

The survey of primary care physicians regarding attitude, confidence and knowledge in providing mental health care in Qatar

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Abstract

Background: In Qatar, the enormous cost of mental health disorders has spurred a primary care-driven national strategy to improve mental health treatment access. However, attitudes, confidence and knowledge about mental health treatment can widely vary in the Qatari primary care physician population, which can have significant implications for the quality of mental health treatment delivery. We know of no published data on these characteristics.

Materials and Methods: We collected anonymous surveys from primary care physicians working in the Primary Health Care Corporation (PHCC). The survey collected demographic data about the respondents, and used the well-validated Mental Illness: Clinicians' Attitude Scale (MICA-4) to assess attitudes and confidence about mental health treatment, as well as a knowledge assessment tool developed locally.

Results: There were 115 respondents, most of whom were male (67%) and aged 36-55 (80.4%). Most respondents (75.7%) had less than two years of psychiatric training or experience, and had taken two or fewer psychiatric education courses in the last year (83.4%).

Most of the physicians expressed positive attitudes about mental health and confidence about treating it. Although respondents lacked in the mental health knowledge when judged against the local policies, they showed good fundamental knowledge of diagnosing and treating common mental health problems. The majority of the physicians chose SS-RIs (citalopram, fluoxetine, paroxetine) as first line treatment of depression (81%) and anxiety (90%). However, they could not identify the proper protocol to manage SSRI-induced hypomania (76.5%). They did identify the importance of thyroid function screening (87.8%) and evidence-based non-pharmacological treatment (71.3%).

Conclusion: Primary care physicians in Qatar are willing to treat mental health conditions and feel confident about doing so. They have good fundamental knowledge but appear to lack knowledge of local (PHCC) policies about managing common mental health conditions.

Limitations: Study limitations include the use of subjective survey data and use of a knowledge assessment tool validated solely by local expert consensus.

Key words: primary care, psychiatry, mental health treatment, quality improvement, mental health care, Qatar

Introduction

Mental health conditions make up about one-third of the total adult disability burden worldwide (1,7). In 2017, estimates show that 970 million people — one out of every eight people — were diagnosed with either a mental health condition or a substance use disorder (8). The economic and social costs of mental health conditions far exceed that of any other category of illness (17). Personal costs of mental illness are also massive: in high-income countries, 90% of suicidal deaths can be attributed to mental health or substance use disorders (8). These alarming numbers show no signs of stopping, as an increasing number of adolescents admit to having mental health problems. Suicide remains the leading cause of death in this age group (2).

Primary care physicians are tasked with the vast majority of the treatment responsibility for mental health conditions. According to a World Health Organization (WHO) study, about one-third of primary care consultations are requested to treat mental health conditions (1). Primary care physicians assume the majority of responsibility for the treatment of depression and anxiety. For most primary care physicians worldwide, they are expected to be the first and most heavily utilized treatment providers for mental health care.

When primary care physicians are involved in mental health care treatment, research shows that treatment outcomes improve (11, 12, 13). Such data supports the notion that early intervention is highly beneficial for those with mental health conditions, despite differences in knowledge and experience between mental health specialists and primary care physicians. There are several distinct advantages to mental health treatment from a primary care physician. Treatment in this setting is accessible, affordable and acceptable to patients and their families (3). Compared to the specialist mental health services, there is less risk of stigma with primary care management of mental health problems (4).

Qatar launched its own national mental health strategy in 2013 where it set out its vision for mental health treatment in the country (5). The main aim of this strategy is to ensure that there is provision of good mental health care for the people of Qatar — care that is supported by integrated mental health services with access to the right treatment, at the right time and at the right place. Primary care is the core of integrated mental health care. This treatment model is in line with the vision of the WHO, which also encourages the provision of integrated mental health care that is both accessible and free from stigma.

Primary care physicians are therefore at the center of this strategy. It is therefore crucial to gain an understanding of the attitude, knowledge and skills of primary care physicians regarding the treatment of mental health conditions. Such data could more effectively guide the efforts to improve mental health treatment delivery in the community. However, there are very few studies on this topic to date (6). Most of the research about provider knowledge and

confidence about mental health treatment is focused on the secondary care of mental health in hospital settings by psychiatrists. In Qatar, there are no existing studies of these attributes in primary care providers; given the Qatar national mental health strategy, it is imperative to conduct research in this field.

Current evidence suggests that knowledge about mental health care can vary widely in the primary care physician population, despite the centrality of their role in mental health treatment (16). Assessments of this population's attitudes and confidence about treating mental health conditions is critical, as these qualities may or may not be in phase with their knowledge base, with significant treatment implications in either case.

Materials and Methods

We collected demographic and practice data about the respondents in five domains: age range, gender, certification type, years of psychiatric training or experience and number of psychiatric educational activities undertaken in the last 12 months (see Appendix 1).

