



دائرة الصحة
DEPARTMENT OF HEALTH

DOH SERVICE REQUIREMENTS FOR THE DIAGNOSIS AND MANAGEMENT OF DEPRESSION AND GENERALIZED ANXIETY DISORDERS (GAD) IN PARTICIPATING PRIMARY HEALTHCARE FACILITIES

November 2019



 دائرة الصحة DEPARTMENT OF HEALTH	
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This document should be read in conjunction with related UAE laws, DOH Standards, Policies and Manuals.	



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1. Purpose

- 1.1. This document specifies the service requirements for the DOH “Program for the Diagnosis and Management of Mild to Moderate Depression and Generalized Anxiety Disorders (GAD) for Adults and Children in Primary Healthcare Settings” (from here onward “the Program”)
- 1.2. This document seeks to improve the recognition of depression and anxiety disorders among adults and children in primary healthcare settings thus improving access to such services and ensuring a certain level of quality of services.
- 1.3. In addition, the document provides guidance to healthcare professionals with respect to the recommended clinical pathways to support timely screening and intervention as well as continuation of care and maintenance to prevent relapse or recurrences.

2. Scope

- 2.1. These service requirements apply to DOH licensed primary healthcare providers that are participating in DOH’s “Program for the Diagnosis and Management of Mild to Moderate Depression and GAD for Adults (aged 18 and above) in Primary Healthcare Settings”, which also covers:
- 2.2. Post-partum depression in women;
- 2.3. Depression and Anxiety and Related Disorders in Children and Adolescents (aged 7-18).

3. General Duties of Healthcare Providers

Primary healthcare providers participating in the Program must:

- 3.1. Deliver culturally and socially relevant patient education and information regarding mental Health service and care;
- 3.2. Document and retain signed consent forms, including where a patient grants or refuses consent for treatment, on medical records;

4. Service level Duties -Facilities, Staffing, Training and Services

4.1. Providers:

Primary healthcare providers participating in the Program must:

- 4.1.1. Offer mental health screening services for mild to moderate depression and/or generalized anxiety disorders as follows:
 - 4.1.1.1. Conduct first-step approach screening for depression and GAD for the adult population attending the clinic and specifically for adult candidates who are at risk (7.5 Appendix 5) utilizing the assessment tools specified in these Service Requirements (PHQ-2¹ and GAD-2² First two questions respectively in Appendix 6

¹ PHQ-2 includes the first two items of the PHQ-9 (Appendix 6)

² GAD-2 includes the first two items of the GAD-7 (Appendix 7)



and Appendix 7). Patients who screen positive should be further evaluated with the PHQ-9 (Appendix 6 and Appendix 7);

4.1.1.2. Conduct screening for postpartum depression in women who recently gave birth and who are attending the clinic and specifically women who are at risk of suicide as per (7.5 Appendix 5) and using the tools in (Appendix 11);

4.1.1.3. Conduct screening for depression and for Child Anxiety Related Disorders (SCARED)³ among the 7-18 years pediatric population attending the clinic and specifically for children and adolescence candidates who are at risk (as per Appendix 5) utilizing the assessment tools specified in these Service Requirements (Appendix 8⁴, Appendix 9⁵ and Appendix 10⁶);

4.1.2. Provide the services detailed in this Service Requirements by a DOH licensed specialist or consultant;

4.1.3. Ensure that its treating healthcare professionals use the Patient Health Questionnaire (PHQ-2⁷ and PHQ-9- Appendix 6) for assessing depression and/or the “7- Point Generalized Anxiety Rating Scale” for anxiety (Appendix 7);

4.1.4. Provide the requisite training and competencies for their staff for mental health assessment to ensure that:

4.1.4.1. Nurses conducting the assessment of common mental health disorders are competent in utilizing the assessment tools specified in this service requirement for assessing patients with suspected generalized anxiety and/or depression disorders;

4.1.4.2. Family Medicine specialist or consultant carrying out the assessment of common mental health disorders are competent in:

4.1.4.2.1. Utilizing the assessment tools specified in this service requirement for assessing patients with suspected generalized anxiety and/or depression disorders;

4.1.4.2.2. Determining the nature, duration, and severity of the presenting disorder (this includes the exclusion of other physical outcomes);

4.1.4.2.3. Identifying appropriate treatment and referral options (in line with Appendix 2 and Appendix 3);

4.1.5. Ensure that the referring primary healthcare physician receives referral feedback from the treating psychiatrist at the specialist psychiatric care unit/facility;

4.1.6. Use the ICD for mental health interventions codes (in line with e-claims/ Shafafiya).

4.1.7. Ensure referral of cases for depression and GAD to the specialist (as per Appendix 2 and Appendix 3);

³ The Screen for Child Anxiety Related Disorders (SCARED) is a 41-item inventory rated on a 3 point Likert-type scale. It comes in two versions; one asks questions to parents about their child and the other asks these same questions to the child directly. The purpose of the instrument is to screen for signs of anxiety disorders in children.

⁴ Appendix 8 is about MFQ Child Self-Report – Long Version. Appendix 8 cont. is about The Pediatric Symptom Checklist-17 (PSC-17) is a brief screening questionnaire used by pediatricians and other health professionals to recognize psychosocial problems and improve treatment in children

⁵ Appendix 9 is about Screen for Child Anxiety Related Disorders (SCARED) - PARENT Version

⁶ Appendix 10 is about Screen for Child Anxiety Related Disorders (SCARED) - CHILD Version

⁷ PHQ-2 includes the first two items of the PHQ-9 (Appendix 6)



4.1.8. Are encouraged to conduct and participate regularly in DOH-organized mental health awareness interventions.

4.2. Professionals:

- 4.2.1. All DOH licensed healthcare professionals in participating primary healthcare facilities must practice within the specified scope of services of their employing facility, the privileges given to them by their employing facilities, the scope of practice approved under the terms of their DOH License and in accordance with their approved mental health Continuing Medical Education (CME) training requirements;
- 4.2.2. Nurses conducting the assessment of common mental health disorders must refer the assessment results to the family physician for evaluation and for required management if indicated;
- 4.2.3. Family medicine physicians will be responsible for evaluating the results of the screening assessment and for conducting the appropriate management based on the evaluation score;
- 4.2.4. Family Medicine specialists or consultants carrying out the assessment of common mental health disorders must be guided by the recommended DOH pathways for mild to moderate depression and/ or GAD in primary healthcare Settings (Appendix 1) or other relevant evidence-based best practice guidelines for diagnosis and initial management;
- 4.2.5. Upon assessment, patients requiring specialist psychiatric care in a secondary or tertiary setting (severe cases or those not responding to treatment) must be referred in accordance with the care pathway provided in Appendix 3 and Appendix 4.

