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Considerations for Implementing a Three-Digit Suicide Prevention Number in Canada

Policy Brief

Mental Health Commission of Canada
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Acknowledgments

This policy brief was authored by Ryan Murphy with leadership provided by Karla Thorpe, Lisa Cowley, and Nitika Rewari at the Mental Health Commission of Canada (MHCC).

We would like to acknowledge our project partners at Crisis Services Canada (CSC), the Canadian Mental Health Association (CMHA-National) and the Centre for Addiction and Mental Health (CAMH). Many others provided important, valued contributions by reviewing this policy brief and by sharing relevant literature and information:

- Karen Letofsky and Stephanie MacKendrick, CSC
- Margaret Eaton, CMHA-National
- Allison Crawford, Jenny Hardy, and Stephanie Carter, CAMH
- Isabel Giardino and Ann Cooke, Public Health Agency of Canada
- Richard McKeon, Substance Abuse and Mental Health Services Administration
- Shari Sinwelski and Alana Leviton, Vibrant Emotional Health
- James Wright, U.S. Department of Veterans Affairs
- Connor Jobes, American Foundation for Suicide Prevention
- Femma Pais, 113 Suicide Prevention (Netherlands)
- Brian Mishara, Université du Québec à Montréal
- Karen Milligan, Ontario 211 (with input from 211 service delivery partners in Canada)
- Alisa Simon, Kids Help Phone
- Sean Krausert and Board Members, Canadian Association for Suicide Prevention
- Mara Grunau, Robert Olson, and Crystal Walker, Centre for Suicide Prevention

The MHCC is solely responsible for the contents of this document, including any errors or omissions.

Production of this policy brief was made possible through a financial contribution from Health Canada.

Ce document est disponible en français

Citation information

Suggested citation: Mental Health Commission of Canada. (2021). *Considerations for implementing a three-digit suicide prevention number in Canada.* Ottawa, Canada: Mental Health Commission of Canada.

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ISBN: 978-1-77318-205-6

Legal deposit National Library of Canada

Health Canada Santé Canada

The views represented herein solely represent the views of the Mental Health Commission of Canada. Production of this material is made possible through a financial contribution from Health Canada.

Contents

Introduction

Purpose

The purpose of this policy brief is to outline considerations for implementing a three-digit suicide prevention number in Canada. It reviews several relevant international contexts; specifically, the implementation of a three-digit suicide prevention and mental health crisis hotline (988) in the United States (U.S.) and the recently approved 113 number in the Netherlands. In addition, it provides findings from a short survey of people living in Canada on the potential benefits and challenges of a three-digit number, the expectations on how the system would work, and the use of a three-digit number (versus the 11-digit number currently in use by the Canada Suicide Prevention Service [CSPS]). The brief is based on the survey, informal interviews, and a scan of academic and grey literature by the Mental Health Commission of Canada (MHCC). The considerations it explores include the accessibility and visibility of the service, the capacity of crisis centres, training and staffing standardization, funding and operating costs, and the three-digit number selection.

Method

The MHCC and its project partners were interested in understanding the benefits of implementing a three-digit suicide prevention number in Canada by learning from countries that are adopting this approach, primarily the Netherlands and the U.S.[*] This brief presents the findings from informal interviews and a non-exhaustive scan of academic and grey literature conducted between August and December 2020. In addition, it includes findings from a survey of 163 people living in Canada collected between September and November 2020, along with information provided by experts and key stakeholders in the field of suicide prevention in Canada, the U.S., and the Netherlands. The experts and key stakeholders include members of Crisis Services Canada, the Canadian Mental Health Association-National, the Centre for Addiction and Mental Health (CAMH), the Public Health Agency of Canada, the Substance Abuse and Mental Health Services Administration (SAMHSA), Vibrant Emotional Health, the U.S. Department of Veterans Affairs (VA), the American Foundation for Suicide Prevention, 113 Suicide Prevention, Université du Québec à Montréal, Ontario 211, Kids Help Phone, the Canadian Association for Suicide Prevention, and the Centre for Suicide Prevention.

Overview of the findings — Key messages

- **Improved access**. A three-digit number will allow easier routing to local suicide prevention services for those in crisis and would be a simple number to provide for referrals to others. If promoted properly, it will help lessen confusion and save lives through improved access and engagement. Broadening accessibility with a three-digit number may also increase call volumes to crisis centres, and the capacity to meet this demand must be carefully assessed.

[*] Many of the lessons gathered from the U.S. are preliminary, since it is in the beginning stages of 988 implementation.

