

Level of Participation of Children & Adolescents with Attention-Deficit/Hyperactivity Disorder (ADHD) at Home, School and Community Settings: A Cross - Sectional Study



By

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This thesis is submitted in total fulfilment of the requirements for the subject RESEARCH 2 & 3 and partial fulfilment of the requirements for the degree of

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Statement of Authorship

Except where it is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis presented by me for any other degree or seminar. No other person's work has been used without due acknowledgement in the main text of the thesis. This thesis has not been submitted for the award of any other degree in any other tertiary institution. The ethical issue of the study has been strictly considered and protected. In case of dissemination of the findings of this project for future publication, the research supervisor will be highly concerned, and it will be duly acknowledged as an undergraduate thesis.

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Dedication

Dedicated to my parents, teachers, friends, and everyone who contributed to this study.

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List of Abbreviations

ADHD	Attention-Deficit/Hyperactivity Disorder
ADLs	Activities of Daily Living
APA	American Psychiatric Association
BHPI	Bangladesh Health Professions Institute
CRP	Centre for Rehabilitation of the Paralysed
CASP	Child and Adolescent Scale of Participation
DSM V	Diagnostic Statistical Manual
ICF	International Classification of Functioning, Disability & Health
ICF-CY	International Classification of Functioning, Disability and Health – Children and Youth
IRB	Institutional Review Board
SPSS	Statistical Package for Social Science
UN	United Nation
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WHO	World Health Organization
WMA	World Medical Association

Abstract

Background: Attention-Deficit/Hyperactivity Disorder (ADHD) is a common neurodevelopmental condition can restrict children's participation in everyday activities. It is characterized by inattention, hyperactivity, and impulsivity, impacting school, home, neighborhood and community and also social functioning.

Aims: This study aimed to assess the level of participation in home, school, and community activities among children and adolescents with ADHD, and to find out their sociodemographic characteristics and the associated factors with participation.

Methods: A cross-sectional study was conducted among 73 participants. Data were collected using a structured socio-demographic questionnaire and the Child and Adolescent Scale of Participation (CASP).

Results: The sample consisted of mostly male (83.6%), and within the age 5-7 years group (52.1%), a mean age of 8.05 years. The majority of the participants resided in urban areas (75.3%), and they were regularly attending school (91.8%). The limitation of participation was experienced in each of the CASP areas. Participation at home was largely restricted (43.8%) or very restricted (38.4%) with 84.9% form of very limited participation being the most severe. There was also limited school participation. In general, the participation was hardly evident in the case of most participants (64.4%). Home participation had significant associations with the family type ($P = 0.025$), community participation with the family size ($P = 0.049$), school participation with the number of the ADHD medications ($P = 0.012$), and home/community living activities.

Conclusion: Study findings highlight the need for participation-oriented interventions that address environmental supports, family, school and community inclusion strategies to improve meaningful engagement and promote participation in daily life.

Keywords: ADHD, CASP, Participation (Home, School & Community), ICF

CHAPTER I: INTRODUCTION

1.1 Background

Attention-Deficit/Hyperactivity Disorder (ADHD) is one of the most common neurodevelopmental disorders in children and adolescents, affecting approximately 5–7% of the global population (American Psychiatric Association [APA], 2013; Polanczyk et al., 2007). Epidemiological studies indicate that boys are 2–3 times more likely to be diagnosed than girls, highlighting a gender disparity in prevalence (Gershon, 2002). Globally, it is estimated that around 280 million people live with ADHD.

It is characterized by persistent patterns of inattention, hyperactivity and impulsivity, and is often accompanied by difficulties in executive functions such as working memory, planning and self-regulation (APA, 2013; Barkley, 2015). Many children with ADHD also present with co-occurring conditions, including learning difficulties, emotional and behavioral disorders, and motor, speech or sensory problems, which can further affect their everyday functioning (Gnanavel et al., 2019; Yochman et al., 2006).

Because of these symptoms and associated difficulties, children and adolescents with ADHD frequently experience problems in daily life across home, school and community settings. They may struggle to follow routines, complete self-care and household tasks, stay focused in class, finish schoolwork, and manage their behavior with peers and adults (Bagwell et al., 2001; Dunn et al., 2009). These functional challenges are linked with lower academic achievement, problems in social relationships and an increased risk of emotional distress, contributing to reduced quality of life compared with typically developing peers (Rocco et al., 2021; Schwörer et al., 2020).

In contemporary rehabilitation and occupational therapy, there is increasing emphasis on understanding not only symptoms, but also how children with ADHD participate in everyday activities that are meaningful and age appropriate. Within the International Classification of Functioning, Disability and Health (ICF), participation is defined as involvement in life situations and is considered a central indicator of child functioning and development (World Health Organization [WHO], 2007). Participation includes both attendance, referring to how often a child takes part in an activity, and involvement, referring to the quality of engagement, such as motivation, enjoyment, social connection and sense of belonging (Imms et al., 2016).

Research article indicates that children with ADHD tend to have lower levels of participation than their typically developing peers. At home they may require more supervision and assistance with daily routines and household chores; at school they often show reduced engagement in classroom learning, group work and social activities; and in the community they may participate less in sports, leisure, cultural or religious activities due to environmental demands, peer difficulties or lack of appropriate support (Klassen et al., 2004; Mendes et al., 2018).

Participation outcomes in ADHD are shaped not only by the severity of symptoms, but also by contextual factors. Environmental influences such as family routines, parenting style, teacher attitudes, classroom structure, school policies, physical and sensory characteristics of settings, and access to services can act as barriers or facilitators to participation. Personal factors, including age, gender, motivation, interests and self-esteem, also contribute to individual differences in participation profiles among children with ADHD (Imms et al., 2016; Mendes et al., 2018). Understanding how these factors interact is essential for designing effective occupational therapy and educational interventions. To measure participation in a

structured way, the Child and Adolescent Scale of Participation (CASP) is often used. CASP is a caregiver report instrument that evaluates the extent to which a child or adolescent participates in everyday activities at a level appropriate for their age across home, school and community domains (Bedell, 2009). It reflects the ICF view of participation by focusing on actual involvement in daily life rather than only on impairments or symptoms.

Although CASP has been widely applied in studies of children with acquired brain injury and other disabilities, its use in ADHD populations has been relatively limited (Bedell, 2009; Coster et al., 2012). As a result, there is still a gap in knowledge about how children and adolescents with ADHD participate in real world activities across different settings and how their participation compares with age expectations. The present study addresses this gap by using CASP to examine participation levels of children and adolescents with ADHD at home, at school and in the community, with the aim of identifying specific areas of restriction and informing targeted interventions to enhance participation and quality of life.

1.2 Justification of the Research

Participation in daily living activities is a key component of functional development for children and adolescents. However, children with ADHD often face difficulties taking part in activities at home, school, and within the community due to challenges with attention, impulsivity, and social interaction. In Bangladesh, most research has focused on the cognitive or behavioral symptoms of ADHD, while very little is known about how these difficulties affect actual participation in everyday life.

The Child and Adolescent Scale of Participation (CASP) is a globally recognized tool for measuring participation, yet it has been rarely used in ADHD research, especially in the Bangladeshi context. Using the CASP provides a more holistic view of children's engagement in meaningful activities across different settings.

This study is necessary because identifying participation barriers can help develop interventions such as task modification, environmental support, parent/caregiver guidance, and activity based therapy. The findings can support families, teachers, clinicians, and rehabilitation centers like CRP to design better programs for children with ADHD.

At a societal level, low participation can lead to social isolation, poor academic performance, and decreased confidence factors that may affect future independence and well-being. The study also aligns with the UNCRPD by highlighting participation as a fundamental right for all children. By providing evidence on participation difficulties, this research supports inclusive education, improved policies, and better rehabilitation planning in Bangladesh.

Overall, this study is justified because it addresses a critical research gap, uses a strong and underutilized assessment tool, and aims to improve the quality of life of children and adolescents with ADHD through informed, evidence-based interventions.

1.3 Operational Definition

1.3.1 Attention-Deficit/Hyperactivity Disorder (ADHD)

Attention-Deficit/Hyperactivity Disorder (ADHD) is a common neurodevelopmental disorder characterized by persistent patterns of inattention, hyperactivity, and impulsivity that are developmentally inappropriate and interfere with daily functioning across multiple settings such as home, school, and the community (American Psychiatric Association [APA], 2013). Children with ADHD may show difficulty sustaining attention, following instructions, organizing tasks, controlling impulses, and regulating activity levels, which can impact academic performance, social interactions, and participation in daily life (Barkley, 2015). ADHD is often identified in childhood, with symptoms typically appearing before the age of 12, and may persist into adolescence and adulthood.

1.3.2 Participation

Participation refers to a child's involvement in age appropriate activities across multiple life settings, including home, school, and community (WHO, 2001; Bedell et al., 2010). Home: Activities such as self-care, household chores, play, and family interactions. School: Classroom learning, completing academic tasks, group work, and social participation with peers. Community: Engagement in sports, recreational activities, religious or cultural events, and neighborhood play. Participation is measured using the Child and Adolescent Scale of Participation (CASP), a caregiver-reported tool that evaluates both the frequency of attendance and the quality of involvement in these activities, providing a practical measure of real life participation in line with the ICF framework (Bedell et al., 2010).

1.3.3 Participation Tool (CASP)

The Child and Adolescent Scale of Participation (CASP) is a caregiver reported tool that measures the extent to which children and adolescents participate in age expected activities at home, school, and in the community. Each item is scored on a 4 point scale from 1 (unable to participate) to 4 (age expected participation), with higher scores indicating better overall participation. CASP captures both the frequency and quality of engagement, providing a practical measure of real-life participation in line with the ICF framework (Bedell, 2009).

1.3.4 (ICF) International Classification of Functioning, Disability and Health

The International Classification of Functioning, Disability and Health (ICF) is a bio-psychosocial framework developed by the World Health Organization that describes a person's functioning and disability as the interaction between their health condition, body functions and structures, activities, participation, and contextual factors (environmental and personal) (WHO, 2001). In this study, ICF is used to conceptualize participation of children and adolescents with ADHD across home, school, and community settings, linking impairments in body functions and activity limitations to participation restrictions.

1.4 Aim of the Study

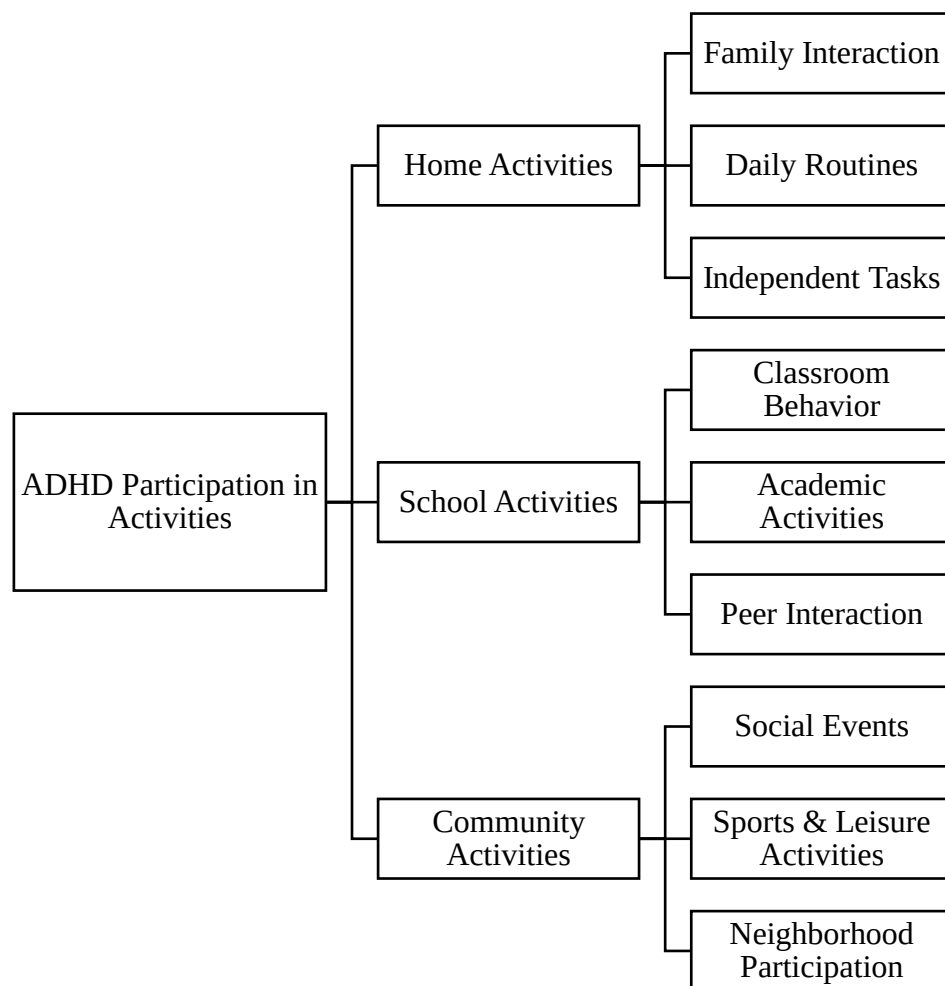
This study aimed to assess the level of participation in home, school, and community activities among children and adolescents with Attention-Deficit/Hyperactivity Disorder (ADHD), and to find out their sociodemographic characteristics and the associated factors with participation.

CHAPTER II: LITERATURE REVIEW

This chapter addresses the review of related literature information about “Identify the level of participation in home, school, and community activities among children & adolescents with ADHD.” It includes the findings, limitations, recommendations of the articles which is related to this study. The key gap in the evidence is also stated at the end of this chapter. Google Scholar, PubMed, Embase, Scopus, and Google have been searched for the related articles. Please see Figure 2.1 for an overview of the findings of the literature review.

Figure 2.1

Overview of Literature Review (ADHD Participation in Activities)



2.1 Overview of ADHD Participation in Activities

This section of the literature review covers participation among the children and adolescents activities across in home, school and community settings. In home activities as like ADLs (Activities of Daily Living), daily routines, family interaction, and independent tasks. In school activities are covers academic activities, peer interaction and classroom behavior. On the other side community activities as like involve in social events, sports and recreational activities or leisure and also neighborhood participation

2.2 Home Activities

Family meals, personal care, and household chores, which are home activities, have a crucial role in determining the cognitive, emotional, and social development of children. Those routines assist in the development of self-regulation, responsibility, and executive functioning, which are particularly necessary in children with ADHD (Larson et al., 2020). Family centered activities, such as shared meals and conversations, enhance communication abilities and emotional strength (Steinberg & Silk, 2022), whereas cleaning or organizing tasks lead to independence and problem solving skills (Weisner, 2021). These routines and organized home settings are especially helpful to children with ADHD, as they help them achieve improved behavior and social interaction (Golos et al., 2024). These activities do not just contribute to personal growth, but also make these children feel belonging and secure, thus enabling them to live a good day to day life.

2.2.1 Family Interaction

The family interaction in the form of eating meals together, discussing and taking part in household debates are also among the shared activities. These interrelations contribute to emotional attachment and communication competence (Steinberg and Silk, 2022). Other activities such as storytelling, board games and family outings also

aid in the development of problem-solving abilities and social competence (Golos et al., 2024). In children with ADHD, participation at home can be mitigated by the negative impact of inattention and impulsiveness because when a child can have supportive and responsive interactions with their family, the effects can be alleviated (Coussens et al., 2020a).

2.2.2 Daily Routines

Activities in the day are planned like washing hands, dressing, making food and sleep patterns. These practices would assist children in the process of self-regulation, time management, and organization (Weisner, 2021). Studies also show that regular home routines are shown to be especially helpful with ADHD children as they are capable of improving their executive functioning and minimizing behavioral difficulties (Larson et al., 2020; McRae et al., 2020). Routine routines are also known to aid in making expectations more understandable and promote more autonomy and engagement in daily home activities (Crespo et al., 2013).

2.2.3 Independent Tasks

As children grow they gradually take on more independent responsibilities at home, such as completing homework, organizing their personal space and performing household chores. These tasks promote independence, self-discipline and accountability (Steinberg & Silk, 2022). Adolescents benefit from learning practical life skills such as cooking, managing money and planning their time, which prepare them for adult roles and independent living (Weisner, 2021).

However, studies of household participation show that children with ADHD often perform similar types of tasks as their peers but require more supervision and assistance from caregivers (Mendes et al., 2018; Spaulding et al., 2021). Parents frequently report that their children with ADHD do not complete tasks independently

or satisfactorily and that they must provide extra prompts or support, which may affect the child's sense of competence and the overall family routine (Cronin, 2004; Segal, 2004).

2.3 School Activities

For children and adolescents with ADHD, the school environment presents both opportunities and challenges for participation. Structured school activities, such as routine based lessons and individualized support, can enhance engagement and help students manage their symptoms (DuPaul & Stoner, 2014). Clear expectations, visual schedules and consistent routines help students with ADHD focus, manage their behavior and improve academic performance (DuPaul & Stoner, 2020).

School participation also includes social aspects. Peer interactions contribute to emotional growth, conflict resolution and resilience (Wentzel, 2016). For children with ADHD, positive peer experiences provide a context to practice social skills, build self-esteem and feel included. Participation in both academic and social activities at school is therefore important for overall development and well-being (Coussens et al., 2020a; Kara et al., 2025).

2.3.1 Classroom Behavior

Many students with ADHD struggle to stay seated, follow instructions, and complete tasks without being distracted. Impulsivity can lead to interruptions and disruptive behaviors, making it more challenging for individuals to concentrate on lessons (DuPaul & Stoner, 2020). Teachers often report that students with ADHD require additional structure, prompts, and support to remain on task and participate effectively in classroom activities (Pfeiffer et al., 2017). Such behavioral challenges can contribute to lower levels of classroom participation and negative feedback from teachers (Langberg et al., 2018).

