Level of Social Support System for Individuals with Substance Abuse: A Cross-Sectional Study

By
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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

I want to dedicate my work to Almighty Allah who keeps me well and on the right track and helps me to keep patience during the work period. I dedicated my thesis I also humbly dedicate this work to my honorable and respected supervisor, Md. Habibur Rahman Sir and whose invaluable guidance, support, and encouragement have inspired me deeply and all the teachers of BHPI for their endless love, support and encouragement throughout my pursuit of education. I hope this achievement will fulfill the dream they envisioned for me.

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List of Abbreviations

APA	American Psychiatric Association
BHPI	Bangladesh Health Professions Institute
BDT	Bangladeshi Taka
CRP	Centre for the Rehabilitation of the Paralysed
IRB	Institutional Review Board
NIMH	National Institute of Mental Health
OT	Occupational Therapy
SD	Standard Deviation
SPSS	Statistical Package for the Social Sciences
WHO	World Health Organization
MSPSS	Multidimensional Scale of Perceived Social Support
SU-SMS	Substance Use Stigma Mechanism Scale

Abstract

Background: Substance use disorders (SUDs) are a significant global population health concern that leads to significant physical, psychological, and social effects. People having SUDs commonly experience stigma and discrimination that is both a barrier to recovery and compliance with treatment. Despite the possibility of enhancing rehabilitation and well-being through social support, stigma is a significant source of reintegration barriers. In Bangladesh, not much research has been done on the relationship between social support and stigma in individuals with SUDs.

Aim: To find out level of social support system for individuals with substance abuse.

Methods: An analytical cross-sectional study was done, on a sample of 180 people with substance abuse in Bangladesh by using a face-to-face survey in form of questionnaire on socio-demographic survey, MSPSS scale, and the SU-SMS scale. The information was gathered among participants who are admitted in Mental health hospital and Addiction center. The SPSS version 27 was used in the statistical analysis in the context of evaluating the relationships between perceived social support and stigma and other demographic variables.

Results: The study included individuals with substance abuse, with an average age of 28.24 ± 3 years. The perceived social support, most of the participants reported low levels of social support (89.4%), 10% reported medium support, and only 0.6% reported high support. Concerning stigma, high enacted stigma was 86.6 percent, high anticipated stigma was 81.67 percent and high internalized stigma was 8.4 percent. Perceived social support was significantly related to family income ($p = 0.011$), age at first use ($p = 0.050$), receipt of counselling ($p = 0.001$) and frequency of counselling ($p = 0.005$). Enacted stigma showed significant correlations with occupation ($p=0.005$), marital status ($p=0.010$), family relations ($p=0.002$), duration of drugs' use ($p=0.003$), level of support ($p=0.001$), counseling ($p=0.028$), impact on health of drugs ($p=0.001$), and willingness to quit drug use ($p=0.001$). Anticipated stigma was significantly associated with occupation $p = 0.023$, family relationships $p = 0.037$, family income $p = 0.002$, duration of drug use $p = 0.003$, level of support $p = 0.001$, drug impact on health $p = 0.001$ and willingness to quit drugs $p = 0.001$. Internalized stigma showed significant associations with family relationship ($p=0.037$); and drug duration ($p=0.009$), impact on health caused by the drugs ($p=0.001$), and willingness to quit drug ($p=0.001$). There was a negative relationship between perceived social support and stigma, meaning that participants with lower social support experienced higher levels of stigma.

Conclusion: Stigma and limited social support remain significant challenges for individuals with substance use disorders in Bangladesh. The relationship between perceived social support and stigma highlights the need for integrated psychosocial interventions that strengthen family and community support while addressing stigma within rehabilitation services. These findings may assist policymakers and healthcare professionals in developing supportive, stigma-reducing strategies to improve recovery and social reintegration.

Keywords: Substance abuse, Social support, MSPSS, Stigma, Rehabilitation, Counseling service

CHAPTER I: INTRODUCTION

1.1. Background

Substance abuse is become a concerning issue in Bangladesh. The problem has been increasing at alarming rates in recent days. It leads our country toward the dark. Young people are the backbone of the nation but they are mostly involving themselves in substance abuse.(Chande & Salum, 2007) Estimated in their article that it is becoming a vital problem which leading to physical, social, and educational damage. Beside this substance abuse directly influences the economic and social aspects of a country. There are millions of substance-addicted people in Bangladesh and most of them are young. According to sources at different healthcare facilities, nowadays nearly 10 percentages of outpatients are visiting the country's hospitals with cases of addiction-related complications involving heroin, marijuana and Phensedyl (Mn et al., 2013). They are from all sections of the society. Estimated that Bangladesh is situated in the central point between the golden triangle" (Myanmar, Thailand and Laos) and the golden crescent" (Pakistan, Afghanistan and Iran) in terms of geographical location. Bangladesh becomes a major transport point because Bangladesh has easy land, sea and air access. Traffickers who supply drugs in the markets of Northern America, Africa, and Europe are routing their shipments through Dhaka, Chittagong, Comilla, Khulna, and other routes in Bangladesh. It is believed that with the increasing quantity of the products more and more people are likely to get involved in drug business. In this way it ultimately contributes to the number of drug abusers as well. To gain money for buying drugs, addict makes him associate of criminal group and commits crimes(Islam et al., 2013) .Today substance abuse shows its impact in all divisions of Bangladesh. Estimated that substance abuse is now widespread everywhere in Bangladesh; in the

house, streets, in the workplace, parks, slums, markets and even in educational institutions both in rural and urban areas. Almost all segments of society are severely affected by this problem. (Mn et al., 2013)

In other literature it has been established that the youth is the most vulnerable section of the population in Bangladesh. Such young adults have tendencies of not controlling their behaviors, forgetting social practices and participating in violence. They are often petulant, have a dogmatic feeling that they are always right, are stubborn to advice, and exaggeratedly confident in their ability. The occasional frustration may result in substance abuse that could destroy hopefulness. In addition, they tend to evade their civic duty hence hampering the development of the country. When the researcher had a third-year placement at Ashokti Punorbashon Nibash (APoN) which is a drug-addiction rehabilitation center and at the National Institute of Mental Health (NIMH) the researcher came across a large number of substance abusers. In these facilities patients are treated and they go through rehabilitation programs. Most of the abusers fall within the age bracket of 1835 years, which is the working age group. The author believes that young generation should be responsible citizens to develop the nation. It is notable that these are the people who are not connected to the real life, are not a part of the society, and live poor, unhealthy lives.

Substance abuse leads to the swift decline in the level of education, culture, moral standards, and family unity. Addicts lose professional and academic abilities, self-esteem and could commit serious or petty crimes. The scenario poses a major challenge in Bangladesh. Otherwise, it will cause a threat to the civilized society in case it is not controlled successfully through rehabilitation (Mn et al., 2013) Valuable rehabilitation programs should also be instituted as early as possible to curb the increasing cases of substance abuse. These patients need different treatment methods to

be rehabilitated successfully, and members of the family should be educated to be aware of addiction signs. This research is, therefore, created to establish the motivating factors and reasons behind drug abuse. The results will be used to educate the families and create awareness to the people. There is a lack of research and resources on the issue of substance abuse among the Bangladeshi context; so far, there has not been any research on the issue of the perceptions of young substance abusers and the factors that correlate with them.

1.2. Justification of the Research

The issue of substance abuse has come out as a burgeoning and emerging important public health issue in Bangladesh, particularly in the youth. Empirical research reveals that most users of drugs are put in the age bracket of 18-30 years, which is normally the age associated with maximum productivity. In this stage of development, irrational addiction causes harmful effects on the physical and mental health, at the same time, it weakens educational achievement, career opportunities, family unity and, in its turn, the socio-economic development in the nation.

National and institutional investigations show that there is an increasing trend in the use of substances, especially cannabis, alcohol, Yaba, and opioids. Conditional factors such as influence of peers, curious desires, family conflicts, lack of parental control, and easy availability of drugs are also a big cause in aggravation of the phenomenon. These results, in their turn, emphasize the non-individualistic nature of substance abuse highlighting how it is highly vulnerable to familial, sociocultural, and environmental factors.

Although what little remaining scholarly work in Bangladesh has focused on has done little but compose prevalence measures, trends in usage, and antecedent risk factors, a lack of in-depth qualitative research on how juvenile drug-abusers perceive themselves as having an addiction problem and as facing a recovery challenge has been observed. The knowledge about their lived experiences, intrinsic motivation, and adversities cannot be ignored in the creation of effective prevention and rehabilitation programs.

Besides this, therapies and rehabilitation regimes often require chronic time and financial costs, which are far much more than the means of many households in addition to increasing risks of relapse. Based on this, the study is justified because it will

question the perceptions of youths and correlative determinants of substance abuse thus providing practical information to policy formulated, families, rehabilitation facilities, and occupational therapists.

Overall, this research is important because it enhances the voices of young substance abusers and provides a more comprehensive picture that is also essential in devising realistic interventions that are culturally compatible and sustainable in reducing substance abuse in Bangladesh.

1.3 Operational Definition

Substance abuse can be defined as the harmful or dangerous use of psychoactive substances such as alcohol and illicit drugs. The use of substances can develop into a dependence syndrome where the individual has a strong urge to use the substance, experiences problems controlling consumption, and experiences withdrawal. Symptoms of dependence include red-filled eyes, mydriasis, frequent periods of epistaxis, loss of appetite or sleep, seizures, smell changes, unexplainable personality changes, mood swings, irritability, anger, or unsuitable laughter. The abuser puts the use of the drug over any other responsibility and can also be in a hyper-acute physical withdrawal state (Kumari Padhy et al., 2014). Substance abuse thus has an impact on the global populations.

Nowadays, substance abuse among all age groups has increased significantly across the globe. Prevalence has risen to epidemic levels over the last two and a half decades with youth being the most susceptible. WDR (2014) indicated that the number of individuals aged 1564 who consumed an illicit substance at least once during the last year amounts to between 153 million and 300 million. Dhaka Mirror (2009) shows that there is an increasing number of psychoactive substance abuse in the developing nations like Bangladesh. In Bangladesh, there are an estimated 65 lakh substance abusers and nearly 90 percent of them are in the 18-25 age group. This is a serious danger to both the society and the country.

There are many reasons why the young adults engage in destructive habitual patterns. These conditions are a result of complicated socio-peer group factors, frustration, depression, curiosity, sub-cultural and psychological conditions that stimulate drug use (Mn et al., 2013) determined that family disorganization, parental neglect, parent-child conflict, spousal loss, general conflict, indiscipline, isolation,

deficiency of emotional support, rejection of affection, overprotection, unemployment, recurrent failure, personality maladjustment, and ease of access to drugs are the main risk factors that lead to drug abuse. All these risk factors make the youths more susceptible, which in most cases leads to a range of negative consequences in their day-to-day lives. These consequences include academic problems (e.g., skipping school and other activities, and a high probability of dropping out of school), health-related issues (e.g., accident-related injuries and the consequences of possible overdoses), and the poor relations with peers. Furthermore, the factors cause concerns among family members, the community, and society, in general. State that a high (Atwoli et al., 2011) number of people inject themselves or herself intravenously. They are also likely to inject themselves using the same point over and over again exposing themselves unconsciously to transmissible diseases like HIV/AIDS, liver cirrhosis, and cancers among other communicable diseases. In 2012, World Health Organization and UNAIDS estimated that the global injecting drug user population stood at 12.7 in the world with 1.7 million injecting drug users being HIV positive. The deaths related to substance abuse are also rising on a daily basis and different diseases afflict individuals. According to a report issued by the United Nations (UN) in 2012, it was observed that some 200,000 people across the world were dying every year due to disease associated with substance abuse. Such diseases severely affect the functioning of individual people in all fields of occupation, which leads to failure to have roles in life and distortion of meaningful activity.

CHAPTER II: LITERATURE REVIEW

Substance abuse refers to the harmful use of substance or drugs or it is a maladaptive pattern of substance use leading to clinically significant impairment or distress. It also means use of a substance for a purpose not consistent with legal or medical guidelines (WHO, 2015). Substance abuse is the continued use of a psychoactive drug despite the knowledge that it is causing a social, occupational, psychological, or physical problem. According to DSM-IV-TR, substance abuse is a maladaptive pattern which leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12-month period:

- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.
- Recurrent substance uses in situations in which it is physically hazardous.
- Recurrent substance-related legal problems.

There is no single cause of youth substance abuse. Substance abuse develops over time. It does not start as complete abuse or addiction. There are different reasons or cause to the development of this problem.

2.1. Causes of substance abuse

There are three main reasons for abusing substance. These are:

Biological reason: Genetics is one of the causes of drug abuse. Parents who are abused drugs child grow up by seeing this and parents put them at risk of abusing substance. Certain people may be more at risk for developing a substance problem because of the way their bodies metabolize a certain substance (Akhter, 2012)

Psychological reason: People who experience trauma or go untreated for depression, anxiety, and other disorders are at higher risk for developing a substance use problem.

Because the substance may make them feel better temporarily (Akhter, 2012).

Social reason: Social reason plays the biggest roles in developing and maintaining substance problems. Parental abuse and neglect are commonly seen as part of the cause of drug abuse. Beside this the peer pressure, poor socialization, and the environment in where a person living also influence in abusing substance(N. Tracy, 2015). Abuse of substances may begin in childhood, teen or in the youth years. Certain risk factors may increase someone's likelihood of abusing substances.

2.2. Family Support and Recovery

Bangladesh, family is an essential part of both development and recovery of substance use disorders. A number of studies point to the fact that parental disagreement, ineffective communication, and family disorganization make a person more likely to become an addict .According to(Mahmud, 2024), the adolescents engaged in substance dependence were much more likely to report greater parental conflict, secrecy, and poor parent-child communication than non-addicted adolescents (pp. 60–61). Substance use was highly related to this breakdown of trust in the family structure. On the same note, peer pressure and parental disputes were found to be major contributing factors by (Kamal et al., 2018)whereas family discussion about the negative impact of substance use was a protective factor. The lack of connection with parents, their absence of warmth, and substance use were also associated with the increased risk of addiction. A national survey by (Alam et al., 2020) found that males (4.8%), as compared to females (0.6%), use substances more often, and both low and high socioeconomic populations are more vulnerable. The contributory factors were socioeconomic instability and lack of supervision in families.(Sharmi & Mahazabin, 2025) have found that 33.3‘% of street children had no memory of any family relation and 50% had minimal contact (p. 5).

This lack of family support greatly exposed them to early drug use, where 70 % started this at the age of 6 -9.

2.3. Peer Support and Relapse Prevention

In Bangladesh, peer influence always comes out as the most imposing risk factor of substance use. According to (Kamal et al., 2018), 54.69% of substance users mentioned peer pressure as the main driving force (p. 2). Similarly, (Stahl, 2021) discovered that 85.7% of the addicts were affected by friends. According to (Mahmud, 2024), peer-relationship influence was stronger among adolescent addicts than it was in non-users. The results of the study by (Soron et al., 2017) conducted in a hospital setting revealed that more than 95 per cent of the participants reported substance-dependent friends. (S. Hossain, 2019) cross-cultural analysis established that social motives and peer conformity had a significant impact on the patterns of drug-usage. Taking drugs was commonly built into group identity and social belonging. In street children, 70% said they used drugs as many times as possible on a daily basis and in most cases, in a group (p. 6), which implies peer-pressure-induced reinforcement and dangerous relapse

2.4 Barriers to Social Support

Although addiction is being considered a widespread health issue, obstacles to assistance are important. According to (Stahl, 2021), rehabilitation procedures and costs are seen as expensive and cumbersome to access care. (Soron et al., 2017) observed that it is a result of sociocultural stigma and legal issues which result in underreporting and late seeking of treatment. Stigma is another limitation to proper prevalence reporting as highlighted by (Alam et al., 2020). Among the street children, insufficient education (30 % drop out rate) and daily work (57 % work full day) diminish the chances of accessing available formal support system (p. 6). Moreover, 63.3 % said that

no relative or family member was aware of them taking drugs (p. 5), which means that they are isolated.

2.5. The Role of Occupational Therapy in Substance Use Recovery

Although none of the reviewed studies explicitly focused on occupational therapy (OT), several findings imply its importance. (Mahmud, 2024) recommended engagement in productive activities, counseling, and structured routines as preventive measures. (Soron et al., 2017) emphasized preventive programming involving family and community engagement. Street children studies highlight school dropout (30%) and excessive work hours (57%), indicating disrupted occupational roles. Occupational therapy could assist by:

- Restoring daily routines
- Enhancing life skills
- Facilitating vocational training
- Promoting social reintegration

Given the multidimensional nature of addiction described by (Kamal et al., 2018), OT can provide holistic rehabilitation targeting social participation and functional independence.

