

EVALUATING THE CHANGES IN OCCUPATIONAL PERFORMANCE
AND SATISFACTION FOLLOWING OCCUPATIONAL THERAPY FOR
THE CLIENT WITH MENTAL ILLNESS.



By
Hafija Tanjin

April 2019

This thesis is submitted in total fulfillment of the requirement for the subject Research 2 and 3 and partial fulfillment of the requirement of degree:

Bachelor of Science in Occupational Therapy
Bangladesh Health Professions Institute (BHPI)
Faculty of medicine, University of Dhaka

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Statement of Authorship

Except where is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis presented by me for any other degree or diploma or seminar.

No others person's work has been used without due acknowledgement in the main text of the thesis.

This thesis has not been submitted for the award of any other degree or diploma in any other tertiary institution.

The ethical issue of the study has been strictly considered and protected. In case of dissemination the findings of this project for future publication, research supervisor will highly concern and it will be duly acknowledged as undergraduate thesis.

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Dedication

*Dedicated to my honorable & beloved parents, my respected all teachers of
Bangladesh Health Professions Institute (BHPI).*

Declaration

*I am **Hafija Tanjin** declare that, the study will not be harmful for the participatory. Then I would like to ensure that all the data and literature were stated correctly. In that case all discussion of this research project is mine and I am only responsible for any mistake in whole study.*

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LIST OF ABBREVIATION OR SYMBOL

CRP: Centre for The Rehabilitation of the paralyzed

BHPI: Bangladesh Health Professions Institute

CAMH: Centre for Addiction and Mental Health Foundation

COPM: Canadian Occupational Performance Measure

WHO: World Health Organization

AOTA: American Occupational Therapy Association

SPD: Sensory processing disorder

OT: Occupational Therapy

OT's: Occupational Therapist.

NHS: National health service

Abstract

Introduction: Mental Health constitutes a major public health challenge undermining the social and economic development throughout much of the developing world. It is estimated that mental disorders account for 13% of the global burden of disease (WHO 2008). A large number of people around the world are suffering from psychiatric disorders. Mental illness constitutes four of the ten most common causes of worldwide burden of disease, yet it remains low on the agenda of policy makers, particularly in developing countries like Bangladesh. But there are insufficient mental health care facilities. So, all professionals should aware about that and in health care claim that they have a holistic approach, whereas in the more humanistic tradition, such as occupational therapy, that focus is on meaningful activities of daily living. Thus, an effective outcome can be resulted and clients are improving their capabilities in daily functioning.

Objectives of the study: The objective of the study is to evaluate occupational performance on activities of daily living of the client with mental illness who receives occupational therapy services. Measuring the effectiveness of occupational therapy services for client with mental illness in day center. Identifying or explore the correlation/ association among Occupational Therapy intervention to client's performance and satisfaction.

Methodology: Quasi experimental study design is selected to conducting the study on 30 participants by using COPM questioner.

Result & discussion: There is resulting a significant change in the pre intervention and post intervention evaluating score. The maximum quantity of clients are improving there occupational performance and satisfaction after receiving occupational therapy treatment.

Conclusion: Occupational Therapy is an effective intervention for the client with mental illness. The COPM is useful aid to evaluate the outcome and is of greatest benefit of the occupational therapy intervention process and client's improvements in functioning.

Key words: *Mental health, mental disorder, occupational therapy.*

<p style="text-align: center;">Chapter 1 INTRODUCTION</p>

1.1 Background

According to the (WHO, 2011), ‘Health may be defined as the ability to adapt and manage physical, mental and social challenges throughout life’. Mental health, is an integral part of human health and wellbeing. Mental disorders is a major public health challenge and account for 13% of the global burden of disease measured as disability adjusted life years (Mathers et al. 2004). Approximately 16% of adult and 18% of child suffering from mental illness nowadays in Bangladesh (daily-sun, 2018). Low- and middle-income countries have higher burden of mental disorders than economically developed countries (Hock et al. 2012). A large number of people around the world are suffering from psychiatric disorders. Mental illness constitutes four of the ten most common causes of worldwide burden of disease, yet it remains low on the agenda of policy makers, particularly in developing countries like Bangladesh. Unfortunately, numerous organizations and NGO’s, that work on chronic non-communicable diseases in Bangladesh also largely ignore mental health. Overall general perception, mental illness constitutes a serious threat to the national health (Burns J, 2009). According to WHO, more than 450 million people in the world are suffering from neuro-psychiatric disorders and in Bangladesh there are 15 million people suffering from mental illnesses and it is variable in types (Hosman C, 2012). In other words, almost 10 % of the population is in need of mental health services. In Bangladesh, data related to mental health is scarce and are not readily available in Bangladesh although a few published articles provide some estimates of different mental disorders. Mental illness is the leading cause of disability in the world (Schierholtz, M. 2010). Mental disorders have serious negative effect on survival and when present with chronic diseases, serious mental disorders may reduce life expectancy by about 20 years. Mental disorders are generally not perceived as a health problem and are not priority in the health care delivery (Colton, & Manderscheid, 2006). It can significantly impact an individual's ability to engage in meaningful daily life activities and lead to productive daily routines. OT is a profession vital to helping individuals with mental illness develop the skills needed to live life to its fullest (Brown & Stoffel, 2011).

The origins of Occupational Therapy are rooted in mental health, as the creation of the profession dovetailed with the early 20th century's mental hygiene movement. Today, Occupational Therapy practitioners provide services in community settings including, but not limited to: Community mental health centers, Assertiveness community treatment (ACT) teams, Psychosocial clubhouses, Homeless and women's shelters, Correctional facilities, Senior centers, Consumer-operated programs, After-school programs, Homes, Worksites (Brown & Stoffel, 2011)

As services for individuals with mental illness have shifted from the hospital to the community, there has also been a shift in the philosophy of service delivery. In the past, there was an adherence to the medical model; now the focus is on incorporating the recovery model. This model acknowledges that recovery is a long-term process, with the ultimate goal being full participation in community activities (Hosman et al. 2004). These activities may include obtaining and maintaining employment, going to school, and living independently. The philosophical base of the recovery model is a good fit with occupational therapy because the purpose of occupational therapy in mental health is to increase an individual's ability to live as independently as possible in the community while engaging in meaningful and productive life roles. Because occupational therapy facilitates participation and is client-centered, it plays an important role in the success of those recovering in the community (AOTA & Scheinholtz M, 2010).

Both OT's and OT assistants are educated to provide services that support mental and physical health and wellness, rehabilitation, habilitation, and recovery-oriented approaches. Such education includes at least one clinical fieldwork experience in a setting focused on psychosocial issues (AOTA, 2010).

There is evidence that occupational therapy interventions improve outcomes for those living in the community with serious mental illness (AOTA, 2012). Such interventions can be found in the areas of education, work, skills training, health and wellness, and cognitive remediation and adaptation. Examples of occupational therapy interventions in community mental health include: Evaluating and adapting the environment at home, work, school, and other environments to promote an individual's optimal functioning (AOTA, 2010). Providing educational programs, experiential learning, and treatment groups or classes to address assertiveness, self-awareness, interpersonal and social skills, stress management, and role development e.g., parenting. Working with clients to develop leisure or avocational interests and pursuits. Facilitating the development of skills needed for independent living such as using community resources, managing one's home, managing time, managing medication, and being safe at home and in the

community. Providing training in activities of daily living e.g., hygiene and grooming (AOTA, 2012). Consulting with employers regarding appropriate accommodations as required by the Americans with Disabilities Act Conducting functional evaluations and ongoing monitoring for successful job placement Providing guidance and consultation to persons in all employment settings, including supportive employment Providing evaluation and treatment for sensory processing deficits (AOTA, 2013). Individuals of all ages who are diagnosed with a mental illness can benefit from OT. Furthermore, friends and family members can also benefit from these services to learn ways to deal with the stress of caregiving and how to balance their daily responsibilities to allow them to continue to lead productive and meaningful lives (Scheinoltz M, 2010). This review was conducted to understand the prevailing situation and trends in mental disorders in Bangladesh. This is expected to generate useful insights and may assist health professionals and policy makers in defining the need and planning service delivery models (Hossain et al. 2014).

2.1 Significance of the study

According to American Psychiatric Association (n.d.), Mental illness is consisting of several mental disorders and health conditioning involving significant changes in thinking emotions and or behavior. It affects clients functioning in social, work or family activities. According to UNIT FOR SIGHT (2015), the person with psychological disorders are at greater risk for decreased quality of life, educational difficulties, lowered productivity and poverty, social problems, vulnerability to abuse, and additional health problems. In addition, psychological disorders result in lowered individual productivity due to unemployment, missed work, and reduced productivity at work. Furthermore, the person with mental illness are vulnerable to low-quality care, abuse, and human rights violations, particularly in low-income areas with limited mental health care resources. Their families may also experience significant social stigma and discrimination (WHO, 2003). The experience of caring for mentally ill relatives varies among families and cultures, a 1999 review article reported that family caregivers' largest challenges were providing assistance with daily activities e.g. providing transportation, offering financial assistance, helping with housework, cleaning, and money management and stress associated with care e.g. concerns about possible violence, embarrassing behaviors, and intra-family conflict (WHO, 2003). In that case, Occupational therapy approaches mental health with some unique perspective

that considers a person's needs within context of family and community. It recognizes that everyday occupational engagement influences mental and physical health and believe that occupational performance, organization, choice and satisfaction are determined by the relationship between persons and their environments (CAOT, n.d.). But in Bangladesh peoples are not well known about the facts and that services because there are lack of establishment of occupational therapy service outcome in mental health care. So this study will be helpful to identify the significant outcome of occupational therapy services for the person with mental illness. It helps the clients and their caregivers to find solutions to address the meaningful daily activities of life. It also helps prevent disability or illness and enhances the way client with mental illness participate in the communities and lives (CAOT, n.d.).

1.3 Research question

The research question guiding this study was:

Is Occupational Therapy service an effective measure for the clients with mental illness?

1.4 Study aim and specific objectives

Aim: The aim of the study is to evaluate the changes in occupational performance and satisfaction for client with mental illness and measure the effectiveness of the occupational therapy services in mental health care.

Objectives:

1. To evaluate occupational performance on activities of daily living of the client with mental illness who receives occupational therapy services.
2. To evaluate occupational satisfaction on activities of daily living of the client with mental illness who receives occupational therapy services.

1.5 Operational definition

According to Medlexicon's medical dictionary, **mental health is:** "Emotional, behavioral, and social maturity or normality; the absence of a mental or behavioral disorder; a state of psychological well-being in which one has achieved a satisfactory integration of one's instinctual drives acceptable to both oneself and one's social milieu; an appropriate balance of love, work, and leisure pursuits.'

Mental disorder

A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning), or with significantly increased risk of suffering death, pain, disability or an important loss of freedom. This syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one (Segen's Medical Dictionary, 2012).

Occupational Therapy

Occupational Therapy is the only profession that helps people across the lifespan to do the things they want and need to do through the therapeutic use of daily activities (occupations). OT practitioners enable people of all ages to live life to its fullest by helping them promote health, and prevent or live better with injury, illness, or disability. (AOTA, 2019).

Chapter 2

Literature review

2.1 Mental health

Mental health can be defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (WHO, 2014). Many people have mental health concerns from time to time.

2.2 Psychological or mental disorder

Mental health concern becomes a mental illness when ongoing signs and symptoms cause frequent stress and affect your ability to function. It refers to a wide range of mental health conditions or disorders that affect your mood, thinking and behavior. Mental illness does not discriminate; it can affect anyone regardless of your age, gender, geography, income, social status, race/ethnicity, religion/spirituality, sexual orientation, background or other aspect of cultural identity. While mental illness can occur at any age (APA, 2018). Mental illness is a relative term. Its meaning depends on what society demands of the individual in learning, skills, and social responsibility.

