

December 10, 2018

Federal Communications Commission  
445 12th Street, SW  
Washington, DC 20554

**Re: Docket 18-336  
Implementation of the National Suicide Hotline Improvement Act of 2018**

Dear Commissioners,

In checking the number of submissions a few hours before deadline, we see the number 861 – most short, a few more detailed … and this one may turn out to be the longest. So it is going to be a long read but we will try and keep it conversational.

Some Notes on Suicide in the US (*to remind us while we are all here)*

This is all general information that is very familiar to the people working in this area.

Although first of all, we must note all of the heartbreaking submissions by family members who have lost a loved one to a suicide, and their advocacy for a 3-digit number that would reduce the chance of that happening to another family. They deserve to be heard.

* Suicide is the 10th largest cause of death in the United States, and the second largest for young people aged 15 to 24 years
* The most likely death through suicide is that of a middle-aged white male
* Suicide rates vary significantly between different states. A mountain state such as Wyoming has a rate that is 4 times that of New York. And we note the submission of Paul Heimer, Executive Director of the United Way of Albany County in Laramie, Wyoming (ID 120795095864). The submission details their challenges and how the lack of an NSPL link in Wyoming has led to their own funding of a Talk and Text Suicide Prevention Hotline, that works with 211 Wyoming who they also fund
* The Department of Veterans Affairs reports that around 20 members of the military family (veterans, active-duty service members, guardsmen and reservists) die by suicide **every day**
* Attempted suicide rates for lesbian, gay, bisexual and transgender youth and adults in the U.S. are an estimated three times higher than the national averages
* Suicide among Native Americans in the United States, both attempted and completed, is more prevalent than for any other racial or ethnic group. Note that this is also the case amongst First Nations, Metis and Inuit communities in Canada, especially with regard to youth. However, the solutions regarding this are more complex than anything a helpline can delivery on its own and must be addressed within a cultural context

Summary of Submission

1. Three-digit access for suicide prevention is absolutely needed

2. There are no existing N11 numbers realistically available. 611 is almost certainly not going to be re-assigned when is it used as a customer service number by three of the country’s largest telecommunications companies

3. 211 is the most compatible existing use -- about 25% of the NSPL call centers are also 211s

4. Using 211 for suicide prevention and community information/referral is technically feasible

5. A joint use could involve either a simple initial command that would place the user in one of two completely independent systems; or else the major partners explore an enhanced integration that provides economies of scale for the providers/funders and potentially improved service for the public

6. From the above choices, AIRS recommends exploring the partnership route

7. Any new or enhanced suicide prevention service that is based around a three-digit number must be realistically funded

Who is AIRS *(and why as we making you wade through this …)*

Our full legal name as a 501(c)(3) incorporated nearly 50 years ago, is the Association of Information and Referral Systems – but you can call us AIRS.

AIRS would be quite happy to learn that very few people reading this have even the slightest awareness that we exist or what we do. We are fine with that. We are the professional association of organizations that are engaged in an endeavor within health, community and social services called “Information and Referral”. We are a support to those organizations. We do not provide direct service ourselves. And we see no reason why the public or many stakeholders need to know about us.

Our job is to help our members provide quality service to their communities.

AIRS membership includes nearly 1,000 organizations in the US and Canada.

* About 95% of 211 services are AIRS members
* About 40% of our members provide specialized services to older adults and persons with disabilities
* About 50 of our members are specialized crisis agencies that also have an I&R component
* About 25% of the providers on the National Suicide Prevention Lifeline (NSPL) are also AIRS members
* Many of our members operate military outreach programs and we generally have about 50+ military personnel at our annual conference (that has had a military track for 20+ years)
* About 90% of our members are incorporated non-profits, with most of the remainder being governmental organizations
* Our members answer around 23 million calls for help every year – more than half of those calls are via our 211 members

Here is what AIRS does:

* We provide Standards and Quality Indicators for those working in our sector. These standards include a crisis component
* We operate a credentialing program for individual practitioners. AIRS Certification follows the standards laid out by the Institute for Credentialing Excellence. An individual must be eligible to take a proctored exam, that is constructed through standard psychometric techniques from a job task analysis through to the mathematical models of developing assessments and monitoring question performance. There are about 4,400 individuals currently holding AIRS Certification.
* We also operate an accreditation program for our I&R programs that assesses compliance against the AIRS Standards. These standards include a crisis component although an agency that also holds AAS certification is deemed qualified in that particular regard.
* Finally, we engage in the usual range of training, networking and support that is typical of professional associations. We provide about 10 webinars a year that are attended by around 4,000 people, we have online training programs that are taken by about 5,000 people, we provide a 650-page training manual that is updated every year, and hold an annual conference which is attended by around 600 people every year. And all of the above material and activities includes crisis training to a degree. And any crisis-related training is only delivered by a recognized subject matter expert.