- **Phone/text/chat modalities.** Consideration should be given to other modes of access, including texting options for the three-digit number, which may increase overall usage by expanding access to those who are unable to call or who prefer text or chat.
- **Training and practice standards**. In a community-based model that is decentralized, evidence-based and culturally relevant training should be made available to crisis centres to ensure that responders provide (as closely as possible) the same level of care. Accreditation of crisis centres may be a solution for ensuring that this occurs.
- **Best-practice models to guide implementation.** Findings from 911 funding methods and the incorporation of the *National Suicide Hotline Designation Act of 2020* into U.S. law could help guide potential funding strategies for a three-digit number in Canada.
- **Anticipating implementation barriers.** Selecting an appropriate and practical three-digit number will not only be important for user recognition, but also for providers of the three-digit number who may need to upgrade technologies due to the change. Considerations around implementation time and costs will need to be factored into this decision.
- **Perspectives of people living in Canada.** Survey findings from 163 people living in Canada indicate that 77 per cent would use a three-digit suicide prevention number themselves as a resource, and 95 per cent would provide a three-digit number as a referral to others needing assistance — indicating a high level of interest and support among those surveyed.

Background on 988 in the U.S.

In 2018, 48,344 Americans died by suicide, and an estimated 1.4 million Americans attempted suicide.[1] In addition, according to the Centers for Disease Control and Prevention, "suicide rates have increased 33% since 1999, with some states reporting increases as high as 58%" (para. 1).[2] To support this need for help, 163 crisis centres are currently linked in a network to receive calls for the Veteran's Crisis Line and the National Suicide Prevention Lifeline (NSPL).[3] While efforts to implement a three-digit suicide prevention and mental health crisis hotline have been ongoing, several important rulings have occurred in recent years.

The *National Suicide Hotline Improvement Act of 2018* (H.R. 2345) mandated that the Federal Communications Commission (FCC) spend one year* evaluating the viability of establishing a three-digit crisis line for mental health emergencies and suicide prevention. It also required the FCC to consult with SAMHSA, VA, and the North American Numbering Council and hold public comment periods on key findings. In 2020, the legislation was passed into law to ensure that a three-digit number would exist and be maintained. Then, on July 16, the FCC approved and adopted rules to establish 988 as the new, countrywide three-digit suicide prevention and mental health crisis hotline.

The FCC's rules stipulate that all telecommunications carriers, including voice-over-internet protocol (VoIP) providers, direct 988 calls to the NSPL in two years, under its July 16, 2022, implementation deadline.[4] This ruling was an important step in securing 988 as a nationwide suicide prevention and mental health crisis hotline. However, on October 17, 2020, the *National Suicide Hotline Designation Act of 2020* became law, which added three more key actions: (1) that the FCC designate 988 as the universal suicide prevention and mental health crisis number, (2) that states be allowed to (optionally)

* The FCC was to report back to Congress by August 14, 2019.

impose and collect a fee for providing 988 services, and (3) that the Department of Health and Human Services (HHS) and the VA report on the resources necessary to make use of 988. In addition, HHS is required to develop a strategy for providing access to specialized supports for high-risk populations.[5]

Background on 113 in the Netherlands

Due to the relatively small land area in the Netherlands, 113 Suicide Prevention (formerly known as 113Online) uses a centralized approach for receiving crisis calls (unlike the decentralized system in the U.S. and Canada). With a population slightly over 17 million, more than 1,800 people die by suicide every year in the Netherlands,[6] with an annual increase in suicide-related deaths of between 3 and 6 per cent.[7] A recent report noted that more people (400 per day) with suicidal thoughts are calling the 113 hotline since the COVID-19 pandemic started, an increase of over 30 per cent.[8] In April 2020, an amendment made to the country's telephone numbering plan and the integrated services digital network service excluded 113 as a harmonized European number, which allowed 113 to be used for a different purpose than it is for other European Union states.[9] As a result, 113 was approved as the Netherlands' three-digit suicide prevention hotline number. It went live in July 2020.[10]

Considerations

The following section provides considerations that draw from both U.S. and Netherland contexts regarding a three-digit suicide prevention number. It includes findings from the informal interviews and literature scan.

Accessibility and visibility

There are many dimensions of accessibility and visibility in the implementation of a new crisis service. These include:

- cost (if any)
- accessibility to people in rural and remote communities
- languages offered
- teletypewriter (TTY) availability for the deaf or hard of hearing
- marketing strategies (to reach as many people as possible)

This brief will focus on the importance of connectivity, how users find suicide prevention contact information, and different modalities of the service.

Ensuring that a three-digit number is connected prior to widespread knowledge of its existence is a direct example of an accessibility consideration that may lead to dire outcomes. In 2019, a woman in the Netherlands died by suicide after trying to dial 113 multiple times before the number was connected.[11] Another man in the Netherlands died by suicide a few months later for the same reason.[12] Although miscommunication of 113 Suicide Prevention cannot be causally linked to these tragic deaths, they highlight the need to have a three-digit number and the importance of implementation prior to widespread communications. Considerations around the number's connectivity and dissemination should be carefully explored if Canada approves a similar service.

