



# Enhancing Equity on Crisis Lines: Understanding the Background, Practices and Learning Needs of Responders in Canada

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## Abstract

Understanding the current state of equity, diversity, and inclusion (EDI) within the crisis line sector is essential to enhancing accessibility and acceptability of crisis line services for all. Through an intersectional lens, we examined 9-8-8 crisis line workers' personal and work demographics, training, resources, perceived competencies in supporting diverse populations. We conducted an electronic survey of crisis line responders and leadership in Canada. Data was analyzed using descriptive statistics, Fisher's test, and Mann-Whitney U/Kruskal-Wallis H tests. Open ended responses were analyzed using content analysis. 323 surveys were completed. Analysis revealed statistically significant associations between respondent demographics, training satisfaction, access to resources, and perceived competency in supporting diverse communities. Conclusion: The findings indicate the need for new approaches to recruitment and training in the crisis line sector to enhance the inclusivity of crisis services for all individuals seeking mental health support.

**Keywords** Crisis · Suicide prevention · Equity · Cultural competence

## Introduction

Crisis and distress lines play a pivotal role in supporting individuals dealing with suicidal ideation, emotional distress, and mental health challenges (Hoffberg et al., 2020; WHO, 2014). These lines vary in their mandates, with some focusing on providing listening and support, others emphasizing suicide prevention, and some targeted to specific populations. They operate across different levels, from local and regional to national, and are increasingly integrated into broader systems of crisis response and mental health care (SAMHSA, 2020). At the systems-level, crisis lines are

integral to public health strategies aimed at reducing suicide rates (Hoffberg et al., 2020; WHO, 2014).

Research supports the use of crisis lines for individuals who are experiencing severe distress and suicidal ideation, with evidence that accessing the lines leads to positive outcomes such as reduced distress, decreased hopelessness, and lower levels of suicidal intent and behaviors during crisis intervention; these benefits have been observed up to four years post-contact (Gould et al., 2013, 2016; Hoffberg et al., 2020; Mishara et al., 2007a, b). However, additional research is needed to better understand the equity of crisis line access, service delivery, and outcomes, including how crisis lines ensure accessibility and inclusivity for individuals from diverse backgrounds. Further, little is known how crisis lines evaluate the effectiveness of services for diverse populations, and how feedback and outcomes are used to improve access and equity.

There has been growing concern about the ability of general crisis lines to adequately address cultural differences and meet the needs of diverse populations. Targeted adaptations may be necessary to ensure that services are accessible and acceptable to all, leading to equitable outcomes across different groups (Lim et al., 2021; Ma et al., 2022; Dichter et al., 2024). Disparities in mental health outcomes among

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different demographic groups highlight the unique barriers faced by Black, Indigenous, and people of colour (BIPOC) in accessing mental health services. These inequities often result in lower utilization of evidence-based care (Alegria et al., 2002; Gary, 2005; Kataoka et al., 2002; Stewart et al., 2017). A mental health paradox among BIPOC service users has been described: individuals from these communities can be more prone to experiencing mental health concerns yet are less likely than the general population to seek support (Arday, 2018; Sancho & Larkin, 2020; Turner et al., 2007; Olaniyan & Hayes, 2022). Similarly, individuals who identify as Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and additional diverse sexual orientations, and gender identities (2SLGBTQIA+) face challenges accessing general mental health services. Instances of heterosexism and transphobia in healthcare also contribute to difficulties in receiving safe and appropriate care (Israel et al., 2008; Jumarali, 2022).

In the context of crisis lines, the introduction of a 3-digit crisis line in the United States (US) has revealed the disparities faced by various communities, including 2SLGBTQIA+, BIPOC, rural residents, immigrants, refugees, non-English speakers, people with disabilities, seniors, those experiencing homelessness, formerly incarcerated or justice-involved individuals, trauma survivors, and neurodiverse individuals (KSCHME, 2022). Some populations with low trust in emergency services and law enforcement may be hesitant to access crisis line services due to concerns about potentially negative consequences (Mubarak et al., 2022). However, research in this area remains limited.

Corollary questions relate to whether crisis line responder characteristics are relevant to achieving diversity, inclusion, accessibility, and ultimately equitable outcomes, from crisis line services. For example, the crisis line operated by the Veterans Administration in the US has examined differential outcomes from crisis line use based upon the gender identity of responders and service users, with recommendations to better meet the unique needs of female veterans (Dichter et al., 2024).

While general studies of crisis lines acknowledge the impact of responder behaviors like empathy and respect on service user outcomes (Mishara et al., 2007b; Sindahl et al., 2019), these studies often overlook potential differences based on socio-demographic factors and identities, such as race, culture, sexual orientation, gender identity, language, and intersecting identities. There are unanswered questions about whether characteristics of both service users and responders, including their congruence, influence the relationship between responder behaviors and service user outcomes. In related mental health fields, congruence of characteristics between the service provider and service users have been shown to be important to service users and may lead to greater retention in therapy, although there is

weak evidence for the link to mental health outcomes (Smith et al., 2016; Chang et al., 2011). On the other hand, research in the provision of psychotherapy to 2SLGBTQIA+ individuals suggests that a mental health service provider's attitudes and knowledge about 2SLGBTQIA+ identities and issues hold more significance than the therapists' sexual identities alone (King et al., 2007).

Organizational practices and policies can significantly impact the ability of crisis services to meet diverse needs. Research suggests that organizations promoting staff diversity and fostering inclusive cultures lead to better outcomes for all service users (Gomez et al., 2019). While it may not always be feasible to match responders and service users based on demographics, training in Equity, Diversity, and Inclusion (EDI) can help address population-specific needs (Asnaani et al., 2012; Steinfeldt et al., 2020). Practices such as responder reflexivity, cultural humility, and organizational commitment to cultural safety and EDI can contribute to more inclusive services.