5. Payment Mechanism

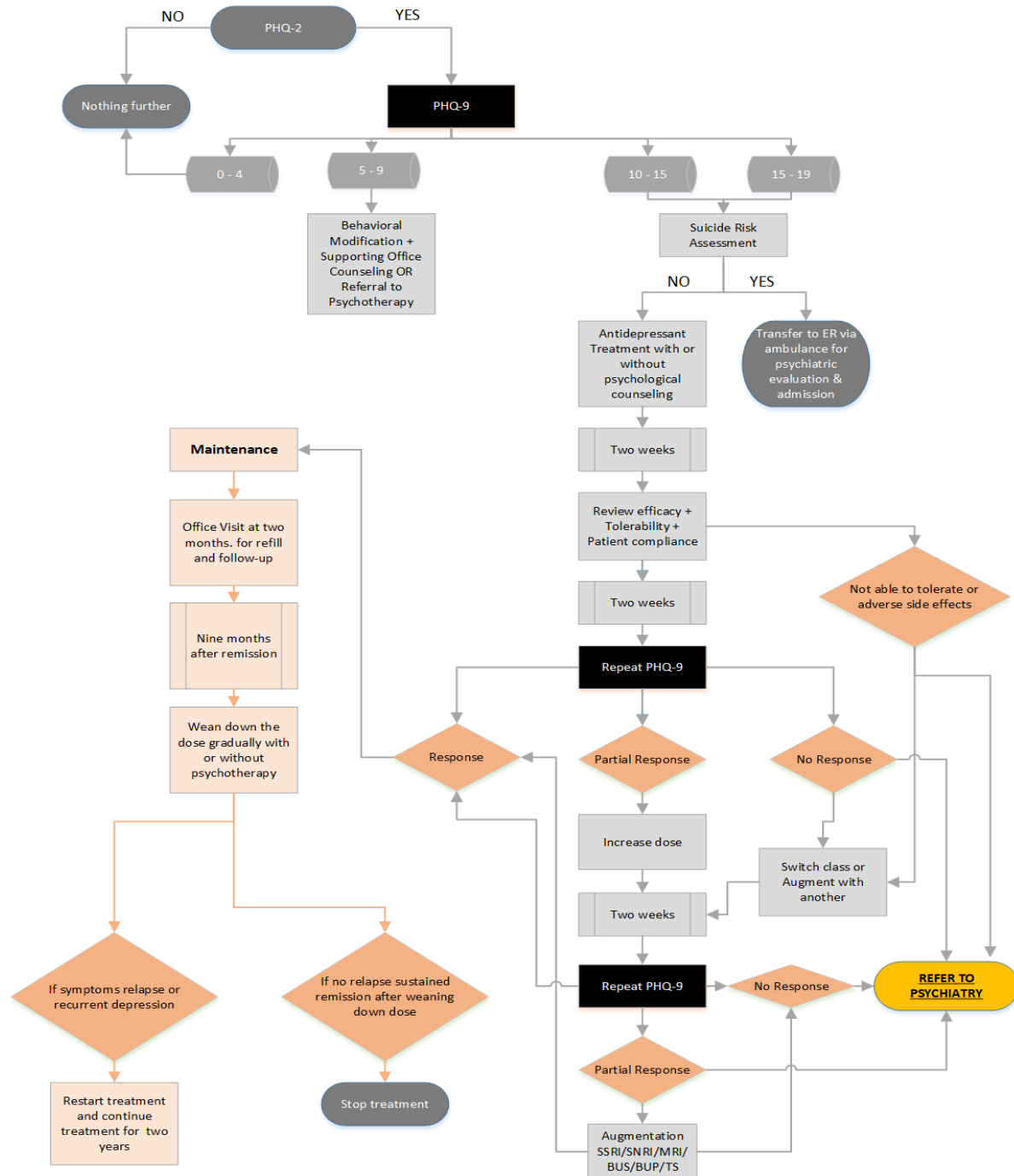
- 5.1. Patients eligible for treatment include those with mild to moderate depression and/or GAD/ SCARED;
- 5.2. Reimbursement of mental health services is in accordance with the health insurance plan and entitlement;
- 5.3. Eligibility for reimbursement for assessment, diagnosis and management of mild to moderate depression and/ or GAD services in Primary healthcare services for the basic, enhanced and Thiqa is in accordance with the DOH schedules of benefits and the individual patient's health insurance plan;
- 5.4. Charges for these services and related services must be in accordance with the service requirement provider contract negotiated rates, and in compliance with mandatory tariff and DoH claims and adjudication rules in effect.

6. Enforcement and Sanctions

DOH may impose sanctions in relation to any breach of requirements under this document in accordance with the chapter on Complaints, Investigations, Regulatory Action and Sanctions, Healthcare Regulator Manual.

7. Appendices

7.1. Appendix 1: Recommended Clinical Guideline for the Management of Suspected Depression Disorder in Children and Adults



Notes: • PHQ-2 (First two questions in the PHQ9 Appendix 6 and Appendix 7).

• Refer to psychiatry is the yellow box, when there is no response to initial treatment, severe side effects to initial treatment, partial response to adjunction and when suicidal.



Suspected Depression disorder indicators relevant for screening include:

1. Previous history or family history of Depression;
2. Co-existing illness, especially if chronic, painful or neurological in nature (note: the elderly patients are at particular risk of mood disorders);
3. Co-existing alcohol or other drug misuse;
4. Social stressors, especially negative life events involving loss (bereavement, separation, unemployment, difficulties within close interpersonal relationships and lack of social support);
5. Postpartum especially in those with past history of psychiatric disorder such as Depression and those with mood disorder during pregnancy. Poor social support and operative intervention at birth, delivering a new-born with a birth defect and having a history of premenstrual dysphoric disorder may also increase risk.