Regarding visibility, when a person enters "suicide" into a Google search in Canada and the U.S., a banner appears at the top of the results page that gives direction and information on current suicide prevention hotlines in both countries. As SAMHSA in the U.S. noted in 2019, "the increased visibility of the [NSPL] number through the media, internet, and social media has been a powerful driver of ongoing growth in call volume for the [NSPL]" (p. 10).[13] With such increasing connectivity and information sharing, Canada will have to continually evaluate its ease of access to crisis information and also consider how to provide differential access to a wide range of people.

While looking at the public comments on 988 (included in the FCC ruling), mentioned that "numerous mental health experts . . . emphasize the importance of texting as a medium by which some individuals, particularly members of certain vulnerable communities such as young people, low-income individuals, members of the LGBTQ community, and individuals who are deaf and hard of hearing, may wish to obtain crisis counseling" (p. 49).[14] Several studies based on surveys confirm that users increasingly choose these newer means of communication as their method of contact.[15,16] Reasons for choosing these modalities may vary, however, such as not feeling comfortable talking, not having privacy to make a call, or not having the technology available to do so. In addition, those experiencing poverty may not have a landline or cellphone with minutes but may be able to either text for free (if the service doesn't incur costs) or access free chat services when connected to the internet.

Considerations:

1. A further examination of how people living in Canada will access this service, particularly with expansion from telephone to text and chat modalities, is necessary.
2. An assessment of how people will learn about this service, including individuals from diverse groups and those living in rural and remote communities, must be considered.
3. It will be important to address implementation barriers and timing, particularly any gaps between public campaigns that advertise the service and its availability.

Capacity

In 2019, the NSPL in the U.S. answered over 2.2 million calls (including to the Veterans Crisis Line) and responded to 102,000 crisis chats.[17] This number of contacts points to the need to ensure that crisis centres are appropriately staffed to meet the potential for increased call volumes created by a three-digit number. As SAMHSA's report to the FCC (February 7, 2019) noted,

> by providing a system of backup centers to local communities, the [NSPL] has substantially improved crisis care in the [U.S.]. 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. (p. 9)[18]

In Canada, backup centres are shared in times of high local demand. In these circumstances, "CSPS can route people in need to responders provincially, regionally or nationally, identifying the right skill sets to support the service user's needs" (p. 3).[19] As every moment counts when someone is in crisis, consideration will need to be given to finding ways of increasing capacity when the overall system becomes overwhelmed. In cases where emergency support is needed for active rescues, it will be important to understand how the system connects to emergency services to ensure a seamless transfer

of calls. This ability will also enable the overall system to triage efficiently when support requires services that surpass the abilities of three-digit number crisis responders.

The first study of its kind found that followup calls to previous NSPL callers at high risk of suicidal behaviours had a positive impact and provided continuity of care following a suicide crisis.[20] This study contributes to the evidence base that regards followup calls as a best practice for suicide prevention hotlines. In relation to capacity, any advances in best-practice interventions may further impact demands on services and the ability to meet people's needs. Additional evaluation at a systems level should consider the return on investment for given interventions and the areas in which they are most effectively and economically delivered in a crisis response system.

Considerations:

1. A three-digit number is likely to increase service levels. The capacity to meet increased demand and sustain continued demands must be met for the safety of callers.
2. Additional services and interventions delivered as part of a suicide prevention line may further impact service needs.
3. The evaluation of interventions should include an economic analysis to understand how to optimize their return on investment.
4. A variety of service models (including decentralized, centralized, or both) should be assessed for such capacities as being able to implement a triaging model in which calls from those who are actively suicidal are answered most quickly.
5. In the U.S., local crisis centres are working to answer calls to the national toll-free NSPL, and back-up centres are paid to handle calls if the system is temporarily overloaded. To maximize efficiency in Canada (if a decentralized model is chosen as the most effective), it is important to consider making as many crisis centres as possible part of a three-digit number network, provided they meet the criteria for offering quality services.

Training and staffing

The importance of specific training and staffing for crisis centres has been established across a number of studies and is an essential consideration for the growth of crisis services. NSPL training standards have been adopted across other countries, including the Netherlands, where in its training and supervising of volunteers, "emphasis is given to structuring the chat within reasonable but flexible time limits, with a pragmatic rather than principal use of solution-focused counseling techniques" (p. 12).[21] In the U.S., all NSPL crisis centres have adopted policies that represent best practices, such as *Suicide Risk Assessment Standards*, *Guidelines for Helping Callers at Imminent Risk for Suicide*, and optional training for crisis responders in Applied Suicide Prevention Skills Training (ASIST).[22] However, due to the wide distribution of centre locations, each may have specific training requirements for its staff and volunteers. Such variation indicates that a national approach for training requirements is needed to ensure that the same level of care is met across all centres (to the extent possible). Including the accreditation of crisis centres, while making training requirements necessary a component for certification, may help with this kind of national oversight.

