Transforming suicide helpline services into resilient global health infrastructure

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Suicide helpline services are crucial components of global mental health and suicide prevention architecture, providing rapid, confidential, and non-judgemental crisis support. These services are effective in relieving and reducing distress during and shortly after contact.[1] As universal crisis intervention services, they have the potential to attract suicidal people and prevent loss of life. Eliminating structural barriers to crisis support is central to global health equity. More than 73% of global suicides occur in low-income and middle-income countries,[2] where formal mental health capacity often falls below two workers per 100 000 people.[3]

In a global survey across 105 countries, Vaghela and colleagues revealed severe and widespread vulnerabilities within suicide helpline services: 79·4% faced chronic underfunding, only 45·1% of full-time and 25·6% of part-time staff received pre-service training, and 61·4% lacked formal active rescue protocols to conduct crisis intervention in accordance with a rights-based approach.[4] To address these structural gaps, we propose action across five domains: sustainable public investment, standardised capacity building, universal access and availability, rights-based active rescue, and statutory artificial intelligence (AI) governance (panel).

To ensure the long-term financial sustainability and service continuity of suicide helpline services, governments should integrate them into statutory public health infrastructure by enacting legislation for essential services and establishing ring-fenced revenue streams. For example, the US National Suicide Hotline Designation Act of 2020 granted states the authority to levy dedicated surcharges on telecommunication accounts, securing a direct, sustainable financing stream for local helpline centres. Other countries, such as Northern Ireland in the UK and Australia, allocate public funding from health budgets for suicide helpline services. These allocations should be informed by health economics data relevant to each country's setting and health system, applying methods such as those of a cost-effectiveness study in Belgium that estimated savings from averted emergency service use and preventable loss of life.[5]

Many helplines worldwide still rely on complex ten-digit phone numbers. Transitioning to freephone, short-digit codes nationwide—such as 988 in the USA and in Canada, 3114 in France, and 14 416 in India—dramatically reduces access thresholds.

Addressing workforce precarity requires operationalising standard training and quality assurance, as is mandated for the 988 network in the USA. Infrequent staff training substantially increases workforce distress.[4] Currently, no single global governing body standardises the qualifications required for crisis helpline workers. Establishing a centralised global entity, or empowering international networks such as Lifeline International, Befrienders Worldwide, or the International Association for Suicide Prevention in collaboration with WHO, to formalise training requirements is essential to develop a standardised operational framework with pre-service certification tiers and mandatory annual refresher courses. Training and test materials should be designed specifically to be translated and culturally adapted to align with local language and context-specific norms. Quality assurance principles could similarly be organised on a global basis.

Emergency interventions during active crises require a rights-based transformation. More than half of suicide helpline services operate without formal active

Panel: Strategic imperatives for resilient suicide helpline services

- Sustainable public investment: ring-fenced national health funding to guarantee long-term operational resilience
- Standardised capacity building: universal and free online pre-service certification and mandatory annual training for all suicide helpline service personnel
- Universal access and availability: freephone, short-digit numbers; targeted digital outreach; and services available 7 days per week
- Rights-based active rescue: non-carceral emergency response protocols integrating mobile mental health teams, social welfare referrals, and multiagency networks
- Statutory governance for artificial intelligence: rigorous pre-deployment stress-testing to restrict artificial intelligence agents to triage and practitioner training while preserving human-led crisis support

For more on the **US National Suicide Hotline Designation Act of 2020** see https://www.congress.gov/bill/116th-congress/senate-bill/2661

For more on **Northern Ireland's suicide prevention strategy** see https://www.health-ni.gov.uk/publications/protect-life-2-suicide-prevention-strategy

For more on **mental health funding in Australia** see https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/mental-health-funding-boost-to-support-thousands-of-australians

rescue policies,[4] often defaulting to police dispatch and doing so without explicitly obtaining the service user's consent. This reliance on non-consensual active rescue persists despite published evidence on imminent-risk responses in crisis helplines, which recommends collaborative engagement with callers and the least invasive intervention necessary.[6] So-called wellness checks led by law and enforcement officers risk criminalisation, coercive detention, or trauma, particularly in marginalised populations.[7] Progressive models, such as Japan's Suicide Countermeasures Promotion Centre framework and Thailand's Hope Taskforce, show how embedding social service referrals and uniting volunteers, hospitals, and social welfare agencies can protect human dignity by coordinating non-carceral care without relying on law enforcement.

For more on **Japan's suicide prevention strategy** see https://www.who.int/news-room/feature-stories/detail/suicide-prevention-in-japan--a-public-health-priority

For more on **Thailand's Hope Taskforce** see https://www.who.int/news-room/feature-stories/detail/suicide-prevention-in-thailand--a-whole-of-society-approach

Digital tools have a place where services are scarce: self-guided interventions targeting suicidality can reduce suicidal ideation by about as much as face-to-face treatment, though the effect is small and not sustained at follow-up.[8] However, these tools are not a substitute for human crisis contact. In a national survey of Australian people who used the Lifeline help service, approximately half said they would be less likely to use the service if automation were introduced, most commonly because they wanted to speak to a real person.[9] This fear persisted even when participants were told a human always answers.[9] Crisis-line workers see a role for AI in triage and training but warn that AI-mediated contact risks being experienced as dehumanising.[10] Human connection is what crisis helplines offer, and strengthening it should take precedence over automation.

To transition suicide helpline services from fragile, non-profit entities into resilient health infrastructure, national governments and global health bodies should prioritise five strategic imperatives (panel). Through public investment, rights-based care, and standardised workforce support, a sustainable global infrastructure for suicide helpline services can be built.

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