

December 10, 2018

Marlene H. Dortch  
Secretary  
Office of the Secretary  
Federal Communications Commission  
445 12<sup>th</sup> Street, SW,  
Washington, DC 20554

**Re: WC Docket No. 18-336, CC Docket No. 92-105**

**Re: The Implementation of the National Suicide Hotline Improvement Act of 2018**

Dear Ms. Dortch:

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On behalf of over 39,000 members of the American College of Emergency Physicians (ACEP), we wish to provide comments on some of the issues that the Federal Communications Commission (FCC) should address in the study and report mandated by the National Suicide Hotline Improvement Act of 2018.

The National Suicide Hotline Improvement Act of 2018 requires the FCC to conduct a study that examines the feasibility of designating a simple, easy-to-remember, 3-digit dialing code (such as an N11 code) that would be used for a national suicide prevention and mental health crisis hotline system. The FCC must consult with federal partners including Substance Abuse and Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services and the Department of Veteran Affairs and produce a report on the study by no later than August 14, 2019. This report must recommend whether a particular 3-digit dialing code or N11 code should be used, and, if so, the logistics and costs associated with creating this code.

ACEP strongly supports the creation of a new 3-digit dialing code for mental health emergencies, as we believe that it would improve access to appropriate care and could reduce the prevalence of psychiatric boarding that is plaguing our emergency departments (EDs). As emergency physicians, we see every day how limited community resources and access to care for individuals with mental health disorders impact our EDs. Many people with mental health illnesses have nowhere to go to when they are in crisis, and they routinely wind up in the ED. The ED is often referred to as a “safety net” for vulnerable patients, such as psychiatric patients.

Overcrowding of the ED caused in part by boarding of psychiatric patients is a serious public health issue. ED boarding is extremely costly and increases adverse outcomes and mortality for our most vulnerable patients. Research shows that psychiatric patients’ length of stay in the ED is 3.2 times longer than that of non-psychiatric

patients who are awaiting inpatient placement.<sup>1</sup> In a survey conducted of ACEP members, 48 percent of respondents said that psychiatric patients are boarded **one or more times a day** in their ED. When asked how long the longest patient waiting in the ED for an inpatient bed was boarded, nearly 38 percent of respondents said 1 to 5 days.<sup>2</sup>

EDs are also typically loud and chaotic and can easily overwhelm these patients. They often do not have readily available, if any, mental health or psychiatric consult to refer or coordinate care of psychiatric patients, which often times leads to delays in care. Furthermore, EDs are already overwhelmed with patients. Many times, it can be challenging for emergency physicians to ensure that psychiatric patients are connected to any available treatment or community services. Thus, these patients wind up waiting in ED hallways, sometimes for days, waiting to be admitted to the hospital or an inpatient psychiatric facility, discharged back to the community, or transferred to another type of facility. A lack of available in-patient beds, decreased outpatient services, lack of psychiatric and mental health providers and many other factors all contribute to the issues around boarding. Having access to a 3-digit mental health dialing code could help ensure that patients access the right level of care for their needs.

Efforts to decrease boarding and create safe alternatives for patients with mental health disorders are ongoing. Some EDs across the country have created crisis stabilization units or other appropriate, hospital-based outpatient programs that accept psychiatric patients in crisis that are specially designed and staffed to treat psychiatric patients. These units allow patients to escape the noisy ED. They include large, open spaces where patients can easily self-access food, drinks, linens, phones, books, games, and TV. There is space to move about and engage in socialization, discussion, and therapy. Within a 24-hour period, patients are evaluated by a psychiatrist, treated by a multi-disciplinary team, provided resources about outside services and providers, and safely discharged. Hospitals and EDs that have incorporated these units have seen a significant reduction in admission rates. For example, Iowa City recently opened up such a unit, and within five weeks, psychiatric inpatient admission rates for patients presenting to the ED decreased from approximately one in two to one in four and 70 percent of patients were discharged within 24 hours.<sup>3</sup> Other promising alternatives to the ED involve interventions such as, telemedicine psychiatric consults, ED case management, or mobile crisis intervention teams that can de-escalate crisis before patients get to the ED.<sup>4</sup>

One major benefit of a new hotline is that emergency physicians and other ED providers would have an additional avenue of helping people who are already in the ED get connected with the appropriate support services. As stated above, many times emergency physicians do not have time to properly treat or screen psychiatric patients. Being able to call one, short, memorable number to help support patients discharged from the ED safely and back to their community more quickly would be extremely beneficial.

ACEP recognizes that we need a more comprehensive solution that would help these patients receive care in the community, outside of the ED. If people are able to call a mental health hotline and immediately be connected to the appropriate social or support services, this could potentially decrease the number of psychiatric patients that must come to the ED in the first place. However, in order for a new hotline to truly help patients with mental health issues get the care they need, there must be adequate resources and services in the community that can provide feasible and safe alternatives to patients seeking care in the ED. For this to happen, communities must be provided adequate funding to establish these services. There must also be an extensive

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<sup>1</sup> Nicks, BA & Manthey, David. (2012). The Impact of Psychiatric Patient Boarding in Emergency Departments. *Emergency medicine international*. 2012. 360308. 10.1155/2012/360308.

<sup>2</sup> American College of Emergency Physicians, "ACEP Physician Poll on Psychiatric Emergencies September 28 – October 6, 2016," available at: [newsroom.acep.org/download/psychemergencypolloct2016.pdf](https://www.acep.org/download/psychemergencypolloct2016.pdf)

<sup>3</sup> Iowa City Press-Citizen, "Five weeks in, Crisis Stabilization Unit shows promise," Smith, Zachary Owen, 26 November, 2018, available at: <https://www.press-citizen.com/story/news/2018/11/26/five-weeks-crisis-stabilization-unit-shows-promise/2116173002/>

<sup>4</sup> American College of Emergency Physicians, "Care of the Psychiatric Patient in the Emergency Department – A Review of the Literature," October 2014. Available at: <https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/resources/mental-health-and-substance-abuse/psychiatric-patient-care-in-the-ed-2014.pdf>

outreach campaign that educates people about this new number, when to call, and what type of response or services they can expect. Currently, many people in crisis immediately call 911. This number has become engrained in our culture as the main— or in some cases, only— way of seeking and obtaining assistance during an emergency. The new 3-digit number for mental health crises must be advertised in such a way that people know about it and understand when to call it versus 911. People should also still be advised to go to the ED immediately if they believe that they are having a medical emergency. The availability of the 3-digit number and the associated response and services that go along with it should not be considered a replacement for the use of appropriate emergency care.

We are hopefully that the FCC study and report highlight some of the issues raised above and that the report ultimately recommends that Congress adopt a 3-digit code along with appropriate funding and resources to ensure that people with mental health disorders get the care they need in the community. We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory Affairs at [jdavis@acep.org](mailto:jdavis@acep.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Vidor E. Friedman". The signature is fluid and cursive, with a large, sweeping flourish at the end.

Vidor E. Friedman, MD, FACEP  
ACEP President