



## Prevalence, Recognition, And Management Of Mental Disorders In Primary Care

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Article History	Abstract
Received: Revised: Accepted:	<p>According to latest figures, 50% of individuals will have a minimum of one mental health issue in their lifetime, with at least 25% experiencing a mental condition in the previous year. primary care doctors are overwhelmingly responsible for recognition, evaluation, therapy, and referral, with at least one-third of their consultations containing a direct and obvious mental aspect Primary care physicians are the foundation of the majority of medical care programs that involve recognizing, diagnosing, treating, and referring patients to specialists for every kind of diseases, whether physical, mental, or both. Over the last two decades, there has been a greater emphasis on this position, notably in the treatment of mental problems in primary care.</p>
CC License CC-BY-NC-SA 4.0	<p><b>Keywords:</b> mental illness, primary care, treatment, recognition</p>

### Introduction:

Primary care physicians are the core of the majority of medical structures that focus on recognizing, diagnosing, treating, and referral patients to specialists for a variety of diseases, either physical, mental in nature or both. Over the past 20 years, there has been a greater focus on this position, notably regarding the management of mental problems in primary care [1]. Originating from an ever-more complicated society. Patients with mental disorder have more medical demands, as well as greater rates of illness and early death than individuals with no, a condition in which inadequate treatment is a significant cause [2].

Though research on extending expertise and skills in mental wellness and mental disorder care has become released, documented methods tend to be on a limited basis and lacking an emphasis on primary care. This is unexpected and troubling, given the importance of general practitioners in the field of mental wellness and the growing need of these patients [3]. Millions of individuals globally struggle with mental or psychological disorders. It is crucial to note that mental disorders and physical illnesses are linked, so they may constitute both the root cause and the outcome. Depression is expected to be the globe's second greatest source of diseases by 2030 [4]. The majority of persons with mental & emotional disorder (MED) are treated in primary health care (PHC). PHC is more accessible to people that do not participate in therapy than professional mental health treatments. Yet, only 49% of all PHC patients who have MED are identified, and just approximately 50% of them are treated appropriately. It is obvious that accurate evaluation and therapy of MED patients in PHC might have a significant socioeconomic effect, both personally and collectively. This is now one of among the most serious worldwide public health concerns. The majority of persons with MED are treated in basic health care (PHC). PHC is more accessible to people who have no interest in therapy than specialized mental health treatments [5].

Recognition and management of mental illnesses in older persons is a significant challenge for health care providers in Europe. Though evidence is scarce on how they are used for this purpose, electronic medical records (EMRs) provide significant potential in this area. To investigate the incidence and management of diagnosed mental disorders in older persons (over the age of 55) employing data from primary care EMRs. Resulting in it is possible to investigate mental illnesses in older persons utilizing data from EMRs. Mental problems are widespread among elderly people who seek primary care, and this study highlights the value of electronic medical records in epidemiology studies of large groups seeking primary care [6].

Depression and anxiety have a substantial impact on general well-being, interpersonal relationships, and work efficiency, which accounts for 18% to 39% of the overall Primary Care Visits. Based on statistics collected by the European Epidemiological Study (ESEMED) in primary care, depression is prevalent than anxiety 13.4% and 9.4%, respectively, with general anxiety disorder accounting for the greatest number of anxiety-related disorders at 8.5%, being followed by panic 2.2% and agoraphobia 1.5%. The majority of persons diagnosed in primary care for depression and anxiety (77.6%) are not given least acceptable care.

This proportion is not significantly higher in mental health, owing primarily to the high prevalence of prevalent mental diseases, which sadly contributes to delays in individual visits [7].

### **Prevalence of MD in PC:**

In industrialized countries such as the United Kingdom, the majority of patients who suffer from mental diseases acquire their care primarily through primary care. In England, about 3 million persons on local primary care (GP) registers had depression between 2013 and 2014, and roughly 500,000 have been identified with serious mental disorders (SMI), that describes individuals who have schizophrenia, bipolar disorder, or other psychosis. Furthermore, from 2012 to 2014, antidepressant prescriptions surged by 46% in England [8].