Diagnosis: There is no absolute measurement for mental retardation. At one time the different types were classified only according to the apparent severity of the mental illness. Since the most practical standard was intelligence, the degree of retardation was based on the score of the patient on intelligence tests such as the intelligence quotient (IQ). The average person is considered to have an IQ of between 90 and 110, and those who score below 70 are considered mentally ill. Today most health care providers use the following classifications: for IQ's from 50 to 70, mild; 35 to 50, moderate; 20 to 35, severe; under 20, profound. Whatever classifications are used, it is agreed that IQ measurements are only one part of the factors to be considered in determining mental illness. Others, such as the client's adaptability to surroundings, the services and training available, and the amount of control shown over his or her emotions, are also very important. About 85 % of patients considered mentally ill are in the least severe, or mild, group. Those in this group do not usually have obvious physical defects and thus are not always easy to identify as mentally ill while they are still infants. Sometimes

such a child's mental defects do not show up until the time of entering school, when the child has difficulty learning and keeping up with others in the same age group. Many persons who are in the mild category, as adults can find employment or a place in society suitable to their abilities, so that they are no longer identified as mentally ill.

2.3 Causes:

The cause of mental illness is often unknown. The known ones are classified as either *genetic* or *acquired*. *Genetic conditions* include chromosomal abnormalities such as down syndrome and Klinefelter's syndrome and errors of metabolism such as phenylketonuria, hypothyroidism, and tay-sachs disease. *Acquired conditions* may be prenatal, perinatal, or postnatal. Prenatal conditions include rubella and other viral infections, toxins, placental insufficiency, and blood type incompatibility. Perinatal causes are anoxia, birth injury, and prematurity. Postnatal causes may include infections, poisons, poor nutrition, trauma, and sociocultural factors such as deprivation.

Many other conditions that can cause severe mental illness can be diagnosed during pregnancy, and in some cases proper treatment can lessen or even prevent mental illness. Proper care for the mother during pregnancy and for the baby in the first months of life is also important.

Generally mental illness is also thought to be caused by a variety of genetic and environmental factors:

Inherited traits: Mental illness is more common in people whose biological (blood) relatives also have a mental illness. Certain genes may increase your risk of developing a mental illness, and your life situation may trigger it. **Environmental exposures before birth:** Exposure to viruses, toxins, alcohol or drugs while in the womb can sometimes be linked to mental illness. **Brain chemistry:** Biochemical changes in the brain are thought to affect mood and other aspects of mental health. Naturally occurring brain chemicals called neurotransmitters play a role in some mental illnesses. In some cases, hormonal imbalances affect mental health (MFMER, 2015). **Drug and alcohol abuse:** illicit drug use can trigger a manic episode (bipolar disorder) or an episode of psychosis. Drugs such as cocaine, marijuana and amphetamines can cause paranoia. **Early life environment:** negative childhood experiences such as abuse or neglect can increase the risk of some mental illnesses. **Trauma and stress:** in adulthood, traumatic

life events or ongoing stress such as social isolation, domestic violence, relationship breakdown, financial or work problems can increase the risk of mental illness. Traumatic experiences such as living in a war zone can increase the risk of post-traumatic stress disorder (PTSD). **Personality factors:** some traits such as perfectionism or low self-esteem can increase the risk of depression or anxiety.

2.4 Types of mental illness:

According to American Psychiatric Association, 2018, there are nearly 300 mental disorders. Some of the main groups of mental disorders are: mood disorders (such as depression or bipolar disorder), anxiety disorders, personality disorders, psychotic disorders (such as schizophrenia), eating disorders, trauma-related disorders (such as post-traumatic stress disorder), substance abuse disorders.

Mood disorder is a mental health class that health professionals use to broadly describe all types of depression and bipolar disorders. Generally, everyone with a mood disorder has ongoing feelings of sadness, and may feel helpless, hopeless, and irritable. Without treatment, symptoms can last for weeks, months, or years, and can impact quality of life. This makes the feelings harder to manage. Sometimes, life's problems can trigger depression. Being fired from a job, getting divorced, losing a loved one, death in the family, and financial trouble, to name a few, all can be difficult and coping with the pressure may be troublesome. These life events and stress can bring on feelings of sadness or depression or make a mood disorder harder to manage (Jons, n.d.).

Anxiety is a feeling of nervousness, worry, or unease that is a normal human experience. Anxiety is a normal response to a threat or to psychologic stress. Normal anxiety has its root in fear and serves an important survival function. When someone is faced with a dangerous situation, anxiety triggers the fight-or-flight response. Anxiety is considered as a disorder when substantially it changes people's daily behavior, including leading them to avoid certain

things and situations (Merck Sharp & Dohme Corp, 2019). Anxiety disorders are more common than any other category of mental health disorder and affect about 15% of adults in the United States.

Personality disorders in general are pervasive, enduring patterns of perceiving, reacting, and relating that cause significant distress or functional impairment.

Personality disorders vary significantly in their manifestations, but all are believed to be caused by a combination of genetic and environmental factors (Merck Sharp & Dohme Corp, 2019).

Psychotic disorders client are lose contact with reality and experience a range of extreme symptoms that usually includes: Hallucinations—hearing or seeing things that are not real, such as voices. Delusions—believing things that are not true. However, these symptoms can occur in people with other health problems, including bipolar disorder, dementia, substance abuse disorders, or brain tumors (Kessler & Frank, 1997).

Eating disorders are actually serious and often fatal illnesses that cause severe disturbances to a person's eating behaviors. Obsessions with food, body weight, and shape may also signal an eating disorder. There is a commonly held view that eating disorders are a lifestyle choice (Constantine, 2016).

Trauma- and stressor-related disorders involve exposure to a traumatic or stressful event. Two of the trauma-related disorders are acute stress disorder (ASD) and posttraumatic stress disorder (PTSD). In acute stress disorder, people have been through a traumatic event, experiencing it directly eg; as a serious injury or the threat of death or indirectly eg, witnessing events happening to others, learning of events that occurred to close family members or friends. People have recurring recollections of the trauma, avoid stimuli that remind them of the trauma, and have increased arousal. Symptoms begin within 4 weeks of the traumatic event and last a minimum of 3 days but, unlike posttraumatic stress disorder, last no more than 1 month (John & Barnhill, 2018).

Substance-related disorders can arise when drugs that directly activate the brain's reward system are taken for the feelings of pleasure they induce. The pleasurable sensations vary with the drug ((Merck Sharp & Dohme Corp, 2019). Substance-related disorders are generally divided into two groups: substances-induced disorders and substance-use disorders. Substance-induced conditions include intoxication, withdrawal, and other mental disorders that can be caused by substances, such as psychotic disorders and sleep disorders. All substance-use disorders are characterized by the continued use of substances, despite their causing significant problems in important areas of an individual's life, such as family, school, and work. According to recent estimates nearly 21 million adults in the United States have a substance-related addictive disorder (Medeiros H et al. 2014).

The diagnosis of mental illness can be controversial. There have been many debates in the medical community about what is and isn't a mental illness. The definition can be influenced by our society and culture, but most mental illnesses occur across all countries and cultures. This suggests that they are not just constructed by social norms and expectations, but have a biological and psychological basis too (Hossain MD et al. 2014).

2.5 Mental Health Situation in Bangladesh

The first national survey on mental health conducted in 2003-2005 demonstrated that 16.1 % of the adult population had some form of mental disorder and that the prevalence of mental disorders was higher among women (19%) than men (12.9%) (WMOHaf, 2007). In other words, in Bangladesh women are more vulnerable to mental illness than their male counterparts. There is widespread stigma against people with mental illness in Bangladesh. There are many myths and superstitions surrounding the cause and outcome of mental illness. Mental disorders are primarily viewed as the result of being possessed by evil spirits rather than as illnesses that can be treated. Consequently, victims of mental illnesses are most often neglected, subjected to delayed care-seeking and abused (Adams, 2013). A community-based survey conducted in 2009 found the prevalence of mental disorders among children at 18.4% (Gausia, et al. 2009). Figure 2 shows the prevalence of mental health disorders among the adult population in Bangladesh from 1974-2005 (Hossain, et al. 2014). It is evident that although the prevalence of mental illness in Bangladesh declined significantly between 1974 (31.4%) and 2005 (16.1%), it was still alarmingly high in 2005 (Hossain et al. 2014).

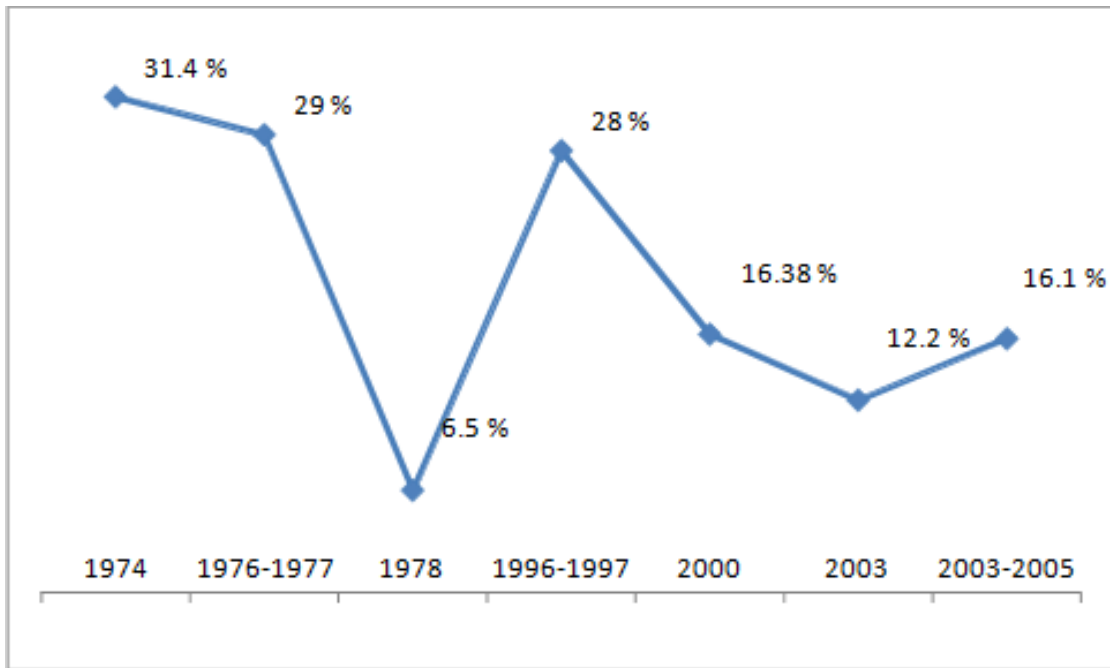


Figure 1. Prevalence of mental disorders among adults in both urban and rural areas..

Mentally ill peoples are ignoring their behavioral health problems, they are more likely to face negative health outcomes and substantial amount of additional money later for their severe illnesses (Lopez et al. 2008). Moreover, people with severe mental illness are also less likely to access general health care. Hossain et al in their systematic review study found that prevalence of mental disorders among children in Bangladesh ranged from 13.40% in 1998 to a high of 22.9% in 2004 (Hossain et al. 2014).

