ORIGINAL ARTICLE

Psychometric properties of MERIT: A concise tool for community health workers to screen priority mental disorders

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ABSTRACT

Background: Task shifting is an accepted way to address the treatment gap for mental health disorders. Community Health Workers (CHWs) can play vital roles through screening, referral, and providing basic counseling. To address the dearth of a concise screening instrument for CHWs, the "**M**ental H**E**alth Sc**R**een**I**ng **T**ool for Community Health Workers in India [MERIT]" was designed and developed. In this paper, we have examined the psychometric properties of MERIT.

Methods: MERIT consists of nine stems (consisting of 11 questions) covering the following five domains: (a) Substance Abuse (alcohol, tobacco), (b) Anxiety, (c) Depression and Somatoform symptoms, (d) Severe Mental Illnesses, and (e) Suicidal risk. MERIT can be applied to one key informant of the household to screen for all its adult members. Mental health professionals (MHPs) with community psychiatry expertise undertook the face and content validity exercise (for both English and Kannada versions; 17 and 11, respectively) and rated the 'adequacy' (ability to pick up a mental health issue) of each of the questions on a Likert scale ranging from 0 (strongly disagree) to 4 (strongly agree). For each of the domains, the item-content validity index (I-CVI) of more than 0.8 was considered adequate. Concurrent validity was examined through concordance between the screened status as per Accredited Social Health Activists (ASHAs; quintessential CHWs; n = 16; n = 116 households) and the independent clinical impression derived by seven MHPs. Inter-rater reliability (IRR) was examined by measuring the concordance between the two groups of ASHAs (first group; n = 7, second group; n = 9), who independently screened the same 116 households.

Results: All experts (for both English and Kannada versions) gave a rating of 3 or more for each of the MERIT domains. I-CVI of each domain

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was > 0.8 (0.86 for English and 0.80 for Kannada). Concurrent validity [n = 116; k = 0.792 indicating substantial agreement between ASHAs and MHPs; $P < 0.001$] and IRR [n = 115, k = 0.744; $P < 0.001$] were excellent. The specificity (97.50%), positive predictive value (92.4%), and negative predictive value (86%) were high. The sensitivity was 62.5%. On average, 5 minutes were required to administer MERIT.
Conclusion: MERIT is concise, valid, and reliable for CHWs to screen for priority psychiatric disorders among adults. While its sensitivity is comparatively lower, it can be easily integrated into public health programs as it offers the advantage of covering the entire household by interviewing one of its key informants.

Key words: Community health workers, concurrent validity, content validity, India, inter-rater reliability, mental health, screening tool

INTRODUCTION

India is the most populous country in the world, with a considerable burden of mental illnesses and a treatment gap ranging from 70% to 92%.[1] An integral component of mental healthcare delivery in low and middle-income countries is task-shifting, where Community Health Workers (CHWs) are trained and empowered to enable screening, early detection, and appropriate referral of persons with mental health issues to the nearest treatment facilities. Furthermore, these healthcare workers can be trained to provide brief psychosocial interventions to improve mental health outcomes.[2]

In India, CHWs, also called Field Level Workers (FLWs), are named variedly, including 'Auxiliary Nurse Midwives (ANMs)', 'Rural Health Organisers (RHOs)', and the quintessential ASHAs (Accredited Social Health Activists). Similar caders from sectors other than health (women and child welfare, social welfare) include Anganwadi workers and Village Rehabilitation Workers (VRWs). They are usually educated until class 10 and assume various responsibilities related to public health, including screening, referral, low-intensity non-specialist interventions, and follow-up.[3]

Mental health is a recent introduction to their work scope, particularly for ASHAs. The available literature shows that mental health can seamlessly integrate into their routine work, provided it is not perceived as an extra burden.[4-9]

Though several self-reported and healthcare worker-administered screening tools exist for various mental illnesses, they are all disorder-specific.[10] Table 1 briefly describes the available tools and their utility. Priority mental disorders in India include psychosis (schizophrenia and severe mood disorders with psychotic symptoms), depression, somatic symptom disorders (which are often idioms of distress in India), substance use disorders (especially alcohol and tobacco), anxiety disorders, and suicide. These are associated with substantial disability and costs to society.[1,11] If one has to screen for all of these, the time taken will be longer than 15 minutes, which is impractical. Furthermore, CHWs in India are overburdened.[12] Any screening tool that CHWs can use must be concise, convenient, and easy to apply. Finally, because most persons with mental illness reside with family members, it would be desirable to have a tool that can be applied to any one member of the family to screen for disorders covering everyone. This study reports the design, development, and testing of the validity and reliability of a new screening tool, abbreviated as MERIT, the "**M**ental H**E**alth Sc**R**een**I**ng **T**ool (MERIT) for Community Health Workers in India." An important difference between all other tools and MERIT is that the latter can be applied to a family as a whole and most others are for individuals. A summary of screening instruments that can be applied in primary care or community settings is listed in Table 1 below.

MATERIALS AND METHODS

MERIT was developed as a byproduct of a larger RCT[22] carried out from October 2018 to September 2021. The validity and reliability exercise was carried out between October 2020 and August 2021. The RCT compared the effectiveness of two modes of training primary healthcare staff (including ASHAs) in carrying out mental health work. The two models of training were (a) a longitudinal hybrid model of extended training and mentoring and (b) one-time classroom training. The study site was Ramanagara, a district in the Karnataka state of India which is located about 50km from National Institute of Mental Health and Neurosceinces (NIMHANS), Bengaluru. Six PHCs in the district were chosen for the RCT through simple random sampling. Three among them formed the study group (SG), and the other three formed the 'control group' (CG). Consenting 35 ASHAs were included in the SG-PHCs and 36 in the CG-PHCs. The population of adults whom Study Group ASHAs (SG-ASHAs) served was 22,623. Control Group ASHAs (CG-ASHAs) were serving 12,400 adults in their respective PHCs.[23]