In developed nations, there are few nationwide research on the occurrence and prevalence of widespread psychiatric diseases in basic care. Yet, it is likely that a considerable majority of such illnesses receive treatment solely in primary care. Two questionnaire-based studies [9, 10] conducted in waiting spaces at primary health care centers in Sweden found that between 3.7 and 6.2% of patients showed signs of depression, and 11.8 to 13.5% exhibited signs of anxiety. According to studies [11, 12] carried out in the UK, which boasts a highly advanced primary medical system, the prevalence of depressive disorders is 13.9 per 1,000 person/years and anxiety is 9.7 per 1000 person/years. In Belgium [13], the average prevalence of depression detected in primary care averaged 7.2 for males and 14.4 for women per 1000 person/years. A recent Swedish research [8] found a 2.4% 1 year incidence of clinically recognized anxiety-, mood, stressful and behavioral adjustment disorders 3.2% in women and 1.5% in males. The researcher's analyzed information collected from a nearby primary health care registry comprised of 75 primary care centers in Stockholm, Värmland, Uppsala, and Gotland. None of those investigations calculated the percentage of patients treated solely in primary care [14]. In a paper used to assess the prevalence of mental health disorder in 4 countries.

1- Australia In 1997 and 2007, Australia conducted nationwide mental health assessments utilizing the Composites Integrated Diagnostic Interview (CIDI). Due to variations in technique, a straight comparison of prevalence's is hard. Yet, there was no decrease in incidence, with 18% having an anxiety, beneficial, or or drug use problem in 1997 compared to 20% in 2007 [15]. With a larger mental health staff, a greater consumption of antidepressants, as well as lately, a growing number of emotional treatments, especially e-therapy, Australia has seen higher funding committed to mental health care. Yet there is no indication of a

- decrease in the prevalence of illnesses or a decrease in symptoms. Statistics are actually pointing oppositely [16].
- 2- Canada over 20 years, big, comprehensive national health surveys in Canada has incorporated a short lay-administered assessment for episodes of major depression. In addition, two national mental health surveys utilized a Canadian variant of the CIDI in 2002 and 2012. The most recent analysis of predictions from this data library discovered no change in incidence between 1994 and 2012, with the overall slope of the meta-analysis line across time approximately zero [17] Plenty of proof of increased availability of medical services and medication for depression in Canada. Given this shift, there is no proof that the incidence of prevalent mental disorders has decreased over the years, as measured by the frequency of episodes of major depression in the previous year or by general distress rates [16].
  - 3- England Latest NPMS analysis indicated no discernible secular growth in the incidence of standard mental disorders in general or depressive episodes in specific between 1993 and 2007. In 1993, the incidence of usual mental disorders was 10.9% in males and 18.1% in women, but by 2007 it had risen to 11.8% and 18.9%, respectively. Since 1993, there has been an increase in the use of antidepressant medications hypnotic drugs, and potentially talking therapy in England. Yet, there is no indication of a drop in disease incidence or diminished symptoms in maturity. Changes are actually heading opposite direction [16].
  - 4- United states of America Very few investigations have looked at shifts in the incidence of prevalent psychological illnesses in the United States, mostly because evaluations and diagnostic standards used in broader mental health studies have evolved over time, making comparability challenging or even unattainable. However, there is little proof that the prevalence of these illnesses has decreased during the past twenty or thirty years, according to existing data [18]. Almost every investigation that has looked at changes in the application of mental health therapies in the United States has discovered an increase since the beginning of the 1990s. The rise was most pronounced between the start of the 1990s and the start of the 2000s, and it was greater for antidepressant prescription therapy, particularly SSRIs. Yet there is no indication of a similar decrease in the prevalence of mental diseases or mental health issues among US adults during the same time. Some proof even suggests that the prevalence of depressive disorders and impairment may be increasing as a result of mental health issues [19].

### **Recognition of MD in PC:**

The primary care environment in low- and middle-income countries (LMICs) is quite distinct from that in wealthy nations. The key distinctions are: care is offered by non-physicians with less practice; the hospital's staff to population proportion is exceptionally inadequate, resulting in a greater amount of patient load per doctor; a chronic care approach, where patients possess the ability to interact with just one doctor and receive surveillance regularly, is hardly heard of in several LMICs; and the client profile in regards to learning, behavioral understanding, and socio-economic status. In many LMICs, these variables, both separately and together, combine against use of services or diagnosis of depression. Therefore, in wealthy countries, approximately half of the instances of depressive disorders seen in primary care go undiagnosed [20].

Despite recognition does not guarantee adequate care, it is a crucial phase on the road to high-quality treatment. Inadequate diagnosis will also have major ramifications for plans to speed up comprehensive health care, particularly an absence in political support. Identifying the variables that influence primary care personnel's recognition of depression is critical [21].

