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A Study To Assess Efficacy Of Community Based Intervention For Empowering Community Leaders For Rendering Mental Health First Aid To People In Crisis

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Abstract

Introduction: India is currently facing a looming mental health crisis, with a significantly higher number of individuals experiencing mental health issues with anxiety and depressive disorders the most common. Researches demonstrated that the mental health first aid (MHFA) program effectively enhances participants' knowledge of mental health, fosters more positive attitudes, and encourages supportive behaviours towards individuals facing mental health challenges. Community leaders including ASHAs can play a useful role in rendering basic mental health first aid skills to the people with mental crisis as they are link or bridge between the rural and vulnerable population within the health service centres and mostly accepted by the community. There is lack of knowledge, attitude and practice (competency) assessment tool regarding MHFA for ASHAs in English as well as in Marathi. Objectives: To generate, validate and test for reliability of the knowledge, attitude and practices/competency regarding MHFA (KAP (C)-MHFA) assessment tool. To test efficacy of community-based intervention regarding MHFA (CBI-MHFA) training program for empowering community leaders to help people in crisis by piloting. To evaluate and compare the efficacy of CBI-MHFA training program as against conventional method in improving knowledge, attitude and practices (competencies) of community leaders in rendering Mental health first aid to people in crisis. To find out correlation between knowledge, attitude and practices (competencies) among the community leaders regarding MHFA. Methodology: Randomized two parallel arm interventional study design was used for the study. 165 ASHAs were randomly allocated to control and experimental group. After loss 150 were finally analysed. Study conducted in 2 phases. In first phase the KAP (C) MHFA tool (Marathi) was developed, validated and tested for reliability and also CBI-MHFA training program (Marathi) was developed and tested its efficacy by piloting. In second phase, efficacy of CBI-MHFA training program was evaluated and compared as against conventional method. Results: Significant improvement in knowledge, attitude and competency score was observed in experimental group as compare to control group as $p<0.01$. The improvement % of knowledge, attitude and practice (competency) in experimental compared to control group at good/most favourable category was 40.1%, 41.4% & 56% respectively, which is higher than the efficacy margin of 40%. Thus rejected the null hypothesis & accepted the alternative hypothesis, that the CBI-MHFA is clinically efficacious for improvement of knowledge, attitude and practices (competency) of community leaders to render Mental Health First Aid to people in crisis as against conventional method. Conclusion: Generated KAP (C)-MHFA Marathi assessment tool was valid and reliable. The CBI- MHFA training program was found to be clinically efficacious in empowering community leaders to render MHFA to people in crisis.

Keywords: *Mental Health First Aid, MHFA, Mental health crisis, Community based intervention, Community leaders and ASHA Workers.*

INTRODUCTION:

In every country, mental health conditions are highly prevalent, affecting approximately one in eight people worldwide. The prevalence of various mental disorders varies based on sex and age. Both males and females commonly experience anxiety disorders and depressive disorders. Suicide impacts individuals and their families across all countries and age groups. Globally, there may be about 20 suicide attempts for every death by suicide, making it responsible for more than one in every 100 deaths. Notably, it is a significant cause of mortality among young people. Numerous factors hinder individuals from seeking help for mental health conditions, including inadequate quality of services, low levels of health literacy in mental health, and stigmatization and discrimination. In many regions, formal mental health services are absent, and even when available, they are often inaccessible or unaffordable. Consequently, individuals may choose to endure mental distress without seeking relief to avoid the discrimination and ostracization associated with accessing mental health services.[1]

The medical field has made significant advancements in the past century, including the field of psychiatry. However, a large portion of the global population still faces challenges in accessing even basic mental healthcare. Simple interventions, such as empathic listening, can have significant mental health benefits, even though they may not appear as dramatic as cardiopulmonary resuscitation. It's crucial to acknowledge that approximately a quarter of all adults will experience mental health problems at some point in their lives. Consequently, considering the available resources, there is a pressing need to develop mental health first aid on a large scale.[2]

