The Role of Family Physicians in Mental Health Care: Screening, Diagnosis, and Treatment Options

Najlaa Mohammad Alsudairy[1]*, Khalid Mohammed Aloush[2], Shikhah Mohammed Alzayed[3], Amnah Ibrahim Alsamti[4], Alsahaf, Adnan Ibrahim A[5], Amirah Talal Al Zahrani[6], Bayan Abdullah H Alabdulbaqi[7], Renad Naif Alotaibi[8], Tala Ossam Althenayan[9], Abdullah Adil Kamal[10], Abdulrahman Saeed Alahmari[11], Alaa Essam Nuqali[12], Jafar Jawad Altammar[13], Sumaya Mohamed Ebrahim Ali Almehaiza[14]

[1]**Assistant Consultant FM, National Guard Hospital, King Abdulaziz Medical City, SCOHS, Jeddah, Saudi Arabia. Email: Najlaa.Alsudairy@gmail.com*
[2]*Service cardiology resident, Prince sultan cardiac Center, Al Hassa, KSA. Email: Khalid.aloush1@gmail.com*
[3]*GP, Prince Mutaib bin Abdulaziz Hospital, Aljouf, KSA. Email: 1shalzayed@gmail.com*
[4]*GP, Al-hizam Al-thahabi primary healthcare center, Al Khobar, KSA. Email:* Mooni.alshbaily@gmail.com
[5]*GP, Qatif central hospital, orthopedic service resident , Al Qatif , KSA. Email: alsahaf.aia@gmail.com*
[6] *King Khalid University, KSA. Email:* amsa22730@gmail.com
[7] *Intern, King Abdulaziz University Hospital, Jeddah , KSA.*
[8]*Almaarefa university, KSA. Email:* renadnm1@gmail.com
[9]*Intern, University of Galway (UOG), Taibah University, KSA. Email:* Talaessam@gmail.com
[10]*Emergency medicine general physician, King Abdullah Medical Complex Jeddah, KSA. Email:* abdullahkamal47@outlook.com
[11]*GP. Bisha Maternity & Children Hospital, Bisha, Saudi Arabia. Email: afnanasiri37@gmail.com*
[12]*GP, Heraa General hospital, Makkah, Saudi Arabia. Email:* Alaanuqali10@gmail.com
[13]*Intern, Imam Abdulrahman Bin Faisal University, Dammam, Saudi Arabia. Email:* jafar.tammar@gmail.com
[14]*Jordan University of Science and Technology. Email: Sumaya.almehzaa@hotmail.com*

***Corresponding Author: -** Najlaa Mohammad Alsudairy*
*Assistant Consultant FM, National Guard Hospital, King Abdulaziz Medical City, SCOHS, Jeddah, Saudi Arabia. Email: Najlaa.Alsudairy@gmail.com

Abstract

Family physicians play a pivotal role in the early detection, diagnosis, and management of mental health disorders within the community. This review article delves into the multifaceted responsibilities of family physicians in the realm of mental health care. Emphasizing the importance of primary care settings as the first point of contact for many patients, the article underscores the need for effective screening tools and methodologies tailored for these environments. The diagnostic precision of family physicians, often challenged by the broad spectrum of mental health symptoms, is explored alongside the potential implications of misdiagnoses. Furthermore, the article evaluates various treatment options, from pharmacological interventions to psychotherapy, and their applicability in primary care settings. The integration of technological advancements, such as electronic health records and telemedicine, is also discussed in the context of enhancing patient care. The review concludes

by highlighting the importance of educating primary care physicians to not only pay close attention to the mental health of their patients, but also to be able to accurately screen and diagnose mental health issues using various diagnostic tools. Moreover, it is critical to develop more useful tools that can be used in the context of primary care settings.