Recognizing the responsibility of mental illnesses, WHO created the Mental Health Gap Action Program (MH GAP) to increase primary care resources for mental, neurological, and addictive disorders, as well as the Mental Health Action Agenda 2013-2020 to widen mental health care in places with limited resources [22]. The proof demonstrates that grassroots initiatives and task-shifting strategies can assist in delivering efficient mental health services in PHCs. Essential mental health education along with suitable guidance by experts in the field can help non-specialist medical professionals identify, recognize, and manage patients who have mental illnesses, thereby decreasing the number of unneeded inquiries and unsuitable and non-specific therapies [23].

Major depressive disorder is a prevalent illness observed in primary care, frequently accompanied by physical symptoms. It could turn out to be a chronic illness with significant morbidity and an elevated likelihood of relapse and repetition. Depressive disorder has a bidirectional connection with long-term medical conditions, as well as a strong correlation with age and comorbid mental illnesses (e.g., anxiety disorders). Testing for severe depression can be done using clinical instruments like the Student Healthcare Inquiries-2, Patients Health Inquiries-9, and Beck Distress inventory, so that therapy can begin on time. To lower deaths and morbidity, an accurate recognition of serious sadness and its extent is required [24].

Adolescence depressive episode is regarded as a severe mental health condition with significant both acute and long-term deaths and morbidity. According to research, just half of all teenagers experiencing sadness receive treatment before reaching maturity. In primary care (PC), as much as two out of every three adolescent with depression are not detected by their PC providers and aren't given any treatment. When these individuals get identified by PC physicians, barely half of them receive adequate treatment. In addition, completing rates of specialized mental health referrals from primary healthcare providers for kids with a documented behavioral disorder are poor [25].

### **Management of MD in PC:**

For over ten years, professionals have advocated for the integration of mental wellness care in primary care in order to overcome the mental health Treatment Gap. General practitioners (GPs) are often the first point of contact for individuals suffering from mental illness. By the conclusion of 2015, the World Health Organization's MH GAP has been systematically deployed to its network of more than 10,000 medical centers in Indonesia as an addition psychological education for partners of GPs and Nurses. An integrated medical paradigm occurs in one of the 34 provinces, with clinical psychologists co-located in primary care facilities. The large Therapy Gap is exacerbated in numerous nations by a lack of mental health specialists and inadequate demand for psychiatric care due to shame. While the global Therapy Gap for psychosis is 32.2%, the Therapy Gap in Low and Middle-Income Countries (LMICs) is projected to be higher than 90%, and allegedly 96.5% in rural areas of Indonesia [26].

The vast majority of people with depression receive treatment in general care, with just a tiny percentage being admitted to mental health facilities. Although numerous randomized pharmacological and treatment trials, only a small fraction of these trials have concentrated on primary care patients. The findings for therapy in specialist mental health care may not be applicable to depressed primary care patients, as depression is thought to be milder in primary care patients [27]. Even though both antidepressants and psychotherapy have minor but favorable benefits for depression, with no medically significant distinctions in the short term, many primary care doctors prescribe antidepressant drugs to depressed patients [28]. Yet, most of patients favor psychological therapies. A systematic review of 34 studies from different PCs found that on a typical basis, 75 % of those with mental illnesses favored psychotherapy over medications, particularly younger patients, though there are a few signs that these findings may be associated with the degree of depressive disorders, with higher-risk patients preferring medication frequently [29].

Cognitive behavior therapy (CBT), behavioral activation treatment (BAT), interpersonal psychotherapies (IPT), solving issues therapy, and non-directive therapy have all been studied the most in primary care settings. The meanings of each of those therapies are provided, in addition to a few significant sources for proof for their efficacy. Numerous additional types of therapy are employed in mental health facilities but have not been extensively investigated in primary care settings. Quick psychodynamic approaches, life review therapy, and mindfulness-based CBT are among the options [30]. The purpose of this study was to compare the efficacy of three low-intensity, online psychological treatments healthy lifestyle psych educational system [HLP], a centered program on positive affect promotion [PAPP], and a brief therapy based on awareness [MP] to the control group (enhancing therapy as typical), Low-intensity internet-based psychological therapies (HLP and MP) are more successful than iTAU after treatment for depressive disorders in primary care. Furthermore, all low-intensity psychological therapies improve moderately and for a long time standards of life. PAPP is beneficial in treating depression by enhancing health-related aspects of existence, adverse effects, and health. Nonetheless, it is critical to investigate potential causes for PAPP's ineffectiveness in lowering depressed symptoms; also, more study is required to evaluate the cost-effectiveness assessment of these therapies [31].

