حكومة دبي
GOVERNMENT OF DUBAI

هيئة الصحة بدبي
DUBAI HEALTH AUTHORITY

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DHA TELEHEALTH CLINICAL GUIDELINES FOR VIRTUAL MANAGEMENT OF DEPRESSION – 32

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INTRODUCTION

Health Regulation Sector (HRS) forms an integral part of Dubai Health Authority (DHA) and is mandated by DHA Law No. (14) of the year (2021) amending some clauses of law No. (6) of 2018 pertaining to the Dubai Health Authority (DHA), to undertake several functions including but not limited to:

- Developing regulation, policy, standards, guidelines to improve quality and patient safety and promote the growth and development of the health sector;
- Licensure and inspection of health facilities as well as healthcare professionals and ensuring compliance to best practice;
- Managing patient complaints and assuring patient and physician rights are upheld;
- Governing the use of narcotics, controlled and semi-controlled medications;
- Strengthening health tourism and assuring ongoing growth; and
- Assuring management of health informatics, e-health and promoting innovation.

The DHA Telehealth Clinical Guidelines aim to fulfil the following overarching DHA Strategic Priorities (2026):

- Pioneering Human-centered health system to promote trust, safety, quality and care for patients and their families.
- Make Dubai a lighthouse for healthcare governance, integration and regulation.

- Leading global efforts to combat epidemics and infectious diseases and prepare for disasters.
- Pioneering prevention efforts against non-communicable diseases.
- Become a global digital health hub.
- Foster healthcare education, research and innovation.

ACKNOWLEDGMENT

The Health Policy and Standards Department (HPSD) developed this Guideline in collaboration with Subject Matter Experts and would like to acknowledge and thank these health professionals for their dedication toward improving quality and safety of healthcare services in the Emirate of Dubai.

Health Regulation Sector

Dubai Health Authority

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EXECUTIVE SUMMARY

Telehealth is based on Evidence Based Practice (EBP) which is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence and guidelines from systematic research.

EBP is important because it aims to provide the most effective care virtually, with the aim of improving patient outcomes. As health professionals, part of providing a professional service is ensuring that practice is informed by the best available evidence.

This guideline is presented in the format comprising of clinical history/symptoms, differential diagnosis, investigations and management. Identification of 'Red Flags' or serious conditions associated with the disease is an essential part of this telehealth guideline as it aids the physician to manage patients safely and appropriately by referrals to ER, family physicians or specialists for a face to face management.

DEFINITIONS/ABBREVIATIONS

Virtual Clinical Assessment: Is the evaluation of the patient's medical condition virtually via telephone or video call consultations, which may include one or more of the following: patient medical history, physical examination and diagnostic investigations.

Patient: The person who receives the healthcare services or the medical investigation or treatment provided by a DHA licensed healthcare professional.

ABBREVIATIONS

ADHD	:	Attention Deficit Hyperactivity Disorder
CBT	:	Cognitive Deficit Hyperactivity Disorder
DHA	:	Dubai Health Authority
DHA	:	Dubai Health Authority
EBP	:	Evidence Based Practice
ER	:	Emergency Room
HIV	:	Human Immunodeficiency Virus
HRS	:	Health Regulation Sector
MAOI	:	Monoamine Oxidase Inhibitors
SSRI	:	Selective Serotonin Reuptake Inhibitors
EBP	:	Evidence Based Practice
ER	:	Emergency Room

1. BACKGROUND

1.1. Introduction

1.1.1. Depression is the most common psychiatric disorder in the general population and the most common mental health condition in patients seen in primary care. Although symptoms of depression are prevalent among primary care patients, few patients discuss these symptoms directly with their primary care clinicians. Instead, two-thirds of primary care patients with depression present with somatic symptoms (e.g., headache, back problems, or chronic pain), making detection of depression more difficult.

1.1.2. Depression is a mental state characterized by persistent low mood, loss of interest and enjoyment, neurovegetative disturbance, and reduced energy, causing varying levels of social and occupational dysfunction.

