MENTAL HEALTH, SOCIAL SUPPORT AND FAMILY MEMBERS OF DRUG USERS IN AIZAWL, MIZORAM

A dissertation submitted in partialfulfilment of the requirements for the Degree of Master of Philosophy

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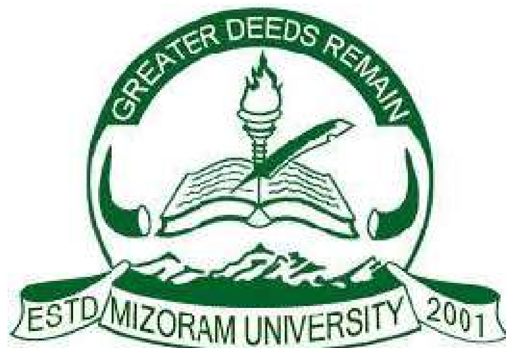

Department of Social Work
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MENTAL HEALTH, SOCIAL SUPPORT AND FAMILY MEMBERS OF DRUG USERS IN AIZAWL, MIZORAM

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CERTIFICATE

This is to certify that the dissertation, **“Mental Health, Social Support and Family Members of Drug Users in Aizawl, Mizoram”**, submitted by Diana Lalrinsiami Chhakchhuak for the award of Master of Philosophy in Social Work is carried out under my guidance and incorporates the student’s bonafide research and this has not been submitted for award of any degree in this or any other university or institute of learning.

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DECLARATION

I, Diana Lalrinsiami Chhakchhuak, hereby declare that the subject matter of this dissertation is the record of work done by me, that the contents of this dissertation did not form basis of the award of any previous degree to me or to do the best of my knowledge to anybody else, and that the dissertation has not been submitted by me for any research degree in any other University/ Institute.

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LIST OF ABBREVATIONS

AAY	: Antyodya Anna Yojana
AFMs	: Affected Family Members
AOD	: Alcohol and Other Drugs
APL	: Above Poverty Line
BPL	: Below Poverty Line
CBOs	: Community Based Organisations
CKTP	: Central Kristian Thalai Pawl
CYMA	: Central Young Mizo Association
DSM -V	: Diagnostic and Statistical Manual of Mental Disorders-5th Edition
FAE	: Fatal Alcohol Effect
FAS	: Fatal Alcohol Syndrome
FBOs	: Faith Based Organisations
FDE	: Fatal Drug Effect
FDS	: Fatal Drug Syndrome
FSW	: Female Sex Worker
GOM	: Government of Mizoram
HIV	: Human Immunodeficiency Virus
ICD	: International Classification of Disease
IDUs	: Injecting Drug Users
KII	: Key Informant Interview
LIFCODE	: Light for Comprehensive Development
MSACS	: Mizoram State AIDS Control Society

MSD&RB	: Mizoram Social Defence & Rehabilitation Board
NACO	: National Aids Control Organization
NDDTC	: National Drug Dependence Treatment Centre
NGOs	: Non-Government Organisations
OST	: Oral Substitution Therapy
PWID	: Persons Who Inject Drugs
SUDs	: Substance Use Disorders
UNODC	: United Nations Office on Drugs & Crime
WDR	: World Drug Report
WEMWBS	: Warwick Edinburgh Mental Well-Being Scale
WHO	: World Health Organization
YMA	: Young Mizo Association

CHAPTER I

INTRODUCTION

The study seeks to understand the mental health status and social support of families affected by drug abuse in Aizawl, Mizoram. It will also delve into the understanding the relationship between mental health and social support. It will also highlight suggestions to promote mental health and social support of families affected by drug abuse that will have relevance in social work practice and policymaking.

Various intoxicating drugs have been used for religious purposes, to boost creativity, and for recreational purposes for ages. The Chinese have been utilising cannabis for medical purposes for thousands of years, while South Americans have been chewing coca leaves for energy for centuries. Peyote is still used by Native Americans for a variety of rituals. The idea of judging substance abuse is a fairly recent societal concept. Alcohol consumption and intoxication were accepted in the United States until the late 1800s, while cocaine and opiates were also commonly used, mostly by the higher classes (Nelson, 2012;National Association of Social Workers, 2008). Before the 1960s, the majority of addicts were from the higher classes: physicians, dentists, and pharmacists, who had easy access to narcotics (Nelson, 2012). It was not until almost 1900 that first alcohol use and, later, other drug use began to be seen as a social problem. As a result, many acts were enacted criminalising various intoxicants, and social attitudes shifted to the point that drug and alcohol misuse was now considered a personal flaw.

Perhaps the most striking feature that distinguishes man from other animals, as Osler (1891) correctly pointed out, is his need to take medicine. Man has taken pleasure in taking chemicals that impact one's mental state since the dawn of time. Among the social and medical ills of the twentieth century, substance abuse ranks as one of the most devastating and costly. The drug problem today is a major global concern including India. It has become widespread and extensive. From what can be seen, heard, and read, from what can be heard from various means of mass media, it is apparent that drug abuse is a complex and multifaceted problem.

Addiction among teenagers has been on the rise across the world (United Nations Office on Drugs & Crime [UNODC], 2007). Substance addiction has evolved into a severe problem in Malaysia, wreaking havoc on people, families, and communities. Several parties, including government and non-governmental groups, have expressed interest in it. In 1993, the drug was identified as the nation's number one enemy since the incidents of drug abuse became a serious internal problem.

The National Drug Dependence Treatment Centre (NDDTC) at AIIMS reported that each year, more than 32,000 substance abuse patients appear for treatment and an additional 21,000 receive community care. As per the World Drug Report (WDR) 2010, illegal internet pharmacies have begun selling drugs online, transforming India into a hub for such activities.

Cannabis was the most commonly used illegal substance in the 2002–2003 National Survey of Drug Use in the General Population, with nearly one in five adults (18.5 percent) reporting using an illegal drug at least once in their lives, with this number rising to nearly one in four (26 percent) among young adults aged 15 to 34.

According to the World Health Organization (WHO), more than 15 million people have been classified as drug users, with injectable drug use occurring in 136 countries.(International Research Collaboration on Drug Abuse and Addiction Research, 2011).

According to estimates from 2004, India had roughly 1.4 million opiate addicts. According to the National Aids Control Organization (NACO), India has 50,000 injectable drug users, the bulk of whom live in Manipur, Nagaland, Mizoram, and Meghalaya.

According to a recent survey pointed out by Ahuja (2014), there are at least 7.5 crore drug addicts in India. There are claims that drug abuse has become dominantly prevalent in youngsters between the ages of 16 to 25. Opioids originating in Southwest Asia and East Asia are now being consumed by over 18% of India's population aged 15 to 64. (Sardar 2016).

According to Ghosal (2003), the outbreak of heroin dependency in the North Eastern States possibly started early in 1984 from Manipur.

Tochhawng (1995) identified several factors such as rapid and social change, degradation of morals in society, the lessening of the social control system, prevalence of corruption, influence of mass media and western lifestyles, the inherent influence of the drug in the music industry, cultural practices such as smoking and drinking rice beer as the main causes of substance abuse in Mizoram (in GOM, 2015).

Before the 80s, there were only rare instances of cannabis consumption in Mizoram. The abuse of various types of drugs increased in recent years, with the injection of drugs gaining prevalence from 1988. However, there were no official records of drug abuse before the 90s. Estimates by the government placed around 2500 drug users in the state in 1992. According to a survey conducted by the Central KristianThalai Pawl (CKTP) in 1999 which covers 111 areas or branches identified 15,188 youths with drug abuse problems, out of which 841 were females (GOM 2007). After 20 years, this number is expected to increase despite the efforts of the government and other NGOs such as KTP, YMA, etc.

According to Sailo (2003), the first recorded incidence of death in Mizoram due to substance abuse was in the 1980s when a young man aged 24 overdosed on heroin. The prevalence of heroin grew after this incidence among the middle and upper economic society. The administration of drugs through injection also gained popularity at the same time, both in rural and urban areas. Following this, the number of deaths due to drug overdose grew exponentially each year.

In Mizoram, there were 12550 injecting drug users and 6739 HIV cases. In Aizawl, there were 6000 injectable drug users and 883 HIV-positive people. 28.1 percent of HIV-positive people used injecting drugs (MSACS, 2012). In the Aizawl district, there were 4218 injecting drug users (MSACS, 2017)

Tarapot (1997) stated in the preliminary survey conducted by the Mizoram Excise and Narcotics Department, that only major cities/towns of the state - Aizawl, Lunglei, and Champhai had cases of drug abuse at the onset. Those who administer drugs through intravenous injection were estimated to be only three hundred. But from 1993 to 1995, the number increased by several folds.

Lallianzuala (2007) stated that even before the prevalence of smuggled heroin, cannabis was consumed by the Mizo people. Soon after the heroin takeover in the mid-1980s, other narcotic and psychotropic substances began gaining popularity. Injection of drugs such as dextro-propoxyphene (also known as Spasmo-Proxyvon), which was not supposed to be injected, was the choice for drug users in the late '80s. This has resulted in a spike in the number of HIV cases in the state along with overdoses and abscesses caused by the drug (In GOM, 2015).

According to the Indian Council of Medical Research (ICMR), drug use is more likely to rise than decrease. If proper measures are not done to combat the evil, there are alarming signals that the situation will deteriorate and spiral out of control. This is proved by the study of Addityarjee and Mohan.D, et al. (1984).

The Juvenile Justice Board of Aizawl, Mizoram reported that from April 2015 to February 2018, in most cases of theft and/or violence where the perpetrators were minors, they were found to be under the influence of alcohol or other substance.

SHALOM (2013-2018) mentioned that most youths of Aizawl did not think to abstain from alcohol, tobacco products, cannabis, cough syrup, etc. as they do not know that these are gateway drugs, often leading them to a more serious form of substance abuse.

The responses of communities in general, the church, and Mizo families show the severity of the substance misuse problem. However, prior to 15 years ago, documentation on the health and societal effects of drug use was difficult to come by (Bajpal, 2002; Mishra, 2000). Although there have been observations and hypotheses on the origins, effects, and implications of substance misuse among the Mizos (Halliday, 2009; Lalchhuana, 2013; Panda, 2006; Sailo, 2003; Tochhawng, 1995, and others), they are insufficient to provide light on substance use patterns. There is also a scarcity of literature on the effects of substance abusers on their families. It is still widely held, and incorrectly held, that only the addicted family member requires assistance. Other family members' needs and problems have received little attention. Barnard (Barnard, 2007).

Sartorius, et. al., (2015) wrote about the different mental disorders and their characteristics, how it causes burden to the family members and the coping strategies which can either increase or decrease the burden along with what and what not to say to the family members of the patients with such conditions.

Mental and emotional well-being is essential to shaping a state of health for Coloradans. People with good mental health can reach their full potential, deal effectively with life's challenges, work efficiently, and contribute meaningfully to their communities. Supporting improved mental health, reductions in substance abuse, and better behavioural health through health system integration are initiatives within the Colorado Governor's 2013 State of Health Report.

The value of family support is being widely recognised, which has a significant impact on the outcomes of children in a family. The experiences and quality time shared within a family can have an impact on the child's educational achievement, their employment, psychological and emotional adjustment, their physical and mental health, along with their status in the community and society as a whole. (Sheldon and Macdonald, 2009)

Barnard (2007) examined the effects of drug use not only on drug users themselves but also the feelings of anger, sadness, anxiety, shame, and loss that are commonly experienced by their extended family. She keeps track of how drug usage affects family dynamics and relationships, as well as the social and emotional consequences. Its influence on family members' physical and emotional wellbeing is also highlighted. The author analyses the viewpoints of practitioners such as teachers, social workers, and health experts in highlighting the frequently ignored role of grandparents in protecting the children of drug users. The conclusion reached is that present service provision, by treating problem drug users in isolation, fails to meet the needs of drug-affected families, and so loses the potential to establish family-oriented support and treatment.

Ranganathan (2002) remarked that addiction in every sense of the term is a 'family disease'. It must be reiterated among health care professionals that treatment for addiction should not be detached and include the family as a whole. The patient's relationship with his family/wife/husband is one of the most crucial components of

treatment. The concept of addiction as an incurable but treatable illness affecting the body, mind, and spirit was developed by Andres and Novick& Associates (1995).

Madan (1969) wrote that alcoholism and drug abuse are not only detrimental to the individual but also their families and society as a whole. There is an old saying, "once a drunkard, always a drunkard". No alcoholic suddenly became an alcoholic overnight. They begin by drinking moderately and slowly increase the amount to eventually become addicts or alcoholics.

Gabhainn and Walsh (2000) concluded that although drug prevention has broadened its horizons having "matured away from a singular focus on the individual," this area still requires a lot of work and suggested that programs working within the framework of family support should have a stronger, more specified and resourceful role to play in drug prevention.

Alexander et.al. (2000) also pointed out the existence of evidence that family-based interventions with older, at-risk youths can result in a better outcome than other forms of intervention.

The literature on family effects suggests that the "family process" can be much more important than "family structure" in developing deviant behaviors in general and also concerning drug use (ACMD, 1998, Wells & Rankin, 1991).

Wolin (1980) defined families as transactional systems in which the collective functioning of each part affects the greater whole. If one member of the family is an addict, the focus is shifted to that member and brings the family system into disorder, affecting all family members.

Kapur (1985) states that the family of a drug user and close relatives feel the most immediate effect of deterioration in relations due to their abuse. Drug users often have attitudes such as wanting to be free from authority or any form of perceived control, reducing contact with parents, strive for independence, and attempts to escape from daily responsibilities such as earning a livelihood. Drug addiction makes it difficult to maintain a healthy relationship with family, friends, and society. As such, the use and abuse of drugs prevent the mind from a healthy and natural development among all affected members.

Greene, et.al, (2012), conducted a study on 'Mental health and social support among HIV positive injection drug users and their caregivers in China'. The goal of this study was to look at the links between caregiver environment and HIV-positive injectable drug users' mental health. They used quantitative techniques to interview 100 patients and carers, with the majority of patients (60.4 percent) being male and the majority of caregivers being female (63.5 percent). A framework was created using a conceptual model. The result showed that aspects of the caregiver context were associated with the functioning and wellbeing of both HIV patients and caregivers in China. The incidence of anxiety and depression among carers was higher than the prevalence of depression among drug users in this sample.

Drug use disorders are a severe health concern, according to the United Nations Office of Drugs and Crime (2017), with a considerable impact for those afflicted and their family. Lost productivity, security difficulties, criminality, increased health-care expenses, and a slew of other negative societal effects are all substantial costs to society. In certain nations, the societal cost of illicit drug usage is estimated to be as high as 1.7 percent of GDP. (World Drug Report, 2016)

Maram (2007) wrote that recovery from addiction is one of the urgent needs of our society since the issue of dependence is volatile and causes tremendous harm to all that are exposed to it. This addiction can no longer be viewed as the user's sole problem because it also affects others within the circle of the user. Hence, it becomes an issueinvolving the family, community, and church.

In a research conducted by a small team of UK researchers led by Copello and Orford(2002), family members of drug users experienced severe and enduring stress, which can often lead to high levels of physical and psychological morbidity.

Research Community interventions were characterised as a set of activities coordinated in a certain region or area, with a focus on young people, parents, and organisations. Cuijpers (2009) identified examples of universal prevention in community settings such as mass media initiatives, community interventions, workplace prevention, community-based mobilization committees, and educational activities in bars and discos.

In a review of family support interventions in the Irish context, McKeown (2000) concluded that family therapy approaches are promising provided that the intervention is tailored to the family definition of need and restores the family's ability to solvetheir problems.

The significance and purpose of a comprehensive drug prevention program for the community are that it will enhance one's value system, give the family unity, perspective and understanding and increase awareness and concern for the issue of substance addiction in communities (Toaha, 1986).

International research suggests that interventions targeted at family support rather than specific drug intervention have greater potential and have resulted in positive social behavior, including decreased substance misuse (Zigler et al, 1992).

Thanga&Thanga (2000) wrote a book on the 'Prevention and Rehabilitation Process among the Addicts' focusing on the means and processes that can help the addict to abstain from drugs. It focuses mainly on the spiritual means i.e. through a reformation for the drug addict to abstain away from drugs and gives assurance and encouragement that they can surely overcome the struggle and not to lose hope as they will have to face hardships for the struggle is real.

The National Drug Strategy 2001-2008 (2001) strives to "significantly reduce the harm caused to individuals and society by the misuse of drugs" (p8) through the four pillars of supply reduction, prevention, treatment, and research.

1.1 Definitions and Concepts

1.1.1 Mental Health

"According to World Health Organization (1957), "mental health is defined as a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can make a contribution to his or her community".The WHO stresses that mental health "is not just the absence of mental disorder."

The term "mental health" refers to our mental, behavioural, and emotional well-being.' It's not only about the lack of mental illnesses or impairments; it's about how we think, feel, and act. Mental illness can have a negative impact on daily

living, relationships, and even physical health. It also includes a person's ability to enjoy life - to attain a balance between life activities and efforts to achieve psychological resilience. It is determined by a range of socio-economic, biological, and environmental factors".

1.1.2 Social Support

Social support, according to Demareyet al. (2005), is "an individual's impression that he or she is liked and appreciated by individuals in his or her social network." Meadows (2007) defines social support as "beliefs and/or perceptions that suggest an individual is a member of an interpersonal relationship including parents and peers." Davison et al., (2000) believed that social support talks about the person's needs for support with close others and provides it when others experience distress which might provide a person with a forum to share and deal with a wide range of issues.

1.1.3 Drug

Drugs were termed 'pharmakon' by the ancient Greeks, a word that meant both poison and medicine. According to UNODC (2000), drug refers to "substances subject to international control". It refers to any chemical that has the potential to heal disease or improve physical or emotional well-being in medicine. Any chemical agent that changes the biochemical or physiological processes of tissues or organisms is referred to as pharmacology. In popular use, the term "drug" refers to psychoactive substances, and more particularly, illegal drugs."

1.1.4 Drug use/Drug Abuse

In the context of international drug control (2000), drug abuse/drug use refers to the use of any substance under international control for purposes other than medical and scientific, including use without a prescription, in excessive dose levels, or over an unjustified period.

1.1.5 Drug abuse-related harm

According to UNODC (2000), this term refers to "any adverse social, physical, psychological, legal or other consequence of drug use which is experienced as harmful to a drug user and/or those living with or otherwise affected by a drug user's actions."

1.1.6 Addiction

WHO (1994) defined addiction- drug or alcohol as, "repeated use of a psychoactive substance or substances to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits a determination to obtain psychoactive substances by almost any means".

From the above definition, we can know that 'addiction' is a term of long-standing and variable usage. The addict's life may be dominated by drug abuse, causing him or her to neglect all other activities and obligations, which may have a negative impact on family members as well as the society in which the addict lives..

1.1.7 Drug Addiction

According to WHO (1957), "drug addiction is a state of periodic or chronic intoxication produced by the repeated consumption of a drug (natural or synthetic)".

"It's characteristics include:

1. An overpowering desire or need (compulsion) to continue taking the drug and to obtain it by means;
2. A tendency to increase the dose;
3. A psychic (psychological) and sometimes a physical dependence on the effects of the drug"
4. An effect detrimental to society and individual". (WHO,1957).

WHO (2003) defined drug addiction as "A psychic (psychological) and sometimes a physical dependence on the effects of the drugs".

Addiction is a chronic, typically relapsing brain illness that involves compulsive drug intake and usage, with negative effects not just for the addict but also for others around them. Drug addiction is classified as a brain disease because it alters the structure and function of the brain. Although most people take drugs voluntarily, repeated use affects the person's decision making ability and self-control while at the same time, creates an intense craving for the drug. These physical, as well as psychological changes, are the main hurdles drug addicts face in quitting their addiction. (Jha 2009:152)

1.1.8 Family Member

Family members refer to any member, child, or adult who lives together in a household in either a nuclear or joint-related through blood or affinity or kinship or adoption.

1.2 Effects of Substance Abuse

Diagnostic criteria for Substance Use Disorder according to DSM-V (2013) is based on a pathological pattern of behaviours related to use of the substance which is divided into four groups, with a total of eleven criteria. The four criteria are criterion A, B, C, and D. Criterion A consist of Criteria 1-4 of impaired control, Criterion B comprises of criteria 5-7 of social impairment, Criterion C (criteria 8-9) consist of risky use and Criterion D (criteria 10-11) consist of pharmacological criteria. Substance use disorder can range in intensity from light to severe, with mild involving two or three criteria, moderate involving four to five, and severe involving six or more. The following are the criteria:

1. The person may consume more of the substance or for a longer period of time than was planned.
2. The individual may indicate a persistent desire to reduce or restrict substance use, as well as multiple unsuccessful attempts to do so.
3. The person may spend a significant amount of time getting the material, using it, or recovering from its effects.
4. Craving
5. Recurrent substance abuse can lead to failure to meet important role responsibilities at work, school, or at home.

