



STANDARD OF CARE FOR DEPRESSION & ANXIETY DISORDERS

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1. Standard Scope and Purpose

- 1.1. This document specifies the service requirements for the DoH Standard of Care for Depression & Anxiety Disorders.
- 1.2. This document aims to ensure comprehensive mental health support, covering key areas such as screening, diagnosis, treatment and recovery.
- 1.3. This document seeks to improve the recognition of depression and anxiety disorders among adults, adolescents, Perinatal Women, people of determination (POD) and children thus improving access to such services and ensuring a certain level of quality of services.
- 1.4. 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 relapses or recurrences.
- 1.5. These service requirements apply to healthcare providers licensed by DoH in the Emirate of Abu Dhabi delivering health services for Depression and/or anxiety disorders.
- 1.6. This standard must be read in conjunction with the Standard for Specialized Mental Healthcare Services.

2. Definitions and Abbreviations

No.	Term / Abbreviation	Definition
2.1	Anxiety	Excessive worry and apprehension about various events or activities, occurring more often than not for at least six months, and accompanied by at least three physical or cognitive symptoms
2.2	CBT	Cognitive behavioral therapy
2.3	CDI	Children's Depression Inventory
2.4	Counselor	A Social Care Professional licensed by Department of Community Development (DCD) who supports individuals or groups (couples, families or larger audiences) in identifying and/ or analyzing their mental health disorders or social conflicts and in assessing the need for treatment
2.5	Depression	The presence of a persistently depressed mood or a loss of interest or pleasure in activities, accompanied by other symptoms that significantly impair daily functioning for at least two weeks
2.6	DSM-5	The Diagnostic and Statistical Manual of Mental Illnesses (fifth edition)
2.7	ECT	Electroconvulsive Therapy

2.8	ECG	Electrocardiography
2.9	EPDS	Edinburgh Postnatal Depression Scale
2.10	GAD	Generalized Anxiety Disorder
2.11	Mental Health Professional	A DoH-licensed clinician specialized in Mental Health, most commonly psychiatrists and psychologists but can also include clinical social workers and occupational therapists. Psychologists and social workers may also be licensed by DCD if working in community-based settings e.g. schools
2.12	MHQoL	Mental Health Quality of Life
2.13	MFQ	Mood and Feelings Questionnaire
2.14	PHQ	Patient Health Questionnaire
2.15	POD	People of Determination
2.16	PTSD	Post Traumatic Stress Disorder
2.17	PCP	Primary Care Physician, includes Family Physician and General Practitioner (GP), unless otherwise specified
2.18	SSRIs	Selective serotonin reuptake inhibitors
2.19	SCARED	Screen for Child Anxiety Related Emotional Disorders
2.20	SDQ	Strengths and Difficulties Questionnaire
2.21	TRD	Treatment Resistant Depression
2.22	TMS	Transcranial Magnetic Stimulation

3. Standard Requirements and Specifications

3.1 Licensure Requirements

- 3.1.1 DoH licensed healthcare facilities shall satisfy DoH licensure requirements to provide mental health services.
- 3.1.2 The healthcare facility shall be integrated to transmit medical record data and information to the health information exchange platform (Malaffi) to be available for review by all medical providers as required.
- 3.1.3 The healthcare facility shall comply with all the regulatory requirements including, but not limited to, such as healthcare provider manual, healthcare professional manual, complaint management,

consent, laboratory, Infection control, first aid training, waste management, fire safety, Unified Healthcare Professional Qualification Requirements (PQR), Medication management, Abu Dhabi occupational safety and health system framework, Abu Dhabi Healthcare Information and Cyber Security [ADHICS] Standard, DoH Data and Digital Governance Standards and DoH standard on Telemedicine.

3.1.4 The healthcare facility shall comply with the requirements of Abu Dhabi Healthcare Information Security Program and shall be AAMEN Certified.

3.2 Staff Qualifications & Training Requirements

3.2.1 All healthcare professionals should hold an active DoH professional license and work within their scope of practice and as per their granted privileges.

3.2.2 All relevant DoH licensed Healthcare Professionals to have completed the Information and Cyber Security Awareness courses assigned to them through Abu Dhabi Healthcare Cyberlearning Program.

3.3 Facility Design:

3.3.1 The Health Facility shall meet the requirements as per the DoH Health Facility Guidelines (Health Facility Briefing & Design Mental Health Unit: Child & Adolescent, Adult and Older Persons and People of Determination)

3.4 Supplies and Equipment:

3.4.1 Healthcare facilities should ensure that adequate and appropriate levels of supplies and medications are available to serve the population of patients treated; and equipment is routinely maintained and serviced in accordance with the manufacturer's recommendations and retain records to evidence this.

3.5 Service Delivery and Care Process:

3.5.1 Anxiety and Depression in Adults (Appendix A):

3.5.1.1 Anxiety and depression are two of the most common mental health disorders worldwide. These conditions impair the emotional and psychological wellbeing of those affected which can lead to professional, social, and personal challenges. They also have a large impact on physical health, daily functioning and quality of life. Anxiety and depression can occur separately or together in the same individual.

3.5.1.2 Signs and symptoms

3.5.1.2.1 Anxiety symptoms include, but are not limited to: Restlessness, feeling keyed up or on edge, being easily fatigued, difficulty concentrating, irritability, muscle tension and sleep disturbance.

3.5.1.2.2 Depression symptoms include, but are not limited to: Persistent sadness, loss of interest, changes in sleep, changes in appetite and difficulty concentrating.

3.5.1.3 Screening

3.5.1.3.1 Nurses will screen patients by administering Patient Health Questionnaire (PHQ)-2 and Generalized Anxiety Disorder (GAD)-2 (Appendix D/E) during vitals check of a primary

care visit or ensure patients complete the screening (either electronically or hard-copy).

3.5.1.3.2 PHQ-2 and GAD-2 screenings are exempt from administration if the patient has completed these screenings within the past three months.

3.5.1.3.3 Any positive result (Score ≥ 3) to PHQ-2 or GAD-2 will be communicated with the Primary Care Physician (PCP), Family Physician or General Practitioner, to complete PHQ-9 and/ or GAD-7 respectively (Appendix F/G).

3.5.1.3.4 Negative screening results require no further assessment during the visit.

3.5.1.4 Diagnosis

3.5.1.4.1 Patients with a positive PHQ-2 and/or GAD-2 will have a PHQ-9 and/or GAD-7, respectively, completed by the PCP as part of the consultation.

3.5.1.4.2 If the patient has self-administered the PHQ-9 or GAD-7, the results will be assessed by the PCP as part of the consultation.

3.5.1.4.3 PHQ-9 or GAD-7 screenings are exempt from administration if the patient has completed these screenings within the past three months.

3.5.1.4.4 Patients with positive results for both PHQ-2 and GAD-2 will have both PHQ-9, and GAD-7 completed or reviewed, as part of the consultation.

3.5.1.4.5 A Family Physician will also conduct a clinical interview to evaluate symptoms, and assess psychiatric history using DSM-5 criteria for diagnosing anxiety or depression.

3.5.1.4.6 The Family Physician should also rule out medical causes through a physical examination including, but not limited to: ECG, Complete blood count, Thyroid function, Vitamin D and Electrolytes e.g. Urea, creatinine, Sodium, chloride potassium.

3.5.1.4.7 In addition to the assessment score, the Family Physician will also assess the following risk factors to determine severity and complexity of disorder: Severity of distress, Psychiatric history including mental health comorbidities e.g. bipolar disorder, personality disorders, risk of self-harm/ harm to others and degree of functional impairment.

3.5.1.4.8 Based on the outcome of the Family Physician's comprehensive assessment, he or she will diagnose the patient with either Mild, Moderate or Severe disorder.

3.5.1.4.8.1 Mild: management continues with Family Physician

3.5.1.4.8.2 Moderate: management continues with Family Physician

3.5.1.4.8.3 Moderate + high complexity: patient referred to psychiatrist within primary care, if available, for complex management

3.5.1.4.8.4 Severe: patient referred to psychiatrist in secondary care for specialized management

3.5.1.4.8.5 High risk of self-harm/ suicidal ideation with active plan, idea or intent to self-harm or harm others: patient sent to Emergency Department for Psychiatric evaluation

3.5.1.4.9 Referral to psychotherapy can occur at any severity based on clinician's assessment and/or patient preferences.

3.5.1.4.10 If a patient declines referral despite high scores, this should be explicitly documented, and patient should be followed up closely with monitoring their scores for worsening or improvement.

3.5.1.5 Intervention and treatment

3.5.1.5.1 The physician (Family Physician or Psychiatrist) will develop a documented, patient-centered treatment plan in collaboration with the patient that considers the patient's severity, complexity and preferences for treatment modalities.

3.5.1.5.2 The treatment plan should include at minimum:

3.5.1.5.2.1 Patient's goals of treatment and outcome measures

3.5.1.5.2.2 The patient's initial assessment (baseline) scores of PHQ-9, GAD-7 and baseline Mental Health Quality of Life (MHQoL) or other validated Health-Related Quality of Life (HRQoL) scores (Appendix I)

3.5.1.5.2.3 Treatment methods to be utilized and the person or discipline responsible for each treatment method (e.g. psychologist, psychiatrist or other)

Note: medications can only be prescribed by a physician

3.5.1.5.2.4 Treatment plan review dates and discharge framework

3.5.1.5.2.5 Referrals required to mental health professionals (psychiatrist, psychologist or other)

3.5.1.5.2.6 When medication is prescribed the following additional parameters shall be included in the treatment plan:

3.5.1.5.2.6.1 Review of risks and benefits of the prescribed medication

3.5.1.5.2.6.2 History of previous treatment

3.5.1.5.2.6.3 Pharmacovigilance

3.5.1.5.2.6.4 Timeframe for therapeutic response

3.5.1.5.2.6.5 Patient consent, and his or her right to withdrawal

3.5.1.5.2.6.6 Discussion of the medication management plan with the patient providing information about reasons for offering pharmaceutical treatment, suitable choice and dose of medication (preference should be given to the use of generic medications), expectations upon initiating therapy, expected onset of therapeutic effects and expected or potential adverse or withdrawal effects

3.5.1.5.3 Primary Care – integrated patient pathways

3.5.1.5.3.1 Mild Disorder

3.5.1.5.3.1.1 As an initial intervention, the Family Physician should recommend lifestyle modifications by educating patients on diet, sleep,

exercise, and mindfulness, and may refer patients to evidence-based psychotherapy, such as Cognitive Behavioral Therapy (CBT), when appropriate

3.5.1.5.3.1.2 As a secondary intervention, pharmacological treatment, such as Selective Serotonin Reuptake Inhibitors (SSRIs), may be considered if lifestyle and psychological interventions prove insufficient.

3.5.1.5.3.2 Moderate Disorder

3.5.1.5.3.2.1 The Family Physician may initiate a combination of lifestyle modifications, referral for psychotherapy, and pharmacological interventions (e.g. SSRIs), tailored to the patient's needs.

3.5.1.5.3.2.2 The medical management of patients using antipsychotics and/ or mood stabilizers should be under the guidance of a psychiatrist. Treatment can be prescribed by Psychiatrists only and can be refilled/ prescription renewed by Family Physicians with no changes to dosage.

3.5.1.5.3.2.3 Patients stable on antipsychotics and/or mood stabilizers who are managed by Family Physicians should have their treatment plan re-assessed by a Psychiatrist at least once annually.

