

SAMHSA

Substance Abuse and Mental Health
Services Administration

5600 Fishers Lane • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

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FEB 01 2019

Mr. Ajit Pai
Chairman
Federal Communications Commission
445 12th Street, SW
Washington, DC 20554

Received & Inspected

FEB 14 2019

FCC Mailroom

Dear Chairman Pai:

The Substance Abuse and Mental Health Services Administration (SAMHSA) is pleased to submit our report to the Federal Communications Commission to inform your study on the feasibility of designating a dialing code to be used for a national suicide prevention and mental health crisis hotline system as mandated by the National Suicide Hotline Improvement Act, signed into law by the President on August 14, 2018.

This report reviews the current context for the Act; the history and structure of the National Suicide Prevention Lifeline, as well as its relationship to the Veterans Crisis Line; the patterns of increasing call volume for the Lifeline; and the challenges in assuring adequate capacity to answer calls. In addition, the report reviews evaluations of the effectiveness of the Lifeline; estimates the potential impact of a new N11 number on national suicide prevention and crisis intervention efforts, as well as the impact on the Lifeline specifically; and reviews potential improvements to the Lifeline. Finally, the report provides concluding recommendations describing how an N11 national suicide prevention and crisis intervention number could play an instrumental role in improving suicide prevention and crisis intervention nationally.

SAMHSA is pleased to be working with you on such an important issue and we look forward to collaborating with you on the final National Suicide Hotline Improvement Act Report.

Sincerely,

Elinore F. McCance-Katz, M.D., Ph.D.

Enclosure

National Suicide Hotline Improvement
Act:
The Substance Abuse and Mental Health
Services Administration Report to the
Federal Communication Commission

February 7, 2019

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Suicide Prevention Branch

SAMHSA
Substance Abuse and Mental Health
Services Administration

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Executive Summary

On August 14, 2018, President Trump signed into law the National Suicide Hotline Improvement Act (hereafter referred to as “the Act”).¹ The Act states:

“(B) SAMHSA STUDY AND REPORT TO ASSIST COMMISSION. – To assist the Commission in conducting the study under paragraph (1), the Assistant Secretary for Mental Health and Substance Use shall analyze and, not later than 180 days after the date of enactment of this Act, report to the Commission on – (i) the potential impact of the designation of an N11 dialing code, or other covered dialing code, for a suicide prevention and mental health crisis hotline system on – (I) suicide prevention; (II) crisis services; and (III) other suicide prevention and mental health crisis hotlines, including – (aa) the National Suicide Prevention Lifeline; and (bb) the Veterans Crisis Line; and (ii) possible recommendations for improving the National Suicide Prevention Lifeline generally, which may include – (I) increased public education and awareness; and (II) improved infrastructure and operations.”

The Act gives SAMHSA 6 months to prepare this report, which is due to the Federal Communications Commission (FCC) on February 14, 2019.

This report reviews the current context for the Act; the history and structure of the National Suicide Prevention Lifeline (hereafter referred to as “the Lifeline”), as well as its relationship to the Veterans Crisis Line; the patterns of increasing call volume for the Lifeline; and the challenges in assuring adequate capacity to answer calls. This report also reviews evaluations of the effectiveness of the Lifeline, estimates the potential impact of a new N11 number on national suicide prevention and crisis intervention efforts, as well as the impact on the Lifeline specifically, and reviews potential improvements to the Lifeline. Finally, this report provides concluding recommendations describing how an N11 national suicide prevention and crisis intervention number could play an instrumental role in improving suicide prevention and crisis intervention nationally.

¹ “National Suicide Hotline Improvement Act” (PL115-233, 14 August 2018), <https://www.congress.gov/bill/115th-congress/house-bill/2345>.

Context and Background of Legislation

In 2017 more than 47,000 Americans died by suicide (Murphy, Xu, Kochanek, Arias, 2018) and more than 1.4 million adults attempted suicide (SAMHSA's National Survey on Drug Use and Health, 2018). According to the Centers for Disease Control and Prevention (CDC), from 1999 to 2016 suicide has increased in 49 of the 50 states and in more than half of those states the increase is greater than 30 percent (Stone, Simon, Fowler, 2018). The largest increase in deaths by suicide occurred in the past decade and from 2016 to 2017 an increase of 3.7 percent (more than 2000 additional suicide deaths) was recorded (Hedegaard, Curtin, Warner, 2018). It was within this context, at a time when the importance of rapid access to crisis intervention and suicide prevention services has never been more critical, that Congress passed and the President signed into law the National Suicide Hotline Improvement Act (hereafter referred to as "the Act"). The Act, signed into law on August 14, 2018, states:

"(B) SAMHSA STUDY AND REPORT TO ASSIST COMMISSION. – To assist the Commission in conducting the study under paragraph (1), the Assistant Secretary for Mental Health and Substance Use shall analyze and, not later than 180 days after the date of enactment of this Act, report to the Commission on – (i) the potential impact of the designation of an N11 dialing code, or other covered dialing code, for a suicide prevention and mental health crisis hotline system on – (I) suicide prevention; (II) crisis services; and (III) other suicide prevention and mental health crisis hotlines, including – (aa) the National Suicide Prevention Lifeline; and (bb) the Veterans Crisis Line; and (ii) possible recommendations for improving the National Suicide Prevention Lifeline generally, which may include – (I) increased public education and awareness; and (II) improved infrastructure and operations."

The passage of the Act also occurs within the context of the passage of the 21st Century Cures Act in December 2016 (hereafter referred to as "the Cures Act"),² which has significant implications for mental health care in America, and for national suicide prevention and crisis intervention efforts in particular. For example, the Cures Act authorized the National Suicide Prevention Lifeline (hereafter referred to as "the Lifeline") in law for the first time,³ authorized an adult suicide prevention program, reauthorized youth suicide efforts through the Garrett Lee

² "21st Century Cures Act" (Public Law 114-255, 13 December 2016), <https://www.congress.gov/114/bills/hr34/BILLS-114hr34enr.xml>

³ "21st Century Cures Act" (Public Law 114-255, 13 December 2016), Section 9005.

Smith Memorial Act, and authorized a grant program to support community crisis response systems.

National Suicide Prevention Lifeline History, Development, and Structure

Congress first appropriated funding for the networking and certification of suicide prevention hotlines using a single toll free number in 2001. SAMHSA awarded a grant to the American Association of Suicidology and the Kristin Brooks Hope Center (KBHC) utilizing the number 1-800-SUICIDE and establishing a network of crisis centers willing to answer these calls. In 2004, SAMHSA re-competed the grant and the award was made to the Mental Health Association of New York City. In 2005, they launched the Lifeline utilizing the number 1-800-273-8255 (TALK). The Kristen Brooks Hope Center decided to continue to manage calls to 1-800-SUICIDE without federal support.

