Level of Community Participation among Person with Mental Illness following Rehabilitation: A Cross-Sectional Study

By

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Statement of Authorship

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Dedication

- **To my honorable and beloved parents & respected teachers**

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List of Abbreviations

ADHD	Attention-Deficit/Hyperactivity Disorder
AMI	Any Mental Illness
ASD	Autism Spectrum Disorder
BHPI	Bangladesh Health professions Institute
CRP	Centre for the Rehabilitation of the Paralysed
IRB	Institutional Review Board
NIMH	National Institute of Mental Health
PWMI	Person with Mental Illness
SMI	Serious Mental Illness
SPSS	The Statistical Package for Social Science
Ss	Sample Size
USPRA	United State Psychiatric Rehabilitation Association
WHO	World Health Organization
WHODAS	World Health Organization Disability Assessment Schedule

Abstract

Background: Mental illness adversely affect individuals because it severely limits their ability to function and engage in daily life. Care for those who suffer from mental illness can have a positive impact on people's lives.

Aim: the aim of the study is to investigate the level of participation at community among person with mental illness after getting treatment from Mental Health Day Centre.

Method: This study was employed through a cross-sectional approach to achieve study aim and objectives. Purposive sampling was used to collect data from 72 participants of different diagnosis of mental illness who had completed rehabilitation service by a structural questionnaire with face to face interview. World Health Organization Disability Assessment Schedule 2.0 was used to conduct this study and data was analyzed by using Statistical Package for Social Science.

Result: After analyzing data, it was found that most of the participants have mild (n= 28) to moderate (n=23) level of impairment and so they face problem in overall community participation. Out of 72 participants, rate of mobility level was very high (84.7%), then the rate of Self-care level (83.1%). 66.7% had cognitive stability. Among them participation in life activities and social functioning rate was comparatively low (47.2%). The rate of getting along level was very low (45.8%) at community setting. Majority of the participants (68.1%) were diagnosed with schizophrenia whereas 18 participants have mild impairment and 18 participants have moderate impairment.

Conclusion: After rehabilitation, the vast majority of participants have no difficulty in mobility or self-care activities. They face difficulties in life activities. Rehabilitation service should be more community-based in order to increase life satisfaction, decrease

dependence on others and increase employment as much as possible. Occupational Therapist have an important role to promote a better social and psychological for quality of life of person with mental illness following rehabilitation.

Key words: *Community participation, Mental illness, Rehabilitation*

Introduction

1.1 Background

Mental health is a basic human right issue. In order to cope with life's stresses, realize one's potential, learn and function well, and give back to one's community, one must be in a state of mental well-being known as mental health (WHO, 2022b). It is a crucial element of health and well-being that supports our individual and societal capacities to make decisions, form relationships, and influence the world in which we live (WHO, 2022b). Everyone is impacted by the problem of mental health (Chest, 2022). The world and the lives of individuals all over the World can be changed by providing care for those who struggle with mental illness or addition (Chest, 2022).

Unfortunately, most nations place little emphasis on mental health and disorders, and there are no facilities available in the local community for their treatment or general well-being (Janardhana & Naidu, 2012). Although mental, psychological and behavioral problems cause a tremendous amount of suffering, they are chronically underrepresented in traditional public health statistics (Janardhana & Naidu, 2012). A person is deemed disable if they are unable to do a certain task owing to a physical impairment or sickness (Chest, 2022). Psychiatric disorders can not physically harm a person, but they might prevent them from doing numerous task that are expected of them (Chest, 2022). Around the world, 970 million people battle some form of mental illness or drug addiction. One of the four people are experiencing mental illness at some point in their lives (Chest, 2022). Mental illnesses are a contributing factor in 8.3 million death annually or 14.3% of all deaths worldwide (Chest, 2022). In 2019, 1 in every 8 people, or 970 million people around the world were living with a mental disorder (WHO, 2022a). 301 million people worldwide suffer from anxiety disorder**,**

280 million from depression**,** 40 million from bipolar disorder**,** 24 million from schizophrenia**,** 14 million from eating disorder**,** 40 million from disruptive behavior and dissocial disorder (WHO, 2022a). More than 23% of the world's population resides in South Asia, where 150–200 million people are thought to be affected by mental illnesses (Hossain et al., 2020). Numerous sociocultural obstacles, such as the stigma associated with mental illnesses and a lack of knowledge, frequently cause underreporting or late reporting of mental illness, which adds to the burden of mental illness on the general population (Hossain et al., 2020). Recent research has shown that Bangladesh has a relatively high prevalence of mental health issues (Psychology, 2022). According to the WHO, Bangladesh is one of the top 10 nations in the world for the prevalence of mental health issues and according to the report, 30% of people have mental health issues (Psychology, 2022).

People who have lived experiences of mental health conditions can benefit from community involvement and cultural engagement in terms of recovery, symptom management, and increased social connections (Baxter, Burton, & Fancourt, 2022). Community participation is essential for developing health-enabling community contexts that support effective prevention, care, treatment and local advocacy (LSE, 2012). It can lead to increased access to information about health problems, better access to practical, emotional and material support for the ill, and increased empowerment (LSE, 2012). The principles of self-empowerment, community and family support, utilization of available resources, involvement in decision-making, and inclusion in community will serve as the foundation for mental health promotion, prevention (WHO, 2016). Community-based psychiatric rehabilitation is a comprehensive approach that unifies the efforts of numerous specialists, pharmacological treatment, the patient’s primary caregivers, and community education

on mental disease (Saha et al., 2020). The key elements of this strategy help people with mental illnesses recover quickly and reintegrate into their families and communities (Saha et al., 2020). The cornerstones of rehabilitation research and practice are the reduction of disability and restoration of functioning (McKibbin et al., 2004). In 2020, 9.1 million (64.5%) of the 14.2 million adults with major mental illnesses got mental health care in the previous year (Chest, 2022). Young adults (18 – 25 years) with major mental illnesses were more likely to obtain treatment (57.3%) than adults (26-49 years) and older individuals (72.9%) with serious mental illnesses (Chest, 2022). In CRP-Ganakbari, a new service for individuals with mental health needs was established as of 2018, allowing the beneficiaries to participate in multifaceted duties which helps them to return to their normal life (CRP, 2020). Around 199 clients with mental health needs have completed their rehabilitation and return their community (CRP, 2020).

The investigator finished his 3rd year placement at the CRP, Ganakbari and National Institute of Mental Health (NIMH) in Dhaka. He had some prior experience working with people with mental illnesses (PWMI). The investigator observed the physical, psychosocial, emotional, social and financial well-being of person with mental illness (PWMI). From that idea, he was motivated to carry out a study to gauge the extent to which PWMI participated in their community after completing their rehabilitation from Ganakbari and returning to it. The 4th year project for the investigator is to conduct a study in accordance with the course curriculum. However, little is known about community participation, the investigator then tried to determine the level of post-rehabilitation community participation among people with mental illness (PWMI).

1.2 Justification of the Study

Severe mental disorders deleteriously affect individuals by substantially interfering with their functioning and life participation (Chronister et al., 2021). Many people recovering from mental illness and their family members have joined self- help groups of people with disabilities (Janardhana & Naidu, 2012).

Firstly, the extent to which a person with mental health needs can return to their daily activities through rehabilitation service will be determined by this study. Secondly, factors that hindering their participation level will also be identified. The findings of this study will pave the way to work on how to make mental health rehabilitation services more quality full. The Occupational Therapy students and interns will be knowledgeable about the level of community participation among person with mental illness. Moreover, in the first of research, it will serve as an evidence base for those working in mental health rehabilitation service. To my knowledge, this is the first study to look into how much people with mental illnesses can participating in their communities in low and middle-income countries or South Asian nations.

1.3 Operational Definition

1.3.1 Mental Illness

Mental illnesses are health conditions involving changes in emotion, thinking or behavior (or a combination of these). Mental illnesses can be associated with distress and/or problems functioning in social, work or family activities (AmericanPsychiatricAssociaton).

1.3.2 Community Participation

According to World Health Organization 2001,Community participation is defined as independent engagement in community-based contexts across any of the following

social life domains: domestic life (e.g., cleaning, shopping); interpersonal life (e.g., formal relationships, intimate relationships, family relationships); major life activities (e.g., education and employment); and community, civic, and social life (e.g., politics, religion, culture) (Terry et al., 2018).

Programs that assist people with serious mental illness frequently hold community inclusion as an objective and goal. Community integration has been described as having three components, though definitions vary: physical integration (extent to which an individual participates in activities and uses community goods and services), social integration (extent to which an individual engages in social interactions with community members), and psychological integration (extent to which an individual feels a part of the community)(Baumgartner & Herman, 2012).

1.3.3 Rehabilitation

Rehabilitation is defined as "a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment"(WHO, 2021).

1.3.4 Psychiatric Rehabilitation

The definition adopted by USPRA in 2007 is: Psychiatric rehabilitation promotes recovery, full community integration and improved quality of life for person who have been diagnosed with any mental health condition that seriously impairs functioning. Psychiatric rehabilitation services are collaborative, person-directed, and individualizes, and an essential element of the human services spectrum and should be evidence-based. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice (Pratt et al., 2014). A crucial part of

the community support networks for those with severe and persistent mental illness is psychosocial rehabilitation (Barton, 1999). Psychiatric rehabilitation could provide the clinical methods and techniques for helping people achieve recovery and overcome disabilities (Iyer et al., 2005).

1.4 Study Question and Aim, Objectives

1.4.1 Study Question

What is the level of community participation of person with mental illness following rehabilitation?

1.4.2 Aim

The aim of the study is to investigate the level of participation at community among person with mental illness after getting treatment from Ganakbari Mental Health Day Centre.

1.4.3 Objectives

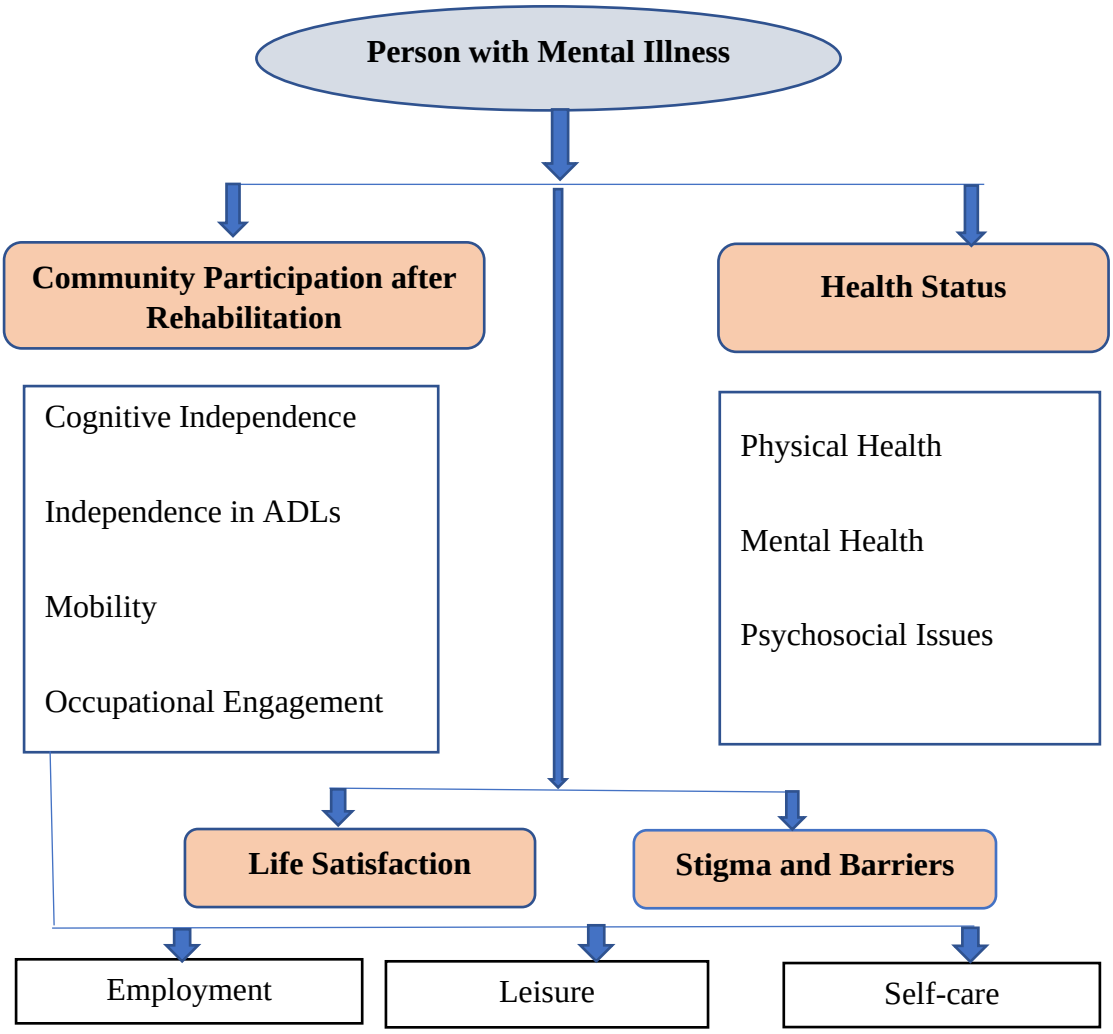
- To state the socio-demographic characteristics of person with mental illness after rehabilitation.
- To find out the cognition level and level of getting along at community setting.
- To explore the level of mobility and level of self-care at community setting.
- To determine the level of life activity engagement among person with mental illness at community.
- To find out the participation level of person with mental illness in social functioning.
- To investigate the level of impairment of person with mental illness at community setting.
- To determine the association between condition and level of impairment of person with mental illness after rehabilitation.