6. The user may continue to use the substance despite persistent or recurrent social or interpersonal difficulties caused or aggravated by the substance's effects.
7. Substance abuse may cause important social, occupational, or recreational activities to be discontinued or diminished.
8. This might take the shape of recurring drug usage in physically dangerous situations.
9. The individual may continue to use the substance despite having a chronic or recurring physical or psychological ailment that is likely to have been caused or exacerbated by it.
10. Tolerance
11. Withdrawal

According to WHO (1993), psychoactive substance disorder is defined as a mental and behavioural disorder due to psychoactive substance use and are classified as under:

1. Mental and behavioral disorders due to use of alcohol.
2. Mental and behavioral disorders due to use of opioids.
3. Mental and behavioral disorders due to use of cannabis.
4. Mental and behavioral disorders due to use of sedatives or hypnotics.
5. Mental and behavioral disorders due to use of cocaine.
6. Mental and behavioral disorders due to use of other stimulants, including caffeine.
7. Mental and behavioral disorders due to use of hallucinogens.
8. Mental and behavioral disorders due to use of tobacco.
9. Mental and behavioral disorders due to use of volatile solvents.
10. Mental and behavioral disorders due to multiple drug use and use of other psychoactive substances.

The following is the ICD-10 coding and classification for Mental, Behavioral, and neurodevelopmental disorders caused by drug abuse, as found in Chapter -5:

Mental and Behavioral Disorders due to...	Code
...use of alcohol	F10
...use of opioids	F11
...use of cannabis	F12
...use of sedatives, hypnotics, anxiolytics	F13
...use of cocaine	F14
...use of other stimulants, including caffeine	F15
...use of hallucinogens	F16
...use of nicotine	F17
...use of inhalants	F18
…use of other psychoactive substances and multiple drug use	F19

The devastating effect and consequences of substance abuse effect not only the users but also the family members and the community as well. Although a number of awareness and prevention programs have been carried out, only half of the picture is painted to fully tackle the harmful consequences that substance abuse can cause on the individual, family, and society. Therefore, it is necessary to take into account the effects that substance abuse can cause so that there may be a greater emphasis on why awareness for the prevention of addiction need to be spread on a larger scale.

1.3 Statement of the Problem

Drug abuse is one of the most burning problems in society as drug is a multifaceted and multidimensional problem. Meanwhile, the mental health of the affected family members is also shaken socially. Mental health is essential for overall health and well-being and should be recognized in all young and elderly people including the drug users as well as their family members with the prime importance of physical health.

Making a diagnosis is the first step toward improving one's mental health. Unfortunately, mental health issues are often misdiagnosed and neglected, leaving many victims to struggle alone.

Palen (1979) says drug use is considered a social issue as it precludes people from living responsibly and from exhibiting self-control. Despite the fact that the Mizos have been extensively influenced by industrialization and westernisation, the general public has negative attitudes and perceptions about injecting drug usage, which leads to stigmatisation and discrimination of those who use it including their family members. These families often cope alone with the problem of their child's addiction in secret for several years, causing more strain and distress to the family. The family faces emotional turmoil due to embarrassment, guilt, anger, and frustration. The family may ultimately choose to isolate themselves from external contacts to avoid further pain and embarrassment. Although there are few social support systems such as rehabilitation centers, homes, drop-in-centers, etc., yet, they are not sufficient enough to meet the needs of the drug user and their family members.

Also, the perception and attitude of the society towards the affected family members and the user themselves plays an important role in the treatment process of drug users.

1.4Objectives

1. To higlight the socio-demographic profile of family members of drug users in Aizawl, Mizoram
2. To explore the mental health status of family members of drug users in Aizawl, Mizoram
3. To find out the social support system of family members of drug users in Aizawl, Mizoram
4. To find out the relationship between mental health and social support of family members of drug users in Aizawl, Mizoram.
5. To suggest measures for social work interventions and policy to improve mental health and social support for family members of drug used s in Aizawl, Mizoram

1.5 Chapter Scheme

Chapter 1 – Introduction

Chapter 2 – Review of Literature

Chapter 3 – Methodology

Chapter 4 – Results and Discussion

Chapter 5 – Conclusion

CHAPTER II

REVIEW OF LITERATURE

This chapter shall highlight the various literatures that is reflective of the objectives of the study. It shall highlight various studies at the international, national and regional level and identify gaps that need urgent attention in the area mental health and social support among families of drug users.

Palen (1979) says drug use is considered a social issue as it precludes people from living responsibly and from exhibiting self-control. Those drugs which are thought to cause the greatest physiological and psychological harm and dependence are regarded most negatively.

Hanjabam et al (2013) concluded from various researches that substance abuse can lead to mental illness and that most mental health institute patients have a history of some sort of drug abuse. Patients with substance abuse disorders are at greater risk of developing other mental disorders. Further, among those youths who seek help for other psychiatric disorders, there is a higher prevalence of a history of substance abuse. Abuse of substances often leads to issues in social functioning like failure to fulfill obligations at home, work, or school.

Drug users encounter physical, social, familial, and psychological issues. For the past three decades, Mizoram's Christian civil society organisations have been responding to this huge challenge with moral and financial support from the Church and the government. These faith-based organisations have been offering in-house therapy to drug users who want to cease using. Their interventions are both religious and secular. These approaches are beneficial to persons who wish to abstain from using drugs. However, the respondents who are inmates of FBO-run treatment centres in the Aizawl district had low levels of recovery capital in all aspects. There was no discernible difference between the levels of faith-based and secular interventions by FBOs. (C. Vanlalhriati, 2019)

The United Nations Office on Drugs and Crime in its Rapid Assessment Survey of Drug Abuse in India (2004) reported that between 40% to 78% of drug users took help from a drug treatment organization and that one in four had experienced difficulty in obtaining help from these organizations. Outreach and

network programs reach only a small proportion of drug users, even though they are found to be effective and only around 10% and below had sought help in five of the sites under survey. One of the key findings was that the treatment centers are inadequate to provide the necessary treatment. It was suggested that a community-based approach intervention be facilitated and also encouraged community participation through training. Drug detoxification services that are easily accessible and/or are home-based were among the options demanded by the drug users themselves and should be prioritized.

The United Nations Office on Drugs and Crime also conducted a case study of 'Women and Drug Abuse' in three cities (2002) – Delhi, Mumbai, and Aizawl. Women drug users were affected mentally and reported suffering from insomnia, depression, and anxiety. There were even cases of attempted suicide. As per the sample collected, drug users from Delhi reported that there was little support from family and friends. Support was sometimes available from non-abusing friends and colleagues at work. In Mumbai, women drug users were usually rejected by their families after learning of their addiction and the women preferred to live on the streets. Only a small percentage regularly utilized treatment services.

Butler &Bauld (2005) studied the impact of drug-using family members among the family. These families often cope alone with the problem of their child's addiction in secret for several years, causing more strain and distress to the family. The drug-associated behaviors such as stealing, violence, belligerence, and volatility all contribute to the difficulties endured by family members.

Deutsch (1982) describes family dynamics as 'remarkably uniform in most addicted homes and significantly different from the conditions which govern most other households'. The family faces emotional turmoil due to embarrassment, guilt, anger, and frustration. The addict becomes more erratic, less trustworthy, and dishonest in matters involving money, which is often used for alcohol or drugs. The family may ultimately choose to isolate themselves from external contacts to avoid further pain and embarrassment.

The Field Guide for Trainers & Service Providers published by the Ministry of Social Justice Empowerment (2002) described the dysfunctional coping behavior of family members of addicts. The family members become absorbed in trying to

straighten the addict into living a meaningful life. The members develop and maintain a set of dysfunctional patterns within the family. The patterns of living, coping, and problem-solving daily interfere with the healthy growth of the family, making it impossible to introduce constructive changes. As a result, family members develop co-dependency behaviour, which is defined by obsession and intense emotional dependence on another person, eventually leading to a pathological state that affects co-dependents in all other relationships. The family members try in vain to control the drug user which made them lose their behavior, resulting in an unmanageable life.

Brook et. al. (2009) suggest that commitment to family, the process of social learning, and intra-personal characteristics have a major influence on substance abuse. It stresses in particular that lack of parental guidance and support leads to poor family relationships, issues of adolescent personality, and involvement with peers who use substances. This means, in effect, that educating parents on how best to supervise and support their children will prevent drug use to some degree.

Kumpher (2003) wrote that reviews of international family-focused prevention programs have shown that these programs are capable of growing family protective factors and reduce drug-related family risk factors. It has also been shown that families with a range of high-risk problems benefit from family-strengthening programs. According to research, their efficacy also depends on ensuring that services of this kind are specifically adapted according to the age, gender, and social circumstances of families and their members.

Morita et.al (2011) conducted a study in which 1,298 questionnaires were distributed to family members of drug users treated at family support groups, medical institutions, or municipal mental health and welfare centers. Among the responses, 543 responses with adequate data were selected for analysis. The survey consisted of a 12-item General Health Questionnaire and a score of less than 3 in this survey indicated poor mental health conditions. 54.7% of the respondents showed such traits. Most of the families indicated having a negative feeling towards the user and problems with re-establishing the relationship. It was verified that the family support group is effective in solving these problems.

McCann, et al. (2017) studied the issue of having a family member who is struggling with drug misuse from the perspective of those who are impacted. Having a family member with a drug addiction issue resulted in nearly 70% of participants in this study experiencing family hostility and/or violence. The aggression and/or violence were usually unpredictable and seems to vary, causing stress and emotional exhaustion to the other family members. To avoid and control this sort of behaviour, the affected family members attempted a variety of direct and indirect techniques. Additional support as well as specialist services and support groups need to be increased to meet the needs of these family members to alleviate their situation.

Lander, et. al., (2013)conducted a study focusing on how substance use disorders are developed, maintained, and means that can influence the treatment of the disorder- both positively and negatively. It was mentioned that both substance user and their families have the same importance since they both have a great impact on each other.

Straussner and Fewell (2006) studied the impacts of substance abuse on children at various stages of development, the role of the family as a treatment resource, drug-using fathers' parental attachment styles, family cohesion and adaptability, family-centered service modes, adolescent substance abuse treatment, and online adolescent substance abuse treatment. The study also examined current research findings from the United States, Australia, Ireland, and Israel on the impact of substance abuse among children of drug-taking parents. Through the study, they found out that children of illicit drug users are more likely to demonstrate immature, impulsive, or irresponsible behavior, have lower IQ scores, and poorer school attendance as compared to a normal student.

Marina (2005) researched drug users and their families in Scotland where it was found that drug users have caused problems for their siblings in many ways and highlighted how drug use by a family member impacts daily functioning and shortens the number the amount of time that parents spend with their non-drug-using children

According to Levinthal (2002), drugs dependence can be viewed in two terms - a physical dependence model, in which drugs are taken to avoid withdrawal symptoms; or a psychological dependence model, in which the user genuinely craves

for the drug and the high reinforcing effects of the drug on his body and mind. The effect of various kinds of drugs vary but they all affect the brain one way or another and are detrimental to mental health. Family support is, without a doubt, crucial in the treatment process of substance users and for avoiding relapse. Family and friends should not feel responsible for the user's decision to enter or reject the treatment process, but should instead support the user on the way to recovery by changing as well, re-establishing communication, develop trust, and try to provide a comfortable and rewarding relationship.

In a study conducted by Ralte (2017), according to 90 respondents, the reasons for substance abuse include peer pressure at 41.1%, family problems at 12.2%, and effects of the social environment at 4.4%. Also, the respondents faced multiple challenges due to drug abuse such as problems with mental health (72.2%), family problems (62.2%), problems in the community (48.9%), work-related problems (23.3%) and 22.2% also reported facing stigma and discrimination.

Lalnunthara (1997) wrote that drug abuse severely affects the mind and body, and induced violent impulses in the users while creating a disregard for social and moral values. They are often willing to commit any crime to enable and satiate their dependency. According to samples obtained from drug users, 22% of them reported that their father has a history of substance abuse and 48% reported that their siblings also have a history of substance abuse. Thus, the influence of family plays an important role in the potential for starting substance abuse. The acceptance and support of family and friends is an integral part of the treatment process for re-integration into everyday life.

Alistair (1985) found out that in the context of socio-cultural aspects, the main social influences on drug use relate to minority group society, parental loss, alienation, disharmony or disease, low income, divorce, relationship failure, deprivation status, peer group impact on deviant sub-cultural activities, limited opportunities for appropriate socialization and easy access to drugs.

Figlie, et.al. (2004) conducted a cross-sectional study to investigate the profile of children, adolescents and families in a selective prevention service offered to the children of addicted parents among 63 parents, 54 children and 45 adolescents, where it was found that 67% of families have an addicted father, 59% of unaddicted

mates were suffering from mental illness. In children- shyness, inferiority feelings, depression, family conflict, need for warm-heartedness and a good level of energy were observed. A greater degree of mental illness, social competency, family system, and leisure/recreational issues were identified in teenagers. The need for a specialized selective prevention service in children, adolescents, and families affected by substance abuse was considered to prevent the risk of developing bio-psychosocial problems.

Ritanti, et.al. (2017) did a study among seven adult participants to explore the experiences of families with drug-using children using the snowballing sampling technique. It was found that the family received unfair treatment from society while expecting support from the community in the form of public acceptance and a proactive attitude towards them. Also, the physical burden felt by families was associated with physical fatigue due to the parents' responsibility for looking after their children while receiving harsh treatment from them. Due to the long-term treatment period, high costs, and the need to provide funds for drugs, the families also carried a high economic burden. It was therefore suggested that drug service agencies should assign a public health nurse to act as a counselor and advocate so that they can help families manage and overcome their problems.

2.1 Drugs

Drugs were widely used by men in India before they were educated. Marijuana was initially introduced to India in 2000 B.C., according to O'Brien and Cohen (1984), and the Indians may have been the first to smoke it. Opium, charas, ganja, and other narcotics have a long history in India, and they were commonly ingested at social and religious gatherings. Stimulants and antidepressants are commonly used by this new generation.Drug misuse has now evolved into a severe social issue that has affected all segments of the country's population (Lalnunthara, 1997)

In Mizoram despite the state's absolute prohibition of liquor, alcohol remains the most often used and perceived recreational substance, according to a report by the MSD & RB (2014). Cannabis use is popular among teenagers due to its accessibility and cost, as well as the fact that it is less stigmatised and seen as quite fashionable.The usage of narcotics including heroin, Amphetamine Type Stimulants

(ATS), cocaine, and medicinal substances has recently become a source of significant concern. Among the different cause factors reported (e.g., peer pressure, curiosity, stress relief, etc.), the existence of substance addiction among family members was a prominent causal factor highlighted.People Using Drugs (PUD) demographic mapping was undertaken in 2004 by MSD & RB in partnership with the Young Mizo Association (YMA) branches and Village Councils, and it was estimated that there were around 25,500 PUD in the state (Lallianzuala, (Ed). 2007). With data like these, it's easy to see how widespread substance misuse is throughout the state.

Prevalence of drug and alcohol usage, particularly among youths, is a major societal problem in Mizoram. Youth substance addiction appears to be on the rise in this country, as it is in other parts of the globe. In addition, it appears that the age of initiation is younger (Mizoram Social Defence and Rehabilitation Board, 2015). Substance abuse has a significant impact on the substance abuser, his or her family, the community, and other facets of social, economic, and political life. Almost the entire state is involved in the anti-substance abuse campaign.

Anxiety, sadness, and quality of life among HIV-positive injecting drug users in Ukraine were examined by Vasylyevet al (2017).The most vulnerable to HIV infection are those using drugs (PWID) in a demography, by 28 times higher in proportion to the existing group of the population. By using a cross-sectional study using questionnaire data, the study was performed.The Hospital Anxiety and Depression Scale was used to create the questionnaire. In a group of 90 HIV positive persons, PWID had anxiety and depression ratings more than 7, with 74 percent (67) and 61 percent (55), respectively, indicating mental health problems. Average scores for general health (40), role limitations due to physical (44) and emotional health (34), vitality (41) and mental health (45) had mean scores less than 50 along with total physical (43) and mental health scores (35).

Kermode (2012) and others conducted a study on the needs of women who use drugs and alcohol in the North East India, specifically in Manipur and Nagaland. Manipur reported more women having problems with heroin abuse. Depression, worry, and tension plagued these women's mental health. While unable to leave their position, some people have reported losing hope and seeing themselves as having no

realistic future. They experienced social exclusion, violence and financial difficulties and rejection by their families were not uncommon, while some women chose to stay away from their families due to shame. Mentions of exclusion from the church were also frequent.

Since 1984, approximately 1400 people have died in Mizoram, in North East India, as a result of drug usage. Vanrozama and Gobalakrishnan (2020) conducted a survey in all eight districts of Mizoram [before 3 new districts were created by the Government of Mizoram] interviewing 2633 drug users with an average age of 28 years and where 80% of them were males. Among the participants, 24.2% were divorced while 20.7% were married and three-fourths were still living with their parents. Drug abusers suffered from mental health problems such as depression, developmental delays, apathy and other psychosocial morbidity. Drug addiction in youths also causes disruption and disharmony within their family, possibly leading to breakdown of family functioning which is one of the greatest threats posed by addiction in the nation.

In a study conducted by Vanlalhriati (2019) among injecting drug users in Aizawl, Mizoram, participants suffered from physical, psychological and family problems. There are a few faith-based organization in the city that provide drug addicts with treatment, intervention, and rehabilitation. The intervention methods used ranges from worship services to spiritual counselling and sharing as well as therapy, sports, exercises, medical treatment, group counselling, family interaction and counselling among others. However, the recovery capital of the participants is marginally low which may be due to the lack of professional staff such as trained psychologists and social workers. These organizations should also make an effort to increase family participation and explore family based interventions as drug abusers need care and support from family to curb their addiction. The general public as well as leaders of community/faith based organizations should be made more aware and encouraged to play a more provocative role.

In a research done by Dhawan et al (2016), 509 children were found to be injection drug users (IDU) out of a total sample of over 4000 youngsters who used drugs across India. Family factors such as substance abuse by parents or family members (56%), verbal and physical abuse (43%) and lack of good relationship with their parents are among the chief contributors leading to substance abuse in these

children. Apart from this, peer influence was a major factor leading to substance use at a younger age. 76% of the sample reported that they had close contact with friends who have a history of substance abuse. Enhanced exposure to friends who have no history of substance abuse is recommended as one of the treatments for children with substance abuse problems.

In a random survey by Karthikeyan et al (1992) among 9863 of the total 70,000 population in one slum pocket of Bombay, 104 persons reported history of substance abuse. 95.2% of the substance users come from families with more than 5 members and 41.35% had a family history of drug abuse while 30.7% had been separated from their fathers since childhood. This may possibly show that children with less parental attention were more susceptible to substance use. It also revealed that having a substance dependent family member sets a bad precedent for children and the children may be predisposed to the use of substances. The absence of a father also seems to have an impact on the behavior of children and their inclination towards substance use.

In an interview of 1,09,104 students in 9th grade in Brazil, it was observed that the prevalence of drug use increased with age and that it was more prevalent with boys than guys (Malta et al, 2014). Students who live with their parents (6.9%) and who have meals with their family on a daily basis were less likely to take drugs (5.7 percent). In terms of mental health, individuals who felt lonely (9.4%), had sleeplessness (11.7%), and had no close friends had the greatest frequency of drug use (10.3 percent). Family relationships, solidarity and activities protect children against falling into substance abuse. Support, supervision and good communication between parents and teachers protect the students strongly against these risk behaviors.

2.2 Family and Drug Users

According to a study on adolescent drug addicts conducted by Rosenberg (1970), drug addiction is not just a manifestation of the adolescents' personality disorder or disturbance, but it is also a symptom of a larger family problem.

Physical and psychological health, economics and employment, social life and family ties were identified as four significant areas of impact on relatives in a government report on supporting drug and alcohol users in Scotland (Barnard, 2005).

There is no doubt that living with someone who is addicted to something would result in an unstable family situation. Families frequently have challenges in responding to, coping with, and living with the changes that come with substance dependence. They must deal with issues that appear to arise in every aspect of life: psychological, occupational, social, and familial relationships, to name a few. If maladaptive coping occurs, a vicious cycle of family dysfunction may ensue. In other words, each family member's actions are likely to effect not just one, but the entire family (Gregg & Tombourou, 2003).

The consequences of substance misuse on Mizo families appear to be similar to those experienced by families in other regions of the world. Many times, family members are oblivious to the warning indicators. They could also be oblivious or even in denial. Small but significant changes in appearance, behaviour, and mood of a family member are frequently predictive of a drug issue (Usher, Jackson, & O'Brien, 2005). Families typically react with panic once the presence of drugs or alcohol is proven, due to a lack of information and experience with the subject. Parents frequently believe that they can simply address the problem, and that the abuser is likewise eager and capable of doing so. The embarrassment that comes with discovering the problem makes them hesitant or afraid to seek professional care, which often leads to the family being isolated (Barnard, 2005).

Families are subjected to a variety of strains and obligations as a result of different forms of substances. Families of illegal drug users face substantially more stressful life events than families of prescription drug abusers. For example, they are subjected to more thievery and financial pressure, as well as legal pressure and health risks (Velleman et al., 1993). According to some studies, parents are more concerned about illegal drug usage than they are about alcohol use (Hayes, Smart, Toumbourou & Sanson, 2004).

In a research on the teenage drug user, Cancrini et al. (1970) used specific criteria to identify compulsive drug users and personally interviewed the families of 80 adolescent drug addicts. Family life was found to be very disrupted, with 40-45 percent of patients having an absent parent or no family at all. The drug problem among teens was viewed as the product of a series of maladaptive remedies. This was one of the few studies that looked at family treatment for drug addicts.