Comparing the number of screened-positive persons with mental health concerns in the community was one of the outcome measures. Accordingly, two rounds of

Table 1: Review of the common screening instruments and their properties

	Tool	Disorders covered	Time taken to apply	Validated in	Use in a Community setting by a community health worker	Remarks
1	Patient Health Questionnaire (PHQ)[13]	Common Mental Disorders	3 minutes	Primary Care	Not Established	Sensitivity of 75% and Specificity of 90%
2	Family History Screen for epidemiological studies[14]	15 DSM III disorders	8 – 23 minutes	Hospital setting	Not Established	Very low sensitivity (33%) for substance abuse disorders. The tool can be administered over the telephone also.
3	The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)[15]	Substance use disorders	5-15 minutes	Primary care	Yes	Includes screening and brief interventions
4	Tobacco, Alcohol, Prescription Medication, and Other Substance use (TAPS)[16] tool	Substance use disorders	5 minutes	Primary Care	Yes	Can be applied by self or by a trained health worker
5	Self-reporting questionnaire (SRQ)[17-20]	Psychosis, non-psychotic disorders, and epilepsy	5-15 minutes	General practice and primary care setting	Yes. 8-10 years of schooling with training in primary health care and scale application	Self and interviewer-administered.
6	Symptoms in others' questionnaire[21]	Psychosis, Epilepsy, Intellectual disability, Neurosis	5-15 minutes	Community	Yes	Also detects Intellectual disability and epilepsy

house-to-house surveys (18 months apart) were completed by ASHAs to screen for priority mental disorders among the adult population residing in their catchment area. Each screened-positive (by ASHAs) person was considered a potential case[24] and was referred to the treatment center. The Symptoms in Others (SiO)[21] tool was used for the first round. Soon, we realized that ASHAs were frequently encountering persons/families with problems related to depression, somatization, and substance use, directing us to think of a new tool to cover more disorders, and hence, MERIT was thought of. The detailed methodology of the larger research is described elsewhere.[22]

Development of MERIT

Before the RCT, NIMHANS in collaboration with World Health Organisation (WHO) had developed a manual for CHWs to provide mental health intervention in the community.[5] The domains of the MERIT were adapted from the manual and were designed to screen individuals for likely mental illness through "identifying psychiatric symptoms". These domains are (a) Substance Abuse (tobacco, alcohol): one question to pick up alcohol abuse and two subquestions to study its impact on health and functioning; one question to pick up tobacco abuse; (b) Anxiety: one question to check for disabling symptoms of anxiety; (c) Sad, worried, and nervous persons: one question to screen for depression and/or somatoform symptoms; (d) Violent, fearful, and disorganized persons: 4 questions to check for symptoms of severe mental disorders; and (e): Suicidal risk: one question. The questions (given in Annexures 1 and 2 in the supplementary data) were framed by the authors after an internal discussion drawing from their work experience in communities. They were developed in both Kannada and English. The wording was kept simple to enable easy usage by the CHW (and also to facilitate easy training). Therefore, MERIT contained nine stems (11 questions) covering five domains. The questions are designed in a fashion that enables their application directly on index individuals or any key informant of a family (the latter to indicate or identify their ward/s with possible mental health issue/s). The CHW can note down details of all screened positive members (of the household) in the same screening sheet in a dedicated space provided below the screening questions.

Measures of validity and interrater reliability

Twenty-four (24) Mental Health Professionals (MHPs) with experience in community psychiatry (15 psychiatrists, 2 clinical psychologists, 2 psychiatric social workers, and 5 psychiatric nurses) were invited to take part in the face and content validity exercise of the English version of MERIT. Eleven (11) MHPs undertook the exercise for the Kannada version (9 psychiatrists, 1 clinical psychologist, and 1 psychiatric nurse). Experts were requested to examine each question of MERIT. However, they were asked to give the rating domain-wise focusing their opinion on the 'adequacy' of an item (or items put together) to enable the identification of a particular mental health issue (domain). The scoring was 0, strongly disagree; 1, disagree; 2, satisfactory; 3, agree; and 4, strongly agree. In addition to scoring, they were also requested to provide feedback and suggestions for further modifications.

Item-Content Validity Index (I-CVI) was calculated for each domain of MERIT. A rating of 3 (agree) and 4 (strongly agree) for a domain was considered appropriate and acceptable (meaning that the question/s of the domain allow the identification of a particular mental health issue). The formula for I-CVI is N^A/N, wherein N^A is the number of

experts who rated a domain 3 or 4 (i.e., agree and strongly agree) and N is the total number of experts. I-CVI above 0.8 indicates that the question/s satisfactorily identifies a mental health issue. Scores 0.70 to 0.79 will require revision, and a score <0.69 indicates that the question/s is/are inadequate and require/s removal or gross modification.[25]

Concurrent validity was examined in the following manner. As mentioned above, ASHAs had already applied MERIT to screen all adults coming under their purview (round-1). As the tool consisted of nine stems, based on the recommended guidelines, the minimum sample size was estimated to be 90 individuals (at 10 individuals for each stem).[26] For the purpose of this study, we chose 'household' as the unit of sampling. For the concurrent validity and interrater reliability exercise, 116 random households were selected from 5 villages of Ramanagara considering the logistics and feasibility of having nonjurisdictional ASHAs' cooperation in the whole exercise. These 116 households happened to have got screened by seven ASHAs (round-1). In addition to the concurrent validity interviews by the MHPs, the same 116 households were screened by a different set of nonjurisdictional ASHAs (n = 9). So, each of these 116 households were interviewed three times: first time by the jurisdictional ASHAs, next time by ASHAs of different catchment areas, and one verification by the gold standard (mental health professional) in that order.