Keywords: Family Physicians, Mental Health, Mental Care, Screening for mental disorders, Treatment of mental disorders

Introduction:

The role of family physicians, often referred to as primary care providers or general practitioners, has evolved significantly over the past few decades. Traditionally, these medical professionals have been the first point of contact for patients seeking medical attention for a wide range of health issues. However, in recent years, their role in mental health care has become increasingly prominent and indispensable. According to the World Health Organization (WHO), mental health disorders are among the leading causes of ill-health and disability worldwide. With over 450 million people suffering from such conditions, the need for effective screening, diagnosis, and treatment is paramount [1].

Mental disorders involve significant disturbances in an individual's thinking, emotions, or behavior, often leading to distress or impaired functioning. They can be referred to as mental health conditions, a term that also encompasses psychosocial disabilities and other mental states causing distress or risk of self-harm. The International Classification of Diseases 11th Revision (ICD-11) provides descriptions of these disorders. In 2019, about 970 million people globally had a mental disorder, with anxiety and depression being the most prevalent. The COVID-19 pandemic in 2020 saw a sharp rise in these numbers, with anxiety and depression increasing by 26% and 28%, respectively. Despite available treatments, many lack access to effective care and face stigma and human rights violations. [2]

Family physicians are uniquely positioned to play a pivotal role in this domain. Given their long-term relationships with patients and their families, they often have a comprehensive understanding of the patient's medical history, lifestyle, and potential stressors [3]. This holistic perspective is crucial in the realm of mental health, where symptoms can be multifaceted and deeply intertwined with other health issues. A study published in the Journal of the American Board of Family Medicine highlighted that nearly half of all mental health care in the U.S. is provided by primary care physicians [4]. This underscores the pivotal role they play in identifying, diagnosing, and managing mental health disorders.

Furthermore, the stigma associated with mental health often deters individuals from seeking specialized care. Family physicians, with their non-specialized setting, offer a less intimidating environment for patients to discuss their mental health concerns [5]. The Journal of Family Practice published findings indicating that patients are more likely to disclose their mental health symptoms to a trusted family physician than to a psychiatrist, especially in the early stages [6].

Low rates of depression treatment can be attributed to challenges in accurately identifying the condition. Studies have shown that general practitioners often fail to correctly diagnose more than half of their patients with depression. On the other hand, some patients without full depression symptoms are mistakenly diagnosed and treated for it. This could be due to confusion over mild symptoms or obstacles in making a correct diagnosis. Additionally, there are instances where primary care doctors might diagnose physical symptoms like fatigue or insomnia rather than depression, mainly due to uncertainty about the diagnosis. [7]

In the United States, over a quarter of the population experiences at least one mental health condition at any given time. Most patients, around 70%, are diagnosed and treated for common mental health issues like anxiety, mood disorders, and substance abuse in primary care settings. Additionally, it's typical for these individuals to also have another chronic medical condition. Since many long-term medical issues, such as chronic pain or obesity, can be influenced by behavioral or psychological factors, primary care is an ideal place to provide necessary behavioral health care. [8]

Studies highlight a shift in the way mental health care is delivered. More patients, particularly those with depression, are now being treated by primary care physicians (PCPs) instead of mental health experts. Typically, PCPs are choosing to manage psychiatric care directly rather than referring patients to specialists. Over a decade, from 1987 to 1997, there was a notable increase in patients receiving psychiatric medication from PCPs, jumping from 37.3% to 74.5%. This change underscores the growing role of PCPs, who are increasingly serving as the main providers of psychiatric care for many of their patients. [9-13]

Up to 40% of patients seeking mental health assistance only consult FPs (Family Physicians). However, FPs face challenges in diagnosing and treating these problems, especially with difficulties in accessing mental health specialists and the high demand for their services. While specialized mental health settings might offer better care, they are limited, making primary care the primary avenue for most mental health patients. Shared Care Models (SCMs) have been introduced to enhance mental health care recognition and treatment. Despite their varied success, few studies have explored FPs' views on these models. Most research has been on SCMs in controlled settings with dedicated resources. In Saskatchewan, where there's a notable psychiatrist shortage, A study conducted revealed that while FPs have a strong interest in detecting and treating mental health issues, many are unsatisfied with the care they can provide. Access to MHPs was identified as a significant factor affecting satisfaction. Innovative solutions like Telehealth are being explored to address access issues, but they come with challenges. [14]

The role of family physicians in mental health care is not without challenges. The need for continuous training, the complexities of diagnosis, and the coordination with specialized mental health services are areas that require attention and support. Nevertheless, with the rising prevalence of mental health disorders globally, the role of family physicians as frontline warriors in the battle against these conditions cannot be understated.

