

9-8-8: Suicide Crisis Helpline – Implementing a Pan-Canadian Program to Prevent Suicide

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Abstract

The 9-8-8: Suicide Crisis Helpline was launched in Canada in November 2023, aligned with an international movement to ensure access to crisis supports as part of a public health approach to suicide prevention. We describe the planning and implementation of 9-8-8 in Canada using the RE-AIM framework, considering the Reach, Effectiveness, Adoption, Implementation and Maintenance of 9-8-8 within the first six months of service (Glasgow et al. 2019). There is evidence of reach and adoption of 9-8-8 across Canada, and we discuss evidence-based strategies to evaluate and enhance effectiveness, implementation and maintenance. We also consider the importance of evaluating 9-8-8 within the larger socio-ecological and health system contexts. 9-8-8 must cultivate a learning health system approach and be part of a larger learning health system focused on reducing suicide in Canada.

Introduction

Every day in Canada, approximately 12 people end their lives by suicide. Suicide is the second leading cause of death for youth and young adults, aged 15 to 24 years. Each of the approximately 4,500 people who die by suicide in Canada every year is a tragedy, impacting families and communities (Public Health Agency of Canada 2022; Statistics Canada 2024). The World Health Organization (WHO 2014) recognizes suicide as a public health imperative that needs to be

addressed not just in healthcare settings, but across all sectors of society and with all levels of government and services working collaboratively to address suicide.

Canada made a renewed commitment to addressing suicide in 2012 by enacting the *Federal Framework for Suicide Prevention Act* (2012), which led to the launch of a federal framework for suicide prevention in 2016 (Government of Canada 2016), followed by the recent launch of the National Suicide Prevention Action Plan in 2024 (Government of Canada 2024). A core part of the federal approach to suicide prevention is to ensure that all people living in Canada have access to crisis supports if they are experiencing suicidal thinking or behaviour or are worried about someone else. We have also called for a national crisis service as part of a public health approach to suicide prevention and as part of a larger national strategy to address suicide (Crawford 2015, 2021).

Telephone and text-based crisis and distress lines are an evidence-based, public health approach to suicide prevention (Hoffberg et al. 2020; Zabelski et al. 2023). Among the greatest risk factors for suicide is a previous suicide attempt; thinking about and planning an attempt are also important risk factors (Favril et al. 2022; Pemau et al. 2024). Crisis lines provide support and help alleviate distress when people are most in need. Equally important, crisis lines can also be protective, providing connection and hope and supporting

callers and texters to leverage their own strengths to cope with distress (Cox et al. 2021; Gould et al. 2016; Kalafat et al. 2007; Mishara et al. 2007).

On November 30, 2023, 9-8-8: Suicide Crisis Helpline was launched across Canada, providing suicide prevention and crisis support in English and French, by phone and text, 24 hours per day. This service is funded by the federal government and is coordinated by the Centre for Addiction and Mental Health (CAMH). The 9-8-8 service prioritizes a community-based approach and is delivered through a network of regional, provincial and national partners. When people call or text 9-8-8, they receive support close to home, wherever possible, with additional options for those under 18 years of age, and for callers who identify as First Nations, Inuit or Métis. Canada's 9-8-8 service joins other countries, most notably the US, that have also adopted 9-8-8 in providing access to evidence-based crisis supports through a national contact point.

While public health approaches to suicide prevention are gaining prominence in a field that has long been dominated by clinical and individual-level interventions, there is also recognition that population-level initiatives often fail to show impact (Zabelski et al. 2023; Zalsman et al. 2016). Attention is now focused on the *implementation* of evidence-based suicide prevention and intervention initiatives, moving research evidence into practice and ensuring the effectiveness of interventions across settings and contexts (Kasal et al. 2023; Krishnamoorthy et al. 2023).