When the MHP (gold standard; either a psychiatrist, psychiatric social worker, or a qualified nurse trained in mental health) visited the above households in-person, either the index individual or a key informant was first spoken to (whoever was available at the time of the visit). Interview was then carried out for those individuals pointed out to have a concern. The MERIT screening status (as assessed by an ASHA in terms of presence or absence of a mental health issue) of a household was compared against the MHP's assessment. The MHP was blind to the ASHAs' assessment status.

The screened status (presence or absence of a mental health issue) of every household was derived as follows: If any individual in a household was deemed positive by the gold standard but the ASHA identified different individuals within the same household as experiencing a mental health concern, we coded this eventuality as 0 for the ASHA and 1 for the gold standard. This ensured clarity in distinguishing persons where the ASHA's identification status diverged from the gold standard. In cases where multiple members of a household were screened positive by the AHSAs, the household positivity status was to be coded as 1. For such scenarios, if the gold standard identified even one person as positive, the code was to be given as 1 and if no one was identified as positive by the gold standard, the code to be given was 0. This eventuality did not arise as there was no household where the ASHA screened multiple family members as positive while the gold standard identified only one or no members as positive. However, in nine households within our sample, the gold standard identified multiple family members as positive (with a maximum of two positive cases per household). In such instances, if the ASHA worker identified even one of the two individuals flagged by the gold standard, the household positivity status was coded as 1 for both the gold standard and the ASHA worker. The Kappa coefficient for concurrent validity was computed by listing the screened status (binary data: either presence or absence of a mental health issue) of the two sets of ASHAs serially and comparing them with the status as opined by the gold standard.

For inter-rater reliability (IRR), agreement between two sets of ASHAs (16 in number) who independently assessed 116 households was examined. Each rater recorded binary data (presence or absence of a mental health issue) for every household. It was coded 1 if any member of the household was screened positive and 0 (zero) if the household was screened negative. The same scoring pattern was followed for individual questions too. For IRR, agreement was evaluated at both the question level and the overall household caseness using Kappa coefficient.

Measures for sensitivity, specificity, positive predictive value, and negative predictive value were calculated separately between gold standard on the one hand and (a) ASHAs of round 1 (b) ASHAs of round 2. We then computed mean values to derive the final measures for sensitivity, specificity, positive predictive value, and negative predictive value.

Finally, the duration to administer MERIT was noted down for every ASHA. The study was approved by the institute's ethics committee.

Statistical analysis

The content validity indices were analyzed using licensed Microsoft Excel 2019. The concurrent validity and IRR were measured using kappa statistics using licensed Statistical Package for Social Sciences software version 23.[27]

RESULTS

Face validity

17/24 experts completed the rating for the English version; 13 were males and 4 were females; their mean age was 33.7 years with the mean duration of experience in the field of mental health being 8.9 years. For the Kannada version, 11 experts rated the items, and 9 were males and 2 were females; the mean age was 34.45 years, and the mean duration of experience in the field of mental health was 7.8 years. For each of the five domains in the English tool, 14 or more (out of 17) experts gave the rating 3 (agree) or 4 (strongly agree). Likewise, for the Kannada version, 9 or more (out of 11) experts gave a rating of 3 (agree) or 4 (strongly agree) for every domain.

Content validity

A rating of 3 or above on the Likert scale was considered for calculating the I-CVI. Details of the I-CVI for each of the five (5) domains and the average content validity index are shown in Table 2. I-CVI for each domain was > 0.8 (Tobacco and Alcohol use, Anxiety, Severe Mental Illnesses, and Suicidal behaviours) in both the English and Kannada versions. The average Content Validity Index was 0.86 for English and 0.83 for Kannada, indicating that they were all appropriate to identify the intended mental health issue. The universal agreement of the items was 0, indicating that for all items, not all experts had the same level of agreement (3 and 4) on the Likert scale.

Concurrent validity and inter-rater reliability

MHPs carrying out the concurrent validity interviews were 5 males and 2 females with a mean age of 36.8 years and a mean duration of experience of 9.1 years. As shown in Table 3, the Kappa coefficient was 0.79 for concurrent validity and 0.74 for IRR.

Sensitivity, specificity, positive predictive value, and negative predictive value

Table 4 gives the MERIT screened status for round-1 ASHAs and round-2 ASHAs, as compared with the gold standard. Mean measures for sensitivity, specificity, positive predictive value, and negative predictive values are given in Table 5.

The average duration for administering MERIT was 5 minutes. The English and Kannada versions of the MERIT are shown as Annexures 1 and 2, respectively. The scoring instructions for MERIT are also given in the Annexure. A 'yes' for any of the 11 questions should be considered as screened-positive and should be referred to the nearest available treatment centers.

DISCUSSION

This study demonstrates that CHWs can reliably employ MERIT to screen for priority mental disorders among adults in the community. Surprisingly, the specificity was very high, indicating that false negative instances are negligible. However, there is a chance of missing out on probable positive cases (62.5% sensitivity indicating that only about 2/3rd of probable mental disorders are likely to be picked). Ideally, a screening instrument should have very high sensitivity at the cost of lower specificity.[28] The reverse finding could be explained by the fact that CMDs are more challenging for CHWs to identify in the community, in contrast to SMDs and SUDs, given the substantial overlap between normalcy and CMDs. This has been examined earlier, where those with milder CMDs lack insight into their illness, and only those with greater severity of symptoms generally visit primary health centres.[29] Other reasons for the lower sensitivity could be the complexity of psychiatric disorders, requiring more nuanced and persistent approaches by the specialist to bring out the phenomenology/psychopathology to be able to come to a confident clinical diagnosis. Lack of awareness and negative perception toward mental illness and attitudes toward help-seeking has been a challenge that has been described in both developed and low-middle income countries.[30-34] These could additionally have contributed toward its lower sensitivity. Moreover, even the patient health questionnaire has a sensitivity of only 75%.[35]

MERIT has better utility and psychometric properties than the family history screen for epidemiological studies which also targets psychiatric disorders in families.[36] We believe that MERIT has practical value in India, where public health systems are overburdened. It may be easily integrated into public healthcare systems as its administration only takes 5 minutes and can easily blend into the existing fieldwork of any CHW. Given the large treatment gap for mental illnesses, a task-shifting approach to engage CHWs and primary care doctors has been recommended. MERIT training can be completed in 1 day and easily translated into regional languages. Therefore, MERIT is scalable to communities elsewhere. This tool can be applied in houses and community visits, thus helping reduce stigma associated with visits to specialists. Timely referrals from CHWs to trained general practitioners in primary care[37] may be the most helpful model for resource-constrained settings.[38] The face validity of the tool was conducted with experts in mental health who had extensive experience working in community psychiatry. Both the English and the translated Kannada versions had good content validity.