2.6. Cultural Considerations in Support Systems

Culture plays a big role in patterns of substance-use and the process of recovery. (S. Hossain, 2019) have shown cross-cultural difference in motivation e.g. hedonism, curiosity, and intoxication. In Bangladesh, the reaction to addiction is molded by the family structure, religious beliefs, and collectivism. . (Mahmud, 2024) reported that the religious education was highly supported as a preventive tool.(Alam et al., 2020) obtained an urban prevalence, which is associated with urbanization and social

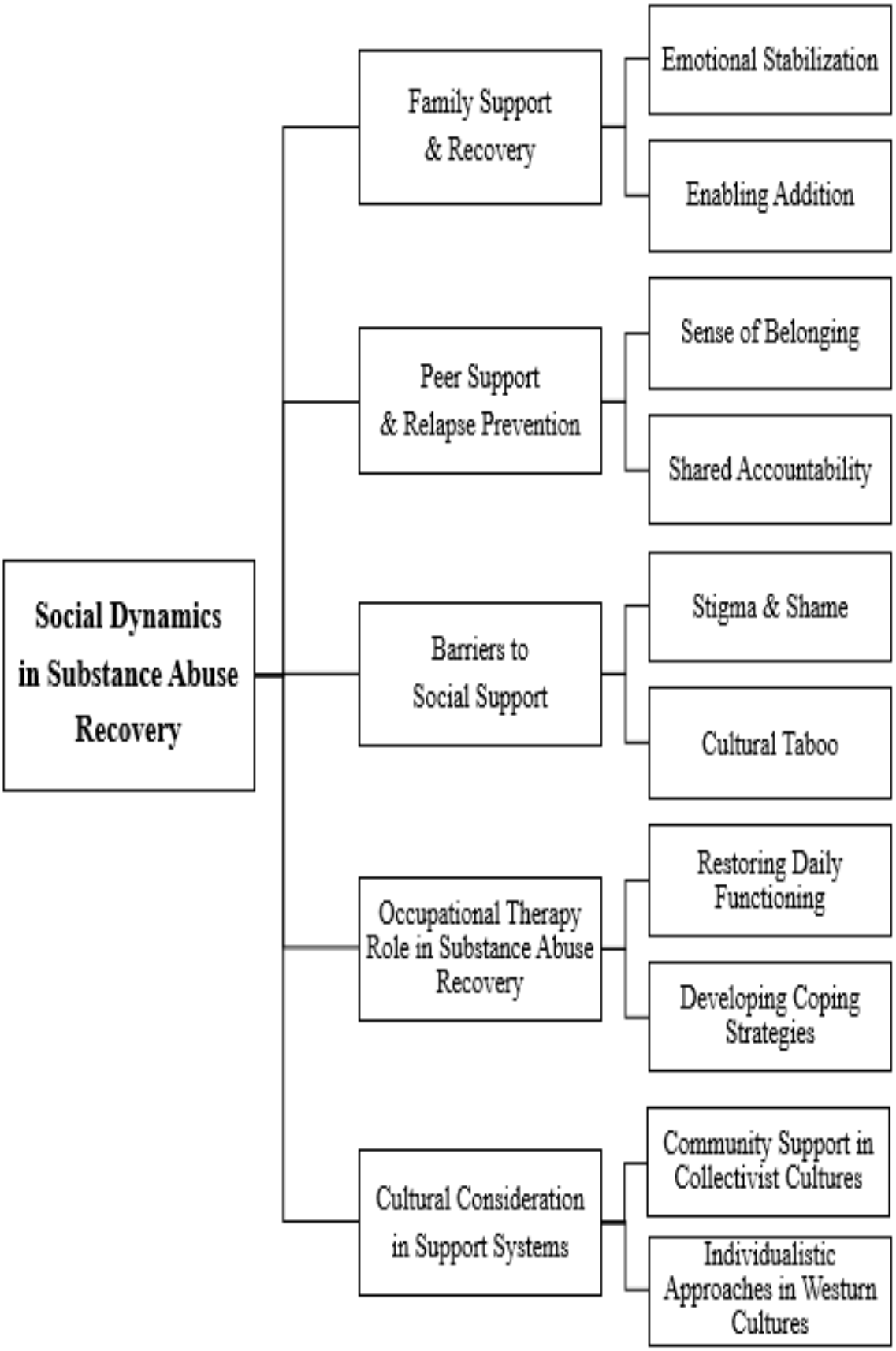
transition. The marginalization and societal rejection of street children also show how cultural stigma increases susceptibility.

2.7 Key Gap of the Studies

- Most of the existing studies are cross-sectional, urban-based, in nature, which excludes the possibility to get national and longitudinal data.
- The population of female substance users is also significantly underrepresented in the academic literature.
- The qualitative studies that explore the experience and subjective perception of youth concerning use of substances are few.
- Many papers have smaller or non-representative sample groups, and therefore, limit the external validity of their results.
- The studies assessing the effectiveness of rehabilitation interventions and their recurrence are deficient.
- In comparison with other mental health disorders, the scholarly attention to comorbid conditions, including depression, trauma, and anxiety, is rather weak.
- There are particularly limited studies on the high-risk groups such as rural youth, slum dwellers and female street children.
- Few studies have done rigorous evaluations of the effectiveness of preventive and policy-based interventions.

Figure 2.1

Overview of the Literature Finding



CHAPTER III: METHODS & METERIALS

3.1 Research Question, Aim, Objectives

3.1.1 Research Question

"What is the level of social support system among individuals with substance abuse?"

3.1.2 Aim of the study

The aim of the study is to find out level of social system for individuals with substance abuse.

3.1.3 Objectives of the study

- To find out the sociodemographic characteristics of participants.
- To assess the level of social support system and stigma for individuals with substance abuse.
- To investigate the factors associated with social support system and stigma for individuals with substance abuse.

3.2 Study Design

3.2.1 Study method: Quantitative Research Design

The researcher followed the quantitative method. Quantitative research is a method that involves the collection of data so that information can be quantified and subjected to statistical treatment to support or refute alternative knowledge claims(Apuke, 2017). In the research, the researcher collected the data by numerical value from the participants, then performed a statistical test to measure the outcome, and the result represented a numerical interpretation Therefore, quantitative design was the most fit method for this study.

3.2.2 Study Approach: Cross-Sectional Approach

the researcher used a cross-sectional approach. The study was conducted among individuals with substance use disorders who were receiving treatment at the National

Institute of Mental Health (NIMH), Pabna Mental Hospital, and selected rehabilitation centers in Bangladesh.

A cross-sectional study is a non-experimental research design that collects data from a specific population at a single point in time to examine the prevalence and relationships between variables (Setia, 2016). This approach was appropriate because the study aimed to assess the level of perceived social support and identify the factors associated with it without manipulating any variables.

Through this method, the researcher collected data on socio-demographic characteristics, substance use history, and perceived social support using standardized instruments. The cross-sectional design provided a clear snapshot of the existing social support system among individuals with substance abuse in Bangladesh and helped to determine the associated factors effectively (Creswell, 2018).

3.3 Study Setting and Period

3.3.1 Study Setting

The selected institutions were included:

- National Institute of Mental Health (NIMH), Dhaka
- Mental Hospital, Pabna
- Rehabilitation centers. (CREA)

These institutions were selected based on their accessibility, availability of patients, and willingness to participate in the study.

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 Participants

3.4.1 Study Population

The study involved people with substance abuse who were admitted to the National

Institute of Mental Health (NIMH) Dhaka, Mental Hospital, Pabna and Rehabilitation clinics centers.

3.4.2 Sampling Techniques

To conduct the study, the participant was selected through a purposive sampling process based on some inclusion and exclusion criteria. The researcher has chosen this type of sampling because the study had some inclusion and exclusion criteria (Liamputtong & Rice, 2022). Therefore, the most suitable method of selecting study participants was purposive sampling.

3.4.3 Inclusion Criteria

- Adults who have been diagnosed with substance use disorder (SUD) and are currently undergoing treatment in a rehabilitation center program in Bangladesh.
- Both male and female patient with substance abuse who are receiving treatment from rehabilitation center.
- Able to give informed consent.

3.4.4 Exclusion Criteria

- Data were excluded for patients whose care givers refused to participate in the data collection process.

3.4.5 Sample Size

$$n = \frac{Z^2 \times p(1-p)}{d^2}$$

n = required sample size., Z = standard normal deviate corresponding to the desired confidence level. p = estimated prevalence of the condition. q = (1 − p), proportion of the population not having the characteristic d = margin of error (degree of precision)

$$n = \frac{Z^2 \times p \times q}{d^2}$$
$$= \frac{Z^2 \times p(1-p)}{d^2}$$
$$= \frac{(1.96)^2 \times 0.049 \times (1-0.049)}{(0.05)^2}$$
$$= \frac{3.8416 \times 0.049 \times 0.951}{0.0025}$$
$$= \frac{0.1789}{0.0025}$$
$$= 71.56 \approx 72$$

Z = 1.96, corresponding to a 95% confidence level. p = 0.049 (4.9%), estimated prevalence of substance use according to (Alam et al., 2020) ,q = 1 − 0.049 = 0.951 , d = 0.05, which represents a 5% margin of error.

According to the previous article (Alam et al., 2020), the sample should be 72 participants. During data collection period at NIMH, Pabna Mental Health Hospital and Rehabilitation Centers (CREA). Based on the inclusion and exclusion criteria and field visits, the researcher found 180 participants.

3.5 Ethical Consideration

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/07/2025/1092 (see in details appendix-A).

3.5.2 Informed Consent

A written information sheet was provided to all potential participants and the student researcher explained the purpose and aims of the study in clear and simple language. After having the opportunity to ask questions and indicating that they were willing to take part, participants were given a consent form to read and sign. Data were then collected from those who provided consent. All participants were informed that the information they shared would be used only for research purposes and that their personal details (such as their name and phone number) would remain strictly confidential.

3.5.3 Unequal Relationship

The student researcher did not have any unequal or power relationship with the participants because data collected from the unknown persons selected the participants according to inclusion and exclusion criteria

3.5.4 Risk and Beneficence

- Student researchers ensured that the participants did not have any risk for participation.
- The participants did not get any payment for giving their data.
- Even without payment, their help made the research better and more useful.

3.5.5 Power Relationship

Researcher ensured that power relationship was executed to prevent any influence on the participants

3.5.6 Confidentiality

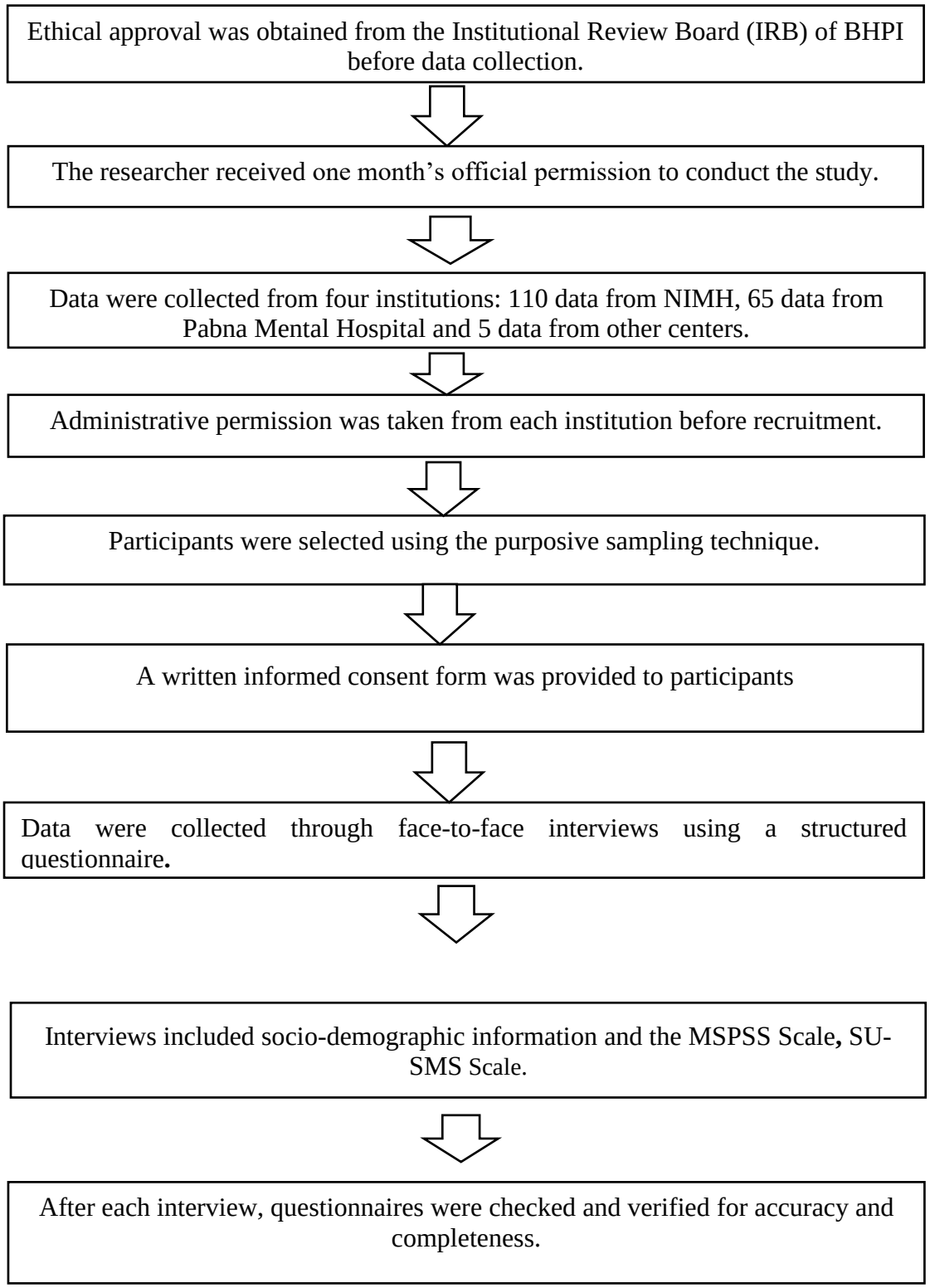
The information of each participant was kept completely private. Their names and identities were not shared with anyone except the research supervisor, as clearly mentioned in the information sheet (see Appendix C). Only the researchers and supervisors, who agreed to maintain confidentiality, were allowed to access the information.

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 was collected through a face-to-face survey by the researcher and trained interviewers through a socio-demographic questionnaire, and the MSPSS Scale and SU-SMS scale (For details about the tools, see section- 3.6.3 "Data Collection Instrument"). The researcher and trained interviewers administered the questionnaire in person. Face-to face surveys maintained the quality of data and decreased the potential biases (James K. Doyle, 2005). Several advantages existed for face-to-face surveys. These surveys were flexible and structured. They were founded on interpersonal communication and were controlled within the survey (Szolnoki & Hoffmann, 2013) Face-to-face surveys 28 provide visual interaction between the respondent and the interviewer, which may encourage respondents to answer all questions correctly. During a face-to-face survey, the survey questions are verbally presented to the respondents so that they can answer them orally (Heerwegh & Loosveldt, 2008).

3.6.3 Data Collection Instrument

- **Structured questionnaire for demographic data:** The Researcher used the demographic information sheet to collect data (Please see Appendix -F).
- **Multidimensional Scale of Perceived Social Support:** MSPSS was used to assess the level of perceived social support among individuals with substance abuse. The MSPSS is a widely recognized self-report tool designed to measure the extent of social support received from three sources: family, friends, and significant others(G. Zimet et al., 2018). This tool consists of 12 items, each rated on a 7-point Likert scale ranging from 1 (Very strongly disagree) to 7 (Very strongly agree), with higher scores indicating greater perceived support(Cohen, 1988). The items assess emotional, informational, and tangible support, focusing on the availability of support in times of need, sharing of joys

and sorrows, and comfort from close relationships.(G. D. Zimet et al., 1988)

- **Substance Use Stigma Mechanism Scale** SU-SMS was employed to measure the stigma experienced by individuals with substance use disorders. The SU-SMS includes three subscales: Enacted Stigma, Anticipated Stigma, and Internalized Stigma, with a total of 18 items. Each item is rated on a 5-point Likert scale. The higher the score, the greater the perceived stigma. The Enacted and Anticipated stigma scales measure past and future experiences with stigma from family members and healthcare workers, while the Internalized Stigma scale evaluates how individuals feel about their substance use history. These scales was allow for the assessment of both social support and stigma, helping to analyze how these factors interact and influence for individuals with substance abuse. (Smith & Earnshaw, 2016)

3.6.4 Field Test

The purpose of the field test was to check the clarity and effectiveness of the questionnaire and interview process before the main data collection. The researcher conducted the field test with two adolescents with substance abuse who met the inclusion and exclusion criteria. MSPSS, SU-SMS and the socio-demographic questionnaire were used during this process.

Based on the field test, a few minor modifications were made to improve the wording and flow of the questions. The field test confirmed that the tools were easy to understand and suitable for use in the main study.

3.7 Data Management and Analysis

Data was collected from participants and analyzed using the Statistical Package for Social Science (SPSS). Research data management involves organizing, documenting, storing, and preserving data generated during the research process (Surkis & Read,

2015). The data was placed into a Microsoft Excel file with each question as a variable to set up the database. This Excel file was then transferred and converted into the Statistical Program for Social Sciences (SPSS), Version 27, for analysis. Descriptive statistics was used to analyze and report the demographic variables, overall MSPSS, and SU-SMS. Descriptive statistical analyses were calculated to determine frequencies and percentages of survey responses, and appropriate statistical tests were adopted to examine the association or relationship between variables.

3.8 Quality Control and Quality Assurance

During the study period, Quality control and quality assurance were strictly maintained. The researcher chose an appropriate study design that best suited the aim and objectives of this study. The researcher followed the five stages of the data management cycle to ensure the quality of the data. 180 persons with substance abuse in this study. The researcher and trained interviewers provided the set of questionnaires to them in a paper format to collect the data. To ensure the safety and security of all the documents were photocopied and kept as soft copies of documents by scanning. The data was placed into a Statistical Program for Social Sciences (SPSS) file with each question as a variable to set up the database for analysis. Additionally, these files were stored in Google Drive with strong passwords to ensure high security, preventing unauthorized access. The researcher used all data safely for 30 analysis the data without any bias. All data were archived in Google Drive for future reference. The researcher and supervisor emphasized the importance of this archival process. They decided to destroy the data after five years to ensure safety, as the data might not be usable after that period.