AIRS is currently in a staff transition phase but by the turn of the year, our full-time staffing component will be …. one. We are not a large organization. But we are flexible and our members are engaged in what we do and we can only get things done because of their willingness to share and collaborate with each other for the greater good.

As far as 211 is concerned, we were part of the FCC submission in 2000 that secured the three-digit 211 dialing code. And we have continued to partner with the United Way Worldwide (UWW) in the development of the 211 system as 200+ grassroots initiatives have gradually coalesced into a national structure – albeit one in which the control is more at the local and state level than at the national one. Within 211, AIRS is more focussed on the operational side whereas UWW works on national partnerships, branding and technology systems.

AIRS gets all of its revenue from its members by virtue of the programs and services we provide and the value that our members ascribe to those activities. We receive no funding by virtue of our direct support to 211 – and will never seek any.

Similarly, if the national suicide prevention service achieves one of the outlined options through the decision of the FCC and the backing of national funders, AIRS will be happy to offer our knowledge, experience and connections in an honest collaboration. We would like to think that we could develop relevant programs to help the new service regardless of what base it is built upon, and that more organizations will see the value of becoming AIRS members.

If we do not provide value, we will not stay sustainable.

To be clear, AIRS will neither be seeking or accepting any direct funding for ourselves regarding any aspect of this new vision in suicide prevention.

What is I&R?

Information and Referral goes back more than 100 years to the settlement movement, although it began taking on a clearer identity in the 1960s. I&R is about linking people to the services they need. And this is best done through a human interaction.

Most I&R providers specialize in two important pursuits:

1. They create and maintain resource databases detailing the services in a community. These details include eligibility, hours of operation, application methods, locations, documentation required, etc., and;
2. They engage in direct contact with the public to help them get to the right place to get the right help. Please do not confuse this as a “411 for community services” – if anyone harbors that assumption, go and listen to some calls. I&R staff use a variety of communication techniques to establish rapport, undertake a non-clinical needs assessment, work with the client to clarify their need, outline the necessary information/referrals in a way that provides a client with an informed choice, and to close the call appropriately. When people call they are usually stressed/anxious, they do not usually know what they want, they may not express themselves clearly, they can sometimes be angry because of what they are going through … and the I&R Specialist uses a variety of active listening techniques to move the client through the sequences.

Over the past few years, funders/stakeholders have responded to the potential of I&R programs to provide more coordination at the front-end of the call, in order to save costs further down the system and to provide a more responsive service to the clients.

This point-of-contact/”I&R Plus” role may include initial eligibility approval, service coordination, application assistance, appointment setting, and needs assessment. These roles also involve practitioners drawing upon a wider range of additional techniques such as person-centered approaches, motivational interviewing and options counseling.

Among the sectors that are implementing these options are health, homelessness, re-entry, food/nutrition provision, and services for older adults and persons with disabilities.

Role of I&Rs in Suicide Prevention

I&R programs are **not** specialized crisis intervention programs – although about 50 of our members *are* crisis intervention agencies who *also* operate I&R programs. The task of an I&R program in these circumstances is to identify and handle the immediate crisis situation and at an appropriate time, make sure the individual gets connected to the longer-term support that is required and/or a more appropriate number to call if they experience another crisis.

When someone calls in a crisis, and their call is answered, that’s a good moment. And I&R folks are trained for those moments. We do not pretend to have the clinical expertise of the true professionals within the sector. But the key moment in a suicide prevention call is the fact that an individual in trouble has reached out and connected, and from that moment, someone is – except in very rare instances – safe.

It is when someone does not know there is anyone available to help, or who wants to reach out but does not know which direction to turn, or tries to call someone but encounters a busy signal or a long wait – those are the people and circumstances that need to connect with an expanded, and better promoted national suicide prevention service.

