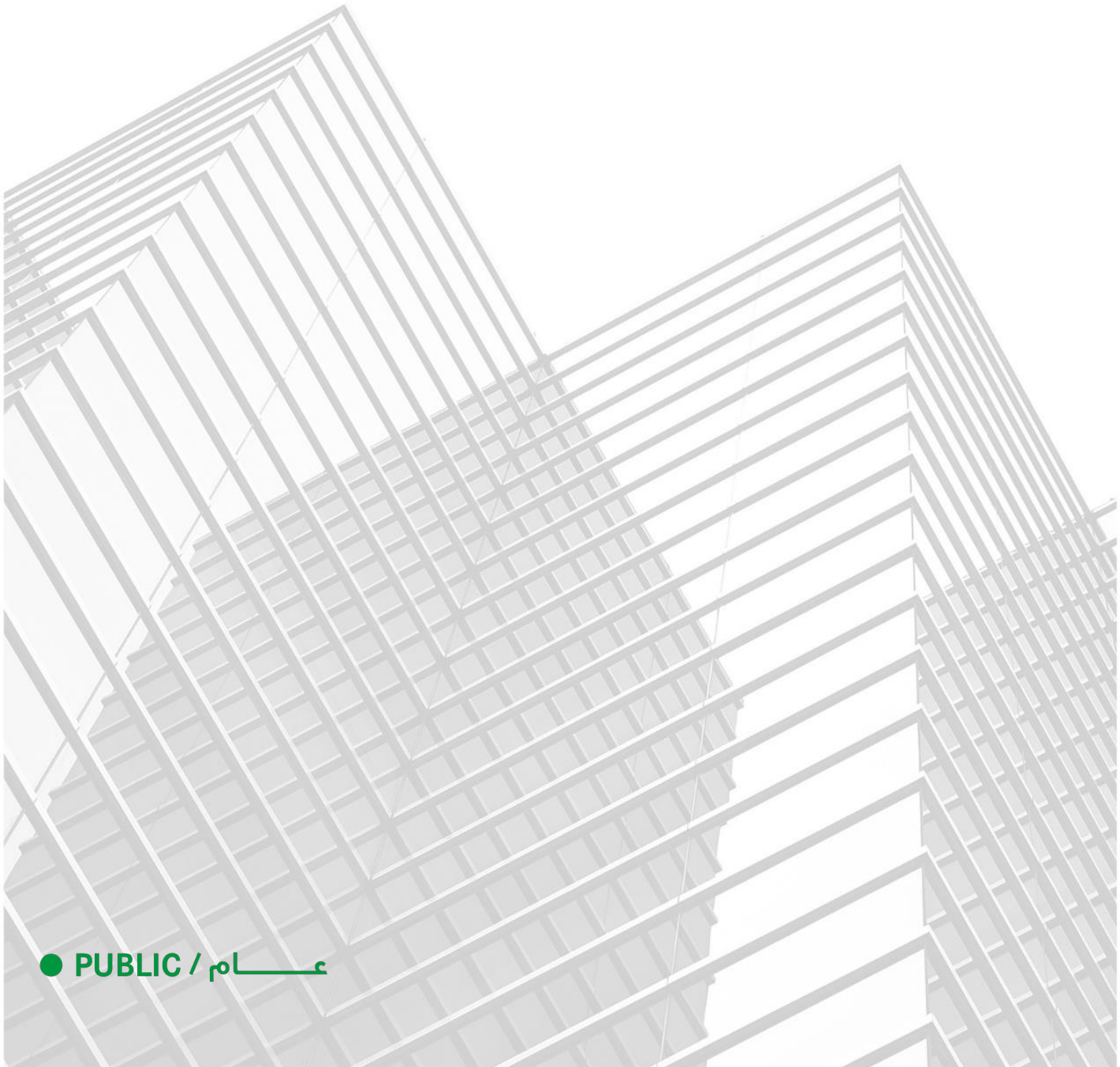
دائـــــرة الـصـحـــة
DEPARTMENT OF HEALTH

STANDARDS OF CARE FOR ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD)



PUBLIC / عـــــام

Document Title:	Standard of Care for Attention-Deficit Hyperactivity Disorder (ADHD)		
Document Ref. Number:	DoH/ST/HQS/CADHD/V1/2025	Version:	V1
New / Revised:	New		
Publication Date:	Oct 2025		
Effective Date:	Oct 2025		
Document Control:	DoH Strategy Sector		
Applies To:	DoH Healthcare Providers that are licensed to provide mental health services.		
Owner:	Healthcare Quality Sector		
Revision Date:	September 2028		
Revision Period:	3 years		
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1. Standard Scope and Purpose

1.1. This standard specifies the service requirements for the DoH Standard of Care for Attention-Deficit Hyperactivity Disorder.

1.2. This standard aims to ensure comprehensive mental health support, covering key areas such as screening, diagnosis, treatment and recovery.

1.3. This standard seeks to improve the recognition of Attention-Deficit Hyperactivity Disorders among adults and children thus improving access to such services and ensuring a certain level of quality of services.

1.4. In addition, the standard 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 attention-deficit hyperactivity disorders.

1.6. This standard must be read in conjunction with the Standard for Specialized Mental Healthcare Services[1].

2. Definitions and Abbreviations

No.	Term / Abbreviation	Definition
2.1	ADEK	Department of Education and Knowledge
2.2	ADHD	Attention-Deficit Hyperactivity Disorder
2.3	ASRS	The Adult ADHD Self-Report Scale: symptom checklist used in the assessment of ADHD
2.4	ASD	Autism Spectrum Disorder
2.5	BAARS	Barkley Adult ADHD Rating Scale: a diagnostic tool for ADHD
2.6	CBT	Cognitive Behavioral Therapy
2.7	CADDRA	The Canadian ADHD Resource Alliance
2.8	Counselor	A professional who supports individuals or groups in identifying and/ or analyzing their mental health disorders or social conflicts and in assessing the need for treatment
2.9	DIVA-5	Diagnostic Interview for Adults, 5th edition: a semi-structured clinician-administered tool used to diagnose ADHD in adults
2.10	DoH	The regulative body of the Healthcare Sector in the Emirate of Abu Dhabi, Established based on law No. (10) of 2018

2.11	DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
2.12	HRQoL	Health-Related Quality of Life: an assessment of quality of life encompassing physical, psychological and social functioning and wellbeing
2.13	KIDSCREEN	A questionnaire that can be used to assess Health-Related Quality of Life
2.14	MHQoL	Mental Health Quality of Life Questionnaire: a standardized, self-administered measure of quality of life for people with mental health conditions
2.15	PCP	Primary Care Practitioner including Family Physician and Pediatrician
2.16	SNAP-IV	The SNAP-IV is a revision of the Swanson, Nolan and Pelham (SNAP) questionnaire used to screen for ADHD
2.17	SDQ	Strengths and Difficulties Questionnaire: a standardized, internationally validated screening tool used to assess emotional and behavioral problems in children aged 2-17 years
2.18	WURS	Wender Utah Rating Scale: a self-report assessment tool for adults to evaluate symptoms of ADHD
2.19	WFIRS	Weiss functional impairment rating scale: a 50-item scale that assesses functional impairment affected by ADHD

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 must 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.

3.1.3 The healthcare facility shall comply with the latest published regulatory requirements as published on the DoH website.

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

3.2 Accreditation Requirements

3.2.1 The healthcare facility must obtain international accreditation within three (3) years from the date of publication of this standard.

3.3 Staff Qualifications & Training Requirements

3.3.1 All healthcare professionals must hold an active DoH professional license and practice strictly within their authorized scope of practice and granted privileges.

3.3.2 All relevant DoH licensed healthcare professionals must complete the Information and Cyber Security Awareness courses assigned through Abu Dhabi Healthcare Cyberlearning Program.

3.4 Facility Design:

3.4.1 The healthcare facility must comply with the health facility requirements outlined in the DoH Health Facility Guidelines (Health Facility Briefing & Design Mental Health Unit: Child & Adolescent, Adult and older persons)

3.5 Supplies and Equipment:

3.5.1 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.