CHAPTER IV: RESULTS

This Chapter represents the findings of the study. This study included Individuals with Substance abuse who was admitted in National Institute of Mental Health (NIMH), Mental Hospital, Pabna and Rehabilitation clinics and outpatient addiction centers According to the Inclusion Criteria I collected 180 data from NIMH Mental Hospital, Pabna and Rehabilitation clinics and outpatient addiction centers. The Chapter contains the study findings in tables and figures focusing the socio-demographic information, Socioeconomic characteristics and overall Level of mental resilience among individuals with Substance abuse.

Table 4.1

Sociodemographic characteristics of the participants (n=180)

Characteristics	Category	Frequency (n)	Percentage (%)
Gender	Male	179	99.4
	Female	1	0.6
Age	15-23 Years	62	34.4
	24-30 Years	66	36.7
	31-65 Years	52	28.9
	Median age = 26 years, Mean age = 28.24, SD = (±3.), Minimum=5, Maximum=17		
Religion	Islam	169	93.9
	Others (Hindu, Buddhist)	11	6.1
Educational status	Illiterate	20	11.1
	Primary	61	33.9
	Secondary	61	33.9
	Higher Secondary	25	13.9
	Bachelors/Masters	13	7.2
Occupation	Unemployed	112	62.2
	Job	10	5.6
	Student	31	17.2
	Business	11	6.1
	Day laborer	16	8.9
Monthly personal income (in BDT)	No Income	162	90.0
	6000-35000 Taka	18	10.0
	Median=0.00, Mean=1711.11, SD= (±5632.596), Minimum=0 Taka, Maximum=35000Taka		
Marital Status	Unmarried	129	71.7
	Married	42	23.3
	Divorced	9	5.0

Residential Area	Rural	118	65.6
	Urban	48	26.7
	Semi-urban	14	7.8

Table 4.1 describes the basic background information of the 180 participants included in the study. In terms of gender, the sample was overwhelmingly male. Out of 180 participants, 179 (99.4%) were male and only 1 (0.6%) was female. This clearly shows that substance abuse in this study was almost entirely concentrated among men. Looking at age distribution, the participants were fairly spread across three age groups. About 34.4% (62 participants) were between 15–23 years, 36.7% (66 participants) were aged 24-30 years, and 28.9% (52 participants) were between 31-65 years. The median age was 26 years and the mean age was 28.24 years (SD ±3). This suggests that most participants were young adults, with substance abuse being particularly common in early adulthood. Regarding religion, the vast majority of respondents were Muslim (93.9%, n = 169), while 6.1% (n = 11) belonged to other religions such as Hinduism or Buddhism. This largely reflects the religious composition of the population in the study area.

Educational status shows that 11.1% (20 participants) were illiterate. The largest groups had completed primary education (33.9%, n = 61) and secondary education (33.9%, n = 61). A smaller number completed higher secondary education (13.9%, n = 25), and only 7.2% (n = 13) had a Bachelor’s or Master’s degree. This indicates that most participants had basic to moderate levels of education, with relatively few reaching higher education. When occupation was considered, 62.2% (112 participants) were unemployed. Students made up 17.2% (31 participants), day laborers 8.9% (16 participants), business owners 6.1% (11 participants), and only 5.6% (10 participants) had formal jobs. This shows a high level of unemployment among the study group.

Monthly personal income further reflects this economic vulnerability. A striking 90% (162 participants) had no personal income, while only 10% (18 participants) earned between 6,000 and 35,000 BDT per month. The median income was 0 BDT, with a mean of 1,711.11 BDT (SD ±5632.596), indicating that most participants were financially dependent. In terms of marital status, most respondents were unmarried (71.7%, n = 129), while 23.3% (42 participants) were married and 5% (9 participants) were divorced. Finally, regarding place of residence, 65.6% (118 participants) lived in rural areas, 26.7% (48 participants) in urban areas, and 7.8% (14 participants) in semi-urban areas. In Table 4.1 shows that the participants were predominantly young, unmarried, unemployed men from rural areas with low income and moderate educational backgrounds, highlighting significant socioeconomic vulnerability within the study population

Table 4.2

Family Characteristics of the participants (n=180)

Family characteristics	**Category**	**Frequency (n)**	**Percentage** (%)
Family type	Joint family	132	73.3
	Nuclear family	48	26.7
Relation with family members	Good	80	44.4
	Moderate	22	12.2
	Poor	78	43.3
Parents relationship	Live together	110	61.1
	Father died	44	24.4
	Mother died	4	2.2
	Not applicable	22	12.2
Living with	Father and Mother	98	54.4
	Mother	32	17.8
	Father	4	2.2
	Spouse/Family	16	8.9
	Alone	30	16.7
Monthly family income (in BDT)	0-19000 Taka	67	37.2
	20000 Taka	42	23.3
	22000-70000 Taka	71	39.4

Table 4.2 focuses on the family background and living conditions of the participants. A large majority (73.3%, n = 132) belonged to joint families, while 26.7% (n = 48) came from nuclear families. This indicates that extended family structures were common among participants. When asked about their relationship with family members, 44.4% (80 participants) described it as good, 12.2% (22 participants) as moderate, and 43.3% (78 participants) as poor. This nearly equal split between good and poor relationships suggests that family dynamics varied considerably among participants, with a significant proportion experiencing strained family relationships. Regarding parents' relationship status, 61.1% (110 participants) reported that their parents were living together. However, 24.4% (44 participants) had lost their father, 2.2% (4 participants) had lost their mother, and for 12.2% (22 participants) the question was not applicable.

In terms of living arrangements, 54.4% (98 participants) lived with both parents. Others lived only with their mother (17.8%, n = 32), only with their father (2.2%, n = 4), with spouse or other family members (8.9%, n = 16), or alone (16.7%, n = 30). The fact that nearly one in six participants lived alone may have implications for emotional and social support. Looking at monthly family income, 37.2% (67 participants) reported earning between 0–19,000 BDT, 23.3% (42 participants) reported around 20,000 BDT, and 39.4% (71 participants) reported between 22,000–70,000 BDT. The median family income was 20,000 BDT, with a mean of 21,750 BDT (SD ±10,602.980). This suggests that most families fell within low to middle-income categories.

Overall, Table 4.2 indicates that most participants came from joint families and low- to middle-income households. Although many lived with both parents, a considerable proportion experienced poor family relationships or lived alone, pointing to possible emotional and social stressors.

Table 4.3

Substance abuse characteristics of the participants (n=180)

Characteristics	**Category**	**Frequency (n)**	**Percentage** (%)
Age at first use	12 to 19	90	50
	20 to 47	90	50
Duration of taking drug	1 to 5	94	52.2
	6 to 45	86	47.8
Other family members taking drugs	No	168	93.3
	Yes	12	6.7
Reason of taking drug firstly	Peer pressure	166	38.4
	Curiosity	167	38.7
	Family problems	50	11.6
	Unemployment	6	1.4
	Relationship issues	10	2.3
	Family instability	28	6.5
	Failure in love	5	1.2
Source of money to purchase drugs	Self	105	32.7
	Family	160	49.8
	Friends	40	12.5
	Illegal activities	16	5
Cost of taking drug per month (in BDT)	1000-2500 Taka	81	45
	2600-6000 Taka	99	55
Drugs are taken	Alcohol	138	21.4
	Phenethyl	58	9
	Cannabis	175	27.1
	Yaba Tablets	123	19
	Heroin	12	1.9
	Tobacco	140	21.7
Route of drug administration	Oral	168	48.1
	Injection	7	2.0
	Smoking	174	49.9
Collection of drugs	Direct purchase	160	43.4
	Friends	165	44.7
	Dealer or Agents	44	11.9
Companion during taking drug	Alone	170	46.4
	Friends	170	46.4
	Others drug users	26	7.1
Help source	Family	159	76.1
	Friends	30	14.4
	Teacher	11	5.3
	Health worker	9	4.3
Counselling	yes	26	14.4
	No	154	85.6
Frequency of counselling	Once every month	8	4.4
	Occasionally	18	10
	Not applicable	154	85.6
Level of support	Supportive	157	87.2
	Neutral	7	3.9
	Not supportive	16	8.9

Impact on health due to taking drug	Yes	163	90.6
	No	17	9.4
Wish for giving it up	Yes	165	91.7
	No	15	8.3

Table 4.3 provides detailed insight into the substance use patterns and related factors among participants. Half of the respondents (50%, n = 90) began using drugs between the ages of 12–19, and the other half (50%, n = 90) between 20–47 years. The median age at first use was 19.5 years, and the mean was 20 years (SD ±4.794). This indicates that many participants-initiated substance use during adolescence or early adulthood.

In terms of duration of drug use, 52.2% (94 participants) had been using drugs for 1–5 years, while 47.8% (86 participants) had been using for 6–45 years. The mean duration was 8.02 years (SD ±7.515), showing that while many were relatively recent users, a substantial portion had long-term substance use histories. Most participants (93.3%, n = 168) reported that no other family members used drugs, while 6.7% (12 participants) did have family members who used drugs. The main reasons for first trying drugs were peer pressure (38.4%, n = 166) and curiosity (38.7%, n = 167). Other reasons included family problems (11.6%), family instability (6.5%), relationship issues (2.3%), unemployment (1.4%), and failure in love (1.2%). This suggests that social influence and psychological factors played major roles in initiating substance use.

Nearly half of the participants (49.8%, n = 160) relied on their families for money to purchase drugs, 32.7% (105 participants) used their own money, 12.5% (40 participants) received money from friends, and 5% (16 participants) engaged in illegal activities. Monthly expenditure on drugs ranged mostly between 1,000–2,500 BDT (45%) and 2,600–6,000 BDT (55%), indicating a significant financial burden. Regarding types of drugs used, cannabis was the most commonly used substance

(27.1%, n = 175), followed by tobacco (21.7%, n = 140), alcohol (21.4%, n = 138), Yaba tablets (19%, n = 123), phenethyl (9%, n = 58), and heroin (1.9%, n = 12).The most common routes of administration were smoking (49.9%, n = 174) and oral intake (48.1%, n = 168), while injection was rare (2%, n = 7).

Participants mainly obtained drugs from friends (44.7%, n = 165) or through direct purchase (43.4%, n = 160), while 11.9% (44 participants) obtained drugs from dealers or agents. Drug use occurred equally alone (46.4%, n = 170) and with friends (46.4%, n = 170), while 7.1% used drugs with other drug users. In terms of help sources, most participants received support from family (76.1%, n = 159), followed by friends (14.4%), teachers (5.3%), and health workers (4.3%). However, only 14.4% (26 participants) had received counseling. Among them, 4.4% attended counseling once per month and 10% attended occasionally, while 85.6% had never received counseling. Despite limited professional support, 87.2% reported receiving supportive help overall. Importantly, 90.6% stated that drug use had negatively affected their health, and 91.7% expressed a desire to quit.

In conclusion, Table 4.3 shows that substance use often began early, was heavily influenced by peers and curiosity, involved multiple substances, created financial and health burdens, and yet was accompanied by a strong desire among most participants to give up drug use.

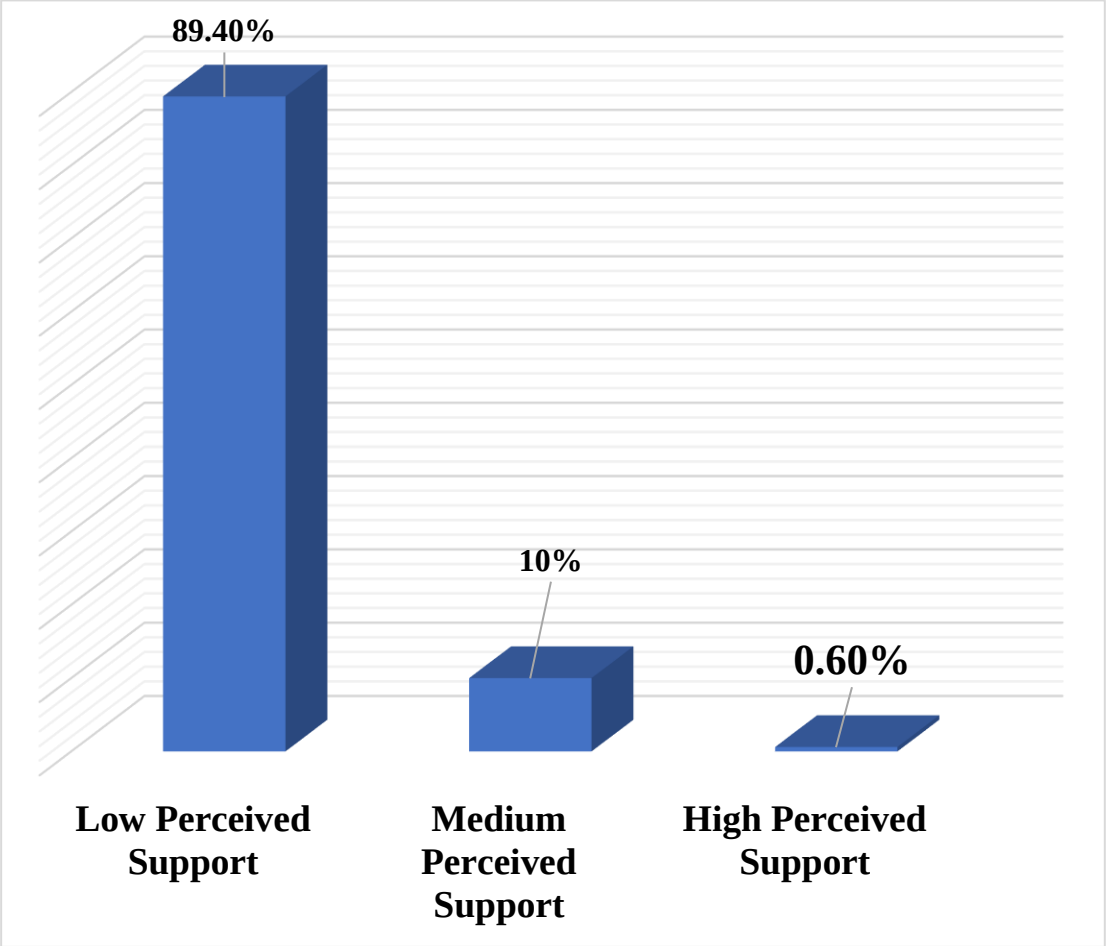
Table 4.4
Multidimensional Scale of Perceived Social Support Questions Frequency and Percentage.

Items		Very Strongly Disagree %(n)	Strongly Disagree %(n)	Mildly Disagree %(n)	Neutral %(n)	Mildly Agree %(n)	Strongly Agree %(n)	Very Strongly Agree %(n)
1	There is a special person who is around when I am in need.	90.6(163)	1.7(3)	3.9(7)	2.8(5)	0(0)	1.1(2)	0(0)
2	There is a special person with whom I can share joys and sorrows	88.9(160)	3.9(7)	2.2(4)	3.9(7)	0(0)	0.6(1)	0.6(1)
3	My family really tries to help me.	12.2(22)	4.4(8)	11.1(20)	19.4(35)	36.1(65)	15.6(28)	1.1(2)
4	I get the emotional help & support I need from my family.	15(27)	3.9(7)	7.8(14)	18.9(34)	31.1(56)	22.8(41)	0.6(1)
5	I have a special person who is a real source of comfort to me.	87.8(158)	2.8(5)	2.2(4)	3.3(6)	2.8(5)	0(0)	0.6(1)
6	My friends really try to help me.	71.1(128)	6.1(11)	12.8(23)	2.2(4)	7.8(14)	0(0)	0(0)
7	I can count on my friends when things go wrong.	72.2(130)	9.4(17)	10.6(19)	2.2(4)	3.3(6)	2.2(4)	0(0)
8	I can talk about my problems with my family.	25(45)	3.9(7)	6.7(12)	11.1(20)	29.4(53)	23.9(43)	0(0)
9	I have friends with whom I can share my joys and sorrows	85.6(154)	5.6(10)	3.3(6)	1.1(2)	3.9(7)	0.6(1)	0(0)
10	There is a special person in my life who cares about my feelings.	87.2(157)	3.9(7)	0.6(1)	3.3(6)	2.8(5)	2.2(4)	0(0)
11	My family is willing to help me make decisions.	23.3(42)	2.8(5)	12.2(22)	23.3(4)	21.1(38)	17.2(31)	0(0)
12	I can talk about my problems with my friends	81.7(147)	3.9(7)	6.7(12)	3.9(7)	3.3(6)	0.6(1)	0(0)

The findings from the MSPSS table indicate a very high lack of perceived support from a “special person,” with approximately 88–91% of respondents very strongly disagreeing with statements related to having someone special for emotional support. Similarly, perceived support from friends is notably low, as about 70–85% of participants very strongly disagreed that friends help them, can be relied upon, or are available to share problems. In contrast, family support appears relatively higher, with around 29–36% of respondents mildly agreeing and 17–23% strongly agreeing that their family provides help and emotional support. Compared to friends and special persons, family emerges as the main source of support, although the level of support is moderate rather than strong. Overall, the data suggest generally low perceived social support among respondents, particularly from friends and significant others, with family being the comparatively strongest source of support.

Figure: 4.1

Overview of the Level of Social Support



The PI-chart illustrates that the majority of participants 89.4% (n=161) demonstrated low perceived social support. A smaller proportion, 10.0% (n=18), reported medium perceived social support, while only 0.6% (n=1) of participants experienced high perceived social support.

The distribution indicates that most individuals with substance use disorders in this study perceived inadequate social support. Very few participants reported a high level of support, highlighting the limited availability of strong emotional and social backing within this population.