Early detection of mental health issues offers individuals the chance for improved long-term outcomes when timely intervention is implemented. Mental health literacy, a related concept, is increasingly recognized as a crucial gauge of awareness and knowledge concerning mental health disorders. A cross-sectional study was conducted among a randomly selected group of pre-university college students (n = 916). Among the 916 respondents, 54.15% were male, while 45.85% were female. The majority (78.60%) of the participants identified with the Hindu religion, mostly hailed from rural areas (57.21%), and were primarily studying in the 11th standard (72.49%). The study revealed a notably low percentage of mental health literacy among the respondents, with only 29.04% being able to identify depression and a mere 1.31% recognizing schizophrenia/psychosis. These findings suggest that there is a prevailing lack of awareness and understanding of mental health conditions among adolescents. Interestingly, the study also revealed that adolescents were more inclined to seek support from informal sources, such as family members, particularly mothers, than from formal resources, highlighting the persisting stigmatization of mental health issues. The results emphasize an urgent need for enhancing adolescents' mental health literacy. This implies the development of programs that equip adolescents to seek help from reliable sources should the need arise and provide them with the necessary knowledge about whom to approach for assistance.[3]

Mental Health First Aid (MHFA) refers to the assistance provided to an individual who is either undergoing the initial stages of a mental health issue, facing a deterioration in an existing condition, or experiencing a mental health crisis. This initial support is administered until the person receives suitable professional help or until the crisis is resolved.[4] The primary objectives of mental health first aid are multifaceted. First and foremost, it aims to safeguard individuals facing potential harm, ensuring their well-being and safety. Additionally, it seeks to offer assistance in preventing the escalation of mental health issues, thus preventing them from worsening. Moreover, it strives to actively promote the recovery of optimal mental health. Lastly, Mental Health First Aid (MHFA) gives you the skills and an Action Plan so you know just what to do in that situation. The MHFA Action Plan (ALGEE) is a step-by-step action plan to use when providing support to someone who may be experiencing a distressing situation.

The MHFA Action Plan has five steps, which can be used in any order.[5]

- A –Approach, assess and assist with any crisis.
- L – Listen non judgmentally.
- G –Give reassurance and information.
- E – Encourage appropriate professional help.
- E – Encourage self-help and other support strategies.

Community leaders including accredited social health activists (ASHA) as backbone of NRHM program, an integral part of social life in the villages of India, acts as a link between community and the health care system. They create awareness and provide information to community.[6] ASHAs are to function as a 'Link worker', a bridge between the rural and vulnerable population within the health service centers.[7] Study reported that improving community health extension workers' competence and knowledge was important to address the problem and to tackle stigma and discrimination regarding mental health.[8]

As community leaders including ASHAs are well accepted by the community due to trustworthy relationship they served as liaisons between persons with mental illness and primary health centre (PHC) staff including home visits and reminding patients about appointments. Community leaders like ASHAs can provide effective MHFA to the people in mental crisis if they properly trained. Existing Mental Health Literacy Scale could not be used for the study because the study intended to assess the knowledge regarding mental health first aid among the community leaders. The existing MHLS is able to assess the knowledge about the mental health in the domains of symptoms, risk factors, knowledge of ability to treat self with non-pharmacological methods, knowledge of help that is available and ability to seek that help and also the knowledge about where to seek the information regarding mental health help in times of needs. However, the need of the current study was to seek and empower the community leaders in the area of mental health first aid. Mental health first aid covers a very specific areas of crisis situations and the help to be rendered during the situation. Simple language and short precise sentences suited for the educational level of ASHAs and other community leaders, which is easy to understand, need to be formed in tool. There is lack of standard tool for the assessment of knowledge, attitude and practice (competency) of community leaders to render mental health first aid to people in crisis. So, the investigator felt a need to develop knowledge, attitude and practices in terms of competency assessment tool regarding mental health first aid (KAP (C)-MHFA) and assessing the efficacy of community-based intervention (CBI) for empowering community leaders for rendering MHFA to help people in crisis.

Rationale of the study:

- Generating and validating knowledge, attitude and practices (competency) assessment tool (KAP (C)-MHFA) and community-based intervention program to empower community leaders to render MHFA effectively to the people in their community who are experiencing mental crisis.
- To generate evidence for efficacy of intervention program (CBI-MHFA) to empower community leaders to render MHFA.

The research study was conducted in two phases

Phase I: -

- Generation and validation of the newly developed Knowledge, Attitude and Practices (competencies) assessment tool regarding MHFA (KAP(C)-MHFA- Marathi)
- Generation and validation of Community based intervention program regarding MHFA (CBI-MHFA-Marathi)

Phase II: -

- Evaluation of the efficacy of community-based intervention program regarding MHFA (CBI-MHFA-Marathi) to empower community leaders (ASHAs) for rendering MHFA to people in crisis.

AIM & OBJECTIVES:

Phase I:

Aim:

To generate, validate and test for reliability of the KAP(C)-MHFA assessment tool and test efficacy of CBI-MHFA program through pilot study.