3.6 Service Delivery and Care Process:

3.6.1 ADHD in children and adolescents

3.6.1.1 Attention-Deficit/Hyperactivity Disorder (ADHD) is characterized by a range of symptoms that can manifest in various settings, including, but not limited to, home and school. In children and adolescents, these symptoms are typically categorized into three primary groups:

3.6.1.1.1 Hyperactivity/impulsivity: Hyperactive and impulsive behaviors may include excessive fidgeting, difficulty remaining seated, and interrupting others

3.6.1.1.2 Inattention: Inattentive symptoms can manifest as challenges in sustaining attention, following through on tasks, and organizing activities

3.6.1.1.3 Combined type ADHD: characterized by symptoms of both inattention and hyperactivity/impulsivity

3.6.1.2 Signs and symptoms: Signs of ADHD can be detected in multiple settings by either teachers, coaches, parents and / or healthcare professionals. These include but are not limited to: Excessive fidgeting, Inability to complete tasks, frequent daydreaming, interrupting, running/climbing in inappropriate situations, difficulty managing frustrations, inattentiveness in class, difficulty remaining seated, Incomplete assignments, difficulty following instructions, difficulty following directions, difficulty reading or writing, difficulty with mathematical calculations, developmental delays.

3.6.1.3 Screening

3.6.1.3.1 School screening

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

3.6.1.3.1.2 All schools should adhere to the School Screening Standard[2] and the National School Health Screening Guideline[3].

3.6.1.3.1.3 Teachers or parents may identify student concerns based on observed behavior

3.6.1.3.1.4 If teachers/parents are concerned, screening for ADHD using the CADDRA questions (Appendix A) or SNAP-IV (Appendix B) should be performed by a teacher, parents or school's internal counselor or in-school Mental Health specialists as per the ADEK School In-School Specialist Services Policy[4]. In case of positive screening, the student will proceed to complete the diagnostic assessment (if the screening was performed

by a school licensed psychologist)

3.6.1.3.1.5 All screening procedures shall ensure accurate and secure documentation, storage, and archiving. Screening results must be communicated to relevant mental health professionals or primary care providers through a secure channel, in accordance with clause 3.6.1.3.1.1.

3.6.1.3.1.6 If counselors or mental health professionals (psychiatrists or psychologists) are not available within the schools, the school shall communicate its recommendations to the student's family for screening and evaluation in Primary Care, to be conducted by family physician or a pediatrician.

3.6.1.3.2 Primary Care screening

3.6.1.3.2.1 Any concerns indicating possible signs of ADHD identified outside of the school setting shall be referred to Primary Care for screening and evaluation.

3.6.1.3.2.2 Screening for ADHD may be performed by a Primary Care Practitioner (PCP), including a family physician, general practitioner or a pediatrician.

3.6.1.3.2.3 The PCP shall conduct ADHD screening using CADDRA questions to determine the need for further assessment.

3.6.1.3.2.4 If the screening result is positive, the PCP shall also exclude other possible medical causes through a comprehensive physical examination, including but not limited to, CBC and electrolytes, thyroid function, and vitamin D.

3.6.1.3.2.5 A positive response to any of the CADDRA questions requires a referral to psychiatrist/psychologist for diagnosis and treatment

3.6.1.3.2.5.1 Children under six (6) years of age should preferably be referred to a psychologist, preferably a child and adolescent psychologist if available, or to a developmental and behavioral pediatrician.

3.6.1.3.2.5.2 Children over six (6) years of age may be referred to a developmental and behavioral pediatrician, psychiatrist, or psychologist, depending on the PCPs clinical judgement and the preferences of the patient and parents.

3.6.1.3.2.6 If the result of the CADDRA questions is negative, and/or if medical causes cannot be excluded, the PCP should continue with a routine evaluation and continue to monitor ADHD symptoms (watchful waiting).

3.6.1.4 Diagnosis

3.6.1.4.1 A diagnosis of ADHD shall only be made by a developmental and behavioral pediatrician or a mental health professional (psychiatrist or psychologist), preferably one specializing in child and adolescent psychiatrist/psychologist, when available.

3.6.1.4.2 The clinical assessment shall be conducted over a minimum of two (2) sessions and include input from patients, parents/caregivers and teachers, such as written reports. Where clinically justified, the assessment may exceed two (2) sessions.

3.6.1.4.3 A focused clinical assessment must be completed, including but not limited to:

- 3.6.1.4.3.1 Evaluation of the child's/adolescent's developmental history.
- 3.6.1.4.3.2 Collection of detailed collateral history from parents, caregivers, and teachers.
- 3.6.1.4.3.3 Identification of acute stressors that my impact the child's behavior, such as recent life changes, trauma, or environmental factors.

3.6.1.4.4 ADHD rating scales must be utilized (e.g., Conner's Rating Scale, SNAP-IV) to assess symptoms and for future retesting to monitor symptom improvement and treatment effectiveness.

3.6.1.4.5 The diagnostic criteria for ADHD, as outlined in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5), must be confirmed, including:

- 3.6.1.4.5.1 Presence of six (6) or more symptoms of inattention and/or hyperactivity and impulsivity.
- 3.6.1.4.5.2 Presence of symptoms across two (2) or more settings (e.g., home, school).
- 3.6.1.4.5.3 Symptom persistence for at least sex (6) months, significantly impairing the child's functioning in social, academic, or occupational domains.

3.6.1.4.6 If not previously completed by PCP, the psychiatrist should exclude medical causes through a thorough physical examination including but not limited to, CBC and electrolytes, thyroid function and vitamin D.

3.6.1.4.7 Based on clinical judgement, screening for differential diagnoses and comorbidities shall be performed. This may include, but is not limited to, autism spectrum disorder (ASD), anxiety disorders, depression and sensory processing differences.

- 3.6.1.4.7.1 If the assessment was conducted by a developmental and behavioral pediatrician, a referral to a psychologist or psychiatrist shall be made for further psychiatric disorders, if suspected by the physician.

3.6.1.4.8 If ADHD is confirmed through the assessment process, appropriate therapeutic interventions shall be initiated.

3.6.1.4.9 If a differential diagnosis is confirmed, treatment should be tailored to address the specific condition identified.

3.6.1.4.10 If neither ADHD nor a differential diagnosis is confirmed, the patient shall be referred to a pediatric primary care provider (PCP) for further evaluation and ongoing support and

education. This referral should include recommendations for monitoring the child's symptoms for any increases in severity or frequency. The PCP can provide guidance on behavioral strategies, lifestyle modifications, and additional resources to support the child's development and well-being such as family counselling on home management.

3.6.1.5 Intervention and treatment

3.6.1.5.1 Once a diagnosis of ADHD is confirmed, the developmental and behavioral pediatrician or psychologist/psychiatrist (preferably a child and adolescent psychiatrist/psychologist) shall provide comprehensive information and education to the patient and their family. This should include recommendations for nursery or school professionals, to be shared with the child's parents.

3.6.1.5.2 If ADHD is not the primary concern, management of any acute comorbidities shall take priority. ADHD treatment and interventions shall begin only once the patient has been stabilized, ensuring that all immediate (mental) health concerns are addressed.

3.6.1.5.3 The developmental and behavioral pediatrician or psychologist/psychiatrist shall develop a documented, patient-centered treatment plan in collaboration with the patient. This plan shall consider the patient's severity, complexity, and the preferences for treatment modalities.

3.6.1.5.4 The treatment plan should include at minimum:

3.6.1.5.4.1 Patient's goals of treatment and outcome measures.

3.6.1.5.4.2 The patient's initial assessment scores using a functional ADHD rating scale (e.g., BAARS) and baseline Health Related Quality of Life (HRQoL) measures validated in pediatric populations (e.g. SDQ, KIDSCREEN or Child Health Questionnaire).