CHAPTER II: LITERATURE REVIEW

This chapter provides information on the health status and community participation of people with mental illness after rehabilitation. This chapter also discuss the signs, consequences, and significance of mental illness rehabilitation. At first it is needed to search the key terms of the research title on different sites like Scopus, PubMed, Embase, Google Scholar etc. For this literature review, related articles that have been published within the last ten years are given more priority. Please see figure 2.1 for the overview of literature review findings.

Figure 2.1

Overview of Literature review findings



2.1 Mental Illness

The prevalence of mental illnesses is high in the US. In America, nearly one in five adults suffer from a mental illness (52.9 million in 2020). There are numerous conditions that fall under the umbrella of mental illnesses, and they can range in severity from mild to severe. These ailments can be divided into two broad categories: Any Mental Illness (AMI) and Serious Mental Illness (SMI). All recognized mental illnesses are covered by AMI. A smaller and more severe subset of AMI is SMI. An emotional, behavioral, or mental disorder is referred to as any mental illness (AMI). AMI can have a range of effects, from no impairment to mild, moderate, or even severe impairment. SMI is defined as a mental, behavioral, or emotional disorder that causes serious functional impairment and significantly limits one or more major life activities. People who experience disability as a result of SMI are particularly affected by mental illnesses (NIMH, 2020).

2.2 Health Status

This part of literature review describes the overall health status of person with mental illness which includes physical and mental health, physical, mental and psychosocial issues associated with mental illness.

2.2.1 Physical Health

The World Health Organization (WHO) has published "Guidelines for the Management of Physical Health Conditions in Adults with Severe Mental Disorders," which states that people with serious mental disorder have a significantly higher risk of developing a number of physical health issues. The non-communicable and communicable diseases are among these health risks. The risk of cardiovascular morbidity and mortality is roughly one to three times higher in people with serious mental disorder than in the general population. In comparison to the general population, diabetes risk is doubled

for people with schizophrenia, bipolar disorder, and depression, and is 1.5 times higher for those with bipolar disorder. An elevated risk of death appears to be associated with infectious diseases, such as hepatitis and tuberculosis, in serious mental disorder patients (WHO, 2018). A qualitative interview study was conducted with 23 individuals who had mild to moderate mental health issues. This study found that some participants had physical obstacles to overcome, such as fatigue or physical health issues (Baxter, Burton, Daisy, et al., 2022).

2.2.2 Mental Health

A nationwide cross-sectional survey on mental health literacy was conducted in Singapore with 3,006 participants from March 2014 to April 2015. It concluded that public perceptions of mental illness may affect how the general public interacts with, supports, and helps those who are affected by it. The Attitudes to Mental Illness questionnaire among the general Singaporean population was found to have a 4-factor structure, consisting of social distance, tolerance/support for community care, social restrictiveness, and prejudice and misconception. More unfavorable attitudes toward those who suffer from mental illness were linked to older age, male gender, lower education, and lower socioeconomic status. Chinese exhibited more unfavorable attitudes than Indians or Malay people (except for prejudice and misconception) (Yuan et al., 2016).

2.2.3 Psychosocial issues

Psychosocial issues brought on by mental illness can include decreased social connectedness and quality of life issues for the person with mental illness as well as their family members. The stigma associated with mental illness, which affects not only the patient but also the family as a whole, makes psychosocial challenges even more difficult. It has been discovered that people with mental illness frequently struggle to

make money and frequently depend on family member's financial assistance to cover their basic living expenses and any medical costs related to their illness. According to a study conducted in rural Ghana, the main challenges faced by caregivers were lack of time, depression, social exclusion, and financial difficulties (Iseselo et al., 2016).

2.3 Community participation

Mark S Salzer, Eugene Brusilovskiy, Janet Prvu-Bettger & Petra Kottsieper conducted a study on May 2014 among 119 individuals with a diagnosis of schizophrenia, bipolar disorder or major depression. It is found that in rehabilitation research and assessment studies with this population, community engagement of people with psychiatric impairments may be accurately monitored utilizing two administration approaches. These people participated in a variety of essential community activities to varied degrees, though typically not to the extent they would like. More intervention activities were required to boost community engagement levels sufficiently (Salzer et al., 2014).

Joy Noel Baumgartner & Daniel B. Herman conducted a research and stated that explicitly focused on promoting active participation in civil society (including employment), will be needed to enhance community integration for persons with severe mental illness. The integration measures we used for the study could have left out crucial aspects, like psychological integration and interactions with people the respondent doesn't know, which could have caused us to overestimate the true impact of the CTI. A randomized trial that enrolled 150 participants with severe mental illness after discharge from inpatient psychiatric treatment, 95 of whom completed 18-month outcome measures. It was investigated how the social and physical components of community integration related to demographic data, symptom ratings, housing situation, and treatment condition. Housing security was therefore not linked to successful integration outcomes. Physical and social integration were negatively

correlated with both general and negative symptoms. Future studies should focus on improving measurement of community integration so that it can be effectively studied as an important outcome of mental health interventions for this population (Vava et al., 2022). An investigation was conducted by Daish Fancourt and Louise Baxter among the 7241 respondents to the taking part survey, an English household survey that was conducted at random face to face. Lower levels of physical, social, and psychosocial opportunity, as well as psychosocial capability, were found to reduce levels of cultural participation among people who have low happiness levels, according to behavior change theory research. However, other real and perceived barriers still need to be investigated (Fancourt & Baxter, 2020).

In a different study, 352 schizophrenia patients were recruited from Spain with the goal of achieving full recovery or, if that were not possible, a level of recovery that would lessen the disease's negative effects on the patient’s daily lives. A thorough battery of tests was completed by them, including ones for psychopathology, functionality, and quality of life. Its temporal stability was evaluated by testing 36 patients again six months later. The results showed a correlation between symptomatology and quality of life, with higher symptomatology being associated with lower social and occupational functioning. This observation was in line with some studies that have linked low functioning, poor quality of life, and high disability levels with the depressive symptoms that schizophrenia patients typically experience (GAYNES et al., 2003; Guilera et al., 2012).

People with lived experience of mental health conditions could benefited from recovery support, symptom management assistance, and increased social connections through community and cultural engagement. In 2022, Baxter et al. conducted a study to examine the constraints and opportunities for people with mental health conditions to

engage in social and cultural activities. The study discovered that participants were driven to participate in cultural and community activities by "a creative identity," the conviction that doing so would aid in the recovery from mental illness, and a desire to socialize and make friends. The enjoyable nature of activities-maintained participation motivation. However, the cost of the event, the activities' inaccessibility and occasionally lack of structure, as well as the attendant social anxiety, hindered participant's ability to participate (Baxter, Burton, Daisy, et al., 2022).

The community functioning of Chinese people with common mental disorders and their relationships to various factors were examined in a study of China. A stratified random sample of 238 patients over the course of a year in three public outpatient psychiatric clinics in Hong Kong. The patients participated in baseline and follow-up evaluations of their community functioning in four areas (self-care, independent living skills, social skills, and work skills), as well as evaluations of their self-efficacy, self-esteem, physical functioning, behavioral regulation, mental states, family expressed emotion, and perceived social stigma. Data revealed that the patients had improved self-care, work skills, and behavioral regulation after a year. Patients with higher baseline self-esteem and diminished stigma-related negative reactions were more likely to improve their social skills, whereas patients with higher baseline self-esteem and increased self-esteem were more likely to improve their work skills. The results suggested that rehabilitation services for people with common mental disorders might emphasize raising self-esteem and reducing discrimination experiences to support their development of social and occupational skills (Chan et al., 2017).

Elise Whatley, Tracy Fortune, and Anne Williams carried out a qualitative study in Australia. Based on their findings, they came to the conclusion that sprout had developed an active participation philosophy. The research highlighted the possibilities

that community development initiatives present for fostering environments that promote participation and social inclusion (Whatley et al., 2015). Kuei-Ru Chou and colleagues conducted a study among 190 outpatients with schizophrenia at 10 community rehabilitation centers in Taipei. Findings showed that empowerment in outpatients with schizophrenia mediates QOL, whereas psychosocial rehabilitation activities seem to increase empowerment, which may in turn increase QOL. Psychotic symptoms seem to have a direct effect of decreasing QOL that could not be mediated by empowerment. The results of this study confirm the value of rehabilitation and empowerment programs in improving community outpatients' quality of life. We suggest that various rehabilitation programs and empowerment health education are required to enhance the quality of life (QOL) for schizophrenia outpatients in the community. (Chou et al., 2012). severe psychotic symptoms were an important factor that could decrease QOL for patients with schizophrenia living in the community.

337 people participated in a study in Italy that looked at the outcomes of every patient who left a psychiatric hospital there. There were no differences in psychopathology or social functioning among patients who moved into the community after being followed up on. The majority of long-term psychiatric patients can successfully transition from inpatient facilities to community housing, according to the results (Barbato et al., 2004). People with mental disorders in general and patients with severe mental illness in particular experience transitions from inpatient to outpatient or community. Ranging between 22% and 90%, the average rate of utilization of after care is about 50%. Large number of psychiatric patients do not receive aftercare in the period immediately following hospital discharge. Community Care Units (CCUs) were created as part of the deinstitutionalization of psychiatric services to offer patients who were being discharged from a large psychiatric hospital's long-stay open wards housing, clinical

care, and rehabilitation. The subjective aspects of the new environment that affected patients the most were CCUs, which improved living conditions for patients. However, over the course of the first year after transfer, the levels of symptoms and disability barely changed on average. A longer follow-up period may allow for the detection of further change, but this is complicated by the fact that the cohort, which was not particularly young to begin with, is aging and that this has its own negative effects. patient population could be to blame for the outcome. Patients being transferred to a community living option with clinical staff may have contributed to the positive outcome because families may have been more willing to trust this option than discharge options with less intensive support (Trauer et al., 2001).

2.3.1 Cognitive Independence

The way in which neurocognitive change, functional change and service intensity during community based psychosocial rehabilitation for schizophrenia are regulated was studied extensively by J. S. Brekke, M. Hoe and M. F. Green (Brekke et al., 2009) in 2009. 130 individuals diagnosed with schizophrenia were chosen to have a year of community-based psychosocial treatments to see how much their neurocognitive function changed. 42% of the group did not show improvement in neurocognitive functioning whereas 58% did.(Brekke et al., 2009). According to a US study, researchers, policymakers, and advocates for mental health have prioritized community integration (Nelson et al., 2001; Ware et al., 2007; Yanos, 2007). Adults with serious mental illnesses may need special attention because of the lack of resources in the community and participation opportunities. Therefore, finding ways to encourage community integration and, ultimately, recovery, may be crucial. Therefore, the results from the present study emphasize the significance of community-based factors,

particularly community participation and a sense of community, in promoting favorable mental health outcomes for adults with serious mental illnesses (Chen et al., 2022).

2.3.2 Independence in activities of daily living (ADLs).

The fundamental abilities required for people to live independently or lead fulfilling lives are activities of daily living. These abilities may deteriorate in people with complex psychosis as a result of the cognitive effects or adverse symptoms. People who are receiving rehabilitation are encouraged to participate in structured group activities and receive training to improve their daily living skills (UK, 2020). Person with mental illness have a significant association with impaired engagement in activities of daily living (ADL). Musculoskeletal, neurological, circulatory, or sensory conditions can lead to decreased physical function leading to impairment in ADL. Other factors such as side effects of medications, social isolation, or the patient's home environment can influence the ability to perform ADLs (Edemekong et al., 2022).

2.3.3 Mobility

Independence and a high quality of life in terms of health depend on mobility (K & J, 2018). Humans are social creatures in that we require regular interaction with other people. A brief conversation at the neighborhood shop, a trip to the library, getting a haircut, or joining a social club can all significantly improve mental health and happiness. Although this makes life easier for us and keeps us connected, many people with mobility issues stop going out and rely more and more on deliveries and the Internet, which means they have little to no real human contact (Wade, 2019). Mobility issues and mental health symptoms are common in the general population of Finland. Socio-demographic and health-related factors were unable to fully account for the observed associations. Health professionals should be aware of the overlap between mobility restriction and mental health symptoms. The relationship between mental

health symptoms and mobility restriction needs to be taken into consideration when developing health services and health promotion because it is well known that people with mental illness face more barriers to accessing health care than the general population (Rask et al., 2015).

2.3.4 Occupational Engagement

In Occupational Therapy, occupation means activities of daily living which includes self-care, productivity and leisure. Engagement in occupation hampers most by the cause of mental illness. It is possible to recover from mental illness and resume work and other worthwhile activities. When the focus is on independence, self-reliance, and community integration, recovery rates are higher. As soon as possible, start doing work that is meaningful to you. Additionally, recovery is aided by setting and achieving personal goals (Kelsey-Sugg, 2015). According to findings from numerous studies, recovery is an ongoing occupational process that appears to involve gradual re-engagement, participation in day-to-day occupational activities, and full community involvement. The promotion of connectedness, hope, identity, meaning, and empowerment as well as the establishment of routines and support for people in managing illness appear to be ways that meaningful and valued work appears to aid in recovery (Doroud & Fortune, 2015).