To assess primary care physicians' attitudes about mental health treatment, we used the Mental Illness: Clinicians' Attitude Scale (MICA-4), a well-validated tool developed in the United Kingdom by Thornicroft, Kassam and colleagues in 2010, with express permission from the authors (18). The MICA-4 is a 28-item questionnaire, consisting of statements with which respondents can indicate their level of agreement using Likert scale responses. Of these items, 16 of them measure respondents' attitudes about mental health (see Appendix 2).

Similarly, 12 subsequent items devised by the authors assessed the respondents' confidence about commonly encountered aspects of mental health treatment provision, again using a Likert scale to signify agreement with the metric's suggested terms (see Appendix 3).

A 10-item, multiple choice knowledge assessment was designed by the authors and administered to respondents, aiming to ascertain primary care physicians' understanding of mental health care management. The examination items were intended to portray common encounters of mental health treatment in the primary care setting. The examination included questions about diagnostic criteria for common conditions, psychiatric medication management and evidence-based psychosocial treatment. The questions were designed to assess the diagnosis and treatment of most common mental health conditions, including generalized anxiety disorder and depression (see Appendix 4).

The four parts of the assessment tool were combined into a single survey, which was then sent anonymously (via the web-based survey administration application Google Forms) to primary care physicians in Qatar's Primary Health Care Corporation (PHCC) system via email. Participation in the study was entirely voluntary, creating a "variable sampling" study design.

Results

There were 115 respondents to the survey. Results were analyzed using descriptive statistics.

Demographics

By far, the most represented age demographic in the responding population were those 36-45 (59.1% of respondents) and 46-55 (31.3%). Respondents were predominantly male, by a ratio of about 2 to 1 (67% vs 33%). The vast majority of surveyed physicians obtained practice qualification through one of three means: Membership of the Royal College of General Practitioners in the United Kingdom, or MRCGP UK (47%), the Arab Board (21.7%) or the General Practitioner, or GP, qualification (13.9%). Most respondents (75.7%) had less than two years of psychiatric training or experience and had taken two or fewer psychiatric education courses in the last year (83.4%).

Age group of respondent		
Age	Frequency (n)	Percentage (%)
25 - 35	3	2.61
36 - 45	68	59.13
46 - 55	36	31.30
56 - 75	8	6.96
Total	115	100.00

Table 1: Age of survey respondents

Gender	Frequency (n)	Percentage (%)
Male	77	66.96
Female	38	33.04
Total	115	100.00

Table 2: Gender of survey respondents

Qualification	Frequency (n)	Percentage (%)
MRCGP UK	54	46.96
Arab Board	25	21.74
GP	16	13.91
MRCGP International	7	6.09
American Board of Pediatrics	1	0.87
Egyptian integrated course of family medicine	1	0.87
MBBS	2	1.74
MICGP, FRCPI, FRCP	1	0.87
MRCPsych	1	0.87
Arab board /Jordanian board	1	0.87
FRACGP	2	1.74
Arab Board + Egyptian fellowship=MRCGP (international)	1	0.87
MMCH	1	0.87
Missing	2	1.74
Total	115	100.00

Table 3: Qualification of survey respondents

Attitude

Survey respondents typically had positive and proactive attitudes toward mental health care; for example, out of 115 respondents, most (65.2%) disagreed that they learn mental health strictly out of obligation, and they largely (77.5%) disagreed with the idea that those with mental illness cannot recover enough to have a good quality of life. and the large majority (83.5%) had at least some level of agreement that they feel just as comfortable talking to someone with a mental illness as they do with someone with a physical illness. An overwhelming majority (87.8%) of respondents felt that working in mental health was just as respectable as working in other health disciplines, and 3 out of every 4 respondents (74.1%) disagreed with the idea that working in mental health was not like working in a “real” health field.

Results were more mixed when respondents answered more personal hypothetical questions about mental illness: nearly half (46.1%) agreed that if they had a mental illness, they would never disclose the mental illness to a friend for fear of being treated differently, and over half (53.9%) agreed that they wouldn't tell a colleague. However, when given the scenario that a colleague had a mental illness, nine of ten respondents (89.5%) expressed continued desire to work with that colleague.

Primary care physicians also felt that people with severe mental illness can be dangerous. A little over half (51.4%) of respondents believed, at some level, that people with severe mental illness are dangerous more often than not. A large majority (74.7%) disagreed with the idea that the public does not need to be protected against those with severe mental illness.

Yet, such concerns did not seem to affect the respondents' sense of comfort with and respect for people with mental illness. The most strongly held sentiment in the entire survey came from the 74 respondents (64.5%) who strongly disagreed with the statement “I would use terms like ‘crazy’, ‘nutter’, ‘mad’, etc. to describe to a colleague someone with a mental illness who I have seen in my work.” Nine of ten respondents (89.5%) expressed some level of disagreement with the statement. About five out of every six respondents (83.5%) stated that they feel as comfortable talking to a person with mental illness as they did talking to a person with a physical illness. Nearly four out of five (78.2%) stated that if a senior colleague instructed them to treat people with a mental illness in a disrespectful manner, they would not follow the colleague's instructions. Notably, 56.5% strongly agreed with this sentiment.