Objectives:

1. To generate KAP(C)-MHFA tool for empowering community leaders to help people in crisis.
2. To validate KAP(C)-MHFA tool and CBI-MHFA program for empowering community leaders to help people in crisis.
3. To assess the reliability of KAP(C)-MHFA tool for empowering community leaders to help people in crisis.

4. To test efficacy of CBI-MHFA program for empowering community leaders to help people in crisis by piloting.

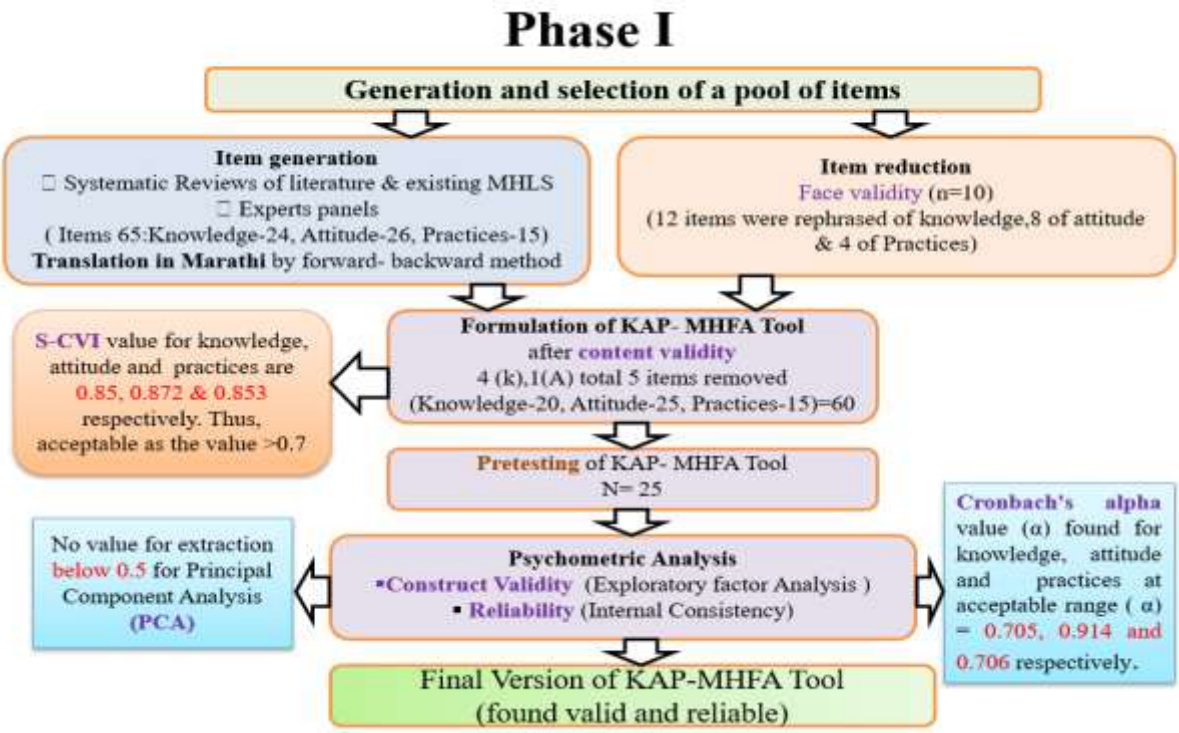

Figure 1: Flow chart showing process applied in the development and validation of KAP (C)-MHFA Tool