In 2006, a Spanish language sub-network was created in the Lifeline network and currently is the “press 2” option in the recorded greeting.

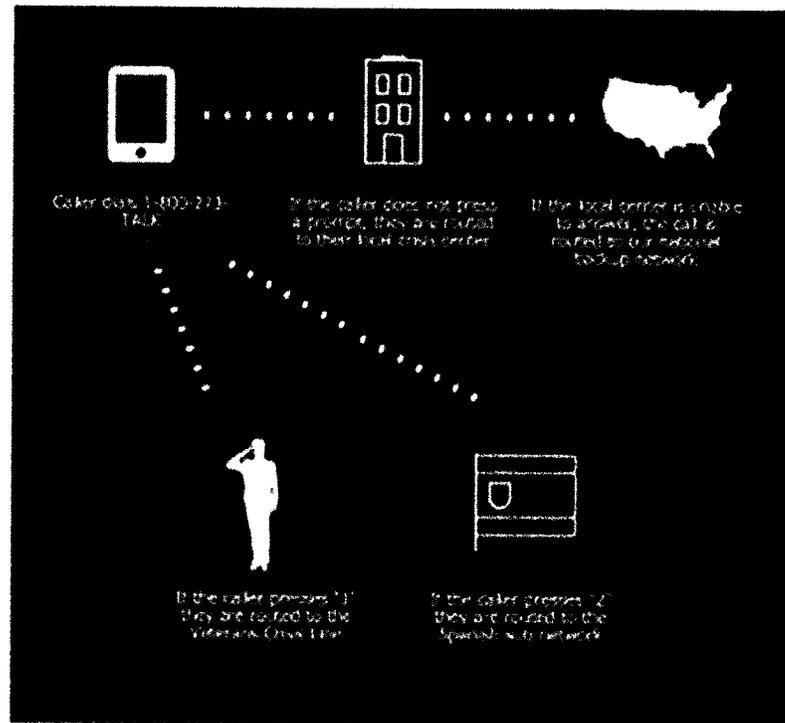
In January 2007, faced with the imminent likelihood of the collapse of the 1-800-SUICIDE number, and at the request of SAMHSA, the FCC temporarily assigned the number 1-800-SUICIDE to SAMHSA. In February 2012, KBHC and SAMHSA filed a joint petition with the FCC requesting that 1-800-SUICIDE be permanently assigned to SAMHSA, which was granted by the FCC in March 2012. Calls coming into 1-800-SUICIDE were routed and answered in the same way as calls to 1-800-273-8255 (TALK).

In 2007, SAMHSA and the U.S. Department of Veterans Affairs (VA) partnered to establish 800-273-8255 (TALK) as the access point for the Veterans Crisis Line (VCL). Callers that dialed 1-800-273-8255 (TALK) hear a recorded announcement and if they press “1” are connected to the VCL. Following recommendations by the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, the VCL was co-branded as the Military Crisis Line within the Department of Defense to answer calls by service members and their families, as well as National Guard, and Reservists. Calls to the VCL are answered by professional VA responders in Canandaigua, New York, Atlanta, Georgia, and Topeka, Kansas. In 2008, approximately 29 percent of Lifeline callers pressed “1”.

Figure 1. National Suicide Prevention Lifeline's Call Flow



The Lifeline's Call Flow



The connection of the VCL to the Lifeline is a central component of the Inter-Agency Agreement between SAMHSA and VA to assure federal collaboration in Lifeline meeting the needs of the nation's veterans and service members. The Cures Act now requires that the VCL is made available through the Lifeline to veterans, service members, and their families. SAMHSA and VA communicate regularly to monitor the implementation of the Lifeline press "1" option, as well as the experience of veterans who call the Lifeline but do not press "1".

In 2011, given the increasing demand for online crisis services, SAMHSA began providing supplemental funds to the Lifeline to build the capacity of network centers to provide chat crisis intervention services, initially for a period of 4 hours a day, 5 days a week. Due to the strong demand for this service, the Lifeline expanded the chat service, which is accessed through the Lifeline website at www.suicidepreventionlifeline.org to 12 hours a day in 2013. Currently, the

26 crisis centers that answer Lifeline crisis chats are available 24 hours a day, seven days a week, and 365 days a year.

The Lifeline is currently a network of 163 crisis centers linked by a toll-free telephone number, 1-800-273-8255 (TALK), and available to people in suicidal crisis or emotional distress at any time of the day or night. Callers to 1-800-SUICIDE also continue to be answered through the Lifeline system. The service routes calls from anywhere in the United States to the closest certified local crisis centers, spanning every state but Wyoming. Should the closest center be overwhelmed by call volume, experience a disruption in service, or if the call is from a part of the state not covered by a Lifeline crisis center, the system automatically routes callers to a backup center.⁴ Trained counselors assess callers for suicidal risk, provide crisis counseling, crisis intervention, engage emergency services when necessary, and offer referrals to mental health and/or substance use services.

In 2018, the Lifeline answered a total of 2,205,487 calls, with an average of 183,790 calls per month. Also in 2018, 102,640 crisis chats were responded to, with an average of 8,553 chats per month.

The Lifeline has become the nation's mental health and suicide prevention safety net. In many communities the only immediately available resource for a suicidal person would be an emergency room or the Lifeline and its network of crisis centers. All network crisis centers have adopted protocols and policies that represent best practices in the field, including "Standards for Suicide Risk Assessment,"⁵ and "Guidelines for Helping Callers at Imminent Risk for Suicide."⁶ The Lifeline has also supported the training of crisis center staff in Applied Suicide Intervention Skills Training (ASIST), an internationally disseminated gatekeeper training program (ASIST; LivingWorks, 2010). In addition, the Lifeline has promoted follow up of suicidal callers as a best practice and many crisis centers have incorporated telephonic follow up into their work. This practice has been shown to be effective in reducing suicidal behavior in research supported

⁴ Calls from Wyoming go directly to a backup center.

⁵ National Suicide Prevention Lifeline Risk Assessment Standards (2007). Retrieved from <https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Suicide-Risk-Assessment-Standards-1.pdf>

⁶ National Suicide Prevention Lifeline Imminent Risk Policy (2012). Retrieved from <https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Lifeline-Policy-for-Helping-Callers-at-Imminent-Risk-of-Suicide.pdf>

by the National Institute of Mental Health and the Department of Veterans Affairs (Miller, et. al., 2017 and Stanley, Brown et. al., 2018).

