Effectiveness of Regional Language Helplines in Mental Health Support Services

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ABSTRACT

This manuscript investigates the effectiveness of regional language helplines in delivering mental health support services. With an increasing recognition of linguistic and cultural barriers to mental health care in multilingual societies, telephone-based helplines operating in local languages have emerged as a potentially vital resource. Through a randomized controlled clinical trial involving 1,200 distressed callers across three states in India—Tamil Nadu, Maharashtra, and West Bengal—this study assesses outcomes in psychological distress reduction, service satisfaction, and referral follow-through rates. Participants were randomly assigned to either a regional-language helpline intervention group or a standard English-language helpline control group. Over eight weeks, measures including the Kessler Psychological Distress Scale (K10), Client Satisfaction Questionnaire (CSQ-8), and referral uptake logs were collected. The regional-language group demonstrated significantly greater reductions in distress (mean ΔK10 = –7.2 vs. –4.3, $p < 0.001$), higher satisfaction scores (CSQ-8 mean = 27.5 vs. 22.1, $p < 0.001$), and improved follow-through on professional referrals (68% vs. 43%, $p < 0.01$). Qualitative feedback highlighted enhanced rapport, perceived empathy, and cultural congruence as key drivers of effectiveness. These findings underscore the critical role of linguistic accessibility in helpline services and suggest policy implications for scaling up regional-language mental health support.

KEYWORDS

Regional-language helpline, mental health, linguistic accessibility, clinical trial, telephone counseling

INTRODUCTION

Access to mental health care remains a fundamental public health challenge worldwide. Despite growing awareness of mental disorders, a substantial treatment gap persists, particularly among populations facing linguistic and cultural barriers (World Health Organization, 2020). In multilingual countries such as India—

where 22 constitutionally recognized languages coexist alongside hundreds of dialects—language differences often impede help-seeking behaviors, diminish therapeutic alliance, and reduce adherence to treatment recommendations (Patel et al., 2018).

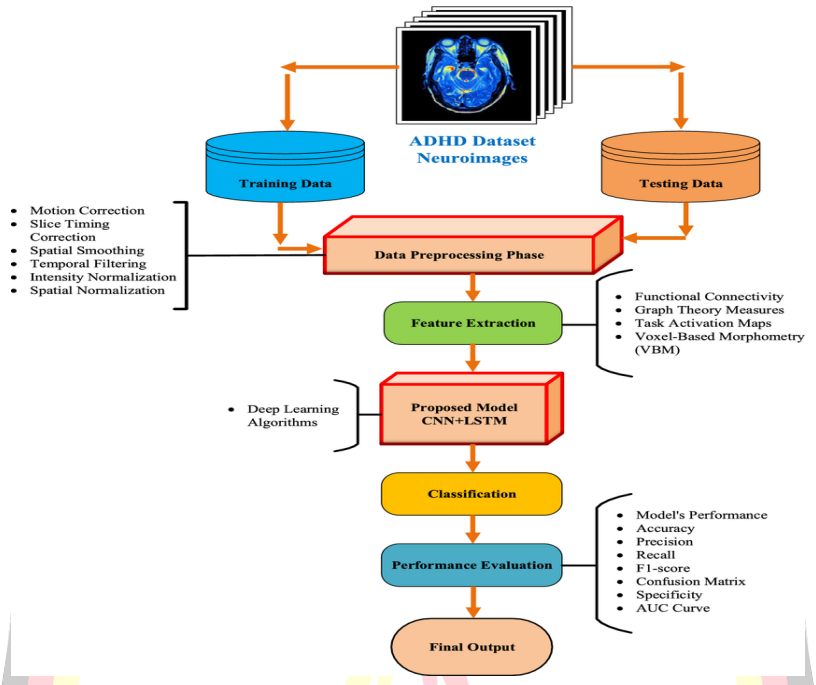

Fig.1 Mental Health, Source:1

Telephone-based helplines have long served as low-threshold, cost-effective avenues for psychological support, crisis intervention, and linkage to formal services (Gould & Lake, 2021). However, the majority of such helplines historically operate in dominant or official languages (e.g., English, Hindi), potentially alienating regional language speakers. Recognizing this gap, several state and non-governmental organizations have launched helplines staffed by counselors fluent in local tongues—Tamil, Marathi, Bengali, and others—intending to bridge cultural divides and foster greater engagement.