Implementation has been critical for 9-8-8, particularly with multiple partners across settings and provinces/territories. Also central to 9-8-8 is ensuring that the service is equitable, meeting the needs of diverse groups and communities across Canada – in particular, communities who may not have access to crisis lines and groups and communities at higher risk of suicide. From the outset, 9-8-8 has relied on implementation principles and processes to ensure an effective launch across Canada. Since launch, we have sought to adopt a more robust framework to capture implementation to date and to ensure iterative attention to implementation, quality, sustainability and growth of 9-8-8. The RE-AIM framework – which measures outcomes related to reach, effectiveness, adoption, implementation and maintenance – has provided a practical scaffold for ongoing planning and evaluation of 9-8-8 (Glasgow et al. 2019). We describe the application of RE-AIM to 9-8-8 as we assess early outcomes of 9-8-8 and turn toward future aspirations for 9-8-8 within the landscape of mental healthcare in Canada.

Applying the RE-AIM Framework to Planning and Evaluation of 9-8-8

In addition to RE-AIM, there are many frameworks to assess planning and implementation contexts and outcomes, such as EPIS (Exploration, Preparation, Implementation, Sustainment;

<https://episframework.com/>), CFIR (Consolidated Framework for Implementation Research; <https://cfirguide.org/>) and PARiHS (Promoting Action on Research Implementation in Health Services; <https://www.nccmt.ca/knowledge-repositories/search/85>), among others. All of them focus on both organizational (so-called “inner”) and external (“outer”) settings and contexts, and all include characteristics of those receiving the program or intervention. All of them also consider multi-level factors and impacts.

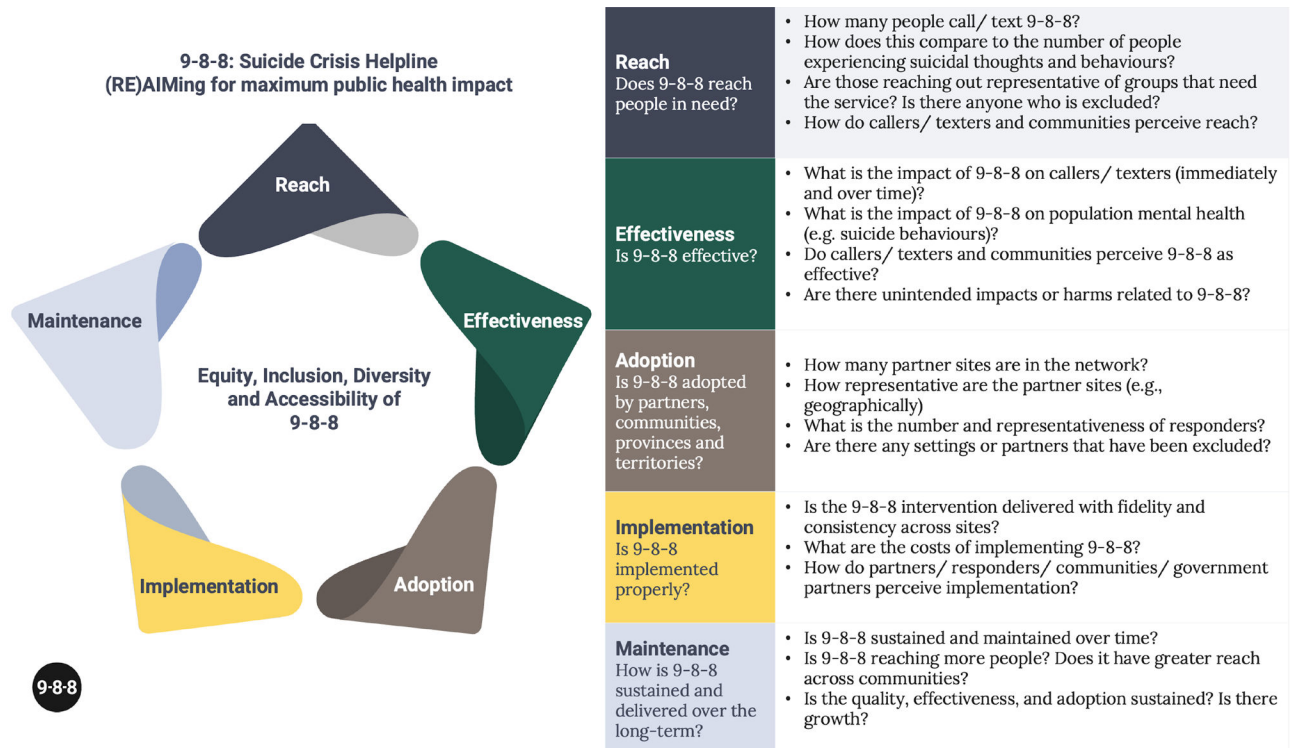
RE-AIM was chosen from among these because of its widespread application to public health initiatives, its accessible tools and supports and its practicality and simplicity. RE-AIM is an acronym for five outcomes including Reach, Effectiveness, Adoption, Implementation and Maintenance, which together determine the public health impact of an intervention or program. The framework was initially developed to ensure consistent reporting of research results but is now widely used to translate research into practice and to help plan programs and improve their chances of success and impact across settings (Glasgow et al. 2019). This framework is aligned with our community-based focus. More recent applications of RE-AIM also support attention to equity (Fort et al. 2023; Jolles et al. 2024), which is discussed in more detail in the later sections.

