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The Third Choice: Suicide Hotlines, Psychiatry, and the Police

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By Hannah Zeavin

With Covid-19 showing no sign of abating, mental health care (from ongoing therapy to helplines) continues to be an important site of treatment for many Americans. While traditional therapy has continued to be prohibitively expensive for most, *te/le*therapy has been covered by most major health insurance companies since the early days of the pandemic and is currently free for upwards of 130 million Americans. 2020 has seen the most widespread offering of fee-less teletherapy in the U.S., but the fact of teletherapy's financial accessibility is not quite new: most forms of tele-mental health care have been free or low-fee across their long history.

Across the 20th century and into our present, new modes of relating at a distance have given individuals in crisis an ever-expanding set of tools for accessing mental health care. From World War II psychotherapeutic broadcasts to Instant Relay Chats, letter writing to e-therapy, psychiatrists, psychoanalysts, and peer-activists have attempted to send therapeutic care beyond the consulting room by harnessing quotidian, habitual media to connect would-be patients to the help that they need wherever they are, whenever they need it. The suicide hotline is one such form of teletherapy, premised on reaching users who otherwise couldn't access traditional therapy as well as those in extremis: it's nearly ubiquitously available, free, and comes in over a household utility or, now, a cellphone. It was designed to provide great flexibility and control to users, and to circumvent traditional modes for seeking care in while in crisis: namely, it has sought to create a space of care outside the jurisdiction of psychiatry and policing and the threats their forms of intervention carry.

The Telephonic Church

Despite the fact that the United States only offered its first nationally funded suicide hotline in 2000, the hotline modality is more than 60 years old, and has an unexpected history: it was first a Christian form of help, not a secular one, and grew out of the tradition of pastoral care. The first known suicide hotline was founded in London in 1953 by Chad Varah, a protestant clergyman, and Vivian Prosser, who was employed as Varah's

secretary. Varah saw suicide and suicidality as a particular problem in his pastoral counseling sessions with parishioners. Firstly, the underlying mental states and, sometimes, concrete reasons, that drove his parishioners to commit suicide were unspeakable—frequently related not just to Christian understandings of despair, or mid-century notions of loneliness and isolation, but to concerns regarding both heteronormative and non-heteronormative sexuality. Secondly, Varah estimated that while many of his parishioners sought out his care specifically for suicidal ideation, his stock piece of advice—consult a psychiatrist—was never followed.

Because the topics surrounding suicidal ideation were so taboo that psychiatry wasn't an available form of care, Varah had to consider how to reach those who were in extremis. He recalls,

“. . . there were three suicides a day in Greater London... how would they get in touch at the moment of crisis? In an emergency the citizen turns to the telephone and dials 999. I looked at mine: FIRE it said. But if you were on a ledge about to jump and needed a ladder, there'd be very few phones on the ledge with you. POLICE it said. But at that time suicide was a felony.”^[1]

Within and beyond Varah's church, where suicide rates were increasing, suicide was figured as both a moral crime *and* a legal one: suicide or the attempt of suicide *both* carried penalties (in a twisted logic by which one would have committed a crime in and after death).

But what if you *could* use the phone to call for help, what if there were a third choice—a non-state option that also wasn't psychiatric? Varah and Prosser provided just that, elaborating a new service at the intersection of pastoral and mental health care from the rectory of a bombed-out, post-Blitz church in London with no standing congregation. Instead of seeking to gather a new group of parishioners together for services, Varah and Prosser offered counseling and no other pastoral activities—Varah made, in short, a telephonic church premised on providing a space for non-judgmental and helpful communication. Immediately, users started calling. Prosser triaged calls according to urgency (much like algorithms now do on some contemporary crisis lines) and Varah counseled. Soon, the demand for the service grew, and Varah and Prosser trained some 50 volunteer counselors to perform “befriendings” free of psychiatric advice and without any interface with the police. This service became known as The Samaritans, still the largest network of crisis counselors in the world. The origin of the suicide hotline, and its success as a modality, depended on rethinking the relationship between policing and suicide prevention. Put simply, The Samaritans was founded in part as an alternative to placing a

phone call to the police as a means of seeking help—with all of the likely consequences that followed from doing so: arrest, injury, and either incarceration or involuntary hospitalization.