Various studies have found that siblings of substance abusers are more likely to suffer from a variety of negative outcomes (Barnard, 2005; Velleman et al., Sharpe & Rossiter, 2002) and greater emotional issues. (Hannah & Midlarsky, 1985; Lobato, 1983; Summers et al., 1994).

Bhattacharya, Cleland, and Holland investigated the connections between peer networks, parental characteristics, and drug use among Asian-Indian youths born in the United States whose parents immigrated from India. The message from parents about the negative consequences of drug use, as well as agreement among adolescents' peer networks, was connected to less drug use by teenagers. Drug use was uncommon among Asian-Indian teenagers. Parents' awareness of their children's school performance, peer networks, and concerns about the expense of drug usage could be utilised to signal drug avoidance among teenagers (Bhattacharya, Cleland and Holland, 1999).

From 1989 through 1992, Plasse performed at a day management centre in New York City, where he defined parenting groups. Parents of addicts and alcoholics took part in the study. In a psycho-educational model, the technique combined short self-motivated group therapy with learning about child development, communication skills, and family management perceptions. The large number of parenting group graduates who also completed the day treatment programme suggested that parenting groups played an important role in the recovery process. Clients said they felt better about themselves as parents after participating in the programmes (Plasse, 1995).

Families with drug-using children are more likely to have a pervasive negative atmosphere because the entire family may be focused on the drug-using sibling, leaving the non-user sibling feeling ignored. The non-drug-using sibling's sense of isolation would also increase, leading to a decrease in family attachment (Gregg & Toumbourou, 2003), as well as an unwillingness to seek social support from outside the family due to fear of disclosure and the intensefeelings of shame (Frye, Dawe, Harnett, Kowalenko, and Harlen , 2008).

Coates *et al.,* (2016) studied on the evaluation of a service to keep children safe in families with mental health and/or substance abuse issues with the aim of improving parenting capacity, child safety and family functioning. This was done through the collection of data during a span of 3 years and 3 months, including

demographic characteristics, service usage, presenting issues and pre and post revised North Carolina Family Assessment Scale (NCFAS-G) scores. The improvement observed between intake and discharge happened on the majority of the 58 NCFAS-G subscale items (32/58) which was significant. Therefore, it was concluded that specialised programs can help in assisting families with child safety concerns suffering from mental health and/or drug problems.

Arias-De la Torre Jet al., (2019) based on data from the uniHcos Project, performed a cross-sectional study on drug use, family support, and related factors among university students..The aim is to make an assessment of use of illegal drugs by College students on any recent occasion, during the past years and recent months and the relationship between illegal drug use and family support and other factors was analysed. The data from the uniHcos project participants (n = 3767) was used in a cross-sectional study. The independent variables were family support, age, location, and job status. They discovered that, with the exception of depressive drugs, lower family support was linked to greater drug usage in both genders, as well as poly consumption.

Ritani*et al* (2013) studied adolescents having the risk of drug abuse during their upbringing, and in which care is needful in a family setting. It explores the experiences of families with drug-using children. Sets of Interview guidelines which were based on the research aims were made and a number of questions were interpreted to them to explore the experiences of the families. The results showed in characteristic the feelings of the parents/families, stigmatisation experienced by different family, mechanisms used by families to cope, family burden, ways of fixing the problem, the approval of the family, expectations of the family of the parties involved. A great, continued and cycle of grieving was experienced by the family.

Kaufman (1986) family therapy is the most promising non-pharmacologic strategy for the treatment of drug addiction that has emerged in the last decade. He specifies four key features on which family therapy can be evolved into a practical system in his essay "A Workable System of Family Therapy for Drug Dependence." They are:

1. An understanding of the common family systems and patterns seen in the patients with drug dependence;

2. developing a system to establish and maintain a drug-free state
3. a workable system of family therapy
4. coping with family readjustment after the cessation of substance abuse

According to Ackerman (1956) individuals as a unit of diagnosis should be replaced by family groups as a unit of diagnosis, therapy, and prevention. llirsch and Imhof (1075) concluded that family therapy is the answer to the problem of drug addiction based on their examination of 47 families of drug users who visited the North Shore University Hospital's Drug Treatment and Education Centre.

Kumpfer, K. L et al., (2007) conducted a study on **p**arenting skills and family support programs for drug-abusing mothers. The aim of this study was to assess the social support system of family members of drug users. In families having scenarios where the mothers were drug users, their children to a certain extent developed suffer from fatal alcohol or drug syndrome (FAS/FDS) or fatal alcohol or drug effect (FAE/FDE). They found out that in order to improve the social support given both to the mother and child, FAS/FDS prevention program, and others as selective and indicated prenatal and postnatal interventions are helpful.

Baptista N.*et al.,* (2013) studied on the Perception of family support in dependents of alcohol and other drugs: relationship with mental disorders. The aim is to evaluate the relationships amongst the understanding of family support, levels of depression, anxiety and hopelessness in alcohol or drug dependent patients (AOD). Male and female from six private institutions for treatment of drug dependency between the age of 18 and 58 years old constituting of 97 patients under treatment were located in Santos-SP/Brazil.Participants were assessed using the Inventory of Perceived Family Support-IPSF, the Beck Depression Inventory-BDI, Beck Anxiety Inventory-BAI, Hopelessness Scale-BHS, and DSM-IV TR Criteria for Substance Abuse and Dependence. The results showed that between the expected family support and the levels of depression, anxiety and hopelessness there was negative correlations. An important factor for levels of anxiety and depression proven is Family support. Therefore, understanding Family support is an important factor for supporting patients with AOD.

Velleman*et al.,* (1993) studied on the families of problem drug users: a study of 50 close relatives. The aim of this study was to conduct an interview with 50 close relatives of the known problem drug users. This study was conducted through the involvement of 6 practitioners and researchers, in South–West England. A vast proportion of the relatives through qualitative and quantitative results showed negative experiences. The associates of the drug users showed a higher and slighter problem than those users of the tranquillizer. The problems faced by the illicit users of drugs were different to those of the parents. The negative effects were drawn out by the relatives as to how they perceive the drug user and the difficult experiences which had a toll on their health. Two very crucial factors are the various coping mechanism and the range of the support that they had obtained.

Keeley*et al* (2015) studied the association between parental and adolescent substance misuse: findings from the Irish case study. The 'Lifestyle and Coping Questionnaire,' which contains questions about lifestyle, coping, difficulties, alcohol and drug use, purposeful self-harm, depression, anxiety, impulsivity, and self-esteem, was used to gather data. In addition, the standard questionnaire was updated to include two additional questions about parental substance addiction. It was found out that Adolescent substance abuse was more frequent in boys; parental substance misuse created the high risk of adolescent abuse of alcohol and drugs; the increased risk was fractionally higher if the parental substance abuse was maternal rather than paternal; the parental substance abuse was at higher risk if it affected both rather than one of the parents, especially regarding adolescent drug abuse; the extent of the increased risk was of no difference for boys and girls. Even after accounting for other family issues and the teenager's psychological traits, parental substance usage enhanced the likelihood of adolescent substance abuse.

McCann et al. (2017) looked at how impacted family members dealt with aggressiveness and violence as a result of problematic drug use. To do so, 31 AFMs (affected family members) from Victoria, Australia, participated in semi-structured, audio-recorded qualitative interviews. Interpretative Phenomenological Analysis was utilised for data gathering and analysis. PSU-related family hostility and/or violence was experienced by over 70% of individuals, and it was varied, changing, and unpredictable, affecting social relationships and family dynamics. In the end it was

noted that to the AFMs, it filled them with upset, stress and it was emotionally exhausting to them.

Gethin*et al* (2016) studied coping with problematic drug use in the family: An evaluation of the Stepping Stones program. The study was done by developing a pre and post study of the Stepping Stones intervention for families which involved 108 participants from March 2013 to March 2014. On all end measures, there was a significant improvement in coping across all areas after the training (Coping Questionnaire and the Family Drug Support Questionnaire). For participants, the improvements were either increased or sustained at 3 months follow up. Participants said they were highly satisfied and gave a good rating.

Small et al. (2014) examined the effect of parental and family education on teenage drug use. This study portrays the effect of the structure of a family and education by parents on adolescents' substance use by employing a racially diverse sample of 14,268, 12th-grade high school adolescents. The result shows to us that structure of the family has its affects on adolescents' substance use. Adding to that, any racial differences are noted. The findings shows us that African American adolescents have a substantially lower rate of substance use compared to White and Hispanic adolescents, however both are affected adversely in the outcomes. The research shows us that parental education and support will help in reducing the substance abuse.

Hussaarts*et al* (2012) studied the problem areas reported by substance abusing individuals and their concerned significant others. This study examined those issues that patients with SUDs (Substance Use Disorders) and their family members may face in terms of quality of relations, psychological problems, physical distress, and quality of life. The Maudsley Addiction Profile health symptoms portion, EuroQol-5D, Relationship Happiness Scale, Dyadic Adjustment Scale, and Dedication Scale were completed by 32 people with SUDs and a family member who were recruited from a drug addiction treatment programme. So a contrary finding where Family members reported eventually that four significant others were directly affected by patients' addiction-related problems, while patients said that less than three family members were affected by their addiction. The overall result of the SUD patient’s habit was more negative than the actual patient himself. Also, the levels of

physical and psychological distress and quality of life scores were almost similar. These observations support the notion that relationships of patients and family members are in dismay and that both the group needed help to improve their physical and psychological well-being.

Strauss *et al.,* (2001) studied the social support systems of women offenders who use drugs: a focus on the mother-daughter relationship. This study aims to understand the structure and functions of women who takes drugs and were under social support for the past 6 months. About two-thirds of the women were known to be mothers as the supporters. These mothers strive their level best to support their daughter to refrain using drugs. Ironically, the support given by the parent in terms of money or some basic needs enabled the daughter to buy drugs. The mixed feelings of being ruled over and controlled over by the parent against the daughter leads to an element of distrust rather than appreciating the mother's support. Through this bridge of comprehension, there could be an assistant to the social supporters for the treatment and assisting them till their recovery and when they return back to their community.

M. Kumar (2019) wrote that each day, number of drug addicts are increasing in India. Drug abusers fail to see the pain and destruction they are causing in their families. The relationship between parents and other family members are strained due to the emotional burden they bear. The guilt and shame brought about by the drug abuser causes families to become isolated from society. If the abuser is married, the relationship with their spouses becomes severely compromised. They are unable to care for their children and their grandparents usually care for them, which in turn lead to a higher risk for developing the same drug abuse problems as their parents. Sustenance of addiction can become a costly affair putting an economic burden on the family.

Manelli P. (2013) stated that families play a complex role in the assistance they provide to a substance dependent family member. Apart from assisting in the treatment process, they also aid in the management of the consequences of addictive behaviour. Family members are directly affected by the addictive behavior and refrain from asking for help either due to ignorance or shame and fear of social

stigma. Thus, by offering assistance to the entire family, therapeutic efficacy may be enhanced, and social prevention can be aided.

Substance abuse impact not only the patient himself, but also affects the family members deeply especially in a country like India where familial ties still play a major role in society. Aside from the spouses of substance abusers who suffer from stress and distress, their children also often demonstrate high levels of behavioral disturbances. Family members are one of the central keys in treatment of substance abuse disorder. They provide motivation and emotional support as well as physical support during the treatment process. Therefore, providers of treatment services should take necessary measures to make sure that family members are more involved in the therapeutic process. (Sarkar et al. 2016)

According to Singh et al (2017), Drug addiction can be treated with medications and psychological treatment. Among the psychological treatment mentioned, family therapy aims to involve non-addict family members in the treatment of substance abusing individuals. Involvement of other family members, however brief, can have a positive impact on the abuser leading to a more engaged treatment process and willingness to continue with the program. Family therapy also aims to understand the patient more and to find out what factors contributed to his substance abuse.

Sharma et al. (2019) found that substance abuse places a significant strain on family members, particularly in low-income households with patients who are addicted to several substances. Female caretakers reported higher proportion of severe burden. The assistance provided by family members is diverse and complex in nature. Apart from the direct care they provide, financial assistance, engagement and retention of treatment has to be managed by them. Communication between families and health providers along with their active involvement in the treatment process is crucial. The success of treatment can be improved by including the entire family and addressing the family load.

2.3 Mental Health of Family Members

Family is a place of socialisation where cultural value conflict is transformed into interpersonal patterns, leading to sickness along the path of disparagement (Cleveland and Longaker 1957).

According to Coode (1964), family can be understood on a sociological, psychological, and biological basis. This understanding aids in gaining a comprehensive view of any problem.According to Van Der Veen, Huebner, Jorgens, and Neja (1970), a person's view of his family is an important determinant for the therapy of family problems.

The family's first response to addiction, according to Melvyn Bowler, a private drug counsellor, is denial, and the addict's behaviour will be attributed to anything other than drugs. When reality sets in, the parent or partner tries a variety of coercive techniques to break the addict's habit.They use a variety of techniques to overcome addiction, and their efforts can last for years. Patience gradually wears down. Members of the group experiences a loss of affection for one another.

The journey to embracing death (described in Dr. Elisabeth Kubler Ross's book on Death and Dying) is commonly used to illustrate how families react to an addict in their midst. Denial and isolation, rage, bargaining, sadness, andacceptance are the successive processes documented by Dr. Kubler.

In a study conducted by Pachuau (2015), a total of 900 Mizo teenagers with ages ranging from 14 to 19 years were recruited from various schools situated in and around Aizawl, the capital city of Mizoram, with 300 (150 Males and 150 Females) having an alcoholic sibling, 300 (150 Males and 150 Females) having a drug-abusing sibling, and 300 (150 Males and 150 Females) having normal siblings. One of the objectives was to study the relationship between siblings substance abuse and psychological health status among mizo adolescents. The findings revealed that adolescent siblings of drug addicts felt more rejection from their fathers, were more agreeable, and had higher rates of generalised anxiety disorder, suicide (suicidal ideation and behaviour), and interpersonal issues. The significance of paternal rejection as a moderator in explaining the association between having a drug-abusing brother and academic issues in males was discovered to be considerable. It is frequently noticed that the drug addiction of one family member does not effect all siblings or family members equally. Mizo teenage boys and girls with alcoholic or drug-abusing siblings face a greater number of psychopathological issues than those with normal siblings.

Hirsh (1962) did a significant study on parents of drug abusers where he identified three mothers and one father of adolescent drug abusers and conducted a group therapy with them. In this therapy, he identified that all these parents were guilt ridden and had a tendency to project the guilt, when they were under stress.

In an attempt to change the addict's behaviours, family members consider themselves as victims of the addict's deceptions and wiles, and they join the game in the hopes of outwitting the opponent. The addict's family is dragged in not only for the addict's life, but also for the family's survival as a whole.The family goes in all directions in search of a solution. The family condemns the addicts and stops providing money, or they feel terrible and try to figure out what went wrong that caused the addict to use drugs (Levinson, 2001).

According to various research on the consequences of a substance abuser including drug users on the family, family members face extreme and long-term stress, which can lead to high levels of physical and psychological morbidity. (Orford, Natera, Davies, Nava, Mora, Rigby, Bradbury, Copello, and Velleman, 1998; Velleman, Bennett, Miller, Orford, and Tod, 1993).

Families frequently cope in secrecy, which adds to emotions of stress and misery. Violence, thievery, marital strife, and unpredictability are all prevalent behaviours connected with addiction. Family members of addicts often feel betrayed because their loved one has "chosen" alcohol or drugs above their connections (Patterson-Sterling, 2004).

Smith et al (2016) studied Families Affected by Parental Substance Use.Children whose parents or caregivers use drugs or alcohol are more likely to suffer short- and long-term effects, which can range from medical problems to psychological and behavioural disorders. In providing medical service to the children, pediatricians are most likely to meet day to day families where the children are affected by parental substance use and they are in a place to help out the suffering children. That is why the clinical pediatricians are required to have the skills and knowledge of how to investigate a child's risk in the context of a parent's substance use.

McCann et al (2018) studied on how a family member dealt with a relative who was abusing alcohol or other drugs. This study is used to draw conclusions whether a relationship between the level of coping and family member type and support-giving experience existed. The data reveal the following relationships: "Other" family members used maladaptive coping methods more frequently than intimate partners (P = 0.012); family members whose role affected or had an effect on their physical health employed maladaptive coping methods more frequently than those whose role did not influence or have an effect on their physical health (P = 0.014); and family members whose role had an impact on their physical health employed maladaptive coping methods more frequently than those whose role had no impact (P = 0.003). In comparison to withdrawal coping strategies, engaged and tolerant inactive maladaptive coping methods had a considerably more negative impact on family members' physical health and/or socialisation. Family and friends, mental health nurses, and other professionals working in the field of alcohol and other drugs can all help family members in this situation.

Jääskeläinen*et al* (2016) studied mental disorders and harmful substance use in children of substance abusing parents.The research was conducted using longitudinal data from a record of children born in Finland in 1991 (n = 65,117) and their biological parents. The kids were tracked until they became 18 years old. The data was obtained from administrative registries in Finland. Even after adjusting for other unfavourable childhood events, parental education, and the child's gender, maternal, paternal, and both parents' substance misuse were significant predictors of mental illnesses and hazardous substance use in children aged 13-17 years. Parental substance abuse had been known as markers of mental disorders in children aged 7-12 years in bivariate model but in multivariate model the association disappeared. In comparison to parents, maternal drug addiction was revealed to have a greater impact on teenage children's hazardous substance usage. Findings also showed that there were no significant interactions between substance abusing parents' gender and the child's gender.

Substance abuse or substance use disorder often creates a burden for the family members with problem. Members are emotionally affected due to anger, frustration and even causing depression. They also cause economic burden as the sustenance of such an addiction does not come cheap. Relationships are strained and

families experience tension, instability, violence, separation of family and parents may become less sensitive and emotionless to other children in their family. There are numerous viable interventions, treatments and mutual support programs for families. Family interventions can help in influencing the member with the problem to seek treatment, help in stabilizing them from a relapse, support the member and help the family itself to address their own problems through family support programs (Daley 2013)

In a cross-sectional study among 114 family members with substance abusers and another 114 without substance abusers in Hamadan, Iran by Shamsaei, et, al (2019), it was discovered that the mental health status of family members with a substance abuser was significantly lower. 29.4% of family members with substance abusers were suspected to have mental disorders while only 16% of family members without substance abusers were suspected to have mental disorders. Substance abuse impacts family in many ways and focus should be given in planning mental health programs for the whole family. Screening of families affected by substance abuse for psychological and mental health conditions should be carried out by health professionals.

In a correlational study of 200 female family members of drug users in Lahore, Pakistan, perceived stigma and caregiver stress were important predictors of mental health. A simple interview form, as well as the Perceived Stigma of Substance Abuse Scale, Kingston Caregiver Stress Scale, and Mental Health Inventory, were used to collect data. Female family members of drug addicts feel the burden of providing money, investing time and energy, which results in overwhelming mental health problems such as anger, shame and depression. They also experience rejection, avoidance and vilification by society. There were no notable variations in the perceived stigma, caregiver stress and mental health among daughters, sisters and wives of drug addicts. As a result, the effects on their mental health were comparable. (Rafiq&Sadiq 2019)

2.4 Social Support

Miller (1974); Cannon (1976) discovered that drug users' families lacked love and their members received little support from the family (Jensen, 1973; Cooper and Olson, 1977).

Families of addicts may experience a perplexing mix of repulsion and self-loathing as a result of the society attitude regarding drug addiction. Society either pities or despises the addict.Family members keep this secret even from their closest relatives and friends for these reasons. Family members gradually lose their sense of direction and become emotionally paralysed. They lose sight of what is and is not acceptable behaviour. Their sound judgement vanishes.Because the family is so profoundly linked in the addictive system, family therapy is the treatment of choice (Coleman and Stanton 1978).

Varghese (1994) conducted a study to make a comparison of family functioning and social support system, between addict families and non-addict families .The study consisted of 100 addict families chosen in such a manner that at least one member of the family was a drug addict and 105 families of non-drug addicts, where none of the members was a drug addict. From the study, it was found that addict families show lesser family sociability, lesser family idealization and greater family disengagement compared to non-addict families.'. From the findings of social support which include emotional support, practical assistance, financial assistance and advice and guidance provided to the family members by significant people, family members, friends and relatives, it was found that non-addict families have greater social support than addict families.

Kelley *et al.,* (2019) conducted a study on Preventing Substance Use in American Indian Youth: The Case for Social Support and Community Connections.The purpose of this study was to look at the impact of social support, community ties, self-esteem, and culture on usage among American Indian teenagers. A 16-question survey was designed for American Indian teenagers aged 12 to 20 who lived in six American Indian villages. Between January 2016 and August 2017, 565 American Indian youth participated in the poll. Community relationships were shown to be adversely linked with marijuana usage among American Indian children. The higher the community support, the higher the social support and self-esteem scores was evaluated which would be helpful in the prevention of substance use.

Rosa *et al.,*(2001) studied on the review of the role of social support systems in the drug use behavior of Hispanics. The aim of this study was to assess the social support system and behaviour of family members of drug users of the Hispanics. The

findings from the research literature show that social support system plays a crucial role in the prevention of drug abuse among Hispanics. A great impact on the drug user behaviours of the Hispanic children, youth and adult drug users shows that factors such as that familial factor, peer influences, involvement with religious institutions, and after-school activities are vital parameters. Result shows that if the social support system was inculcated in the society, the prevention and treatment programs will be a greater success.