As you are reading this, somewhere in the United States, an I&R Specialist, quite likely at a 211, is answering a suicide prevention call. It may be from a veteran battling PTSD, or from a young person feeling adrift, or someone in a rural area struggling with opioid addiction. It may not even be an obvious suicide prevention call – perhaps someone who is in the habit of calling a few times every week about nothing much in particular but who once called during a severe mental health crisis and who continues to call because s/he feels welcome to do so. Even though the I&R regularly makes sure the person knows the number of their local crisis program.

For the most part, the I&R program has not *encouraged* the call that the I&R Specialist is now handling. I&R’s are not crisis specialists but *are trained in handling crisis calls*, including suicide calls. Because people in crisis have always called I&R services either because they do not know other numbers, they can’t get through to other numbers or they have previously called the I&R on something quite different and feel it is a place they trust.

*(Personal note: I have answered suicide calls myself and the reality is that once you have assessed immediate risk and established a rapport, and you know the person’s name and s/he knows your name; and you are moving to the next stages of the process and you are building a relationship – suddenly saying “I now need to transfer you to a professional service”, always feels the wrong move. It is generally best to stay with the caller for the next 30, 40 or 60 minutes or however long it takes. And the call should end along the lines of offering to conduct a warm transfer or if they do not wish to do so, making sure they have the number for the professional crisis service should they ever need it.)*

We were going to include the next piece as an Appendix (where no-one would read it) but feel it is pretty important and merits being upfront (even if you just scan it). The [AIRS Standards and Quality Indicators for Professional Information and Referral](http://www.airs.org/standards) feature five main areas of I&R activity (Service Delivery, Resource Database, Cooperative Relationships, Disaster Preparedness, and Organizational Effectiveness). Within the Service Delivery Standards, Standard 3 is specific to Crisis Intention within the context of I&R.

Here is what it says:

“**Standard 3: Crisis Intervention**

The I&R service is prepared to assess and meet the immediate, short-term needs of inquirers who are experiencing a crisis and contact the I&R service for assistance. Included is assistance for individuals threatening suicide, homicide or assault; suicide survivors; victims of domestic abuse or other forms of violence, child abuse/neglect or elder/dependent adult abuse/neglect; sexual assault survivors; runaway youth; people experiencing a psychiatric emergency; people with a substance use disorder who are in crisis; survivors of a traumatic experience; and others in distress.

Quality Indicators

1. The I&R service has written crisis intervention policies and procedures that provide protocols for specific types of emergencies. Included are lethality assessment procedures, protective measures relating to inquiries from individuals in endangerment situations and protocols that address inquirers who wish to remain anonymous yet require direct intervention.

2. If the I&R service does not itself provide a formal crisis intervention service, it has a prearranged agreement and documented protocol with an appropriate crisis center that does.

3. The I&R service ensures through training, monitoring and coaching that I&R specialists have the skills to recognize when an inquirer is experiencing a crisis, and that they determine whether the individual is in immediate danger and take steps to ensure that s/he is safe before continuing with an assessment. In assault and sexual assault cases, for example, the specialist ensures that the assailant has left the vicinity and determines whether the individual needs emergency medical treatment. In domestic violence situations, the specialist ensures that the abusive person is not present and threatening the inquirer. The specialist follows the I&R service’s protocol to determine when to access 911 or other emergency rescue services.

4. The I&R service ensures through training, monitoring and coaching that I&R specialists have the intervention skills to:

• De-escalate and stabilize the individual and help him/her remain calm;  
• Help the inquirer talk about and work through his/her feelings as part of the assessment and problem solving stages of the interaction; and  
• Keep the inquirer on the telephone pending referral or rescue.

5. The I&R service has a protocol for debriefing of I&R specialists, as needed, following a crisis call.

6. The I&R service ensures through training, monitoring and coaching that I&R specialists have the skills to recognize the warning signs of people at imminent risk of suicide, violence or victimization (including signs of abuse/neglect, domestic violence and risk of homicide or self-harm) whether the risk issues are explicitly stated or implicit; and to recognize when an inquirer is in immediate need of intervention (e.g., when a person is in medical crisis due to alcohol or drug intoxication, has taken steps to end his or her life, is a victim of recent violence or is experiencing a psychiatric emergency). When warranted, staff follow the I&R service’s rescue protocol for when to access 911 or other emergency personnel to request that they intervene. In these circumstances, inquirer safety overrides confidentiality concerns.