National Suicide Prevention Lifeline Effectiveness

Empirical evidence to support the effectiveness of Lifeline crisis centers for suicide prevention has steadily grown (Gould, Cross, Pisani, Munfakh, & Kleinman, 2013; Gould & Kalafat, 2009; Gould, Kalafat, Munfakh, & Kleinman, 2007; Gould et al., 2018; Gould et al., 2016; Gould, Munfakh, Kleinman, & Lake, 2012). The Lifeline has systematically utilized these findings to promote improvement throughout the Lifeline network. The Lifeline is increasingly recognized as a critical and effective component of the mental health and suicide crisis response care system in the United States and has been recognized as a model program and key national resource helping to advance knowledge and move suicide prevention efforts forward (U.S. Department of Health and Human Services, 2012, pp. 54, 57, 99).

The evaluation of the national network of certified crisis call centers has been ongoing since the network's inception in 2001, and has become a gold standard in data-driven decision-making. The initial evaluations of SAMHSA's earliest hotline initiatives examined proximal outcomes of crisis centers' effectiveness as measured by changes in callers' crisis and suicide states from the beginning to the end of their calls and intermediate outcomes within three weeks of their calls. Data collected from 2002 to 2004 from nearly 3,000 callers from eight crisis centers demonstrated that seriously suicidal individuals were calling telephone crisis services (e.g., 8 percent in midst of attempt, 58 percent had made prior attempt); and that significant reductions in callers' self-reported crisis and suicide states occurred from the beginning to the end of the calls. Specifically, there were significant decreases in callers' reports of intent to die, hopelessness, and psychological pain over the course of the call (Kalafat, Gould, Munfakh, & Kleinman, 2007; Gould, Kalafat, Munfakh & Kleinman, 2007).

While providing support for the clinical effectiveness of the network of crisis centers, early evaluation results also raised a concern about the adequacy of suicide risk assessments conducted by some crisis center staff (Mishara et al., 2007a; 2007b; Kalafat et al., 2007). In response, SAMHSA and the Lifeline focused on standardizing crisis counselor practices and training across the network (Joiner et al., 2007), including disseminating ASIST. An evaluation of the impact of ASIST's implementation demonstrated improvements in caller's outcomes. For

example, data from 1,507 monitored calls from 1,410 suicidal individuals across 17 Lifeline crisis centers showed that callers were significantly more likely to feel less depressed, less suicidal, less overwhelmed, and more hopeful by the end of calls handled by ASIST-trained counselors (Gould, Cross, Pisani, Munfakh, & Kleinman, 2013). Additionally, a study of California suicide prevention hotlines found that California hotlines affiliated with the Lifeline, which asks crisis centers to adhere to its Standards for Suicide Risk Assessment, were significantly more likely to assess for the presence of suicidal ideation and behavior than centers not affiliated with the Lifeline (Ramchand, et.al, 2017).

The concept of imminent suicide risk is critical to and used regularly by suicide crisis counselors, as well as emergency department staff, and other first responders. The need for a clear and explicit policy for such high-risk callers to the Lifeline was highlighted by the series of SAMHSA-funded evaluations of network crisis centers published in 2007 (Gould et al., 2007; Mishara et al., 2007a; Mishara et al., 2007b). Gould and colleagues (2007) found that for callers who had taken some action to kill themselves immediately before calling the crisis center, emergency rescue was initiated in only 37.9 percent of cases. On monitored calls where a suicide attempt was in progress, Mishara et al (2007) found that emergency services were known to be dispatched in 18.2 percent of cases (6/33), and the caller changed his/her mind about the attempt in 24.2 percent (8/33), leaving 57.6 percent of calls (19/33) apparently without a satisfactory resolution. In January 2008, the Lifeline disseminated guidelines and policies for helping callers at imminent risk of suicide, to which the crisis centers across the network have been asked to conform. Following the dissemination of the Lifeline Imminent Risk policy, an evaluation of the assessment and management of imminent risk callers to the Lifeline employed data from 491 call reports completed by 132 counselors at eight crisis centers (Gould et al., 2016). Findings demonstrated that crisis counselors actively obtained the collaboration of the vast majority (over 75 percent) of callers they identified as being at imminent risk, consistent with the Lifeline Imminent Risk policy. On 19.1 percent of imminent risk calls, the counselors sent emergency services (police, sheriff, EMS) with the collaboration of the callers, while on a quarter of the imminent risk calls, the counselors sent emergency services without the caller's collaboration. For the remaining 55 percent of calls involving imminent risk, the risk level was able to be reduced without the use of police or ambulance through collaborative interventions,

such as reducing access to lethal means, involving a third party, collaborating on a safety plan, and agreeing to receive rapid follow-up from the crisis center.