The Anonymous Ear

The suicide hotline form first appeared in The United States in earnest^[iii] in 1959 in San Francisco—the suicide capital of America at the time—helmed by Bernard Mayes, a “closeted queer priest,” (his self-appellation). When Mayes moved to the Bay Area, he noticed two intersecting and linked groups of people in crisis on whom the city had turned its back: an increasingly targeted LGBT+ community (this was in the era of the Lavender Scare, and raids on queer spaces were commonplace) and those considering taking their own lives (sometimes by leaping from the notorious Golden Gate bridge). Mayes found, just as Varah and Prosser asserted in their work on *The Samaritans*, that free, anonymous, peer-led help allowed callers to speak what was on their mind without fear of recrimination and carceral consequence.^[iii] Importantly, Mayes explicitly refused to condemn suicide morally, freeing the service from Christian doctrine. He only wanted to aid those who *wanted* to be helped; he wasn’t interested in suicide *intervention*—or preventing suicide by any means necessary, including calling the police or helping to initiate hospitalization. Instead, Mayes provided a space in which callers could initiate their own care and set the terms of that care themselves. This meant necessarily that the hotline would not collaborate with emergency services or police; it was counter to the mandate of the hotline to contribute to incarceration or forced hospitalization. To this end, Mayes was very particular about who could serve as staff on his hotline; he rejected prospective volunteers with *any* mental health training (turning down social workers, psychiatrists, and the like) and heavily screened all volunteers for bias that would reintroduce any punitive communication. The service placed matchbooks in the bars that populated the Tenderloin district (including recently raided queer spaces) that contained a “secret” message on the inside flap: “Thinking of ending it all? Call Bruce, PR1–0450, San Francisco Suicide Prevention.”^[iv] Users began to call and the suicide rate in San Francisco began to decline.



Bernard Mayes on the red telephone at the offices of the San Francisco Suicide Prevention Center, Courtesy Douglas Jones for *Look Magazine*, Library of Congress

Mayes specifically removed the problems with seeking *professional, expert* psychiatric care in his moment—especially for the LGBT+ community he intended to aid—while still providing what he called “the anonymous ear,” keeping an intensive focus on psychodynamic listening, but removing nearly all identifying features of both caller and volunteer. Just seven years prior, in 1952, the American Psychological Association had released the DSM I, in which “homosexuality” was listed as a sociopathic personality disorder (as it would remain until 1974). In Mayes’ moment, psychiatric and psychological intervention saw queerness as something to cure, and it had the diagnostic criteria to carry out “cures,” from electroshock therapy to lobotomy.^[vi] For Mayes’ callers, looking to be helped with feelings of extreme depression and despair, psychiatry was therefore not a viable source of care, nor were state-based social services. Anonymity conferred a protection against intervention; in order to be diagnosed or apprehended, one must be named and locatable.

The first U.S. suicide hotline thus posed itself as an explicit alternative to both psychiatric care *and* police involvement. Taken together, Mayes’ stance and practice constituted a revolution in U.S. mental health care—and drew substantial negative attention from experts in the field. Part of what was so radical about Varah, Prosser, and Mayes’ work was that it removed the stigma of seeking care by dislocating would-be patients from their helpers, adding a protective distance, making use of anonymity, and by shifting what that help could look like. The Los Angeles Suicide Prevention Center even moved to shut the fledgling service down for its use of volunteers at a distance, before eventually adopting Mayes’ protocol itself.^[vii] Throughout the 1960s, this initially Christian form of mental health was taken up by a megachurch in Los Angeles and by

Catholic groups in New York City, but, by the 1970s, the phone also began to be used by other groups who needed to sidestep or avoid professional psychiatric care and policing in order to help particularly vulnerable communities and populations. Soon hotlines were offering specific services for the elderly, for survivors of domestic and child abuse, lesbian and gay support hotlines, and drug/addiction hotlines. In conjunction, community activists set up referral services and “warm” lines for palliative care.^[viii] As just some examples of the many uses of the phonenumber for extra-psychiatric and extra-carceral care provision: in 1971, Oleta Kirk Abrams and Julia Schewendinger founded the first rape crisis hotline, in part as a reaction to the hospital and police’s mishandling of Abrams’ daughter’s sexual assault;^[ix] Raphael Flores founded his own crisis support hotline in 1971, nicknamed “La Familia,” which was run out of the Washington Houses in East Harlem and staffed by teen activists—including those with ties to The Young Lords;^[x] more recently, the still-active Black Panther’s made a PACH line (Police Accountability Clinic and Helpline), which combined both in-person workshops and a hotline.^[xi]