7.2. Appendix 2: Types of Referral

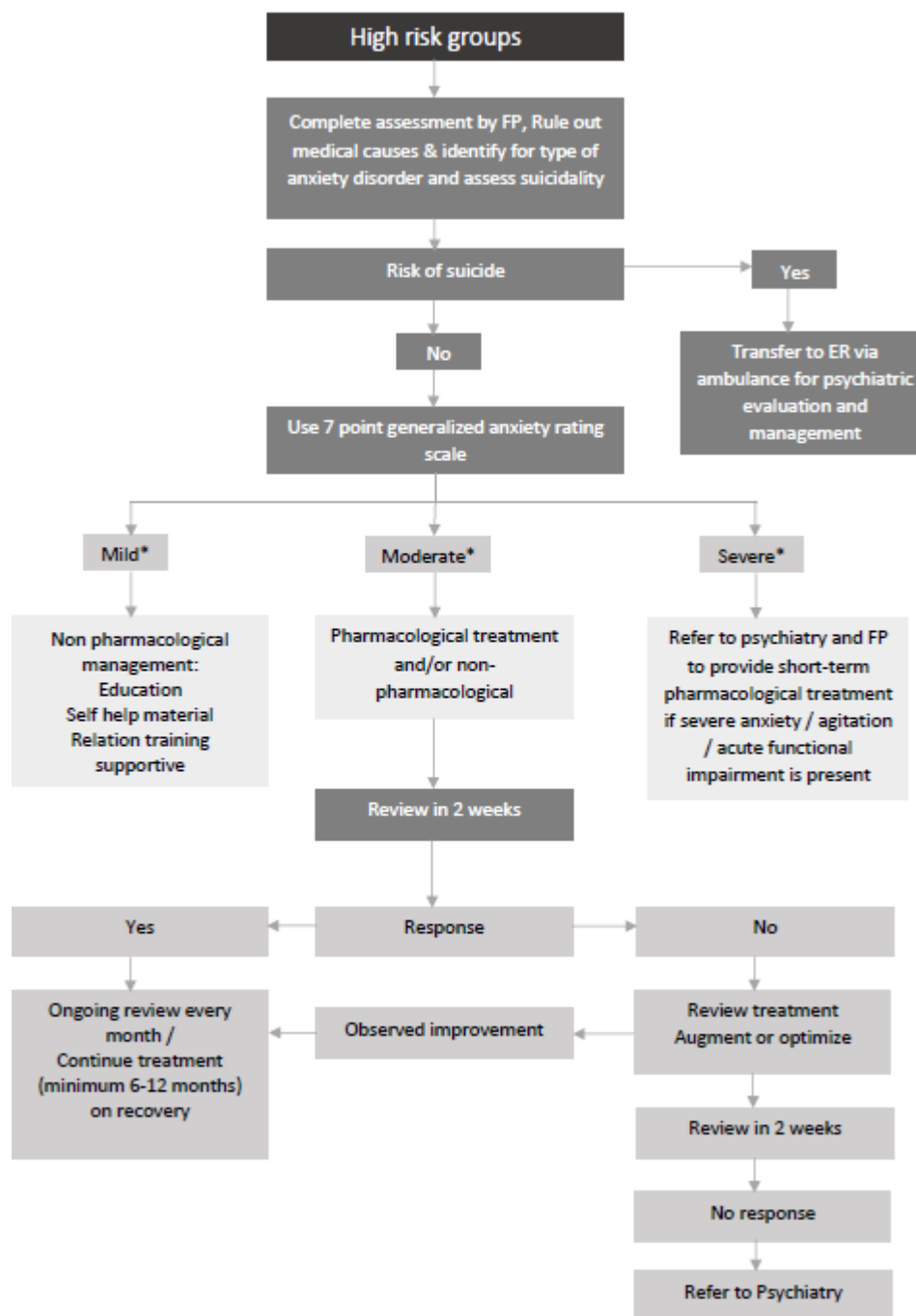
Consultation (With co-located Psychiatrist in PHC clinic)	Primary care physician (PCP) (at PHC) may recommend to the patient that a consultation with a Psychiatrist (at PHC) is warranted. If the patient should agree, the Psychiatrist will not automatically assume responsibility for ongoing care. This responsibility will vary with the clinical situation and the wishes of the patient. If a consultation results in a transfer of clinical responsibility, the Psychiatrist formally notifies the PCP of the transfer of care and documents it in the patient's records.
Transfer Outpatient: (To Psychiatric specialized clinics)	PCP (at PHC) or Psychiatrist (at PHC) may recommend to the patient that a consultation with a sub-specialized Psychiatrist (Geriatric Psychiatry, Addiction Psychiatry, Child Psychiatrist) as per the patient's need. This responsibility will vary with the clinical situation and the wishes of the patient. A consultation may result in a transfer of clinical responsibility to other specialist mental health care providers who are equipped to provide the required services e.g. Neurodevelopmental assessments, Clozapine clinics developmental Disorders Clinic, Electroconvulsive Therapy (ECT) or Transcranial Magnetic Stimulation (TMS) Clinic, Clozapine Clinic or Community Psychiatry etc.) or community psychiatry outreach services.
Transfer Inpatient: (To Psychiatric inpatient facility)	The PCP (at PHC) or the Psychiatrist (at PHC) may recommend an inpatient level of care for safety and stability reasons or to address medication management issues according to the patient's need. The decision for inpatient admission is to be made by the psychiatric facility. The inpatient psychiatrist will assume ongoing clinical responsibility and the patient's care may be resumed by the PCP (and/or Psychiatrist at PHC), upon the patient's discharge from the facility. This should include discussion about timing of transfer of clinical responsibility back to the PCP when the condition is stabilized. Decisions on transfer should be documented in the patient's records.
Emergency (Immediate transfer of patient to confinement)	An emergency necessitates the immediate transfer of the patient to safety and confinement in the hospital's ER. Responding to an emergency may include providing emergency transport by road to a facility able to provide the necessary level of Psychiatric care.