Figure 1 outlines the RE-AIM framework as applied to 9-8-8. Highlights of each step are described in the later sections. Although presented according to the acronym, analysis of each step is iterative; in relation to 9-8-8, each step is at various stages of inquiry; and both process and outcomes are relevant for each step. A variety of data sources and methods to collect data are used, from volumetric data such as call volumes and wait times, surveys, community outreach and consultation, qualitative interviews and the tracking of feedback through quality assurance and quality improvement processes, to support planning and ongoing evaluation. The most developed steps for 9-8-8, with the greatest amount of current outcome data, are reach and adoption.

The Reach of 9-8-8

Reach refers to the total number of people who called and texted 9-8-8, how representative those callers and texters are of the population and the proportion of those individuals who called or texted 9-8-8 out of the total number of possible callers and texters. Table 1 includes early volumetric data and service outcomes for 9-8-8. In the first six months of service, 9-8-8 received 216,462 interactions, including 139,202 calls and 77,250 texts. We are tracking representativeness along dimensions of geography, but this data will not be publicly available until one year post launch; when available, this will allow us to understand reach within local, regional and provincial/territorial geographies across Canada. Approximately 14% of calls are abandoned by callers prior to connecting to a

FIGURE 1.
RE-AIM framework applied to 9-8-8: Suicide Crisis Helpline



responder, despite a very fast response time (i.e., time to answer). While this value is anticipated, we will continue to monitor the percentage of calls that are not connected and will engage people with lived experience of 9-8-8 to understand contributing factors.

Understanding the proportion of callers/texters to the total number of possible callers and texters is more nuanced. The largest possible denominator is the number of people in Canada, or 38.93 million people. More meaningfully, we can also consider those who are most likely to require the service. In 2021, 4.2% of people living in Canada reported thoughts of suicide (Liu et al. 2022), which at the population level would equate to approximately 1.6 million people annually. Another relevant projection is the 0.3% of the Canadian population who attempt suicide per year, or approximately 117,000 people (Public Health Agency of Canada 2022). These numbers suggest that 9-8-8 is reaching a significant number of people.