In the same moment, there were other mental health intervention services—performing crisis intervention in particular—that worked closely with policing, whether that collaboration was under the sign of providing the survivor of sexual assault assistance in filing a police report, or in practicing suicide *intervention*, rather than the non-judgmental *prevention* favored by Mayes’ hotline and The Samaritans. Yet the majority of these hotlines (including the largest and most successful networks) managed to operate just beyond the reach of psychiatric power and policing, providing an alternative both to the dangerous and punitive nature of diagnosis and the carceral logics applied to those in crisis. Part of this security stemmed from these hotlines’ commitment to anonymity, a feature conveyed by the untraced phone call. Anonymity was used in conjunction with stripping tele-help of a particular power dynamic: the helper was always to be a civilian uninvolved in psychiatry or its related fields and not part of any legal framework.

From Analog Prevention to Digital Intervention

Today, hotlines continue to be accessible and free via the phone, and their use has increased in the wake of environmental disasters such as Hurricanes Sandy and Maria, the trauma of national elections, and during the COVID-19 pandemic. Hotlines now offer federalized care, as opposed to the ad hoc services of the 1950s and 1960s (although smaller activist and NGO hotlines are still thriving). In addition to traditional phone-based lines, new services that remediate the hotline form into text- and chat-based dialogs also abound, from The Trevor Project (the nation’s leading organization for LGBT+ youth mental health care, which offers a traditional hotline, a chatline, and a peer support forum moderated by

clinicians) to The Crisis Text Line (a non-profit, SMS-based crisis line whose Board of Directors includes danah boyd of Data and Society, Elizabeth Cutler, the founder of SoulCycle, and Jeff Lawson of Twilio).^[xi] These services may incorporate algorithmic triage and use gathered data as feedback and for research, but they aim to offer the same crisis care that countless users have turned to over the last 60 years. Anonymity, so central to the practices first championed by Varah, Prosser, and Mayes, still features heavily in the conventions of contemporary hotlines and chatlines, as does the practice of using volunteers (although now many welcome those with mental health backgrounds and hire clinicians as trainers and supervisors). While hotlines still offer care under the sheltering sign of anonymity, that protection is more an enabling user experience than a truth: a volunteer may not know the name of their caller, but they may well know where they're located, down to the street address level. Many hotlines now listen like a state: their calls carry with them a literal trace, geo-locating their callers and texters, or have collaborated with cell phone providers to ensure that a caller can be located.

If a hotline traces their users (either via IP address, via their landline, or by full geo-location—these practices vary), they may do so for a few intersecting reasons. The United States' federal suicide intervention program's hotline, The National Suicide Prevention Lifeline (founded in 2005), for instance, locates users for a dual purpose: first, because the federal line is a collation of over 150 local support centers,^[xii] hotline calls are redirected from a central operating system to these local lines to offer callers precise, updated, local resources. The second reason is that, unlike crisis lines like the Trevor Project, the federal Lifeline practices suicide *intervention* alongside its prevention, calling emergency services, including the police, to the home of a caller/chatter who is in active distress.^[xiii]

Part of what all suicide hotlines do is evaluate their callers for risk of a suicide attempt. Some lines use a scale of 1-5 (where 5 means they have the plan for suicide, the means to execute it, and an imminent intention to do so). Some hotlines practice what is termed "active rescue": they will send police and other emergency services to the location of the caller. Hotlines have many tools at their disposal before resorting to calling emergency services to a caller's location, from safety planning (as an example, helping a caller put some distance between themselves and a weapon) to engaging with "protective factors" (why a caller might want to live). If a hotline practices intervention, and a caller/texter seems at imminent risk of attempting suicide, and safety planning has failed, the hotline initiates such a "rescue."

