‘Help the patient turn back to happy’: A qualitative study with mental health professionals in Vietnam

A Bachelor of Science Thesis in Occupational Therapy about how mental health staff support their patients back into society, conducted as a Minor Field Studies project

MAIN FIELD: Occupational Therapy
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Abstract

The purpose of this study was to identify in what way health care staff at a psychiatric facility in Vietnam support patients with mental illness to participate in society. This research is based on a qualitative interview study with inductive reasoning and semi-structured interviews. The participants were mental health professionals at the applicable facility. The respondents consisted of a total of ten health care professionals and the participants were recruited using snowball sampling. Content analysis according to Lundman & Graneheim-Hällgren (2017) was used to examine the data. The results eventuated in individual-based interventions that consist of the different ways the staff supports the individual patient such as validating, advising, coaching and encouraging. The findings also resulted in several strategies for group-based interventions such as rehabilitation efforts and creative activities. There were also interventions regarding cooperation with the family and the community where the staff work together with the community to have the patient return to a varied social life. The staff at the psychiatric facility have several ways of working with supporting the patients to participate in society; by individual-based interventions, group-based interventions and cooperation with the family and the community.

**Key Words:** Participation, Mental Health, Vietnam, Occupational Therapy, Society
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1. Statement of the Topic and Need for the Study

The term ‘Mental Illness’ is defined in the Oxford Dictionary of English as “A condition which causes serious disorder in a person's behaviour or thinking” (Stevenson, 2011). In some Asian countries, treatments for mental illness have shifted towards having more of a focus on the achievement of recovery rather than simply managing the symptoms. Strategies to attain a good mental health are used in the recovery process. Despite this, complete recovery remains elusive for most people - partly because of the lack of mental health resources in the clients’ communities and partly due to the prevalence of negative attitudes towards mental illness amongst health care professionals. Therefore it is of great importance that there are good treatment programmes available for health care professionals to help their clients integrate into society. Effective techniques and materials are essential in helping clients achieve their greatest potential and advancing in their mental health wellbeing (Tan et al., 2016).

An occupational therapist can help patients with mental illness to integrate into society but also to meet their expected role and the responsibilities that come with that particular role (Gibson, D’Amico, Jaffe & Arbesman, 2011). As stated in the Oxford Dictionary, ‘society’ can be referred to as “the community of people living in a particular country or region and having shared customs, laws, and organizations” (Oxford Dictionary, 2019). To get the support to maintain a productive life is an important part of reaching participation for these patients with mental illness. The activity of daily living is a part of a normal life and to be included in the community, as are instrumental activities of daily living which includes leisure activities, social participation, work and or education, life skills training and even physical activity (Gibson et al., 2011).

Unfortunately today there is a shortage of practicing occupational therapists in Asia, specifically Vietnam, with a sole focus on mental health care. This has been confirmed by The World Health Organization (2006), which states that only a small number of occupational therapists in Vietnam work within the field of mental health care. After decades of colonial rule by France, Vietnam suffered the ravages of civil war between the communist north and the US supported south. Vietnam has traditionally been an agricultural society but shifting more towards a market based economy has helped to alleviate poverty and increased economic growth (Utrikespolitiska Institutet, 2016). It is a great challenge for any nation to provide comprehensive health care which is both affordable and cost effective whilst at the same time meeting the needs of communities and individual patients alike. Vietnam has the advantage of being able to learn quickly from lessons learnt over many years by countries with much longer traditions of market economics (Derstine, Shepard, Nixon-Cave & Kinneally, 2003). Hayashi (2010) mentions that representatives from several countries have visited Vietnam with the hope of promoting occupational therapy throughout the years. In 2015 there was still no occupational therapy education program available in Vietnam (Söderback, 2015).

This inquiry is the product of a scholarship project called Minor Field Studies financed from Styrelsen för Internationellt Utvecklingssamarbete [SIDA] enabling undergraduate students to
write their Bachelor's Thesis in a developing country for a total of eight weeks. The purpose of the project is the opportunity to gain knowledge about development issues around the globe and address a motive as to why the particular study is needed (SIDA, 2017). This study was initiated in relation to the Global Goals which were set by world leaders in 2015 at an historic UN summit (United Nations, n.d.). The aspiration of these goals is to achieve a sustainable future and development in relation to many challenges facing the world today; poverty, environmental degradation, climate change and health related problems, to name but a few. The target year for the Global Goals is set at 2030 and it is crucial that everyone contributes in making a change. This research has a specific approach regarding health care which relates to the third Global Goal which is “Good health and wellbeing”. Target 3.4 “Reduce mortality from non-communicable diseases and promote mental health” directly relates to the focus of this study as the choice of subject is mental health (United Nations, n.d.).

The hope is that this project may inspire the development of the country’s health resources and increase awareness of the merits of occupational therapy. Occupational therapists play an important role in the rehabilitation of mental health patients back into their societal context but since there is a shortage of occupational therapists within mental health facilities in Vietnam - who is working with it and how is it being done?
2. Theoretical Paradigm

2.1 Mental Illness in Asia

Historically, broad research into issues relating to psychiatric needs in Asia is not easy to find, with existing studies giving rise to further questions, however it is estimated that 12 million people in Vietnam may be in some need of mental health services. The most common issues regarding mental illness are alcohol abuse, depression and anxiety (Vuong et al, 2011). WHO–AIMS’ report on the mental health system in Vietnam (2006) reveals that patients treated at psychiatric hospitals suffer mainly from neurotic, stress-related disorders and somatoform disorders as well as affective disorders. The majority of the patients with psychiatric needs are initially treated at a mental hospital followed by outpatient facility care.

People suffering from any kind of psychiatric disorder face the risk of discrimination and even being considered as potentially dangerous, which inevitably leads to segregation from the general population. These people are those who more often pin their hopes on supernatural and religious solutions rather than the health care treatments that are available. The stigma attached to those with psychiatric special needs can be even greater within individual households than outside, with families themselves expressing social disapproval (Lauber & Rössler, 2007). The development of mental health care in low to middle income countries hinges equally on awareness (attitude/priorities) and finance (investment/education). People with mental health issues and their families often find themselves outside the public debate and outside the standard view of society in low- & middle income countries. The interest from the general public regarding people with mental illness is often very small (Saraceno et al., 2007).

