Eileen F. Zeller
12808 Brighton Dam Road
Clarksville, MD 21029
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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:

I am writing to support the establishment of a 3-digit dialing code for a national suicide prevention and mental health crisis hotline system. People in crisis are desperate and scared: they need a number that is easy to remember and that will be immediately answered by a trained, caring crisis counselor.

Establishing the new dialing code must be coupled with sufficient funding for the National Suicide Prevention Lifeline to ensure that there is adequate capacity to answer the crisis calls. I am liberally borrowing the next section from David W. Covington, LPC, MBA and Michael F. Hogan, MD, who previously submitted their comments to this docket:

> It is estimated that more than 16 million psychiatric emergency calls per year are made to the 165 independently funded crisis call centers that comprise the National Suicide Prevention Lifelin18-e ("Lifeline"). In 2017, approximately 2 million of those callers use Lifeline's toll-free number (1-800-273-TALK). Lifeline routed ~700,000 callers—those who electronically identified as Veterans or service members—to the Veterans Crisis Line. The remaining ~1.3 million callers were routed to the closest crisis center. The majority of callers dialed the call centers directly, using one of the centers' local, county, and state crisis lines.
>
> An unknown number of individuals with a mental health, addiction or suicidal crisis and/or their family members don't know the Lifeline 10-digit number or their local crisis hotline number. These are desperate situations and can be frightening to both the person in crisis and their loved ones. Seeking help quickly, they find a way to the nearest hospital Emergency Department or call the numbers they know, like 9-1-1.
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> **Tragically, the US still doesn't have a 9-1-1 for the brain.**
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> This legislation provides a pathway for an important first step: *utilize N-1-1 as a simple to remember and immediate response by trained and caring mental health and addiction crisis experts*. Deploy the existing infrastructure in the National Suicide

Prevention Lifeline network of crisis centers and coordinated through the SAMHSA grantee, Vibrant Emotional Health.

A vital next step is to adequately fund the National Suicide Prevention Lifeline. Over the past several years, the Veterans Administration has provided the resources necessary to support callers who press 1 after calling the National Suicide Prevention Lifeline. These 700,000 annual calls are routed to more than 1,000 VA staff across three national call centers for the Veterans Crisis Line (VCL), with annual support of $90 million. This funding assures a timely and consistent service akin to 9-1-1.

However, apart from some administrative overhead for Vibrant Emotional Health to coordinate the network and funding for the telephony charges, there is no material federal funding for the crisis centers who manage non-VCL calls to the National Suicide Prevention Lifeline. This means that local, county, and state crisis lines must leverage unused capacity and/or volunteer support. The heroic efforts of these centers have made the difference in the lives of millions of people, but this is an unsustainable model.

I do not believe that the 2-1-1 dialing code should be used to meet the unique needs of people in psychiatric or suicidal crisis. I again use the words of a colleague who previously submitted comments (Kenneth Norton, Executive Director, NAMI NH The National Alliance On Mental Illness):

> We oppose suggestions that the existing 211 number can be used for this purpose. Doing so will create confusion; 211 provides an excellent service and is recognized by the general public as an information and resource line. The significant increase in call volume seen by the Lifeline during the past few years shows public recognition and comfort in utilizing the Lifeline for what it is – an immediate lifeline for someone in a mental health crisis. Assigning the Lifeline to 211 would also likely result in operators who have not been trained in suicide crisis response to initially answer calls, and possible delays while calls are routed to an appropriate responder. While there are some 211 centers that are currently valued certified crisis centers for the Lifeline with trained counselors, those centers receive calls originating through the current 1-800-273-TALK number. The majority of 211 call centers are not certified to respond to suicide calls. Those 211 centers who do choose to be certified to take Lifeline calls will likely be able to do so via a call forwarding system that will not confuse the public about the role of 211 vs an N11 suicide prevention line.

Thank you for the opportunity to comment on this vitally important issue.

Sincerely,

Eileen F. Zeller, MPH