Table 2: Content validity indices for the English version and Kannada version of MERIT

	Q1-2 Substance Abuse (Tobacco and Alcohol)	Q3 Anxiety	Q4 Sadness and Somatoform Symptoms	Q5-8 Persons who are disorganised, violent, fearful	Q9 Suicide Risk	Average CVI (content validity index) of all items
ENGLISH VERSION						
Number of raters, rating 3 and 4 (total 17)	14	14	14	16	15	0.86
Item Content Validity (I-CVI)	0.82	0.82	0.82	0.94	0.88	
KANNADA VERSION						
Number of raters, rating 3 and 4 (total 11)	9	9	9	10	9	0.83
Item Content Validity (I-CVI)	0.81	0.81	0.81	0.90	0.81	

Table 3: Concurrent validity and Interrater reliability of MERIT

	Kappa value	Asymptotic standard error	Approximate *T*	Significance
Concurrent validity *n*=116	0.792	0.062	8.563	<0.001
Inter-rater reliability *n*=115 (After excluding one missing entry)	0.744	0.072	8.034	<0.001

Table 4: MERIT screened-status of ASHAS vs gold standard in two different rounds of interviews

Round-1		
ASHAs (*n*=7)	**Gold Standard**	
	Positive	**Negative**
Positive	16	1
Negative	20	79
Sensitivity=44.44%; Specificity=98.75; Positive Predictive value=94.12%; Negative Predictive value=79.79%; number of households=116		
Round-2		
ASHAs (*n*=9)	**Gold Standard**	
	Positive	**Negative**
Positive	29	3
Negative	7	77
Sensitivity=80.56%; Specificity=96.25%; Positive predictive value=90.63%; Negative Predictive value=91.67%; number of households=116		

Table 5: Mean sensitivity, specificity, and predictive values

Psychometric Property	Percentage
Sensitivity	62.50%
Specificity	97.50%
Positive predictive value	92.38%
Negative predictive value	85.73%

MERIT can also facilitate primary care referral and treatment which will subsequently integrate with the district mental health program that has now expanded to more than 700 districts in India. Such a stepped-up care model based on initial screening by health workers has been established to be both reliable and cost-effective.[39]

The excellent concurrent validity and IRR add value to MERIT as a screening tool but must be replicated in other states and settings.

The existing screening instruments are either cumbersome[40] or have poor sensitivity or specificity[41] or deal with individual disorders[13,38] rendering their use complex in the community. Additionally, the robust positive and negative predictive values, with good specificity, indicate an excellent chance of positively screened persons having a mental disorder.[42] Although ideally, a screening test is designed to have maximum sensitivity, in the Indian context, a screening test with acceptable sensitivity and high positive/negative predictive value is likely to reduce the stigma associated with the false screening of patients for possible mental illness. Predictive values always have a better role in assessing a screening instrument when people are screened.[28] The trade-off in achieving more sensitivity could theoretically lead to decreased predictive values. This, in turn, may lead to more false positives, which may have implications for public health, burdening the already stretched mental health systems at the risk of falsely categorizing a person as having a mental illness.[43]

Limitations

Apart from the relatively lower sensitivity, MERIT does not include all psychiatric disorders under its ambit, limiting its utility to only adults and only to priority mental disorders. The tool was developed keeping in mind disorders with the largest treatment gap in the community, that is, severe mental disorders, substance use disorders, and common mental disorders. A comprehensive iteration of a screening instrument to include all psychiatric disorders would make it more cumbersome and less useful for a CHW.[43] Though the IRR and concurrent validity interviews were carried out approximately after 3 months after baseline screening by the ASHAs, the possibility of practice effect cannot be ruled out.

CONCLUSIONS

Mental Health Screening Tool for Community Health Workers of India [MERIT] is a novel, valid, reliable screening instrument for CHWs that can be applied in about 5 minutes. Notwithstanding its important limitation (of low sensitivity), it offers the advantage of interviewing one key informant of the households to cover for all its adults members.

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Ethical clearance

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The trial is registered with Clinical Trial Registry-India, CTRI number: CTRI/2019/12/022245.

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Conflicts of interest

There are no conflicts of interest.