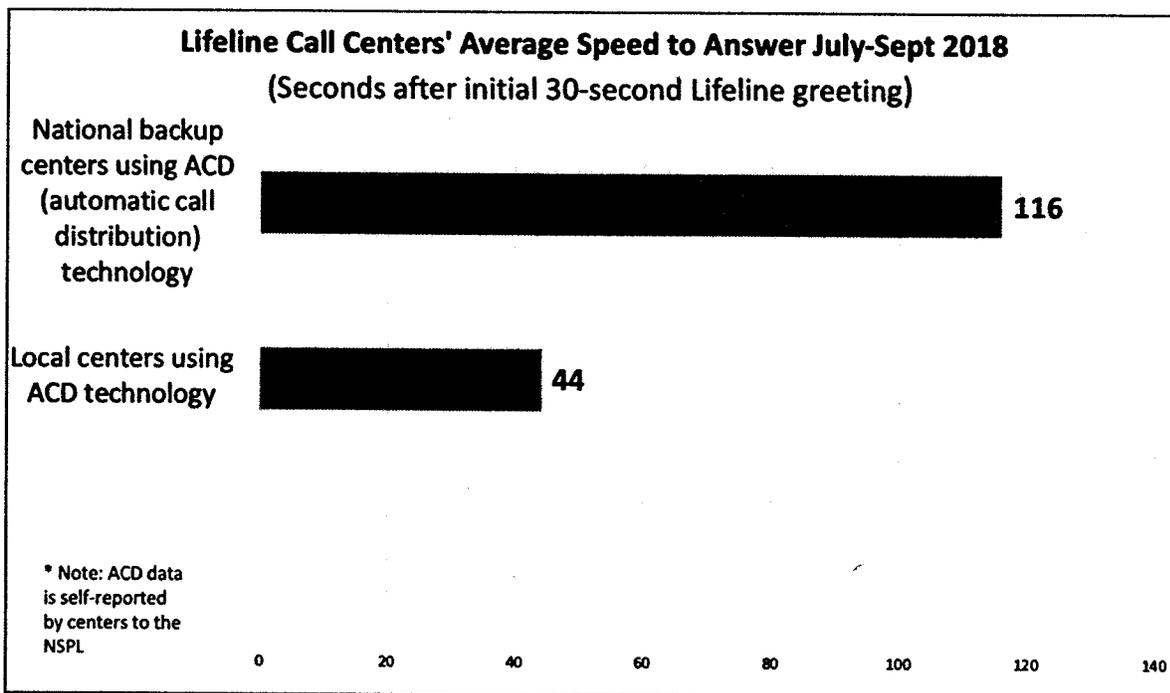
The evaluations also highlighted the need to heighten outreach strategies to minimize suicide risk and enhance referrals. Gould and colleagues (2007) found that 43 percent of suicidal callers who completed evaluation follow-up assessments experienced some recurrence of suicidality (ideation, plan, or attempt) in the weeks after their crisis call, and only 22.5 percent of suicidal callers had been seen by the mental health care system to which they had been referred. In response to these findings, SAMHSA funded an initiative in 2008 to offer and provide follow up to all Lifeline callers who reported suicidal desire during or within 48 hours before making a call to Lifeline. The follow-up was designed to enhance continuity of care during the high-risk period following a suicidal crisis. An evaluation of 550 callers followed by 41 crisis counselors from six crisis centers revealed that 79.6 percent of callers interviewed 6-12 weeks after their crisis call reported that the follow-up calls stopped them from killing themselves (53.8 percent a lot, 25.8 percent a little) (Gould, Lake, Galfalvy, Kleinman, Munfakh, Wright, & McKeon, R. (2018). Callers said follow-up gave them hope, made them feel cared about, and helped them connect to further mental health resources. These callers also reported that the initial crisis calls stopped them from killing themselves (76.2 percent a lot, 18.7 percent a little). Currently 119 of the Lifeline centers report providing some follow-up services, typically within 48 hours of the initial call. However, the majority of these centers do not receive any funding for the follow-up services (National Suicide Prevention Lifeline, 2017). Building upon evaluations of crisis centers' experience providing follow-up services to suicidal Lifeline callers, SAMHSA has funded Lifeline crisis centers to engage in follow-up activities with suicidal individuals discharged from emergency departments and hospitals. The evaluation of these expanded follow-up efforts are underway.

National Suicide Prevention Lifeline Challenges: The Need for Growth in Community Crisis Center Capacity to Meet Growing Volume

While evaluation of calls to the Lifeline have shown good results regarding effectiveness, including reduction of suicidal ideation and hopelessness, improved suicide risk assessment, response to callers at imminent risk, and improving follow up, the greatest challenge to the

effectiveness of the Lifeline is its capacity to respond rapidly to the steadily increasing call volume. Any call not responded to, or where the response is delayed long enough that a suicidal caller hangs up (call abandonment), has the potential for a tragic outcome. By providing a system of backup centers to local communities, the Lifeline has substantially improved crisis care in the United States. However, this system is challenged by both rising call volumes and uneven coverage in many states. This results in many calls going directly to the back-up centers, which are unable to respond as quickly as a local crisis center could.

Figure 2. National Suicide Prevention Lifeline Call Centers' Average Speed to Answer



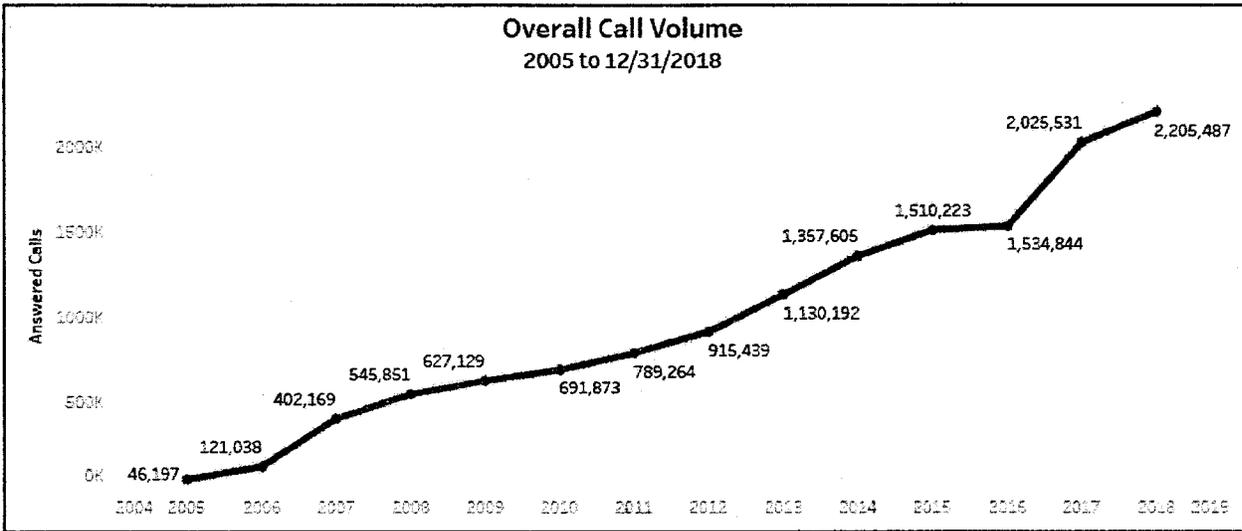
On average local Lifeline crisis centers answered calls within 44 seconds while the average speed to answer calls going to the Lifeline back up centers was 116 seconds. This illustrates the importance of increasing local Lifeline crisis center capacity. Some potential ways of accomplishing this would be by assisting centers to increase the number of staff available to answer calls or by adding more crisis centers to the Lifeline network to minimize areas that send calls directly to back up centers. From April 2017 to April 2018 the average longest wait increased 29 percent. Appendix 1 includes a table of the in state answer rate for every state (excluding callers who “press 1” to be connected to the VCL). The fiscal year 2019 increase of \$4.9 million in the Lifeline appropriation (to a total of \$12 million) will provide assistance in

increasing both local Lifeline and backup center call capacity to improve the average speed to answer for Lifeline calls, as well as to decrease the call abandonment rate.