The group was also mostly in accordance when offering opinions about the role of health providers in patients with mental illness. There was nearly universal agreement (96.6%) that anyone who supports someone with a mental illness should ensure that their physical health is assessed. The majority of the group (60.3%) believed that health care/social care staff know more about the lives of people with mental illness than do their family or friends. More than four out of five respondents (81.5%) disagreed with the idea that they would ascribe physical symptoms to mental illness. Finally, three out of four respondents (75.6%) strongly disagreed with the opinion that general practitioners should not be expected to complete a thorough assessment for people with psychiatric symptoms since they can be referred to a psychiatrist.

Table 2 - Responses for confidence rating

Response items	Strongly disagree	Disagree	Somewhat disagree	Neutral	Somewhat agree	Agree	Strongly agree	Missing
I feel confident in my clinical ability to detect common mental health problems like anxiety or depression	1 (0.9%)	0	4 (3.5%)	2 (1.7%)	19 (16.5%)	1 (0.9%)	88 (76%)	0
I feel confident in my clinical ability to detect serious mental health problems like psychosis (including schizophrenia)	3 (2.6%)	1 (0.9%)	5 (4.3%)	23 (20%)	41 (35.7%)	0	42 (36.5%)	0
I feel confident in my clinical ability to detect substance misuse problems	1 (0.9%)	0	7 (6.1%)	32 (27.8%)	53 (46.1%)	0	22 (19.1%)	0
I feel confident in my clinical ability to take a proper psychiatric history	0	0	5 (4.3%)	11 (9.6%)	51 (44.3%)	0	48 (41.7%)	0
I feel confident in my clinical ability to carry out a mental state examination	0	0	7 (6.1%)	14 (12.2%)	36 (31.3%)	0	58 (50.4%)	0
I feel confident in my clinical ability to do risk assessment in a patient with mental health problem	1 (0.9%)	0	4 (3.5%)	11 (9.6%)	56 (48.7%)	0	43 (37.4%)	0
I feel confident in my clinical ability to complete PHQ-9 and HADS-7	1 (0.9%)	0	4 (3.5%)	7 (6.1%)	19 (16.5%)	0	84 (73%)	0
I feel confident in my clinical ability to make diagnosis of a common mental health problem like anxiety or depression	0	0	2 (1.7%)	5 (4.3%)	21 (18.3%)	0	85 (73.9%)	2 (1.7%)
I feel confident in my clinical ability to provide active listening and helpful advice to the patients suffering from common mental health problems like anxiety or depression	0	0	1 (0.9%)	5 (4.3%)	36 (31.3%)	0	73 (63.5%)	0
I feel confident in my clinical ability to initiate / change pharmacological treatment for common mental health problem like anxiety or depression	2 (1.7%)	0	5 (4.3%)	8 (7%)	42 (36.5%)	0	58 (50.4%)	0
I feel confident in my clinical ability to provide psycho-education to patients with common mental health problems like anxiety or depression	1 (0.9%)	0	9 (7.8%)	9 (7.8%)	50 (43.5%)	0	46 (40%)	0
I feel confident in my clinical ability to manage patients with suicide/self-harm tendencies	15 (13%)	0	15 (13%)	24 (20.9%)	41 (35.7%)	0	20 (17.4)	0

Confidence

Respondents expressed high levels of confidence about their abilities to detect common mental health problems like anxiety or depression (94.3%) and with 92.5% of this physician group at least somewhat agreeing that they feel competent at treating these conditions. Nearly three out of four (73.9%) respondents strongly felt that they could readily make diagnoses of depression and anxiety. When asked if they felt confident about medication management for common conditions, 86.5% of physicians agreed (at least in part) that they do.

With regards to identifying serious mental health conditions (e.g., psychosis or schizophrenia), more than two third (72%) felt confident enough to detect these conditions in the community. Similarly, nearly two thirds (65%) of the physicians, felt confident in diagnosing substance use disorders. More than 9 out of 10 physicians (94.8%) felt confident to listen to patients and provide psychological advice to them. A vast majority of the physicians (86.1%) felt confident in carrying out risk assessment on mental health patients, but only about half of the physicians (53.1%) felt confident that they can manage patients with suicide / self-harm risks.