The launch of 9-8-8: Suicide Crisis Helpline, Canada's national 3-digit suicide prevention crisis line has emphasized the need to understand the current state of the sector, particularly in terms of EDI practices, responder training, and educational supports. The demand for crisis services significantly increased during the Covid-19 pandemic, with a 185% surge in usage and a 200% increase compared to 2019 (Cullen, 2020), underscoring the importance of timely and accessible services in addressing the mental health and crisis needs of Canadians.

To enhance equity and ensure accessibility and acceptability of crisis lines services for all, we examined the current state of the Canadian crisis sector with regards to EDI. We engaged crisis line workers to explore their perspectives on strengths, challenges, and learning needs within the sector, especially concerning support for underserved and equity-seeking populations. Our objectives included understanding current workforce demographics, perceived competencies in addressing mental health concerns, approaches to identifying and supporting individuals from diverse and equity-seeking groups, satisfaction with training and access to resources, and predictors of perceived competency in supporting diverse service users. These findings will guide efforts to strengthen services and promote EDI within crisis services.

## Materials and Methods

### Survey Design

As part of a larger, multi-methods study, we conducted an electronic survey of the Canadian crisis and distress sector to gain insight into the perspectives of crisis line responders

and organizational leadership (i.e., administrators and supervisors) on the strengths, challenges, and learning needs of those working in the sector, particularly as they pertain to supporting equity-seeking populations. The survey development included a rapid review of available crisis sector literature, a scan of data available through the Public Health Agency of Canada (PHAC) and the Canadian Suicide Prevention Service (CSPS), and iterative consultations with sector experts across the country with backgrounds in crisis line supervision and training, health equity, EDI and accessibility within education. The survey examined: (1) respondent socio-demographics; (2) work background and organizational characteristics; (3) current practices and perceived competencies for supporting diverse and/or equity-seeking groups; and (4) access to resources and learning preferences.

### Respondent Demographics

Demographic variables were adapted from established institutional demographic forms, in alignment with CAMH Health Equity Office standards. Age, gender, sexual orientation, racial background, education and community setting were included in the survey to describe responders that are providing crisis services across Canada and to contextualize findings in other sections of the survey.

### Work Background and Organizational Characteristics

Questions were developed to understand participant role in the crisis line sector, years of experience, as well as organizational characteristics such as communities served, service modalities (i.e., phone, text, chat services), languages offered, and service volumes.

### Current Practices and Perceived Competencies for Supporting Diverse and/or Underserved Groups

Questions sought to understand how participants identified individuals from diverse and/or underserved groups among service users. Survey participants were also asked to rate their self-perceived competencies for supporting service users across a range of mental health and crisis concerns, as well as for populations from diverse identities, communities or groups using a rating scale of 0–100 (where 0 = low competency/knowledge/skills and 100 = high competency/knowledge/skills).

### Access to Resources and Learning Preferences

This section focused on understanding current training practices, availability of resources to support crisis line workers, and identifying learning preferences for future training and resource development. Question formats included “select

all that apply”/multi-select as well as 5-point Likert scales (strongly disagree – strongly agree).

The final phase of survey development involved pilot testing with representatives from the distress sector. Six participants, reflecting a small cross-section of the target audience of crisis line staff (i.e. responders, executive directors, trainers) were recruited to review the survey and provide feedback related to content, flow, clarity, time requirement, possible omissions of interest, redundancies, and to consider any accessibility or feasibility challenges associated with survey design and delivery. The survey was further refined based on pilot feedback. The finalized survey included 26 multi-part questions and, where appropriate, open-text options to elaborate on survey responses. The survey was created and distributed via REDCap, a secure web application for disseminating and managing online surveys and databases (Harris et al., 2009, 2019).

### Participant Recruitment and Survey Dissemination

Organizations were identified and approached for participation using a comprehensive database of national crisis and distress lines, leveraging existing databases from the Public Health Agency of Canada (PHAC) and the Canadian Mental Health Association (CMHA) National. The database was purposively expanded to incorporate organizations that provided specialized support to diverse and underrepresented communities which were not formally established as a crisis line but offered call-based crisis support. The only exclusions were crisis lines operating in the province of Quebec, which has its own system of crisis supports. An electronic link to the survey in REDCap was distributed via Mailchimp to at least three individuals per organizations including leadership and administrators, with the request to disseminate the survey to paid and volunteer crisis line responders staff in their organization. Email reminders were sent to prompt organizations as appropriate.

Data collection took place between October–December 2022. Completion of the survey was voluntary, and participants were informed that their data would be aggregated for analysis to maintain anonymity. A gift card raffle was offered as an incentive to encourage participation. This project underwent ethical review from CAMH Quality Projects Ethics Review (Ref #2022\_021).

### Statistical Analysis

Survey data was imported and cleaned in SPSS version 27 (IBM Corp., 2020). Missing values were kept as missing and were removed from the analysis. Multiple response questions were recoded into indicator questions for each level and analyzed separately where possible. Data analysis was conducted in R software version 4.3.1 (R Core Team,

2023). Descriptive statistics were calculated and reported as means, counts, and percent. Statistical tests used Fisher's test with  $p$ -values estimated over 100,000 simulations for categorical variables. Non-parametric Mann-Whitney U (2 levels) and Kruskal-Wallis H tests (more than 2 levels) were used to compare continuous variable distribution over levels of categorical variables. Standardized effect sizes are reported as Cohen's  $w$  for categorical variables (Small = 0.1; Medium = 0.3, Large = 0.5) and Cohen's  $d$  (2 levels) or Cohen's  $f$  (more than 2 levels) for comparison of continuous variables across levels of categorical variables (for Cohen's  $d/f$  the conventions for effect sizes are: Small = 0.2/0.1; Medium = 0.5/0.25; Large = 0.8/0.4).

Detectable effect size: Considering 2 groups of roughly equal sizes, a sample of 323 respondents provides 80% power to detect a standardized effect sizes Cohen's  $d = 0.31$ , considered a small to medium effect size. It provides the same power to detect an absolute difference in proportions of 15%, assuming a baseline proportion of 50%. These calculations were conducted assuming significance level 0.05 and two tailed tests.