2.3.2 Academic Activities

ADHD is associated with lower academic performance, not because students lack ability, but because they often struggle with organization, time management, and sustained attention (Langberg et al., 2018). Difficulties with homework completion, test performance, and participation in class discussions are commonly reported among students with ADHD (DuPaul & Stoner, 2014; Dunn et al., 2009). Research suggests that structured learning plans, such as Individualized Education Programs (IEPs), classroom accommodations, and behavioral interventions, can support academic success and improve participation in learning activities (Evans et al., 2021).

2.3.3 Peer Interaction

Socializing can be challenging for children and adolescents with ADHD. They may interrupt conversations, struggle with turn-taking, or misunderstand social cues, which can lead to peer rejection or difficulties forming and maintaining friendships (Mikami, 2019). These social difficulties may reduce participation in group projects, recess activities, and extracurricular events. Interventions such as social skills training, peer mentoring, and small-group programs have been recommended to support more positive peer interactions and increase social participation at school (Hoza, 2020; Cordier et al., 2019). When schools combine structured academic support, positive behavioral strategies, and opportunities for meaningful peer interaction, students with ADHD are more likely to thrive both academically and socially (Kara et al., 2025).

2.4 Community Participation Activities

Children and adolescents with ADHD often face challenges when engaging in community activities due to difficulties with attention, impulse control, and social interaction. Nevertheless, participation in social events, recreational activities, and neighborhood interactions plays a crucial role in their social, emotional, and physical

development (King et al., 2019; Coussens et al., 2020b).

2.4.1 Social Events

Attending social gatherings such as birthday parties, community celebrations and religious events can be difficult for children with ADHD because they may struggle with waiting their turn, following social norms or coping with overstimulating environments (Mikami, 2019). Impulsivity and difficulty regulating behavior can interfere with forming and maintaining friendships in these settings. However, research suggests that structured social skills training and supportive adult supervision can improve children's ability to participate in group interactions more effectively (Hoza, 2020).

2.4.2 Sports and Recreational Activities

Participation in sports and recreational activities gives children with ADHD opportunities for physical activity, teamwork and self-discipline. However, sports that demand sustained attention and strict adherence to rules, such as certain team sports or activities like chess, may be more challenging for them (Drechsler et al., 2020). In contrast, activities involving short bursts of movement, such as martial arts, swimming or gymnastics, tend to be more engaging and can help improve self-regulation, attention and overall participation (Verret et al., 2017).

2.4.3 Neighborhood Participation

Neighborhood participation includes playing outside with friends, joining local clubs and taking part in community projects. These experiences can support social skills, independence and a sense of belonging. Children with ADHD may find it difficult to maintain friendships, follow group rules or resolve conflicts, which can limit their involvement in neighborhood activities (Cordier et al., 2019). When communities provide structured, inclusive and well-supervised programs, children with ADHD are

more likely to develop stronger social connections and feel included in community life (Khetani et al., 2015; Guichard & Grande, 2019). Creating supportive environments is therefore essential to enable meaningful community participation for this population.

2.5 Conceptual Framework

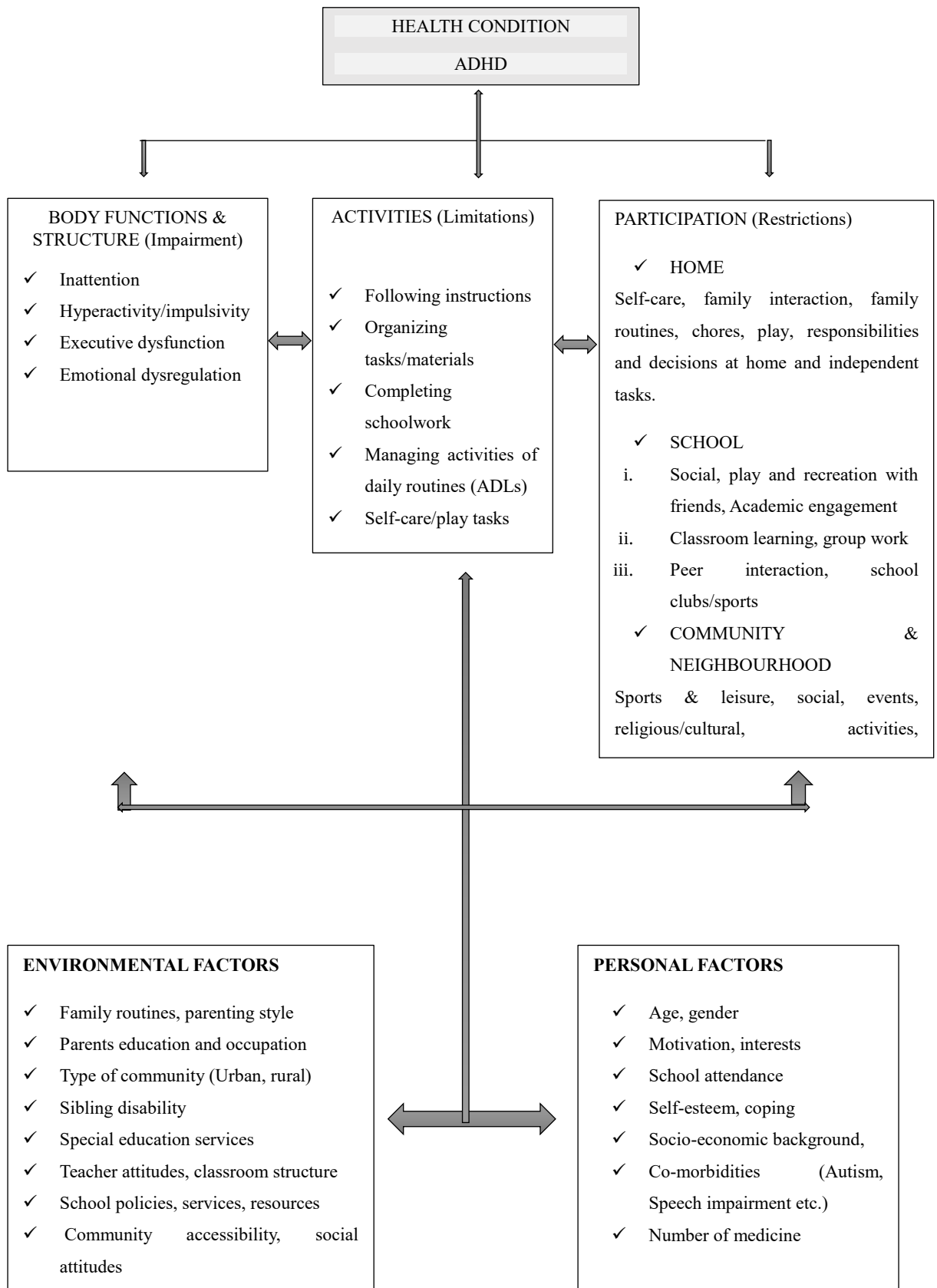
In this study, the International Classification of Functioning, Disability and Health (ICF) is used as the conceptual framework for describing the functional problems associated with ADHD. The World Health Organization created the ICF to offer a rational and extensive structure, as well as a shared terminology, to describe and evaluate the functional impacts of health conditions irrespective of the disease or disorder at hand. The application of this model can be used to compare health-related states of conditions, studies, interventions, populations, and countries.

The current research is clearly informed by the International Classification of Functioning, Disability and Health -Children and Youth (ICF-CY) (WHO, 2007). The ICF-CY has built upon the ICF framework to include more developmental features of the childhood and adolescent stage. It gives a systematic bio-psychosocial model explaining how a health condition affects daily functioning in the dynamic interaction between body functions and structures, activities, participation and contextual factors.

In the International Classification of Functioning, Disability and Health the functioning has body functions, activities, and participation that are closely related and affect one another. Sound environmental and individual influences condition and constrain general functioning.

Figure 2.5

Conceptual model of International Classification of Functioning, Disability and Health (ICF) on ADHD



2.5.1 ICF-Based Theoretical Framework of Participation on ADHD

According to the ICF, functioning is described through the following main components:

A. Health Condition

In this study, the health condition is Attention-Deficit/Hyperactivity Disorder (ADHD).

a. Body Functions and Structures

ADHD mainly affects mental functions, including attention, impulse control, activity level, working memory, planning, organization, emotional regulation and self-regulation (APA, 2013; Barkley, 2015).

b. Activities

Activities are the execution of tasks or actions by an individual (WHO, 2007). For children and adolescents with ADHD, activity limitations may include difficulty following instructions, completing schoolwork, organizing personal belongings, maintaining daily routines and managing self-care or homework tasks (Dunn et al., 2009; Langberg et al., 2018).

c. Participation

Participation is defined as involvement in life situations and is a central outcome in the ICF (WHO, 2007). For this study, participation refers to the child's involvement in everyday activities at home, school and in the community. Participation includes both attendance (frequency and range of activities) and involvement (quality of engagement, such as motivation, enjoyment and social connection; Imms et al., 2016).

B. Contextual Factors

a. Environmental Factors

Environmental factors include the physical, social and attitudinal environment in which children live and grow (WHO, 2007). Examples relevant to ADHD are family routines, parenting style, teacher attitudes, classroom structure, school policies, accessibility of

community programmes, transport, financial resources and social attitudes towards ADHD (Mendes et al., 2018; Kara et al., 2025). These factors can act as barriers (e.g., negative attitudes, noisy classrooms, lack of support) or facilitators (e.g., supportive teachers, structured routines, inclusive community activities) of participation.

b. Personal Factors

Personal factors include characteristics such as age, gender, motivation, interests, self-esteem, coping style and co-occurring conditions. These factors influence how each child experiences ADHD and responds to environmental demands (Imms et al., 2017). Within this framework, ADHD is conceptualized as the health condition that gives rise to impairments in body functions (e.g., attention, executive functioning). These impairments can lead to activity limitations (for example, difficulty organizing schoolwork or completing chores), which then result in participation restrictions in home, school and community life. At the same time, environmental and personal factors can either reduce or increase the impact of ADHD on participation (WHO, 2007; Imms et al., 2016).

In the current study, participation is operationalized using the Child and Adolescent Scale of Participation (CASP). CASP is a caregiver-report measure that assesses how much a child or adolescent participates in everyday activities compared with age expectations across home, school and community domains (Bedell, 2009). It is consistent with the ICF concept of participation because it focuses on involvement in real life situations rather than only on symptoms.

2.6 Associated Demographic and Contextual Factors

The symptoms of ADHD do not affect the participation in daily activities. Various demographic and contextual aspects as well influence the participation of children and adolescents with ADHD in domestic, school and community activities. These are age, sex, family background, parents education level, type of school and place of living (urban or rural; Mendes et al., 2018; Coussens et al., 2020a). Children and adolescents are often supposed to do more at home, including chores, homework and to be more involved in school and community activities, on their own. According to the studies, the older age may be correlated with the augmented involvement in particular activities, in particular, when children obtain the necessary support and can train the skills during the period (Mendes et al., 2018). Nevertheless, when the symptoms of ADHD are not managed, elderly children can still be dependent on adults to assist them in the areas of organization, planning and behaviour, which stifles their autonomy.

Gender disparity has also been cited in ADHD and involvement. ADHD is more frequently diagnosed in boys compared to girls and hyperactivity and disruptive behaviour are typically more apparent in boys, whilst girls may show more manifestations of inattentiveness (Gershon, 2002; APA, 2013). Certain researchers may indicate that boys can be assigned more physical or outdoor duties, whereas girls can get more indoor or caregiving duties at home, establishing disparities of participation between boys and girls with ADHD (Mendes et al., 2018).

The participation of children is related to the family features like parental education, family income, and family structure. It is believed that higher parental education and family income are also likely to lead to increased access to health, educational and community resources, and more chances of organized extracurricular activities (Guichard & Grande, 2019). More resourceful parents can perhaps offer

regular routines, instructional resources and facilitating conditions, and this can be useful in improving participation of children with ADHD. Conversely, those families who are less resourceful can have further complications like inadequate access to services, transportation issues and high-crowded households that can limit both household and community involvement (Khetani et al., 2015).

Factors related to the school also contribute a lot. Children with ADHD who were placed in schools with small classes, positive attitudes of teachers, and opportunities to use special education services or accommodations are more likely to engage in classroom, social and extracurricular activities (Kara et al., 2025; Pfeiffer et al., 2017). Conversely, high classes, academic acuity and lack of support may enhance the restriction of participation. Participation opportunities may also be influenced by school type (e.g. the difference between a public and a private school) and access to inclusive programs.

Lastly, environment (urban or rural) and neighborhood infrastructure also affect participation in sports, leisure and neighborhood activities. In cities, formal programs can be offered (sports clubs, community centres), whereas in rural areas, there can be more out of doors play but less of specialized facilities. Structured, predictable, and inclusive, whether in the classroom, at home, or elsewhere, are some of the settings that children with ADHD may find effective (Cordier et al., 2019; Coussens et al., 2020b).

Overall, demographic and contextual variables like age, gender, family resources, school context and living environment interplay with the ADHD symptoms to contribute to the participation pattern. These factors are significant to understand to develop interventions and policies that will facilitate participation of a number of children and teenagers with ADHD.

2.7 Key Gaps of the Studies

- Majority of research on ADHD has focused on the severity of symptoms, executive dysfunction and academic performance, and has not considered participation as an outcome of functional and real life functioning.
- Tools like the Child and Adolescent Scale of Participation (CASP) are rarely applied in ADHD populations, especially to measure participation across multiple settings.
- Many studies assess only one context (e.g., home routines or school performance), despite ADHD symptoms affecting multiple environments simultaneously.
- Community and neighborhood participation is less studied compared to home and school, even though it is crucial for social inclusion, peer interaction, leisure engagement, and overall development.
- Due to these gaps, there is insufficient evidence to identify which participation domains are most restricted and which contextual factors influence participation, limiting occupational therapy and related services in designing targeted, participation focused interventions.

CHAPTER III: METHODS AND MATERIALS

3.1 Study Question, Aim and Objectives

3.1.1 Study Question

What is the level of activities participation among child and adolescent with Attention-Deficit/Hyperactivity Disorder (ADHD) in home, school, and community activities?

3.1.2 Aim

The aim of this study is to identify the level of participation in home, school, and community activities among children & adolescents with Attention-Deficit/Hyperactivity Disorder (ADHD).

3.1.3 Objective(s)

- To find out the socio-demographic characteristics of the participants.
- To assess the participation level of children and adolescent with Attention-Deficit/Hyperactivity Disorder (ADHD) at home, school, community settings.
- To find out the factor associated with the participation pattern in daily activities at home, school, community settings.

3.2 Study Design

3.2.1 Study Method

A quantitative study was suitable for this research because it allowed for the objective measurement of participation levels among children and adolescents with ADHD. Since this study aimed to assess participation across home, school, and community settings using a standardized tool (CASP), a quantitative approach was appropriate for generating measurable and comparable data. Quantitative research enables systematic data collection and statistical analysis from a larger sample within a limited timeframe. (Williams, 2021). The structured design also ensures consistency and replicability, which strengthens the reliability and validity of the findings. Moreover, using a

standardized participation measure supports objective evaluation of functional outcomes rather than relying solely on subjective opinions (Gajdošová & Janičová, 2021). Overall, quantitative research was an effective and appropriate approach for examining participation restrictions among children and adolescents with ADHD.

3.2.2 Study Approach

A cross-sectional study design facilitated data collection at a single point in time, providing a snapshot of the current level of participation among children and adolescents with ADHD (Oudejans et al., 2021). This approach was appropriate for estimating the prevalence of participation restrictions across home, school, and community settings. According to the research aim, the cross-sectional design allowed the assessment of existing participation levels without requiring long-term follow-up. Cross-sectional studies are particularly useful for measuring the prevalence of conditions and associated factors within a specific population (Oudejans et al., 2021). In this study, the design helped quantify the current level of activity participation and identify patterns across different environments. Additionally, the cross-sectional approach was cost-effective and enabled the assessment of multiple variables simultaneously. The research objectives aligned well with this design, as it allowed the examination of participation levels across various contexts at a single time point.

3.3 Study Setting and Period

3.3.1 Study Setting

This study was conducted across several selected special schools within the Dhaka Division, Bangladesh, where children and adolescents with ADHD receive therapeutic, educational, and rehabilitation services. Data were collected from parents and caregivers whose children were enrolled in the following institutions:

- Alokito Shishu (Shyamoli and Uttara Branch)

- Ingenious Care, Pallabi, Mirpur
- Prottasha Centre for Autism Care, Savar
- Therapist Point & Shanirvor Special School for Autism and Neurodevelopmental Disorders, Savar
- Smiling Children Special School, Bonosri, Rampura
- Society for the Welfare of Autistic Children (SWAC), Adabor
- Tara Special Child Care, Mirpur
- Unique Gift Foundation, South Baridhara, Nadda

All these institutions serve child and adolescent from urban, rural, and semi-urban backgrounds, offering a combination of therapeutic interventions and structured school participation programs. Services commonly available in these settings include occupational therapy, speech therapy, physiotherapy, special education, and parental counseling making them ideal environments for recruiting parents and caregivers of children with ADHD.

3.3.2 Study Period

The study period was from June 2025 to December 2025, and the data collection period was from August 2025 to September 2025.

3.4 Study Participant

3.4.1 Study Population

The target population of this study comprised children and adolescents aged 5 to 18 years who had been diagnosed with ADHD. However, as children and adolescents may have limitations in accurately reporting their own participation, parents or primary caregivers were considered the appropriate respondents. Therefore, all data were collected exclusively from parents or caregivers of children receiving services at selected special schools that provide support for children with ADHD.