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

3.6.1.5.4.4 Treatment plan review dates and discharge framework.

3.6.1.5.4.5 Referrals to other mental health specialists (psychiatrist/psychologist or other), where applicable.

3.6.1.5.4.6 Where medication is prescribed, the treatment plan must also include the following parameters:

3.6.1.5.4.6.1 Review of risks and benefits of the prescribed medication

3.6.1.5.4.6.2 History of previous treatments

3.6.1.5.4.6.3 Pharmacovigilance requirements

3.6.1.5.4.6.4 Timeframes for therapeutic response

3.6.1.5.4.6.5 Guardian consent, including their right to withdraw, shall be obtained and documented.

3.6.1.5.4.6.6 The medication management plan shall be discussed with the patient and family (if applicable), including the rationale for pharmaceutical treatment,

choice and dosage of medication (with preference for generic medications where appropriate), expected onset of therapeutic effects, and potential adverse or withdrawal effects.

3.6.1.5.5 Intervention and treatment options

3.6.1.5.5.1 Non-pharmacological interventions shall be offered to children and adolescents of all age groups. These interventions shall be selected based on clinical judgement and patient/family preferences and may include, but are not limited to:

3.6.1.5.5.1.1 Parent/family training to equip caregivers with evidence-based strategies for managing the challenges associated with ADHD.

3.6.1.5.5.1.2 Lifestyle modifications, including changes in diet, sleep, and physical activity

3.6.1.5.5.1.3 Cognitive Behavioral Therapy (CBT) may be employed

3.6.1.5.5.1.4 Behavioral classroom interventions may be suggested by mental health specialists (psychologist/psychiatrist) and shall be implemented by educators to support students with ADHD in the school setting.

3.6.1.5.5.1.5 Occupational therapy (OT) and speech and language therapy (SLT) shall be considered, as required.

3.6.1.5.5.2 Pharmacological interventions shall be considered for children over six (6) years of age, in conjunction with non-pharmacological strategies. For children under six (6), medication shall only be introduced if non-pharmacological approaches yield limited improvements in symptoms and quality of life.

3.6.1.5.5.2.1 Prior to prescribing medication, a physical examination and medication history must be completed to exclude contraindications and potential medication interactions.

3.6.1.5.5.2.2 ADHD medication management shall include both stimulant and non-stimulant options, tailored to the child's/adolescent's needs. Medication titration shall be closely monitored by a developmental and behavioral pediatrician or child and adolescent psychiatrist, if available, until optimal dosage is determined.

3.6.1.6 Treatment Monitoring

3.6.1.6.1 The frequency of treatment review shall be determined by the developmental and behavioral pediatrician, psychologist or psychiatrist, as clinically indicated. At a minimum, a treatment shall include an evaluation of the patient's response at the following timeframes:

3.6.1.6.1.1 Within one (1) month of treatment initiation.

3.6.1.6.1.2 After two (2) months of treatment: if no improvement is observed, the treatment plan shall be modified, or an escalation of treatment shall be considered

3.6.1.6.1.3 After six (6) months of initiating treatment.

3.6.1.6.1.4 At the end of treatment.

3.6.1.6.2 The six (6) month review shall include documentation of the following:

3.6.1.6.2.1 Progress against the outcome measures specified in the treatment plan

3.6.1.6.2.2 Repeat baseline assessments (e.g., ADHD rating scales).

3.6.1.6.2.3 Patient-reported quality of life assessments (e.g. SDQ or KIDSCREEN).

3.6.1.6.3 Review of patient progress shall incorporate feedback from school or nursery, where possible.

3.6.1.6.4 The involvement of a multidisciplinary team (MDT) shall be evaluated based on the individual's needs, including but not limited to occupational therapists, speech therapists and social workers.

3.6.2 Adult ADHD

3.6.2.1 Attention-Deficit/Hyperactivity Disorder (ADHD) in adults is characterized by a range of symptoms that manifest in various settings, including professional, social, and personal environments. Symptoms can be categorized into two primary groups:

3.6.2.1.1 *Hyperactivity/impulsivity*: Behaviors may present as restlessness, difficulty waiting for turns, or frequent interruptions during conversations.

3.6.2.1.2 *Inattention*: Symptoms may include difficulty in sustaining attention, disorganization, forgetfulness, and impaired daily functioning, which may affect professional performance and personal responsibilities.

3.6.2.2 Signs and symptoms

3.6.2.2.1 Signs of ADHD in adults can be identified in multiple settings by family members, friends, colleagues, or healthcare professionals. These include but are not limited to:

3.6.2.2.1.1 Excessive fidgeting

3.6.2.2.1.2 Inability to complete tasks and difficulty organizing tasks

3.6.2.2.1.3 Difficulty maintaining deadlines and responsibilities

3.6.2.2.1.4 Frequent daydreaming

3.6.2.2.1.5 Interrupting

3.6.2.2.1.6 Inability to remain seated during meetings

3.6.2.2.1.7 Restlessness

3.6.2.2.1.8 Difficulty managing frustrations

3.6.2.2.1.9 Inattentiveness

3.6.2.2.1.10 Incomplete assignments

3.6.2.2.1.11 Difficulty following instructions

3.6.2.2.1.12 Difficulty reading, writing, or mathematical calculations

3.6.2.3 Screening

3.6.2.3.1 Primary care screening

3.6.2.3.1.1 Concerns regarding potential ADHD symptoms shall be referred to Primary Care for screening and evaluation.

3.6.2.3.1.2 Screening for ADHD in adults may be conducted by a Primary Care Practitioner (PCP),

including a family physician or general practitioner.

3.6.2.3.1.3 The PCP will screen for ADHD using CADDRA questions to determine the need for further assessment

3.6.2.3.1.4 If screening results are positive, the PCP shall also exclude potential medical causes through a comprehensive physical examination including, but not limited to CBC and electrolytes, thyroid function and vitamin D.

3.6.2.3.1.5 A positive response to any of the CADDRA questions requires a referral to psychiatrist or psychologist for diagnosis and treatment. The choice of referral (psychiatrist or psychologist) shall depend on the PCP's clinical judgement and patient preference.

3.6.2.3.1.6 If screening results are negative, and/or if medical causes cannot be excluded, the PCP shall continue with a routine evaluation and monitor ADHD symptoms (watchful waiting).

3.6.2.3.1.7 For self-referred patients with persistent concerns where no further assessment is deemed necessary, the PCP shall provide basic education and resources on ADHD, support the patient in implementing lifestyle changes, and screen for other mental health conditions such as anxiety and depression.

3.6.2.4 Diagnosis

3.6.2.4.1 A diagnosis of ADHD shall only be made by a psychiatrist or psychologist.

3.6.2.4.2 The clinical assessment shall be conducted over a minimum of two (2) sessions. Where clinically justified, the assessment may exceed two (2) sessions.

3.6.2.4.3 A corroborative history shall be obtained, where possible, to assess the onset of symptoms prior to age twelve (12). This may include, but is not limited to:

3.6.2.4.3.1 Interviews with individuals familiar with the patient since childhood, where possible (e.g. parent, sibling, childhood friend).

3.6.2.4.3.2 A review of documents and school reports.

3.6.2.4.3.3 Retrospective assessment tools (e.g., WURS).

3.6.2.4.4 ADHD rating scales shall be used (e.g., ASRS, BAARS, DIVA-5 - Conner's Adult ADHD Rating Scale). These tools shall also be used for follow-up retesting to assess symptom improvement and treatment effectiveness.

3.6.2.4.5 The diagnostic criteria for adult ADHD as outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) must be confirmed.

3.6.2.4.5.1 Presence of at least five (5) symptoms of inattention and/or hyperactivity and impulsivity.

3.6.2.4.5.2 Presence of symptoms across two (2) or more settings (e.g., home, work)

3.6.2.4.5.3 Symptom persistence for at least six (6) months, with onset prior to age twelve (12), significantly impairing the patient's functioning in social, academic, or occupational domains.