7.3. Appendix 3: Level of Referral

Level	Urgency	Description
Level 1	Seen same day	Emergency (Immediate transfer of patient to confinement) Patients who are actively suicidal, homicidal, acutely psychotic/manic or grossly disorganized with limited insight into safety. Severely anorexic, requiring Total Parenteral Nutrition (TPN). Catatonic
Level 2	Seen within 1 week	Urgent assessment. (To psychiatric inpatient facility) Patients who present with suicidal ideation but who have no active plans, can ensure their safety at home and who are willing to engage with services. Patient under the influence of psychoactive substances desiring detox.
Level 3	Seen within 1 month	Routine (To psychiatric specialized clinics) For further specialized care, while the patient is receiving treatment at PHC (e.g. geriatric psychiatry, addiction psychiatry, women mental health clinic, developmental disorders clinic, ECT or TMS clinic, clozapine clinic or community psychiatry etc.

7.4. Appendix 4: Recommended Clinical Guideline for the Management of Cases with Suspected Anxiety Disorder in Adults (above 18 year old)



Reference:

* Mild Anxiety $>5- <10$

* Moderate Anxiety $\geq 10- <15$

* Severe Anxiety ≥ 15



Please note for Children under the age of 18 referral should be after 1 month of no response.

Suspected anxiety disorder indicators relevant for screening include:

1. Genetics/Family history for anxiety disorder;
2. Environmental Factors: Having overprotective and/or critical parents has been consistently associated with General Anxiety Disorders in offspring;
3. Life events (e.g. bereavement, separation and unemployment);
4. Demographic factors: Female gender for most types of General Anxiety Disorders, and Younger age;
5. Alcohol and drug misuse.



7.5. Appendix 5: Cues for Depression and Generalized Anxiety Disorders, and Suicide Risk Factors

Cues to conduct screening include:

- Clinician's suspicion.
- Interview with patient.
- Patients' self-identification and/or complain of depressed mood.
- Cues in assessment revealing poor medication adherence and /or frequent somatic complaints etc.
- Cues in chronic diseases clinic (high incidence of co-morbid Depression).

Risk factors for suicide include:

- History of suicide attempt.
- Stressful life events.
- Social isolation.
- Substance abuse.
- Family history of suicide.
- Bipolar disorder/ Schizophrenia.



7.6. Appendix 6: Patient Health Questionnaire 9 (PHQ-9)⁸

Patient Name: _____

Date: _____

- A. Over the last 2 weeks, how often have you experienced any of the following problems?
(Place a √ in the response box)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, sad, or hopeless	☐	☐	☐	☐
3. Trouble falling asleep/staying asleep, sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you are moving around more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

For office coding: Total Score

_____ = _____ + _____ + _____

Total Score _____

⁸ PHQ-9, adapted from Psychiatric Annals, 2002



B. How difficult have these problems made it to do your work, take care of things as home, or get along with other people? (Circle response)

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

According to Patient Health questionnaire 9 (PHQ-9) scale

- Moderate Depression 10 - 14.
- Moderately Severe Depression 15 - 19.
- Severe Depression ≥ 20 .

In addition, question B about difficulty at work or home or getting along with others should be answered at least "Somewhat difficult".



Patient Health Questionnaire (PHQ- 9)⁹ in Arabic

استبيان عن صحة المريض - 9
(PHQ-9)

خلال الأسبوعين الماضيين، كم مرة عانيت من أي من المشاكل التالية؟
(ضع علامة "✓" للإشارة لجوابك)

ولا مرة	عدة أيام	أكثر من نصف الأيام	تقريباً كل يوم
0	1	2	3
1. قلة الاهتمام أو قلة الاستمتاع بممارسة بالقيام بأي عمل			
2. الشعور بالحزن أو ضيق الصدر أو اليأس			
3. صعوبة في النوم أو نوم متقطع أو النوم أكثر من المعتاد			
4. الشعور بالتعب أو بامتلاك القليل جداً من الطاقة			
5. قلة الشهية أو الزيادة في تناول الطعام عن المعتاد			
6. الشعور بعدم الرضا عن النفس أو الشعور بأنك قد أخذت نفسك أو عائلتك			
7. صعوبة في التركيز مثلاً أثناء قراءة الصحيفة أو مشاهدة التلفزيون			
8. بطء في الحركة أو بطء في التحدث عما هو معتاد لدرجة ملحوظة من الآخرين / أو على العكس من ذلك التحدث بسرعة وكثرة الحركة أكثر من المعتاد			
9. راودتك أفكار بأنه من الأفضل لو كنت ميتاً أو أفكار بأن تقوم بإيذاء النفس			

_____ + _____ + _____ + _____ = Total Score: _____ (FOR OFFICE CODING)

إذا أشارت إلى أية من المشاكل أعلاه، فإلى أية درجة صغرت عليك هذه المشاكل القيام بعملك، الاعتياد بالأمور المعتادة، أو الانسجام مع أشخاص آخرين؟

ليست هناك أي صعوبة	هناك بعض الصعوبات	هناك صعوبات شديدة	هناك صعوبات بالغة التعقيد
☐	☐	☐	☐

د. طور هذا الاستبيان كل من الدكتور روبرت سميتسر، الدكتور جاني ويليامز، الدكتور كيرت كورنيل وزملائهم، وتم ذلك بفضل منحة من مؤسسة Pfizer Inc. ليست هناك أية حاجة للحصول على تصريح من أجل الاختصاص أو الترجمة أو العرض أو التوزيع.