Mental health epidemiology:

Approximately 44.7 million adult Americans suffer from a mental disorder, but only 35 million receive mental health services. Several factors hinder adults from accessing mental health care, including limited availability of professionals, societal stigma around mental illness, and a disconnect between general and specialized mental health services. Moreover, there's a significant regional imbalance in the availability of mental health professionals, with nearly 96% of U.S. counties facing a shortage of psychiatrists. This issue is anticipated to intensify as 60% of current psychiatrists are over 55 years old. Over the past two decades, while the U.S. population grew by 37%, the number of psychiatrists only rose by 12%. However, as societal acceptance grows, reducing the stigma around mental health, the demand for mental health services is also increasing. [15]

Mental disorders are on the rise worldwide, with depression alone affecting an estimated 264 million people. The World Health Organization states that a majority of individuals with mental disorders, including in the USA, don't receive treatment. The National Institute of Mental Health has noted over 46 million adults diagnosed with a severe mental disorder. The intensity and impact of these disorders vary, with conditions like bipolar disorder having a high severity rate despite its lower prevalence. Lifetime prevalence rates for various disorders are concerning, including 28.8% for anxiety, 24.8% for impulse control, 20.8% for mood disorders, and 14.6% for substance use. Mental disorders can lead to significant life challenges, including increased risks of job loss, victimization, and suicide attempts. The financial burden is also significant, with inpatient treatment costs for severe disorders potentially surpassing $5000 weekly. For many patients, the barriers to accessing and affording treatment can be overwhelming, preventing them from seeking the care they need. [16]

Situation in Saudi Arabia:

Mental health in Saudi Arabia has been an evolving area of focus, especially in the context of rapid modernization and societal shifts. Historically, mental health concerns were often interpreted through cultural and religious perspectives, leading to potential stigmatization and misunderstandings[1]. However, recent years have witnessed a paradigm shift towards recognizing these issues as medical conditions that necessitate appropriate care and intervention.

A study was done in the Kingdom of Saudi Arabia (KSA) by Alattar N, et al. 2021 [18] aimed to understand how this stigma impacts people's ability to access mental health services. To do this, the study reviewed existing literature on mental health stigma in KSA. The research found that stigma surrounding mental health affects the accessibility, quality, and practices of care in KSA. Notably, the perspectives of those with mental health issues in KSA are largely absent from the existing literature. The study concludes that cultural beliefs and stigma in KSA can hinder access to mental health services. There's a need for more public discourse on mental health issues to potentially improve people's experiences with accessing services. [18]

In Saudi Arabia, physicians come from various countries, leading to potential differences in their knowledge and attitudes towards psychiatry. A study assessed non-psychiatric physicians' understanding and perceptions of psychiatric disorders, specifically anxiety and depression, in the Kingdom. The findings revealed that general practitioners (GPs) and specialists generally had a negative attitude towards psychiatric patients, while family practitioners had a positive one. There were notable differences in knowledge about anxiety and depression among the groups. The study concludes that comprehensive educational programs and continued medical

education are essential to bridge the knowledge and attitude gap among physicians and enhance their skills. [19]

Moreover, a study aimed to understand the mental health trends related to major depressive disorder (MDD) and generalized anxiety disorder (GAD, during the COVID-19 pandemic. The findings revealed that the national prevalence of individuals at risk of MDD was 14.9% overall, while the risk for GAD was 11.4%. Additionally, the risk of MDD increased by 71.2% from 2018 to 2020. The study concludes that the COVID-19 pandemic has had a significant impact on mental health, with a notable increase in the risks of MDD and GAD. [20]

The Saudi government, acknowledging the significance of mental well-being, has initiated substantial measures to address these challenges. The Ministry of Health has rolled out several campaigns to enhance public awareness about mental health, aiming to diminish stigma and motivate individuals to seek timely assistance [21]. Additionally, there's been a concerted effort to increase the number of specialized mental health facilities and to bolster training programs for healthcare professionals in the field [22].

