HARMONIZED QUALITY IMPROVEMENT STANDARDS

AFGHANISTAN

COMPREHANSIVE HEALTH CENTER

MENTAL HEALTH

2016

AREA: MENTAL HEALTH

PROVINCE: _____ **FACILITY NAME:** _____ **CODE:** _____ **IMPLEMENTER:**_____

ASSESSOR: _____ **ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3 ☐) **DATE:**_____

PERFORMANCE STANDARDS		VERIFICATION CRITERIA	1,0,NA	COMMENTS
Instructions for the assessor : For any verification criteria fill in each unblocked cell with one of the following options "1" if the verification criteria is met, "0" if the verification criteria is not met or partially achieved, "NA" if Not applicable. Any cells left unfilled will be considered as missing data.				
PART ONE: Getting history, examination and investigation;				
1. *In OPD, the health provider examine the patient with mental disorder/psych osocial problems in cordial manner.	**Observe whether the health provider use inter-personal communication skill properly during mental health patient exam?**			
	1.1*	Greets the patient and companion in a cordial manner		
	1.2*	Patient confidentiality consideration.		
	1.3*	Ensures that she/he speaks the language spoken by the patient		
	1.4*	Introduces her/himself for the client and her/his companion		
	*1.5	Listens to all complaint of patient properly and respond to questions by using good basic communication skills (Eye contact, body language, etc)		
	1.6*	Summarizes the findings		
	1.7*	Discusses treatment plan		
	1.8*	Sets follow up dates		
TOTAL:				

PERFORMANCE STANDARDS		VERIFICATION CRITERIA	1,0,NA	COMMENTS
2. The health provider asks the following question from client or her/his companions about mental disorder/ psychosocial problems.	**Observe whether health provider takes the accurate history based on protocol;**			
	2.1	Name, Father name, Address, Age, Sex, Occupation, Marital status		
	2.2	Physical symptom and signs such as Headache, Body pain, sweating, Tachycardia, hot flushes, tremor, shortness of breath, chest pain, gastro intestinal discomfort, weight problem, Fatigue, sleep and appetite problems.		
	2.3	Psychological sign and symptom. Loss of Memory, weak concentration and attention, irritability, nervousness, sadness, worry, fear, impatience, loss of interest, deprivation, faint		
	2.4	Current stressors (family problem, unemployment, etc.)		
	2.5	Impact of signs and symptoms on patient's daily life		
	2.6	Current medication and past treatment		
TOTAL:				
COMULATIVE % OF PART ONE : Getting history, examination and investigation				
PART TWO: Psychosocial counseling				
3. *Psychosocial counselor perform counseling with clients suffering from psychosocial problems/mental disorders according to	**Observe whether the psychosocial counselor use inter-personal communication skill properly during counseling session with client**			
	3.1*	Greets the patient and companion in a cordial manner		
	3.2*	Psychosocial counselor considers confidentiality of client during counseling.		
	3.3*	Psychosocial counselor speaks the language spoken by the client		
	3.4*	Psychosocial counselor introduce her/himself to the client and her/his companion		
	3.5*	Listens to all complaint of patient properly and respond to questions by using good basic communication skills (Eye contact, body language, etc.)		

PERFORMANCE STANDARDS	VERIFICATION CRITERIA		1,0,NA	COMMENTS
BPHS standard manual.	3.6	Summarizes the findings		
	3.7	Discusses treatment plan		
	3.8	Sets follow up dates		
TOTAL:				
4. *Psychosocial counselor takes history from client or her/his companions about psychosocial problems/mental disorders?	**Observe whether psychosocial counsellor takes the accurate history based on psychosocial counselling protocol;**			
	4.1	Name, Father name, Address, Age, Sex, Occupation, Marital status		
	4.2	Physical symptom and signs such as Headache, Body pain, sweating, Tachycardia, hot flushes, tremor, shortness of breath, chest pain, gastro intestinal discomfort, weight problem, Fatigue, sleep and appetite problems.		
	4.3	Psychological sign and symptom. Loss of Memory, weak concentration and attention, irritability, nervousness, sadness, worry, fear, impatience, loss of interest, deprivation, faint		
	4.4*	Current stressors (family problem, unemployment, etc.)		
	4.5*	Impact of signs and symptoms on patient's daily life		
	4.6	Current medication and past treatment		
TOTAL:				
COMULATIVE % OF PART TWO: Psychosocial counseling				
PART THREE: Diagnosis and treatment of depression				
5. The health provider can	**Observe whether health provider classifies the mental health disorders**			
	5.1	Depression		