3.5.1.5.3.2.4 Referrals to Mental Health professionals (psychologist/psychiatrist or other) should be based on a treatment plan developed with the patient.

3.5.1.5.4 Specialist Care

3.5.1.5.4.1 Patients referred to specialist care include patients with severe anxiety/ depression or high complexity patients due to comorbidities, risk factors or patient preference.

3.5.1.5.4.2 Specialist care should include a combination of lifestyle interventions (e.g., physical activity, social engagement), evidence-based psychotherapy (e.g., CBT, interpersonal therapy), and pharmacological options. Augmentation strategies may be considered for patients requiring a multifaceted approach.

3.5.1.5.5 Treatment plans are required for each patient including the parameters specified above.

3.5.1.5.6 Initiation of any new medication must have clear documentation of indication, duration and plan for monitoring response to treatment.

3.5.1.6 Treatment monitoring

3.5.1.6.1 Frequency of review should be determined by the treating clinician, as clinically indicated. It shall include, at minimum, a review of the patient's response and tolerance to

treatment (including any adverse effects experienced by the patient) at the following timeframes:

3.5.1.6.1.1 Within 1 month of initiation of treatment

3.5.1.6.1.2 After 6 months of initiating treatment

3.5.1.6.1.3 At the end of treatment

3.5.1.6.2 Six-month review shall include documentation of:

3.5.1.6.2.1 Progress against the outcome measures specified in the treatment plan

3.5.1.6.2.2 Repeat PHQ-9/GAD-7

3.5.1.6.2.3 Patient reported quality of life assessment score or using validated Health-Related Quality of Life (HRQoL) e.g. MHQoL

3.5.1.6.3 Primary Care - integrated patient pathways

3.5.1.6.3.1 Patient's progress should be first reviewed within 2 weeks. Thereafter, progress should be reviewed at least every 2-4 weeks, or otherwise if clinically indicated. Overall progress shall be assessed at least every 6 months.

3.5.1.6.3.2 If the patient shows improvement (e.g., reduced symptoms, lower PHQ-9 scores), the Family Physician continues the current treatment, adjusting as necessary.

3.5.1.6.3.3 If the patient is not responding to treatment, the Family Physician may modify the intervention, after 6 weeks of medications on optimum dose or 3 months of psychotherapy. Intervention modification involving the initiation of antipsychotics or mood stabilizers requires a Referral to a psychiatrist.

3.5.1.6.3.4 Persistent lack of improvement (for up to 6 weeks after the first treatment plan was commenced) requires a referral to a psychiatrist for escalation of care. Escalation of care by referring to a psychiatrist or pharmacological modification can occur prior to 6 months from treatment onset, if patient symptoms are worsening or limited improvement is documented by Family Physician.

3.5.1.6.4 Specialist Care

3.5.1.6.4.1 Patient progress will be reviewed as clinically indicated in the patient's treatment plan.

3.5.1.6.4.2 If the patient shows sustained improvement, the Psychiatrist may consider de-escalation to primary care for ongoing management.

3.5.1.6.4.3 If the patient is at high risk of harm to self or others with an active plan, idea or intent to harm, the Psychiatrist should refer the patient to Emergency for Psychiatric evaluation. If the patient refuses, the police or ambulance may be sought to transfer him or her to Emergency for Psychiatric evaluation as outlined in Federal Law No. 10 and its Executive Regulation.

3.5.1.7 Treatment Resistant Depression (TRD)

3.5.1.7.1 An inadequate response to a minimum of 2 antidepressants from at least 2 different classes with different mechanisms of action (with adequate dose, duration and compliance to treatment) is classified as treatment-resistant depression (TRD). This can be associated with Major Depressive Disorder (MDD) or other psychiatric conditions where depressive features or mood dysregulation are prominent including, but not limited to Bipolar Depression, Persistent Depressive Disorder, Depression in comorbid psychiatric conditions, neuropsychiatric conditions with Depression and some select cases of Postpartum Depression

3.5.1.7.2 Management of TRD includes, but is not limited to the following,

3.5.1.7.2.1 Augmentation Therapy

3.5.1.7.2.1.1 Augmentation can be with another antidepressant or a non-antidepressant such as a mood stabilizer or an antipsychotic agent.

3.5.1.7.2.1.2 Clear documentation of failure to meet the goals of the treatment plan is required before prescribing any antipsychotic or mood stabilizer as per 3.6.1.5.2.

3.5.1.7.2.1.3 Consider consulting with an endocrinologist on the medical management of patients with metabolic disorders e.g. Type 2 Diabetes or obesity to minimize side effects of augmentation with antipsychotics.

3.5.1.7.2.2 Transcranial Magnetic Stimulation (TMS)

3.5.1.7.2.2.1 Facilities providing TMS treatment shall use evidence-based guidelines and treatment protocols.

3.5.1.7.2.2.2 Eligibility Criteria

3.5.1.7.2.2.2.1 Adult patients, 18 years of age or older

3.5.1.7.2.2.2.2 Confirmed, documented diagnosis of moderate-severe depression or anxiety, supported by standardized rating scales e.g. PHQ-9

3.5.1.7.2.2.2.3 Evidence of TRD as per 3.6.1.7.1 or intolerance/inability to take antidepressants or incomplete response to psychotherapy alone or strong patient preference for non-medication treatment

3.5.1.7.2.2.2.4 Comprehensive evaluation to rule out contraindications with TMS

3.5.1.7.2.2.2.5 Assessment of history of seizures

3.5.1.7.2.2.3 Exclusion Criteria

3.5.1.7.2.2.3.1 History of epilepsy or seizure disorder – unless cleared by neurologist

3.5.1.7.2.2.3.2 Presence of metal implants or medical devices in the head (excluding dental fillings)

3.5.1.7.2.2.4 TMS Administration

3.5.1.7.2.2.4.1 Treatment shall be overseen by psychiatrists or neurologists.

3.5.1.7.2.2.4.2 TMS can be provided in outpatient or inpatient settings.

3.5.1.7.2.2.4.3 TMS is delivered as 20–30-minute sessions daily (or 5 days per week) for 4-6 weeks. Maintenance sessions can be administered weekly or monthly based on clinical response.

3.5.1.7.2.2.4.4 Accelerated protocol for TMS can be delivered as multiple 10 minute sessions per day (up to 10sessions/day) for 5 days/week.

3.5.1.7.2.2.4.5 Frequency, intensity and coil placement should be determined by a psychiatrist or neurologist based on standardized protocols.

3.5.1.7.2.2.4.6 Facilities providing TMS treatment shall have clear protocols in place for treatment .

3.5.1.7.2.2.5 Documentation

3.5.1.7.2.2.5.1 Documentation prior to commencing treatment shall include, but is not limited to:

3.5.1.7.2.2.5.1.1 Psychiatric diagnosis

3.5.1.7.2.2.5.1.2 Patient history and indication for TMS treatment

3.5.1.7.2.2.5.1.3 Baseline neurological assessment

3.5.1.7.2.2.5.1.4 Medical and psychiatric history

3.5.1.7.2.2.5.1.5 Previous treatment attempts and responses

3.5.1.7.2.2.5.1.6 Patient consent form detailing risks and benefits

3.5.1.7.2.2.5.1.7 Patient education received

3.5.1.7.2.2.5.1.8 Baseline PHQ-9 assessment and score

3.5.1.7.2.2.5.1.9 Treatment protocol details: frequency, duration and target area used during the session

3.5.1.7.2.2.5.2 Documentation after each session must

include, but is not limited to:

- 3.5.1.7.2.2.5.2.1 Date and time of treatment
- 3.5.1.7.2.2.5.2.2 Duration of treatment session
- 3.5.1.7.2.2.5.2.3 Treatment delivered in each session, including any adjustments made
- 3.5.1.7.2.2.5.2.4 Stimulation parameters (including intensity and coil position)
- 3.5.1.7.2.2.5.2.5 Patient reported side effects after each session
- 3.5.1.7.2.2.5.2.6 Plan and follow up
- 3.5.1.7.2.2.5.2.7 Repeat PHQ-9 should be performed every 1-2 weeks to track symptom improvement.

3.5.1.7.2.3 Esketamine

3.5.1.7.2.3.1 Eligibility Criteria

- 3.5.1.7.2.3.1.1 Adult patients, 18 years of age or older
- 3.5.1.7.2.3.1.2 Confirmed, documented diagnosis of moderate-severe depression or anxiety, supported by standardized rating scales e.g. PHQ-9
- 3.5.1.7.2.3.1.3 Evidence of TRD as per 3.6.1.7.1
- 3.5.1.7.2.3.1.4 Evaluation of medical or psychiatric risk factors with potential adverse effects associated with esketamine (e.g. history of psychosis, bipolar disorder, unstable cardiovascular or respiratory conditions)

3.5.1.7.2.3.2 Exclusion Criteria

- 3.5.1.7.2.3.2.1 Patients with comorbidities of uncontrolled blood pressure or intracranial pressure (e.g. history of cardiovascular events 6 weeks prior, history of intracerebral hemorrhage, aneurysmal vascular disease)
- 3.5.1.7.2.3.2.2 Uncontrolled hypertension

3.5.1.7.2.3.3 Esketamine Treatment

- 3.5.1.7.2.3.3.1 Esketamine must be prescribed by a psychiatrist.
- 3.5.1.7.2.3.3.2 Treatment is performed in outpatient setting of healthcare facility.
- 3.5.1.7.2.3.3.3 All administration of Esketamine must be performed under medical supervision. Esketamine must not be taken home by the patient.
- 3.5.1.7.2.3.3.4 Facilities providing Esketamine treatment must

have clear protocols in place for treatment.

3.5.1.7.2.3.3.5 All patients shall undergo a post-administration observation period of 90 minutes to monitor side effects such as dissociation, sedation, nausea and vomiting.

3.5.1.7.2.3.3.6 Blood pressure should be monitored before administration, for at least 30 minutes post-administration and at discharge.

3.5.1.7.2.3.3.7 Treatment is conducted over twice weekly sessions for a 4-week induction period. Maintenance sessions can be administered weekly or biweekly thereafter.