1.1.3. Depressive symptoms include depressed mood, anhedonia, weight changes, libido changes, sleep disturbance, psychomotor problems, low energy, excessive guilt, poor concentration, and suicidal ideation. In some cases, the mood is not sad, but anxious or irritable or flat.

1.1.4. Major depressive disorder is characterized by the presence of at least 5 symptoms and can be classified along a spectrum of mild to severe.

Severe episodes may include psychotic symptoms such as paranoia, hallucinations, or functional incapacitation.

1.1.5. Subthreshold (minor) depression is characterized by the presence of 2 to 4 depressive symptoms, including depressed mood or anhedonia, lasting longer than 2 weeks.

1.1.6. Persistent depressive disorder (dysthymic disorder) is characterized by at least 2 years of 3 or 4 dysthymic symptoms for more days than not. Dysthymic symptoms include depressed mood, appetite change, sleep disturbance, low energy, low self-esteem, poor concentration, and hopelessness.

1.2. Etiology

1.2.1. The etiology of depression remains poorly understood. Integrative models, taking into account biological and social variables, most effectively reflect the complex etiology. There is strong evidence for a genetic component to depression, but specific genetic factors have not been identified.

1.2.2. Gene-environment interaction will probably help explain susceptibility to depression; however, the evidence is mixed. Variants of several genes have been associated with depression in the subset of individuals who have experienced significant life stress. With or without a known genetic

component, stressful life events and personality may also play a modifying role in depression risk.

2. SCOPE

1.1. Telehealth services in DHA licensed Health Facilities.

3. PURPOSE

2.1. To support the implementation of Telehealth services for patients with complaints of Depression in Dubai Health Authority (DHA) licensed Health Facilities

4. APPLICABILITY

3.1. DHA licensed physicians and health facilities providing Telehealth services.

3.2. Exclusion for Telehealth services are as follows

3.2.1. Emergency cases where immediate intervention or referral is required

3.2.2. Prescribe Narcotics, Controlled or Semi-Controlled medications

5. RISK FACTORS

5.1. Age > 65 years

5.1.1. The prevalence of depression in medical outpatients older than age 65 years ranges from 7% to 36%, depending on the setting. Up to 50% of patients with Alzheimer disease and Parkinson disease develop a depressive disorder; their caregivers, regardless of age, are also at increased risk.

5.2. Postpartum status

5.2.1. About 19% of postpartum women have a major depressive episode during the first 3 months after delivery. Women with a previous psychiatric disturbance, poor social support, and an unplanned pregnancy are at higher risk. Parenting programs may improve the short-term psychosocial health of mothers.

5.3. Personal or family history of depressive disorder or suicide

5.3.1. A family history of depression is associated with a twofold increased risk, more functional impairment, longer episodes, more frequent recurrence, and persistent thoughts of death and suicide. The rate of suicide is twice as high in families of suicide victims.

5.4. Coexisting medical conditions

5.4.1. Patients with various chronic medical conditions, including diabetes, cancer, stroke, coronary artery disease, HIV, chronic pain, polycystic ovary syndrome, and obesity have significantly higher rates of depression than people without comorbidities. Moreover, the relationship is bidirectional. Depressed patients are more likely to develop chronic medical conditions. Adults who experienced chronic medical illness in childhood also have higher rates of depression.

5.5. Depression is a documented adverse effect of the following medications:

5.5.1. Corticosteroids

5.5.2. Propranolol

5.5.3. Interferon

5.5.4. Oral Contraceptives

6. RECOMMENDATION/ASSESSMENT

6.1. History of present illness — History is the most important component of the evaluation. The history should be obtained from the patient and may often involve others such as family members or other clinicians. Issues of patient confidentiality and consent must be recognized when sources other than the patient are considered. The assessment should:

6.1.1. Establish the presence of depressive symptoms:

a. Depressed mood most the day
b. Loss of interest or pleasure in most or all activities
c. Insomnia or hypersomnia
d. Significant weight loss or weight gain (e.g., 5% within a month) or decrease or increase in appetite nearly every day
e. Psychomotor retardation or agitation nearly every day that is observable by others
f. Fatigue or low energy
g. Decreased ability to concentrate, think, or make decisions
h. Thoughts of worthlessness or excessive or inappropriate guilt

i. Recurrent thoughts of death or suicidal ideation, or a suicide attempt

j. Slowed speech or movements, or decreased speech output or agitation (e.g., restlessness, handwringing, inability to sit still, or pulling on clothing or skin) must be observed

k. In older adults, and in younger persons at risk for major or mild neurocognitive disorder or delirium because of general medical/neurologic illness, it is important to ask about neurocognitive symptoms (e.g., attention, concentration, and memory).

