



Use and Outcomes of the 1926 National Mental Health Helpline During the COVID-19 Pandemic in Sri Lanka

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Abstract

Background: The COVID-19 pandemic significantly impacted global mental health, necessitating accessible support services. In Sri Lanka, the 1926 National Mental Health Helpline played a crucial role during the pandemic and associated lockdowns. This study aimed to assess the mental health needs of its users and the outcomes of the helpline's interventions during this period.

Methods: A descriptive cross-sectional study was conducted with 401 users of the 1926 National Mental Health Helpline between March 20th and June 20th, 2020. Data were collected via interviewer-administered structured forms and a 10-item user satisfaction questionnaire. Statistical analysis was performed using SPSS version 23.0 to describe demographic characteristics, reasons for seeking help, interventions provided, and satisfaction levels.

Results: The majority of users were female (56.8%) and married (73.7%). Mental health concerns/information (50.8%), relationship issues (12.7%), and emotional issues (10.0%) were the primary reasons for seeking help. Reassurance (61.1%) and counseling (27.7%) were the most common interventions. A high proportion of users reported receiving the support they needed (72.1%), found operators polite and helpful (96.7%), and were overall satisfied with the service (85.0% extremely or very satisfied). Help-seeking for child mental health ($p=0.010$), relationship issues ($p=0.015$), and emotional issues ($p=0.034$) was significantly higher among females.

Conclusion: The COVID-19 pandemic severely impacted the mental health of the Sri Lankan population, with the 1926 helpline providing substantial support for diverse mental health needs. The high user satisfaction underscores its effectiveness and importance as an accessible mental health resource during crises. These findings highlight the need to strengthen and promote such services for future public health emergencies.

Introduction

The COVID-19 pandemic profoundly impacted global mental health, underscoring the need for accessible support services [1, 2]. Lockdowns and social isolation exacerbated existing mental health concerns, leading to potential long-term issues [3]. Telephone helplines emerged as crucial tools for timely and effective mental health management during this crisis, affecting all segments of the population, from the general public to frontline workers [4, 5]. Global studies revealed diverse helpline call patterns, with some focusing on quarantine issues [6] and others noting male callers with anxiety [7]. In Sri Lanka, the 24/7 National Mental Health Helpline (1926), launched in 2018 by the National Institute of Mental Health (NIMH), became instrumental during the COVID-19 outbreak [8]. This study aims to assess the use and outcomes of the 1926 Helpline during the pandemic in Sri Lanka, informing future crisis preparedness.

Design

This descriptive cross-sectional study provided a snapshot of mental health needs among 1926 helpline users and the effectiveness of its interventions during the COVID-19 pandemic and lockdown in Sri Lanka. This design efficiently collected data from a large sample, enabling the description of mental health patterns and helpline utility.

Methods

Study Setting

The study was based at the 1926 National Mental Health Helpline center in Angoda, Sri Lanka.

Study Population Users of the 1926 National Mental Health Helpline during the COVID-19 pandemic period.

Inclusion Criteria

1926 helpline users from March 20th to June 20th, 2020.

Exclusion Criteria Incomplete calls, untraceable callers, users aged below 18 years, and callers lacking capacity to consent.

Sample Size Calculation and Sampling Method

A simple random sampling method was used. The sample size was calculated using the formula by Lwanga and Lemeshow[9]: $N = \frac{Z_{1-\frac{\alpha}{2}}^2 p(1-p)}{d^2}$ With $Z=1.96$, $P=0.5$, $d=0.05$, the minimal sample size was 385. Adjusting for a 20% non-response rate, the total required sample size was 482. A total of 401 participants were included in the final analysis.

Study Instruments

1. Structured Data Collection Form: Captured demographics, reasons for accessing the helpline, and interventions.
2. 1926 National Mental Health Helpline User Satisfaction Questionnaire: A 10-item questionnaire assessing user satisfaction on a 6-item Likert scale.

Procedure of Data Collection

Trained data collectors identified eligible participants via phone calls, explaining the study. Consenting individuals spoke with the principal investigator for recruitment and received written information via post. Relevant caller sheets were traced, and data collectors administered both forms.