Table 4.5

Enacted Stigma (SU-SMS) Questions Frequency and Percentage

	ENACTED STIGMA	Never n (%)	Not often n (%)	Somewhat often n (%)	Often n (%)	Very Often n (%)
1.	Family members have thought that I cannot be trusted.	3(1.7)	29(16.1)	77 (42.8)	54(30.0)	17 (9.4)
2.	Family members have looked down on me.	2(1.1)	37 (0.6)	73 (40.6)	53(29.4)	15 (8.3)
3.	Family members have treated me differently.	3(1.7)	32(17.8)	84 (46.7)	46(25.6)	15 (8.3)
4.	Healthcare workers have not listened to my concerns.	32(17.8)	73(40.6)	53 (29.4)	16 (8.9)	5 (2.8)
5.	Healthcare workers have thought that I'm pill shopping, or trying to con them into giving me prescription medications to get high or sell.	119(66.1)	53(29.4)	6 (3.3)	1(0.6)	1 (0.6)
6.	Healthcare workers have given me poor care.	169(93.9)	7 (3.9)	2 (1.1)	1 (0.6%)	1(0.6)

Family members have thought that I cannot be trusted**.** Most respondents reported experiencing this *somewhat often* (42.8%) and *often* (30.0%), while 9.4% experienced it *very often*. Only 1.7% reported *never*. This indicates that distrust from family members is commonly experienced. Family members have looked down on me**.** The majority indicated *somewhat often* (40.6%) and *often* (29.4%), with 8.3% reporting *very often*. Very few (1.1%) reported *never*. This suggests frequent negative judgment from family. Family members have treated me differently**.**

Nearly half (46.7%) reported *somewhat often*, and 25.6% reported *often*. Only 1.7% indicated *never*. This reflects considerable differential treatment by family members. Healthcare workers have not listened to my concerns**.** Most respondents selected *not often* (40.6%) or *somewhat often* (29.4%). A smaller percentage reported *never* (17.8%). This suggests moderate communication-related stigma. Healthcare workers have thought that I'm pill shopping. The majority reported *never* (66.1%) or *not often* (29.4%). Very few experienced this often or very often. This indicates low perceived accusation of drug-seeking behavior. Healthcare workers have given me poor care**.** An overwhelming majority (93.9%) reported *never*. Very small percentages reported any occurrence. This shows minimal experienced poor care.

Table 4.6

Anticipated Stigma (SU-SMS) Questions Frequency and Percentage

	ANTICIPATED STIGMA	Very unlikely n (%)	Unlikely n (%)	Neither unlikely nor likely n (%)	Likely n (%)	Very Likely n (%)
1	Family members will think that I cannot be trusted.	3 (1.7)	36 (20)	35(19.4)	90 (50)	16(8.9)
2	Family members will look down on me.	2 (1.1)	34(18.9)	28(15.6)	101(56.1)	15(8.3)
3	Family members will treat me differently.	4 (2.2)	33(18.3)	34(18.9)	95(52.8)	14(7.8)
4	Healthcare workers will not listen to my concerns.	43(23.9)	61(33.9)	50(27.8)	23(12.8)	3 (1.7)
5	Healthcare workers will think that I'm pill shopping, or trying to con them into giving me prescription medications to get high or sell.	118(65.6)	53(29.4)	7 (3.9)	1 (0.6)	1 (0.6)
6	Healthcare workers will think that I'm pill shopping, or trying to con them into giving me prescription medications to get high or sell.	163(90.6)	8 (4.4)	3 (1.7)	4 (2.2)	2 (0.1)

Family members will think that I cannot be trusted. Half of the respondents (50%) reported likely, and 8.9% reported very likely. This indicates a strong expectation of distrust. Family members will look down on me. Most participants indicated likely (56.1%) and very likely (8.3%). Anticipation of negative judgment is high. Family members will treat me differently. A majority reported likely (52.8%) and very likely (7.8%), indicating expectation of discriminatory treatment. Healthcare workers will not listen to my concerns. Most responses fell under unlikely (33.9%) and neither unlikely nor likely (27.8%). Fewer respondents expected this to be likely. Healthcare workers will think I'm pill shopping. The majority indicated very unlikely (65.6%) or unlikely (29.4%). Anticipated stigma is low. Healthcare workers will give me poor care. A very high percentage (90.6%) reported very unlikely. This shows low expectation of poor treatment

Table 4.7

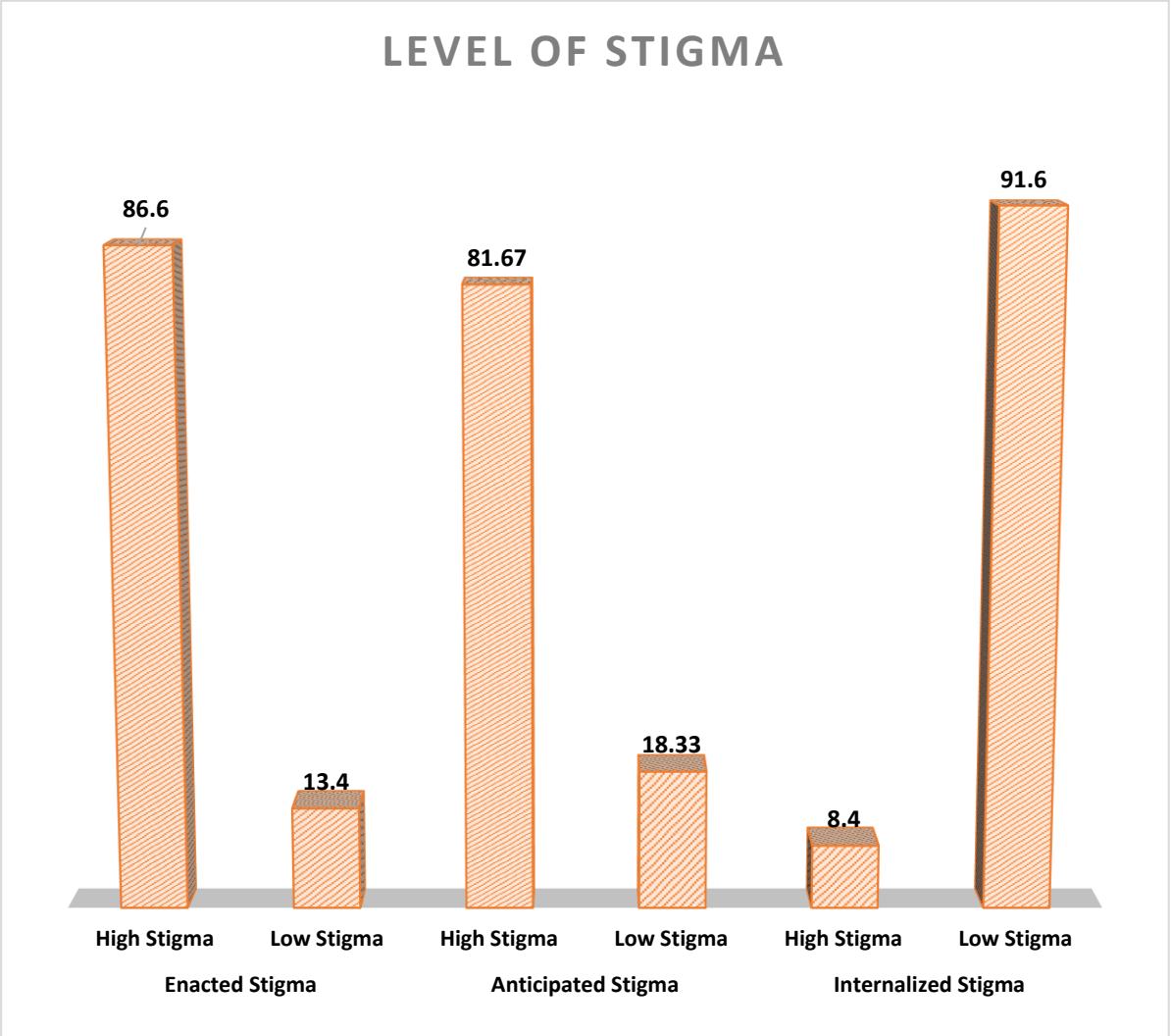
Internalized Stigma (SU-SMS) Questions Frequency and Percentage.

	INTERNALIZED STIGMA	Strongly disagree n (%)	Disagree n (%)	Neither disagree nor agree n (%)	Agree n (%)	Strongly agree n (%)
1.	Having used alcohol and/or drugs makes me feel like I'm a bad person.	6 (3.3)	8 (4.4)	55(30.6)	85(47.)	26(14.4)
2.	I feel I'm not as good as others because I used alcohol and/or drugs.	2 (1.1)	5 (2.8)	67 (37.2)	88(48.9)	18 (1)
3.	I feel ashamed of having used alcohol and/or drugs.	3 (1.7)	3 (1.7)	31 (17.2)	78(43.3)	65 (36.1)
4.	I think less of myself because I used alcohol and/or drugs.	4 (2.2)	7 (3.9)	122(67.8)	36(20)	11 (6.1)
5.	Having used alcohol and/or drugs makes me feel unclean.	5 (2.8)	9 (5)	127(70.6)	21(11.7)	18(10)
6.	Having used alcohol and/or drugs is disgusting to me.	5 (2.8)	1(0.6)	13 (7.2)	18 (10)	143(79.4)

The majority of participants indicated significant levels of internalized stigma associated with substance use. A significant percentage reported likely or very likely feelings of being a bad person (61.4%) and not measuring up to others (58.9%). Shame was the most common feeling, with 79.4% saying it was likely or very likely. On the other hand, perceptions of self-devaluation and feeling unclean mostly got neutral responses (67.8% and 70.6%, respectively). This shows that there is some uncertainty or variability in these areas. A very strong internalized sense of disgust was noted, with 79.4% of respondents indicating it was very likely, showing a high level of negative self-directed perception.

Figure: 4.2

Overview of the Level of Stigma



This column illustrates that the majority of participants 86.6% (n = 155) demonstrated higher enacted stigma, while 13.4% (n = 24) experienced lower enacted stigma. The distribution of anticipated stigma presented 81.67% (n = 147) participants experienced higher anticipated stigma, whereas 18.33% (n = 33) experienced lower anticipated stigma. Interestingly, despite variations in enacted and anticipated stigma, a total of 91.6% (n = 164) participants reported lower internalized stigma, whereas 8.4% (n = 15) participants expressed higher internalized stigma

Table 4.8

Association Between Socio-Demographic Variables and Multidimensional Scale of Perceived Social Support (MSPSS)

Variables		Multidimensional Scale of Perceived Social Support (MSPSS)			Fisher's Exact Test	*P* value
		Low Perceived Support %(n)	Medium Perceived Support % (n)	High Perceived Support % (n)		
Family Income	0-19000 BDT	35.6 (64)	1.7(3)	0(0)	10.577	**0.011**
	20000 BDT	21.7 (3)	1.1 (2)	0.6 (1)		
	22000-70000 BDT	32.2 (58)	7.2 (13)	0 (0)		
Age at first use	12-19 Years	47.2 (85)	2.8 (5)	0(0)	4.935	**0.050**
	20-47 Years	42.2 (76)	7.2(13)	0.6(1)		
Counseling	Yes	9.4(17)	5(9)	0(0)	15.852	**0.001**
	No	80(144)	5(9)	0.6(1)		
Frequency of counseling	Once per week	1.1(2)	1.1(2)	0(0)	19.012	**0.005**
	Once every month	3 (3)	0.6 (1)	0(0)		
	Occasionally	7.2 (13)	2.8(5)	0(0)		
	Not applicable	79.4 (143)	5.6 (10)	(1)0.6		

This table presents the results of the Chi-Square Test to assess the relationship between socio-demographic characteristics and the level of mental resilience. The analysis identified two statistically significant associations.

Significant Findings: There is a statistically significant association between family income and the perceived level of social support ($p = 0.011$). Those with lower income levels (0-19000 BDT) have a higher percentage of individuals with low perceived support, compared to those in higher income groups. The age at first use of substances is significantly associated with perceived support ($p = 0.050$). Those who started using substances at a younger age (12-19 years) reported more instances of low perceived support. There is a statistically significant relationship between receiving counseling and the perceived level of social support ($p = 0.001$). Participants who received counseling were more likely to report higher levels of support. The frequency of counseling also significantly affects perceived support ($p = 0.005$). Individuals who received counseling more frequently reported higher perceived support compared to those with less frequent counseling. This table provides insights into the significant socio-demographic and clinical factors influencing perceived social support, highlighting areas like family income, age at first substance use, and counseling frequency. These factors are crucial for understanding how socio-economic and clinical backgrounds influence resilience and mental health support.

Table: 4.9
Association Between Socio-Demographic Variables and Enacted Stigma

Variables		Enacted Stigma		Fisher's Exact Test	*P* value
		Low stigma %(n)	High stigma %(n)		
Occupation	Unemployed	57.4(89)	88 (22)	16.376	**0.005**
	Job	6.5(10)	0(0)		
	Student	31(20)	0(0)		
	Business	7.1(11)	0(0)		
	Day laborer	8.4 (13)	8 (2)		
	Retired	0(0)	4 (1)		
	Others	1(0.6)	0 (0)		
Marital status	Unmarried	74.8 (116)	52 (13)	10.294	**0.010**
	Married	21.9 (34)	32 (8)		
	Divorced	3.2 (5)	12 (3)		
	Widow/Widower	0.0 (0)	4 (1)		
Family Relationship	Good	48.4 (75)	32 (8)	15.672	**0.002**
	Very Good	25.8 (40)	12 (3)		
	Moderate	18.1 (28)	24 (6)		
	Poor	7.7 (12)	24 (6)		
	Very Poor	0 (0)	8 (2)		
Drug duration Years	1-5 Years	56.8(88)	24 (6)	9.268	**0.003**
	6-45 Years	43.2(67)	76 (19)		
Level of support	Very supportive	59.4 (92)	20 (5)	30.895	**0.001**
	Supportive	32.3 (50)	40 (10)		
	Neutral	3.9 (6)	4 (1)		
	Not supportive	1.9 (3)	12 (3)		
	Not supportive at all	2.6 (4)	24 (6)		

Counseling	yes	16.8 (26)	0 (0)	4.902	**0.028**
	No	83.2 (129)	100 (25)		
Drug impact on health	Yes	95.5(148)	60 (15)	31.693	**0.001**
	No	4.5 (7)	40 (10)		
Want to quit Drug	Yes	95.5 (148	68 (17)	21.288	**0.001**
	No	4.5 (7)	32 (8)		

Table 4.9 presents the association between selected variables and enacted stigma using the Chi-square test and Fisher's Exact test where appropriate. Since all reported p-values are less than 0.05, statistically significant associations were observed. Occupation was significantly associated with enacted stigma ($\chi^2 = 16.376$, $p = 0.005$). Higher proportions of high enacted stigma were observed among unemployed participants compared to other occupational groups. Marital status also showed a statistically significant association ($\chi^2 = 10.294$, $p = 0.010$). Divorced and married respondents demonstrated relatively higher percentages of high stigma compared to unmarried individuals. Family relationship was significantly associated with enacted stigma ($\chi^2 = 15.672$, $p = 0.002$). Participants reporting poor or very poor family relationships had higher proportions of high stigma compared to those reporting good or very good relationships. Drug duration was significantly associated with enacted stigma ($\chi^2 = 9.268$, $p = 0.003$). Participants with longer drug use duration (6–45 years) showed higher levels of enacted stigma compared to those with shorter duration (1–5 years).Level of support demonstrated a strong significant association ($\chi^2 = 30.895$, $p = 0.001$). Individuals receiving little or no support reported markedly higher levels of enacted stigma. Counseling status was significantly associated with enacted stigma ($\chi^2 = 4.902$, $p = 0.028$). Those who did not receive counseling had higher levels of stigma. Drug impact on health showed a highly significant association ($\chi^2 = 31.693$, $p = 0.001$).

Participants reporting negative health impacts experienced higher enacted stigma. Similarly, willingness to quit drugs was significantly associated with enacted stigma (χ^2 = 21.288, p = 0.001), indicating higher stigma among those unwilling to quit. Overall, enacted stigma was significantly associated with occupation, marital status, family relationship, duration of drug use, level of support, counseling status, perceived health impact, and willingness to quit drug.

Table: 4.10

Association Between Socio-Demographic Variables and Anticipated Stigma

Variables		Anticipated Stigma		Fisher's Exact Test	*P* value
		Low stigma %(n)	High stigma %(n)		
Occupation	Unemployed	81.8 (27)	57.1(84)	13.173	**0.023**
	Job	3(1)	6.1(9)		
	Student	3(1)	20.4(30)		
	Business	6.1 (2)	6.1(9)		
	Day laborer	3 (1)	9.5(14)		
	Retired	0 (0)	0.7(1)		
	Others	3 (1)	0 (0)		
Family Relationship	Good	36.4 (12)	48.3 (71)	9.652	**0.037**
	Very Good	21.2(7)	24.5 (36)		
	Moderate	18.2(6)	19.0 (28)		
	Poor	18.2(6)	8.2 (12)		
	Very Poor	6.1(2)	0.0 (0)		
Family Income	Yes	63.6(21)	31.3 (46)	12.167	**0.002**
	20000 BDT	18.2 (6)	24.5 (36)		
	22000-70000 BDT	18.2 (6)	44.2 (65)		
Drug duration Years	1-5 Years	24 (6)	56.8 (88)	9.268	**0.003**
	6-45 Years	76 (19)	43.2(67)		
Level of support	Very supportive	36.4 (12)	57.8 (85)	18.068	**0.001**
	Supportive	27.3 (9)	34.7 (51)		
	Neutral	9.1 (3)	2.7 (4)		
	Not supportive	9.1 (3)	2 (3)		
	Not supportive at all	18.2 (6)	2.7 (4)		
Drug impact on health	Yes	66.7 (22)	95.9 (141)	26.963	**0.001**
	No	33.3 (11)	4.1 (11)		
Want to quit Drug	Yes	75.8 (25)	95.2 (140)	10.422	**0.001**
	No	24.2 (8)	4.8 (7)		

Table 4.10 shows the association between selected factors and anticipated stigma. Statistically significant associations were observed for all listed variables ($p < 0.05$). Occupation was significantly associated with anticipated stigma ($\chi^2 = 13.173$, $p = 0.023$), with unemployed and student participants showing higher levels of high anticipated stigma. Family relationship demonstrated a significant association ($\chi^2 = 9.652$, $p = 0.037$). Poor family relationships were related to higher anticipated stigma. Family income was significantly associated with anticipated stigma ($\chi^2 = 12.167$, $p = 0.002$). Lower income categories showed higher levels of stigma. Drug duration was also significantly associated ($\chi^2 = 9.268$, $p = 0.003$), with longer duration linked to higher anticipated stigma. Level of support had a strong significant association ($\chi^2 = 18.068$, $p = 0.001$). Participants with limited or no support reported higher anticipated stigma. Drug impact on health showed a highly significant association ($\chi^2 = 26.963$, $p = 0.001$), indicating greater anticipated stigma among those experiencing health consequences. Willingness to quit drugs was significantly associated with anticipated stigma ($\chi^2 = 10.422$, $p = 0.001$), with higher stigma among those not willing to quit. Overall, anticipated stigma was significantly influenced by occupation, family relationship, income, drug duration, level of support, health impact, and willingness to quit.

