See* Harlow v. Fitzgerald, 457 U.S. 800, 814 (1982) (noting the social costs of litigation against public officials).

135. Hyer v. City & County of Honolulu, 654 F. Supp. 3d 1111, 1143 (D. Haw. 2023) (citing Pearson v. Callahan, 555 U.S. 223, 232 (2009)).

136. *See, e.g.*, Timpa v. Dillard, 20 F.4th 1020, 1032 (5th Cir. 2021) (overturning the lower court's holding that officers should succeed in their motion for summary judgment, which argued that they were protected under the doctrine of qualified immunity, but doing so without finding fault among the officers and stating that it is possible for a jury to conclude "that [the victim] was not

are, under current interpretations, likely to continue to defer to police in the context of behavioral health first response.[137] Such a system establishes yet another barrier for families attempting to hold law enforcement officers accountable, meaning that even if their claim survive the court's narrow interpretations, officers have a second chance to challenge the lawsuit with, most likely, winning outcomes.

C. IMPLICATIONS IN THE FACE OF EXPANDING MENTAL HEALTH CARE INFRASTRUCTURE

Even though the United States seems interested in making in-person responders available to those dealing with behavioral health crises such as acute distress, suicidal ideation, or substance use issues, the country has created a service landscape wherein police officers are the only government service that is readily available 24/7.[138] And, despite efforts to equip police officers with the requisite skills, inadequacies in the system

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subdued and that he continued to pose an immediate threat throughout his restraint" and that "[the police officer]'s decision to continue exercising force might be reasonable").

137. *See* Castro, *supra* note 42, at 604–05 (describing an encounter between an individual with schizophrenia and a police officer, wherein the police officer used unreasonably excessive force, but would likely still be protected by the doctrine of qualified immunity given the caselaw and precedent informing courts' approaches to these sorts of situations); WHITNEY K. NOVAK, CONG. RSCH. SERV., LSB10492, POLICING THE POLICE: QUALIFIED IMMUNITY AND CONSIDERATIONS FOR CONGRESS 3 (2023), https://crsreports.congress.gov/product/pdf/LSB/LSB10492 [https://perma.cc/GFN6-52CF] ("According to one recent study, appellate courts have shown an increasing tendency to grant qualified immunity, particularly in excessive force cases. From 2005 to 2007, for example, the study reported that 44 percent of courts favored police in excessive force cases. That number jumped to 57 percent in excessive force cases decided from 2017 to 2019.").

138. *See supra* Part I.B (explaining how police came to be the primary and most consistent public service in the face of emergency calls).

persist.[139] Furthermore, as demonstrated above,[140] when police officers cause harm to the people to whom they are responding—whether legally justified or not—accountability against individual officers is difficult to come by, and the headlines describing settlements and officer discipline represent an uncommon win in an otherwise unforgiving landscape.

Recognizing that a mismatch between community needs and available services exists is the first step in informing alternative pathways as mental health care resources expand. Various communities have begun to push for completely alternative response systems, presenting one approach to addressing the issues articulated above. However, as long as the Lifeline exists as the national resource for those in need of emergency behavioral health support, it should also be considered in any conversations about reform and reimagination of the public safety system. Specific interrogation of the Lifeline as one entity subject to intervention is the focus this Note's upcoming Part.

III. NEW ELEMENTS THAT HAVE ARISEN WITH EXPANSION OF THE SUICIDE HOTLINE

Having identified the shortcomings of police as first responders—both during the interactions themselves and in the aftermath of interactions that have caused harm—an expanded national Lifeline that specializes in behavioral health crisis response may seem like a positive reform.[141] This is especially the case because, since its establishment, the Lifeline has become a

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139. *See* Goble, *supra* note 69, at 1047–48 ("The International Association of Chiefs of Police has indicated that identifiable law enforcement presence may make a crisis worse for those with mental health disorders or illnesses."); Jackson Beck et al., *Behavioral Health Crisis Alternatives: Shifting from Police to Community Response*, VERA INST. OF JUST. (Nov. 2020), https://www.vera.org/behavioral-health-crisis-alternatives [https://perma.cc/5PCT-7AXK] ("Police themselves have been saying for years that they are asked to do too much. Why do we continue to ask them to respond to crisis calls that health professionals could address more safely and effectively?").

140. *See generally supra* Part II.B.1–2.

141. Madelyn S. Gould et al., *National Suicide Prevention Lifeline: Enhancing Mental Health Care for Suicidal Individuals and Other People in Crisis*, 42 SUICIDE & LIFE-THREATENING BEHAV. 22, 22 (2012) ("The Lifeline has . . . emerged as a key component of a range of suicide prevention programs. . . . The Lifeline is also prominently referenced in public awareness messaging campaigns and on federal-, community-, and advocacy-level information and referral documents and Web sites . . . .").

well-recognized and highly-utilized resource in the nation's effort to address suicidal behavior.[142] Moreover, early evaluations of the Lifeline have found that crisis centers achieve significant reductions in the distress of callers and their risk of suicidal behavior.[143] That said, as it currently exists, the Lifeline is not the expansive solution that it is being held up as, in part because the structure and operating procedures explicitly carve out a role for police officers and law enforcement in the behavioral health response landscape.[144]

Concerns persist, particularly among demographic groups that are historically marginalized (and, thus, may have a different baseline relationship with state-based emergency response services[145]) and individuals who are at the highest risk of

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142. *2012 National Strategy*, *supra* note 45, at 99 ("In October 2011, the Lifeline answered its 3 millionth call."); *see also 988 and the Research Behind Suicide Hotlines*, *supra* note 34 ("Suicide hotlines are now well-established in the United States . . . . But when Madelyn Gould . . . first started evaluating suicide hotlines in 2001, the services were not held in high regard by the mental health community and not even mentioned in the Surgeon General's 1999 Call to Action to Prevent Suicide.").

143. John Kalafat et al., *An Evaluation of Crisis Hotline Outcomes Part 1: Nonsuicidal Crisis Callers*, 37 SUICIDE & LIFE-THREATENING BEHAV. 322, 322 (2007) (finding "[s]ignificant decreases in callers' crisis states and hopelessness" at follow-up); Madelyn S. Gould et al., *An Evaluation of Crisis Hotline Outcomes Part 2: Suicidal Callers*, 37 SUICIDE & LIFE-THREATENING BEHAV. 338, 345 (2007) (finding that among a sample of 1,085 callers, "there was a significant reduction in suicide status" from the start to the end of the call, as well as from the start of the call to follow-up time a few weeks later, and that at both time points, generally, callers' intent to die, their hopelessness, and their psychological pain had decreased as a result of their outreach to the Lifeline).

144. On the FAQ page of the Lifeline's website, regarding a question about if first responders like police or EMS would ever be dispatched, the role of police is minimized:

> Currently, fewer than two percent of Lifeline calls require a connection to emergency services like 911. While some safety and health issues may warrant a response from law enforcement and/or Emergency Medical Services . . . the 988 Lifeline coordinated response is intended to promote stabilization and care in the least restrictive manner.

988 FAQs, *supra* note 40. *See generally National Suicide Prevention Lifeline: Policy for Helping Callers at Imminent Risk of Suicide*, *supra* note 87 (providing specifics details about the Imminent Risk Policy, which currently governs when a call-taker can engage law enforcement officers).