3.4.2 Sample Size

According to Cochran's formula (Ahmed, 2024), $n = \frac{Z^2 \cdot P \cdot q}{d^2}$

Here, n = required sample size

z = standard normal deviation; usually set at 1.96 which corresponds to a 95% Confidence Interval (CI).

p = Prevalence of ADHD (Prevalence, e.g., 5%, 0.05) (American Psychiatric Association [APA], 2013; (Polanczyk et al., 2007)

$p = 0.05$, $q = (1-p) = (1-0.05) = 0.95$

d = degree of accuracy desire, usually set at 0.05

Then, $z = 1.96$, $p = 0.05$, $q = 0.95$ and $d = 0.05$

$$\text{Sample size, } n = \frac{1.96^2 \cdot 0.05 \cdot 0.95}{0.05^2}$$

$$= 72.9 + 10\% = 80 \text{ (10\% non-response rate would be added)}$$

Because of the short time, the student researcher reached 73 participants and collected data from them.

3.4.3 Sampling Techniques

In this research, the researcher used a convenience sampling technique. This method allowed the recruitment of participants who were easily accessible, making the process cost-effective and time-efficient (Ahmed, 2024). Considering the study focused on children and adolescents with ADHD from selected centers, convenience sampling was practical and feasible within the given timeframe. This approach facilitated the recruitment of a larger sample size, which ensured adequate statistical power, and enabled rapid data collection, making it suitable for a cross-sectional quantitative design (Stratton, 2021). In addition, it reduced research costs by permitting quick data collection when time was limited.

3.4.4 Inclusion Criteria

- Children and adolescents who are diagnosed as ADHD.
- Children and adolescents with ADHD who are going to special or inclusive school.
- Children and adolescents with ADHD were between aged 5 to 18 years old.

3.4.5 Exclusion Criteria

- Incomplete questionnaires responses and parents or caregiver who are unwilling to provide informed consent.

3.5 Ethical Considerations

3.5.1 Ethical Clearance

Ethical approval was obtained from the Institutional Review Board (IRB) at the Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI). The IRB form number is CRP- BHPI/IRB/05/2024/1122 (see in details appendix-A).

3.5.2 Informed Consent

The researcher provided an information sheet explaining the aim, objective, and purpose of the study, consent form and withdrawal form to the participants.

3.5.3 Unequal Relationship

There was no personal relationship between the investigator and the participant. Before data collection, the data collector did not know the participants.

3.5.4 Risk and Beneficence

Participants had no risk in participating in this study. There was no personal or financial benefit between the participants and the investigator.

3.5.5 Confidentiality

The researcher-maintained confidentiality regarding all the participants throughout the research procedure. The investigator ensured and maintained the confidentiality of

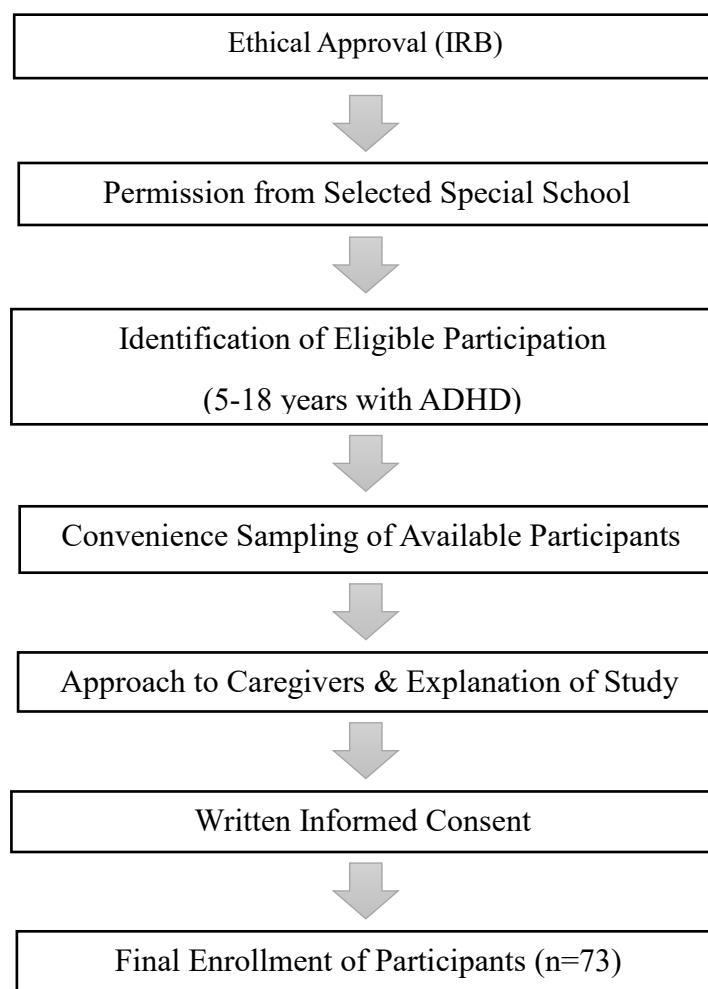
participants. Only the investigator and responsible supervisor had access to the data, and that information was clearly stated in the information sheet and provided before collecting the data.

3.6 Data Collection Process

3.6.1 Participant Recruitment Process

Figure 3.6.1

Overview of the participant recruitment process



3.6.2 Data Collection Method

The data collected by face-to-face survey through a socio-demographic questionnaire, and the Child and Adolescent Scale of Participation (CASP) questionnaire. The student researcher physically presented and the CASP questionnaire was conducted by the

student researcher. Face-to-face survey maintained the quality of data and decreased the potential biasness (Doyle, 2005).

3.6.3 Data Collection Instrument

- A self-administrated semi-structured questionnaire was developed based on collecting socio-demographic information from the respondents (see details in Appendix F).
- **Child and Adolescent Scale of Participation (CASP):** The Child and Adolescent Scale of Participation (CASP) measures the extent to which children and adolescents participate in home, school, and community activities (Bedell, 2004, 2009). The CASP were informed by the International Classification of Functioning (ICF, WHO, 2001). As well, feedback was obtained by parents of children and adolescents with ADHD and clinical and measurement experts to develop and refine the CASP (Bedell, 2004, 2009). The CASP consists of 20 ordinal-scaled items and four subsections: 1) Home Participation (6 items), 2) Community Participation (4 items), 3) School Participation (5 items), and 4) Home and Community Living Activities (5 items). The 20 items are rated on a four-point scale: “Age Expected (Full participation),” “Somewhat Restricted,” “Very Restricted,” “Unable.” A “Not Applicable” response is selected when the item reflects an activity in which the child would not be expected to participate due to age (e.g., work). Most items are applicable to children who are five and older and thus it is suggested that the CASP is used for school-aged children (5 years and older) so that most items and subsections can be completed.

3.6.4 Field Test

The student researcher, with the help of the supervisor and an expert in formal Bengali writing, translated the questionnaire into Bengali, which is the native language of

Bangladesh. To identify potential problems with the questionnaire, it was pretested between two respondents who were similar to the study population but outside the study area. After pretesting, the questionnaire was finalized with the necessary corrections for the study.

3.7 Data Management and Analysis

Statistical analysis was performed using IBM SPSS Statistics version 20.0 (IBM Corporation, Armonk, NY, USA). Descriptive statistics (mean, median, IQR, SD, frequency, and percentage) were used to summarize socio-demographic characteristics and CASP participation scores across home, school, neighborhood and community, and home and community living domains. Associations between demographic variables and participation levels were examined using the Chi-square test or Fisher's Exact Test when assumptions were not met. Unstandardized coefficients (B) with 95% confidence intervals (CI) were calculated where applicable. Statistical significance was set at $P < 0.05$.

3.8 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 Participation scale. The scale was already translated into Bangla. After the field test, the question was modified to match our cultural perspective to get wider information and make it understandable.

CHAPTER IV: RESULTS

A cross-sectional study was conducted on the Level of participation among children and adolescents with ADHD. This section provides a statistical analysis of the findings. The findings of the study have been analyzed and represented by using table in a systematic way.

4.1 Sociodemographic characteristics of the participants (Children and Adolescent)

Table 4.1

General Sociodemographic characteristics of the participants (Children and Adolescent)

Variable	Category	Frequency n=73	Percentage (%)
Age	5-7 years	38	52.1
	8-11 years	24	32.9
	12-18 years	11	15.1
	Mean=8.049 years, SD (± 2.8047), Minimum= 5 years, Maximum= 16 years		
Gender	Male	61	83.6
	Female	12	16.4
Type of community living	Urban	55	75.3
	Semi-Urban	12	16.4
	Rural	6	8.2
School attendance	Regularly	67	91.8
	Irregularly	6	8.2
Medication use for ADHD	Yes	59	80.8
	No	14	19.2
Number on ADHD medication	No medicine	14	19.2
	Single medicine	12	16.4
	Multiple medicines	47	64.4
	Mean= 2.19, SD (± 1.596), Minimum= 0 medicine, Maximum= 7 medicine		

ADHD diagnosis age	1-2.9 years age	37	50.7
	3-5 years age	36	49.3
	Mean= 2.816 years, SD (.8873), Minimum= 1.2 years, Maximum= 5 years		
Type of treatment received	Doctor	45	61.6
	Therapist	3	4.1
	Doctor & Therapist	25	34.2
Siblings status	No	29	39.7
	Yes	44	60.3
Number of siblings	No siblings	29	39.7
	Have only 1 sibling	42	57.5
	2 & more siblings	2	2.7
	Mean= .75 person, SD ($\pm$.778), Minimum= 0 person, Maximum= 4 people		
Presence of associated conditions or disability	No	24	32.9
	Yes	49	67.1
Type of associated condition or disability with ADHD	Autism	23	31.5
	Physical Disability	1	1.4
	Visual Impairment	1	1.4
	Speech Impairment	15	20.5
	Intellectual Disability	1	1.4
	Hearing Impairment	1	1.4
	Down Syndrome	1	1.4
	Multiple Disability	6	8.2
	No associated condition or disability (Not applicable)	24	32.9

Table 4.1 presents the sociodemographic characteristics of the 73 children and adolescents with ADHD who participated in the study. The majority of participants were male (83.6%, $n = 61$), resulting in a male-to-female ratio of approximately 5:1, which aligns with global ADHD prevalence patterns. Most participants were in the early school-aged group (5–7 years, 52.1%, $n = 38$), followed by middle childhood (8–11 years, 32.9%, $n = 24$), and adolescents aged 12–18 years formed the smallest group (15.1%, $n = 11$). The mean age was 8.05 years ($SD \pm 2.80$).

Regarding community living, most children resided in urban areas (75.3%, $n = 55$), followed by semi-urban (16.4%, $n = 12$) and rural areas (8.2%, $n = 6$). School attendance was high, with 91.8% ($n = 67$) attending regularly. A majority of the participants (80.8%, $n = 59$) were currently receiving medication for ADHD, with multiple medications being the most common regimen (64.4%, $n = 47$). All participants were diagnosed before the age of 5, with a mean diagnosis age of 2.82 years ($SD \pm 0.89$). Most participants had received treatment from a doctor, therapist, or both (61.6%, 4.1%, and 34.2%, respectively). In terms of family structure, 60.3% ($n = 44$) had siblings, with one sibling being the most common (57.5%, $n = 42$), while 39.7% ($n = 29$) had no siblings.

Over two-thirds (67.1%, $n=49$) of the children had more than one other condition with ADHD, and 32.9% ($n=24$) of the children had no associated condition or disability. The most common condition among the reported was Autism (31.5%, $n=23$) and the next common condition was Speech Impairment (20.5% $n=15$). Fewer percentage of respondents had multiple disabilities (8.2%, $n=6$), with other disabilities of physical, visual, intellectual, hearing impairment and Down syndrome reported in low cases (1.4% and 1.4% each).

4.2 Family and parents socio-demographic characteristics of the participants (Children and Adolescent)

Table 4.2

Family and parents socio-demographic characteristics of the participants (Children and Adolescent)

Variable	Category	Frequency n=73	Percentage (%)
Mothers education level	Secondary	7	9.6
	Higher Secondary	18	24.7
	Bachelor or above	48	65.8
Fathers education level	Secondary	9	12.3
	Higher Secondary	9	12.3
	Bachelor or above	55	75.3
Mothers occupation	Homemaker	61	83.6
	Government Job	2	2.7
	Private Job	5	6.8
	Self-employed	3	4.1
	Other	2	2.7
Mothers age during child's birth	<20 years	8	11.0
	20 to 34 years	61	83.6
	>35 years	4	5.5
	Mean= 25.07 years, SD (± 5.154), Minimum= 17 years, Maximum= 40 years		
Fathers occupation	Government Job	14	19.2
	Private Job	27	37.0
	Self-employed	28	38.4
	Other	4	5.5
Family income (monthly)	20000-60000 TK	33	45.2
	60001-120000 TK	26	35.6
	120001-200000 TK	14	19.2
	Mean= 83589.04 TK, SD (± 52389.258) Minimum= 20000 TK, Maximum= 200000 TK		
Family members	3-4 members	42	57.5
	5-6 members	20	27.4
	7-10 members	11	15.1
	Mean= 4.67 People, SD (± 1.841) Minimum 3 people, Maximum= 10 people		

Family disability status	No	69	94.5
	Yes	4	5.5
Number of persons with disability in family	0 person	69	94.5
	1 person	4	5.5
Family type	Joint family	30	41.1
	Nuclear family	43	58.9
Parents relationship status	Separated	0	0.0
	Jointly living	73	100.0
Main caregiver	Both Parents	20	27.4
	Mother	49	67.1
	Others	4	5.5
Educational level of main caregiver	Secondary	11	15.1
	Higher Secondary	15	20.5
	Bachelor or above	47	64.4

Table 4.2 shows the findings of socio-demographic characteristics of participants' families and parents. Most parents were highly educated, with 65.8% (n=48) of mothers and 75.3% (n=55) of fathers holding a Bachelor or above degree, which may support their children's engagement in home, school, and community activities. The majority of mothers were homemakers 83.6% (n=61), while fathers were primarily self-employed (38.4%) or in private jobs (37.0%), reflecting family caregiving and economic roles. Mothers' age at childbirth ranged from 17 to 40 years, with a mean age of 25.07 years (SD $\pm$ 5.15). Most mothers 83.6% (n=61) gave birth between 20 and 34 years (Typical reproductive age), 11.0% (n=8) were under 20 (Teenage Mothers), and 5.5% (n=4) were above 35 years (Advanced maternal age). Monthly family income varied, with nearly half of families (45.2%) earning 20,000–60,000 TK (Low income), 35.6% earning 60,001–120,000 TK (Middle income), and 19.2% earning 120,001–200,000 TK (Upper income). The mean income was 83,589 TK (SD $\pm$ 52,389). Most families consisted of 3–4 members (57.5%, n=42), followed by 5–6 members (27.4%, n=20) and 7–10 members (15.1%, n=11), with a mean of 4.67 members (SD $\pm$ 1.84). Only a small number of families reported having a member with a disability (5.5%,

n=4). Finally the family type, 58.9% (n=43) lived in nuclear families and 41.1% (n=30) in joint families. All parents were living together (100%, n=73). The main caregiver was most often the mother (67.1%, n=49), while 27.4% (n=20) had both parents as caregivers. The educational level of the main caregiver was similar to parental education, with 64.4% (n=47) having a Bachelor or above degree.

4.3 Frequency distribution of the respondents on the CASP

Table 4.3

Participation responses for child and adolescent with ADHD as reported by Child and Adolescent Scale of Participation (CASP)

Details	Full participation %(n)	Somewhat limited %(n)	Very limited %(n)	Unable %(n)	Not applicable %(n)
HOME PARTICIPATION					
1. Social, play or leisure with family	11.0(8)	61.6(45)	23.3(17)	4.1(3)	-
2. Social, play or leisure with friends	8.2(6)	53.4(39)	34.2(25)	3 (4.1)	-
3. Family chores	21.9(16)	41.1(30)	31.5(23)	5.5(4)	-
4. Self-care activities	15.1(11)	45.2(33)	28.8(21)	9.6(7)	1.4(1)
5. Moving about in and around home	60.3(44)	32.9(24)	6.8(5)	-	-
6. Communication	9.6(7)	52.1(38)	35.6(26)	2.7(2)	-
NEIGHBORHOOD AND COMMUNITY PARTICIPATION					
1. Social, play, or leisure with friends	6.8(5)	52.1(38)	38.4(28)	2.7(2)	-
2. Structured events	9.6(7)	47.9(35)	37.0(27)	5.5(4)	-
3. Moving around	16.4(12)	54.8(40)	27.4(20)	1.4(1)	-
4. Communication	5.5(4)	47.9(35)	39.7(29)	6.8(5)	-

SCHOOL PARTICIPATION					
1. Educational activities	16.4(12)	57.5(42)	23.3(17)	2.7(2)	-
2. Social, play and recreation with peers	17.8(13)	49.3(36)	31.5(23)	1.4(1)	-
3. Moving around	46.6(34)	38.4(28)	11.0(8)	4.1(3)	-
4. Using educational materials and equipment	9.6(7)	19.2(14)	20.5(15)	11.4(1)	49.3(36)
5. Communication	13.7(10)	49.3(36)	32.9(24)	4.1(3)	-
HOME AND COMMUNITY LIVING ACTIVITIES					
1. Household activities	12.3(9)	32.9(24)	34.2(25)	13.7(10)	6.8(5)
2. Shopping and managing money	2.7(2)	9.6(7)	38.4(28)	21.9(16)	27.4(20)
3. Managing daily schedule	16.4(12)	60.3(44)	19.2(14)	4.1(3)	-
4. Using transportation	60.3(44)	26.0(19)	9.6(7)	4.1(3)	-
5. Work activities and responsibilities	3.1(3)	34.2(25)	39.7(29)	8.2(6)	13.7(10)

Table 4.3 the frequency distribution of respondents on the Child and Adolescent Scale of Participation (CASP) showed that children and adolescents with ADHD had varied participation across different settings. In school-related activities, full participation ranged from 8.2% to 46.6%, with most respondents showing somewhat limited or very limited participation, particularly in social and communication activities. For neighborhood and community participation, full participation was generally low (5.5%–16.4%), with a majority experiencing limitations in social interactions, structured events, and communication. In home and community living activities, higher participation was observed for moving around and using transportation (60.3%), while

activities like shopping, managing money, and work responsibilities were more limited, with a substantial proportion unable to perform these tasks independently. Overall, the results indicate that children and adolescents with ADHD face significant participation restrictions in daily life, especially in social, educational, and community contexts.