3.5.1.7.2.3.3.8 Dosage of administration shall be determined by a psychiatrist.

3.5.1.7.2.3.4 Documentation

3.5.1.7.2.3.4.1 Documentation prior to commencing treatment must include, but is not limited to:

3.5.1.7.2.3.4.1.1 Psychiatric diagnosis

3.5.1.7.2.3.4.1.2 A baseline medical assessment to rule out comorbidities, specifically focusing on cardiovascular and respiratory conditions

3.5.1.7.2.3.4.1.3 Medical and psychiatric history

3.5.1.7.2.3.4.1.4 Previous treatment attempts and responses

3.5.1.7.2.3.4.1.5 Patient consent form detailing risks and benefits as per the DoH Patient Consent Standard

3.5.1.7.2.3.4.1.6 Baseline PHQ-9 assessment and score

3.5.1.7.2.3.4.1.7 Vital signs prior to each dose administration

3.5.1.7.2.3.4.1.8 Documentation after each session must include, but is not limited to:

3.5.1.7.2.3.4.1.9 Date and time of treatment

3.5.1.7.2.3.4.1.10 Dose of administration

3.5.1.7.2.3.4.1.11 Vital signs 30 minutes post dose and prior to discharge

3.5.1.7.2.3.4.1.12 Patient reported side effects after each session

3.5.1.7.2.3.4.1.13 Repeat PHQ-9 should be performed every 4 weeks to track symptom improvement

3.5.1.7.2.3.5 Electroconvulsive Therapy

3.5.1.7.2.3.5.1 Eligibility Criteria

- 3.5.1.7.2.3.5.1.1 Adult patients, 18 years of age or older
- 3.5.1.7.2.3.5.1.2 Confirmed, documented diagnosis of severe depression or anxiety, supported by standardized rating scales e.g. PHQ-9 or evidence of TRD as per 3.6.1.7.1
- 3.5.1.7.2.3.5.1.3 Need for rapid symptom relief due to severe, life-threatening symptoms such as high risk of suicide, catatonia

3.5.1.7.2.3.5.2 Exclusion Criteria

- 3.5.1.7.2.3.5.2.1 Increased intracranial pressure
- 3.5.1.7.2.3.5.2.2 Unstable cardiovascular disease
- 3.5.1.7.2.3.5.2.3 History of severe pulmonary disease
- 3.5.1.7.2.3.5.2.4 History of prolonged seizures or status epilepticus, unless cleared by a neurologist
- 3.5.1.7.2.3.5.2.5 High anesthesia risk
- 3.5.1.7.2.3.5.2.6 Pacemaker in place

3.5.1.7.2.3.5.3 ECT Administration

- 3.5.1.7.2.3.5.3.1 Facilities providing ECT treatment must have clear protocols in place for treatment
- 3.5.1.7.2.3.5.3.2 ECT treatment should be overseen by a psychiatrist and includes conducting psychiatric assessment pre-treatment as well as determining ECT indication, frequency and treatment parameters and managing post ECT follow-up care
- 3.5.1.7.2.3.5.3.3 Prior to treatment a medical evaluation should be conducted including, but not limited to: Baseline ECG, Cardiac assessment, Neurological examination (if indicated due to history of seizures or epilepsy), Blood work including CBC, electrolytes, renal and liver function tests and Anesthesia assessment
- 3.5.1.7.2.3.5.3.4 ECT administration must be performed by a trained physician (psychiatrist or anesthesiologist) with competencies in ECT or a trained ECT nurse or technician – with evidence of training
- 3.5.1.7.2.3.5.3.5 ECT course of treatment usually spans 6-12 sessions administered 2-3 times per week

3.5.1.7.2.3.5.3.6 ECT can be conducted in either inpatient or outpatient setting

3.5.1.7.2.3.5.3.7 Maintenance therapy, if required, can be conducted weekly to monthly, depending on relapse risk

3.5.1.7.2.3.5.4 Documentation

3.5.1.7.2.3.5.4.1 Documentation prior to commencing treatment must include, but is not limited to:

3.5.1.7.2.3.5.4.2 Psychiatric evaluation including ECT indication

3.5.1.7.2.3.5.4.3 Medical evaluation of risk factors, bloodwork (CBC, electrolytes, renal and liver function tests and Anesthesia assessment)

3.5.1.7.2.3.5.4.4 Baseline medical assessment to rule out comorbidities (cardiovascular, respiratory),

3.5.1.7.2.3.5.4.5 Medical and psychiatric history

3.5.1.7.2.3.5.4.6 Patient consent form detailing risks and benefits

3.5.1.7.2.3.5.4.7 Baseline PHQ-9 assessment and score

3.5.1.7.2.3.5.4.8 Documentation after each session must include, but is not limited to:

3.5.1.7.2.3.5.4.9 Dose settings

3.5.1.7.2.3.5.4.10 Seizure duration

3.5.1.7.2.3.5.4.11 Anesthesia used

3.5.1.7.2.3.5.4.12 Vital signs

3.5.1.7.2.3.5.4.13 Post-procedure evaluation of recovery including conscious level, orientation, side effects (cognitive or physical)

3.5.1.7.2.3.5.4.14 Repeat PHQ-9 should be performed at the end of treatment with follow ups at 1, 3 and 6 months after completing treatment

3.5.2 Anxiety and Depression in Perinatal Women (Appendix B)

3.5.2.1 Anxiety and depression are common mental health concerns for women during the perinatal period, which includes pregnancy and the first year after childbirth. These conditions can significantly impact a woman's emotional and psychological well-being and may also influence her physical health, ability to care for her newborn, and overall quality of life. Early identification and intervention are essential to improve outcomes for both the mother and child.

3.5.2.2 Signs and Symptoms

3.5.2.2.1 Anxiety symptoms include, but are not limited to: Restlessness or feeling on edge, Difficulty concentrating, Muscle tension, Sleep disturbances and Increased irritability

3.5.2.2.2 Depression symptoms include, but are not limited to: Persistent sadness or low mood, Loss of interest or pleasure in activities, Changes in sleep or appetite, Feelings of guilt or worthlessness and Difficulty bonding with the newborn

3.5.2.3 Screening

3.5.2.3.1 Screening by the Perinatal Team

3.5.2.3.1.1 Antenatal

3.5.2.3.1.1.1 Nurses will screen patients by screen using PHQ-9 / Edinburgh Postnatal Depression Scale (EPDS) at each antenatal visit (Appendix H). Screening does not need to be administered if the patient has had this screening completed in the 1 month prior

3.5.2.3.1.1.2 Any positive result will be communicated to obstetricians to refer to a mental health professional (psychiatrist or psychologist)

3.5.2.3.1.2 Post-natal

3.5.2.3.1.2.1 Midwives will screen using PHQ-9 / EPDS at each post-natal home visit

3.5.2.3.1.2.2 Any positive result will be communicated to the treating physician to refer the patient to a mental health professional (psychiatrist or psychologist)

3.5.2.3.2 Screening by Pediatrician and PCP

3.5.2.3.2.1 In addition to perinatal care, screenings should be performed during visits for the child or routine checks for the mother in the first-year post birth. Nurse will screen mother by administering a PHQ-2 and GAD-2 to mother at well-child visits

3.5.2.3.3 A positive result on any screening tool (PHQ-9, EPDS, PHQ-2, or GAD-2) requires a referral to a Mental health professional (psychologist or psychiatrist) for a comprehensive assessment. Reason for referral should include the positive result of screening performed

3.5.2.3.4 Negative screening results require no further assessment

3.5.2.4 Diagnosis

3.5.2.4.1 For patients referred due to positive screening results, a mental health professional (psychologist or psychiatrist) will conduct a clinical interview to evaluate symptoms, and assess psychiatric history using DSM-5 criteria for diagnosing anxiety or depression

3.5.2.4.2 In addition, the clinician will also assess risk factors, including but not limited to: Patient's level of distress, Risk of self-harm / harm to the newborn, Comorbidities,

Functional impairment, Family and personal history of mental illness and Mother's relationship/attachment with her newborn (in postnatal phase)

3.5.2.4.3 Based on the outcome of the comprehensive assessment, the psychologist / psychiatrist will diagnose the patient with either Mild, Moderate or Severe disorder (in case pharmacological treatment is needed, referral should be to psychiatrist)

3.5.2.4.4 For high-risk patients with high level of distress or high risk of self-harm or harm to the newborn, consider referral to inpatient care

3.5.2.5 Intervention and Treatment

3.5.2.5.1 The psychologist / psychiatrist will develop a documented, patient-centered treatment plan in collaboration with the patient that considers the patient's severity, complexity and preferences for treatment modalities.

3.5.2.5.2 The treatment plan should include:

3.5.2.5.2.1 Patient's goals of treatment and outcome measures

3.5.2.5.2.2 Baseline scores from initial assessments (PHQ-9, EPDS) and baseline MHQoL or other validated Health-Related Quality of Life (HRQoL) scores

3.5.2.5.2.3 Treatment methods to be utilized and the person or discipline responsible for each treatment method (e.g. psychologist, psychiatrist or other).

Note: medications can only be prescribed by a physician

3.5.2.5.2.4 Treatment review dates and discharge framework

3.5.2.5.2.5 Referrals required to other specialties

3.5.2.5.2.6 When medication is prescribed the following additional parameters shall be included in the treatment plan:

3.5.2.5.2.6.1 Review of risks and benefits of the prescribed medication

3.5.2.5.2.6.2 Medications safety on pregnancy and breastfeeding

3.5.2.5.2.6.3 History of previous treatment

3.5.2.5.2.6.4 Pharmacovigilance

3.5.2.5.2.6.5 Timeframe for therapeutic response

3.5.2.5.2.6.6 Patient consent, and his or her right to withdrawal

3.5.2.5.2.6.7 Discussion of the medication management plan with the patient providing information about reasons for offering pharmaceutical treatment, suitable choice and dose of medication (preference should be given to the use of generic medications), expectations upon initiating therapy, expected onset of therapeutic effects and expected or potential adverse or withdrawal effects

3.5.2.5.3 Mild Disorder

3.5.2.5.3.1 As a first-line treatment, the specialist can recommend lifestyle changes (e.g., increased physical activity, mindfulness) and can refer the patient to evidence-based psychotherapy (e.g., cognitive behavioral therapy [CBT], interpersonal therapy)

3.5.2.5.3.2 As a second-line intervention, pharmacological treatment (e.g., SSRIs) may be considered if lifestyle and psychological interventions are ineffective

3.5.2.5.4 Moderate/ Severe Disorder

3.5.2.5.4.1 The specialist may initiate a combination of lifestyle modifications, referral for psychotherapy, and pharmacological intervention (if psychiatrist), tailored to the patient's needs

3.5.2.5.4.2 When prescribing pharmacological treatment, the psychiatrist must ensure coordination with the perinatal team to discuss pharmacological treatment choice to ensure safety for both the mother and newborn

3.5.2.6 Treatment Monitoring

3.5.2.6.1 Frequency of review should be determined by the treating clinician, as clinically indicated. It must include, at minimum, a review of the patient's response and tolerance to treatment (including any adverse effects experienced by the patient) at the following timeframes:

3.5.2.6.1.1 Within 1 month of initiation of treatment; and monthly thereafter

3.5.2.6.1.2 After 6 months of initiating treatment

3.5.2.6.1.3 At the end of treatment

3.5.2.6.2 The 6-month review shall include documented: Progress against outcome measures specified in the treatment plan, Repeat PHQ-9/GAD-7 and Patient reported quality of life assessment using validated Health-Related Quality of Life (HRQoL) tool e.g. MHQoL

3.5.2.6.3 If the patient shows no improvement or is at high risk of harm to herself or others (e.g. her child), the specialist may refer her to inpatient care for more intensive support

3.5.2.6.3.1 If the patient shows sustained improvement, the specialist may consider de-escalation to primary care for ongoing management

3.5.3 Anxiety and Depression in Children and Adolescents (Appendix C)

3.5.3.1 Anxiety and depression are common mental health concerns in children and adolescents. These conditions can impair emotional, social, and academic functioning, impacting a young person's ability to engage in daily activities and affecting their development. Early identification and intervention are essential to improve outcomes and support long-term well-being.