Richter *et al.,* (1991) studied on the impact of social support and self-esteem on adolescent substance abuse treatment outcome. The aim of this study was to assess the social support system and behaviour of family members of drug users. A self-reported questionnaires and a research interview during treatment and at 6 and 12 months post-treatment was undertaken by adolescents and their parents. The findings revealed a relationship between the quality of social resources used during treatment (i.e., substance-use patterns of supporters) and post-treatment alcohol and drug usage. Inpatient satisfaction with self-esteem, the number of high-quality supports available, and social support accounted for 16 percent of the variation in 6-month drug use outcomes and 25% of the difference in psychosocial functioning 6 months following treatment. Social support and self-esteem measurements for six-month were correspondent to 1-year outcome.

Usher *et al.,* (2005) studied on the Adolescent drug abuse: helping families survive. The use of drugs by adolescent is a major concern where problems with regards to the legal system, schooling, or within the family are commonly the triggers for recognition of substance misuse problems in a young person which becomes the responsibilities of the family members especially the parents of the adolescent to deal with these problems. This is a crisis for families, and therefore, on-going social support including support from health worker is needed if they are to overcome the challenges.

Hiller et al. (2013) performed a qualitative study on social support and recovery among female sex workers who inject drugs in Mexico. The aim of this research is to analyse the extent to which the female workers who uses drugs (FSW-IDUs) receive social support and the family members and intimate partners who makes an effort in their recovery. A total of 47 FSW-IDUs were enrolled in an in-

depth interview. Some intimate relationships offered contradictory good and negative assistance during the rehabilitation, according to the participants. The limited positive support was seen because of the occurrence of problems in the family especially those families who were not united. In order to better understand the socio-cultural and contextual determinants, the Mexican drug treatment has to consider taking evidence-based initiatives that deals with partners, kids and the members of the family.

Lewandowskiet al., (2009) studied on the effect of emotional and material social support on women's drug treatment completion. The aim of this study was to understand how the emotional and the social support of women affected them, after the completion of their dose of drug intake. Various studies has introspected the recovery when social support is available, yet very few did analyse the dual, i.e. the types and the sources of social support. The hypothesis of the study was to analyse post treatment, whether the understanding of woman's emotional and social support from her family, friends, partners, drug treatment, child welfare will eventually affect her or not. In the program, a number of 117 women enrolled to form the study. A semi structured initial and follow up interview by utilising a history calendar, the degree of the known social support, their treatment were the Data collected for the experiment. The findings from the result support the hypothesis. Both positive and negative effects after the treatment depend on the degree in which social support can be caused as per the type and its source of support.

Adejoh*et al.,* (2018) conducted a study on Rehabilitation of Drug Abusers: The Roles of Perceptions, Relationships, and Family Supports, which aimed to explore the perceived influence of perceptions, relationships, and family support on drug abusers' rehabilitation using a non-experimental study design. It was found out that an important catalyst for the abuser for quick rehabilitation were finance, material and moral supports given by the family.It was also advised that rehabilitation officers and policymakers think about how they might improve the function of professional connections and family support in drug addicts' rehabilitation.

Morita et al (2011) studied the mental health and emotional connections of family members with drug-addicted relatives. This research looks at the stress that drug addicts' families face, their relationships, and the variables that influence them, as well as strategies to help them. The poll included the 12-item General Health Questionnaire (GHQ-12) as well as questions about family disturbances, drug users' relationships, and the usage of family support services. The study found that the average GHQ score was 4.5, with 54.7 percent of respondents having a score of 3 or above, indicating poor mental health. More than half of the subjects responded that drug problems have affected family members in terms of the health condition, daily living, and financial problems. Most of the families said they had unfavourable sentiments toward the addicts, such as "being pulled into drug issues" and "being too protective." In the results, most of the family members of drug users have problems with mental health and the recovery of relationships even though they have accessed to support centres, and it was verified that the family support group works effectively to help solve their problems.

Kumpfer, K. L et al., (2007) studied parenting skills and family support programs for drug-abusing mothers. The aim of this study was to assess the social support system of family members of drug users. Family having scenarios where the mothers were drug users, their children to a certain extent develop suffers from fetal alcohol or drug syndrome (FAS/FDS) or fetal alcohol or drug effect (FAE/FDE). The potential of having acute or chronic physical, cognitive and behavioral problems in such children is exceedingly higher. It was observed that when a developing foetus is exposed to tobacco, alcohol, or drugs while in the womb, the environment and family system have an impact on the infants and children of substance-abusing parents, and that even after birth, the environment and family system have an impact on the infants and children of substance-abusing parents.

Atadokht, et, al., (2015) studied the role of expressed emotion and perceived social support in predicting addiction relapse.Their findings showed that a recurrence after recovery was influenced by how the family conveyed emotion. Absence of social support from family, negative criticism and compassion from family puts a strain on persons with substance abuse disorder, leading to regression and relapse, the only way they know how to cope with the added stress. A support network for

drug abusers, who often feel alone and stigmatized, can help prevent relapse and the support system can reassure them even when they attempt to quit.

Garmendia, et, al., (2008) stated that lack of social support can be one of the influencing factors in recurrence of drug use after rehabilitation. 153 subjects who were abstinent at discharge were interviewed six months later and 71% of them were still abstaining.Their research revealed that social support played an essential role in preventing relapse and had a beneficial influence on health. In individuals in treatment for heroin addiction, those who had more social support significantly decreased the use of heroin and other hard drugs, as well as levels of depression and anxiety.

Wermuth and Scheidt (1986) present a model for enlisting family support in drug treatment, which is similar to Stanton and Todd's ideas of family therapy recruitment. They proposed that only one family member be included in multi-family groups, with psycho-educational instruction instead of therapy being provided.

2.5 Relationship between Mental Health and Social Support

McCann et al. (2019) performed a cross-sectional survey questionnaire on the affected family member dealing with a relative who misuses alcohol or other drugs. The aim of this study was to assess the social support system of family members of drug users and the coping behaviours of the family members affected towards a relative with drug misuse and to evaluate the relationship as how the level of coping and the support given by the family towards the relative with drug misuse is exemplified. From the study the results were as follows, maladaptive coping strategies was more frequent in the 'Other' members of the family than used by intimate partners ($P = 0.012$);family members whose role had a negative impact on their physical health used maladaptive coping strategies more frequently than those whose role had a positive impact ($P = 0.014$); maladaptive coping strategies was used more extensively by members of the family whose role had a negative effect with regards to their social activity capacity than those who had positive effect ($P = 0.003$). Affected family members should be encouraged to use adaptive coping strategies to lessen the negative effects of their support-giving role and to keep them in it. Family members going through such a scenario in the family should be

supported enough by family and friends, mental health nurses, and other clinicians in the alcohol and other drug field.

Sakiyamaet al. (2015) studied family members who sought social help as a result of a relative's substance misuse. The participants filled out a structured questionnaire that asked about their socio-demographics, how long it took them to seek help, and where they found treatment. The participants were from the 'Amor Exigente' mutual self-help organisation in Sao Paulo, Brazil. The greatest group of family members were parents of drug abusers. It was said that it took an average of 3.7 years for family members to learn that their relatives had died due to substance misuse was noted. 42% of the group had taken help instantly; it took an average of 2.6 years for the remaining 58% of the sample to seek some form of assistance and help. The most notable reason for the delay in administering help is because the family thought that the problem was small or that they could help themselves to withdraw from it.

2.6 Research Gap

Although there has been some research on the experience of the family of drug users, they are still lacking and often focused on isolated incidences. While there are largely authoritative books on parenting in the midst of a drug problem, only a fraction of research has focused on experiences of children of addicts who ended up being parented by extended families, or the state. There is also very little research on the experiences of parents of a drug user and little to no research on the experiences of siblings (Barnard 2007).

In Mizoram too, we do find data on certain demographics related to drug abuse but as literature shows, there is a scarce study or none at all on matters relating to mental health aspects and social support of family members of drug users. Therefore, this study attempts to fill this gap so that family members can contribute to the rehabilitation of drug use/abuse related incidents in society.

CHAPTER III

METHODOLOGY

3.1 Design

The study is exploratory in design and cross-sectional in nature. Mixed research method i.e. Quantitative and Qualitative methods were used for the study. The field of study was conducted withinAizawl Municipality area.

3.2 Source of Data

Data were collected from both primary and secondary sources. The primary sources were collected fromadult female or male family members affected by drug abuse. Secondary source were collected from government and non-government reports and records.

3.3 Method of Sampling

A multi-stage sampling procedure was utilized to collect the sample. In the first stage, a list of rehabilitation centers in the Aizawl Municipality area was collected. In the next stage, all admitted clients who are drug users and addicts residing within the Aizawl Municipality area were identified from the rehabilitation centers, and from the identified clients their home address were collected with their consent. In the next stage, from the address, families were identified. The final selection of the sample was based on the consent of the family members. The sample size for the quantitative study was 60. From the qualitative study, the sample size was 20 which included 8 case studies and 12 key informant interviews. Overall, the sample size was 80.

3.4 Tools of Data Collection

A semi-structured interview schedule was used as the tool for data collection to collect information with regards to the objectives of the study. Qualitative data were also collected with the help of case studies and key informant interviews.

The tool included a standardized questionnaire based on Warwick-Edinburgh Mental Well-being Scale (WEMWBS) developed by a group of researchers at theUniversities of Edinburgh and Warwick in the year, 2007 to support the

development of an evidence base relating to public health which encompasses the promotion of well-being, the prevention of mental illness and recovery from mental illness. This scale was used to find out the mental health of the family members of drug users. It is a fourteen (14) items scale worded positively relating to the main components of 'positive mental wellbeing' covering both subjective well-being and psychological functioning.It has the ability to capture both eudaimonic and hedonic perspectives on wellbeing (people's functioning, social relationships, sense of purpose, and personal development) (e.g. feelings of happiness, optimism, cheerfulness, relaxation).

To find out the social support of family members of drug users, a 5 point structured scale was constructed to measure 3 items each such as the availability, quality and adequacy of social support across various dimensions of social support *viz.* basic needs support, emotional support, physical health support, mental health support, support in life skills and instrumental support. The different dimensions of social support were constructed based on John and Katherine (2008), Schwarzer, Knoll &Rieckmann (2003), Dunst, Trivette, & Cross (1986), Schaefer, Coyne, & Lazarus (2002), Olsson et.al. (2015), and Cutrona and Suhr (1992). The different agent of supporters were also constructed based on the study of Chhangte (2017), Meral and Cavkaytar (2012), Lifshitz and Glaubman (2004), Teklu (2010), Parette et.al (2010), Mishra & Gupta (2006) and Lalmuanpuii (2016).

Table I : Reliability test of Scale of WEMWBS

Number of Items	**14**
Cronbach's Alpha	**0.830 (n=60)**
Parallel	**0.836 (n=60)**

Source: Computed

Table I shows the reliability test of scale for Warwick Edinburgh Mental Well-Being Scale (WEMWBS). The table shows that there are 14 items in this scale and the reliability test for this scale based on Cronbach's Alpha is 0.830 and 0.836 based on Parallel test.

Table II : Reliability test of Scale of Social Support

Number of Items	**54**
Cronbach's Alpha	**0.849 (n=60)**
Parallel	**0.854 (n=60)**

Source: Computed

Table II represents the reliability test of scale of social support across six dimensions for primary, secondary and tertiary supporters. We can see from the table that there are 54 items in this scale and the reliability test for this scale based on Cronbach's Alpha is 0.849 and reliability test based on Parallel is 0.854.

Table III: Reliability Test of Scale of Social Support by Primary Supporters

Number of Items	**18**
Cronbach's Alpha	**0.926 (n=60)**
Parallel	**0.929 (n=60)**

Source: Computed

Table III highlights the reliability test of scale of social support by primary supporters. The table shows that there are 18 items in this scale and the reliability test for this scale according to Cronbach's Alpha is 0.926 and Parallel test is 0.929.

Table IV: Reliability test of Scale of Social Support by Secondary Supporters

Number of Items	**18**
Cronbach's Alpha	**0.954 (n=60)**
Parallel	**0.955 (n=60)**

Source: Computed

Table IV depicts the reliability test of scale of social support by secondary supporters. It is evident from the table that there are 18 items in this scale and the reliability test for this scale based on Cronbach's Alpha is 0.954 and 0.955based on Parallel test.

Table V: Reliability test of Scale of Social Support by Tertiary Supporters

Number of Items	**18**
Cronbach's Alpha	**0.966 (n=60)**
Parallel	**0.968 (n=60)**

Source: Computed

Table V shows the reliability test of scale of social support by tertiary supporters. The table shows that there are 18 items in this scale. The reliability test of this scale according to Cronbach's Alpha is 0.966 and Parallel reliability test for this scale is o.968.

3.5Data Analysis

Microsoft Excel and the SPSS Package were used to analyze the data. Simple frequency and descriptive statistics were highlighted to interpret the findings of the study related to the socio-demographic profile, mental health, and social support of family members of drug users in Aizawl Mizoram. The Mental Health of family members of drug userswere analysed based upon the WEMWBS protocol of measuring the scales.The level of social support received by family members across the dimensions of social support was also analyzed using the Social Support scale that was developed. Pearson’s Correlation Coefficient statistics was also analysed to find out the relationship between Mental Health and Social Support of family members of drug users. It also included findings related to suggestions for effective measures for improving mental health and social support.

3.6Inclusion Criteria

Any female or male adult individual from a family who had been affected by drug abuse were the respondent for the study and only those who gave consent formed the sample.

3.7Ethical Consideration

Prior permission and informed consent were sought from the family members and confidentiality was maintained. Changes were made accordingly to fit the context and to reduce any imposition.

3.8Operational Definition

In this study the Warwick-Edinburgh Mental Well-being Scale (WEMWBS), a 14-item mental well-being scale that covers subjective well-being and psychological functioning that was developed by a collaboration of academics from the Universities of Edinburgh and Warwick in 2006, was used. Mental well-being, according to the developers, is described as a person's psychological functioning, life satisfaction, and ability to form and maintain mutually beneficial relationships. The capacity to retain a feeling of autonomy, self-acceptance, personal progress, life purpose, and self-esteem are all important aspects of psychological health.

In this study, social support referred to support given by Primary Supporters (family members), Secondary Supporters (peers, relatives, community and NGOs) and Tertiary Supporters (Government agencies) across six (6) dimensions of social support such as basic needs support (fooding, shelter, clothing), emotional support (love, care, concern, empathy, sympathy), physical health support (medical attention, provisions and services), mental health support (professional counselling, guidance, and psychiatric care and services), support in life skills (education and training including vocational training), and instrumental support (sponsorship, donation, aid or help in form of money, aids, appliances, goods).

In this study, only people using, abusing, or addicted to psychoactive drugs such as Central Nervous System (CNS) Depressants (Alcohol is not included), Hallucinogens, Mood modifiers (Major Tranquilizers and Antidepressants), Narcotic Analgesics, and Stimulants were included. Opium, Cannabis, Heroin, LSD, Barbiturates, and other narcotics are exampleswhich have adverse social, physical, psychological, legal or other consequences which are harmful to drug users, user or the addict and those he/she is living with or affected by his/her action.

In this study, the family members include only adults, male or female who lives with the person using or abusing drugs and is related to him or her through blood, marriage/affinity, kinship or adoption.

CHAPTER IV

RESULTS AND DISCUSSION

This chapter will provide and discuss key and relevant findings from the current study in separate sections based on the research objectives.

4.1Socio-Demographic Profile

This section covers the socio-demographic profile such as age-group, gender, sub-tribe, denomination, family characteristics, form of family, educational level, family occupation, family monthly income and socio- economic category of family of all the respondents.

Table 1: Age Group

Sl. No.	Age-Group	Frequency
1.	**20 – 39 Years**	31 (51.7)
2.	**40-59 Years**	22 (36.7)
3.	**60-75 Years**	7 (11.7)
	Total	**60 (100.0)**

Source: Computed Figures in parenthesis indicates percentages

Table 1 shows the distribution of the respondents according to the age-group. According to the table, more than half of the respondents (51.7%) are between the ages of 20 and 39, while more than a third (36.7%) are between the ages of 40 and 59, and more than a tenth (11.7%) are between the ages of 60 and 75.

Table 2: Gender

Sl. No.	Gender	Frequency
1.	**Female**	41 (68.3)
2.	**Male**	19 (31.7)
	Total	**60 (100.0)**

Source: Computed Figures in parenthesis indicates percentages

Table 2 indicates the distribution of the respondents according to their gender. From the table, more than half (68.3%) of the respondents are female and less than a third (31.7%) are male. This was because female family members were more convenient and available at the time of interview.

Table 3: Sub-tribe

Sl. No.	Sub-Tribe	Frequency
1.	**Lusei**	49 (81.7)
2.	**Hmar**	5 (8.3)
3.	**Paihte**	2 (3.3)
4.	**Mara**	2 (3.3)
5.	**Lai**	2 (3.3)
	Total	**60 (100)**

Source: Computed Figures in parenthesis indicates percentages

Table 3 indicates the distribution of the respondents according to their sub-tribe. From the table, it is evident that majority of the respondents (81.7%) belongs to the Lusei sub-tribe, followed by the Hmar sub-tribe (8.3%) and the rest of the respondents are distributed equally among the sub-tribes Paite, Mara and Lai constituting of only 3.3% each.

Table 4: Denomination

Sl. No.	Denomination	Frequency
1.	**Presbyterian Church**	42 (70.0)
2.	**The Salvation Army**	9 (15.0)
3.	**Evangelical Church of Maraland (ECM)**	2 (3.3)
4.	**United Pentecostal Church (UPC)**	2 (3.3)
5.	**Baptist Church**	2 (3.3)
6.	**Evangelical Baptist Convention (EBC)**	1 (1.7)
7.	**Seventh Day Adventist (SDA)**	1 (1.7)
8.	**Isua Krista Kohran (IKK)**	1 (1.7)
	Total	**60 (100.0)**

Source: Computed Figures in parenthesis indicates percentages

Table 4 represents the denomination of the respondents. From the table, we see that more than half of the respondents (70.0%) belongs to Presbyterian Church followed by Salvation Army constituting 15 per cent of the respondents while

Evangelical Church of Maraland (ECM), United Pentecostal Church (UPC) and Baptist Church constituted 3.3 per cent each among the respondents and the rest of the respondents (1.7% each) belongs to Evangelical Baptist Convention (EBC), Seventh-day Adventist (SDA) and Isua Krista Kohhran (IKK), a local denomination.

Table 5: Type of Family

Sl. No.	Type of Family	Frequency
1.	**Nuclear Family**	51 (85.0)
2.	**Joint Family**	9 (15.0)
	Total	**60 (100.0)**

Source: Computed Figures in parenthesis indicates percentages

Table 5 shows the distribution of respondents according to the type of family. With reference to the type of family from the given table, it is evident that more than two-third of the respondents (85.0%) are from nuclear family while the rest of the respondents (15.0%) are from Joint Family.

Table 6: Form of family

Sl. No.	Form of family	Frequency
1.	**Stable Family**	54 (90.0)
2.	**Broken Family**	5 (8.3)
3.	**Reconstituted Family**	1 (1.7)
	Total	**60 (100.0)**

Source: Computed Figures in parenthesis indicates percentages

Table 6 shows the distribution of respondents based on their form of family. With regards to the form of family of the respondents, the table shows that majority of the respondents (90.0%) are from a stable family, followed by a broken family constituting 8.3 per cent of the respondents and only 1.7 per cent of the respondents are from reconstituted family.

Table 7: Educational Level

Sl. No.	Educational Level	Frequency
1.	**High School**	20 (33.3)
2.	**Higher**	16 (26.7)
3.	**Graduate**	8 (13.3)
4.	**Primary**	6 (10.0)
5.	**Middle**	6 (10.0)
6.	**Post Graduate**	4 (6.7)
	Total	**60 (100.0)**

Source: Computed Figures in parenthesis indicates percentages

Table 7 indicates the distribution of the respondents according to their level of education. The table shows that one-third of the respondents (33.3%) studied up to high school level, followed by higher level of education constituting 26.7 per cent of the respondents. We can also see that there are 13.3 per cent of the respondents who studied till the graduate level, followed by primary andmiddle level of education constituting a tenth (10%) each of the total respondents and the least number of respondents (6.7%) are post-graduates.

Table 8: Family Occupation

Sl. No.	Family Occupation	Frequency
1.	**Govt. Servant**	22 (36.7)
2.	**Business**	21 (35.0)
3.	**Daily Labour**	16 (26.7)
4.	**NGO Worker**	1 (1.7)
	Total	**60 (100.0)**

Source: Computed Figures in parenthesis indicates percentages

The data pertaining to family occupation of the respondents is presented in table 8. More than one-third of the respondents (36.7 per cent) reported that their family's occupation is government service, followed by 35% who reported that their family's occupation is business, 26.7 per cent who reported that their family's

occupation is daily labour, and only a few (1.7 per cent) who reported that their family's occupation is NGO work.