Table 2 - Responses for confidence rating

Response items	Strongly disagree	Disagree	Somewhat disagree	Neutral	Somewhat agree	Agree	Strongly agree	Missing
I feel confident in my clinical ability to detect common mental health problems like anxiety or depression	1 (0.9%)	0	4 (3.5%)	2 (1.7%)	19 (16.5%)	1 (0.9%)	88 (76%)	0
I feel confident in my clinical ability to detect serious mental health problems like psychosis (including schizophrenia)	3 (2.6%)	1 (0.9%)	5 (4.3%)	23 (20%)	41 (35.7%)	0	42 (36.5%)	0
I feel confident in my clinical ability to detect substance misuse problems	1 (0.9%)	0	7 (6.1%)	32 (27.8%)	53 (46.1%)	0	22 (19.1%)	0
I feel confident in my clinical ability to take a proper psychiatric history	0	0	5 (4.3%)	11 (9.6%)	51 (44.3%)	0	48 (41.7%)	0
I feel confident in my clinical ability to carry out a mental state examination	0	0	7 (6.1%)	14 (12.2%)	36 (31.3%)	0	58 (50.4%)	0
I feel confident in my clinical ability to do risk assessment in a patient with mental health problem	1 (0.9%)	0	4 (3.5%)	11 (9.6%)	56 (48.7%)	0	43 (37.4%)	0
I feel confident in my clinical ability to complete PHQ-9 and HADS-7	1 (0.9%)	0	4 (3.5%)	7 (6.1%)	19 (16.5%)	0	84 (73%)	0
I feel confident in my clinical ability to make diagnosis of a common mental health problem like anxiety or depression	0	0	2 (1.7%)	5 (4.3%)	21 (18.3%)	0	85 (73.9%)	2 (1.7%)

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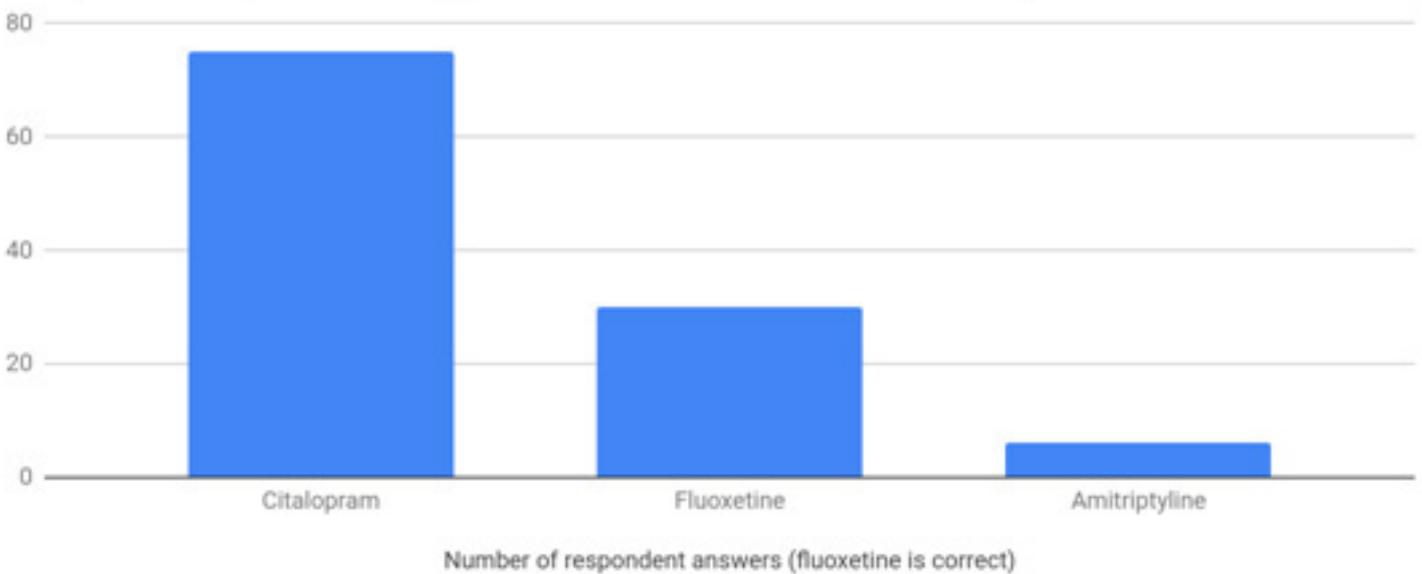
I feel confident in my clinical ability to provide active listening and helpful advice to the patients suffering from common mental health problems like anxiety or depression	0	0	1 (0.9%)	5 (4.3%)	36 (31.3%)	0	73 (63.5%)	0
I feel confident in my clinical ability to initiate / change pharmacological treatment for common mental health problem like anxiety or depression	2 (1.7%)	0	5 (4.3%)	8 (7%)	42 (36.5%)	0	58 (50.4%)	0
I feel confident in my clinical ability to provide psycho-education to patients with common mental health problems like anxiety or depression	1 (0.9%)	0	9 (7.8%)	9 (7.8%)	50 (43.5%)	0	46 (40%)	0
I feel confident in my clinical ability to manage patients with suicide/self-harm tendencies	15 (13%)	0	15 (13%)	24 (20.9%)	41 (35.7%)	0	20 (17.4)	0