3.5.3.2 Signs and Symptoms

3.5.3.2.1 Anxiety symptoms in children and adolescents include, but are not limited to: Excessive worry or fear, Avoidance of social situations, Physical symptoms such as headaches or stomachaches, Restlessness or feeling on edge, Sleep disturbances and Difficulty concentrating

3.5.3.2.2 Depression symptoms in children and adolescents include, but are not limited to: Persistent sadness or irritability, Loss of interest or pleasure in activities, Changes in sleep or appetite, Fatigue or low energy, Difficulty concentrating and Withdrawal from family and friends

3.5.3.3 Screening

3.5.3.3.1 Screening at school

3.5.3.3.1.1 Any screening performed requires parent/caregiver consent prior to proceeding

3.5.3.3.1.2 Screening on admission may be conducted using the Strengths and Difficulties Questionnaire (SDQ) to identify potential emotional or behavioral difficulties. Please note: SDQ is not a specific tool, it assesses the overall emotional and behavioral status

3.5.3.3.1.3 Teachers or parents may also identify student concerns based on observed behavior

3.5.3.3.1.4 If the SDQ is indicative of potential signs of anxiety/ depression or teachers/parents are concerned for signs of depression, student screening using a validated screening tool e.g. PHQ-9/ GAD-7/ SCARED/ CDI/ MFQ, should be performed by: School's internal counselor or in-school specialists (Mental Health) as per the ADEK School In-School Specialist Services Policy

3.5.3.3.1.5 In case of positive screening, the student will proceed to complete the diagnostic assessment by in-school mental health professional (if available at the school)

3.5.3.3.2 Screening in Primary care - integrated patient pathways

3.5.3.3.2.1 if counselors or psychologists are not available in schools, the school will communicate its recommendation to the student's family for screening and evaluation in Primary Care by either a Family physician or a pediatrician

3.5.3.3.2.2 Nurses will screen patients by administering PHQ-2 and GAD-2 during vitals check of a primary care visit during vitals check of a primary care visit or ensure patients complete the screening (either electronically or hard-copy). PHQ-2 and GAD-2 screenings are exempt from administration if the patient has completed these screenings within the past three months.

3.5.3.3.2.3 Any positive result to PHQ-2 or GAD-2 will be communicated with the

PCP to complete a more detailed assessment

3.5.3.3.2.4 Negative screening results require no further assessment during the visit, but the physician will focus on addressing and monitoring for continued symptoms

3.5.3.4 Diagnosis

3.5.3.4.1 Patients with a positive PHQ-2 and/or GAD-2 will have a PHQ-9 and/or GAD-7 completed by the PCP or electronically by the patient, if age-appropriate, as part of the consultation. Other age-appropriate tools such as Children's Depression Inventory (CDI), or Mood and Feelings Questionnaire (MFQ), could be used

3.5.3.4.2 PHQ-9 or GAD-7 screenings are exempt from administration if the patient has completed these screenings within the past three months.

3.5.3.4.3 The PCP (Family Physician or Pediatrician) or psychologist/psychiatrist will conduct a clinical interview with both the child/adolescent and his or her family to evaluate symptoms and assess psychiatric history using DSM-5 criteria for diagnosing anxiety or depression.

3.5.3.4.4 The Family physician or psychiatrist should also rule out medical causes through a physical examination including, but not limited to: Complete blood count, Thyroid function, Vitamin D, Electrolytes (including calcium, phosphate, magnesium)

3.5.3.4.5 In addition, the clinician will also assess risk factors, including but not limited to: Medical history, Family / Patient's history of mental illness, Severity of distress, Functional impairment (Impact of symptoms on academic and social functioning), Risk of self-harm (suicidal ideation) / harm to others

3.5.3.4.6 Based on the outcome of the PCP's (Family Physician or Pediatrician's) comprehensive assessment, he or she will diagnose the patient with either Mild, Moderate or Severe disorder

3.5.3.4.6.1 Mild: management continues with PCP

3.5.3.4.6.2 Moderate: patient referred to psychiatrist for assessment, preferably a child and adolescent psychiatrist or psychiatrist privileged in child and adolescent psychiatry

3.5.3.4.6.3 Severe: patient referred to psychiatrist in secondary care for specialized management, preferably a child and adolescent psychiatrist or psychiatrist privileged in child and adolescent psychiatry

3.5.3.4.6.4 High risk of self-harm/ suicidal ideation with active plan, idea or intent to self-harm or harm others: patient sent to Emergency Department for Psychiatric evaluation

3.5.3.5 Intervention and treatment

3.5.3.5.1 The physician (Family Physician, Pediatrician or Psychiatrist) will develop a documented, patient-centered treatment plan in collaboration with the patient and the family that considers the severity of the symptoms, complexity and preferences for treatment modalities.

3.5.3.5.2 Antidepressant therapy in children should be initiated by a psychiatrist (preferably child and adolescent or privileged in child and adolescent psychiatry)

3.5.3.5.3 The treatment plan should include at minimum:

3.5.3.5.3.1 The patient's initial assessment scores of PHQ-9, GAD-7 (or SCARED / CDI / MFQ) and baseline MHQoL score or other validated Health-Related Quality of Life (HRQoL) scores

3.5.3.5.3.2 Treatment methods to be utilized and the person or discipline responsible for each treatment method (e.g. psychologist, psychiatrist or other).

Note: medications can only be prescribed by a physician

3.5.3.5.3.3 Treatment plan review dates and discharge framework

3.5.3.5.3.4 Referrals required to mental health professionals (psychiatrist, psychologist or other)

3.5.3.5.3.5 When medication is prescribed the following additional parameters must be included in the treatment plan:

3.5.3.5.3.5.1 Review of risks and benefits of the prescribed medication

3.5.3.5.3.5.2 History of previous treatment

3.5.3.5.3.5.3 Pharmacovigilance

3.5.3.5.3.5.4 Timeframe for therapeutic response

3.5.3.5.3.5.5 Patient consent, and his or her right to withdrawal

3.5.3.5.3.5.6 Risk assessment/ assessment of suicidal ideation

3.5.3.5.3.5.7 Discussion of the medication management plan with the patient and family, providing information about reasons for offering pharmaceutical treatment, suitable choice and dose of medication (preference should be given to the use of generic medications), expectations upon initiating therapy, expected onset of therapeutic effects and expected or potential adverse or withdrawal effects

3.5.3.5.4 Primary Care - integrated patient pathways

3.5.3.5.4.1 Mild Disorder

3.5.3.5.4.1.1 As a first-line treatment, the Family Physician or Pediatrician recommends lifestyle changes (e.g., increased physical activity, mindfulness) and can refer the patient to evidence-based psychotherapy (e.g., cognitive behavioral therapy [CBT], interpersonal therapy)

3.5.3.5.4.1.2 As a second-line intervention, pharmacological treatment (e.g., SSRIs) require referral to psychiatrist for further management

3.5.3.5.4.2 Moderate Disorder

3.5.3.5.4.2.1 Patients with moderate disorders should be referred to psychiatry for management

3.5.3.5.4.2.2 The medical management of patients using antipsychotics and/ or mood stabilizers should be under the guidance of a psychiatrist. Treatment can be prescribed by psychiatrists only and can be refilled/ prescription renewed by PCPs with no changes to dosage

3.5.3.5.4.2.3 Referrals to Mental Health professionals (psychologist/psychiatrist or other) should be based on treatment plan developed with the patient and family

3.5.3.5.5 Specialist Care

3.5.3.5.5.1 Patients referred to specialist care include patients with moderate or severe anxiety/ depression or high complexity patients due to comorbidities, risk factors or patient preference

3.5.3.5.5.2 Specialist care should include a combination of lifestyle interventions (e.g., physical activity, social engagement), evidence-based psychotherapy (e.g., CBT), and pharmacological options. Augmentation strategies may be considered for patients requiring a multifaceted approach

3.5.3.5.5.3 Treatment plans are required for each patient including the parameters specified above

3.5.3.5.5.4 Initiation of any new medication shall have clear documentation of indication, duration and plan for monitoring response to treatment

3.5.3.5.5.5 Commencing SSRIs and SSRI management should always be accompanied by a risk assessment of suicidal ideation in children and adolescents

3.5.3.6 Treatment monitoring

3.5.3.6.1 Frequency of review should be determined by the treating clinician, as clinically

indicated, and must always be guided by a risk assessment . It shall include, at minimum, a review of the patient's response and tolerance to treatment (including any adverse effects experienced by the patient) at the following timeframes:

3.5.3.6.1.1 Within 1 month of initiation of treatment; and monthly thereafter

3.5.3.6.1.2 After 6 months of initiating treatment

3.5.3.6.1.3 At the end of treatment

3.5.3.6.2 Six-month review must include documented:

3.5.3.6.2.1 Progress against the outcome measures specified in the treatment plan

3.5.3.6.2.2 Repeat PHQ-9/GAD-7

3.5.3.6.2.3 Patient reported quality of life assessment using validated Health-Related Quality of Life (HRQoL) tool e.g. MHQoL

3.5.3.6.3 Primary Care

3.5.3.6.3.1 Patient's progress and tolerance to treatment should be first reviewed within 2 weeks, if medication is commenced, and within 4 weeks, if no medication is commenced. Thereafter, progress should be reviewed at least every 4 weeks in case of pharmacological intervention, or otherwise if clinically indicated. Overall progress must be assessed at least every 6 months

3.5.3.6.3.2 Frequency of review of progress must always be guided by a risk assessment

3.5.3.6.3.3 If the patient shows improvement (e.g., reduced symptoms, lower test scores), the Family Physician or Pediatrician continues the current treatment, adjusting as necessary

3.5.3.6.3.4 If the patient is not responding to treatment, the PCP may modify the intervention

3.5.3.6.3.5 Persistent lack of improvement (for up to 3 months after the first treatment plan was commenced) requires a referral to a psychiatrist for escalation of care. Escalation of care can occur prior to 3 months from treatment onset if patient symptoms are worsening or limited improvement is documented by PCP

3.5.3.6.4 Specialist Care

3.5.3.6.4.1 Patient progress will be reviewed as clinically assessed as appropriate in the patient's treatment plan

3.5.3.6.4.2 If the patient shows sustained improvement, the specialist may consider de-escalation to primary care for ongoing management

3.5.3.6.4.3 If the patient is at high risk of harm to self or others, the specialist should refer the patient to inpatient care. If the patient poses danger to himself or herself or to others, the police or ambulance may be sought to transfer him or her to Emergency for Psychiatric evaluation as outlined in Federal Law No. 10 and its

Executive Regulation

3.5.4 Escalation of Care

3.5.4.1 Admission to an inpatient psychiatric unit should be considered if the patient meets any of the admission criteria below:

- 3.5.4.1.1 Acute suicide risk
- 3.5.4.1.2 History of recent suicide attempts or self-harm requiring close monitoring
- 3.5.4.1.3 Homicidal ideation with high risk of aggression towards others
- 3.5.4.1.4 Severe self-neglect e.g. refusal to eat, drink or take medications
- 3.5.4.1.5 Complete inability to perform daily activities
- 3.5.4.1.6 Catatonia or severe psychomotor retardation
- 3.5.4.1.7 Severe insomnia leading to psychotic symptoms or cognitive dysfunction
- 3.5.4.1.8 Failure of partial hospitalization or outpatient treatment
- 3.5.4.1.9 Severe comorbid psychiatric conditions e.g. psychosis, bipolar disorder with mania, substance intoxication or withdrawal requiring detoxification
- 3.5.4.1.10 Severe medical instability related to psychiatric conditions e.g, hypertensive crisis, syncope from malnutrition
- 3.5.4.1.11 Requirement for intensive medical or psychiatric monitoring e.g. ECT initiation

3.5.4.2 Admission to Partial Hospitalization Program (PHP) should be considered if the patient meets any of the admission criteria below.