145. *See generally 2021 Police Violence Report*, *supra* note 74, at 10 (displaying the high rate of violence and force used by police when dealing with individuals who are suffering from serious mental illness or behavioral health crises); Rafla-Yuan et al., *supra* note 65, at 1772 ("[R]acist systems of social control

imminently enacting harm upon themselves or others. Some of these concerns were so front of mind for impacted individuals and service providers that in the first few weeks of 988's transition, these groups publicly condemned utilization of the Lifeline.[146] Critics warned of the risks that individuals would bear should they call the services, specifically "police involvement, involuntary treatment at emergency rooms or psychiatric hospitals, and the emotional and financial toll of those experiences."[147] Assessing the changes that were implemented with the Lifeline's recent expansion and identifying opportunities for improvement is the focus to which this Note turns next.

A. TRACING THE FEDERAL GOVERNMENT'S APPROACH TO EXPANSION

Responding to the ubiquity of behavioral health issues across the country and the contemporary increase in mental health challenges, lawmakers passed the National Suicide Hotline Improvement Act of 2018.[148] This Act required the Federal

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rooted in White supremacy continue to result in poor health outcomes for Black and other marginalized groups. Broad discrimination against patients with mental health conditions leads to a constant struggle for equality with other areas of medicine. These two inequities coalesce to chronically imperil Black patients with mental illness, whose intersection of identities and conditions places them at great risk from police and other structural violence.").

146. Aneri Pattani, *Social Media Posts Warn People Not to Call 988. Here's What You Need to Know*, NPR (Aug. 25, 2022), https://www.npr.org/sections/health-shots/2022/08/11/1116769071/social-media-posts-warn-people-not-to-call-988-heres-what-you-need-to-know [https://perma.cc/3L49-ZJZB].

147. *Id.*

148. National Suicide Hotline Improvement Act of 2018, Pub. L. No. 115-223, 132 Stat. 2424; *see also* Wireline Competition Bureau Off. Of Econ. & Analytics, *Report on the National Suicide Hotline Improvement Act of 2018*, FED. COMMC'NS COMM'N 1–2 (Aug. 14, 2019) [hereinafter *FCC Report*], https://docs.fcc.gov/public/attachments/DOC-359095A1.pdf [https://perma.cc/Q6S5-6B9J] ("Congress passed the Act 'at a time when the importance of rapid access to crisis intervention and suicide prevention services has never been more critical.' As SAMHSA explains, in 2017, 'more than 47,000 Americans died by suicide and more than 1.4 million adults attempted suicide.' According to the [CDC], from 1999 to 2016, suicide increased in 49 of the 50 states, and in more than half of those states, the increase was greater than 20%. Moreover, the largest increase in deaths by suicide occurred in the past decade, and from 2016 to 2017, an increase of 3.7% (more than 2,000 additional suicide deaths) was recorded." (quoting FED. COMMC'NS COMM'N, WC DOCKET NO. 18-336, CC DOCKET NO. 92-105, NATIONAL SUICIDE HOTLINE IMPROVEMENT ACT: THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION REPORT TO THE FEDERAL

Communications Commission (FCC), in coordination with SAMHSA and the VA, to examine the feasibility of a three-digit code "to be used for a national suicide prevention and mental health crisis hotline system" in lieu of the ten-digit number which was assigned at the inception of the program.[149] In addition to a feasibility study, the Act also required that the FCC, SAMHSA, and the VA to conduct a joint study to "analyze[] the effectiveness of the National Suicide Prevention Lifeline."[150]

After this legislation was signed, a number of federal agencies engaged in comprehensive research regarding the Lifeline.[151] They ultimately recommended that the Lifeline switch from a ten-digit number to a three-digit number,[152] which was then codified in the National Suicide Hotline Designation Act of 2020.[153] The legislation explicitly stated that suicide continues to be a significant cause of death throughout the United States[154] and that certain communities suffer from suicidal behavior disproportionately.[155] Passage of the Act also inspired hope that the new number would expand accessibility of suicide prevention services,[156] which, when implemented in concert with other

COMMUNICATIONS COMMISSION 2 (Feb. 7, 2019), https://www.fcc.gov/ecfs/document/1022280990575/1 [https://perma.cc/LR8G-ALWK])).

149. National Suicide Hotline Improvement Act § 3(a)(1)(A).

150. *Id.* at § 3(a)(1)(B).

151. *See id.* at § 3(a) (requiring that SAMHSA put together a study reporting on the potential impacts of having a three-digit dialing code and possible recommendations for general improvements to the Lifeline, and that the VA put together a study reporting how well the Lifeline is working to support veterans and their specific needs).

152. *FCC Report*, *supra* note 148, at 8–15 (noting that the Lifeline could be more effective with a 3-digit code, recommending 988 as the 3-digit number, and providing justifications for the recommended change).

153. National Suicide Hotline Designation Act of 2020, Pub. L. No. 116-172, 134 Stat. 832.

154. *Id.* § 2 ("According to the American Foundation for Suicide Prevention, on average, there are 129 suicides per day in the United States.").

155. *Id.* § 6(a) (enumerating the disproportionate prevalence of suicide among certain demographic groups—e.g., LGBTQ youth, American Indian and Alaska Natives, and individuals living in rural counties).

156. Press Release, Substance Abuse & Mental Health Servs. Admin., U.S. Transition to 988 Suicide & Crisis Lifeline Begins Saturday (July 15, 2022), https://www.samhsa.gov/newsroom/press-announcements/20220715/us-transition-988-suicide-crisis-lifeline-begins-Saturday [https://perma.cc/N4XY-VW6E] ("In 2021, the Lifeline received 3.6 million calls, chats, and texts. That number is expected to at least double within the first full year after the 988 transition.").

efforts (e.g., destigmatizing mental health care, engaging in public education around suicidal behaviors and risk factors, supporting individuals in accessing protective factors, etc.), would reduce the prevalence of death by suicide and other severe behavioral health crisis issues across the country.[157]

The 988 Lifeline, just like the ten-digit Suicide Hotline number before it, serves as a national resource through which all outreaches flow.[158] Administered and overseen by Vibrant Emotional Health, all of the local service providers that comprise the national network receive assistance and are subject to "oversight[] and performance monitoring through operations meetings and data review" by Vibrant.[159] This national network model complements the long-term objective that SAMHSA aspires to achieve with 988:

> SAMHSA's longer-term vision is that the transition to 988, which began in July 2022, will spur the growth of a robust crisis care system across our country that links callers to community-based providers who can deliver a full range of crisis care services (like mobile crisis teams or stabilization centers).[160]

And it is likely that the system will achieve this goal, in terms of utilization, as SAMHSA projects a significant increase in calls once the transition to the three-digit hotline is complete.[161] However, the expansion of the Lifeline does not automatically resolve issues that exist, and certain pitfalls must be addressed if the Lifeline's expansion is to achieve the aspirational objectives set forward in the establishing legislation.

B. Limitations that the Lifeline Must Address in Order to Facilitate Actual Change in the National Behavioral Health Network

The Lifeline must address two specific vulnerabilities. First, the regulations that control when and how in-person first

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157. *Id.*

158. *SAMHSA Appropriations Report*, *supra* note 3, at 6 ("As required in the National Hotline Designation Act, all 988 calls will flow through the Lifeline system. This national structure contrasts notably with the 911 system, which is managed at the state and local levels.").