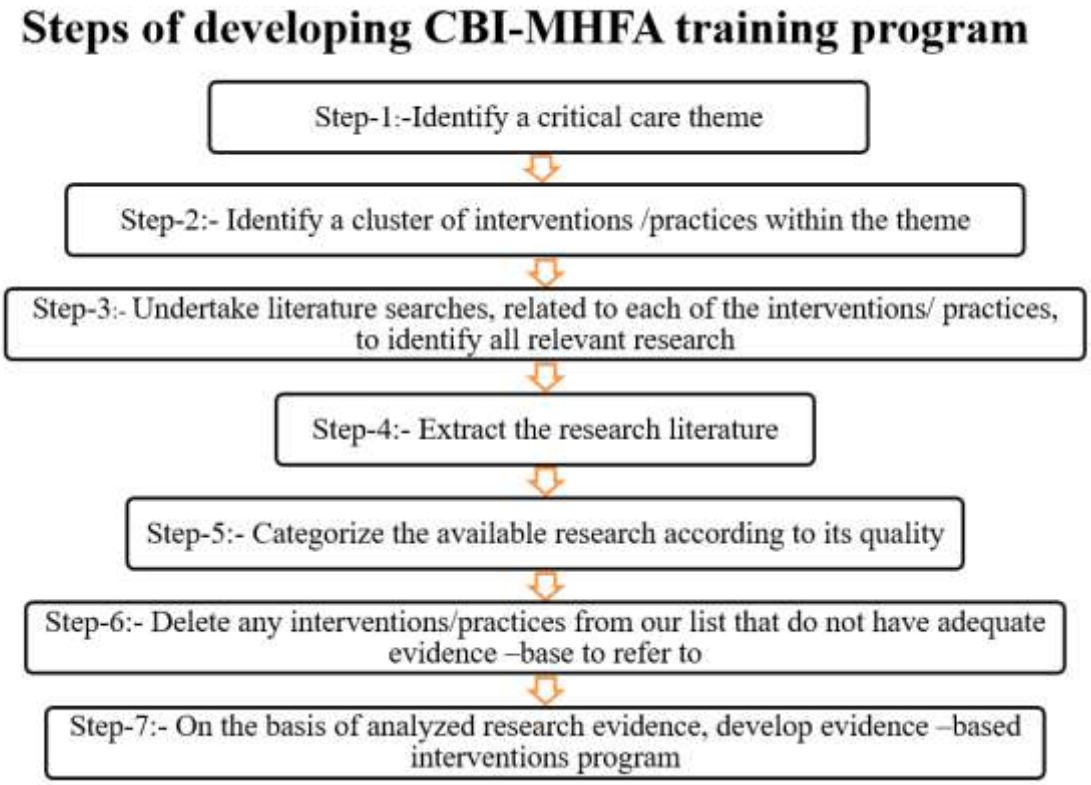

Figure 2: Flow chart showing steps of developing CBI-MHFA training program

RESULTS OF PILOT STUDY:

Pilot study conducted among 25 ASHA workers.

Sr No.	Parameters	Post test	Pre test	% Difference
1	Knowledge	65.60%	33.2%	33.4%
2	Attitude	90.84%	67.76%	23.08%
3	Practices (Competencies)	71.2%	30.93%	40.27%

Effect size (%) for improvement predicted = 40%

The generated CBI- MHFA training program found to be valid and reliable.

Phase II:

Aim:

To evaluate and compare the efficacy of CBI-MHFA training program as against conventional method in improving knowledge, attitude and practices (competency) of community leaders in rendering Mental health first aid to people in crisis.

Objectives:

1. To assess the knowledge, attitude and practices (competencies) of community leaders in control and experimental group at baseline.
2. To assess and compare the improvement in knowledge, attitude and practices (competencies) of community leaders in both groups (Pre and Post).
3. To compare the improvement in knowledge, attitude and practices (competencies) of community leaders in interventional group (CBI-MHFA) as against control group.
4. To find out correlation between knowledge, attitude and practices (competencies) among the community leaders regarding MHFA in both groups.

Generated hypothesis:

(Null Hypothesis)

H_{01}: The CBI-MHFA is not clinically efficacious for the improvement of the knowledge of community leaders to render Mental Health First Aid to people in crisis as against conventional method.

H_{02}: The CBI-MHFA is not clinically efficacious for the improvement of the, attitude of community leaders to render Mental Health First Aid to people in crisis as against conventional method.

H_{03}: The CBI-MHFA is not clinically efficacious for the improvement of the practices (competencies) of community leaders to render Mental Health First Aid to people in crisis as against conventional method.

(Alternative Hypothesis): -

H_1: The CBI-MHFA is clinically efficacious for the improvement of knowledge of community leaders to render Mental Health First Aid to people in crisis as against conventional method.

H_2: The CBI-MHFA is clinically efficacious for the improvement of attitude of community leaders to render Mental Health First Aid to people in crisis as against conventional method.

H_3: The CBI-MHFA is clinically efficacious for the improvement of practices (competencies) of community leaders to render Mental Health First Aid to people in crisis as against conventional method.