3.6.2.4.6 Based on clinical judgement, screening for differential diagnoses and comorbidities shall be conducted. This may include but is not limited to autism spectrum disorder (ASD), bipolar disorder, anxiety disorders, depression and sensory processing differences.

3.6.2.4.7 ADHD severity shall be assessed through evaluation of functional impairment, e.g., with rating scales like WFIRS

3.6.2.4.8 If ADHD is confirmed through the diagnostic assessment, appropriate therapeutic interventions shall be initiated. (See 3.6.2.5 Intervention and Treatment for details).

3.6.2.4.9 If a differential diagnosis is confirmed, treatment shall be tailored to address the specific condition identified while also evaluating the impact of ADHD treatment on comorbid conditions (e.g. anxiety and/or depression).

3.6.2.4.10 If neither ADHD nor a differential diagnosis is confirmed, the patient shall be referred to a primary care provider (PCP) for further evaluation, ongoing support, and education. This referral should include recommendations for monitoring symptoms and implementing strategies for managing overall health.

3.6.2.5 Intervention and treatment

3.6.2.5.1 Following the confirmation of an ADHD diagnosis, intervention and treatment shall be initiated by psychologist or psychiatrist to provide tailored support for the adult patient.

3.6.2.5.2 Once the diagnosis of ADHD is confirmed, mental health specialists (psychologist/psychiatrist) shall provide comprehensive information and education to the patient.

3.6.2.5.3 If ADHD is not the primary concern, management of any acute comorbidities shall take precedence. ADHD treatment and interventions shall commence only after stabilization of the patient, ensuring all immediate (mental) health concerns are addressed.

3.6.2.5.4 The psychologist/psychiatrist shall develop a documented, patient-centered treatment plan in collaboration with the patient. This plan shall consider the conditions' severity, complexity and preferences for treatment modalities.

3.6.2.5.5 The treatment plan should include at minimum:

3.6.2.5.5.1 Patient's goals of treatment and outcome measures.

3.6.2.5.5.2 The patient's initial assessment scores of a validated ADHD rating scale (e.g., BAARS) and baseline MHQoL or other validated Health-Related Quality of Life scores.

3.6.2.5.5.3 Treatment methods to be utilized, along with the responsible professional/discipline (e.g. psychologist, psychiatrist or other), covering both pharmacological and non-pharmacological approaches.

3.6.2.5.5.4 Treatment plan review dates and discharge framework.

3.6.2.5.5.5 Referrals to other allied health professionals (e.g. psychologist, social worker, occupational therapist, speech and language therapist) where applicable.

3.6.2.5.5.6 When a medication is prescribed, the following additional parameters must be included in the treatment plan:

3.6.2.5.5.6.1 Review of risks and benefits of the prescribed medication

3.6.2.5.5.6.2 History of previous treatments

3.6.2.5.5.6.3 Pharmacovigilance requirements

3.6.2.5.5.6.4 Timeframe expected for therapeutic response

3.6.2.5.5.6.5 Patient consent, including their right to withdraw.

3.6.2.5.5.6.6 Documentation of the medication management plan, including rationale for pharmaceutical treatment, suitable choice and dosage (with preference for generic medications where appropriate), expected onset of therapeutic effects and potential adverse or withdrawal effects.

3.6.2.5.6 Intervention and treatment options

3.6.2.5.6.1 Intervention and treatment options shall be selected based on functional impairment

3.6.2.5.6.2 Treatment planning and decisions, including medication titration, shall be lead by a psychiatrist.

3.6.2.5.6.3 In case of low functional impairment, management strategies for daily living shall be provided. These may include, but are not limited to:

3.6.2.5.6.3.1 Environmental modifications

3.6.2.5.6.3.2 Optimized sleep hygiene

3.6.2.5.6.3.3 Improved nutritional habits

3.6.2.5.6.3.4 Regular physical exercise

3.6.2.5.6.4 If these strategies yield limited improvements in symptoms and quality of life, further interventions may be considered, including both non-pharmacological and pharmacological options.

3.6.2.5.6.5 In cases of high functional impairment, the appropriateness and acceptance of ADHD medication shall be determined. The psychologist/psychiatrist shall ensure informed decision making by providing the patient with education and guidance on available medication options.

3.6.2.5.6.6 Non-pharmacological interventions shall be offered to adults with ADHD, primarily led by a psychologist, particularly where there is no indication for or acceptance of ADHD medication. Depending on patient needs and clinical judgement, a combination of non-pharmacological and pharmacological interventions may also be beneficial. Non-pharmacological interventions may include, but are not limited to:

3.6.2.5.6.6.1 Psychotherapy, including CBT

3.6.2.5.6.6.2 Group group-based interventions

3.6.2.5.6.7 Pharmacological interventions shall be considered by a psychiatrist for adults who require or accept ADHD medication. Pharmacological interventions may also be

combined with non-pharmacological interventions.

3.6.2.5.6.7.1 Prior to prescribing medication, a physical examination and medication history must be conducted to exclude contraindications and potential interactions with other medications.

3.6.2.5.6.7.2 ADHD medication management shall include options for stimulant and non-stimulant medication, tailored to the adult's needs.

3.6.2.5.6.7.3 Medication titration shall be conducted under close monitoring by a psychiatrist, until the optimal dosage is determined.

3.6.2.5.7 Treatment Monitoring

3.6.2.5.7.1 The frequency of review shall be determined by the psychologist or psychiatrist, as clinically indicated. The treatment review must include, at least, a review of the patient's response to treatment at the following timeframes:

3.6.2.5.7.1.1 Within one (1) month of treatment initiation.

3.6.2.5.7.1.2 After two (2) months of treatment: if no improvement is observed, the treatment plan shall be modified, or escalation of treatment shall be considered.

3.6.2.5.7.1.3 After six (6) months of initiating treatment: If no improvement is observed, the treatment plan shall be modified, or escalation of treatment shall be considered.

3.6.2.5.7.1.4 At the end of treatment.

3.6.2.5.7.2 The six (6) month review shall include documented:

3.6.2.5.7.2.1 Progress against the outcome measures specified in the treatment plan.

3.6.2.5.7.2.2 Repeat baseline assessment (e.g., ADHD rating scales)

3.6.2.5.7.2.3 Patient reported quality of life assessment (e.g., MHQoL or other validated Health-Related Quality of Life (HRQoL) scales).

3.6.2.5.7.3 The involvement of a multidisciplinary team (MDT) shall be evaluated based on the patient's individual needs and may include, but is not limited to: occupational therapists, speech therapists and social workers.

4.Key stakeholder Roles and Responsibilities

4.1 The facility shall meet the service specifications and requirements set out in this standard and other relevant DoH regulations.

4.2 Healthcare professionals must deliver services to a licensed facility that provides the appropriate equipment, support, and other resources necessary for safety and quality of care.

4.3 Patients shall comply with their responsibilities as per Ministerial Resolution No. (14) of 2021 on the Patient's Rights & Responsibilities Charter

4.4 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 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, where applicable

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

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.	2024	Standard for Specialized Mental Healthcare Services	https://www.doh.gov.ae/en/resources/standards
2.	2025	School Screening Standard	https://www.doh.gov.ae/en/resources/standards
3.	2024	National School Health Screening Guideline-MOHAP	https://mohap.gov.ae/documents/d/guest/national-school-health-screening-guideline-2024-pdf-pdf
4.	Accessed on 23/05/2025	In-School Specialist Services Policy - ADEK	https://www.adek.gov.ae/en/Education-System/Education-Policies/School-Policies
5.	2014	Singapore Ministry of Health Clinical Practice Guidelines ADHD	www.smj.org.sg/sites/default/files/5508/5508cpg1.pdf
6.	2019	NICE guideline: Attention deficit hyperactivity disorder: diagnosis and management	https://www.nice.org.uk/guidance/ng87
7.	2019	Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of ADHD in Children and Adolescents	https://pubmed.ncbi.nlm.nih.gov/31570648/
8.	2024	Tools for the Diagnosis of ADHD in Children and Adolescents: A Systematic Review	https://pubmed.ncbi.nlm.nih.gov/38523599/
9.	2024	NHS Scotland ADHD Guidelines	https://rightdecisions.scot.nhs.uk/tam-treatments-and-medicines-nhs-highland/adult-therapeutic-guidelines/mental-health/adhd-guidelines/
10.	2017	Royal College of Psychiatrists Scotland ADHD in adults: good practice guidelines	https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2023-college-reports/cr235
11.	Accessed on 18/10/2024	ADHD UK Diagnosis Pathways for Adult ADHD	https://adhduk.co.uk/diagnosis-pathways/
12.	2022	Australian Evidence-Based Clinical Guideline for ADHD	https://adhdguideline.aadpa.com.au/