Knowledge

During the knowledge assessment, this primary care physician group was easily able to identify the most important laboratory value for common mental health conditions like depression and anxiety, with 87.8% of respondents correctly answering, “thyroid function tests.” Generally, they also correctly identified the most evidence-based psychosocial treatment as cognitive behavioral therapy (71.3%). The group had mixed success with medication management questions. The vast majority of the physicians chose SSRIs (citalopram, fluoxetine, paroxetine) as first line treatment of depression (81%) or anxiety (90%) which is in line with the National Institute for Health and Care Excellence (NICE) guidelines in the United Kingdom (19, 20). Respondents did not know the first line SSRI treatments for depression (73.9% with an incorrect answer) or anxiety (89.6%), as per PHCC’s policy. Also, they could not identify the proper protocol to manage SSRI-induced hypomania (76.5%).

Of note, qualification through MRCGP UK was associated with a choice of SSRI for first-line treatment of depression (OR = 17.99, 95% CI 1.01 to 319.69, p = 0.049), and was highly correlated with an answer of paroxetine (the correct answer per PHCC policy) for the first-line treatment of anxiety (OR = 48.24, 95% CI 2.77 to 838.69, p = 0.0078); all 12 correct responses came from physicians with the MRCGP UK qualification.

Which antidepressant would you consider as your first choice for the treatment of depression (considering there are no contraindications) in PHCC?



Which medication would you consider as your first choice for the treatment of Generalized Anxiety Disorder in PHCC?