⁹ PHQ-9, adapted from Psychiatric Annals, 2002



7.7. Appendix 7: The Generalized Anxiety Disorder 7-Item Scale (GAD-7)¹⁰

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column		+	+	+
Total Score (add your column scores) =				

***According to the Generalized Anxiety Disorder 7-Item Scale*

- Mild Anxiety > 5 - <10
- Moderate Anxiety ≥ 10 - <15
- Severe Anxiety ≥ 15

¹⁰ Adapted from the Annals of Internal Medicine, 2007



The Generalized Anxiety Disorder 7-Item Scale¹¹ in Arabic

GAD-7				
أبدأ	بعض الأيام	أكثر من نصف الأيام	كل يوم تقريباً	خلال الأسبوعين الماضيين، كم مرة أقلقك المشكل التالي؟ (ضع علامة "✓" للإشارة لجوابك)
0	1	2	3	1- الشعور بالغضب أو القلق أو الانفعال الشديد.
0	1	2	3	2- عدم القدرة على إنهاء القلق أو التحكم فيه.
0	1	2	3	3- القلق المفرط على أشياء مختلفة.
0	1	2	3	4- الصعوبة في الاسترخاء.
0	1	2	3	5- شدة الاضطراب لدرجة صعوبة البقاء في هدوء.
0	1	2	3	6- السرعة في الانزعاج أو الانفعال.
0	1	2	3	7- الشعور بالخوف كما لو أن شيئاً قسيماً قد يحدث.
(____ + ____ + ____ = Total Score T ____ For office coding)				

إعداد الأطباء روبرت إل سبيترز، جانيت بي ديلور، وليامز، كيرت كرونك والزملاء، بمنحة تعليمية من شركة Pfizer Inc. لا يلزم الحصول على إذن لإعادة النسخ أو الترجمة أو العرض أو التوزيع.

¹¹ Adapted from Annals of Internal Medicine, 2007

7.8. Appendix 8: Mood and Feelings Questionnaire (MFQ-C)¹²

Background information

The Mood and Feelings Questionnaire (MFQ-C; Costello and Angold 1988) is a 33-item self-report measure of depression for young people (7-18 years old), covering a broad range of affective, cognitive and vegetative symptoms. It is useful as a screening measure. When combined with face-to-face interview, the MFQ-C can aid in the diagnostic assessment of depressive disorders in young people. The MFQ-C is also sensitive to change, and so it can aid in evaluating the effect of treatment.

Description of the measure

The MFQ-C has 33 items. Each item is rated on a 3-point scale (True, Sometimes, Not true) according to how the young person has been feeling over the previous 2 weeks. Items are simple for children to understand and cover a broad range of child and adolescent depressive symptoms. There is a parent version of the form.

Administration

Young people can complete the MFQ-C within 5 minutes. Younger children may need some help with completing it.

Scoring

Scoring is simple. True = 2; Sometimes = 1; Not true = 0. The total score is the sum of all 33 items. There are no reversed items or subscales.

Interpretation of scores using normative data

Optimal cut-off points (i.e. score indicating likely diagnosis) will differ according to sample characteristics (e.g. clinic/community, age, gender) (Daviss et al 2007).

For clinical samples, the optimal cut-off is a total score of score of 27 or more (Wood et al 1995). Daviss et al (2007) compared young people with a diagnosis of major depressive disorder (N=77) to those with any other mood disorder (such as dysthymia, major depression in remission, N= 75), and those with no mood disorder (N=318). Mean scores (and standard deviations) are shown below:

- Major depression
- Other mood
- No mood disorder
- Disorder 33 (14) 24 (14) 12 (10)

¹² Costello E. J., & Angold A. (1988). Scales to assess child and adolescent depression: checklist, screens, and nets. *Journal of the American Academy of Child and Adolescent Psychiatry*: 27, 726-737.

Daviss, W.B., Birmaher, B., Melmem, N.A., Axelson, D., Michales, S., & Brent, D.A. (2007). Criterion validity of the mood and feelings questionnaire for depressive episodes in clinic and non-clinic subjects *Journal of Child Psychology and Psychiatry*: 47, 927-934.

Wood, A., Kroll, L., Moore, A., & Harrington, R. (1995). Properties of the mood and feelings questionnaire in adolescent psychiatric outpatients: a research note. *Journal of Child Psychology and Psychiatry*: 36, 327-334.



Cont. Appendix 8

MOOD AND FEELINGS QUESTIONNAIRE: Child Self-report - Extended Version

This form is about how you might have been feeling or acting **recently**.

For each question, please check (√) how you have been feeling or acting **in the past two weeks**.

If a sentence was not true about you, check NOT TRUE.

If a sentence was only sometimes true, check SOMETIMES.

If a sentence was true about you most of the time, check TRUE.

Score the MFQ as follows:

NOT TRUE = 0

SOMETIMES = 1

TRUE = 2

To code, please use a checkmark (√) for each statement.	NOT TRUE	SOME TIMES	TRUE
1. I felt miserable or unhappy.			
2. I didn't enjoy anything at all.			
3. I was less hungry than usual.			
4. I ate more than usual.			
5. I felt so tired I just sat around and did nothing.			
6. I was moving and walking more slowly than usual.			
7. I was very restless.			
8. I felt I was no good anymore.			
9. I blamed myself for things that weren't my fault.			
10. It was hard for me to make up my mind.			
11. I felt grumpy and cross with my parents.			
12. I felt like talking less than usual.			
13. I was talking more slowly than usual.			



To code, please use a checkmark (√) for each statement.	NOT TRUE	SOME TIMES	TRUE
14. I cried a lot.			
15. I thought there was nothing good for me in the future.			
16. I thought that life wasn't worth living.			
17. I thought about death or dying.			
18. I thought my family would be better off without me.			
19. I thought about killing myself.			
20. I didn't want to see my friends.			
21. I found it hard to think properly or concentrate.			
22. I thought bad things would happen to me.			
23. I hated myself.			
24. I felt I was a bad person.			
25. I thought I looked ugly.			
26. I worried about aches and pains.			
27. I felt lonely.			
28. I thought nobody really loved me.			
29. I didn't have any fun in school.			
30. I thought I could never be as good as other kids.			
31. I did everything wrong.			
32. I didn't sleep as well as I usually sleep.			
33. I slept a lot more than usual.			