Data Analysis

Statistical analysis was performed using SPSS version 23.0. Descriptive statistics (frequencies, percentages) summarized demographics, reasons for seeking help, interventions, and satisfaction. Associations between demographic factors and reasons for seeking help were explored using appropriate statistical tests (e.g., chi-square tests), with $p < 0.05$ considered significant.

Ethical Considerations

Ethics approval was obtained from the Ethics Review Committee of the National Institute of Mental Health (NIMH), Sri Lanka. Permission was also sought from the Director of NIMH and the Consultant Psychiatrist in charge of the helpline. Verbally informed consent was obtained from all participants after assessing capacity. Confidentiality of data was ensured through secure storage and password protection.

Benefits and Risks to Participants.

Potential psychological distress during interviews was managed by providing adequate support and referral for psychiatric assessment when needed. No risks to researchers were identified.

Dissemination of Project Outcomes.

Outcomes were planned for publication in a peer-reviewed journal.

Conflict of Interest

None declared.

Results

This chapter details the demographic characteristics, reasons for contacting the helpline, interventions, and satisfaction levels of the 401 study participants.

Demographic Characteristics

Table 1 presents the demographic profile. The mean age was 44.86 years. Females constituted the majority (56.8%), and most participants were married (73.7%).

Table 1: Demographic Factors (N=401)

Demographic Factor	Frequency (n)	Percentage (%)
Age	(Mean) - 44.86	20-39 = 45.6 40-59 = 40.1 >60 = 14.3
Gender		
Male	173	43.3
Female	227	56.8
Marital Status		
Single	95	24.0
Married	292	73.7
Separated	6	1.5
Divorced	3	0.8

Figure 1 illustrates educational levels: A/L (45.4%), Tertiary (25.6%), O/L (22.6%), and up to Grade 8 (6.5%).

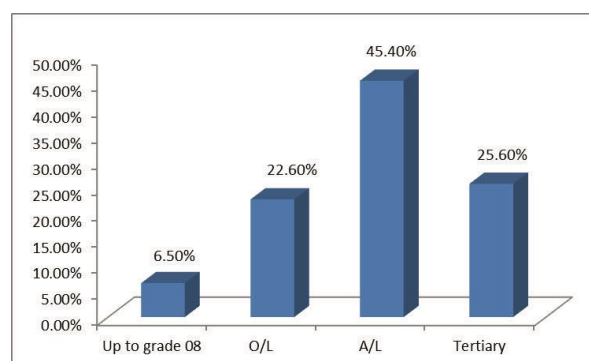


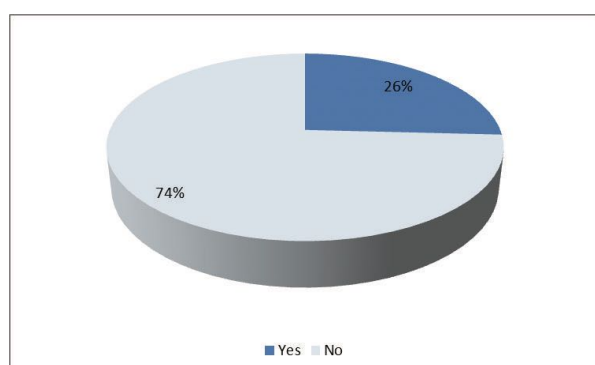
Figure 1: Distribution of Education Level

Table 2 shows occupations: Professional managers/technicians (28.5%), housewives (23.9%), and unemployed (16.3%) were the largest groups.

Figure 2 indicates that 74% had no prior psychiatric diagnoses, while 26% did.

Table 2: Type of Occupation (N=393, missing 8 responses)

Occupation	Frequency (n)	Percentage (%)
Professionals, Managers, Technicians	112	28.5
Clerical support workers	51	13.0
Skilled agricultural forestry fishery workers	37	9.4
Plant and machine operators	9	2.3
Elementary occupations	13	3.3
Armed forces occupations	13	3.3
Housewife	94	23.9
Unemployed	64	16.3

**Figure 2: Diagnosis of Psychiatric Illness**

Reasons for Seeking Help

Table 3 shows mental health concerns/information (50.8%), relationship issues (12.7%), and emotional issues (10.0%) were primary reasons. Suicidal ideation was reported by 6.0%.