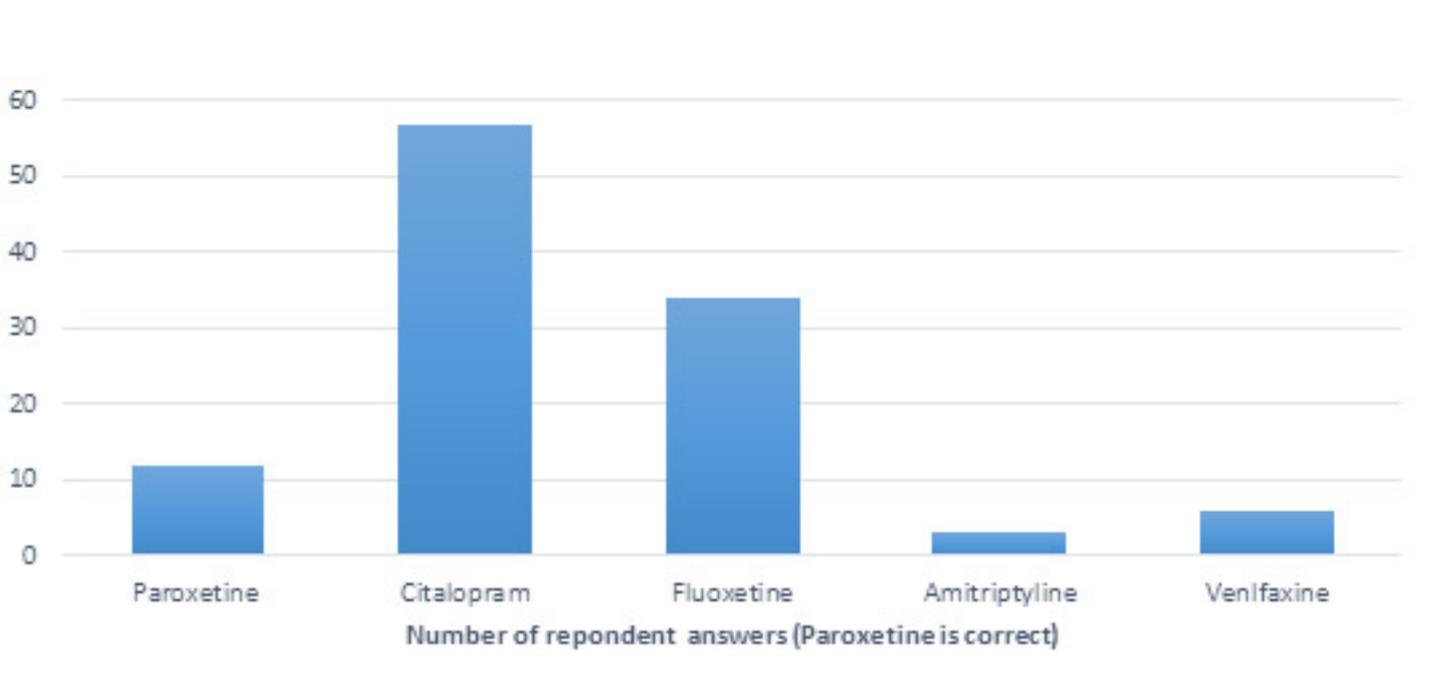


Table 3 - Responses on items regarding knowledge

Possible answers	72 hours	1 week	2 weeks	1 month	2 months	6 months	There is no time limit
D1	12 (10.4%)	1 (0.9%)	65 (56.5%)	9 (7.8%)	10 (8.7%)	4 (3.5%)	12 (10.4%)
Possible answers	72 hours	2 weeks	1 month	2 months	6 months	There is no time limit	Missing
D2	7 (6.1%)	47 (40.9%)	21 (18.3%)	12 (10.4%)	15 (13%)	13 (11.3%)	0
Possible answers	CBC	CMP	Glucose	Testosterone	TFT	Missing	
D3	2 (1.7%)	5 (4.3%)	6 (5.2%)	1 (0.9%)	101 (87.8%)	0	
Possible answers	Amitriptyline	Citalopram	Fluoxetine	Missing			
D4	6 (5.2%)	75 (65.2%)	30 (26.1%)	4 (3.5%)			
Possible answers	Amitriptyline	Citalopram	Fluoxetine	Paroxetine	Venlafaxine	Missing	
D5	3 (2.6%)	57 (49.6%)	34 (29.6%)	12 (10.4%)	6 (5.2%)	3 (2.6%)	
Possible answers	Straightaway	Within 72 hours	Within 1 week	Within 2 to 4 weeks	Within 4 to 6 weeks	Missing	
D6	3 (2.6%)	8 (7%)	14 (12.2%)	69 (60%)	21 (18.3%)	0	
Possible answers	Stop	Half the dose and stop in 2 months	Slowly reduce over 4 weeks and stop	Continue with same dose and consider stopping in 4 months	Continue with same dose and consider stopping in 12 months	Missing	
D7	5 (4.3%)	7 (6.1%)	26 (22.6%)	42 (36.5%)	32 (27.8%)	3 (2.6%)	
Possible answers	CBT	EMDR	Counselling	All above are equally effective	Missing		
D8	82 (71.3%)	2 (1.7%)	5 (4.3%)	26 (22.6)	0		
Possible answers	Change medication and refer to psychiatry	Increase the dose and refer to psychiatry	Reduce the dose and refer to psychiatry	Stop the medication and refer to psychiatry	Refer to psychiatrist	Review him in 2 weeks	Missing
D9	4 (3.5%)	3 (2.6%)	15 (13%)	27 (23.5%)	36 (31.3%)	27 (23.5%)	3 (2.6%)
Possible answers	GAD	Hypochondriasis	IBS	Somatization	Undiagnosed depression	Missing	
D10	15 (13%)	50 (43.5%)	4 (3.5%)	40 (34.8%)	5 (4.3%)	1 (0.9%)	

Discussion

A significant limitation of the study is that while measures of clinician attitudes about mental health care treatment were obtained with a well-validated tool, assessments of primary clinicians' confidence and knowledge were made using tools designed by the authors. Validation of the confidence and knowledge assessments has come from local consensus. Another limitation is its reliance on subjective responses rather than on patient records or directly observed procedures. Potential consequences of this approach include potential participant bias toward answers perceived to be desirable. The respondents' candor, especially in their responses about the dangers engendered by mental illness, makes the existence of such bias somewhat less likely. Strengths include the usage of a well-validated instrument and a relatively large sampling.

In 2008, the number of primary care physicians in Qatar was estimated to be 419 (21); this study had 115 respondents, 27.4% of the 2008 estimated population.

Previous research has suggested that there are gaps in primary care physicians' knowledge about mental health care (14, 15, 22). This study shows that, particularly regarding psychiatric medication management and diagnostic criteria for conditions like depression and anxiety, primary care physicians appear to have a lack of knowledge of the local (PHCC) policies regarding managing common mental health conditions at primary care level. However, a vast majority of the physicians did show that they have knowledge of some of the fundamental mental health principles to recognize and manage common mental health problems. Although primary care physicians lack knowledge of the local PHCC's policies in the management of common mental health conditions like anxiety and depression, they have

fundamental knowledge required to treat these conditions as per NICE guidelines.

One of the reassuring findings of this survey is that a vast majority of the primary care physicians feel confident in recognizing and managing common mental health problems in the community. More than two thirds of the physicians felt confident that they can detect serious mental health conditions like psychosis and schizophrenia. This is very encouraging. Of course, they are not expected to manage these patients in the community, but early recognition and diagnosis mean that these patients will be referred to psychiatry teams on time and they will be given appropriate treatment and support. This can help improve the long term prognosis and outcome for these patients.

Among the most surprising findings for this respondent group was the wide disparity between their knowledge gap and their generally positive attitudes and high levels of confidence about mental health treatment. Primary care physicians expressed a high level of confidence about medication management for common conditions — 86.5% of the respondents agreed, at least in part, that they feel comfortable with managing psychiatric medications, but only 26.1% of the respondent group knew the first-line medication for depression, and only 10.4% of the group knew the first-line medication for anxiety. At first glance, these findings appear grim; a detailed look reveals that they chose one of the SSRIs (citalopram, fluoxetine, paroxetine) as a first line medication in the treatment of depression (81%) and anxiety (90%) which is in line with NICE guidelines in the UK. The reason for this may be the fact that nearly half of the physicians (47%) had an MRCGP qualification and were used to practicing under the UK's NICE guidelines, but were not aware of the local PHCC policies on the management of depression and anxiety.