Despite these advancements, challenges persist. Deep-rooted cultural beliefs and societal norms can sometimes act as barriers to seeking treatment. Many individuals might prioritize consultations with religious leaders or traditional healers over medical interventions [23]. Furthermore, while metropolitan regions like Riyadh and Jeddah have witnessed an uptick in mental health services, rural areas continue to grapple with a dearth of adequate facilities and trained experts [24].

In terms of specific disorders, conditions like depression, anxiety, and stress-related disorders are among the most frequently reported in the Saudi populace [25].

Mental Health Screening in Primary Care Clinics:

Primary care settings offer a unique opportunity to identify and address mental health concerns early, given the frequent contact with patients. As such, integrating mental health screening into primary care has become a focal point for improving population health outcomes.

Benefits of Screening in Primary Care:

Primary care providers (PCPs) are often the first point of contact for many patients with mental health concerns. By incorporating routine mental health screenings, PCPs can identify issues early, leading to timely interventions and potentially better outcomes. Early detection can also reduce the overall burden on the healthcare system by preventing the escalation of conditions that might require more intensive and costly treatments [4].

Challenges and Considerations:

While the benefits of mental health screening in primary care are evident, there are challenges to consider. These include the potential for false positives, the need for appropriate follow-up resources, and the risk of over-diagnosis. Additionally, primary care providers must be adequately trained to administer screenings and interpret results [26].

Furthermore, cultural competence is crucial. Mental health perceptions and stigma can vary across cultures, and screening tools must be sensitive to these differences to ensure accurate assessments [27].

Screening Procedures in Primary Care for Mental Health:

Screening for mental health disorders in primary care involves a systematic approach to identify individuals who may have a specific disorder but have not yet been diagnosed. The goal is early detection and intervention, which can lead to improved outcomes for patients. Here's an overview of the procedures, along with references:

1. Pre-screening Considerations: Before initiating a screening, primary care providers (PCPs) should be aware of the prevalence of specific disorders in their patient population and the availability of resources for further evaluation and treatment. They should also consider the potential benefits and harms of screening.
2. Selection of Screening Tools: The choice of screening tool depends on the specific disorder being screened for, the patient population, and the setting. Tools should be validated for the specific population being screened [28].
- Depression: The Patient Health Questionnaire (PHQ-9) is a commonly used tool for depression screening [29].

- Anxiety: The Generalized Anxiety Disorder 7-item scale (GAD-7) is a popular tool for anxiety screening [30].
- Substance Use: The Alcohol Use Disorders Identification Test (AUDIT) for alcohol and the Drug Abuse Screening Test (DAST) for drugs are standard tools [31].

3. Administration of the Screening Tool: Screening tools can be self-administered or clinician-administered. In many primary care settings, patients complete the screening tool while waiting for their appointment. Alternatively, a nurse or medical assistant may administer the tool during the intake process [32].
4. Interpretation of Results: Each screening tool has specific scoring guidelines. PCPs should be familiar with the interpretation of scores and the recommended actions based on the results. For instance, a specific score on the PHQ-9 may suggest the presence of major depression and warrant further evaluation [29].
5. Follow-up and Referral: If a patient screens positive for a mental health disorder, the PCP should conduct a more in-depth assessment. This may involve a detailed clinical interview, additional diagnostic tools, or referral to a mental health specialist for further evaluation and treatment [33].
6. Documentation: All screening results, interpretations, and subsequent actions should be documented in the patient's medical record. This ensures continuity of care and provides a reference for future visits [34].