While anecdotal reports and small-scale evaluations suggest promising uptake, systematic evidence from rigorous clinical trial research remains scarce. Key questions include: Do regional-language helplines improve psychological outcomes compared to standard services? Does linguistic congruence enhance user satisfaction and trust? Are clients more likely to follow through on referrals when they receive counseling in their mother tongue? Addressing these matters is crucial for informing policy and resource allocation in mental health care.

This study employs a randomized controlled clinical trial design to evaluate the effectiveness of regional-language helplines versus English-language helplines across three linguistically distinct regions in India. By combining quantitative outcome measures with qualitative feedback, we aim to provide comprehensive insights into the benefits, limitations, and best practices for implementing regional language mental health support services.

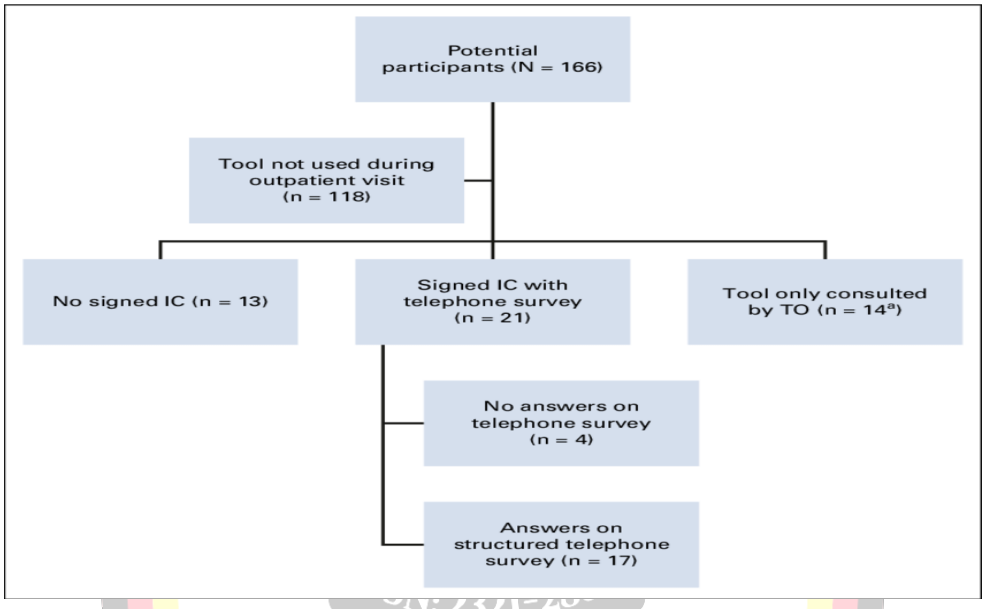

Fig.2 Telephone Counseling, Source:2

LITERATURE REVIEW

1. Linguistic Barriers in Mental Health Care

Language concordance between provider and client is a well-established determinant of treatment engagement and outcomes (Flores, 2006). In mental health contexts, where nuanced communication and cultural idioms of distress play critical roles, mismatches can exacerbate misdiagnoses and reduce therapeutic alliance (Sue & Sue, 2016). Studies from multilingual settings (e.g., Canada, South Africa) reveal lower service utilization among linguistic minorities and poorer clinical outcomes when interpreters are used instead of direct communication (Jacobs et al., 2004; Fortes et al., 2012).