Table: 4.11

Association Between Socio-Demographic Variables and Internalized Stigma

Variables		Internalized Stigma		Fisher's Exact Test	*P* value
		Low stigma %(n)	High stigma %(n)		
Family Relationship	Good	47.3(78)	33.3(5)	9.32	**0.037**
	Very Good	23.6(39)	26.7(4)		
	Moderate	20(33)	6.7(1)		
	Poor	8.5(14)	26.7(4)		
	Very Poor	0.6(1)	6.7(1)		
Drug duration Years	1-5 Years	55.2(91)	20(3)	6.809	**0.009**
	6-45 Years	44.8(74)	80(12)		
Drug impact on health	Yes	93.3(154)	60(9)	17.864	**0.001**
	No	6.7(11)	40(6)		
Want to quit Drug	Yes	94.5(156)	60(9)	21.481	**0.001**
	No	5.5(9)	40(6)		

Table 4.11 presents the relationship between selected factors and internalized stigma. All reported associations were statistically significant ($p < 0.05$). Family relationship was significantly associated with internalized stigma ($\chi^2 = 9.32$, $p = 0.037$). Participants with poor or very poor family relationships showed higher levels of internalized stigma. Drug duration was significantly related to internalized stigma ($\chi^2 = 6.809$, $p = 0.009$), with longer duration associated with higher stigma levels. Drug impact on health showed a strong significant association ($\chi^2 = 17.864$, $p = 0.001$).

Individuals reporting health impacts experienced higher internalized stigma. Willingness to quit drugs was also significantly associated ($\chi^2 = 21.481$, $p = 0.001$). Higher internalized stigma was observed among those unwilling to quit drugs. In summary, internalized stigma was significantly associated with family relationship quality, duration of drug use, perceived health impact, and willingness to quit dru

CHAPTER V: DISCUSSION

The study aimed to assess the level of social support systems individuals with substance abuse in Bangladesh. The majority of participants were young adults, predominantly male, unemployed, and had secondary-level education. These findings are consistent with previous studies in Bangladesh, which reported that substance use is more common among young males in their productive age and is often associated with unemployment and socio-economic instability (M. D. Hossain et al., 2014,Alam et al., 2020). This demographic pattern reflects the broader public health concern regarding youth involvement in substance abuse in Bangladesh.

The present study found that more than half of the respondents had a moderate level of perceived social support. Among the three domains of MSPSS, family support was higher than support from friends and significant others. This result aligns with the socio-cultural context of Bangladesh, where family plays a central role in caregiving and decision-making. Previous studies also emphasized that family involvement significantly influences treatment adherence and recovery among individuals with substance use disorders(Alam et al., 2020).However, despite relatively higher family support, the overall moderate level suggests that many participants still experience limited emotional and social backing during rehabilitation.

Regarding stigma, the study revealed that 52.2% of participants experienced high anticipated stigma, and a considerable proportion reported enacted and internalized stigma. These findings are similar to earlier research indicating that individuals with substance use disorders frequently face discrimination, social rejection, and self-stigmatization (Livingston et al., 2012)(Corrigan Patrick et al., 2009). Stigma not only affects social relationships but also reduces self-esteem and

discourages help-seeking behavior. In Bangladesh, where substance use is often viewed as a moral failing rather than a health condition, stigma may be even more pronounced.

The current study also found significant associations between stigma and occupation, income, family relationship, duration of drug use, perceived health impact, and willingness to quit. Unemployed and low-income participants reported higher levels of stigma, which is consistent with findings that socio-economic disadvantage increases vulnerability to marginalization and discrimination (Room, 2005),(Luoma et al., 2007) Furthermore, longer duration of drug use was associated with higher internalized stigma, possibly due to repeated relapse, strained family dynamics, and accumulated negative social labeling. Poor family relationships were also linked with higher stigma levels, suggesting that family conflict may reinforce feelings of shame and social exclusion.

The most important finding of this study was the inverse relationship between perceived social support and stigma. Participants who reported lower social support experienced higher anticipated and internalized stigma. This finding is supported by previous research demonstrating that social support acts as a protective factor against stigma and plays a critical role in recovery (Yang et al., 2017),(K. Tracy & Wallace, 2016). Social support may buffer the negative psychological effects of stigma, while stigma may weaken existing support networks, creating a cycle that hinders recovery.

Overall, the findings highlight that psychosocial factor are strongly interconnected in substance abuse rehabilitation. Strengthening family engagement, enhancing peer and community support, and implementing stigma-reduction interventions within rehabilitation services are essential steps to improve treatment outcomes and psychosocial well-being among individuals with substance abuse in Bangladesh.

CHAPTER VI: CONCLUSION

6.1 Strength and Limitation

Strength

- This study used well-established and validated instruments, such as the Multidimensional Scale of Perceived Social Support (MSPSS) and the Substance Use Stigma Mechanism Scale (SU-SMS), which ensures the reliability of the data collected.
- The study involved 180 participants, which is a significant sample size, increasing the robustness and generalizability of the findings.
- The design offered a valuable snapshot of social support's impact on substance abuse at a specific point in time.
- The researcher collected data through face-to-face interviews, which helped improve the accuracy and quality of responses and reduced possible bias.
- The study obtained ethical approval from the Institutional Review Board (IRB) of BHPI, ensuring that all data collection followed ethical rules and participant rights were protected.
- The results of this study are supported by sever al international studies, which makes the findings more reliable and comparable with global evidence.

Limitation

- This design limits the ability to establish causality between variables, such as social support and substance abuse recovery.
- The sample had a high gender imbalance, with 179 male participants and only 1

female participant. This may affect the generalizability of the findings, particularly in understanding gender-specific issues.

- Data were collected from a few settings, affecting the representativeness of the findings for the broader population.
- The study used purposive sampling, which may limit generalization since participants were chosen based on set criteria instead of random selection.

6.2 Practice Implication

Recommendations for Future Practice:

The results of the current study form the basis for several recommendations for future practice. Family support is shown to be vital when people recover from substance abuse so rehabilitation facilities should implement family-based interventions (e.g., family therapy and psychoeducational materials) in order to help patients in their recovery. Family communication skills can be developed to reduce family conflict and improve long-term treatment outcomes. A majority of the respondents reported they had not received any consistent form of counselling; therefore, increased access to psychological counselling, occupational therapy treatment, and rehabilitative services should be made available to individuals throughout the duration of their rehabilitation treatment.

The respondents in this study indicated that stigma and lack of community awareness/social understanding were barriers to receiving appropriate services; therefore, community awareness and anti-stigma initiatives should be implemented in order to create a more supportive environment for individuals with substance use disorders. Since most participants had no job or source of income, vocational training and income-generating services should be part of a rehabilitation programme, which

will promote independence and decrease the likelihood of future relapse. Peer support groups at rehabilitation facilities can be used to create emotional attachments among recovering individuals which will foster long-term success in sobriety. Finally, early preventative programs designed to target youth should be implemented, as many of our participants reported that they began using substances because of peer pressure or curiosity. Additionally, the role of occupational therapy in substance use continuation should be expanded.

Recommendations for Future Research:

Longitudinal designs will be employed to continue to further explore and analyze the effects of social support in the addition recovery process or in preventing relapse. Thus far, this study has utilized a quantitative cross-sectional design, thus additional qualitative research is needed to further understand individuals' personal experiences, perceived stigma, or barriers to social supports. Since this sample consisted primarily of men, research also needs to focus on substance use disorder within the female population to determine how they may have been different than the male.

It is also suggested that comparative studies of rural and urban populations would further aid in understanding the different types of social support systems based upon their geographical location. Experimental or intervention-based research should also be conducted to measure the effectiveness of family therapy, peer support activities, or occupational therapy related to improving the ability to effectively recover. Future research should include a larger, more diverse sample from various geographic locations throughout Bangladesh to better generalize and achieve a more comprehensive understanding of the social support systems available to individuals with substance use disorders.

6.3 Conclusion

The purpose of this study was to assess the level and availability of social supports for those affected by addiction as well as explore the barriers individuals experience when accessing those supports in Bangladesh. The majority of participants in this study were young, male, unemployed, unmarried, and from a rural background which demonstrates their vulnerability from a sociodemographic perspective. The large majority of participants who abused substances began using them in their teenage years as a result of peer pressure and curiosity. The study results also show that substance abuse negatively impacts health, social relationships, and economic stability.

The Multidimensional Scale of Perceived Social Support (MSPSS) results indicate that family is still the primary source of support for people, but almost half of the participants had poor relationships with their family. Many participants reported some level of perceived supportive environment but there was limited access to professional counseling services. The barriers to gaining adequate support were stigma, financial dependence, unemployment and instability of family relationships.

Individuals who received regular counseling and who had better family relationships displayed higher levels of perceived support. Therefore, the results of this study highlight that social support is a critical factor in the recovery and rehabilitation process for people suffering from substance abuse issues and that enhancing family involvement will help to create an environment conducive to successful recovery for individuals with substance use issues.

CHAPTER VII: LIST OF REFERENCE

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APPENDICES

Appendix A: Ethical Approval Letter

Ethical Approval Letter from IRB

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

Ref: CRP-BHPI/IRB/07/2025/1092 Date: 21.07.2025

To
Md Ashraful Alam
4th Year B.Sc. in Occupational Therapy
Session: 2020-2021, Student ID: 122200404
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Subject: Approval of the thesis proposal **Level of Social Support System for Individuals with Substance Abuse** by ethics committee.

Dear Md Ashraful Alam,
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, 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	Multidimensional Scale of Perceived Social Support (MSPSS) (Bangla & English)
3	Information sheet & consent form

The purpose of the study is to find-out the socio-demographic characteristics of participant, to find-out level of social support system of the participant, to find-out the factor associated with social support system. The study involves use of a Multidimensional Scale of Perceived Social Support (MSPSS), to find-out the sociodemografic characteristics of participant, to find-out level of social support system of the participant, to find-out the factor associated with social support system that may take 15 to 20 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

সিআরপি-চাপাইন, সাভার, ঢাকা-১৩৪৩, বাংলাদেশ। ফোন: +৮৮ ০২ ২২৪৪৪৫৪৬৪-৫, +৮৮ ০২ ২২৪৪৪১৪০৪, মোবাইল: +৮৮ ০১৭৩০ ০৫৯৬৪৭
CRP-Chapain, Savar, Dhaka-1343, Bangladesh. Tel: +88 02 224445464-5, +88 02 224441404, Mobile: +88 01730059647
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Date: 24/06/25
The Chairman
Institutional Review Board (IRB)
Bangladesh Health Professions Institute (BHPI)
CRP-Savar, Dhaka-1343, Bangladesh

Subject: **Application for review and ethical approval.**

Sir,

With due respect I would like to draw your kind attention that I am a student of B.Sc. in Occupational Therapy at Bangladesh Health Professions Institute (BHPI) which is an academic institute of Centre for the Rehabilitation of the Paralysed (CRP), affiliated to Faculty of Medicine, University of Dhaka. I would like to conduct a thesis titled, **"Level of Social Support System for Individual with Substance Abuse"** with myself, as the principal investigator and Md. Habibur Rahman , Assistant Professor and Course Coordinator, MSc. in OT, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP as my thesis supervisor. The purpose of the study is to find-out the sociodemographic characteristics of participant , to find-out level of social support system of the participant ,to find-out the factor associated with social support system.

Multidimensional Scale of Perceived Social Support (MSPSS) ,will be used in the study that will take about 15 to 20 minutes. Other related information will be collected from the Socio-demographic questions. Data collectors will receive informed consents from all participants and data collected will be kept confidential.

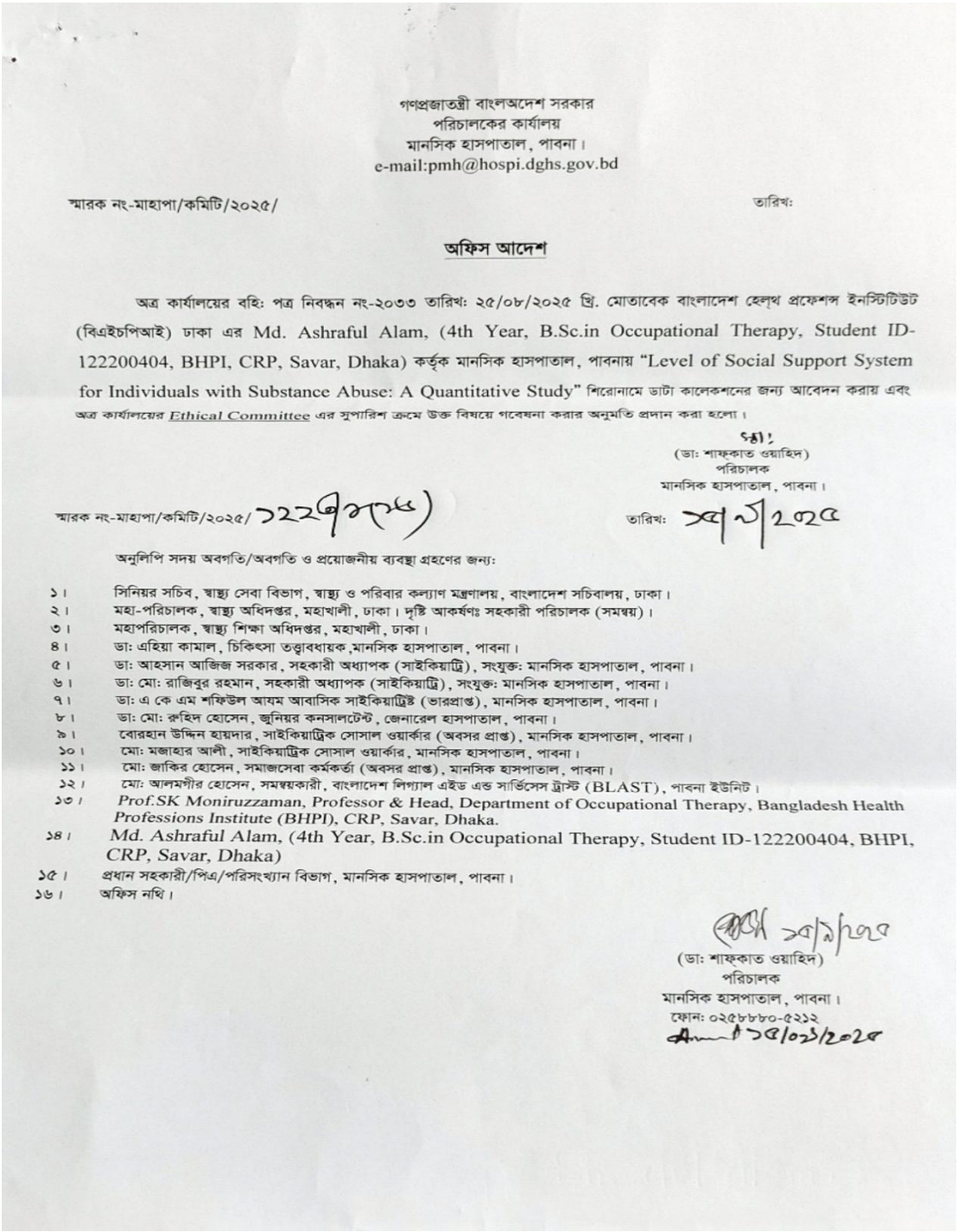
Therefore, I look forward to having your approval for the thesis proposal and to start data collection. I also assure you that I will maintain all the requirements for study.