REFERENCES

1. Murthy RS. National mental health survey of India 2015–2016. Indian J Psychiatry 2017;59:21-6.
2. Grant KL, Simmons MB, Davey CG. Three Nontraditional approaches to improving the capacity, accessibility, and quality of mental health services: An overview. Psychiatr Serv 2018;69:508–16.
3. Selvaraj S, Karan K, Srivastava S, Bhan N, Mukhopadhyay I. India health system review. New Delhi; 2022.
4. Varshney P, Malathesh BC, Nirisha PL, Harshitha NR, Kulal N, Kumar CN, *et al*. Stake holder perspectives on the role of accredited social health activists (ASHAs) in Indian public mental healthcare space: A qualitative study. J Family Med Prim Care 2022;11:7308-15.
5. Nirisha PL, Malathesh BC, Kulal N, Harshithaa NR, Ibrahim FA, Suhas S, *et al*. Impact of Technology Driven Mental Health Task-shifting for Accredited Social Health Activists (ASHAs): Results from a randomised controlled trial of two methods of training. Community Ment Health J 2023;59:175-84.
6. Ibrahim FA, Nirisha L, Barikar M, Kumar CN, Chand PK, Manjunatha N, *et al*. Identification of psychiatric disorders by rural grass-root health workers: case series and implications for the National Mental Health Program of India. Psychiatr Q 2021;92:389–95.
7. Rahul P, Chander KR, Murugesan M, Anjappa AA, Parthasarathy R, Manjunatha N, *et al*. Accredited Social Health Activist (ASHA) and her role in district mental health program: Learnings from the COVID 19 pandemic. Community Ment Health J. 2021;57:442-5.
8. Paramasivam R, Elangovan A, Amudhan S, Kommu JS, Haridas H, Sriramalu S. Intervention-based mental health training for community level workers in India –A systematic review. J Family Med Prim Care 2022;11:1237-43.
9. Malathesh BC, Ibrahim FA, Nirisha PL, Kumar CN, Chand PK, Manjunatha N, *et al*. Embracing technology for capacity building in mental health: New path, newer challenges. Psychiatr Q 2021;92:843-50.
10. Mulvaney-Day N, Marshall T, Downey Piscopo K, Korsen N, Lynch S, Karnell LH, *et al*. Screening for behavioral health conditions in primary care settings: A systematic review of the literature. J Gen Intern Med 2018;33:335–46.
11. GBD 2019 Mental Disorders Collaborators. Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990–2019: A systematic analysis for the Global Burden of Disease Study 2019. Lancet Psychiatry 2022;9:137–50.
12. Gopalan SS, Mohanty S, Das A. Assessing community health workers' performance motivation: A mixed-methods approach on India's Accredited Social Health Activists (ASHA) programme. BMJ Open 2012;2:e001557.
13. Kroenke K, Spitzer RL, Williams JBW. The PHQ-9. J Gen Intern Med 2001;16:606–13.
14. Weissman MM. Brief screening for family psychiatric history: The Family history screen. Arch Gen Psychiatry 2000;57:675–82.
15. McNeely J, Strauss SM, Wright S, Rotrosen J, Khan R, Lee JD, *et al*. Test–retest reliability of a self-administered Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) in primary care patients. J Subst Abuse Treat 2014;47:93–101.
16. Gryczynski J, McNeely J, Wu LT, Subramaniam GA, Svikis DS, Cathers LA, *et al*. Validation of the TAPS-1: A Four-item screening tool to identify unhealthy substance use in primary care. J Gen Intern Med 2017;32:990–6.
17. Harding TW, De Arango V, Baltazar J, Climent CE, Ibrahim HHA, Ladrido-Ignacio L, *et al*. Mental disorders in primary health care: A study of their frequency and diagnosis in four developing countries. Psychol Med 1980;10:231–41.
18. Do TTH, Bui QTT, Ha BTT, Le TM, Le VT, Nguyen QCT, *et al*. Using the WHO Self-Reporting Questionnaire-20 (SRQ-20) to detect symptoms of common mental disorders among pregnant women in Vietnam: A validation study. Int J Womens Health 2023;15:599–609.
19. Prasetio CE, Triwahyuni A, Prathama AG. Psychometric properties of self-report questionnaire-20 (SRQ-20) Indonesian Version. J Psikol 2022;49:69-86.
20. Netsereab TB, Kifle MM, Tesfagiorgis RB, Habteab SG, Weldeabzgi YK, Tesfamariam OZ. Validation of the WHO self-reporting questionnaire-20 (SRQ-20) item in primary health care settings in Eritrea. Int J Ment Health Syst 2018;12:61.
21. Kapur RL, Isaac M. An inexpensive method for detecting psychosis and epilepsy in the general population. The Lancet 378;312:1089.
22. Kumar CN, Chand PK, Manjunatha N, Math SB, Shashidhara HN, Basavaraju V, *et al*. Impact Evaluation of VKN–NIMHANS–ECHO model of capacity building for mental health and addiction: Methodology of two randomized controlled trials. Indian J Psychol Med 2020;42 (6_suppl):S80–6.
23. Office of the Registrar General and Census Commissioner I. Population Composition, 2011 Census of India. New Delhi; 2011. Available from: https://censusindia.gov.in/vital_statistics/SRS_Report/9Chap%202%20-%202011.pdf. [Last accessed on 2021 May 20].
24. Williams P, Tarnopolsky A, Hand D. Case definition and case identification in psychiatric epidemiology: Review and assessment. Psychol Med 1980;10:101–14.
25. Pezeshki MZ, Shadman A, Alizadeh M, Hakimi S, Heidari F. Validity and reliability of the questionnaire for assessing women's reproductive history in Azar Cohort Study. J Caring Sci 2017;6:183–6.
26. Anthoine E, Moret L, Regnault A, Sébille V, Hardouin JB. Sample size used to validate a scale: A review of publications on newly-developed patient reported outcomes measures. Health Qual Life Outcomes 2014;12:176.
27. IBM. IBM SPSS Statistics for Windows, Version 23.0. Armonk, NY: IBM Corporation; 2015.
28. Trevethan R. Sensitivity, specificity, and predictive values: Foundations, pliabilities, and pitfalls in research and practice. Front Public Health 2017;5:307.
29. Verhaak P, Prins M, Draisma S, Spreeuwenberg P, van der Meer K, Bensing JM, *et al*. Help seeking in common mental disorders. In: World Psychiatric Association and Wonca Thematic Conference "Depression and other Common Mental Disorders in Primary Care" Granada, Spain:

Folia Neuropsiquiatrica; 2008. p. 75–6.
30. Sneha CR, Reddy MM, Nongmeikapam M, Narayana JS. Awareness and attitude toward mental illness among a rural population in Kolar. Indian J Soc Psychiatry 2019;35:69-74.
31. Devrick Z, Russel L, Hudson S. Attitudes of adults towards people with experience of mental distress: Results from the 2015 New Zealand Mental Health Monitor. Wellington, 2017. Available from:http://doi.org/10/60967/healthnz.26786530.v1. [Last accessed on 2025 Mar 06].
32. Ganesh K. Knowledge and Attitude of Mental Illness Among General Public of Southern India. Natl J Community Med 2011;2:175–8.
33. Jayan V, Vishwas S. Awareness and practices of a rural community regarding mental health problems. Cureus 2023;15:e40263.
34. Salve H, Goswami K, Sagar R, Nongkynrih B, Sreenivas V. Perception and attitude towards mental illness in an urban community in South Delhi-A community based study. Indian J Psychol Med 2013;35:154–8.
35. Spitzer RL, Kroenke K, Williams JB. Validation and utility of a self-report version of PRIME-MD: The PHQ primary care study. Primary Care Evaluation of Mental Disorders. Patient Health Questionnaire. JAMA 1999;282:1737-44.
36. Lish JD, Weissman MM, Adams PB, Hoven CW, Bird H. Family psychiatric screening instrument for epidemiologic studies: Pilot testing and validation. Psychiatry Res 1995;57:169–80.
37. Pahuja E, Kumar TS, Uzzafar F, Manjunatha N, Kumar CN, Gupta R, *et al*. An impact of a digitally driven primary care psychiatry program on the integration of psychiatric care in the general practice of primary care doctors. Indian J Psychiatry 2020;62:690-6.
38. Angermeyer MC, van der Auwera S, Carta MG, Schomerus G. Public attitudes towards psychiatry and psychiatric treatment at the beginning of the 21st century: A systematic review and meta-analysis of population surveys. World Psychiatry 2017;16:50–61.
39. Sen B, Wilkinson G, Mari JJ. Psychiatric morbidity in primary health care. A two-stage screening procedure in developing countries: Choice of instruments and cost-effectiveness. Br J Psychiatry 1987;151:33-8.
40. Schmitz N, Kruse J, Heckrath C, Alberti L, Tress W. Diagnosing mental disorders in primary care: The General Health Questionnaire (GHQ) and the Symptom Check List (SCL-90-R) as screening instruments. Soc Psychiatry Psychiatr Epidemiol 1999;34:360–6.
41. Tarnopolsky A, Hand DJ, McLean EK, Roberts H, Wiggins RD. Validity and Uses of a Screening Questionnaire (GHQ) in the Community. Br J Psychiatry 1979 134:508–15.
42. Rutter LA, Brown TA. Psychometric Properties of the Generalized Anxiety Disorder Scale-7 (GAD-7) in outpatients with anxiety and mood disorders. J Psychopathol Behav Assess 2017;39:140–6.
43. Leon AC, Portera L, Olfson M, Weissman MM, Kathol RG, Farber L, *et al*. False positive results: A challenge for psychiatric screening in primary care. Am J Psychiatry 1997;154:1462–4.

ANNEXURE I

Mental Health Screening Tool for Community Health Workers of India (MERIT)

ADDRESS: PHONE NUMBER:	NUMBER OF FAMILY MEMBERS: No. of Adults: No. of Children:	DATE OF SCREENING: FAMILY INCOME :

Medical History: Ask for Hypertension, Diabetes, Anaemia, Tuberculosis (TB) , Others. If present Mention below

Sl No	QUESTION		
A	**ALCOHOL AND TOBACCO ABUSE**		
1.	Have you or anybody in your family been consuming alcohol in the past few months **If YES ,**	**YES**	**NO**
	1a.) Has that caused any health problems ?		
	1b.) Has that caused difficulty in working regularly / problems in your relationship with family/ friends?		
2.	Do you or anybody in your family consume BEEDI/GUTKA/CIGARETTES/ KAINI/ KADDI PUDI - early in the morning (Just after waking up from bed) in the past few months	**YES**	**NO**
B	**ANXIETY**	**YES**	**NO**
3.	Have you or any member of your family experience uncontrolled anxiety/stress/tension/worries/nervousness for no reason or for trivial reasons in the past few weeks or months		
C	**SADNESS /SOMATOFORM Symptoms**	**YES**	**NO**
4.	In the past few weeks/months, have you or anybody in your family experienced **sadness or felt tired** without any reason or have experienced **multiple physical or bodily complaints** despite assurances by the doctor against the presence of a physical ailment?		
D	**PEOPLE WHO ARE DISORGANISED, VIOLENT, FEARFULL**	**YES**	**NO**
5.	Has anybody in your family heard voices in isolation/seeing things that others don't see and Smile or talk to himself/herself or behave in a strange manner anytime in the past few weeks or months ?		
6.	Has anybody in your family experienced suspiciousness/ odd beliefs or making tall claims such holding super powers etc in the past few weeks or months ?		
7.	Does anybody in your family have poor self-care (not bathing or changing clothes for many days) or wanders aimlessly in the past few weeks or months		
8.	Has anybody in your family experienced excess happiness without any apparent reason, overtalkativeness, hyperactivity and increased self-esteem in the past few weeks or anytime in the past		
E. 9.	Have you or anybody in the family experienced suicidal ideas or attempted suicide recently or in the past?	**YES**	**NO**

DETAILS OF FAMILY MEMBERS WITH POSSIBLE MENTAL ILLNESS					
Sl No	Name	Gender M/F/ Others	Age	Medical History	Mental Health issue (YES/NO)
1					
2					

Instructions for MERIT

1. **Before using MERIT**:
    - Ensure you have a quiet, private setting to maintain confidentiality and comfort for the family.
    - Gather all necessary materials: the MERIT tool, a pen/ pencil, and the relevant forms for documentation or keep the devise ready if using digital format