During data analyses, demographic variables had to be collapsed in order to ensure sufficient statistical power; specifically, racial, gender and sexuality identities. Survey responses were recoded to fit the updated variable categories where necessary; this is outlined in Table 1.

34% of respondents ( $n = 103$ ) identified as management or leadership; in order to maintain statistical power, analyses were conducted across sector roles.

When applicable, open-text responses underwent frequency counts to quantify their prevalence, aligning with standard quantizing methods as detailed in Popping (2015). For responses where participants offered more extensive insights, content analysis was conducted by two members of the research team (VD and CP). The open-text responses presented in these findings represent the most frequently mentioned categories of responses.

## Results

### Participant Demographics

323 surveys were included in the analysis; a detailed breakdown of respondent demographics is included in Table 2. The majority of respondents ( $n = 115$ ) selected white, heterosexual, cisgender girls/women descriptors. Most had obtained a post-secondary level of education and were relatively new to the sector, with 65% ( $n = 181$ ) reporting  $\leq 4$  years of experience working in crisis lines. The majority of respondents ( $n = 207$ ) resided in urban settings with populations  $\geq 100,000$ .

Demographic differences were noted between BIPOC and white participants: specifically, in comparison to white-identifying respondents, BIPOC participants were younger (63.0% identified as  $< 31$  years of age vs. 31% of white participants,  $p < .001$ ,  $w = 0.302$ ), and reported fewer years in the sector (77.0% worked  $\leq 4$  years vs. 53.2% for white participants,  $p < .001$ ,  $w = 0.237$ ). Additionally, a greater proportion of BIPOC respondents identified as belonging to the 2SLGBTQIA + community (43% BIPOC vs. 30% white respondents;  $p = .02$ ;  $w = 0.134$ ).

### Work Background and Organizational Characteristics

Occupation-related details including key characteristics of survey respondents' affiliated organizations are presented in Table 3. Approximately two thirds of survey respondents ( $n = 181$ ) were crisis line responders. More paid [full and part-time;  $n = 170$  (59.9%)] employees completed the survey than volunteers [ $n = 116$ , (40.1%)]. There were significant differences in years worked and employment status; most volunteers had less experience and had been working in the sector for  $\leq 4$  years (81.9%,  $p < .001$ ,  $w = 0.391$ ).

Survey participants largely served Ontario (54.7%), followed by the North (i.e. Nunavut, Yukon and Northwest Territories, 20.0%) and the Prairie provinces (i.e. Manitoba, Saskatchewan and Alberta, 18.9%) and their organizations supported a wide range of service volumes. Respondents' affiliated organizations provided services mostly in English ( $n = 211$ ), although almost 50% had access to third-party translation services, typically in large cities (48.8%,  $p = .0248$ ,  $d = 0.176$ ). The most common services provided by organizations included call, chat, text, referrals and follow-up contact. Organizations primarily served the following populations: general population, youth including 2SLGBTQIA + youth, Indigenous communities, and survivors of sexual abuse/domestic violence.

### Current Practices and Perceived Competencies for Supporting Diverse and/or Underserved Groups

Survey respondents varied in their approach to identifying service users belonging to diverse and/or equity-seeking communities. The most cited strategy identified by respondents was to wait until the service user discloses such information ( $n = 153$ , 59.3%), while others indicated they make inferences ( $n = 51$ , 17.4%), or only ask when they deem it relevant to the interaction ( $n = 57.2%$ ). Only four respondents identified tools that they use to collect service user identity or demographic information, and these tools were an intake assessment protocol ( $n = 2$ ), and service-user completed identifiers at the start of an interaction ( $n = 2$ ).

**Table 1** Data categorical Breakdown, Demographic Variable

Race	Category Breakdown
BIPOC	Black (African, African-Caribbean, African Canadian descent) Indigenous (First Nations, Inuit/Inuk, Métis descent) Latin American (Hispanic or Latin American descent) Middle Eastern (Arab, Persian, West Asian descent e.g. Afghan, Egyptian, Iranian, Kurdish, Lebanese, Turkish) South Asian (South Asian descent e.g. Bangladeshi, Indian, Indo-Caribbean, Pakistani, Sri Lankan) Southeast Asian (Cambodian, Filipino, Indonesian, Thai, Vietnamese, or other Southeast Asian descent) East Asian (Chinese, Korean, Japanese, Taiwanese descent)
White	White (European descent)
Gender	
Cis-Male	Cisgender boy Cisgender man
Cis-Female	Cisgender girl Cisgender woman
Trans & Gender Non-Conforming (TGNC)	Transgender girl Transgender woman Transgender boy Transgender man Two-Spirit Genderqueer Genderfluid Androgynous Non-binary Questioning
Sexuality	
2SLGBTQIA+	Asexual Bisexual Demisexual Gay Lesbian Pansexual Queer Questioning Two-Spirit
Heterosexual	Heterosexual/Straight

An exploratory analysis of the relationship between asking for service user identifiers and work characteristics indicated that respondents employed in the sector for fewer years ( $\leq 4$  years) were more likely not to ask for identifiers ( $p = .0382$ ,  $w = 0.194$ ) or make inferences ( $p = .0525$ ,  $w = 0.184$ ) and wait until disclosed ( $p = .0331$ ,  $w = 0.194$ ).