Sincerely yours,
Ashraf
Md Ashraful Alam
4th Year B.Sc. in Occupational Therapy
Session: 2020-2021, Student ID: **122200404**
BHPI, CRP, Savar, Dhaka-1343

Recommendation from the thesis supervisor/concerned authority:

30.06.25
Md. Habibur Rahman
Assistant Professor,
Course Coordinator, MSc. in OT
Department of Occupational Therapy
Bangladesh Health Professions Institute (BHPI),
CRP,Savar, Dhaka-1343

Appendix B: Permission Letter for Data Collection



গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
পরিচালকের কার্যালয়
মানসিক হাসপাতাল, পাবনা।
e-mail:pmh@hospi.dghs.gov.bd

স্মারক নং-মাহাপা/কমিটি/২০২৫/ তারিখ:

অফিস আদেশ

অত্র কার্যালয়ের বহি: পত্র নিবন্ধন নং-২০৩৩ তারিখ: ২৫/০৮/২০২৫ খ্রি. মোতাবেক বাংলাদেশ হেল্‌থ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই) ঢাকা এর Md. Ashraful Alam, (4th Year, B.Sc.in Occupational Therapy, Student ID-122200404, BHPI, CRP, Savar, Dhaka) কর্তৃক মানসিক হাসপাতাল, পাবনায় "Level of Social Support System for Individuals with Substance Abuse: A Quantitative Study" শিরোনামে ডাটা কালেকশনের জন্য আবেদন করায় এবং অত্র কার্যালয়ের Ethical Committee এর সুপারিশ ক্রমে উক্ত বিষয়ে গবেষনা করার অনুমতি প্রদান করা হলো।

(ডা: শাফকাত ওয়াহিদ)
পরিচালক
মানসিক হাসপাতাল, পাবনা।

স্মারক নং-মাহাপা/কমিটি/২০২৫/১২২৫(৬৯) তারিখ: ২৭/১১/২০২৫

অনুলিপি সদয় অবগতি/অবগতি ও প্রয়োজনীয় ব্যবস্থা গ্রহণের জন্য:

১। সিনিয়র সচিব, স্বাস্থ্য সেবা বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, বাংলাদেশ সচিবালয়, ঢাকা।
২। মহা-পরিচালক, স্বাস্থ্য অধিদপ্তর, মহাখালী, ঢাকা। দৃষ্টি আকর্ষণঃ সহকারী পরিচালক (সমন্বয়)।
৩। মহাপরিচালক, স্বাস্থ্য শিক্ষা অধিদপ্তর, মহাখালী, ঢাকা।
৪। ডা: এহিয়া কামাল, চিকিৎসা তত্ত্বাবধায়ক,মানসিক হাসপাতাল, পাবনা।
৫। ডা: আহসান আজিজ সরকার, সহকারী অধ্যাপক (সাইকিয়াট্রি), সংযুক্ত: মানসিক হাসপাতাল, পাবনা।
৬। ডা: মো: রাজিবুর রহমান, সহকারী অধ্যাপক (সাইকিয়াট্রি), সংযুক্ত: মানসিক হাসপাতাল, পাবনা।
৭। ডা: এ কে এম শফিউল আযম আবাসিক সাইকিয়াট্রিষ্ট (ভারপ্রাপ্ত), মানসিক হাসপাতাল, পাবনা।
৮। ডা: মো: রুহিদ হোসেন, জুনিয়র কনসালটেন্ট, জেনারেল হাসপাতাল, পাবনা।
৯। বোরহান উদ্দিন হায়দার, সাইকিয়াট্রিক সোসাল ওয়ার্কার (অবসর প্রাপ্ত), মানসিক হাসপাতাল, পাবনা।
১০। মো: মজাহার আলী, সাইকিয়াট্রিক সোসাল ওয়ার্কার, মানসিক হাসপাতাল, পাবনা।
১১। মো: জাকির হোসেন, সমাজসেবা কর্মকর্তা (অবসর প্রাপ্ত), মানসিক হাসপাতাল, পাবনা।
১২। মো: আলমগীর হোসেন, সমন্বয়কারী, বাংলাদেশ লিগ্যাল এইড এন্ড সার্ভিসেস ট্রাস্ট (BLAST), পাবনা ইউনিট।
১৩। Prof.SK Moniruzzaman, Professor & Head, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP, Savar, Dhaka.
১৪। Md. Ashraful Alam, (4th Year, B.Sc.in Occupational Therapy, Student ID-122200404, BHPI, CRP, Savar, Dhaka)
১৫। প্রধান সহকারী/পিএ/পরিসংখ্যান বিভাগ, মানসিক হাসপাতাল, পাবনা।
১৬। অফিস নথি।

২৭/১১/২০২৫
(ডা: শাফকাত ওয়াহিদ)
পরিচালক
মানসিক হাসপাতাল, পাবনা।
ফোন: ০২৫৮৮৮০-৫২১২
২৭/০১/২০২৫

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
পরিচালক ও অধ্যাপকের কার্যালয়
জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট ও হাসপাতাল
শের-ই-বাংলা নগর, ঢাকা- ১২০৭

স্মারক নং-এনআইএমএইচ/একাডেমিক/২০২৫/২৫২৪ তারিখঃ ২৪/৮/২৫

বরাবর

এসকে মনিরুজ্জামান
অধ্যাপক এন্ড প্রধান
অকুপেশনাল থেরাপি বিভাগ
পক্ষাঘাতগ্রস্তদের পূনর্বাসন কেন্দ্র (সিআরপি)
চাপাইন, সাভার, ঢাকা।

বিষয় : গবেষনা সংক্রান্ত তথ্য (ডাটা) সংগ্রহের অনুমতি প্রদান প্রসঙ্গে।

উপরোক্ত বিষয়ের আলোকে বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই), ঢাকা এর বিএসসি চতুর্থ বর্ষের শিক্ষার্থী কে জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট, শেরে বাংলা নগর, ঢাকায় "Level of Social Support System for Individuals with Substance Abuse: A Quantitative Study" বিষয়ক গবেষনা সংক্রান্ত থিসিসের তথ্য উপাত্ত (ডাটা) সংগ্রহের জন্য অনুমতি প্রদান করা হলো।

(অধ্যাপক ডা. মোঃ মাহবুবুর রহমান)
পরিচালক (ভারপ্রাপ্ত) ও
অধ্যাপক (চলতি দায়িত্ব), সাইকিয়াট্রি
জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট, ঢাকা।

স্মারক নং-এনআইএমএইচ/একাডেমিক/২০২৫/ তারিখঃ

অনুলিপি অবগতি ও প্রয়োজনীয় ব্যবস্থা গ্রহনের জন্য প্রেরন করা হলো ঃ-

১। সহযোগী অধ্যাপক, চাইল্ড, এডলোসেন্ট এন্ড ফ্যামিলি সাইকিয়াট্রি বিভাগ, এনআইএমএইচ, ঢাকা।।
২। সহযোগী অধ্যাপক, জেরিয়াট্রিক এন্ড অর্গানিক সাইকিয়াট্রি, এনআইএমএইচ, ঢাকা।
৩। ড. মোঃ জহির উদ্দিন, সহকারী অধ্যাপক, ক্লিনিক্যাল সাইকোলজি, এনআইএমএইচ, ঢাকা।
৪। মোঃ জামাল হোসেন, সাইকিয়াট্রিক সোসাল ওয়ার্কার, এনআইএমএইচ, ঢাকা।
৫। রেসিডেন্ট সাইকিয়াট্রিস্ট, এনআইএমএইচ, ঢাকা।
৬। প্রশাসনিক কর্মকর্তা, এনআইএমএইচ, ঢাকা।
৭। পরিচালক মহোদয়ের ব্যক্তিগত সহকারী, জাতীয় মানসিক স্বাস্থ্য ইনষ্টিটিউট, ঢাকা।
৮। সহকারী লাইব্রেরিয়ান, এনআইএমএইচ, ঢাকা।
৯। অফিস কপি।

(অধ্যাপক ডা. মোঃ মাহবুবুর রহমান)
পরিচালক (ভারপ্রাপ্ত) ও
অধ্যাপক (চলতি দায়িত্ব), সাইকিয়াট্রি
জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট, ঢাকা

Appendix C : Information Sheet (English Version and Bangla version)

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)

Department of Occupational Therapy

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

Code no.: .....

Participants Information sheet:

Research Title: "Level of Social Support System for Individuals with Substance Abuse"

Researcher: Md. Ashraful Alam, Student of B.Sc 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 and approved by the Ministry of Health and Family Welfare, Government of Bangladesh.

Supervisor: Md. Habibur Rahman, Assistant Professor and Course Coordinator, MSc. in OT, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP-Savar.

Place of research: The study was conducted at NIMH, Pabna Mental Hospital, the Central Drug Addiction Treatment Center, and in semi-urban and rural areas of Dhaka.

Part -1 Information sheet:

Introduction:

I am Md. Ashraful Alam , student of B.Sc 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 and approved by the Ministry of Health and Family Welfare, Government of

Bangladesh. 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 and Course Coordinator, MSc in OT, 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 participate in this research because, in Bangladesh, there is a lack of studies on the level of social support systems for individuals with substance abuse. This study aims to investigate the current state of social support systems and the factors associated with it for individuals suffering from substance abuse in Bangladesh. Your input will be valuable in understanding the existing social support structures and the factors influencing them, and your voluntary participation will contribute to revealing the key aspects of this population's support systems.

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, it‘s 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 over phone.

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 was funded entirely by the researcher. The study was conducted on a small scale, and no external funding was received.

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: Md. Ashraful Alam , Student of B.Sc. in Occupational Therapy, Department of Occupational Therapy, BHPI, CRP, Savar, Dhaka

Cell No:01974611789

Gmail: muhammadaalam11110@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 (Bengali Version)

বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)

অকুপেশনাল থেরাপি বিভাগ

সিআরপি-চাপাইন, সাভার, ঢাকা-১৩৪৩।

টেলিঃ ০২-৭৭৪৫৪৬৪-৫, ৭৭৪১৪০৪, ফ্যাক্সঃ ০২-৭৭৪৫০৬

কোড নং:.....

অংশগ্রহণকারীদের তথ্য এবং সম্মতিপত্র

গবেষণার বিষয়ঃ মাদকাসক্ত ব্যক্তিদের জন্য সামাজিক সহায়তা ব্যবস্থা স্তরের মূল্যায়ন

গবেষকঃ মোঃ আশরাফুল আলম, বি.এ.সি.ইন অকুপেশনাল থেরাপি (৪র্থ বর্ষ), সেশনঃ ২০২০-২০২১, বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই), সিআরপি, সাভার, ঢাকা-১৩৪৩।

তত্ত্বাবধায়কঃ মো. হাবিবুর রহমান, সহকারী অধ্যাপক এবং কোর্স কোঅর্ডিনোটর, এমএসসি, ইন অকুপেশনাল থেরাপি, অকুপেশনাল থেরাপি বিভাগ, বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (BHPI), সিআরপি, সাভার, ঢাকা-১৩৪৩।

পর্ব-১ তথ্যপত্রঃ

আমি মোঃ আশরাফুল আলম, ঢাকা বিশ্ববিদ্যালয়ে চিকিৎসা অনুষদের অধীনে বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউটে বি.এস.সি ইন অকুপেশনাল থেরাপি বিভাগের ৪র্থ বর্ষের ছাত্র হিসেবে (২০২০-২০২১) সেশনে অধ্যয়নরত আছি। বিএইচপিআই থেকে অকুপেশনাল থেরাপি বি.এস, সি শিক্ষা কার্যক্রমটি সম্পূর্ণ করার জন্য একটি গবেষণা প্রকল্প পরিচালনা করা বাধ্যতামূলক এ গবেষণা প্রকল্পটি বাংলাদেশ হেলথ প্রফেসন্স ইন্সটিটিউট ও অকুপেশনাল থেরাপি বিভাগের সহকারী অধ্যাপক মোঃ হাবিবুর রহমান এর তত্ত্বাবধায়নে সম্পন্ন করা হবে। এ অংশগ্রহণকারী তথ্যপত্রের মাধ্যমে গবেষণার প্রকল্পটির উদ্দেশ্য, উপাত্ত সংগ্রহের প্রণালী গবেষণাটির সাথে সংশ্লিষ্ট বিষয়ে কিভাবে রক্ষিত হবে তা বিস্তারিত ভাবে আপনার কাছে উপস্থাপন করা হবে। যদি এই গবেষণায় অংশগ্রহণ করতে আপনি ইচ্ছুক থাকেন, সে ক্ষেত্রে এ গবেষণার সম্পৃক্ত বিষয় সম্পর্কে স্বচ্ছ ধারণা থাকলে সিদ্ধান্তগ্রহণ সহজতর হবে। অবশ্য এখন

আপনার অংশগ্রহণ আমাদের নিশ্চিত করতে হবে না, যেকোনো সিদ্ধান্ত গ্রহণের পূর্বে, যদি চান আপনার আত্মীয়-স্বজন বন্ধু অথবা আস্থাভাজন যে কারো সাথে এই ব্যাপারে আলোচনা করে নিতে পারেন। অপরপক্ষে, অংশগ্রহণকারী তথ্যপত্রটি পড়ে, যদি কোনো বিষয়বস্তু বুঝতে সমস্যা হয় অথবা যদি কোন কিছু সংম্পর্কে আরও বেশি জানা প্রয়োজন হয় তবে নির্দ্বিধায় প্রশ্ন করতে পারেন।

গবেষণার প্রেক্ষাপট ও উদ্দেশ্যঃ

আপনাকে এই গবেষণার অংশ হওয়ার জন্য আন্তরিকভাবে আমন্ত্রণ জানানো হচ্ছে, কারণ বাংলাদেশে মাদকাসক্ত ব্যক্তিদের জন্য সামাজিক সহায়তা ব্যবস্থা এবং এর প্রভাব নিয়ে এখনো কোন বিস্তৃত এবং গভীর গবেষণা করা হয়নি। বর্তমান সমাজে, মাদকাসক্তি একটি অন্যতম সামাফিক সমস্যা হিসেবে চিহ্নিত হয়েছে, যার প্রভাব শুধুমাত্র শারীরিক নয়, বরং মানসিক, সামাজিক এবং অর্থনৈতিক দিক থেকেও ব্যাপক। তাই এই গবেষনার মাধ্যমে মাদকাসক্ত ব্যক্তিদের জন্য সামাজিক সহায়তার স্তর এবং তার কার্যকারিতা সম্পর্কে বিস্তারিত তথ্য সংগ্রহ করা অত্যন্ত জরুরি। এই গবেষণাটি বাংলাদেশের মাদকাসক্ত ব্যক্তিদের জন্য সামাজিক সহায়তার অবস্থা, তার ধরন এবং সামাজিক সহায়তার প্রভাব সম্পর্কে একটি পূর্ণাঙ্গ চিত্র প্রদান করবে।

এছাড়া, এই গবেষণার মাধ্যমে আমরা সামাজিক সহায়তার বিভিন্ন মাত্রা যেমন পারিবারিক, বন্ধু, কমিউনিটি এবং সরকারি সহায়তা ব্যবস্থার মধ্যে সম্পর্ক এবং তার সঠিক কার্যকারিতা নিয়ে মূল্যবান তথ্য সংগ্রহ করতে পারবো। আপনার তথ্য এই গবেষণায় স্বেচ্ছায় অংশগ্রহণের মাধ্যমে মাদকাসক্ত ব্যক্তিদের জীবনে সামাজিক সহায়তার বাস্তব চিত্র এবং তার প্রভাব তুলে ধরতে অত্যন্ত গুরুত্বপূর্ণ ভূমিকা রাখবে বলে আমরা আশাবাদী।

এই গবেষণা কর্মে অংশগ্রহণের সাথে সম্পর্কিত বিষয়সমূহঃ

গবেষণার অংশগ্রহণের পূর্বে, আমরা আপনাকে একটি তথ্যপত্রের মাধ্যমে গবেষণা প্রকল্পটির বিস্তারিত তথ্য জানাবো। আপনি যদি এই গবেষণায় অংশগ্রহণ করতে চান, তবে আপনাকে একটি সম্মতিপত্রে স্বাক্ষর করতে হবে। যদি আপনি স্বাক্ষর করতে ভাক্ষম হন অথবা অন্য কোনো কারণে স্বাক্ষর প্রদান না করেন, তবে একজন সাক্ষীর উপস্থিতিতে আপনার বৃদ্ধাঙ্গুলির ছাপ নেওয়া হবে সম্মতিপত্তো এই সম্মতি

পত্রের একটি কপি আপনাকে সংরক্ষণের জন্য প্রদান করা হবে।

গবেষক কর্তৃক সংগৃহীত তথ্য-উপাত্ত একটি দলের প্রতিনিধি আপনার কাছে পৌঁছে যাবে। এরপর, আপনির কাছ থেকে নির্দিষ্ট সময়ের মধ্যে একটি প্রশ্নপত্রের মাধ্যমে তথ্য সংগ্রহ করা হবে। গবেষণায় আপনার অংশগ্রহণ সম্পূর্ণভাবে আপনার নিজস্ব ইচ্ছার ওপর নির্ভরশীল। আপনি যদি সম্মতি না দেন, তবে আপনাকে অংশগ্রহণ করতে হবে না। এছাড়া, আপনি যেকোনো সময়, কোনো কারণ ছাড়াই, আপনার আংশগ্রহণ প্রত্যাহার করতে পারবেন এবং আপনাকে এর জন্য কোনো ব্যাখ্যা দিতে হবে না। এভাবে, গবেষণায় আপনার অংশগ্রহণ একদম স্বেচ্ছামূলক এবং আপনি যে কোনো সময়, আপনার ইচ্ছা অনুযায়ী, এতে অংশগ্রহণ বা প্রত্যাহার করতে পারেন।

অংশগ্রহণ এর সুবিধা ঝুঁকিসমূহ কি?

গবেষণা প্রকল্পটিতে ডাংশগ্রহণের জন্য আপনি সরাসরি কোনো সুবিধা পাবেন না। এই গবেষণায় অংশগ্রহণে আপনার দৈনন্দিন কাজে সাময়িক অসুবিধার কারণ হতে পারে। তবে আমরা আশাবাদী যে, এ গবেষণার ফলাফল থেকে প্রাপ্ত উপকারিতা এই অসুবিধা কে অতিক্রম করবে। যে সমস্ত প্রশ্নের মাধ্যমে। আপনার পরিচয় সম্পর্কে অন্যরা জানতে পারে সেই বিষয়ে উদ্বিগ্ন না হবার জন্য অনুরোধ করা হচ্ছে। অংশগ্রহণকারীর নাম, ঠিকানা উপাত্ত বিশ্লেষণের সফটওয়ারে উল্লেখ না করে পরিচয় উন্মুক্ত হবার ঝুঁকি কমানো হবে। তথ্যের গোপনীয়তা কি নিশ্চিত থাকবে?