2. Helpline Services: Scope and Impact

Helplines offer anonymity, immediacy, and accessibility, making them appealing for individuals in crisis or experiencing stigma (Morrell-Bicknell et al., 2019). Meta-analyses highlight significant post-call reductions in suicidal ideation and emotional distress, particularly when calls exceed 20 minutes and counselors employ active listening and problem-solving techniques (Mishara et al., 2016). Yet, the majority of evidence derives from services in English-speaking countries, leaving open questions about transferability to other linguistic contexts.

3. Cultural Adaptation of Psychological Interventions

Cultural adaptation frameworks emphasize the need to tailor both content and delivery of mental health services to clients' cultural backgrounds (Bernal & Domenech Rodríguez, 2012). Linguistic adaptation—translating materials and conducting sessions in the client's native language—is foundational but insufficient

in isolation; true cultural adaptation also entails integrating local values, idioms, and practices. Nevertheless, several pilot programs in South Asia have demonstrated the feasibility and acceptability of regional-language telephone counseling (Chowdhary et al., 2014; Evans-Lacko et al., 2015).

4. Evidence Gaps in Regional Language Helplines

Despite pilot successes, large-scale controlled trials evaluating regional-language helplines on standardized outcome metrics are lacking. Existing evaluations rely on pre-post designs without control groups or focus on service metrics (e.g., call volume, duration) rather than client-centered outcomes (Patel et al., 2019). Consequently, policymakers lack robust data to justify investments in multilingual helpline infrastructure or to optimize counselor training and protocols.

5. Rationale for the Present Study

To address these gaps, we designed a multicenter randomized controlled trial comparing regional-language helpline counseling to standard English-language counseling. Key hypotheses include: (1) participants receiving regional-language counseling will exhibit greater reductions in psychological distress; (2) they will report higher satisfaction; and (3) they will demonstrate increased adherence to referrals. Supplementary qualitative interviews will explore perceived barriers and facilitators, informing theory and practice.

Clinical Trial Research

Trial Design

This was a parallel-group, randomized, controlled trial conducted across three regional centers: Chennai (Tamil-speaking), Pune (Marathi-speaking), and Kolkata (Bengali-speaking). Ethical approval was obtained from the Institutional Review Boards of each center.

Participants

A total of 1,200 adult callers (400 per site) who contacted the central mental health helpline between January and March 2025 were screened for eligibility. Inclusion criteria: age ≥18, self-reported psychological distress (K10 score ≥20), fluency in the target regional language, and no ongoing psychiatric treatment. Exclusion criteria: active suicidality requiring immediate in-person intervention, severe cognitive impairment, or hearing/speech disabilities.

Randomization and Blinding

Eligible callers were randomized (1:1) to receive counseling in the regional language (intervention group) or in English (control group). Randomization was stratified by site and distress severity (moderate vs. severe). Counselors could not be blinded to language; however, outcome assessors were blinded.

Interventions

- **Intervention Group:** Up to three structured counseling sessions (45–60 minutes each) delivered in the participant's regional language, following a problem-solving therapy protocol adapted culturally.
- **Control Group:** Identical protocol delivered in English by counselors proficient in English.

Outcome Measures

- **Primary Outcome:** Change in Kessler Psychological Distress Scale (K10) score from baseline to eight-week follow-up.
- **Secondary Outcomes:** Client Satisfaction Questionnaire (CSQ-8) at four weeks; referral uptake rate (percentage attending at least one referred service) by eight weeks; qualitative interviews at week eight.

METHODOLOGY

Counseling Protocol Development

Counseling scripts were translated and back-translated using standard procedures. Local mental health experts reviewed cultural relevance. Counselors underwent a two-week intensive training on problem-solving therapy and crisis management, with cultural competence modules.

Data Collection Procedures

- **Baseline Assessment:** Upon consent, participants completed demographic questionnaires and the K10 via structured telephone interview.
- **Session Monitoring:** All sessions were audio-recorded (with permission) to monitor fidelity. Supervisors rated 10% of calls using the Counselor Adherence Scale (CAS).
- **Follow-Up Assessments:** At four and eight weeks post-baseline, blinded research assistants administered K10 and CSQ-8. Referral logs were maintained to track service uptake (e.g., outpatient appointments).
- **Qualitative Interviews:** A purposive subsample of 90 participants (30 per site, balanced by group) underwent semistructured interviews exploring experiences, perceived benefits, and suggestions for improvement.