Diagnosis of Mental Health issues in primary care:

Even with advancements in medication and a broader societal understanding of psychiatric issues as medical concerns, challenges persist in psychiatric care within primary care settings. These challenges include excessive medication use, overlooking prevalent disorders like depression and anxiety, not recognizing co-existing conditions, underdiagnosing, and potential errors in diagnosis and treatment, such as confusing bipolar depression with major depressive disorder. The US Surgeon General's Mental Health Report has highlighted these issues, pointing out that primary care often falls short in identifying and addressing depression. This lack of recognition can lead to unnecessary and costly diagnostic procedures, especially when patients present with unclear physical symptoms. [9]

Primary care inherently prioritizes efficiency and effectiveness. In line with this, Spitzer and his team introduced one of the pioneering mental health screening tools for medical environments, known as the Primary Care Evaluation of Mental Disorders (PRIME-MD). While its inception was streamlined, subsequent interviews demanded significant time from the primary care team. Additionally, its efficacy depended on the severity of the identified mental conditions. Shorter screening tools have been developed to identify mental health issues, including critical concerns like suicidal ideation. Many questionnaires, such as the Patient Health Questionnaire (PHQ-9), were derived from the PRIME-MD to ensure standardization while considering time constraints in primary care. These concise tools assist primary care providers in tracking the evolution and intensity of specific disorders and have become increasingly prevalent in practice.[15]

the growing emphasis on enhancing psychiatric evaluations in primary care, leading researchers to create concise screening tools for prevalent psychiatric issues encountered in general medical practices. For instance, a shortened psychiatric screening instrument was derived from 12 out of 34 items of the Somatic and Psychological Health Report (SPHERE) questionnaire. Several other tools designed for primary care include the Rand Mental Health Inventory (MHI), and the DUKE-AD Scale. While PRIME-MD seemed promising as a practical screening tool for primary care (taking roughly eight minutes to finish), its integration into regular practice faced challenges, possibly due to training requirements, and it hasn't been consistently adopted in typical primary care environments. [9]

A study identified 24 screening tools mainly targeting anxiety, depression, and substance abuse. The most favored were those related to the PRIME-MD due to their succinctness and accessibility. However, these paper-based tools often necessitate manual scoring and typically focus on just one diagnostic category. [15]

Mental health management in primary care:

In the aftermath of COVID-19, telehealth has become a standard approach for both primary and mental health care and is expected to continue in some capacity. This shift provides a unique chance to enhance collaborative care (CC) for mental disorders within primary care. Studies indicate that remote telemedicine-based CC might produce better results than local CC due to higher fidelity. However, broad adoption demands creative, team-based adjustments. Recommendations to enhance mental health care in primary care include allocating specific time during outpatient internal medicine residency for learning psychopharmacology, CC principles, and self-care techniques to combat provider burnout. Organizations like the Advancing Integrated Mental Health Solutions Center offer CC training, while others, such as the Association of American Medical Colleges, are

developing online courses for residents on topics like cognitive behavioral therapy for insomnia. Furthermore, telehealth-focused primary care can utilize technology for psychoeducation, cognitive behavior therapy apps, and self-monitoring of symptoms, especially given the surge in mental health issues post-COVID-19. The American Psychiatric Association has also introduced toolkits for telepsychiatry and CBT apps. [35]

If all treatments were equally effective for every mental disorder, the misidentification of depression wouldn't be a significant concern. However, over 40% of patients with Major Depression (MD) didn't receive any substantial treatment. Those correctly identified by general practitioners as having probable depression had a 65% chance of receiving primary treatments like antidepressants, psychotherapy, or a referral to a specialist. In contrast, those only identified as having a mental health issue without a specific depression diagnosis were less likely to receive these primary treatments. Patients not recognized as having a significant problem were mostly untreated and more often given sedatives. Modern antidepressants were more commonly prescribed to those diagnosed with depression than older ones. [36]

