University Students' Utilization and Attitudes Toward Crisis Lines/Text Services

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Abstract

There are growing concerns about the significant rise of mental health-related problems, symptoms of mental illness, and suicide attempts among postsecondary students in Canada. Expanding global research shows that initiatives focused on promotion, prevention, and early intervention yield positive results, such as reducing mental distress. The present study assessed postsecondary students' attitudes toward and usage of crisis lines, including phone and text services. A sample of 221 students completed validated measures of current distress, attitudes towards crisis lines, help-seeking attitudes and behaviours, perceived helpfulness and usage of informal and formal mental health supports, as well as levels of self-stigma, self-reliance, and shame. Overall, students perceived crisis line/text services as significantly more helpful than they reported being likely to use them, and perceived crisis line and text services as most helpful for suicide-related concerns. Students used mental health and other health professionals, and internet resources, more frequently than crisis line/text services. The most common reason for non-use of crisis line/text services was a preference for self-reliance: wanting to solve the problem themselves, believing that the problem was not serious enough, or expecting that it would improve on its own. Positive attitudes towards seeking psychological help, and older age, were predictors of likelihood to use crisis line/text services in the future. Language also seemed to play a role, as participants reported the greatest likelihood of using a support line, followed by a help line, and a crisis line. Given the high levels of distress among university students and their limited engagement with crisis services, further research is needed to understand how postsecondary students perceive these services and what influences their decisions not to use them.

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In recent years, Canadian postsecondary students (PSSs) have experienced increasing amounts of chronic stress, psychological distress, and symptoms related to mental illness (Linden, 2021; Monaghan et al., 2021). These high levels of stress have been shown to have negative effects on PSSs, including decreased academic performance and motivation (Linden, 2021; Pascoe et al., 2019), as well as heightened risk of anxiety and depression (Duffy et al., 2020).

Linden et al. (2022) found that PSSs consistently rated academic demands as some of the most severe stressors. However, the frequency and type of academic demand experienced varied. For example, stressors such as thesis deadlines, practicum requirements, and advisor meetings were relevant only to a smaller group of students (most likely in graduate and professional programs), whereas stress within the wider learning environment was generally rated as less frequent and less intense. The intensity and occurrence of stress related to campus culture varied widely. For instance, incidents like sexual harassment, although rarely reported, were described as extremely distressing. Among all categories of stress, one of the most commonly experienced was the pressure students placed on themselves to meet personal expectations. Stress in the personal domain was also common but varied in terms of severity. While health-related concerns (e.g., sleep, cooking, and exercise) were rated as less severe, financial stress and unemployment concerns after graduation were some of the most overwhelming concerns (Linden et al., 2022).

Data from the 2019 National College Health Assessment II aids in highlighting the severity of this situation. Nearly nine out of ten Canadian students reported feeling overwhelmed and almost 70% described feeling very lonely or overwhelmingly anxious. More than half said they felt so depressed that it was difficult to function. Research conducted by Duffy et al. (2020)

found results that were similarly concerning among 1,530 undergraduate students. At the beginning of their first year of university, 28% of undergraduate students screened positive for clinical depression and 33% for anxiety, and by the end of the academic year, these rates had increased to 36% and 39%, respectively. At the end of the year, 14% of students also reported thoughts of suicide, while 1.6% reported having attempted suicide. Many of these mental health difficulties persisted over time and often co-occurred. In addition, these difficulties were also associated with worse academic performance and lower overall well-being (Duffy et al., 2020).

PSSs as a Distinct and Vulnerable Group

The increase in stress and mental health concerns among Canadian students has gained attention from postsecondary institutions (Holmes & Silvestri, 2016; Council of Ontario Universities, 2017). In response, several stakeholders (such as the Ontario Undergraduate Student Alliance, the College Student Alliance, the Council of Ontario Universities, and Colleges Ontario) worked together to release *In It Together 2020: Foundations for Promoting Mental Wellness in Campus Communities*, an updated action plan that emphasized a shared responsibility to treat students as a distinct population with unique mental health needs (Zohil-Morton, 2023).

While PSSs are capable and full of potential, they are also at a higher risk for developing mental illnesses and substance use issues compared to non-students of a similar age range (Ontario University College Health Association [OUCHA], 2009). The OUCHA found that university students experience significantly more distress and are more likely to report mental health symptoms compared to non-university students. Data show that Canadians aged 15-24 are more likely to experience mental illness and/or substance use issues compared to any other age group (Statistics Canada, 2023). Additionally, seven and a half million Canadians are expected to

be living with mental illness by the age of 25, which represents approximately 1 in every 5 people (Mental Health Commission of Canada, 2023).

The 18-25 age range is commonly referred to as ‘emerging adulthood’ (Arnett, 2000) and is a period when many mental health challenges first become visible (Kessler et al., 2007; Matud et al., 2020). Most Canadian PSSs fall within this developmental window (Ecclestone et al., 2023; Canadian Alliance of Student Associations, 2022). In fact, the student population has increasingly begun to mirror the emerging adult general population (Cunningham & Duffy, 2019). For many students, postsecondary education is their first time living independently in a fast-paced, demanding environment (Zohil-Morton, 2023). This period of unsteadiness and uncertainty highlights how vulnerable students are to serious distress (Matud et al., 2020) and how their cognitive-affective strategies (i.e., coping skills) are likely to be negatively impacted (Conley et al., 2020a).

Emerging adulthood is a phase of transition and students often encounter major life adjustments, such as familiarizing themselves with a brand-new academic setting, forming new social circles, and managing an increase in autonomy as well as personal and parental expectations (Ecclestone et al., 2023). Many students live far away from their home, which means being apart from their family and usual support systems (OUCHA, 2009). In addition, they may be trying to balance work responsibilities, experiencing intense academic pressure, or dealing with social pressures related to alcohol and drug use (OUCHA, 2009). Even changes like reduced sleep and changes in diet can impair students’ coping skills (OUCHA, 2009). The stress of entering adulthood and a new period in life may also trigger unresolved trauma in some students, as these individuals may begin confronting childhood abuse or neglect for the first time during their university years (OUCHA, 2009).

Research also shows that students often struggle to sustain old relationships while broadening their social network and forming new friendships, making them feel a disconnect from not only their past but also their present social network (Khullar et al., 2021). Lacking meaningful connections and support during this transition can lead to isolation, homesickness, and mental health problems (Buote et al., 2007; Hefner & Eisenberg, 2009). Conversely, strong social support has been shown to protect against burnout and can help students manage stress and loneliness more effectively (Kim et al., 2018; Lee & Goldstein, 2016).

Suicide Ideation and Crisis Risk Among PSSs

In Ontario, the overall impact of mental illness and addiction is significantly greater than many other health issues (Ratnasingham et al., 2012). It is about one and a half times higher than the combined burden of all cancers and over seven times greater than that of all infectious diseases (Ratnasingham et al., 2012). The data take into account both reduced quality of life and premature death.

College campuses are among environments that are most impacted by depression, making PSSs vulnerable to thoughts of suicide and behaviours (Mei et al., 2020). According to Statistics Canada (2025), suicide is the second leading cause of death among individuals aged 15-24 in Canada, followed only by accidental causes. In 2023 alone, suicide accounted for 15% of deaths among children aged 10-14, 19% among youth aged 15-19, and 17% among emerging adults aged 20-24 (Statistics Canada, 2025).

Surveys show that suicide ideation is not uncommon on postsecondary campuses. According to the 2019 National College Health Assessment II, over 16% of Canadian PSSs reported seriously considering suicide. In addition, further data from the 2022 National College Health Assessment III showed that nearly 36% of PSSs scored a positive suicidal screening score

on the Suicide Behaviour Questionnaire-Revised (SBQR). These statistics align with the tragedies that several Canadian universities have experienced. During the 2018-2019 academic year, both the University of Toronto and the University of Waterloo lost four students each to suicide, while the University of Ottawa experienced five students die by suicide within a ten-month span (Greenfield, 2020). A student union representative at the University of Ottawa described the situation, stating, "I don't think any student does not know of another student who is struggling with mental health issues, and many know of classmates and others who have considered suicide. I know I do" (Greenfield, 2020, para. 2).

A review by Linden et al. (2018) found that thoughts of suicide and self-harm are at times linked to intense academic workload and competition, as well as the other chronic stressors that students face. These findings have increased public concern about student well-being and how institutions can account for this (Linden et al., 2018).

Although students face many risks, they are often at an ideal point for intervention. According to the OUCHA (2009), because many students are still likely early in the course of their mental illness, they are more responsive to treatment. They also tend to be open to new ideas, which may include adopting healthier coping strategies or challenging the stigma around mental illness (OUCHA, 2009). When students are supported effectively, they are more likely to succeed academically and thrive in future roles (Duffy, 2023), making them an especially important group for targeted mental health interventions and early prevention.

The Impact of COVID-19

The demand for campus mental health services has grown steadily, often outpacing what can realistically be provided by institutions (McGartland, 2013). When the COVID-19 pandemic happened, it placed an even greater strain on these already limited resources and increased

existing pressures (Zohil-Morton, 2023). For example, a national survey reported that more than 8 out of 10 Canadians experienced negative impacts from the pandemic, with the highest distress found in those aged 18-34 (Statistics Canada, 2024). Students in Ontario appeared to be hit especially hard. According to the Canadian Alliance of Student Associations (2022), PSSs in Ontario and Alberta reported higher rates of negative mental health effects compared to students in other provinces.

Moghimi et al. (2023) revealed that 66.5% of Ontario-based PSSs experienced a significant decline in their mental health after starting school during the pandemic. A meta-analysis by Li (2021) found that depression rates among PSSs increased to 39% during the pandemic and anxiety rates increased to 36%. One particularly damaging effect was loneliness, which appeared to affect adolescents and young adults more than any other age group (Prowse et al., 2021). This increase in social isolation is linked to depression, suicide ideation, and overall worse mental health among students (Killgore et al., 2020; Patterson et al., 2021).

As PSSs attempt to recover from the psychological aftermath of the pandemic, the demand for mental health services only continues to grow (Zhu et al., 2021). Many institutions are still working to adjust their supports and policies to meet this surge in need.

Mental Health Resource Use and Awareness Among PSSs

Although the prevalence of mental health challenges among PSSs is well researched, there is much less known about the adequacy, accessibility, and availability of campus supports (Jaworska et al., 2016). A national survey found that 74% of respondents believed that students were well informed about mental health resources on campus and about mental health issues in general, yet 84% of respondents felt that current mental health promotion and outreach programs could be increased (Jaworska et al., 2016).

Moghimi et al. (2023) reported similar results in a study across Ontario institutions. They found that although most campuses had mental health services in place, 73% of students believed more resources were needed. In addition, over half of the respondents felt their campus services were insufficient in meeting their current mental health needs.

Barriers to Accessing Mental Health Services Among PSSs

A large proportion of university students struggling with mental health concerns do not seek professional help (Eisenberg et al., 2007; Lally et al., 2016). Even among those students who have a diagnosable mental health condition, fewer than half report having accessed treatment (Zivin et al., 2009), despite many institutions offering low-cost or free support (Eisenberg et al., 2009). Many PSSs are faced with barriers that prevent them from seeking help, such as a preference for self-management, limited time to access services, and concerns about stigma (Broglia et al., 2021; Czyz et al., 2013; Fullmer et al., 2021; Moroz et al., 2020). Many of these challenges are often shaped by structural/logistical, financial, cultural, and technological factors that reduce PSSs ability and/or willingness to seek help.

Structural and Logistical Barriers

Some groups of students may be particularly vulnerable to structural barriers, such as those from lower socioeconomic backgrounds, racialized communities, and gender-diverse populations (Ecclestone et al., 2023). Additionally, students with multiple responsibilities (e.g., work, caregiving, or extracurricular commitments) may struggle to fit scheduled appointments or services into their daily routines (Ecclestone et al., 2023). Moreover, many students do not know where to find mental health resources on campus, especially when services are scattered across multiple locations rather than being placed in a centralized location (Dopp & Lantz, 2020, as

cited in Ecclestone et al., 2023). This issue can be even more evident at larger institutions with sprawling campuses.

Financial Barriers

Cost also remains a significant barrier for many students. In 2022, the average annual cost of living for Ontario PSSs was $25,552, and this number has only continued to rise (Canadian Alliance of Student Associations, 2022). While some mental health resources are covered through tuition or student fees, others may require additional expenses (Ecclestone et al., 2023). For example, mental health education courses often have registration fees, which limits access for students who are already struggling financially (Ecclestone et al., 2023). This financial pressure adds onto the stress put on students and reduces their ability to pay for extra mental health supports, including training programs like Mental Health First Aid and SafeTALK, which at times charge fees for enrollment (Ecclestone et al., 2023). Differences in institutional funding also affect service availability as larger universities often have more resources to dedicate to mental health initiatives, while smaller institutions may struggle to offer the same level of support (Ecclestone et al., 2023).

Cultural Barriers

Ontario has over 400,000 international students (Erudera, 2023), which stresses the importance of culturally relevant mental health care (Lawrence, 2020; Ng & Padjen, 2019). International students and recent immigrants may be more vulnerable due to cultural and language barriers and limited knowledge of local resources (OUCHA, 2009; Srivastava & Srivastava, 2019). For many international students, stigma related to mental illness, unfamiliarity with the local health care system, and distrust of providers may all contribute to hesitation in relation to seeking support (Ng & Padjen, 2019; Srivastava & Srivastava, 2019). Language

differences and a lack of culturally sensitive services are also shown to contribute to limited use (Srivastava & Srivastava, 2019).