Table 9: Family Monthly Income

1.	**Rs. 10,000 - 30,000**	28 (46.7)
2.	**Rs. 50,001 - 1,00,000**	10 (16.7)
3.	**Rs. 30,001 - 50,000**	9 (15.0)
4.	**Below Rs. 10,000**	6 (10.0)
5.	**No Response**	4 (6.7)
6.	**Above Rs, 1,00,000**	3 (5.0)
	Total	**60 (100.0)**

Source: Computed Figures in parenthesis indicates percentages

Table 9 indicates the distribution of the respondents according to their family monthly income. From the table, we can see that almost half of the respondents (46.7%) have a family monthly income between Rs.10,000-Rs.30, 000, followed by 16.7 per cent of the respondents whose family monthly income is between Rs. 50,001-Rs.1, 00,000. It is also evident that the family monthly income of 15 per cent of the respondents is between Rs.30,001-50,000 which is followed by a tenth (10%) of the total respondent whose family monthly income falls below Rs.10,000. We can also see that 6.7 per cent of the respondents did not give any response with regards to their family monthly income while less than a tenth (5.0%) of the respondent have a family monthly income of above Rs.1,00,000.

Table 10: Socio-Economic Category

Sl. No.	Socio-Economic Category	Frequency
1.	**APL**	45 (41.7)
2.	**No Category**	19 (31.7)
3.	**BPL**	33 (21.7)
4.	**AAY**	2 (5.0)
	Total	**60 (100.0)**

Source: Computed Figures in parenthesis indicates percentages

Table 10 represents the distribution of socio-economic category among the respondents. We can see from the table that less than half of the respondents (41.7%) belong to APL category while 31.7 per cent of the respondents do not belong to any category, followed by those who belong to the BPL category which constituted of 21.7 per cent of the respondents and the least number of respondents (5.0%) belong to the AAY category.

4.2 Mental Health

The respondents' mental health status and scores are highlighted in this section.

The Warwick Edinburgh Mental Well-Being Scale (WEMWBS) was used to create the mental health scale, which consists of fourteen (14) items used to measure an individual's mental well-being. For each item, the scale is evaluated by summing up responses on a 1 to 5 Likert scale. WEMWBS rates each of the 14 item responses on a scale of 1 (never), 2 (rarely), 3 (occasionally), 4 (often), and 5 (often), with the total score obtained by adding the 14 individual item scores. The minimum score is 14 and the maximum is 70. Total score of 14 to 42 were considered to reflect a low mental well-being, 43 to 60 reflect having medium and score of 61 to 70 indicate a high mental well-being.

Table 11: Mental Health

Sl. No.	Level (Score)	Frequency
1.	**Medium (43-60)**	35 (58.3)
2.	**Low (14-42)**	21 (35.0)
3.	**High (61-70)**	4 (6.7)
	Total	**60 (100.0)**

Source: Computed Figures in parenthesis indicates percentages

Table 11 depicts the distribution of respondents according to the score of WBMWES. According to the table, more than half of the respondents (58.3%) had a mental health score of medium (43-60), followed by 35% of respondents with a mental health score of low (14-42) and just 4% of respondents with a mental health score of high (61-70).

4.3Social Support

This section covers the social support received by the respondents from primary, secondary and tertiary supporters across various dimensions which includes basic needs, emotional needs, physical health, mental health, life skills and instrumental support.

The Social Support was calculated based on a 5 point scale measuring the availability, quality and adequacy across the dimensions of social support such as basic needs, emotional needs, physical health, mental health, life skills and instrumental need support. For measuring the availability of social support the scales are 1 for very unavailable, 2 for unavailable, 3 for neither unavailable nor available, 4 for available and 5 for very available. For measuring quality of social support the scales are 1 for very poor, 2 for poor, 3 for neither poor nor good, 4 for good and 5 for very good and for measuring the adequacy of social support the scales are 1 for very inadequate, 2 for inadequate, 3 for neither inadequate nor adequate, 4 for adequate and 5 for very adequate.

Table 12: Overall Social Support across Dimensions

Sl. No.	Social Support	Availability	Quality	Adequacy
1.	**Primary Support**	3.74	3.64	3.50
2.	**Secondary Support**	3.15	2.96	2.81
3.	**Tertiary Support**	2.68	2.62	2.39
Total Average		**3.19**	**3.07**	**2.90**

Source: Computed

Table 12 shows the overall social support from different supporters across dimensions. From the given table, we can see that the total average of availability of social support across dimensions is medium (3.19) and the total average of the quality of social support is also medium (3.07) across various dimensions from different supporters. Also, we can identify that the total average in the adequacy of social support is medium (2.90) across various dimensions from primary, secondary and tertiary supporters.

Table 13: Social Support by Primary Supporters across Dimensions

Sl. No.	Dimensions	Availability	Quality	Adequacy
1.	**Basic Needs Support**	3.77	3.72	3.50
2.	**Emotional Support**	3.87	3.75	3.52
3.	**Physical Health Support**	3.98	3.85	3.68
4.	**Mental Health Support**	3.67	3.53	3.38
5.	**Life skills Support**	3.53	3.45	3.43
6.	**Instrumental Support**	3.63	3.53	3.50
Total Average Mean		**3.74**	**3.64**	**3.50**

Source: Computed

Table 13 indicates the distribution of the respondents according to the dimensions of social support received from primary supporters based on availability, quality and adequacy of support.

From the table, we can see that the overall social support from primary supporters in all the dimensions with regards to availability is high (3.74), quality is also high (3.64), and also adequacy of social support is high (3.50) from primary supporters.

The basic need support from primary supporters is high (3.77) in terms of availability, high (3.72) in terms of quality, and also it is high (3.50) with regards to adequacy of basic need support.

The availability of emotional support from primary supporters is high (3.87) and the quality of emotional support is high (3.75). The adequacy of emotional support from primary supporters is also high (3.52).

The availability of physical health support from primary supporters is high (3.98), it is high (3.85) with regards to quality and in terms of adequacy of physical health support, it is also high (3.68).

The mental health support from primary supporters with regards to availability is high (3.67), high (3.53) in terms of quality and with regards to adequacy, it is medium (3.38).

The life skills support from primary supporters is high (3.53) when it comes to availability, medium (3.45) with regards to quality and in terms of adequacy, it is also medium (3.43).

Also, the availability of instrumental support from primary supporters is high (3.63), the quality is also high (3.53). Also, it is high (3.50) with regards to adequacy of instrumental support.

Table 14: Social Support by Secondary Supporters across Dimensions

Sl. No.	Dimensions	Availability	Quality	Adequacy
1.	**Basic Needs Support**	3.00	2.90	2.72
2.	**Emotional Support**	3.65	3.37	3.10
3.	**Physical Health Support**	3.13	2.88	2.82
4.	**Mental Health Support**	3.40	3.18	2.92
5.	**Life Skills Support**	2.87	2.78	2.68
6.	**Instrumental Support**	2.85	2.67	2.60
Total Average Mean		**3.15**	**2.96**	**2.81**

Source: Computed

Table 14 indicates the distribution of the respondents according to the dimensions of social support received from tertiary supporters based on availability, quality and adequacy of support.

From the table, we can see that the overall score of social support from secondary supporters in all the dimensions is medium (3.15) with regards to availability, is medium (2.96) in terms of quality, and adequacy is also medium (2.81).

The basic need support from secondary supporters is medium (3.00) in terms of availability, medium (2.90) in terms of quality and also medium (2.72) with regards to adequacy of basic need support.

The availability of emotional support from secondary supporters is high (3.65), medium (3.37) with regards to quality and the adequacy of emotional support from secondary supporters is also medium (3.10).

The availability of physical health support from secondary supporters is medium (3.13), it is medium (2.88) with regards to quality and in terms of adequacy of physical health support, it is also medium (2.82).

The mental health support from secondary supporters with regards to availability is medium (3.40), medium (3.18) in terms of quality and with regards to adequacy, it is medium (2.92) again.

The life skills support from secondary supporters is medium (2.87) when it comes to availability, medium (2.78) with regards to quality and in terms of adequacy, it is also medium (2.68).

Also, the availability of instrumental support from secondary supporters is medium (2.85), the quality is also medium (2.67), and it is medium (2.60) with regards to adequacy of instrumental support.

Table 15: Social Support by Tertiary Supporters across Dimensions

Sl. No.	Dimensions	Availability	Quality	Adequacy
1.	**Basic Needs Support**	2.47	2.48	2.18
2.	**Emotional Support**	2.70	2.62	2.38
3.	**Physical Health Support**	2.83	2.72	2.45
4.	**Mental Health Support**	2.75	2.73	2.45
5.	**Life Skills Support**	2.70	2.63	2.43
6.	**Instrumental Support**	2.63	2.52	2.47
Total Average Mean		**2.68**	**2.62**	**2.39**

Source: Computed

Table 15 indicates the distribution of the respondents according to the dimensions of social support received from tertiary supporters based on availability, quality and adequacy of support.

From the table, we can see that the overall score of social support from tertiary supporters in all the dimensions is medium (2.68) with regards to availability, medium (2.62) in terms of quality but the adequacy of social support is low (2.39) from tertiary supporters.

The basic need support from tertiary supporters is low (2.47) in terms of availability, low (2.48) in terms of quality and it is also low (2.18) with regards to adequacy of basic need support.

The availability of emotional support from tertiary supporters is medium (2.70) and the quality of emotional support is medium (2.62). However, the adequacy of emotional support from tertiary supporters is low (2.38).

The availability of physical health support from tertiary supporters is medium (2.83), it is medium (2.72) with regards to quality and in terms of adequacy of physical health support, it is low (2.45).

The mental health support from tertiary supporters with regards to availability is medium (2.75), medium (2.73) in terms of quality and with regards to adequacy, it is low (2.45).

The life skills support from tertiary supporters is medium (2.70) when it comes to availability, medium (2.63) with regards to quality but in terms of adequacy, it is low (2.43).

Also, the availability of instrumental support from tertiary supporters is medium (2.63), the quality is also medium (2.52) however, it is low (2.47) with regards to adequacy of instrumental support.

4.3 Relationship between Mental Health and Social Support

This section highlights the relationship between Mental Health and Social Support.

Table 16: Correlation of Mental Health and Availability of Social Support by Primary Supporters across Dimensions

Sl.No.	Dimensions	Mental Health
1.	**Basic Needs Support**	.251
2.	**Emotional Support**	.199
3.	**Physical Health Support**	.234
4.	**Mental Health Support**	.115
5.	**Life Skill Support**	.124
6.	**Instrumental Support**	.117

Source: Computed **Correlation is significant at the 0.01 level (2-tailed)
* Correlation is significant at the 0.05 level (2-tailed)

Table 16 shows the correlation of mental health and availability of social support by primary supporters across the dimensions of social support. The table shows that there is no relationship between mental health and availability of social support across the dimensions.

Table 17:Correlation of Mental Health and Quality of Social Support by Primary Supporters across Dimensions

Sl.No.	Dimensions	Mental Health
1.	**Basic Needs Support**	.194
2.	**Emotional Support**	.173
3.	**Physical Health Support**	.180
4.	**Mental Health Support**	.109
5.	**Life Skill Support**	.142
6.	**Instrumental Support**	.153

Source: Computed ** Correlation is significant at the 0.01 level (2-tailed)
* Correlation is significant at the 0.05 level (2-tailed)

Table 17 depicts the correlation of mental health and quality of social support by primary supporters across the dimensions of social support. The table shows that there is no relationship between mental health and quality of social support across the dimensions.

Table 18:Correlation of Mental Health and Adequacy of Social Support by Primary Supporters across Dimensions

Sl.No.	Dimensions	Mental Health
1.	**Basic Needs Support**	.111
2.	**Emotional Support**	.089
3.	**Physical Health Support**	.202
4.	**Mental Health Support**	.137
5.	**Life Skill Support**	.164
6.	**Instrumental Support**	.083

Source: Computed ** Correlation is significant at the 0.01 level (2-tailed)
* Correlation is significant at the 0.05 level (2-tailed)

Table 18 indicates the correlation of mental health and adequacy of social support by primary supporters across the dimensions of social support. The table shows that there is no relationship between mental health and adequacy of social support across the dimensions.

Table 19:Correlation of Mental Health and Availability of Social Support by Secondary Supporters across Dimensions

Sl.No.	Dimensions	Mental Health
1.	**Basic Needs Support**	.216
2.	**Emotional Support**	.239
3.	**Physical Health Support**	.100
4.	**Mental Health Support**	.058
5.	**Life Skill Support**	.112
6.	**Instrumental Support**	.069

Source: Computed ** Correlation is significant at the 0.01 level (2-tailed)
* Correlation is significant at the 0.05 level (2-tailed)

Table 19 shows the correlation of mental health and availability of social support by secondary supporters across the dimensions of social support. The table shows that there is no relationship between mental health and availability of social support across the dimensions.

Table 20:Correlation of Mental Health and Quality of Social Support by Secondary Supporters across Dimensions

Sl.No.	Dimensions	Mental Health
1.	**Basic Needs Support**	.136
2.	**Emotional Support**	.209
3.	**Physical Health support**	.126
4.	**Mental Health support**	.041
5.	**Life Skill support**	.071
6.	**Instrumental support**	.205

Source: Computed ** Correlation is significant at the 0.01 level (2-tailed)
* Correlation is significant at the 0.05 level (2-tailed)

Table 20 represents the correlation of mental health and quality of social support by secondary supporters across the dimensions of social support. The table shows that there is no relationship between mental health and quality of social support across the dimensions.

Table 21:Correlation of Mental Health and Adequacy of Social Support by Secondary Supporters across Dimensions

Sl.No.	Dimensions	Mental Health
1.	**Basic Needs Support**	.102
2.	**Emotional Support**	.084
3.	**Physical Health Support**	.180
4.	**Mental Health Support**	.018
5.	**Life Skill Support**	.082
6.	**Instrumental Support**	.132

Source: Computed ** Correlation is significant at the 0.01 level (2-tailed)

Table 21 highlights the correlation of mental health and adequacy of social support by secondary supporters across the dimensions of social support. The table shows that there is no relationship between mental health and adequacy of social support across the dimensions.

Table 22:Correlation of Mental Health and Availability of Social Support by Tertiary Supporters across Dimensions

Sl.No.	Dimensions	Mental Health
1.	**Basic Needs Support**	.066
2.	**Emotional Support**	.197
3.	**Physical Health Support**	.094
4.	**Mental Health Support**	.070
5.	**Life Skill Support**	.181
6.	**Instrumental Support**	.095

Source: Computed ** Correlation is significant at the 0.01 level (2-tailed)

Table 22 depicts the relationship between tertiary supporters' mental health and the availability of social support across the social support categories. The table shows that there is no relationship between mental health and availability of social support across the dimensions.

Table 23:Correlation of Mental Health and Quality of Social Support by Tertiary Supporters across Dimensions

Sl.No.	Dimensions	Mental Health
1.	**Basic Needs Support**	.109
2.	**Emotional Support**	.144
3.	**Physical Health Support**	.075
4.	**Mental Health Support**	.017
5.	**Life Skill Support**	.129
6.	**Instrumental Support**	.191

Source: Computed ** Correlation is significant at the 0.01 level (2-tailed)

Table 23 indicates the correlation of mental health and quality of social support by primary supporters across the dimensions of social support. The table shows that there is no relationship between mental health and quality of social support across the dimensions.

Table 24:Correlation of Mental Health and Adequacy of Social Support by Tertiary Supporters across Dimensions

Sl.No.	Dimensions	Mental Health
1.	**Basic Needs Support**	.108
2.	**Emotional Support**	.167
3.	**Physical Health Support**	.090
4.	**Mental Health Support**	.064
5.	**Life Skill Support**	.089
6.	**Instrumental Support**	.181

Source: Computed ** Correlation is significant at the 0.01 level (2-tailed)

Table 24 represents the correlation of mental health and adequacy of social support by tertiary supporters across the dimensions of social support. There is no correlation between mental health and social support adequacy across the dimensions, as shown in the table.

4.4 Suggestions

This section includes different suggestions given by the respondents that will improve their mental health and social support.

Table 25: Suggestions to Improve Mental Health

Sl. No.	Suggestions	Frequency
1.	**Reliance on Religious Faith & Prayer**	35 (58.3)
2.	**Self Determination**	9 (15.0)
3.	**Support & Care from Family.**	8 (13.3)
4.	**Support & Care from the Government**	7 (11.7)
5.	**Support & Care from NGOs**	6 (10.0)
6.	**Support & Care from Friends**	5 (8.3)
7.	**Doing Hobbies and Pastimes**	4 (6.7)

Source: Computed Figures in parenthesis indicates percentages

The data pertaining to suggestions for improving mental health is presented in Table 25. From the table, we can see that more than half of the respondents (58.3%) gave a suggestion to rely on religious faith and prayer in order to improve their mental health, followed by 15.0 per cent of the respondent suggesting that self-determination by the user is important for them to have a healthy mind. We can also see that 13.3 per cent of the respondents suggested that support & care from the family is important, a tenth (10%) of them suggested support and care from NGO's, followed by 8.3 per cent of them suggesting support and care from friends and less than a tenth (6.7%) of the respondents suggested that doing their hobbies such as reading books, travelling, etc. could help them in improving their mental health.

Table 26: Suggestions to Improve Social Support

Sl. No.	Suggestions	Frequency
1.	**Improving emotional support**	60 (63.3)
2.	**Support from family in household chores**	32 (30.0)
3.	**Establishment of rehabilitation & camping centres by the government, Church, NGOs etc.**	23 (21.7)
4.	**Non Stigmatization and Discrimination**	10 (16.7)
5.	**Counselling Services**	9 (15.0)
6.	**Awareness Programme**	7 (11.7)
7.	**Financial support from government**	7 (7.3)
8.	**Quality professional care**	4 (4.3)

Source: Computed Figures in parenthesis indicates percentages

Table 26 highlights the distribution of suggestions for social support from the respondents. The table shows that more than half of the respondents (63.3%) advised that they get emotional assistance in order to enhance their social support, followed by 30 per cent of the respondents suggesting in getting support from family in matters such as household chores and establishment of Rehabilitation and Camping centre by the government, church, NGOs, etc. were suggested by 21.7 per cent of the respondents, meanwhile, 16.7 per cent of the respondents also suggested in less stigmatization and discrimination. Counselling as a means of social support was suggested by 15 per cent of the respondents, 11.7 per cent also suggested awareness for social support, followed by 7.3 per cent of the respondents suggesting financial support from government and less than a tenth (4.3%) of the respondents suggested that they should be taken good care by professionals.

4.6Case Vignettes

In-depth interviews were conducted in order to understand the lived experiences of the family members of drug users in Aizawl covering aspects of their mental health and social support. These interviews were conducted with five female family members of drug users and three male family members of drug users.

4.6.1 Case 1

Mr.Tluanga (fictitious) is a 60 year old married man and has three sons. He works as a government servant and lives in a nuclear family with his wife, his three sons and one grand-daughter who is five years old. The nature of the problem is that his eldest son is a drug user due to which the other family members are affected mentally leading to deterioration of physical health as well.

His eldest son got married five years back and has one daughter. Unfortunately, the eldest son started taking drugs after marriage due to peer influence which led him to divorce due to addiction. His son works in a private sector but would finish his one month salary within two days spending it on drugs. He would be out till late night which made Mr.Tluanga and his wife worry and feel uncomfortable about his where-abouts. He was admitted in a Rehabilitation in Delhi in the year 2017 for about three months. But then, he relapsed again after a while. There are times when he would stop taking drugs but again relapse due to influence by friends. He also had multiple suicidal attempts but luckily he was saved in time by his family members.

The abuse of drugs by Mr.Tluanga's eldest son affected the whole family mentally leading to physical health problems. His son is dependent on him for money which he uses to take drugs, therefore, financial issue has become one of the family problem also. Although, the son is not a bad person, yet, when he is under the influence of drugs, he would get out of control trying to create disputes within the family as well as outside the house. Mr.Tluanga and his other family members have tried many ways to help him overcome his addiction, but, it does not last long.

Due to his son's behaviour, Mr.Tluanga had lack of sleep, and at times would take leave from work because he had to stay at home and look after his son and sometimes the reason would be due to lack of sleep. There are also times that he had to call on the police to help them. The younger son would also face shame among peers because of his elder brother. All these experiences and struggle led him and his other family members to various mental health issues such as stress, depression, loss of appetite leading to health problems and could not stay focused. Mr.Tluanga would often lose hope and believe that living has no meaning. The only thing that they could rely on is to pray and ask for help.

Mr.Tluanga and his family received moral support from their peers getting different suggestions such as keeping their son in a rehabilitation centre and camping centres and handing him over to the police. He did not receive support from the society because of the stigma attached towards drug users and their family member. With regards to support from church, the youth of the church would come and visit them once a quarter which is very helpful yet insufficient. They do not receive any kinds of support and aid from the government sector.

The social support suggested by Mr.Tluanga that could be helpful to support them is to have conduct more awareness programmes for the public by the government and that there should be more counsellors for the affected family member as well. The church should have more family visit, praying for them and supporting them. The government should also establish good rehabilitation and camping centres for drug users.