2.2 Participation in Society

Stigmatization of people with mental illness is a common problem which affects participation in society and also halters their recovery. Over the long term, stigmatization can lead to a smaller network of friends, difficulties at work and discrimination in society in daily life (Gaebel et al., 2011). People suffering from a mental illness diagnosis such as schizophrenia can therefore experience social exclusion due to their mental disability. They can also experience a lack of participation in domestic life and choose to participate in fewer activities. Community-based services and occupations can play a big part in supporting these people to participate in activities (Lipskaya-Velikovsky, Jarus, Easterbrook & Kotler, 2016). According to Taylor and Kielhofner (2017) the term participation refers to occupation or doing. To be participating in an activity is to be engaged in the activity which could be related to work, occupations in daily life, leisure activities and/or activities that are felt to be necessary in a social-cultural context for mental and social wellbeing e.g. having a job, going to school, being with friends or participating in voluntary work.

Being an active member in society or experiencing social integration are key components in recovery from mental illness. The work-place offers another forum with the potential to positively impact the recovery process, where people meet and bond through working together. Poor health, not least mental, constitutes a barrier for social inclusion. People with psychiatric
needs often experience a feeling of shame and marginalization from society. The lack of meaningful daily activities can lead to a feeling of loneliness and a feeling of not being needed. Those with psychiatric needs who have a sense of belonging to a specific group in society, such as their work place or being part of an organization, feel less lonely (Granerud & Severinsson, 2006). A study done by van Nierkirk (2009) revealed that participation in work was shown to be important for the recovery of patients. Participation in work was not only beneficial to wellness but also an important source of income. Bredfell and Eliason (2018) did a qualitative interview study to see how people with social anxiety experience how limited participation in social activities can affect them in daily life. The results presented showed that limited participation in social activities had a negative effect on their participation in daily life activities. The respondents reported that they felt uncomfortable in bigger crowds and that they also felt marginalized in society.

2.3 Occupational Therapy
Activity and occupation were first recognised long ago in ancient times. Over hundreds of years of knowledge and influences have developed occupational therapy into the practices of today. Occupational therapy transpired in the early 20th century and especially in the arts and crafts movement. Roughly a hundred years ago was the time when ideas started to be shared and thoughts on the topic were expressed which brought the early components of occupational therapy practice together, emphasising the connection between the mind and the body as well as the focus on science. During this century occupational therapy sought legitimacy as a profession practising within the field of medical practices. Today occupational therapy has been directed into being described in terms of health, quality of life, wellness and participation - including social participation. Occupational therapy is the core of everyday activities in which people participate when they are engaged in roles in different areas of their life; in their home, at their workplace, in the community and so on (Andersen & Reed, 2017).

The Model of Human Occupation is an occupational therapy theoretical model describing the volition, performance capacity and the habituation as well as the importance of roles of a person’s activity pattern. In general, typical for adulthood is the presence of a job and that specific role affects other parts of their life such as their social life and leisure activities. It is all connected together. It is crucial that an adult has the ability to manage an everyday life with different activities and obligations (Taylor & Kielhofner, 2017). Mental illness can lead to psychiatric disabilities which can result in difficulties in performing daily tasks and important areas of everyday life (Statens Offentliga Utredningar, 2006). With that said, some activities in daily life might have to be reevaluated with performance capacity in mind (Taylor & Kielhofner, 2017).

The goal of occupational therapy is that people shall have the possibility to perform their daily tasks in a meaningful way. The occupational therapist usually works with individual based interventions but can also work with group based interventions and towards the community. When working with individuals the occupational therapist will assess the patients need and prerequisites for activity and participation with an assessment tool (Sveriges Arbetsterapeuter, 2018). After the assessment the appropriate interventions matching the needs of the patient will
be used. With the right interventions and tools the occupational therapist will give the patient the possibility to be active and to participate in social and everyday activities. When the occupational therapist works with groups or with the community it can be to consult, educate, assess or perform interventions leading to increased participation (Sveriges Arbetsterapeuter, 2018). Group-based interventions within mental health is common practice for occupational therapists. Groups will often work with activities to improve skills and to encourage social interaction (Bullock & Bannigan, 2011). According to Eklund, Gunnarsson and Leufstadius (2010) there are several varieties of group constellations but they can be divided into two separate groups; one being task oriented and the other supportive. The task oriented group will often work with activities focusing on developing skills while the supportive group focuses on self evaluation and unstructured activities such as creative activities. Creative activities constitute a cultural need and hold a strong socio-cultural value. When we create something, multiple senses are activated simultaneously, resulting in a sense of happiness. When used in a therapeutic setting it is not the end product that is in focus but rather the activity itself which could be anything from ceramics or textiles to gardening. Occupational therapists also work with setting goals with their patients, both long-term and short-term goals. The short-term goals work as a strategy towards accomplishing the long-term goals (Eklund et al., 2010). To help their clients achieve their goals the occupational therapist can validate the client’s experience and give advice as well as coach and encourage the client (Taylor & Kielhofner, 2017). An occupational therapist can use a variety of approaches to support their client in achieving their goals, one being by having the patient perform constructive activities e.g. handcraft and both by carrying out and sharing their performance of these and other such daily tasks (Vizzotto, Buchain, Netto & Elkis, 2015). The occupational therapist works to a great extent with means of rehabilitation (Sveriges Arbetsterapeuter, 2018).

According to The American Occupational Therapy Association Foundation (2013) occupational therapists within mental health care focus on recovery with the goal of full participation into society meaning obtaining a job, managing studies and having an independent lifestyle. The aim of community mental health is to increase the ability of independence within the community and to engage in life roles. Occupational therapists within mental health can work with adapting the environment whether it is at home, at work or at school to encourage self dependence. Treatment can take place in groups to work with social skills, stress management, self-awareness among other classes or as an educational programme. The occupational therapist can work with the patient to develop or pursue leisure activities as well as helping them manage their daily life with time management, managing the home and assembling the skills necessary for an independent life including daily living e.g. personal hygiene. The occupational therapist can also work with educating employers and support the patient at their place of work in a supportive employment capacity. Another important job for the occupational therapist is to work with the barriers to mental health in the community, stigmatization being one such.

Additionally, having the patient become socially active in the rehabilitation process often has a significant positive impact generating momentum and appetite for more (Eklund et al., 2010). Occupational therapy methods continue to be a successful approach for people with disabilities
and difficulties with integrating in society. However occupational therapy needs to advance and develop into becoming a natural choice of rehabilitation in the traditional health care sector (Crouch & Alers, 2014).
3. Purpose of Research

The purpose of this study was to identify in what way health care staff at a psychiatric facility in Vietnam support patients with mental illness to participate in society.