Future directions for reach involve understanding the demographics of callers and texters beyond geography and comparing these with the number of callers/texters from specific population groups. Systematically collecting demographic details of callers and texters raises a number of privacy concerns and warrants further consideration. However, we will soon implement a voluntary post-call and post-text survey that includes demographic questions to increase our

understanding of who is using the 9-8-8 service and, importantly, who is not. Established methods for improving reach include outreach, such as community consultations; engagement of people with lived and living experience, particularly from relevant target groups; and advertising, including market research to identify effective messages and forms of advertising. We are actively working on all these strategies, with the first formal national advertising campaign for 9-8-8 launching in September 2024, based upon the findings from market research on awareness of 9-8-8. Transparency of communication is also critical to building and sustaining trust in the service; the 9-8-8 website (www.9-8-8.ca) and the Public Health Agency of Canada (PHAC) present monthly data reports, and PHAC is also mandated to conduct an independent evaluation of the first year of service.

Effectiveness of 9-8-8

Effectiveness refers to the impact of 9-8-8 on the outcomes of those who call or text 9-8-8, including both positive and potentially negative outcomes. It can also include broader impacts such as economic outcomes. Our premise for implementing 9-8-8 is that crisis line services have shown evidence of efficacy and effectiveness (Hoffberg et al. 2020; Zabelski et al. 2023). At the individual level, we will be starting to monitor effectiveness through an analysis of a

TABLE 1.
Key early volumetric data for 9-8-8

	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	Total
Total calls + texts	37,411	35,001	32,890	37,337	37,488	36,335	216,462
Calls (percentage)	23,677 (63%)	22,417 (64%)	21,080 (64%)	24,654 (66%)	24,831 (66%)	22,553 (62%)	139,202 (64%)
Calls answered	16,658 (85%)	15,987 (86%)	15,699 (88%)	18,760 (89%)	19,119 (89%)	16,979 (88%)	103,202 (88%)
Calls that failed to connect	2,944 (15%)	2,580 (14%)	2,167 (12%)	2,900 (14%)	2,898 (13%)	2,866 (15%)	16,355 (14%)
Texts (percentage)	13,734 (37%)	12,584 (36%)	11,810 (36%)	12,683 (34%)	12,657 (34%)	13,782 (38%)	77,250 (36%)
Time to answer – call	00:00:22	00:00:20	00:00:18	00:00:19	00:00:23	00:00:55	00:00:26
Time to answer – text	00:02:03	00:01:28	00:01:29	00:01:28	00:01:39	00:01:34	00:01:37
Average length of call	00:16:47	00:15:44	00:15:29	00:14:13	00:13:36	00:15:40	00:15:09
Average length of text interaction	00:34:26	00:35:08	00:34:18	00:34:27	00:34:06	00:33:28	00:34:19

post-call survey and through changes in caller or texter distress during the 9-8-8 interaction, as rated by the responder.

Over the first months of implementation, we have been carefully monitoring any unintended adverse outcomes or events, with network partners required to report adverse events. We also have a caller and texter feedback process, which is monitored as part of our quality assurance and quality improvement program. In addition, we track emergency interventions, which are calls that result in the involvement of emergency services personnel through 9-1-1. We aim to keep this at or below 3% of all interactions. While it is the goal of 9-8-8 responders to support callers and texters and to decrease distress, we recognize that there are some situations in which further intervention is necessary to ensure the safety of callers, texters and others, so while we aim to keep the percentage of emergency interventions low, we acknowledge that some emergency interventions will be required.

Known ways to enhance effectiveness include continuing to build the evidence base for the intervention by measuring outcomes, tracking outcomes through quality assurance and quality improvement programs and through soliciting ongoing feedback from callers and texters. We are currently engaged in a journey mapping exercise (Davies et al. 2023) to understand the caller/texter experience through 9-8-8 and to identify *pain points* for callers and texters and identify barriers to service

effectiveness. One aspect of 9-8-8 planning that was designed to support improvements in effectiveness was the standardization of the 9-8-8 intervention; delineating the core components of the intervention is necessary for further evaluation. An ongoing gap in the field is understanding the long-term outcomes and effectiveness of crisis lines, such as 9-8-8 (Hoffberg et al. 2020; Zalsman et al. 2016).