13.	2021	UCSF Benioff Children's Hospitals ADHD Pathway	https://www.ucsfbenioffchildrens.org/conditions/adhd
14.	Accessed on 23/05/2025	Strengths and Difficulties Questionnaire (SDQ)	https://depts.washington.edu/dbpeds/Screening%20Tools/Strengths_and_Difficulties_Questionnaire.pdf
15.	Accessed on 23/05/2025	Conners' Parent Rating Scale	https://www.pediatricenter.com/assets/forms/Conners_Parent_Rating.pdf
16.	Accessed on 23/05/2025	KIDSCREEN	https://www.kidscreen.org/english/questionnaires/kidscreen-27/
17.	2020	Community Behavior Health Philly, Clinical Guidelines for Pharmacologic Treatment of ADHD	https://cbhphilly.org/wp-content/uploads/2020/08/2020-08-06_clinical_guidelines_adhd_children_adolescents.pdf
18.	2021	CADDRA Guidelines for ADHD	https://adhdlearn.caddra.ca/wp-content/uploads/2022/08/Canadian-ADHD-Practice-Guidelines-4.1-January-6-2021.pdf
19.	2025	Scope of Practice for Psychologist and Psychologist Assistant	https://www.doh.gov.ae/en/resources/scope-of-practice
20.	2024	Abu Dhabi Healthcare Information and Cyber Security Standard	https://www.doh.gov.ae/en/resources/standards
21.	2025	Standard For The Management Of Narcotics, Psychotropic And Semi-Controlled Medicinal Products	https://www.doh.gov.ae/en/resources/standards
22.	2023	Federal Law No.10 of 2023 on Mental Health	https://uaelegislation.gov.ae/en/legislations/2166/download
23.	2024	Patient Consent Standard	https://www.doh.gov.ae/en/resources/standards

Appendix A: CADDRA Questions

Do you/ your child find it harder to focus, organize yourself, manage time and complete paperwork than most people?
Do you/ your child get into trouble for doing impulsive things you wish you had not?
Do you/ your child find you are always on the go, or that you are constantly restless or looking for something exciting to do?
Do you/ your child find it really difficult to get motivated by boring things, though it is easier to do the things you enjoy?
Do people complain that you/ your child are annoying or are easily annoyed, unreliable or difficult to deal with?

Appendix B: SNAP-IV

SNAP-IV Teacher and Parent 18-Item Rating Scale

James M. Swanson, Ph.D., University of California, Irvine, CA 92715

Patient/Client Name: _____

Date of birth: _____ Gender: _____

Grade: _____ Type of class: _____ Class size: _____

Completed by: _____ Date: _____

Physician Name: _____

For each item, check the column which best describes this child/adolescent:

	Not at all	Just a little	Quite a bit	Very much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks				
2. Often has difficulty sustaining attention in tasks or play activities				
3. Often does not seem to listen when spoken to directly				
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties				
5. Often has difficulty organizing tasks and activities				
6. Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort				
7. Often loses things necessary for activities (e.g., toys, school assignments, pencils or books				
8. Often is distracted by extraneous stimuli				
9. Often is forgetful in daily activities				
10. Often fidgets with hands or feet or squirms in seat				
11. Often leaves seat in classroom or in other situations in which remaining seated is expected				
12. Often runs about or climbs excessively in situations in which it is inappropriate				
13. Often has difficulty playing or engaging in leisure activities quietly				
14. Often is "on the go" or often acts as if "driven by a motor"				
15. Often talks excessively				
16. Often blurts out answers before questions have been completed				
17. Often has difficulty awaiting turn				
18. Often interrupts or intrudes on others (e.g., butts into conversations/ games				

Appendix C: 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 *For example: freedom of choice, financial, co-decision making*

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 *For example: partner, children, family, friends*

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 *For example: work, study, household, leisure activities*

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'

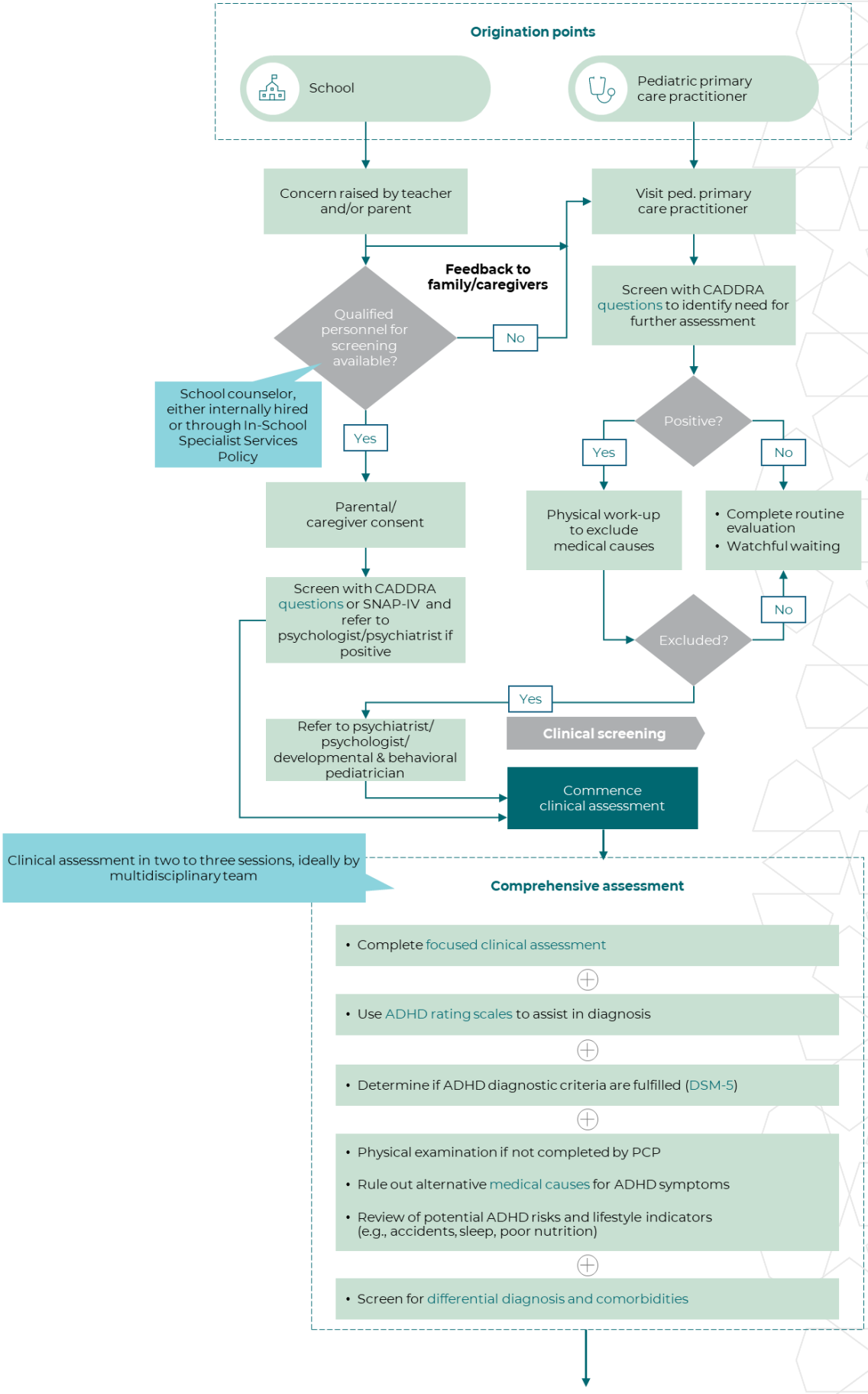
☐ Level 2 is scored as '2'