7. In cases of suspected child abuse or elder abuse, the I&R service understands the agency’s responsibilities under the prevailing legislation of the jurisdiction regarding mandatory reporting and completes a report when required.

8. In situations involving suicide or homicide, the I&R service understands the circumstances under which a lethality risk assessment is required and conducts an appropriate assessment when necessary. Lethality risk assessments are recorded in writing and include a description of specific actions taken in response to the situation. (A lethality risk assessment is an evaluation based on research of how dangerous a situation is and addresses issues such as the person’s intention, method, timing and state of mind. Questions include: Has the person already taken steps toward committing suicide by swallowing pills Have there been previous attempts? Does the person have a specific plan? Are the means to carry out the plan readily available? Is there a gun nearby? What is the likely timeframe for a life threatening event – the next few minutes or hours or longer? Has the individual had psychiatric help in the past? Are there other risk indicators such depression, hopelessness, feelings of isolation, intoxication, significant recent loss?)

9. In cases of domestic violence and other endangerment situations, the I&R service takes special precautions to safeguard the inquirer’s identity and all aspects of their interaction.

10. The I&R service uses a variety of means to support its ability to connect with rescue services including Caller ID or a call tracing arrangement with the telephone company or the appropriate 911 service. At a minimum, there is a separate telephone or a separate external line that is available for initiating rescue procedures without interrupting the crisis call. The specialist follows the I&R service’s protocol for addressing inquirers who wish to remain anonymous yet require rescue.

11. When feasible, the I&R service connects inquirers in crisis situations to a formal crisis intervention service in their community for assistance and support once the inquirer’s immediate, short-term needs have been assessed. The connection is made by warm transfer, when possible, and the specialist follows the protocol established by agreement with the crisis center.

12. The I&R service records acts of crisis intervention and its outcomes for use in reports.”

For the record, we are not advocating that every 211 Specialist *should* be answering suicide prevention calls in any blended/integrated service – although many are capable of adding to the overall capacity of any such service.

What is 211?

Essentially, 211 is an easy-to-remember three-digit phone number that allows people to easily reach a comprehensive I&R service.

* There are around 200 organizations engaged in providing 211 services across the US, about half of those operate out of a United Way
* About 40 of those are also engaged in formal crisis intervention
* 211s collectively respond to just under 14 million requests for help last year (nearly 13 million phone calls with the remainder coming through text, chat and email)
* Add to that more than 16 million web visits to 211 online resource databases
* 211 resource databases collectively maintain information on more than 300,000 human service providers
* More than 100 211s have secured AIRS Accreditation
* Many 211s are key members of their statewide emergency planning systems and 211s have been actively engaged in every major disaster since Katrina/Rita.
* Last year, there were 948,051 contacts that involved mental health and substance use disorders
* The vast majority of calls cover the ‘hard-edge’ of the human experience – people needing housing, food, utilities assistance, income support, health care, etc.

Response to Submission from Veterans Affairs

We have not read all the submissions but we note an earlier one provided by Joseph Hurlbert from the Department of Veterans Affairs (ID 1203972218987) and feel the need to address some of the statements within that submission concerning the 211 service.