### **Conclusion:**

More research is needed to assess not just the high incidence of mental problems in PC, but also the related load, the utilization of medical services, the efficacy of therapies provided by PC medical professionals, and individuals' clinical development. This is particularly important for depressed individuals due to their high incidence and the fact that optimal mental health and overall well-being can be achieved, while paying enough attention to developing adequate methods of accurate diagnosis of multiple mental disorders and for the management of the patients by providing suitable regimen of treatment & well educated GPs.

**References:**

1. Wittchen, H. U., Mühlig, S., & Beesdo, K. (2003). Mental disorders in primary care. *Dialogues in clinical neuroscience*, 5(2), 115-128.
2. Pouls, K. P., Koks-Leensen, M. C., Mastebroek, M., Leusink, G. L., & Assendelft, W. J. (2022). Adults with intellectual disabilities and mental health disorders in primary care: a scoping review. *The British journal of general practice: the journal of the Royal College of General Practitioners*, 72(716), e168–e178. <https://doi.org/10.3399/BJGP.2021.01642>
3. van Venrooij, L. T., Rusu, V., Vermeiren, R. R. J. M., Kuposov, R. A., Skokauskas, N., & Crone, M. R. (2022). Clinical decision support methods for children and youths with mental health disorders in primary care. *Family practice*, 39(6), 1135–1143. <https://doi.org/10.1093/fampra/cmab051>
4. de Azevedo Marques, J. M., & Zuardi, A. W. (2008). Validity and applicability of the Mini International Neuropsychiatric Interview administered by family medicine residents in primary health care in Brazil. *General hospital psychiatry*, 30(4), 303-310.
5. Moscovici, L., De Azevedo-Marques, J., Bolsoni, L., Rodrigues-Junior, A., & Zuardi, A. (2018). Impact of different approaches of primary care mental health on the prevalence of mental disorders. *Primary Health Care Research & Development*, 19(3), 256-263. doi:10.1017/S1463423617000743
6. McCombe, G., Fogarty, F., Swan, D., Hannigan, A., Fealy, G. M., Kyne, L., & Cullen, W. (2018). Identified mental disorders in older adults in primary care: A cross-sectional database study. *European Journal of General Practice*, 24(1), 84-91.
7. Martín, J. C., Garriga, A., Egea, C., Díaz, G., Campillo, M. J., & Espinosa, R. M. (2018). Stepped psychological intervention with common mental disorders in Primary Care. *anales de psicología*, 34(1), 30.
8. Grigoroglou, C., Munford, L., Webb, R., Kapur, N., Ashcroft, D., & Kontopantelis, E. (2020). Prevalence of mental illness in primary care and its association with deprivation and social fragmentation at the small-area level in England. *Psychological Medicine*, 50(2), 293-302. doi:10.1017/S0033291719000023
9. Bodlund, O. (1997). Anxiety and depression as a hidden problem in primary health care. Only one case in four identified. *Lakartidningen*, 94(49), 4612-4.
10. Nordström, A., & Bodlund, O. (2008). Every third patient in primary care suffers from depression, anxiety or alcohol problems. *Nordic journal of psychiatry*, 62(3), 250-255.3.
11. Martín-Merino, E., Ruigómez, A., Johansson, S., Wallander, M. A., & García-Rodríguez, L. A. (2010). Study of a cohort of patients newly diagnosed with depression in general practice: prevalence, incidence, comorbidity, and treatment patterns. *The Primary Care Companion for CNS Disorders*, 12(1), 26885.
12. Martín-Merino, E., Ruigomez, A., Wallander, M. A., Johansson, S., & García-Rodríguez, L. A. (2010). Prevalence, incidence, morbidity and treatment patterns in a cohort of patients diagnosed with anxiety in UK primary care. *Family practice*, 27(1), 9-16.
13. Boffin, N., Bossuyt, N., Declercq, T., Vanthomme, K., & Van Casteren, V. (2012). Incidence, patient characteristics and treatment initiated for GP-diagnosed depression in general practice: results of a 1-year nationwide surveillance study. *Family practice*, 29(6), 678-687.
14. Lejtzen, N., Sundquist, J., Sundquist, K., & Li, X. (2014). Depression and anxiety in Swedish primary health care: prevalence, incidence, and risk factors. *European archives of psychiatry and clinical neuroscience*, 264, 235-245.
15. Department of Health and Ageing. (2013). National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993–2011.
16. Jorm, A. F., Patten, S. B., Brugha, T. S., & Mojtabai, R. (2017). Has increased provision of treatment reduced the prevalence of common mental disorders? Review of the evidence from four countries. *World Psychiatry*, 16(1), 90-99.
17. Patten, S. B., Williams, J. V. A., Lavorato, D. H., Bulloch, A. G. M., Wiens, K., & Wang, J. (2016). Why is major depression prevalence not changing?. *Journal of affective disorders*, 190, 93–97. <https://doi.org/10.1016/j.jad.2015.09.002>
18. Kessler, R. C., Demler, O., Frank, R. G., Olfson, M., Pincus, H. A., Walters, E. E., Wang, P., Wells, K. B., & Zaslavsky, A. M. (2005). Prevalence and treatment of mental disorders, 1990 to 2003. *The New England journal of medicine*, 352(24), 2515–2523. <https://doi.org/10.1056/NEJMsa043266>
19. Mojtabai R. (2011). National trends in mental health disability, 1997-2009. *American journal of public health*, 101(11), 2156–2163. <https://doi.org/10.2105/AJPH.2011.300258>