MATERIAL AND METHODS:

Research Design: Randomized two parallel arm interventional study

Research Setting: Wardha district, Maharashtra, India

Study participants: Community leaders (ASHA Workers from different PHCs)

Variables:

Demographical variables: Age, education, income and work experience

Outcome Variables: Knowledge, Attitude and Practices (Competency)

Eligibility Criteria:

Inclusion Criteria:

- ASHA workers who have given informed written consent to participate in study.
- Must primarily be a resident of the village
- Who can read, write and comprehend Marathi

Exclusion criteria:

- ASHA workers who have undergone mental health training program

Sample size estimation:

$$N = \frac{\left(Z_{(\alpha/2)} + Z_{\beta}\right)^2 (P_1(1-P_1) + (P_2(1-P_2))}{(P2-P1)^2}$$

$$Z_{\alpha/2} = at\ 99\ \%\ \ (CI) = 2.576\ at\ typeIerror\ (\ 1\%)$$

Represents the desired level of statistical significance

$Z_{\beta} = 2.376$: Represents the desired power = 2.376 for 99 %

$$N = \ \ Minimum\ sample\ required\ for\ each\ group$$

Where,

Knowledge pre score% =33.2% (As pilot study)

Knowledge post score% =73.2 % (Expected)

At Level of significance at 1 % & power 99 %

Minimum sample size required

N= (2.576 +2.376)2 (0.332) * (1-0.332) + (0.732) * (1-0.732)/ (0.40) ^2 = 64 per group

Considering 15% sample size drop out = 10

Total sample size required =64 + 10 =74 per group

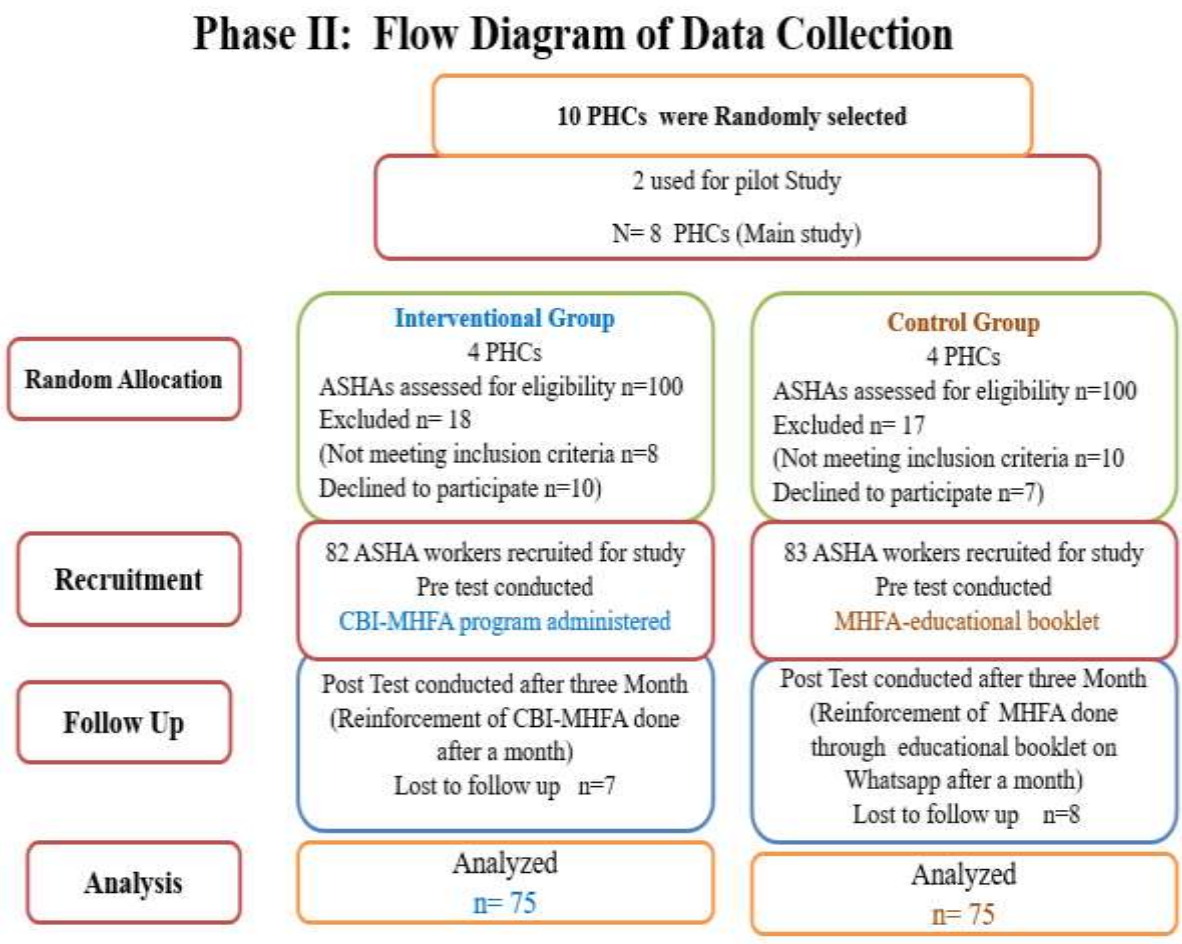

Fig 3: Flow diagram of data collection

Description of Newly developed KAP-MHFA Assessment tool:

Domains	No. of Item	Nature of item	Content
Knowledge Questionnaire	20	Structured questionnaire with multiple choice options. Scoring system: score 0 for every wrong response and score 1 for every correct response. Knowledge score categorized as Poor (0 to 33.33%), Average (33.33 to 66.66%) and Good (66.6 to 100%)	Meaning of mental health, characteristics of mentally healthy person, common mental health disorders, recognition of mental illness, professional help, MHFA & MHFA action plan (ALGEE)
Attitude Scale	25	5-point Likert scale with responses: Never, once in a while, Sometimes, most of the times and always with scores ranging from 0 to 4 assigned to each questions respectively. A value of 4 is assigned for the most ideal response, while non-ideal response is assigned with a value of 0. Attitude score categorized as unfavorable (0 to 33.33%), favorable (33.33 to 66.66%) and most favorable (66.6 to 100%). Reverse scored items: 4, 5 and 7	Views, perceptions, beliefs, thoughts, intentions, attitude towards mental health problems, Myths and stigmatizing behavior, Attitudes that promote the recognition, First aid skills, professional help and appropriate help-seeking behavior, beliefs and self-help strategies.
Practices (Competency) Checklist	15	Assessment of practices (competency) based on OSCE checklist in yes or no options with scoring 0, and 1 for wrong and right action respectively. The total score of competencies varied from 0 (minimum) to 15 (maximum). Competency score categorized as Poor (0 to 33.33%), Average (33.33 to 66.66%) and Good (66.6 to 100%)	Checklist based on: Mental Health First Aid action plan based on ALGEE

The structure of Community Based Intervention-MHFA training program:

Duration	Teaching learning methods/ activities	Content
2 hours	Learning Resource Material (LRM), Lecture cum Discussions 8 Groups of 10 participants each prepared. (Named from alphabet; Group A to Group H)	Introduction of CBI-MHFA training program. Explanation regarding Meaning of Mental Health, Characteristics of mentally healthy person, confidentiality, Myths, misconception, stigmatization regarding mental illness, recognition of Various mental disorders and crisis, referral, MHFA and MHFA action Plan: ALGEE.
2 hours	Focus group discussions, Case studies, Storytelling, Role plays, Standardized patient	Focus group discussions regarding mental crisis. Case studies of depression, anxiety disorders for recognition. Short stories and role play for better understanding of crisis situation in common mental issues. Sensitizing regarding myths, misbelieves, stigmatizing behavior, professional help and, self-help strategies and MHFA

2 hours (Total 6 hours)	Demonstration of MHFA action plan (ALGEE) with Standardized/ Simulated patients, Practice of Screening of depression cases in community with PHQ- 2	Volunteers were appointed as standardized patients for depression, anxiety and suicidal behavior. The skill for delivering MHFA on standardized patients was demonstrated

RESULTS:

No significant difference was found in control and experimental groups for distribution of ASHAs according to demographic characteristics like age, education, income and field experience at baseline which indicate homogeneity of groups.

Table 1: Pre-post assessment of knowledge, attitude and competency score in control vs. experimental group (n=75+75=150)

Variables of assessment	Group	Mean (Before) B	Mean (After) A	Difference (A-B)	Difference (E-C)	P-value
Knowledge (0-20)	Control (C)	12.8000	13.7333	0.9333	3.52	<0.01
	Experimental (E)	12.2267	16.6800	4.4533		
Attitude (0-100)	Control (C)	49.1867	50.0800	0.8933	18.52	<0.01
	Experimental (E)	49.7467	69.1600	19.4133		
Practices (Competency) (0-15)	Control (C)	6.1333	6.3600	0.2267	3.1867	<0.01
	Experimental (E)	6.7333	10.1467	3.4134		

As per Table 1, Significant improvement in knowledge, attitude and competency score was observed in Experimental group as compare to control group as $p<0.01$

Table 2: Percentage Improvement in Knowledge Score in control & experimental group