6.1.2. Determine the chronology of the current depressive symptoms and any prior history of depressive episodes and their course and treatment.

6.1.3. Determine the impact of the depressive episode upon occupational and interpersonal functioning.

6.1.4. Elicit alleviating or aggravating factors, including stressful life events and social or occupational circumstances.

6.1.5. Address comorbidity.

6.1.6. Psychiatric (e.g., anxiety disorders and substance use disorders)

6.1.7. Include questions about a past history of mania or hypomania. Bipolar disorder often presents initially with depression rather than mania or

hypomania, and multiple episodes of bipolar depression may occur prior to the first lifetime episode of mania/hypomania.

6.1.8. It is useful to distinguish unipolar major depression that has lasted less than two years from depressive syndromes (including major depression) that have lasted two or more years (i.e., persistent depressive disorder "dysthymia"). Clinicians can ask, "During the last two years, have you had a period of two or more consecutive months when you had none of the problems you just described?" Recall of such a period can be followed by questions about specific symptoms, because these follow-up questions often reveal that the symptom free interval was less than 2 months. 2 months with no symptoms or the near absence of symptoms is generally regarded as defining remission from the depressive episode.

6.2. Assessment should also include:

6.2.1. Suicide risk — All depressed patients must be queried specifically about suicidal ideation and behavior. Any positive or equivocal response should prompt clinicians to:

a. Ask about the specific nature of the ideation, intent, plans, available means (e.g., firearms), and actions

b. Assess the patient for risk factors for suicide, including prior history of suicide attempts, comorbid psychiatric and general medical illnesses, and family history of suicidal behavior

c. Develop a safety plan for further evaluation and treatment that depends upon the level of risk and may range from continued primary care follow-up alone to outpatient psychiatric or emergency room psychiatric evaluation

d. In addition, if the clinical history or patient presentation suggest that the patients is at risk for violence directed towards others, clinicians should ask about homicidal ideation and behavior.

6.2.2. General medical illness

a. Given the potential for general medical conditions (spanning all organ systems) and drugs to cause or contribute to depressive episodes, the assessment should address all current and significant past general medical illnesses.

b. Medication use and a review of systems are also part of an assessment of potential contributors to the depressive condition.

6.2.3. Family history

a. A family history may confer increased risk for particular disorders or suicide; thus, the patient should be asked about a family history of

depression, suicide, psychosis (e.g., delusions and hallucinations), and bipolar disorder.

b. A family history of bipolar disorder suggests the possibility that the patient's current depressive episode may represent bipolar depression.

6.2.4. Social history — The evaluation should include:

a. Interpersonal, occupational, and financial stressors

b. The context for the clinical presentation (which may impact treatment)

c. In addition, the social history may identify possible sources of support that may be enlisted for treatment.

d. Assessment of family functioning is often useful in understanding the context of the presenting disorder and possible need for family therapy.

6.2.5. Mental status examination — The mental status examination supplements the history by understanding the presence of depressive signs, including alterations in affect, cognition (attention, concentration, and memory), psychomotor activity, ruminative thought processes, speech, and suicidal thoughts.

6.2.6. Laboratory evaluation — For patients with depressive symptoms in the absence of general medical symptoms, the utility of screening laboratory tests has not been demonstrated. Nevertheless, tests for:

a. New onset depression (especially if the psychosocial context or precipitant is not clear)

b. Severe depression (particularly patients with melancholic or psychotic features), or

c. Treatment-resistant depression is recommended.

d. Commonly performed screening laboratory tests include:

- Complete blood count
- Serum chemistry panels
- Urinalysis
- Thyroid stimulating hormone
- Human chorionic gonadotropin (pregnancy), and
- Urine toxicology screen for drugs of abuse.

e. Additional laboratory evaluations should be pursued as guided by the medical history and review of systems. More extensive testing (e.g., vitamin B_{12}, folate, and electrocardiogram) is often indicated for patients who have chronic medical conditions, or are at increased risk

for medical illnesses, including elderly or institutionalized patients, and patients with self-neglect or substance use disorders.

f. Neuroimaging studies are typically reserved for patients whose evaluation suggests an increased likelihood of structural brain disease in whom referral for face to face consultation and physical examination are needed.