* *“Gaps in coverage include large cities as well as large rural areas.*” (AIRS response: With no federal funding but with the energy of local communities, 211 now covers more than 94% of the US population. The main gap is Chicago, although ongoing efforts continue to be made to address this gap. The other gaps are mainly rural counties in states such as Arkansas and Georgia. There are 40 states that have 100% coverage. DC and Puerto Rico also have 100% coverage. Four of the 10 states that do not yet have 100% coverage, have 90% coverage. This has been an amazing achievement within the human services sector and maybe with just a slither of federal help, we can get to the 100% mark).
* *“Recently county in Indiana lost funding and is closing it’s 211 call center*.” AIRS response: This is true. But here is the context – Indiana was one of the first states to provide 100% coverage to its residents. All Hoosiers have had access to 211 for the past 15+ years and continue to do so. There are a handful of 211 services in Indiana. One recently left the fold, but the calls for the county it served were simply routed to the other providers with no interruption in service).
* *“There are no mandated service levels”* (AIRS response: The AIRS Standards lists dozens of key performance indicators which an I&R should monitor – and our knowledge of call center techniques and technologies is probably stronger than anyone else in the human services sector. 211 grew organically with no federal interest, oversight or funding. Nearly all 211s have local and/or state funding and that funding nearly always details/mandates minimum service levels. There may be slightly different mandated service levels in Michigan compared to Texas but they will not be *that* different).
* *“The qualifications of 211 staff varies, many not qualified to assist someone facing suicidal thoughts.*” (AIRS response: The qualifications of everybody everywhere tend to vary. We would contend that most 211 staff are trained to handle suicidal thoughts but that this is not a preferred option. There is a certification program for individual practitioners that includes crisis intervention skills. About 20% of 211s are also crisis agencies, most of whom answer calls on the NSPL. Many 211s also operate community outreach programs to their local veterans and often have vets on staff).
* *“Most 211 call centers would not be able to accommodate increased call volumes.”* (AIRS response: Not arguing overmuch with this as a general statement. Every non-profit agency and government program is challenged to balance resources that are inadequate compared to the demands made upon them. There are good people doing good work every day while battling difficult circumstances. And we are all wary of that day when everyone who is potentially eligible for our help, shows up on our metaphorical doorsteps at the same time. **Unless there is additional funding, *no-one* involved in this project would be able to accommodate the increased call volumes this involves.** And let’s just say that the VA itself is not exactly immune to the struggle of matching needs with available resources …).

For the remainder of our submission, we would like to comment on each of the options outlined by the FCC in its letter to the North American Numbering Council.

1. *Consider the feasibility of using each of the currently-designated three-digit dialing codes to be used for a national suicide prevention and mental health crisis hotline system, including codes the Commission has established for other purposes*

It seems obvious that SAMSHA and the VA are better connected than AIRS. On one level, we imagine that if these federal bodies have earmarked 611 as the most likely source for a realignment of the N11 numbers, then they must have engaged in some preliminary discussions.

On another level, from everything within our experience of the FCC, we believe the re-acquisition of 611 for another purpose to be extremely unlikely. However, we will be happy to be surprised.

Although not officially designated, 611 has been regarded as a “taken” N11 number for decades. It is sometimes described as being a number for ‘technical line issues’ but in reality, it is now a prime customer service number.

Three of the country’s four main wireless carriers (Sprint seemingly the exception) currently use the convenience of 611 as part of their direct customer service system:

* “Wireless Care, Service and Billing Questions. Dial 611 from your wireless phone, or visit AT&T Mobility Support or 800.331.0500”
* Dial \*611 from your Verizon mobile phone and press Send to be directly connected with a Verizon customer service representative.”
* “From the T-Mobile app, on a T-Mobile phone, From your T-Mobile phone: 611”

The ethos within the FCC is to minimize the active regulation of telephone companies, preferring to work with them in a collaborative fashion where required. Generally, the FCC tries to avoid making major telephone providers do things that they do not want to do. And that is not written as a value judgement.

We can share a relevant example:

When 211 was designated as a number for community information and referral in 2000, the FCC chose not to force the landline phone companies to implement 211 access for free, and technically, the wireless sector was not forced to implement 211 at all. The result was years of struggle to deal with the complexities of who to ask for what and where, with conversion costs almost seeming like random numbers between providers and coverage areas. A simple directive would have done the trick.

By comparison, here is the decision of the Canadian Radio-television and Telecommunications Commission (CRTC 2001-475) from 2001: “With respect to the proposal that TELUS be compensated for implementing 211 access, the Commission notes that TELUS did not identify what these costs would be, or even if they would be significant. Furthermore, the Commission notes that 211 dialing will be implemented over a number of years and scheduled with other work on switching. In the absence of any cost details from Bell Canada et al., TELUS, and in the United Way et al. plan, the Commission considers that the cost issue is not significant … In view of the above, the Commission directs the carriers to bear the cost of implementing 211 on an incremental basis …”

As written earlier, we will be happy to be surprised regarding the re-purposing of 611 – and if the FCC is going to be directive towards implementation costs, we would welcome that whatever rules are developed, the courtesy should also be extended to 211.