159. *Id.* at 2.

160. *988 FAQs*, *supra* note 40 (answering the question: Does everyone have the same access to services provided by 988?).

161. The 988 Appropriation Reports forecasts that contact volume will increase to 7.6 million in FY2023. *SAMHSA Appropriations Report*, *supra* note 3, at 10.

responder services are deployed. And, second, infrastructural decisions that allow for police and law enforcement officials to fill gaps in services when and if they arise. It is essential that the Lifeline works to limit the involvement of law enforcement officials, as opposed to expanding involvement while failing to explicitly consider their role. Ignoring these areas in exchange for quick expansion will further entrench the status quo, thus making reform down the line even more difficult to achieve.

1. Involuntary Engagement of Other Services

"In previous years, before the 988 number launched, emergency services were dispatched in 2% of the hotline's interactions, the service reported. With about 2.4 million calls a year, that means emergency services were initiated for roughly 48,000 calls."[162] This subset of calls is uniquely vulnerable to issues with service provision because a different service is engaged—one which may not prioritize the best practices for mental health care and de-escalation, instead prioritizing compliance and restoration of "order."[163] In the case of significant risk or impending/active harm, the new Lifeline is still guided by the *Policy for Helping Callers at Imminent Risk of Suicide* adopted in 2012 (hereinafter referred to just as the *Imminent Risk Policy*).[164] This policy encourages staff to use the "least invasive intervention and consider involuntary emergency interventions as a last resort," but also allows for call-takers to use their discretion.[165] Furthermore, the policy does not require that individuals provide consent in order for the staff to initiate the engagement or dispatch of rescue services.[166]

While the lack of consent required is alone alarming, this policy is made even more dangerous because, in many areas, the only services that are universally available to be sent out are law enforcement officers. Police officers have demonstrated their fundamental inability to handle such calls when they arise

162. Pattani, *supra* note 146.

163. *See supra* Part II (discussing issues that commonly arise when police are dispatched for behavioral health care crisis situations).

164. See *infra* Part IV.A.1 for further discussion on this topic. *See also National Suicide Prevention Lifeline: Policy for Helping Callers at Imminent Risk of Suicide*, *supra* note 87.

165. *National Suicide Prevention Lifeline: Policy for Helping Callers at Imminent Risk of Suicide*, *supra* note 87, at vi.

166. *Id.*

separate from a Lifeline outreach.[167] Furthermore, studies focused on behavioral health calls have also found worse outcomes. For example, in the statewide crisis line that serves Georgia:

> [W]hen [call-takers] did send rescue, a caller at imminent risk was five times more likely to have law enforcement dispatched to them in areas of the state that do not possess home-based mobile crisis outreach services. Further, . . . individuals in crisis [were] four times more likely to be referred to an emergency room [when mobile-crisis units were] unavailable.[168]

The *Imminent Risk Policy* itself acknowledges that engaging law enforcement may increase the risk of inappropriate force, arrest, or other undesirable outcomes, yet argues that that should not, alone, change the policy[169]—a position that advocates should remain very wary of.

Beyond a caller's direct interaction with police, another weakness of the current system concerns the limited treatment options that are available as secondary follow-up.[170] Failure to address this topic creates a gap in the emergency response protocol that states can fill with a variety of different approaches and programs. Based on what sort of system each state has set up, a responding law enforcement officer may only have the choice of placing a caller under civil confinement or taking them to the emergency room.[171] Even for someone with a serious mental illness, neither of these resources provide the caller the treatment that they need to address the core issues that caused the mental health crisis to appear in the first place. In Florida, for example, law enforcement are able to "detain and transport a person who meets criteria, based on (1) recorded observations of

167. *See supra* Part II.

168. *National Suicide Prevention Lifeline: Policy for Helping Callers at Imminent Risk of Suicide*, *supra* note 87, at 16.

169. *Id.* at 21 ("While such incidences are tragic when they do occur, and may occur more frequently in jurisdictions where specialized police services for mentally ill persons are unavailable, fears of how the police may respond should not be a determinant in decision-making related to active rescue.").

170. In the current handbook that controls the imminent risk policy, call-takers are provided with information only about collaborating with emergency service providers and only during the duration of the outreach. *Id.* at xiv–xv. The guidelines discuss developing partnerships with emergency service providers, but do not discuss follow-up or continuums of care after a caller has been connected with local services. *See id.*

171. See *supra* Parts I.B and II.A, for a discussion of the expanding purview of police officers, as well as limited tools that are available within the law enforcement operating procedures.

dangerous behavior, or (2) a court order authorizing involuntary transportation to a facility, based on the court's determination that the person meets criteria."[172] The power and discretion that this statute passes onto law enforcement is particularly troubling in the context of poor mental health training and specialized skill building of law enforcement officials.[173]

The coordinators of the Lifeline are aware of this critique. In a recent publication by the Lifeline operating group, Vibrant Emotional Health, program coordinators acknowledge that, "for some individuals, having contact with emergency services can be traumatic and dangerous, and that the impacts on historically harmed communities and individuals has and continues to be disproportionate."[174] Yet this publication, like the *Imminent Risk Policy*, concludes that the benefits of engaging emergency services, in certain circumstances, outweighs the risks of not engaging third-party service providers.[175] A key difference between this recent publication and the 2012 policy is the program's commitment to updating policies so that: (1) crisis centers are required to investigate and prioritize alternative interventions before engaging 911 or dispatching traditional first responders, and (2) that local crisis response and public health authorities are engaged before law enforcement.[176] However, this statement and promise to reconsider standard operating procedures must not be the only intervention. Coordinators of the Lifeline must proactively block law enforcement from intervening, empower behavioral crisis responders to retain control of the scene when and if police officers arrive, and create mechanisms for accountability when police involve themselves inappropriately. With the transition to a new phone number, there is an opportunity to facilitate investment in non-police resources which would influence local programs across the country because of the standard-setting role that this national program plays.

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172. Judy Ann Clausen & Joanmarie Davoli, *No-One Receives Psychiatric Treatment in a Squad Car*, 54 TEX. TECH L. REV. 645, 659 (2022).

173. *See id.*

174. *Why Might the 988 Suicide & Crisis Lifeline Utilize Any Sort of Intervention That May Involve Police?*, 988 SUICIDE & CRISIS LIFELINE & VIBRANT EMOTIONAL HEALTH 1, https://www.vibrant.org/wp-content/uploads/2022/07/988-Suicide-Crisis-Lifeline_Police-Intervention_FINAL.pdf [https://perma.cc/EBH9-3328].

175. *Id.* at 2.

176. *Id.*

2. Infrastructure

Lifeline coordinators' ability to move away from their reliance on law enforcement will require not only explicit policy changes, but also transformation of the current infrastructure. With the transition to 988, which is expected to increase outreach rates significantly,[177] plus the expansion of the Lifeline to include text in addition to phone call and chat tools,[178] the limits of the current infrastructure will be tested. In July 2022, when the Lifeline went live, SAMHSA press releases touted a "network of more than 200 state and local call centers"[179] that help thousands of people overcome crisis situations every day, which is already an increase from the size of the network at its founding.[180] That said, even before the transition to 988, the continually expanding network failed to keep pace with outreaches to the Lifeline. As of December 2020, Lifeline capacity was "only sufficient to address approximately 85 percent of calls, 56 percent of texts, and 30 percent of chats."[181] With an even higher volume of outreaches, calls will be routed from their local service provider to the national back-up or outreaches will go unanswered.[182] The core source of this issue, despite increased investment over the past year,[183] is a lack of resources being allocated to build a nimble and robust mental health and crisis response infrastructure at both a local and national level. Such a hurdle has collateral consequences in the areas of staffing and

177. *See supra* note 156.