4. Methodology

4.1 Research Design

This research is based on a qualitative interview study with inductive reasoning, which is a method of unprejudiced analysis of the findings usually related to the respondent’s account of their experience (Lundman & Graneheim-Hällgren, 2017). The qualitative interview study is a good way to conduct a study when not being an experienced researcher as the focus of the analysis is to find similarities and differences in the material. Together with this semi-structured interviews were used, as it is the best way to collect the data needed because the respondents could answer freely, the questions did not have to be presented in exactly the same order to everyone and it would be possible to ask supplementary questions if needed (Kristensson, 2014).

4.2 Participants

The participants relevant for this study are mental health professionals at the applicable facility. The participants are practicing in inpatient and/or outpatient care. The respondents consisted of a total of ten health care professionals; three psychologists, three doctors, two nurses and two physiotherapists. The participants were representatives from the staff from the rehabilitation unit and the pediatric unit, as a way of getting a varied sample and a diffusion of experiences (Kristensson, 2014). A few of the participants saw patients from several units, such as the pediatric unit and an outpatient unit with adult patients. The participants were of different ages and genders. The respondents all had some kind of patient contact with mental health patients, both adults, children and adolescents, suffering from varieties of mental illnesses. The collection was constructed using snowball sampling, also known as chain-referral sampling, of recruited participants with help from the facility (Kristensson, 2014). The sampling method consisted of getting information about other participants relevant for the study and then consider if it was convenient to gather more information from them (Yin, 2013).

4.3 Data Collection

Apart from assembling suitable candidates, help was secured from an interpreter during the semi-structured interviews, which were held with one participant at a time and included a time frame of approximately ten to twenty-five minutes, depending on the specific interview. The interviews took place in different rooms over two days at the facility together with the interpreter. The interview questions were asked in a predetermined order. Notes were written down and the interviews were also recorded, with the approval of the participants, in addition to taking notes. Using a tape recorder was an effective way to record the conversation, as a good recording increases the veracity of the fieldwork, as the interviews were vital. Notes were
also taken so that certain information would not have to be searched for again at a later stage, e.g. the profession of the respondent (Yin, 2013). It was also of great importance to confirm permission to record and interview prior to beginning and to make sure that the technical equipment did not hinder the interview (Stein, Rice & Cutler, 2013).

4.4 Principles of Ethics
The principles of Autonomy, Non-Maleficence, Beneficence and Justice were considered (Kristensson, 2014). Every effort was made to ensure that there was informed consent of the participants with a well-prepared information letter, which was translated into vietnamese by the interpreter, and a consent form (with a temporary project title), provided in "8. Appendix” also translated into vietnamese. The confidentiality and integrity of the respondents was respected, as described in the information letter the participants were assured that their participation in the study was voluntary and could be terminated at any time. The information was in the care of, and stored on the computers of, those people responsible for the study. In order to avoid harm to the participants great care was taken how best to present the interview questions. Complete anonymity could not be guaranteed but confidentiality was guaranteed by summarising the findings without any information that could identify the individual participant. At no point were the participants’ names or other personal data noted, only their profession. The participants all received the same information about the study, in writing and verbally. Both the participants and the interpreter were given a consent form to sign, available in “8. Appendix” (Kristensson, 2014). An ethical audit according to the standards of Jönköping University was submitted and accepted prior to the data collection (see “9.5 Ethical Audit”).

4.5 Data Analysis
The data was compiled and reviewed during the stay in Vietnam. Content analysis according to Lundman and Graneheim-Hällgren (2017) was used to examine the data. The data was transcribed, meaning the transfer process from the multimedia dialogical interaction to the written word, which resulted in a total of 30 pages. The transcription process always has a risk of systematic bias as there is no transcription notification system available providing the exact reproduction and a complete accuracy of the conduct, therefore the transcription process must be approached with a critical eye and ear (Kowal & O’Connell, 2014). The data was also read through thoroughly along with taxonomization, meaning classification or scheme (Oxford Dictionary, 2019), of the data. The taxonomy includes different subcategories, depending on the narrative, along with text constructions. The quotations were converted into a written text that makes it easier to understand (Klartext, 2010). Open coding was being used when summarizing the findings because it is a way of methodically compiling the data (Yin, 2013). The coding is a technique of labelling the units of meaning, describing their content (Lundman & Graneheim-Hällgren, 2017). Findings that are similar to each other receive the same code (Yin, 2013) and the coding has to be done with consideration of the context related to the unit of meaning (Lundman & Graneheim-Hällgren, 2017). The ten interviews resulted in three main categories during the analysis in which the results are presented in Figure 1.0. The categories and sub-categories of the activities were chosen taking into consideration the variety of forms of practice of an occupational therapist, as described in “2.2 Occupational Therapy”.

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**Figure 1.0 Chart describing an example of the analysis of the data**

<table>
<thead>
<tr>
<th>Unit of Meaning</th>
<th>Condensed Unit of Meaning</th>
<th>Code</th>
<th>Sub-category</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>“When patient want to turn back to their job or [their] hobby they listen to the patient and [consult]”</td>
<td>They listen and consult the patients about important decisions</td>
<td>Listen to the patient</td>
<td>Validating &amp; Advising</td>
<td>Individual-Based Interventions</td>
</tr>
<tr>
<td>“[…] we can remind the patient about their [hobbies that] they already have […] and encourage them to turn back to that hobby, or [if] the patient has […] depression we can [encourage] them join some activity in [the] community”</td>
<td>They encourage the patient to return to their hobbies and to join activities in the community</td>
<td>Encouragement to activity</td>
<td>Coaching &amp; Encouraging</td>
<td></td>
</tr>
<tr>
<td>“[They will] organize a game [so that] the patient can play or […] [have a] dance audition and he said that the audition is very good because the patient [has] to coordinate the visual and the activity of the leg […]”</td>
<td>They organize games and dance auditions; that is good because the patient must coordinate the mind and the body</td>
<td>Games and dancing</td>
<td>Rehabilitation Efforts</td>
<td>Group-Based Interventions</td>
</tr>
<tr>
<td>“They use some occupational therapy [at the rehabilitation unit], and they instruct the patient to make clothes, to plant […] vegetables or some activity to help patient join [in the community]”</td>
<td>They use occupational therapy like making clothes and planting vegetables</td>
<td>Construct with their hands</td>
<td>Creative Activities</td>
<td></td>
</tr>
<tr>
<td>“To help [them] back to social life […] they invite student […] from the university or some school [to] come here to interact with the patient”</td>
<td>Students interact with patients to practice social life activities</td>
<td>Social interaction</td>
<td>Social Skills Training</td>
<td>Cooperation with the Family and the Community</td>
</tr>
<tr>
<td>“…they have a programme [at] the community to help the patient return to work[…] [The] hospital will come to the community [at the medical centre] to work with the family […] to help the patient maintain their job and […] support them to work”</td>
<td>They have a program with the community to help the patient maintain their job and support them to work</td>
<td>Vocational rehabilitation</td>
<td>Collaboration with the Community</td>
<td></td>
</tr>
</tbody>
</table>
5. Results

Figure 2.0 Chart describing the overview of the results

<table>
<thead>
<tr>
<th>Sub-category</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validating &amp; Advising</td>
<td>Individual-Based Interventions</td>
</tr>
<tr>
<td>Coaching &amp; Encouraging</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Efforts</td>
<td>Group-Based Interventions</td>
</tr>
<tr>
<td>Creative Activities</td>
<td></td>
</tr>
<tr>
<td>Social Skills Training</td>
<td>Cooperation with the Family and the Community</td>
</tr>
<tr>
<td>Collaboration with the Community</td>
<td></td>
</tr>
</tbody>
</table>

5.1 Individual-Based Interventions
The individual-based interventions consist of the different ways the staff supports the individual patient.