In addition to this, many international students were uniquely impacted by COVID-19. A scan of 44 Ontario postsecondary institutions during the COVID-19 pandemic found that 59% did not offer any targeted mental health supports for international students who were required to return home during campus closures (Seko et al., 2024), showing unbalanced support with lower support for international students.

Digital and Online Learning Barriers

Hybrid and online learning have continued to play a role in postsecondary education and as such, result in barriers (CASA, 2022). Although remote learning increases flexibility, it can also lead to feelings of isolation (Croft et al., 2010) and disconnect (Hensley et al., 2022). Students often struggle to form meaningful relationships with classmates or professors (Napierala et al., 2022), which may limit their social support networks and sense of belonging.

In relation to mental health, these forms of social disconnection have serious consequences (Ecclestone et al., 2023). Luckily, many institutional mental health supports remain tied to in-person activities such as workshops or on-campus events (Ecclestone et al., 2023). However, this setup excludes certain students such as remote learners, those who commute, and those studying abroad, and it risks leaving these students without the support they need (Ecclestone et al., 2023).

Community-Based Approaches

Considering the rise of mental health concerns among PSSs, it does not come as a surprise that many institutions are starting to recognize the importance of looking beyond current campus-based services to support students in crisis. Many institutions are adopting a more

holistic and multifaceted approach (Abrams, 2022). Crisis lines have been shown to be a community-based approach to suicide prevention and mental health promotion (Cramer & Kapusta, 2017).

Some postsecondary institutions in the U.S. are taking steps to actively integrate these services (Abrams, 2022). For instance, Penn State University offers its own crisis line to ensure that trained counsellors are available to students 24/7, and John Hopkins is even exploring a crisis support program which would send crisis clinicians to perform wellness checks alongside public safety officers (Abrams, 2022).

Students themselves have shown awareness of these services. In a recent study, undergraduate students from a postsecondary institution in Ontario identified a number of community organizations that provide mental health support, including crisis hotlines and text-based helplines (Zohil-Morton, 2023). Well-known options such as Kids Help Phone, Crisis Services Canada, and regional hotlines were mentioned as potential supports (Zohil-Morton, 2023).

The Role of Crisis Lines in Mental Health Support and Suicide Prevention

Research shows that mental health promotion, prevention, and early intervention can improve mental health outcomes (Roberts & Grimes, 2011). In 2023, 9-8-8, Canada's first three-digit suicide crisis helpline launched. In the same sense that 9-1-1 transformed emergency services, 9-8-8 was intended to transform mental health crisis services (DeAngelis, 2020).

The World Health Organization [WHO] (2018) highlights the important role that crisis lines play in suicide prevention. These services first gained popularity in the 1950s with the rise of telephone use in high-income countries and quickly became a preferred source of support due to their privacy, accessibility, and wide geographic reach. Today, crisis lines exist in nearly every

country, even those with limited mental health resources. The WHO estimates that there are now over 1,000 crisis lines operating across the world.

Crisis lines typically offer confidential, non-judgmental emotional support to individuals experiencing a wide range of issues, including, however, not limited to, suicide ideation (WHO, 2018). Many operate 24 hours a day, year-round, making them an available resource when other support systems are inaccessible, such as after hours (Roennfelft et al., 2024; WHO, 2018). They are staffed by trained responders, who are either volunteers, paid workers, or professionals (WHO, 2018). These individuals are trained to offer compassionate support, de-escalate crises, provide emotional validation, assess for risk, and refer callers to other relevant resources when appropriate, all while holding unconditional positive regard (WHO, 2018). Services are usually free of charge and available via telephone, text, chat, email, or social media platforms (WHO, 2018). Over the past decade, the reach of crisis lines has only continued to expand through the use of new technologies (Mishara & Kerkhof, 2013). Many services now offer chat-based or text-based communication options, which are quite appealing to younger populations who prefer chats over phone calls (Evans et al., 2013).

The Importance of Crisis Lines/Text Services

According to the WHO (2018), people's need for emotional connection is usually and ideally met through relationships with family, friends, teachers, or coworkers. However, when considering individuals who are socially or geographically isolated, or those who experience chronic physical or mental illness, these personal sources of support may not be as easily available (WHO, 2018). Considering that crisis lines offer immediate access to human connection, they may help serve as a steady support for those who need it (WHO, 2018).

In regions with limited resources, crisis lines are sometimes the only form of organized suicide prevention available (WHO, 2018). Their value lies not only in their accessibility but also in their ability to reduce stigma (WHO, 2018). Many people who are thinking about suicide do not disclose their distress to friends, family, or even mental health professionals (Pauwels et al., 2024). Crisis lines offer a private space where individuals can reach out without fear of judgment, making them particularly important for people who may not have anyone in their personal life they can speak to (WHO, 2018).

Research has consistently shown that many individuals experiencing thoughts of suicide do, in fact, reach out to crisis lines. For example, research has found that individuals thinking about suicide were well represented among callers (Sawyer et al., 2010). Further research by Mishara et al. (2007) found that 35.2% of calls to crisis lines in the United States were made by individuals in an active suicide crisis. In addition, a detailed analysis by Gould et al. (2007) revealed that over half of U.S. callers considering suicide had a specific suicide plan at the time of the call, nearly 60% had previously tried to die by suicide, and 8% had taken some form of action to harm themselves immediately before calling.

However, it is not as if crisis lines only focus on suicide prevention. Crisis lines also respond to a broad range of concerns unrelated to suicide. According to data from Lifeline Australia, the most commonly cited issues among callers included family and relationship problems (43.6%), health and disability (36.2%), and concerns related to personal identity and community connection (32.7%; WHO, 2018). Another study focusing on Samaritans hotline users found that callers reported mental health problems (13.2%), self-harm (12.3%), relationship breakdowns (7.6%), relationship challenges (6.8%), and family issues (6.5%) as top reasons for seeking support (Pollock et al., 2010).

In addition, crisis lines help serve individuals with poor mental health who may be at elevated risk for suicide but are not currently connected to other formal care (Radke et al., 2008). These services offer a widely accessible support option that bypasses common barriers such as appointment wait times, distance, or inability to pay (Radke et al., 2008). By doing this, crisis lines extend the continuum of care beyond that of other traditional mental health systems, aiming to reach individuals who might otherwise go unsupported during moments of high risk (Radke et al., 2008).

The Effectiveness of Crisis Lines

Although crisis lines have existed since the 1950s, little was known about whether they actually worked for much of their history (Miller, 2019). Even during the recent launch of the new national 9-8-8 line, critics questioned whether a simple three-digit number could meaningfully reduce the rates of suicide (Miller, 2019).

When psychiatric epidemiologist Madelyn Gould began studying suicide hotlines nearly 20 years ago, even her colleagues questioned the value of the research (Miller, 2019). As Gould explained, many experts at the time doubted that volunteers without clinical training could meaningfully intervene in a suicide crisis. "I was skeptical, too," she admitted, but she moved forward with the research anyway (Miller, 2019, para. 7). From there Gould and her colleagues conducted a critical study in which they examined 1085 calls to eight crisis centers and found that callers (both considering suicide and not considering suicide) showed significant reductions in distress, hopelessness, and suicide ideation by the end of the call and at follow-up two to three weeks later (Gould et al., 2007). Of those who were considering suicide during the call, 11.6% reported that the conversation prevented them from harming themselves. Another study silently monitored 2,611 calls across 14 centers (Mishara et al., 2007). It found that 52.3% of callers left

the call feeling more decisive about next steps, 48.7% felt more resourceful, and 40.2% felt more hopeful (Mishara et al., 2007). Together, these two studies showed that crisis lines can reduce suicide intent, hopelessness, and psychological pain, while also identifying opportunities to improve quality (Radke et al., 2008). This led to a major shift in practice. The National Suicide Prevention Lifeline (NSPL) responded promptly by assembling national experts, including those who were involved in the original studies, to develop the first evidence-informed risk assessment standards for crisis lines across the U.S. (Radke et al., 2008).

Later studies continued to support the effectiveness of crisis lines. In a study conducted over a decade later, Gould et al. (2018) found that among callers considering suicide who received a follow-up call, nearly 80% said the call had stopped them from killing themselves and 90% reported that the follow-up helped them stay safe.

International research has matched these findings. In the United Kingdom, Tyson et al. (2016) reported reductions in suicide and self-harm ideation among crisis line users. An Australian study of youth crisis line callers found decreased thoughts of suicide during the call itself (King et al., 2003). Other studies from Europe and North America have also reported reductions in hopelessness, suicide intent, perceived entrapment, and increases in emotional regulation and social support following crisis line engagement (Britton et al., 2022; Coveney et al., 2012; Hoffberg et al., 2019; Hvidt et al., 2016; Mazzer et al., 2021; Pauwels et al., 2024; Ramchand et al., 2017).

In addition to emotional impact, caller satisfaction is consistently high. Many callers reported feeling heard and more hopeful following their interaction. In some studies, over 99% of callers reported that the call was helpful (Boness et al., 2021), and satisfaction rates remained

high either immediately after the call or at follow-ups (Coveney et al., 2012; Hvidt et al., 2016; Mazzer et al., 2021; Pauwels et al., 2024; Ramchand et al., 2017).

Despite these statistics, researchers note that crisis lines face unique limitations. Their anonymous nature, one-session format, and lack of continuity make it difficult to evaluate long-term suicide prevention outcomes (DeAngelis, 2020; Trial et al., 2022). Even so, the overall evidence makes a clear conclusion that crisis lines play an important role in reducing the risk of suicide and acute distress (Miller, 2019).

Specialized Crisis Lines/Text Services

Crisis lines/text services have increasingly worked to tailor their services to meet the unique needs of diverse populations (Boness et al., 2021; Zabelski et al., 2023). These population specific lines aim to provide culturally responsive and identity affirming support, which in turn may increase help-seeking behaviours (Zabelski et al., 2023).

Language-accessible services are one important adaptation as providing crisis support in a caller's preferred language helps reduce cultural and communication barriers (Zabelski et al., 2023). In addition, many crisis lines have been developed for communities with elevated suicide risk or distinct support needs, such as LGBTQ+ youth, Indigenous communities, veterans, and people who are Deaf or Hard of Hearing (Boness et al., 2021). For example, the Nunavut Kamatsiaqtut Help Line (NKHL) which operates out of Iqaluit, Nunavut is an example of a regional crisis line created to meet regional, cultural, and linguistic needs across the Canadian arctic (Tan et al., 2012).

To highlight the importance of specialized care, one study found that nearly half of callers to an LGBTQ+ youth crisis line reported that they would not have reached out to a general crisis service (Goldbach et al., 2019). Their decision to use the LGBTQ+ line was

strongly influenced by the presence of sexual and gender minority affirming responders that answered the calls (Goldbach et al., 2019). A study by Mereish et al. (2022) examined LGBTQ+ youth engagement with tailored crisis services and reported high levels of user satisfaction, as participants reported positive perceptions and highlighted the warm, compassionate, and affirming nature of crisis workers trained to serve LGBTQ+ populations. Another specialized crisis line, Good2Talk, was created specifically to serve PSSs in Ontario, Canada. A cross-sectional study by Erbach et al. 2024 surveyed 619 postsecondary students after they called Good2Talk and found significant decreases in distress and an increase in students' ability to face their concerns. Furthermore, 87% of students stated that the call helped with at least one of their concerns, and 82% stated that they would reach out again as well as recommend the service to others (Erbach et al., 2024). Other crisis lines specialize in issues like substance use or mood disorders (Boness et al., 2021).

Who Uses Crisis Lines/Text Services?

Research shows that crisis lines are often a first point of contact with the mental health care system for some individuals (Predmore et al., 2017), which makes them an important tool for prevention and intervention. Therefore, understanding who does and does not use these services is essential to improving access.

While crisis lines are open to people of all ages, usage tends to differ within certain demographics. The highest number of telephone contacts typically comes from adults aged 25 to 55, while chat and text services tend to attract younger users, especially those under 18 (Callahan & Inckle, 2012; WHO, 2018). A large-scale study by Spittal et al. (2014) evaluating Australia's Lifeline service found that callers usually fell into the 25-34 (13.3%), 35-44 (12.7%), and 45-54 (10.6%) age ranges. Adolescents and young adults aged 15 to 24 made up only 9.3% of callers.

Moreover, increased age was associated with being a frequent caller (Spittal et al., 2014). Compared to individuals under 24, those aged 55-64 were nearly six times more likely to be repeat callers (Spittal et al., 2014). Another study looking at Australia's Lifeline service found similar results as callers primarily fell into the 25-44 (26%), 45-65 (52%), and >65 (15%) age ranges (Middleton et al., 2017). Callers who were <25 only made up 5% of the calls.

Although crisis lines have a long history as one of the most effective and frequently used interventions for adults in crisis, younger populations continue to underutilize them (Evans et al., 2013). Data from the Maryland Youth Crisis Hotline highlights this discrepancy well, as only a mere 8% of their callers were under the age of 18, and 15% were under the age of 24. These data show that adults are the main users of crisis lines, even when the services are specifically marketed toward youth (Maryland Garrett Lee Smith Suicide Prevention Grant Team, 2011).

Youth and Crisis Line/Text Services Usage

As previously mentioned, although adolescents and young adults are a high-risk group for suicide ideation and psychological distress, they remain one of the least likely populations to contact crisis lines (Gould et al., 2006). For example, youth ages 5-18 in Nevada made up only 2% to 3% of approximately 100,000 calls to the Crisis Call Center (Evans & Davidson, 2009, as cited in Evans et al., 2013).