20. Mitchell, A. J., Rao, S., & Vaze, A. (2011). International comparison of clinicians' ability to identify depression in primary care: meta-analysis and meta-regression of predictors. *British Journal of General Practice*, 61(583), e72-e80.
21. Fekadu, A., Medhin, G., Selamu, M., Giorgis, T. W., Lund, C., Alem, A., ... & Hanlon, C. (2017). Recognition of depression by primary care clinicians in rural Ethiopia. *BMC family practice*, 18(1), 1-9.
22. Saxena, S., Funk, M., & Chisholm, D. (2013). World health assembly adopts comprehensive mental health action plan 2013–2020. *The Lancet*, 381(9882), 1970-1971.
23. Olofsson, S., Sebastian, M. S., & Jegannathan, B. (2018). Mental health in primary health care in a rural district of Cambodia: a situational analysis. *International journal of mental health systems*, 12(1), 1-13.
24. Ng, C. W. M., How, C. H., & Ng, Y. P. (2016). Major depression in primary care: making the diagnosis. *Singapore medical journal*, 57(11), 591.
25. Zuckerbrot, R. A., Cheung, A., Jensen, P. S., Stein, R. E., Laraque, D., Levitt, A., ... & GLAD-PC STEERING GROUP. (2018). Guidelines for adolescent depression in primary care (GLAD-PC): Part I. Practice preparation, identification, assessment, and initial management. *Paediatrics*, 141(3).
26. Anjara, S. G., Bonetto, C., Ganguli, P., Setiyawati, D., Mahendradhata, Y., Yoga, B. H., & Van Bortel, T. (2019). Can General Practitioners manage mental disorders in primary care? A partially randomised, pragmatic, cluster trial. *PLoS One*, 14(11), e0224724.
27. Bortolotti, B., Menchetti, M., Bellini, F., Montaguti, M. B., & Berardi, D. (2008). Psychological interventions for major depression in primary care: a meta-analytic review of randomized controlled trials. *General hospital psychiatry*, 30(4), 293-302.
28. Olfson, M., & Marcus, S. C. (2010). National trends in outpatient psychotherapy. *American Journal of Psychiatry*, 167(12), 1456-1463...
29. McHugh, R. K., Whitton, S. W., Peckham, A. D., Welge, J. A., & Otto, M. W. (2013). Patient preference for psychological vs. pharmacologic treatment of psychiatric disorders: a meta-analytic review. *The Journal of clinical psychiatry*, 74(6), 13979.
30. Cuijpers, P., Quero, S., Dowrick, C., & Arroll, B. (2019). Psychological treatment of depression in primary care: recent developments. *Current psychiatry reports*, 21, 1-10
31. Gili, M., Castro, A., García-Palacios, A., Garcia-Campayo, J., Mayoral-Cleries, F., Botella, C., ... & Baños, R. M. (2020). Efficacy of three low-intensity, internet-based psychological interventions for the treatment of depression in primary care: randomized controlled trial. *Journal of medical Internet research*, 22(6), e15845.