There is extensive disagreement about whether or not hotlines should initiate active rescue in the first place. Hotlines that subscribe to

non-consensual active rescue believe that calling a crisis lifeline initiates an ethical demand to use every possible means to save that person. Or, that by calling the hotline in the first place, the caller wanted to be prevented from suicidal action, no matter how the call then unfolds. An additional argument may be that, beyond the loss of the individual caller, suicide can traumatize peers, family members, and community.^[xiv] According to this logic, the hotline also has a wider ethical and social responsibility to interrupt imminent attempts with police action. Active rescue is sometimes consensual: the caller has specifically asked for emergency services to be called to their home. Frequently, the active rescue is not consensual, but emergency services and/or the police are called to do a wellness check nonetheless. The National Lifeline reports that it utilizes active rescue in about 3% of calls,^[xv] The Crisis Text Line initiates active rescue in .82% of conversations, or about 28 times a day on average.^[xvi]

For hotlines that are staunchly against intervention as a model, nearly the same set of arguments apply, but in reverse. In brief, these hotlines see their work to be engaging with a caller, helping them via the tools and techniques of crisis prevention, without taking away the autonomy of their caller or jeopardizing their wellbeing further. There is an ethical imperative to allow the caller to continue to have bodily autonomy, even if that autonomy is used to commit suicide, or as Adam Phillips puts it, "...it's unethical to keep people alive if they can't bear their lives."^[xvii] This ethic is the one at work on Mayes' hotline and, of course, directly contradicts the ethics of active rescue hotlines.

The Samaritans, for most of their history, the Trevor Project, and the Trans Lifeline do not practice non-consensual active rescue; no matter what, they refuse to involve emergency services and/or the police in crisis situations.^[xviii] These hotlines argue that calling the police and initiating involuntary psychiatric holds (in which individuals are held, usually against their will, in psychiatric settings within hospitals, often for 72 hours) often result in community-wide rejection of crisis lines, and serve as a large deterrent to seeking help for those most at risk of suicide. On the one hand, hotlines all maintain a confidential line, and tout this in their literature—but some lines break confidentiality for active rescue, and tuck this in their Terms of Service where questions of informed consent have been raised. On the other hand, many callers assume *all* hotlines trace calls and will provide third parties with that information. Endless forums exist online in which peers coach one another about how to use Lifeline services and avoid an active rescue, regardless of what is actually taking place for the caller. Many who call into hotlines, or would, have had negative and traumatic experiences with psychiatry or the police. In one survey completed by the Trans Lifeline, users or potential users rated how comfortable they were interacting with emergency services, nurses,

doctors, and the police. None were rated favorably, and respondents ranked the police the lowest. ^[xix] The survey concluded that using non-consensual active rescue actually increases the risk of suicidality.

Once underway, police involvement can jeopardize the safety of the caller (and others nearby) for a wide variety of reasons: police training for crisis intervention is generally minimal and voluntary, and police violence is an uneven risk along lines of race, class, gender presentation, and sexuality. In addition, callers that meet the criteria for active rescue are often armed (with knives or guns), which, taken together with a lack of preparation and systemic violence, can be deadly for the very person active rescue aims to save. Put bluntly, active rescues and wellness checks performed by the police can and do end in police shootings and death. Given the racialization of criminality, threat to self can all too quickly be perceived to flip to life-endangering for the other, here the police.

As just one example among many, in 2016, Kayden Clarke, a white trans man who identified as having Asperger's Syndrome, called a suicide hotline from his home in Mesa, Arizona. Police were dispatched and responded by making a non-consensual active rescue attempt, and fatally shot Clarke. In a joint statement put out condemning the killing, the Autistic Self Advocacy Network reported, "Only one of the three officers had received crisis-intervention training. Officers claim that they shot Kayden after he approached them with a knife...we note that Kayden's death strongly resembles the shooting of Teresa Sheehan, a California woman with mental illness who was shot nine times while experiencing a mental health crisis. Upon finding that Sheehan was holding a knife, officers failed to take reasonable measures...The Ninth Circuit Court of Appeals later ruled that, by failing to follow best practices in de-escalation despite knowing that Sheehan was in mental health crisis, the police might have violated the Americans with Disabilities Act."^[xx] In 2020 alone, Daniel Prude, Nicholas Chavez, Linden Cameron, Roxanne Moore, and most recently, Walter Wallace Jr., were shot by the police during active rescue or mental health calls placed by others about them (whether family members, hotlines, or bystanders). In all six of these cases, the police are acting as a deadly extension of mental health policy.