2. **Collecting Basic Information**: Start by filling out the basic details at the top of the tool
    - Record the family's address, phone number and family income
    - Note the number of family members, categorizing them into adults and children.
3. **Screening Questions**: covering Sections A, B, C, D
    - **Ask all questions as it is** – do not shorten or omit any of the questions.
    - **Documenting Responses**: Record responses, marking "YES" or "NO" as applicable for each question.
4. **Medical History**:
    - Ask if any family members have a history of medical conditions such as Hypertension, Diabetes, Anaemia, Tuberculosis (TB), or other significant illnesses. Document these details in the box provided.
5. **Detailing Family Members with Possible Mental Illness**: In the box provided, give the details
6. **Follow-Up Action**: Provide support and information about available treatment resources and services.
7. **Concluding the Session**:
    - Provide information regarding mental health issues
    - Thank them for their cooperation and inform them that they can reach out if there is any concern

ANNEXURE II

Mental Health Screening Tool for Community Health Workers of India (MERIT)- Kannada Version

ಮಾನಸಿಕ ಅಸ್ವಸ್ಥತೆಗೆ ಸ್ಕ್ರೀನಿಂಗ್ ಟೂಲ್

ವಿಳಾಸ::	ಮನೆಯ ಸದಸ್ಯರ ಸಂಖ್ಯೆ:	ದಿನಾಂಕ:___/___/____
	ದೂರವಾಣಿ ಸಂಖ್ಯೆ::	ಕುಟುಂಬದ ಆದಾಯ:

ವೈದ್ಯಕೀಯ ಇತಿಹಾಸ: ಅಧಿಕ ರಕ್ತದೊತ್ತಡ, ಮಧುಮೇಹ, ರಕ್ತಹೀನತೆ, ಕ್ಷಯ (ಟಿಬಿ), ಮತ್ತು ಇತರೆ ದೈಹಿಕ ಅಥವಾ ವೈದ್ಯಕೀಯ ವಿವರಗಳ ಬಗ್ಗೆ ಕೇಳಿ ಮತ್ತು ಇದ್ದರೆ ಕೆಳಗೆ ಉಲ್ಲೇಖಿಸಿ