The increased visibility of the Lifeline number through the media, internet, and social media has been a powerful driver of continuing increased call volume for the Lifeline. For example, individuals who use *Google* as their browser when searching for “suicide” or phrases indicating that they may be in danger (e.g., “ways to kill yourself”) receive an automated response at the top of their search results that says, “You’re not alone. Confidential help is available for free” and provides the Lifeline number. On *Apple iPhones*, the “Siri” system responds to “suicide” with the message, “If you are thinking about suicide, you may want to speak with someone at the Lifeline. They’re at 1-800-273-8255 (TALK). Shall I call them for you?” Online users who mention “suicide” in their postings to *Help.com* receive a response urging them to call 1-800-273-8255 (TALK). Another way that the Lifeline has recently expanded support systems available to individuals contemplating suicide is through the use of social media to raise awareness of its services, increase awareness of mental illness, spread hope, and educate communities about suicide prevention and prevention measures. Their work includes a strong presence on social networking sites (e.g., Facebook, Twitter, Tumblr, Pinterest, Myspace), as well as active relationships with social media organizations.

In addition to increased visibility of the Lifeline number online and through social media, high profile events such as suicides of Robin Williams, Kate Spade, and Anthony Bourdain; the publicizing of the Lifeline number on the Grammys with the Logic song “800-273-8255;” and the recent CDC reports of increasing suicide rates nationally have also led to increases in call volume that have been maintained over time. In light of the increasing attention to this issue, SAMHSA and its partners have widely promoted resources to educate and inform the media and journalists writing about suicide, including dissemination of *The Recommendations for Reporting on Suicide*, <http://reportingonsuicide.org/>. These efforts not only aim to improve the accuracy of reporting, but also often translates into additional advertising of the Lifeline number and other local and national crisis intervention resources.

Figure 3. National Suicide Prevention Lifeline Overall Call Volume



Year ⁷	Number of Answered Calls	Funding to the Lifeline
2005	46,197	\$3,052,000
2006	121,038	\$3,021,000
2007	402,169	\$4,484,000
2008	545,851	\$5,081,304
2009	627,129	\$4,484,000
2010	691,873	\$5,522,000
2011	789,264	\$5,522,000
2012	915,439	\$5,511,563
2013	1,130,192	\$6,071,062
2014	1,357,605	\$7,117,699
2015	1,510,223	\$7,198,000
2016	1,534,844	\$7,198,000
2017	2,025,531	\$7,198,000
2018	2,205,487	\$7,198,000

Potential Impact of an N11 Number on National Suicide Prevention and Crisis Intervention Efforts

Based on SAMHSA’s experience with national and state crisis intervention efforts over the past 18 years, and informed by a meeting of experts and stakeholders in mental health, crisis intervention, emergency services and suicide prevention that SAMHSA convened November 29 to 30, 2018,⁸ our judgment is that an N11 national suicide prevention number has the potential to

⁷ The ‘Number of Answered Calls’ refers to calendar year. The ‘Funding to the Lifeline’ refers to fiscal year.

⁸ See Appendix 3 for list of participants from the November 2018 expert stakeholder meeting.

play a key role in improving national crisis intervention and suicide prevention efforts; if the launch of a new number is accompanied by efforts to develop a more coordinated crisis system with greater capacity and access to sophisticated data and technology systems, and an ongoing commitment to data driven quality improvement.

The arguments in favor of an N11 national number, as articulated by mental health, crisis intervention, emergency services, and suicide prevention stakeholders at the stakeholder meeting convened by SAMHSA, appear to fall into two categories. One is the assertion that an N11 number would be easier to remember than a 10 digit number, and that this would lead to more people who are in need of help being able to access it. Of particular importance, it is also felt that remembering the number during a time of crisis would be enhanced for an N11 number. Cognitive access during a time of crisis is critical and impacted by the complexity of the information needed to be remembered. If a family member experiences severe chest pains in the company of another family member, both the patient and the family member, despite their heightened anxiety, would remember the number 911, while the concern is that many suicidal people or their family members at a similar moment of suicidal crisis might not remember 1-800-273-8255 (TALK). The issue of greater accessibility of an N11 number is currently being further explored by scientists in the psychology lab at Florida State University under the leadership of Dr. Thomas Joiner. Preliminary data suggest that an N11 number will be more effective than any other shortened dialing code. This is consistent with the possibility that, in the long run, N11 could be more effective than 1-800-273-TALK.

The fact that we can clearly document that many, many actively suicidal people call the Lifeline, at least 500,000 per year based on the Lifeline estimate of 25 percent of callers being suicidal at the time of the call, does not mean that there are not many others who could or would call if they only could remember the number at the moment they most need it. An N11 number should certainly be easier to remember than a 10 digit number, especially if the number is reinforced by repeated public awareness campaigns such as those that have led to 911 achieving such a high level of community awareness.

The second major argument in favor of an N11 number is the need for what has been called “a 911 for the brain.” This view, articulated by experts such as Michael Hogan, former Mental Health Commissioner in New York, Ohio, and Connecticut and former chair of President Bush’s

New Freedom Commission on Mental Health, is that compared to the system of emergency medical services in the United States of which 911 centers are a core component, crisis services in mental health are fragmented, poorly coordinated, under resourced, and at times even counterproductive for their stated goals of promoting health and safety. In this view, availability of an N11 number for mental health and suicide prevention could be a transformative step forward in the improvement of crisis systems in America. While an N11 number alone would not achieve such a transformation, the combination of the N11 number and the message that mental health crises and suicide prevention are of equivalent importance to medical emergencies would, over time, bring needed parity and could result in additional attention and resources to improve typical local psychiatric crisis services throughout our nation. This could accelerate a trend started already by a small number of states that have taken steps to dramatically improve their crisis systems.

While there is no exact analogy within a state that would help precisely anticipate the impact of an N11 national suicide prevention number, review of the experience with the launching of new statewide crisis numbers and new crisis systems is instructive. For example, in 2006, Georgia moved from a system of local crisis lines to a single statewide crisis line with a new statewide number, the Georgia Crisis and Access Line (GCAL), 1-800-715-4225. While it is not possible to tabulate the full volume of calls that were being answered by Georgia crisis lines pre-GCAL, Behavioral Health Link, which operates GCAL, believes it likely that the introduction of the statewide number and the accompanying public education campaign led to a significant increase in overall call volume. Perhaps of even greater importance, the introduction of a state wide number as a single point of access established GCAL as the hub of a coordinated crisis system that also dispatches mobile outreach services, monitors psychiatric bed capacity, provides outpatient appointments and can use sophisticated electronic dashboards to monitor patient movement and safety across the acute care and crisis system. The introduction of a state wide number did not by itself create these major steps forward, rather the consolidation of multiple hotline numbers into one statewide number became the linchpin and the crisis center the hub for a more coordinated, responsive, and accountable crisis response system.