A 2008-09 study demonstrated that calls from suicidal individuals to crisis responders in the NSPL network who were trained in ASIST showed fewer signs of depression and suicidality, were less

overwhelmed, and had an improvement in feelings of hope by the end of the call.[23] While these results suggest that ASIST should be an important consideration in training crisis responders, other evidence-based and culturally relevant training programs with similar results should also be considered.

Additional evidence suggests that trained volunteers may be just as effective (if not more so) at managing suicide-related crises as qualified mental health professionals.[24] Since using trained volunteers is a common practice in Canada, this finding supports the model's continued use and allows for an impactful yet cost-effective means of meeting the needs of a suicide prevention service. At the same time, more evidence and cost analysis is required. Costs associated with the use of volunteers include training and supervision, turnover (a secondary cost), and those related to the efficiency of the service. In addition to cost factors, some services in Canada rely on a blended model (using professionals and volunteers) for crisis support to ensure that 24-7 coverage is met.

Considerations:

1. Expanding crisis services in Canada through a three-digit number will require standards of training and practice as well as the possibility for the accreditation of crisis centres. This requirement will have to account for best practices while recognizing regional differences in community-based services and the potential for having different training programs with equal merit.
2. Training programs that have a robust evidence base and are culturally relevant should be considered for widespread dissemination across crisis centres.
3. The use of volunteer providers has been shown to be equal to or better than the use of mental health professionals, but it requires considerations related to training, supervision, and workforce retention and wellness.
4. In blended models, professionals and volunteers are relied on for some services in Canada to ensure full coverage. Careful consideration must be given to adopting an appropriate staffing model for the three-digit suicide prevention number that balances costs and service coverage.

Costs

Cost considerations for implementing a suicide prevention number come in various forms, including human life and financial sustainability.

In assessing one cost component of implementing 988 in the U.S., the FCC determined that if the new number could deter just one out of 1,000 suicides and suicide attempts, "the estimated benefit of $2.4 billion in present value over the course of ten years will exceed the estimated, one-time $367 million in present value implementation cost to service providers [of the three-digit number]" (p. 20).[25] This one-time service cost includes technology updates and replacements of old equipment.

With the *National Suicide Hotline Designation Act of 2020* becoming law in the U.S., states can collect "a fee or charge applicable to a commercial mobile service or an IP-enabled voice service" from customers for these services (Sect. 4(a)1).[26] This ability to obtain such additional funding is significant, since it could improve how the network of crisis centres works as a whole and be a potential revenue stream for Canada's three-digit suicide prevention number. Similar lessons can also be sought from the variety of ways 211 is funded across the country's jurisdictions and from the structure used in Canada to fund 911 (by means of governments, providers of the three-digit number, and individual Canadians through an approved monthly fee from retail wireline phone companies).[27]

Considerations:

1. Canada should undertake an economic analysis that considers the immediate technology costs of the transition to a three-digit number and the longer-term return on investment in years of life saved, as well as the reduced impacts on the many lives affected by each death by suicide.
2. Funding models for n11 numbers, such as 211 and 911 in Canada, should be examined to determine if similar models should be utilized for the three-digit suicide prevention number.

Three-digit number selection

The process of selecting a three-digit number for suicide prevention and mental health crises requires a number of considerations, including whether

- an existing three-digit number is already in use
- the number would interfere with existing numbers or area codes
- the selected number can be dialed from large internal phone systems (hospitals, etc.)
- the possibility exists for misdialing the number
- the same number is used for different purposes in bordering countries.

In addition, the selection of a three-digit number can increase implementation costs if technological changes to existing crisis centre systems are required.

The use of 113 as a three-digit number varies in Europe, with Italy, Luxembourg, and Slovenia utilizing it for police services,[28-30] Latvia for emergency medical services,[31] and Romania as an alternate way of connecting to 112 emergency (through a text message to 113).[32] As this number is available across Europe, the Netherlands has managed to get 113 approved specifically for suicide prevention. Yet it is important to consider whether such a strategy would benefit a country or add confusion for visitors or people living in other European countries, given its varied ways of utilizing 113.

In the FCC's July 16, 2020, ruling, justifications for selecting 988 over reutilizing an n11 number were clearly outlined in staff reports. The reasons for choosing 988 include simpler marketing and communications, less disruption to providers and users, and shorter implementation timelines.[33] As Canada and the U.S. both form part of the North American Numbering Plan, most current n11 numbers (i.e., 211, 311, 411, 611, 711, 911) connect to similar services.[34] These similarities allow individuals in both countries to know which easy-to-remember numbers to dial for a particular service, even when visiting the other country. If the services for a new three-digit number are similar in Canada and the U.S., 988 may cause the least disruption for Canada's providers and users.