4.4 Level of Overall Participation

Table 4.4

Level of Overall Participation

Domain (D1-D4)	Mean ± SD	Level of Participation				
		Full Participation %(n)	Limited %(n)	Very limited %(n)	Extremely Limited %(n)	Unable %(n)
Domain 1 Home Participation	3.30 ± .758	1.4 (1)	43.8(32)	38.4(28)	16.4(12)	-
Domain 2 Neighborhood & Community Participation	2.04 ± .389	-	-	9.6(7)	84.9(62)	5.5(4)
Domain 3 School Participation	3.01 ± .935	4.1(3)	28.8(21)	34.2(25)	30.1(22)	2.7(2)
Domain 4 Home & Community Living Activities	2.77 ± .858	-	21.9(16)	38.4(28)	34.2(25)	5.5(4)
Overall Participation	3.05 ± .598	-	20.5(15)	64.4(47)	15.1(11)	-

Table 4.4 presents the various levels of participation among children and adolescents with ADHD across home, school, neighborhood, and community settings. The results provide an overview of the Child and Adolescent Scale of Participation (CASP) across its four major domains, as well as an overall participation score derived from the combined results of these domains.

In Domain 1 (Home Participation), most participants showed limited (43.8%) or very limited (38.4%) participation, with only 1.4% achieving full participation. The mean score (3.30 ± 0.758) indicates moderate restriction in home activities. In Domain 2 (Neighborhood and Community Participation), participation was severely restricted. The majority (84.9%) had extremely limited participation, and 5.5% were unable to participate. The mean score (2.04 ± 0.389) reflects the lowest participation across all domains. In Domain 3 (School Participation), participation varied, with 28.8% limited, 34.2% very limited, and 30.1% extremely limited. Only 4.1% demonstrated full participation. The mean score (3.01 ± 0.935) suggests considerable school-related difficulties. In Domain 4 (Home and Community Living Activities), most participants had very limited (38.4%) or extremely limited (34.2%) participation. The mean score (2.77 ± 0.858) indicates substantial limitations in daily living skills.

Overall, the findings show significant participation restrictions across all domains, particularly in community settings.

4.5 Association between Overall CASP Scores and Demographic Variables

Table 4.5

Association between Demographic Variables and Overall Participation Level (n=73)

Demographic variables		Full Participation %(n)	Limited %(n)	Very limited %(n)	Extremely Limited %(n)	Unable %(n)	Fisher's Exact Test	P-value
Home Participation								
Family type	Joint family	3.3(1)	36.7(11)	30.0(9)	30.0(9)	-	8.270	.025
	Nuclear family	-	48.8(21)	44.2(19)	7.0(3)	-		
Neighborhood & Community Participation								
Family members	3–4 members (Small family)	-	-	4.8(2)	92.9(39)	2.4(1)	7.873	.049
	5–6 members Medium family	-	-	20.0(4)	65.0(13)	15.0(3)		
	7–10 members (Large family)	-	-	9.1(1)	90.9(10)	-		
School Participation								
Number on ADHD medication	No medicine	7.1(1)	28.6(4)	35.7(5)	21.4(3)	7.1(1)	16.772	.012
	Single medicine	16.7(2)	25.5(3)	58.3(7)	-			
	Multiple medicines	-	29.8(14)	27.7(13)	40.4(19)	2.1(1)		
Home & Community Living Activities								
Age	5-7 years old (Early entry school aged childhood)	-	15.8(6)	31.6(12)	42.9(16)	10.5(4)	12.506	.032
	8-11 years old (Middle childhood)	-	16.7(4)	58.3(14)	25.0(6)	-		
	12-18 years old (Adolescence)	-	54.5(6)	18.2(2)	27.3(3)	-		
All Domain Participation								
Family type	Joint family	-	30.0(9)	46.7(14)	23.3(7)	-	6.902	.033
	Nuclear family	-	14.0(6)	76.7(33)	9.3(4)	-		

Table 4.5 presents the analysis of demographic variables revealed several significant associations with the participation levels of children with ADHD across different domains. Home participation was significantly associated with family type (Fisher's exact test value = 8.270, $P = 0.025$), with children from joint families showing higher proportions of very limited (30.0%) and extremely limited (30.0%) participation, whereas children from nuclear families demonstrated comparatively better participation at home, with only 7.0% being extremely limited. Neighborhood and community participation was significantly related to family size (Fisher's exact test value = 7.873, $P = 0.049$). Children from smaller families (3–4 members) showed higher participation in community activities, while children from medium (5–6 members) and large families (7–10 members) participated less, with a notable proportion exhibiting extremely limited participation (65.0% and 90.9%, respectively). School participation was significantly influenced by the number of ADHD medications taken (Fisher's exact test value = 16.772, $P = 0.012$). Children taking multiple medications had the highest proportion of extremely limited participation at school (40.4%) compared to those taking a single medication or no medication. Additionally, participation in home and community living activities was significantly associated with child age (Fisher's exact test value = 12.506, $P = 0.032$), with younger children (5–7 years) showing the highest levels of extremely limited participation (42.9%), while older children (8–11 and 12–18 years) demonstrated better engagement. Overall participation across all domains was also significantly associated with family type (Fisher's exact test value = 6.902, $P = 0.033$), with children from joint families showing lower overall participation compared to those from nuclear families. These findings indicate that family structure, family size, child age, and medication regimen play important roles in influencing activity participation among children with ADHD.

CHAPTER V: DISCUSSION

This study aimed to identify the level of participation in home, school, and community activities among children and adolescents with ADHD and to explore factors associated with participation patterns using the Child and Adolescent Scale of Participation (CASP). All in all, the results show that the majority of children had major limitations on participation in all types of settings with the highest degree of limitations realized in neighborhood and community activities. Such results can be correlated with the ICF-CY framework that underlines that participation is influenced by the relationship between body processes, activity limitations, and the context including family, school, and community environment (WHO, 2007; Imms et al., 2016).

The sociodemographic profile of the sample is per the worldwide trends of ADHD. Most of the participants were male, which is a well-known fact that boys are more commonly diagnosed and often display more overt hyperactive and impulsive behaviors (APA, 2013; Gershon, 2002). The majority of children were young school-aged, which aligns with the literature that states that ADHD is usually diagnosed at the time when children enter formal education and have to struggle with organized academic tasks (Barkley, 2015; DuPaul and Stoner, 2014). There is a high percentage of children under medication, and in some cases more than one type of medication, which indicates multimodal treatment strategies when dealing with ADHD symptoms (Evans et al., 2021). Associated condition, especially autism and speech deficit, were very common, which is aligned with the studies that indicate that ADHD is widely comorbid with other neurodevelopmental disorders that cause additional impairment and involvement (Gnanavel et al., 2019).

Although the majority of families were urban, educated, middle, and upper socioeconomic status, a large limitation of participation was still pronounced. According to the previous research, increased parental education and income can help to access services and structured activities (Guichard and Grande, 2019; Khetani et al., 2015). Nevertheless, current evidence suggests that these protective components might not be as important as ADHD-linked functional impairments and environmental pressures.

There was no demonstration of complete participation in domains by any of the children in overall CASP results. The majority of them were categorized as very limited participation and other children had limited or extremely limited participation. The average total CASP corresponded to the moderate to severe limitations in everyday life. This is congruent with the existing literature that has shown that children with ADHD tend to have a lower involvement level when compared to their normally-developing counterparts at home, school, and community levels (Klassen et al., 2004; Mendes et al., 2018; Spaulding et al., 2021). They also support the worth of participation CAM centered measures like CASP that encapsulate actual life participation than symptom severity (Bedell, 2009; Coster et al., 2012).

In home participation area, majority of children were found to have a little or very little participation. Some of them needed supervision, prompts and organised instructions to go about their day-to-day activities. This is in line with the literature published that demonstrates that children with ADHD often have difficulties in terminating tasks, organizing, and performing constant behavior in everyday living activities (Cronin, 2004; Dunn et al., 2009; Segal, 2004). Even though participation may be improved with the help of structured family routines and promoting interactions

(Larson et al., 2020; Coussens et al., 2020a), the results indicate that there may still be a problem with age expected independence.

The greatest limitations were seen in the field of neighborhood and community participation. Most of the children were rated as being extremely limited and none had full participation. This tendency is in line with the evidence showing that community involvement tends to be the most limited area among children with ADHD and other neurodevelopmental cases (King et al., 2019; Coussens et al., 2020b). Possible causes might be the lack of inclusive programs, hyper stimulating environments, safety, social skills challenges, and anxiety of parents regarding how they will behave in supermarkets (Mikami, 2019; Hoza, 2020). Other barriers that can make the community less engaged include transportation issues, a shortage of services available, and social stigma, which are common in the Bangladeshi setting. These results emphasize the role of recreational opportunities and community programs with the help of which meaningful participation is possible (Verret et al., 2017; Drechsler et al., 2020).

The involvement in schools was greatly limited as well. A very small percentage of them were able to participate fully, and a good number of them showed less or minimal classroom participation and peer interaction. The results are aligned with ample research on the literature of students with ADHD who have issues with academic and social participation (DuPaul and Stoner, 2014; Langberg et al., 2018; Mikami, 2019). Notably, every participant was placed in special schools or centers where they are provided with therapeutic care which indicates that even in case of therapeutic care, the issue of participation remains problematic. This highlights the importance of participation-driven interventions, environmental modifications, and collaboration between the educators and therapists (DuPaul and Stoner, 2020; Evans et al., 2021).

Most children were found to have little independence in schedules, responsibilities and mobility in communities in the home and community living activities. Studies have found that adolescents with ADHD tend to be much behind their peers in learning applicable life skills such as time management and traveling alone (Langberg et al., 2018; Weisner, 2021). The engagement of older children was slightly higher although not a large number of them had achieved age expected independence.

A number of contextual factors were related to participation in a significant manner. Participation at home, community, and in general was associated with family type and family size, and children in larger and joint families were more restricted. This could be indicative of environmental distraction, split parental attention, or less hope on performing independent tasks (Khetani et al., 2015; Guichard and Grande, 2019). School participation was linked to medication condition, which might depict more severe symptoms in children who took a combination of medications (Gnanavel et al., 2019). At the home and community level, age was linked to participation in the living which is in line with developmental progression (Mendes et al., 2018).

Altogether, the results indicate a significant level of participation limitation in the children and adolescents with ADHD in all areas of major life especially in community activities. As the ICF framework (WHO, 2007; Imms et al., 2016) suggests, there is, in addition to child factors, the environmental contexts that affect participation. Interventions can thus be based on management of symptoms alongside environmental interventions, skill training, and family focused interventions to ensure meaningful interactions at home, school and in community.

CHAPTER VI: CONCLUSION

6.1 Strengths and Limitations

6.1.1 Strengths

- Data was collected through a face-to-face survey using a standardized scale, eliminating the possibility of bias during both data collection and data entry processes.
- The study population has a particular and focused specific group in mind.
- The author received permission to use the CASP questionnaire.
- There was no unauthorized access to the data, which was used without any modifications.
- To ensure data validity, all data used in this study will be destroyed after a certain period.
- Participation was assessed across multiple domains (home, school, neighborhood/community, and home & community living activities)

6.1.2 Limitations

There are some limitations of the study. There are,

- Participants were recruited from selected special schools, which limits the generalizability of the findings to the broader national population.
- The sample size was relatively small, which may reduce the statistical power of the findings.
- Data were obtained through caregiver reports rather than direct observation, which may increase the risk of reporting bias and subjective interpretation.

6.2 Practical Implication

6.2.1 Recommendation for Further Practice

- Early identification and early intervention services should be strengthened to address participation challenges.
- Schools and community organizations should recognize occupational therapy as an essential service in supporting academic participation, social inclusion, self-regulation, and functional independence among children and adolescents with ADHD.
- Intervention programs should emphasize improving participation in daily life activities at home, school, and in the community rather than focusing only on symptom reduction.
- Occupational therapists should work closely with mental health professionals, educators, pediatricians, and families to implement participation-focused and occupation-based interventions for children and adolescents with ADHD, ensuring holistic and collaborative care.

6.2.2 Recommendation for Future Research

- Future research should include larger and more diverse samples, including rural populations and different socio-economic groups, to improve generalizability.
- Use mixed-method and qualitative research designs to explore the lived experiences of children with ADHD and their families, particularly regarding participation barriers and facilitators.
- Intervention based studies evaluating participation-focused occupational therapy programs, school-based supports, and community interventions are needed to build stronger evidence for improving participation and quality of life in this population.

6.3 Conclusion

This study provides important evidence on the participation patterns of children and adolescents with ADHD across home, school, and community settings. The findings indicate that participation restrictions are present in all three environments, with the most severe limitations observed in community and neighborhood activities, followed by school participation. Home participation was also restricted, highlighting difficulties in daily routines, family interactions, and independent activities. These results confirm that ADHD affects not only symptoms and academic performance but also meaningful engagement in everyday life roles.

CHAPTER VII: LIST OF REFERENCE

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APPENDICES

Appendix A: Ethical Approval Form and Permission Letter

Ethical Approval Letter from IRB



বাংলাদেশ হেলথ প্রফেশন ইনস্টিটিউট (বিএইচপিআই) Bangladesh Health Professions Institute (BHPI)

(The Academic Institute of CRP)

Ref: CRP-BHPI/IRB/07/2025/1122

Date: 21.07.2025

To
Mustain Billah Tanzil
4th Year, B.Sc. in Occupational Therapy
Session: 2020-21, Student ID: 122200418
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Subject: Approval of the thesis proposal **Level of Participation of Children & Adolescents with Attention Deficit Hyperactivity Disorder at Home, School and Community Settings: A Cross-Sectional Study** by ethics committee.

Dear Mustain Billah Tanzil,
Congratulations.

The Institutional Review Board (IRB) of BHPI has reviewed and discussed your application to conduct the above mentioned dissertation, with yourself, as the principal investigator and Md. Habibur Rahman, Assistant Professor and Course Coordinator, M.Sc. in OT, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP as thesis supervisor. The Following documents have been reviewed and approved:

SL No.	Name of the Documents
1	Research Proposal
2	The Child and Adolescents Scale of Participation (CASP) (English & Bangla)
3	Information sheet & consent form

The purpose of the study is to identify the level of participation in home, school, and community activities among children & adolescents with ADHD. The study involves use of The Child and Adolescents Scale of Participation (CASP) to find out the identify the level of participation in home, school, and community activities among children & adolescents with ADHD that may take 30 to 40 minutes to fill in the questionnaire and there is no likelihood of any harm to the participants. There is no benefit 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, 17 June, 2025 at BHPI (50th 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, Project and Course Coordinator, MRS
Member Secretary, Institutional Review Board (IRB)
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Author Permission Letter for Scale

**Subject: Inquiry Regarding Permission to Use the Child & Adolescent Scale of Participation (CASP)**

2 messages

Mustain Billah Tanzil <mustainbillah313@gmail.com>
To: gary.bedell@tufts.edu

Thu, Jan 30, 2025 at 8:51 PM

Dear Dr. Gary Bedell,

I hope you are doing well. My name is Mustain Billah Tanzil, and I am a final-year Bachelor of Science in Occupational Therapy student at the Bangladesh Health Professions Institute (an academic institute of CRP) in Bangladesh. As part of our curriculum, we are required to conduct undergraduate research.

I am particularly interested in studying "Identifying the Level of Activities Participation Among Children & Adolescents with ADHD: A Cross-Sectional Study." For this research, I would like to use the Child & Adolescent Scale of Participation (CASP), which your team developed. I have a few questions regarding the questionnaire and would greatly appreciate your guidance:

1. How can I obtain permission to use this questionnaire?
2. What is the process or licensing system for its use?
3. Is there a fee associated with using the questionnaire?
4. What is the scoring system for the CASP?
5. Would it be possible to translate the questionnaire into Bengali while maintaining its original meaning? Since my participants are native Bengali speakers, a translated version would be beneficial for the study.

Your insights on these queries would be extremely helpful. I have also copied this email to my supervisor, Arifa Jahan Ema, Lecturer in Occupational Therapy and Course Coordinator of the MSc in Occupational Therapy program at BHPI.

I look forward to your response and sincerely appreciate your time and assistance.

Best regards,
Mustain Billah Tanzil
B.Sc. in Occupational Therapy (Session: 2020-21)
Bangladesh Health Professions Institute
CRP, Chapain, Savar, Dhaka-1343
Phone: +8801829062338

Bedell, Gary M. <gary.bedell@tufts.edu>
To: Mustain Billah Tanzil <mustainbillah313@gmail.com>
Cc: ajema27@gmail.com <ajema27@gmail.com>

Thu, Jan 30, 2025 at 11:25 PM

Hello Mustain, thank you for your interest in the CASP. I sent an email to your supervisor, Professor Arifa Jahan Ema and three other students who are interested in using it in their studies. Please keep your supervisor (cc'd) on all of our correspondences. Please check to see if the Bengali Translation was already developed (you can do this as a group). The translation guidelines for the CASP and the larger CFFS are posted on my website as are the original US English versions: <https://sites.tufts.edu/garybedell/measurement-tools/>

The measures are free to use, there are no licensing agreements, and you have approval to use them in your study. The administration guidelines and scoring guidelines are posted on my website as well. However, you must follow translation guidelines if no translation was done.

Please let me know if you have any questions.

Thank you.

Permission Letter for Data Collection



বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)

Bangladesh Health Professions Institute (BHPI)

(The Academic Institute of CRP)

CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

23.09.25
Chairman
Society for the Welfare of
Autistic Children (SWAC)

Date: 01/09/2025

To,

The Chairperson,

SWAC-Society For The Welfare Of Autistic Children.

House- 279, Road-01, Baitul Aman Housing Society, Adabar 1212 Dhaka, Bangladesh.