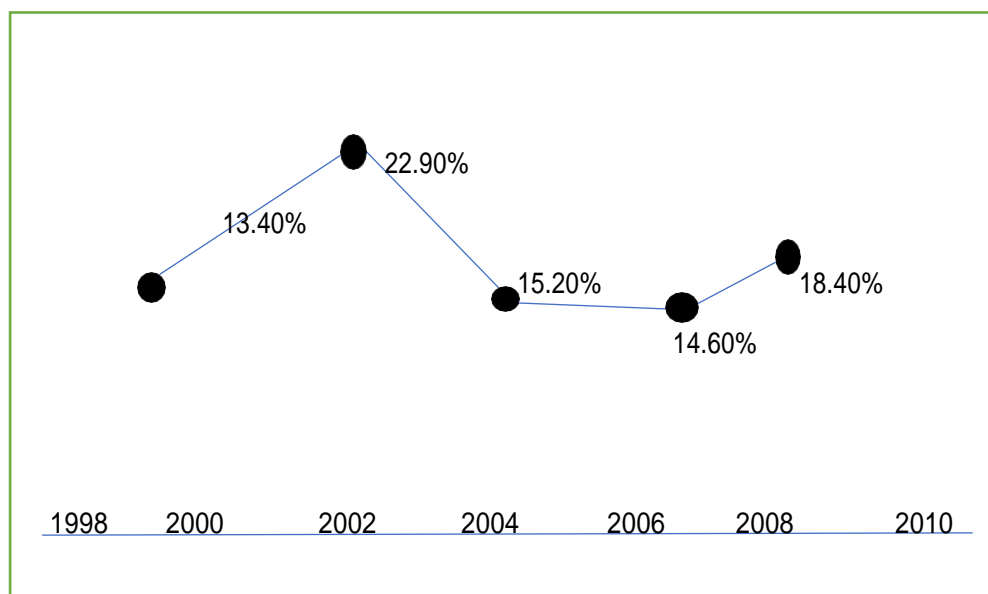


Figure 2. Prevalence mental disorder among the children in Bangladesh

2.6 Impact of mental illness:

There is growing evidence of the global impact of mental illness. Mental health problems are among the most important contributors to the burden of disease and disability worldwide. Five of the 10 leading causes of disability worldwide are mental health problems. They are as relevant in low-income countries as they are in rich ones, cutting across age, gender and social stigma. Furthermore, all predictions indicate that the future will see a dramatic increase in mental health problems (Brundtland, 2000). In fact, mental health problems are a leading cause of illness and disability (Al-Zaidy, 2016). It has been estimated that 20% of the adult working population has some type of mental health problem at any given time (Helsinki, 1999). In the USA, it is estimated that more than 40 million people have some type of mental health disorder and, of that number, 4-5 million adults are considered seriously mentally ill (NIDRR, 1993).

Mental health problems affect functional and working capacity in numerous ways. Depending on the age of onset of a mental health disorder, an individual's working capability of working may be significantly reduced. Mental disorders are usually one of the three leading causes of disability for example, mental health disorders are a major reason for granting disability pensions (Lahtinen et al. 1999). Disability not only affects individuals but also impacts on the entire community. The cost to society of excluding people with disabilities from taking an active part in community life is high. This exclusion often leads to diminished productivity and losses in human potential. The United Nations estimates that 25% of the world's population is adversely affected in one way or another as a result of disabilities. For example, analysis of Tanzanian survey data has revealed that households with a member who has a disability have a mean consumption less than 60% of that of the average household. People with disabilities, particularly psychiatric disabilities, face numerous barriers in obtaining equal opportunities – environmental, access, legal, institutional and attitudinal barriers which cause social exclusion (Colton et al. 2006). For people with mental illness, social exclusion is often the hardest barrier to overcome and is usually associated with feelings of shame, fear and rejection. It is clear that mental illness imposes a heavy burden in terms of human suffering, social exclusion, stigmatization of the mentally ill and their families and economically. Unfortunately, the burden is likely to grow over time as a result of ageing of the global population and stresses resulting from social problems and unrest, including violence, conflict and natural disasters (Burton et al. 2000).

The biopsychosocial model of health which demonstrated the influence of biological, psychological, social factors on mental health.

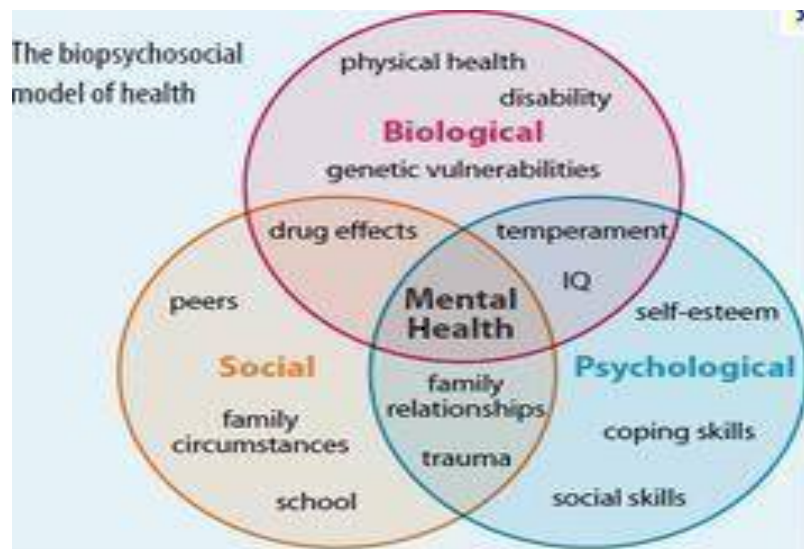


Figure 3: Bio-psycho-social model

2.7 Occupational Therapy in mental health care

Occupational Therapy is defined as “the therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of enhancing or enabling participation in roles, habits, and routines in home, school, workplace, community, and other settings” (AOTA, 2014). To put it more simply, occupational therapists help individuals get back to doing what they want to do. Occupational therapists can work with individuals with physical injuries, cognitive impairments, psychosocial dysfunction, mental illness, and developmental or learning disabilities. Occupational therapists evaluate the whole individual by looking at the transaction between client factors (values, beliefs, spirituality, mental function, sensory function, etc.), performance skills (motor skills, process skills, social interaction skills), environment/context, and performance patterns (habits, routines, roles, rituals) in order to promote, establish/restore, maintain, or modify the task to enable participation in desired life activities. In addition, occupational therapists can focus on prevention of the potential barriers to participation in desired activities (AOTA, 2014).

Occupational therapists working in the mental health settings focus on enabling individuals to re-engage in meaningful occupations through a variety of skill sets such as skills development, establishing positive habits and routines, setting therapy goals, using cognitive-behavioral techniques (CBT), and understanding underlying physiological influences (AOTA, 2016). Specifically, occupational therapy within the setting of child and adolescent mental health focuses on those underlying physiological influences and teaching patients to identify and utilize self-regulation strategies in order for patients to get back to participating in meaningful occupations such as going to school, being with friends, and participating within the family system (AOTA, 2016). In addition, occupational therapists can work with individuals with sensory processing disorders (SPD) and social-emotional learning dysfunction, which are commonly seen within the child and adolescent setting of mental health (AOTA, 2016).

2.8 Occupational therapy approaches for the client with mental illness

The evidence-based approaches support the profession of occupational therapy within this child and adolescent mental health setting. These evidence-based approaches include:

- Providing education on coping skills and self-regulation skills to use in a variety of contexts
- Providing education on sensory exploration and implementation of sensory approaches for self-regulation
- Incorporating yoga and movement interventions to provide sensory input and achieve self-regulation
- Utilizing CBT approaches to facilitate participation in desired activities
- Identifying and implementing healthy, positive habits and structure into daily routines
- Providing education and implementation of skills related to social competence, such as making and keeping friends, coping with anger, solving problems, learning about social etiquette, and following school rules
- Evaluating factors interfering with success in school, home, community, etc.
- Modifying the environment to support improved attention, participation and decrease sensory overload in the classroom
- Providing parents with education on behavioral and psychosocial approaches to enhance the child's and adolescents daily functioning.

- Reducing restraints and separations in the inpatient setting by conducting comprehensive assessments to determine facilitators and barriers to participation in life tasks, promoting the use of self-awareness and skills development, collaborating with the client to develop attainable goals, modifying the environment for optimal fit, promoting use of self-regulation and sensory strategies, and educating the interdisciplinary team on prevention techniques.

Overall, it is clear that occupational therapists have the distinct knowledge and skill sets to provide effective, holistic interventions within the mental health setting. There is strong evidence to support the incorporation of occupational therapy skills such as sensory approaches and psychosocial techniques within psychiatric settings to facilitate daily life functioning (Tonsager, 2017).