The knowledge section of the survey did highlight that physicians need to be more aware of the criteria for duration of symptoms for diagnosing anxiety or depression. They also need to be aware of how long they should continue with the treatment and when to consider stopping medications. Only 27.8% of these respondents could identify the proper length of time to remain on an antidepressant after resolution of depressive symptoms. Just 23.5% — less than one quarter — of the group could properly identify the procedure when an SSRI creates hypomanic symptoms.

Despite these gaps in the knowledge of mental health management, primary care physicians appear to be highly willing and feel confident to treat common mental health conditions. Such attitudes suggest that the clinicians' positivity can be leveraged with dedicated training on mental health care delivery especially familiarity with local guidelines and policies. We believe that most of the primary care physicians are well placed in managing common mental health problems in the community. However, in order to have a well-integrated community care as per the vision of Qatar National Mental Health Strategy, primary

care physicians should be trained with specific focus on the local policies and pathways.

Summary

Primary care physicians represent the first line of treatment of mental health conditions, and they perform the bulk of such treatment. In Qatar, where primary care physicians are the centerpiece of the national strategy to improve mental health care delivery, primary care doctors consistently demonstrate strongly positive attitudes and confidence about mental health care treatment. These physicians appear to have good fundamental knowledge but lack knowledge of the local policies about mental health treatment. Further study can help psychiatrists, primary care providers and government officials efficiently target resources to optimize mental health treatment provision.

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Appendix1. Demographics

1. Age

- 25 - 35
- 36 - 45
- 46 - 55
- 56 - 75

2. Gender

- Male
- Female

3. Qualification

- MRCGP UK
- MRCGP International
- Arab Board
- MRCPsych
- Other:
-

4. Years of previous psychiatric training / experience:

- 0 years
- 1 - 2 years
- 3 - 5 years
- 5 - 10 years
- More than 10 years

5. How many educational sessions have you attended regarding mental health care in the last 12 months?

- 0
- 1
- 2
- 3
- 4
- 5

Appendix 2. Attitude questions as per MICA-4.

1. Strongly Agree
2. Agree
3. Somewhat Agree
4. Somewhat Disagree
5. Disagree
6. Strongly Disagree

1. I just learn about mental health when I have to, and would not bother reading additional material on it.
2. People with a severe mental illness can never recover enough to have a good quality of life.
3. Working in the mental health field is just as respectable as other fields of health and social care.
4. If I had a mental illness, I would never admit this to my friends because I would fear being treated differently.
5. People with a severe mental illness are dangerous more often than not.
6. Health/social care staff know more about the lives of people treated for a mental illness than do family members or friends.
7. If I had a mental illness, I would never admit this to my colleagues for fear of being treated differently.
8. Being a health/social care professional in the area of mental health is not like being a real health/social care professional.
9. If a senior colleague instructed me to treat people with a mental illness in a disrespectful manner, I would not follow their instructions.
10. I feel as comfortable talking to a person with a mental illness as I do talking to a person with a physical illness.
11. It is important that any health/social care professional supporting a person with a mental illness also ensures that their physical health is assessed.
12. The public does not need to be protected from people with a severe mental illness.
13. If a person with a mental illness complained of physical symptoms (such as chest pain) I would attribute it to their mental illness.
14. General practitioners should not be expected to complete a thorough assessment for people with psychiatric symptoms because they can be referred to a psychiatrist.
15. I would use the terms 'crazy', 'nutter', 'mad' etc. to describe to colleagues people with a mental illness who I have seen in my work.
16. If a colleague told me they had a mental illness, I would still want to work with them.

Appendix 3. Questionnaire items examining confidence about mental health treatment.

1. I feel confident in my clinical ability to detect common mental health problems like anxiety or depression

1. Strongly agree
2. Somewhat agree
3. Neutral
4. Somewhat disagree
5. Strongly disagree

2. I feel confident in my clinical ability to detect serious mental health problems like psychosis (including schizophrenia)

1. Strongly agree
2. Somewhat agree
3. Neutral
4. Somewhat disagree
5. Strongly disagree

3. I feel confident in my clinical ability to detect substance misuse problems

1. Strongly agree
2. Somewhat agree
3. Neutral
4. Somewhat disagree
5. Strongly disagree

4. I feel confident in my clinical ability to take a proper psychiatric history

1. Strongly agree
2. Somewhat agree
3. Neutral
4. Somewhat disagree
5. Strongly disagree

5. I feel confident in my clinical ability to carry out a mental state examination

1. Strongly agree
2. Somewhat agree
3. Neutral
4. Somewhat disagree
5. Strongly disagree

6. I feel confident in my clinical ability to do risk assessment in a patient with mental health problem.

1. Strongly agree
2. Somewhat agree
3. Neutral
4. Somewhat disagree
5. Strongly disagree

7. I feel confident in my clinical ability to complete PHQ-9 and HADS-7

1. Strongly agree
2. Somewhat agree
3. Neutral
4. Somewhat disagree
5. Strongly disagree

8. I feel confident in my clinical ability to make diagnosis of a common mental health problem like anxiety or depression