178. *See 988 Suicide and Crisis Lifeline*, *supra* note 62.

179. Press Release, Substance Abuse & Mental Health Servs. Admin., *supra* note 156.

180. *2012 National Strategy*, *supra* note 45, at 99 (noting that the Lifeline consisted of a "national network of more than 150 crisis centers in 49 states" at the time the 2012 national strategy was published).

181. *SAMHSA Appropriations Report*, *supra* note 3, at 2.

182. *See How Our Calls Are Routed*, 988 SUICIDE & CRISIS LIFELINE, https://988lifeline.org/wp-content/uploads/2022/09/HowOurCallsAreRouted-InfographicsRefresh-2.pdf [https://perma.cc/J2EA-4FWD] (describing what happens when one reached out for support via the Lifeline and specifying that when "the local center is unable to answer, the call is routed to [the] national backup network").

183. *988 and the Research Behind Suicide Hotlines*, *supra* note 34 ("The Substance Abuse and Mental Health Services Administration gave $105 million to states to fund their call centers. And the Biden Administration's FY23 budget requested nearly $700 million to staff crisis centers and build out other parts of the system.").

technological innovations, two other factors that are critical for the Lifeline's long-term success.

Staffing concerns—which were an issue for centers before the transition—are now even more urgent for organizations that are part of the crisis center network, implicating choices that states make around funding, training, and development of crisis centers, specifically, and behavioral health resources, more broadly. In Illinois, for example, organizations based in the state "answered just 1 in 5 of all calls to the National Lifeline coming from people in [Illinois]."[184] When local organizations fail to answer, callers are routed to a national call center, so individuals are still able to connect with the service.[185] But, calls routed to national call centers—80% of calls in Illinois—may be subject to longer wait times and less individualized or geographically specific care.[186] Illinois is not the only state with this pattern: "Between 2016 and 2021, a majority of calls in 11 states were routed to backup centers from local centers that were unable to answer . . . ."[187] Staffing, training, and uncertainty about long-term funding all play a role in these gaps; thus, addressing the shortcomings in call answers will require attention to and investment in infrastructure.

Technology limitations present another structural challenge since the Lifeline does not have geolocation capacity yet. When someone calls the Lifeline, the call is routed based on a caller's area code as opposed to the location from which they are actually calling.[188] The lack of geolocation may be particularly troubling considering the heightened prevalence of suicidal behavior among young people, who also may be likely to live somewhere besides their hometown—think of college-aged students who move out of state for higher education or career opportunities for

184. Carter Barrett, *Officials Scramble to Hire for the 988 Mental Health Crisis Hotline*, NPR (July 7, 2022), https://www.npr.org/2022/07/07/1110224089/officials-scramble-to-hire-for-the-988-mental-health-crisis-hotline [https://perma.cc/9JDV-X2DW].

185. *See id.*

186. *Id.*

187. Brianna Abbott, *What Is 988? Behind the New Mental Health Crisis Lifeline Number*, WALL ST. J. (July 16, 2022), https://www.wsj.com/articles/what-is-988-suicide-lifeline-11657376158 [https://perma.cc/YJ3L-DEUT].

188. *988 Suicide and Crisis Lifeline*, *supra* note 62 ("For example, when a caller located in Virginia with a 703 area code calls 988, the Lifeline will route the call to a Virginia Lifeline call center regardless of the caller's location.").

adults who don't live in the location where they first received their number.[189] The FCC acknowledges this gap, but says that geolocation would "involve different technical, legal, privacy, and cost considerations."[190] They have recommended the convening of a "multi-stakeholder group . . . to further examine the key issues and collaborate on potential next steps."[191] In the meantime, however, this is a structural gap that may complicate service provision and, more specifically, the ability of callers to connect with follow-up and long-term care when they call the Lifeline.[192]

Unanswered calls, lack of technology, and insufficient staffing or support for call-takers can result in a subpar response that leaves the caller without support or stabilization.[193] And, in extreme cases, such gaps can mean the difference between life and death. For example, analysis of one call found that while engaging with a caller who had taken fifty-eight pills and explicitly articulated a desire to die, the call-taker's response when the caller said that they were going to "fall asleep and that will be it," was "Ok, go to sleep, call us back."[194] While on the call, the

189. *Cf.* Meredith Dost & Kyley McGeeney, *Moving Without Changing Your Cellphone Number: A Predicament for Pollsters*, PEW RSCH. CTR. (Aug. 1, 2016), https://www.pewresearch.org/methods/2016/08/01/moving-without-changing-your-cellphone-number-a-predicament-for-pollsters [https://perma.cc/9VDH-6DNF] ("10% of U.S. adults have a cellphone number that doesn't match the state where they actually live.").

190. *988 Suicide and Crisis Lifeline*, *supra* note 62.

191. *Id.*

192. It is worth noting that the lack of geolocation services means that callers have more control over when and if third-party service providers are able to find them, presenting challenges in cases of imminent risk, but also providing a protective factor against undesired engagement with law enforcement officials. Were behavioral crisis lines to transition to a default where engagement by non-police first responders is normalized, then the purpose and popularity of geolocation services may shift. See *infra* Part IV, for a discussion of recommended changes.

193. *E.g.*, *National Suicide Prevention Lifeline: Policy for Helping Callers at Imminent Risk of Suicide*, *supra* note 87, at 3 ("In [a number of] instances, the helper did not engage in any attempt at emergency rescue nor did the helper attempt to get the caller to stop the attempt or suggest a no-harm agreement or call back. Four of these callers hung up on the helper when still apparently on the verge of a suicide attempt and it is not known what occurred, in three instances the call ended with the caller still in the process of an attempt . . . and in one [instance] the caller became unconscious during the call without any help being sent.").

194. *Id.*

caller became unconscious and unresponsive, at which point the call-taker hung up the phone.[195] Inconsistent treatment of this degree is a major vulnerability for a system that endeavors to provide holistic services for individuals dealing with suicidal behavior and mental health crises, demonstrating the need for an analysis of standard operating procedures.[196] Furthermore, such infrastructural gaps increase the likelihood that individual callers will be met with law enforcement officials, an outcome that does little to achieve the holistic aspirations of the Lifeline. Awareness of the vulnerabilities of the current structure clarify where future investments should be directed, which is the focus of the final Part of this Note.

IV. OPPORTUNITIES WITHIN THE 988 NATIONAL SUICIDE & CRISIS LIFELINE TO ACHIEVE A REIMAGINED PUBLIC SAFETY LANDSCAPE

Recommendations for how to improve behavioral health systems across the country have been top of mind for many communities, especially since the summer of 2020 when widespread calls to reimagine public safety rang out.[197] Organizers, policymakers, and service-providers alike now recognize that behavioral health crises, while they may require specialized response

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195. *Id.*

196. *See generally* Brian L. Mishara et al., *Comparing Models of Helper Behavior to Actual Practice in Telephone Crisis Intervention: A Silent Monitoring Study of Calls to the U.S. 1-800-SUICIDE Network*, 37 SUICIDE & LIFE-THREATENING BEHAV. 291 (2007) (comparing intervention criteria and call-outcomes across fourteen call centers and 2,611 calls).