Even when youth are aware of hotlines, many still choose not to use them (Gould et al., 2006). In fact, 98% of adolescents were aware of hotlines, but only 2.1% had ever utilized one. Gould et al. (2006) found that common reasons for avoiding crisis services included believing the issue was not serious enough or a desire to handle it alone. These attitudes suggest that crisis lines may not align with how young people view their health needs (Gould et al., 2006). This is

particularly disheartening given that youth who do engage with hotline services generally report positive experiences (King et al., 2003).

Evans et al. (2013) noted that many youths prefer text-based communication over phone calls. Youth interviewed by Evans and colleagues (2013) explained that talking in person or even on the phone felt intimidating. Texting on the other hand, allowed them to express themselves more freely while maintaining a sense of privacy. One study found that one in four users of Canada's suicide prevention text service was an adolescent (Côté & Mishara, 2025).

To better engage with the youth population, Evans and colleagues (2013) evaluated how text-based support lines (TextToday in specific) can be promoted in schools. Nearly all youth surveyed were aware of the promotional materials placed around their schools, though understanding varied depending on poster location and how the program was introduced. Posters inside bathroom stalls, for example, were read more closely than those placed in hallways or near sinks. Students who had received a formal announcement about the program (such as during a school assembly or classroom visit) were better able to recall its features, including how to access the service and what it was for (Evans et al., 2013).

When asked about reasons youth might use the TextToday service, responses ranged from concerns like thoughts of suicide, abuse, bullying, or fear, to more general issues like feeling sad, or needing someone to talk to. Most students emphasized that they just wanted someone to listen and hoped to receive encouragement, emotional support, or advice (Evans et al., 2013). Youth also responded positively to the design and tone of the promotional materials. They felt the posters were relatable and expressed appropriate emotions. Some suggested expanding the visuals to include a more diverse range of peer identities, so that "all cliques" could feel represented (Evans et al., 2013). Evaluation data from the TextToday campaign

indicated that the service increased help-seeking behaviours among adolescents and young adults (Evans et al., 2013). These findings support prior research showing that text-based services are more effective at reaching youth than traditional telephone hotlines (Gould et al., 2006).

Although there seems to be a preference for text-based services, additional research found that adolescents who were referred to crisis line services were often willing to engage with those services (Busby et al., 2020). Another study reported that over 73% (n = 123) surveyed youth said they would be more likely to use a crisis line if a trusted adult recommended it (Crosby Budinger et al., 2015). These findings show that crisis lines can play a role in risk management and prevention (Busby et al., 2020), especially if referred to youth by people that they trust.

Emerging Adults and Crisis Line/Text Service Usage: The PSSs Gap

Although considerable research has explored how youth and older adults engage with crisis services, much less is known about how emerging adults (particularly PSSs) interact with crisis lines. This is a significant gap, especially given the mental health challenges faced by this group as highlighted earlier in this paper. Considering that many student barriers toward help-seeking are structural, financial, or involve privacy concerns (Eisenberg et al., 2007), crisis lines should, in theory, help limit these obstacles. However, although studies suggest that PSSs are aware of crisis lines, utilization rates remain low (Hedman-Robertson, 2018; Shaikh et al., 2024).

A U.S. study conducted by Hedman-Robertson (2018) offers insight into PSSs' awareness and perceptions of the National Suicide Prevention Lifeline (NSPL). In a sample of 560 undergraduate students aged 18-27, participants were shown an NSPL advertisement and asked about their previous exposure to it such as where they had seen it, how often, and whether they had ever called. Knowledge of the NSPL was assessed through a series of multiple-choice

questions. Participants were also asked to rate how helpful they believed the NSPL would be and how likely they were to use it when experiencing various symptoms.

The scales used parallel symptoms and likelihood to use the NSPL was rated lower than perceived helpfulness (Hedman-Robertson, 2018). The highest reported likelihood of calling was in cases of a suicide attempt (58%), suicide plans (56%), and active thoughts of suicide (50%). However, willingness to call dropped off abruptly for symptoms that may also be warning signs, such as feeling like a burden (70% unlikely to call), increased substance use (71%), or feeling trapped in emotional pain (63%). Other low likelihood of calling symptoms included social withdrawal and changes in mood (e.g., instability or rage).

The study also found that roughly half of the respondents had seen the NSPL advertisement, and those who had greater exposure rated the service as more helpful. Feedback from students offered further insight. Several respondents noted a general lack of awareness about the hotline, with one student stating that if more people knew about the hotline, fewer people would die by suicide. Others emphasized the need for stronger on-campus promotion. One participant suggested that every dorm should feature crisis line posters and that resident assistants should talk about it during orientation (Hedman-Robertson, 2018).

Additional comments by students pointed to a reluctance to seek help for oneself, even among those willing to help others. One participant reflected that people who are considering suicide often avoid reaching out, instead preferring to support someone else. Another stated, "If I felt like a burden to others, the last thing I would do is call, I would feel like an even bigger burden then." (Hedman-Robertson, 2018, pg. 115). These statements align with previous research conducted with adolescents suggesting that stigma, shame, and self-reliance may prevent students from thinking they need professional help (Gould et al., 2006).

More recent research provides further insight into how college students perceive helplines. Harris (2024) conducted 14 focus groups with 95 college students across three colleges and universities in New York. Students identified convenience, immediate support, comfort, privacy, and anonymity as potential benefits of helplines. However, students perceived major helplines as being intended primarily for suicide or acute mental health crises. Due to this, some students believed that their own concerns were not severe enough to warrant calling or worried they would use up resources they did not need (Harris, 2024).

Barriers to Seeking Support

For many PSSs, reaching out to a crisis line involves navigating not only emotional distress, but also a mix of psychological and social barriers. Even when students acknowledge their need for support, factors such as internalized stigma, shame, and beliefs about self-reliance can prevent help-seeking (Eisenberg et al., 2009; Gould et al., 2006; Gulliver et al., 2010; Rüsch et al., 2014). Considering usage remains disproportionately low in spite of being helpful, this may suggest that attitudes and behaviours around crisis lines may also be key barriers.

Help-Seeking Attitudes and Behaviours

Seeking help is rarely a straightforward process; rather, it is shaped by factors such as help-seeking attitudes, feasibility, personal experiences, perceived usefulness, and fear of vulnerability (Gulliver et al., 2010). Studies assessing help-seeking in university student populations have noticed significant needs being unmet and barriers to service use (Eisenberg et al., 2007; Furr et al., 2001; Hyun et al., 2006). These barriers, as highlighted earlier, include attitudes and knowledge about services, privacy concerns, time constraints, as well as financial constraints (Eisenberg et al., 2007). Overall campus culture was also a factor, as students who

view their campus as unsupportive report poorer mental health outcomes and are less open to accessing support (Fink, 2014).

Research consistently shows that students prefer informal supports (such as friends, family, or romantic partners) over professional or anonymous services (Czyz et al., 2013). While peer support networks can be valuable, they may not always be equipped to handle acute crises. Services like crisis lines could fill this gap, but only if students view them as relevant.

Shaikh et al. (2024) observed a similar pattern in Generation Z college students aged 18-25. When experiencing personal or emotional problems, participants reported stronger intentions to seek help from intimate partners and friends than from a phone helpline. Phone helplines were among the least preferred sources of support, with students reporting a greater likelihood of seeking no help at all than of contacting a helpline (Shaikh et al., 2024).

One frequently cited barrier is the belief that one's problem is not "serious enough" to justify using a crisis line (Gould et al., 2006). In Hedman-Robertson's (2018) study, students familiar with the NSPL expressed hesitation to call unless they were actively considering suicide, reflecting a narrow definition of what qualifies as a crisis. This matches findings by Gould et al. (2006), who found that adolescents often viewed hotlines as a last resort rather than a valid source of early intervention. Common reasons included beliefs that the problem was not serious enough (35.3%), could be managed independently (33.1%), or preferences for informal supports and beliefs that calling would not have done any good. Negative attitudes toward crisis lines were also significantly stronger than those toward other forms of mental health help. Gould and colleagues (2006) found that teenagers reported greater reluctance to contact hotlines than to seek out therapists or substance abuse programs. Together, these findings suggest that crisis line

underutilization among students may be due to a combination of general help-seeking preferences and beliefs that are specific to crisis lines/text services.

Barriers to Help-Seeking

Stigma

One important factor that limits help-seeking is stigma (Clement et al., 2015). In fact, stigma remains one of the most prevalent barriers to mental health help-seeking, particularly in academic environments (Vidourek et al., 2014). Public stigma and self-stigma are two sides of the same coin. On one side we have public stigma, which exists at the group level and describes the occurrence of social groups supporting negative stereotypes against people with mental illness as well as acting against people who have a mental illness (Corrigan et al., 2005). On the other side of the coin is self-stigma, which occurs when individuals internalize public stigma (Corrigan et al., 2005). This self-stigma may result in a loss of self-esteem, self-efficacy, and shame (Corrigan et al., 2005; Livingston & Boyd, 2010; Smalley et al., 2015) and is negatively related to hope and help-seeking behaviours (Hamidi et al., 2023; Smalley et al., 2015). Smalley et al. (2015) found that while self-stigma and public stigma share mechanisms (such as stereotypes and discrimination), they interact differently. A useful equation illustrating the stages of self-stigma was given: self-stereotype + self-prejudice + self-discrimination = self-stigma (Smalley et al., 2015). An individual may have awareness that some of society believes people with a mental illness may be dangerous or incapable of doing certain things (stereotype awareness). However, this does not constitute the individual having self-stigma. The individual may start participating in self-prejudice and experience feelings of incompetence, which can foster feelings of self-disgust and further worsen self-esteem and self-efficacy. The individual may then engage in self-discrimination, such as avoiding support because of feelings of

worthlessness and hopelessness. These three stages, self-stereotype, self-prejudice, and self-discrimination together equate to self-stigma (Smalley et al., 2015).

Recent Canadian data confirms the role of stigma in shaping help-seeking behaviours (Moghimi et al., 2023). In a large provincial study, Moghimi et al. (2023) found that 31.4% of students identified stigma as a major barrier to accessing mental health care on campus. Another study found that university students who had higher levels of stigma associated with depression had fewer positive attitudes towards help-seeking (Gulliver et al., 2023).

Even the design and branding of services can create stigma barriers, as youth may worry about being teased or judged by peers if they are caught using crisis services (Evans et al., 2013).

Self-reliance

One barrier to help-seeking that perhaps might be tied to stigma is self-reliance. Self-reliance is essentially the reliance one has on their own abilities (Ishikawa et al., 2023). It is clear that although a significant number of PSSs experience mental health problems, many of them do not seek out treatment or professional support. Considering that young adults go through a massive shift in autonomy, initiative, and control (Steinberg 1986; Radez et al., 2021), especially when they join postsecondary education, it makes sense why they prefer to manage their problems on their own. However, this shift also creates difficulty when trying to balance independence and support (Morris et al., 2007; Wilson & Deane, 2012). In addition, research shows that perceived stigma and self-stigma are positively related to self-reliance, which subsequently leads to greater opposition to treatment-seeking (Jennings et al., 2015). Along with this, perceived support (which many PSSs lack) can be linked to more extreme self-reliance and is more relevant than actual support (Ishikawa et al., 2023; Lenkens et al., 2020). This is concerning considering extreme self-reliance is linked to an increase in depressive symptoms and

suicide ideation, as well as a decrease in help-seeking (Labouliere et al., 2015). Self-reliance was also a theme explored in relation to crisis services, and findings showed that reasons for crisis line non-use were highly linked to self-reliance, including sentiments like "I wanted to solve the problem myself."

Shame

Another prominent barrier to help-seeking is shame (Rüsch et al., 2014). University students are often striving for independence and success and when they encounter psychological challenges, they may interpret these experiences as personal failures. This fosters shame, a feeling of being flawed or inadequate, which can drive students to hide their distress rather than seek help (Yin et al., 2023). Shame promotes secrecy and avoidance, both of which reduce the likelihood that students will reach out to crisis resources, even when in urgent need (Gould et al., 2006).

Shame was a predictor of more negative views surrounding professional mental health support (Rüsch et al., 2014). Furthermore, shame was a common reason adolescents gave for not using hotlines, even when they had used other types of support, such as school counsellors or online resources (Gould et al., 2006). Students experiencing higher impaired functioning or hopelessness were especially likely to avoid hotlines out of shame or skepticism about their usefulness (Gould et al., 2006).

The Present Study

This study aimed to address a notable gap in the literature. Although previous work has examined crisis line outcomes and utilization, no study to date has focused specifically on how PSS attitudes affect their likelihood of using crisis services in the future. Findings may help

explain why crisis lines/text services, which are accessible, free, and confidential, remain underutilized among one of the most at-risk groups for distress and suicide ideation.

This research had two goals: the first aim was to understand if PSSs perceive crisis lines/text services as a source of support as well as their attitudes and behaviours toward crisis lines/text services, and the second aim was to explore potential barriers that limit usage (such as help-seeking attitudes, stigma, self-reliance, and shame). Specifically, the following research questions and hypotheses were developed:

Q1: Do PSSs utilize crisis lines/text services as a source of mental health support? If so, how do crisis lines/text services compare to their utilization of other mental health supports?

H1: PSSs will be less likely to contact a crisis line than other mental health supports. This hypothesis is based on previous research conducted by Gould and colleagues on adolescents in 2006.

Q2: What attitudes do PSSs hold toward using crisis lines/text services, and how do these attitudes influence their likelihood of engaging with them? Furthermore, does this pattern differ by type of support/resource?