2.4 Stigma and Barriers in participation

Stigma is one of the most fundamental and unceasing challenges that individuals with mental illness face. Stigma can be associated with a variety of health conditions, but mental illness stigma remains especially severe and pervasive. Negative attitudes, discrimination, and a lack of knowledge are the three main causes of stigma. The prevalence of self-stigma is high, ranging from 22.5% to 97.4% and is thought of as a

"second illness" by those suffering. Mental illness stigma is multifaceted and can be caused by both social and psychological factors (Conklin, 2021). Stigma associated with mental illness, including that which exists within the healthcare system and among healthcare providers, poses significant obstacles to access and high-quality care (Knaak et al., 2017). People with mental illnesses and the people who care about them, such as their family members, are both negatively impacted by stigma. Many diverse racial and ethnic communities struggle with the stigma associated with mental illness, which makes it difficult for members of those communities to access mental health services (AmericanPsychiatricAssociation, 2020). According to research, participation is significantly hampered for those who are dealing with mental health issues. In 2022, Baxter et al. proposed that people with mental health conditions may be at risk of encountering barriers to community and cultural engagement due to existing social inequalities and social anxiety, but that believing that involvement will support mental health was an enabler to participation (Baxter, Burton, Daisy, et al., 2022).

2.5 Mental Health and Occupational Therapy

In both modern and historical societies, mental health issues are pervasive. The historical foundation of occupational therapy development also centers on mental health. Therefore, a special issue of the British Journal of Occupational Therapy with a focus on mental health occupational therapy is greatly needed and appreciated (Eklund, 2021). A qualitative study from the UK of veterans with mental health issues who took part in a workshop to improve daily tasks and resilience reveals that the participants set occupational goals and started to change their lifestyles, gained insight into the relationship between work and health, and thought back on their recovery journeys (Vaughan-Horrocks, 2020). The advantages of being in a group were emphasized, just like in numerous other group-based occupational therapy programs (Lund et al., 2019).

Another Australian study looks into the activity and participation of people who use mental health services (Jennings et al., 2021).The objective of this quantitative cross-sectional study was to find any correlations between these patterns and demographic traits (Bejerholm & Eklund, 2006). Home-based activities and unpaid work were the most prevalent activities, according to the findings, which are consistent with earlier research (Bejerholm & Eklund, 2006). The study also identifies some demographic traits that are linked to activity and participation patterns, such as older users being less active in employment and physical activity, and female and culturally diverse users being less likely to participate in community activities (Bejerholm & Eklund, 2006). The fact that so much about occupational therapy for mental health is already known is encouraging, and the unknown opens up intriguing and alluring possibilities for future study (Eklund, 2021).

2.6 Key gaps of the study

- Most of the studies was conduct in a specific hospital. So, the results cannot be generalized all over the world.
- Some studies focused on social integration. But other important areas of community functioning such as physical independence, financial dependency was not focused well.
- Also, Employment, empowerment is not well focused in maximum studies.
- In Bangladesh, no study has been conducted regarding community participation of person with mental illness following rehabilitation.

CHAPTER III: METHODS

3.1 Study Design

3.1.1 Study method

To conduct this study the investigator used quantitative study design with cross sectional study/approach to explore the participation level of person with mental illness when they return back to their community after completing rehabilitation from Ganakbari mental health day centre. Since the issue is well-known, straightforward, and clear-cut, a quantitative approach was appropriate for this study. In a quantitative study contracting the quantity of responses, collecting numerical data; analyzing the data in how many or how much, so it was the best study design for the student researcher to collect data (Madisha, 2018).

3.1.2 Study approach

Cross sectional approach was used to conduct this study. The best technique to assess prevalence is through a cross sectional study that is one type of observational study, which is also helpful in detecting associations that may later be more thoroughly investigated through the use of a cohort or a randomized controlled research (Mann, 2003). The main benefit of cross-sectional studies is that they are typically quick and affordable. Less resources are needed to carry out the study because there is no follow -up (Mann, 2003). On the other hand, a cross sectional study involves collecting data from populations at a specific point at a time, so this study design was also the best study design of this research (cherry, 2019).

3.2 Study Setting and Period

3.2.1 Study Setting

This study was conducted at the community of person with mental illness who took rehabilitation service from CRP, Ganakbari.

3.2.2 Study Period

The study was conducted on August 2022- February 2023. Data of this study was collected from November 2022 to December 2022.

3.3 Study Participants

3.3.1 Study Population

The person who had mental health needs and got Occupational Therapy treatment from Ganakbari Mental Health Day Centre and go back to their community.

3.3.2 Sampling Technique

Sampling is the process of selecting a portion of the population to represent the entire population so that inferences about the population can be made. The researcher used purposive sampling method for collecting the sample in the study.

Purposive sampling represents a group of different non-probability sampling techniques. Also known as judgmental, selective or subjective sampling, purposive sampling relies on the judgement of the researcher when it comes to selecting the unit (e.g., people, cause/organization, events, pieces of data) that are to be studied. Usually, the sample being investigated is quite small, especially when compared with probability sampling technique(dissertation).

3.3.3 Inclusion Criteria

- Both male and female who were 18 or above 18 years old and completed the rehabilitation service from Ganakbari mental health day Centre.

- Individual with pure mental illness like Schizophrenia, Bipolar Mood Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, Generalized Anger Disorder, Personality Disorder, Conduct Disorder, Anxiety Disorder.
- In medical note, it was clearly mentioned that participant's insight was good.

3.3.4 Exclusion Criteria

- Individual with neurodevelopmental disorder like ASD, ADHD, Intellectual Disability.

3.3.5 Sample Size

$$n = \frac{z^2 \times pq}{d^2}$$

Here,

n= sample size

N= Population

z= the standard normal deviate usually set at 1.96; 95% confidence interval.

p= anticipated prevalence (0.5); though the prevalence of person with mental illness is yield, so total amount of disability (50%) is consider.

q= (1-p) = 0.5; proportion in the target population not having the particular characteristics

d= Allowable error (0.05); degree of accuracy required (level of significance/ margin of error)

So, the sample size= $n = \frac{(1.96)^2 \times 0.5 \times 0.5}{(0.05)^2}$

$$= \frac{3.8416 \times 0.5 \times 0.5}{.0025}$$

$$= \frac{0.9604}{0.0025}$$

$$= 384.16$$

About 199 clients with mental health needs completed their rehabilitation and return their community. And in case of this study sample size < population.

When, Ss< N

Finite correction $= \frac{n}{1+\frac{n}{N}}$

$$= \frac{384.16}{1+\frac{384.16}{199}}$$

$$= \frac{384.16}{2.93}$$

$$= 131.11262$$

According to this calculation, the standard sample size was 131. But the investigator selected only 72 participants who completed their rehabilitation service from Ganakbari, CRP for the time limitation (0ctober 2022- November 2022).

3.4 Ethical consideration

- First of all, Ethical clearance was sought from the Institutional Ethical Review Board of Bangladesh Health Professions Institute (BHPI) through the department of Occupational Therapy, BHPI.
- Then the investigator took consent form from the Institutional Review Board (IRB).
- The investigator also informed the entire participants about the purpose and aim of the study.

- All the participants were informed that their information would be used in the research but their name and address would be confidential.
- All participant participated voluntarily in this study.
- After receiving the clearance (CPR/ BHPI/ IRB/ 09/ 22/ 630 attached on appendix) from the board, the investigator continued the further process.

3.4.1 Informed Consent

Before conducting the data collection, the investigator read out the information sheet where the title of the study, aim and objectives of the study mentioned clearly. After understanding the purpose of the study, the populations had full freedom to make the decision if they wanted to participate or not. After confirming it, the investigator again read out the consent form where ethical consideration, confirmation was described. After hearing and understanding everything, the participants gave their consent. Participants have the right and can voluntarily withdraw to participate in the study before starting the data analysis. Those who rejected their participation in the study, the investigator thanked them for giving their time.

3.4.2 Unequal Relationship

The investigator did not know the participants personally. He selected the participants according to inclusion and exclusion criteria. So equal relationship was ensured.

3.4.3 Risk and Beneficence

- Investigator ensured that he would not occur any risk for the participants.
- Investigator also contacted with a psychologist and referred the vulnerable participants.
- Monetary Benefit

Investigator did not pay the participants for their given data. But include the benefit that came from giving this data.

3.4.4 confidentiality

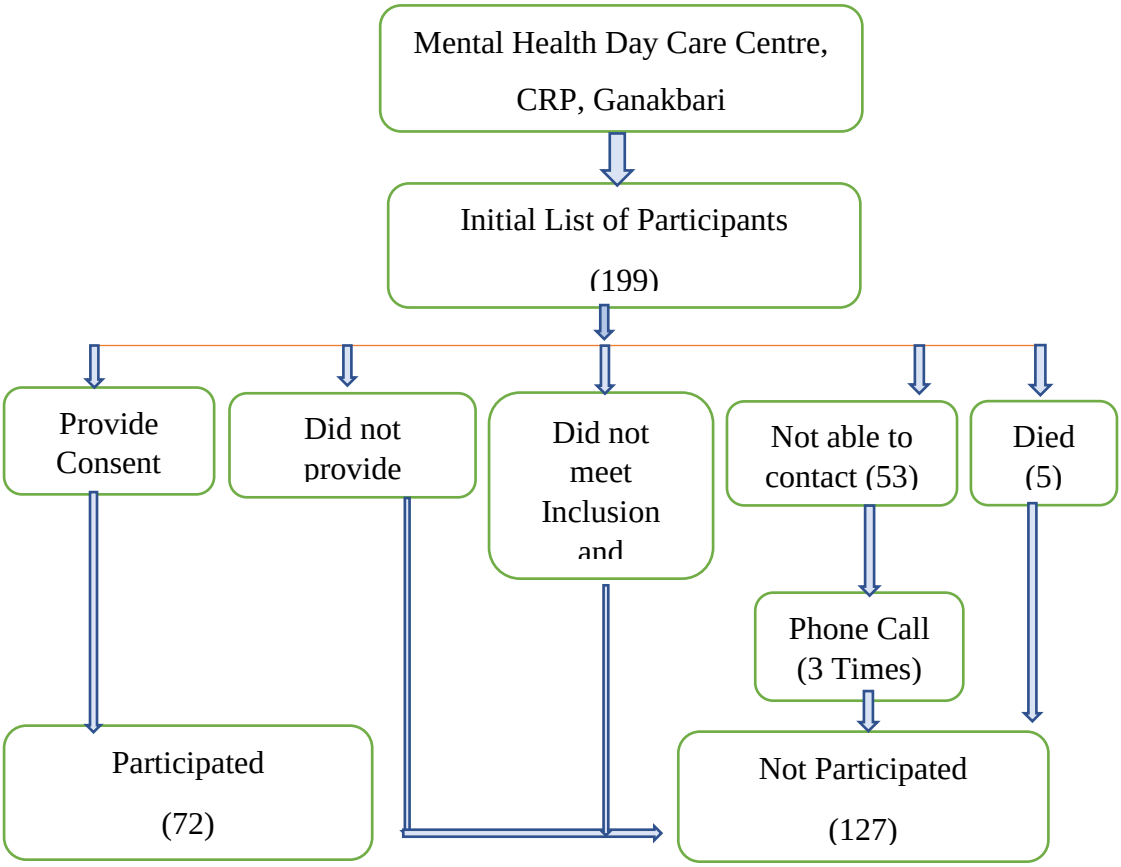
The information of each participant was kept private. Their name and identity were not disclosed to anyone except for the supervisors and it was state on the information sheet.

3.5 Data Collection Process

3.5.1 Participant Recruitment Process

Figure 3.1

Flow chart of Participant Recruitment Process



72 participants with different condition were recruited with different background. Participant recruitment diagram is given in figure 3.1. The participants were recruited

through meeting the inclusion and exclusion criteria. Those who had completed their rehabilitation from a mental health day centre within the age of 18 years or above. Individual who had pure mental illness such as Schizophrenia, Bipolar Mood Disorder, Obsessive Compulsive Disorder, Depressive Mood Disorder, Personality Disorder, Generalized Anxiety Disorder were included in this study. After collecting the initial list of total participants, the investigator contacted with the participants through phone call. Whom did not able to contact, the investigator tried for 3 times to connect. Individual who did not interested to participate willingly were excluded from this study. Person with neurodevelopmental disorder would not be able to participate in this study.

3.5.2 Data Collection Method

First, the investigator introduced to the participants prior to data collection. Investigator also verbally presented the details of the study, including aim, objectives and purpose of the study. After that, he allowed the participant to ask relevant question. Before starting data collection, the investigator asked the participant about his/her location, place and time of interview. When the participant agreed with the investigator and they felt comfort with the place, then the he started taking data from the participants.

3.5.3 Data Collection Instrument

WHODAS 2.0 is a practical, generic assessment instrument that can measure health and disability at population level or in clinical practice (WHO 2023). WHODAS 2.0 captures the level of functioning and questionnaire contains the interviewer administered 36-item version in six domains of life. For all six domains, WHODAS 2.0 provides a common metric of the impact of any health condition in terms of functioning. Being a generic measure, the instrument does not target a specific disease- it can thus be used to compare disability due to different diseases (WHO 2023). WHODAS 2.0 also makes it possible to design and monitor the impact of health and health related

interventions. The instrument has proven useful for assessing health and disability levels in the general population and in specific groups (people with a range of different mental and physical conditions). Furthermore, WHODAS 2.0 makes it easier to design health and health related interventions and to monitor their impact. The six domains are: Cognition, Mobility, Self-care, Getting-along, Life activities and Participation.

The investigator took face to face interview to collect data. In this study WHODAS 2.0 questionnaire was used as data collection tool.The investigator used simple scoring where the scores assigned to each of the items: This method was referred to as simple scoring thus there was no weighting of individual items. This approach was practical to use as a hand-scoring approach and may be the method of choice in busy clinical settings or in paper-pencil interview situations.

Simple scoring of WHODAS was specific to the sample at hand (Ustun et al., 2012). WHODAS 2.0 World Health Organization Disability Assessment Schedule 2.0 (0-100, higher greater activity limitations and participation restrictions). Data was collected from the participants who have completed their rehabilitation and return to their community.