There were also differences between paid and volunteer respondents, with less volunteers indicating they ask for

**Table 2** General respondent demographics

Gender	Total $n = 323$
Cisgender Woman	73.4% (237)
Cisgender Man	15.2% (49)
Gender Queer (gender fluid, genderqueer, nonbinary, two-spirited, Prefer not to answer	10% (32)
	5% (16)
Age	Total $n = 323$
Under 31	40.2% (130)
31 to 45	29.7% (96)
Over 45	29.4% (95)
Prefer not to answer	0.61% (2)
Sexuality	Total $n = 323$
Straight/Heterosexual	62.5% (202)
2SLGBTQIA+	32.5% (105)
Prefer not to answer	4.95% (16)
Race	Total $n = 324$
White	67.2% (217)
BIPOC	9.59% (100)
Prefer not to answer	2.16% (7)
Community Setting	Total $n = 323$
Rural/Reserve	7.1% (23)
Small population (1k-29k)	14.8% (48)
Medium population (30k-99k)	12.1% (39)
Large population (Over 100k)	64.1% (207)
Prefer not to answer	1.5% (5)
Education	Total $n = 323$
High school/GED	9.0% (29)
Undergraduate Level (e.g. college, university)	62% (197)
Trade school	6.2% (2)
Graduate Level (e.g. Master's, PHD)	26.7% (88)
Prefer not to answer	2.2% (7)

identifiers either when deemed relevant, directly, or via a tool ( $p = .04$ ,  $w = 0.169$ ).

Mean perceived competencies for supporting service users with a range of mental health concerns are presented in Table 4. Mean competency ratings were greatest for supporting service users experiencing suicidal ideation, anxiety, loneliness and depression. Lowest mean competency ratings were for service users experiencing racism, cannabis use, and financial insecurity.

Table 5 presents mean perceived competencies for supporting service users from diverse populations. Greatest competency ratings were for supporting people with pre-existing mental health concerns, youth and young adults, older adults/seniors, and people living in poverty. Respondents rated their competencies supporting Francophones, linguistically diverse populations, veterans, and Black communities lowest.

**Table 3** Working Demographics and Settings

Working Status	Total <i>n</i> = 287
Paid part-time	23.3% (67)
Paid full-time	35.9% (103)
Volunteer	40.4% (116)
Prefer not to answer	0.4% (1)
<b>Role</b>	<b>Total <i>n</i> = 301</b>
CEO	4.3% (13)
Executive Director/ Director	5.6% (17)
Centre Coordinator	9.3% (28)
Manager/Supervisor	14.9% (45)
Trainer	0.7% (2)
Responder	60.1% (181)
Navigator	1.3% (4)
Other	2.65% (8)
Prefer not to answer	1.0% (3)
<b>Years of Experience</b>	<b>Total <i>n</i> = 301</b>
Less than 1 year	19.9% (60)
1 to 2 years	28.9% (87)
3 to 4 years	15.9% (48)
5 to 10 years	19.3% (58)
10 years or more	14.9% (45)
Prefer not to answer	1.0% (3)
<b>Areas/Province(s) Served</b>	<b>*Participant could select multiple*</b>
Atlantic (New Brunswick, Newfoundland and Labrador, Nova Scotia, and Prince Edward Island)	(12)
Prairies (Manitoba, Saskatchewan, and Alberta)	(127)
Northern Canada (Yukon, Northwest Territories and Nunavut)	(59)
Ontario	(128)
British Columbia	(34)
National (serves all provinces)	(43)
<b>Call average per year</b>	<b>*Only executives received this question*</b>
Less than 1k	(1)
1-9k	(11)
10-49k	(7)
50-100k	(10)
Over 100k	(1)
Uncertain	(1)
<b>Languages provided</b>	<b>*Participant could select multiple*</b>
English	(303)
French	(86)
TTY Accessibility	(41)
3rd party language translation	(138 yes) (166 no)
Other	(12)

\*Participants scored their perceived competencies from 0–100

**Table 4** Perceived Competencies Mental Health Concerns

Mental Health Concern	Mean (SD)
Anxiety	80.30 (13.35)
Loneliness	80.42 (13.84)
Depression	78.03 (14.19)
Alcohol and/or Substance Use	71.46 (17.79)
Cannabis Use	68.64 (19.98)
Intimate Partner Violence	71.65 (19.46)
Racism	67.53 (19.86)
Housing Instability	70.84 (18.71)
Financial Insecurity	69.50 (17.42)
Stigma	73.09 (17.99)
Lack of belonging or sense of connection	78.58 (14.66)
Concerns for safety (e.g., physically safe, emotionally safe)	78.21 (16.64)
Thoughts of suicide	82.98 (15.08)

\*Participants scored their perceived competencies from 0–100

**Table 5** Perceived Competencies Populations

Community	Mean (SD)
Black Communities	59.15 (21.43)
Healthcare Workers	69.34 (18.555)
Indigenous Peoples	66.86 (19.92)
2SLGBTQIA + individuals	69.44 (18.47)
Older Adults/Seniors	74.32 (17.70)
Parents of Young Children	70.28 (19.99)
People living with pre-existing mental health conditions	77.75 (16.15)
People living with incomes below the poverty line	70.55 (18.86)
People with occupational exposures to COVID-19 (e.g., people working in supermarkets, teachers, waste management, etc.)	68.27 (19.67)
People with current or prior justice system involvement	65.24 (19.56)
People living with disabilities (physical, sensory, mental, intellectual, etc.)	69.71 (18.25)
Public Safety Personnel (EMS, Police, Firefighters, RCMP)	63.85 (22.11)
Racialized communities	65.72 (21.19)
Recent Immigrants and/or Refugees	63.04 (21.16)
Francophones	46.79 (26.07)
Linguistically diverse groups (e.g., people speaking a language other than English or French)	49.86 (23.76)
Veterans, military personnel and/or military families	56.57 (21.74)
Youth and young adults	77.46 (16.37)
Rural communities	68.38 (18.67)

\*Participants scored their perceived competencies from 0–100

Open-text responses revealed that, alongside the populations for which respondents rated their competencies, certain