এ সম্মতি পত্রের স্বাক্ষর করার মধ্য দিয়ে, আপনি এই গবেষণা প্রকল্পের সাধ্যয়নরত গবেষণা কর্মীকে আপনার ব্যক্তিগত তথ্য সংগ্রহ ও ব্যবহার করার অনুমতি দিয়েছেন। এই গবেষণা প্রকল্পের জন্য সংগৃহীত যেকোনো তথ্য, যা আপনাকে শনাক্ত করতে পারে তা গোপনীয় থাকবে। শুধুমাত্র এর সাথে সরাসরি সংশ্লিষ্ট গবেষক ও তাঁর তত্ত্বাবধায়ক এই তথ্যসমূহে প্রবেশাধিকার পাবেন। সাংকেতিক উপায়ে চিহ্নিত উপাত্ত সমূহ পরবর্তী উপাত্ত বিশ্লেষণের কাজে ব্যবহৃত হবে তথ্য পরগুলো তালাবদ্ধ ড্রয়ার এ রাখা হবে। বিএইচপিআই এর আঅকুপেশনাল থেরাপি বিভাগে ও গবেষকের ব্যক্তিগত ল্যাপটপে উপায় সমূহের ইলেকট্রনিক ভার্সন সংগৃহীত থাকবে। পত্যাশা করা হচ্ছে যে, এই গবেষণা প্রকল্পের ফলাফল বিভিন্ন ফোরামে প্রকাশিত এবং উপস্থাপিত হবে। যেকোনো ধরনের প্রকাশনা ও উপস্থাপনার ক্ষেত্রে তথ্যসমূহ

এমন ভাবে সরবরাহ করা হবে, যেন আপনার সম্মতি ছাড়া আপনাকে কোনো ভাবেই সনাক্ত করা না যায়। তথ্য-উপাত্ত প্রাথমিকভাবে কাগজপত্র সংগ্রহ করা হবে। ফলাফল প্রচার সংম্পর্কিত তথ্যঃ

এই গবেষণার ফলাফল বিভিন্ন সামাজিক মাধ্যম, ওয়েবসাইট, সম্মেলন, আলোচনা সভায় এবং পর্যালোচিত জার্নালে প্রকাশ করা হবে।

অংশগ্রহণকারীর পারিশ্রমিকঃ

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

গবেষণা পরিচালনার ব্যয়কৃত অর্থের উৎসঃ

এই গবেষণাটি খরচ সম্পূর্ণ গবেষকের নিজস্ব তহবিল থেকে ব্যয় করা হবে। এই গবেষণাটি ছোট পরিসরে করা হবে এবং এখানে কোন অর্থ বহিরাগত উৎস থেকে আসবে না।

অংশগ্রহণ থেকে প্রত্যাহার সম্পর্কিত তথ্যসমূহঃ

আপনি সম্মতি প্রদান করা সত্ত্বেও তথ্য দেওয়ার এক সপ্তাহের মধ্যে যে কোনো সময় গবেষককে কোনো ব্যাখ্যা প্রদান করা ছাড়াই নিজের অংশগ্রহণ প্রত্যাহার করতে পারবেন। বাতিল করার পর তথ্যসমূহ কি ব্যবহার করা যাবে কি যাবে না তার অনুমতি অংশগ্রহণকারীর প্রত্যাহারপত্রে (শুধুমাত্র স্বেচ্ছায় প্রত্যাহারকারীর জন্য প্রযোজ্য। উল্লেখ করা থাকবে।

গবেষকের সাথে যোগাযোগের ঠিকানাঃ

গবেষনা প্রকল্পটির বিষয়ে যোগাযোগ করতে চাইলে অথবা গবেষণা প্রকল্পটির সম্পর্কে কোন প্রশ্ন থাকলে, এখন অথবা পরবর্তীতে যেকোনো সময়ে তা জিজ্ঞাসা করা যাবে। সেক্ষেত্রে আপনি গবেষকের সাথে উল্লেখিত নাম্বারে (০১৯৭৪৬১১৭৮৯ মোঃ আশরাফুল আলম) অথবা ইমেইলে (muhammadaalam11110@gmail.com) যোগাযোগ করতে পারেন।

অভিযোগ

এই গবেষণা প্রকল্প পরিচালনার বিষয়ে কোন অভিযোগ থাকলে, এসোসিয়েশন অফ এথিকা (৭৭৪৫৪৬৪-৫) এর সাথে যোগাযোগ করুন। এই প্রস্তাবটি ইনস্টিটিউশনাল রিভিউড বোর্ড (আইআরবি), বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (বিএইচপিআই), সিআরপি, সাভার, ঢাকা-১৩৪৩,

বাংলাদেশ দ্বারা পর্যালেচনা করা হয়েছে, যেটি একটি কমিটি যার কাজ হল গবেষণায় অংশগ্রহণকারীদের ক্ষতি থেকে রক্ষা করা নিশ্চিত করা। আপনি যদি আইআরবি সম্পর্কে আরও জানতে চান, তাহলে বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট, সিআরপি, সাভার, ঢাকা-১৩৪৩, বাংলাদেশ-এ যোগাযোগ করুন।

Appendix D: Consent Form (English and Bangla version)

Consent form

(**Please read out to the participant)**

I am Md. Ashraful Alam Rahman, Student of B.Sc of Science in Occupational Therapy, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP-Savar, Dhaka1343. 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 Social Support System for Individuals with Substance Abuse". The purpose of the study is to find-out the sociodemographic characteristics of participant, to find-out level of social support system of the participant, to find-out the factor associated with social support system. Data will be gathered over the phone call. This will take approximately 15-20 minutes. 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.

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

YES NO

Signature & Date of Participant

…….

Signature &Data Researcher

.....

Consent Form (Bengali Version)

সম্মতিপত্র
(যারা ইন্টারভিউতে অংশ নিচ্ছেন তাদের জন্য)

আমি **মোঃ আশরাফুল আলম**, ঢাকা বিশ্ববিদ্যালয়ের চিকিৎসা অনুষদের অধীনে **বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউটে** বি.এস.সি ইন অকুপেশনাল থেরাপি বিভাগের **৪র্থ** বর্ষের ছাত্র (২০২০-২০২১ সেশন)। আমার বি.এস.সি ডিগ্রি সম্পন্ন করতে, আমাকে একটি গবেষণা প্রকল্প পরিচালনা করতে হবে, যা আমার অধ্যয়নের একটি গুরুত্বপূর্ণ অংশ।

আমার গবেষণার শিরোনাম হলো: **"মাদকাসক্ত ব্যক্তিদের জন্য সামাজিক সহায়তা ব্যবস্থা স্তরের মূল্যায়ন"।**

এই গবেষণার প্রকল্পটি পূর্ণ করতে, ডেটা সংগ্রহের জন্য আমার আপনার কাছ থেকে কিছু তথ্য প্রয়োজন। সুতরাং, আপনি এই গবেষণার একজন সম্মানিত অংশগ্রহণকারী হতে পারেন। ফোনের মাধ্যমে তথ্য সংগ্রহ করা হবে এবং কথোপকথনের সময় ১৫-২০ মিনিট হতে পারে।

আমি আপনাকে জানাতে চাই যে, এটি একটি সম্পূর্ণ একাডেমিক গবেষণা এবং অন্য কোনো উদ্দেশ্যে ব্যবহার করা হবে না। আমি আশ্বস্ত করছি যে, সমস্ত তথ্য গোপন রাখা হবে এবং ব্যক্তিগত গোপনীয়তা রক্ষা করা হবে। আপনার অংশগ্রহণ স্বেচ্ছায় হবে। ডেটা সংগ্রহের এক সপ্তাহের মধ্যে আপনি আপনার সম্মতি প্রত্যাহার করার অধিকার রাখবেন। তবে, ডেটা সংগ্রহের এক সপ্তাহ পর সম্মতি প্রত্যাহার করা সম্ভব হবে না।

এই গবেষণা সম্পর্কে আপনার কোন প্রশ্ন থাকলে, আপনি গবেষক মোঃ আশরাফুল আলম অথবা সুপারভাইজার মো. হাবিবুর রহমান, সহকারী অধ্যাপক এবং কোর্স কোঅর্ডিনেটর, এমএসসি. ইন অকুপেশনাল থেরাপি, অকুপেশনাল থেরাপি বিভাগ, বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (BHPI), সিআরপি; এর সাথে যোগাযোগ করতে পারেন।

তথ্য প্রদান শুরু করার আগে আপনার কোন প্রশ্ন আছে?

হ্যাঁ ○ **না** ○

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

হ্যাঁ ○ **না** ○

অংশগ্রহণকারীর স্বাক্ষর এবং তারিখঃ **তথ্য সংগ্রহের স্বাক্ষর এবং তারিখঃ**

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Appendix E : Withdrawal Form (English and Bangla version)

Participant's Withdrawal Form

(Applicable only for voluntary withdrawal)

Participant's Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Reason for withdrawal:

Signature and Date of Participant:

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Withdrawal Form (Bengali Version)

অংশগ্রহণকারীর প্রত্যাহার পত্র

(শুধু মাত্র স্বেচ্ছায় প্রত্যাহারকারীর জন্য প্রযোজ্য)

অংশগ্রহণকারীর নাম : ----------

প্রত্যাহার করার কারণ :

অংশগ্রহণকারীর স্বাক্ষর ও তারিখ :

Appendix F: Questionnaire (English and Bangla version)

Questionnaire (English version)

No.	Questions	Comments	Code
1	What is your gender?	Male Female	1 2
2	How old are you?	…..... Years	
3	What is your religion?	Islam Hindu Christian Buddhist Others:	1 2 3 4 5
4.	What is your educational qualification?	Illiterate Primary education Secondary education Higher Secondary education Graduation/ above graduation	1 2 3 4
5.	What is your current occupation?	Unemployed Employee Student Businessman Day laborer Retired House wife Others:	1 2 3 4 5 6 7 8
6.	What is your marital status?	Single Married Divorced Widowed	1 2 3 4
7.	Where do you live?	Rural area Urban area Semi-urban area	1 2 3
8.	What type of family do you live in?	extended family Nuclear family Single-parent family	1 2 3
9	What is your family's monthly income? (Approximate),	_____Taka.	
10.	How much do you earn per month?	.....taka.	
11	Who do you currently live with?	Both parents Mother Father Spouse/own family Relatives Friends Live alone	1 2 3 4 5 6 7
12.	Are your parents still alive ? (If the answer to question 11 is 1, then dont ask question 12.)	Both alive Father died Mother died	1 2 3
13	What is your relationship like with your family ?	Good Very good Avarage Bad Very bad	1 2 3 4 5

14.	At what age did you first start using drugs?	.....years (age)	
15.	For how long have you used drugs?	.....day/month/year.	1 2
16.	Does anyone else in your family use or ever used drugs?	No Yes (If yes, who: .....)	1 2 3 4 5 6 7 8
17.	What was the main reason you started using drugs?	Peer pressure Curiosity Family problems Unemployment Relationship failure Family Disharmony Failure in love Other (please specify):	1 2 3 4 5
18.	In what ways do you manage money to buy drugs?	Self Family Friends Illegal activities (e.g., theft, robbery) Other (please specify):	
19.	How much money did you spend on drugs each month ?	.....Taka.	
20.	What type of drugs do you use? (Select all that apply)	Alcohol Phensedyl Ganja Yaba Heroin Prescription drugs (e.g., Alprazolam, painkillers) Tobacco Other (please specify):	1 2 3 4 5 6 7 8
21.	In what way did you use drugs?	Oral(pills/tablets) Ingestion Inhalation Mutiple	1 2 3 4
22.	In what ways did you get drugs?	Directly Friends Dealers/agents Delivery Others (please specify:.....)	1 2 3 4 5
23.	Who did you usually take drugs ?	Alone Friends Other drugs users Other (please specify:.....)	1 2 3 4

24.	Did anyone support you in avoiding/overcoming drug use?	Family Friends Teacher Health professionals	1 2 3 4
25.	How supportive are your family, friends, and society regarding your drug problem?	Very supportive Supportive Neutral Not supportive Not supportive at all	1 2 3 4 5
26.	Have you ever taken part in any counseling or therapy sessions related to drug use?	Yes No	1 2
27.	If yes, how often do you attend counseling or therapy sessions?	Once per week Once every two weeks Once every month sometimes	1 2 3 4
28.	Do you think your drug addiction affected your overall health?	Yes No	1 2
29.	Do you want to completely recover from drug addiction?	Yes No	1 2

Substance Use Stigma Mechanism Scale (SU-SMS)

Co-developed by: Laramie R. Smith, Ph.D. and Valerie A. Earnshaw, Ph.D.

Intended use: The SU-SMS was developed for use in a diverse range of substance using populations. It can be adapted for persons affected by alcohol use and/or drug use disorders accordingly. The SU-SMS may be administered to substance-using populations more broadly, including those who are out-of-treatment, non-treatment seeking, treatment-seeking, and in-treatment for substance use disorders.

Scoring: All responses are given on a 5-point Likert-type scale, with higher scores indicating greater endorsement of substance use stigma. Enacted (6 items), Anticipated (6 items), and Internalized (6 items) scales can be created by taking the average of the item responses given for each stigma mechanism respectively. Stigma source sub-scales can be created for Enacted and Anticipated stigma by taking the average responses given for the healthcare worker (3 items) and family members (3 items) item responses respectively.

Citation: Smith LR, Earnshaw VA, Copenhaver MM, Cunningham C. Substance use stigma: Reliability and validity of a theory-based scale for substance-using populations. Drug Alcohol Depend. In press

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Instructions: The following questions ask about your **alcohol and/or drug use history,** this includes any past or current experiences using alcohol and/or drugs. Please think about each question and circle your answer. The first group of questions asks about how people have treated you **in the past** because of alcohol and/or drug use history. The second group of questions asks about how people will treat you **in the future** because of your alcohol and/or drug use history.

ENACTED STIGMA (header can be omitted in survey)
How often have people treated you this way **in the past** because of your alcohol and/or drug use history? Please circle your response.

		Never	Not often	Somewhat often	Often	Very Often
1.	Family members have thought that I cannot be trusted.	1	2	3	4	5
2.	Family members have looked down on me.	1	2	3	4	5
3.	Family members have treated me differently.	1	2	3	4	5
4.	Healthcare workers have not listened to my concerns.	1	2	3	4	5
5.	Healthcare workers have thought that I'm pill shopping, or trying to con them into giving me prescription medications to get high or sell.	1	2	3	4	5
6.	Healthcare workers have given me poor care.	1	2	3	4	5

ANTICIPATED STIGMA (header can be omitted in survey)

How likely is it that people will treat you in the following ways **in the future** because of your alcohol and/or drug use history?

		Very unlikely	Unlikely	Neither unlikely nor likely	Likely	Very likely
1.	Family members will think that I cannot be trusted.	1	2	3	4	5
2.	Family members will look down on me.	1	2	3	4	5
3.	Family members will treat me differently.	1	2	3	4	5
4.	Healthcare workers will not listen to my concerns.	1	2	3	4	5
5.	Healthcare workers will think that I'm pill shopping, or trying to con them into giving me prescription medications to get high or sell.	1	2	3	4	5
6.	Healthcare workers will give me poor care.	1	2	3	4	5

INTERNALIZED STIGMA (header can be omitted in survey)

How do you **feel** about your alcohol and/or drug use history?

		Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
1.	Having used alcohol and/or drugs makes me feel like I'm a bad person.	1	2	3	4	5
2.	I feel I'm not as good as others because I used alcohol and/or drugs.	1	2	3	4	5
3.	I feel ashamed of having used alcohol and/or drugs.	1	2	3	4	5
4.	I think less of myself because I used alcohol and/or drugs.	1	2	3	4	5
5.	Having used alcohol and/or drugs makes me feel unclean.	1	2	3	4	5
6.	Having used alcohol and/or drugs is disgusting to me.	1	2	3	4	5

To what extent do you agree with the following? *Please fill in the appropriate circle.*	Very Strongly Disagre (1)	Strongly Disagree (2)	Mildly Disagree (3)	Neutral (4)	Mildly Agree (5)	Strongly Agree (6)	Very Strongly Agree (7)
1.There is a special person who is around when I am in need.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
2.There is a special person with whom I can share joys and sorrows.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
3.My family really tries to help me.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
4.I get the emotional help & support I need from my family.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
5.I have a special person who is a real source of comfort to me.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
6.My friends really try to help me.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
7.I can count on my friends when things go wrong.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
8.I can talk about my problems with my family.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
9. I have friends with whom I can share my joys and sorrows.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
10.There is a special person in my life who cares about my feelings.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
11.My family is willing to help me make decisions.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
12.I can talk about my problems with my friends.	☐1	☐2	☐3	☐4	☐5	☐6	☐7

Questionnaire (Bengali Version)

ব্যক্তিগত তথ্য ও আর্থসামাজিক প্রশ্নাবলী

অংশগ্রহণকারীর নামঃ.....তারিখঃ.....

মোবাইল নাম্বারঃ.....