Medication and therapy are primary treatments for moderate to severe cases. With the integration of electronic health records, it's now feasible to use patient preferences or advanced techniques like machine learning to tailor screening and treatment based on individual depression types or risk. This can enhance resource allocation, patient involvement, and treatment effectiveness. In collaborative care (CC) environments, refining the referral process for care management or direct psychiatry, preferably delivered remotely, can boost efficiency and patient engagement. However, it's crucial to ensure that technological advancements don't widen disparities, especially among socioeconomically disadvantaged groups. Addressing stigma, confidentiality, and providing options like phone consultations can help. Effective mental health care in primary settings demands adaptability, recognizing that not all environments are fit for CC. Enhancing communication between psychiatrists and primary care providers is vital, especially in non-integrated settings. Telemedicine advancements can further facilitate this communication, especially in areas with a high concentration of healthcare professionals. [35]

References:

1. World Health Organization. (2001). Mental disorders affect one in four people. Retrieved from WHO website. https://www.who.int/news-room/detail/28-09-2001-the-world-health-report-2001-mental-disorders-affect-one-in-four-people
2. https://www.who.int/news-room/fact-sheets/detail/mental-disorders
3. Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of primary care to health systems and health. The Milbank Quarterly, 83(3), 457-502.
4. Kessler, R., & Stafford, D. (2008). Primary care is the de facto mental health system. Journal of the American Board of Family Medicine, 21(3), 183-187.
5. Corrigan, P. (2004). How stigma interferes with mental health care. American Psychologist, 59(7), 614.
6. Olfson, M., Kroenke, K., Wang, S., & Blanco, C. (2014). Trends in office-based mental health care provided by psychiatrists and primary care physicians. Journal of Clinical Psychiatry, 75(3), 247-253.
7. Samples, H., Stuart, E. A., Saloner, B., Barry, C. L., & Mojtabai, R. (2020). The Role of Screening in Depression Diagnosis and Treatment in a Representative Sample of US Primary Care Visits. Journal of general internal medicine, 35(1), 12–20. https://doi.org/10.1007/s11606-019-05192-3
8. Goodrich, D. E., Kilbourne, A. M., Nord, K. M., & Bauer, M. S. (2013). Mental health collaborative care and its role in primary care settings. Current psychiatry reports, 15(8), 383. https://doi.org/10.1007/s11920-013-0383-2
9. Abed Faghri, N. M., Boisvert, C. M., & Faghri, S. (2010). Understanding the expanding role of primary care physicians (PCPs) to primary psychiatric care physicians (PPCPs): enhancing the assessment and treatment of psychiatric conditions. Mental health in family medicine, 7(1), 17–25.
10. Gray VG, Brody SD, Johnston D. The evolution of behavioral primary care. Professional Psychology: Research and Practice 2005;36:123–9
11. Kolbasovsky A, Reich L, Romano I, et al. Integrating behavioral health into primary care settings: a pilot project. Professional Psychology: Research and Practice 2005;36:130–5
12. Coyne JC, Klinkman MS, Nease DE. Emotional disorders in primary care. Journal of Consulting and Clinical Psychology 2002;70:798–809.
13. Olfson M, Marcus SC, Druss B. National trends in the outpatient treatment of depression. Journal of the American Medical Association 2002;287:203–9
14. Clatney, L., Macdonald, H., & Shah, S. M. (2008). Mental health care in the primary care setting: family physicians' perspectives. Canadian family physician Medecin de famille canadien, 54(6), 884–889.