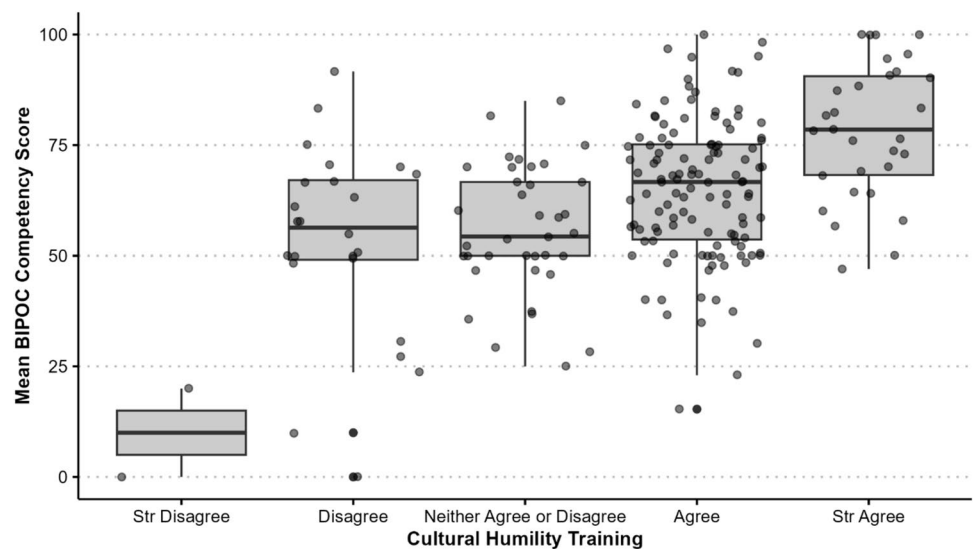
communities were perceived to bear a disproportionate burden of mental health challenges and social inequities. This included individuals who are unemployed or underemployed, those experiencing homelessness, international students, individuals facing chronic or stigmatized health conditions (e.g. HIV) or terminal illnesses, those struggling with substance use, survivors of domestic violence, and neurodiverse populations. Furthermore, respondents identified a myriad of mental health concerns brought forward by service users including agoraphobia, technology dependence, heightened anger and abuse compulsions, loss of intimacy, burnout, public distrust, political division, eating disorders, interpersonal conflicts, frustration with culturally insensitive care, challenges related to borderline personality disorder, inquiries about Medical Assistance in Dying (MAID), healthcare system burdens, and food insecurity.

Respondents were also asked to identify areas where they felt additional support, resources, or training could enhance their ability to provide crisis support to service users. Suggestions encompassed a spectrum of needs, including training to alleviate compassion fatigue and mitigate unconscious bias, increased emphasis on EDI, cultural competency training, expanded de-escalation training, certification-oriented training, incorporation of role-play exercises, and firsthand lived experiences during training, exploration of community outreach and support alternatives to police involvement, provision of comprehensive resources tailored to specific populations, adaptable resources that evolve with service changes, more local programming and the creation of accessible online spaces to address lengthy wait times prevalent in remote areas, promotion of diverse hiring practices within their organizations, implementation of regular team meetings to discuss ongoing issues and receive updated training, and expansion of peer support networks. Furthermore, there was an expressed need for resources aimed at supporting diverse populations. This encompasses training modules addressing effective communication techniques tailored to various age groups (e.g., teenagers) and frequent callers, strategies for establishing rapport with service users from different demographic backgrounds, guidance on asking service user demographics, techniques for assisting service users residing in rural or under-supported areas, training on how to respond to medical assistance in dying (MAID) inquiries, and access to language interpreters.

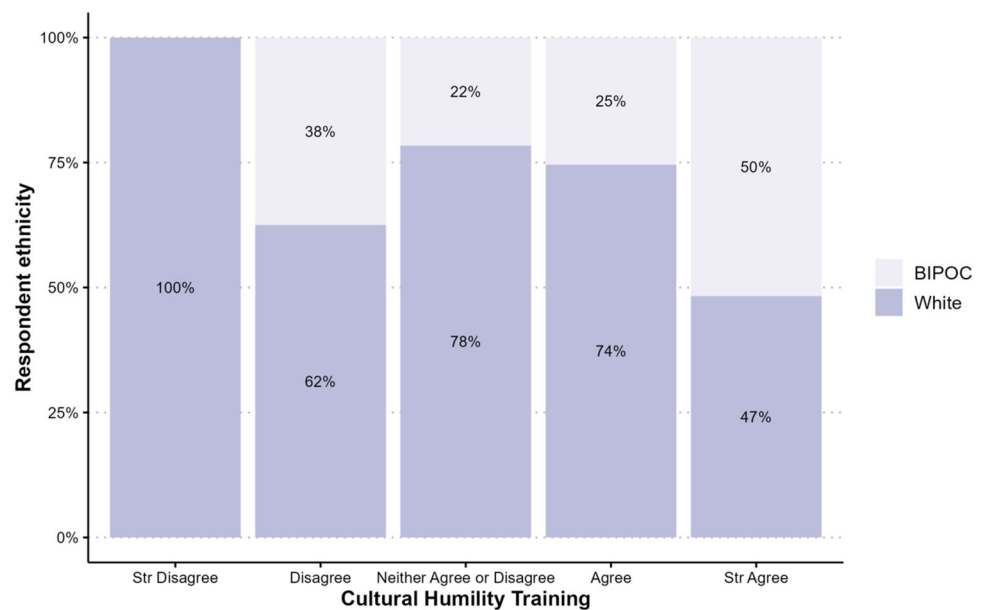
### Access to Resources and Learning Preferences

In terms of existing training, survey respondents agreed that they felt adequately trained to demonstrate cultural humility during crisis interactions ( $n = 149$ , 70.3% agreement) and to support the needs of diverse service users ( $n = 162$ , 76.4% agreement). A little over half of the respondents also felt they had access to high quality resources to support the