* **AIRS does not believe that the current active use of 611 by some of America’s largest telecommunications companies, makes 611 an realistic option.**

1. *Consider the feasibility of using a new easy-to-remember, three-digit dialing code for such a system, including, for example, digits preceded by a star or number sign*

The overall issue of the feasibility of a “new easy-to-remember, three-digit dialing code” will be addressed in other areas of this submission.

So let’s look at the idea of “digits preceded by a star or number sign”. Interesting. Our first reaction was to assume that this *was* technically feasible but would only be accessible by cellular users. And whereas this might be a moot issue in 5-7 years time, the effective barring of access to something such as \*711 by all current landline users, would seem reason enough to make that option inadvisable.

We note the submission of TGM CONSULTING (ID 12061802923613) which addresses this issue, “as a subject matter expert on the technical aspects of numbering and how it relates to telecom networking” and which succinctly states, “Is a code preceded by a \* or # symbol feasible? No.” The submission goes on to explain the issue in a much clearer and far more technically credible and convincing perspective than we can offer.

But we can also suggest a scenario whereby if there is a recommendation for #211 or \*99 or #5555 or anyone of several thousand variations, then the FCC and NANC need to get prepared for a deluge of new requests for memorable numbers for all manner of arguably important reasons, in addition to major corporations looking for their own marketing edge.

As often stated, N11 numbers are a scarce resource. Probably best to keep them that way. If the main aim is to reduce confusion in critical areas, then introducing # and \* variations, will only create confusion. If you do this once, you will be asked to do it many more times.

* **AIRS does not regard “digits preceded by a star or number sign” as a technically viable option in terms of genuine public access, or a desirable one.**

1. *Outline the logistics of using a currently-designated or newly-designated three-digit dialing code, including but not limited to the need for translation changes in the network and cell site analysis and reprogramming by wireless carriers*

Our overall recommendation is that a single national switch is required, whether that is for a dedicated suicide prevention line or a 211 line that combines both functions.

As far as the spectre of reprogramming is concerned. To begin with, the wireless carriers are not currently required to have any 211 switch whatsoever, but nearly all now do so.

Let us share an example of how the switching of 211 currently works:

* Parker County is now ready to offer a 211 service through a local community service provider. The provider has to make contact with all of the major telephone service companies and ask them to translate any 211 calls from Parker County to their local 10-digit number. Parker County may also be large enough that some areas would require toll-free access and that also needs to be set up. Some state 211 systems have developed local contacts to ease this process but every state is different. After a few months of service, the 211 will discover a few smaller wireless providers who have not made the switch – mainly because they were not aware – and then those folks need to be tracked down and persuaded and/or paid. About 5 years later, some other problem emerges and the new 211 director at Parker County has to figure out the local phone contacts, many of whom have also changed.

After nearly 20 years of 211 service, variations of the above scenario are constantly in motion in communities across the country.

Here’s an actual and very-timely example -- Yellowstone County, Montana, has just made 211 available through their local United Way with the calls being answered by Voices of Hope based in Great Falls, Montana. By the way, Voices of Hope is a 211, an AIRS member and also a member of the NSPL. The switch was made *last week* but was preceded by dozens of emails coming and going in all directions before the right people were given the right information.

* **AIRS believes that a single national switch would make life actually much easier for telephone service providers. And certainly for any new suicide prevention system whether it was via 211 or another number.**

1. *Estimate the costs associated with using a currently-designated or newly-designated dialing code, including costs incurred by service providers to carry out the above logistics, and any costs the federal government, states, and localities may incur to implement the dialing code*

In the creation of 211, the federal government did not incur any costs, although some states and some counties may have funded some 211 start-up costs across the country. The telephone service providers themselves for the most part, charged for the cost of the switching – although the range of those costs varied (and continues to vary) from state-to-state, from carrier-to-carrier, and between all of the telephony types (landline, cellular, VoIP, etc.). One provider might charge X in one state and X+ in an adjoining state. Some will do it for free.

However, it seems that over the last few years, most telephony providers have been treating the establishment of the 211 switch as an inbuilt cost of business, so may regard a new N11 in the same manner.

Having said that, this is an opportunity regardless of the final decision, to implement a planned strategy to establish a single national switch system that will be more cost-effective for the suicide prevention service, less overall work for the myriad telephone providers and also much more geared to the needs of the service users (faster, more flexible, more responsive, etc.).