The FCC's equivalent in Canada is the Canadian Radio-television and Telecommunications Commission (CRTC). Like the FCC, the CRTC is responsible for establishing three-digit abbreviated codes. Since it is also responsible for working with the telecommunications industry, it will be important for all partners working on the three-digit suicide prevention number in Canada to engage with the CRTC as early as possible in the implementation process.

Considerations:

1. Canada must select a number that is not already in use, either as a three-digit number or as an area code.

2. Avoiding an n11 number may be less disruptive and simplify marketing; however, any new three-digit number will need consistent and continual marketing to build awareness on aspects such as differences to existing three-digit numbers.
3. There is value in aligning this new number with the three-digit number in the U.S. to increase consistency, visibility, and recall, while avoiding dangerous errors in access.

Perceptions in Canada: Highlights from Survey Findings

In September 2020, the MHCC and its project partners developed an online survey, which provided a brief history of 988 in the U.S., background on CSPS, and a link to questions regarding perceptions of a three-digit suicide prevention number in Canada (see Appendix). The survey was disseminated to over 3,000 MHCC contacts, including members of the public, persons with lived and living experience, and those generally interested in mental health and suicide prevention. The survey link was also shared with the MHCC's core committees (i.e., Hallway Group, Youth Council) and with partner organizations for dissemination. Out of 163 people living in Canada who responded to the anonymous survey, the following highlights were noted.

Benefits and disadvantages

Respondents were asked to describe the perceived benefits and challenges of having a three-digit suicide prevention number in Canada.

- **Top advantage.** A three-digit number would be easier to remember than a ten-digit number.
- **Top disadvantage.** The number could potentially be confused with other three-digit numbers, such as 911.

Other responses touched on themes of access, prevention, stigma, quality of service, and cost. For example:

- **Improved access.** It would give "more people . . . access to a service that can prevent them from taking their lives."
- **Decreased stigma.** "It would [have] significant media and public interest, thereby increasing open conversation about suicide."
- **Barriers to access.** The number "may not be able to connect them to appropriate local supports in a timely manner, depending on location."
- **Quality of care.** A problem could occur if "people who answer the phone [are] not trained in suicide intervention."
- **Cost.** It would be "another level of service that needs to be paid for."

Service expectations

Respondents were also asked how they expected the three-digit suicide prevention number service to work. Many responses indicated that it would

- work similarly to 911
- operate 24 hours a day, with trained staff
- be the sole number for suicide prevention.

Key response areas on service expectations include themes similar to those of 911, such as centralization, its alignment with current services, and the availability of skilled responders. For example:

- **Similarity to 911 model.** "It could work as its own number, managed by current local distress lines or connecting through 911."
- **Centralization.** (1) "A centralized system would handle all incoming calls and reach out to social workers/emergency staff on an as-needed basis"; (2) "This number would become the only suicide prevention line, and . . . there could be a person who answers and then the call could be directed to the appropriate responder (i.e., support based on demographics)."
- **Alignment with current service.** It could work "through the existing [Canada Suicide Prevention Service] system, where one number is dialed from anywhere in Canada and calls are responded to by local or next-available sites."
- **Availability of skilled crisis responders.** "It would connect you to a skilled suicide prevention specialist that could talk or text you through the situation or help to guide someone through what to do if they suspect someone is suicidal."