Fred Moten has recently argued that we can rethink policy as police and police as policy:

We're not gonna sit here and argue over, or against 'defunding the police'! We're just gonna say, once you defund the police, then you gotta take care of policy, more generally. Because policy kills more black folks than the police do. That's one way to put it. The other way to put it is that the police are just policy by another name, policy at its most brutal, at its most logically inconsistent, at

its most blatant. And what we have said, you know, look — when it comes to black folks, between policy and the police, they're gonna kill us all. ^[xxi]

COVID-19 has again made clear what has long been so: crisis intervention and tele-therapy are deeply intertwined. Similarly, the uprisings in the summer of 2020 and into this fall have reasserted longstanding facts about intervention: policing is lethal, and unevenly so.

Suicide has long been considered to be something that by and large only afflicts white people—especially white men (accounting for about 70% of suicides in the United States per year). ^[xxii] This is less and less the case, and this traditional understanding needs urgent reevaluation and to be swiftly upended at a policy level. Compounded by systemic racism and the pandemic, suicide is now the second leading cause of death for Black children and the suicide rate for Black children aged 10-19 is growing faster than for any other group in the United States, with attempts up 73% since 1991. ^[xxiii] As many scholars, activists, and clinicians have attested, psychiatry, community mental health care, and policing have long been part of the same apparatus (as in part evidenced by the American Psychological Association's call for renewed partnerships between psychologists and police just this summer as a response to George Floyd's murder). ^[xxiv] As Saidiya Hartman writes, "If slavery persists as an issue in the political life of black America, it is not because of an antiquarian obsession with bygone days or the burden of a too-long memory, but because black lives are still imperiled and devalued by a racial calculus and a political arithmetic that were entrenched centuries ago. This is the afterlife of slavery—skewed life chances, limited access to health and education, premature death, incarceration, and impoverishment." ^[xxv] Or as Beth Semel recently wrote, the "U.S. mental health care system's carceral logics of capture and containment, disproportionately [harm] BIPOC, queer, trans, disabled, unsheltered, and non-U.S. citizen individuals." ^[xxvi] The people who might want and need to turn to a free, anonymous form of mental health care are the same people most likely to be harmed by the surveillance and policing that can be associated with the hotline in our moment.

Hotlines were initially an experiment in what can happen when we *don't* call the police and instead perform mental health care in community, by community, without intervention, or as Adam Phillips says of psychoanalysis, it was an experiment in "finding out what else might happen *then*, if you don't call the police." ^[xxvii] Contemporary digital mental health has increasingly smuggled back in exactly what Varah, Prosser, and Mayes knew those in crisis needed to be able to avoid: interfacing with involuntary hospitalization and the carceral state. Algorithms can

triage crisis calls, new platforms can remediate the hotline to make it more appealing to a broader user base, and digital efforts can bolster access to mental health—but digital mental health also turns care into a backdoor for surveillance and state violence in a moment where so many are, and have been, vulnerable.

Notes

^[i]Chad Varah, *Why I Started the Samaritans*.

<http://www.samaritans.org/about-us/history-samaritans/how-and-why-i-started-samaritans-chad-varah>. Accessed 15 June. 2016.

^[ii]There were some earlier, adjunctive phone lines but they were the extension of pastoral counseling and not only for suicide, run by one clergyman, etc.

^[iii]For a greatly extended consideration of these two hotlines, as well as others in the same moment, see chapter three in my forthcoming book: “The Far Voice” in *The Distance Cure: A History of Teletherapy* (MIT Press, Fall 2021).

^[iv]*History*, San Francisco Suicide Prevention, <http://www.sfsuicide.org/about-sfsp/history>, accessed June 15, 2016.

^[v]<https://cedar.wvu.edu/cgi/viewcontent.cgi?article=1001&context=orwwu>
p. 9

^[vi]Bernard Duncan Mayes, *Escaping God’s Closet: The Revelations of a Queer Priest* (Charlottesville: University of Virginia Press, 2001), 145.

^[vii]For some examples of this kind of warm line and referral service, see Cait McKinney, “Calling to Talk and Listen Well: Information as Care at Telephone Hotlines” in *Information Activism: A Queer History of Lesbian Media Technologies*.

^[viii]I’ve volunteered on this hotline on and off for the last five years. Oleta ‘Lee’ Abrams, 77; Co-Founded Nation’s First Rape Crisis Center. *The Los Angeles Times*. January 15, 2005.