Chapter 3
Methodology

3.1 Conceptual framework

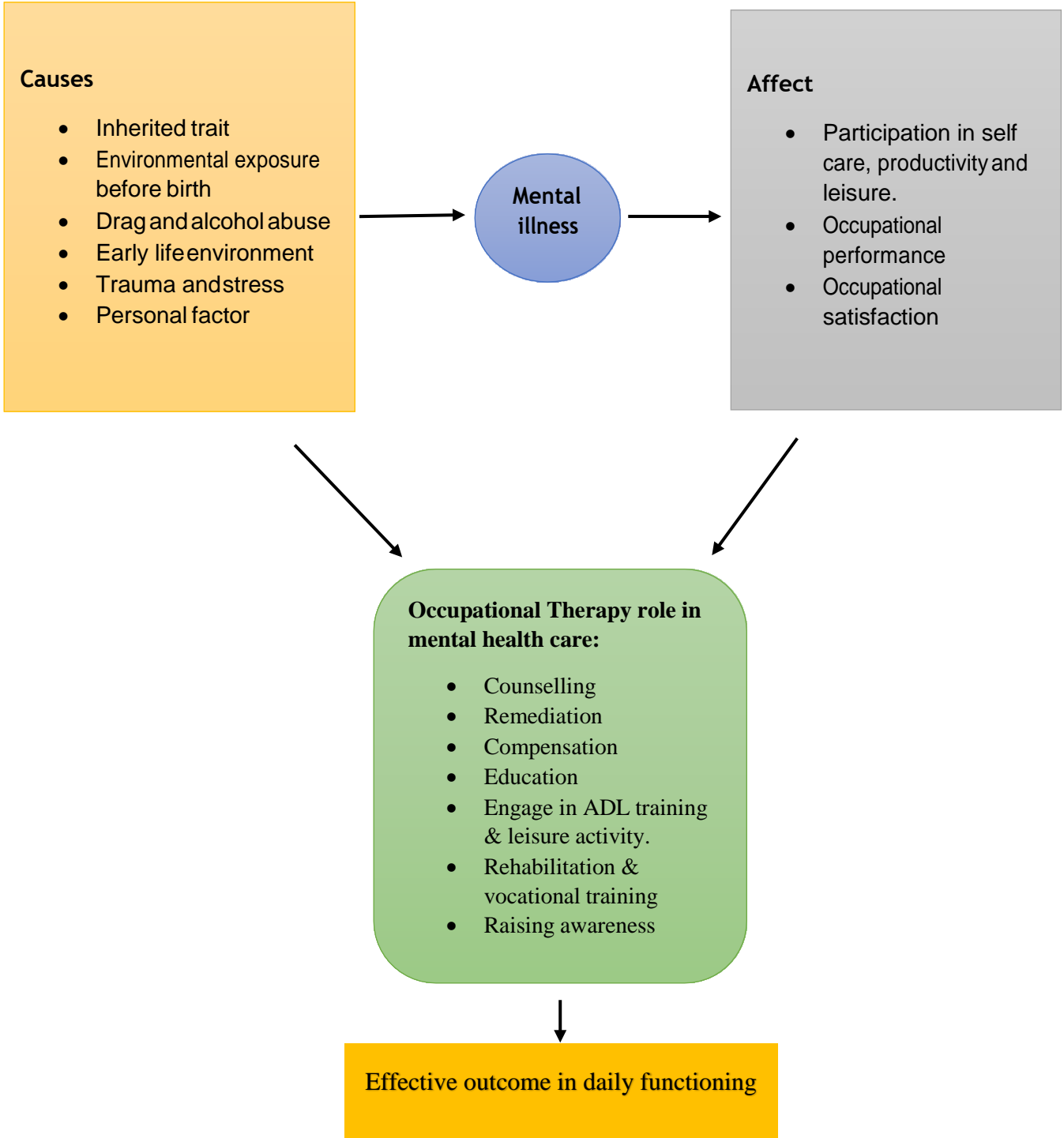


Figure 4: Conceptual framework of the study

3.2 Study design

A pre-test / post-test quasi-experimental study design will be used to determine the benefits of receiving the occupational therapy services. This type of study design aims to evaluate an intervention without randomization. Although randomized control trials have the highest credibility to assess causality, quasi-experimental study designs are becoming more prevalent in the medical field. Due to small sample sizes, ethical considerations, and difficulty randomizing participants, quasi-experimental study designs are often used. The advantages of this type of pre-test/post-test design are that a control group is not required. Another advantage is that it gives the researcher the opportunity to retrospectively demonstrate causality between an intervention and an outcome. It gives a comparison between pre- test and post-test scores that can be statistically analyzed and more widely interpreted than data in a post-test only or descriptive study design. In this study there was no separate control group due to the study being done retrospectively. The same group of participants were used for pre-test (initial data measurements before the intervention) and post-test comparison. Pre-existing data for 2009 - 2012 was used. Data were collected from participant by using socio-demographic questionnaire and had a face to face interview with participant (Bailey et al., 1997). The nature of the study is cross sectional study. It was very easy and takes short time to conduct this type of study. Cross sectional study provides a snapshot of parents' opinion in quantitative way at one point in time. The paper is based on a review of published and unpublished reports. Online search was conducted for primary research articles on prevalence of mental disorders covering both rural and urban areas of Bangladesh. Most of the studies were focused on prevalence and comorbid conditions of mental illness. A few studies also focused on utilization pattern of mental health services. However, the search was limited to English language studies, articles, reports and other materials only. In searching the data bases, the following key words were used: mental disorder, chronic disease, depression, mood disorder, health services, mental health services, and Bangladesh. Titles and/ or abstracts of selected articles were manually searched to identify materials relevant for inclusion in the study. Reference lists from these studies were also searched to identify additional relevant studies information. An extensive grey literature search was also conducted by the authors.

3.3 Study population

Study population is the person with psychiatric illness, who meets the inclusion and exclusion criteria. Also, target population is selected people with mental illness in their own community in Bangladesh.

3.4 Study settings

Occupational therapy day center for people with mental health needs. (Gonokbari, Savar).

3.5 Study period

The period of this study is from September 2018 to February 2019.

3.6 Sample size

The researcher took 30 clients of all users who met the inclusion criteria. There are 20 male and 10 female clients in total number.

3.7 Inclusion and exclusion criteria

- ✓ **Inclusion criteria:**
 - People with psychiatric illness
 - Male and female
 - Receiving treatment from Occupational therapy day center.

- ✓ **Exclusion criteria**
 - unwilling people
 - Physically ill (like having of typhoid, jaundice, Pneumonia, severe fever etc.)
 - Unable to follow instruction.

3.8 Sampling technique:

Hicks (1999) stated that, “*Findings the appropriate number and types of people take part in your study called sampling*”. Purposive sampling technique will be use in this study. Purposive sampling starts with a purpose in mind and the sample is thus selected to include people of interest and exclude those who do not suit the purpose. Usually, the population is too large for the research to attempt to survey all of its members. A small, but carefully chosen sample can be used to represent the population. The sample reflects the characteristics of the population from which it is drawn.

3.9 Data collection tool/materials

Data collecting tools and instrument

1. Pen
2. Pencil
3. Paper
4. Rubber
5. Sharper
7. Canadian Occupational Performance Measure (COPM).

The COPM: The COPM is an individualized outcome measure that is ‘client-centred and incorporates role and role expectations within the client’s own environment’ (Law et al. 1990, p.84). There is evidence in the literature that the COPM is a valid, reliable, clinically useful and responsive outcome measure acceptable for OT practitioners and researchers (Carswell et al. 2004). The COPM has been used with in a variety of settings and enables client centred practice, facilitates evidence-based practice and supports outcomes research. Test-retest reliability of the COPM is high at 0.842 (Pan et al., 2003). The COPM measures clients’ self-perception of occupational performance by evaluating areas of self-care, productivity and leisure before interventions, at intervals agreed by both client and therapists and after interventions (Chatsworth et al. 2002). The method of administration is a semi-structured interview.

3.10 Data collection methods

Data collection technique

The researcher conducted face to face interviews for collecting data about the Outcome of Occupational Therapy services in mental health care through a structured questionnaire. Using face to face interviews the researcher developed rapport with the caregiver to collect accurate data. Bailey (1997) stated that, “*Interview conducted face to face is more innovate allowing the interviewer to indirect directly and develop rapport with the interview*”.

Data collection procedure

Firstly, in order to collect data, the researcher obtained permission from the project coordinator of the Occupational therapy day center for people with mental health needs. (Gonokbari, Savar). The researcher fixed a date and time with the participant, according to his availability. The aim of the study, and study procedure was explained to participants before collecting data. The participant was given information sheets and consent forms and these were explained by

the researcher. Participants had an opportunity to ask question, and they signed the consent form after being if they were satisfied. The researcher completed the signed questionnaire on the consent form with regards to demographic data. After that, the researcher collected the demographic information from the participant. Once it had completed, the researcher completed the “COPM” questionnaire through face to face interview in a silent place rather than the work place. Through this face to face interview the interviewer had a chance to understand the nonverbal cues given by the interviewee who may indicate confusion or lack of understanding. The interviewer helped the interviewee to understand the questions by changing some words with the same meaning (Bailey, 1997). The researcher was explained the question into local language that will be helpful to the participant.

3.11 Data analysis

Researcher input the data in statistical package for social science (SPSS) software 20 version and analyzed the data by selecting the frequency of the descriptive statistics and the central themes and standard deviation of the dispersion to show the percentage, mean and standard deviation of the dataset. To show the outcome of Occupational Therapy intervention to occupational performance and satisfaction frequency the chi-square test (χ^2) was selected. The researcher used statistical analysis to show the effectiveness of Occupational Therapy intervention for thr client with mental illness by calculating the pre and post scoring of the intervention. Every questionnaire was rechecked for missing information or unclear information. The researcher put the name of the variables into SPSS and the types, values, decimal, label alignment and measurement level of data (Stemler, 2001) and finally researcher fulfilled the objectives and showed the result.

3.12 Ethical consideration

“In all research in the human sciences the rights; privacy and welfare of the participants should be respected” (Berg, 2009).

- The Researcher obtained permission from the Head of OT Department in BHPI.
- The Researcher obtained permission from the authority of the Occupational therapy day center for people with mental health needs.
- The Researcher maintained confidentiality about service information of the institutes.
- Informed consent was collected from the participants.
- The Researcher ensured that the confidentiality is maintained about the participants.
- All participants were informed about the aim of the study.
- The participant was allowed to leave from the study at any time.
- The Researcher also ensured that their participation would not cause any harm but would benefit them but in future.

3.13 Quality control & quality assurance

The method of data collection will be accurate and interpret carefully according to guidelines before initiating the data collection. It ensures the reliability and validity of COPM scale is understandable by the participants. Researcher carried out a field test before collecting the final data because it helps the researcher to refine the data collection plan and find out the limitation. Then the researcher will get chance to rearrange the demographic questionnaires to make it more understandable, clear and enough for the participants and the study. Procedure of data collection and ethical consideration of the thesis is maintained to ensure quality.

Chapter 4

Result

4.1 Result

This section focuses on the findings which explore the association of variables. This study has done by using quantitative method. The socio-demographic background of the participants in this study was also identified. Each of the table represents the collected data.

Socio-demographic characteristic of the participant:

Variables	Frequency	Percentage	Mean±Std.Deviation
Age of the participant: 15 – 24 25 – 34 35 – 44 45 – 54	11 11 5 3	36.7% 36.7% 16.7% 10%	28.8333±10.81214
Sex of the participant: Male Female	20 10	66.7% 33.3%	
Educational status: Up to primary Up to high school Up to SSC UPtoHSC Graduated Illiterate	5 6 5 6 3 5	16.7% 20.0% 16.7% 20.0% 10.0% 16.7%	
Marital status: Married unmarried	8 22	26.7% 73.3%	
Occupation: Student Housewife Service holder Businessman	14 6 6 3	46.7% 20% 20% 10%	

Table 1: Socio demographic data

Table 1 shows the demographic data of the participant.

Age of the participant

Among 30 participant, here highest number of participant were in age range of (15-24) and (25-34) and the number of participant are 11(36.7%), 11(36.7%). 5(16.7%) participants were in age range of (35-44), 3(10.0%) participants were in the age range of (45-54).

Gender distribution

The study was conducted on 30 participants with mental illness and among them 20 (67%) were male and female were 10 (33%).

Table 1 also shows the educational status, marital status and occupation of the participant. Among (n=30) participant, there are 5 (16.7%) participants are primary pass, 6 (20.0%) participants are high school pass, 5 (16.7%) participants are SSC pass, 6 (20.0%) participants are HSC pass, 3 (10.0%) participants are graduated, 5 (16.7%) participants are illiterate. There are 26.7% participants are married and 73.3% participants are unmarried among 30 participants. With regards of occupation 14(46.7%) are student, 6(20.0%) are housewife, 6(20.0%) participants are service holder, 3(10.0%) are businessman, 1(3.3%) participants are not engage in occupation.

Occupational performance:

Here is the number of client's occupational performance pre and post scoring according to the COPM scale. The table shows that occupational performance of the clients with mental illness is improved by receiving Occupational Therapy service.

Patient code	Occupational performance pre score	Occupational performance postscores	Changes in performance (Postscore – Prescore)
1	1.41	3.59	2.18
2	1.67	3.35	1.66
3	1.19	3.81	2.62
4	1.27	3.73	2.46
5	1.71	3.29	1.58
6	1.00	4.00	3.00
7	2.15	2.85	0.7
8	1.23	3.87	2.74
9	1.77	3.23	1.46
10	1.97	3.03	1.06
11	1.15	3.85	2.78
12	1.70	3.30	1.6
13	1.97	2.69	0.72
14	1.29	3.71	2.42
15	1.31	3.10	1.19
16	1.52	3.48	1.96
17	1.47	3.53	2.06
18	1.68	3.32	1.64
19	1.37	3.63	2.26
20	1.38	3.37	1.99
21	1.59	3.41	1.82
22	1.00	4.00	3.00
23	1.18	3.82	2.64
24	1.44	3.56	2.12
25	1.54	3.46	1.92

26	2.17	2.70	0.53
27	2.50	2.58	0.08
28	2.11	2.89	0.78
29	2.25	2.76	0.51
30	1.72	3.29	1.57

Table 2: Occupational performance

Occupational satisfaction:

Here is the number of client's occupational performance pre and post scoring according to the COPM scale. The table shows that occupational satisfaction of the clients with mental illness is improved by receiving Occupational Therapy service.