- 3.5.4.2.1 Require daily intensive treatment but do not meet inpatient admission criteria
- 3.5.4.2.2 Significant functional impairment but no immediate safety risk (e.g. unable to work, severe social withdrawal, difficulty with daily tasks)
- 3.5.4.2.3 Persistent suicidal thoughts without immediate intent or plan
- 3.5.4.2.4 Severe anxiety symptoms preventing normal functioning such as panic attacks, or PTSD flashbacks disrupting life
- 3.5.4.2.5 Post-hospitalization step-down for stabilization
- 3.5.4.2.6 Non-adherence to outpatient treatment requiring structured intervention
- 3.5.4.2.7 Requires daily monitoring of psychiatric medications but does not need 24/7 care
- 3.5.4.2.8 Needs intensive therapy (CBT, group therapy, skills training) multiple times a week
- 3.5.4.2.9 Patients are medically and psychiatrically stable enough to go home
- 3.5.4.2.10 Support system available to support with safety monitoring

4.Key stakeholder Roles and Responsibilities

- 4.1 Healthcare facilities shall meet the service specifications and requirements set out in this standard and other relevant federal and local regulations.
- 4.2 Healthcare professionals must deliver service to a licensed facility that provides the appropriate equipment, support, and other resources necessary for safety and quality of care.
- 4.3 Billing and reimbursement shall be in accordance with Standard Provider Contract, DoH Mandatory Tariff and associated Claims and Adjudication Rules, and the Claims and Adjudication Standard. All documents are available from the DoH website: <https://www.doh.gov.ae/shafafiya>

5.Monitoring and Evaluation

- 5.1 A monitoring and evaluation framework is in place to evaluate the effectiveness, outcomes, and impact

Jawda KPIs for Outpatient Mental Health
Percentage of Patients on Antipsychotic Medication(s) Who Had Complete Routine Investigation and ECG performed within 12 months prior to prescription
Percentage of Patients Who Were Concurrently Prescribed Three or More Different Antipsychotic Medications
Percentage of Patients Who Were Concurrently Prescribed Two or More Different Benzodiazepines
Percentage of Patients Receiving Psychotherapy Who Achieved a Reduction in Depression Symptoms
Percentage of Patients Receiving Psychotherapy Who Achieved a Reduction in Anxiety Symptoms
Percentage of First Available Appointment for Patients Referred for Mental Health Services

of this Standard, and where necessary adopt changes to ensure continuous improvement within the health system in line with emerging new developments in healthcare sciences, medical practices, and healthcare education and training.

- 5.2 Outpatient facilities should report the following data parameters through the JAWDA portal

6.Enforcement and Sanctions

- 6.1 DoH may impose sanctions in relation to any breach of requirements under this Standard in accordance with the disciplinary regulation of the healthcare sector.

7.Exempted from Scope

NA

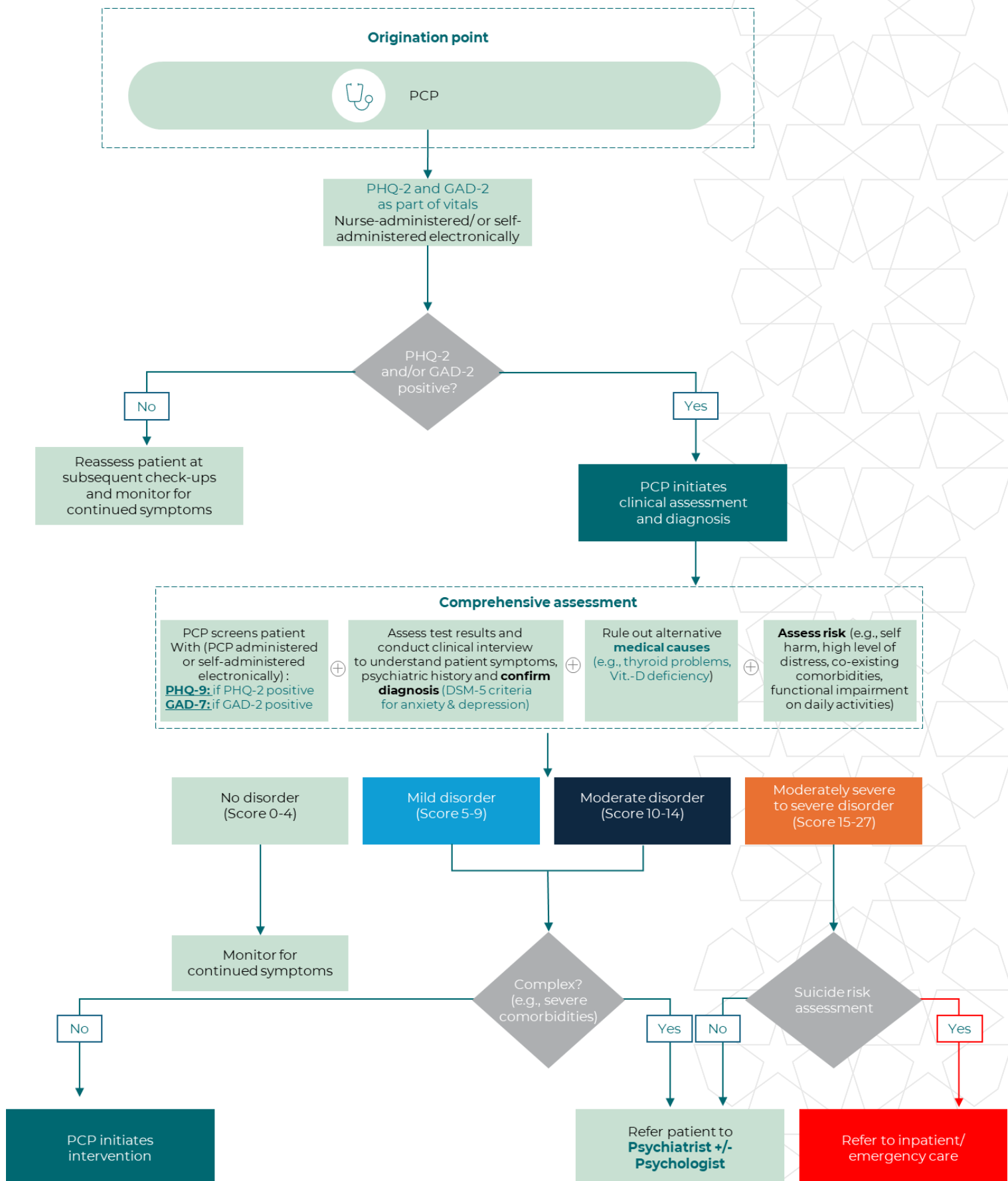
8. Relevant Reference Documents

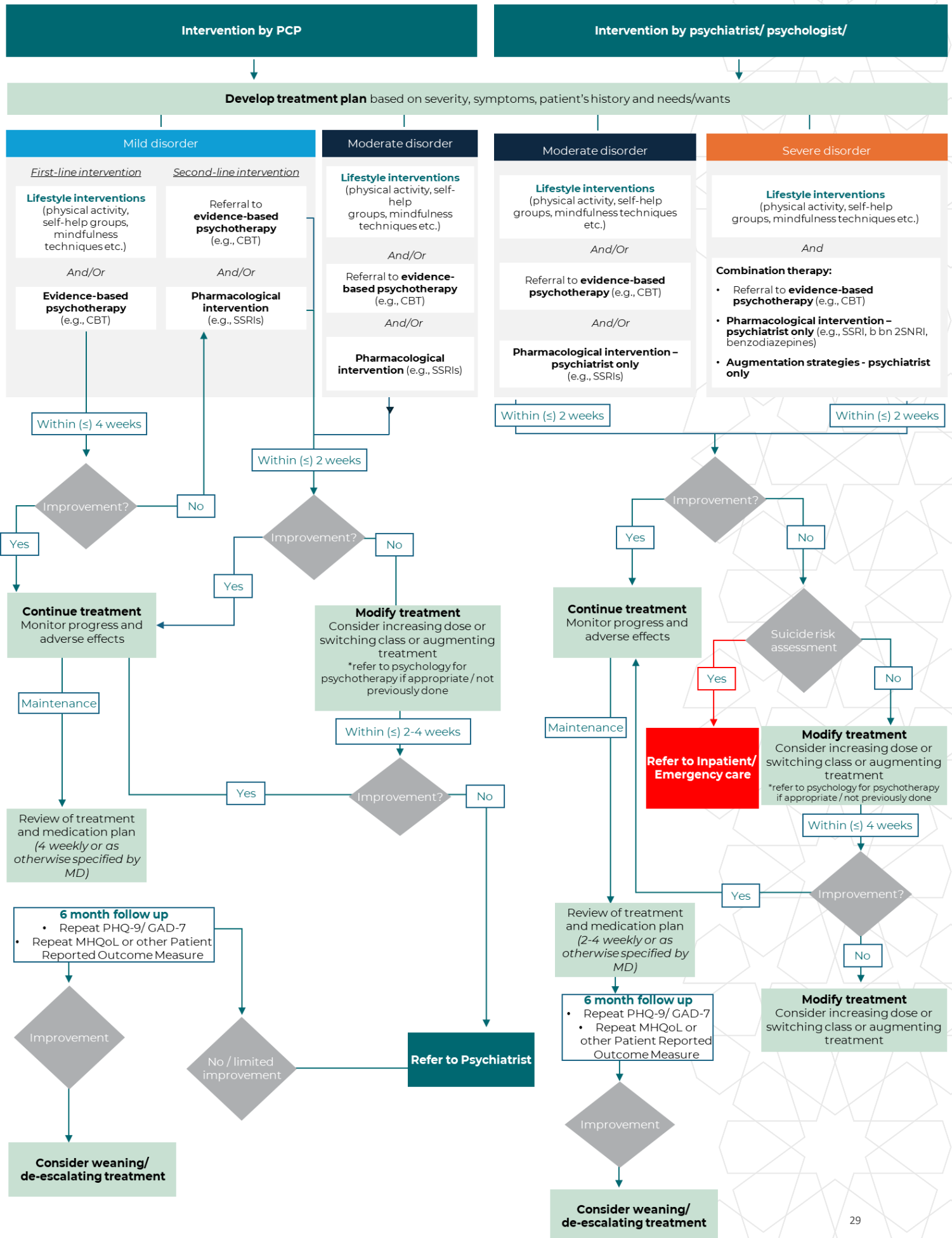
No.	Reference Date	Reference Name	Relation Explanation / Coding / Publication Links
1.	Accessed on: 29/10/2024	Ministry of Singapore: Clinical Practice Guidelines for Depression	Ministry of Health clinical practice guidelines: depression - PubMed
2.	Accessed on 29/10/2024	Ministry of Health Clinical Practice Guidelines: Anxiety Disorders	Ministry of Health Clinical Practice Guidelines: Anxiety Disorders - PMC
3.	Accessed on 31/10/2024	<u>Children's Hospital of Philadelphia: Depression pathway</u>	https://pathways.chop.edu/clinical-pathway/depression-clinical-pathway
4.	Accessed on 31/10/2024	<u>Children's Hospital of Philadelphia: Anxiety pathway</u>	https://pathways.chop.edu/clinical-pathway/anxiety-and-ocd-clinical-pathway
5.	Accessed on 31/10/2024	Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of panic disorder, social	RANZCP Anxiety Clinical Practice Guidelines
6.	Accessed on 31/10/2024	<u>Anxiety Primary Care Pathway – Canada</u>	CZ Anxiety pathway
7.	Accessed on 31/10/2024	NICE Guideline: Depression in adults - treatment and management (2022)	Overview Depression in adults: treatment and management Guidance NICE
8.	Accessed on 31/10/2024	NHS: Treatment of depression guidelines	Depression in adults: further line