H2: Students who report higher levels of negative attitudes and behaviours around help-seeking, stigma, shame, and self-reliance will be significantly less likely to indicate willingness to contact a crisis line/text service compared to their peers who report more favourable attitudes.

Methods

Participants

Participants were university students from a mid-sized Ontario university. The only eligibility criterion was current enrollment at the university. An a priori sample size analysis was completed in order to determine the necessary sample size needed to achieve a small-to-medium

effect size ($f^2 = 0.08$) with a statistical power of .80. Based on this analysis, this study aimed to have a minimum sample of 155 participants. Students were recruited using the university's SONA system and received partial course credit for their participation. Recruitment was also conducted through direct methods such as posters and in-person recruitment (communicating with professors and emailed correspondence).

The sample participants were primarily female (70.6%) while the remaining 29.4% were male. A majority of participants identified as women (64.8%), while 29.1% identified as men. A smaller portion of participants identified as another gender identity (6.16%). Most participants identified as White (70.6%). Approximately 41% of participants reported having received a previous mental health diagnosis, whereas 56.6% reported no previous diagnosis. Anxiety disorders (32.0%) and mood disorders (26.7%) were the most frequently reported diagnoses. Table 1 presents the overall demographic characteristics of the participants.

Table 1

Demographic Characteristics of Study Participants

Sample Characteristics	*N (221)*	%	*M*	*SD*
Biological sex				
Male	65	29.4		
Female	156	70.6		
Intersex	0	0		
Prefer not to answer	0	0		
Gender				
Men	66	29.1		
Women	147	64.8		
Non-binary	7	3.08		
Genderfluid	1	0.44		
Queer	3	1.32		
Two-spirit	2	0.88		

Prefer not to answer	1	0.44		
Age (years)			22.9	6.5
Race				
White	156	70.6		
Indigenous	18	7.00		
African	17	6.61		
South Asian	16	6.23		
Black	13	5.06		
East/Southeast Asian	12	4.67		
Caribbean	8	3.11		
Latinx	8	3.11		
Middle Eastern	8	3.11		
Prefer not to answer	1	0.39		
Previous mental health diagnosis				
Yes	91	41.2		
No	125	56.6		
Prefer not to answer	5	2.3		
Diagnosis category				
Anxiety disorder	66	32.0		
Mood disorder	55	26.7		
Neurodevelopmental disorder	26	12.6		
Obsessive-compulsive disorder	17	8.25		
Eating disorder	16	7.77		
Trauma-related disorder	14	6.80		
Personality disorder	8	3.88		
Substance use disorder	2	0.97		
Psychotic disorder	1	0.49		
Other	1	0.49		
History of serious thoughts of suicide				
No, never	125	56.6		
Yes (ever)	89	40.2		
Over 12 months ago	57	25.8		
Within the last 12 months	18	8.1		
Within the last 30 days	5	2.3		
Within the last 2 weeks	9	4.1		
Prefer not to answer	7	3.2		

Note. Participants could select more than one gender identity, race, and diagnosis category; therefore, percentages for those variables exceed 100%. Diagnosis categories are reported only for participants who indicated having a previous mental health diagnosis.

Procedure

Following ethics approval from the university's Research Ethics Board (REB #1471529), participants were directed to an online survey hosted on Qualtrics. After providing informed consent, participants completed a series of self-report questionnaires assessing demographic information, current distress, attitudes towards crisis lines, help-seeking attitudes and behaviours, perceived helpfulness and usage of informal and formal mental health supports, as well as levels of self-stigma, self-reliance, and shame. Participants were also asked about their preferences for a student-specific crisis line and service names. A data-quality attention check was embedded within the survey. Participants were instructed to select a specific response option (B) from four response choices (A, B, C, D). Responses for the attention check were used only as an exclusion criterion if answered incorrectly and were not included in the calculation of any study measure. Following the study, a debrief letter was given to participants to provide resources and information about crisis lines and the purpose of the study.

Measures

Demographic Questionnaire

Participants completed a demographic questionnaire (Appendix A) which contained questions regarding their biological sex, age, gender, racial, ethnic, and/or cultural background, relationship status, year of study, and name of program. Participants were also asked if they had ever had any thoughts of suicide and how recent those thoughts were. In addition, participants

were asked if they have ever been diagnosed with a mental health disorder, and those who answered yes were asked to list which category the disorder(s) fall in.

Current Distress

Current distress was measured using the 21-item short form Depression Anxiety Stress Scales (DASS-21; Appendix B). The DASS-21 is a shortened form of the original DASS-42 and measures the severity of symptoms of depression, anxiety, and stress by using a set of three self-report scales corresponding to each of these domains (Lovibond & Lovibond, 1995). Participants rate each item on a 4-point Likert scale (0 = "*Did not apply to me at all*", 4 = *Applied to me very much or most of the time*") with higher scores indicating greater severity of emotional distress. Studies have reported the DASS-21 to have good estimates of internal consistency reliability in both clinical and nonclinical samples (Henry & Crawford, 2005; Lovibond & Lovibond, 1995; Moret-Tatay et al., 2025). In a postsecondary sample, the DASS-21 demonstrated Cronbach's alphas of .85 for Depression, .81 for Anxiety, and .88 for Stress, and McDonald's omegas of .86, .82, and .88 respectively (Osman et al., 2012).

Self-Stigma

Self-stigma was measured using the Self-Stigma of Mental Illness Scale - Short Form (SSMIS-SF; Corrigan et al., 2012; Appendix C) and the Self-Stigma of Seeking Help Scale (SSOSH; Vogel et al., 2006; Appendix D).

The SSMIS-SF (Corrigan et al., 2012) is a 20-item shortened version of the original 40-item SSMIS scale (Corrigan et al., 2006). The measure is grounded in Corrigan's four-stage model of self-stigma and assesses the awareness, agreement, application, and harm associated with negative stereotypes about individuals with mental illness(es). The scale items correspond to each of these stages and participants rate each item on a 9-point Likert scale (1 = *"Strongly*

disagree", 9 = *"Strongly agree"*). Higher scores demonstrate greater stigma. Across studies, the SSMIS-SF subscales demonstrate adequate internal consistency (Corrigan et al., 2012; Conley et al., 2020b; Hansson et al., 2017). In a postsecondary sample, alphas ranged from .80 to .89 (Conley et al., 2020b).

The SSOSH is a 10-item scale of self-stigma created to measure the belief that seeking help from a mental health professional would threaten a person's self-regard, sense of satisfaction, self-confidence, and overall self-worth (Vogel et al., 2006). As such, the SSOSH assesses the extent to which individuals internalize stigma related to seeking professional psychological help (Vogel et al., 2006). Participants rate each item on a 5-point, partly anchored, Likert scale ranging from 1 (*Strongly disagree)* to 5 (*Strongly agree*). Five items are reverse scored so that higher scores indicate greater self-stigma associated with seeking professional help. The scale demonstrates strong internal consistency with alpha coefficients ranging from .86 to .90 in a postsecondary sample, and a 2-week test-retest reliability of .72 (Vogel et al., 2006). Moreover, the reliability and validity of the SSOSH was tested across six different countries and findings indicate that the scale has a similar univariate structure across all six countries (Vogel et al., 2013).

Help-Seeking Attitudes

Help-seeking attitudes were assessed using the 10-item short-form Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH-SF; Appendix E). The ATSPPH-SF (Fischer & Farina, 1995) was adapted from the original 29-item ATSPPH (Fischer & Turner, 1970) and is now used widely to measure general attitudes toward seeking professional psychological help. Participants rate each item on a 4-point Likert scale (0 = *"Disagree"* to 4 = *"Agree"*) and items 2, 4, 8, 9, and 10 are reverse-scored. Total scores range from 0-30, with

higher values indicating more favorable attitudes toward professional help-seeking (Fischer & Farina, 1995). Among college students, internal consistency was adequate and ranged from .77 to .84 (Constantine, 2002; Elhai et al., 2008; Fischer & Farina, 1995; Komiya et al., 2000). The ATSPPH-SF also demonstrated a one-month test-retest reliability of .80, and a .87 correlation with the original scale (Fischer & Farina, 1995).

Prevalence of Use of Crisis Lines Compared to Other Formal Supports

Items were drawn from a previous study conducted by Gould and her colleagues in 2006 (Appendix F). Participants were asked about their use of formal supports (crisis hotline/text service, mental health professional, other health professional, substance program, internet, and clergy/spiritual) during times when they felt very upset, sad, stressed, lonely, or angry. Participants were first asked whether they had accessed each support within the past year and those who answered "No" were then asked whether they had *ever* used that particular support. Participants who answered "No" to an "ever use" question were excluded from analysis for that particular support and were prompted to subsequent questions that detail their reasons for non-use of that specific support.

Reasons for Non-use Questionnaire - Assessing Shame and Self-reliance

In line with Gould et al. (2006), participants were asked their reason(s) for not using a specific service and were given 16 nonexclusive response options (Appendix G). Some responses were tailored to specific services. For example, crisis line/text service non-use included items such as "I was ashamed to call/text"; 'I did not know where to call/text"; and "I had problems getting a private telephone," whereas non-use of other services included items such as "I was ashamed to go"; "I did not know where to go"; and "I had transportation problems." One item, "I have never heard of a crisis hotline," was specific to crisis lines. The non-use

options were organized into themes reflecting self-reliance (e.g., “I wanted to solve the problem myself”), shame (e.g., “I was concerned what my family might think or say”), and structural barriers (e.g., “Services are too expensive”).

Perceived Helpfulness and Likelihood to Use Crisis Lines

This instrument was drawn from a previous study conducted by Hedman in 2018 (Appendix H). Participants were asked to rate how helpful a crisis line would be to them if they were experiencing certain symptoms (e.g., “You feel like you are a burden to others”). There were a total of 14 close-ended items, 3 of which include symptoms of suicide: “You feel like you want to die or kill yourself”; “You feel hopeless or like you have no reason to live”; and “You have a plan to attempt suicide.” Participants rated helpfulness on a 4-point Likert scale (1 = *“Not helpful”,* 4 = *“Very helpful”*). In addition, participants were asked to rate the likelihood they would call/text a crisis line in the future for each parallel symptom. Participants rated likelihood of usage on a 4-point Likert scale (1 = *“Very unlikely”,* 4 = *“Very likely”*).

Preference for a Student-Specific Line

Participants were asked to indicate, through a 4-point Likert scale (1 = *“Very likely”,* 4 = *“Very unlikely”*), whether they would be more likely to use a student-specific crisis line or text service compared to a general crisis line or text service (Appendix I).

Preference of Language

Participants were also asked to indicate whether language would have an impact on their likelihood to use crisis lines/text services (Appendix J). They were asked how likely they would be to use a service based on the name used; crisis line, help line, or support line through a 5-point Likert scale (1 = “*Extremely unlikely*”, 5 = “*Extremely likely*”).

Ethical Considerations

Participants were provided with a detailed letter of information outlining the purpose of the study, what participation would look like, and any potential risks/benefits. Informed consent was obtained before beginning the survey. Participation was entirely voluntary and students were informed that they could decline to answer any question or withdraw from the study at any point with no repercussion. Given the sensitive nature of some survey items (e.g., mentions of suicide, emotional distress, stigma, shame), all participants were provided with a comprehensive list of mental health resources, including local campus counselling services, national and regional crisis lines, and text-based support options at the end of the survey. These were displayed on a debriefing page and accessible even if the survey was not completed.

Data Analyses

All analyses were conducted using the IBM SPSS Statistics software (Version 31). Descriptive statistics were used to understand the demographics of the survey sample. Analyses were structured around the research questions and current hypotheses.

To test for Hypothesis 1 (PSSs will be less likely to contact a crisis line than other mental health supports), percentages of lifetime and past-year use were calculated for each support type. McNemar's chi-square tests were used to compare whether crisis lines were used significantly less often than other formal supports, matching the analytic strategy used by Gould et al. (2006). The reasons for non-use were consolidated by using a principal component factor analysis with varimax rotation. The number of students who answered "Yes" to any item within each factor were also calculated. We tested for significant differences between the reasons for non-use using McNemar's chi-square tests.

To test for Hypothesis 2 (Students who report higher levels of negative attitudes and behaviours around help-seeking, stigma, shame, and self-reliance will be significantly less likely

to indicate willingness to contact a crisis line), various analyses were used. Hierarchical multiple regression analyses were conducted to test whether demographic characteristics, distress, higher self-stigma, negative help-seeking attitudes, and shame predicted lower reported likelihood of crisis line use.

Results

Data Cleaning

Prior to hypothesis testing, the data were screened for accuracy, missing values, and assumptions underlying the planned analyses. A total of 275 participants initially completed the survey. Responses were examined for survey completion, response duration, attention check accuracy, and missing data. Forty participants were removed due to incomplete survey progress, 12 participants were excluded because their completion times fell within the lowest 5% of response durations, and one participant was removed for failing the attention check. An additional participant was excluded because they had considerable missing data across the SSMIS-SF, SSOSH, and ATSPPH scales, which prevented reliable scoring. In total, 54 participants were removed, resulting in a final sample of 221 participants. For the remaining sample, any missing data patterns were examined. Little's MCAR test was not significant, $\chi^2(189) = 148.36$, $p = .987$, indicating that the pattern was missing completely at random. Missing SSMIS-SF item-level data (ranging from 1.35% to 4.1% across the scale) were imputed using the Expectation-Maximization algorithm. One participant had substantial missing items on the Likelihood to Use Crisis Lines scale, which prevented a total score calculation. Therefore, this participant was excluded from analyses involving the likelihood to use scale through listwise deletion, but was retained in all other analyses for which valid data were available. The final sample consisted of 221 participants (age: $M = 22.9$, $SD = 6.5$).