Adoption of 9-8-8

The adoption of 9-8-8 is assessed at an organizational, rather than individual caller/texter level – in other words, the people or agents who deliver 9-8-8. Adoption is based upon the number, proportion and representativeness of partner sites that offer the 9-8-8 service and the number of responders within each. Of interest is also the number of provinces and territories that have adopted 9-8-8, since the aim of 9-8-8 is to be pan-Canadian. At launch, there were 38 partner sites delivering the 9-8-8 service as part of a network. These include: Alberta, two sites; British Columbia, seven sites; Manitoba, one site; New Brunswick, one site; Nova Scotia, one site; Newfoundland and Labrador, one site; Nunavut, one site; Ontario, 16 sites; Quebec, one site; Prince Edward Island, one site; Saskatchewan, three sites; and Yukon, one site. The Northwest Territories has one site that will join in November 2024. There are four additional national partners, including Kids Help Phone (<https://kidshelpline.ca/>) and Hope for

Wellness (<https://www.hopeforwellness.ca/>), which service First Nations, Inuit and Métis callers. There are approximately 1,000 trained 9-8-8 responders across these partners. This initial data demonstrate adoption across Canada. Important differences in the number of sites per province/territory and the range of sizes of organizations and capacity will be a focus of further evaluation. In addition, the model of service delivery differs for Quebec, Newfoundland and Labrador, New Brunswick, Prince Edward Island and Nova Scotia, which have each incorporated 9-8-8 into existing provincial mental health crisis lines.

Exclusion is an important component of assessing adoption. We set initial inclusion criteria for participating partner sites: being an existing provider of a crisis line service and able to provide service in English and French. Further expansion of the network in the future may have different inclusion/exclusion characteristics to support the inclusion of diverse communities.

Future exploration of adoption will also involve quantitative (e.g., surveys) and qualitative (e.g., interviews or focus groups) feedback from the leadership at partner sites. Administrative and training/supervisory leadership by 9-8-8 partners has been a key driver in the adoption and other aspects of 9-8-8 planning and implementation. Organizational leaders were included from the early stages of 9-8-8 planning, through a network of partner sites and through national implementation steering committees and working groups. We are interested in perspectives across sites, particularly in relation to interaction volumes within a province/territory or region, number of staff and model of 9-8-8 delivery.

Adoption at the staffing/responder level was also important and will likely change over time. Staff are a mix of volunteer and paid responders, and partners had to ensure that staff received appropriate training in order to provide the 9-8-8 intervention. There is a shift toward a higher number of paid responders, which was enabled by the funding of and investment in 9-8-8. As we consider fidelity (i.e., the degree to which an intervention or programme is delivered as intended) toward the 9-8-8 intervention, there may be additional future considerations in the competencies, training and/or qualifications required from responders. Responders will also be included in both quantitative and qualitative evaluations relevant to adoption.

Early efforts around adoption focused on inclusive and meaningful 9-8-8 planning and on engaging leadership to buy into the mission, vision and values of 9-8-8 and to see the alignment with their own service. Challenges for each site to work through included whether their organization had the necessary resources, capacity and expertise to provide the 9-8-8 service, while CAMH and the federal government, as a funder, had to ensure that resources to provide funding and capacity-building were available and distributed equitably.

Future efforts around adoption will have to continue to support organizations through to sustainability, while providing continued opportunities for meaningful engagement, leadership and service design to partners.

Cultural safety and trauma-informed care are required training for 9-8-8 responders to instill a culture of inclusion.