**Fig. 1** Cultural humility as a predictor of perceived competency supporting BIPOC communities



**Fig. 2** Association between race and cultural humility training



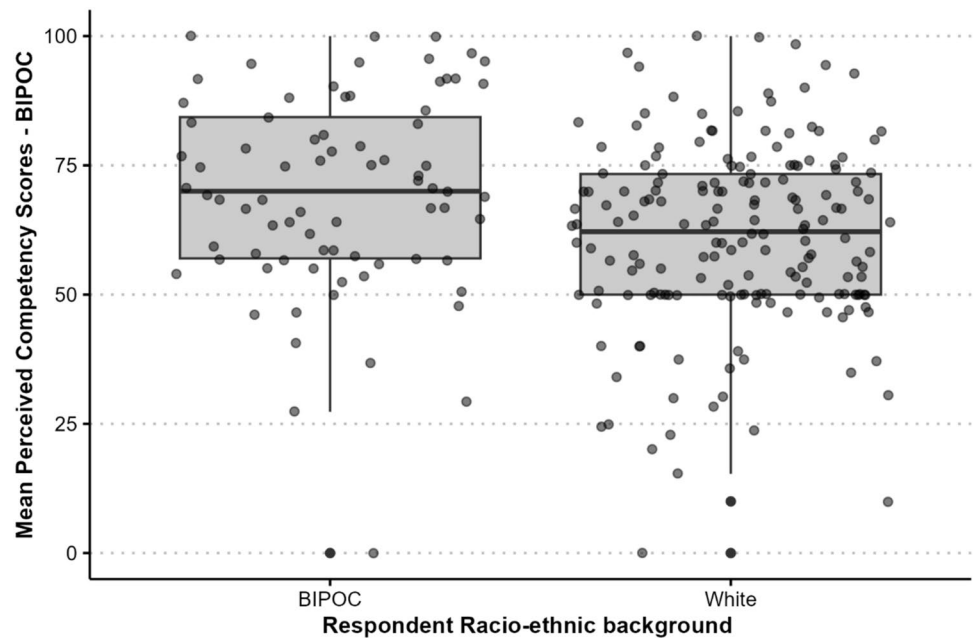
needs of diverse and underserved communities ( $n = 125$ , 59.0% agreement), yet almost all indicated they would benefit from access to more up-to-date resources to help support the needs of diverse communities ( $n = 189$ , 89.2% agree or strongly agree).

The resources accessed most frequently to support diverse service users included websites and online resources, online training modules, webinars and other virtual presentations, and in-person training sessions. Survey respondents identified interest in the development of a wide range of tools, including an online portal, evidence-based summaries, videos, simulations, role-play, decision support tools, and infographics. Barriers to training most frequently identified included lack of time either while on shift or during time off, and limited resources from organizations to support training.

**Predictors of Cultural Competency** To understand predictors of perceived competency in supporting diverse populations, further analyses were conducted to examine relationships between perceived competencies and factors such as trainings, access to resources, and respondent demographics.

**Do Cultural Humility Scores Predict Self-Efficacy Ratings for Supporting Racialized Populations?** For each survey respondent, competency rating for supporting Black, Indigenous and racialized communities were combined to generate a mean BIPOC competency score. Analysis of this score alongside ratings of cultural humility training demonstrated a relationship amongst the two variables: the higher

**Fig. 3** Mean BIPOC Competency Scores by racio-ethnicity of responder



the agreement with sufficient cultural humility training, the greater perceived competence supporting BIPOC communities ( $p < .001$ ,  $d = 0.555$ ) Fig. 1.

**Do the Socio-Demographics of the Responder Predict Ratings of Cultural Humility?** The results of a Fisher's test indicate an association between cultural humility rating and racio-ethnicity ( $p = .0365$ ,  $w = 0.224$ ). As seen in Fig. 2, BIPOC respondents more strongly agreed to feeling adequately trained on ways to demonstrate cultural humility during crisis service interactions compared to white-identifying respondents.

**Do the socio-demographic characteristics of survey responders predict their mean competencies for supporting diverse or equity-seeking populations? Specifically, are there differences in perceived competencies supporting diverse communities based on whether crisis line workers identify as belonging to the community?** Race As indicated by A Wilcoxon Rank Sum test there is a significant association between respondent racio-ethnicity and perceived competency supporting BIPOC populations ( $p < .001$ ,  $d = 0.48$ ). Mean BIPOC competency ratings were higher for BIPOC survey respondents compared to white-identifying survey respondents (Fig. 3).

**Gender** An association between gender and mean competency supporting 2SLGBTQIA+ populations was confirmed via a Kruskal-Wallis rank sum test: Trans and gender non-conforming (TGNC) survey respondents indicated greater self-efficacy supporting 2SLGBTQIA+ populations

in comparison to cisgender respondents,  $p < .001$ ,  $d = 0.281$  (Fig. 4).

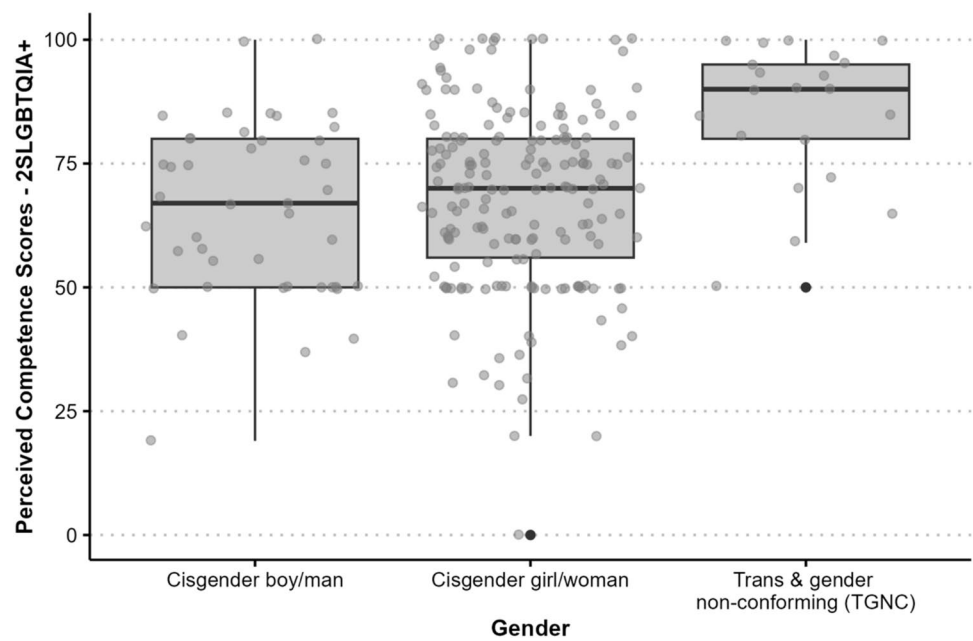
Sexuality 2SLGBTQIA+ identifying responders indicated greater competencies supporting 2SLGBTQIA+ populations in comparison to heterosexual-identifying survey respondents,  $p < .001$ ,  $d = 0.601$  (Fig. 5).