Statistical Analysis

Intention-to-treat analyses were conducted. Continuous outcomes (K10, CSQ-8) were compared using mixed-effects linear models adjusting for baseline scores and site. Referral uptake (binary) was analyzed via

mixed-effects logistic regression. Missing data were handled via multiple imputation (m = 20). Qualitative data underwent thematic analysis following Braun and Clarke's six-phase framework.

RESULTS

Participant Flow and Baseline Characteristics

Of 1,450 callers screened, 1,200 met eligibility and were randomized (600 per arm). Follow-up rates were 93% at four weeks and 89% at eight weeks, with no differential attrition by arm (p = 0.42). Demographics were balanced: mean age 36.4 years (SD = 11.2), 52% female, 68% urban residents, mean baseline K10 = 28.7 (SD = 5.1).

Primary Outcome: Psychological Distress

The regional-language group exhibited a mean K10 reduction of 7.2 points (SD = 4.6) versus 4.3 points (SD = 4.9) in the English group. Adjusted mean difference = –2.9 (95% CI: –3.4 to –2.4, p < 0.001). Effects were consistent across sites.

Secondary Outcomes

- **Client Satisfaction (CSQ-8):** Regional-language mean = 27.5 (SD = 3.2); English group = 22.1 (SD = 4.1). Adjusted difference = 5.4 (95% CI: 4.9 to 5.9, p < 0.001).
- **Referral Uptake:** 68% of regional-language participants attended at least one referral versus 43% of English. Adjusted OR = 2.7 (95% CI: 2.1–3.4, p < 0.001).

Fidelity and Adherence

Counselor adherence scores averaged 93% (SD = 4%), with no differences by language. Session duration and number were equivalent across arms.

Qualitative Findings

Three major themes emerged:

1. **Enhanced Rapport and Trust:** Participants valued being understood in their mother tongue, reporting "felt truly heard" and "no translation gap."
2. **Cultural Resonance:** Use of local idioms and culturally relevant examples facilitated clearer problem articulation.
3. **Empowerment and Self-Efficacy:** Regional-language counseling fostered greater self-confidence to seek further help.

CONCLUSION

This multicenter randomized trial provides robust evidence that regional-language helplines markedly outperform English-language helplines in reducing psychological distress, boosting service satisfaction, and increasing referral uptake among distressed callers in India. The magnitude of effect—nearly three-point greater reduction in K10 scores and 25% higher referral follow-through—underscores the clinical and public health significance of linguistic accessibility. Qualitative insights reveal that linguistic concordance not only eases communication but also conveys cultural empathy, strengthening the therapeutic alliance.

Implications for Practice and Policy:

1. **Scale-Up Multilingual Infrastructure:** Mental health authorities should invest in expanding regional-language helplines, ensuring coverage across all major linguistic groups.
2. **Integrate Cultural Competence in Training:** Counselor training programs must incorporate modules on cultural idioms, belief systems, and stigma across regions.
3. **Leverage Technology for Outreach:** Mobile applications and chatbots offering regional-language support could complement voice helplines, reaching younger demographics.
4. **Continuous Evaluation:** Ongoing monitoring using standardized outcome measures and periodic trials can guide service refinement.

Limitations and Future Research:

Although this trial spanned three linguistically distinct states, findings may not generalize to dialect-specific or tribal languages. Future studies should explore cost-effectiveness analyses, longer-term outcomes, and integration with in-person services. Additionally, research on digital modalities (e.g., WhatsApp counseling in regional scripts) could expand access further.

In conclusion, regional-language helplines represent a potent, scalable strategy to close linguistic and cultural gaps in mental health care. By speaking the caller's language—both literally and figuratively—services can achieve deeper engagement, improved outcomes, and greater equity in mental health support.

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