Control (n= 75)				**Experimental (n= 75)**			
Percentage Criteria (Knowledge)	Before	After	Control Improvement	Before	After	Experimental Improvement	% Efficacy
Poor (0-33.33%)	5	1	5.40%	9	0	12% (Increased)	6.60 %
	6.70%	1.30%		12.00%	0.00%		
Average (33.33-66.66%)	32	28	5.40%	30	1	38.70% (Increased)	33.30 %
	42.70%	37.30%		40.00%	1.30%		
Good (66.67-100%)	38	46	10.60%	36	74	50.70% (Increased)	**40.10%**
	50.70%	61.30%		48.00%	98.70%		

The Improvement percentage of knowledge in experimental compared to Control group at good category was 40.1% which is higher than the efficacy margin of 40% as per table 2.

Table 3: Percentage Improvement in Attitude Score in control & experimental group

Control (n= 75)				**Experimental (n= 75)**			
Percentage Criteria (Attitude)	Before	After	Control Improvement	Before	After	Experimental Improvement	% Efficacy
Unfavorable (0-33.33%)	3	3	0.00%	3	0	4% (Increased)	4%
	4.00%	4.00%		4.00%	0.00%		
Favorable (33.33-66.66%)	69	68	1.30%	69	40	38.70% (Increased)	37.40%
	92.00%	90.70%		92.00%	53.30%		
Most favorable (66.67-100%)	3	4	1.30%	3	35	42 .7% (Increased)	**41.40%**
	4.00%	5.30%		4.00%	46.70%		

As per table 3, the Improvement percentage of attitude in experimental as compared to control, at most favourable category was 41.4 % which is higher than the efficacy margin of 40%.

Table 4: Percentage improvement in competency score in control & experimental group

Control (n= 75)				**Experimental (n= 75)**			
Percentage Criteria (Practices/ competency)	Before	After	Control Improvement	Before	After	Experimental Improvement	% Efficacy
Poor (0-33.33%)	30	24	8.00%	22	4	21.30% (Increased)	13.30%
	40.00%	32.00%		29.30%	5.30%		
Average (33.33-66.66%)	34	37	4%	38	11	36 % (Increased)	32 %
	45.30%	49.30%		50.70%	14.70%		
Good (66.67-100%)	11	14	4%	15	60	60.00% (Increased)	**56%**
	14.70%	18.70%		20.00%	80.00%		

The Improvement percentage of practices/competency, in experimental compared to control group at good category was 56% which is higher than the efficacy margin of 40% in table 4

Correlation Results (knowledge, attitude and practices (competency): Very Strong positive correlation was found between knowledge/ attitude, attitude/practices and knowledge/practices as r =0.827, 0.953 and 0.842 respectively.

Conformity with hypothesis: (After 6 steps Hypothesis testing)

The CBI-MHFA training program is clinically efficacious for 40% efficacy over the improvement of knowledge, attitude and Practices (competency) of community leaders to render Mental Health First Aid to people in crisis as against conventional method. Results show χ^2obs = 54.33 >χ^2(critical value) =17.5755 at 40 % efficacy, thus observed value is greater than critical value (for area of rejection). Thus, rejecting the null hypothesis & accepting the alternative hypothesis, that the CBI-MHFA is clinically efficacious

for improvement of knowledge, attitude and practices (competency) of community leaders to render Mental Health First Aid to people in crisis as against conventional method.

DISCUSSION:

In present study Scale-Level Content Validity Index (S-CVI) value for knowledge, attitude and practices (competency) are 0.85, 0.872 & 0.853 respectively. Thus, acceptable as the value >0.7. In a study conducted by Joonas Korhonen et al (2019)[9] to adapt the content validity of the Mental health literacy scale (MHLS) developed by O'Connor & Casey (2015) for PHCWs in low- and middle-income contexts in South Africa and in Zambia, both Professional Research Experts (n=11) and Clinical Experts (Nurses) (n=10), totalling 21, the Scale-Level Content Validity Index (S-CVI) was ranked by PREs=0.95,CEs (Nurses)= 0.62. For Nurses it is less than S-CVI score in present study.

In present study the Cronbach's alpha of newly developed KAP (C)-MHFA tool for assessment of attitude in 5-point Likert scale was 0.914. In a cross-sectional study conducted by Mehbobeh Nejatian et al (2021)[10] aimed to evaluate the validity and reliability of the Iranian version of the MHLS with 1273 individuals. Modified version of the MHLS included 29 items with 6 attributes. Items were measured using 4- & 5-point Likert scale. Cronbach's alpha for final version of MHLS (All attributes) was 0.789, which is less than Cronbach's alpha in present study.