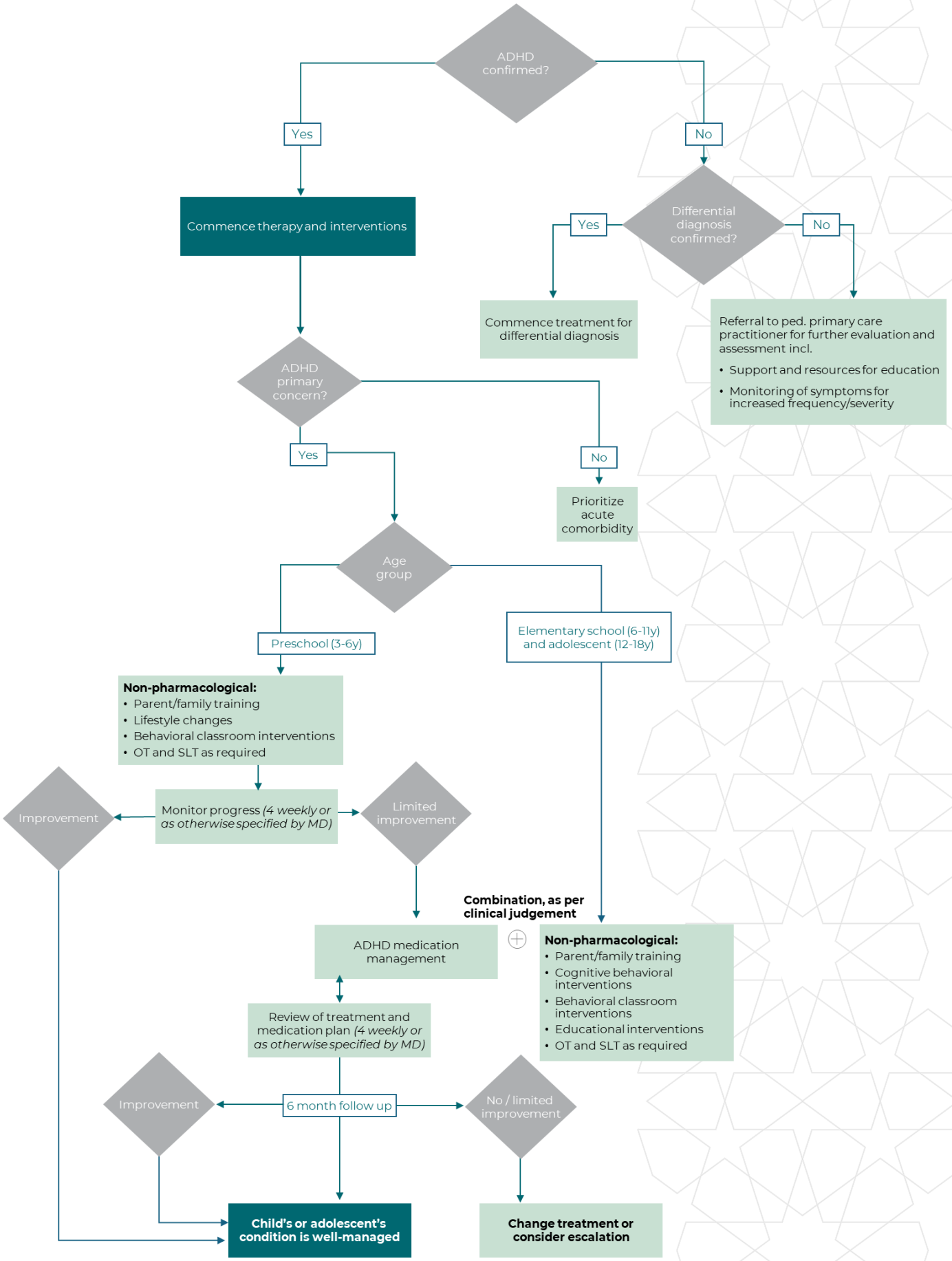
☐ Level 3 is scored as '1'

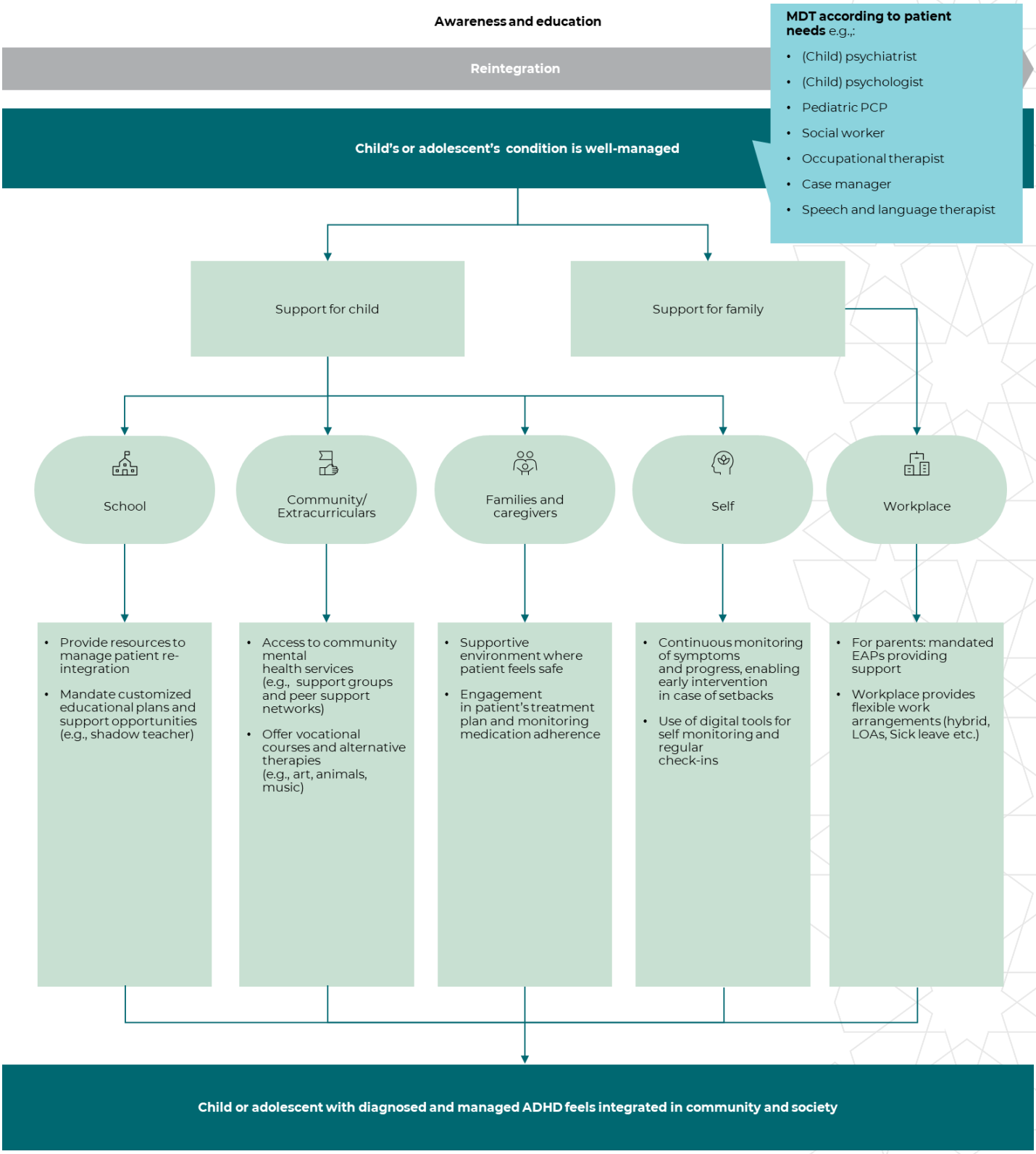
☐ Level 4 is scored as '0'

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.