Similarly, the state of Colorado launched a statewide number (844-493-TALK),⁹ which also, utilizing the Lifeline crisis center Rocky Mountain Crisis Partners, serves as a hub for several coordinated crisis services, including the ability to use the call center to provide telephonic follow up to suicidal persons leaving multiple Colorado emergency rooms. This effort has used a model that has been shown to result in significant reductions in suicidal behavior in two controlled studies (Miller, et. al., 2017 and Stanley, Brown et. al., 2018). The launch of the statewide number has also been associated with an increase in the total statewide crisis call volume. Colorado has also been building on this crisis center hub model to discourage the use of jails for mental health treatment and support transporting people to a crisis center rather than an emergency department.

One international experience may be instructive. In England, the move to 111 as the National Health Service urgent care number has been reported to be associated with a steady increase in demand over time (Pope, Turnbull, Jones, et. al., 2017).

Potential Impact of a New N11 Number on the National Suicide Prevention Lifeline

The language of the Act does not explicitly state what the precise relationship of an N11 number to the Lifeline should be. For example, the Lifeline could be separate from a new N11 suicide prevention number; a new N11 number could become the new Lifeline number; or an N11 number and the existing Lifeline number could both be portals into one unified system. Much of the dialog surrounding the Act, including feedback that SAMHSA received from the expert stakeholder meeting held in November 2018, has referenced the option of a new N11 number becoming the new number for the Lifeline. Federal and state experience with other legacy numbers suggests that if new numbers are developed, legacy numbers must be maintained. For example, SAMHSA's experience with 1-800-SUICIDE, as well as the experience with other legacy numbers in Georgia is that it can take many years, for call volume on no longer promoted hotline numbers to dwindle to the point where shutting them off would not be a threat to the public safety. SAMHSA committed to continuing support of the 1-800-SUICIDE number even though we were promoting 1-800-273-8255 (TALK) as the national suicide prevention number.

⁹ This number was utilized to build on consistency with the National Suicide Prevention Lifeline 1-800-273-8255 (TALK) number.

Although SAMHSA has not promoted 1-800-SUICIDE since 2007, the Lifeline still receives an average of 178,864 calls annually that are routed from 1-800-SUICIDE. The increased exposure of the Lifeline number, 1-800-273-8255 (TALK), online and through social media, which greatly exceeds the previous internet presence of 1-800-SUICIDE, indicates that 1-800-273-8255 (TALK) will likely continue to be a vital suicide prevention hotline number. If an N11 number was disconnected from the Lifeline, this would needlessly divide the nation's efforts to improve crisis response. The best option would be the value added to the existing Lifeline efforts by the establishment of an N11 number that would also be a portal into the Lifeline network. In our judgment, this would have the potential for reaching significantly more people at risk for suicide and to significantly enhance crisis services.

911, 211, and 611 Significance for the National Suicide Prevention Lifeline

In discussions at SAMHSA's November 2018 expert stakeholder meeting, it was clear that in the mental health and suicide prevention communities 911 is viewed as the gold standard for crisis response. Even among mental health providers and programs the statement "If this is an emergency, call 911" is commonly the recorded message most will hear if unable to reach a provider. A "911 for the brain" model could potentially have many advantages. As described by the Office of Emergency Services in the National Highway Transportation Administration, over the past 40 years a national vision of comprehensive, evidence-based emergency medical services and 911 systems that is inherently safe, effective, integrated, seamless, and socially equitable has driven positive change. Yet, even after 40 years of progress, the 911 system while pervasive across America, does not exist in every county. While 911 is not perfect, no one would seriously argue about returning to a time before 911 and its pivotal role in a national effort to dramatically improve emergency medical services. A crucial observation here is that while assignment by the FCC of 911 as a national emergency number did not in and of itself create an evolving and improving emergency medical response system, the 911 number has undoubtedly played a critical role in catalyzing the development of these services, in the same way that the statewide numbers in Georgia and Colorado have played a pivotal role in improving crisis services in those states.

The rapid dispatching of ambulance and EMTs through 911 is vitally important when someone has made a suicide attempt. The capacity of 911 centers to utilize geolocation technology to identify the physical location of an individual who has made a suicide attempt is a significant advantage that 911 centers have over the current Lifeline, particularly in a time when cell phones are so common. Though contacting 911 to dispatch police or ambulance may be necessary in some circumstances where there is a high imminent risk of suicide, many calls related to suicidal ideation are able to be addressed with talk alone and without the dispatching of a first responder. The ability of the Lifeline crisis center to provide telephonic crisis intervention, referral, and follow up may be sufficient to avoid ambulance and police dispatch and transport to overcrowded emergency departments. For example, collaborations such as the Harris Center in Houston's colocation with 911 services allows many 911 callers to be seamlessly responded to by a Lifeline call center. Similarly, the backup system of crisis centers that currently exists within the Lifeline is an advantage that 911 centers do not have. While 911 might not be a perfect model for suicide prevention, there are likely many lessons that can be adapted from the emergency medical services experiences that could improve crisis intervention and suicide prevention in the United States.

In addition to 911, 211, which is the national information and referral number, has also been suggested as a potential model for suicide prevention. Forty of the 163 Lifeline crisis centers are currently blended 211/crisis centers, meaning those centers have both information and referral and crisis response capacity. Suicidal callers frequently need an array of community services. So this connection has numerous advantages in making community connections. However, not all 211 centers have crisis capacity and the number 211 is associated with information and referral, which, while valuable, does not communicate that this number is a number that suicidal people or their families can call at any time of the day or night for immediate crisis intervention. In other words, the numbers 211 do not communicate a crisis or emergency service in the way that 911 does. In addition, using 211 as the national suicide prevention number would involve combining two different functions, one urgent or emergent and the other not. A crisis number needs to have unique characteristics, including availability 24 hours a day, seven days a week, 365 days a year. In addition, calling the number should result in rapid response and the number should be widely recognized as a crisis number, these are not typically characteristics associated with 211 as a number.