PERFORMANCE STANDARDS	VERIFICATION CRITERIA		1,0,NA	COMMENTS
state common mental disorders.	5.2	Anxiety disorders		
	5.3	Stress related disorders (Trauma and Conversion disorder)		
TOTAL:				
6. The health provider can make diagnosis of depression according to BPHS training manual	**Observe whether health provider states the sign and symptoms of depression;**			
	6.1	Depressed mood, (at least two weeks or more), loss of interest plus at least three or more of the following symptoms		
	6.2	• Tiredness, Loss of energy • Insomnia or heavy sleep and early morning waking up. • Anxiety or psychomotor slowness. • appetite problem and weight loss • poor concentration, difficulty in making decisions • Anger on family members and other persons If the Suicidal idea, divagations and hallucinations are with patients; depression is severe.		
	6.3	Main Psychosocial stressors and relationship to current sign & Symptoms		
	6.4	Associated Physical illness		
	6.5	Associated Substance abuse		
	6.6	Mode of referral (who referred the patient to HF)		
	6.7	Current treatment (medication or Counseling)		
	4.8	Impact of symptoms on patient's daily life		
TOTAL:				
7. The health	**Observe or interview whether health provider;**			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA		1,0,NA	COMMENTS
provider can make plan of intervention for depression according to BPHS standard treatment guide line	7.1*	Primary, shares the intervention plan with patient and his/her family		
	7.2*	Explains Importance of psycho social counseling		
	7.3	Explains nature of illness		
	7.4	Fluoxetine capsule 20mg a day single dose after breakfast for adult at least for 6 months, in case of no response after 3 weeks increase to 40 mg/day as advice above **or**		
	7.5	Amitriptyline tab; • First period: (start with25 to 75 mg daily in two divide doses) • Second period: evaluate the effect of drug after 2 to3 weeks if it was not effective dose can be increased 25 mg each three days and reached 150 mg (50 mg morning and 100 mg night) • Third period: if the treatment did not effect after six weeks, or patient has cardiac illnesses, epilepsy, prostatic adenoma, or over 65 years old ; then drug must be substituted to fluoxetine		
	7.6	In case of no response of treatment; other possible ways explained		
	7.7	Possible risks (self-harming, job losing, family problem, narcotic drug abuse, isolation, mania phases and physical disorders.		
	7.8	Explain suicide risks (for patients or relatives)		
	7.9	Refer to psychosocial counselor		
	7.10	Ask for follow up visit		
	7.11	In case of psychotic symptoms in order to fluoxetine administration, first dose of haloperidol 5 mg daily in 24 hours, in response to treatment must be increased up to 10 mg.		
	7.12	In case of psychotic symptom treatment, risk of extra pyramidal syndrome is available; Trihexofenidyl 2 mg single dose as OPD treatment must be administered and based on need the dose can be given 2 to 3 times/day.		