Current Distress, Stigma, and Help-Seeking Behaviours

On average, participants reported mild to moderate symptoms of depression (M = 14.9, SD = 11.6), anxiety (M = 13.3, SD = 10.2), and stress (M = 17.5, SD = 10.1) on the DASS-21. Based on the DASS-21 scoring, scores in the moderate range fall between 14-20 for depression and 10-14 for anxiety, while scores in the mild range fall between 15-18 for stress. Descriptive statistics and internal consistency estimates for all study variables are presented in Table 2.

Table 2

Descriptive Statistics and Internal Consistency Estimates for Distress, Stigma, and Help-Seeking Measures

Measure	Min	Max	*M*	*SD*	α
DASS-21 Depression	0	42	14.9	11.6	.92
DASS-21 Anxiety	0	42	13.3	10.2	.85
DASS-21 Stress	0	42	17.5	10.1	.86
SSMIS Awareness	5	45	23.6	9.9	.90
SSMIS Agreement	5	35	14.1	7.0	.88
SSMIS Apply	5	36	13.4	7.4	.83
SSMIS Hurts Self	5	45	13.8	8.8	.88
SSOSH-SF Total	10	50	23.7	7.1	.83
ATSPPH-SF Total	3	29	18.5	5.4	.78

Crisis Line Helpfulness and Likelihood of Usage

Perceived helpfulness and likelihood to use crisis lines were assessed using the *Perceived Helpfulness and Likelihood to Use NSPL* instrument (Hedman-Robertson, 2017). Both scales presented the same 14 items and for each symptom participants rated how helpful they believed crisis lines/text services would be and how likely they would be to use these services. Responses were summed across the 14 items, producing scores from 14 to 56 for each scale (with higher scores indicating greater perceived helpfulness or greater future likelihood of use). Similar to the

approach taken by Hedman-Robertson (2017), we compared perceived helpfulness with likelihood to use. Participants perceived crisis line/text services as significantly more helpful (M = 36.7, SD = 12.1) than they reported being likely to use them (M = 32.8, SD = 12.3), $t(219)$ = 6.48, $p < .001$, d = .44, 95% CI for the mean difference [2.74, 5.13]. As shown in Table 3, participants generally perceived crisis line and text services as most helpful for suicide-related concerns. The largest proportion viewed these services as helpful or very helpful when a person had a plan to attempt suicide (73.3%), had attempted suicide (70.6%), or was experiencing thoughts of suicide (69.2%). Crisis services were perceived as least helpful for sleeping too much or too little (26.7%), followed by feeling anxious or agitated (41.6%), social isolation (42.1%), and extreme mood swings (42.1%). Perceived helpfulness ratings were compared to the highest-rated helpfulness item, "You have a plan to attempt suicide." The results of these paired-samples t-tests are presented in Table 3.

A similar pattern emerged for participants' reported likelihood of using a crisis line or text service in the future (Table 4). Participants were most likely to use these services following a suicide attempt (62.7%), when experiencing a plan to attempt suicide (60.9%), or when having thoughts of suicide (57.7%). They were least likely to use a crisis service for sleeping too much or too little (16.8%), social isolation (29.1%), and feeling anxious or agitated (29.5%). Despite participants generally perceiving crisis services as helpful for suicide-related concerns, a large proportion indicated that they would be unlikely or very unlikely to use one in these circumstances. Specifically, 43.6% would be unlikely to use a crisis service when wanting to die or kill themselves, 44.1% when looking for a way to kill themselves, and 42.3% when experiencing thoughts of suicide. Likelihood ratings for each symptom were compared with the

highest-rated likelihood item, “You have attempted suicide.” Paired-samples t-test results are presented in Table 4.

Table 3

Symptoms for Which a Crisis Line/Text Service Is Perceived Most Helpful

Item	Not helpful *N* (%)	Somewhat helpful *N* (%)	Helpful or very helpful *N* (%)	Item mean *(SD)*
You have a plan to attempt suicide	31 (14.0)	28 (12.7)	162 (73.3)	3.1 (1.1)
You have attempted suicide	40 (18.1)	25 (11.3)	156 (70.6)	3.0 (1.2)*
You have thoughts of suicide	26 (11.8)	42 (19.0)	153 (69.2)	3.0 (1.0)*
You feel like looking for a way to kill yourself	35 (15.8)	38 (17.2)	148 (67.0)	2.9 (1.1)***
You feel like you want to die or kill yourself	27 (12.2)	47 (21.3)	147 (66.5)	2.9 (1.0)**
You feel hopeless or like you have no reason to live	34 (15.4)	49 (22.2)	138 (62.4)	2.8 (1.1)***
You feel trapped or in unbearable pain	45 (20.4)	61 (27.6)	115 (52.0)	2.6 (1.1)***
You have increased the use of alcohol or drugs	50 (22.6)	57 (25.8)	114 (51.6)	2.5 (1.1)***
You feel like you are a burden to others	42 (19.0)	70 (31.7)	109 (49.3)	2.6 (1.1)***
You feel rage or revengeful	54 (24.4)	61 (27.6)	106 (48.0)	2.4 (1.1)***
You isolate yourself or withdraw from others	58 (26.2)	70 (31.7)	93 (42.1)	2.3 (1.0)***
You are experiencing extreme mood swings	54 (24.4)	74 (33.5)	93 (42.1)	2.3 (1.0)***
You feel anxious or agitated	56 (25.3)	73 (33.0)	92 (41.6)	2.3 (1.0)***
You are sleeping too much or too little	101 (45.7)	61 (27.6)	59 (26.7)	1.9 (1.0)***

Note. * indicates $p < .05$; ** indicates $p < .01$, *** indicates $p < .001$. Asterisks indicate a significant difference compared to the item “A plan to attempt suicide.”

Table 4

Symptoms for Which Participants Would Likely Use a Crisis Line/Text Service

Item	Very unlikely or unlikely	Very likely or likely	Item mean (*SD*)

	N (%)	*N* (%)	
You have attempted suicide	82 (37.3)	138 (62.7)	2.8 (1.2)
You have a plan to attempt suicide	86 (39.1)	134 (60.9)	2.8 (1.2)
You have thoughts of suicide	93 (42.3)	127 (57.7)	2.7 (1.1)**
You feel like you want to die or kill yourself	96 (43.6)	124 (56.4)	2.7 (1.1)**
You feel like looking for a way to kill yourself	97 (44.1)	123 (55.9)	2.7 (1.1)**
You feel hopeless or like you have no reason to live	103 (46.8)	117 (53.2)	2.6 (1.1)***
You feel trapped or in unbearable pain	119 (54.1)	101 (45.9)	2.4 (1.1)***
You have increased the use of alcohol or drugs	138 (62.7)	82 (37.3)	2.2 (1.1)***
You feel like you are a burden to others	140 (63.6)	80 (36.4)	2.2 (1.1)***
You are experiencing extreme mood swings	149 (67.7)	71 (32.3)	2.1 (1.0)***
You feel rage or revengeful	151 (68.6)	69 (31.4)	2.0 (1.0)***
You feel anxious or agitated	155 (70.5)	65 (29.5)	2.0 (1.0)***
You isolate yourself or withdraw from others	156 (70.9)	64 (29.1)	2.0 (1.0)***
You are sleeping too much or too little	183 (83.2)	37 (16.8)	1.7 (0.9)***

Note. ** indicates $p < .01$, *** indicates $p < .001$. Asterisks indicate a significant difference compared to the item "You have attempted suicide."

Crisis Line Utilization Compared to Other Supports

The first research question examined participants' utilization of crisis lines relative to other formal and informal mental health supports. Past 12-month and lifetime utilization frequencies were calculated for each support. Frequencies for use of each support resource are presented in Table 5.

Table 5

Utilization of Mental Health Support Resources

Support type	Past 12 Months *N* (%)	Lifetime Use *N* (%)
Crisis line	17 (7.7)	54 (24.4)

Mental health professional	71 (32.1)	125 (56.6)
Other health professional	55 (24.9)	80 (36.2)
Internet resources	88 (39.8)	113 (51.1)
Substance use program	8 (3.6)	13 (5.9)
Spiritual/clergy	21 (9.5)	37 (16.7)

To compare utilization across support resources, a series of McNemar tests were conducted comparing lifetime crisis line/text service utilization with each alternative source of support. McNemar tests with continuity correction indicated that crisis line/text services were used significantly less frequently than mental health professionals, $\chi^2(1) = 59.04$, $p < .001$; other health professionals, $\chi^2(1) = 8.68$, $p = .003$; and internet resources, $\chi^2(1) = 41.53$, $p < .001$. In contrast, crisis line/text services were used significantly more frequently than substance-use programs, $\chi^2(1) = 30.19$, $p < .001$. The difference between the use of crisis line/text services and spiritual or clergy supports was not statistically significant, $\chi^2(1) = 3.82$, $p = .050$.

Reasons for Crisis Line/Text Service Non-Use

Participants who indicated that they had never used one or more of the support options were asked to endorse their reasons for non-use (as per Gould et al., 2006). Frequencies for each reason why participants did not use a crisis line/text service in particular are presented in Table 6.

Table 6

Reasons for Not Using a Crisis Line

Reason	*N*	%
Wanted to solve the problem myself	83	37.6
Problem was not serious enough	77	34.8
Thought it would get better by itself	70	31.7
Family/friend could help instead	50	22.6
Thought it would not do any good	47	21.3

Problem was too personal	39	17.6
Other	30	13.6
Ashamed to call	28	12.7
Didn't know where to call	22	10.0
Concerned about family's reaction	19	8.6
Would have taken too much time	18	8.1
Would not have trusted the advice	17	7.7
Too expensive	16	7.2
Concerned about friends' reaction	11	5.0
Never heard of a crisis line	9	4.1
Couldn't access a private phone	1	0.5

Note. Participants were allowed to select more than one reason; therefore, percentages exceed 100%.

Principal Component Analysis of Crisis Line/Text Service Non-Use

To examine the underlying structure of reasons for crisis line/text service non-use, a principal component factor analysis with varimax rotation was conducted on the 15 non-use items (as per Gould et al., 2006) among participants who reported not having used a crisis line/text service ($N = 167$). Sampling adequacy was acceptable (Kaiser-Meyer-Olkin measure = .63) and Bartlett's Test of Sphericity was statistically significant, $\chi^2(105) = 456.47$, $p < .001$, indicating appropriateness for factor analysis.

A three-factor solution was chosen to match the factor structure reported by Gould et al. (2006) and accounted for 40.6% of the total variance (Table 7). Following rotation, the first component accounted for 15.7% of the variance, the second accounted for 12.9%, and the third accounted for 11.9%.

The first factor primarily reflected concerns related to shame and anticipated negative evaluation from others (e.g., embarrassment about calling and concerns regarding family or friends' reactions). The second component reflected self-reliance and beliefs that personal coping

strategies would be sufficient (e.g., solving the problem independently, believing that reaching out would not have done any good, not trusting the help they would receive). The third component reflected aspects of perceived exclusion or lack of need, including beliefs that the problem was not serious enough, that family or friends could help, or that the problem would get better by itself. Three composite variables representing Shame, Self-Reliance, and Misapprehension were created by averaging the items associated with each factor. The reliability estimates (Cronbach alpha coefficient) were .79, .58, and .44 for the three factors respectively. Considering that only the Shame factor demonstrated acceptable internal consistency, it was the only factor retained for subsequent analyses. Factor structures and item loadings are displayed in Table 7.

Table 7

Reasons for Non-Use of Crisis Lines Rotated Factor Structure and Item Loadings

Item	Shame	Self- Reliance	Misapprehension
Factor 1: Shame (3 items)			
Family concerns	.86		
Ashamed	.78		
Friend concerns	.76		
Factor 2: Self-Reliance (5 items)			
Wouldn't trust the advice/help		.68	
Solve myself		.62	
Too personal		.58	
Would not have done any good		.47	
Never heard of the service		.47	
Factor 3: Misapprehension (4 items)			
Get better by itself			.66
Family/friend could help			.65
Not serious enough			.50

Expensive	.49

Predictors of Likelihood of Crisis Line Use in the Future

To examine the second research question, two hierarchical multiple regression analyses were conducted to identify predictors of participants' reported likelihood of contacting a crisis line in the future. The first regression used validated measures of self-stigma and help-seeking attitudes as predictors of crisis line use, whereas the second regression used the Shame factor identified through the principal component analysis as a predictor. For both analyses, demographic variables (age, gender, race, mental health diagnosis, and suicide history) were entered in the first block, followed by DASS-21 depression, anxiety, and stress scores in the second block. The third block entered the predictor of interest (i.e., SSMIS Awareness, Agreement, Apply, and Hurts Self subscales, SSOSH total score, and ATSPPH total score; Shame factor).

In addition to the hierarchical multiple regression analyses, Pearson correlations were examined between the predictor variables and likelihood of future crisis line/text service use. These correlations are displayed in Table 8.

Table 8

Pearson Correlations Among Predictors and Future Likelihood of Crisis Services Use

Variable	1	2	3	4	5	6	7	8	9
1. Likelihood of use									
2. DASS-21 Depression	-.24***								
3. DASS-21 Anxiety	-.20**	.70***							

4. DASS-21 Stress	-.22**	.74***	.75***						
5. SSMIS Aware	.01	.10	.07	.08					
6. SSMIS Agree	.03	.03	.00	-.07	.22**				
7. SSMIS Apply	-.22***	.42***	.34***	.31***	.16*	.47***			
8. SSMIS Hurts Self	-.26***	.40***	.30***	.35***	.16*	.37***	.79***		
9. SSOSH	-.23***	.20**	.16*	.15*	-.10	.31***	.35***	.37***	
10. ATSPPH	.31***	-.09	-.02	-.05	.21**	-.25***	-.33***	-.30***	-.66***
Shame[a]	-.05								

Note. $N = 220$ for variables 1-10. * indicates $p < .05$; ** indicates $p < .01$, *** indicates $p < .001$.