Subject: Prayer for seeking permission to collect data for the research project

Sir,

With due respect to state that, I am a student of 4th year B. Sc. in Occupational Therapy department of Bangladesh Health Professions Institute (BHPI). In 4th year, I have to submit a research project to the University of Dhaka in partial fulfillment of requirements of the degree of Bachelor of Science in Occupational Therapy. My research title is "Level of Participation of Children & Adolescents with Attention Deficit Hyperactivity Disorder at Home, School and Community Settings: A Cross-Sectional Study" which is supervised by Md. Habibur Rahman, Assistant Professor and Course Coordinator, M.Sc. in OT, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP -Savar, Dhaka-1343, Bangladesh. The purpose of the study is to identify the level of participation in home, school, and community activities among children & adolescents with ADHD. Now I am looking for your kind approval to start my data collection and I would like to assure that anything of my research period will not be harmful for the participants.

I therefore pray and hope that you would be kind enough to give me the permission for collecting the data and oblige thereby.

Sincerely

Mustain

Mustain Billah Tanzil

4th Year, B.Sc. in Occupational Therapy

Session: 2020-21; Student ID: 122200418

BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Recommendation from the Head of the Department:

[Signature]

Prof. Sk. Moniruzzaman

Professor & Head

Department of Occupational Therapy

Bangladesh Health Professions Institute (BHPI)

CRP, Savar, Dhaka-1343

Attachments: Copy of IRB Approval Letter



বাংলাদেশ হেলথ প্রফেশন ইনস্টিটিউট (বিএইচপিআই)

Bangladesh Health Professions Institute (BHPI)

(The Academic Institute of CRP)

CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

Date: 24/08/2025

To,
Director
Tara Special Child Care
Spring Rahmat E- Tuba complex, House (132), Road: 02, Block: A, Dhaka 1216

Subject: Prayer for seeking permission to collect data for the research project

Sir,

With due respect to state that, I am a student of 4th year B. Sc. in Occupational Therapy department of Bangladesh Health Professions Institute (BHPI). In 4th year, I have to submit a research project to the University of Dhaka in partial fulfillment of requirements of the degree of Bachelor of Science in Occupational Therapy. My research title is "**Level of Participation of Children & Adolescents with Attention Deficit Hyperactivity Disorder at Home, School and Community Settings: A Cross-Sectional Study**" which is supervised by Md. Habibur Rahman, Assistant Professor and Course Coordinator, M.Sc. in OT, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP -Savar, Dhaka-1343, Bangladesh. The purpose of the study is to identify the level of participation in home, school, and community activities among children & adolescents with ADHD. Now I am looking for your kind approval to start my data collection and I would like to assure that anything of my research period will not be harmful for the participants.

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Sincerely

Mustain

Mustain Billah Tanzil

4th Year, B.Sc. in Occupational Therapy

Session: 2020-21; Student ID: 122200418

BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Recommendation from the Head of the Department:

Prof. Sk. Moniruzzaman
Prof. Sk. Moniruzzaman

Professor & Head

Department of Occupational Therapy

Bangladesh Health Professions Institute (BHPI)

CRP, Savar, Dhaka-1343

Attachments: Copy of IRB Approval Letter





বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)

Bangladesh Health Professions Institute (BHPI)

(The Academic Institute of CRP)

CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

Date: 01/09/2025

To,

The Chairperson,

Therapist point and Shanirvor Special School for Autism and Neurodevelopmental Disorder.

Dogmora, CRP Road, Savar, Dhaka-1343

Subject: Prayer for seeking permission to collect data for the research project

Sir,

With due respect to state that, I am a student of 4th year B. Sc. in Occupational Therapy department of Bangladesh Health Professions Institute (BHPI). In 4th year, I have to submit a research project to the University of Dhaka in partial fulfillment of requirements of the degree of Bachelor of Science in Occupational Therapy. My research title is "Level of Participation of Children & Adolescents with Attention Deficit Hyperactivity Disorder at Home, School and Community Settings: A Cross-Sectional Study" which is supervised by Md. Habibur Rahman, Assistant Professor and Course Coordinator, M.Sc. in OT, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP -Savar, Dhaka-1343, Bangladesh. The purpose of the study is to identify the level of participation in home, school, and community activities among children & adolescents with ADHD. Now I am looking for your kind approval to start my data collection and I would like to assure that anything of my research period will not be harmful for the participants.

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4th Year, B.Sc. in Occupational Therapy

Session: 2020-21; Student ID: 122200418

BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Recommendation from the Head of the Department:

Prof. Sk. Moniruzzaman

Prof. Sk. Moniruzzaman

Professor & Head

Department of Occupational Therapy

Bangladesh Health Professions Institute (BHPI)

CRP, Savar, Dhaka-1343

Attachments: Copy of IRB Approval Letter



Md. Nayem Nizam Majumder
B.Sc. OT (CRP, DU), MDS (JU-Incoursa)
Senior Occupational Therapist & Head
Therapist Point & Shonivor Special School



বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)

Bangladesh Health Professions Institute (BHPI)

(The Academic Institute of CRP)

CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

Date: 19/08/2025

To,
Director
Unique Gift Foundation
Harez Road, South Baridhara, Nadda, Dhaka-1229

Subject: Prayer for seeking permission to collect data for the research project

Sir,

With due respect to state that, I am a student of 4th year B. Sc. in Occupational Therapy department of Bangladesh Health Professions Institute (BHPI). In 4th year, I have to submit a research project to the University of Dhaka in partial fulfillment of requirements of the degree of Bachelor of Science in Occupational Therapy. My research title is "**Level of Participation of Children & Adolescents with Attention Deficit Hyperactivity Disorder at Home, School and Community Settings: A Cross-Sectional Study**" which is supervised by Md. Habibur Rahman, Assistant Professor and Course Coordinator, M.Sc. in OT, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP -Savar, Dhaka-1343, Bangladesh. The purpose of the study is to identify the level of participation in home, school, and community activities among children & adolescents with ADHD. Now I am looking for your kind approval to start my data collection and I would like to assure that anything of my research period will not be harmful for the participants.

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Sincerely,

Mustain

Mustain Billah Tanzil

4th Year, B.Sc. in Occupational Therapy

Session: 2020-21; Student ID: 122200418

BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Recommendation from the Head of the Department:

[Signature]

Prof. Sk. Moniruzzaman

Professor & Head

Department of Occupational Therapy

Bangladesh Health Professions Institute (BHPI)

CRP, Savar, Dhaka-1343

Attachments: Copy of IRB Approval Letter





বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)

Bangladesh Health Professions Institute (BHPI)

(The Academic Institute of CRP)

CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

Date: 01/09/2025

To,
The Principle,
Prottasha Centre for Autism Care.
Dogormora, CRP Road, Savar, Dhaka-1343

Subject: Prayer for seeking permission to collect data for the research project

Sir,

With due respect to state that, I am a student of 4th year B. Sc. in Occupational Therapy department of Bangladesh Health Professions Institute (BHPI). In 4th year, I have to submit a research project to the University of Dhaka in partial fulfillment of requirements of the degree of Bachelor of Science in Occupational Therapy. My research title is "Level of Participation of Children & Adolescents with Attention Deficit Hyperactivity Disorder at Home, School and Community Settings: A Cross-Sectional Study" which is supervised by Md. Habibur Rahman, Assistant Professor and Course Coordinator, M.Sc. in OT, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP -Savar, Dhaka-1343, Bangladesh. The purpose of the study is to identify the level of participation in home, school, and community activities among children & adolescents with ADHD. Now I am looking for your kind approval to start my data collection and I would like to assure that anything of my research period will not be harmful for the participants.

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4th Year, B.Sc. in Occupational Therapy

Session: 2020-21; Student ID: 122200418

BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Recommendation from the Head of the Department:

Prof. Sk. Moniruzzaman

Prof. Sk. Moniruzzaman

Professor & Head

Department of Occupational Therapy

Bangladesh Health Professions Institute (BHPI)

CRP, Savar, Dhaka-1343

Attachments: Copy of IRB Approval Letter

Kawsar Ahmed
Kawsar Ahmed
Vice Principal
Prottasha Centre for Autism Care



বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)

Bangladesh Health Professions Institute (BHPI)

(The Academic Institute of CRP)

CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

Date: 19/08/2025

To,
Principle
Smiling Children Special School
House No.40, Road No.6, Block E, Aftab Nagar (Jahurul Islam City)

Subject: Prayer for seeking permission to collect data for the research project

Sir,

With due respect to state that, I am a student of 4th year B. Sc. in Occupational Therapy department of Bangladesh Health Professions Institute (BHPI). In 4th year, I have to submit a research project to the University of Dhaka in partial fulfillment of requirements of the degree of Bachelor of Science in Occupational Therapy. My research title is **"Level of Participation of Children & Adolescents with Attention Deficit Hyperactivity Disorder at Home, School and Community Settings: A Cross-Sectional Study"** which is supervised by Md. Habibur Rahman, Assistant Professor and Course Coordinator, M.Sc. in OT, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP -Savar, Dhaka-1343, Bangladesh. The purpose of the study is to identify the level of participation in home, school, and community activities among children & adolescents with ADHD. Now I am looking for your kind approval to start my data collection and I would like to assure that anything of my research period will not be harmful for the participants.

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Mustain Billah Tanzil

4th Year, B.Sc. in Occupational Therapy

Session: 2020-21; Student ID: 122200418

BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Recommendation from the Head of the Department:

[Signature]

Prof. Sk. Moniruzzaman

Professor & Head

Department of Occupational Therapy

Bangladesh Health Professions Institute (BHPI)

CRP, Savar, Dhaka-1343

Attachments: Copy of IRB Approval Letter



[Handwritten signature]
19.08.25



বাংলাদেশ হেলথ প্রফেশন ইনস্টিটিউট (বিএইচপিআই)

Bangladesh Health Professions Institute (BHPI)

(The Academic Institute of CRP)

CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

Date: 19/08/2025

To,
Managing Director
Ingenious Care
House- 108, road- 4, block- A, Section -12, Pallabi, Mirpur, Dhaka

Subject: Prayer for seeking permission to collect data for the research project

Sir,

With due respect to state that, I am a student of 4th year B. Sc. in Occupational Therapy department of Bangladesh Health Professions Institute (BHPI). In 4th year, I have to submit a research project to the University of Dhaka in partial fulfillment of requirements of the degree of Bachelor of Science in Occupational Therapy. My research title is "Level of Participation of Children & Adolescents with Attention Deficit Hyperactivity Disorder at Home, School and Community Settings: A Cross-Sectional Study" which is supervised by Md. Habibur Rahman, Assistant Professor and Course Coordinator, M.Sc. in OT, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP -Savar, Dhaka-1343, Bangladesh. The purpose of the study is to identify the level of participation in home, school, and community activities among children & adolescents with ADHD. Now I am looking for your kind approval to start my data collection and I would like to assure that anything of my research period will not be harmful for the participants.

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Mustain Billah Tanzil
4th Year, B.Sc. in Occupational Therapy
Session: 2020-21; Student ID: 122200418
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Recommendation from the Head of the Department:

[Signature]
Prof. Sk. Moniruzzaman

Professor & Head
Department of Occupational Therapy
Bangladesh Health Professions Institute (BHPI)
CRP, Savar, Dhaka-1343

Attachments: Copy of IRB Approval Letter

Approved
[Signature]
24/08/25
Nazmul Huda
Managing Director
Ingenious Care Limited



বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)

Bangladesh Health Professions Institute (BHPI)

(The Academic Institute of CRP)

CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

Date: 19/08/2025

To,

The Chairperson

Alokito Shishu

House - 1107/A, BAHS, Ring Road, Adabar

Subject: Prayer for seeking permission to collect data for the research project

Sir,

With due respect to state that, I am a student of 4th year B. Sc. in Occupational Therapy department of Bangladesh Health Professions Institute (BHPI). In 4th year, I have to submit a research project to the University of Dhaka in partial fulfillment of requirements of the degree of Bachelor of Science in Occupational Therapy. My research title is "**Level of Participation of Children & Adolescents with Attention Deficit Hyperactivity Disorder at Home, School and Community Settings: A Cross-Sectional Study**" which is supervised by Md. Habibur Rahman, Assistant Professor and Course Coordinator, M.Sc. in OT, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP -Savar, Dhaka-1343, Bangladesh. The purpose of the study is to identify the level of participation in home, school, and community activities among children & adolescents with ADHD. Now I am looking for your kind approval to start my data collection and I would like to assure that anything of my research period will not be harmful for the participants.

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4th Year, B.Sc. in Occupational Therapy

Session: 2020-21; Student ID: 122200418

BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Recommendation from the Head of the Department:

[Signature]

Prof. Sk. Moniruzzaman

Professor & Head

Department of Occupational Therapy

Bangladesh Health Professions Institute (BHPI)

CRP, Savar, Dhaka-1343

Attachments: Copy of IRB Approval Letter

Permitted for data collection.
Zahir
Occupational Therapist
Md. Zahir Uddin Akanda
B.Sc OT (DU), PGDHAM (IPM) M. Sc ECD
(BKAU) BEd (NU) MEd (DU)
Chief OT & ECD Consultant, Chairperson
Alokito Shishu (A Treatment Based School)
Mohammadpur, Dhaka-1207

Appendix B: Information Sheet, Consent Form and Withdrawal Form (English & Bangla)

Information Sheet (English)



বাংলাদেশ হেলথ প্রফেশন ইনস্টিটিউট (বিএইচপিআই)

Bangladesh Health Professions Institute (BHPI)

(The Academic Institute of CRP)

CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

Code no.:

Participants Information sheet

Research Title: Level of Participation of Children & Adolescents with Attention Deficits Hyperactivity Disorder at Home, School and Community Settings: A Cross Sectional Study

Researcher: Mustain Billah Tanzil, 4th year, Student of Bachelor of Science in Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP- Savar, Dhaka-1343. The B.Sc. in Occupational Therapy program is affiliated to the University of Dhaka under the Faculty of Medicine.

Supervisor: Md. Habibur Rahman, Assistant Professor, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP, Savar, Dhaka- 1343.

Part -1 Information sheet:

Introduction:

I am Mustain Billah Tanzil, student of Bachelor of Science in Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP- Savar, Dhaka-1343. The B.Sc. in Occupational Therapy program is affiliated to the University of Dhaka under the Faculty of Medicine. To complete B.Sc. in Occupational Therapy from BHPI, conducting a research project is mandatory. This research project will be done under the supervision of Md. Habibur Rahman, Assistant Professor, Department of Occupational Therapy, BHPI. The purpose of the research project is the collection of data and how it will be related to the research and this will be presented to you in detail through this participant paper. If you are willing to participate in this research, in that case, a clear idea about the research topic will be easier for decision-making. Of course, you do not have to make sure you participate now. Before taking any decision, you can discuss it with your relatives, or guardians about this. On the other hand, after reading the information sheet if you feel a problem understanding the content or if you need to know more about something, you can freely ask.

Research Background and Objectives:

You are invited to be a part of this research because, in Bangladesh, there is no research on the level of participation of children & adolescents with ADHD at home, school and community

settings. It will be investigating the activities participation level at home, school and community settings. Your information will be helpful to reveal the activities participation level at home, school and community through your voluntary participation in this study.

Let's know about the topic related to participation in this research work:

Before signing the consent form from you, the details of managing the research project will be presented to you in detail through this participation note. If you want to participate in this study, you will have to agree to participate in the study. If you ensure participation, a copy of your consent will be given. After a representative of collection data till by the researcher will call you. At any given time taken from you by a question paper information will be collected. Your participation in this research project is optional. If you do not agree then you do not have to participate. Despite your consent, you can withdraw your participation at any time without giving any explanation to the researcher.

The Benefits and Risks of Participation:

You will not get any benefit directly to participate in this research project. Participation in this study can lead to many difficulties in your daily work. However, we are hopeful that the benefits direct from the results of this research will remove the disadvantages. Don't worry about your identity, its request. Patient's name, address will not be included in the data analysis software to reduce the risk of uncover identity.

Confidentialities of Information:

By signing this agreement, you are allowing the research staff to study this research project to collect and use your resources. Any information gathered for this research project, which can identify you, will be confidential. The information collected about you will be able to access this information directly. Symbolic ways identified data will be used for the next data analysis. Information sheets will be kept in a locker drawer. The Electronics versions of the data analysis will be collected in BHPI's Occupational Therapy department and on the research's laptop. It is expected that the results of this research project will be published and presented in different forums. In any publication and presentation, the information will be provided in such a way that you cannot be identified in any way without your consent. Data will be initially collected by purposive technique.

Information about Promotional Result:

The result of this study will be published in various social media, websites, conference, discussion, and reviewed journals.

Participant's Fees:

There is no stimulus and remuneration for participation in this study.

Source of Funding to Manage Research:

The cost of this research will be spent entirely by the researcher's funds. This study will be done in small areas and no money comes from an external source.

Information about Withdrawal from Participation:

Despite your consent, you can withdraw your participation within one week after giving information without giving any explanation to the researcher. If the information can be used after the cancellation, its permission will be mentioned in the participant's withdrawal letter (application only volunteer withdrawal).