PERFORMANCE STANDARDS	VERIFICATION CRITERIA		1,0,NA	COMMENTS
TOTAL:				
COMULATIVE % OF PART THREE : Diagnosis and treatment of depression;				
PART FOURTH: Diagnosis and treatment of anxiety disorder;				
8. The health provider can make diagnosis of Anxiety disorders according BPHS training manual.	**Observe or interview whether health care provider;**			
	8.1	Physical problem: sleep disorder, Muscle rigidity, body pain, headache, confusion, tremor, weakness, breath shortness, strangulation feeling, chocking, chest pain, heart palpation feeling ,tachycardia, sweeting, nausea, abdomen disorder, heat and cold feeling of body		
	8.2	Psychiatric symptoms: De-realization, feelings of losing control, feelings of dying (having heart attack), hyper phobia, concentration and memory problem, irritability, impetuousness, distraction decision making problem. excessive self-caring		
	8.3	GAD (generalized Anxiety Disorder) if continuous phobia and concern in order to above symptoms existed for more than 6 months and disturb the daily tasks of person.		
	8.4	Panic disorder: As acute and sadden attack with above severe physical and psychotic symptoms with scare from death and raving is appearing it continues less than 30 minutes and causes daily tasks disturbance of person.		
	8.5	Phobia disorder (fears of a specific object or social phobia) when patient face with specific objects, location or social situations, and appear some above psychiatric and physical symptoms which disturb the daily tasks of patient.		

PERFORMANCE STANDARDS	VERIFICATION CRITERIA		1,0,NA	COMMENTS
	8.6	OCD is a disorder characterized by obsessions and compulsions. In OCD the person is unable to control thoughts, idea or urges, which force themselves into the mind, repeatedly. • Obsession: Fear of dirt or germs and contamination, fear of harming a family member or friend, fearing aggressive urges, excessive doubts, concern with order, symmetry and exactness etc. • Compulsion: Repetitive behavior for reducing high level of anxiety due to obsession • Obsessive compulsive actions: repetitive actions of checking doors, drawers, switches, shop and appliances to be sure they are shut, locked or turned off, washing and cleaning, such as washing hands, showering or brushing teeth over and over again, etc.		
	8.7	Exploring psychosocial stressors and their relation with actual signs and symptoms.		
	8.8	Associated physical illnesses.		
	8.9	Substance abuse		
	8.10	Mode of Referral (who refers the patient to HF)		
	8.11	Current management (medication or counseling)		
	8.12	Impact of symptoms on patient's daily life		
TOTAL:				
9. The health provider can make plan of intervention for depression according to BPHS standard	**Observe or interview whether health provider;**			
	9.1	Explain the intervention plan with patient and his/her family		
	9.2	Diazepam 5-10 mg OD or BID for maximum 14 days		
	9.3	Anti-depressants (fluoxetine or amitriptyline) as mentioned in treatment of depression.		

PERFORMANCE STANDARDS	VERIFICATION CRITERIA		1,0,NA	COMMENTS
treatment guide line	9.4	Explains nature of illness		
	9.5	Asking for follow up visits		
	9.6	Associated possible risks (addiction to benzodiazepines, depression, substance abuse, suicide, problem in work place)		
	9.7	In case of no response of treatment; other possible ways explained		
	9.8	Explaining importance of psychosocial counseling		
	9.9	Refer to psychosocial counselor		
TOTAL:				
COMULATIVE % OF PART FOURTH: Diagnosis and treatment of anxiety disorder;				
PART FIFTH: Diagnosis and treatment of PTSD (Post traumatic stress disorders)				
10. Health provider diagnosis the post traumatic stress disorder according to BPHS guideline.	**Certify by observe/interview that health provider can diagnose the PTSD as follow;**			
	10.1	Person faced with traumatic cases like natural accidents, rape, war etc…where his/her or other life be threatened. Patient reacts serious fear, worry and hopelessness against accidents.		
	10.2	Sadden appearance of past painful memories (Re memorizing of past issues in sleep or awake status or in during work)		
	10.3	Excessive caution, feeling for flight, and readiness to fight, nervousness, nightmares and physical symptoms such as sleep disorder, blood hypertension, palpitation, tremor (Hyperarezol syndrome)		
	10.4	Active avoidance to appear in society and locations which cause flashback the memories and inactive avoidance of emotions due to fear.(avoid syndrome)		