5.1.1 Validating & Advising
According to the respondents the individual-based interventions consist of a dialogue with the patients to hear what they have to say, to give them advice about their daily activities and/or to consult them about future decisions. They do not do any structured assessment of the patient. It was mentioned that they instruct the patient on what to do when they leave the rehabilitation unit and they make a plan for the patient in their rehabilitation department. Prior to attending the hospital the patient might have been able to do ten things in their daily routine, but the plan for the patient might now consist of doing just one or two of those things and then increasing the activity level over time. The patients are also instructed to do certain activities at home by themselves. The staff wants to stimulate the patient’s behaviour so that the patient can understand about the importance of activity. If the patient has a wish to return to their job the psychologist, the nurse and the doctor will coordinate with a social worker to sit down and discuss with the patient about the patient’s different options.

“Yeah they have many activity to help the patient more confident, to help the patient know the importance of walking everyday and they help to instruct the patient direct to [a] career like make clothes or make something, to help in the future they can earn money from their career.” -Interview 4
First and foremost the staff build up a relationship with the patient before conducting therapy. The staff will consult the patients and advise them on what to do. One way of doing this is by an activity that will reveal the problem that the patient may have so that they can instruct the patient on how to solve the problem when it occurs.

“The patient have to analyze by themselves [the] difficulties they have and after that they use problem solving therapy for their patients.” -Interview 9

They use different strategies and therapies depending on the patient and what problems they are facing, including behavioural therapy, which seems to be the most suitable and common therapy according to the participants. It was mentioned that relaxation therapy and problem solving therapy was being used for their depressed patients.

5.1.2 Coaching & Encouraging
The staff works regularly to educate the patients about health to help the patient understand how they can take care of themselves, like managing their hygiene, as it involves the patient understanding their role and their independence in activities in daily life. Overall, the staff works with supporting and motivating the patients in various ways, talking a lot about the goal of the patient, increasing their level of activity and helping the patients feeling more confident.

“Firstly she have to make relationship with the patients and help the patient motivate and make them more confident and more believable about life. And then ask patient was the patient happy before. Ask if happy still there and if they still have the happy they will consult. And [...] help patient turn back to happy.” -Interview 3

Another aspect of the individual based interventions was the staff’s ambition to encourage and motivate the patients to stay active and to participate in their hobbies and interests again. According to the respondents activity led to the patient feeling more confident.

“ [...] we can remind the patient about their [hobbies that] they already have [...] and encourage them to turn back to that hobby, or [if] the patient has [...] depression we can encourage them join some activity in [the] community” -Interview 10

5.2 Group-Based Interventions
The findings resulted in several strategies for group-based interventions and for many of which they had a programme that they followed, where the information was sent by email. The examples that they gave orally during the interviews can be shown to fall into two subcategories.

“She said that there are many kind of activities that they work with [the] patients. If you give her your email address she will send [...] the information about the activity” -Interview 1
5.2.1 Rehabilitation Efforts
At the rehabilitation unit the participations said that they also have activities at the facility where the staff occasionally arrange some kind of audition for the patients where the patients can dance and sing. The audition activities combine the ability of being able to perform and stand in front of a group of people with coordinating the different movements of the body. There are also activities available for those with different interests, such as playing badminton. At the rehabilitation unit they have a schedule from Monday to Thursday where the patients can sit in a group, talk about their hobbies and/or career and the staff will listen to the patients to understand more about them. If a patient wants to turn back to their hobby or their job the staff will consult with and advise the patient during these sessions. The staff at the rehabilitation unit would have an activity designed to improve the patient’s memory which was to play a movie and then have the patient remember certain sequences in the movie that they would describe.

“[At the pediatric unit they] may have activity for patient can play something. […] with the adult patient have activity for them to play badminton or play something.” -Interview 7

5.2.2 Creative Activities
The creative activities mainly consists of a variety of activities such as going to the beach once a week picking up litter, planting vegetables and doing other handicraft activities such as making clothes. The patients are often instructed to work in the garden at the facility. These group activities also include motivating the patients to talk openly about their problems in public as the staff says that it helps the patient.

“We […] instruct the patient to make the clothes. Sewing something. […] In Vietnam we have tradition to [sleep] on the cushion. It look like mattress but [it is of another]material. And they instruct the patient to [make them]. She said that there are many activity like that. Instruct them with the career to help the patient that they can return to […] social [life].” -Interview 1

5.3 Cooperation with the Family and the Community
The interventions regarding cooperation with the family and the community focus on the staff working together with the different parts of the community to enable the patient to return to a varied social life.

5.3.1 Collaboration with the Community
According to the participants at the pediatric unit family played an important role in the rehabilitation of the patient since they were dependent on their families care and support. They also found it important for the family to have knowledge about their childrens’ mental illness and diagnosis. At the rehabilitation unit, where they only had male adults as patients, they didn’t include the family in their rehabilitation, even if the family were the sole providers of the patient. It was clearly said that family was an important part of rehabilitation, but that time was a limited factor.
Work with the family very important but here they don’t have no enough time to work with the family.” -Interview 3

The pediatric unit worked closer to the community to make sure that the children would return to school. They had a close contact with some of the local schools. They would educate the teachers to make sure they understood the difficulties these children may be facing since the teachers can be scared if a child acts out with strong emotions. The pediatric unit also used a book called “Kích hoạt Hành vi” and translates into “Activate Behaviour”. It was a guide consisting of several programmes to help the children with different areas of life: how to balance their daily activities, how to return to social life, to school and the community. To have the children return to school was the main focus at the pediatric unit. They also had a skill class during the summer holidays for all the children aged eight to fifteen in the community.