Analysis of Case 1

This case shows how drug abuse by an individual can affect the family as a whole. Mr.Tluanga's case is a perfect description of how a drug user in a family affects other family members leading to many mental health issues such as stress, depression, deterioration of physical health as well and even suicidal ideation. We also learn that the affected family members do not receive much support from the secondary groups i.e. church, friends, community as well as the tertiary groups i.e. government supporters. However, from this case, we can learn that getting support from others could help in reducing mental stress.

4.6.2 Case 2

Mrs.Siami (fictitious) is a 53-year-old widow who lives with her 4 children – 1 son who is the eldest while the others are daughters. Her husband died in 2000 due to an unfortunate accident. After the death of her husband, she has been struggling to take care of her family and she is the only breadwinner of the family. Due to this, she is unable to devote more of her time in developing a healthy relationship with her children. She admitted her son to a boarding school. Perhaps as a result of all this, her son started experimenting with gateway drugs when he was in class 9 in the boarding school.

The son completed his class 12 and trained in photography. After a few years, the son continued to indulge in stronger substance abuse. His behavior started to change and he started withdrawing himself from his family. As they all live together, Mrs.Siami started noticing changes in her son and tried to stop him from further addiction. Still, the son had no intention of stopping his drug abuse and this caused a severe strain on the family relationship. At first, Mrs.Siami, due to her anger and mental pain, stopped talking to her son for several months. But she realized that she is the only support that her son has. There was no support from other relatives, either morally or financially.

He became aggressive and irritable, sometimes even getting physically abusive with his siblings when he has the urge for a fix. To rub salt in the wound, their neighbours blamed and denounced the whole family and poured scorn on them. This put a heavy mental strain on the family of Mrs.Siami. The addict also put a financial strain on the family as he needed money to buy drugs, and as he has no source of income, he relied on his mother. Relatives, instead of supporting them, deride and ridicule them. The other siblings find it stressful to stay at home and often try to find excuses to stay away. Mrs.Siami suffered a lot of grief and also guilt as she somehow blamed herself for not taking enough care of her son.

They received a good deal of support from the local church's youth organization, the KTP in the form of prayer, camping and other recreational activities. Mrs.Siami sent her son for the gospel camping whenever they are organized. He would abstain for a few months after the campings, but would eventually fall back to his old habits again. The family find it difficult to put any kind of trust in the addict, and they do not trust him to work as he may use any money he earns for buying drugs. The lack of trust further puts a strain on their family. Mrs.Siami feels that the only relief she gets is from prayer and trust in God. Apart from the free rehabilitation and gospel camping organized by the church, there was no financial support from any source whatsoever. Mrs.Siami's family became financially strained, both from the cost of treatment of the addict and the money spent to support his addict lifestyle. She has to bear the entire burden herself, however, she shares her problems with her close friends who provide her mental support. She wished that the church provides a form of counselling to the family members as well. The gospel camping only usually last a short time, and this time is

often insufficient for rehabilitation, so it is oftentimes better to admit the addict in a home. However, the fees are usually very high and are unaffordable for the economically weaker section. Thus, Mrs.Siami wished that the NGOs or government make provisions to provide rehabilitation homes for a lesser price.

Analysis of Case 2

This case highlights the problems faced by broken family and how this can lead to drug abuse. We learn that a single parent like Mrs.Siami has to juggle between earning for her family and caring for her family, which ultimately leads to her son developing drug userion who started from gateway drugs. Being, the only breadwinner, Mrs.Siami blame herself for her son's addiction as she did not spare enough time with her children for a fealthy relationship. Change of behaviour and withdrawal from the family by the drug user caused strain in the family relationship leading to various mental health issues and financial constraint causing lack of trust, further tearing the family apart. The relatives deride and ridicule them, while the neighbours blamed and poured scorn on them rather than supporting them for a better recovery. We can learn from this case that stigma against drugs addict and their family still exist in parts of the state. The family did not receive much support from secondary or tertiary supporters. However, they did receive support from church organizations in terms of prayer, camping and other recreational activities, somewhat helping alleviate their mental stress but is not sufficient enough. This case also showed that good rehabilitation centres or homes at an affordable price are still lacking. Therefore, NGOs and government should take initiatives measure in providing awareness and rehabilitation centre.

4.6.3 Case 3

Mr.Kima (fictitious) is the second youngest of 5 siblings, 3 girls and 2 boys. The eldest died tragically in 1998 due to a heart attack. Their family has no history of drugs or substance abuse. Around 2002, he had his suspicions that his younger brother is taking drugs. He believes that his brother started taking the pills as a recreational drug. He became suspicious of his brother as his behaviour changed and stayed at home all day long. After the family confirmed their suspicion, they confronted him and tried to intervene. But his habit grew worse and worse as time passes.

In 2006, Mr.Kima and his family learned from other relatives that his younger brother started injecting drugs. They tried various methods of intervention and rehabilitation. They admitted him to rehabilitation homes on various occasions. It is usually effective for some time. But he would relapse again every time. They would re-admit him to the rehabilitation homes on his own volition, but the results were always the same.

The family tried to forcefully rehabilitate the addict brother by restricting his movements outside their house. But he would somehow find ways to slip out while they are not on guard, and sometimes his friends would bring him drugs to their house and pass it to him in secret. Mr.Kima experienced pain both from seeing his brother being unable to function like a normal person and also from seeing his brother's health in such a dilapidated state. It took a toll on his mental health too, and became a constant source of stress for him. He tried to provide care and love to his brother as best he could, and although his brother showed signs of remorse, it was not enough to help him abstain without professional help. The only professional help they could find was through a rehabilitation home.

Mr.Kima and his family felt no stigmatization from society. However, they still feel ashamed and withdrawn from society. Although they come from a well-to-do family, the addiction has also caused a financial burden on the family. Mr.Kima, as the older brother, used to be very close to his younger brother and they share a lot of friends, thus he suffered the most from his brother's addiction. It made him guilt-ridden, as he felt it partly his fault for not noticing it earlier and for failing to stop him from falling into addiction. He also felt ashamed before their friends, withdrawing from most social activities. He found renewed strength from the constant support of friends and church youth groups, who never gave up on them.

The whole situation has affected Mr.Kima even in his studies, although it also motivated him to become involved in the medical field in order to help more people like his brother. After completion of his studies, he has tried his best to rehabilitate his brother and is successful to a certain extent. However, they are afraid that he might relapse so they are constantly maintaining vigilance. He felt that they received good support from immediate family and relatives as well as the church. They felt

most reassured from receiving prayers of the church members. They wished for the church to have their own rehabilitation home under the management of a pastor.

Analysis of Case 3

Mr.Kima's case shows that even with the same upbringing among siblings, there can be some that still develop drug userion. One of the reason become an addict is by starting to take pills as a recreational activity leading to injecting of drugs. It shows that family problem is not always the cause for developing addiction. The affected family members tried various methods of intervention and rehabilitation process including showing compassion and loving to the user, but it lasted only for a short period. The one particular reason for relapse is due to the supply of drugs by friends. There is also financial burden even if they have a good source of income. Further, from this case, we see that even without feeling any stigmatization from society, the family still feel withdrawn and guilt-ridden. The mental stress affects their family functioning and personal lives. It also shows that support from friends and church members can help strengthen the resolve and relieve mental stress of the family members. Having the knowledge to properly care for an addict family member is also of immense help.

4.6.4 Case 4

Mr.Muana (fictitious), 48 years, lives with his wife and his 5 children – 2 boys and 3 girls. He is self-employed and is the sole earner of the family. One of his sons, Hminga (fictitious), started experimenting with drugs when he was still in high school back in the year 2000, seemingly from peer pressure in his school. He soon developed an addiction and when the problem became more severe, Mr.Muana and his wife only came to know about it, that too from someone else outside of their family. This was almost 10 years after Hminga started experimenting with drugs. They never noticed their son's addiction nor did they have any suspicions. They blamed themselves for being so ignorant and missing the signs. They felt that they could have prevented this from happening if only they noticed earlier.

After Mr.Muana and his family became aware about Hminga's addiction, they tried to give any form of support and care they can in the home. They tried whatever means they can think of to help him recover, but to no avail. When they were at their wits' end, they sent him to a boarding school outside the state in the

hopes that he will abstain from his addiction as it will be next to impossible to acquire drugs in the hostels. However, this did not seem to be successful as he still had access to drugs somehow. When he is at home, he would steal stuff from their own house and sell it to get money for drugs. He became irritable and withdrawn from his family. Mr.Muana would send Hminga to gospel camping whenever they are organized by the church. They received lots of support and prayers from the church community. But as most cases of addiction, he would relapse shortly after coming out of the camping. The camping programs did not last long-enough for them to fully recover.

The addiction problem of Hminga has sent the family dynamics spiraling downwards. They are on constant alert for any deviant behaviour which caused them to be mentally stressed. His brothers and sisters are in a constant state of pain and anger along with being ashamed of their brother, which is fuelled by the frequent abashing they receive from others. They would feel untroubled at times, but most times they feel hopeless and helpless causing them to lose faith. They did not feel like participating in church activities and feel spiritually displaced. They are affected not only mentally but also physically as they often have no appetite due to the stressful environment in the house.

Mr.Muana and his wife also experienced deteriorating mental health due to their concern for their son. They would even go to a psychiatrist on numerous occasions. Within the helplessness they felt, they still have a sliver of hope that Hminga would recover. Thus, by clinging on to this little hope that they have left, they refuse to give up on their son. Although they risk being ridiculed for their situation, they did not hide the fact about their son’s addiction. Instead they would often ask for help from neighbours and friends. Hminga has a girlfriend who also provided support to him and she constantly nagged him to give up his addiction. This has also helped to give the family a new hope for their son. Although they wished for a professional counselling service to the affected families on a regular basis, it is still lacking and the government and NGOs are still ignorant about the importance of such services. They are praying for him every day and this prayer has also become one of the foundation for their mental health support. They believe that it gives them courage and renewed strength and that their prayers will become fruitful one day.

Analysis of case 4

The case is an example of how peer pressure can lead someone to addiction by experimenting it. Mr.Muana and his family wished that they were more alert about their son's situation and blame themselves for being ignorant. It also shows that having an addict brother causes a severe amount of mental strain and pain to the other siblings. Mr.Muana and his wife also suffered deteriorating mental health even needing the help of a psychiatrist as they felt helpless and hopeless, starting to lose faith and they are always in constant alert for any deviant behaviour of the users. Further, the family members are withdrawn from the church activities and spiritually displaced because of feeling ashamed. This case also shows that the addict having a romantic relationship with a non-addict may help in curbing his addiction. Asking for help from friends and neighbours may also help somewhat. Prayer is one of the pillars for their mental support. It highlights that NGOs and government agencies are still ignorant about the importance of support and counselling to the affected family members.

4.6.5 Case 5

Mrs.Nuni (fictitious),33, lives with her husband, Mr.Zira (fictitious) and his mother. Her other siblings had already gotten married. She and her husband met through friends and recently got married. Mr.Zira is 29 years old and his father left them when he was 13 years old. Although his father pays them alimony and maintains a certain degree of communication, he was particularly hit hard by the separation. The mental stress brought along by this and the peer pressure he received lured him into starting with drugs when he was only 18 years old.

He never drank alcohol and first started with pills. It helped him relax and sleep more easily. It offered an easy way out from the emotional damage he was dealing with. His drug use escalated, he was out of control and mere pills could not provide the same fix as before. He gradually moved to injecting drugs. When his mother finally found out about the addiction, she was devastated. From a truly delightful child and loving son, he became distant, reclusive and often times verbally abusive. They soon became a dysfunctional family.

Before he got married, only he and his mother lived together and his addiction caused his mother to be in a constant state of turmoil - never knowing what he is up to and never truly trusting him. He doesn't seem to care about anything or anyone. He became thin, spotty and reclusive. She was heart-broken to see her beloved son gripped by the evils of drugs, made worse by the associated lying and deceitfulness that also came with his habits. His estranged father does not seem to care about their plight and distanced himself farther.

Mrs.Nuni, although knew about his problem, but she believed that she could change him for the better and help him recover from his addiction. However, this became more like a fantasy. Instead of recovering, it became worse after their marriage. Although she loved her husband completely, the pain caused by the addiction puts a strain on their marriage and also made them to struggle financially. Although they have a good source of income, it was not enough to sustain his addiction. He constantly lied to her face, promising her that he will stop. But they were just empty promises. They would often fight over money, as he always needed more for buying drugs. The feeling of helplessness is unbearable for Mrs.Nuni. Her husband sometimes did not come home at night and is off somewhere getting high. Countless sleepless nights due to the stress and worry about him had left her physically tired. Although her husband is not physically abusive, she felt emotionally abused. She was also shunned by friends and family for marrying a known drug user.

Mrs.Nuni and her mother-in-law tried several methods of rehabilitation. They admitted him to gospel campings, de-addiction centres and also took him to see several counsellors. The rehabilitation programs seem to help only a little. They received little support from society and struggled mostly on their own. They have a few trustworthy friends who support them and Mrs.Nuni is also able to find multiple silver linings in her family's ordeal, even if the reality is that her husband may never fully recover. The friends who came around her and supported her, mentally and financially at times, are one. Another is the tremendous strength and untapped resilience she was able to discover in herself and her mother-in-law in the midst of a genuine crisis. They are trying their best to support and care for Mr.Zira and continue to find ways to help him recover.

Analysis of Case 5

This case shows that a broken family makes a person more susceptible to drug abuse in ways that makes them to take drugs in order to cure their mental stress. It also shows the mental stress suffered by a single-parent over their child's addiction. Mrs.Nuni's case is a good example of the false notion that partners usually have about marrying drug users – that trying to change them on their own is more like a fantasy. Promises of becoming clean because of a loved one seldom last, and instead they end up hurting the person they love and are shunned by friends and families for marrying a known drug users. The change of behaviour of Mr.Zira led to dysfunctional family and state of turmoil including countless sleepless nights due to stress and worry further leading to deterioration of physical health. Not only that, they also have financial issues even if they are from a well to do family. From this case, we learn that spouses can suffer extreme mental stress and be emotionally abused by their drug using partners. It also shows that the support from friends is a valuable asset to help improve mental health of affected family members as there is lack of support from society.

4.6.6 Case 6

Dr.Ruati (fictitious) is a medical doctor and married with 3 children. Her father is a retired pastor and she has 5 siblings. They have one brother, Sanga (fictitious) who is the eldest. As a youngster, he was considered bright and smart, excelling in his studies. Unfortunately, early on when drugs abuse was still relatively new in Mizoram, i.e. around 1985, Sanga also started injecting drug. He was just 17 years old. He did not have a history of alcohol or taking pills. It was mainly due to peer pressure as he often hung around with drug users. It was ironically considered being among the cool crowd to be able to inject drugs during those times. Dr.Ruati's family learned about the abuse from others.

Sanga's addiction began to take a toll on his health, and he started to show signs of poor mental health. He was self-harming, anxious, paranoid and, at times, psychotic. His addiction also put a strain on his personal relationships. He got married 3 times, and even had a son. However, his addiction did not allow for him to have a proper relationship and all his marriages ended in divorce, and also unable to care for his son. He is in no condition to find work as his drug userion takes

precedence above all else. His habit caused his parents and siblings to suffer from a great deal of pain and humiliation. Dr.Ruati, as the sibling with a medical degree, took it upon herself to be personally responsible for his recovery. They have admitted him to all the rehabilitation homes within their reach. It never produces a change, as he himself does not have any willingness and moral reason to quit. He goes back into the habit as soon as he comes out from the rehabilitation homes. He continued moving back and forth from living in his parents' house to his siblings' house. Although there were brief period of time when he seemed to have quit, he would quickly go back to relapsing, partly because of addict friends. He and his addict friends seem to have a strong connection.

The whole ordeal has left Dr.Ruati with a tremendous amount of burden and mental strain. Sanga would often leave them sleepless at nights, making loud noises and finding things to complain about. He disappears for nights on end from the house. He often steals money from her. This led to her giving him money for drugs as he would steal it anyway. Dr.Ruati, being a doctor, may be considered prestigious in society, but her brother would often drag her name down in the mud. Her health has also suffered as a consequence of the trauma and stress. The embarrassment they felt caused them to be withdrawn from society. The almost non-existing support from society and church did not help. Her whole family is also uncoordinated in providing support, including verbally and financially. The government provides no financial support to them either. The financial burden mostly falls on her and as she herself has a family to support, this often times caused a strain in the relationship with her husband, although her husband is fully supportive and helps with the care of her brother.

Sanga is now 53 years old and still shows no hope for recovery. His mental and physical health has deteriorated extremely, with continuing paranoia and psychosis. His family has in part given up on him, and resigned themselves to accept the situation. Dr.Ruati wished that there were home visits and family counselling programs. She felt that it is better to have a dedicated person working on counselling rather than someone with just high qualifications. Apart from awareness campaigns, she felt that the government should invest more in rehabilitation programs.

Analysis of Case 6

Dr.Ruati's case shows the burden and mental stress that is suffered by siblings of drug users as well as the financial burden carried by them. It shows that in spite of having a prestigious position in society, having a drug using family member can still cause them to be embarrassed, humiliated and be withdrawn from society. The illegal use of drugs can lead to self-harming, anxiousness, at times psychotic behaviour including strain in their personal relationship. Their physical health is also often affected as a consequence of their severe mental stress along with the affected family members. There is also financial issue as Mr.Sanga would steal money for drugs due to which they had to give him knowingly. Due to heavy burden laid on Dr.Ruati, she would often have sleepless nights, thus resulting to deterioration of physical health. It can also be learned that self-determination and willingness of the addict is very important in the rehabilitation process. The importance of co-ordination between family members in taking care of a drug user is also highlighted. Therefore, measures to provide family visit and family counselling by a dedicated person rather than highly qualified person should be made.

4.6.7 Case 7

Mrs.Nghaki (fictitious) lives with her family and her husband's younger brother Chhuana (fictitious). Mrs.Nghaki's husband and Chhuana, 27 years old, did not have any other siblings. Their parents had passed away a few years ago. During his early teens, Chhuana started using drugs. At first, cough syrup and painkillers, but quickly he spiraled into using stronger drugs. That was in his high school days. He was heavily influenced by his peers who were slightly older than him. He started trying various other drugs and substances and, unfortunately, developed an addiction that began to have a devastating impact on his life. His addiction meant he was unable to function, which meant he could not hold down a job. Although his family had an inkling that he had been experimenting with cough syrups, which was already concerning — but the fact he had been using drugs came as a frightening surprise.

As his addiction grew, his family saw a total change in his personality. At first, he refused to believe he had a problem and deflected the blame onto others. His life ultimately spiraled out of control. He got married in 2016 and got divorced just after two years. They did not have children. His drug use was the main reason for

their divorce. As his dependency grew stronger, he started suffering from insomnia and cannot sleep without popping some pills.

Mrs.Nghaki has lived with her family along with Chhuana for 10 years. Although they love him very much, he has put a huge strain on the family relationship. They are struggling financially because of his addiction as he did not have a job. They have not admitted him to any rehabilitation home. They have talked about rehabilitation, but have not acted on it yet. When he is sober, he is caring and loving towards his family, nephews and nieces. But there was a conflict between the love of his family and the dark side of addiction. Due to his substance abuse, he had suffered four psychotic episodes. These episodes affected the children mentally. They spend most nights without sleeping. They have consulted a Psychiatrist several times, for his episodes and for his addiction. He would seemingly recover for a few months, but would relapse again. His relapses are mainly because of the influence of his old friends.

Mrs.Nghaki's family felt humiliation and shame. Their children are also in a state of alertness and fear of their uncle, not knowing when he will have another psychotic episode. The episodes made it easy for the family to be mocked by others. The children are sometimes ridiculed even in school because of their uncle. They received advice from neighbours but felt secretly scorned by them. Although they receive moral support from society, there was no financial support. The church community has also offered their best support with prayer. Their relatives have also offered their support, even giving them financial support at times. They have benefitted from family counselling. Her family has accepted that they are powerless and rely heavily on prayer.

Analysis of Case 7

This case shows how gateway drug influenced by peers can lead to injecting drug that can completely change the personality of the user and how it affects other family members. These drastic changes in personality caused trauma to children living in the same household as addiction led to psychotic episodes. It becomes difficult to maintain a proper relationship with loved ones and tends to put the blame on others. There is also financial strain because of the amount needed for drugs as there is no financial support from the society and government except in few

situations where relatives tends to give money for treatment process which is insufficient. The humiliation suffered by the family affected their mental wellbeing. The stigmatization and discrimination suffered by family members and the children even extend as far as their school and being mocked by others. It shows that the public still need awareness in this regard. It also shows that when all other measures seem to fail, the family relies heavily on prayer and their religious faith.

4.6.8 Case 8

Mrs.Biaki (fictitious) lives with her husband and 5 children. She is a loving and caring mother who devotes her entire time to her children. Unfortunately, despite all this, her youngest daughter, Rini (fictitious)) struggled with drug use. It all started back in 2014 when Rini was in a boarding school. One of her friends had started experimenting with drugs. This friend had often remarked to Rini how good it felt to get high on the substance. This enticed her to try it just once. But as with all substance, it did not end with one dose. It was like magic. One hit and suddenly, she not only was euphoric but also hyper-functional. It eventually led to her being dependent on the drugs. She confessed to her mother about her addiction. Her parents were shocked and dumfounded at the confession. This was not something they ever thought would be possible and were at a loss on how to deal with it. The initial shock turned to pain and outrage. The family was thrown in disarray.