PERFORMANCE STANDARDS	VERIFICATION CRITERIA		1,0,NA	COMMENTS
	10.5	Common psychosocial stressors.		
	10.6	Mode of referral (who refereed the patient to HF).		
	10.7	Associated physical illnesses.		
	10.8	Associated substance abuse.		
	10.9	Impact of symptoms on patient's daily life		
	10.10	Current management. (medication or counseling)		
TOTAL:				
11. Health provider can treat the post traumatic stress disorder according to BPHS guideline.	**Observe whether HF has following area;**			
	11.1	Explains the importance of psychosocial counseling.		
	11.2	Explain the intervention plan with patient and his/her family		
	11.3	Refers to Psychosocial counselor in CHC.		
	11.4	Fluoxetine 20 to 40 mg single dose in the morning after breakfast for adult people, **or**		
	11.5	Amitriptyline 25 to 150 mg daily, **with**		
	11.6	Diazepam 5 to 10 mg daily for 7 to 10 days (short course)		
	11.7	Awareness about nature of illness and drug side effects.		
	11.8	Ask for follow up visit		
TOTAL:				
COMULATIVE % OF PART FIFTH: Diagnosis and treatment of post-traumatic stress disorder				
PART SIXTH: Diagnosis and management of conversion disorder.				

PERFORMANCE STANDARDS	VERIFICATION CRITERIA		1,0,NA	COMMENTS
12. Health provider can diagnose conversion disorder according to BPHS guideline.	**Information for assessor or health provider** **Conversion disorder is a condition where patients present with neurological symptoms such as numbness, paralysis or fits, but no neurological explanation can be found. These problems arise in response to difficulties in the patient's life but the nature of the association between the psychological factors and the neurological symptoms remains unclear.**			
	Certify by observation/interview whether health provider can diagnose conversion disorder;			
	12.1	Motor: Weakness/paralysis of a limb or the entire body, impairment or loss of speech, fixed dystonia unlike normal dystonia, tremor, myoclonus or other movement disorders, gait problems (motor symptoms)		
	12.2	Sensory: Impaired hearing or vision, loss/disturbance of sensation (sensory symptoms)		
	12.3	Non-epileptic seizures (pseudo seizures)		
	12.4	Mix of above symptoms.		
	12.5	Mode of referral (who referred the patient to HF)		
	12.6	Associated physical illnesses.		
	12.7	Associated substance abuse.		
	12.8	Impact of symptoms on patient's daily life		
	12.9	Current management. (medication or counseling)		
TOTAL:				
13. Health provider can treat the conversion disorder	**Information for assessor or health provider** **Must be correlate and emphasized that this status is common and reversible. It is not mean that patient has mental disorder.**			
	Certify by observation/interview whether health provider can treat the conversion disorder;			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA		1,0,NA	COMMENTS
according to BPHS guideline.	13.1	Explain the intervention plan with patient and his/her family		
	13.2	Awareness about nature of illness		
	13.3	Explains the role of stress and importance of psychosocial counseling.		
	13.4	In case, depression or anxiety are associated with conversion disorder, fluoxetine 20 - 40 mg single dose after breakfast daily for adults or Amitriptyline 25- 150 mg daily administered. If the patient has convulsion administer diazepam 2-5 mg IM daily. If anxiety symptoms are present, administer diazepam 2-5 mg daily by oral for 7 to 10 days (short course).		
	13.5	Always refers to psychosocial counselor for getting counseling.		
	13.6	Ask for follow up visit		
	13.7	In case of no response of treatment; other possible ways explained		
	13.8	Possible risks (Self-harm and suicide attempts, substance or alcohol abuse, sleep problems, including nightmares, development of another mental illness, such as anxiety or depression, difficulties in relationships and at work)		
TOTAL:				
COMULATIVE % OF PART SIXTH: Diagnosis and management of conversion disorder.				
PART SEVENTH: Detection of symptoms and diagnosis of psychosis including of postpartum psychosis.				
14. Health provider can explain the symptoms of psychosis	**Certify by observation/interview that health provider can state the following symptoms;**			
	14.1	Hallucination (hearing, visual, smelling etc.)		
	14.2	Delusion (suspiciousness, grandiosity, etc.)		