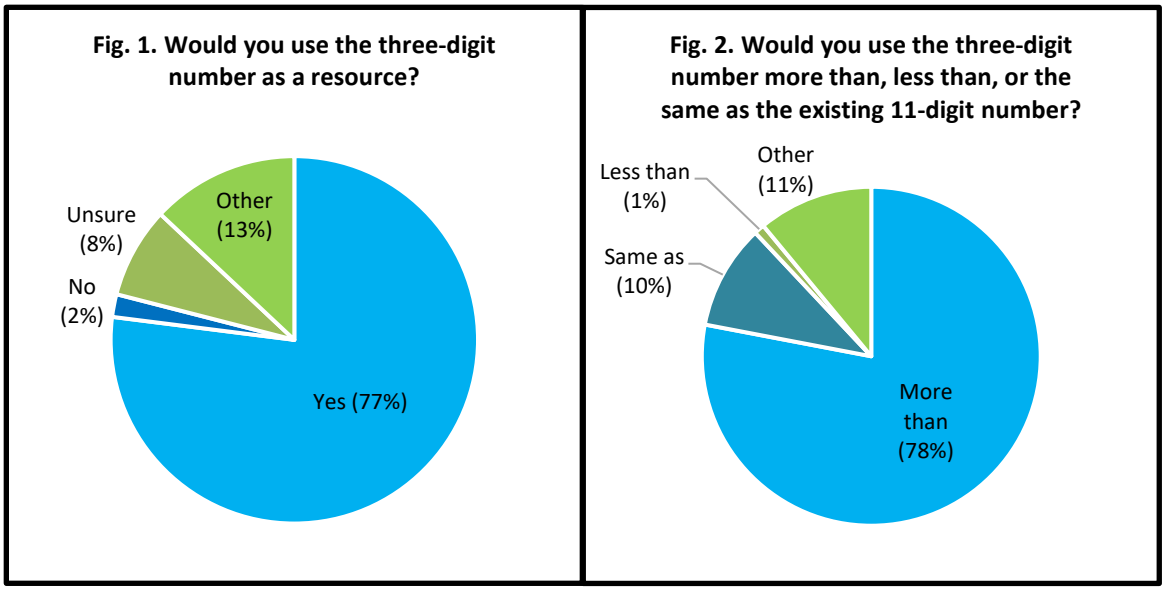
Self-Use and referrals

The final survey questions centred on the topics of self-use and using the three-digit number as a referral.

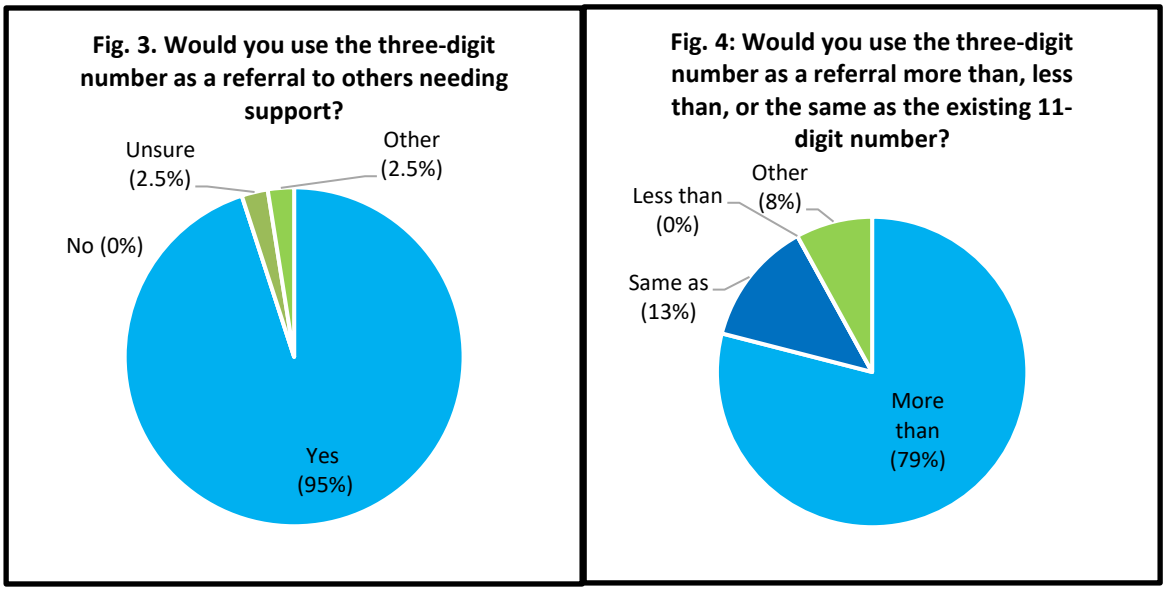
- **Respondents supported a three-digit number for self-use.** Overall, 77 per cent indicated that they would use such a number; 78 per cent that it would be more than the existing 11-digit number.
- **Respondents supported a three-digit number for referrals.** Overall, 95 per cent indicated that they would use this number; 79 per cent that it would be more than the existing 11-digit number.

Figures 1-4 highlight the breakdown of percentages in perceived usage.

Figures 1 & 2. Perceptions for Self-Use of a Three-Digit Suicide Prevention Number



Figures 3 & 4. Perceptions for Referral Use of a Three-Digit Suicide Prevention Number



Other considerations raised with respect to the potential use of a three-digit suicide prevention number included the following responses:

- Usage would be higher if it was available to far reaching and remote communities.
- Respondents would use their local number instead of a national number.
- They would use this number but would want to see it advertised.

- They didn't know the 11-digit number existed.
- An 11-digit number is too long.

Survey limitations

The following points summarize the most significant limitations to the survey and its results:

- limited distribution outside MHCC contacts, with partial control and visibility on how it was shared beyond those contacts
- absence of demographic data
- narrow geographic distribution
- restricted distribution due to exclusive online availability
- low response rate
- lack of definitions for survey terms

In light of these limitations, the responses highlighted in this brief should be taken to describe just some of the standpoints of those living in Canada, rather than all potential views. A lack of defined terms may have also led respondents to misinterpret certain questions and produce responses that may not have occurred otherwise. Further studies and surveys that address the limitations mentioned should be conducted to more fully understand the perspectives of people living in Canada regarding a three-digit suicide prevention number.