**Does Responder Perceived Ability to Access Resources Predict mean Competencies Supporting Racialized Communities?** As evident in Fig. 6 and confirmed by a Kruskal-Wallis Rank Sum test, there is an association between increasing agreement with sufficient access to resources and higher ratings of perceived competence supporting racialized communities ( $p = .008$ ,  $f = 0.312$ ).

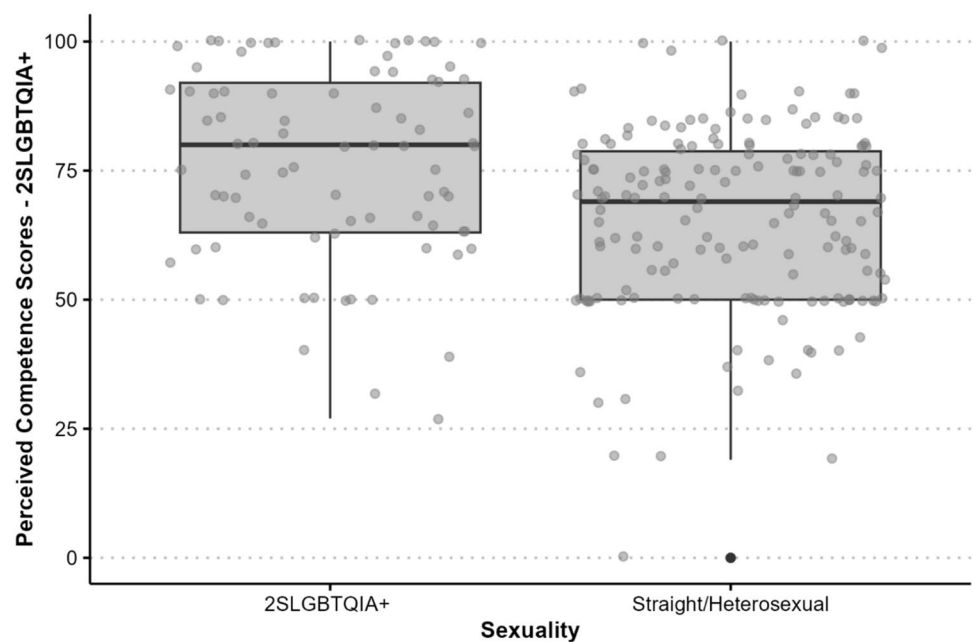
## Discussion

We sought to understand the characteristics and practices of crisis responders at national and local-serving crisis and distress lines in Canada, focusing on considerations rooted in equity, diversity, and inclusion. Most survey respondents identified as white, heterosexual, cisgender females. BIPOC respondents often had fewer years of experience in the sector. In general, respondents expressed confidence in their ability to support service users with a variety of mental health and crisis issues, as well as in assisting diverse and underserved communities, despite the prevailing trend of not directly asking for service user demographics. Survey respondents indicated they were satisfied with their training and access to resources overall, however, open-text responses indicated that there was a need for and interest in

**Fig. 4** Association between respondent gender and perceived competency supporting 2SLGBTQIA+ communities



**Fig. 5** Association between sexuality and competency supporting 2SLGBTQIA+ communities



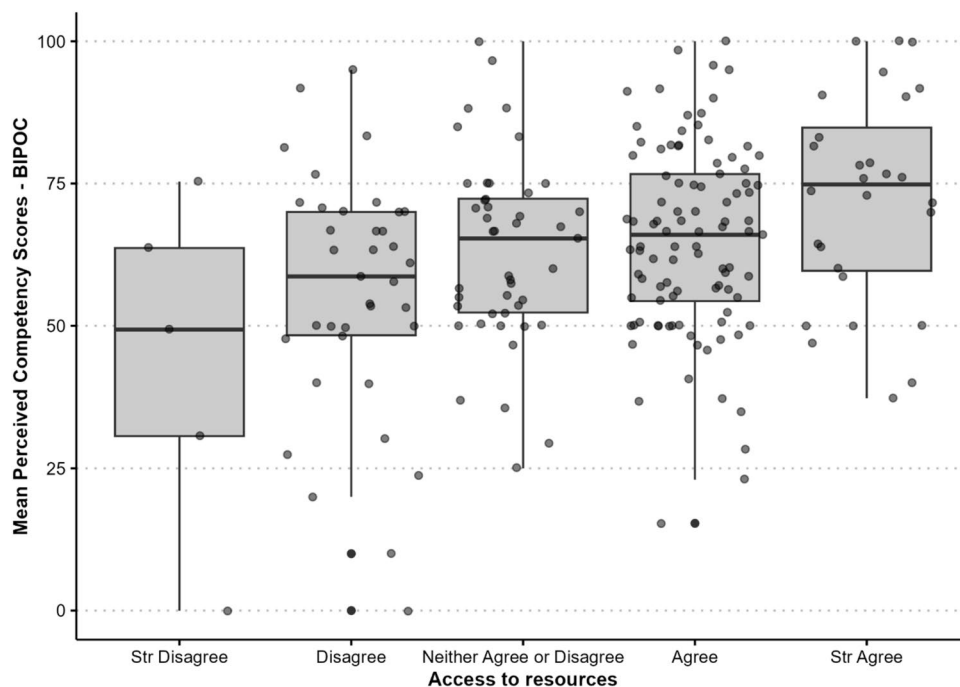
more EDI and cultural competency training and resources to support them in their roles. Socio-demographic characteristics of crisis responders, as well as satisfaction with training and resources, were associated with perceived competency supporting diverse communities.