After trying to cope with the situation, Mrs.Biaki and her husband tried their best to take care of their daughter. They admitted her to a rehabilitation home once. She relapsed soon after. She would occasionally stay off the drugs when she runs out of money. It also put a major strain on the family finances. Mrs.Biaki’s family feel ashamed of their addict daughter. There is still a lot of stigma towards drug users, and female addicts are especially scorned upon and treated more harshly. The family feel unmotivated to involve themselves in social and church activities, knowing all too well how they are viewed because of the addict daughter. There are even some who blamed them, the parents, for the plight of their daughter. This led to them becoming more and more socially distant from their local community. They did not sleep well at night due to the stress. Fortunately, their physical health is not affected too much. They receive a good deal of support from their relatives, and the church

community through prayers. Still, they receive no attention or support from the government.

Rini is 27 now. There are times when she would get clean. But she would relapse because of friends who she often hung out with. Her only friends were also addicts. Her addiction was consuming her family. They were too busy caring for her that they neglected to care for themselves. Mrs. Biaki's physical and mental health suffered as a result of resentment, humiliation, and constant anxiety for their loved one. Although she still aches for her daughter to recover, the act of sharing her experiences with others, and knowing they might benefit from knowing they're not alone, has helped her put her life back on track. She says that prayer is the key to her strength. She hoped that the church or the government would open a rehabilitation home that is affordable for the lower income classes.

Analysis of case 8

From this case, we can see how deeply family members are affected by the unexpected drug use of a loved one who started taking drugs because of experimenting with friends. The affected family members become withdrawn from social and religious activities because they feel ashamed to take part as stigmatisation still exist in the society. To add to the mental stress and burden that they have already suffered, there are some who blamed them for the drug use of their family member. This shows the lack of awareness by some parts of the population. This case also shows that neglecting one's own health in caring for an affected family member can also result in deteriorating health and that family members should care for themselves as much as they do for the affected member. It further shows that sharing experiences in caring for an affected member with other families who also have the same problem can have a therapeutic effect and renewed strength as there is no other support system to rely to. Therefore, it is suggested to open a rehabilitation home at an affordable price by the church and the government.

4.7 Key Informant Interviews (KII)

This section highlights the information gathered by interviewing different key persons from various organisations working in connection with drug abuse. A total of 12 Key Informant Interviews (KIIs) were conducted.

4.7.1 KII-1

The key informant interview was held with Dr. Alex (fictitious), who is the Caretaker and doctor-in-charge of Khawngaihna Ward. Khawngaihna Ward or K-Ward is a ward dedicated specifically for drugs addict in Synod Hospital, Durtlang and was established in 1998. The focus of the KII was regarding mental health resilience and social support of families affected by drug abuse with regards to the experience in the ward.

According to the informant, many of the families affected by drug abuse are in denial and find it hard to accept that the problem is real and we need to find a way to break this false notion which will require the co-ordination and unity of all members of society. Denial still persists in the society despite the fact that there are many problems regarding drug use which affects the individual's mental health, their resilience and also contribute to social issues.

He further added that the drug users along with their families receive little to no social support but are rather criticized and condemned. The whole family becomes a victim just because of one family member with drug abuse problem. It is the duty of the Caretaker to provide counselling and advice to the family on how to take care of the addict as well as themselves in regards to their mental health, and encourage them to seek the support of a counsellor if needed. It was learned that there are very few institutions or private clinics providing support and guidance to the affected family members.

Analysis of KII-1

This interview reveals that though drug users are kept in the K-ward which is dedicated for the special treatment of drug users, yet, the family members of the users are in denial and find it hard to accept the fact that there exist a drug users within their family. The one reason they do not wish to accept is because of the perception of the society towards them. Instead of receiving social support, they are being criticized and condemned becoming a victim of drug abuse problem as social support is crucial in the treatment and rehabilitation process. Therefore, counselling and advice should be provided to the affected family members along with awareness to the public with regards to social support and attitude towards the drug users and their family.

4.7.2 KII-2

The key informant interview was held with Ms.Brenda (fictitious), who is the main caretaker of Protective Home located at Maumual, established in 1990 under Social Welfare Department, Govt. of Mizoram. The home is meant exclusively for female substance users and the focus of the interview was to develop an understanding on the issues of the inmates.

The key informant revealed that most of the inmates are usually from Aizawl, who are usually admitted by their families or parents. According to her, there are cases of emotional blackmail among the inmates. The inmates do not know who to approach for help and assistance when they face any hardships or require counselling. She further stated that there is no support system for families and home visits and family counselling are not organized, despite the fact that the affected families are in dire need of counselling on how best to take care of the addict member. There hasn't been any research done on the parents of drug users, to her knowledge. Family support should be provided to all the affected families as it is the most important stepping stone in treatment of substance users and also to prevent other members from falling into the same vice.

Analysis of KII-2

The interaction with the key informant reveals that the inmates staying in the Protective Home do not have anyone to approach for help with regards to emotional blackmails that exist among them. There is no kinds of social support received by the drug users as well as the family members which is essential for the recreational process as drug abuse is a not a disease of an individual but rather a disease of the family member and the society. The interview revealed that the family members are in high need of availability of family counselling on how to take care of the drug users and the skills to cope with their daily stressful life. It was also found that there is no study conducted on parents of substance abusers in Mizoram till today. Therefore, family support is one of the prime importance in the treatment of drug users.

4.7.3 KII-3

Synod Rescue Home, Durtlang was established in 1987 under the management of the Synod Church. The home provides accommodation to any person who needs to be rescued from the hardship and torment of life. The majority of the patients are from Aizawl and are kept in the home based on their willingness to stay and support of their families. The key informant interview was held with Mr. Chama (fictitious), who is the Social Worker in the home. The focus of the interview is to understand the level of support given to patients in the home as well as their family members.

According to the key informant, the biggest factor for relapse among drug users is their family members as they lack the knowledge and proper skills to take care of the addicts and are unable to provide the necessary care and support. So, the home provides counselling to family members, who felt the need for it, on how to take care of the drug user family member. However, this does not fully solve the problem as the affected family members do not feel the need for support or counselling from professionals. The home also has four counsellors to provide counselling services to the patients at all times. Thus, Synod Rescue Home has one of the better provisions for providing care and support through counselling not only to the patients, but also to the family members. However, the family members are often unwilling and reluctant to receive such counselling even though family counselling and family support system plays a vital role in the process of rehabilitating patients. Awareness in this regard needs to be provided to the family in order to provide the best support to the drug abuser.

Analysis of KII-3

The interview highlights that though rescue home is being organised for providing accommodation to any person facing hardships and torment of life and they are being taken care by the caretakers, yet, the family members play a very important role. It was found that the biggest factor of relapse among the drug users is because of the lack of knowledge and inadequate skills among the other family members. The recuse home provides available counselling to the affected family members but they are often unwilling and reluctant to receive them. Therefore, awareness with regards to the importance of knowledge and attainment of proper

skills by the family members should be made in order to have a better outcome in the treatment process.

4.7.4 KII-4

The key informant interview with Mrs. Daisy (fictitious), who is a key worker under Mizoram State Aids Control Society. The focus of the interview was to get suggestions, ideas and advice with regards to the concerned topic and its relevance in the context of Mizoram. According to the key informant, the main issue faced in Mizoram in regards to substance abuse is drug abuse. As far as she can recall, there has been no studies concerned with the affected family members of drug users in Mizoram. She stressed the importance of the role of parents in shaping the life of their children – either positive or negative.

Further, she reiterated that as a society is constituted by a collection of families and individuals, society also plays an important, yet constructive role in helping drug abuse victims and their families. But rather than giving support, society often have negative perception towards the drug users and their families, leading to discrimination and stigmatization. From this interview, it was learned that while parents play an important role in the rehabilitation and recovery of drug users by providing care and support, many of the family members are unaware of this fact and lack the sufficient knowledge to take care of the drug abusing family member. Studies and awareness in this regard are sorely lacking.

Analysis of KII-4

The interview reveals that the main issue with regards to substance abuse in Mizoram is drug abuse. Though there are many different initiatives and organizations set up to reduce and treat drug users, family members along with the larger society also plays a very important in the rehabilitation process and in shaping the future generation. Rehabilitation is a group work that involves the drug user, family members and the whole society. But, disappointingly, they do not receive good social support, rather they are being discriminated and stigmatized. The members of the affected family are also often unaware of their importance and have less to no knowledge in treating the users. The effort to impart knowledge for treating drug users by the family members and the perception of the society in a positive way should be made aware.

4.7.5 KII-5

The Young Mizo Association is the largest NGO in the state of Mizoram and has many activities aimed at improving the society including youth recreation, promotion of sports and rehabilitation of substance users. The key informant, Mr. Francis (fictitious) is an Executive Committee Member of the CYMA concerned with the rehabilitation of substance users. The focus of the interview is to find out the social percept of the largest NGO with regards to substance users. According to the key informant, most substance users are shunned by society, which in turn leads to them withdrawing from their responsibilities from the church and society. Most of the family of the drug users do not accept that their family member is a drug user, in fear of being shamefaced in society. He feels that the families do not receive enough social support and admitted that even the YMA has not provided enough attention and support to them, emphasizing the need for family counselling.

The key informant feel its highly necessary for churches to conduct awareness in this regard, as the churches play a leading role in society in Mizoram and have a higher influence level than the other NGOs. The churches have not given enough effort and support till now to alleviate the situation. He stated that mental health and social support go strictly hand in hand, and that the affected families do not receive any financial support to help care for their drug abusing family member. This interview highlights the stigma still faced by the affected family members as well as lack of support both from the society and the religious organization.

Analysis of KII-5

The interview reveals that in our very own society, drug users are shunned by the people which led them to withdrawal from the society and the church as well. Due to the perception and attitude towards the drug users, the affected family members find it hard to accept in fear of shamefaced from their friends and neighbours resulting to various mental issues. They do not receive enough social support which is essential for the treatment of drug users as mental health and social support goes hand in hand. Therefore, through the interview, we can find out that awareness to the public is very important with regards to giving social support and attitude towards the drug users and the family members, and in that, the church should conduct the awareness as they play a leading role in Mizoram.

4.7.6 KII-6

Blessino Nursing Home and Wellness Centre, located at Maubawk, is one of the few private run rehabilitation centres in the state. The key informant was Mr.Faka (fictitious), a Counsellor at the centre. The interview focused on the experiences of a private centre on social support provided to patients and their families. In this regard, the key informant stated that as far as they can tell, there is no social support for both the drug abuser and their families. Instead, they are discriminated and are not accepted, which is a far cry from receiving social support. According to him, the family members need training on the way and means to take care of the drug abuser. This can be carried out in such a way that the relationship between the family members and the drug users will be healthier and stronger, resulting in a more effective treatment of the drug abuser.

The centre provides family counselling to the patients before they are discharged and follow ups are conducted through phone call. There is no support from society and the government. Religious institutions have offered some assistance, but it is insufficient. The families are also reluctant to participate in the rehabilitation process and are uncooperative when they are requested to visit their drug abusing family member in the centre. The parents simply provide the finance and do not devote enough of their time for their children. The informant also felt that awareness is crucial in order to change the perception and attitude towards drug users and their families. Through this interview, it can be seen that the Mizo society and even their own family members still lack the necessary awareness in order to provide the desired care and support to drug users.

Analysis of KII-6

The interview highlights that the family members of the drug users admitted in the wellness centre do not receive any kind of social support rather they are discriminated and are not accepted in the society. As abstaining away from drug depends on self -determination, yet, family members play a very important role in the rehabilitation process, but they are often reluctant and uncooperative to participate in the rehabilitation process. They simply provide financial support but do not spare time in treating them. Therefore, interview reveals that family members need training

in giving support to the drug users and change their attitude towards them for a better and faster recovery.

4.7.7 KII-7

LIFCODE is located at Lungbial and established in 2004. It functions as a shelter home for children below 18 years of age with deviant behaviour who dropped out from school. They work with the Child Welfare Committee of the Social Welfare Department, Govt. of Mizoram and provide psycho education and life skill education. The children come from all over the state but the majority of them are from Aizawl. The key informant interview was held with Mr.Tlana (fictitious), the Superintendent. The key focus of the interview was to understand services and support given to minors with drug abuse problem and their families. They do not give any type of social assistance to the children's family members, according to the key informant. However, they conduct monthly meetings with the families in which they are informed of the situation their child is in and what they are going through to make them more aware. They also conduct home visits for all the children once a month.

The key informant further stated that mothers of the children develop co-dependency which at times leads to the child becoming more and more deviant and abusive to substances, in the case of a substance abuser. Co-dependency has a negative impact on the family and on the health of the family members of drug users. Co-dependency is a mental illness that arises due to a substance abuse problem. But to many in the Mizo society, it’s a disorder that does not even exist. Since co-dependency problems appear in tandem with substance abuse, it’s vital for a family to get the help required in order to rehabilitate the child.

Analysis of KII-7

The interview disclose that there is a development of co-dependency between mother and child causing children to be more deviant and abusive resulting to negative impact on the child along with the other family members. The co-dependency is a mental illness that arise due to substance problem including drug use, therefore, family members should be educated and get help required to rehabilitate the child as early as possible.

4.7.8 KII-8

Mrs.Hmangaihi (fictitious), CEO of MSD&RB, was interviewed as a key informant with a focus to gain insight into the current scenario of Mizo society regarding social support to drug users. To combat Mizoram's increasing drug epidemic, the state government formed the Mizoram Social Defense and Rehabilitation Board in 1999. They are equipped with consultancy expertise and technical resource services for partner NGOs, MSACS and other agencies. The key informant revealed that the board is currently supporting two de-addiction centres. Further discussing the social support received, she notes that it is acutely lacking for both the drug abuser and their families. Such kind of support is partly given by NGOs and agencies but not by the society as a whole.

She also noted that the drug users lack confidence, have low self-esteem and are usually withdrawn from society, developing co-dependency. The support of family is crucial in helping to cope with these disorders and need to be sensitized in regards to co-dependency. Family members play an important role in helping a drug abuser with co-occurring mental health and substance use disorders get on the road to recovery. Social support, if available, can reduce stress and facilitate coping. Thus, necessary measures need to be taken to increase social support and general awareness, which is still largely neglected by the government. The board is in the process of formalizing accreditation rules through Social Welfare Department, which will allow the board to monitor and inspect activities of all NGOs involved. She added that the board faced a lot of financial constraints.

Analysis of KII-8

From the interview with the key person, we can know that there is lack of social support for the affected family members by the society and the government as well. Illegal use of drugs have resulted in lacking of confidence, lowering of self-esteem and withdrawal from society by the user. In order to abstain from drugs, family members play a crucial role by giving the necessary support to the users that could be helpful for them to cope with their daily life and in the rehabilitation process. The interview also reveals that effective measure needs to be taken by the government in giving support to the affected family members and that they should

also provide the necessary financial support to the Board in matters of drugs as they face a lots of financial constraint.

4.7.9 KII-9

Mission for Social Reform is an agency based in Tuikhuahtlang, Aizawl covering various localities in the city. Mr.Isaac (fictitious), a Counselor at MSR was interviewed as the key informant. The focus is on understanding the services available and the work being carried out in the field with regards to drug abuse and to understand the mental health, resilience and social support of families affected by drug abuse and drug users themselves. The agency has a counsellor to provide counselling to clients and an outreach worker and peer educator working in the field. According to the key informant, apart from support given by NGOs, no social support is given to drug users by the society as a whole unless through initiatives undertaken by Community Based Organizations (CBOs).

Further, according to the key informant, the families of drug users are also neglected, with no support given to them, and sometimes even ostracized by society. Due to this, the families feel distressed and it can greatly affect their mental state and well-being. The provision of counselling and mental health awareness is imperative to create a healthy environment for recovery. From this interview, it may be concluded that the need for social support and counselling services to affected families is momentous.

Analysis of KII-9

The interview reveals that certain initiatives have been taken up by the Community Based Organisations (CBO) in giving support to drug users but no social support by the society in general. Not only do the drug users lack social support, even the family members are also neglected with no support leading to distress and effect on mental health. Therefore, through the interview it was advised that, provision of counselling and awareness of mental health should be made for the drug user as well as the affected family members.

4.7.10 KII-10

SHALOM is a society established in 1993. A Drop-in Centre which provides OST to clients all over Aizawl was opened at Zarkawt. Mr. Jacky (fictitious), a Counsellor was interviewed as the key informant with a focus on finding out the support received by drug users from the perspective of a drop-in centre. The informant asserted that they do not provide direct family counselling but conduct mass meetings with the family members every three months. He stated that the drug users did not receive the expected support from the government and society. Their families also lack the proper skills and knowledge to take care of them. The key informant stressed the importance of family in the life of a drug user, as the family dynamics plays a huge factor in a person falling into drug userion. One sad fact highlighted by the informant was that most of the clients of the centre come from a broken family, with no parents to give them support. The society is very much alert when it comes to things perceived as social evil. However, perhaps due to the prevalence of stigma and discrimination, the key informant iterated that there is no support given to drug users and their families from society.

The informant stated that although churches gives good support, he suggested that religious organizations take a more active role and proposed that every church has a counsellor. He also felt that the YMA is not conducting enough awareness campaign. As the CYMA is the largest NGO, they are the most effective force in providing the necessary awareness and support. According to him, the role played by the government is inadequate as it did not provide suitable financial support and fails to create proper awareness among the public. This interview highlighted some of the problems persisting in regards to support by society and the government.

Analysis of KII-10

The interview highlights that majority of the clients coming to take OST are from a broken family with no parents to give support. Not only do they lack of support from family, but also lack from the society and the government as well rather there exist stigmatisation and discrimination from the society. The little support that the clients receive from their family is not enough so family members need to be given knowledge and proper skill to take care of the drug user. It was also recommended by the key person that every church should have a counsellor and play

more active role, and YMA should also conduct more awareness and campaigns in the perception and attitude of society towards the drug users and the family members along with the ways of social support system. Also, the role played by the government is inadequate as they do not provide any financial support required for the rehabilitation process.

4.7.11 KII-11

The Seventh-day Adventist Church, one of the Christian denominations having its presence in Mizoram, has been conducting revival camping and rehabilitation programs for drug users. One of their programs, NEWSTART being run at the Adventist Hospital, aims at providing rehabilitation and recovery through a series of natural remedies, good food and exercises. The key informant interview was held with Mr.Kima (Fictitious), a pastor and the Youth Director for the church. The focus of the interview was to find out the level of support given by religious organizations to drug users and to gain insight on their treatment of drug users. According to the key informant, the drug users are affected mentally and spiritually. Their spiritual capacity diminishes and their moral compass broken. The affected family feels greatly distressed and feels shamefaced and becomes withdrawn from society and the church. The societies still finds it hard to accept the drug users and are disdained.

The key informant felt that the church did not take an active role and has utterly failed in providing support. Some level of support is provided through revival camping but this does not provide the necessary support to family members. The participation of the drug users in such rehabilitation programs rely heavily on his cooperativeness and willingness. Thus, it is essential to build a sense of mutual trust with the addict. The key informant asserted that having a healthy relationship with the drug user will result in a better mental health and showing kindness to them is essential in order to convince them to enroll in such rehabilitation programs. However, the proper awareness to the public is still lacking. From their experience, small group workshops and trainings are quite effective in providing awareness. He felt that the media should provide more awareness in regards to support to be provided by their families and for them to recognize when the drug user family member has relapsed.

Analysis of KII-11

From the interview, we can know that illegal use of drugs can affect a person mentally and spiritually and the family members are also withdrawn from society and church because of the shame and distress they face. Although drug users can be found in almost all the localities in Mizoram, Aizawl in particular, yet, they are still not accepted by the society wherein there is lack of awareness in this regard. One of the effective measure in the rehabilitation process is to build mutual trust and show kindness towards the addict and the affected family members but even the church fails to do so. Therefore, small group workshops and trainings should be organised and media should also provide more awareness with regards to social support.

4.7.12 KII-12

Mr. Rama (Fictitious), a Counsellor in a drop-in centre at Melriat run by Social Guidance Agency was interviewed as a key informant with a focus on finding out the support given to drug users and issues faced with distribution of OST. According to him, the drug users suffer from depression and feelings of being an outcast of society. They have a multitude of issues including in terms of money. The informant feels that the religious organizations and society gave support as best they can, but awareness is still lacking and the government has given little to no support including in terms of financial support.

The informant feels that one of the most important thing is to create awareness in regards to OST and its benefits. The media should be encouraged to create a wider awareness. Some religious organizations have started opening their own OST centres. Although the social support has improved gradually, some communities are against opening OST centres in their locality. He further discussed advocacy meetings, which are meetings held with leaders of the locality to discuss the support that can be provided by the community. These advocacy meetings are supposed to be held twice a year, but are usually delayed due to delays in funding. The delay in funding also caused the workers not receiving their pay on time. This interview pointed out the importance of government support to provide the necessary services.

Analysis of KII-12

The interview reveals that there is lack of awareness in providing social support to drug users and their family members as lack of support leads them to suffer from various mental issues and feelings of outcast from the society. The importance of Oral Substitution Therapy (OST) and its benefits along with the social support system should be made aware to the general public through media as it is helpful in the treatment process. As of now, there is no government aid including financial aid received by the affected family members and the advocacy meeting is also being delayed due to financial constraint. Further, the workers do not receive pay on time due to the delay in funding by the government. Therefore, the government should look into the consideration and take effective measures in providing the necessary services as they play an important role in the rehabilitation process.