6.3. Diagnostic and statistical manual of mental disorders, fifth edition (DSM-5)

The Diagnostic and statistical manual of mental disorders, fifth edition (DSM-5) divides depression into:

6.3.1. Major depressive disorder

6.3.2. Persistent depressive disorder (dysthymia)

6.3.3. Premenstrual dysphoric disorder

6.3.4. Other depressive disorders (not meeting major depressive disorder criteria due to substance abuse, medication side effects, medical conditions, or other specified or unspecified reasons).

6.4. Major depression

6.4.1. 5 or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning. At least 1 of the symptoms is either depressed mood or loss of interest or pleasure:

a. Depressed mood most of the day, nearly every day, as self-reported or observed by others
b. Diminished interest or pleasure in all or almost all activities most of the day, nearly every day
c. Significant weight loss when not dieting, weight gain, or decrease or increase in appetite nearly every day
d. Insomnia or hypersomnia nearly every day
e. Psychomotor agitation or retardation nearly every day
f. Fatigue or loss of energy nearly every day
g. Feelings of worthlessness or excessive or inappropriate guilt nearly every day
h. Diminished ability to think or concentrate nearly every day
i. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan.

6.4.2. There are 3 degrees of severity of major depression defined in the DSM-5:

a. Mild: few if any symptoms more than number required for diagnosis of major depression with minor functional impairment

b. Moderate: more than required number of symptoms for diagnosis of depression with greater intensity and moderate impairment in functioning

c. Severe: many more symptoms than required for diagnosis of depression with intense functional impairment; psychotic features such as hallucinations or paranoia may be present.

6.4.3. Depressive disorder (subthreshold or minor depression)

This diagnostic designation does not exist in DSM-5, but when used in the past it referred to a patient who had from 2 to 4 depressive symptoms, including either sad mood or anhedonia for at least 2 weeks.

6.5. Persistent depressive disorder

6.5.1. This diagnosis encompasses and expands the now-unused diagnosis "dysthymic disorder". The patient has a major depressive syndrome or 3 or 4 dysthymic symptoms, including depressed mood, for ≥2 years. Impairment compared with major depressive disorder may be less severe. Dysthymic symptoms are as follows:

a. Depressed mood

b. Appetite changes

c. Sleep changes

d. Low self-esteem

e. Fatigue

f. Poor concentration

g. Hopelessness.

6.6. Premenstrual dysphoric disorder

6.6.1. Premenstrual dysphoric disorder is marked by emotional and behavioral symptoms that occur repeatedly during the week before onset of menses and remit with onset of menses or a few days thereafter, and which interfere with some aspect of the patient's life.

6.7. Depressive disorder due to:

6.7.1. Substance/medication use/abuse: full or partial major depressive syndrome attributable to pharmaceuticals or other intoxicants

6.7.2. Medical condition: full or partial major depressive syndrome attributable to another somatic medical illness

6.7.3. Other (specified or unspecified) depressive disorder: major depressive syndrome attributable to another external or somatic cause, or a depressive syndrome that for other known or unknown reasons falls short of a full major depressive syndrome.

7. RED FLAGS

7.1. Suicidal ideation and attempt

7.2. Potential risk of harm or neglect for others

7.3. Moderate to severe depression

7.4. Psychotic or bipolar features

8. DIFFERENTIAL DIAGNOSIS

8.1. General medical illnesses — Many other medical illnesses, affecting most organ systems, can give rise to depressive symptoms.

8.1.1. Patients with another general medical illness may present with a persistently depressed or irritable mood, or diminished interest or pleasure in most activities, which results in significant distress or impairs psychosocial functioning. The diagnosis in these cases is depressive disorder due to another medical condition.