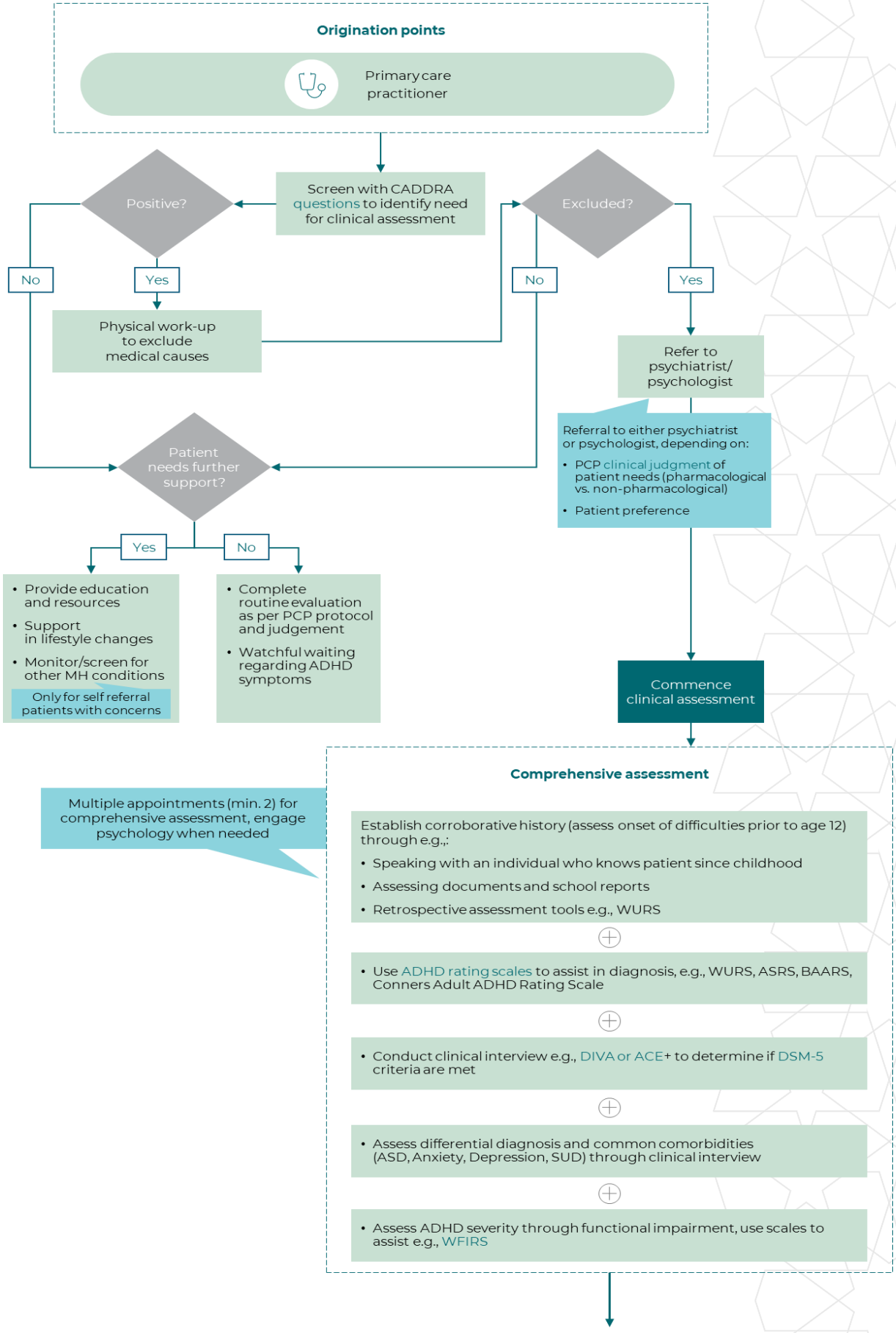
Appendix D: ADHD Pathway for Children and Adolescents