In SAMHSA's experience, utilizing one number for a dual purpose has not been successful. Specifically, in the wake of Hurricane Katrina, which was prior to the establishment of SAMHSA's National Disaster Distress Helpline, the Lifeline number was also used for disaster mental health crisis. Many individuals in post disaster distress did not understand why they were being encouraged to call a suicide hotline, but to have taken the word suicide out of the Lifeline's recorded message would have been to risk compromising its basic function.

Numerous participants at SAMHSA's November 2018 expert stakeholder meeting proposed 611 as the most likely and potentially available N11 number. The establishment of 611 or an alternative N11 number for suicide prevention and crisis intervention would also have the potential, because it would be designated for urgent or emergent crisis situations, to be utilized as an alternative to 911 by primary care offices or other health providers. Such providers might otherwise contact 911 anytime they encounter a person expressing suicidal ideation. Because such an N11 number would not be linked to near automatic dispatch of ambulance or police there could be a reduction in unnecessary emergency department use.

In summary, the establishment of an N11 national suicide prevention number may be a critical catalyst in the transformation of the nation's psychiatric emergency and crisis system in the same way that the establishment of 911 has led to an ongoing transformation of the nation's emergency medical system. The establishment of an N11 phone number has the potential to significantly increase the number of people in suicidal crisis who are helped and assist crisis centers to become the central hub for an improved community crisis system. To make this vision a reality would require more than an N11 number. It would require a coordinated effort between the federal government, states, the health care system, and many others to fill the gaps in our current systems and help halt the tragic rise in suicide across the country. It would also require careful analysis by states, potentially in consultation with SAMHSA, of the necessary crisis center capacity to answer current and projected call volume safely and effectively, as well as a commitment to ongoing, data driven quality improvement efforts.

Recommendations for Improving the Lifeline

Increased public education and awareness

If an N11 number is assigned by the FCC, a public education and awareness campaign to publicize the new number would be instrumental in encouraging the use of the new number. Implementation of such a campaign should be done in coordination with ramped up capacity to respond to these calls. An example of this approach that is instructive was New York City's simultaneous public awareness campaign with the upscaling of the LifeNet Crisis Center. The reach of the campaign could be tracked by looking at call volume data in the targeted areas. Regardless of whether an N11 number is assigned, public education regarding when to call 911 versus when to call the Lifeline could potentially be of benefit in increasing access while decreasing emergency department utilization.

Education focused on state and local policy makers to correct the misunderstanding that the Lifeline is a centrally located federally funded large crisis center, rather than a decentralized system that relies on community crisis center capacity and local resources, would also be important. Greater recognition that the Lifeline rests on the shoulders of 163 local crisis centers could lead to greater support and increased capacity for these crisis centers who comprise the nation's safety net for suicidal persons.

Improved infrastructure and operations

As previously described, the major challenge regarding Lifeline's infrastructure and operations is the need to expand Lifeline's community crisis center capacity, either by adding more crisis centers to the network or by resourcing existing crisis centers to expand their coverage areas. States such as Colorado and Utah invested in their crisis systems and provide support to have Lifeline calls answered and as a result have most of their Lifeline calls answered in state. Some changes to the Lifeline infrastructure were suggested at the November meeting convened by SAMHSA. For example, one suggestion was funding 1-3 large crisis centers to answer calls in a manner similar to what the VA has done in establishing 3 large crisis centers to answer VCL calls. This would require a very significant expansion of SAMHSA funding and would lose the connection to local emergency and mental health resources that exists in the current system. Others at the meeting have pointed to the consolidation of poison control centers in the U.S. as a

model which led to better funding and greater capacity. This Poison Control model has advantages that could benefit the Lifeline if adapted, such as, the shared use of specialized professionals, such as toxicologists, and the close links to emergency departments and other health care facilities. Closer linkages between the Lifeline crisis centers with the health and mental health systems would be a great advantage. While currently some centers are deeply embedded in their state's health care system (e.g. Georgia, Colorado, Arizona), other centers are much more detached. Connections to advanced data systems and technologies as called for in the Crisis Now model would also be significant, including enhanced telehealth capacities (National Action Alliance for Suicide Prevention: Crisis Services Task Force, 2016). Adding geolocation capacities would also be a significant improvement to better enable locating acutely suicidal individuals who have made suicide attempts or who are at imminent risk of doing so.

Continued attention to data driven improvement efforts, such as those that led to the development of the Lifeline's Standards for Suicide Risk Assessment and the Guidelines for Callers at Imminent Risk, are important, but can also be expanded to more effectively follow up with suicidal individuals who currently become lost between the fragmented components of our systems. Making Lifeline centers the hub of more coordinated crisis systems with what the Crisis Now model calls Air Traffic Control Capacity — the ability to track and not lose suicidal people during acute care transitions — could ideally become a crucial performance improvement metric, as vitally important as call abandonment rates or call response time.

Finally, it is noted that 911 and the emergency medical services system has a federal home and locus for envisioning and driving forward improvements across the nation, in a way that currently does not exist for psychiatric emergency and crisis services. SAMHSA's efforts with its Lifeline Steering Committee is probably the closest effort currently. A federal effort modeled on the Office of Emergency Medical Services (housed in the Department of Transportation) could serve a key role in helping to achieve the kind of transformative impact for which 911 is the exemplar.

Cost Considerations

In addition to the costs that will be evaluated by the FCC, such as the costs of translation changes, cell site analysis, and reprogramming by wireless carriers, there are other very relevant

cost considerations associated with responding to increased volume of crisis calls. The Lifeline estimated that the cost for a high performing crisis center to respond to a crisis call would be approximately \$25 per call (National Suicide Prevention Lifeline, 2018). Based on this estimate, if the ease of use of an N11 number led to a 100 percent increase in the number of crisis calls (or approximately an additional two million calls), the additional cost for this capacity would be \$50 million. If each suicidal caller were to receive telephonic follow up until connected to care, a study estimated that there would be a 2 to 1 return on investment because of reduced emergency department and hospitalization costs (Richardson, Mark, McKeon, 2014). Similarly another recent study showed that telephonic follow up of suicidal people leaving emergency departments was cost effective compared to usual care for these same reasons at a cost of \$4300 per life year saved annually (Denchev, Pearson, Allen, et.al, 2018). Increasing funding by about \$50 million would enable the current system to increase capacity to manage anticipated call volume and is likely to be associated with cost offset or savings through reduced emergency department visits and avoidable hospitalizations.