Directions for future study might include viewpoints from Canadian organizations that may be connected to the implementation of a three-digit suicide prevention number or from Canadian organizations or services that may be impacted by it.

Three-Digit Number Status in Canada

With legislation for 988 being passed in the U.S., implementing a three-digit number in Canada is gaining momentum. On October 30, 2020, a motion brought forward by Conservative member of Parliament Todd Doherty states that "given that the alarming rate of suicide in Canada constitutes a national health crisis, the House call[s] on the government to take immediate action to establish a national suicide prevention hotline that consolidates all suicide crisis numbers into one easy to remember three-digit (988) hotline that is accessible to all Canadians" (Oct. 30, para. 1).[35] Continued pressure from MPs in support of this motion occurred in question periods throughout October and November, resulting in a unanimous vote in favour of the motion by parliamentarians on December 11, 2020.

Summary

Implementing a three-digit suicide prevention number in Canada would bring many benefits by providing people in crisis an easy-to-remember way to reach trained support services. If properly implemented and promoted, the number could lessen the burden on other services and save lives. A centralized number that still allows for a unified network of community-based crisis lines to provide national coverage (i.e., the U.S. model and likely Canada's), will require standards, certification, and training across all crisis centres to ensure quality of care. Also, as this brief recommends, considerations regarding a three-digit number should include a carefully selected number to ensure user recognition and the best implementation.

While significant upfront costs are involved, the benefit to human life far outweighs them. In addition, other country's medium- and long-term returns suggest that economic gains may result from these initial investments.

As the U.S. works toward its 988 implementation deadline of July 16, 2022, Canada must continue to learn from the relevant activities there (and in other countries) to better understand the benefits and opportunities of implementing a three-digit suicide prevention number.

References

[1] Hedegaard, H., Curtin, S. C., & Warner, M. (2020). *Increase in suicide mortality in the United States, 1999-2018* (Data Brief No. 362). National Center for Health Statistics. https://www.cdc.gov/nchs/data/databriefs/db362-h.pdf

[2] News Cap: The federal communications commission (FCC) has proposed a three-digit hotline number for suicide prevention. (2020). *American Journal of Nursing, 120*(4), 16. https://doi.org/10.1097/01.NAJ.0000659968.45024.ae

[3] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2019). *National Suicide Hotline Improvement Act: The Substance Abuse and Mental Health Services Administration report to the Federal Communication Commission.* https://ecfsapi.fcc.gov/file/1022280990575/19021504-1.pdf

[4] Federal Communications Commission. (2020, July 16). FCC designates "988" as 3-digit number for national suicide prevention hotline. FCC News. https://www.fcc.gov/document/fcc-designates-988-national-suicide-prevention-lifeline

[5] National Suicide Hotline Designation Act of 2020, 47 U.S.C. § 2661 (116th). Public Law No: 116-172. https://www.congress.gov/bill/116th-congress/senate-bill/2661

[6] Stichting 113Online. (n.d.). *Contact 113 suicide prevention*. https://www.113.nl/english

[7] Government of the Netherlands. (n.d.). *Preventing suicide*. https://www.government.nl/topics/mental-health-services/preventing-suicide

[8] Stichting 113Online. (2020, December 1). *More and more people are calling 113 suicide prevention*. https://www.113.nl/actueel/steeds-meer-mensen-bellen-113-zelfmoordpreventie

[9] Staatscourant. (2020). *Decree of the state secretary for Economic Affairs and Climate Policy of March 22, 2020 no. DGBI-DE / 20068537, amending the numbering plan telephone and ISDN services in connection with the use of the number 113 for help in the context of suicide prevention.* https://zoek.officielebekendmakingen.nl/stcrt-2020-19241.html

[10] Suicide prevention hotline now available at number 113. (2020, July 7). *NL Times*. https://nltimes.nl/2020/07/07/suicide-prevention-hotline-now-available-number-113

[11] Groningen woman takes own life after confusion over number for suicide prevention hotline. (2019, September 24). *NL Times*. https://nltimes.nl/2019/09/24/groningen-woman-takes-life-confusion-number-suicide-prevention-hotline

[12] Second suicide linked to confusion over helpline number. (2019, October 7). *NL Times*. https://nltimes.nl/2019/10/17/second-suicide-linked-confusion-helpline-number

[13] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2019). *National Suicide Hotline Improvement Act: The Substance Abuse and Mental Health Services Administration Report to the Federal Communication Commission.*

[14] Federal Communications Commission. (2020). *Ruling FCC 20-100.* https://docs.fcc.gov/public/attachments/FCC-20-100A1.pdf

[15] Pollock, K., Armstrong, S., Coveney, C., & Moore, J. (2010). *An evaluation of Samaritans telephone and email emotional support service.* University of Nottingham. http://media.samaritans.org/documents/Samaritans_service_evaluation_Nottingham_-_Full_Report.pdf

[16] Lester, D. (2008). The use of the internet for counseling the suicidal individual: Possibilities and drawbacks. *Omega, 58*(3), 233-250. https://doi.org/10.2190/OM.58.3.e

[17] Vibrant Emotional Health. (2020). *Bringing wellness to you: 2019 annual report*. https://www.vibrant.org/wp-content/uploads/2020/01/Vibrant_AnnualReport_Digital_Spread.pdf

[18] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2019).