Contact Address with the Researcher:

If you have any questions about the research, you can ask me now or latter. If you wish to ask a question later, you may contact any of the following: Mustain Billah Tanzil, 4th year, Student of B.Sc. in Occupational Therapy, Department of Occupational Therapy, BHPI, CRP, Savar, Dhaka and Cell No: 01829062338, Gmail: mustainbillah@gmail.com

Complaints:

If there is any complaint regarding the conduct of this research project, contact with the Association of Ethics (77454645). This proposal has been reviewed by the institutional Reviewed Board (IRB), Bangladesh Health Professions Institute (BHPI), CRP, Savar, Dhaka-1343, Bangladesh, which is a committee whose task it is to make sure that research participants are protected from harm. If you wish to find about more about the IRB, contact Bangladesh Health Professions Institute (BHPI), CRP, Savar, Dhaka-1343, Bangladesh

Information Sheet (Bangla)



বাংলাদেশ হেলথ প্রফেশন ইনস্টিটিউট (বিএইচপিআই)
Bangladesh Health Professions Institute (BHPI)
(The Academic Institute of CRP)

CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

অংশগ্রহণকারীর তথ্যপত্র

Code no.:

গবেষণার বিষয়ঃ

"ADHD সম্পূর্ণ শিশু ও কিশোরদের ঘর, বিদ্যালয় ও সমাজভিত্তিক পরিবেশে অংশগ্রহণের স্তর নিরূপণ: একটি ক্রস-সেকশনাল স্টাডি"।

গবেষক:

মোস্তাইন বিল্লাহ তানজিল

৪র্থ বর্ষ, ব্যাচেলর অব সায়েন্স ইন অকুপেশনাল থেরাপি

বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (বিএইচপিআই), সিআরপি-সভার, ঢাকা-১৩৪৩

(ঢাকা বিশ্ববিদ্যালয়ের মেডিসিন অনুষদের অধীন)

তত্ত্বাবধায়কঃ

মোঃ হাবিবুর রহমান

(সহকারী অধ্যাপক এবং কোর্স সমন্বয়কারী, এমএসসি ইন অকুপেশনাল থেরাপি)

অকুপেশনাল থেরাপি বিভাগ,

বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (বিএইচপিআই), সিআরপি-সভার, ঢাকা-১৩৪৩

পার্ট-১: তথ্যপত্র

ভূমিকা:

আমি মোস্তাইন বিল্লাহ তানজিল, বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (বিএইচপিআই), সিআরপি-সভার অকুপেশনাল থেরাপি বিভাগের ৪র্থ বর্ষের শিক্ষার্থী। বিএসসি ইন অকুপেশনাল থেরাপি ডিগ্রি অর্জনের জন্য একটি গবেষণা প্রকল্প সম্পন্ন করা বাধ্যতামূলক। এই গবেষণা প্রকল্পটি, মোঃ হাবিবুর রহমান সহকারী অধ্যাপক, অকুপেশনাল থেরাপি বিভাগের তত্ত্বাবধানে পরিচালিত হবে। এই অংশগ্রহণকারীর তথ্যপত্রের মাধ্যমে গবেষণার উদ্দেশ্য, পদ্ধতি এবং আপনার ভূমিকা বিস্তারিতভাবে উপস্থাপন করা হয়েছে, যাতে আপনি গবেষণায় অংশগ্রহণের বিষয়ে সঠিক ধারণা পেতে পারেন। অংশগ্রহণের সিদ্ধান্ত নেওয়ার আগে আপনি আপনার পরিবার বা অভিভাবকদের সঙ্গে আলোচনা করতে পারেন। যদি তথ্যপত্রটি বুঝতে অসুবিধা হয় অথবা অতিরিক্ত কোনো প্রশ্ন থাকে, তাহলে নির্দিষ্ট জিজ্ঞাসা করতে পারেন।

গবেষণার পটভূমি ও উদ্দেশ্য:

বাংলাদেশে মনোযোগ ঘাটতি ও অতিসক্রিয়তা সম্পন্ন শিশু ও কিশোরদের বাড়ি, বিদ্যালয় এবং সমাজভিত্তিক পরিবেশে অংশগ্রহণের মাত্রা নিয়ে এখনও গবেষণা হয়নি। এই গবেষণায় অংশগ্রহণের মাধ্যমে আমরা অংশগ্রহণের স্তর নির্ধারণ করতে সক্ষম হব। আপনার দেওয়া তথ্য গবেষণার জন্য গুরুত্বপূর্ণ ভূমিকা পালন করবে।

গবেষণার বিবরণ:

গবেষণায় অংশগ্রহণ নিশ্চিত করার আগে আপনাকে গবেষণার বিস্তারিত তথ্য প্রদান করা হবে। অংশগ্রহণ নিশ্চিত হলে আপনার সম্মতির একটি কপি দেওয়া হবে। গবেষকের প্রতিনিধি আপনার সঙ্গে যোগাযোগ করবে এবং নির্ধারিত

সময়ে সাক্ষাৎকার গ্রহণ করবে। তথ্য সংগ্রহের সময় একটি প্রশ্নমালা পূরণ করতে হবে, যা সম্পূর্ণ স্বেচ্ছায় এবং আপনি যেকোনো সময় অংশগ্রহণ থেকে সরে দাঁড়াতে পারবেন, কোনো কারণ উল্লেখ ছাড়াই।

অংশগ্রহণের সুবিধা ও ঝুঁকি:

গবেষণায় সরাসরি কোনো আর্থিক বা ব্যক্তিগত সুবিধা পাওয়া যাবে না। অংশগ্রহণের ফলে দৈনন্দিন জীবনে কিছু অসুবিধা হতে পারে, তবে গবেষণার ফলাফল থেকে ভবিষ্যতে উন্নতি আশা করা যায়। আপনার গোপনীয়তা রক্ষা করা হবে; নাম, ঠিকানা সহ ব্যক্তিগত তথ্য ডেটা বিশ্লেষণ থেকে বাদ থাকবে।

তথ্যের গোপনীয়তা:

এই গবেষণায় অংশগ্রহণের মাধ্যমে আপনি গবেষক ও সংশ্লিষ্ট গবেষণা টিমকে আপনার তথ্য সংগ্রহ ও ব্যবহারের অনুমতি প্রদান করছেন। আপনার পরিচয় গোপন রাখা হবে এবং তথ্য কেবলমাত্র গবেষণার উদ্দেশ্যে ব্যবহার করা হবে। তথ্য নিরাপদ স্থানে সংরক্ষিত থাকবে, যেমন লকারে ও গবেষণার ল্যাপটপে। গবেষণার ফলাফল প্রকাশের সময় আপনার পরিচয় প্রকাশ করা হবে না। তথ্য সংগ্রহে পছন্দসই (purposive) পদ্ধতি ব্যবহার করা হবে।

গবেষণার ফলাফল প্রচার:

গবেষণার ফলাফল বিভিন্ন সামাজিক মাধ্যম, ওয়েবসাইট, সম্মেলন ও বৈজ্ঞানিক জার্নালে প্রকাশিত হবে।

অংশগ্রহণকারীর পারিশ্রমিক:

গবেষণায় অংশগ্রহণের জন্য কোনো আর্থিক অনুদান বা পারিশ্রমিক প্রদান করা হবে না।

গবেষণার অর্থায়ন:

এই গবেষণার সকল ব্যয় গবেষকের নিজস্ব তহবিল থেকে বহন করা হবে এবং গবেষণা সীমিত এলাকার মধ্যে পরিচালিত হবে। কোনো বহিরাগত অর্থায়ন নেই।

অংশগ্রহণ থেকে প্রত্যাহারের তথ্য:

আপনি যেকোনো সময়, সর্বোচ্চ এক সপ্তাহের মধ্যে, অংশগ্রহণ প্রত্যাহার করতে পারবেন, কোনো কারণ ব্যাখ্যা ছাড়াই। তথ্য ব্যবহারের অনুমতি প্রত্যাহারের ক্ষেত্রে তা স্পষ্টভাবে আবেদনপত্রে উল্লেখ করতে হবে।

গবেষকের সাথে যোগাযোগের ঠিকানা:

গবেষণা সম্পর্কে কোনো প্রশ্ন থাকলে আপনি এখনই বা পরে যোগাযোগ করতে পারেন।

যোগাযোগের ঠিকানা:

মোস্টাইন বিল্লাহ তানজিল

৪র্থ বর্ষ, ব্যাচেলর অব সায়েন্স ইন অকুপেশনাল থেরাপি

অকুপেশনাল থেরাপি বিভাগ, বিএইচপিআই, সিআরপি-সাভার, ঢাকা

মোবাইল: ০১৮২৯০৬২৩৩৮

ইমেইল: mustainbillah@gmail.com

অভিযোগ জানানোর ব্যবস্থা:

গবেষণার যেকোনো অভিযোগের জন্য ইথিক্স অ্যাসোসিয়েশনের (Association of Ethics) নম্বরে যোগাযোগ করুন: ৭৭৪৫৪৬৪৫। এই গবেষণা প্রকল্পটি বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (বিএইচপিআই), সিআরপি, সাভার, ঢাকা-১৩৪৩-এর Institutional Review Board (IRB) দ্বারা পর্যালোচনা ও অনুমোদিত। IRB নিশ্চিত করে যে গবেষণায় অংশগ্রহণকারীরা কোনো ক্ষতির সম্মুখীন হচ্ছেন না। IRB সম্পর্কে আরো জানতে চাইলে বিএইচপিআই, সিআরপি, সাভার, ঢাকায় যোগাযোগ করুন।

Consent Form (English)



বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
Bangladesh Health Professions Institute (BHPI)

(The Academic Institute of CRP)

CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

Consent form

Code No: _____

(Please read out to the participant)

Assalamualaikum. I am Mustain Billah Tanzil, 4th year, Student of Bachelor of Science in Occupational Therapy, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP-Savar, Dhaka-1343. To fulfill the requirement of a B.Sc. in Occupational therapy degree I have to do a research project. My research title is — “Level of Participation of Children & Adolescents with Attention Deficits Hyperactivity Disorder at Home, School and Community Settings: A Cross Sectional Study”. The purpose of this research is to identify the level of activities participation in home, school, and community activities among children & adolescents with ADHD. Data will be collected through face-to-face interviews. This will take approximately 25-30 minutes. No payment will be provided for your participation in this study.

I am committed that the study will not harmful or risky for you. There is no payment for taking part in the study. All information provided by you will be treated as confidential and in the event of any report or publication, it will be ensured that the source of information remains confidential. Your participation in this study is voluntary and you may withdraw yourself at any time during this study without any negative consequences. You also have the right not to answer a particular question that you don't like or do not want during the interview.

Do you have any questions about providing the information?

YES ☐

NO ☐

So, may I have your consent to proceed with the interview?

YES ☐

NO ☐

Signature & Date of Participant

.....

Signature & Date of Researcher

.....

Phone No:

Consent Form (Bangla)



বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট(বিএইচপিআই)
Bangladesh Health Professions Institute (BHPI)

(The Academic Institute of CRP)

CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

সম্মতিপত্র

কোড নম্বর: _____

(যারা ইন্টারভিউতে অংশ নিচ্ছেন তাদের জন্য)

আসসালামু আলাইকুম। আমি মুস্তাঈন বিল্লাহ তানজিল, ঢাকা বিশ্ববিদ্যালয়ের চিকিৎসা অনুষদের অধীনে বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউটে বি.এস.সি ইন অকুপেশনাল থেরাপি বিভাগের ৪র্থ বর্ষের ছাত্র হিসেবে (২০২০-২০২১) সেশনে অধ্যয়নরত আছি। আমার বি.এস.সি ডিগ্রি সম্পূর্ণ করতে, আমাকে একটি গবেষণা পরিচালনা করতে হবে। এবং এটি আমার অধ্যয়নের একটি অংশ। আমার গবেষণার শিরোনাম হলো - "ADHD সম্পূর্ণ শিশু ও কিশোরদের ঘর, বিদ্যালয় ও সমাজভিত্তিক পরিবেশে অংশগ্রহণের স্তর নিরূপণ: একটি ট্রান্স-সেকশনাল স্টাডি"। আমার গবেষণার লক্ষ্য হলো, ADHD সম্পূর্ণ শিশু ও কিশোরদের ঘর, বিদ্যালয় ও সমাজভিত্তিক পরিবেশে অংশগ্রহণের স্তর নিরূপণ করা। এই গবেষণায় অংশগ্রহণের জন্য আপনাকে কিছু প্রশ্ন করা হবে যা মোটামুটি ২৫-৩০ মিনিট সময় লাগতে পারে। এতে অংশগ্রহণের জন্য আপনাকে কোন রকম পারিশ্রমিক দেয়া হবে না।

আমি আপনাকে জানাতে চাই যে, এই তথ্য সম্পূর্ণরূপে একাডেমিক গবেষণার উদ্দেশ্যে এবং একাডেমিক ছাড়া অন্য উদ্দেশ্যে ব্যবহার করা হবে না। আমি আশ্বাস দিচ্ছি যে সমস্ত তথ্য গোপন রাখা হবে। আপনার অংশগ্রহণ স্বৈচ্ছায় হবে। ডেটা সংগ্রহের এক সপ্তাহের মধ্যে যে কোনো সময় আপনার সম্মতি প্রত্যাহার করার অধিকার থাকতে পারে। তবে ডেটা সংগ্রহের এক সপ্তাহের পরে প্রত্যাহার করতে পারবেন না।

এই গবেষণা সম্পর্কিত আপনার কোন প্রশ্ন থাকলে, প্রধান গবেষক মুস্তাঈন বিল্লাহ তানজিল অথবা সুপারভাইজার মোঃ হাবিবুর রহমান (সহকারী অধ্যাপক এবং কোর্স সমন্বয়কারী, এমএসসি ইন অকুপেশনাল থেরাপি, অকুপেশনাল থেরাপি বিভাগ, বিএইচপিআই, সাভার, ঢাকা-১৩৪৩) এর সাথে যোগাযোগ করতে পারেন।

তথ্য প্রদান করা সম্পর্কে আপনার কোন প্রশ্ন আছে?

হ্যাঁ ☐ না ☐

তাহলে, ইন্টারভিউ নেয়ার জন্য আমি কি আপনার সম্মতি পেতে পারি?

হ্যাঁ ☐ না ☐

.....
 অংশগ্রহণকারীর স্বাক্ষর এবং তারিখঃ

.....
 তথ্য সংগ্রাহকের স্বাক্ষর এবং তারিখঃ

মোবাইল নম্বর :

Withdrawal Form (English)

Participant Withdrawal Form
(Applicable only for voluntary withdrawals)

Participant's Name:

Reason for Withdrawal:

.....

.....

.....

.....

Permission to use previously collected data: Yes / No

Participant's Signature & Date

Withdrawal Form (Bangla)

অংশগ্রহণকারীর প্রত্যাহার পত্র

(শুধু মাত্র স্বেচ্ছায় প্রত্যাহারকারীর জন্য প্রযোজ্য)

অংশগ্রহণকারীর নাম:

প্রত্যাহার করার কারণঃ

.....

.....

.....

পর্ববর্তী তথ্য ব্যবহারের অনুমতি থাকবে কিনা?

হ্যাঁ / না

অংশগ্রহণকারীর স্বাক্ষর ও তারিখ

Appendix C: Questionnaire (English & Bangla)

Sociodemographic Questionnaires (English)

SOCIO-DEMOGRAPHIC QUESTIONNAIRE – (OMR BASED) (For Children & Adolescents with ADHD)

<p>1. Child's age? _____ Years Old.</p> <p>2. Child's gender? ① Male ② Female ③ Other: _____</p> <p>3. What type of community do you live in? ① Urban ② Semi-Urban ③ Rural</p> <p>4. Child's mother's education level? ① Illiterate ② Primary ③ Secondary ④ Higher Secondary ⑤ Bachelor or above</p> <p>5. Child's father's education level? ① Illiterate ② Primary ③ Secondary ④ Higher Secondary ⑤ Bachelor or above</p> <p>6. Child's mother's current occupation? ① Homemaker ② Government Job ③ Private Job ④ Self-employed ⑤ Other: _____</p> <p>7. Mother's age at child's birth?" _____ years old</p> <p>8. Child's father's current occupation? ① Day laborer ② Government Job ③ Private Job ④ Self-employed ⑤ Other: _____</p> <p>9. Family's monthly income? _____ Thousand Tk.</p> <p>10. Child's family type? ① Joint family ② Nuclear family</p>	<p>11. How many people live together in your household? _____ people</p> <p>12. Does your child have any siblings? ① No ② Yes</p> <p>13. How many siblings? _____ siblings</p> <p>14. Does anyone in the family have a disability? ① No ② Yes</p> <p>15. How many people have disability? _____ people</p> <p>16. What type of school does your child attend? ① Mainstream ② Special School ③ Inclusive School</p> <p>17. How regularly does your child attend school? <i>(Number of days per week)</i> ① Regularly(5–6 days) ② Irregularly(1–4 days) ③ Dropped Out</p> <p>18. What is the current relationship status between the child's parents? ① Separated ② Jointly living</p> <p>19. Who is the main caregiver of the child? ① Both Parents ② Mother ③ Father ④ Other _____</p> <p>20. What is the education level of the main caregiver? ① Illiterate ② Primary ③ Secondary ④ Higher Secondary ⑤ Bachelor or above</p> <p>21. Is your child currently using any medication for ADHD? ① Yes ② No</p>
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<p>22. How many medicines currently taking your child's? _____ medicine</p> <p>23. What age child's diagnosed with ADHD? _____ years</p> <p>24. Did you receive any treatment after your child's illness/disability? ① None ② Yes</p> <p>25. What type of treatment did your child receive? ① Doctor ② Therapist ③ Traditional healer ④ Religious/spiritual ⑤ Both 1 & 2</p> <p>26. Who is currently providing treatment to the child? ① Doctor ② Therapist ③ Both 1 & 2 ④ Religious</p>	<p>27. Does the child have any other condition or disability besides ADHD? ① None ② Yes</p> <p>28. Which condition or disability?</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">① Autism</td> <td style="width: 50%; padding: 5px;">② Physical Disability</td> </tr> <tr> <td style="padding: 5px;">③ Mental Illness</td> <td style="padding: 5px;">④ Visual Impairment</td> </tr> <tr> <td style="padding: 5px;">⑤ Speech Impairment</td> <td style="padding: 5px;">⑥ Intellectual Disability</td> </tr> <tr> <td style="padding: 5px;">⑦ Hearing Impairment</td> <td style="padding: 5px;">⑧ Deaf-Blindness</td> </tr> <tr> <td style="padding: 5px;">⑨ Cerebral Palsy</td> <td style="padding: 5px;">⑩ Down Syndrome</td> </tr> <tr> <td style="padding: 5px;">⑪ Multiple Disabilities</td> <td style="padding: 5px;">⑫ Others: _____</td> </tr> </table>	① Autism	② Physical Disability	③ Mental Illness	④ Visual Impairment	⑤ Speech Impairment	⑥ Intellectual Disability	⑦ Hearing Impairment	⑧ Deaf-Blindness	⑨ Cerebral Palsy	⑩ Down Syndrome	⑪ Multiple Disabilities	⑫ Others: _____
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Sociodemographic Questionnaire (Bangla)