ಕ್ರಂ ಸಂಖ್ಯೆ	ಪ್ರಶ್ನೆ		
A.	**ಮದ್ಯಪಾನ ಮತ್ತು ಧೂಮಪಾನ ದುರುಪಯೋಗ**		
1.	ನೀವು ಅಥವಾ ನಿಮ್ಮ ಕುಟುಂಬದಲ್ಲಿ ಯಾರಾದರೂ ಕಳೆದ ಕೆಲವು ತಿಂಗಳುಗಳಿಂದ ಮದ್ಯಪಾನ ಮಾಡುತ್ತಿದ್ದಾರಾ? **ಹೌದು ಆಗಿದ್ದಲ್ಲಿ,**	**ಹೌದು**	**ಇಲ್ಲ**
	1a.) ಇದರಿಂದ ಏನಾದರೂ ಆರೋಗ್ಯದ ಸಮಸ್ಯೆಗಳನ್ನು ಉಂಟಾಗಿದೆಯೇ ?	**ಹೌದು**	**ಇಲ್ಲ**
	1b.)ಮದ್ಯಪಾನ ಮಾಡುವುದರಿಂದ ಕೆಲಸ ಮಾಡಲು ಅಥವಾ ಕುಟುಂಬದ ಸದ್ಯಸರೊಂದಿಗೆ ಸಂಬಂಧದಲ್ಲಿ ತೊಂದರೆ ಉಂಟುಮಾಡಿದೆಯೇ?	**ಹೌದು**	**ಇಲ್ಲ**
2.	ಕಳೆದ ಕೆಲವು ತಿಂಗಳುಗಳಲ್ಲಿ, ನೀವು ಅಥವಾ ನಿಮ್ಮ ಕುಟುಂಬದಲ್ಲಿ ಯಾರಾದರೂ ಬೀಡಿ / ಗುಟ್ಕಾ / ಸಿಗರೇಟ್ / ಖೈನಿ / ಕಡ್ಡಿಪುಡಿ ಮುಂತಾದವುಗಳನ್ನು ಮುಂಜಾನೆಯೇ ಅಂದರೆ ಹಾಸಿಗೆಯಿಂದ ಎದ್ದ ಕೂಡಲೇ ತೆಗೆದುಕೊಳ್ಳುತ್ತಾರೆಯೇ ?	**ಹೌದು**	**ಇಲ್ಲ**
B.	**ಆತಂಕ**		
3.	ಕಳೆದ ಕೆಲವು ವಾರ ಅಥವಾ ತಿಂಗಳುಗಳಲ್ಲಿ, ನೀವು ಅಥವಾ ನಿಮ್ಮ ಕುಟುಂಬದ ಇತರೆ ಸದಸ್ಯರು ಯಾರಾದರೂ ಯಾವುದಾದರು ಸಣ್ಣಪುಟ್ಟ ಕಾರಣಗಳಿಂದ ಸಹಿಸಲಾಗದಷ್ಟು ಆತಂಕ / ಒತ್ತಡ / ಟೆನ್ಷನ್ /ಚಿಂತೆ / ಹೆದರಿಕೆ (ಆತಂಕ) ಅನುಭವಿಸುತ್ತೀರಾ?	**ಹೌದು**	**ಇಲ್ಲ**
C.	**ಬೇಸರ/ ಮನೋ-ದೈಹಿಕ ನೋವು (ಬೇನೆ) ಯ ಲಕ್ಷಣಗಳು**		
4.	ಕಳೆದ ಕೆಲವು ವಾರಗಳಲ್ಲಿ / ತಿಂಗಳುಗಳಲ್ಲಿ, ನೀವು ಅಥವಾ ನಿಮ್ಮ ಕುಟುಂಬದಲ್ಲಿ ಯಾರಾದರೂ ಸರಿಯಾದ ಕಾರಣವಿಲ್ಲದ **ದುಃಖ ಅಥವಾ ದಣಿವನ್ನು** ಅನುಭವಿಸಿದ್ದೀರಾ ಅಥವಾ ವೈದ್ಯರ ಪ್ರಕಾರ ಯಾವುದೇ ದೈಹಿಕ ತೊಂದರೆ ಇಲ್ಲದೆ ಇದ್ದರೂ ಬೇರೆ ಬೇರೆ ರೀತಿಯ **ವಿವರಿಸಲಾಗದ ದೈಹಿಕ ನೋವಿನ** ಬಗ್ಗೆ ಮಾತನಾಡುವುದು ನಿಮ್ಮ ಗಮನಕ್ಕೆ ಬಂದಿದೆಯೇ?	**ಹೌದು**	**ಇಲ್ಲ**
D.	**ಅಸ್ತವ್ಯಸ್ತಗೊಂಡ, ಹಿಂಸಾತ್ಮಕ, ಭಯಭೀತರಾದ ಜನರಿಗೆ**		
5.	ಕಳೆದ ಕೆಲವು ವಾರಗಳಲ್ಲಿ,ತಿಂಗಳು, ನಿಮ್ಮ ಕುಟುಂಬದಲ್ಲಿ ಯಾರಾದರೂ ಒಬ್ಬರೇ ಇರುವಾಗ ಕಿವಿಯಲ್ಲಿ ಮಾತನಾಡಿದ ಅಥವಾ ಬೇರೆಯರಿಗೂ ಕಾಣಿಸದನ್ನು ತಮಗೆ ಕಾಣಿಸುವ ಅನುಭವ ನಿಮ್ಮ ಬಳಿ ಹಂಚಿಕೊಂಡಿದ್ದಾರೆಯೇ? ಹಾಗೆಯೆ ಅವರಷ್ಟಕ್ಕೆ ಅವರೇ ನಗುವುದು, ಮಾತನಾಡುವುದು ಅಥವಾ ವಿಚಿತ್ರವಾಗಿ ವರ್ತಿಸುವುದು ನಿಮ್ಮ ಗಮನಕ್ಕೆ ಬಂದಿದೆಯೇ?	**ಹೌದು**	**ಇಲ್ಲ**
6.	ನಿಮ್ಮ ಕುಟುಂಬದಲ್ಲಿ ಯಾರಾದರೂ ಕಳೆದ ಕೆಲವು ವಾರ,ತಿಂಗಳು, ವರ್ಷಗಳಿಂದ ಬೇರೆಯವರ ಮೇಲೆ ಅನುಮಾನ ಪಡುವುದು / ವಿಚಿತ್ರ ನಂಬಿಕೆ ಅಥವಾ ತನ್ನಲ್ಲಿ ವಿಶೇಷ ಶಕ್ತಿ ಇತ್ಯಾದಿ ಬಗ್ಗೆ ಮಾತನಾಡುವುದು ಗಮನಿಸಿದ್ದೀರಾ?	**ಹೌದು**	**ಇಲ್ಲ**
7.	ಕಳೆದ ಕೆಲವು ವಾರ,ತಿಂಗಳು, ನಿಮ್ಮ ಕುಟುಂಬದಲ್ಲಿ ಯಾರಾದರೂ ಸ್ವಯಂ ಸ್ವಚ್ಛತೆಯ ಬಗ್ಗೆ ಕಡಿಮೆ ಗಮನ ಹೊಂದಿದ್ದಾರೆಯೇ (ಸ್ನಾನ ಮಾಡದೇ ಇರುವುದು ಅಥವಾ ಹಲವು ದಿನಗಳವರೆಗೆ ಬಟ್ಟೆ ಬದಲಾಯಿಸದಿರುವುದು) ಅಥವಾ ಕಾರಣವಿಲ್ಲದೆ ಅಲೆದಾಡುವುದು ಗಮನಿಸಿದ್ದೀರಾ?	**ಹೌದು**	**ಇಲ್ಲ**
8.	ನಿಮ್ಮ ಕುಟುಂಬದಲ್ಲಿ ಯಾರಾದರೂ ಇತ್ತೀಚಿಗೆ ಅಥವಾ ಯಾವತ್ತಾದರೂ ಒಮ್ಮಿಂದೊಮ್ಮೆ ಕಾರಣ ಇಲ್ಲದೆ ಅತಿಯಾದ ಸಂತೋಷ, ಅತಿಯಾಗಿ ಮಾತನಾಡುವುದು, ಅತೀ ಕ್ರಿಯಾಶೀಲತೆ ತೋರ್ಪಡಿಸಿದ್ದನ್ನು ಗಮನಿಸಿದ್ದೀರಾ?	**ಹೌದು**	**ಇಲ್ಲ**
E. 9.	ನೀವು ಅಥವಾ ಕುಟುಂಬದಲ್ಲಿ ಯಾರಾದರೂ ಇತ್ತೀಚೆಗೆ ಅಥವಾ ಹಿಂದೆ ಯಾವತ್ತಾದರೂ ಆತ್ಮಹತ್ಯಾ ಮಾಡಿಕೊಳ್ಳುವ ಬಗ್ಗೆ ಮಾತನಾಡಿರುವುದು ಅಥವಾ ಆತ್ಮಹತ್ಯೆಗೆ ಪ್ರಯತ್ನಿಸಿರುವ ಘಟನೆ ನಡೆದಿದೆಯೇ?	**ಹೌದು**	**ಇಲ್ಲ**

ಮಾನಸಿಕ ಅರೋಗ್ಯ ಸಮಸ್ಯೆ ಸಾಧ್ಯತೆ ಹೊಂದಿರುವ ವ್ಯಕ್ತಿಗಳ ವಿವರಗಳು					
ಕ್ರಂ ಸಂಖ್ಯೆ	**ಹೆಸರು:**	**ಲಿಂಗ ಗಂ/ ಹೆ/ ಇತರೆ**	**ವಯಸ್ಸು**	**ವೈದ್ಯಕೀಯ ಇತಿಹಾಸ**	**ಮಾನಸಿಕ ಅರೋಗ್ಯ ಸಮಸ್ಯೆ**
1					
2					