[a] Shame was examined only among participants who had not previously used a crisis line/text service resulting in a restricted sample ($n = 166$).

Stigma and Help-Seeking

The first hierarchical regression model was statistically significant, with the final model explaining 20.6% of the variance in likelihood of crisis line use, $R^2 = .21$, Adj. $R^2 = .15$, $F(14, 195) = 3.62$, $p < .001$. Table 9 presents the regression coefficients for each model.

Following entry of the demographic variables, the model significantly predicted likelihood of crisis line use, $F(5, 204) = 2.82$, $p = .018$, accounting for 6.5% of the variance. Within this model, older age was associated with a greater reported likelihood of contacting a crisis line ($\beta = .17$, $p = .014$), whereas participants with a history of thoughts of suicide reported a lower likelihood of contacting a crisis line ($\beta = –.18$, $p = .027$). Gender, race, and mental health diagnosis were not significant predictors.

After psychological distress variables were entered in the second block, the model remained statistically significant, $F(8, 201) = 2.53$, $p = .012$, accounting for 9.1% of the variance.

Depression, anxiety, and stress collectively explained an additional 2.7% of the variance; however, this increase was not statistically significant, $\Delta R^2 = .027$, $\Delta F(3, 201) = 1.98$, $p = .118$. Age remained a significant positive predictor ($\beta = .15$, $p = .035$); however, history of serious thoughts of suicide was no longer statistically significant after controlling for depression, anxiety, and stress. None of the DASS-21 subscales predicted likelihood of crisis line use with the other variables in the model.

After adding the stigma and help-seeking variables, the final model remained statistically significant, $F(14, 195) = 3.62$, $p < .001$. The addition of the stigma and help-seeking variables explained a significant additional 11.5% of the variance in future likelihood of crisis line/text service use, $\Delta R^2 = .115$, $\Delta F(6, 195) = 4.70$, $p < .001$. After controlling for demographic characteristics and psychological distress, positive attitudes toward seeking professional psychological help (ATSPPH) significantly predicted greater reported likelihood of contacting a crisis line ($\beta = .30$, $p = .001$). Age also remained a significant positive predictor ($\beta = .15$, $p = .024$). No stigma variables predicted likelihood of crisis line use after accounting for the remaining variables in the model.

Table 9

Hierarchical Multiple Regression Predicting Likelihood of Crisis Line/Text Service Use

Predictor	*B*	*SE*	β	*t*	*p*
Block 1					
Age	0.32	0.13	.17	2.48	.014
Suicide history	-4.35	1.96	-.18	-2.22	.027
White (vs. non-White)	-2.34	1.88	-.09	-1.25	.214
Male (vs. non-male)	-0.37	1.95	-.01	-0.19	.851
Diagnosis (vs. none)	0.72	2.11	.03	0.34	.733

Block 2					
Depression	-0.14	0.12	-.13	-1.17	.243
Anxiety	-0.04	0.13	-.03	-0.30	.768
Stress	-0.06	0.14	-.05	-0.43	.666
Block 3					
SSMIS Awareness	0.01	0.09	.01	0.12	.904
SSMIS Agreement	0.12	0.15	.07	0.84	.400
SSMIS Apply	0.01	0.20	.01	0.07	.947
SSMIS Hurts Self	-0.25	0.15	-.18	-1.67	.096
SSOSH	-0.03	0.16	-.02	-0.17	.865
ATSPPH	0.69	0.21	.30	3.27	.001

Model	R^2	*Adjusted* R^2	ΔR^2	*F*	*p*	ΔF	*p* for ΔF
Block 1	0.06	.04		2.82	.018		
Block 2	0.09	.06	.03	2.53	.012	1.98	.118
Block 3	0.21	.15	.12	3.62	<.001	4.70	<.001

Shame

A second hierarchical multiple regression was conducted to examine whether shame predicted participants' reported likelihood of contacting a crisis line/text service in the future. This analysis was restricted to participants who had not previously used a crisis line/text service and therefore completed the non-use items from which the Shame factor was derived. The final model was statistically significant, explaining 14.2% of the variance in likelihood of future crisis line/text service use, $R^2 = .142$, adjusted $R^2 = .090$, $F(9, 147) = 2.70$, $p = .006$. Table 10 presents the regression coefficients for each step of the model.

Following entry of the demographic variables, the model significantly predicted likelihood of future crisis line/text service use, $F(5, 151) = 3.79$, $p = .003$, accounting for 11.2% of the variance. Within this model, participants with a history of thoughts of suicide reported a

lower likelihood of contacting a crisis line/text service ($\beta = -.22$, $p = .010$). Race, gender, age, and previous mental health diagnosis were not significant predictors.

After psychological distress variables were entered in the second step, the overall model remained statistically significant, $F(8, 148) = 3.05$, $p = .003$, accounting for 14.1% of the variance. Depression, anxiety, and stress collectively explained an additional 3.0% of the variance; however, this increase was not statistically significant, $\Delta R^2 = .030$, $\Delta F(3, 148) = 1.71$, $p = .167$. History of thoughts of suicide was no longer statistically significant after controlling for depression, anxiety, and stress, and none of the DASS-21 subscales significantly predicted likelihood of future crisis line/text service use with the other variables in the model.

The addition of the Shame factor in the final step did not significantly improve the model, $\Delta R^2 = .001$, $\Delta F(1, 147) = 0.12$, $p = .735$. Shame was also not a significant independent predictor of likelihood of future crisis line/text service use, $\beta = .03$, $p = .735$. No individual predictor was statistically significant in the final model.

Table 10

Hierarchical Multiple Regression Predicting Likelihood of Crisis Line Use: Non-Use Factors

Predictor	B	*SE*	β	*t*	*p*
Block 1					
Age	0.28	0.15	.15	1.94	.055
History of suicidal thoughts (vs. none)	-5.99	2.28	-.22	-2.63	.010
White (vs. non-White)	-3.17	2.08	-.12	-1.53	.129
Man (vs. non-man)	2.23	2.13	.09	1.05	.296
Previous diagnosis (vs. none)	-0.29	2.41	-.01	-0.12	.905
Block 2					
DASS Depression	-0.16	0.15	-.14	-1.08	.281
DASS Anxiety	-0.17	0.16	-.13	-1.07	.285
DASS Stress	0.08	0.17	.06	0.47	.642

Block 3							
Shame		1.28	3.78	.03		0.34	.735

Model	R^2	*Adjusted* R^2	ΔR^2	*F*	*p*	ΔF	*p* for ΔF
Block 1	.112	.082		3.79	.003		
Block 2	.141	.095	.030	3.05	.003	1.71	.167
Block 3	.142	.090	.001	2.70	.006	0.12	.735

Additional Preferences for Crisis Line/Text Services

Participants were also asked whether they would be more likely to use a student-specific crisis line/text service as opposed to a general crisis line/text service. As shown in Table 11, responses were relatively evenly divided, with 49.3% of participants reporting that they would be likely or very likely to use a student-specific service and 50.7% indicating they would be unlikely or very unlikely.

Participants also rated their likelihood of contacting a service based on whether it was described as a crisis line, help line, or support line. A repeated-measures ANOVA indicated that the assumption of sphericity was violated, $\chi^2(2) = 51.17$, $p < .001$. Therefore, Greenhouse-Geisser corrected values are reported. There was a significant effect of service name on reported likelihood of use, $F(1.66, 364.13) = 51.22$, $p < .001$, $\eta_{p^2} = .189$. Participants reported the greatest likelihood of using a support line, followed by a help line, and a crisis line (see Table 11 for means and standard deviations). Bonferroni-adjusted pairwise comparisons indicated that all three names differed significantly from one another ($p < .001$).

Table 11

Additional Preferences for Crisis Line/Text Services

	Student-specific crisis line

Response	*n*	%
Very likely	23	10.4
Likely	86	38.9
Unlikely	74	33.5
Very unlikely	38	17.2

	Effect of language	
Service name	*M*	*SD*
Crisis line	2.7	1.2
Help line	3.1	1.1
Support line	3.5	1.2

Note. Ratings ranged from 1 (extremely unlikely) to 5 (extremely likely), with higher ratings representing greater likelihood of using the service.

Discussion

The purpose of this study was to examine PSSs' utilization of crisis lines/text services, their attitudes toward these services, and barriers to utilization. Overall, the findings suggest that students recognize crisis line/text services as potentially helpful, particularly for suicide-related concerns, but are less likely to view themselves as users of these services.

Crisis Line/Text Service Utilization

The first hypothesis, that PSSs will be less likely to contact a crisis line than other mental health supports, was partially supported. Participants reported that they used crisis lines/text services less frequently in their lifetime than several other sources of support, including mental health professionals, other health professionals, and internet resources. This finding is consistent with a recent study from Shaikh et al. (2024), who found that college students reported lower intentions to seek help from a phone helpline for personal or emotional problems than from several other informal and formal supports, including intimate partners, friends, parents, other

family members, mental health professionals, physicians, and religious leaders. Students in that study also reported being more likely to seek no help at all for personal or emotional problems than to contact a phone helpline (Shaikh et al., 2024). Although intentions to use a phone helpline were higher when students were asked about thoughts of suicide, helplines remained less preferred than most other sources of support, with the exception of religious leaders (Shaikh et al., 2024). These findings suggest that although crisis line/text services play some part in the mental health care system, they are not among the main or preferred sources of support used by PSSs.

One possible explanation is that university students prefer supports that offer continuity of care or supports that feel more familiar to them. Mental health professionals and other health care providers may be viewed as better suited to addressing ongoing mental health concerns, whereas crisis line/text services may be perceived as appropriate only during severe crises. This interpretation is supported by research that found that college students expressed concerns about the lack of continuity offered by helplines and uncertainty regarding what would happen when the conversation with the crisis worker ended (Harris, 2024). One important thing to consider is that the setting of the present study may also matter. The university in which this study was conducted does not have a dedicated student-specific crisis line or text service. As such, students may have less familiarity and/or comfort with these services, which may affect their likelihood of future use.

The comparatively high use of internet resources may reflect the accessibility and familiarity of digital resources among emerging adults, who are often highly engaged with the online world. There is other research demonstrating that university students generally hold favourable attitudes toward online mental health resources (Ryan et al., 2014) and that online

mental health interventions can be effective for this population (Farrer et al., 2013). In addition, previous research shows that online resources may appeal to university students because they are readily available, can be accessed anonymously, can be accessed outside regular service hours, and allow students to obtain support while minimizing stigma (Chan et al., 2016). Internet resources may therefore represent an accessible source of support, particularly for students who are not yet prepared to disclose their concerns or access professional support.

It is important to note that crisis line and text services were used more frequently than substance use programs. The lower use of substance use programs may partly reflect gaps in service availability. Noël et al. (2025) found that although most publicly funded postsecondary institutions in Ontario offered general mental health services, fewer than half provided counselling or psychoeducational resources specifically addressing substance use. Therefore, the pattern seen may reflect broader differences in students' help-seeking preferences, as well as limitations in the availability of specialized substance use services.

Reasons for Crisis Line/Text Service Non-Use

Among participants who had never used a crisis line/text service, the most commonly endorsed reasons for non-use reflected self-reliance. Specifically, participants most frequently reported wanting to solve the problem themselves, believing that the problem was not serious enough, or expecting that it would improve on its own. In contrast, relatively few participants reported barriers related to awareness, accessibility, cost, or concerns about others reactions. These findings suggest that students' decisions not to use crisis line/text services may be influenced more so by their views of their own distress rather than by structural barriers.

The prominence of self-reliant attitudes is consistent with previous research demonstrating that young adults often prefer to manage emotional difficulties on their own

before seeking professional support (Gulliver et al., 2010). During emerging adulthood, increased independence and autonomy is being fostered (Radez et al., 2021; Steinberg 1986) and may contribute to a reluctance to seek external assistance, particularly for concerns that are perceived as 'manageable.' As a consequence, many students may delay accessing crisis line/text services until they believe their distress has reached a level that 'justifies' crisis intervention.

Interestingly, stigma-related reasons, such as concerns about family's reaction and concerns about friend's reactions, were endorsed relatively infrequently (8.6% and 5.0% respectively). One possible explanation is the nature of crisis line and text services, as they are private and confidential. College students have identified privacy and anonymity as important benefits of using helplines (Harris et al., 2024). Text-based services were perceived as offering additional privacy because users' voices could not be recognized and conversations could be conducted more discreetly when living with others. Some students also reported using helplines to discuss concerns they did not feel comfortable disclosing to people in their personal lives (Harris et al., 2024). It is also possible that beliefs about the severity of one's distress may present more of an immediate barrier to crisis service use compared to concerns about stigma. Participants may have been less concerned about being judged for accessing support than about whether their situation was serious enough to warrant contacting a crisis service. This interpretation is consistent with the regression analyses, where stigma measures did not significantly predict likelihood of crisis line and text service use after accounting for demographic characteristics and psychological distress.