Copyright Adrian Angold & Elizabeth J. Costello, 1987; Developmental Epidemiology Program; Duke University



Cont. Appendix 8: Parent's Assessment Questionnaire for Younger Children

Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this Form: _____ Date: _____

Name of Child: _____

		Please mark under the heading that best fits your child			For Office Use		
		NEVER	SOME-TIMES	OFTEN	I	A	E
1.	Fidgety, unable to sit still						
2.	Feels sad, unhappy						
3.	Daydreams too much						
4.	Refuses to share						
5.	Does not understand other people's feelings						
6.	Feels hopeless						
7.	Has trouble concentrating						
8.	Fights with other children						
9.	Is down on him or herself						
10.	Blames others for his or her troubles						
11.	Seems to be having less fun						
12.	Does not listen to rules						
13.	Acts as if driven by a motor						
14.	Teases others						
15.	Worries a lot						
16.	Takes things that do not belong to him or her						
17.	Distracted easily						



	Please mark under the heading that best fits your child			For Office Use		
	NEVER	SOME-TIMES	OFTEN	I	A	E
(scoring totals)						

Scoring:

- Fill in unshaded box on right with:
“Never” = 0,
“Sometimes” = 1, “Often” = 2
- Sum the columns.
PSC17 Internalizing score is sum of column I
PSC17 Attention score is sum of column A
PSC17 Externalizing score is sum of column E
PSC-17 Total Score is sum of I, A, and E columns

Suggested Screen Cutoff:

PSC-17 - I ≥ 5
PSC-17 - A ≥ 7
PSC-17 - E ≥ 7
Total Score ≥ 15

Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.

PSC-17 may be freely reproduced.
Created by W Gardner and K Kelleher (1999), and based on PSC by M Jellinek et al. (1988). Formatted by R Hilt, inspired by Columbus Children’s Research Institute formatting of PSC-17

PSC-17 Scoring

The PSC-17 can help primary care providers assess the likelihood of finding any mental health disorder in their patient. The brief and easy to score PSC-17 has fairly good mental health screening characteristics, even when compared with much longer instruments like the CBCL (Child Behavior Checklist by T. Achenbach).

A 2007 study in primary care offices compared use of the PSC-17 to simultaneous use of the CBCL in 269 children aged 8-15, showing reasonably good performance of its three subscales compared to similar subscales on the CBCL. The gold standard here was a KSADS diagnosis, which is a standardized psychiatric interview diagnosis. These comparison statistics are summarized below, with positive and negative predictive values shown based on different presumed prevalence (5 or 15%) of the disorders. Providers should notice that despite its good performance relative to longer such measures, it is not a foolproof diagnostic aide. For instance the sensitivity for this scale only ranges from 31% to 73% depending on the disorder in this study:

K-SADS	Screen	Sensitivity	Specificity	PPV 5%	PPV 15%	NPV 5%	NPV 15%
ADHD	PSC-17 Attention	0.58	0.91	0.25	0.53	0.98	0.92
	CBCL Attention	0.68	0.90	0.26	0.55	0.98	0.94
Anxiety	PSC-17 Internalizing	0.52	0.74	0.10	0.26	0.97	0.90
	CBCL Internalizing	0.42	0.88	0.13	0.38	0.97	0.90
Depression	PSC-17 Internalizing	0.73	0.74	0.13	0.33	0.98	0.94
	CBCL Internalizing	0.58	0.87	0.19	0.44	0.98	0.92
Externalizing	PSC-17 Externalizing	0.62	0.89	0.23	0.50	0.98	0.93
	CBCL Externalizing	0.46	0.95	0.33	0.62	0.97	0.91
Any Diagnosis	PSC-17 Total	0.42	0.86	0.14	0.35	0.97	0.89
	CBCL Total	0.31	0.96	0.29	0.58	0.96	0.89

W Gardner, A Lucas, DJ Kolko, JV Campo “Comparison of the PSC-17 and Alternative Mental Health Screens in an At-Risk Primary Care Sample” JAACAP 46:5, May 2007, 611-618

PSC-17 Internalizing score positive if ≥ 5
PSC-17 Externalizing score positive if ≥ 7
PSC-17 Attention score positive if ≥ 7
PSC-17 Total score positive if ≥ 15

“Attention” diagnoses can include ADHD, ADD
“Internalizing” diagnoses can include any anxiety or mood disorder
“Externalizing” diagnoses can include Conduct disorder, Oppositional Defiant Disorder, adjustment disorder with disturbed conduct or mixed disturbed mood and conduct



7.9. Appendix 9: Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version—(to be filled out by the PARENT)

Name: _____ Date: _____

Directions: Below is a list of sentences that describe how people feel. Read each phrase and decide if it is “Not True or Hardly Ever True” or “Somewhat True or Sometimes True” or “Very True or Often True” for your child. Then, for each statement, fill in one circle that corresponds to the response that seems to describe your child <i>for the last 3 months</i> . Please respond to all statements as well as you can, even if some do not seem to concern your child.	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When my child feels frightened, it is hard for him/her to breathe	☐	☐	☐	PN
2. My child gets headaches when he/she am at school.	☐	☐	☐	SH
3. My child doesn't like to be with people he/she doesn't know well.	☐	☐	☐	SC
4. My child gets scared if he/she sleeps away from home.	☐	☐	☐	SP
5. My child worries about other people liking him/her.	☐	☐	☐	GD
6. When my child gets frightened, he/she feels like passing out.	☐	☐	☐	PN
7. My child is nervous.	☐	☐	☐	GD
8. My child follows me wherever I go.	☐	☐	☐	SP
9. People tell me that my child looks nervous.	☐	☐	☐	PN
10. My child feels nervous with people he/she doesn't know well.	☐	☐	☐	SC
11. My child gets stomachaches at school.	☐	☐	☐	SH
12. When my child gets frightened, he/she feels like he/she is going crazy.	☐	☐	☐	PN
13. My child worries about sleeping alone.	☐	☐	☐	SP
14. My child worries about being as good as other kids.	☐	☐	☐	GD