8.1.2. Patients using prescribed medications or substances for recreational purposes may also present with a persistently depressed or irritable mood, or diminished interest or pleasure in most activities, which results in significant distress or impairs psychosocial functioning. The diagnosis in these cases is substance/medication induced depressive disorder.

8.2. Complicated grief — Complicated grief is a form of acute grief that is abnormally intense, prolonged, and disabling. Although several symptoms such as sadness, insomnia, and social withdrawal can occur in both complicated grief and major depression, complicated grief is a unique and recognizable disorder that can be distinguished from depression.

8.3. Attention deficit hyperactivity disorder — Impaired concentration, inattention, and fidgeting can occur in both attention deficit hyperactivity disorder (ADHD) and depressive disorders. However, these symptoms become prominent in depressive disorders only during active mood episodes, whereas the symptoms are persistent in ADHD. In addition, depressive disorders are characterized by symptoms such as sleep and appetite disturbance and suicidality, which are not present in ADHD.

8.4. Bipolar disorder — Bipolar disorder is often underdiagnosed in patients who present with depressive syndromes, and it is critical to ask about a history of mania or hypomania which define bipolar disorder and affect treatment of the depressive episode. However, clinicians should also avoid over diagnosing bipolar disorder in patients with unipolar depression; over-diagnosis of bipolar depression may be more likely in depressed patients who are more severely ill (e.g., have higher rates of comorbidity, chronicity, and functional impairment).

8.5. Schizophrenia and schizoaffective disorder — Unipolar major depression with psychotic features, schizophrenia, and schizoaffective disorder can all present with

delusions and hallucinations. However, in unipolar psychotic depression, delusions and hallucinations occur only during an episode of major depression. By contrast, in schizophrenia and schizoaffective disorder, psychotic symptoms can and do occur in the absence of major depression.

8.6. Adjustment disorder with depressed mood — Adjustment disorder with depressed mood and depressive disorders such as unipolar major depression can both present with dysphoria that occurs in the context of psychosocial stressors. However, adjustment disorder is diagnosed only if symptoms do not meet criteria for another specific disorder (e.g., major depression or another depressive disorder). Adjustment disorder with depressed mood is classified in the category trauma- and stressor-related disorders, and is marked by depressed mood that occurs in response to an identifiable psychosocial stressor (e.g., marital conflicts, job loss, academic failure, or persistent painful illness with progressive disability). The stressor may be a single event or there may be multiple stressors, and a stressor may be recurrent or continuous.

8.7. Sadness — Periods of sadness and irritability (dysphoria) in the absence of other symptoms do not warrant the diagnosis of a depressive disorder. As an example, the diagnosis of unipolar major depression. requires not only that the dysphoria occurs for most of the day for nearly every day for at least 2 weeks, but that the dysphoria is accompanied by at least 4 other depressive symptoms as well as significant

distress or psychosocial impairment. Sadness and irritability are a normal, adaptive part of the human condition, particularly in response to loss, disappointment, or perceived failure.

9. MANAGEMENT

9.1. Refer to APPENDIX 1 for the Virtual Management of Depression Algorithm

9.2. The goal of initial treatment for depression is symptom remission and restoring baseline functioning. Management will include:

9.2.1. Supportive Care: The use of clinician-guided self-help therapy for initial treatment of milder episodes of depression is consistent with multiple practice guidelines.

a. Relaxation and positive activities — For patients with unipolar major depression, we suggest adding to the primary treatment regimen. relaxation techniques which might include:

- Progressive muscle relaxation or relaxation imagery (imagining beautiful or peaceful places)
- Autogenic training (visualizing and inducing a state of warmth and heaviness throughout the body)

b. Clinicians should also encourage patients to pursue positive activities ("behavioral activation") that may have ceased due to depression.

Patients may take the position that they will engage in those activities after they are less depressed; clinicians need to explain that engaging in these activities is a means of relieving depression.