197. Giunta, *supra* note 30, at 498–89 ("The political discussion surrounding police reform and the institution of crisis response teams is increasingly volatile, especially after Black Lives Matter protests swept the nation during the summer of 2020 in response to the killing of George Floyd, and sparked an ongoing debate about police reform across the country. Sixty-three percent of Americans support reallocating a portion of police funding to create first responder programs that specifically deal with issues related to mental illness." (footnote omitted)). *See generally* Tiffany Yang, *"Send Freedom House!": A Study in Police Abolition*, 96 WASH. L. REV. 1067 (2021) (exploring how a historical example that reduced law enforcement presence in community can provide helpful guidance as organizers and advocates renew calls for a reimagined public safety system); KABA & RITCHIE, *supra* note 77 (providing an account for what communities without police would look like and how different institutions could takeover police functions).

tactics, do not require the presence of armed police officers.[198] And, beyond the choice of who to dispatch, there are questions about how to provide support that address the root cause of a caller's issues, as opposed to providing a short-term response that fails to provide robust treatment or service options.

There is no doubt that these are complicated and multidimensional questions, with benefits and costs for every choice made. That said, with the new Lifeline's emphasis on creating a national network of local service providers, there is an opportunity for communities to reallocate resources away from police departments and into the hands of individuals who prioritize de-escalation, harm reduction, non-punitive treatment, and long-term service provision. Such an intervention would create meaningful opportunities to build a robust mental health care network—a fundamental goal of the Lifeline—and sidestep a number of the legal pitfalls that exist when police are the front-line responders for mental health crisis events. This reallocation of resources is the primary recommendation discussed in this Part, followed by other policy changes that may complement the removal of police officers from Lifeline calls.

A. Recommendation 1: Avoid Dispatching Law Enforcement in the Initial Response Unit

Fundamentally, one method by which to facilitate the 988 Lifeline's broad objectives is to restrict and remove the features that have been sources of violence and misconduct. The role of police officers in our society is to ensure compliance with laws and policies that are believed to achieve public safety. This purpose informs their conduct in moments when they are faced with individuals engaging in illegal conduct (like drug use, or certain behaviors deemed dangerous or erratic), or individuals who are unable to comply with police instructions because of a disability or behavioral health crisis. The limited options available to police officers, as well as issues like officer bias and overreliance on use of force, continue to result in violent, sometimes fatal,

198. *See, e.g.*, Jennifer J. Carroll & Taleed El-Sabawi, *The Case for Non-Police Response to Behavioral Health Crises*, BILL OF HEALTH (April 1, 2021), https://blog.petrieflom.law.harvard.edu/2021/04/01/non-police-response-behavioral-health-crises [https://perma.cc/6YN4-UAEL] (discussing the mismatch between the presence of police officers during behavioral health calls and the actual needs of the caller and behavioral health first responders).

outcomes for individuals in crisis.[199] At its core, this purpose sits in tension with an ideal mental health care response that is focused not on compliance, but individualized treatment and de-escalation.

Furthermore, given the fraught history of policing in particular communities[200] and the difficulty that families have in holding officers accountable in the aftermath of misconduct,[201] there is legitimacy to calls demanding the restriction of officer involvement in calls that concern substance use issues, mental health issues, and behavioral health crises. As such, this intervention has been supported by many policymakers[202] and police officers[203] in the wake of instances of law enforcement wrongdoing.

1. Targeting the *Imminent Risk Policy*

Currently, decisions about when and how to engage local emergency service providers where telephone services are not sufficient are controlled by the *Imminent Risk Policy*. This policy was first approved in January 2008 and the most recent version of the policy (updated in January 2012) still controls call center practices today.[204] The policy establishes requirements that

199. *See* KABA & RITCHIE, *supra* note 77, at 157 ("Anywhere between one-third and one-half of people killed by police are—or are perceived to be—in a mental health crisis at the time of their deaths.").

200. *See supra* Part I.B (discussing issues with the dispatch of law enforcement); *see also* Mimi E. Kim, et al., *Defund the Police - Invest in Community Care: A Guide to Alternative Mental Health Responses*, INTERRUPTING CRIMINALIZATION 22–23 (May 2021), https://static1.squarespace.com/static/5ee39ec764dbd7179cf1243c/t/60ca7e7399f1b5306c8226c3/1623883385572/Crisis+Response+Guide.pdf [https://perma.cc/KW4U-4Z3Q] (describing the way that presence of police officers reinforces reliance on criminal justice approaches without addressing root causes).

201. *See supra* Part II.B (discussing barriers to accountability).

202. KABA & RITCHIE, *supra* note 77, at 157 ("High-profile cases of fatal and nonfatal police violence against disabled Black and Brown people—like the killing of Walter Wallace by Philadelphia police in 2020—typically prompt a surge of interest in 'alternative' mental health crisis response programs. Defund organizers made removing cops from crisis response a high priority in the 2020 Uprisings, and it was the arena in which policymakers were most willing to consider reducing the role of police." (footnote omitted)).

203. *See supra* note 139.

204. *National Suicide Prevention Lifeline: Policy for Helping Callers at Imminent Risk of Suicide*, *supra* note 87.

apply in the case of imminent risk,[205] ranging from active engagement and non-invasive interventions to active rescue and direct communication with local emergency service providers.[206] It arose after research of the early call centers comprising the Lifeline network found widely varying practices that provided callers with inconsistent responses and outcomes.[207] While proportionally a small number of individuals fall within the "imminent risk" category when they make calls,[208] this population is at particularly high risk of a negative interaction arising from the engagement of in-person services.[209]

The issue addressed by the *Imminent Risk Policy* is foundational to a functional crisis response system—it is inevitable that call-takers will confront situations where telephonic counseling is insufficient and in-person intervention is required. There is also consensus that it is okay for call-takers to refuse to "accept a caller's choice to die as a rational, responsible decision," especially when the person has reached out to a crisis hotline.[210] And yet, the *Imminent Risk Policy* leaves room for improvement in certain key areas.

205. *Id.* at ix ("A Caller is determined to be at imminent risk . . . if the Center Staff responding to the call believe, based on information gathered during the exchange from the person at risk or someone calling on his/her behalf, that there is a close temporal connection between the person's current risk status and actions that could lead to his/her suicide.").

206. *Id.* at vi–vii.

207. *Id.* at 1 ("[I]t is difficult to know the types and frequency of actions employed by center staff to assist Lifeline callers assessed to be imminently at risk of attempting suicide. However, in a data sample of 42,242 Lifeline calls in 2007 offered to Lifeline by four network centers, one measure of assistance to callers at imminent risk of suicide—deployment of emergency rescue services—revealed notable differences of practice across these four agencies. While 2.4% of calls in this sample prompted center staff to send emergency rescue services to the caller, the variance between the four centers ranged from 0.5% of calls at one center . . . to 8.5% at another center . . . .").