Implementation of 9-8-8

Implementation is a broad concept. Within the RE-AIM framework, implementation refers to the fidelity to the various elements of 9-8-8's key functions or components – in other words, the consistency of delivery of 9-8-8 as intended. The time and cost of delivering 9-8-8 are additional considerations under the implementation step within the RE-AIM framework. Early implementation outcomes of 9-8-8 are favourable. All of the sites and responders have reviewed existing 9-8-8 standard operating procedures and the 9-8-8 intervention manual. Adherence to the 9-8-8 intervention and service components and consistency of 9-8-8 delivery are being continuously monitored and evaluated through a quality improvement process, which includes monitoring of interactions across sites by a quality assurance team and follow-up of both complaints and any safety incidents.

Fidelity is a central focus of current improvements. We are standardizing our processes for monitoring fidelity (e.g., development of fidelity checklists) and providing feedback to partner sites. We have developed a competency framework for responders as well as operationalized the core components of the 9-8-8 intervention to ensure that the intended delivery of 9-8-8 is measurable and clear. We are in the process of developing interactive e-learning modules to support learning and knowledge acquisition related to the 9-8-8 intervention. We also have a robust community of practice to support the application of these components into practice. In the coming year, we are working with Health Service Organization/Accreditation Canada to further define and refine standards for the delivery of crisis response in Canada.

Maintenance and Sustainability of 9-8-8

Within the RE-AIM framework, maintenance can be measured at both the organizational/setting level and the individual level. The former would assess the extent to which 9-8-8 becomes a routine part of the partner organization's practices and policies. This is also of interest at the governmental level – to what extent will 9-8-8 become a routine part of the mental healthcare landscape at both provincial and federal levels? At the individual level, maintenance extends effectiveness. What are the longer-term impacts of 9-8-8 intervention? If it was effective, how long does this intended effect

last? Research in other contexts shows effectiveness for up to four years following crisis line contact, but this evidence is of low quality and is not available for our Canadian setting (Hoffberg et al. 2020). At six months post launch, we are not yet evaluating maintenance and sustainability, but we are planning to do so.

Equity of 9-8-8

Equity is a core value of the 9-8-8 service, and we actively prioritize efforts toward inclusion, diversity and accessibility for both callers/texters and responders. Although equity is not one of the five key RE-AIM outcomes, recent work has emphasized the importance of equity and opportunities to enhance equity across each of the five steps of the RE-AIM framework (Fort et al. 2023; Jolles et al. 2024). The very processes of planning, development and implementation can be directed toward mitigating inequities. For example, ensuring engagement and representativeness of diverse callers and texters across Canada; engaging those with lived experience of 9-8-8 across all aspects of planning, implementing and evaluating 9-8-8; adapting aspects of the 9-8-8 intervention where possible to fit the needs of unique groups; and measuring equity by analyzing the reach, adoption and effectiveness of 9-8-8 based upon sub-group analyses to ensure equity across users of 9-8-8.

We have used all of these strategies since the initial planning for 9-8-8, and equity remains a priority. The national 9-8-8 implementation committee, and all of its working groups, include people with lived experience. One of the working groups is focused on health equity. 9-8-8 has also developed a Lived Experience Caucus to develop a diverse cadre of lived experience for ongoing engagement. We have also undertaken extensive community engagement, meeting with diverse groups – such as Indigenous organizations, LGBTQ2SIA+ [lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual and other sexual and gender minority] communities, rural communities, neurodiverse communities, healthcare providers, the Francophone community, the deaf and hard of hearing, seniors and youth groups and organizations – to understand their needs, preferences and values. We are working with priority populations, such as public safety personnel, and with healthcare workers who use 9-8-8 and will engage in co-design to ensure that the service is trustworthy and meaningful for these groups. Cultural safety and trauma-informed care are required training for 9-8-8 responders to instill a culture of inclusion.

Evaluating equity is a challenge that we are addressing. With community groups, we are conducting health equity impact assessments for 9-8-8. We are exploring ways to collect the necessary demographic data that will enable an analysis of reach and effectiveness based on equity-seeking groups. As

mentioned earlier, to this end, we will soon launch a voluntary post-text survey.

