

# Making the Invisible Visible: Routine Mental Health Screening as a Primary Care Standard

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Dear Editor,

Mental health can no longer remain the hidden diagnosis of primary care. The World Health Organization recently reported that more than 1 billion people are living with mental health disorders, with anxiety and depression among the most common conditions and a major source of long-term disability worldwide (World Health Organization, 2025). Yet for many patients, particularly in low- and middle-income countries, primary care remains the first and sometimes the only point of contact with the health system (Alegre et al., 2024). In this context, routine mental health screening should not be viewed as an optional service; it should be treated as a basic standard of comprehensive care.

The need is especially urgent because common mental health disorders rarely present in a clear psychiatric language. Depression, anxiety and stress-related disorders often appear as fatigue, sleep disturbance, headache, palpitations, chronic pain or gastrointestinal complaints. Without a structured screening approach, these patients may experience repeated consultations, unnecessary investigations and delayed treatment while the underlying psychological distress remains unrecognized. In South Asia and other resource-constrained regions, this challenge is intensified by stigma, low mental health literacy and limited specialist availability (Naveed et al., 2020; Keynejad, Spagnolo and Thornicroft, 2022).

Practical screening pathways already exist. Ultra-brief tools such as the PHQ-2 can be used as an entry point during triage, vital-sign assessment or routine chronic disease review, followed by the PHQ-9 when results are positive (Kroenke, Spitzer and Williams,

2003; Kroenke, Spitzer and Williams, 2001). Similarly, the GAD-2 or GAD-7 can help identify clinically significant anxiety symptoms, with the GAD-7 supported by strong evidence in clinical and general population settings (Spitzer et al., 2006; Löwe et al., 2008). These instruments are brief, inexpensive, easy to score and suitable for repeated monitoring. However, screening must not be reduced to a checklist exercise. A positive result should trigger clinical evaluation, suicide-risk assessment when indicated, consideration of medical differentials, shared decision-making, and a clear plan for counselling, treatment, follow-up or referral.

Implementation barriers are real but manageable. Primary care providers often face high patient volume, limited consultation time, inadequate mental health training, weak referral systems and stigma at both patient and provider levels (Sangwan et al., 2024). These barriers can be addressed through a stepped model: administer ultra-brief screeners at registration or nursing assessment; train nurses, general practitioners and community health workers in basic mental health recognition; use locally validated and culturally adapted tools; create simple referral algorithms; and use digital reminders or electronic health records to support follow-up. Recent evidence also suggests that time-efficient screening tools can support general practitioners in identifying patients with mental health problems, although stronger implementation studies are still needed (Neulinger et al., 2024).

Making mental health screening routine would help shift primary care from a reactive model to a preventive and person-centred model. Screening is not a replacement for clinical judgement, specialist care or

psychosocial support; rather, it is the doorway through which silent distress becomes visible and treatable. We therefore urge policymakers, health-system leaders and primary care institutions to mandate routine mental health screening, fund workforce training, strengthen

referral pathways and monitor implementation as a quality-of-care indicator. The time has come to move mental health screening from the margins of practice to the core of primary care.

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## Statements and Declarations

### Keywords

Mental Health; Primary Care; Depression Screening; Anxiety Screening; Public Health; Low- and Middle-Income Countries.

### Ethics Approval

Ethical approval was not required, as this letter is a commentary based on existing published literature and did not involve human participants, animal subjects, or the collection of primary data.

### Conflict of Interest

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### Data Availability

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