In addition, somewhere it needs to be noted that the average funding received by the agencies currently operating the NSPL is around $3,000 a year. We know that they are happy to take those calls because that is what they do but they are only able to participate based on existing local funding for their crisis and/or I&R service.

If a three-digit or otherwise enhanced national phone number is secured, **then federal funding must follow**. We appreciate that this is not the responsibility of the FCC or NANC. But there needs to be some acknowledgement that an increased awareness will generate thousands of more calls every day (which is a good thing) – providing those calls are answered.

No-one will want to be reading about unanswered calls to a new national suicide prevention service.

* **AIRS recommends that increased call volumes be estimated from existing models in the US and other counties, and that service providers are adequately funded for their work to ensure that the service is sustainable**

1. *Recommend whether the Commission should designate a three-digit dialing code for a national suicide prevention and mental health crisis hotline system and, if so, what three-digit code it should designate*

Does the United States need a three-digit dialing code for a national mental health crisis hotline system? Yes. The numbers are desperate. The response should be in keeping.

Our experiences with 211 shows that the concept that “people will remember a three-digit number in moments of crisis”, is indeed a true one.

The essence of our entire submission is the belief that the 611 number is not realistically available but that the 211 number is the closest match – even to the extent of having a high number of agencies that are currently working on both 211 and the NSPL.

Technically, both the suicide prevention and I&R component could be organized so that they are two separate branches of the same 211 switch … i.e. pressing 1 takes you into one area that is separately organized, routed, administered, governed, etc., while pressing 2 takes you into the other fiefdom.

The submission of United Way Worldwide recommends to: *“Formalize the partnership between National Suicide Prevention Lifeline, United Way Worldwide, and the Alliance of Information and Referral Systems to create a wholistic, blended system supported by training and technology infrastructure.”*

**AIRS endorses this recommendation.**

We believe that there are several economies of scale that make sense both from the purview of operational costs (capacity, routing, cross-training, reporting, quality assurance, connectivity, marketing, multi-channel access, etc.) and more importantly, providing a better, more integrated and responsive service to individuals with mental health/behavioral crises.

There are many technical, operational and governance issues that would need to be addressed in any such as partnership, but with the right attitude, these are not inherently impossible to overcome in and of themselves.

In some respects, it may make matters easier. For the past 20 years of promoting 211, great care is taken to clarify that the service is for all manner of health, community and social needs *except* suicide prevention and mental health crisis. It may well be that “dial 211 when you need help” is the easiest public message of all.

We also note that the three organizations mentioned above are not the only agencies that could be engaged in some aspect of a more integrated system.

Another strong concern is that the suicide prevention hotline, whatever the structure and leadership, be developed with multi-channel access in mind. It must incorporate text messaging and web chat.

(Sidebar: As I&Rs began to debate whether and how to handle chat and text services, there were concerns about losing the human element. And while it is more challenging, we discovered that the essence of our person-centered, active listening approach, remained the same even within a text “active-reading” environment).

We know everyone knows this but for people under 30 years, their device might be called a “phone”, but that function (making a telephone call) is about the 10th most likely thing they are going to do with it. Note that in Canada, the Kids Help Phone (AIRS member) is the national telephone counseling service for young people, and last year, about half of their contacts were through Live Chat.

* **AIRS recommends that, assuming the unavailability of 611, the 211 number be used for the national suicide prevention hotline; and that:**
  + **The service and the local service providers be adequately funded**
  + **The NSPL, UWW and AIRS engage in partnership discussions to take advantage of collective strengths that both streamline costs and enhance service**
  + **The service offers multi-channel access across the public preferences**

1. *Provide a proposed cost-benefit analysis comparing use of a three-digit dialing code with the current use of a toll-free number to operate the National Suicide Prevention Lifeline*

We are assuming that most of the current costs of the NSPL are related to its telephony issues – i.e. routing calls, including toll-free costs. We are not sure about their phone system but it is quite possible that the costs structure will not dramatically change.

Most of the cost differences will relate to the scale of the new operation – trying to anticipate the number of calls and the resources needed to answer them.

Finally, we appreciate your patience, your engagement and your commitment to this process. AIRS is willing to provide any assistance required or requested to the best of our ability. We hope that one way or another, this is the start of a new era for suicide prevention in the United States.

Yours in service,



Clive Jones  
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