9.	Accessed on 31/10/2024	APA Clinical Practice guideline for the treatment of depression across three age cohorts (2019)	<u>Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts</u>
10.	Accessed on 13/11/2024	Postpartum Depression: Diagnostic and Treatment issues	<u>Postpartum Depression: Diagnostic and Treatment Issues</u>
11.	Accessed on 31/10/2024	Royal Australian and New Zealand College of Psychiatrists Guidelines	<u>The 2020 Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders</u>
12.	Accessed on 26/11/2024	The PHQ-9: validity of a brief depression severity measure	<u>The PHQ-9: validity of a brief depression severity measure - PubMed</u>
13.	Accessed on 26/11/2024	A brief measure for assessing generalized anxiety disorder: the GAD-7	<u>A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7 Anxiety Disorders JAMA Internal Medicine JAMA Network</u>
14.	Accessed on 26/11/2024	Mental Health Quality of Life Questionnaire	<u>Mental Health Quality of Life Questionnaire - IMTA</u>
15	Accessed on 23/05/2025	The National Policy for the Promotion of Mental Health in the United Arab Emirates Ministry of Health and Prevention - UAE	<u>https://mohap.gov.ae/en/w/the-national-policy-for-the-promotion-of-mental-health-in-the-united-arab-emirates</u>
16	Accessed on 23/05/2025	Mental Health Policy and Procedure	<u>https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjKl6Hx44aOAxWH1wIHHRAlFjwQFnoECBcQAQ&url=https%3A%2F%2Fwww.dhcc.ae%2Fgallery%2FMentalHealthdPP.pdf&usg=AOvVaw37A2cVGM8HaE_CYWwTyO2d&opi=89978449</u>

17	Accessed on 23/05/2025	Standard for Specialized Mental Healthcare Services	Standards Department of Health Abu Dhabi
18	Accessed on 23/05/2025	Scope of Practice for Psychologist and Psychologist Assistant	Scope of Practice Department of Health Abu Dhabi
19	Accessed on 23/05/2025	Abu Dhabi Healthcare Information and Cyber Security Standard	Standards Department of Health Abu Dhabi
20	Accessed on 23/05/2025	DoH Standard For The Management Of Narcotics, Psychotropic And Semi-Controlled Medicinal Products	Standards Department of Health Abu Dhabi
21	Accessed on 23/05/2025	Federal Law No.10 of 2023 on Mental Health	https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwibm8PE74aOAxWLSvEDHTobEX4QFnoECBwQAQ&url=https%3A%2F%2Fuaelegislation.gov.ae%2Fen%2Flegislations%2F2166%2Fdownload&usg=AOvVaw0dBVLGRHF4aq_6dSRwB8S&opi=89978449
22	Accessed on 23/05/2025	Patient Consent Standard	Standards Department of Health Abu Dhabi
23	Accessed on 23/05/2025	In-School Specialist Services Policy	School Policies

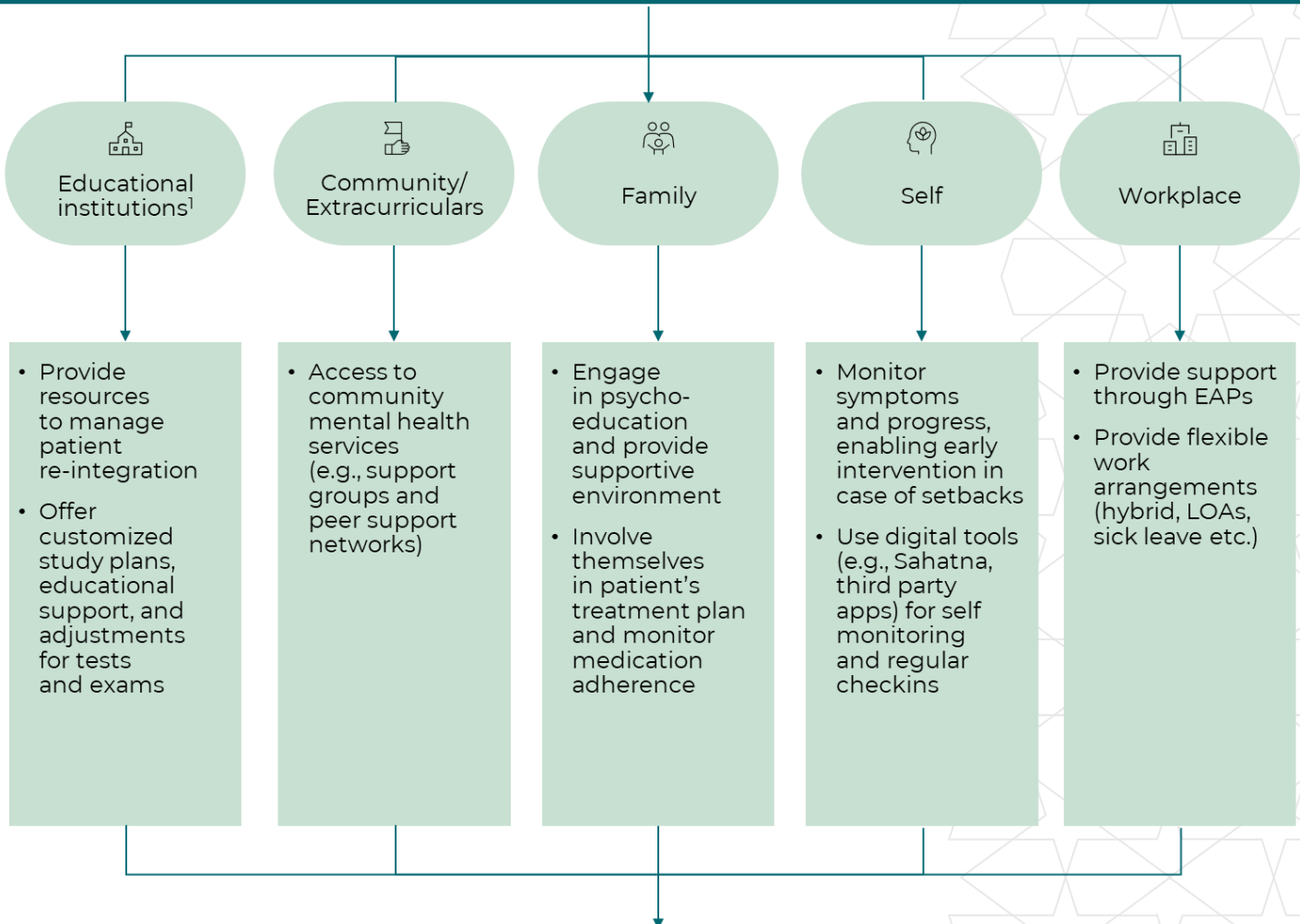
Appendix A: Adult Pathway for Depression and Anxiety