PERFORMANCE STANDARDS	VERIFICATION CRITERIA		1,0,NA	COMMENTS
according to BPHS guideline.	14.3	Disorganized speech (using wrong words or incomplete sentence)		
	14.4	Behavior disorder (collecting or keeping things that have no value) motion interruption (retardation or disorganized)		
	14.5	Absence of emotions (improper and indifferent emotions)		
	14.6	Absence of initiative		
	14.7	Absence of interest		
	14.8	Absence of movement		
	14.9	Presence of sign and symptom of psychosis for lease than one month is called acute psychosis and more than one month is called chronic psychosis.		
TOTAL:				
15. Health provider can diagnose the psychosis according BPHS guideline	**Certify by observation or interview that health provider can state the qualifications of psychosis;**			
	15.1	Signs and symptoms suddenly started in acute psychosis.		
	15.2	Signs and symptoms continue more than one month in chronic psychosis.		
	15.3	Often psychosocial stressors are present		
	15.4	Dominant symptoms in acute psychosis are delusion, hallucination, behavior disorders and disorganized speech.		
	15.5	Dominant symptoms in chronic psychosis are delusion, hallucination, behavior disorders, disorganized speech, absence of emotions, absence of initiative, absence of interest, absence of psycho-motor movements		
	15.6	agitation and aggression is common		

PERFORMANCE STANDARDS	VERIFICATION CRITERIA		1,0,NA	COMMENTS
	15.7	Common psychosocial stressors		
	15.8	Associated physical illnesses		
	15.9	Associated substance abuse		
	15.10	Current management. (medication or counseling)		
TOTAL:				
16. Health provider can diagnose postpartum psychosis according to BPHS guideline.	**Certify by observe/interview that health provider can state the common symptoms PPP**			
	Appearance of following signs and symptoms after two weeks of delivery.			
	16.1	Confusion, disorientation and agitation.		
	16.2	Self-talk or laugh, neglect of self-care, neglect of baby		
	16.3	Hallucination (hearing and seeing unreal sounds and things)		
	16.4	Delusion (grandiosity, suspiciousness, Beliefs that the newborn is possessed or a child of Satan)		
	16.5	Risk of self-harm or harming baby		
	16.6	Labile or inappropriate affect		
	16.7	No insight of the problem		
	16.8	Associated physical illnesses		
	16.9	Mode of referral (who refers the patient to HF)		
	16.10	Current management (medication etc.)		
TOTAL:				

PERFORMANCE STANDARDS	VERIFICATION CRITERIA		1,0,NA	COMMENTS
COMULATIVE % OF PART SEVENTH: Detection of symptoms and diagnosis of psychosis include of postpartum psychosis.				
PART EIGHT: Detection of symptoms and treatment of epilepsy				
17. Health provider classify the epilepsy according to BPHS guideline	**Information for assessor or health provider** **Epilepsy is a brain disorder characterized by spontaneous, repetitive seizures. (At least 2 unprovoked seizures 24 hours apart.) Epilepsy is not a mental disorder, but a neurological disorder. During an epileptic seizure the normal pattern of neuronal activity becomes disturbed, resulting in muscle spasms, loss of consciousness, and additional symptoms.**			
	Certify by interview that provider can classify the epilepsy;			
	17.1	Partial seizures. Partial-onset seizures begin in a focal area of the cerebral cortex; this includes simple partial seizure (SPS), complex partial seizures (CPS) also seizure with secondary generalization.		
	17.2	Generalized seizures. They have an onset recorded simultaneously in both cerebral hemispheres.		
TOTAL:				
18. Health provider can explain common symptoms of epileptic seizure attack based on BPHS guideline.	**Certify by observe or interview that health provider can diagnose epileptic seizure based on its symptoms**			
	18.1	Sudden fall		
	18.2	Loss of consciousness		
	18.3	Jerky movements of limbs		
	18.4	Cyanosis in lips and extremities		
	18.5	tongue bite, frothing from mouth		
	18.6	Incontinence of urine and feces		