9.2.2. Exercise — Exercise may provide other health benefits beyond relief of depression. For patients with milder episodes of depression, exercise alone rather than as add-on treatment is a reasonable alternative, provided patients are sufficiently monitored (e.g., every two to four weeks) for worsening symptoms. Prescribing exercise as adjunctive treatment or monotherapy is consistent with multiple practice guidelines

a. Modality – Aerobic exercise (e.g., brisk walking, running, or cycling) or resistance training (upper and lower body weight lifting)

b. Session frequency – 3 to 5 exercise sessions per week

c. Session duration – 45 to 60 minutes per session

d. Exercise intensity

- Aerobic exercise: 50 to 85% maximum heart rate
- Resistance training: 3 sets of 8 repetitions at 80% of maximum weight that can be lifted in a single repetition for a given exercise

e. Intervention duration – At least 10 weeks

If psychotherapy or medication is need, then patient should be referred to family physician/psychiatrist for further management.

9.2.3. Psychotherapy: Psychotherapies that are available to treat unipolar major depression include:

a. Cognitive-behavioral therapy (CBT)
b. Interpersonal psychotherapy
c. Behavioral activation
d. Family and couples' therapy
e. Problem solving therapy
f. Psychodynamic psychotherapy
g. Supportive psychotherapy

9.2.4. Antidepressant Pharmacotherapy: Treatment options - These will warrant a face to face consultation and cannot be prescribed via telehealth consultation.

a. Second-generation antidepressants that are available to treat unipolar major depression include:
   - Selective serotonin reuptake inhibitors (SSRIs) (Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline)
   - Serotonin-norepinephrine reuptake inhibitors (Desvenlafaxine, Duloxetine, Levomilnacipran, Milnacipran, Venlafaxine)

- Atypical antidepressants

  (Agomelatine, Bupropion, Mirtazapine)

- Serotonin modulator

  (Nefazodone, trazodone, Vilazodone, Vortioxetine)

b. Older, first-generation antidepressants include:

- Tricyclic antidepressants

  (amitriptyline, amoxapine, clomipramine, desipramine, doxepin, n ortriptyline)

- Monoamine oxidase inhibitors (MAOIs

  (Tranylcypromine, Phenelzine, Selegiline)

10. REFERRAL CRITERIA

10.1. Referral to Psychiatric department through Emergency Department:

10.1.1. Suicidal ideation and attempt

10.1.2. Potential risk of harm or neglect for others

10.1.3. Moderate to severe depression

10.1.4. Psychotic or bipolar features

10.2. Referral to Family Physician:

10.2.1. Patients for whom the diagnosis of depression or its comorbidities is uncertain

10.2.2. Patient with mild depression need medication

11. SUMMARY

11.1. Depression can refer to a mood state, syndrome, or specific clinical disorder.

11.2. The assessment of patients who are being evaluated for a depressive disorder includes the history of present illness, current and past medical illness, family history, social history, mental status examination, and focused laboratory tests. The history must address suicidal ideation and behavior.

11.3. Although there is no evidence to support screening routine laboratory testing in the diagnosis of depression, a complete blood count, serum chemistry panels, urinalysis, thyroid stimulating hormone, may be helpful when underlying medical conditions are suspected.

11.4. Depressive disorders include unipolar major depression, persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, and depressive disorder due to another medical condition.

11.5. Episodes of major depression require the presence of at least 5 depressive symptoms, including depressed mood or loss of interest, for a minimum of 2 consecutive weeks.

11.6. Persistent depressive disorder (dysthymia) is diagnosed in patients with 3 or more depressive symptoms for at least 2 consecutive years; at least 1 symptom must be depressed mood.

11.7. The differential diagnosis of depressive disorders includes another (general) medical disorder, complicated grief, attention hyperactivity disorder, bipolar disorder, schizoaffective disorder, schizophrenia, and adjustment disorder with depressed mood.

11.8. Referral to a mental health specialist is indicated for patients in whom the diagnosis of depression or its comorbidities is uncertain; patients with moderate to severe depression, psychotic or catatonic depression; or depression that is part of bipolar disorder, schizoaffective disorder or schizophrenia and depression need medication.

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APPENDIX 1 – VIRTUAL MANAGEMENT OF DEPRESSION ALGORITHM