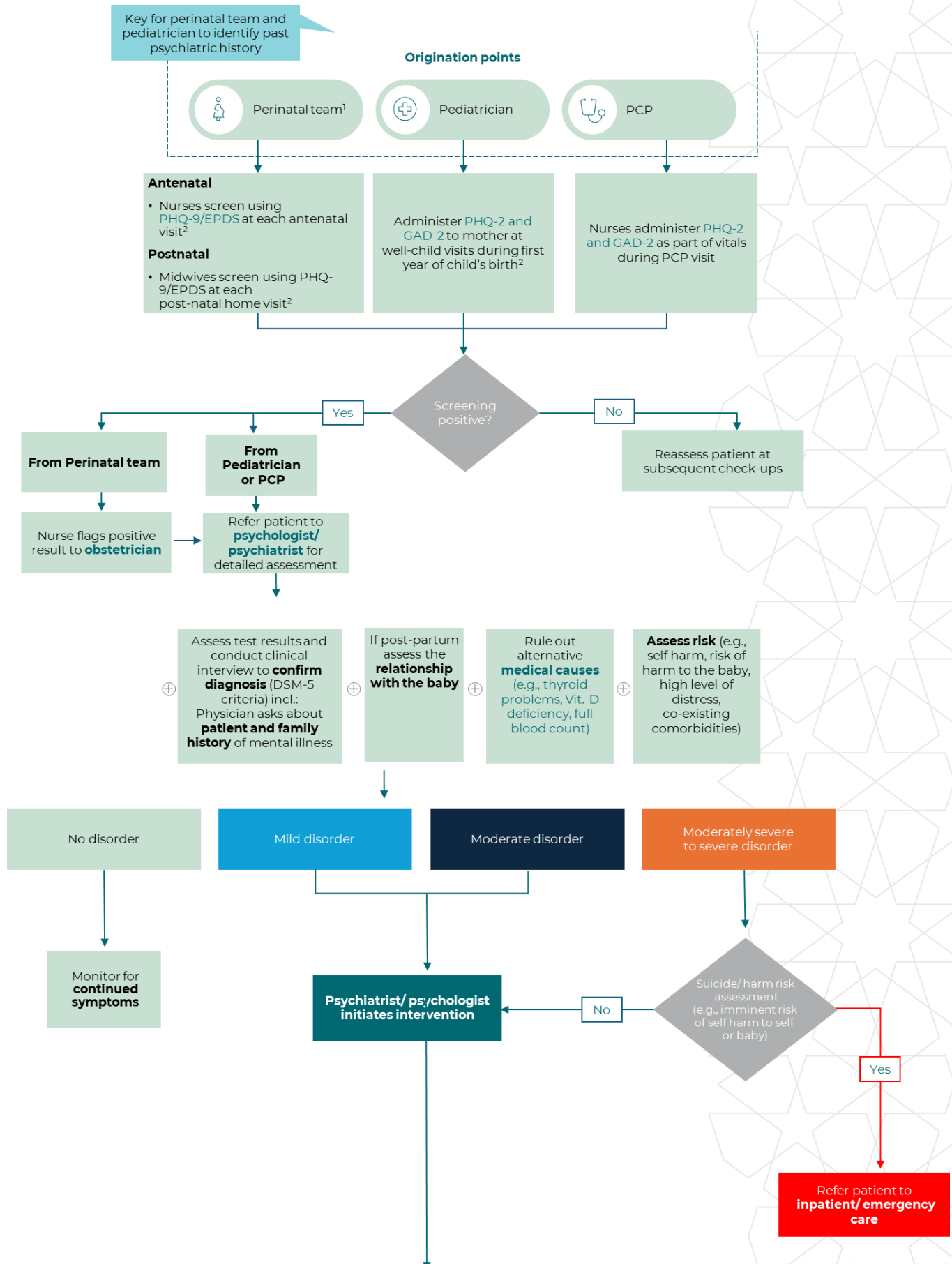
Reintegration

Patient's condition is well-managed

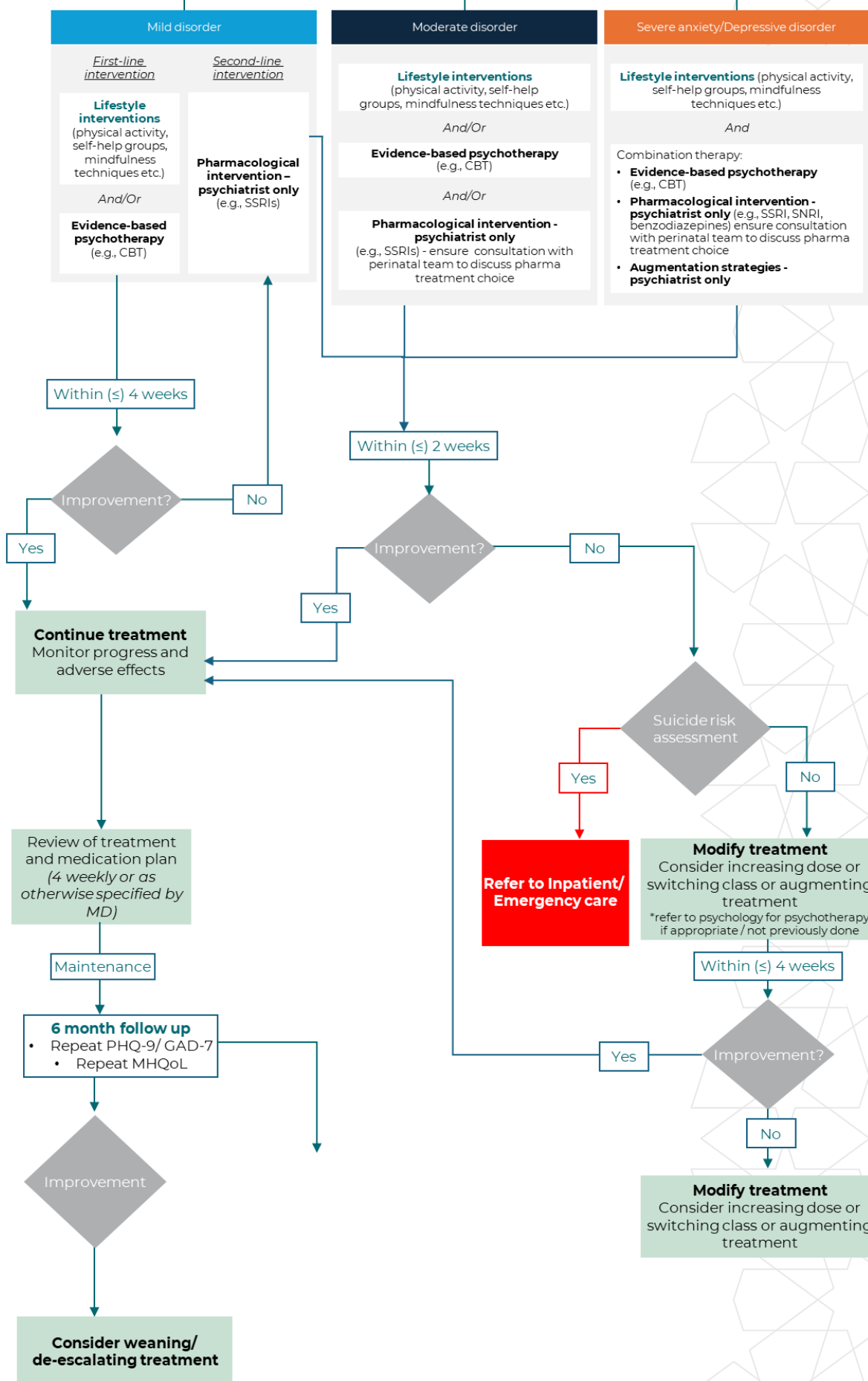


Adult with diagnosed and managed anxiety/depression feels integrated in community and society

Appendix B: Perinatal Pathway for Depression and Anxiety

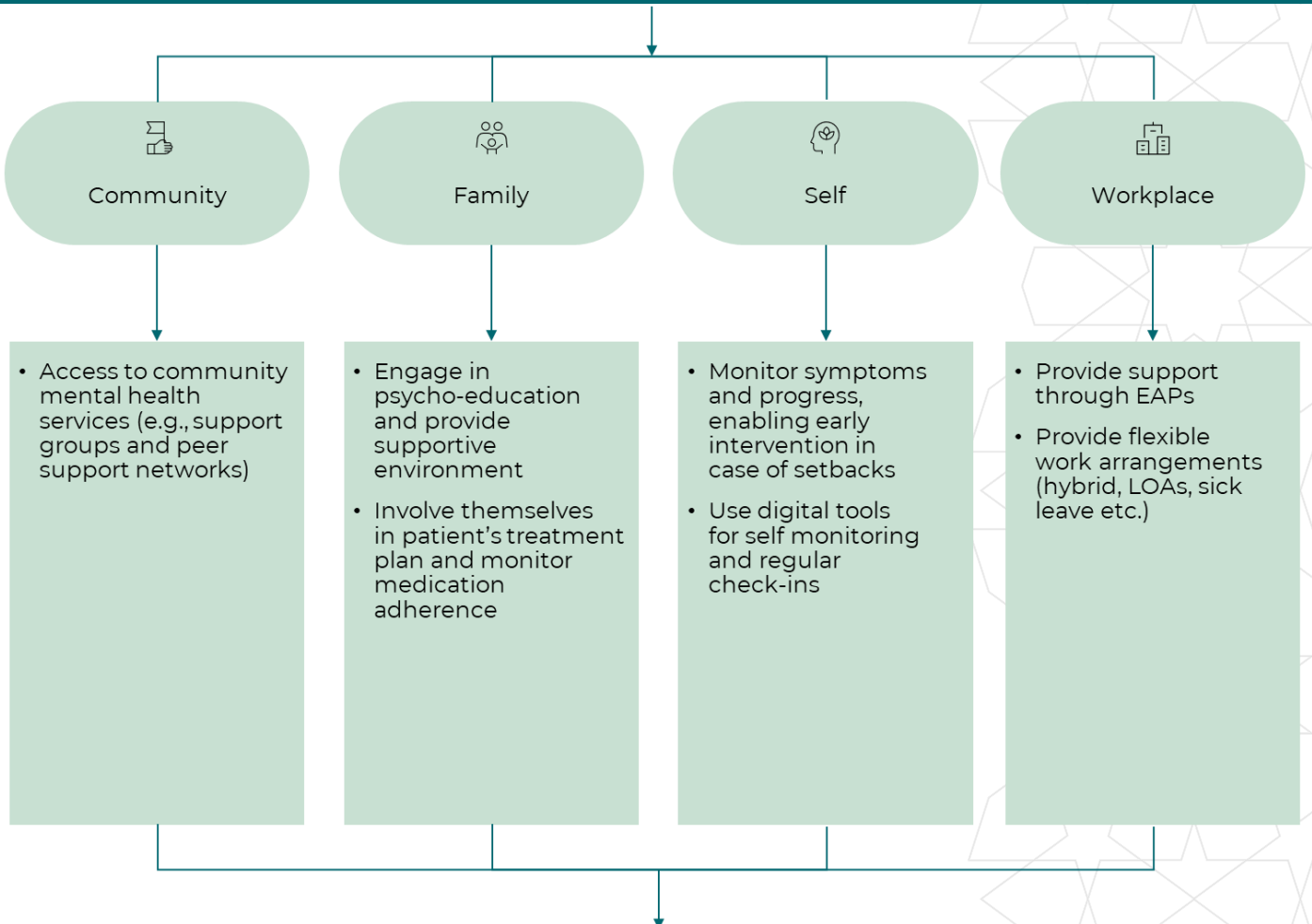


Psychiatrist/ psychologist develops **treatment plan** in collaboration with patient based on severity and category of the disorder