3.6 Data Management and Analysis

After completing the initial data collection, every questionnaire was check again to find out any mistake or unclear information. Then the investigator did set up the variable and input the all data in SPSS version 26. Then data was analyzed through Statistical package of social science (SPSS) version 26 and data was levelled in Microsoft Excel worksheet and arranged in results. Then data was analyzed through descriptive statistics to find out the frequency, percentage, mean, minimum, maximum and standard deviation value.

3.7 Quality Control and Quality Assurance

All data was done accurately under the supervision of the respected supervisor and followed all the instructions. Before selecting the study methodology, it was ensured that it may fulfil the study purpose. The data was collected by using the “Bangla version” question. The question was selected from the published research, the name of the scale was “WHODAS 2.0. The scale was already translated into Bangla. As the participant was the community people, a field test is done with 3 participants to find out any understanding difficulty and cultural issues. After the field test, the question was modified to match our cultural perspective to get wider information and make it understandable.

CHAPTER IV: RESULT

In this chapter the results of the investigation are presented. The findings of this study are represented in the chapter by use of tables and figures, with an emphasis on sociodemographic data, cognition levels, mobility levels, levels of self-care, levels of getting along, and levels of life activity engagement and participation level among people with mental illness in the community. The socio-demographic characteristics of person with mental illness after rehabilitation were given in table 4.1.

4.1 Socio-Demographic Characteristics of person with mental illness

Table 4.1

Socio-Demographic Characteristics of person with mental illness following rehabilitation (N=72).

Variable	Category	Count	Percentage
Age	18- 31 years	42	58.3%
	32- 45 years	27	37.5%
	46- 59 years	3	4.2%
Gender	Female	26	36.1%
	Male	46	63.9%
Living situation at the time of interview	Independent in community	47	65.3%
	Assisted living	23	31.9%
	Hospitalized	2	2.8%
Education (years)	Illiterate	2	2.8%
	Primary Level	9	12.5%
	Secondary level	42	58.3%
	Higher Secondary level	19	26.4%
Current Marital Status	Never married	43	59.7%
	Currently Married	19	26.4%
	Separated	4	5.6%
	Divorced	5	6.9%
	Widowed	1	1.4%
Occupation	Paid Work	16	22.2%
	Self-employed, such as own your business or farming.	10	13.9%
	Student	9	12.5%
	Keeping house/ Home maker	7	9.7%
	Unemployed (health reasons)	28	38.9%
	Unemployed (other reasons)	2	2.8%
Diagnosis	Bipolar mood disorder	15	20.8%
	Schizophrenia	49	68.1%
	Obsessive Compulsive Disorder	1	1.4%
	Generalized Anxiety Disorder	4	5.6%
	Depressive mood disorder	1	1.4%
	Personality Disorder	2	2.8%

Table 4.1 provides an overview of socio-demographic information including living situation at the time of interview, gender, age, educational status, current marital status, occupation, and diagnosis of people with mental health issues after completing rehabilitation. Male involvement was higher (63.9%) than female participation (36.1%). The major number of participants 68.1% (n=49) had the diagnosis of Schizophrenia, whereas 15% (n= 15) Bipolar mood Disorder, 5.6% (n= 4) Generalized anxiety Disorder, 2.8% (n= 2) Personality Disorder, Obsessive Compulsive Disorder and depressive Mood Disorder are same as 1.4%. 42 (58.3%) participants of the study were between the age range of 18 years to 30 years, 27 (37.5%) were between the ages of 31 years to 40 years, and 3 (4.2%) were above 40 years.

Table 4.1 showed that, During the interview, 65.3% (n= 47) were self-sufficient and gave the data by own, 31.9% (n= 23) were in assisted living, and 2.8% (n=2) were hospitalized. Out of 72 participants, 58.3% (n= 42) were in secondary level of education, 26.4% (n= 19) were in higher secondary level, 12.5% (n= 9) were in primary level of education, and 2.8% were illiterate. It also showed that 59.7% were unmarried, 26.4% were married, 6.9% were divorced, 5.6% were separated and 1.4% were widowed.

Additionally, after returning their community 41.1% were unemployed because of their health conditions and other reasons, 22.2% joined in paid work, 13.9% were self-employed and maintaining their own business or farming. 12.5% were continuing their study. 9.7% were keeping their house.

4.2 To Identify the level of cognition, mobility, self-care, getting along, life activities and participation of person with mental illness following rehabilitation.

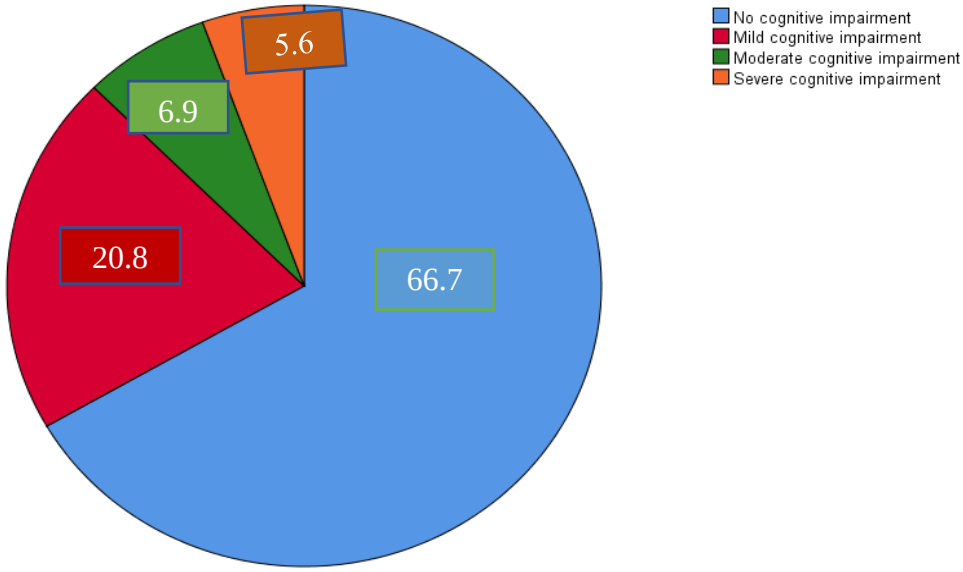
According to WHODAS 2.0, Here level of cognition, mobility, self-care, getting along, life activities and participation range 0-100, where 0= normal or no disability, 100= full participation restriction or disability for 72 participants. The investigator used complex scoring; it takes into account multiple levels of difficulty for each WHODAS 2.0 item. This type of scoring for WHODAS 2.0 allows for more fine-grained analyses that make use of the full information of the response categories for comparative analysis across populations or subpopulations. It took the coding for each item response as none, mild, moderate, severe, extreme separately, and then used a computer to determine the summary score by differentially weighting the items and the levels of severity. Basically, the scoring had three steps; 1= summing of recorded item scores within each domain, 2= summing of all six domain scores, 3= converting the summary score into a metric ranging from 0 to 100 (WHO, 2012). After calculating the scores of the domains, the investigator divided the scores into different range (lower to higher percentage) where 0 to 24 means no disability, 25- 49 means mild disability, 50 to 74 means moderate disability and 75 to 100 means fully disable. No disability indicated that highest level of community participation and fully disable indicated the lowest level of community participation. Mild disability means good community participation level with minimum difficulties and moderate disability means low level of community participation.

4.2.1 Level of Cognition

Level of Cognition was identified in the figure 4.1.

Figure 4.1

Level of Cognition of person with mental illness following rehabilitation (N=72).



Closer inspection of the figure 4.2 shows that out of 72 participants, 66.7% (n= 48) of participants have no cognitive impairment, 20.8% (n= 15) have mild cognitive impairment, 6.9% (n= 5) have moderate cognitive impairment, and 5.6% (n= 4) have severe impairment or disability. It can be seen from table 4, 84.7% of the total participant has no problem in mobility and 15.3% have mild problem. No participant has moderate or severe problem in this component.

4.2.2 Level of Mobility

To know the level of mobility, see in table 4.2.

Table 4.2

Level of Mobility of person with mental illness following rehabilitation (N=72).

Points	Frequency	Percentage
No problem	61	84.7%
Mild problem	11	15.3%
Total	72	100%

From table 4.2, It was founded that out of 72 participants 84.7% (n = 61) have no problem in their Mobility issues. They were independent to move in home and out of their home. 15.3% faced mild problem in mobility. No participants disclosed having moderate or severe problem in this domain.

4.2.3 Level of Self-care

Self-care level of person with mental illness was identified in the table 4.3.

Table 4.3

Level of self-care of person with mental illness following rehabilitation (N=72).

Points	Frequency	Percentage
No problem	60	83.3%
Mild problem	7	9.7%
Moderate problem	4	5.6%
Severe problem	1	1.4%
Total	72	100%

The majority of the participants (n = 60), as shown in table 4.3, stated that they were capable of performing self-care tasks like bathing, dressing, eating, and staying alone for a few days. About 83.3% were able to take care of themselves by their own. 9.7% of participants (n = 7) had some difficulty in doing their selfcare. 5.6% of the sample (n = 4) had moderate issues in this domain. 1.4% of respondents reported having serious difficulties carrying out self-care tasks at home. The most striking result to emerge from the data was that no participant reported having problem in their sexual activities.

4.2.4 Level of Getting-along

In the table 4.4, Level of Getting-along was identified.

Table 4.4

Level of Getting along of person with mental illness following rehabilitation (N=72).

Points	Frequency	Percentage
No problem	33	45.8%
Mild problem	30	41.7%
Moderate problem	8	11.1%
Severe problem	1	1.4%
Total	72	100%

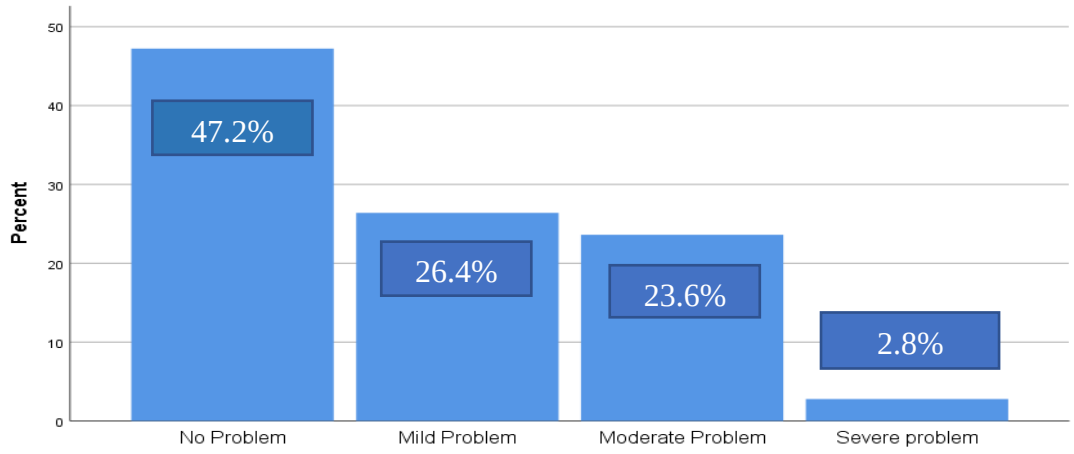
According to the findings which were presented in Table 4.4, 45.8% of the sample (n = 33) were capable of maintaining friendships, interacting with strangers, getting along with people in their immediate circle, making new friends, and performing their sexual activity. Getting along was a challenge for 41.7% of the population (n = 30). A moderate problem was mentioned by 8 participants (11.1%). 1.4% of people (n = 1) had serious problems and were unable to engage in getting along activities.

4.2.5 Level of Life-activities at community

Level of Life-activities at community was given below in the figure 4.2.

Figure 4.2

Level of Life activities of person with mental illness following rehabilitation (N=72).



It was apparent from this chart that 47.2% (n = 34) participants had no difficulties in their life activities. 26.4% (n = 19) of respondents reported minor difficulties with their homes, jobs, or studies. Participants who faced moderate problems with daily tasks comprise 23.6% (n = 17). Only 2.8% (n = 2) of participants did not perform or face severe problem in their life activities including household activities and work activities.

4.2.6 Level of Participation of person with mental illness

Participation level of person with mental illness was described. in the table 4.5

Table 4.5

Level of Participation in Social Functioning of person with mental illness following rehabilitation (N=72).

Points	Frequency	Percentage
No problem	34	47.2%
Mild problem	24	33.3%
Moderate problem	12	16.7%
Severe problem	2	2.8%
Total	72	100%

Table 4.5 highlighted the level of participation in social functioning of person with mental illness at their community. Whereas 47.2% (n = 34) claimed that they had no trouble taking part in social activities. 33.3% of people (n = 24) experienced mild problems. 16.7% (n = 12) of participants said it was somewhat difficult to get involved in community activities. Only 2.8% (n=2) of people faced numerous obstacles, which prevents them from participating in social activities and from living with dignity.

We found that 66.7% people had no problem in cognition, 84.7% participants were fully independent in their mobility, 83.3% participants were fully independent in their self-care activities, 45.8% people were fully independent in getting along, 47.2% people had no problem in their life activities and participation in the community.

4.3 Identify the Association between Condition and Level of Impairment.

Table 4.6

Association between Condition and Level of Impairment of person with mental illness following rehabilitation (N=72).