^[ix]Russell Leigh Sharman, *The Tenants of East Harlem* (Berkeley: University of California Press, 2006), 64.

^[x]Carole Haymes Howard, “Rest in Power Elbert ‘Big Man’ Howard, Founding Father of the Black Panther Party,” *San Francisco Bay View*,

July 18, 2018. For more on the radical health care services and initiatives of the Black Panthers, see Alondra Nelson, *Body and Soul: The Black Panther Party and the Fight Against Medical Discrimination* (Minneapolis: University of Minnesota Press, 2011).

[xi] The Crisis Text Line, which at the start of COVID placed calls for more volunteers due to an increase in usage, has just ousted its CEO Nancy Lublin publicly for fostering a racist and abusive environment as well as evaluating the effectiveness of its volunteer crisis counselors by race and ethnicity. No amount of technologization or lay mental health care is protection against human bias and its presence in digital tools. There is now a new board and new protocols in place, lead in part by the same people who called for her resignation.

[xii] Shari Sinwelski, direction of the National Lifeline as interviewed for Buzzfeed
<https://www.buzzfeednews.com/article/carolinekee/what-happens-when-you-call-suicide-hotline>

[xiii] From its founding in 2005 to 2008, there was no standard across the National Lifeline for suicide assessment risk or how to respond to that risk. Each hotline operated according to their own standards and procedures. In 2008, an Imminent Risk Protocol was put in place across all the feeder crisis centers under the National Lifeline umbrella.

[xiv]
<https://onlinelibrary.wiley.com/doi/full/10.1111/sltb.12128?campaign=wholearlyview>

[xv] Shari Sinwelski, direction of the National Lifeline as interviewed for Buzzfeed
<https://www.buzzfeednews.com/article/carolinekee/what-happens-when-you-call-suicide-hotline>

[xvi]
<https://www.crisistextline.org/mental-health/the-tldr-on-suicide-prevention-and-active-rescues-at-crisis-text-line/>

[xvii]
<https://fivedials.com/reportage/social-media-is-a-kind-of-refuge-its-a-refuge-from-dealing-with-the-more-enlivening-conflicts-within-ones-real-life-adam-phillips/>

[xviii] Emergency services are called if child abuse is reported or if intention to harm another is disclosed, in keeping with mandated reporter practices.

[xix] <https://translifeline.org/blog/post/why-no-active-rescue>

[xx]

<https://autisticadvocacy.org/2016/02/asan-joint-statement-death-of-kayden-clarke/>

[xxi]

<https://non.copyriot.com/wildcat-the-totality-the-undercommons-in-a-time-of-pandemic-and-rebellion/>

[xxii] https://www.cdc.gov/nchs/data/hestat/suicide/rates_1999_2017.htm

[xxiii] According to a recent report entitled, “Ring the Bell: The Crisis of Black Youth Suicide in America,”

[xxiv] <https://www.apa.org/news/press/releases/2020/06/police-partnerships>

[xxv] Hartman, Saidiya. *Lose Your Mother: A Journey Along the Atlantic Slave Trade Route Terror*. Farrar, Straus and Giroux, 2007, p. 6.

[xxvi] <http://somatosphere.net/2020/the-body-audible.html/>

[xxvii] <https://www.youtube.com/watch?v=a8mcaCWGFmg>

*Hannah Zeavin is a Lecturer in the Departments of English and History at UC Berkeley, affiliated with the University of California at Berkeley Center for Science, Technology, Medicine, and Society. Her first book, [The Distance Cure: A History of TeleTherapy](#) is forthcoming from MIT Press in August 2021, with a Foreword by John Durham Peters. *The Distance Cure* is a transnational social history of therapies deployed beyond the classic consulting room. Starting with a reading of epistolary conventions and Freud’s treatments-by-mail, my book shows that tele-therapy, far from being a recent invention, is at least as old as psychoanalysis itself. Subsequent chapters demonstrate that psychotherapy has always operated through multiple communication technologies and media, including the letter, newspaper columns, radio broadcasts, crisis hotlines, the earliest mainframe networks, home computing, and now mobile phones. She received her Ph.D. from the Department of Media, Culture, and Communication at NYU in 2018. Other work has appeared in The Los Angeles Review of Books, Slate, American Imago, Logic Magazine, and beyond.*

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