Table 3: Reasons for Seeking Help (N=401)

Variable	Frequency (n)	Percentage (%)
MH concerns/Information	203	50.8
Domestic Violence	10	2.5
Information Regarding Other Services	51	12.7
Suicidal ideation	24	6.0
Child Mental Health	16	4.0
Information regarding media	40	10.0
Alcohol (Only alcohol takers)	22	5.5
Relationship issues	51	12.7
Ideas of harming others	7	1.7
Cyber related issues	1	0.2
Sexual Problems	4	1.0
Emotional issues	40	10.0
Psychological first aids	14	3.5
Other	17	4.2
Ambulance	18	4.5
Covid 19	13	3.2
Academic Related	2	0.5
Other Substances+Alcohol (Poly substance - cannabis)	14	3.5

Interventions Provided by the Helpline

Table 4 shows reassurance (61.1%) and counseling (27.7%) were most frequent. OPD referrals were 29.8%.

Table 4: Distribution of Intervention (N=401)

Intervention	Frequency (n)	Percentage (%)
OPD	117	29.8
Health care facility	41	10.2
Counseling	111	27.7
Call with MO (Medical Officer)	59	14.7
Call with Reg/SR (Registrar/Senior Registrar)	7	1.8
Call with consultant	10	2.5
Home visit	1	0.2
CPN/PSW (Community Psychiatric Nurse/Psychiatric Social Worker)	47	11.7
Listening /reassured	245	61.1
Police	14	3.5
GBV (Gender Based Violence)	6	1.5
Other	57	14.2

Helpline Accessibility and User Satisfaction

Table 5 details accessibility and perceptions. Most (77.3%) contacted on the first attempt. High percentages reported receiving needed support (72.1%), polite operators (96.7%), adequate time (90.3%), and understanding (84.0%). Most (87.5%) felt better able to cope, and 96.0% would recommend the service.

Table 5: Method of Helpline and its Accessibility (N=401)

Factor	F (n)	(%)
Method of finding out about the 1926 helpline		
Another person	98	24.7
Organization	81	20.4
Television	90	22.7
Newspaper	37	9.3
Internet	75	18.9
Other	16	4.0
Accessibility		
Ability to contact the helpline at individuals' first attempt at dialing	300	77.3
No. of participants tried more than one attempt to contact helpline	8	12.7
No. of individuals who were called back by helpline	2	33.3
No. of participants who received the support they needed	279	72.1
No. of participants who accepted that operator is polite and helpful	384	96.7
Calling for themselves or on behalf of someone else		
Self	249	62.3
Someone else	151	37.8
No. of participants accepted that they were given adequate time to talk about their difficulties	361	90.3
No. of participants accepted that the person who answered call understood their problem	336	84.0
No. of participants who were in a better position to cope with their problem after calling the helpline	351	87.5
No. of participants recommend this helpline to another person	383	96.0

Table 6: Satisfaction of Service of the 1926 Helpline (N=401)

Satisfaction Levels regarding the Service of the 1926 Helpline	Frequency (n)	Percentage (%)
Extremely satisfied	182	45.5
Very satisfied	158	39.5
Somewhat satisfied	40	10.0
Somewhat dissatisfied	5	1.3
Very dissatisfied	6	1.5
Extremely dissatisfied	9	2.3

Overall satisfaction levels are in Table 6. Most (85.0%) were extremely or very satisfied.

Associations between Demographic Factors and Reasons for Seeking Help (Selected Findings).

Age was significantly associated with relationship issues ($p=0.042$), with the 20-39 age group showing higher rates (16.9%). Gender significantly correlated with help-seeking for child mental health ($p=0.010$), relationship issues ($p=0.015$), and emotional issues ($p=0.034$), all higher among females (Table 9). The Internet was a common source for 20-39 year olds (26.5%), while television was for older groups (Table 8). Most males (61.0%) and females (63.0%) called for themselves. Age was significantly associated with relationship issues ($p=0.042$), with the 20-39 age group showing higher rates (16.9%). Gender significantly correlated with help-seeking for child mental health ($p=0.010$), relationship issues ($p=0.015$), and emotional issues ($p=0.034$), all higher among females. The Internet was a common source for 20-39 year olds (26.5%), while television was for older groups (Table 8). Most males (61.0%) and females (63.0%) called for themselves.