Patient code	Occupational satisfaction prescore	Occupational satisfaction postscores	Change in satisfaction (Postscore – prescore)
1	0.63	4.38	3.75
2	1.50	3.50	2.00
3	0.96	4.04	3.08
4	1.40	3.60	2.20
5	1.13	3.87	2.74
6	1.13	3.86	2.73
7	0.93	4.07	3.14
8	1.02	3.98	2.96
9	1.07	3.93	2.86
10	1.66	3.10	1.44
11	0.57	4.13	3.86
12	1.07	3.93	2.86
13	1.29	3.71	2.42
14	1.68	3.32	1.64
15	1.44	3.56	2.12

16	1.65	3.35	1.7
17	1.31	3.13	1.82
18	1.88	3.13	1.25
19	1.40	3.61	2.21
20	1.85	3.15	1.30
21	1.58	3.42	1.84
22	1.12	1.25	.95
23	1.12	3.89	2.77
24	2.18	2.82	.64
25	1.33	3.67	2.34
26	2.31	2.69	0.38
27	2.08	2.92	.84
28	2.24	2.76	0.52
29	0.67	3.33	2.66
30	1.76	3.24	1.48

Table 3: Occupational satisfaction

Change in occupational performance

The figure 7 visualizes the percentage of changes in occupational performance between pre intervention and post intervention. There is resulting 100% improvement in occupational performance in post intervention.

Change in occupational satisfaction

The figure 8 visualizes the percentage of changes in occupational satisfaction between pre intervention and post intervention. There is resulting 96.7% improvement in occupational performance in post intervention.

4.2 Discussion

This chapter outlines the discussion among this study with others interrelated study in the world. The researcher had investigated the outcome of occupational therapy intervention for the client with mental illness.

The findings of the study show that there are among 30 participants 20 are male and 10 are female. Samsonraj, 2012 stated that, their research participants are 30 male and 23 females among 53 clients. The study findings show that there is significant change is resulted occupational performance and satisfactions pre and post score (figure 4 and 5). Samsonraj, 2012 stated that, there were also significant increases between pre and post therapy in mean performance score and pre and post therapy in mean satisfaction score. The researcher faced some difficulties to measuring the outcome by scale COPM because of clients lack of insight, lack of motivation. Samsonraj, 2012 stated that they have also some difficulties in using this scale for evaluating outcome because of clients lack of insight, lack of motivation, clients refusing to participate in the evaluation and the time-consuming nature of the scale. This suggests that although the COPM has the advantage of focusing on service user involvement in the assessment, it may be less useful than other measures as a routine evaluation tool for use Across mental health services. Previous studies have also identified problems with use of the tool related to the degree of insight needed for clients to participate in its completion (Tryssenaaar et al. 1999; Walters 1995). This appears to reflect previous findings that some occupational therapists have difficulty measuring clinical outcomes (Bowman & Llewellyn, 2002). With the UK government determining that care in the NHS will focus on continuously improving those things that really matter to patients, particularly the outcome of their healthcare (Department of Health, 2010), it is important for occupational therapists to increase their use of outcome measures. Translational research is needed to better implement changes in practice in order both to meet NHS requirements, and more fundamentally to improve the quality of care offered by mental health occupational therapists. The COPM did not prove to be a practical measure for use within all areas of mental health provision and this study supports previous evidence that some occupational therapists appear to have difficulty using any outcome measures and mental health professionals have variable attitudes towards the use of outcome measures.

The country has a small number of community's care facilities for patients with mental

disorders. National Institute of Mental Health in Dhaka is the only national level tertiary care mental health treatment and research facility in the country (Choudhury et al. 2006). In addition, a few NGOs such as CRP are also involved in mental health in the country, primarily focusing on treatment and rehabilitation. The absence of a specific mental health authority makes it difficult to systematically monitor and evaluate the mental health services in the country. On the other hand, national child and adolescent mental health policy guidelines have therefore also been developed (South Africa is included in the 2002 audit by Shatkin and Belfer (2004).

There is only one day treatment of mental health facilities available in the country. (WHO AIMS, 2007). According to WHO AIMS 2005, there are 81 mental health day centre in South Africa. According to National Mental Health Survey in 2003-2005 about 16.05% of the adult population in the country are suffering from mental disorders. There are only the 0.002142857 number of occupational therapists for the huge amount of client. This is not sufficient for ensuring the total needs of the mental health care. Only a small percentage of all health publications in the country are on mental health.

In the mental health care sectors, the occupational therapists play an important role to overcome the difficulties and impairment's in the activities of daily living of the client with mental illness. The study was found that by using COPM the mentally ill client's occupational performance and satisfaction is improved after receiving occupational therapy intervention following figure 7 and 8.

According to the respondent's client-identified problems were more focused on activity and occupational performance, while earlier they focused more on functions. From the perspective of the occupational therapists this was seen as an advantage, but other professionals could have problems with this activity focus (Disability and Rehabilitation, 2003). The occupational therapists considered that their own documentation had improved. Clear goals that were raised from client-identified problems improved the documentation, and facilitated the evaluation of the outcome (Taylor and Francies, 2003). The use of the COPM resulted in more distinct goals than without the COPM, goals represented a broader area than before, and goals concerned occupational performance rather than functions. The COPM changed the focus from body functions to activity and participation. The client-identified goals, which were further discussed by the team members in team-conferences, facilitated the treatment

planning as well as the occupational therapists' documentation. The client-centered approach was supported when clients identified goals and evaluated the outcome. Team members also commented that the COPM was a good outcome measure, which showed the client's perception of change over time and made the results clear to the client (Disability and Rehabilitation, 2003). An additional finding was the higher correlation between performance and satisfaction in the re-evaluation of the initial evaluation. The same tendency was shown in an earlier study. There are certain difficulties with implementing client centred practice. Changing routines is a difficult task, and when it comes to changing approach or further developing the extent of client-centeredness, it is even more difficult. It also takes a lot of time to change roles and habits. All professionals in health care claim that they have a holistic approach, but they tend to focus more on functions and pain, whereas in the more humanistic tradition, such as occupational therapy, the focus is on meaningful activities of daily living. The improved post-therapy scores on all three measures provide promising evidence that the occupational therapies offered helped towards clients' recovery. This finding goes some way towards supporting the value of occupational therapy within mental health settings, and the value of using outcome measures to evidence improvements. However, a controlled research design beyond the scope of routine service evaluation would be required to confidently attribute improvements to the therapies offered. Also, the sample would need to be a representative of the total population to produce generalizable results.

4.3 Limitation of the study

During the research work it is observed that some limitations and barriers. So the researcher acknowledges in these limitations and barriers investigation. These include:

- There are very limited published literatures available in Bangladesh regarding occupational therapy outcome measure for the client with mental illness
- A limitation of our study was that we recruited subjects from one institute, which may not be representative of the whole country.
- The study has a small sample size because of short time duration and lack of availability of occupational therapy mental health care sector.

4.4 Recommendations

As this study has a small sample size, additional, larger studies are needed. All professionals should be aware about the outcome of occupational therapy in mental health care. Parents must be educated and aware themselves and others to ensuring their rights and safety. According to the WHO AIMs report on Bangladesh mental health system there are not remaining a sufficient amount of mental health care facilities and professionals such as occupational therapists. So government should be aware about that and take necessary steps. Moreover, it is necessary for the clients with mental illness to provide proper support. Informing the public about how the mental health care and rehabilitation is important, the radio, TV, and local newspapers should be used to inform society about substance use. At the rehabilitation period, family counseling is important for planning and processing the treatment program.

4.5 Conclusion

An occupational therapist focuses on what is purposeful occupation to the client, occupational performance and is sensitive to change over time. However, the occupational therapy intervention increased client participation, resulted in distinct goals, and focused on goals that were achieving meaningful outcome to the client. Involvement and motivation for changing practice were difficult to obtain. The study shows that support during the introduction and implementation period is paramount in order to change the team's focus and routines. In this study, the use of the COPM can show changes of occupational performance and satisfaction between before and after intervention. It also resulted that the occupational therapy can be so effective treatment for the client with mental illness for developing their capabilities in daily life functioning. So occupational therapists working sectors in mental health care should be increased in Bangladesh as well as other developed countries.

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Appendix 1



বাংলাদেশ হেল্থ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
Bangladesh Health Professions Institute (BHPI)
(The Academic Institute of CRP)

Ref. CRP-BHPI/IRB/10/18/1242

Date: ২৫/৯/২০১৮

To
Hafija Tanjin
B.Sc. in Occupational Therapy
Session: 2014-2015, Student ID: 122140168
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Subject: Approval of research proposal, "Evaluating the Outcome of Occupational Therapy Service for Client with Mental Illness in Day Center" by ethics committee.

Dear Hafija Tanjin,

Congratulations,

The Institutional Review Board (IRB) of BHPI has reviewed and discussed your application on 1/08/2018 to conduct the above-mentioned dissertation, with yourself, as the Principal investigator. The Following documents have been reviewed and approved:

Sl. No.	Name of the Documents
1	Dissertation Proposal
2	Questionnaire (English and Bengali version)
3	Information sheet & consent form.

Since the study involves Bangla version of GAF (global assessment of functioning) scale, COPM (Canadian occupational performance measure) scale, Recovery scale will be used for face to face and telephone interview, that takes 20 to 25 minutes and have no likelihood of any harm to the participants, the members of the Ethics committee have approved the study to be conducted in the presented form at the meeting held at 10:00 AM on September 1, 2018 at BHPI.

The institutional Ethics committee expects to be informed about the progress of the study, any changes occurring in the course of the study, any revision in the protocol and patient information or informed consent and ask to be provided a copy of the final report. This Ethics committee is working accordance to Nuremberg Code 1947, World Medical Association Declaration of Helsinki, 1964 - 2013 and other applicable regulation.

Best regards,

Muhammad Millat Hossain
Assistant Professor, Dept. of Rehabilitation Science
Member Secretary, Institutional Review Board (IRB)
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

সিআরপি-চাপাইন, সবার, ঢাকা-১৩৪৩, বাংলাদেশ, ফোন : ৭৭৪৫৪৬৪-৫, ৭৭৪১৪০৫ ফ্যাক্স : ৭৭৪৫০৬৯

CRP-Chapain, Savar, Dhaka-1343, Tel : 7745464-5, 7741404, Fax : 7745069, E-mail : contact@crp-bangladesh.org, www.crp-bangladesh.org

Appendix 2



বাংলাদেশ হেল্থ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)
(The Academic Institute of CRP)
CRP-Chapain, Savar, Dhaka, Tel: 7745464-5, 7741404, Fax: 7745069
BHPI-Mirpur Campus, Plot-A/5, Block-A, Section-14, Mirpur, Dhaka-1206, Tel: 8020178, 8053662-3, Fax: 8053661

তারিখ : ০৮.০১.২০১৯

প্রতি

প্রজেক্ট কোঅর্ডিনেটর

সিআরপি-গনকবাড়ি, সাভার, ঢাকা।

বিষয় : রিসার্চ প্রজেক্ট (dissertation) প্রসঙ্গে।

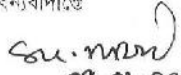
জনাব,

বিএইচপিআই'র ৪র্থ বর্ষ বিএসসি ইন অকুপেশনাল থেরাপি কোর্সের ছাত্রী হাফিজা তানজিনকে তার রিসার্চ সংক্রান্ত কাজের জন্য আগামী ১৫.০১.২০১৮ তারিখ থেকে ২০.০২.২০১৯ তারিখ পর্যন্ত সময়ে আপনার নিকট প্রেরণ করা হলো। তার রিসার্চ শিরোনাম

“Evaluating the outcome of Occupational Therapy services for the client with mental illness.”