Condition	None	Mild	Moderate	Severe	Total
Bipolar Mood Disorder	26.7% (4)	60.0% (9)	13.3% (2)	0%	100% (15)
Schizophrenia	18.4% (9)	36.7% (18)	36.7% (18)	8.2% (4)	100% (49)
Obsessive Compulsive Disorder	0%	100% (1)	0%	0%	100% (1)
Generalized Anxiety Disorder	50% (2)	0%	50% (2)	0%	100% (4)
Depressive Mood Disorder	0%	0%	100% (1)	0%	100% (1)
Personality Disorder	0%	0%	0%	100% (2)	100% (2)
Total	20.8% (15)	38.9% (28)	31.9% (23)	8.3% (6)	100% (72)

According to table 4.6, The most striking result to emerge from the data was that out of 72 participants 28 participants had mild impairment (where 18 with schizophrenia, 9 with bipolar mood disorder and 1 with obsessive compulsive disorder), 23 participants had moderate impairments (where 18 participants with schizophrenia, 2 with bipolar mood disorder and 2 with generalized anxiety disorder and 1 depressive mood disorder), out of 15 participants who had no impairment 9 were diagnosed with schizophrenia, 4 diagnosed with bipolar mood disorder, 2 diagnosed with generalized

anxiety disorder. 5 participants had severe impairment (whereas 4 with schizophrenia, and 1 with personality disorder. 1 participant diagnosed with personality disorder had extreme level of impairment though completing rehabilitation service and returning his community.

Chi-Square Test

	Value	**Exact Significance (1-sided)**
Fisher's Exact test	33.201	.002
N of Valid Cases	72	

Association between diagnosis of participants and their level of impairments were showed in the above. The investigator did a chi-square test to identify the significance of the association. And the result of chi-square test was 0.00 ($p < .05$). so, it can say that the level of impairment and the diagnosis of participants were associated to each other.

From this study it was identified that 20.8% (n=15) participants can fully participate in their community activities and their community participation level is highest. 38.9% (n=28) participants considerably participate in their community activities which indicates good community participation level with minimum difficulties. 31.9% (n=23) participants faced moderate problem and their community participation level is low. 8.3% (n=6) participants did not participate in their community activities and that means their community participation level is very poor or lowest.

CHAPTER V: DISCUSSION

This was the cross-sectional study to investigate the level of community participation of person with mental illness who have completed their rehabilitation from Ganakbari mental health day centre, CRP and return to their community. The study also identifies the socio-demographic characteristics and the level of impairment of the participants. The investigator contacts the participants over telephone and collected data through face-to-face interview with the response rate 50%.

Among 72 participants, 65.3% are independent in community, 31.9% person are assisted living and 2.8% are hospitalized where majority participants (47) are within the age range 18 to 29 years another study stated that all the participants were assisted in living and all of them were middle aged. That study also stated that most of the participants were male (McKibbin et al., 2004) which is similar to this study. This study indicates that most of the participants 68.1% are diagnosed with schizophrenia whereas 18 participants have mild impairment and 18 participants have moderate impairment. Participants in the study of Mckibbin, Patterson et al. reported the greatest disability severity in the area of social participation, reflecting the isolation, emotional distress, and financial loss associated with schizophrenia (McKibbin et al., 2004). In the study of Mckibbin, patients with more severe depressive symptoms reported a higher level of disability. Another study says that Depressive symptoms, which are common in people with schizophrenia, have been linked to poorer functioning and a lower quality of life (GAYNES et al., 2003).

M.B.A. Rahman and S.K. Indran conducted a study where the participants are between the overall age range of 18 to 65 years as like the current study. But the diagnosis of the participants are schizophrenia and mood disorder and the range of recovery varies

greatly throughout their lives; a reasonable estimate is that 20-30% are able to live relatively normal lives. However, 20-30% of patients continue to have mild symptoms and 40-60% continue to be significantly impaired throughout their lives (Indran, 1996; Mahurin et al., 1996). The finding of the study also states that in patients with chronic schizophrenia, 28 (35%) had no dysfunction, while 52 (65%) had some form of dysfunction, ranging from mild to severe. In patients with chronic mood disorders, 19 (40%) had no dysfunction, while 29 (60%) had mild to severe behavioral dysfunctions. The severity of dysfunctions was the same in both groups. Most subjects (84% of chronic schizophrenics and 10% of patients with chronic mood disorders) were described by their informants as well adjusted to their illness and managing their lives fairly well (Indran, 1996). Where the current study state that out of 72 patients with mental illness 28 (38.9%) have mild impairment, 23 (31.9%) have moderate impairment and 15 (20.8%) have no problem or disability (table 8). According to the study of Indran 1996, there is no statistically significant difference in the prevalence and severity of psychiatric disabilities between patients with schizophrenia and those with mood disorders. The current study also finds the same result.

The current study finds the level of cognition, mobility, self-care activities, getting along, life-activities and participation in social functioning. The result of association between impairment level and diagnosis is fully significant ($p < .005$). It was also identified that the level of mobility and self-care participation are very high rather than the other domains among person with mental illness after getting treatment from a mental health day centre. In a study, the domains with the greatest difference in disability level compared to controls were life activities, participation in society, understanding and communicating with the world, and getting along with people, whereas self-care appeared to be relatively less affected. According to one study,

disability in schizophrenia begins primarily in social and occupational roles and interpersonal relationships, and in more severe cases, self-care begins to suffer. The study found no link between disability and deficits in attention, visual memory, or executive functions in people with schizophrenia. (ErtugÆrul & B, 2002). In some of the previous studies, neurocognitive functions and social functioning were found to be related (Mahurin et al., 1996).

Participation rates have been associated with levels of functioning during inpatient rehabilitation and after discharge. Higher levels of participation have been linked to higher levels of affect, adherence, and attendance as well as lower levels of depression (Bright et al., 2015).

This study found the overall impairment level among the respondents. Not only that but also identify the individual level of six domain of WHODAS 2.0 (1. Understanding and communication, 2. Mobility, 3. Self-care, 4. Getting along, 5. Life activities, 6. Participation). From the result it is identified that out of 72 participants rate of mobility level is very high (84.7%), then the rate of Self-care level (83.1%). 66.7% have cognitive stability. Among them participation in life activities and social functioning rate is comparatively low (47.2%). The rate of getting along level is very low (45.8%).

CHAPTER VI: CONCLUSION

6.1 Strength and Limitations

6.1.1 Strength

- This is the first attempt in Bangladesh on this topic. There has previously been no research on this phenomenon in Bangladesh.
- The data of the study is completely valid because it was conducted through a face-to-face interview rather than a telephone survey.
- It is a significant strength of this research. This study will pave the way for future research in this area as well as in the mental health sector.

6.1.2 Limitations

There were some limitations that the investigator considered while conducting the study. They were:

- The participants discharged from a specific rehabilitation center, so the population of the study was a small group of people. As a result, there were only a few participants.
- There were numerous invalid phone numbers in the database, making it difficult to reach the entire population.
- It was too difficult and expensive for an investigator to collect data from a community setting within a short period of time.

6.2 Practice implication

6.2.1 Institution based implication

CRP's current mental health project focuses on both adult and non-adult patients with mental health needs. This project should make the follow-up system more accessible and increase the frequency of community visits. A massive free health camp and community awareness program at the community level may be more effective in reducing stigma associated with mental illness.

6.2.2 Community based implication

They should also inform the community about the needs, rights, and challenges that people with mental illnesses face after rehabilitation. The Occupational Therapist should be their patient's community advocate. The Occupational Therapist should inform the patients' families as well as the surrounding community about their mental illness.

6.2.3 Recommendation

- Further research should be conducted to investigate the environmental and societal barriers that people with mental illnesses face after rehabilitation.
- More research is needed to determine the need for follow-up and environmental facilities for people with mental illnesses.
- Investigate the lived experience of a person with mental illness after rehabilitation.
- Explore the life satisfaction of people who have recovered from mental illnesses.
- Determine the quality of life and the relationship between socio-demographic characteristics and quality of life.
- Investigate caregiver satisfaction with the rehabilitation of a person with a mental illness after rehabilitation.

6.3 Conclusion

To determine level of community participation after rehabilitation of a person with mental illness was the main goal of the study. This is Bangladesh's first report on the health status of this population. According to the findings of this study, the overall impairment level among this group is low, indicating a high level of participation in community activity. After rehabilitation, the vast majority of participants have no difficulty in mobility or self-care activities. Their comprehension and communication abilities are also relatively high. However, they encounter difficulties in carrying out life activities (such as household and work). Many of them are even unemployed. As a result, it is necessary to schedule follow-up sessions within a certain time frame after rehabilitation. In this sector, Rehabilitation service should be more community-based in order to increase life satisfaction, decrease dependence on others and increase employment as much as possible.

CHAPTER VII: LIST OF REFERENCE

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APPENDIX

Appendix A: Ethical Approval letter from IRB

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

Ref: CRP/BHPI/IRB/09/22/630

Date: 28th September, 2022

Abdullah Al Mamun Rafi
4th Year B.Sc. in Occupational Therapy
Session: 2017-18, Student ID: 122170252
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Subject: Approval of the thesis proposal "Level of Community Participation among Person with Mental Illness following Rehabilitation." by ethics committee.

Dear Abdullah Al Mamun Rafi
Congratulations.
The Institutional Review Board (IRB) of BHPI has reviewed and discussed your application to conduct the above-mentioned dissertation, with yourself, SK. Moniruzzaman as thesis supervisor. The Following documents have been reviewed and approved:

Sr. No.	Name of the Documents
1	Thesis Proposal
2	Questionnaire
3	Information sheet & consent form.

The purpose of the study is to "identify the level of community participation among person with mental illness following rehabilitation". The study involves use of a WHODAS 2.0 scale to identify the level of community participation that may take 12 to 20 minutes to answer and there is 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 8.30 AM on 27th August, 2022. at BHPI (32nd IRB Meeting).

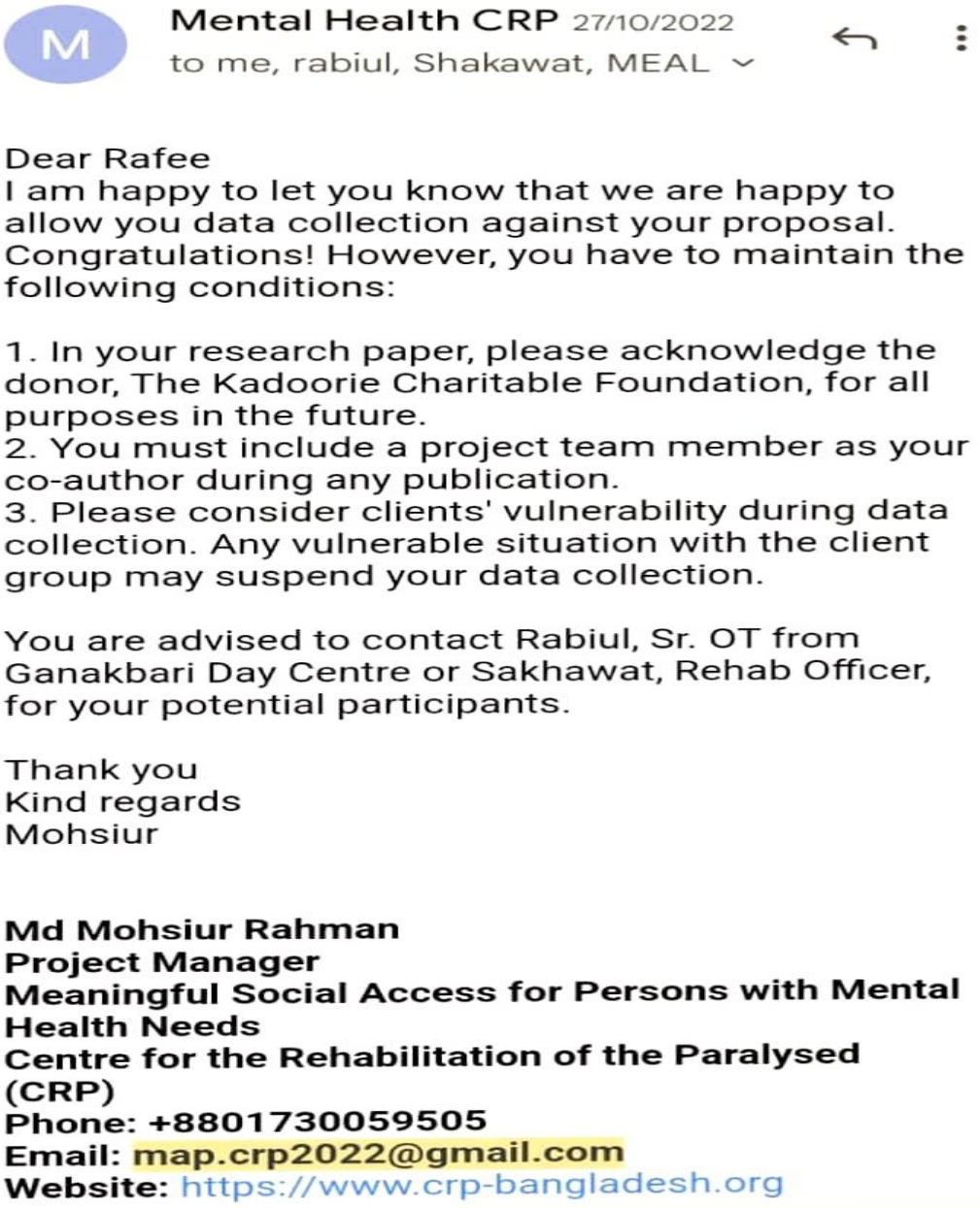
The institutional Ethics committee expects to be informed about the progress of the study, any changes occurring in the course of the study, any revision in the protocol and patient information or informed consent and ask to be provided a copy of the final report. This Ethics committee is working accordance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

Best regards,

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

সিআরপি-চাপাইন, সাভার, ঢাকা-১৩৪৩, বাংলাদেশ। ফোন: +৮৮ ০২ ২২৪৪৪৫৪৬৪-৫, +৮৮ ০২ ২২৪৪৪১৪০৪, মোবাইল: +৮৮ ০১৭৩০ ০৫৯৬৪৭
CRP-Chapain, Savar, Dhaka-1343, Bangladesh. Tel: +88 02 224445464-5, +88 02 224441404, Mobile: +88 01730059647
E-mail : principal-bhpi@crp-bangladesh.org, Web: bhpi.edu.bd

Appendix B: Permission for data collection



Mental Health CRP 27/10/2022
to me, rabiul, Shakawat, MEAL

Dear Rafee
I am happy to let you know that we are happy to allow you data collection against your proposal. Congratulations! However, you have to maintain the following conditions:

1. In your research paper, please acknowledge the donor, The Kadoorie Charitable Foundation, for all purposes in the future.
2. You must include a project team member as your co-author during any publication.
3. Please consider clients' vulnerability during data collection. Any vulnerable situation with the client group may suspend your data collection.