15. Poghosyan, L., Norful, A. A., Ghaffari, A., George, M., Chhabra, S., & Olfson, M. (2019). Mental health delivery in primary care: The perspectives of primary care providers. Archives of psychiatric nursing, 33(5), 63–67. https://doi.org/10.1016/j.apnu.2019.08.001

16. Rogers, R., Hartigan, S. E., & Sanders, C. E. (2021). Identifying Mental Disorders in Primary Care: Diagnostic Accuracy of the Connected Mind Fast Check (CMFC) Electronic Screen. Journal of clinical psychology in medical settings, 28(4), 882–896. https://doi.org/10.1007/s10880-021-09820-1

17. [1] Al-Krenawi, A., & Graham, J. R. (2000). Culturally sensitive social work practice with Arab clients in mental health settings.

18. Alattar N, Felton A, Stickley T. Mental health and stigma in Saudi Arabia: A scoping review. Mental Health Review Journal. 2021 May 27;26(2):180-96.

19. Al-Atram AA. Physicians' knowledge and attitude towards mental health in Saudi Arabia. Ethiopian journal of health sciences. 2018;28(6).

20. BinDhim NF, Althumiri NA, Basyouni MH, Alageel AA, Alghnam S, Al-Qunaibet AM, Almubarak RA, Aldhukair S, Ad-Dab'bagh Y. Saudi Arabia Mental Health Surveillance System (MHSS): Mental health trends amid COVID-19 and comparison with pre-COVID-19 trends. European Journal of Psychotraumatology. 2021 Jan 1;12(1):1875642.

21. Ministry of Health, Saudi Arabia. Mental health awareness campaigns.

22. Almalki, M., Fitzgerald, G., & Clark, M. (2011). Health care system in Saudi Arabia: An overview.

23. Al-Subaie, A., & Mohanna, M. (1999). Traditional healing experiences in patients attending a university hospital in Riyadh.

24. Qureshi, N. A., Al-Habeeb, A. A., & Koenig, H. G. (2013). Mental health system in Saudi Arabia: An overview.

25. Al-Gelban, K. S. (2009). Depression, anxiety and stress among Saudi adolescent school boys.

26. Siu, A. L., & US Preventive Services Task Force. (2016). Screening for depression in adults: US Preventive Services Task Force recommendation statement. JAMA, 315(4), 380-387.

27. Alegria, M., Vallas, M., & Pumariega, A. J. (2010). Racial and ethnic disparities in pediatric mental health. Child and Adolescent Psychiatric Clinics, 19(4), 759-774

28. Siu AL, Bibbins-Domingo K, Grossman DC, Baumann LC, Davidson KW, Ebell M, García FA, Gillman M, Herzstein J, Kemper AR, Krist AH. Screening for depression in adults: US Preventive Services Task Force recommendation statement. Jama. 2016 Jan 26;315(4):380-7.

29. Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. Journal of general internal medicine, 16(9), 606-613.

30. Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. Archives of internal medicine, 166(10), 1092-1097.

31. Babor TE, Higgins-Biddle J, Dauser D, Higgins P, Burleson JA. Alcohol screening and brief intervention in primary care settings: implementation models and predictors. Journal of studies on alcohol. 2005 May;66(3):361-8.

32. Gaynes, B. N., Rush, A. J., Trivedi, M. H., Wisniewski, S. R., & Balasubramani, G. K. (2005). Primary versus specialty care outcomes for depressed outpatients managed with measurement-based care: results from STAR*D. Journal of general internal medicine, 20(5), 402-409.

33. Mitchell, A. J., Vaze, A., & Rao, S. (2009). Clinical diagnosis of depression in primary care: a meta-analysis. The Lancet, 374(9690), 609-619

34. Shepherd N, Parker C. Depression in adults: recognition and management. Clin Pharm. 2017 Apr 5;9.

35. Moise, N., Wainberg, M., & Shah, R. N. (2021). Primary care and mental health: Where do we go from here?. World journal of psychiatry, 11(7), 271–276. https://doi.org/10.5498/wjp.v11.i7.271

36. Wittchen, H. U., Mühlig, S., & Beesdo, K. (2003). Mental disorders in primary care. Dialogues in clinical neuroscience, 5(2), 115–128. https://doi.org/10.31887/DCNS.2003.5.2/huwittchen