ক্রমিক নং	প্রশ্নাবলী সমূহ	মতামত সমূহ	কোড
১	**আপনার লিঙ্গ কী?**	পুরুষ	১
		নারী	২
২	**আপনার বয়স কত?**	..... **বছর**	
৩	আপনার ধর্ম কী?	ইসলাম	১
		হিন্দু	২
		খ্রিষ্টান	৩
		বৌদ্ধ	৪
		অন্যান্য:_____	৫
৪	**আপনার শিক্ষাগত যোগ্যতা কী?**	নিরক্ষর	১
		প্রাথমিক শিক্ষা	২
		মাধ্যমিক শিক্ষা	৩
		উচ্চ মাধ্যমিক শিক্ষা	৪
		স্নাতক/স্নাতকোত্তর	৫
৫	**আপনার বর্তমান পেশা কী?**	বেকার	১
		চাকরিজীবী	২
		শিক্ষার্থী	৩
		ব্যবসায়ী	৪
		দিনমজুর	৫
		অবসরপ্রাপ্ত	৬
		গৃহিণী	৭
		অন্যান্য: _____	৮
৬	আপনার বৈবাহিক অবস্থা কী ?	অবিবাহিত	১
		বিবাহিত	২
		তালাকপ্রাপ্ত	৩
		স্বামী/স্ত্রী মৃত	৪
৭	আপনি কোথায় বসবাস করেন ?	গ্রাম	১
		শহর	২
		আধা-শহর	৩
৮	আপনি কোন ধরনের পরিবারে বসবাস করেন ?	যৌথ পরিবার	১
		একক পরিবার	২
		একক অভিভাবক পরিবার	৩
৯	**আপনার পরিবারের মাসিক আয় কত টাকা ? (প্রায়)**	_____ টাকা.	
১০	**আপনার মাসিক আয় কত টাকা? (প্রায়)**	_____ টাকা.	

১১	বর্তমানে আপনি কার সাথে থাকেন?	মা-বাবার সাথে	১
		মায়ের সাথে	২
		বাবার সাথে	৩
		স্ত্রী/নিজের পরিবার	৪
		আত্মীয়	৫
		বন্ধু	৬
		একা থাকি	৭
১২	আপনার বাবা-মায়ের বৈবাহিক সম্পর্ক কী? (যদি ১১ নম্বর প্রশ্নের উত্তর ১ হয়, তবে ১২ নম্বর প্রশ্ন প্রযোজ্য নয়)	একসাথে থাকেন	১
		আলাদা থাকেন	২
		বাবা মৃত	৩
		মা মৃত	৪
		প্রযোজ্য নয়	৫
১৩	**পরিবারের সাথে আপনার সম্পর্ক কেমন?**	ভালো	১
		খুব ভালো	২
		মোটামুটি	৩
		খারাপ	৪
		খুব খারাপ	৫
১৪	**আপনি কত বছর বয়সে প্রথম মাদকদ্রব্য গ্রহণ শুরু করেছিলেন?**	_____ বছর	
১৫	**কতদিন ধরে আপনি মাদকদ্রব্য গ্রহণ করেছিলেন?**	_____ দিন/মাস/বছর	
১৬	আপনার পরিবারে আর কেউ কি মাদকদ্রব্য গ্রহণ করে বা করেছিলেন?	না	১
		হ্যাঁ (যদি হ্যাঁ হয়, কে: _____)	২
১৭	**আপনি মাদকদ্রব্য গ্রহণ শুরু করার প্রধান কারণ কী ছিল?**	বন্ধুদের চাপ	১
		কৌতূহল	২
		পারিবারিক সমস্যা	৩
		বেকারত্ব	৪
		সম্পর্ক ভাঙন	৫
		পারিবারিক অশান্তি	৬
		প্রেমে ব্যর্থতা	৭
		অন্যান্য (উল্লেখ করুন): _____	৮
১৮	**মাদকদ্রব্য কেনার জন্য টাকা কীভাবে জোগাড় করতেন?**	নিজে	১
		পরিবার	২
		বন্ধু-বান্ধব	৩
		বেআইনি কাজের মাধ্যমে (যেমন: চুরি, ডাকাতি)	৪
		অন্যান্য (উল্লেখ করুন): _____	৫
১৯	**আপনি মাসে মাদকদ্রব্য পিছনে কত টাকা খরচ করতেন?**	_____টাকা ,	
২০	**আপনি কোন ধরনের মাদকদ্রব্য ব্যবহার করতেন? (যতগুলো প্রযোজ্য চিহ্নিত করুন)**	মদ	১
		ফেনসিডিল	২
		গাঁজা	৩

	আপনি কোন ধরনের মাদকদ্রব্য ব্যবহার করতেন? (যতগুলো প্রযোজ্য চিহ্নিত করুন)	ইয়াবা	৪
		হেরোইন	৫
		প্রেসক্রিপশন ড্রাগ (যেমন: অ্যালপ্রাজোলাম, ব্যথানাশক)	৬
		ভামাক	৭
		অন্যান্য (উল্লেখ করুন): _____	৮
২১	আপনি কীভাবে মাদকদ্রব্য গ্রহণ করতেন?	মুখে (ট্যাবলেট/ক্যাপসুল)	১
		শিরার মাধ্যমে	২
		নিশ্বাসের মাধ্যমে	৩
		একাধিকভাবে	৪
২২	আপনি কীভাবে মাদকদ্রব্য সংগ্রহ অথবা ক্রয় করতেন?	সরাসরি	১
		বন্ধুদের মাধ্যমে	২
		ডিলার/এজেন্ট থেকে	৩
		ডেলিভারি সার্ভিস	৪
		অন্যান্য (উল্লেখ করুন):_____	৫
২৩	আপনি কাদের সাথে মাদকদ্রব্য গ্রহণ করতেন?	একা	১
		বন্ধু	২
		অন্যান্য মাদক ব্যবহারকারীদের সাথে	৩
		অন্যান্য (উল্লেখ করুন): _____	৪
২৪	**মাদকদ্রব্য ব্যবহার এড়িয়ে চলা বা ছাড়ার ক্ষেত্রে আপনাকে কি কেউ সাহায্য করেছিলেন?**	পরিবার	১
		বন্ধু	২
		শিক্ষক	৩
		স্বাস্থ্যকর্মী	৪
২৫	**মাদকদ্রব্য সমস্যা নিয়ে আপনার পরিবার, বন্ধু এবং সমাজ কতটা সহায়ক ছিল?**	খুব সহায়ক	১
		সহায়ক	২
		নিরপেক্ষ	৩
		সহায়ক নয়	৪
		একেবারেই সহায়ক নয়	৫
২৬	**আপনি কি কখনো মাদকাসক্তি সংক্রান্ত কোনো কাউন্সেলিং বা থেরাপি সেশনে অংশগ্রহণ করেছেন?(যদি ২৬ নং প্রশ্নের উত্তর ২ হয়, তাহলে ২৭ নং প্রশ্ন প্রযোজ্য নয়)**	হ্যাঁ	১
		না	২
২৭	যদি হ্যাঁ হয়, তাহলে কত ঘনঘন কাউন্সেলিং বা থেরাপি সেশনে যেতেন?	সপ্তাহে একবার	১
		দুই সপ্তাহে একবার	২
		মাসে একবার	৩
		মাঝে মাঝে	৪
		প্রযোজ্য নয়	৫
২৮	আপনি কি মনে করেন, মাদকাসক্তি আপনার সামগ্রিক স্বাস্থ্যের উপর প্রভাব ফেলেছে?	হ্যাঁ	১
		না	২
২৯	আপনি কি সম্পূর্ণভাবে মাদকাসক্তি থেকে মুক্ত হতে চান?	হ্যাঁ	১
		না	২

Multidimensional Scale of Perceived Social Support (MSPSS)-Bangla Version

উক্তি সমূহ	সম্পূর্ণভাবে দ্বিমত (১)	মোটামুটিভাবে দ্বিমত (২)	কিছুটা দ্বিমত (৩)	নিরপেক্ষ (৪)	কিছুটা একমত(৫)	মোটামুটিভাবে একমত (৬)	সম্পূর্ণভাবে একমত (৭)
১। আমার এমন বিশেষ একজন আছে যাকে আমি প্রয়োজনে কাছে পাই।	১	২	৩	৪	৫	৬	৭
২। আমার দুঃখ ও আনন্দগুলো ভাগাভাগি করার জন্য বিশেষ একজন আছে।	১	২	৩	৪	৫	৬	৭
৩। আমার পরিবার আমাকে প্রকৃত পক্ষেই সাহায্য করার চেষ্টা করে।	১	২	৩	৪	৫	৬	৭
৪। আমি আমার পরিবারের কাছ থেকে মানসিক সাহায্য ও সমর্থন পাই।	১	২	৩	৪	৫	৬	৭
৫। আমার জীবনে এমন বিশেষ একজন আছে যে আমার প্রশান্তির/স্বস্তির প্রকৃত উৎস।	১	২	৩	৪	৫	৬	৭
৬। আমার বন্ধুরা আমাকে আসলেই সাহায্য করার চেষ্টা করে।	১	২	৩	৪	৫	৬	৭
৭। বিপদের সময় আমি আমার বন্ধুদের উপর ভরসা করতে পারি।	১	২	৩	৪	৫	৬	৭
৮। আমার সমস্যাগুলো নিয়ে আমার পরিবারের সাথে কথা বলতে পারি।	১	২	৩	৪	৫	৬	৭
৯। আমার দুঃখ ও আনন্দগুলো ভাগ করে নেয়ার মতো বন্ধু আছে।	১	২	৩	৪	৫	৬	৭
১০। আমার জীবনে এমন একজন আছে যে আমার অনুভূতিগুলোকে গুরুত্ব দেয়।	১	২	৩	৪	৫	৬	৭
১১। আমার পরিবার আমাকে সিদ্ধান্ত গ্রহনে সহায়তা করে।	১	২	৩	৪	৫	৬	৭
১২। আমার সমস্যাগুলো সম্পর্কে আমি বন্ধুদের সাথে আলোচনা করতে পারি।	১	২	৩	৪	৫	৬	৭

Substance Use Stigma Mechanism Scale (SU-SMS)-Bangla Version.

প্রচলিত কুসংস্কার	কখনোই নয় (১)	খুব কম (২)	মাঝেমধ্যে (৩)	প্রায়ই (৪)	প্রায় সবসময়(৫)
১) পরিবারের সদস্যরা ভেবেছিল যে আমাকে আর বিশ্বাস করা যাবে না।	১	২	৩	৪	৫
২) পরিবারের সদস্যরা আমাকে উপেক্ষা করে।	১	২	৩	৪	৫
৩) পরিবারের সদস্যরা আমার সাথে অন্যরকম আচরণ করেছে।	১	২	৩	৪	৫
৪) স্বাস্থ্যসেবা কর্মীরা আমার সমস্যা বা চিন্তার কথা শোনেন নি।	১	২	৩	৪	৫
৫) ডাক্তার/নার্সরা ভেবেছে আমি নেশার ট্যাবলেট চাইছি, বা তাদের ঠকিয়ে প্রেসক্রিপশনের ওষুধ নিতে চাই, যাতে সেটা খেয়ে নেশা করতে পারি বা বিক্রি করতে পারি।	১	২	৩	৪	৫
৬) স্বাস্থ্যসেবার কর্মীরা আমাকে ঠিক মতো সেবা/যত্ন নেয় নি।	১	২	৩	৪	৫

পূর্ব ধারণাগত কুসংস্কার	একেবারেই সম্ভাবনা নেই (১)	কম সম্ভাবনা আছে (২)	নিরপেক্ষ (৩)	সম্ভাবনা আছে (৪)	খুব বেশি সম্ভাবনা আছে (৫)
১) পরিবারের সদস্যরা ভাববে আমি আর বিশ্বাসযোগ্য নই।	১	২	৩	৪	৫
২) পরিবারের সদস্যরা আমাকে অবজ্ঞার চোখে দেখবে।	১	২	৩	৪	৫
৩) পরিবারের সদস্যরা আমার সাথে ভিন্ন/ খারাপ আচরণ করবে।	১	২	৩	৪	৫
৪) স্বাস্থ্যসেবার কর্মীরা আমার সমস্যা বা চিন্তার কথা শুনবে না।	১	২	৩	৪	৫
৫) ডাক্তার/নার্সরা ভাববে যে আমি নেশার ট্যাবলেট চাইছি, বা তাদের ঠকিয়ে প্রেসক্রিপশনের ওষুধ নিতে চাই, যাতে সেটা খেয়ে নেশা করতে পারি বা বিক্রি করতে পারি।	১	২	৩	৪	৫
৬) স্বাস্থ্যকর্মীরা আমাকে বাজে সেবা দেবে।	১	২	৩	৪	৫

অভ্যন্তরীণ কুসংস্কার	একদম অসম্মত (১)	অসম্মত (২)	নিরপেক্ষ (৩)	সম্মত (৪)	একদম সম্মত (৫)
১) মদ্যপান অথবা মাদকদ্রব্য ব্যবহার করার ফলে আমার মনে হয় আমি একজন খারাপ মানুষ।	১	২	৩	৪	৫
২) আমার মনে হয় আমি অন্যদের মতো ভালো নই, কারন আমি মদ্যপান অথবা মাদকদ্রব্য সেবন করতাম।	১	২	৩	৪	৫
৩) আমি মদ্যপান বা মাদকদ্রব্য সেবনের জন্য লজ্জিত।	১	২	৩	৪	৫
৪) আমি নিজেকে নিয়ে কম ভাবি কারন আমি মদ্যপান অথবা মাদকদ্রব্য সেবন করতাম।	১	২	৩	৪	৫
৫) মদ্যপান এবং/অথবা মাদক ব্যবহার করলে আমার নিজেকে অপরিষ্কার মনে হয়।	১	২	৩	৪	৫
৬) আমার কাছে মদ্যপান এবং/অথবা মাদকদ্রব্য সেবন ঘৃণার বিষয়।	১	২	৩	৪	৫

Appendix G: Author Permission Letter

Request for Permission to Use the Bengali Version of the MSPSS Scale

1 message

MUHAMMAD ASHRAF <muhammadaalam11110@gmail.com> Tue, Jul 22, 2025 at 11:56 PM
To: mnipsy@cu.ac.bd

Dear **Md. Nurul Islam** Sir,

Assalamu Alaikum.

I hope this message finds you well. My name is Md. Ashraful Alam, and I am currently a 4th-year student in the Bachelor of Science in Occupational Therapy program at Bangladesh Health Professions Institute (BHPI), which is the academic institute of the Centre for the Rehabilitation of the Paralysed (CRP) in Savar.

I am conducting a research project as part of my academic requirements, focusing on the "Level of Social Support System for Individuals with Substance Abuse". I am serving as the principal investigator for this study, with Md. Habibur Rahman, Assistant Professor and Course Coordinator, MSc. in OT, Department of Occupational Therapy, BHPI, serving as my thesis supervisor.

I recently came across your published research, where you used the Bengali version of the MSPSS scale in your study with patients in the Bangladeshi context. I would be truly grateful if you could kindly grant me permission to use the same validated Bengali version of the MSPSS scale that was employed in your research.

Your work in this field has been highly inspiring to students like me, and I believe that using a tool developed and validated by you would greatly enhance the quality and relevance of my research. If you kindly approve, I would be very appreciative if you could share the Bengali version of the scale with me. Please rest assured that the scale will be used strictly for academic and research purposes only, with proper confidentiality maintained at all times.

Thank you very much for your time and consideration. I eagerly look forward to your positive response.

Sincerely,

Md. Ashraful Alam
B.Sc. in Occupational Therapy (4th Year)
Bangladesh Health Professions Institute (BHPI)
Centre for the Rehabilitation of the Paralysed (CRP), Savar, Dhaka
Email: muhammadaalam11110@gmail.com
Phone: 01974611789

Appendix H : Supervisor Contact Schedule

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 Social Support System for Individuals with Substance Abuse: A Cross-Sectional Study

Name of student: Md Ashraful Alam

Name and designation of thesis supervisor: Md. Habibur Rahman, Assistant Professor & Course Coordinator, 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	Ashraf	
2	27.05.25	BHPI Office Building	Proposal Presentation Guideline	1 hour	Got a clear concept	Ashraf	
3	01.06.25	BHPI Office Building	Proposal Presentation Feedback	1 hour	Got a clear concept	Ashraf	

4	04.06.25	BHPI Building	Discussion about sample size, data collection method	1 hour	Effective discussion	Ashraf	
5	07.06.25	BHPI Building	Discussion about socio-demographic questionnaire	2 hours	Effective discussion	Ashraf	
6	09.06.25	BHPI Building	Feedback on socio-demographic questionnaire	2 hours	Effective discussion	Ashraf	
7	11.06.25	Reddaway Hall	Feedback on Bangla translation of the questionnaire	1 hour	Effective discussion	Ashraf	
8	14.06.25	BHPI Building	Guideline on literature review	1 hour	Got a clear idea	Ashraf	
9	21.06.25	BHPI Office Building	Feedback on literature review	2 hours	Got a clear idea	Ashraf	
10	06.08.25	BHPI Office Building	Guideline on data collection	2 hours	Got a clear idea	Ashraf	
11	19.08.25	BHPI Office Building	Discussion about data collection status	2 hours	Effective discussion	Ashraf	
12	30.08.25	BHPI Classroom	Discussion about data entry and data analysis	3 hours	Got a clear idea	Ashraf	
13	01.09.25	BHPI Classroom	Variables set and data entry guideline	3 hours	Got a clear idea	Ashraf	
14	10.11.25	BHPI Classroom	Data entry on SPSS	3 hours	Got a clear idea	Ashraf	
15	11.11.25	BHPI Classroom	Descriptive analysis	4 hours	Got a clear concept	Ashraf	

16	12.11.25	BHPI Classroom	Feedback on descriptive analysis and result writing	4 hours	Got a clear concept	Ashraf	
17	13.11.25	BHPI Classroom	Discussion on inferential statistics	4 hours	Effective discussion	Ashraf	
18	16.11.25	BHPI Classroom	Discussion and feedback on overall result writing	3 hours	Got a clear concept	Ashraf	
19	23.11.25	BHPI Building	Feedback on 1st draft	3 hours	Got a clear concept	Ashraf	
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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.