[…] in the summer holiday they organize the class about a skill […] They can come here to learn that class and not all the children have […] mental problem but also the normal children can come here to learn.” -Interview 7

5.3.2 Social Skills Training
The rehabilitation unit invited students from the local university to interact with the patients, in a form of social skills training. Another connection to the community was the recently opened local medical center where they had different programmes to help the patients get or maintain a job. The staff support patients to have more activities related to the community and educate patients together with other people related to their lives.

“To help [the patient] turn back to social life activity they invite student or people from the university or some school, they come here to interact with the patient.” -Interview 3
6. Discussion of the Findings

6.1 Discussion of the Methodology

6.1.1 Participants & Recruitment
The sampling method as described in “4.2 Data Collection” could be used without modification. The participants of the study were originally intended to be patients but after consideration this was changed to the staff at the hospital which proved to be a wise choice, since the staff are the ones most suitable to talk about the different interventions as they meet a lot of patients with different needs. One patient may not know what treatment another patient gets in their rehabilitation process and so the sample should then have been a very much bigger one to get representative answers. The staff consisted of various professions which was a way of getting different points of view from their perspectives. A varied selection of participants was desirable to reach a certain level of credibility (Kristensson, 2014).

6.1.2 Interview Guide
The interview guide was made before the trip to Vietnam and with the preconceptions of what information had to be collected related to the purpose of the study. While in Asia and as the study proceeded further questions arose as interesting and having seen the facility in reality there could have been other questions better suited to the situation. Since the situation was overwhelming with many people involved and an environment that was loud and open (see further under “6.2.3 Data Collection”) some of the preparation could have been more methodically done beforehand. For example there could have been supplementary questions provided in the interview guide as a help along the way and searching through other similar studies conducted in Asia could have been done to be even more prepared for the scenario. However the questions did give answers that were of interest and could be connected to the purpose of the study. The interview guide was constructed with the preconceptions about ADL and IADL in mind, as mentioned in “1. Statement of the Topics and Need for the Study”, to get as representative answers as possible regarding participation in society (Kristensson, 2014).

6.1.3 Data Collection
The choice of a qualitative rather than a quantitative method was made in order to secure a variety of experiences and thoughts (Kristensson, 2014). The interpreter for the study was a contact person at the local university; a qualified physiotherapist and a practising teacher. Since the contact person had medical knowledge, hence would be able to pick up designations within the medical field - along with working at the university and therefore having knowledge in science methodology - this person was a suitable choice as being the interpreter. When conducting the interviews some aspects did not go as expected. The location that the hospital staff had arranged for the interview session was some sort of staff room with doors that would not close properly along with construction noise outside, not enabling the respondents to be fully heard when giving answers. The respondents should be the ones deciding the location of the study, but preferably in a secluded place with little or no interruptions (Kristensson, 2014). There were other members of the staff present in the room which could have been a significant issue had they also given their answers. The interpreter would occasionally give the
respondents the questionnaire for them to read before the interview started. Along with this, patients would enter the room a couple of times during the interview session and the staff and the interpreter would still go on with the answers. Another issue was the difficulty of language differences which would present itself multiple times during the data collection. The interpreter could not fully understand certain questions wherefore the questions had to be simplified. The respondents would not in turn understand some questions and the answers would be in a slightly different direction than expected. Apart from this there was also a time limit set to the days of the interviews as the interpreter would only be available for a maximum of two hours each time. As the respondents answered the questions the interpreter would go on with the next question, so there was not the expected time frame for more in-depth supplementary questions. After one respondent had answered the questions the next would be waiting ‘in line’. Otherwise the methodology could be used as expected and no major change had to be done. Considering the circumstances the collection of data was nevertheless completed satisfactorily as the answers from the interviews culminated in a varied result. With hindsight a quantitative survey could well have been adopted as the challenge proved to be finding enough time for the interpreter rather than engaging participants. A conventional survey might not perhaps have been as susceptible to disturbance and distraction as an interview study, thus providing a greater degree of control and reducing the risk of bias (Kristensson, 2014).

6.1.4 Data Analysis
The data was compiled with people of various professions and their answers match well with what other staff in their profession had said during the interviews. Due to language differentialities some words were not quite the same but had to mean the same thing when looking at the contextual facts. Some of the answers the respondents gave did not always connect with the intention of the interview questions, such as the question about work rehabilitation and the question about their procedures. This could be due to the fact that this is something that differs from the healthcare system in Sweden, with standard procedures as mentioned in “2.2 Occupational Therapy”, and there could have been a challenge to understand the question. It is inevitable that there are differences between the participants’ answers and the interpreter’s summaries of the participants’ responses when conducting interviews which must be considered when overlooking the validity in the data analyzation process (Williamson et al., 2011). Nevertheless answers were given so the respondents clearly answered in the best way they thought possible. The analysis of the data is reasonable for the sample that was interviewed since they all independently confirmed the different methods used when answering the questions. It is important to keep in mind that the data analysis may disguise misunderstandings resulting from the influence of personal interpretation and bias on part of the authors.

6.2 Discussion of the Results
The results revealed that the staff at the applicable psychiatric facility in Vietnam support the patients in many ways towards participation in society and activities in daily life, including instrumental activities in daily living (such as work/education, life skills training, leisure activities and social participation). The discussion of the results will be focused on the specific
findings regarding structure of assessing patients, interventions for group activity and enabling work rehabilitation.

6.2.1 Structure for Assessing Patients
As there is no routine of assessing the patients’ abilities today at the psychiatric facility, relating to occupational therapy assessment, the use of standardised instruments could contribute to a more evidence-based practice (Romli, Wan-Yunus & Mackenzie, 2019). There are several strategies that can be used when assessing a patient, with the first step being an interview. Other strategies include instruments/questionnaires, observations, home visits and/or seeing your patient in another environment, along with creative activities. These can all be combined and followed in a certain order since they are all good for assessment of a patient and their capabilities. These assessments can give information about the patient's performance capacity in the past and the present, their capability of performing a task, their thoughts about their abilities, motivation and plans for the future in addition to information about the patient’s environment and surroundings (Taylor & Kielhofner, 2017). Several instruments could be used to get a broad picture of the patients’ abilities, their current situation and lifestyle. There are several instruments that are good to use within psychiatric facilities such as Canadian Occupational Performance Measure (COPM), Occupational Circumstance Assessment Interviews and Rating Scale (OCAIRS), Occupational Self Assessment (OSA) and Satisfaction with Daily Occupations (SDO), to mention a few (Eklund et al., 2010). Instruments can be used as a tool for goal setting together with the patient. Not only does goal setting motivate the patient but it also sets a goal for the entire rehabilitation team. To have a more formal goal setting ensures the motivation of the patient, the team working towards the same goal, makes sure that significant actions are not overlooked and can be used for dismissing ineffective interventions (Wade, 2009). Both short-term goals and long-term goals can be used, with the short-term goals being segments and/or components towards reaching the long-term goal. The activities used as interventions towards the goal are based on an activity analysis with focus on the mental, cognitive and motor skills needed for the activity. The activity used in the short-term goal has to be decided based on the long-term goal so that the activity will be a step in the direction of the long-term goal (Eklund et al., 2010).