208. *SAMHSA Appropriations Report*, *supra* note 3, at 7 ("In 2020, there were 1,509,920 total answered Lifeline calls . . . . Based on the available data from the sample Lifeline centers . . . it is estimated that in 2020 there were 340,789 individuals who called with current suicidal ideation, 60,850 individual callers who were determined to be at imminent risk, and 13,589 individuals who called while a suicide attempt was in progress.").

209. *See, e.g.*, *supra* note 90 and accompanying text.

210. *National Suicide Prevention Lifeline: Policy for Helping Callers at Imminent Risk of Suicide*, *supra* note 87, at 19.

With the transition to 988, SAMHSA has acknowledged the shortcomings implicit in this system.[211] For one, the *Imminent Risk Policy* was developed in the context of the Lifeline, whose stated mission was "to prevent suicide by reaching and effectively serving all persons at suicidal risk in the United States through a network of crisis hotlines."[212] In determining when a call-taker may initiate active rescue, the current policy allows for calling emergency service providers if the caller "[r]emains unwilling and/or unable to take such actions likely to prevent his/her suicide; and [r]emains at [i]mminent [r]isk."[213] Relying on the *Imminent Risk Policy*, which was tailored specifically to a suicide hotline, but which is now attempting to serve a much wider range of callers,[214] risks leading to intervention policies that are both over- and under-inclusive. Furthermore, it exposes callers to interactions with first responders who may not be any better equipped to deal with their circumstances than the call-taker and, in the case of police officers, who may enter the interaction with a goal of ensuring compliance with legal standards as opposed to de-escalation and treatment.[215]

This impossible tension illustrates why a regulatory change to the *Imminent Risk Policy*, one that requires non-police crisis responders when and if in-person response is deemed necessary,

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211. *See supra* note 174 and accompanying text.

212. *National Suicide Prevention Lifeline: Policy for Helping Callers at Imminent Risk of Suicide*, *supra* note 87, at 1.

213. *Id.* at vi. Note that the definition of "imminent risk" only considers suicidality, excluding danger associated with other acute mental health crisis events. *See id.* at ix.

214. *988 FAQs*, *supra* note 40 (characterizing the Lifeline as a resource for individuals in need of "support for suicidal, mental health, and/or substance use crisis" and articulating a goal of facilitating a generalized "crisis care system across [the] country that links callers to community-based providers who can deliver a full range of crisis care services").

215. *See, e.g.*, Amos Irwin & Betsy Pearl, *The Community Responder Model: How Cities Can Send the Right Responder to Every 911 Call*, CTR. FOR AM. PROGRESS 14–19 (Oct. 2020), https://www.americanprogress.org/wp-content/uploads/sites/2/2020/10/Alternatives911-report.pdf [https://perma.cc/UZ4A-DKQW] ("Under the Community Responder model, to divert 911 calls to [Community Responders (CRs)], jurisdictions could embed a CR dispatcher alongside the 911 call-takers and police and fire dispatchers. Houston, for example, uses this setup for the Crisis Call Diversion (CCD) program, which relies on clinicians to resolve nonemergency mental health calls for service over the phone. As calls come into 911, call-takers would flag situations that might be appropriate for CR response." (footnote omitted)).

is such a critical first step to achieving the mental health network to which the Lifeline aspires. That said, it is not the only policy lever that advocates can recommend in order to achieve a holistic and treatment-centered Lifeline.

2. Leveraging New Policy Angles to Effect Change

Beyond regulations controlling the Lifeline's operations, state and federal laws may be passed to reshape how police officers may engage in certain types of calls (i.e., they do not have control of the scene or they are not allowed on the scene unless a behavioral health first responder reaches out for support).[216] In addition, there are policies that can facilitate fewer carceral-type encounters, even among non-police responders, which can have the effect of facilitating community buy-in and improved outcomes for those individuals callers. In this area, reforms may include ensuring that individual responders are not wearing police uniforms,[217] training responders in crisis de-escalation and trauma-informed conduct,[218] and decriminalizing drug activities while ensuring that individuals use a public health approach as

216. *See, e.g.*, Nazish Dholakia & Daniela Gilbert, *What Happens When We Send Mental Health Providers Instead of Police*, VERA INST. OF JUST. (May 27, 2021), https://www.vera.org/news/what-happens-when-we-send-mental-health-providers-instead-of-police [https://perma.cc/4G9A-SYDW] (describing programs in which police officers only join the call response if behavioral health responders request their support, including CAHOOTS, in which teams requested police backup on only 311 of roughly 18,000 calls, and Denver's STAR, in which respondents have responded to 1,323 calls without any arrests or requests for police backup).

217. Uniforms may trigger or provoke individuals with certain behavioral health disorders. *See* Irwin & Pearl, *supra* note 215, at 5 ("[P]olice presence can be triggering for people with behavioral health disorders, as these individuals are more likely to have experienced negative or traumatic contacts with the justice system. In fact, according to the International Association of Chiefs of Police, 'the mere presence of a law enforcement vehicle, an officer in uniform, and/or a weapon . . . has the potential to escalate a situation' when a person is in crisis. Police may not understand how a particular disability manifests and may assume that an individual's reaction—or lack of reaction—to law enforcement is a show of defiance." (second alteration in original) (footnote omitted)).

218. Kim et al., *supra* note 200, at 16–17 (identifying "[h]arm-reduction, trauma-informed, peer-led or involved community-based mental health resources" as one of the key features of meaningful crisis response).

opposed to a criminal justice approach when responding to cases that involve substance use disorder.[219]

Such reforms work to narrow the scope of police officer purview, thereby lessening officers' ability to criminalize behavior that is much better matched with a behavioral health approach. As a result of expanding police presence throughout the 1960s,[220] American society has seemed to take for granted the involvement of police officers in various features of society that are best addressed by a perspective that expands beyond the immediate illegal conduct, looking to the source and providing a long-term solution. This does not have to be a default part of American public safety infrastructure, and the 988 Lifeline expansion is a perfect opportunity to innovate in this area, thus creating a system that responds to the root causes of individuals reaching out to the Lifeline in the first place.

B. RECOMMENDATION 2: DEVELOP ROBUST OVERSIGHT, REPORTING, AND ACCOUNTABILITY MEASURES

An important feature of any updated crisis response infrastructure is adequate oversight and accountability measures that can be used to correct misconduct swiftly after it occurs. It is, unfortunately, very easy to call to mind examples of fatal-police encounters that resulted in very little accountability for the officer, which has broken the trust of communities across the country and undermined the authority of law enforcement officials.[221] While the policy changes recommended above would set behavioral crisis response systems apart from law enforcement officers purposefully, this does not mean that such oversight mechanisms would be unimportant in this new infrastructure. In fact, building these oversight mechanisms early on is a way to facilitate buy-in at both the local and national level.

Certain recommendations that have arisen in the context of police misconduct oversight may have translatability and relevance in the context of both local and national mental health response networks. These include (1) supporting the development

219. *See* Irwin & Pearl, *supra* note 215, at 16 (describing overdose prevention sites as contributing to a behavioral health network that both responds to emergency calls and helps to "avoid[] crises in the first place").

220. *See supra* notes 75–79 and accompanying text (discussing the history of police presence in neighborhoods).