In present study new competency-based assessment tool (KAP (C)-MHFA) was used and also short version of MHFA suitable for community leaders was developed. This is concurrent with the recommendations suggested by Sarira El-Den, Rebekah Moles, Huai-Jin Choong, Claire O'Reilly (2020)[11] in their systematic review of 12 studies between the period 2011-2018, where they stated that most assessments relied on self-reported measures. Future studies involving different versions of MHFA training and the exploration of novel competency-based assessment methods among a diverse range of students from different countries are warranted.

The present study utilized the newly developed and validated KAP (C)-MHFA to empower community leaders in offering MHFA to individuals in crisis. Additionally, a CBI-MHFA program was developed for this purpose. The study involved a total of 150 ASHAs, with 75 participants in each group (control and experimental). The findings are consistent with a study conducted by Mehul Patel and Shobha Misra[12] in 2022, which involved 112 ASHAs (55 in the intervention group and 57 in the control group). Pre intervention mean KAP score was 46.49, after the intervention, the mean KAP score was 69.67. Mean score difference between KAP pre and post-test was 23.18. In the present study, following intervention, the mean scores for KAP were 95.99 in post-test and 68.69 in pretest. Mean score difference between KAP pre and post-test was 27.29 which is higher than the score of above said study. Also in present study, the Mean post KAP score difference in intervention and control group was 25.2267 which is much higher as compare to the 19.31 in above said study. These differences were statistically significant ($P < 0.01$).

Similarly in a study conducted by Rentala et al (2022)[13], improvement in mean knowledge & attitude score after MHFA training was 5.62 and 4.76 respectively while in present study improvement in mean knowledge & attitude score after CBI-MHFA training was 4.4533 and 19.4133 respectively which showed much higher improvement in attitude score.

The CBI-MHFA program has shown its effectiveness in enhancing the knowledge, attitude, and competency of ASHA workers. It empowers them to provide Mental Health First Aid (MHFA) to individuals experiencing crises. These findings are corroborated by a study conducted by Yaw Amankwa Arthur, Gayelene H. Boardman, Amy J. Morgan, and Terence V. McCann in 2020.[14] The authors of this study concluded that the program has the potential to improve participants' understanding of helpful interventions and recognition of depression. The positive outcomes of this program carry significant implications for public mental health, as they can promote early help-seeking behaviours and lead to better outcomes for individuals facing mental health challenges.

CONCLUSION:

The finding of this study can serve as the baseline information for further studies of such Mental Health First Aid Training by using KAP (C)-MHFA tool for early identification, prevention and first aid management and referral of person with mental illness for further professional management. CBI-MHFA

training program helps grass root level health care professionals for early identification of mental illnesses to provide MHFA. As there is no any tool developed till date in Marathi to assess knowledge, attitude and practices (competencies) of community leaders/ASHA workers to render mental health first aid to people in crisis, newly developed competency based KAP (C)-MHFA (Marathi) tool can be able to test the untested areas of mental health first aid in terms of ALGEE action plan, where the practices (competencies) can be assessed by third person. It's a user-friendly tool where unlike other MHL scale subjective bias is minimal. KAP (C)-MHFA is the first Marathi tool can be used among community leaders to assess their knowledge, attitude and competencies for rendering Mental Health First Aid. The CBI-MHFA training program was found to be clinically efficacious in empowering community leaders to render MHFA to people in crisis.

Limitations of the study:

Due to time bound manner of study, competency of community leaders (ASHAs) in rendering MHFA in actual population could not be assessed.

RECOMMENDATIONS:

KAP(C)-MHFA assessment tool needs to be validated by generating real world evidence through multi-centric pragmatic trial.

Generation of real-world evidence for efficacy of CBI-MHFA program through multi-centric pragmatic trial need to be assessed.

The application for other primary health care workers as well as community level workers will further expands its utility.

Consent and Ethical approval:

This study strictly follows the ethical guidelines established by Institution. The present study was approved by Institutional ethical committee (Ref. No. DMIMS (DU)/ IEC/2017-2018/6934 dated 17/12/2017). Informed consent was obtained from all participants, and their confidentiality was maintained throughout the study. No participant was coerced, and all were informed of their rights to withdraw at any time. Data handling was transparent, and no personal data has been disclosed. This research study aims to contribute to academic knowledge while upholding the highest ethical standards in data collection and analysis.

Competing Interests: Authors have declared that no competing interests exist.

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