Predictors of Crisis Line/Text Service Use

The second hypothesis, that PSSs who report higher levels of negative attitudes and behaviours around help-seeking, stigma, shame, and self-reliance will be significantly less likely

to indicate willingness to contact a crisis line, was also partially supported. Pearson correlation analyses indicated that several measures of stigma and help-seeking attitudes were associated with likelihood of future crisis line/text service use. However, contrary to expectations, general attitudes toward seeking professional psychological help emerged as the only psychological predictor of crisis line use after controlling for demographic characteristics and psychological distress. More positive attitudes toward professional help-seeking increased willingness to contact a crisis line. This finding shows that willingness to engage with professional sources of support may generalize to crisis services, in spite of differences in how services are delivered.

In contrast, measures of stigma and the Shame factor were not significant predictors of crisis line/text service use after controlling for demographic characteristics and psychological distress. These findings are noteworthy as previous research demonstrates associations between stigma and reduced professional help-seeking (Clement et al., 2015). As previously mentioned, one possible explanation is that crisis line/text services differ from many traditional mental health services in ways that reduce the influence of stigma. Research indicates that college students view discomfort and embarrassment as barriers to seeking in-person mental health support and perceive helplines as a way to reduce these barriers (Harris, 2024). Since crisis services provide immediate and confidential support, unlike face-to-face services, they may help with concerns about being judged when seeking help.

Instead, the findings suggest that attitudes toward professional help-seeking may play a more important role in crisis line use than stigma. Individuals who generally view professional support as acceptable and beneficial may be more willing to consider a crisis line/text service when experiencing distress, regardless of their level of stigma. On the other hand, students with less favourable attitudes toward professional help-seeking may be reluctant to access crisis

services even when stigma is relatively low. This is consistent with recent research identifying favourable attitudes toward professional help-seeking as the strongest facilitator of intentions to seek support (Li et al., 2022).

Interestingly, in the first regression model, older age was associated with a greater reported likelihood of using a crisis line/text service. Although the effect was modest, this finding is consistent with previous research indicating that older university students (≥ 26 years old) are more likely to perceive a need for mental health care and access services than students 18-22 years old (Eisenberg et al., 2007).

The Influence of Service Presentation and Service Name

An additional finding was that the way crisis/talk services were presented or advertised appeared to influence participants' reported willingness to use them. Although participants were relatively divided on whether they would be more likely to use a student-specific crisis line/text service than a general crisis line/text service, the language used to describe the service significantly influenced participants' ratings. Specifically, participants reported the greatest likelihood of contacting a service labelled as a support line, followed by a help line, with a crisis line having the lowest likelihood ratings.

One possible explanation is that the term crisis may imply that a service is intended only for individuals experiencing severe or life-threatening situations, whereas support conveys a broader and more approachable source of help. This interpretation is consistent with the overall findings of the present study, as these findings may indicate that students recognize the value of crisis services but do not identify themselves as suitable users, particularly if they do not perceive their difficulties as constituting a ‘crisis.’

This interpretation is also supported by prior research. As previously mentioned, Harris (2024) found that college students perceived major helplines as being intended primarily for suicide and acute mental health crises. Participants specifically indicated that the words “crisis” or “suicide” in service names reinforced the impression that these services were only for people experiencing thoughts of suicide or an immediate crisis. As a result, many reported that they would not contact a helpline for their own concerns because they did not consider them severe enough and did not want to divert resources from individuals perceived to be in greater need. Participants therefore emphasized the need for service names and promotional messaging to communicate that helplines can also be used for emotional distress outside of an acute crisis (Harris et al., 2024).

Clinical Implications/Relevance

The present findings have several implications for suicide prevention and mental health promotion initiatives targeting PSSs. Firstly, the discrepancy between perceived helpfulness and reported likelihood of using crisis line/text services suggests that increasing awareness of these services alone may not be enough to increase utilization. Although participants generally recognized crisis line/text services as helpful, many did not view themselves as likely users. Outreach efforts may benefit from emphasizing not only the availability of crisis services, but also the range of situations in which these services can be used. Clarifying that crisis line/text services are intended to support individuals experiencing varying levels of emotional distress, rather than solely those who are thinking about or may have attempted to die by suicide, may encourage students to seek support earlier. This interpretation is consistent with information shared by students, who claim that if helplines were presented more broadly for mental health concerns, they would have another resource to depend upon (Harris, 2024).

Secondly, the finding that attitudes toward professional psychological help significantly predicted likelihood of crisis line/text service use hints that broader efforts to promote positive help-seeking attitudes may also increase willingness to access crisis services. These efforts could include campus initiatives explaining the benefits of seeking support, addressing misconceptions about crisis line services, and providing clear information about what students can expect when they do reach out to crisis services. Research has shown that once students were informed of helplines and their purpose, many seemed interested in using them or referring their friends to them (Harris, 2024). Testimonials from other students with positive help-seeking experiences may normalize and promote service use. Universities and colleges may also benefit from using information about crisis line/text services and incorporating this information into already existing help-seeking campaigns. Positioning crisis line/text services as a part of a broader continuum of mental health may help students view them as a legitimate source of support. Students themselves have recommended promoting helplines through non-stigmatizing campus communications, including course syllabi, institutional websites, emails, and student service centres, as well as displaying helpline information on student identification cards (Harris, 2024).

Thirdly, the prominence of self-reliance as a reason for not using crisis line/text services highlights the importance of addressing beliefs surrounding coping. Mental health initiatives may continue to benefit from challenging the narrative that individuals should manage their struggles on their own and reinforce that seeking support early is not only proactive but protective as well. Encouraging students to access support before their distress escalates may ultimately improve engagement with crisis services and contribute to earlier intervention.

Limitations

Some limitations should be considered when looking at the present study. Firstly, one limitation was the wording of the gender identity response options. We included “Queer” as an identifier within the gender identity question, however in retrospect, “Genderqueer” would have been the appropriate term. When analyzing the demographic data, we assumed that participants who selected “Queer” were referring to their gender identity.

Another limitation is that although some variables were associated with reported likelihood of crisis line/text service use (i.e., help-seeking intentions), it is not possible to know whether they would predict actual usage over time. One meta-analysis which synthesized 15 longitudinal studies that explored mental health help-seeking intentions and subsequent help-seeking behaviour found a small to moderate intention-behaviour association; however, the available evidence does not establish that intentions independently predict changes in service use over time (Weng et al., 2026). In addition, the study relied exclusively on self-report measures. Participants reported their previous service use, attitudes, and intended likelihood of contacting a crisis line/text service rather than actual behaviour during a crisis. Therefore, reported intentions may not actually reflect behaviour in real life situations. Furthermore, although the sample consisted of Canadian PSSs, the sample was limited to one mid-sized institution. This may impact the generalizability of the results and indicate attitudes or concerns related to this specific university and their promotion of mental health resources. Additionally, the majority of participants identified as White and women. Consequently, the findings may not generalize to more diverse student populations. Future research should examine crisis line/text service utilization among more culturally diverse samples across various Canadian institutions.

An additional limitation is the measurement of reasons for crisis line and text service non-use. The principal component analysis provided partial support for the factor structure

proposed by Gould et al. (2006). Although the principal component analysis yielded three factors reflecting concepts of Shame, Self-Reliance, and Misapprehension; only the Shame factor demonstrated acceptable internal consistency and could be retained for subsequent analysis. In contrast, Self-Reliance and Misapprehension demonstrated lower reliability, suggesting that these constructs may have been less applicable in the present sample. This finding may reflect differences between PSSs and the adolescent sample examined by Gould et al. (2006), or it may indicate that reasons for non-use are more varied among PSSs. This is important as it suggests that PSSs' reasons for not using crisis line/text services may require further exploration rather than adoption of factor structures derived from younger samples. Further research is needed to develop and validate measures of crisis service non-use specifically for postsecondary populations before conclusions can be made about the influence of these barriers. In addition, the analysis examining shame as a predictor of future crisis line use was also limited to participants who had not previously used a crisis line/text service as shame items were designed to assess reasons for non-use. This resulted in a restricted sample of participants, potentially limiting the ability to detect an association between shame and future use likelihood.

Finally, the finding that participants were more likely to use a service described as a support line rather than a help line or crisis line should be understood in light of how the question was presented. Participants rated each service name without being given a specific reason for contacting it. Their responses reflect general preferences for these terms and do not indicate whether the preference of each name varies according to the concern. For example, students may be more willing to contact a service described as a crisis line when experiencing thoughts of suicide but may prefer the term support line for other concerns (e.g., anxiety, social isolation, relationship problems, or sleep difficulties). Future research could present participants with

various symptom or crisis scenarios and examine whether the effect of service name differs across concerns. Another limitation is the use of the term “crisis line” throughout the study. The word “crisis” may suggest a higher level of distress or a more severe situation than terms such as “help line” or “support line.” As a result, participants may have been less likely to view these services as appropriate for their own needs, which could have influenced their reported likelihood of use. Using terms such as “help line” or “support line,” or including these terms alongside “crisis line,” may have resulted in different responses than the ones in the current study.

Conclusion

Overall, these findings contribute to the scarce literature examining crisis line/text service utilization among PSSs and provide insight into how students perceive these services within the broader mental health care system. Findings suggest that although students do not view crisis line/text services negatively, but they may not perceive them as personally useful or appropriate until distress has become severe or they experience thoughts of suicide. This discrepancy has important implications for mental health promotion efforts aimed at encouraging earlier engagement with crisis supports.

As demand for accessible mental health services continues to grow, understanding the factors that influence students' willingness to access crisis services (which are accessible, free, and confidential) should be an important area of research to focus on. By identifying barriers to utilization and factors associated with likelihood of usage, the present study provides evidence that may inform future research, mental health initiatives and promotions, and other efforts to improve access to crisis services for PSSs.

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Appendix A: Demographic Questionnaire

Please provide the following information about yourself:

1. **What is your current age? _____**
2. **What was your sex assigned at birth?**

   ☐ Male ☐ Female ☐ Intersex ☐ Prefer not to Answer

3. **What options best describe your gender? (*Select all that apply*)**

   ☐ Man

   ☐ Woman

   ☐ Gender Fluid

   ☐ Non-Binary

   ☐ Queer

   ☐ Two-Spirit

   ☐ Prefer not to answer

   ☐ I identify as (please specify): _____

4. **How do you describe your racial, ethnic and/or cultural background? Please check all that apply.**

   ☐ African (e.g., Ghana, Nigeria)
   ☐ Black
   ☐ Caribbean (e.g., Jamaica, Trinidad and Tobago, Guyana, St. Lucia)
   ☐ East/Southeast Asian (e.g., Chinese, Korean, Japanese, Taiwanese, Filipino, Vietnamese, Cambodian, Thai, Malaysian, Indonesian, etc.)
   ☐ Indigenous (e.g., First Nations, Métis, Inuit, etc.)
   ☐ Latinx (e.g., Latin American, Hispanic, etc.)
   ☐ Middle Eastern (e.g., Arab, Persian, Afghan, Egyptian, Iranian, Lebanese, Turkish, Kurdish, etc.)

- ☐ South Asian (e.g., East Indian, Pakistani, Bangladeshi, Sri Lankan, etc.)
- ☐ White (e.g., European decent)
- ☐ I use other terms to describe my racial, ethnic, and/or cultural background: Please specify _____
- ☐ Prefer not to answer

5. What is your marital status?

- ☐ Married, or in a domestic partnership
- ☐ Divorced
- ☐ Separated
- ☐ In a relationship
- ☐ Single
- ☐ Widowed

6. What is your year of study? _____

7. What is the name of your major/program? _____

8. Have you ever been diagnosed with a mental illness?

☐ Yes ☐ No ☐ Prefer not to answer

9. To your best knowledge, which category best fits the diagnosis you were given?

Please select all that apply

- ☐ Mood Disorder (depression, bipolar disorder, etc.)
- ☐ Anxiety Disorder (general anxiety disorder, panic disorder, etc.)
- ☐ Personality Disorder (borderline personality disorder, narcisstic personality disorder, etc.)
- ☐ Psychotic Disorder (schizophrenia, schizoaffective disorder, etc.)
- ☐ Eating Disorder (anorexia, bulimia, etc.)
- ☐ Trauma-related Disorder (post-traumatic stress disorder, adjustment disorder, etc.)
- ☐ Substance-related Disorder (substance abuse disorder, gambling disorder)
- ☐ Obsessive-compulsive Disorder (OCD, body dysmorphic disorder, etc.)
- ☐ Neurodevelopmental Disorder (autism, ADHD, etc.)

☐ Other (please specify) _____

10. Have you ever seriously considered suicide?

☐ No, never

☐ Yes, over 12 months ago

☐ Yes, in the last 12 months

☐ Yes, in the last 30 days

☐ Yes, in the last 2 weeks

☐ Prefer not to Answer

Appendix B: Current Distress (DASS-21; Lovibond & Lovibond, 1995)

DASS21

Name _____ Date _____

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all

1 Applied to me to some degree, or some of the time

2 Applied to me to a considerable degree or a good part of time

3 Applied to me very much or most of the time

---

1 (s) I found it hard to wind down	0 1 2 3
2 (a) I was aware of dryness of my mouth	0 1 2 3
3 (d) I couldn't seem to experience any positive feeling at all	0 1 2 3
4 (a) I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0 1 2 3
5 (d) I found it difficult to work up the initiative to do things	0 1 2 3
6 (s) I tended to over-react to situations	0 1 2 3
7 (a) I experienced trembling (e.g. in the hands)	0 1 2 3
8 (s) I felt that I was using a lot of nervous energy	0 1 2 3
9 (a) I was worried about situations in which I might panic and make a fool of myself	0 1 2 3
10 (d) I felt that I had nothing to look forward to	0 1 2 3

11 (s) I found myself getting agitated 0 1 2 3

12 (s) I found it difficult to relax 0 1 2 3

13 (d) I felt down-hearted and blue 0 1 2 3

14 (s) I was intolerant of anything that kept me from getting on with what I was doing 0 1 2 3

15 (a) I felt I was close to panic 0 1 2 3

16 (d) I was unable to become enthusiastic about anything 0 1 2 3

17 (d) I felt I wasn't worth much as a person 0 1 2 3

18 (s) I felt that I was rather touchy 0 1 2 3

19 (a) I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat) 0 1 2 3

20 (a) I felt scared without any good reason 0 1 2 3

21 (d) I felt that life was meaningless 0 1 2 3

Appendix C: Self-Stigma of Mental Illness Scale - Short Form (SSMIS-SF; Corrigan et al., 2012)

Name or ID Number_____ Date _____

The public has believed many different things about persons with serious mental illnesses over the years, including some things that could be considered offensive. We would like to know what you think most of the public as a whole, or most people in general, believe about persons with serious mental illnesses at the present time. Please answer the following items using the 9-point scale below.