সামাজিক-জনসংখ্যাগত প্রশ্নাবলী - (OMR ভিত্তিক)

(ADHD-যুক্ত শিশু ও কিশোরদের জন্য)

<p>১. শিশুর বয়স কত? _____ বছর।</p> <p>২. শিশুর লিঙ্গ পরিচয় কী? ① পুরুষ ② নারী ③ অন্যান্য: _____</p> <p>৩. আপনি কোন ধরনের কমিউনিটিতে বাস করেন? ① শহর ② উপশহর ③ গ্রাম</p> <p>৪. শিশুর মায়ের শিক্ষাগত যোগ্যতা কী? ① অশিক্ষিত ② প্রাথমিক ③ মাধ্যমিক ④ উচ্চ মাধ্যমিক ⑤ স্নাতক বা তদুর্ধ্ব</p> <p>৫. শিশুর পিতার শিক্ষাগত যোগ্যতা কী? ① অশিক্ষিত ② প্রাথমিক ③ মাধ্যমিক ④ উচ্চ মাধ্যমিক ⑤ স্নাতক বা তদুর্ধ্ব</p> <p>৬. শিশুর মায়ের বর্তমান পেশা কী? ① গৃহিণী ② সরকারি চাকরি ③ বেসরকারি চাকরি ④ স্বনিয়োজিত ⑤ অন্যান্য: _____</p> <p>৭. শিশুর জন্মের সময় মায়ের বয়স কত ছিল? _____ বছর।</p> <p>৮. শিশুর পিতার বর্তমান পেশা কী? ① দিনমজুর ② সরকারি চাকরি ③ বেসরকারি চাকরি ④ স্বনিয়োজিত ⑤ অন্যান্য: _____</p>	<p>৯. পরিবারের মাসিক আয় কত? _____ হাজার টাকা মাত্র।</p> <p>১০. পরিবারে মোট কতজন একসাথে বসবাস করেন? _____ জন।</p> <p>১১. শিশুর ভাইবোন আছে? ① নেই ② আছে</p> <p>১২. থাকলে কতজন? _____ জন।</p> <p>১৩. পরিবারের কারও কি কোনো প্রতিবন্ধিতা আছে? ① না ② হ্যাঁ</p> <p>১৪. থাকলে কতজন? _____ জন।</p> <p>১৫. শিশুটি কোন ধরনের পরিবারে বসবাস করে? ① যৌথ পরিবার ② একক পরিবার</p> <p>১৬. শিশুটি কোন ধরনের স্কুলে পড়ে? ① সাধারণ স্কুল ② স্পেশাল স্কুল ③ ইনক্লুসিভ স্কুল</p> <p>১৭. শিশুর স্কুলে উপস্থিতির হার কেমন? (সপ্তাহে কতদিন) ① নিয়মিত (৫-৬ দিন) ② অনিয়মিত (১-৪ দিন) ③ স্কুল ছেড়ে দিয়েছে/ড্রপআউট</p> <p>১৮. শিশুর বাবা-মায়ের বর্তমান সম্পর্কের অবস্থা? ① আলাদা ② একসঙ্গে বসবাস করছে</p> <p>১৯. শিশুর প্রধান দেখাশোনাকারী কে? ① উভয় পিতা-মাতা ② মা ③ বাবা ④ অন্যান্য: _____</p>
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<p>২০. প্রধান কেয়ারগিভার/দেখাশোনাকারীর শিক্ষাগত যোগ্যতা:</p> <p>① অশিক্ষিত ② প্রাথমিক ③ মাধ্যমিক ④ উচ্চ মাধ্যমিক ⑤ স্নাতক বা তদুর্ধ্ব</p> <p>২১. আপনার সন্তান বর্তমানে ADHD-এর কোনো ওষুধ সেবন করছে কি?</p> <p>① হ্যাঁ ② না</p> <p>২২. বর্তমানে আপনার সন্তান কয়টি ওষুধ সেবন করছে?</p> <p>_____ টি ওষুধ।</p> <p>২৩. কত বছর বয়সে আপনার সন্তানের ADHD নির্ণয় করা হয়?</p> <p>_____ বছর বয়সে।</p> <p>২৪. শিশুর অসুস্থতা বা প্রতিবন্ধিতা নির্ণয়ের পর কোনো চিকিৎসা গ্রহণ করেছেন কি?</p> <p>① না ② হ্যাঁ</p> <p>২৫. আপনার সন্তান কী ধরনের চিকিৎসা পেয়েছে?</p> <p>① ডাক্তার ② থেরাপিস্ট ③ প্রথাগত চিকিৎসক ④ ধর্মীয়/আধ্যাত্মিক ⑤ ডাক্তার ও থেরাপিস্ট উভয়</p>	<p>২৬. বর্তমানে সন্তানের চিকিৎসা কে দিচ্ছেন?</p> <p>① ডাক্তার ② থেরাপিস্ট ③ ডাক্তার ও থেরাপিস্ট উভয় ④ ধর্মীয় ব্যক্তি</p> <p>২৭. ADHD ছাড়াও কি শিশুটির অন্য কোনো অবস্থা বা প্রতিবন্ধিতা আছে?</p> <p>① না ② হ্যাঁ</p> <p>২৮. কোন অবস্থা বা প্রতিবন্ধিতা আছে? নিচের কোনটি চিহ্নিত করুন:</p> <table border="1"> <tr> <td>① অটিজম</td> <td>② শারীরিক প্রতিবন্ধিতা</td> </tr> <tr> <td>③ মানসিক অসুস্থতা</td> <td>④ দৃষ্টিপ্রতিবন্ধকতা</td> </tr> <tr> <td>⑤ বাক প্রতিবন্ধিতা</td> <td>⑥ বুদ্ধিপ্রতিবন্ধিতা</td> </tr> <tr> <td>⑦ শ্রবণ প্রতিবন্ধিতা</td> <td>⑧ শ্রবণ ও দৃষ্টি উভয় প্রতিবন্ধিতা</td> </tr> <tr> <td>⑨ সেরিব্রাল পালসি</td> <td>⑩ ডাউন সিনড্রোম</td> </tr> <tr> <td>⑪ একাধিক প্রতিবন্ধিতা</td> <td>⑫ অন্যান্য: _____</td> </tr> </table>	① অটিজম	② শারীরিক প্রতিবন্ধিতা	③ মানসিক অসুস্থতা	④ দৃষ্টিপ্রতিবন্ধকতা	⑤ বাক প্রতিবন্ধিতা	⑥ বুদ্ধিপ্রতিবন্ধিতা	⑦ শ্রবণ প্রতিবন্ধিতা	⑧ শ্রবণ ও দৃষ্টি উভয় প্রতিবন্ধিতা	⑨ সেরিব্রাল পালসি	⑩ ডাউন সিনড্রোম	⑪ একাধিক প্রতিবন্ধিতা	⑫ অন্যান্য: _____
① অটিজম	② শারীরিক প্রতিবন্ধিতা												
③ মানসিক অসুস্থতা	④ দৃষ্টিপ্রতিবন্ধকতা												
⑤ বাক প্রতিবন্ধিতা	⑥ বুদ্ধিপ্রতিবন্ধিতা												
⑦ শ্রবণ প্রতিবন্ধিতা	⑧ শ্রবণ ও দৃষ্টি উভয় প্রতিবন্ধিতা												
⑨ সেরিব্রাল পালসি	⑩ ডাউন সিনড্রোম												
⑪ একাধিক প্রতিবন্ধিতা	⑫ অন্যান্য: _____												

Child & Adolescent Scale of Participation (CASP) -English

Child & Adolescent Scale of Participation (CASP)

ADHD Children's and Adolescents Information

Code No: _____

Your name: _____ Date of Survey: ____/____/____

Relationship with the child: _____ Phone Number: _____

Childs Name: _____ Date of birth: ____/____/____

Name of school: _____

Grade/Class: _____ ID Number: _____

- Instructions -

1. This scale asks questions about your participation in activities and events at home, school and the community. There also are a few questions that ask about strategies, assistive devices or modifications that are used or have been done to help you participate if this is needed.
2. There are no right or wrong answers. You will have to choose, and in some cases write, the answer that best describes your participation and things that help or interfere with your participation. If you are not sure about how to answer a question, give your best guess.

Thank you!

Item Level	Score
Age Expected (Full participation)	4
Somewhat restricted/limited	3
Very restricted/limited	2
Unable to participate	1
Not applicable	0

We are interested in finding out about the activities that your child participates in at home, school and in the community.

You will be asked about your child's current level of participation with activities as compared to other children his or her age. For each item, choose one of the following responses:

- **Age expected (Full participation)**, your child participates in the activities the same as or more than other children his or her age. [*With or without assistive devices or equipment*]
- **Somewhat limited**, your child participates in the activities somewhat less than other children his or her age [*Your child may also need occasional supervision or assistance*]
- **Very limited**, your child participates in the activities much less than other children his or her age. [*Your child may also need a lot of supervision or assistance*]
- **Unable**, your child can not participate in the activities, although other children his or her age do participate.
- **Not applicable**, other children your child's age would not be expected to participate in the activities.

Please select one answer by placing an X in one of the boxes next to each item. If you are not sure, choose your best guess.

Compared to other children your child's age, what is your child's current level of participation in the following activities?	Age expected (4)	Somewhat limited (3)	Very limited (2)	Unable (1)	Not applicable (0)
HOME PARTICIPATION					
1) Social, play or leisure activities with family members at home (e.g., games, hobbies, "hanging out")	4	3	2	1	0
2) Social, play or leisure activities with friends at home (can include conversations on the phone or internet)	4	3	2	1	0
3) Family chores, responsibilities and decisions at home (<i>For younger children</i> this may be getting things or putting things away when asked or helping with small parts of household chores; <i>For older children</i> this may be more involvement in household chores and decisions about family activities and plans)	4	3	2	1	0
4) Self-care activities (e.g., eating, dressing, bathing, combing or brushing hair, using the toilet)	4	3	2	1	0
5) Moving about in and around the home	4	3	2	1	0
6) Communicating with other children and adults at home	4	3	2	1	0

Compared to other children your child's age, what is your child's current level of participation in the following activities?	Age expected (4)	Somewhat limited (3)	Very limited (2)	Unable (1)	Not applicable (0)
NEIGHBORHOOD AND COMMUNITY PARTICIPATION					
7) Social, play, or leisure activities with friends in the neighborhood and community (e.g., casual games, "hanging out," going to public places like a movie theater, park or restaurant)	4	3	2	1	0
8) Structured events and activities in the neighborhood and community (e.g., team sports, clubs, holiday or religious events, concerts, parades and fairs)	4	3	2	1	0
9) Moving around the neighborhood and community (e.g., public buildings, parks, restaurants, movies) [<i>Please consider your child's primary way of moving around, NOT his or her use of transportation</i>]	4	3	2	1	0
10) Communicating with other children and adults in the neighborhood and community	4	3	2	1	0

Answer the following 5 questions if your child attends school or another structured educational program such as an early intervention program or day care center. Please specify the type of program your child is attending here:

Compared to other children your child's age, what is your child's current level of participation in the following activities?	Age expected (4)	Somewhat limited (3)	Very limited (2)	Unable (1)	Not applicable (0)
SCHOOL PARTICIPATION					
11) Educational (academic) activities with other children in his or her classroom at school	4	3	2	1	0
12) Social, play and recreational activities with other children at school (e.g., "hanging out," sports, clubs, hobbies, creative arts, lunchtime or recess activities)	4	3	2	1	0
13) Moving around at school (e.g., to get to and use bathroom, playground, cafeteria, library or other rooms and things that are available to other children his or her age)	4	3	2	1	0
14) Using educational materials and equipment that are available to other children in his or her classroom/s or that have been modified for your child (e.g., books, computers, chairs and desks)	4	3	2	1	0
15) Communicating with other children and adults at school	4	3	2	1	0

Compared to other children your child's age, what is your child's current level of participation in the following activities?	Age expected (4)	Somewhat limited (3)	Very limited (2)	Unable (1)	Not applicable (0)
HOME AND COMMUNITY LIVING ACTIVITIES					
16) Household activities (e.g., preparing some meals, doing laundry, washing dishes)	4	3	2	1	0
17) Shopping and managing money (e.g., shopping at stores, figuring out correct change)	4	3	2	1	0
18) Managing daily schedule (e.g., doing and completing daily activities on time; organizing and adjusting time and schedule when needed)	4	3	2	1	0
19) Using transportation to get around in the community (e.g., to and from school, work, social or leisure activities) [<i>Driving vehicle or using public transportation</i>]	4	3	2	1	0
20) Work activities and responsibilities (e.g., completion of work tasks, punctuality, attendance and getting along with supervisors and co-workers)	4	3	2	1	0

21.a. Please describe the type of things that interfere with your child's participation in the above-mentioned activities (e.g., things that your child does or that others do; or things about your home, school or community) [*Please write clearly*]:

21.b. Please describe the type of things that help with your child's participation in the above-mentioned activities (e.g., things that your child does or that others do; or things about your home, school or community). [*Please write clearly*]:

22. Does your child currently use any assistive devices or equipment to help him or her participate (e.g., adapted eating utensils, shower chair, note-taker for school, daily planner, and computer)?

☐ Yes ☐ No

[*If Yes*], please identify:

23. Have any changes been made to your home, community or the school (or work) setting to help your child participate (e.g., rearranging furniture and materials, adjusting lighting or noise levels, building a ramp or other physical structures)?

☐ Yes ☐ No

[*If Yes*], please describe:

Child & Adolescent Scale of Participation (CASP) -Bangla

চাইল্ড এন্ড অ্যাডোলেসেন্টস স্কেল অফ পারটিসিপেশন (সিএএসপি)-বাংলা

(ADHD-যুক্ত শিশু ও কিশোরদের তথ্য)

কোড নম্বর: _____

আপনার নাম: _____ জরিপের তারিখ: ____/____/____

শিশুর সাথে আপনার সম্পর্ক: _____ ফোন নম্বর: _____

শিশুর নাম: _____ জন্ম তারিখ: ____/____/____

বিদ্যালয়ের নাম: _____

শ্রেণি/ক্লাস: _____ আইডি নম্বর: _____

নির্দেশাবলী

- এই স্কেলটি আপনার সন্তানের বাড়ি, স্কুল এবং সমাজে (কমিউনিটি) বিভিন্ন কার্যক্রমে অংশগ্রহণ সম্পর্কে জানতে চায়। এছাড়াও আপনার অংশগ্রহণকে সাহায্য করতে প্রয়োজনের ভিত্তিতে যে সমস্ত কৌশল, সহায়ক যন্ত্র ব্যবহার করা হয়েছে বা পরিবর্তন (মডিফিকেশন) করা হয়েছে সে সম্পর্কিত কিছু প্রশ্ন জিজ্ঞাসা করা হবে।
- এখানে কোনও সঠিক বা ভুল উত্তর নেই। আপনাকে এমন উত্তর বেছে নিতে হবে এবং কিছু ক্ষেত্রে লিখতে হবে, যা আপনার অংশগ্রহণ এবং অংশগ্রহণে সাহায্যকারী বা বাধা সৃষ্টিকারী বিষয়গুলিকে সবচেয়ে ভালোভাবে বর্ণনা করে। যদি কোনও প্রশ্নের উত্তর নিয়ে আপনি নিশ্চিত না হন, তবে আপনার সেরা অনুমান দিন।

ধন্যবাদ!