6.2.2 Interventions for Group Activity
The staff at the psychiatric facility used several group based activities such as dance auditions, making clothes, planting vegetables and going to the beach picking up litter. Planting vegetables, also called horticulture therapy (HT), is a way to use planting as a form of therapy. Therapeutic horticulture could also be used with the sole aim to improve well-being. The specific horticulture therapy on the other hand has a therapeutic goal. This therapy can be used by physical therapists and occupational therapists amongst others. Evidence has shown that HT is beneficial for patients with mental illness (Cipriani et al., 2017). This could create a new complementary occupational setting, providing a meaningful context for the patients (Taylor & Kielhofner, 2017). Studies have shown that there are several positive outcomes from attending group-based therapy interventions when suffering from mental health disorders. Engagement in meaningful occupations that occurred within group therapy showed a positive outcome on health and wellbeing. Another positive outcome were a sense of structure in their
weeks but that group treatment also reduced social isolation, as mentioned in Rouse and Hitch (2014). The staff at the psychiatric facility emphasized that the group activity depended on the patients. This is of great importance when having group-based activities since the choice one makes as a therapist can have different effects on the group and one has to be prepared to handle that (Beynon-Pindar, 2017). This is one of the reasons why Action over Inertia would be a good group-based therapy for the hospital since it relies on the therapists expertise to tailor the programme after the patient’s need (Edgelow, 2016).

Action over Inertia (AOI) is a group therapy that focuses solely on interventions for activity health and participation. AOI shows how important it is with evidence based practice and the benefits of participation in everyday activities (Edgelow, 2016). The gist of AOI is that activities included in our IADL like physical-, social-, leisure- or work activities make up the components of one’s life. Therefore the absence of activity in the lives of many people with mental illnesses prevents them from being part of community living and recovery in rehabilitation. The AOI consist of worksheets and all the activities are organized in sections. The worksheets can be assigned for homework but ideally for an inpatient should be carried out in group format. AOI also consist of a worksheet to help the staff assess their patient and monitor their level of engagement (Kinley, 2011).

When working in groups there is a several aspects to take into account or components as Eklund et al. (2010) puts it. These are the framework of the group, the competence of the group members and the competence of the group leaders. All of these components cooperate with each other and create the group dynamic. There are frameworks that guide the group consisting of time, physical and organizational aspects. It is important to consider during what time of the day or for how long the group activity should take place since everyone has different time rhythms. The physical aspects are the location where the activity is held, meaning an appropriate location for the activity. The activity could be held outdoors but this could be distracting if the participants would need to concentrate. Furnishing, materials and the number of group members are other additional considerations. It is important to have both an introduction and a discussion phase in conjunction with the main activity when organizing activities. The personal characteristics of the group members such as functional level, age, gender, phase of life and ethnicity constitutes another framework. Here the focus lies more on the members as individuals rather than as a group. It is important to consider what kind of strengths and weaknesses in addition to motivation that each individual member would bring to the group. It is desirable to have a dynamic group. The group leader or leaders have to consider all of these aspects when forming a group, in the light of their own knowledge. All of these components create the group dynamic or group process. This is called a functional group model and can be used when creating a group, describing a group or when analyzing a group.

6.2.3 Enabling Work Rehabilitation
The staff at the psychiatric facility did not have a specific work rehabilitation programme, as can be read in the result and compared with the questionnaire, but they encouraged and consulted their patients and also taught them useful crafts related to handicraft career paths. The work at the facility towards the community is important for the rehabilitation process and
for the patients being able to participate in society again. Being part of the greater context of society and the culture of where one lives is important for meaningfulness (Eklund et al., 2010). This can also be connected to a person’s habituation and role identification, where one common denominator is the role in a person’s occupation and how it affects their everyday life (Taylor & Kielhofner, 2017).

According to Håkansson and Wagman (2014) people with paid employment experience a greater sense of wellbeing as it leads them to take part more in society. As mentioned in Hillborg, Svensson and Danermark (2010), mental and physical balance in life, the patient's faith in themselves together with their support system were of importance in being able to return to work. Other factors that affect the ability to return to work are social and communication skills. Achieving work participation is challenging for those with mental illness where in spite of having the desire to work, unemployment is around 95 %. One intervention for work rehabilitation is Supported Employment and is one of the most effective interventions for people with mental illness with results of employment rates of 40-60 %. One model that incorporates Supported Employment is IPS which stands for Individual Placement and Support. An explanation of IPS is given by amongst others Modini (2016): founded in the USA during the 1990s the system is based on the premise that given the right support and suitable matching, everyone is capable of employment. IPS works on key principles which depend on a high level of consistency, the main goal being competitive employment for the patients based on their choice. They use a rapid job search, targeted job development tailored to suit the needs of the employer and give priority to personal preference in the patient’s job search. IPS also use long-term support and personalized benefit counselling. Occupational therapists are well-qualified to implement the work of vocational rehabilitation. They have the ability to see the importance of work, provide job matching, environmental support and development of skills (Machingura & Lloyd, 2017).
7. Conclusion

It can be concluded that the staff at the applicable psychiatric facility in Vietnam have several ways of working to support patients participate in society again, namely: individual-based interventions, group-based interventions and cooperation with the family and the community. The individual-based interventions consisted of validating, advising, coaching and encouraging. The group-based interventions consisted of rehabilitation efforts and creative activities. The cooperation with the family and the community consisted of collaboration with the family and the community as well as social skills training.

7.1 How Occupational Therapy Practices can Benefit from the Findings

An occupational therapist could be a complement to the facility in many ways with a broad knowledge in activity based rehabilitation, as mentioned further in “2.2 Occupational Therapy”. One way could be by working more with social skills with both the children and the adolescents, as the focus is more on getting them back to their occupation again. An occupational therapist could also work more with getting the patients to participate even more in activities in daily life and enabling them to conquer obstacles that they feel they face alone. The occupational therapist could have a consulting role to educate the staff about including female patients in the rehabilitation unit so that they would have access to the same care, in addition to teaching about a structured and evidence based way of working. The findings are of great value since occupational therapists, as stated in the theoretical paradigm, do not work within the field of mental health care in Vietnam to this day. What this study uncovered was that occupational therapy, as in focusing on activities and the patient’s goals and motivation in rehabilitation is in fact in use but by those in other professions. One conclusion which may be safely drawn is that occupational therapy is in fact a field of practice that is covered in mental health services in Vietnam. These findings can be one of many things that might spark interest in occupational therapy even more and may lead to a greater understanding of what an occupational therapist can contribute to mental health care. The results of this study can be used to create a greater understanding of the work with client centered activities done by staff at the psychiatric facility to help their patients back to participating in society.