তাই তাকে সার্বিক সহযোগিতা প্রদানের জন্য অনুরোধ করছি।

ধন্যবাদান্তে


০৪.০১.২০১৯

শেখ মনিরুজ্জামান

সহকারী অধ্যাপক ও বিভাগীয় প্রধান

অকুপেশনাল থেরাপি বিভাগ

বিএইচপিআই।

Appendix 3

October 15, 2018
The Chairman
Institutional Review Board (IRB)
Bangladesh Health Professions Institute (BHPI)
CRP- Chapain, Savar, Dhaka- 1343, Bangladesh

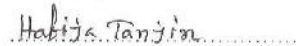
Subject: Application for review and ethical approval

Sir,

With due respect, I would like to draw your kind attention that I am a student of 4th year B.Sc. in Occupational Therapy course at Bangladesh Health Professions Institute. For the requirement of my course curriculum, I have to conduct a research project. My research title is "Evaluating the Outcome of Occupational Therapy Service for Client with Mental Illness in Day Center" will be supervised by Md. Safayeter Rahman, Lecturer, Department of Occupational Therapy, BHPI, CRP. The purpose of the study is to explore the effectiveness of occupational therapy treatment service in day center. Bangla version of GAF (global assessment of functioning) scale, COPM (Canadian occupational performance measure) scale, Recovery scale will be used for face to face and/or telephone interview. That will take about 20-30 minutes. Related information will be collected from the participant. The study will not be cause of any harm to the participant. Data collectors will receive informed consents from all participants as written record. Any kind of collected data will be kept confidential.

Therefore, I look forward to having your kind approval for the research proposal and to data collection. I also assure you that I will maintain all the requirements for study.

Sincerely yours,



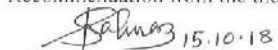
Hafija Tanjin

Session: 2014-2015

Student ID: 122140168

4th Year Student of B. Sc. in Occupational Therapy,
BHPI, CRP, Savar, Dhaka- 1343, Bangladesh

Recommendation from the thesis supervisor:

 15.10.18

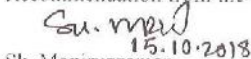
Md. Safayeter Rahman

Lecturer

Dept. of Occupational Therapy,

BHPI, CRP- Chapain, Savar, Dhaka- 1343

Recommendation from the Head of the Department:

 15.10.2018

Sk. Moniruzzaman

Assistant Professor & Head

Department of Occupational Therapy,

BHPI, CRP- Chapain, Savar, Dhaka- 1343

Appendix 4

Informed Consent Form for the Health Professions Students

Title: Evaluating the outcome of Occupational Therapy service for client with mental illness in day center.

Investigator: Hafija Tanjin, Student of B.Sc. in Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP- Savar, Dhaka- 1343

Place: Occupational Therapy Day Center for People with Mental Health Needs. (Gonokbari, Savar)

Part I: Information Sheet Introduction

I am Hafija Tanjin B.Sc. in Occupational Therapy student of Bangladesh Health Professions Institute (BHPI), have to conduct a thesis as a part of this Bachelor course, under thesis supervisor, Md. Safayeter Rahman. You are going to have details information about the study purpose, data collection process, ethical issues. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research. If this consent form contains some words that you do not understand, please ask me to stop. I will take time to explain.

Background and Purpose of the study

You are being invited to be a part of this research because Occupational Therapy day Centre services for the client with mental illness are essential and efficient for your better livelihood in future. However, how different persons are interact and collaborate with each other, whether they know about inter-personal relationship, collaboration, self- identity, self- dependence etc. or not, what are the strategies of Occupational Therapy services for the client with mental illness are not clear in this context. The general purpose of the study is to evaluating the outcome of occupational therapy services for the client with mental illness in the day centre.

This study also aims to explore how effective the Occupational Therapy day care services for the client with mental illness.

Research related information

The research related information will be discussed with you throughout the information sheet before taking your signature on consent form After that Bangla version of GAF (global assessment of functioning) scale, COPM (Canadian occupational performance measure) scale, Recovery scale will be used for face to face and/or telephone interview. That will take about 20-30 minutes to fill. In this questionnaire there will be questions on socio-demographic factors (for example: Age, sex, experience). It will also contain some specific questions for client's symptom diagnosis and measure their level of functional capacity and the effectiveness of occupational therapy service for the client with mental illness in the day centre. However, we will also select participants from the current Occupational Therapy Day Center for People with Mental Health Needs. (Gonokbari, Savar)

The data collection period will be one month followed by the date of approval. During that time, the questionnaire will be distributed among you to self-administer. Investigator will give you a reminder at day three/five and finally will come to collect data during sixth working day. The survey questionnaire will be distributed and collected by Hafija Tanjin. If you do not wish the questions included in the survey, you may skip them and move on to the next question. The information recorded is confidential, your name is not being included on the forms, only a number will identify you, and no one else except Md. Safayeter Rahman. Supervisor of the study will have access to this survey.

Voluntary Participation

The choice that you make will have no effect on your job or on any work-related evaluation or reports. You can change your mind at any time of the data collection process even throughout the study period. You have also right to refuse your participation even if you agreed earlier.

Right to Refuse or Withdraw

I will give you an opportunity at the end of the interview to review your remarks, and you can ask to modify or remove portions of those, if you do not agree with my notes or if I did not understand you correctly.

Risks and benefits

We are asking to share some personal and confidential information, and you may feel uncomfortable talking about some of the topics. You do not need to answer any question or take part in the discussion interview/survey if you don't wish to do so, and that is also okay. You do not have to give us any reason for not responding to any question, or for refusing to take part in the interview. On the other hand, you may not have any direct benefit by participating in this research, but your valuable participation is likely to help us find out the effectiveness of Occupational Therapy services for the client with mental illness in the day center.

Confidentiality

Information about you will not be shared to anyone outside of the research team. The information that we collect from this research project will be kept private. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is and we will lock that information up with a lock and key. It will not be shared with or given to anyone except, Md. Safayeter Rahman Nahid study supervisor.

Sharing the Results

Nothing that you tell us today will be shared with anybody outside the research team, and nothing will be attributed to you by name. The knowledge that we get from this research will be shared with you before it is made widely available to the public. Each participant will receive a summary of the results. There will also be small presentation and these will be announced. Following the presentations, we will publish the results so that other interested people may learn from the research.

Who to Contact?

If you have any questions, you can ask me now or later. If you wish to ask questions later, you may contact any of the following : Hafija Tanjin, Bachelor science in Occupational Therapy, Department of Occupational Therapy, e-mail:hafija.ot18.edu@gmail.com, Cell phone-01788801410.This proposal has been reviewed and approved by Institutional Review Board (IRB), Bangladesh Health Professions Institute (BHPI), CRP-Savar, Dhaka-1343, Bangladesh, which is a committee whose task it is to make sure that research participants are protected from harm. If you wish to find about more about the IRB, contact Bangladesh Health Professions Institute (BHPI), CRP-Savar, Dhaka-1343, Bangladesh. You can ask me any more questions about any part of the research study, if you wish to. Do you have any questions?

Can you withdraw from this study:

You can cancel any information collected for this research project at any time. After the cancellation, we expect permission from the information whether it can be used or not.

Withdrawal Form

Participants Name:

ID number:

Reason of Withdraw:

.....

Participants Name:

Participants Signature:

Day/Month/Year:

Part II: Certificate of Consent

Statement by Participants

I have been invited to participate in research titled evaluating the outcome of Occupational Therapy services for the client with mental illness in the day centre. I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Name of Participant _____

Signature of Participant _____ Date

Statement by the researcher taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

- 1.
- 2.
- 3.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability.

I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.

Name of Researcher taking the consent_

Signature of Researcher taking the consent_____

Date _____

Appendix 5

বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই) অকুপেশনাল থেরাপি বিভাগ



সিআরপি- চাপাইন, সাভার, ঢাকা-১৩৪৩. টেলি: ০২-৭৭৪৫৪৬৪-৫, ৭৭৪১৪০৪, ফ্যাক্স: ০২-৭৭৪৫০৬

শিরোনাম: মানসিকভাবে অসুস্থ রোগীদের জন্য অকুপেশনাল থেরাপি সেবাক্রম কতটুকু উপযুক্ত এবং কার্যকরী তার মূল্যায়ন।

গবেষনাকারী: হাফিজা তানজিন, বি. এস. সি. অকুপেশনাল থেরাপি বিভাগ এর ছাত্রী, বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বি এইচ পি আই), সিআরপি-সাভার, ঢাকা- ১৩৪৩

স্থান: মানসিক সমসস্যাজনিত ব্যক্তিদের জন্য অকুপেশনাল থেরাপি ডে সেন্টার (গণকবাড়ি, সাভার), মানসিক সাহ্যকেন্দ্র সমূহ

পর্ব ১ তথ্যপত্রঃ

ভূমিকাঃ

আমি হাফিজা তানজিন বি. এস. সি. এর অকুপেশনাল অকুপেশনাল থেরাপি বিভাগ এর ৪র্থ বর্ষের ছাত্রী। বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই) এর অকুপেশনাল থেরাপি বিভাগের থিসিস সুপারভাইজার মোঃশাফায়েতর রহমান স্যারের অধীনে সংশ্লিষ্ট কোর্সের অংশ হিসাবে একটি গবেষণা সম্পন্ন করতে হবে। অংশগ্রহণকারীর তথ্য পত্রের মাধ্যমে গবেষণা প্রকল্পটির উদ্দেশ্য, উপাত্ত সংগ্রহের প্রণালী ও গবেষণাটির সাথে সংশ্লিষ্ট বিষয় কীভাবে রক্ষিত হবে তা বিস্তারিতভাবে আপনার কাছে উপস্থাপন করা হবে। যদি এই গবেষণায় অংশগ্রহণ করতে ইচ্ছুক থাকেন, সেক্ষেত্রে এই গবেষণার সম্পৃক্ত বিষয় সম্পর্কে স্বচ্ছ ধারণা থাকলে সিদ্ধান্ত গ্রহণ সহজতর হবে। অবশ্য এখন আপনার অংশগ্রহণ আমাদের নিশ্চিত করতে হবে না। যে কোন সিদ্ধান্ত গ্রহণের পূর্বে যদি চান তাহলে আপনার অষ্টীয়, সহকর্মী, কর্মকর্তার সাথে এই ব্যাপারে আলোচনা করতে পারেন। এবং এই তথ্য পত্রটির আরও কিছু আপনার জানার থাকলে, নির্দিধায় প্রশ্ন করতে পারেন।

গবেষণার প্রেক্ষাপট ও উদ্দেশ্য

আপনাকে এই গবেষণার অংশ হিসাবে আমন্ত্রণ জানানো হচ্ছে কারণ মানসিকভাবে অসুস্থ রোগীদের জন্য অকুপেশনাল থেরাপি সেবাক্রম ভবিষ্যতে আপনার ভালভাবে জীবনযাপনের জন্য ফলপ্রসূ হবে এবং রোগীকে সনিভরশীল হতে সহায়তা করবে। এই সেবাক্রমটি আপনাকে আনন্দিতকরিতা, আনন্দ ব্যক্তিগত সম্পর্ক, সহযোগিতা, স্ব-পরিচয়, সামাজিক মূল্যবোধ, স্বাভাবিক জীবনযাপন ইত্যাদি সম্পর্কে, এবং মানসিক অসুস্থ রোগীদের জন্য অকুপেশনাল থেরাপি সেবাক্রমের কৌশলগুলি সম্পর্কে পরিষ্কার ধারণা পেতে এবং দক্ষতা বৃদ্ধিতে সহায়তা করবে। গবেষণার সাধারণ উদ্দেশ্য হলো মানসিক অসুস্থতার রোগীদের জন্য অকুপেশনাল থেরাপি কতটুকু উপযুক্ত এবং কার্যকরী তার মূল্যায়ন। এই গবেষণার ফলাফলটি রোগীকে স্বাবলম্বী হতে সহায়তা করবে এবং ভবিষ্যতে আরও বিভিন্ন ধরনের মানসিক রোগীদের এই সেবা গ্রহণে আগ্রহী করে তুলবে যা প্রতিষ্ঠান ও রোগী উভয়ের জন্য ফলপ্রসূ হবে।