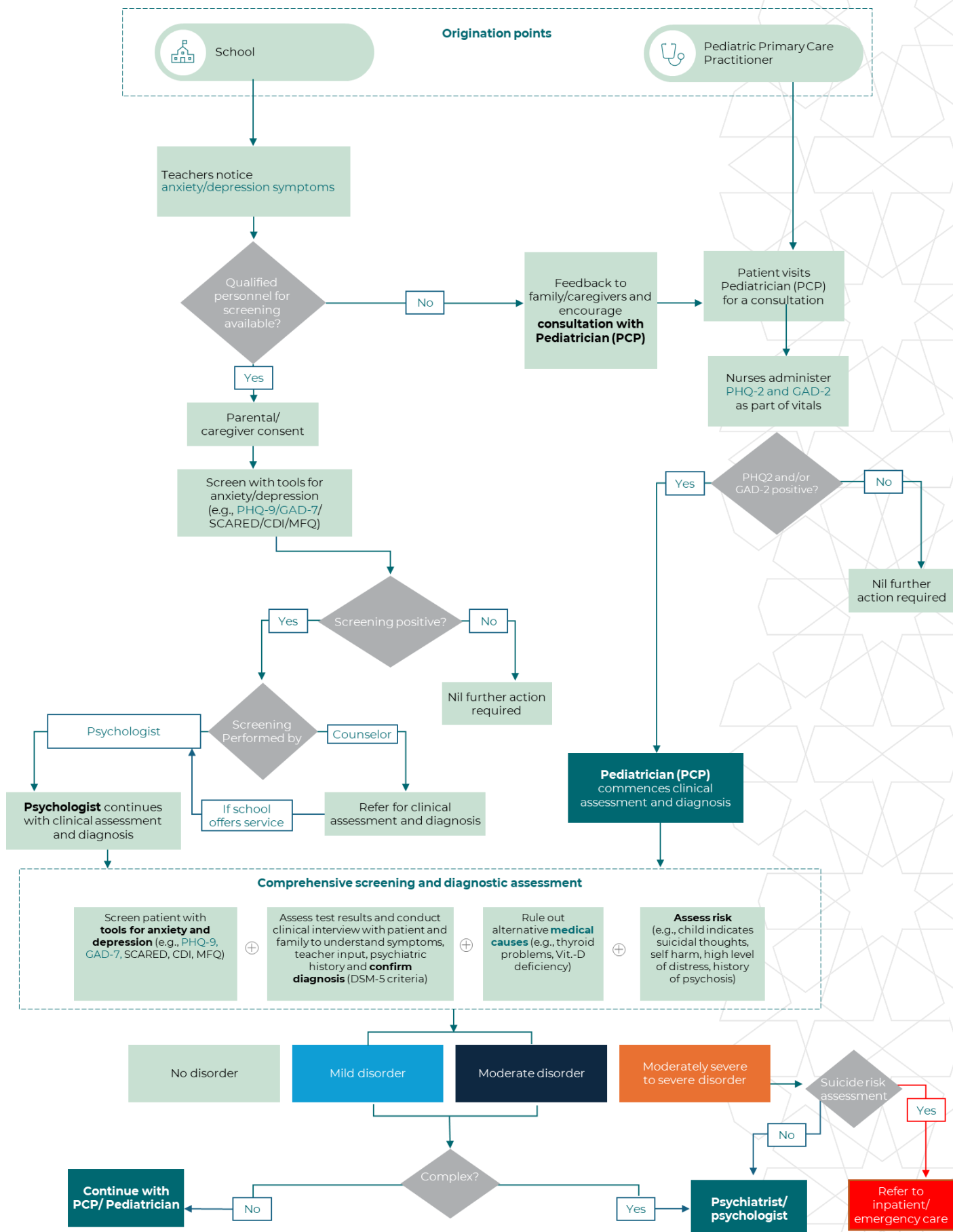
Reintegration

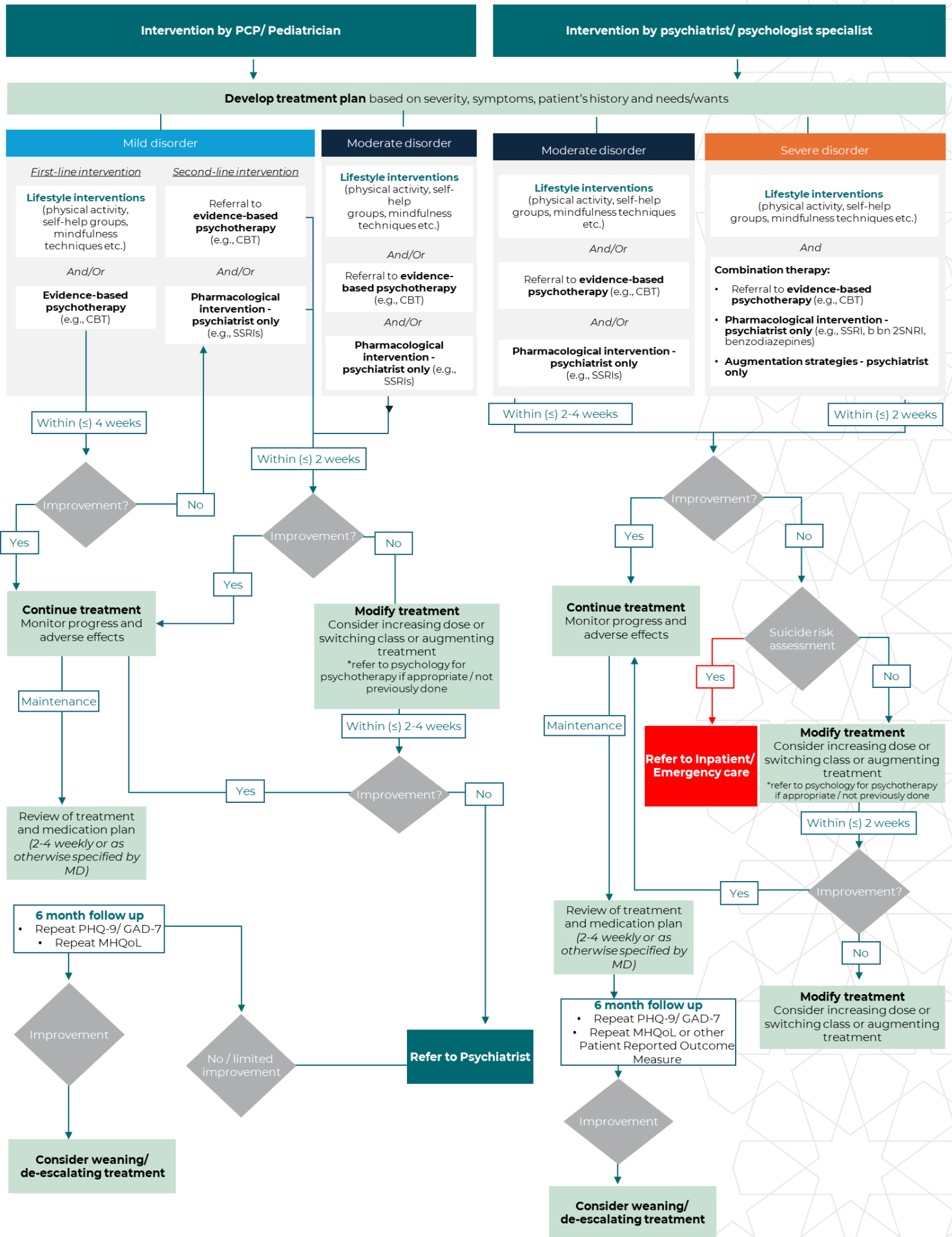
Patient's condition is well-managed



Woman with diagnosed and managed anxiety/depression feels integrated in community and society

Appendix C: Children & Adolescent Pathway for Depression and Anxiety





Reintegration

Patient's condition is well-managed



Schools

- Provide resources to manage patient re-integration
- Offer customized study plans, educational support, and adjustments for tests and exams



Community

- Access to community mental health services (e.g., support groups and peer support networks)



Family

- Engage in psychoeducation and provide supportive environment
- Involve themselves in patient's treatment plan and monitor medication adherence



Self

- Monitor symptoms and progress, enabling early intervention in case of setbacks
- Use digital tools (e.g., Sahatna, third party apps) for self monitoring and regular check-ins

Child with diagnosed and managed anxiety/depression feels integrated in community and society

D. Patient Health Questionnaire (PHQ)-2

Over the past two weeks, how often have you been bothered by any of the following problems?	<i>Not at all</i>	<i>Several days</i>	<i>More than half days</i>	<i>Nearly every day</i>
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Scoring: A score of 3 or more is considered a positive result.

E. Generalized Anxiety Disorder (GAD)-2

Over the past two weeks, how often have you been bothered by any of the following problems?	<i>Not at all</i>	<i>Several days</i>	<i>More than half days</i>	<i>Nearly every day</i>
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to sleep or control worrying	0	1	2	3

Scoring: A score of 3 or more is considered a positive result.

F. PHQ-9

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ DATE: _____

Over the last 2 weeks, how often have you been
bothered by any of the following problems?
(use "✓" to indicate your answer)

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

add columns + +

(Healthcare professional: For interpretation of TOTAL, TOTAL:
please refer to accompanying scoring card).

10. If you checked off any problems, how difficult
have these problems made it for you to do
your work, take care of things at home, or get
along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

PHQ-9 Score	Symptom Severity
0-4	None/Minimal
5-9	Mild
10-14	Moderate
15-19	Moderately Severe
20-27	Severe

G. GAD-7

GAD-7				
Over the last 2 weeks, how often have you been bothered by the following problems? (Use "✓" to indicate your answer)	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 is 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

(For office coding: Total Score T___ = ___ + ___ + ___)

GAD-7 Score	Symptom Severity
0-4	None/Minimal
5-9	Mild
10-14	Moderate
15-21	Severe

H. Edinburgh Postnatal Depression Scale (EPDS)

Edinburgh Postnatal Depression Scale (EPDS)

Patient Label

Mother's OB or Doctor's Name: _____

 Doctor's Phone #: _____

Since you are either pregnant or have recently had a baby, we want to know how you feel. Please place a **CHECK MARK (✓)** on the blank by the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**—not just how you feel today. Complete all 10 items and find your score by adding each number that appears in parentheses (#) by your checked answer. This is a screening test; not a medical diagnosis. If something doesn't seem right, call your health care provider regardless of your score.

Below is an example already completed.

I have felt happy:

Yes, all of the time	_____ (0)
Yes, most of the time	_____ (1) ☒
No, not very often	_____ (2)
No, not at all	_____ (3)

This would mean: "I have felt happy most of the time" in the past week. Please complete the other questions in the same way.

1. I have been able to laugh and see the funny side of things:

As much as I always could	_____ (0)
Not quite so much now	_____ (1)
Definitely not so much now	_____ (2)
Not at all	_____ (3)
2. I have looked forward with enjoyment to things:

As much as I ever did	_____ (0)
Rather less than I used to	_____ (1)
Definitely less than I used to	_____ (2)
Hardly at all	_____ (3)
3. I have blamed myself unnecessarily when things went wrong:

Yes, most of the time	_____ (3)
Yes, some of the time	_____ (2)
Not very often	_____ (1)
No, never	_____ (0)
4. I have been anxious or worried for no good reason:

No, not at all	_____ (0)
Hardly ever	_____ (1)
Yes, sometimes	_____ (2)
Yes, very often	_____ (3)
5. I have felt scared or panicky for no good reason:

Yes, quite a lot	_____ (3)
Yes, sometimes	_____ (2)
No, not much	_____ (1)
No, not at all	_____ (0)
6. Things have been getting to me:

Yes, most of the time I haven't been able to cope at all	_____ (3)
Yes, sometimes I haven't been coping as well as usual	_____ (2)
No, most of the time I have coped quite well	_____ (1)
No, I have been coping as well as ever	_____ (0)

7. I have been so unhappy that I have had difficulty sleeping:

Yes, most of the time	_____ (3)
Yes, sometimes	_____ (2)
No, not very often	_____ (1)
No, not at all	_____ (0)
8. I have felt sad or miserable:

Yes, most of the time	_____ (3)
Yes, quite often	_____ (2)
Not very often	_____ (1)
No, not at all	_____ (0)
9. I have been so unhappy that I have been crying:

Yes, most of the time	_____ (3)
Yes, quite often	_____ (2)
Only occasionally	_____ (1)
No, never	_____ (0)
10. The thought of harming myself has occurred to me:

Yes, quite often	_____ (3)
Sometimes	_____ (2)
Hardly ever	_____ (1)
Never	_____ (0)

TOTAL YOUR SCORE HERE ►

Thank you for completing this survey. Your doctor will score this survey and discuss the results with you.

Verbal consent to contact above mentioned MD witnessed by: _____

Edinburgh Postnatal Depression Scale (EPDS). Adapted from the *British Journal of Psychiatry*, June, 1987, vol. 150 by J.L. Cox, J.M. Holden, R. Segovsky.

Score ≥ 10 : possible depression (positive result)

I. MHQoL

The descriptive system of the MHQoL, the MHQoL-7D, comprises seven questions, covering seven dimensions each with four response levels. The levels of the MHQoL-7D are scored as follows:

Please indicate below which statements best describe your situation TODAY by ticking ONE box in each of the seven subjects.		
SELF-IMAGE		
I think very positively about myself	☐	3
I think positively about myself	☐	2
I think negatively about myself	☐	1
I think very negatively about myself	☐	0
INDEPENDENCE <i>For example: freedom of choice, financial, co-decision making</i>		
I am very satisfied with my level of independence	☐	3
I am satisfied with my level of independence	☐	2
I am dissatisfied with my level of independence	☐	1
I am very dissatisfied with my level of independence	☐	0
MOOD		
I do not feel anxious, gloomy, or depressed	☐	3
I feel a little anxious, gloomy, or depressed	☐	2
I feel anxious, gloomy, or depressed	☐	1
I feel very anxious, gloomy, or depressed	☐	0
RELATIONSHIPS <i>For example: partner, children, family, friends</i>		
I am very satisfied with my relationships	☐	3
I am satisfied with my relationships	☐	2
I am dissatisfied with my relationships	☐	1
I am very dissatisfied with my relationships	☐	0
DAILY ACTIVITIES <i>For example: work, study, household, leisure activities</i>		
I am very satisfied with my daily activities	☐	3
I am satisfied with my daily activities	☐	2
I am dissatisfied with my daily activities	☐	1
I am very dissatisfied with my daily activities	☐	0
PHYSICAL HEALTH		
I have no physical health problems	☐	3
I have some physical health problems	☐	2
I have many physical health problems	☐	1
I have a great many physical health problems	☐	0
FUTURE		
I am very optimistic about my future	☐	3
I am optimistic about my future	☐	2
I am gloomy about my future	☐	1
I am very gloomy about my future	☐	0

☒ Level 1 is scored as '3'

☐

☐

☐

☐

☐ Level 2 is scored as '2'

☒

☐

☐

☐ Level 3 is scored as '1'

☐

☒

☐

☐ Level 4 is scored as '0'

☐

☐

☒

An overall index score can be calculated by summing the scores of the seven questions. The MHQoL-7D index score can vary from 0 to 21, with higher scores indicating better quality of life.