As stated in the Code of Ethics for Occupational Therapists in Sweden the occupational therapist is obliged to spread information about their work to the general public and other global actors as well as participate in working towards the Globals Goals. Doing a project like this rhymes well with these commitments to the profession, which is why further projects such as this are to be encouraged (Sveriges Arbetsterapeuter, 2018). The American version of the Association of Occupational Therapy also has an edition of statements regarding the responsibilities of being an occupational therapist. The Occupational Therapy Practice Framework: Domain and Process (The American Occupational Therapy Association Foundation, 2008) states that the main responsibility of the occupational therapist narrows down to “supporting health and participation in life through engagement in occupation” and in its Centennial Vision (The American Occupational Therapy Association Foundation, 2007) “enabling people to improve their physical and mental health, secure wellbeing, and enjoy
higher quality of life through preventing and overcoming obstacles to participation in the activities they value”.

### 7.2 Recommendations and Implications for Research

Since this study was done as a qualitative research with semi-structured interviews with the staff at a psychiatric facility in Vietnam, no inferences can be made on a national level indeed one may conclude that there is a need for further studies at a variety of facilities. Further studies could be made with more staff and even with more patients at the facility. Studies can also be made using a more in-depth approach for the questions enabling the staff to give more detailed answers in conjunction with a quantitative method in order to draw more comprehensive conclusions from the results.

While in Vietnam, those responsible for the study were requested by the hospital director and the staff to make a presentation at the facility about occupational therapy and what the health care system surrounding that field of practice is like. In conversations outside the interview situation the hospital director and the staff expressed that they would appreciate the opportunity of learning more about activity-based rehabilitation, such as occupational therapy, and that they would be happy to assist whomsoever might be interested in working together with the psychiatric facility in the future. This study is possibly the start of a collaboration between the psychiatric facility and other universities for further research, clinical placements and implementation of occupational therapy practices.
8. References


9. Appendix

9.1 Information Letter for Participants

**Information Letter regarding participation in the study project**

This is an invitation letter to participate in a student science research project. This letter provides information about the project and explains the circumstances for participation.

**Why should I participate in this study?**

The purpose of this study is to identify in what way health care staff at a psychiatric facility in Vietnam are able to help patients with mental illness to participate in society. Successful social integration depends often on acceptance by others, free from any stigma or prejudice. Participation involves being engaged in an activity which could be related to work, occupations in daily life, leisure activities and/or activities that are felt to be necessary in a social-cultural context for mental and social wellbeing, e.g. having a job, going to school, being with friends or participating in voluntary work. Your answers are of great value since you may have important opinions regarding psychiatric disorders and participation in society.

**Possible outcomes**

This research is based on interviews. The interviews will be between 30-60 minutes and will follow an interview guide. You will only participate once. Notes and recordings will be used. The interviews will only take place with your consent; it is voluntary and can be terminated at any time. In order to protect your integrity as a participant we will take great care in preparing and presenting the interview questions to you. If there is any question you do not feel comfortable answering, you do not have to answer. Complete anonymity cannot be guaranteed but we do guarantee confidentiality. The results of our findings will be presented without any information that can identify the individual participant.

**What is going to happen with the information I may give?**

This project will collect your answers for analysis. The information will be strictly in the care of and kept only by those people responsible for the study. The aim is to prevent any unauthorized person getting hold of your information. Neither your name or any personal data will be recorded or saved, only your profession. The information will be saved for six months and then be destroyed. Your answers can only be used in the way to which you have consented. The material will be taken back to Sweden where the study project will be completed. Your participation in this study is voluntary and you remain free to terminate your participation at any time. You may choose to withdraw from the study without any explanation, however you must contact those responsible (see below).
Responsible for the study

If you wish to access the results you are welcome to contact those responsible for the study: Louise Björn bjlo1604@student.ju.se and Beatrice Causey cabe1694@student.ju.se, attending Jönköping University in Sweden. The supervisor responsible for the students is Eva Edström eva.edstrom@ju.se.
9.2 Consent Form for Participants

Consent Form regarding participation in the study project

I have received written and verbal information about the study and I have had the chance to ask questions about it. I can keep a copy of this written information.

☐ I consent to being a part of this study ‘Mental Illness and Participation’

☐ I consent to having personal information and answers processed as described in this information letter.

☐ I consent to having personal information and answers retained as described in this information letter.

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<th>Date and City</th>
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9.3 Consent Form for Interpreter

Consent Form regarding being an interpreter in this study project

I have received verbal information about the study and I have had the chance to ask questions about it.

☐ I consent to being an interpreter in this study ‘Mental Illness and Participation’

☐ I understand that professional secrecy must be used and that the anonymity of the respondent must be respected.

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9.4 Interview Guide

- Give the respondents the Information Letter and let them sign their Consent Form
- Let the interpreter sign their Consent Form
- Greet the interpreter
- Greet the respondent in their language and present the interview questions

Organization related questions:
- What kind of patients do you have here?
  - Diagnosis?
  - Number of patients?
  - Outpatients/inpatients?
- What are the standard procedures for patients? What kind of treatment and methods are being used?
- Is there a difference in how you treat inpatients and outpatients in rehabilitation?
- Do you have any kind of work rehabilitation for the patients? If so, what can it look like?

Rehabilitation related questions:
- How is the patients’ family included in rehabilitation?
- How do you work to help your patients return to activities in daily life such as managing a household and personal hygiene?
- How do you work towards helping the patients return to social activities?
- How do you work to help the patients return to their leisure activities or hobbies?
- How do you work to help the patients return to work or studies?

- Thank the respondent in their language
- Thank the interpreter
9.5 Ethical Audit

Blankett för etisk egengranskning av examensarbeten\(^1\) vid Hälsohögskolan

Datum: 21st February 2019

Examensarbets titel: "Mental Illness and Participation"

Student/studenter\(^2\): Louise Björn / Beatrice Causey

Student/studenter mejladress: bjlo1604@student.ju.se / cabe1694@student.ju.se

Utbildningsprogram: Bachelor of Arts Degree in Occupational Therapy

Utbildningsnivå: Undergraduate

Handledare: Eva Edström

Handledare mejladress: eva.edstrom@ju.se

Examensarbeten vid Hälsohögskolan, Jönköping University, ska följa forskningsetiska principer så som de uttrycks i etikprövningslagen (EPL). Denna blankett är ett hjälpmedel för granskning av etiska frågeställningar knutna till examensarbetet.