Directions: Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then, for each statement, fill in one circle that corresponds to the response that seems to describe your child <i>for the last 3 months</i> . Please respond to all statements as well as you can, even if some do not seem to concern your child.	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
15. When my child gets frightened, he/she feels like things are not real.	☐	☐	☐	PN
16. My child has nightmares about something bad happening to his/her parents.	☐	☐	☐	SP
17. My child worries about going to school.	☐	☐	☐	SH
18. When my child gets frightened, his/her heart beats fast.	☐	☐	☐	PN
19. He/she child gets shaky.	☐	☐	☐	PN
20. My child has nightmares about something bad happening to him/her.	☐	☐	☐	SP
21. My child worries about things working out for him/her.	☐	☐	☐	GD
22. When my child gets frightened, he/she sweats a lot.	☐	☐	☐	PN
23. My child is a worrier.	☐	☐	☐	GD
24. My child gets really frightened for no reason at all.	☐	☐	☐	PN
25. My child is afraid to be alone in the house.	☐	☐	☐	SP
26. It is hard for my child to talk with people he/she doesn't know well.	☐	☐	☐	SC
27. When my child gets frightened, he/she feel like he/she is choking.	☐	☐	☐	PN
28. People tell me that my child worries too much.	☐	☐	☐	GD
29. My child doesn't like to be away from his/her family.	☐	☐	☐	SP
30. My child is afraid of having anxiety (or panic) attacks.	☐	☐	☐	PN
31. My child worries that something bad might happen to his/her parents.	☐	☐	☐	SP
32. My child feels shy with people he/she doesn't know well.	☐	☐	☐	SC



Directions: Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then, for each statement, fill in one circle that corresponds to the response that seems to describe your child <i>for the last 3 months</i> . Please respond to all statements as well as you can, even if some do not seem to concern your child.	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
33. My child worries about what is going to happen in the future.	☐	☐	☐	GD
34. When my child gets frightened, he/she feels like throwing up.	☐	☐	☐	PN
35. My child worries about how well he/she does things.	☐	☐	☐	GD
36. My child is scared to go to school.	☐	☐	☐	SH
37. My child worries about things that have already happened.	☐	☐	☐	GD
38. When my child gets frightened, he/she feels dizzy.	☐	☐	☐	PN
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/ her (for example: read aloud, speak, play a game, play a sport.)	☐	☐	☐	SC
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/ she doesn't know well.	☐	☐	☐	SC

SCORING:

A total score of ≥ 25 may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PN =**

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**. **GD =**

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety SOC**. **SP =**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. **SC =**

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. **SH =**

The SCARED is available at no cost at www.wpic.pitt.edu/research_under_tools_and_assessments, or at www.pediatric_bipolar.pitt.edu/instruments.



7.10. Appendix 10: Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 1 of 2 (to be filled out by the CHILD)

Name: _____ Date: _____

Directions: Below is a list of sentences that describe how people feel. Read each phrase and decide if it is “Not True or Hardly Ever True” or “Somewhat True or Sometimes True” or “Very True or Often True” for you. Then, for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When I feel frightened, it is hard to breathe	☐	☐	☐	PN
2. I get headaches when I am at school.	☐	☐	☐	SH
3. I don't like to be with people I don't know well.	☐	☐	☐	SC
4. I get scared if I sleep away from home.	☐	☐	☐	SP
5. I worry about other people liking me.	☐	☐	☐	GD
6. When I get frightened, I feel like passing out.	☐	☐	☐	PN
7. I am nervous.	☐	☐	☐	GD
8. I follow my mother or father wherever they go.	☐	☐	☐	SP
9. People tell me that I look nervous.	☐	☐	☐	PN
10. I feel nervous with people I don't know well.	☐	☐	☐	SC
11. I get stomachaches at school.	☐	☐	☐	SH



Directions: Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then, for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
12. When I get frightened, I feel like I am going crazy.	☐	☐	☐	PN
13. I worry about sleeping alone.	☐	☐	☐	SP
14. I worry about being as good as other kids.	☐	☐	☐	GD
15. When I get frightened, I feel like things are not real.	☐	☐	☐	PN
16. I have nightmares about something bad happening to my parents.	☐	☐	☐	SP
17. I worry about going to school.	☐	☐	☐	SH
18. When I get frightened, my heart beats fast.	☐	☐	☐	PN
19. I get shaky.	☐	☐	☐	PN
20. I have nightmares about something bad happening to me.	☐	☐	☐	SP
21. I worry about things working out for me.	☐	☐	☐	GD
22. When I get frightened, I sweat a lot.	☐	☐	☐	PN
23. I am a worrier.	☐	☐	☐	GD
24. I get really frightened for no reason at all.	☐	☐	☐	PN
25. I am afraid to be alone in the house.	☐	☐	☐	SP



Directions: Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then, for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
26. It is hard for me to talk with people I don't know well.	☐	☐	☐	SC
27. When I get frightened, I feel like I am choking.	☐	☐	☐	PN
28. People tell me that I worry too much.	☐	☐	☐	GD
29. I don't like to be away from my family.	☐	☐	☐	SP
30. I am afraid of having anxiety (or panic) attacks.	☐	☐	☐	PN
31. I worry that something bad might happen to my parents.	☐	☐	☐	SP
32. I feel shy with people I don't know well.	☐	☐	☐	SC
33. I worry about what is going to happen in the future.	☐	☐	☐	GD
34. When I get frightened, I feel like throwing up.	☐	☐	☐	PN
35. I worry about how well I do things.	☐	☐	☐	GD
36. I am scared to go to school.	☐	☐	☐	SH
37. I worry about things that have already happened.	☐	☐	☐	GD
38. When I get frightened, I feel dizzy.	☐	☐	☐	PN
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport).	☐	☐	☐	SC



Directions: Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then, for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	☐	☐	☐	sc
41. I am shy.	☐	☐	☐	sc

SCORING:

A total score of ≥ 25 may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PN =**

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**. **GD =**

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety SOC**. **SP =**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. **SC =**

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. **SH =**

For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions. The SCARED is available at no cost at www.wpic.pitt.edu/research_under_tools_and_assessments, or at www.pediatric_bipolar.pitt.edu/instruments.



Appendix 11: Questionnaire for Postpartum Depression in Women

Edinburgh Postnatal Depression Scale (EPDS)¹³

Postpartum depression is the most common complication of childbearing.¹⁴ The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for “perinatal” depression. The EPDS is easy to administer and has proven to be an effective screening tool. However, this Questionnaire was developed to assess women's comprehension of individual scale items identified problems associated with “Western” terminology and concepts.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt *during the previous week*. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

- **QUESTIONS 1, 2, & 4 (without an *)**
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.
- **QUESTIONS 3, 5, 10 (marked with an *)**
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30

Possible Depression: 10 or greater

Always look at item 10 (suicidal thoughts)

Users may reproduce the scale without further permission, providing they respect copyright by quoting the names of the authors, the title, and the source of the paper in all reproduced copies.