PERFORMANCE STANDARDS	VERIFICATION CRITERIA		1,0,NA	COMMENTS
	18.7	upward rotation of the eyes		
	18.8	The postictal period includes a period of unconsciousness during which the patient becomes quiet and breathing resumes. Patient gradually awakens, often after a period of sleep, and is confused. Headache and muscular pain are common. The patient does not have memories about what happened during the seizure.		
TOTAL:				
19. Health provider can treat epilepsy in according to BPHS guideline.	**Certify by observe/interview that health provider can manage the epilepsy patient in according to Standard treatment guideline**			
	19.1	Explain the intervention plan with patient and his/her family		
	19.2	In case of no response of treatment; other possible ways explained		
	19.3	Adult: Valproic acid is considered the drug of first choice since it treats a broad spectrum of seizure types. The dose of valproic acid is, 250-750mg/day, in divided doses. This is the drug of choice for primary generalized epilepsies, can be used for the treatment of partial seizures.		
	19.4	Carbamazepine can be used for partial seizures. The dose is 200-400 mg; not to exceed 1000 mg/d.		
	19.5	Phenobarbital for children (up to 10 years) 15-30 mg /day single dose at night. Maximum dose is 5 mg / Kg / day in two divided doses and with gradual dose increasing.		
	19.6	Phenobarbital for adults 100 mg / day/single dose at night. Dose can be increased 50 mg weekly and maximum dose is up to 200 mg / day.		
	19.7	Explain effects and side effects of drugs.		
	19.8	Explains nature of illness and its prevention.		

PERFORMANCE STANDARDS	VERIFICATION CRITERIA		1,0,NA	COMMENTS
	19.9	Treatment must be continued, till epileptic seizure not to be seen for 3-5 years.		
	19.10	Ask for follow up visit		
	19.11	In case of problem in diagnose and treatment, patient should be referred to high level center.		
TOTAL:				
COMULATIVE % OF PART EIGHTH: Detection of symptoms and treatment of epilepsy				
PART NINTH: Detection of signs and symptoms of Heroine, Morphine and Opium withdrawal				
20. Health provider can explain the common sign and symptoms of heroine, morphine and opium withdrawal in according to BPHS guideline.	**Information for assessors and health providers: Withdrawal syndromes: quitting of heroine, morphine, opium, benzodiazepine, will cause physiologic withdrawal syndrome (mental and physical).**			
	Certify by observe/interview that health provider common signs and symptoms of heroine, morphine and opium withdrawal;			
	20.1	Body pain		
	20.2	Restlessness and Yawning		
	20.3	Eye, nose and mouth watery		
	20.4	Sleep problems		
	20.5	Abdomen pain		
	20.6	Diarrhea		
	20.7	Strong desire to use again		
TOTAL:				

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	1,0,NA	COMMENTS
COMULATIVE % OF PART NINTH: Detection of signs and symptoms of Heroine, Morphine and Opium			

TOTAL NUMBER OF STANDARDS	20
TOTAL NUMBER OF PARTS	9
COMULATIVE % OF PART ONE : Getting history, examination and investigation	
COMULATIVE % OF PART TWO : Psychosocial counseling	
COMULATIVE % OF PART THREE: Diagnosis and treatment of depression	
COMULATIVE % OF PART FOURTH: Diagnosis and treatment of anxiety disorder	
COMULATIVE % OF PART FIFTH: Diagnosis and treatment of post-traumatic stress disorder	
COMULATIVE % OF PART SIXTH: Diagnosis and management of conversion disorder	
COMULATIVE % OF PART SEVENTH: Detection of symptoms and diagnosis of psychosis include of postpartum psychosis.	
COMULATIVE % OF PART EIGHT: Detection of symptoms and treatment of epilepsy	
COMULATIVE % OF PART NINTH: Detection of signs and symptoms of Heroine, Morphine and Opium withdrawal	
TOTAL % OF PARTS OF Mental Health	