1. Strongly agree
2. Somewhat agree
3. Neutral
4. Somewhat disagree
5. Strongly disagree

9. I feel confident in my clinical ability to provide active listening and helpful advice to the patients suffering from common mental health problems like anxiety or depression

1. Strongly agree
2. Somewhat agree
3. Neutral
4. Somewhat disagree
5. Strongly disagree

10. I feel confident in my clinical ability to initiate / change pharmacological treatment for common mental health problem like anxiety or depression

1. Strongly agree
2. Somewhat agree
3. Neutral
4. Somewhat disagree
5. Strongly disagree

11. I feel confident in my clinical ability to provide psycho-education to patients with common mental health problem like anxiety or depression

1. Strongly agree
2. Somewhat agree
3. Neutral
4. Somewhat disagree
5. Strongly disagree

12. I feel confident in my clinical ability to manage patients with suicide/self-harm

1. Strongly agree
2. Somewhat agree
3. Neutral
4. Somewhat disagree
5. Strongly disagree

1. Refer the patient to psychiatry

2. Change the antidepressant and refer the patient to psychiatry

3. Increase the dose of antidepressant and refer the patient to psychiatry

4. Reduce the dose of antidepressant and refer the patient to psychiatry

5. Stop the antidepressant and refer the patient to psychiatry

6. It's too early to change anything at this stage. Review him again in 2 weeks.

Appendix 4. knowledge based questions.

1. In order to diagnose a patient with clinical depression, he or she must have depressive symptoms for a minimum duration of

1. 72 hours
2. 2 weeks
3. 1 month
4. 2 months
5. 6 months
6. There is no time limit

2. In order to diagnose a patient with clinical Generalized Anxiety Disorder (GAD), he or she must have anxiety symptoms for a minimum duration of

1. 72 hours
2. 2 weeks
3. 1 month
4. 2 months
5. 6 months
6. There is no time limit

3. The single most important blood test to do in a patient with common mental health problem (anxiety or depression) is

1. Complete Blood Count - CBC
2. Comprehensive Metabolic Profile - CMP
3. ESR
4. Thyroid Function Test - TFT
5. Glucose
6. Testosterone

4. Which antidepressant would you consider as your first choice for the treatment of depression (considering there are no contraindications) in PHCC?

1. Citalopram
2. Paroxetine
3. Fluoxetine
4. Amitriptyline
5. Venlafaxine

5. Which medication would you consider as your first choice for the treatment of Generalized Anxiety Disorder (considering there are no contraindications) in PHCC?

1. Citalopram
2. Paroxetine
3. Fluoxetine
4. Amitriptyline
5. Venlafaxine

6. SSRIs / antidepressants work

1. Straightaway
2. Within 72 hours
3. Within 1 week
4. Within 2 – 4 weeks
5. Within 4 – 6 weeks

(continued)

7. You have successfully treated a patient with first episode of depression, who is now symptoms free and back to his/her baseline. What would you do next?

1. Stop the antidepressant
2. Slowly reduce the antidepressant over a 4 week period to stop it.
3. Half the dose and stop it after 2 months' time.
4. Continue with same dose and consider stopping it in 4 months' time.
5. Continue with the same dose and consider stopping it in 12 months' time.
6. Advise them to stay on it for life.

8. The following psychological therapy has the most evidence-based role in the management of common mental health problems like anxiety or depression

1. Counselling
2. Debriefing
3. Cognitive Behavioral Therapy
4. Hypnotherapy
5. EMDR
6. All the above are equally effective

9. You have started a patient on antidepressant. During a follow-up appointment after 2 weeks, you notice that the patient exhibit signs and symptoms of hypomania. What would you do next?

1. Refer the patient to psychiatry
2. Change the antidepressant and refer the patient to psychiatry
3. Increase the dose of antidepressant and refer the patient to psychiatry
4. Reduce the dose of antidepressant and refer the patient to psychiatry
5. Stop the antidepressant and refer the patient to psychiatry
6. It's too early to change anything at this stage. Review him again in 2 weeks.

10. A 36 year old female patient has a history of repeated presentations for abdominal pain because she is worried about cancer. She has been intensively investigated including CT abdomen and Endoscopies by the gastroenterologist who did not find any evidence of bowel cancer or other physical cause. Despite all the normal investigations she is still worried about bowel cancer. What is the likely diagnosis?

1. Diverticulosis
2. IBS
3. Generalized anxiety disorder
4. Undiagnosed depression presenting with physical health symptoms
5. Somatization
6. Hypochondriasis