You are advised to contact Rabiul, Sr. OT from Ganakbari Day Centre or Sakhawat, Rehab Officer, for your potential participants.

Thank you
Kind regards
Mohsiur

Md Mohsiur Rahman
Project Manager
Meaningful Social Access for Persons with Mental Health Needs
Centre for the Rehabilitation of the Paralysed (CRP)
Phone: +8801730059505
Email: map.crp2022@gmail.com
Website: https://www.crp-bangladesh.org

Appendix C: Information Sheet and consent form (English version)

Participants Information and Consent Sheet

Research topic: Level of Community Participation of Person with Mental Illness following Rehabilitation.

Investigator: Abdullah Al Mamun Rafi, 4th year student of B.Sc. in Occupational Therapy, 2017-18 session, Bangladesh Health Professions Institute (BHPI).

Supervisor: SK. Moniruzzaman, Associate Professor & Head of the department of Occupational Therapy Department, Bangladesh Health Professions Institute (BHPI).

Place: Community of person with mental illness who took rehabilitation service from "Mental Health Project for Person with Mental Illness," CRP, Ganakbari.

Information Sheet

Participant explanatory statement/ Information Sheet Introduction

I am Abdullah Al Mamun Rafi, 4th year student of B.Sc. in Occupational Therapy, 2017-18 session, at Bangladesh Health Professions Institute (BHPI). Conducting a research project is required to complete B. Sc in Occupational Therapy from BHPI. This research project will be done under the supervision of SK Moniruzzaman, Associate Professor & Head of the department of Occupational Therapy and Khadija Akter lily, lecturer of Occupational Therapy Department. This participant paper will give you a detailed explanation of the research project's goals for data collection and how those goals relate to the research. It will be simpler to make decisions if you have a clear understanding of the research topic and are willing to participate in the study. Of course, you are not required to confirm your participation at this time. Before taking any decision, you can discuss with your relatives or guardian about this. Before you

decide, you can talk to anyone you feel comfortable with about the research. If the information sheet 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 as a person with mental health issues you have better understanding about community participation. The purpose of my study is to identify the level of participation at community among person with mental illness after getting treatment from Ganakbari Mental Health Day Centre.

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 participants will be asked to complete a WHODAS 2.0 scale which may need 15-20 minutes. In this scale there will be questions on socio-demographic factors (for example: Age, sex, current occupation etc.). It will also contain some specific questions related to community participation. Particularly, we have selected persons who had mental illness and completed their rehabilitation for the study. The information will be confidential and your identity will not be disclosed.

Benefits and risks of the participants:

We will ask you some questions, and some of them might make you uncomfortable. If you choose not to participate in the discussion interview or survey, that is also acceptable. On the other hand, you may not have any direct benefit by participating in this research, but your valuable participation is likely to help to find out the possible finding of the purpose.

Confidentiality of information:

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. Only the investigator will know about your information's, and we will lock that information up with a lock and key. It will not be shared with or given to anyone except study supervisor and co-supervisor.

Sharing the results:

Nothing you shared today will be disclosed to any other than the research team and your name won't be mentioned anywhere. We'll let you know what we learn from this research before making it widely known to the general public. 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.

Source of funding to conduct the research:

The cost of the research will be spent entirely by the investigator's own fund. No money comes from external source.

Contact address with the researcher and complaints:

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: Abdullah Al Mamun Rafi, Bachelor science in Occupational Therapy, Department of Occupational Therapy, Cell phone-01640781070. 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 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?

Consent form

Research Title: Level of Community Participation of Person with Mental Illness following Rehabilitation.

Purpose: The purpose of my study is to identify the level of participation at community among person with mental illness following rehabilitation.

Abdullah Al Mamun Rafi (investigator) is a 4th year student of B.Sc. in Occupational Therapy Department, 2017-18 session at Bangladesh Health Professions Institute (BHPI), the academic institute of Centre for the Rehabilitation of the paralyzed (CRP). This study is a part of the course curriculum of Occupational Therapy Department. The study supervised by SK. Moniruzzaman, Head of the department & Associate Professor of Occupational Therapy Department, Bangladesh Health Professions Institute (BHPI). All participants are informed about the purpose and nature of the study. After knowing the following information, participants will decide to participate in the study-

- Investigator will receive permission from participants to take part in the study.
- The participant will not be harmed for participating in the study.
- Investigator will be available to answer the participants any questions related to this study.
- Participants are free to decline to answer any question during interview.
- Investigator will maintain the confidentiality of the participants
- Participants can withdraw from the study at any time.

I_____ am a participant of this study is clearly informed about the aim of the study. I am participating willingly in this study. I have right to withdraw my name from this study at any time and I am not bound to answer anyone for that.

Signature:

Signature of the participant	Date:
Signature of the investigator	Date:
Signature of the Witness	Date:

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 (Applicable only for voluntary withdrawal)

Participants Name:

Reason for withdrawal:

……

……

……

Permission from the information whether it can be used or not. 1) Yes / 2) No

Participants signature & date:

Appendix C: Information Sheet and consent form (Bangla Version)

তথ্য পত্র

আমি আব্দুল্লাহ আল মামুন রাফি, ঢাকা বিশ্ববিদ্যালয়ে চিকিৎসা অনুষদের অধীনস্থ বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই) এর একজন ছাত্র। যা পক্ষাঘাতগ্রস্থদের পুনর্বাসন কেন্দ্র (সিআরপির) একটি শিক্ষা প্রতিষ্ঠান। আমি বি এস সি ইন অকুপেশনাল থেরাপি বিভাগের ৪র্থ বর্ষে অধ্যয়নরত আছি। এই কোর্সের অংশ হিসেবে চূড়ান্ত বর্ষে আবশ্যকভাবে একটি গবেষণা প্রকল্প সম্পন্ন করতে হয়। তারই ধারাবাহিকতায় আমি আপনাকে আমার গবেষণায় অংশগ্রহণের জন্য আমন্ত্রণ জানাচ্ছি। আমার গবেষণার বিষয় হচ্ছে, "পূনর্বাসন সেবা নেয়ার পর মানসিক ভাবে অসুস্থ ব্যক্তিদের সমাজিক কর্মকাণ্ডে অংশ নেওয়ার হার"

উক্ত গবেষণার মূল উদ্দেশ্য হল মানসিক সমস্যায় আক্রান্ত ব্যক্তিগন পূনর্বাসন সেবা নেওয়ার পর সামাজিক কর্মকান্ডে কতটুকু অংশগ্রহণ করতে পারে তা খুঁজে বের করা। আপনার কার্যকরী অংশগ্রগন গবেষণার উদ্দেশ্য পূরনে সহায়তা করবে বলে আমরা আশাবাদী।

উক্ত গবেষণায় অংশগ্রহণ সম্পূর্ণ আপনার ব্যক্তিগত এবং এই অংশগ্রহণ আপনার কোনো ধরনের ক্ষতি সাধন করবে না। আপনি যেকোনো সময় আপনার অংশগ্রহণ প্রত্যাহার করতে পারেন। গবেষণায় অংশগ্রহণের জন্য কোনো প্রকার উপহারের ব্যবস্থা নাই। এই গবেষণার মাধ্যমে ভবিষ্যতে মানসিক সমস্যায় আক্রান্ত ব্যক্তিগণের পূনর্বাসন সেবার উন্নয়ন সাধন হবে।

আপনার কাছ থেকে প্রাপ্ত তথ্য সম্পূর্ণভাবে গোপনীয় রাখা হবে। শুধুমাত্র গবেষক এবং তার তত্ত্বাবধায়ক তথ্যগুলো সম্পর্কে আবগত থাকবেন। আপনার পরিচয় গবেষণার কোথাও প্রকাশ করা হবে না। গবেষণা সংক্রান্ত কোনো রূপ প্রশ্ন যদি থাকে তাহলে নির্দ্বিধায় আমাকে জিজ্ঞাসা করতে পারেন। গবেষণা বিষয়ক সকল প্রশ্নের উত্তর দিতে আমি সচেষ্ট থাকবো। সেক্ষেত্রে আপনি গবেষকের সাথে উল্লেখিত ০১৬৪০৭৮ ১০৭০ (আব্দুল্লাহ আল মামুন রাফি) নাম্বারে যোগাযোগ করতে পারেন।

এই গবেষণার ফলাফল বিভিন্ন সামাজিক মাধ্যম, ওয়েবসাইট, সম্মেলন, আলোচনাসভায় এবং পর্যালোচিত জানালে প্রকাশ করা হবে।

আব্দুল্লাহ আল মামুন রাফি

বি. এস. সি. ইন অকুপেশনাল থেরাপি, ৪র্থ বর্ষ

সেশনঃ ২০১৭-২০১৮

বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)

সি. আর. পি, চাপাইন, সাভার, ঢাকা-১৩৪৩

সম্মতি পত্র

গবেষণার শিরোনাম: পুনর্বাসনের পর মানসিক অসুস্থতায় আক্রান্ত ব্যক্তির সামাজিক কর্মকান্ডে অংশগ্রহণের হার।

আব্দুল্লাহ আল মামুন রাফি (গবেষক), বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই) এর চতুর্থ বর্ষের একজন ছাত্র। এই গবেষণাটি অকুপেশনাল থেরাপি বিভাগের পাঠ্যক্রমের একটি অংশ। উক্ত গবেষণাটির সুপারভাইজার এস কে মনিরুজ্জামান, বিভাগীয় প্রধান ও অকুপেশনাল থেরাপি বিভাগের সহযোগী অধ্যাপক, বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)। সমস্ত অংশগ্রহণকারীদের গবেষণার উদ্দেশ্য এবং প্রকৃতি সম্পর্কে অবগত করা হল।

- তথ্য জানার পর, অংশগ্রহণকারীরা উক্ত গবেষণায় অংশগ্রহণের সিদ্ধান্ত নেবে।
- গবেষক অংশগ্রহণকারীদের কাছ থেকে অংশগ্রহণের জন্য অনুমতি নিবে।
- অংশগ্রহণকারী এই গবেষনায় অংশগ্রহণের মাধ্যমে ক্ষতিগ্রস্ত হবে না।
- গবেষক এই গবেষণার সাথে সম্পর্কিত যেকোন প্রশ্নের উত্তর দিতে বাধ্য থাকবেন।
- গবেষক অংশগ্রহণকারীদের গোপনীয়তা বজায় রাখবেন। অংশগ্রহণকারী যে কোন সময় গবেষণা থেকে তার তথ্য প্রত্যাহার করতে পারবেন।

আমি..... (অংশগ্রহনকারীর নাম) উপরোক্ত বিষয়ে অবগত আছি, গবেষণায় আমার অংশগ্রহণের প্রকৃতি বুঝত পেরেছি এবং আমি স্বাধীনভাবে অংশগ্রহণ করতে সম্মতি প্রকাশ করছি। আমি যে কোনো সময়ে এই গবেষণা থেকে আমার নাম প্রত্যাহার করার অধিকার রাখি। এবং আমার অংশগ্রহণের তথ্য কঠোরভাবে গোপনীয় থাকবে।

সাক্ষরঃ

অংশগ্রহণকারীর সাক্ষরঃ	তারিখঃ
গবেষকের সাক্ষরঃ	তারিখঃ
সাক্ষীর সাক্ষরঃ	তারিখঃ

প্রত্যাহার পত্র

আংশগ্রহণকারীর নামঃ.....

প্রত্যাহার করার কারনঃ

.....

.....

পূর্ববর্তী তথ্য ব্যাবহারের অনুমতি থাকবে কি না?

হ্যাঁ/না.....

আংশগ্রহণকারীর সাক্ষর/বৃদ্ধাঙ্গুলীর ছাপঃ..... তারিখঃ.....

Appendix D: WHODAS 2.0 Questionnaire (English and Bangla Version)

WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

36-item version, self-administered

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:						
Understanding and communicating						
D1.1	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.2	Remembering to do important things?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.3	Analysing and finding solutions to problems in day-to-day life?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.4	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.5	Generally understanding what people say?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.6	Starting and maintaining a conversation?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting around						
D2.1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.2	Standing up from sitting down?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.3	Moving around inside your home?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.4	Getting out of your home?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.5	Walking a long distance such as a kilometre [or equivalent]?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page ...

WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

36
Self

In the past 30 days, how much difficulty did you have in:						
Self-care						
D3.1	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.2	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.3	Eating?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.4	Staying by yourself for a few days?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting along with people						
D4.1	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.2	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.3	Getting along with people who are close to you?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.4	Making new friends?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.5	Sexual activities?	None	Mild	Moderate	Severe	Extreme or cannot do
Life activities						
D5.1	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.2	Doing most important household tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.3	Getting all the household work done that you needed to do?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.4	Getting your household work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page ...

WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

36
Self

If you work (paid, non-paid, self-employed) or go to school, complete questions D5.5–D5.8, below. Otherwise, skip to D6.1.