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Appendix 1: National Suicide Prevention Lifeline In-State Answer Rate

In-State Answer Rate by Originating State, 7/1/2018 to 9/30/2018

State	In-State Answered Rate^a
Alabama	64%
Alaska	68%
Arizona	93%
Arkansas	57%
California	87%
Colorado	84%
Connecticut	88%
Delaware	87%
District of Columbia	56%
Florida	77%
Georgia	22%
Hawaii	90%
Idaho	76%
Illinois	27%
Indiana	57%
Iowa	66%
Kansas	63%
Kentucky	29%
Louisiana	73%
Maine	94%
Maryland	90%
Massachusetts	65%
Michigan	36%
Minnesota	2%
Mississippi	80%
Missouri	87%
Montana	82%
Nebraska	72%
Nevada	54%
New Hampshire	70%
New Jersey	83%
New Mexico	83%
New York	40%
North Carolina	88%
North Dakota	82%
Ohio	70%
Oklahoma	79%
Oregon	79%

Pennsylvania	37%
Rhode Island	17%
South Carolina	12%
South Dakota	95%
Tennessee	68%
Texas	24%
Utah	95%
Vermont	5%
Virginia	57%
Washington	78%
West Virginia	70%
Wisconsin	30%
Wyoming	0%

^a These percentages exclude callers who "press 1" to be connected to the Veterans Crisis line.

Appendix 2: 21st Century Cures Act – Section 9005: National Suicide Prevention Lifeline Program

SEC. 9005. NATIONAL SUICIDE PREVENTION LIFELINE PROGRAM. Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq.) is amended by inserting after section 520E–2 (42 U.S.C. 290bb–36b) the following: “SEC. 520E–3. NATIONAL SUICIDE PREVENTION LIFELINE PROGRAM. “(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary, shall maintain the National Suicide Prevention Lifeline program (referred to in this section as the ‘program’), authorized under section 520A and in effect prior to the date of enactment of the Helping Families in Mental Health Crisis Reform Act of 2016. “(b) ACTIVITIES.—In maintaining the program, the activities of the Secretary shall include— “(1) coordinating a network of crisis centers across the United States for providing suicide prevention and crisis intervention services to individuals seeking help at any time, day or night; “(2) maintaining a suicide prevention hotline to link callers to local emergency, mental health, and social services resources; and “(3) consulting with the Secretary of Veterans Affairs to ensure that veterans calling the suicide prevention hotline have access to a specialized veterans’ suicide prevention hotline. “(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated \$7,198,000 for each of fiscal years 2018 through 2022.”

Appendix 3: National Suicide Hotline Improvement Act Expert Stakeholder Meeting Participant List

National Suicide Hotline Improvement Act Meeting

November 29-30, 2018

PARTICIPANT'S LIST

ATTENDEES

Michael Allen
Rocky Mountain Crisis Center
michael.allen@ucdenver.edu

Jennifer Battle
Harris Center
jennifer.battle@theharriscenter.org

Sam Brinton
The Trevor Project
sam.brinton@thetrevorproject.org

Colleen Carr
Education Development Center, Inc.
ccarr@edc.org

David Covington
RI International
david.covington@riinternational.com

Colleen Creighton
American Association of Suicidology
ccreighton@suicidology.org

Kita Curry
Didi Hirsh Mental Health Services
kcurry@didihirsch.org

Jeffrey Davis
American College of Emergency Physicians
jdavis@acep.org

Michelle Dirst
American Psychiatric Association
mdirst@psych.org

Ashby Dodge
Vibrant Emotional Health
adodge@vibrant.org

John Draper
Vibrant Emotional Health
JohnD@vibrant.org

Katherine Elkins
National Highway Traffic Safety
Administration
katherine.elkins@dot.gov

Pam End of Horn
Indian Health Service
pamela.endofhorn@ihs.gov

Lynda Gargan
National Federation of Families for
Children's Mental Health
lgargan@ffcmh.org

Madelyn Gould
New York State Psychiatric Institute
madelyn.gould@nyspi.columbia.edu

Tristan Gorrindo
American Psychiatric Association
tgorrindo@psych.org

Deborah Hobbs
American Psychiatric Nurses Association
dhobbs@apna.org

Dwight Holton
Lines for Life
dwighth@linesforlife.org

Roshni Janakiraman
Florida State University
janakiraman@psy.fsu.edu

Connor Jobs
American Foundation for Suicide Prevention
cjobs@afsp.org

Marilyn Jones
Federal Communications Commission
marilyn.jones@fcc.gov

Savannah Kalman
SAMHSA
savannah.kalman@samhsa.hhs.gov

Stephen Kaminski
American Association of Poison Control
Centers
kaminski@aapcc.org

Tracy Kennedy
Real Crisis Services
tskennedy@embarqmail.com

Angela Kimball
National Alliance on Mental Illness -
ISMICC
akimball@nami.org

David Koosis
Vibrant Emotional Health
dkoosis@vibrant.org

Kristin Kroeger
American Psychiatric Association
kkroeger@psych.org

Celia Lewis
Federal Communications Commission
celia.lewis@fcc.gov

John Madigan
American Foundation for Suicide Prevention
jmadigan@afsp.org

Christy Malik
National Association of State Mental Health
Program Directors
christy.malik@nasmhpd.org

Richard McKeon
SAMHSA
richard.mckeon@samhsa.hhs.gov

Matthew Miller
Veterans Crisis Line
matthew.miller8@va.gov

Kimberly Mullen
Veterans Crisis Line
Kimberly.Mullen2@va.gov

Monica Nemec
Centerstone America
Monica.Nemec@centerstone.org

Craig Obey
American Psychiatric Association
cobey@psych.org

Jane Pearson
NIMH
jpearson@mail.nih.gov

Rajeev Ramchand
Cohen Veterans Network
rajeev.ramchand@cohenveteransnetwork.org
g

Jerry Reed
Education Development Center, Inc.
jreed@edc.org

Brie Reimann
National Council for Behavioral Health
communications@thenationalcouncil.org

Catherine Reynolds
Mental Health America
creynolds@mentalhealthamerica.net

Loren Rives
American College of Emergency Physicians
lrives@acep.org

Jack Rozel
American Association for Emergency
Psychiatry
rozeljs@upmc.edu

Sandra Schneider
American College of Emergency Physicians
sschneider@acep.org

Michelle Sclater
Federal Communications Commission
michelle.sclater@fcc.gov

Shari Sinwelski
Vibrant Emotional Health
ssinwelski@vibrant.org

Matt Taylor
Vibrant Emotional Health
mtaylor@vibrant.org

Caitlin Thompson
Cohen Veterans Network
Caitlin.thompson@cohenveteransnetwork.org
g

James Wright
Veterans Crisis Line
James.wright@va.gov