Future Directions for 9-8-8 Implementation and Evaluation

In addition to the future directions and enhancements described in the above-mentioned sections, we plan to use the expanded Practical Implementation Sustainability Model (PRISM) to assess the implementation and impact of 9-8-8 within its larger socio-ecological and health systems context (Rabin et al. 2022). PRISM includes RE-AIM but also looks at wider and multi-level contextual factors relevant to implementation. Four multi-level PRISM domains, as applied to 9-8-8, include the following: (1) perspectives on the 9-8-8 intervention (e.g., history with similar programs, relationships); (2) characteristics of implementers of 9-8-8, their settings, and those receiving the 9-8-8 intervention (i.e., callers and texters, responders, staff, organizational decision makers and community levels); (3) the external environment (e.g., policies, distribution of resources, health and social system structure and coverage); and (4) the implementation and sustainability infrastructure for 9-8-8 (e.g., resources and capacity, staff roles and responsibilities, monitoring and evaluation systems). With the initial implementation stabilizing, we need to consider these wider contexts to understand current and future integrations of 9-8-8 into communities and the continuum of healthcare. Evaluation is warranted at multiple levels including the use of emergency departments and other healthcare resources, as well as the use of emergency service interventions (e.g., 9-1-1). In addition, it will be important to understand the potential economic impacts of the 9-8-8 service, as well as impacts on societal suicide literacy and stigma reduction. Attention to these larger, multi-level contexts will also allow a greater understanding of the structural drivers of inequities in suicide prevention, crisis line access and outcomes and ways to address them.

Summary and Key Lessons

The 9-8-8: Suicide Crisis Helpline is an important pillar of a public mental health approach to suicide prevention. It represents a major commitment to suicide prevention by the federal government and is an evidence-based mainstay of coordinated national action to prevent suicide. It is also the result of exemplary leadership and collaboration across the existing crisis and distress sector and would not be possible without the dedicated work and training of responders across the country. There has been a priority focus on equity from the outset of planning and implementation of 9-8-8, including ensuring that 9-8-8 serves diverse callers and texters representative of all people living in Canada and of the responders who provide that service; that it cultivates an inclusive, culturally safe

environment; and that it is accessible to all who need it. These goals will only be achieved if the individuals, groups and communities that may need 9-8-8 are aware of and able to access the 9-8-8 service, feel safe and have trust in 9-8-8 and find it meaningful and effective.

Adopting the RE-AIM framework has allowed us to attend to all dimensions of planning, implementation and evaluation that are necessary to reach these goals. As described above, there are already promising outcomes related to the reach and adoption of 9-8-8, and we have taken important steps to undertake ongoing enhancement of the effectiveness, implementation, and maintenance of 9-8-8, including standardizing the 9-8-8 intervention, developing standards and training, initiating a quality assurance process, developing fidelity checks, engaging people with lived experience and employing qualitative and quantitative measurement of outcomes.

Expanding implementation evaluation to include the PRISM framework will enable a greater understanding of the implementation of 9-8-8 within the larger socio-ecological context of healthcare and measurement of the impacts of 9-8-8 beyond the service. This is paramount if 9-8-8 is to move the dial on suicide prevention. Suicide prevention requires a public health approach but that approach must be integrated and sustained. 9-8-8 must be part of a larger learning health system in which data from 9-8-8 outcomes and experience are systematically integrated with data from other healthcare and suicide prevention levels. These data will add to our evidence base for effective suicide prevention. We must use this

continuous feedback not only to improve 9-8-8 and enhance 9-8-8 outcomes but also to further direct and refine our public health approach to suicide prevention.

Attending to implementation and evaluation will ensure that 9-8-8 will reach all people living in Canada, that they have trust and feel safe to reach out to 9-8-8 when they need it the most and that anyone who calls or texts will receive effective support that will address their suffering while inspiring hope. On an individual level, we know that one connection can save a life. We must make sure that at the health systems level that connection is possible for all. **HQ**

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