Student och handledare går igenom blanketten tillsammans, identifierar etiska problem och enas om hur dessa ska hanteras. I de fall där tvetsamheter kvarstår, ska en ansökan om rådgivande yttrande skickas till Forskningsetiska kommittén (se del C).

Forskning som faller under EPL måste prövas av Etikprövningsmyndigheten\(^3\). Det finns två typer av studier som normalt inte räknas till forskning och som måste hanteras speciellt. Det ena är examensarbeten och det andra är verksamhetsförlagt förbättringsarbetet i hälsa och välfärd.

Gränsdragningen mellan forskning och dessa två typer av studier berörs inledningsvis i del A.

Del B hanterar vad som faller under EPL samt etiska principer som är viktiga att reflektera över inför genomförandet.

Del C innehåller tillvägagångssätt för att få ett rådgivande yttrande från forskningsetiska kommittén.

Om examensarbetet redan ingår i ett etikgranskat och godkänt projekt behöver ingen etisk egengranskning genomföras.

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\(^1\) Blanketten gäller även verksamhetsförlagda förbättringsarbeten.

\(^2\) Alternativt utföra av verksamhetsförlagt förbättringsarbetet.

\(^3\) www.etikprövning.se
Del A: Är detta en forskningsstudie?

Del A syftar till att avgöra om studien avser vara forskning. Examensarbeten räknas normalt inte som forskning och kan då inte heller prövas av Etikprövningsmyndigheten. Under vissa omständigheter kan dock examensarbeten vara forskning, nämligen om de:

1. syftar till publicering i vetenskaplig tidskrift
2. har en vetenskaplig frågeställning och en design som kan besvara densamma
3. leds av forskare inom området, antingen som del av ett större projekt eller med forskare som handledare.

Alla dessa tre bör uppfyllas för att studien ska betraktas som forskning och ska då hanteras av Etikprövningsmyndigheten.

Är studien forskning i dessa tre avseenden?

☐ JA (Studien ska prövas av Etikprövningsmyndigheten.)
☒ NEJ (Fortsätt till del B och C.)

Del B: Innehåller examensarbetet sådant som enligt etikprövningslagen kan identifieras som etiskt känsligt?

Frågorna i del B syftar till att undersöka om examensarbetet har sådana etiska problem som om det vore forskning skulle krävt prövning av Etikprövningsmyndigheten, samt hur etiska principer hanteras.

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<tr>
<td>1</td>
<td>Avser studien att behandla känsliga personuppgifter enligt GDPR, det vill säga vid något skede länkta till en person och där uppgifterna avslöjar ras eller etiskt ursprung, politiska åsikter, religiös eller filosofisk övertygelse, medlemskap i tassförening, hälsa eller sexualliv?</td>
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<td>Avser studien att behandla personuppgifter som avser lagöverträdelser som innehåller brott, domar i brottmål, straffprocessuella tvingsmedel eller administrativa frihetsberövanden?</td>
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<td>Innebär studien ett fysiskt ingrepp på deltagna (även sådant som ingår i gänguartiner, men också är del i studien)?</td>
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<td>Är syftet med studien att fysiskt eller psykiskt påverka deltagna?</td>
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<td>Innebär studien en uppenbar risk att skada deltagen fysiskt eller psykiskt?</td>
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<td>Används biologiskt material som kan härledas till en identifierbar individ eller avläs demänniska (exempelvis biodprov eller vävnadsprov)?</td>
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<td>Kan frivilligheten för deltagarens inbäddas (exempelvis utsetta grupper såsom barn, personer med kognitiva nedsättningar och psykosociala funktionsnedsättningar, eller personer i beroendeställning som patienter eller studenter i förmånen att försöksledaren)?</td>
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<td>Kommer personer med begränsad autonomi engageras (exempelvis personer med kognitiva svårigheter, underåldriga) där förståelsen för innebörd av samtycken är begränsat?</td>
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<td>9</td>
<td>Tillhör deltagarna en extra särskild och utsatt grupp i samhället (minortettsgrupp)?</td>
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<td>10</td>
<td>Upprättas ett personregister där data kan kopplas till en fysisk person?</td>
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<td>11</td>
<td>Kommer inforerat samtycke att innefinns (det vill säga att deltagarna kommer att få information om undersökningen och/eller möjlighet att avsäga sig ett deltagande)?</td>
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<td>Beskrivs studien så att deltagarna förstår dess syfte och upplägg och vad deltagande i projektet innebär (exempelvis antal besök, projektängd, med lätt svenska utan fackuttryck)?</td>
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<td>13</td>
<td>Framgår det i den skriftliga informationen till deltagarna att deltagandet i studien är frivilligt?</td>
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<td>Innehåller informationsbrevet överlåtande formuleringar (som utgör från att personen ska eller bör sitta upp utan att fullt visa respekt för valet, exempelvis milt överlåtande så som &quot;tack på förhand&quot;)?</td>
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<td>Framgår det tydligt att deltagaren kan avstå från medverkan utan att detta påverkar deltagarens omhändertagande eller behandling eller, om studenter, betyg?</td>
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<td>Framgår det tydligt att deltagaren när som helst och utan ungåva av skäl kan avbryta deltagandet utan att detta påverkar deltagarens omhändertagande eller behandling eller, om studenter, betyg?</td>
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<tr>
<td>17</td>
<td>Om konfidentialitet är motiverat, finns det rutiner för att garantera konfidentialitet vid datamäktet?</td>
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<tr>
<td>18</td>
<td>Om konfidentialitet är motiverat, beskriv resultatet på ett sätt så att deltagarna är konfidentiella, det vill säga de ej kan identifieras efteråt (inklusive små förutsättningar för så kallad bakåtgående identifikation)?</td>
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<tr>
<td>19</td>
<td>Om anonymisering är uteblivet, finns rutiner för att säkerställa hantering av insamlade data på ett enligt GDPR?</td>
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<tr>
<td>20</td>
<td>Finns det tydliga rutiner för att säkerställa hantering av insamlade data på ett enligt GDPR?</td>
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<tr>
<td>21</td>
<td>Finns det skäl att erbjudas deltagarna att få ta del av forskningsresultaten?</td>
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</tbody>
</table>