Instructions for using the Edinburgh Postnatal Depression Scale:

13 Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

14 Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression *N Engl J Med* vol. 347, No 3, July 18, 2002, 194-199.



1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman).
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.



For information on the translation of this resource, please contact the Perinatal and Infant Mental Health Service on (02) 9827 8071	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;">Affix ID Label Here</td> <td style="text-align: center;">MRN</td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> </tr> <tr> <td colspan="2">Surname</td> <td colspan="6">Given Names</td> </tr> <tr> <td colspan="2">Address - Street</td> <td colspan="3">Suburb</td> <td colspan="3">Postcode</td> </tr> <tr> <td>Date of Birth</td> <td>Sex</td> <td colspan="6">AMO</td> </tr> <tr> <td colspan="2">Hospital Name</td> <td colspan="6">Ward</td> </tr> </table>	Affix ID Label Here		MRN						Surname		Given Names						Address - Street		Suburb			Postcode			Date of Birth	Sex	AMO						Hospital Name		Ward					
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ARABIC سيدتي: بما أنك قد أنجبت طفلاً مؤخراً ، فنود أن نعرف مشاعرك. نرجو أن تضعي خطاً تحت أنسب جواب يعبر عن مشاعرك في الأيام السبعة الماضية، وليس مشاعرك اليوم فحسب. واليك المثال التالي: لقد شعرت بالتي سعيدة: — نعم، في كل الأوقات — نعم، في معظم الأوقات — كلا، ليس أغلب الأحيان — كلا، أبداً هذا يعني: لقد شعرت لتي سعيدة معظم الوقت" خلال الأسبوع الماضي. نرجو أن تكلمي الأسئلة الأخرى بنفس الطريقة																																									
FOR OFFICE USE ONLY English version of EDS introduction As you have recently had a baby we would like to know how you are feeling. Please <u>underline</u> the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today. Here is an example, already completed: I have felt happy: Yes, all the time <u>Yes, most of the time</u> No, not very often No, not at all This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.																																									
خلال الأيام السبعة الماضية 1. لقد تمكنت من الضحك ورؤية الجانب المضحك من الأمور: - بالمقدار الذي إستطعته دائماً - ليس تماماً بالمقدار نفسه الآن - قطعاً ليس بالمقدار نفسه الآن - كلا، مطلقاً 2. لقد تطلعت إلى الأمور بمتعة: - بالمقدار نفسه مثل أي وقت مضى - نوعاً ما، أقل مما إعتدتُ - قطعاً أقل مما إعتدتُ - نادراً 3. لقد لمت نفسي بدون لزوم عندما سارت الأمور على غير ما يرام: - نعم، في معظم الأحيان - نعم، في بعض الأحيان - ليس أغلب الأحيان - كلا، أبداً 4. لقد كنت قلقة ومشغولة بالبال بدون سبب وجيه: - كلا، مطلقاً - نادراً - نعم، في بعض الأحيان - نعم، أغلب الأحيان (الرجاء قلب الصفحة للإجابة على بقية الأسئلة.)																																									



Cont. Appendix 11: Questionnaire for Postpartum Depression in Women

5. لقد شعرت بالخوف والذعر بدون سبب وجيه:
- نعم، أكثر الأحيان
- نعم، في بعض الأحيان
- كلا، ليس كثيراً
- كلا، مطلقاً

6. تراكمت الأعمال علي فلم أستطع القيام بها:
- نعم، في معظم الأحيان لم أستطع القيام بها مطلقاً
- نعم، في بعض الأحيان لم أستطع القيام بها كالمعتاد
- كلا، لقد إستطعت القيام بها في بعض الأحيان
- كلا، لقد إستطعت القيام بها كالمعتاد

7. لقد كنت غير سعيدة لدرجة أنه كنت لدي صعوبة في النوم:
- نعم، في معظم الأحيان
- نعم، في بعض الأحيان
- ليس أغلب الأحيان
- كلا، مطلقاً

8. لقد شعرت بأنني حزينة وبائسة:
- نعم، في معظم الأحيان
- نعم، أغلب الأحيان
- كلا، ليس أغلب الأحيان
- كلا، مطلقاً

9. لقد كنت غير سعيدة للغاية لدرجة أنني كنت أبكي:
- نعم، في معظم الأحيان
- نعم، أغلب الأحيان
- فقط من وقت لآخر
- كلا، أبداً

10. لقد خطرت لي فكرة إلحاق الأذى بنفسي:
- نعم، في أحوال كثيرة
- نعم، في بعض الأحيان
- نادراً
- كلا، أبداً

مع الشكر الجزيل.

English version of questions

1 I have been able to laugh and see the funny side of things: As much as I always could Not quite so much now Definitely not so much now Not at all	6 Things have been getting on top of me: Yes, most of the time I haven't been able to cope at all Yes, sometimes I haven't been coping as well as usual No, most of the time I have coped quite well No, I have been coping as well as ever
2 I have looked forward with enjoyment to things: As much as I ever did Rather less than I used to Definitely less than I used to Hardly at all	7 I have been so unhappy that I have had difficulty sleeping: Yes, most of the time Yes, sometimes Not very often No, not at all
3 I have blamed myself unnecessarily when things went wrong: Yes, most of the time Yes, some of the time Not very often No, never	8 I have felt sad or miserable: Yes, most of the time Yes, quite often Not very often No, not at all
4 I have been worried and anxious for no good reason: No, not at all Hardly ever Yes, sometimes Yes, very often	9 I have been so unhappy that I have been crying: Yes, most of the time Yes, quite often Only occasionally No, never
5 I have felt scared or panicky for no very good reason: Yes, quite a lot Yes, sometimes No, not much No, not at all	10 The thought of harming myself has occurred to me: Yes, quite often Sometimes Hardly ever Never