The lack of tools or approaches to ask explicitly about service user demographics, identities, or preferences highlights a gap in practices to support EDI in the Canadian crisis line sector. Notably, most BIPOC respondents were relatively new to the field ( $\leq 4$  yrs), which may be indicative of a shift in recruitment practices as our understanding

of the importance of diverse representation in mental health service provision continues to develop (e.g. Atkinson et al., 1990; Townes et al., 2009; Meyer & Zane, 2013, Olaniyan & Hayes, 2022). While evidence of increasing diversity in the sector is promising, further efforts should be pursued to increase representation and training, particularly for populations and groups that tend not to access crisis lines, or those who have increased risks or unique needs related to suicide prevention.

Greater perceived competencies in supporting service users with shared racial, ethnic, gender, or sexual

**Fig. 6** Access to resources and competency supporting BIPOC populations



identities is consistent with findings from service users in other therapeutic settings, and reflects the significance of seeking support from individuals who share similar identities (e.g. Townes et al., 2009; Meyer & Zane, 201; King et al., 2007; Jumarali, 2022). However, most survey respondents indicated they did not directly ask service user demographics, relying instead on inference, highlighting the potential incongruence in perceptions of competence and service delivery. Responders may refrain from asking demographics on crisis lines for several reasons. One primary consideration is the desire to create a safe and non-judgmental space for individuals in distress. By avoiding inquiries about demographics such as age, gender identity, or ethnicity, crisis line responders may believe that they foster an environment where service users feel valued and understood solely based on their immediate concerns and emotions, and/or that omitting demographic questions can help protect service user anonymity and confidentiality. Further exploration of standardized and best-practices approaches to gathering service user demographics and identifiers is needed. Advocates of standardization argue that it can enhance service provision by streamlining processes and facilitating more tailored assistance (Perry et al., 2022; Zabelski et al., 2023).

Conversely, it has been argued that asking service user demographics may raise privacy concerns, and that without a tool or training, asking demographics could lead to potential biases in data collection, and overlook intersectionality (Barbara et al., 2007). However, this “blind” approach fails to acknowledge the significant disparities faced by underserved and equity-seeking populations in

mental health, and where identity factors may be important risk and protective factors for suicide. Without such data, it is challenging to evaluate service efficacy through an equity lens. Moreover, the absence of demographic information limits the organization’s ability to advocate for resources or funding tailored to the diverse needs of their service user base (Zabelski et al., 2023).

The findings also highlight the crucial role of training and access to resources in enhancing competency. Specialized programs, such as cultural safety and humility training foster an understanding of the importance of service user values and preference. By cultivating cultural humility, individuals develop the capacity to approach interactions with an antiracist lens, with openness, and an understanding of cultural differences (Jones & Branco, 2023; Lewis et al., 2018), thus contributing to a cultural safe and inclusive environment. Interestingly, those who rated themselves as having greater cultural humility, also rated their perceived cultural competence as higher. This could be interpreted in various ways, from increased competency and skill to, paradoxically, decreased self-awareness.

Alongside targeted training, access to resources emerges as a pivotal factor in enhancing competency and reinforces the need to ensure access to novel tools and trainings offered in a variety of formats. A multifaceted approach should ensure availability beyond traditional work hours and provide secure, dedicated time or compensation for training. By addressing these needs, the sector will empower responders with the necessary skills and knowledge to cultivate a culture of inclusion. The importance of these factors at the organizational-level should

also be addressed – it is not just up to responders to create accessible, inclusive environments, and equity in crisis line outcomes.

Several limitations in this study should be acknowledged. Firstly, despite efforts to avoid a purely convenience-based sampling approach, responders who participated in the survey were likely predisposed to do so and may differ from the full workforce of responders. Those who had the time and inclination to complete this voluntary survey may have been less burdened by work-related stressors, potentially skewing the data towards individuals with lower levels of burnout and higher levels of enthusiasm for training initiatives. Furthermore, in the analysis, it also became necessary to combine groups in order to retain statistical power. While this yielded valuable insights, it also prevented us from looking at more population-specific findings. Future studies should use a larger sample size to allow for these explorations.

While the results of this survey support setting priorities for recruiting more diverse responders; creating training focused on EDI, cultural safety and cultural humility; exploring the development of practices and tools to better elicit and engage with the intersectional identities of service users; and the need to better understand and develop organizational values and practices that support a culture of equity and inclusion; this preliminary survey relied on self-ratings. Further studies should research and employ more objective means of assessing cultural competence, safety, and humility in crisis services. Most importantly, responder characteristics, cultural competency, and cultural humility should be explored in relation to service user socio-demographics and outcomes, including service user ratings of cultural safety, to inform future best-practices.

## Conclusion

To the best of our knowledge, this is the first study to describe responder characteristics through a lens of equity, diversity, and inclusion, including their self-rated competence at providing support to diverse and equity-seeking populations. The findings highlight the need for recruiting a more diverse workforce of responders and the importance of supporting responders through training in EDI, including in cultural safety and humility, and resource development. These results will be used to support quality improvements in the new Canadian 3-digit crisis service and may be of interest to crisis lines in other jurisdictions and to those crisis lines that work with diverse populations.

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**Data Availability** The data that support the findings of this study are available on request from the corresponding author, [AC]. The data are not publicly available due to information that could compromise the privacy of research participants.

## Declarations

**Conflict of interest** None of the authors have any conflicts of interest to declare.

**Ethical Approval** This study received Quality Project Ethics Review (QPER) approval at the Centre for Addiction and Mental Health, in Toronto, Canada, and was exempt from formal research ethics review (reference2022\_021).

**Consent for Publication** Participation in this study was voluntary and all surveys were completed anonymously.

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