Because of your health condition, in the past 30 days, how much difficulty did you have in:						
D5.5	Your day-to-day work/school?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.6	Doing your most important work/school tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.7	Getting all the work done that you need to do?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.8	Getting your work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do

Participation in society						
In the past 30 days:						
D6.1	How much of a problem did you have in joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.2	How much of a problem did you have because of barriers or hindrances in the world around you?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.3	How much of a problem did you have living with dignity because of the attitudes and actions of others?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.4	How much time did you spend on your health condition, or its consequences?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.5	How much have you been emotionally affected by your health condition?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.6	How much has your health been a drain on the financial resources of you or your family?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.7	How much of a problem did your family have because of your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.8	How much of a problem did you have in doing things by yourself for relaxation or pleasure?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page ...

WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

WHO disability assessment schedule WHODAS 2.0 শিরোনামের অধীনে ২০১০ এ বিশ্ব স্বাস্থ্য সংস্থা কর্তৃক প্রকাশিত।

বিশ্ব স্বাস্থ্য সংস্থা বাংলা সংস্করণের অনুবাদ ও প্রকাশনার অনুমোদন বঙ্গবন্ধু শেখ মুজিব মেডিকেল বিশ্ববিদ্যালয় কে দিয়েছে, অনুবাদের দায়িত্ব এককভাবে অনুবাদকের। ইংরেজী এবং বাংলা সংস্করণের অসংগতির ক্ষেত্রে, মূল ইংরেজী সংস্করণ প্রাধান্য পাবে।

বিশ্ব স্বাস্থ্যসংস্থা অক্ষমতা মূল্যায়ন পদ্ধতি ২.০

বিশ্ব স্বাস্থ্যসংস্থা অক্ষমতা মূল্যায়ন পদ্ধতি ২.০

WHODAS 2.0

WORLD HEALTH ORGANIZATION DISABILITY ASSESSMENT SCHEDULE 2.0

বিশ্ব স্বাস্থ্যসংস্থা অক্ষমতা মূল্যায়ন পদ্ধতি ২.০

৩৬ টি বিষয়
রোগী কর্তৃক লিপিবদ্ধ

এই প্রশ্নমালায় সাক্ষাৎকার নেয়ার ৩৬ টি বিষয় আছে:

ধারা ১-

সাক্ষাৎকারের পূর্বে ১ থেকে ২ পূরণ করুন				
১	উত্তরদাতার সনাক্তকরণ নম্বর:			
২	সাক্ষাৎকার গ্রহনকারীর সনাক্তকরণ নম্বর:			
৩	পর্যালোচনার সময় (১,২ ইত্যাদি)			
৪	সাক্ষাৎকার গ্রহনের তারিখ:	দিন	মাস	বছর
৫	সাক্ষাৎকার গ্রহনের সময় অবস্থা	স্বনির্ভর		১
		পরনির্ভর		২
		হাসপাতালে অবস্থান		৩

ধারা ২-

জনসংখ্যা সম্বলিত এবং পূর্বের তথ্য

স্বাস্থ্য ঝুঁকিতে আক্রান্ত ব্যক্তিবর্গকে ভালোভাবে বোঝার জন্য বিশ্ব স্বাস্থ্য সংস্থা কর্তৃক এই সাক্ষাৎকারটি প্রনীত। এই সাক্ষাৎকারটিতে প্রদত্ত তথ্যসমূহ গোপন থাকবে এবং কেবল মাত্র গবেষনার কাজে ব্যবহার হবে। সাক্ষাৎকারটি গ্রহনে ২০ থেকে ২৫ মিনিট সময় প্রয়োজন হবে।

উত্তর প্রদানকারী সাধারণ জনগনের (যারা শারীরিকভাবে অসুস্থ নন) জন্যঃ

এমনকি আপনি পুরোপুরি সুস্থ হওয়া সত্বেও জরিপের প্রয়োজনে আপনাকে সবগুলো প্রশ্ন জিজ্ঞেস করা প্রয়োজন।

১	রোগীর লিঙ্গ	মেয়ে	১
		ছেলে	২
২	আপনার বয়স কত?	_____বৎসর	
৩	স্কুল, কলেজ অথবা বিশ্ববিদ্যালয়ে আপনি কত বৎসর ব্যয় করেছেন ?	_____বৎসর	
৪	আপনার বর্তমান বৈবাহিক অবস্থা কি? (সঠিক উত্তরটি বেছে নিন)	বিবাহ করেননি	১
		সম্প্রতি বিবাহ করেছেন	২
		বিবাহিত কিন্তু আলাদা থাকেন	৩
		তালাকপ্রাপ্ত	৪
		বিধবা/ বিপত্নিক	৫
		একসংগে বসবাস	৬
৫	কোনটি আপনার কাজের আসল অবস্থা বর্ণনা করে?(সঠিক উত্তরটি বেছে নিন)	কাজ করলে বেতন	১
		স্বউদ্যোক্তা যেমন ব্যবসা বা চাষাবাদ করছেন	২
		অলাভজনক কাজ যেমন স্বেচ্ছা সেবক বা সমাজ সেবা	৩
		ছাত্র	৪
		বাসাবাড়ী দেখাশোনা	৫
		অবসর প্রাপ্ত	৬
		বেকার (স্বাস্থ্যগত কারণে)	৭
		বেকার (অন্য কারণে)	৮
		অন্যান্য	৯

ধারা ৩- প্রস্তাবনা

উত্তরপ্রদানকারীকে বলুন:

এই সাক্ষাৎকারটি যারা শারীরিক সমস্যায় রয়েছেন তাদের জন্য।

উত্তর প্রদানকারীকে ফ্লাশকার্ড # ১ দিন এবং নির্দেশ করুন:

শারীরিক সমস্যা বলতে বুঝাবে রোগ বা অসুস্থতাকে অথবা অন্য স্বাস্থ্য সমস্যা যা দীর্ঘস্থায়ী বা স্বল্পস্থায়ী আঘাত, মানসিক বা আবেগীয় সমস্যা। এমনকি মদ্যপান বা মাদক জনিত সমস্যা এর অন্তর্ভূক্ত।

প্রশ্নের উত্তর দেয়ার সময়ে সব ধরনের শারীরিক সমস্যার কথা মনে রাখবেন। যখন আমি কোন সমস্যার কথা জিজ্ঞেস করবো তার অর্থ হলো- কাজ করতে গিয়ে কোন শারীরিক সমস্যায় পড়েছেন কিনা।

ফ্লাশকার্ড #১ নির্দেশ করার সময় ব্যাখ্যা করুন যে 'কাজের সময় অসুবিধা পড়া' বলতে কী বোঝায়-

* অতিরিক্ত প্রচেষ্টায় কাজটি করা

* অস্বস্তি বা ব্যথা স্বত্বেও করা

* সময় নিয়ে কাজটি করা

* যেভাবে করতে চান, সেভাবে করতে না পারা

উত্তরপ্রদানকারীকে বলুন:

যখন উত্তর দিবেন বিগত ৩০ দিনের কথা চিন্তা করে বলবেন। সাধারনত: কাজটি করার সময় ৩০ দিনের গড় অসুবিধার কথা বলবেন।

ফ্লাশকার্ড # ২ দেখান ও নির্দেশ করুন-

উত্তর দেয়ার সময় নিম্নলিখিত মাপকাঠি ব্যবহার করুন।

মাপকাঠিটি উচ্চস্বরে পড়ুন:

কোন সমস্যা নাই, খুব অল্প সমস্যা, মাঝারি সমস্যা, তীব্র সমস্যা, প্রচন্ড সমস্যা বা কিছুই করতে না পারা।

নিশ্চিত হোন যে সাক্ষাৎগ্রহনকালে সাক্ষাৎদানকারী যেন ফ্লাশকার্ড ১ ও ফ্লাশকার্ড ২ এর মাপকাঠিগুলো সহজেই দেখতে পারেন।

ধারা ৪-পর্যবেক্ষন ক্ষেত্র

ক্ষেত্র ১- বোধশক্তি

আমি এখন বোঝার ক্ষমতা ও ভাব বিনিময় বিষয়ে কিছু প্রশ্ন করছি।

উত্তর প্রদানকারীকে ক্লাশকার্ড ০১ এবং ক্লাশকার্ড ০২ দেখাল।

বিগত ৩০ দিনে আপনি কতটুকু সমস্যায় পড়েছেন:		কোন সমস্যা নাই	খুব অল্প সমস্যা	মাঝারি সমস্যা	তীব্র সমস্যা	প্রচন্ড সমস্যা বা কিছুই করতে না পারা
০১.১	কোন কিছু করতে ১০ মিনিট মনোযোগ দিতে পারেন?	১	২	৩	৪	৫
০১.২	গুরুত্বপূর্ণ কিছু করার কথা মনে থাকে?	১	২	৩	৪	৫
০১.৩	দৈনন্দিন কাজে সমস্যা হলে বিশ্লেষণ ও সমাধান করতে পারেন ?	১	২	৩	৪	৫
০১.৪	নতুন কিছু শেখা (যেমন নতুন কোন স্থানে কি করে যেতে হয়)?	১	২	৩	৪	৫
০১.৫	সচরাচর মানুষ যা বলে, তা বুঝতে পারেন?	১	২	৩	৪	৫
০১.৬	কোন বিষয়ে আলোচনা শুরু করতে ও চালিয়ে যেতে পারেন?	১	২	৩	৪	৫

ক্ষেত্র ২: চলাফেরা-

এখন আমি চলাফেরার অসুবিধা সম্পর্কে জানতে চাইবো।

উত্তর প্রদানকারীকে ক্লাশকার্ড ০১ এবং ক্লাশকার্ড ০২ দেখাল।

বিগত ৩০ দিনে আপনি কতটুকু সমস্যায় পড়েছেন:		কোন সমস্যা নাই	খুব অল্প সমস্যা	মাঝারি সমস্যা	তীব্র সমস্যা	প্রচন্ড সমস্যা বা কিছুই করতে না পারা
০২.১	একটানা ৩০ মিনিট দাঁড়িয়ে থাকতে পারেন?	১	২	৩	৪	৫
০২.২	বসা থেকে দাঁড়াতে পারেন?	১	২	৩	৪	৫
০২.৩	বাড়ীর ভিতর চলা-ফেরা করতে পারেন?	১	২	৩	৪	৫
০২.৪	বাড়ী থেকে বাইরে যেতে পারেন?	১	২	৩	৪	৫
০২.৫	একটানা এক কিলোমিটার হাঁটতে পারেন?	১	২	৩	৪	৫

ক্ষেত্র ৩ নিজের যত্ন-

আমি এখন আপনার কাছে জানতে চাইবো- নিজের যত্ন নিজে নিতে পারেন কিনা।

ফ্লাশকার্ড ০১ এবং ফ্লাশকার্ড ০২ দেখিয়ে-

বিগত ৩০ দিনে আপনি কতটুকু সমস্যায় পড়েছেন:		কোন সমস্যা নাই	খুব অল্প সমস্যা	মাঝারি সমস্যা	তীব্র সমস্যা	প্রচন্ড সমস্যা বা কিছুই করতে না পারা
০৩.১	নিজে নিজে গোসল করতে পারেন?	১	২	৩	৪	৫
০৩.২	নিজে নিজে কাপড় পরতে পারেন?	১	২	৩	৪	৫
০৩.৩	নিজে নিজে খেতে পারেন?	১	২	৩	৪	৫
০৩.৪	দিন কয়েক একা থাকতে পারেন?	১	২	৩	৪	৫

ক্ষেত্র ৪ মানুষের সাথে মানিয়ে চলা-

মানুষের সাথে থাকার ব্যাপারে কোন সমস্যা হয় কিনা সে সম্পর্কে এখন আমি আপনাকে জিজ্ঞেস করছি। অনুগ্রহপূর্বক মনে রাখবেন যে কেবল মাত্র অসুস্থতার কারনে সৃষ্ট সমস্যা সম্বন্ধেই প্রশ্ন করা হবে। এর অর্থ আমি বোঝাচ্ছি রোগ বা অসুস্থতা, আঘাত, মানসিক বা আবেগজনিত সমস্যা এবং মদ্যপান বা মাদক জনিত সমস্যা।

ফ্লাশকার্ড ০১ এবং ফ্লাশকার্ড ০২ দেখিয়ে-

বিগত ৩০ দিনে আপনি কতটুকু সমস্যায় পড়েছেন:		কোন সমস্যা নাই	খুব অল্প সমস্যা	মাঝারি সমস্যা	তীব্র সমস্যা	প্রচন্ড সমস্যা বা কিছুই করতে না পারা
০৪.১	অপরিচিত লোকের সঙ্গে আচরনে?	১	২	৩	৪	৫
০৪.২	বন্ধুত্ব রক্ষা করতে?	১	২	৩	৪	৫
০৪.৩	পরিচিত লোকের সাথে থাকতে?	১	২	৩	৪	৫
০৪.৪	নতুন বন্ধু তৈরিতে?	১	২	৩	৪	৫
০৪.৫	যৌন কার্যকলাপে?	১	২	৩	৪	৫

ক্ষেত্র ৫ জীবন-যাপন প্রনালী

৫(১) গৃহস্থালী কার্যাবলি-

এখন আমি আপনাকে গৃহস্থালী কাজের ব্যাপারে জিজ্ঞেস করবো। আপনার আপনজন যাদের সাথে আপনি থাকেন তাদের প্রতি আপনি কতটা যত্নশীল। এই কার্যক্রমের মধ্যে অন্তর্ভূক্ত রয়েছে -রান্নাবান্না, পরিষ্কার, পরিচ্ছন্নতা, বাজার, অন্যের প্রতি এবং নিজের জিনিসপত্রের যত্ন আত্তি করা।