এখন গবেষণা কমিটিতে অংশগ্রহণের সাথে সম্পৃক্ত বিষয় সমূহ ;

গবেষণা সম্পর্কিত তথ্য:

সম্মতি পত্র সম্পর্কিত তথ্যের সাথে আপনার স্বাক্ষর গ্রহণ করার আগে গবেষণা সম্পর্কিত তথ্যটি নিয়ে আপনার সাথে আলোচনা করা হবে। এর পরে এর বাংলা সংস্করণ জি এ এফ (কর্মক্ষমতার বিশ্বব্যাপী মূল্যায়ন), সিওপিএম (কানাডিয়ান পেশাগত কর্মক্ষমতা পরিমাপ) স্কেল, রিকভারী স্টার স্কেল ব্যবহার করা হবে মুখোমুখি এবং টেলিফোন সাক্ষাৎকার এর মাধ্যমে তথ্য সংগ্রহের জন্য যা পূরণ করতে প্রায় ২০-৩০ মিনিট সময় লাগতে পারে। এই প্রশ্নাবলীতে সামাজিক-জনসংখ্যাতাত্ত্বিক বিষয় সম্পর্কিত প্রশ্ন থাকবে (উদাহরণস্বরূপ: বয়স, লিঙ্গ, অভিজ্ঞতা)। এর মাধ্যমে রোগীদের উপসর্গ নির্ণয়ের জন্য কিছু নির্দিষ্ট প্রশ্ন থাকবে এবং কার্যকরী ক্ষমতার স্কেল এবং মানসিক অসুস্থ রোগীদের জন্য অকুপেশনাল থেরাপি সেবাক্রমটির কার্যকারিতা পরিমাপ করা তথ্য সংগ্রহের সময় এক মাসের পর অনুমোদনের তারিখ হবে। সেই সময়, প্রশ্নপত্র আপনাদের মধ্যে বিতরণ করা হবে। গবেষনাকারী আপনাকে তিন / পাঁচ দিনের মধ্যে একটি অনুস্মারক দেবে এবং অবশেষে ছয়টি কর্মদিবসের সময় তথ্য সংগ্রহ করবে। জরিপ প্রশ্নপত্র বিতরণ ও সংগ্রহ করবে হাফিজা তানজিন। যদি আপনি সমীক্ষায় অসম্মত প্রশ্নগুলি না চান তবে আপনি তাদের ছেড়ে দিতে পারেন এবং পরবর্তী প্রশ্নে চলে যেতে পারেন। রেকর্ড করা তথ্যটি গোপনীয়, আপনার নাম ফর্মগুলিতে অসম্মত করা হচ্ছে না, শুধুমাত্র একটি নম্বর আপনাকে সনাক্ত করবে এবং মোঃ শাফায়েতর রহমান স্যার ছাড়া অন্য কেউ অবগত থাকবে না।

অংশগ্রহণের সুবিধা ও ঝুঁকিসমূহ

গবেষণায় প্রকল্পে অংশগ্রহণে আপনি সরাসরি কোনো সুবিধা পাবেন না। তবে আমরা আশাবাদী যে, এই গবেষণার ফলাফলের মাধ্যমে প্রাপ্ত উপাত্ত থেকে মানসিক রোগীদের পেশায় অংশগ্রহণের ক্ষেত্রে কাজের পরিবেশের প্রভাব সম্পর্কে জানা যাবে এবং এই গবেষণায় অংশগ্রহণে কোনোরকম ঝুঁকি, বিপত্তি বা অসম্মতি নেই বলে আশা করা যাচ্ছে।

তথ্য এর গোপনীয়তা কি রক্ষা হবে?

আপনি সম্মতিপত্রে স্বাক্ষর করার মাধ্যমে আপনার ব্যক্তিগত তথ্য গবেষণা প্রকল্পে অধ্যয়নরত কর্মীকে সংগ্রহ ও ব্যবহার করতে অনুমতি দিয়েছেন। গবেষণায় সংগৃহীত তথ্যগুলোর গোপনীয়তা বজায় রাখা হবে, আপনার নাম পত্রে সংযোগ করা হবে না, আপনাকে শুধুমাত্র একটি নাম্বার এর মাধ্যমে চিহ্নিত করা হবে এবং শুধুমাত্র এর সাথে সম্পৃক্ত গবেষক ও তার তত্ত্বাবধায়ক ছাড়া আর কেউ এই গবেষণার কোনো তথ্য উপাত্তসমূহের প্রবেশাধিকার পাবেন না। সাংকেতিক উপায়ে চিহ্নিত উপাত্ত সমূহ পরবর্তী উপাত্ত বিশেষণ এর কাজে ব্যবহার করা হবে। প্রত্যাশা করা হচ্ছে, এই গবেষণার ফলাফল বিভিন্ন জায়গায় প্রকাশিত ও উপস্থাপিত করা হবে। যে কোনো ধরনের প্রকাশনা ও উপস্থাপনার ক্ষেত্রে এমনভাবে তথ্যসমূহ সরবরাহ করা হবে যাতে আপনার সম্মতি ছাড়া কোনোভাবেই আপনাকে সনাক্ত করা না যায়। তথ্য উপাত্ত সমূহ প্রাথমিকভাবে কাগজপত্রে সংগ্রহ করা হবে।

তথ্যের গোপনীয়তা কি নিশ্চিত থাকবে?

এই সম্মতি পত্রে স্বাক্ষর করার মাধ্যমে আপনি এই গবেষণা প্রকল্পে অধ্যয়নরত গবেষণা কর্মীকে আপনার ব্যক্তিগত তথ্য সংগ্রহ ও ব্যবহার করার অনুমতি দিয়েছেন। এই গবেষণা প্রকল্পের জন্য সংগৃহীত যেকোনো তথ্য, যা আপনাকে সনাক্ত করতে পারে তা গোপনীয় থাকবে। আপনার সম্পর্কে সংগৃহীত তথ্যসমূহ সাংকেতিক উপায়ে উল্লেখ থাকবে। শুধুমাত্র এর সাথে সরাসরি সংশ্লিষ্ট গবেষক ও তত্ত্বাবধায়ক এই তথ্যসমূহে প্রবেশাধিকার পাবেন। সাংকেতিক উপায়ে সনাক্তকৃত উপাত্ত সমূহ পরবর্তী উপাত্ত বিশেষণের কাজে ব্যবহৃত হবে। তথ্য পত্রগুলি তালাবদ্ধ ড্রয়ারে রাখা হবে। বি এইচপি আই এর অকুপেশনাল থেরাপি বিভাগে ও গবেষকের ব্যক্তিগত ল্যাপটোপে উপাত্তসমূহের ইলেকট্রনিক ভার্সন সংগৃহীত থাকবে। প্রত্যাশা করা হচ্ছে যে, এই গবেষণা প্রকল্পের ফলাফল বিভিন্ন ফোরামে প্রকাশিত এবং উপস্থাপিত হবে। যে কোন ধরনের প্রকাশনা ও উপস্থাপনার ক্ষেত্রে তথ্যসমূহ এমনভাবে সরবরাহ করা হবে, যেন আপনার সম্মতি ছাড়া আপনাকে কোন ভাবেই সনাক্ত করা না যায়। তথ্য ও উপাত্ত প্রাথমিক ভাবে কাগজপত্রে সংগ্রহ করা হবে।

ফলাফল প্রচার সম্পর্কিত তথ্য

এই গবেষনার ফলাফল বিভিন্ন সামাজিক মাধ্যম, ওয়েবসাইট, সম্মেলন, আলোচনাসভায় এবং পর্যালোচিত জার্নালে প্রকাশ করা হবে।

অংশগ্রহণকারীর পারিশ্রমিক

এই গবেষণায় অংশগ্রহণের জন্য কোন উদ্দীপনা ও পারিশ্রমিক দেবার ব্যবস্থা নেই।

গবেষণা সম্পর্কে জানতে কোথায় যোগাযোগ করতে হবে?

যদি আপনার কোন প্রশ্ন থাকে, আপনি এখন বা পরে গবেষনাকারিকে জিজ্ঞাসা করতে পারেন। আপনি যদি পরে প্রশ্ন জিজ্ঞাসা করতে চান তবে আপনি উলেখিত ঠিকানায় যোগাযোগ করতে পারেন: হাফিজা তানজিন,বি,এস,সি ইন অকুপেশনাল থেরাপি বিভাগ, ফোন নম্বর- ০১৭৮৮৮০১৪১০. এই প্রস্তুত্বটি ইনস্টিটিউশন রিভিউ বোর্ড (আইআরবি), বাংলাদেশ হেলথ প্রফেশন ইনস্টিটিউট (বিএইচপিআই), সিআরপি সাভার, ঢাকা -১৩৪৩, বাংলাদেশ দ্বারা পর্যালোচনা এবং অনুমোদিত হয়েছে, যা নিশ্চিত করে যে গবেষণা অংশগ্রহণকারীরা ক্ষতি থেকে সুরক্ষিত। আপনি যদি আইআরবি সম্পর্কে আরও জানতে চান তবে বাংলাদেশ হেলথ প্রোফেশন ইনস্টিটিউট (বিএইচপিআই), সিআরপি সাভার, ঢাকা -১৩৪৩, বাংলাদেশ এ যোগাযোগ করুন। আপনি যদি গবেষণা করতে চান তবে গবেষণা অধ্যয়নের যে কোনও অংশ সম্পর্কে আমাকে আরও প্রশ্ন করতে পারেন।

অভিযোগ

এই গবেষণা প্রকল্প পরিচালনা প্রসঙ্গে যেকোনো অভিযোগ থাকলে প্রাতিষ্ঠানিক নৈতিকতা পরিষদের সাথে এই নাম্বারে (৭৭৪৫৬৪-৫) যোগাযোগ করবেন। এই গবেষণা প্রকল্পটি বাংলাদেশ হেলথ প্রফেশন ইনস্টিটিউট, সাভারের প্রাতিষ্ঠানিক নৈতিকতা পরিষদ থেকে সি আর পি- বি এইচ পি আই/আই আর বি/১০/১৮/১২৪২ পর্যালোচিত ও অনুমোদিত হয়েছে।

প্রত্যাহার পত্র

(শুধুমাত্র স্বেচ্ছায় প্রত্যাহারকারীর জন্য প্রযোজ্য)

অংশগ্রহনকারীর নাম:

প্রত্যাহার করার কারণ:

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পূর্ববর্তী তথ্য ব্যবহারের অনুমতি থাকবে কিনা?