[19] Canada Suicide Prevention Service. (2017). *CSC/CSPS Public fact sheet.* https://www.crisisservicescanada.ca/wp-content/uploads/2019/04/CSC-Public-Fact-Sheet-2019-1.pdf

[20] Gould, M. S., Lake, A. M., Galfalvy, H., Kleinman, M., Munfakh, J. L., Wright, J., & McKeon, R. (2018). Follow-up with callers to the national suicide prevention lifeline: Evaluation of callers' perceptions of care. *Suicide and Life-Threatening Behavior, 48*(1), 75-86. https://doi.org/10.1111/sltb.12339

[21] Mokkenstorm, J. K., Eikelenboom, M., Huisman, A., Wiebenga, J., Gilissen, R., Kerkhof, A. J. F. M., & Smit, J. H. (2017). Evaluation of the 113Online Suicide Prevention crisis chat service: Outcomes, helper behaviors and comparison to telephone hotlines. *Suicide and Life-Threatening Behavior,47*(3), 282-296. https://doi.org/10.1111/sltb.12286

[22] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2019).

[23] Gould, M. S., Cross, W., Pisani, A. R., Munfakh, J. L., & Kleinman, M. (2013). Impact of applied suicide intervention skills training on the National Suicide Prevention Lifeline. *Suicide and Life-Threatening Behavior. 43*(6), 676-691. https://doi.org/10.1111/sltb.12049

[24] Mishara, B. L., Daigle, M., Bardon, C., Chagnon, F., Balan, B., Raymond, S., & Campbell, J. (2016). Comparison of the effects of telephone suicide prevention help by volunteers and professional paid staff: Results from studies in the USA and Quebec, Canada. *Suicide and Life-Threatening Behavior, 46*(5), 577-587. https://doi.org/10.1111/sltb.12238

[25] Federal Communications Commission. (2019). *Implementation of the National Suicide Hotline Improvement Act of 2018* (WC Docket No. 18-336). *Notice of proposed rulemaking*. https://docs.fcc.gov/public/attachments/DOC-360939A1.pdf

[26] National Suicide Hotline Designation Act of 2020, 47 U.S.C. § 2661 (116th). Public Law No: 116-172.

[27] Canadian Radio-television and Telecommunications Commission. (2013). *A report on matters related to emergency 9-1-1 services.* https://crtc.gc.ca/eng/publications/reports/rp130705.htm

[28] European Commission. (2019). *112 in Italy.* https://ec.europa.eu/digital-single-market/en/112-italy

[29] European Commission. (2020). *112 in Luxembourg.* https://ec.europa.eu/digital-single-market/en/112-luxembourg

[30] European Commission. (2019). *112 in Slovenia.* https://ec.europa.eu/digital-single-market/en/112-slovenia

[31] European Commission. (2019). *112 in Latvia.* https://ec.europa.eu/digital-single-market/en/112-latvia

[32] European Commission. (2019). *112 in Romania.* https://ec.europa.eu/digital-single-market/en/112-romania

[33] Federal Communications Commission. (2020). *Ruling FCC 20-100.*

[34] North American Numbering Plan Administrator. (2020). *Numbering resources: N11 codes.* https://nationalnanpa.com/number_resource_info/n11_codes.html

[35] Parliament of Canada. House of Commons. (2020, November 3). *Orders of the day*. https://www.ourcommons.ca/DocumentViewer/en/43-2/house/sitting-25/order-notice/page-5

Appendix — Survey Questions

The following details the survey questions which appeared in an online survey developed by the MHCC in collaboration with its partners:

1. What do you see as being the benefits or disadvantages of having a three-digit suicide prevention number in Canada?
    - Open-ended response

If a three-digit suicide prevention number was implemented in Canada:

2. How would you expect the service to work?
    - Open-ended response
3. What would make this number useful as a resource?
    - Open-ended response
4. What impact would you expect to see in Canada?
    - Open-ended response
5. Would you use this number as a resource?
    - Yes
    - No
    - Unsure
    - Other — Write in (required)
6. Would you use this number more than, less than, or the same as the existing 11-digit number?
    - More than
    - Less than
    - Same as
    - Other — Write in (required)
7. Would you use this number as a referral to others needing support?
    - Yes
    - No
    - Unsure
    - Other — Write in (required)
8. Would you use this number as a referral more than, less than, or the same as the existing 11-digit number?
    - More than
    - Less than
    - Same as
    - Other – Write in (required)

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