221. *See, e.g.*, notes 87–91 and accompanying text.

of civilian oversight boards with legal power to conduct investigations and implement discipline when responders are found in violation of best practices;[222] and (2) maintaining a national list of approved network partners or individuals who have been found responsible for significant misconduct (perhaps with a rating system for the practices that they implement and notes about both strengths and weaknesses of the system).[223]

Individuals concerned about the accountability measures recommended above may bring up the fact that law enforcement officers have access to qualified immunity,[224] and it would be important to extend this protection to individuals working in the behavioral health response space as well. While an interrogation of qualified immunity in the context of mental health crisis response is beyond the scope of this Note, addressing the question at the root of the qualified immunity debate—what constitutes appropriate accountability—is still a worthwhile endeavor. Especially with the implementation of a new system, transparency and accountability measures will be important because, separate from one-off punishment for responders that engage in misconduct, the whole system will be better if there is a mechanism for users to report negative experiences and encourage improvement. Models such as civilian oversight boards or administrative actions (e.g., license suspension or maintenance of misconduct incidences) may serve as accountability measures that provide a midpoint between abolishing qualified immunity and leaving misconduct completely unchecked and oversight unsupported.

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222. The National Association for Civilian Oversight of Law Enforcements serves as a "clearing house" for best practices related to civilian oversight. *See* NAT'L ASS'N FOR CIVILIAN OVERSIGHT OF L. ENF'T, https://www.nacole.org [https://perma.cc/BP56-SUJU]. Shared resources and guidelines outlining best practices are available for anyone hoping to learn about this type of program, and there are many ways that the resources could translate to civilian oversight of any mental health first responder system that is developed, whether or not the infrastructure is explicitly connected to law enforcement.

223. There have been proposed bills addressing some of these issues. *See, e.g.*, George Floyd Justice in Policing Act of 2021, H.R. 1280, 117th Cong.

224. *See supra* Part II.B.3 (providing a brief overview of qualified immunity in the context of behavioral health crisis calls and subsequent litigation).

C. RECOMMENDATION 3: EXPAND NON-POLICE INFRASTRUCTURE

1. Make In-Person Support Part of the Default Response, Thus Lowering the Threshold for Engagement of Behavioral Health Specialists

As discussed above, the baseline standard for in-person intervention in the case of crisis calls is controlled by the Lifeline's *Imminent Risk Policy*.[225] The policy takes the approach that telephonic intervention can and should remain the default, usually providing sufficient support to address a caller's immediate risk of suicide or behavioral health crisis.[226] However, this assumes that in-person intervention should only be dispatched in the case of the most severe or high-risk moments of crisis—an assumption that does not have to remain part of the standard. Instead of withholding resources except in the riskiest situations, a reimagined Lifeline network could prioritize widespread, easy-to-access, in-person resource provision, lowering the threshold for sending in-person support. This sort of system would necessarily engage non-police service providers and allow for the incorporation of service provision options that go beyond civil confinement or hospitalization. Such additional services could include transportation to non-carceral, community-based service providers; engaging callers in brief mental health assessments that identify treatment options and next steps; and immediate provision of shoes and blankets or food items.[227] This would have the added benefit of lowering the threshold for reaching out for help and destigmatizing the Lifeline along the way.

225. *See supra* Part III.A.1.

226. *See supra* Part III.A.1.

227. *See* Nazish Dholakia, *The People Responding to 911 Calls Instead of Police*, VERA INST. OF JUST. (Apr. 2022), https://www.vera.org/the-people-responding-to-911-calls-instead-of-police [https://perma.cc/Z9T7-9W4G] ("Over the last few years, [Crisis Response Unit] responders have delivered countless shoes and blankets."); Jackson Beck et al., *Case Study: CRU and Familiar Faces, Olympia, WA*, VERA INST. OF JUSTICE (Nov. 2020), https://www.vera.org/behavioral-health-crisis-alternatives/cru-and-familiar-faces [https://perma.cc/WAR2-QH6M] ("Peer [navigators] provide wide-ranging services. . . . Services include problem-solving with clients to address housing transitions and child-care challenges; transporting clients to and from treatment and department stores for necessities; supporting clients with haircuts, laundry, and showers; and providing a listening ear.").

The National Alliance on Mental Illness (NAMI) promotes a three-pronged system that incorporates Mobile Crisis Teams and Crisis Stabilization Programs in addition to 24/7 call centers.[228] The Mobile Crisis Team could be dispatched in cases where phone support is insufficient and would comprise mental health professionals who are able both "to de-escalate crisis situations and connect people to additional care."[229] Such a team has a wider scope than teams dispatched to respond to imminent risk, which suggests that harm is immediately forthcoming or already taking place, at which point the nature of the intervention necessarily has a more urgent and reactionary focus. Furthermore, as the Lifeline endeavors to provide services for a wider array of behavioral health and substance use issues, it may be the case that the needs of callers no longer fit into the categories of imminent or non-imminent risk.

Practically, this is a feature that would need to be implemented at the state and local level, which is possible given the network approach of the 988 Lifeline.[230] As more organizations join the network, it is possible that such organizations may have greater capacity to staff a group of behavioral health crisis response teams. It is also possible that with additional successful models within the Lifeline network, other localities that do not yet have in-person responders may be encouraged to develop such a structure through national training programs and updated Lifeline regulations that change the nature of in-person response. Another recommendation that facilitates localized and long-term support for those who desire it is more comprehensive collaboration between call-takers and local mental health care resources.

2. Increase Collaboration Between Local Service Providers and Call-Takers

Many of the individuals who call the Lifeline have persistent mental health challenges that contribute to the individual reaching out to the Lifeline in the first place and which may persist

228. *988: Reimagining Crisis Response*, NAT'L ALL. ON MENTAL ILLNESS, https://nami.org/Advocacy/Crisis-Intervention/988-Reimagining-Crisis-Response [https://perma.cc/35B3-4ZC7].

229. *988 Mental Health Crisis Response,* NAT'L ALL. ON MENTAL ILLNESS, https://nami.org/NAMI/media/Advocacy/988-MH-Crisis-Response.pdf [https://perma.cc/NM7F-W3CG].

230. *See supra* Part III.B.2.

after their engagement with the Lifeline.[231] As such, and to avoid overreliance on this emergency resource, it is critical that the Lifeline, and especially local call centers, create call-taking protocols that consider long-term care. Sample legislation drafted by NAMI acknowledges the importance of such structure, encouraging states and municipalities to establish Crisis Stabilization Programs that "identify long-term treatment needs, keep a person from needing more intensive care and ensure a warm hand-off to follow-up care."[232] Additionally, organizations across the country have begun building systems that integrate mobile crisis response with long-term services provision. For example, Olympia, Washington's, Crisis Response Unit (CRU) has a program called Familiar Faces, which provides peer support to people with behavioral health needs who are consistently on the radar of the law enforcement system.[233] And another program, the Fireweed Collective in Richmond, California, holds multiple support groups covering a wide variety of topics in order "to build peer-led crisis prevention [and] systems of support and care," which are not limited to one-off interactions in a moment of crisis or distress.[234]

This type of integration is feasible because of the local network approach being promoted within the Lifeline. Local call centers have received funding to join the network,[235] which allows them to more easily make referrals and engage in follow-up with those who reach out for support. Success of this sort of continuum of care will, however, require innovations in the network's technological capacity, as well as reconsideration of caller privacy and information sharing between organizations. It also depends upon a robust network of service providers within areas

231. Madelyn S. Gould et al., *Follow-Up with Callers to the National Suicide Prevention Lifeline: Evaluation of Callers' Perceptions of Care*, 48 SUICIDE AND LIFE-THREATENING BEHAV. 75, 76 (2018) ("Evaluations demonstrated that Lifeline callers experience a reduction in hopelessness and suicidal intent over the course of their hotline call. However, 43% of suicidal callers who completed evaluation follow-up assessments experienced some recurrence of suicidality (ideation, plan, or attempt) in the weeks following their crisis call, and only 22.5% of suicidal callers had been seen by the behavioral health care system to which they had been referred." (citations omitted)).