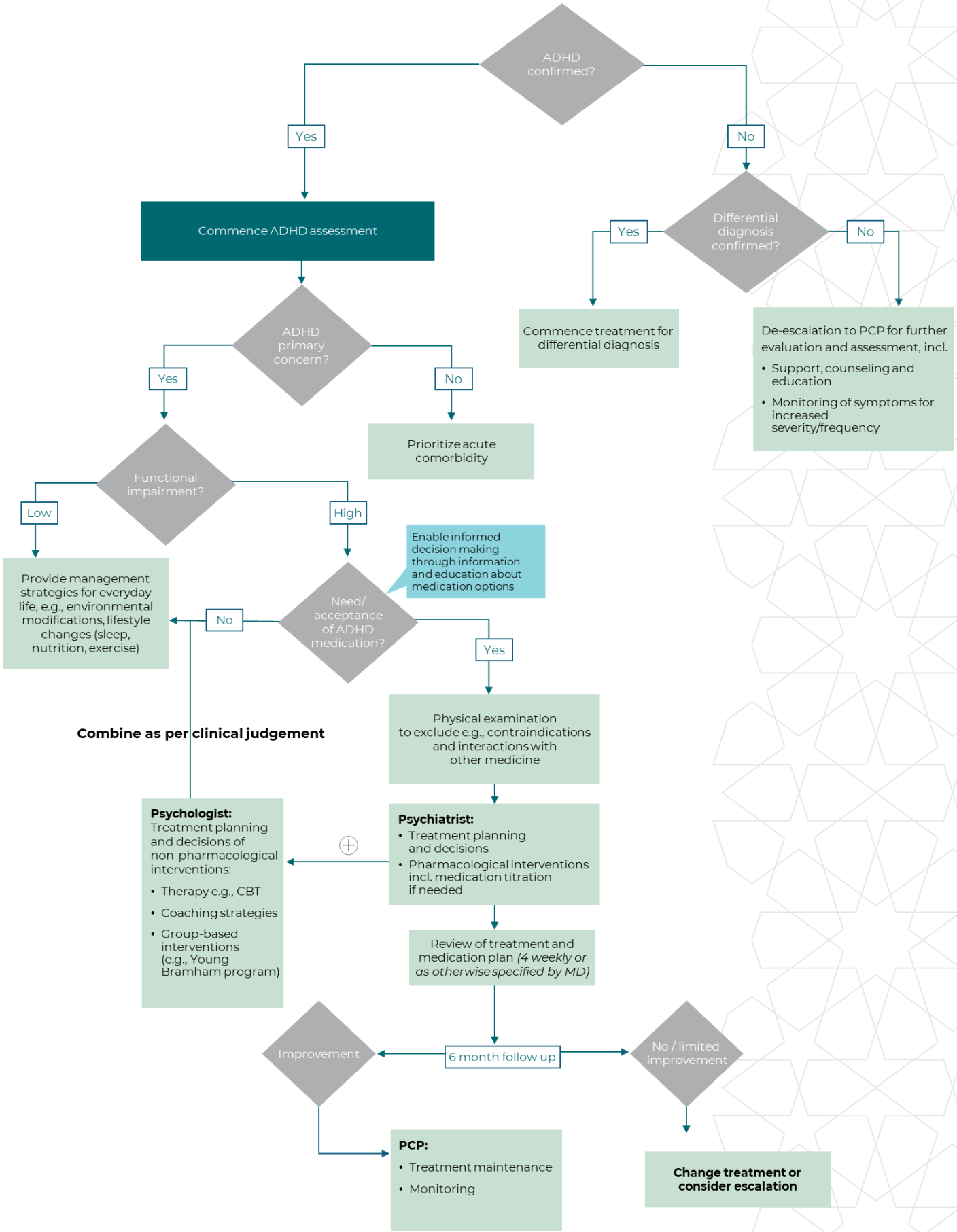


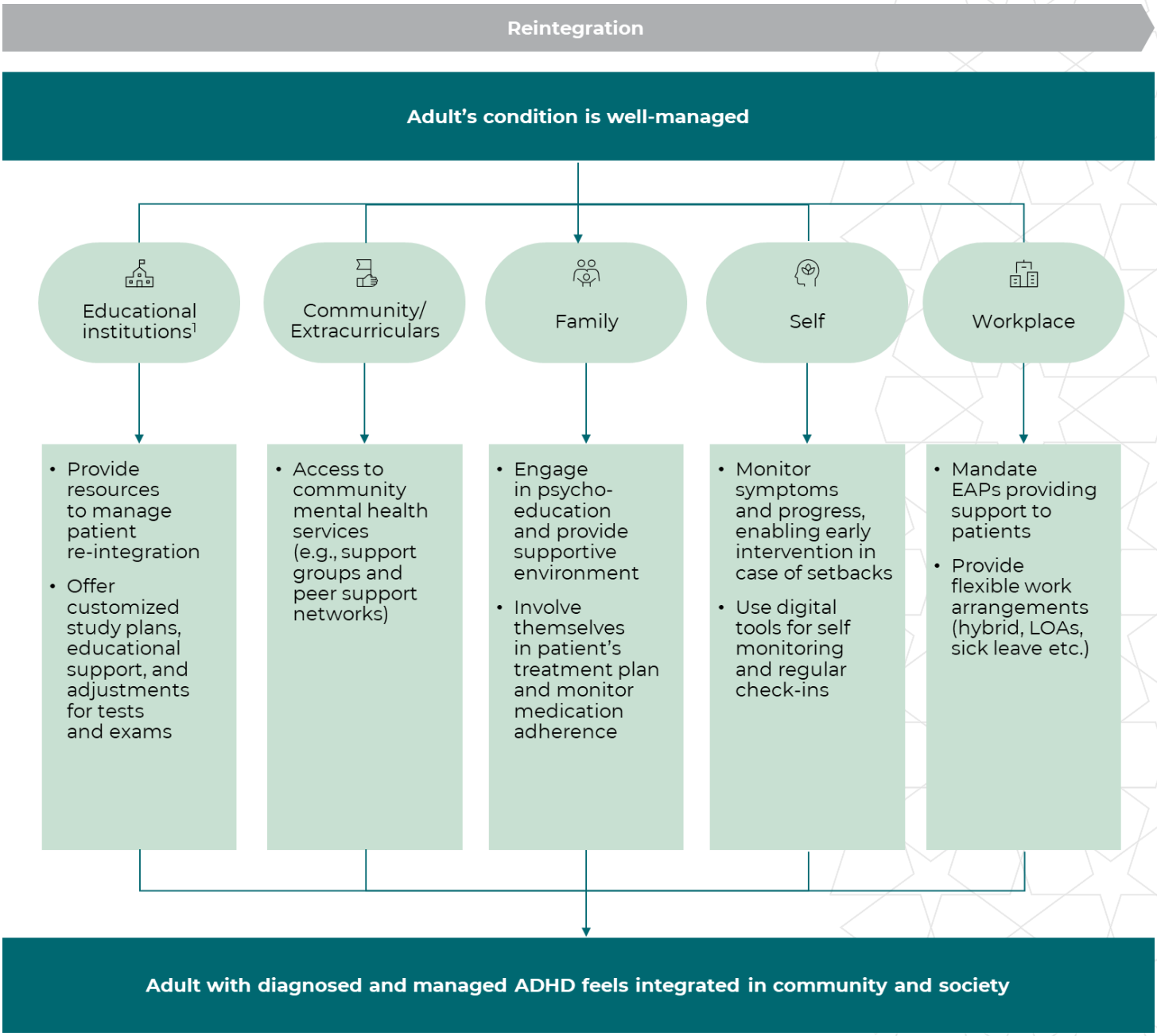

ADHD confirmed?
Yes
No
Commence therapy and interventions
Differential diagnosis confirmed?
Yes
No
Commence treatment for differential diagnosis
Referral to ped. primary care practitioner for further evaluation and assessment incl.
• Support and resources for education
• Monitoring of symptoms for increased frequency/severity
ADHD primary concern?
Yes
No
Prioritize acute comorbidity
Age group
Preschool (3-6y)
Elementary school (6-11y) and adolescent (12-18y)
Non-pharmacological:
• Parent/family training
• Lifestyle changes
• Behavioral classroom interventions
• OT and SLT as required
Improvement
Monitor progress (4 weekly or as otherwise specified by MD)
Limited improvement
Combination, as per clinical judgement
ADHD medication management
Non-pharmacological:
• Parent/family training
• Cognitive behavioral interventions
• Behavioral classroom interventions
• Educational interventions
• OT and SLT as required
Review of treatment and medication plan (4 weekly or as otherwise specified by MD)
Improvement
6 month follow up
No / limited improvement
Child's or adolescent's condition is well-managed
Change treatment or consider escalation


Awareness and education
MDT according to patient needs e.g.,:
(Child) psychiatrist
(Child) psychologist
Pediatric PCP
Social worker
Occupational therapist
Case manager
Speech and language therapist
Reintegration
Child's or adolescent's condition is well-managed
Support for child
Support for family
School
Community/ Extracurriculars
Families and caregivers
Self
Workplace
Provide resources to manage patient re-integration
Mandate customized educational plans and support opportunities (e.g., shadow teacher)
Access to community mental health services (e.g., support groups and peer support networks)
Offer vocational courses and alternative therapies (e.g., art, animals, music)
Supportive environment where patient feels safe
Engagement in patient's treatment plan and monitoring medication adherence
Continuous monitoring of symptoms and progress, enabling early intervention in case of setbacks
Use of digital tools for self monitoring and regular check-ins
For parents: mandated EAPs providing support
Workplace provides flexible work arrangements (hybrid, LOAs, Sick leave etc.)
Child or adolescent with diagnosed and managed ADHD feels integrated in community and society

Appendix F: ADHD Pathway for Adults




ADHD confirmed?
Yes
No
Commence ADHD assessment
Differential diagnosis confirmed?
Yes
No
Commence treatment for differential diagnosis
De-escalation to PCP for further evaluation and assessment, incl.
• Support, counseling and education
• Monitoring of symptoms for increased severity/frequency
ADHD primary concern?
Yes
No
Prioritize acute comorbidity
Functional impairment?
Low
High
Provide management strategies for everyday life, e.g., environmental modifications, lifestyle changes (sleep, nutrition, exercise)
Enable informed decision making through information and education about medication options
Need/ acceptance of ADHD medication?
No
Yes
Combine as per clinical judgement
Physical examination to exclude e.g., contraindications and interactions with other medicine
Psychologist:
Treatment planning and decisions of non-pharmacological interventions:
• Therapy e.g., CBT
• Coaching strategies
• Group-based interventions (e.g., Young-Bramham program)
Psychiatrist:
• Treatment planning and decisions
• Pharmacological interventions incl. medication titration if needed
Review of treatment and medication plan (4 weekly or as otherwise specified by MD)
Improvement
6 month follow up
No / limited improvement
PCP:
• Treatment maintenance
• Monitoring
Change treatment or consider escalation


Reintegration
Adult's condition is well-managed
Educational institutions[1]
Community/ Extracurriculars
Family
Self
Workplace
• Provide resources to manage patient re-integration
• Offer customized study plans, educational support, and adjustments for tests and exams
• Access to community mental health services (e.g., support groups and peer support networks)
• Engage in psycho-education and provide supportive environment
• Involve themselves in patient's treatment plan and monitor medication adherence
• Monitor symptoms and progress, enabling early intervention in case of setbacks
• Use digital tools for self monitoring and regular check-ins
• Mandate EAPs providing support to patients
• Provide flexible work arrangements (hybrid, LOAs, sick leave etc.)
Adult with diagnosed and managed ADHD feels integrated in community and society