হ্যাঁ/না

অংশগ্রহনকারীর নাম:

অংশগ্রহনকারীর স্বাক্ষর:

তারিখ:

'যি নিরক্ষর হয়*

অংশগ্রহনকারীর আঙ্গুলের ছাপ

স্বাক্ষীর নাম:

স্বাক্ষীর স্বাক্ষর:

তারিখ:

সম্মতি পত্র

মানসিকভাবে অসুস্থ রোগীদের জন্য অকুপেশনাল থেরাপি সেবাক্রম কতটুকু উপযুক্ত এবং কার্যকরী তার মূল্যায়ন। - শীর্ষক গবেষণায় অংশগ্রহণের জন্য আমাকে আমন্ত্রন জানানো হয়েছে। আমি পূর্বলিখিত তথ্য পত্রটি পড়েছি বা এটা আমাকে পড়ে শোনানো হয়েছে। এই বিষয়ে আমার প্রশ্ন জিজ্ঞাসা করার সুযোগ ছিল এবং যে কোন প্রশ্নের আমি সন্তুষ্টজনক উত্তর পেয়েছি। এই গবেষণায় একজন অংশগ্রহণকারী হবার জন্য আমি স্বেচ্ছায় সম্মতি দিচ্ছি।

অংশগ্রহণকারীর নাম:

অংশগ্রহণকারীর স্বাক্ষর:

তারিখ:

'যি নিরক্ষর হয়*

অংশগ্রহণকারীর আঙ্গুলের ছাপ

স্বাক্ষীর নাম:

স্বাক্ষীর স্বাক্ষর:

তারিখ:

গবেষক ও সম্মতিকারীর বিবৃতি:

আমি অংশগ্রহনকারীকে অংশগ্রহনকারীর তথ্যপত্রটি পড়ে শুনিয়েছি এবং আমার সর্বোচ্চ সামর্থ অনুযায়ী নিশ্চিত করেছি যে, অংশগ্রহনকারীর বোধগম্য হয়েছে যে, নিম্নোক্ত বিষয়সমূহ করা হবে।

- ১) সকল তথ্য গবেষণার কাজে ব্যবহৃত হবে।
- ২) তথ্যসমূহ সম্পূর্ণভাবে গোপনীয় করা হবে।
- ৩) অংশগ্রহনকারীর নাম ও পরিচয় প্রকাশ করা হবে না।

আমি নিশ্চিত করেছি যে, এই বিষয় সম্পর্কে অংশগ্রহনকারীকে প্রশ্ন জিজ্ঞাসা করার সুযোগ দেয়া হয়েছে এবং অংশগ্রহনকারী যে সকল প্রশ্ন জিজ্ঞাসা আমার সর্বোচ্চ সামর্থ অনুযায়ী, সেগুলোর সঠিক উত্তর প্রদান করা সম্ভব হয়েছে। আমি নিশ্চিত করেছি যে, কোন ব্যক্তিকে সম্মতি দান করতে বাধ্য করা হয়নি। তিনি অবাধে অথবা স্বেচ্ছায় সম্মতি দিয়েছেন।

অংশগ্রহনকারীকে অংশগ্রহনকারীর তথ্য ও সম্মতিপত্রের একটি অনুলিপি দেওয়া হয়েছে।

গবেষকের নাম:

গবেষকের স্বাক্ষর :

তারিখ:

Appendix 6

CANADIAN OCCUPATIONAL PERFORMANCE MEASURE

Authors:

Mary Law, Sue Baptiste, Anne Carswell,
Mary Ann McColl, Helene Polatajko, Nancy Pollock

The Canadian Occupational Performance Measure (COPM) is an individualized measure designed for use by occupational therapists to detect self-perceived change in occupational performance problems over time.

Client Name:		
Age:	Gender:	ID#:
Respondent (if not client):		
Date of Assessment:	Planned Date of Reassessment:	Date of Reassessment:

Therapist:
Facility/Agency:
Program:

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STEP 1: IDENTIFICATION OF OCCUPATIONAL PERFORMANCE ISSUES

To identify occupational performance problems, concerns and issues, interview the client, asking about daily activities in self-care, productivity and leisure. Ask clients to identify daily activities which they want to do, need to do or are expected to do by encouraging them to think about a typical day. Then ask the client to identify which of these activities are difficult for them to do now to their satisfaction. Record these activity problems in Steps 1A, 1B, or 1C.

STEP 2: RATING IMPORTANCE

Using the scoring card provided, ask the client to rate, on a scale of 1 to 10, the importance of each activity. Place the ratings in the corresponding boxes in Steps 1A, 1B, or 1C.

STEP 1A: Self-care

Personal Care
(e.g., dressing, bathing, feeding, hygiene)

Functional Mobility
(e.g., transfers, indoor, outdoor)

Community Management
(e.g., transportation, shopping, finances)

IMPORTANCE

STEP 1B: Productivity

Paid/Unpaid Work
(e.g., finding/keeping a job, volunteering)

Household Management
(e.g., cleaning, laundry, cooking)

Play/School
(e.g., play skills, homework)

1C: Leisure

Quiet Recreation
 (e.g., hobbies,
 crafts, reading)

Active Recreation
 (e.g., sports,
 outings, travel)

Socialization
 (e.g., visiting,
 phone calls, parties,
 correspondence)

IMPORTANCE

STEPS 3 & 4: SCORING - INITIAL ASSESSMENT and REASSESSMENT

Confirm with the client the 5 most important problems and record them below. Using the scoring cards, ask the client to rate each problem on performance and satisfaction. Then calculate the total scores. Total scores are calculated by adding together the performance or satisfaction scores for all problems and dividing by the number of problems. At reassessment, the client scores each problem again for performance and satisfaction. Calculate the new scores and the change score.

Initial Assessment:

OCCUPATIONAL PERFORMANCE PROBLEMS:

1. _____
2. _____
3. _____
4. _____
5. _____

PERFORMANCE 1

SATISFACTION 1

PERFORMANCE 2

SATISFACTION 2

SCORING:

$$\text{Total score} = \frac{\text{Total performance or satisfaction scores}}{\text{\# of problems}}$$

PERFORMANCE SCORE 1

SATISFACTION SCORE 1

PERFORMANCE SCORE 2

SATISFACTION SCORE 2

CHANGE IN PERFORMANCE = Performance Score 2 - Performance Score 1 =

CHANGE IN SATISFACTION = Satisfaction Score 2 - Satisfaction Score 1 =

ADDITIONAL NOTES AND BACKGROUND INFORMATION

Initial Assessment:

Reassessment:

Appendix 7

ক্যানাডিয়ান অকুপেশনাল পারফরমেন্স মেজার

রোগীর পরিচয়মূলক কোড নং:

বয়স:

লিঙ্গ:

আইডি নং:

রোগীর পরিবর্তে উত্তরদাতা:

মূল্যায়ন তারিখ:

পুনরমূল্যায়ন তারিখ:

সংশ্লিষ্ট থেরাপিসট:

সংস্থা:

ধাপ ১; কর্ম সম্পাদনে বিভিন্নরকম সমস্যা, উদ্বেগ এবং বিষয় সনাক্তকরণ। রোগীদেরকে তাদের দৈনন্দিন কাজকর্ম যেমন: (নিজের যত্ন নেয়া, উৎপাদনশীল কাজকর্ম, অবসর মূলক কাজ) সম্পর্কে জিজ্ঞাসা করতে হবে। দৈনন্দিন কাজের মধ্যে কোন কাজ গুলো রোগীরা বেশি গুরুত্বপূর্ণ এবং প্রয়োজনীয় মনে করে সেগুলি সনাক্ত করতে রোগীদের জিজ্ঞাসাবাদ করতে হবে। একটি সাধারণ দিন সম্পর্কে চিন্তা করতে বলতে হবে, তারপর রোগীকে সেইসব কাজগুলি সনাক্ত করতে বলতে হবে যা তার জন্য তার সন্তুষ্টি অনুযায়ী করা কঠিন বলে মনে হয়। ধাপ ১এ, ১বি, ১সি তে সনাক্তকৃত সমস্যা গুলি রেকর্ড করতে হবে।

ধাপ ২; গুরুত্ব নির্ধারণ রোগীকে স্কেরিং কার্ড ব্যবহারের মাধ্যমে প্রত্যেকটি কাজের গুরুত্ব নির্ধারণ করতে হবে এবং স্কেলের (১-১০) এর মধ্যে সজ্জায়িত করতে হবে। নির্ধারিত সংখ্যাটি ধাপ ১এ, ১বি, ১সি,তে সংশ্লিষ্ট বাক্সে লিখতে হবে।

ধাপ ১এ; স্ব- যত্ন

ব্যক্তিগত যত্ন

(উদা: পোশাক পরিধান,

গোসল করা, খাবার

খাওয়া, সাস্থ্যবিধি)

গুরুত্ব

ক্রিয়া মূলক গতিশীলতা -----
(উদাঃ স্থানান্তর,ভিতর,বাহির) -----

গুরুত্ব

কমিউনিটি ম্যানেজমেন্ট -----
(উদাঃ পরিবহন, কেনাকাটা,
আর্থিক) -----

ধাপ ১বি: উৎপাদনশীলতা

গুরুত্ব

বৈতনিক / অবৈতনিক -----
কাজ (উদাঃ চাকরি খোজা -----
অথবা নিয়োজিত থাকা, -----
সেচ্ছাসেবক) -----

গৃহস্থালি ব্যবস্থাপনা -----
(উদাঃ পরিষ্কার করা,লন্ড্রি, -----
রান্না করা) -----

খেলা / বিদ্যালয় -----
(উদাঃ খেলার দক্ষতা, -----
বাড়ির কাজ) -----

ধাপ ১সি: অবসর

গুরুত্ব

শান্ত বিনোদন

(উদা: শখ, কারুশিল্প

বই পড়া)

সক্রিয় বিনোদন

(উদা: ক্রীড়া, ঘুরতে যাওয়া,

বনভোজন, ভ্রমণ)

সামাজিকতা

(উদা: পরিদর্শন, দলগত

ভাবে কাজ করা)

ধাপ ৩ এবং ৪; স্কোরিং – প্রাথমিক মূল্যায়ন এবং পুনঃমূল্যায়ন

রোগীর মতামত অনুযায়ী ৫ টি গুরুত্বপূর্ণ সমস্যা মূল্যায়ন করতে হবে এবং নিম্নে তা রেকর্ড করতে হবে।

স্কোরিং কার্ড ব্যবহার করে রোগীকে তার কর্মক্ষমতা এবং সন্তুষ্টি বিষয়ক সমস্যার গুরুত্ব নির্ধারণ করতে হবে, তারপর মোট স্কোর গণনা করতে হবে। কর্মক্ষমতা এবং সন্তুষ্টি সবগুলি স্কোর যোগ করে সমস্যার সংখ্যা দ্বারা ভাগ করার মাধ্যমে মোট স্কোর গণনা করতে হবে। পুনঃমূল্যায়ন এর সময় রোগী আবার তার প্রতিটি সমস্যাকে স্কোরিং করবে তার বর্তমান পরিবর্তনশীল কর্মক্ষমতা এবং সন্তুষ্টি অনুযায়ী। নতুন স্কোর গণনা এবং পরিবর্তন করতে হবে।

প্রাথমিক মূল্যায়ন;	কর্মক্ষমতা ১		সন্তুষ্টি ১		পুনঃমূল্যায়নঃ	
পেশাগত কর্মক্ষমতা জনিত সমস্যাঃ					কর্মক্ষমতা ২	সন্তুষ্টি ২
১।-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
২।-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
৩।-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
৪।-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
৫।-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

স্কোরিং

মোট স্কোর=মোট কর্মক্ষমতা স্কোর

সমস্যা সংখ্যা

কর্মক্ষমতা স্কোর ১ সন্তুষ্টি স্কোর ১

= / =

কর্মক্ষমতা স্কোর ২ সন্তুষ্টি স্কোর ২

= / =

কর্মক্ষমতার মধ্যে পরিবর্তন = কর্মক্ষমতার স্কোর ২ - কর্মক্ষমতার স্কোর ১ =

সন্তুষ্টির মধ্যে পরিবর্তন = সন্তুষ্টির স্কোর ২ - সন্তুষ্টির স্কোর ১ =

নোট এবং ব্যাকগ্রাউন্ড তথ্য

প্রাথমিক মূল্যায়নঃ

পুনঃমূল্যায়নঃ