ফ্লাশকার্ড ০১ এবং ফ্লাশকার্ড ০২ দেখিয়ে-

বিগত ৩০ দিনে স্বাস্থ্যগত কারনে আপনি কতটুকু সমস্যায় পড়েছেন:		কোন সমস্যা নাই	খুব অল্প সমস্যা	মাঝারি সমস্যা	তীব্র সমস্যা	প্রচন্ড সমস্যা বা কিছুই করতে না পারা
০৫.১	গৃহস্থালী দায়িত্বগুলো পালন করতে পারেন?	১	২	৩	৪	৫
০৫.২	সবচেয়ে গুরুত্বপূর্ণ গৃহস্থালী কাজগুলো ভালভাবে করতে পারেন?	১	২	৩	৪	৫
০৫.৩	প্রয়োজনীয় সকল গৃহস্থালী কাজগুলো সমাপ্ত করতে পারেন?	১	২	৩	৪	৫
০৫.৪	গৃহস্থালী কাজগুলো যথা সম্ভব দ্রুত করতে পারেন?	১	২	৩	৪	৫

যদি ০৫.২ -০৫.৫ এর মান 'কোন সমস্যা নাই' (১) এর বেশি হয় তাহলে জিজ্ঞেস করুন-

০৫.০১	বিগত ৩০ দিনের মধ্যে কতদিন গৃহস্থালীর কাজ কম হয়েছে অথবা কতদিন কাজ পুরোপুরি বাদ গেছে।	উক্ত দিনগুলোর হিসেব লিখুন।

যদি সাক্ষাৎদানকারী চাকুরী করেন (বেতন ভুক্ত, অবৈতনিক, স্বকর্মসংস্থান) অথবা স্কুলে যায়, তাহলে পরবর্তী পৃষ্ঠায় ০৫.৫-০৫.১০ এর প্রশ্নগুলো শেষ করুন। অন্যথায় ০৬.১-এ চলে যেতে পারেন।

৫(২) পেশাগত বা স্কুলের কাজকর্ম-

এখন আমি আপনার পেশাগত বা স্কুলের কাজকর্ম নিয়ে জানতে চাইব।

ফ্লাশকার্ড ০১ এবং ফ্লাশকার্ড ০২ দেখিয়ে-

আপনার স্বাস্থ্যগত সমস্যার কারণে বিগত ৩০ দিনের মধ্যে কতটুকু সমস্যায় পড়েছেন:		কোন সমস্যা নাই	খুব অল্প সমস্যা	মাঝারি সমস্যা	তীব্র সমস্যা	প্রচন্ড সমস্যা বা কিছুই করতে না পারা
০৫.৫	আপনার দৈনন্দিন বা স্কুলের কাজ করতে?	১	২	৩	৪	৫
০৫.৬	আপনার পেশাগত বা স্কুলের জরুরী কোন কাজ সমাধান করতে?	১	২	৩	৪	৫
০৫.৭	আপনার প্রয়োজনীয় সকল কাজগুলো করতে?	১	২	৩	৪	৫
০৫.৮	আপনার কাজগুলো নির্দিষ্ট সময়ে প্রয়োজনীয় দ্রুততার সাথে শেষ করতে?	১	২	৩	৪	৫

০৫.৯	শারীরিক অবস্থার কারণে আপনাকে কি আপনার মর্যাদার চাইতে নিম্নস্তরে কাজ করতে হয়?	না	১
		হ্যাঁ	২
০৫.১০	শারীরিক অবস্থার কারণে কম উপার্জন করেছেন কি?	না	১
		হ্যাঁ	২

যদি ০৫.৫-০৫.৮ এর মান 'কোন সমস্যা নাই' (১) এর চেয়ে বেশি হয় তাহলে জিজ্ঞেস করুনঃ

০৫.২	বিগত ৩০ দিনের মধ্যে কতদিন আপনি অর্ধবেলা বা তার বেশি সময় আপনার স্বাস্থ্যগত সমস্যার কারণে কাজ থেকে অনুপস্থিত থেকেছেন ?	উক্ত দিনগুলোর হিসেব লিখুন।

ক্ষেত্র ৬ অংশ গ্রহনঃ

এখন আমি আপনাকে জিজ্ঞেস করব সমাজে আপনার অংশগ্রহন এবং আপনার নিজের ও পরিবারের উপর আপনার শারীরিক সমস্যার প্রভাব সম্পর্কে। কিছু প্রশ্ন হতে পারে বিগত ৩০ দিন আগের আপনার সমস্যা সম্পর্কে। উত্তর দেয়ার সময় অনুগ্রহপূর্বক বিগত ৩০ দিনের উপর আলোকপাত করবেন। আবারো আমি আপনাকে মনে করিয়ে দিতে চাই যে, এই প্রশ্নগুলোর উত্তরের সময় শারীরিক, মানসিক বা আবেগীয়, মদ্যপান বা মাদক জনিত সমস্যার কথা বলবেন।

ফ্লাশকার্ড ০১ এবং ফ্লাশকার্ড ০২ দেখিয়ে-

বিগত ৩০ দিনেঃ		কোন সমস্যা নাই	খুব অল্প সমস্যা	মাঝারি সমস্যা	তীব্র সমস্যা	প্রচন্ড সমস্যা বা কিছুই করতে না পারা
০৬.১	সামাজিক অনুষ্ঠান গুলোতে (যেমন উৎসব, ধর্মীয় অনুষ্ঠান বা অন্যান্য কর্মকান্ড) অন্যদের মত অংশ গ্রহন করতে গিয়ে কোন অসুবিধার মুখোমুখি হয়েছেন?	১	২	৩	৪	৫
০৬.২	আপনার পারিপার্শ্বিক বাধা-বিঘ্নের দরুন কতটুকু সমস্যায় পড়েছেন?	১	২	৩	৪	৫
০৬.৩	অন্যের দৃষ্টিভঙ্গি ও কাজের কারণে আপনি মর্যাদাপূর্ন জীবনযাপনে কতটুকু সমস্যায় পড়েছেন?	১	২	৩	৪	৫
০৬.৪	আপনার শারীরিক সমস্যা ও এর ফলে উদ্ভূত সমস্যাগুলোর জন্য কতটুকু সময় ব্যয় করেন?	১	২	৩	৪	৫
০৬.৫	নিজের শারীরিক সমস্যার কারনে কতটুকু আবেগ তারিত হন?	১	২	৩	৪	৫
০৬.৬	আপনার শারীরিক সমস্যার কারণে আপনার বা পরিবারের কী পরিমান আর্থিক ক্ষতি হচ্ছে?	১	২	৩	৪	৫
০৬.৭	আপনার শারীরিক সমস্যার কারণে আপনার পরিবার কতটুকু ভুক্তভোগী ?	১	২	৩	৪	৫
০৬.৮	বিশ্রাম বা বিনোদনের জন্য কিছু করতে গিয়ে আপনি কতটুকু সমস্যায় পড়েছেন ?	১	২	৩	৪	৫

১	সব মিলিয়ে, গত ৩০ দিনে, মোট কতদিন উপরোক্ত সমস্যা গুলো হয়েছে?	দিনগুলোর হিসাব রাখুন।
২	বিগত ৩০ দিনের মধ্যে কতদিন আপনি আপনার সাধারণ কাজে সম্পূর্ন অপারগ ছিলেন?	দিনগুলোর হিসাব রাখুন।
৩	বিগত ৩০ দিনের অসুস্থতার কারণে কতদিন স্বাভাবিক কাজকর্ম কম করেছেন?	দিনগুলোর হিসাব রাখুন।

সাক্ষাৎকার এখানেই শেষ। আপনাকে ধন্যবাদ।

Appendix E: Supervision schedule sheet

Bangladesh Health Professions Institute
Department of Occupational Therapy
4th Year B. Sc in Occupational Therapy
OT 401 Research Project

Thesis Supervisor- Student Contact; face to face or electronic and guidance record

Title of thesis: "Level of Community Participation among Person with Mental Illness following Rehabilitation."

Name of student: Abdullah Al Mamun Rafi

Name and designation of thesis supervisor: SK. Moniruzzaman, Associate Professor, Head of the department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI) CRP, Savar, Dhaka- 1343, Bangladesh

Appointment No	Date	Place	Topic of discussion	Duration (Minutes/ Hours)	Comments of student	Student's signature	Thesis supervisor signature
1	20.03.2021	BHPI, office Building.	Introduction & Research Title, aim, objectives.	2 hours 30 minutes	Prepare Title, aim and objectives	Abdullah Al Mamun Rafi	
2	22.08.2022	BHPI, office Building.	Research tool selection and discussion.	7 minutes	prepare and select tool.	Abdullah Al Mamun Rafi	
3	25.08.2022	Library Building	Guideline for Research proposal presentation	29 minutes	prepare Research proposal presentation.	Abdullah Al Mamun Rafi	

4	28.08.22	Library Building	Feedback on proposal presentation.	90 minutes	Correction of proposal.	Abdullah Al Mamun Fadi	
5	29.08.22	BHPI office building.	Discussion about scale	35 min.	Final tool selection	Abdullah Al Mamun Fadi	
6	31.08.22	Library building	Discussion about bangali form of scale	1 hour	Prepare bangla form of scale.	Abdullah Al Mamun Fadi	
7	03.09.22	"	Research proposal submission.	20 min	completing permission letter.	Abdullah Al Mamun Fadi	
8	06.09.22	"	Feedback on Research proposal.	25 min	Completing info sheet concent form.	Abdullah Al Mamun Fadi	
9	13.09.22	"	Feedback on permission letter	20 min	completing withdrawal form.	Abdullah Al Mamun Fadi	
10	17.09.22	"	Feedback about information sheet concent form & withdrawal form.	35 min	field test discussion	Abdullah Al Mamun Fadi	
11	21.09.22	"	Bangali All form discussion and feedback.	25 min	field test.	Abdullah Al Mamun Fadi	
12	11.10.22	"	field test related sharing and discussion.	30 min	Preparation for data collection.	Abdullah Al Mamun Fadi	
13	30.11.22	"	Data collection related feedback.	20 min	Completing data collection.	Abdullah Al Mamun Fadi	
14	2.12.22	"	Guideline for ongoing Research project work.	1 hour	participation related discussion.	Abdullah Al Mamun Fadi	

No	Date	Place	Topic of discussion	Duration (Minutes/ Hours)	Comments of student	Student's Signature	Thesis supervisor signature
15	6.12.22	Library building	Participant related discussion	20 min	Introduction, back ground writing.	Abdullah Al Mamun Padi	
16	12.12.22	"	Research related problem & discussion on introduction, background & literature review	1 hour	literature reviews and other feedback	Abdullah Al Mamun Padi	
17	20.12.22	"	Submission, discussion and feedback on introduction, Background & literature reviews.	40 min	Data entry related solution.	Abdullah Al Mamun Padi	
18	23.12.22	"	Data entry and discussion. & writing related feedback.	1 hour	Data analysis. related discussion	Abdullah Al Mamun Padi	
19	28.12.22	"	Data entry related discussion	30 min	Data analysis.	Abdullah Al Mamun Padi	
20	03.01.23	"	Data analysis related guideline.	20 min	Problem solving about data analysis	Abdullah Al Mamun Padi	
21	4.01.23	"	feedback on data analysis	15 min	Completing data analysis.	Abdullah Al Mamun Padi	
22	04.01.23	"	Feed back on data analysis	10 min	Solution of the data analysis problem.	Abdullah Al Mamun Padi	
23	07.01.23	"	Guideline on result writing.	15 min	Preparing resulting part of thesis.	Abdullah Al Mamun Padi	
24	8.01.23	"	feedback on result writing.	35 min	Preparing discussion part of the thesis.	Abdullah Al Mamun Padi	

25	12.01.23	Library building	Guideline on discussion part of the research	10 min	feedback on discussion.	Abdullah Al Mamun Pabi	
26	14.01.23	"	Feed back on discussion part.	25 min	completing 1st draft.	Abdullah Al Mamun Pabi	
27	15.01.23	"	First draft submission.	10 min	Literature search.	Abdullah Al Mamun Pabi	
28	25.01.2023	BHPS office building	Guideline about literature search and discussion session.	30 min.	find out related articles.	Abdullah Al Mamun Pabi	
29	29.01.2023	BHPS office building	Feedback session about literature search & review	20 min.	Completing literature review.	Abdullah Al Mamun Pabi	
30	05.02.2023	Library building	Feedback session about Introduction and literature reviews.	25 min	connecting the problems about	Abdullah Al Mamun Pabi	
31	06.02.2023	Library building.	overall feedback of 1st draft and sequencing	40 min	introduction, lit-reviews.	Abdullah Al Mamun Pabi	
32	07.02.23	"	Feed back on first draft.	1 hour	objective connection	Abdullah Al Mamun Pabi	
33	13.02.23	"	objective related discussion and connection	15 min	Completing discussion of the study.	Abdullah Al Mamun Pabi	
34	15.02.23	"	Analysis related discussion.	20 min	preparing conclusion of the thesis.	Abdullah Al Mamun Pabi	

35	04.05.23	Library building	Guideline for completing thesis write up.	20 min	final feedback and completion of thesis write up.	Abdullah Al Mamun Rafi	
36	09.04.23	"	Guideline for preparation of defence.	25 min	feedback of defence presentation.	Abdullah Al Mamun Rafi	
37	7.05.2023	"	Discussion and guideline for defence presentation.	35 min	Completing presentation for defence.	Abdullah Al Mamun Rafi	
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40							

Note:

1. Appointment number will cover at least a total of 40 hours; applicable only for face-to-face contact with the supervisors.
2. Students will require submitting this completed record during submission your final thesis.