I strongly disagree			Neither agree nor disagree				I strongly agree
1	2	3	4	5	6	7	8	9

Section 1:

I think the public believes...

1. _____ most persons with mental illness are to blame for their problems.
2. _____ most persons with mental illness are unpredictable.
3. _____ most persons with mental illness will not recover or get better.
4. _____ most persons with mental illness are dangerous.
5. _____ most persons with mental illness are unable to take care of themselves.

Section 2:

Now answer the next 5 items using the agreement scale.

I strongly disagree			Neither agree nor disagree				I strongly agree
1	2	3	4	5	6	7	8	9

I think...

1. _____ most persons with mental illness are to blame for their problems.
2. _____ most persons with mental illness are unpredictable.
3. _____ most persons with mental illness will not recover or get better.
4. _____ most persons with mental illness are dangerous.
5. _____ most persons with mental illness are unable to take care of themselves.

Section 3:

Now answer the next 5 items using the agreement scale.

I strongly disagree			Neither agree nor disagree				I strongly agree
1	2	3	4	5	6	7	8	9

Because I have a mental illness...

1. _____ I am unable to take care of myself.
2. _____ I will not recover or get better.
3. _____ I am to blame for my problems.
4. _____ I am unpredictable.
5. _____ I am dangerous.

Section 4:

Finally, answer the next 5 items using the agreement scale.

I strongly disagree			Neither agree nor disagree				I strongly agree
1	2	3	4	5	6	7	8	9

I currently respect myself less...

1. _____ because I am unable to take care of myself.
2. _____ because I am dangerous.
3. _____ because I am to blame for my problems.
4. _____ because I will not recover or get better.
5. _____ because I am unpredictable.

Self-Stigma of Mental Illness Scale – Short Form Score Sheet (Corrigan et al., 2012)

Name or ID Number_____ Date _____

Summing items from each section represents the 3 A's plus 1.

_____ Aware: (Sum all items from Section 1).

_____ Agree: (Sum all items from Section 2).

_____ Apply: (Sum all items from Section 3).

_____ Hurts self: (Sum all items from Section 4).

Appendix D: Self-Stigma of Seeking Help Scale (SSOSH; Vogel et al., 2006).

Please read each statement carefully and select the option that best describes your level of agreement with each statement.

I. I would feel inadequate if I went to a therapist for psychological help.

1	2	3	4	5
Strongly disagree	Disagree	Agree and disagree equally	Agree	Strongly agree

2. My self-confidence would NOT be threatened if I sought professional help.*

1	2	3	4	5
Strongly disagree	Disagree	Agree and disagree equally	Agree	Strongly agree

3. Seeking psychological help would make me feel less intelligent.

1	2	3	4	5
Strongly disagree	Disagree	Agree and disagree equally	Agree	Strongly agree

4. My self-esteem would increase if I talked to a therapist.*

1	2	3	4	5
Strongly disagree	Disagree	Agree and disagree equally	Agree	Strongly agree

5. My view of myself would not change just because I made the choice to see a therapist.*

1	2	3	4	5
Strongly disagree	Disagree	Agree and disagree equally	Agree	Strongly agree

6. It would make me feel inferior to ask a therapist for help.

1	2	3	4	5

Strongly disagree	Disagree	Agree and disagree equally	Agree	Strongly agree

7. I would feel okay about myself if I made the choice to seek professional help.*

1	2	3	4	5
Strongly disagree	Disagree	Agree and disagree equally	Agree	Strongly agree

8. If I went to a therapist, I would be less satisfied with myself.

1	2	3	4	5
Strongly disagree	Disagree	Agree and disagree equally	Agree	Strongly agree

9. My self-confidence would remain the same if I sought professional help for a problem I could not solve.*

1	2	3	4	5
Strongly disagree	Disagree	Agree and disagree equally	Agree	Strongly agree

10. I would feel worse about myself if I could not solve my own problems.

1	2	3	4	5
Strongly disagree	Disagree	Agree and disagree equally	Agree	Strongly agree

Appendix E: Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH-SF; Fischer & Farina, 1995)

Please check the response that applies to you.

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

☐ Disagree ☐ Partly Disagree ☐ Partly agree ☐ Agree

2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

☐ Disagree ☐ Partly Disagree ☐ Partly agree ☐ Agree

3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

☐ Disagree ☐ Partly Disagree ☐ Partly agree ☐ Agree

4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.

☐ Disagree ☐ Partly Disagree ☐ Partly agree ☐ Agree

5. I would want to get psychological help if I were worried or upset for a long period of time.

☐ Disagree ☐ Partly Disagree ☐ Partly agree ☐ Agree

6. I might want to have psychological counseling in the future.

☐ Disagree ☐ Partly Disagree ☐ Partly agree ☐ Agree

7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.

☐ Disagree ☐ Partly Disagree ☐ Partly agree ☐ Agree

8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

☐ Disagree ☐ Partly Disagree ☐ Partly agree ☐ Agree

9. A person should work out his or her own problems; getting psychological counseling would be a last resort.

☐ Disagree ☐ Partly Disagree ☐ Partly agree ☐ Agree

10.Personal and emotional troubles, like many things, tend to work out by themselves.

☐ Disagree ☐ Partly Disagree ☐ Partly agree ☐ Agree

Appendix F: Prevalence of Use of Crisis lines Compared to Other Formal Supports

When you felt very upset, sad, stressed, lonely, or angry, did you use any of the following supports? For each, indicate if you have ever used it and if you used it in the past 12 months.

1) Crisis hotline or crisis text service:

Ever used? ☐ Yes ☐ No

Used in the past 12 months? ☐ Yes ☐ No

2) Mental health professional (e.g., counsellor, psychologist, psychiatrist):

Ever used? ☐ Yes ☐ No

Used in the past 12 months? ☐ Yes ☐ No

3) Other health professional (e.g., family doctor, nurse practitioner):

Ever used? ☐ Yes ☐ No

Used in the past 12 months? ☐ Yes ☐ No

4) Substance use program or service:

Ever used? ☐ Yes ☐ No

Used in the past 12 months? ☐ Yes ☐ No

5) Internet-based support (e.g., online forum, app, social media):

Ever used? ☐ Yes ☐ No

Used in the past 12 months? ☐ Yes ☐ No

6) Clergy or spiritual leader:

Ever used? ☐ Yes ☐ No

Used in the past 12 months? ☐ Yes ☐ No

Appendix G: Reasons for Non-Use of Supports (Gould et al., 2006)

Please tell us why you did not use _____. Check all that apply:

For all other formal supports:

☐ I was ashamed to go

☐ I was concerned about what my family might think or say

☐ I was concerned about what my friends might think or say

☐ The problem was too personal to tell anyone

☐ I wanted to solve the problem by myself

☐ I thought the problem would get better by itself

☐ I thought a family member or friend could help me

☐ I thought it probably would not have done any good

☐ I thought the problem was not serious enough

☐ I would not have trusted the advice or help they would give me

☐ Services are too expensive

☐ It would have taken too much time

☐ I did not know where to go

☐ I had transportation problems

Specific for crisis hotline/text service:

☐ I was ashamed to call

☐ I was concerned about what my family might think or say

☐ I was concerned about what my friends might think or say

☐ The problem was too personal to tell anyone

☐ I wanted to solve the problem by myself

☐ I thought the problem would get better by itself

☐ I thought a family member or friend could help me

☐ I thought it probably would not have done any good

☐ I thought the problem was not serious enough

☐ I would not have trusted the advice or help they would give me

☐ I have never heard of a crisis hotline/text service

☐ Services are too expensive

☐ It would have taken too much time

☐ I did not know where to call

☐ I had problems getting a private telephone

Appendix H: Perceived Helpfulness and Likelihood to Use Crisis Lines (Hedman-Robertson, 2018)

Part 1: For each statement, rate how helpful calling/texting a crisis line would be for you if this were true.

1. You feel like you want to die or kill yourself.

☐ Not helpful ☐ Somewhat helpful ☐ Helpful ☐ Very helpful

2. You feel like looking for a way to kill yourself.

☐ Not helpful ☐ Somewhat helpful ☐ Helpful ☐ Very helpful

3. You feel hopeless or like you have no reason to live.

☐ Not helpful ☐ Somewhat helpful ☐ Helpful ☐ Very helpful

4. You feel trapped or in unbearable pain.

☐ Not helpful ☐ Somewhat helpful ☐ Helpful ☐ Very helpful

5. You feel like you are a burden to others.

☐ Not helpful ☐ Somewhat helpful ☐ Helpful ☐ Very helpful

6. You have increased the use of alcohol or drugs.

☐ Not helpful ☐ Somewhat helpful ☐ Helpful ☐ Very helpful

7. You feel anxious or agitated.

☐ Not helpful ☐ Somewhat helpful ☐ Helpful ☐ Very helpful

8. You are sleeping too much or too little.

☐ Not helpful ☐ Somewhat helpful ☐ Helpful ☐ Very helpful

9. You isolate yourself, withdraw from others.

☐ Not helpful ☐ Somewhat helpful ☐ Helpful ☐ Very helpful

10. You feel rage or revengeful.

☐ Not helpful ☐ Somewhat helpful ☐ Helpful ☐ Very helpful

11. You are experiencing extreme mood swings.

☐ Not helpful ☐ Somewhat helpful ☐ Helpful ☐ Very helpful

12. You have thoughts of suicide.

☐ Not helpful ☐ Somewhat helpful ☐ Helpful ☐ Very helpful

13. You have a plan to attempt suicide.

☐ Not helpful ☐ Somewhat helpful ☐ Helpful ☐ Very helpful

14. You have attempted suicide.

☐ Not helpful ☐ Somewhat helpful ☐ Helpful ☐ Very helpful

Part 2: For each statement, rate how likely you would be to call/text a crisis line if this were true.

1. You feel like you want to die or kill yourself.

☐ Very unlikely ☐ Unlikely ☐ Likely ☐ Very likely

2. You feel like looking for a way to kill yourself.

☐ Very unlikely ☐ Unlikely ☐ Likely ☐ Very likely

3. You feel hopeless or like you have no reason to live.

☐ Very unlikely ☐ Unlikely ☐ Likely ☐ Very likely

4. You feel trapped or in unbearable pain.

☐ Very unlikely ☐ Unlikely ☐ Likely ☐ Very likely

5. You feel like you are a burden to others.

☐ Very unlikely ☐ Unlikely ☐ Likely ☐ Very likely

6. You have increased the use of alcohol or drugs.

☐ Very unlikely ☐ Unlikely ☐ Likely ☐ Very likely

7. You feel anxious or agitated.

☐ Very unlikely ☐ Unlikely ☐ Likely ☐ Very likely

8. You are sleeping too much or too little.

☐ Very unlikely ☐ Unlikely ☐ Likely ☐ Very likely

9. You isolate yourself, withdraw from others.

☐ Very unlikely ☐ Unlikely ☐ Likely ☐ Very likely

10. You feel rage or revengeful.

☐ Very unlikely ☐ Unlikely ☐ Likely ☐ Very likely

11. You are experiencing extreme mood swings.

☐ Very unlikely ☐ Unlikely ☐ Likely ☐ Very likely

12. You have thoughts of suicide.

☐ Very unlikely ☐ Unlikely ☐ Likely ☐ Very likely

13. You have a plan to attempt suicide.

☐ Very unlikely ☐ Unlikely ☐ Likely ☐ Very likely

14. You have attempted suicide.

☐ Very unlikely ☐ Unlikely ☐ Likely ☐ Very likely

Appendix I: Preference for a Student Specific Crisis Line

How likely are you to call a student-specific crisis line or text service, compared to a general crisis line or text service?

☐ Very likely ☐ Likely ☐ Unlikely ☐ Very unlikely

Appendix J: Preference of Language

Language and word choice can influence whether people feel comfortable seeking support. Please indicate how likely you would be to call or text a service based on the name used: “Crisis line,” “Help line,” or “Support line.”

Crisis line

- ☐ Extremely unlikely
- ☐ Somewhat unlikely
- ☐ Neither likely nor unlikely
- ☐ Somewhat likely
- ☐ Extremely likely

Help line

- ☐ Extremely unlikely
- ☐ Somewhat unlikely
- ☐ Neither likely nor unlikely
- ☐ Somewhat likely
- ☐ Extremely likely

Support line

- ☐ Extremely unlikely
- ☐ Somewhat unlikely
- ☐ Neither likely nor unlikely
- ☐ Somewhat likely
- ☐ Extremely likely