উপাদান স্তর	স্কোর
প্রত্যাশিত বয়স (পূর্ণ অংশগ্রহণ)	৪
কিছুটা সীমাবদ্ধ	৩
খুব সীমাবদ্ধ	২
অংশগ্রহণ করতে অক্ষম	১
প্রয়োজ্য নয়,	০

আমরা আপনার সন্তান বাড়িতে, স্কুলে এবং সমাজে যে সমস্ত কার্যক্রমে অংশগ্রহণ করে সেগুলো খুঁজে বের করতে আগ্রহী।

সমবয়সী অন্যান্য শিশুদের তুলনায় আপনার সন্তানের বিভিন্ন কার্যক্রমের বর্তমান অংশগ্রহণের মাত্রা বিষয়ে আপনাকে জিজ্ঞেস করা হবে। নিম্নলিখিত উত্তর থেকে যে কোনো একটি বাছাই করবেন।

- **প্রত্যাশিত বয়স (পূর্ণ অংশগ্রহণ)**, আপনার সন্তান সমবয়সী অন্য শিশুদের মত বা তাদের তুলনায় বেশি বিভিন্ন কার্যক্রমে অংশগ্রহণ করে (সহকারী উপকরণ অথবা সামগ্রী সহ বা বাদে।)
- **কিছুটা সীমাবদ্ধতা**, আপনার সন্তান সমবয়সী ও অন্যান্য শিশুদের তুলনায় কিছুটা কম অংশগ্রহণ। (মাঝে মাঝে সাহায্য বা কিছুটা তত্ত্বাবধান বা সহায়তা প্রয়োজন হতে পারে)
- **খুব সীমাবদ্ধতা**, আপনার সন্তান সমবয়সী ও অন্যান্য শিশুদের তুলনায় অনেক কম অংশগ্রহণ করে (বেশি তত্ত্বাবধান বা সাহায্য লাগে)
- **অক্ষম**, যেখানে সমবয়সীরা অংশগ্রহণ করে, সেখানে অংশ নিতে পারে না।
- **প্রয়োজ্য নয়**, এই বয়সের জন্য এই কাজ প্রত্যাশিত নয়।

কলামে প্রতিটি আইটেম এর পাশে ক্রস x বসিয়ে একটি উত্তর নির্বাচন করুন। যদি আপনি নিশ্চিত না হন তাহলে সেরাটি অনুমান করুন

বাড়িতে অংশগ্রহণ

সমবয়সী অন্যান্য শিশুদের তুলনায় নিম্নলিখিত কার্যক্রমে আপনার সন্তানের বর্তমান অংশগ্রহণের মাত্রা কি? (বাড়িতে অংশগ্রহণ)	পূর্ণ অংশগ্রহণ (৪)	কিছুটা সীমাবদ্ধতা (৩)	খুব সীমাবদ্ধতা (২)	অক্ষম (১)	প্রয়োজ্য নয় (০)
১) পরিবারের সদস্যদের সাথে বাড়িতে মেলামেশা, খেলা বা অবসর কার্যক্রম (যেমন: খেলা, শেখের কাজ, আড্ডা)	৪	৩	২	১	০
২) বন্ধুদের সাথে বাড়িতে মেলামেশা, খেলা বা অবসর কার্যক্রম (এর মধ্যে ফোন বা ইন্টারনেটে কথা বলা অন্তর্ভুক্ত হতে পারে)	৪	৩	২	১	০
৩) বাড়িতে পারিবারিক টুকিটাকি কাজ, পারিবারিক দ্বায়িত্ব ও সিদ্ধান্তে অংশগ্রহণ। (ছোট শিশুদের ক্ষেত্রে বলার ভিত্তিতে কোন কিছু নিয়ে আসা বা রেখে দেওয়া বা পরিবারের টুকিটাকি কাজের ছোট অংশে সাহায্য করা এবং বড় শিশুদের ক্ষেত্রে এটা হতে পারে পারিবারিক টুকিটাকি কাজে অধিক অংশগ্রহণ ও পারিবারিক অন্যান্য কার্যক্রমের সিদ্ধান্ত গ্রহণ ও পরিকল্পনা)	৪	৩	২	১	০
৪) নিজের যত্নের জন্য কার্যাবলী (খাওয়া, জামাকাপড় পড়া, গোসল করা, চুল আঁচড়ানো, পায়খানা করা)	৪	৩	২	১	০
৫) বাড়ির ভিতরে এবং চারপাশে ঘুরা/চলাচল	৪	৩	২	১	০
৬) বাড়িতে বড়দের সাথে এবং অন্য শিশুদের সাথে যোগাযোগ	৪	৩	২	১	০

পাড়া-প্রতিবেশী ও সামাজিক অংশগ্রহণ

সমবয়সী অন্যান্য শিশুদের তুলনায় নিম্নলিখিত কার্যক্রমে আপনার সন্তানের বর্তমান অংশগ্রহণের মাত্রা কি? (পাড়া-প্রতিবেশী ও সামাজিক অংশগ্রহণ)	পূর্ণ অংশগ্রহণ (৪)	কিছুটা সীমাবদ্ধতা (৩)	খুব সীমাবদ্ধতা (২)	অক্ষম (১)	প্রয়োজ্য নয় (০)
৭) পাড়া ও সমাজে বন্ধুদের সাথে মেলামেশা, খেলা বা বিনোদনমূলক কার্যক্রম (যেমন: নিত্যদিনের খেলা, ঘুরতে বাহিরে যাওয়া, গনস্থান এর মতো জায়গা গুলোতে যাওয়া যেমন মুন্ডি থিয়েটার, পার্ক বা রেস্টোরাঁতে যাওয়া)	৪	৩	২	১	০
৮) পাড়ায় ও সমাজে সংগঠিত কার্যক্রম ও অনুষ্ঠান (যেমন: দলগত খেলাধুলা, ক্লাব, উৎসব বা ধর্মীয় অনুষ্ঠান, কনসার্ট, শোভাযাত্রা এবং মেলা ইত্যাদি)	৪	৩	২	১	০
৯) পাড়ায় ও সমাজের আশেপাশে ঘুরা/চলাচল (যেমন: সরকারি ভবন, পার্ক, রেস্টুরেন্ট, সিনেমা হল); (দয়া করে আপনার সন্তানের ঘোরাক্ষেপের করার প্রাথমিক পদ্ধতি বিবেচনা করুন যানবাহন ব্যবহার নয়)	৪	৩	২	১	০
১০) পাড়া ও সমাজে অন্যান্য শিশু এবং বয়স্কদের সাথে যোগাযোগ	৪	৩	২	১	০

স্কুলে অংশগ্রহণ

নীচের ৫ টি প্রশ্নের উত্তর দিন যদি আপনার সন্তান স্কুলে যায় অথবা অন্য কোন শিক্ষামূলক প্রোগ্রাম যেমন- প্রারম্ভিক চিকিৎসা প্রোগ্রাম অথবা ডে কেয়ার সেন্টার। দয়া করে সুনির্দিষ্টভাবে উল্লেখ করুন আপনার শিশুটি কোন ধরনের প্রোগ্রামে অংশগ্রহণ করছে:					
সমবয়সী অন্যান্য শিশুদের তুলনায় নিম্নলিখিত কার্যক্রমে আপনার সন্তানের বর্তমান অংশগ্রহণের মাত্রা কি? (স্কুলে অংশগ্রহণ)	পূর্ণ অংশগ্রহণ (৪)	কিছুটা সীমাবদ্ধতা (৩)	খুব সীমাবদ্ধতা (২)	অক্ষম (১)	প্রয়োজ্য নয় (০)
১১) বিদ্যালয়ে তার শ্রেণির সহপাঠীদের সাথে তার শিক্ষামূলক (একাডেমিক) কার্যক্রম	৪	৩	২	১	০
১২) স্কুলে অন্যান্য শিশুদের সাথে/সহপাঠীদের সাথে তার মেলামেশা, খেলাধুলা এবং বিনোদনমূলক কাজ (উদাহরণ- ঘুরাফেরা, আড্ডা, খেলাধুলা, ক্লাব, শখের কাজ, সৃজনশীল শিল্পকর্ম/শিল্পকলা, দুপুরে খাওয়া অথবা বিরতির সময়ের কার্যক্রম)	৪	৩	২	১	০
১৩) বিদ্যালয়ে চলাফেরা করা (যেমন: বাথরুমে যাওয়া ও ব্যবহার করা, খেলার মাঠ, ক্যাফেটেরিয়া, লাইব্রেরি বা অন্যান্য কক্ষ ও স্থান ব্যবহার যা তার সমবয়সী অন্য শিশুদের জন্য উন্মুক্ত)	৪	৩	২	১	০
১৪) তার শ্রেণীকক্ষে অন্যান্য শিশুদের জন্য যে শিক্ষামূলক উপকরণ ও সরঞ্জাম পাওয়া যায় অথবা আপনার সন্তানের জন্য পরিবর্তিত করা হয়েছে, সেগুলোর ব্যবহার (যেমন, বই, কম্পিউটার, চেয়ার এবং ডেস্ক)	৪	৩	২	১	০
১৫) স্কুলে অন্যান্য শিশু এবং বয়স্কদের সাথে আপনার শিশু যোগাযোগ	৪	৩	২	১	০

বাড়ি এবং সামাজিক জীবনের কাজকর্ম

সমবয়সী অন্যান্য শিশুদের তুলনায় নিম্নলিখিত কার্যক্রমে আপনার সন্তানের বর্তমান অংশগ্রহণের মাত্রা কি? (বাড়ি এবং সামাজিক জীবনের কাজকর্ম)	পূর্ণ অংশগ্রহণ (৪)	কিছুটা সীমাবদ্ধতা (৩)	খুব সীমাবদ্ধতা (২)	অক্ষম (১)	প্রয়োজ্য নয় (০)
১৬) গৃহস্থালির কাজ (যেমন: কিছু খাবার তৈরি করা, কাপড় ধোয়া, থালা-বাসন ধোয়া)	৪	৩	২	১	০
১৭) কেনাকাটা এবং অর্থ ব্যবস্থাপনা (উদাহরণ দোকানে কেনাকাটা করা ও সঠিক ভাংতি বুঝে নেওয়া)	৪	৩	২	১	০
১৮) দৈনন্দিন সময়সূচি মেনে চলা (যেমন: প্রতিদিনের কাজ সময়মতো করা ও শেষ করা; প্রয়োজন হলে সময় ও পরিকল্পনা ঠিকমতো সাজানো ও পরিবর্তন করা)	৪	৩	২	১	০
১৯) এলাকায় চলাফেরার জন্য পরিবহন ব্যবহার করা (যেমন: স্কুল, কাজ, সামাজিক বা বিনোদনমূলক স্থানে যাতায়াত করা) [গাড়ি চালিয়ে বা গণপরিবহন ব্যবহার করে]	৪	৩	২	১	০
২০) কাজ ও দায়িত্ব (যেমন: কাজ সম্পন্ন করা, সময়ানুবর্তিতা, এবং সুপারভাইজার ও সহকর্মীদের সাথে ভালো সম্পর্ক বজায় রাখা)	৪	৩	২	১	০

২১.ক) উপরে উল্লেখিত কার্যক্রমে আপনার শিশুর অংশগ্রহণে যেসব বিষয় বাধা সৃষ্টি করে, সেগুলো বর্ণনা করুন (যেমন: আপনার সন্তান বা শিশুরা যা করে; অথবা বাড়ি, স্কুল বা সমাজের কোনো বিষয়) [দয়া করে স্পষ্টভাবে লিখুন]:

২১.খ) উপরে উল্লেখিত কাজকর্মে অংশগ্রহণ করতে যা আপনার সন্তানকে সাহায্য করে তা অনুগ্রহপূর্বক বর্ণনা করুন (যেমন: আপনার সন্তান বা অন্যান্য শিশুরা যা করে; অথবা বাড়ি, স্কুল বা সমাজের কোনো বিষয়) [দয়া করে স্পষ্টভাবে লিখুন]:

২২) আপনার সন্ধান কি বর্তমানে কোন এসিস্টিভ ডিভাইস বা সহায়ক যন্ত্র ব্যবহার করে যা তাকে অংশগ্রহণে সাহায্য করে? (উদাহরণ অভিযোজিত খাবারের পাত্র, গোসলের চেয়ার, স্কুলের টীকা সংগ্রাহক, দৈনিক পরিকল্পক, কম্পিউটার)।
☐ হ্যাঁ ☐ না (যদি হ্যাঁ হয়, বর্ণনা করুনঃ)

২৩) আপনার বাড়িতে, সমাজে, স্কুলে বা কর্মক্ষেত্রে আপনার বাচ্চার অংশগ্রহণে সহায়তার জন্য কি কোন পরিবর্তন করা হয়েছে? (যেমন: আসবাবপত্র ও উপকরণ নতুনভাবে সাজানো, আলো বা শব্দের মাত্রা ঠিক করা, র‍্যাম্প বা অন্যান্য শারীরিক কাঠামো তৈরি করা)
☐ হ্যাঁ ☐ না (যদি হ্যাঁ হয়, বর্ণনা করুনঃ)

Child & Adolescent Scale of Participation (CASP) -Scoring or Interpretation System

Child and Adolescent Scale of Participation (CASP) Scoring: General interpretation of scores

Gary Bedell, Ph.D., OT 1/22/19

Colleagues have requested an approach to categorize CASP scores into levels of extent of age-expected participation and/or participation restriction because there are no age-based norms (given that the CASP uses a "comparison to age" in the rating scale). **The below table** represents one approach (currently untested) based on patterns of CASP scores I have examined in my samples. Scores are not normally distributed and are typically higher so more discrimination of levels at the higher end was needed. **NOTE:** Colleagues can also develop their own category system to get a general estimate of age-expected extent of participation/ restriction based on patterns in their own samples/data.

It is important to remember, that the CASP can only provide a general estimate of extent of age-expected participation or restriction because: 1) there are no age-based norms; 2) some items are not applicable for younger children and adolescents; and 3) each CASP item is a broad activity type (inclusive of some examples) and thus does not focus on participation in a specific activity or life situation.

Average Score (Sum / # items)	Total (POMP) Score ([Sum/Maximum possible] x 100)	Category (Extent of participation/restriction)
1.00 – 1.24	25 - 31	Unable /Extremely limited
1.25 – 1.49	31.25 – 37.25	Extremely limited
1.50 – 1.74	37.50 – 43.50	Extremely limited
1.75 – 1.99	43.75 – 49.75	Extremely limited
2.00 – 2.24	50 - 56	Extremely / Very limited
2.25 – 2.49	56.25 – 62.25	Very limited
2.50 – 2.74	62.50 – 68.50	Very limited
2.75 – 2.99	68.75 – 74.75	Very limited / Limited
3.00 – 3.24	75 - 81	Limited
3.25 – 3.59	81.25 -89.75	Limited / Somewhat limited
3.60 – 3.79	90 – 94.75	Somewhat limited
3.80 – 3.89	95 – 97.25	Mildly limited
3.90 – 4.00	97.50 - 100	Age-expected / Full participation

The approach can use the **Average score** to get a sense of where the child or adolescent falls on the 4-point scale (1=Unable; 2 = Very Limited; Somewhat Limited; Age-expected/ "Full" Participation):

- Sum all item -level scores and divide by number of items.

OR the traditional **Percent Of Maximum Possible (POMP) score**:

- Sum item level scores then divide by maximum possible scores (i.e., based on number of applicable CASP items) and then multiply this by 100.

There should be a perfect correlation between the Average scores and the Percent Of Maximum Possible (POMP) scores. This approach can be used with CASP subsection scores too if there is an adequate number of applicable / completed items per subsection.

Examples:

Total CASP Score:

- **20 items completed (e.g., all items applicable)**
- Summary score (sum of item scores) = 70
- Percent Of Maximum Possible (POMP) score = $[70/80] \times 100 = 87.5$
- Average score = $70/20 = 3.5$
- "Limited/Somewhat limited" (Using Category system)
- **15 items completed (e.g., 5 items not applicable)**
- Summary score (sum of item scores) = 48
- Percent Of Maximum Possible (POMP) score = $[48/60] \times 100 = 80$
- Average score = $48/15 = 3.2$
- "Limited" (Using Category system)

Subsection Scores

- **4 items completed (e.g., Neighborhood and Community Participation)**
- Summary score (sum of item scores) = 11
- Percent Of Maximum Possible (POMP) score = $[11/16] \times 100 = 68.75$
- Average score = $11/4 = 2.75$
- "Very limited / Limited" (Using Category system)
- **6 items completed (e.g., School Participation)**
- Summary score (sum of item scores) = 22
- Percent Of Maximum Possible (POMP) score = $[22/24] \times 100 = 91.67$
- Average score = $22/6 = 3.67$
- "Somewhat limited" (Using Category system)

Appendix D: Supervision Records

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 participation of children and Adolescents with Attention-Deficit/Hyperactivity Disorder (ADHD) at Home, school and community*

Name of student: *Mustain Billah Tanzil* Settings: *A cross sectional study*

Name and designation of thesis supervisor: *MD. Habibur Rahman*
Assistant Professor and course co-ordinator,
BHPI, CRP, Savar, Dhaka *Msc in OT*

Appointment No	Date	Place	Topic of discussion	Duration (Minutes/Hours)	Comments of student	Student's signature	Thesis supervisor signature
1	25.05.25	BHPI office Building	Title, Aim, Objective, Scale	1 Hour	Got a clear concept	Mustain	<i>[Signature]</i>
2	27.05.25	BHPI office Building	Proposal presentation guideline	1 Hour	Got a clear concept	Mustain	<i>[Signature]</i>
3	01.06.25	BHPI office Building	Proposal presentation feedback	1 Hour	Got a clear concept	Mustain	<i>[Signature]</i>

4	04.06.25	BHPI Building	Discussion about sample size, data collection	1 Hour	Effective discussion	Mustain	<i>[Signature]</i>
5	07.06.25	BHPI Building	Discuss about socio-demographic questionnaire	2 Hours	Effective discussion	Mustain	<i>[Signature]</i>
6	09.06.25	BHPI Building	Feedback on socio-demographic questionnaire	2 Hours	Effective discussion	Mustain	<i>[Signature]</i>
7	11.06.25	Reddaway Hall	Feedback on Bengla translation of the questionnaire	1 Hour	Effective discussion	Mustain	<i>[Signature]</i>
8	14.06.25	BHPI Building	Guideline on literature review	1 Hour	Got a clear idea	Mustain	<i>[Signature]</i>
9	21/06.25	BHPI office Building	Feedback on literature review	2 Hours	Got a clear idea	Mustain	<i>[Signature]</i>
10	06.08.25	BHPI office Building	Guideline on data collection	2 Hours	Got a clear idea	Mustain	<i>[Signature]</i>
11	19.08.25	BHPI office Building	Discussion about data collection status	2 Hours	Effective discussion	Mustain	<i>[Signature]</i>
12	30.08.25	BHPI classroom	Discussion about data entry and data analysis	3 Hours	Got a clear idea	Mustain	<i>[Signature]</i>
13	01.09.25	BHPI classroom	Variables set and data entry guideline	3 Hours	Got a clear idea	Mustain	<i>[Signature]</i>
14	10.11.25	BHPI classroom	Data entry on spss	3 Hours	Got a clear idea	Mustain	<i>[Signature]</i>
15	11.11.25	BHPI classroom	Descriptive analysis	4 Hours	Got a clear concept	Mustain	<i>[Signature]</i>
16	12.11.25	BHPI classroom	Feedback on descriptive analysis & result writing	4 Hours	Got a clear concept	Mustain	<i>[Signature]</i>

17	13-11-25	BHPI classroom	Discussion inferential statistics	4 hours	Effective Discussion	Mustain	
18	16-11-25	BHPI classroom	Discussion and feedback on overall result writing	3 hours	Not a clear concept	Mustain	
19	23-11-25	BHPI Building	Feedback on 1st draft	3 hours	Not a clear concept	Mustain	
20	28-11-25	BHPI Library Building	Feedback on 2nd draft after Defense	2 hours	Not a clear concept	Mustain	

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.