232. *988 Mental Health Crisis Response*, *supra* note 229.

233. Beck et al., *supra* note 227.

234. Kim et al., *supra* note 200, at 18.

235. *SAMHSA Appropriations Report*, *supra* note 3, at 2 (detailing the funding of local centers).

where individuals are making calls. That said, efforts to expand the mental health care resources that individuals are able to utilize will only increase awareness of the value of such programs and destigmatize early intervention, thus facilitating the robust and responsive network model that the 988 policymakers seem to imagine.

Reporting around the increase in utilization of the 988 Lifeline has acknowledged that with more calls come higher costs;[236] however, there are a number of ways that local service providers, states, and the federal government can address this budgetary need. Most fundamentally, states can pass laws integrating 988 fees into cell phone bills the same way that they already do for the 911 dispatch system.[237] They may also take advantage of increased funding available at the federal level as a result of attention paid to the 988 transition and mental health services more generally.[238] While it is true that these funding mechanisms—especially federal grant funding—may not be available in perpetuity and may change quite drastically depending on the political landscape from administration to administration, states taking advantage of these early opportunities may access an infusion of capital that is critical for establishing strong program foundations.

One such consideration that is not dependent on grant applications is the reallocation of state and municipal funds from law enforcement budgets to mental health care service providers. Such a reallocation would result in long-term cost savings,

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236. *See id.* at 9–11 (outlining expected FY22 resources, as well as future costs related to updating and expanding infrastructure, engaging in public education, and providing funding for local service providers); *id.* at 17 ("After 988 goes live in July 2022, call, chat, and text volume is expected to increase over time. While contact volume is not the sole driver of 988 crisis line costs, it is an important one.").

237. *Id.* at 11 ("The Hotline Designation Act of 2020 allows states to impose and collect cell phone fees to support 988 operations.").

238. *See supra* notes 236–37 and accompanying text (describing the SAMHSA-based grant funding that is available to states implementing local mental health programming and infrastructure); *see also* Press Release, Substance Abuse & Mental Health Servs. Admin., HHS Announces $3 Billion in American Rescue Plan Funding for SAMHSA Block Grants to Address Addiction, Mental Health Crisis (May 18, 2021), https://www.samhsa.gov/newsroom/press-announcements/202105181200 [https://perma.cc/LM8L-XWNZ] (describing the allocation of American Rescue Plan Act funds for mental health and substance use programs, and characterizing this investment as "the largest aggregate amount of funding to date" for these purposes).

not because less money is going to law enforcement budgets per se, but because the programs are both relatively less expensive to operate than traditional police programming and because they keep people out of the expensive public safety system.[239] For example, the CAHOOTs model in Eugene, Oregon, which receives some of its budget through the police department, is sustained in part because of the cost savings that it creates within the criminal-justice system.[240] Second, one study of Crisis Intervention Training (which could be understood as a precursor to full adoption of a mental health responder system) found drastic cost-savings, which freed up monies to be used for other areas of investment.[241]

To be sure, these recommendations are not the easiest to implement, nor will they garner widespread support throughout every community across the country. Yet, they are worth mentioning all the same because they represent policy changes that both address the gaps left by elements of the former Suicide Prevention Lifeline and shortcomings that exist within the legal system to promote accountability and long-term impact.

239. *See* McKechnie, *supra* note 70, at 265–66 ("The cost of creating a program like CAHOOTS is insignificant compared to city police budgets. For CAHOOTS, the cost is two percent of [the city]'s police budget, or $2,000,000, whereas [city] police have an annual budget of $90,000,000. The Denver initiative, STAR, is even less, at a cost of $200,000. . . . These programs create additional savings downstream when you consider police equipment, training, healthcare, and incarceration costs. By treating the individuals whom CAHOOTS and STAR respond to, they dampen the likelihood of that person ending up in jail, the costs of which are covered by taxpayers. Also, by focusing on a deescalation model that aims to prevent future crises, societal costs are lessened as sick individuals are treated and rehabilitated rather than cycling through the criminal justice system." (footnotes omitted)).

240. Dholakia & Gilbert, *supra* note 216 ("With an annual budget of roughly $2 million, the program saves Eugene $14 million annually in ambulance trips and emergency room costs, plus an estimated $8.5 million in public safety costs—and has successfully diverted thousands from the criminal legal system.").

241. Peggy L. El-Mallakh et al., *Costs and Savings Associated with Implementation of a Police Crisis Intervention Team*, 107 S. MED. J. 391, 391 (2014) ("Based on an average of 2400 CIT calls annually, the overall costs associated with CIT per year were $2,430,128 ($146,079 for officer training, $1,768,536 for hospitalizations of patients brought in by CIT officers, $508,690 for emergency psychiatry evaluations, and $6823 for arrests). The annual savings of the CIT were $3,455,025 ($1,148,400 in deferred hospitalizations, $2,296,800 in reduced inpatient referrals from jail, and $9825 in avoided bookings and jail time). The balance is $1,024,897 in annual cost savings.").

Conversations around the new Lifeline have been optimistic and aspirational—appropriately so. But, to actually achieve a system that respects each individual caller and attends to their needs in a way that does not create further harm and provides opportunities to address root causes of their substance use disorder and/or mental health and behavioral health issues, institutions need to reconceive the policy and legal frameworks informing implementation.

CONCLUSION

Serious mental illness and suicidal behavior will always be a part of our society. In all likelihood, so too will some sort of institution that is tasked with investigating criminal activity. At this point in time, there is significant overlap among these two concepts. However, this need not be the case. Especially as the federal government works to promote the updated 988 Lifeline, services providers, advocates, and communities across the country have unique opportunities to reimagine their approach to transforming how we structure these perennial features of society.

While much progress has been made to destigmatize and lower barriers to care for those dealing with issues that the 988 Lifeline attempts to address, gaps in the system still exist, which result from a long history of disinvestment in public mental health systems and the continued criminalization of behavior associated with behavioral health crises. That said, by prioritizing behavioral health care, de-escalation, and the provision of individualized services that do not threaten incarceration or involuntary hospitalization, first responders may be able to reduce harm and address the persistent issues that cause people to reach out for support in the first place. There is ample evidence that police are not the right group to respond to such calls, and legal frameworks shield them from accountability when they inevitably cause harm. Given the way the current system operates, it is high time for the Lifeline coordinators to explicitly separate Lifeline services from police departments. Doing so would directly improve outcomes for callers and would have beneficial impacts on other features of the system. Not only is this a worthwhile discussion to have because of the opportunity that comes with the expansion of the 988 Lifeline, it is necessary to justify

the country's investment and realize the program's stated objectives.