Discussion

The COVID-19 pandemic severely impacted global mental health, underscoring the vital role of accessible support services during crises [2, 10]. The 1926 National Mental Health Helpline served as a crucial resource in Sri Lanka, addressing diverse needs exacerbated by lockdowns and lifestyle changes [8, 11]. Our study found mental health concerns, relationship issues, and emotional distress were primary reasons for contact, aligning with the broader psychological impact of the pandemic.

Comparison with Similar Studies and Global Perspectives

Our findings resonate with global helpline studies. For instance, a Greek helpline reported distress from confinement and social changes [6], consistent with our observations on relationship and emotional issues. While a Bangladesh study noted male callers predominantly [7], our study found more female callers, particularly for domestic violence, child mental health, and emotional issues. This gender disparity may reflect Sri Lanka's socio-cultural context or higher prevalence of these issues among females during lockdown [12]. The significant proportion of professional managers and technicians seeking help (28.5%) offers a unique insight. While healthcare professionals globally faced immense mental health burdens [5], our focus on the general public suggests that remote work and reduced social interactions negatively impacted the well-being of other professional groups, likely a global phenomenon. Our finding that younger users accessed the helpline via the Internet, while older users preferred television, highlights universal trends in media consumption [13]. This underscores the need for multi-platform awareness campaigns to ensure equitable access to mental health services across all demographics. The high satisfaction reported by 1926 helpline users (85%) is consistent with the general efficacy of mental health helplines worldwide, which serve as accessible, low-barrier points of contact for individuals in distress [14]. This positive feedback indicates the helpline's crucial contribution during the pandemic.

Lessons for Medical Administrators/Health System Managers

This study offers critical lessons for medical administrators and health system managers:

1. **Proactive Mental Health Preparedness:** Helplines are vital for disaster preparedness. Administrators must advocate for and resource such infrastructure proactively.
2. **Strategic Resource Allocation:** Ensure sustainable funding and human resources for training operators, maintaining technology, and integrating helplines with broader mental health referral pathways.
3. **Data-Driven Service Improvement:** Utilize helpline data to identify needs, vulnerable

groups, and effective interventions, informing policy and resource allocation.

4. Multi-Channel Communication: Disseminate awareness campaigns through diverse media (Internet, television) to maximize reach across all demographics.
5. Addressing Staff Mental Well-being: Proactively implement support systems for healthcare staff to ensure workforce resilience.
6. Integration within Health System: Facilitate seamless integration of helplines with primary care, specialized mental health services, and social support networks for comprehensive, continuous care.

Limitations

This study's limitations include its cross-sectional design (limiting causality and temporal changes), data collection over a three-month period (limiting generalization to the entire pandemic), and a focus on reasons for contact rather than in-depth clinical assessment. The inability to explore reasons for dissatisfaction also presents a limitation. Despite these, the study provides valuable knowledge on mental health issues during COVID-19 and the helpline's effectiveness.

Conclusions

The COVID-19 crisis significantly impacted Sri Lankan mental health, with the 1926 National Mental Health Helpline providing substantial support for diverse needs. High user satisfaction underscores its effectiveness and importance as an accessible mental health resource during crises.

Recommendations

1. Strengthen and Promote Helpline Services: Continuously resource and promote the 1926 Helpline for sustained functioning during future crises.
2. Targeted Awareness Campaigns: Implement multi-platform campaigns to enhance accessibility across all demographics.
3. Address Gender-Specific Needs: Develop services catering to females for domestic violence, child mental health, relationship, and emotional issues.

4. Continuous Training for Operators: Ensure ongoing, in-depth training for helpline operators.
5. Policy Development: Guide policymakers with evidence-based findings to ensure accessible and comprehensive mental health support.
6. Future Research: Conduct qualitative and longitudinal research to explore dissatisfaction and long-term impacts.

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