CHAPTER V

CONCLUSION

The study attempts to profile the socio- demographic characteristics of family members of drug users, find out the mental health status and the social support system that they receive within their family, from secondary as well as tertiary supporters across various dimensions. It will also delve into understanding the relationship between mental health and social support. It also attempts to suggest measures for effective interventions to improve mental health and social support for family members affected by drug use.

Drug abuse is a major problem being faced in many parts of the world. It not only causes pain and suffering to the individuals involved, but also those around them which includes their family members, relatives and the society as a whole. Drug, being a multifaceted and multidimensional problem, has an impact on the mental health of the family members of drug users. The mental health of the affected family members is shaken socially. Also, the social support system of the affected family members from primary, secondary and tertiary supporters has an impact on their mental health and further helps in the recovery process.

Although the percentage of drug users in Mizoram is quite high, there are negligible studies in regards to the affected family members. As a result of this, we are more or less unaware of their mental health status. The family members themselves are also generally unaware of their mental wellbeing and measures that can be taken to improve their mental health. The social support received by the family members also needs to be strengthened through various measures and interventions in order to provide a more effective support system. More studies in this topic can help in creating more awareness and also help in identifying better measures that can be implemented to improve the mental health and support system of the affected family members.

The study is exploratory in design and cross-sectional in nature. Mixed research methods i.e. quantitative and qualitative methods are used for the study.For this study, data was gathered from both primary and secondary sources in the Aizawl Municipal area. Primary sources include family members affected by drug use and

secondary source include information collected from government and non-government reports and data.

A semi-structured interview schedule formed the tool for data collection in order to gain information to achieve the objectives of the study. The tool also included standardized questionnaire based on Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) to find out the mental health status of the affected family members which were divided into low, medium and high mental health depending on the overall score on the scale

In order to find out the social support of family members of drug users, five (5) point structured scale was used to measure three items each such as the availability, quality and adequacy of social support across various dimensions of social support *viz*. basic needs support, emotional support, physical health support, mental health support, support in life skills and instrumental support. Case studies and participatory techniques which include Key Informant Interviews were also conducted to collect information and knowledge to meet the objectives of the study. Data were analysed by using Microsoft Excel and SPSS Package. Simple frequency and descriptive statistics were highlighted to interpret the findings of the study. The sample size for the quantitative study was sixty (60) and twenty (20) for qualitative study. The sample for quantitative study was collected from any female or male individual who has been affected by drug abuse and only those who gave consent.

5.1 Major Findings

The study was able to generate relevant findings about the family members of drug users in Aizawl, Mizoram. The following are the key findings:

1. The age group 20-39 years had the highest number of respondents, followed by 40-59 years, and 60-75 years had the least number of respondents.
2. Female responders made up more than half of the total.
3. The Lusei sub-tribe accounted for the majority of the respondents.
4. The Presbyterian Church is comprised by over half of the respondents.
5. With regards to the type of family, majority of the respondents were from nuclear family and only small amounts were from joint family.

6. Almost all the respondents were from a stable family and only few respondents were from broken and reconstituted family.
7. One- third of the respondents had an educational level of high school, followed by higher, graduate, primary, middle and post graduate level of education.
8. The family occupation of a significant number of respondents was Government servant and business.
9. Nearly half of the respondents' family monthly income was between Rs. 10,000-30,000.
10. Majority of the respondents were from the APL category while the other respondents were from other category. However, there were also those who do not have any category.
11. From the WEMWBS scale, it was found that more than half of the respondents fall under the medium mental health category , followed by those in the low mental health category and only less than a tenth fall in the high mental health category. So, from the study, we can find that there are very few respondents who have high mental health which is essential for a healthy living. Therefore, there is still scope for improving mental health. *This findings is consistent to the study conducted by Satorius, et.al.(2015) talking about the different mental disorders and their characteristics and how it causes burden to the family.*
12. From case vignettes, it was found that majority of the respondents suffered from mental issues leading to health problems which even led to losing hope and suicidal ideation. Due to the grief, guilt and stress that hasbeen poured upon them, many a times, they lack sleep which causes problems in their normal routine.This findings is consistent to the study by *Figlie, et, al., (2004) where the affected family members including children face shyness, inferiority feelings, depression, family conflict and need for warm-heartedness.*
13. It was found that emotional abuse existed within the affected family members leading to family dysfunction and strain.*This is also consistent with the findings of Barnard (2007) where the effects of drugs caused the feelings of anger, sadness, anxiety, shame, and loss by the affected family*

members. Also, according to Deutsch (1982), the family is experiencing emotional turmoil as a result of humiliation, guilt, wrath, and frustration.

14. Through Key Informant Interviews, it was found that many family members were in denial and found it hard to accept the fact that there exists a drug user in their family.*This finding is consistent with the study of Butler and Bauld (2005) where the families often cope alone with the problem of their child's addiction in secret for several years.*
15. The overall findings from social support scales indicates that the availability, quality and adequacy of social support is medium respectively with regards to support from primary, secondary and tertiary supporters across various dimensions. The dimensions include- basic need, emotional need, physical health, mental health, life skills and instrumental need.*This finding is consistent to the study of Palen (1979) mentioning that drug use is considered a social issue but the affected family members cope alone with their problems.*
16. The overall availability of social support from primary supporters is high along with quality and the adequacy across various dimensions. However, the quality and adequacy of life skills is medium with the adequacy of mental health.

    This finding is consistent with the study of Sheldon and Macdonald where growing awareness of the importance of family support plays an important role. Also, Zigler, et, al., (1992) through their research suggested that interventions targeted at family support have greater potential.
17. From the findings, the overall availability, quality and adequacy of social support from secondary supporters is medium respectively. However, it is high in terms of the availability of emotional need. *This finding is consistent to the study of Alistair (1985) where he mentioned that the main social influences on drug use relates to minority group society, parental loss, alienation, disharmony or disease, low income, divorce, relationship failure and peer group impact. Also, it is consistent to the study by Ritanti, et, al (2017), where it was found that the family received unfair treatment from society while expecting support.*

18. The overall social support from tertiary supporters with regards to availability is medium, quality is also medium but the adequacy of social support is low. However, besides the availability and quality of all the other dimensions, it is low with regards to basic needs.
19. From the qualitative study it was found that rather than support from friends and society, the affected family members often faced shame and mockery, are being criticized and condemned, which led them to withdrawal from society as well as church activities. They often face discrimination and stigmatization from the society.
20. Almost all the respondents did not receive any financial support from the government as well as other supporters which led to many financial issues.
21. The findings related to the correlations between mental health and social support among the family members of drug users reveals that there is no correlation between mental health and availability, quality and adequacy of social support by primary supporters across dimensions. Moreover, there is no correlation between mental health and availability, quality and adequacy of social support by secondary supporters across dimensions. Further, there is no correlation between mental health and availability, quality and adequacy of social support by tertiary supporters across dimensions
22. Majority of the respondents suggested that reliance on religious faith and prayer is helpful to improve mental health, suggestions to have self-determination by the drug user, support and care from other family members, support and care from the government, support and care from NGOs, support and care from friends and lastly, doing hobbies and pastimes as a means of improving their mental health, has been suggested. The majority of responders in the qualitative study agreed the same.
23. Majority of the respondents suggested emotional support to improve social support, followed by support from family in matters such as household chores, establishment of rehabilitation and camping centre by the government, church, NGOs., non-stigmatization and discrimination, counselling, awareness, financial support from government and

suggestions for drug users to be taken good care by professionals. These suggestions were also found in the qualitative study as well.

5.2 Suggestions

Here are suggestions to improve mental health and social support for the family members of drug users in Aizawl, Mizoram:

1. One of the main consequences of drug use is its impact on mental health of the drug user as well as on the family members.Although there have been several research on the effects of drugs on the user, there have been little studies on the mental health of impacted family members. Therefore, the need for conclusive studies in this topic is of the utmost importance in order to improve the mental health of the affected family members which will in turn help in the recovery process of the drug users.
2. There should be more studies on the social support received by the affected family members in order to improve the support system across all dimensions from different level of supporters.
3. Family is one of the strongest support system for drug users. However, family members often do not have the essential knowledge and skills to provide the required support. Training courses could be offered to the affected family members in order to provide a more efficient support system.
4. According to the findings, the majority of respondents in the WEMWBS have medium mental health and are ignorant of their own mental health status. They should be educated about the importance of mental health as well as their own mental health status so that they may take appropriate steps to enhance their mental health.
5. There is still a lot of stigmatization and discrimination towards not only drug users, but also their family members. Sensitization and awareness on drug user as a disease must be initiated at the grass root level to reduce stigma and discrimination. The church can play a leading role in society in Mizoram as they have higher influence than other NGOs.
6. There is a need for an open counselling centre for the affected family members. The presence of these centres will greatly help to improve the

mental health as well as provide a better coping strategy for the family members, to help them function normally in society.

7. Family based intervention and prevention programmes should be provided to parent(s), partner(s), children and siblings to improve skills in relationship and communication among family members.
8. There is very little to no support from secondary and tertiary supporters. The government, the church and the NGOs such as YMA, MSACS etc. needs to strengthen their existing support and also extend their support system to the affected family members as well.
9. Government organizations must increase their support by establishing affordable centres for rehabilitating drug users. Similarly, support from society must also be strengthened to improve interest in the care and rehabilitation of drug users and their families.
10. Institutions providing care and rehabilitation services must improve their services in the area of health, counselling, home visit, follow up and family re-integration programmes. Moreover, these institutions should also provide recreational activities which include the affected family members.
11. As the family members have indicated through the study, they rely strongly on faith-based interventions. Thus, the churches should organize programmes and home visit more frequently for the drug users. This will also give assurance of peace and relief to the family members.
12. Media being an important source of information and knowledge, should play an important role in providing awareness to the public with regards to the importance of mental health and social support that can be provided to family members of drug users.
13. One of the biggest factor for relapse among drug users is the lack of knowledge and proper skills to take care of them by their family members. Meanwhile, many a times, family members are unwilling and reluctant to receive family counselling and support system for the user.As a result, it is necessary to raise awareness in this area.

APPENDICES

Mental Health, Social Support and Family Members of Drug Users in Aizawl, Mizoram		
Interview Schedule (Confidential and for Research Purpose only)		
Research Scholar **Ms. Diana Lalrinsiami Chhakchhuak** **M.Phil Scholar** **Department of Social Work,** **Mizoram University**		**Supervisor** **Dr. Henry ZodinlianaPachuau** **Asst. Professor** **Department of Social Work,** **Mizoram University**
Schedule Number:		Date :

I.	**PERSONAL CHARACTERISTICS**	
1.	Name (Optional)	:
2.	Age	:
3.	Gender (Tick)	: Male / Female
4.	Sub Tribe (Tick)	: Lusei/Paihte/Hmar/Mara/Lai/ Others (______________)
5.	Religion (Tick)	: Kristian/ Hindu/Mosolman/ Bhuddist/ Others (__________)
6.	Religious Denomination	:
7.	Locality	:
8.	Type of family (Tick)	: Nuclear family/Joint family/Others
9.	Form of Family (Tick)	: Stable/Broken/Reconstituted/Others (________________________)
10.	Educational Level	: Primary/ Middle/ High School/ Higher/ Graduate/ Post Graduate/ Others
11.	Family Occupation (Tick)	: Govt. Servant/ Business/ Daily Labour/ NGO worker/ Others (__________________________)
12.	Family monthly income (per month)	:
13.	Socio-Economic Category of family (Tick)	: AAY/BPL/APL /No Category

II MENTAL HEALTH

14 WARWICK EDENBURGH MENTAL WELL-BEING SCALE (Measurement of mental health)

SI No.	Items/Statements	None of the time	Rarely	Some of the time	Often	All of the time
i	I've been feeling optimistic about the future	1	2	3	4	5
ii	I've been feeling useful	1	2	3	4	5
iii.	I've been feeling relaxed	1	2	3	4	5
iv.	I've been feeling interested in other people	1	2	3	4	5
v.	I've had energy to spare	1	2	3	4	5
vi.	I've been dealing with problems well	1	2	3	4	5
vii.	I've been thinking clearly	1	2	3	4	5
viii.	I've been feeling good about myself	1	2	3	4	5
ix.	I've been feeling close to other people	1	2	3	4	5
x.	I've been feeling confident	1	2	3	4	5
xi.	I've been able to make up my own mind about things	1	2	3	4	5
xii.	I've been feeling loved	1	2	3	4	5
xiii.	I've been interested in new things	1	2	3	4	5
xiv.	I've been feeling cheerful	1	2	3	4	5

15. Suggest some effective measures to take when facing mental health issues due to drug abuse

III	DIMENSIONS OF SOCIAL SUPPORT															
16	**Support from Primary Supporters**															
Sl. No	**Form of support**	**Is it available? (Availability)**					**Is it good enough? (Quality)**					**Is it adequate? (Adequacy)**				
		VA 5	**A 4**	**NA UA 3**	**U 2**	**VU 1**	**VG 5**	**G 4**	**NG P 3**	**P 2**	**VP 1**	**VA Q 5**	**AQ 4**	**NQ I 3**	**IA 2**	**VI A 1**
i	Provisions of basic needs (Food, shelter and clothing)															
ii	Emotional Support (Love and Care)															
iii	Physical Health Support															
iv	Mental Health Support (Counseling and Guidance)															
v	Support in Life Skills (Including education)															
vi	Instrumental Support (including money, aid, etc)															

VA: Very Available-5; A:Available-4; NAU: Neither available nor unavailable-3;U: Unavailable-2; VU: Very Unavailable 1
VG: Very Good-5; G:Good-4; NGP: Neither Good nor poor-3;P: Poor-2; VP: Very Poor-1
VAQ: Very Adequate-5; AQ: Adequate -4;NAQI:Neither Adequate nor inadequate-3; IA:Inadequate-2; VIA: Very Inadequate -1

17	**Support from Secondary Supporters**															
Sl. No	**Form of support**	**Is it available? (Availability)**					**Is it good enough? (Quality)**					**Is it adequate? (Adequacy)**				
		VA 5	**A 4**	**NA UA 3**	**U 2**	**VU 1**	**VG 5**	**G 4**	**NG P 3**	**P 2**	**VP 1**	**VA Q 5**	**AQ 4**	**NQ I 3**	**IA 2**	**VI A 1**
I	Provisions of basic needs (Food, shelter and clothing)															
Ii	Emotional Support (Love and Care)															
Iii	Physical Health Support															
iv	Mental Health Support (Counseling and Guidance)															
v	Support in Life Skills (Including education)															
vi	Instrumental Support (including money, aid, etc)															

VA: Very Available-5; A:Available-4; NAU;Neither available nor unavailable-3;U: Unavailable-2; VU: Very Unavailable 1
VG: Very Good-5; G:Good-4; NGP: Neither Good nor poor-3;P: Poor-2; VP: Very Poor-1
VAQ: Very Adequate-5; AQ: Adequate -4;NAQI:Neither Adequate nor inadequate-3; IA:Inadequate-2; VIA: Very Inadequate -1

18	Support from Tertiary Supporters															
Sl. No	Form of support	Is it available? (Availability)					Is it good enough? (Quality)					Is it adequate? (Adequacy)				
		VA 5	A 4	NA UA 3	U 2	VU 1	VG 5	G 4	NG P 3	P 2	VP 1	VA Q 5	AQ 4	NQ I 3	IA 2	VI A 1
i	Provisions of basic needs (Food, shelter and clothing)															
ii	Emotional Support (Love and Care)															
iii	Physical Health Support															
iv	Mental Health Support (Counseling and Guidance)															
v	Support in Life Skills (Including education)															
vi	Instrumental Support (including money, aid, etc)															

19	Write down the most effective support you would suggest to receive from others (immediate family members, friends, society, government) when facing problems due to drugs.

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Abstract

MENTAL HEALTH, SOCIAL SUPPORT AND FAMILY MEMBERS OF DRUG USERS IN AIZAWL, MIZORAM

A dissertation submitted in partial fulfilment of the requirements for the Degree of Master of Philosophy

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INTRODUCTION

The study seeks to understand the mental health status and social support of families affected by drug abuse in Aizawl, Mizoram. It will also delve into the understanding the relationship between mental health and social support. It will also highlight suggestions to promote mental health and social support of families affected by drug abuse that will have relevance in social work practice and policymaking.

Various intoxicating drugs have been used for religious purposes, to boost creativity, and for recreational purposes for ages. The Chinese have been utilising cannabis for medical purposes for thousands of years, while South Americans have been chewing coca leaves for energy for centuries. Peyote is still used by Native Americans for a variety of rituals. The idea of judging substance abuse is a fairly recent societal concept. Alcohol consumption and intoxication were accepted in the United States until the late 1800s, while cocaine and opiates were also commonly used, mostly by the higher classes (Nelson, 2012; National Association of Social Workers, 2008). Before the 1960s, the majority of addicts were from the higher classes: physicians, dentists, and pharmacists, who had easy access to narcotics (Nelson, 2012). It was not until almost 1900 that first alcohol use and, later, other drug use began to be seen as a social problem. As a result, many acts were enacted criminalising various intoxicants, and social attitudes shifted to the point that drug and alcohol misuse was now considered a personal flaw.

Perhaps the most striking feature that distinguishes man from other animals, as Osler (1891) correctly pointed out, is his need to take medicine. Man has taken pleasure in taking chemicals that impact one's mental state since the dawn of time. Among the social and medical ills of the twentieth century, substance abuse ranks as one of the most devastating and costly. The drug problem today is a major global concern including India. It has become widespread and extensive. From what can be seen, heard, and read, from what can be heard from various means of mass media, it is apparent that drug abuse is a complex and multifaceted problem.

Addiction among teenagers has been on the rise across the world (United Nations Office on Drugs & Crime [UNODC], 2007). Substance addiction has evolved into a severe problem in Malaysia, wreaking havoc on people, families, and

communities. Several parties, including government and non-governmental groups, have expressed interest in it. In 1993, the drug was identified as the nation's number one enemy since the incidents of drug abuse became a serious internal problem.

The National Drug Dependence Treatment Centre (NDDTC) at AIIMS reported that each year, more than 32,000 substance abuse patients appear for treatment and an additional 21,000 receive community care. As per the World Drug Report (WDR) 2010, illegal internet pharmacies have begun selling drugs online, transforming India into a hub for such activities.

Cannabis was the most commonly used illegal substance in the 2002–2003 National Survey of Drug Use in the General Population, with nearly one in five adults (18.5 percent) reporting using an illegal drug at least once in their lives, with this number rising to nearly one in four (26 percent) among young adults aged 15 to 34.

According to the World Health Organization (WHO), more than 15 million people have been classified as drug users, with injectable drug use occurring in 136 countries. (International Research Collaboration on Drug Abuse and Addiction Research, 2011).

According to estimates from 2004, India had roughly 1.4 million opiate addicts. According to the National Aids Control Organization (NACO), India has 50,000 injectable drug users, the bulk of whom live in Manipur, Nagaland, Mizoram, and Meghalaya.

According to a recent survey pointed out by Ahuja (2014), there are at least 7.5 crore drug addicts in India. There are claims that drug abuse has become dominantly prevalent in youngsters between the ages of 16 to 25. Opioids originating in Southwest Asia and East Asia are now being consumed by over 18% of India's population aged 15 to 64. (Sardar 2016).

According to Ghosal (2003), the outbreak of heroin dependency in the North Eastern States possibly started early in 1984 from Manipur.

Tochhawng (1995) identified several factors such as rapid and social change, degradation of morals in society, the lessening of the social control system,prevalence of corruption, influence of mass media and western lifestyles, the inherent influence of the drug in the music industry, cultural practices such as smoking and drinking rice beer as the main causes of substance abuse in Mizoram (in GOM, 2015).

Before the 80s, there were only rare instances of cannabis consumption in Mizoram. The abuse of various types of drugs increased in recent years, with the injection of drugs gaining prevalence from 1988. However, there were no official records of drug abuse before the 90s. Estimates by the government placed around 2500 drug users in the state in 1992. According to a survey conducted by the Central KristianThalai Pawl (CKTP) in 1999 which covers 111 areas or branches identified 15,188 youths with drug abuse problems, out of which 841 were females (GOM 2007). After 20 years, this number is expected to increase despite the efforts of the government and other NGOs such as KTP, YMA, etc.

According to Sailo (2003), the first recorded incidence of death in Mizoram due to substance abuse was in the 1980s when a young man aged 24 overdosed on heroin. The prevalence of heroin grew after this incidence among the middle and upper economic society. The administration of drugs through injection also gained popularity at the same time, both in rural and urban areas. Following this, the number of deaths due to drug overdose grew exponentially each year.

In Mizoram, there were 12550 injecting drug users and 6739 HIV cases. In Aizawl, there were 6000 injectable drug users and 883 HIV-positive people. 28.1 percent of HIV-positive people used injecting drugs (MSACS, 2012). In the Aizawl district, there were 4218 injecting drug users (MSACS, 2017)

Tarapot (1997) stated in the preliminary survey conducted by the Mizoram Excise and Narcotics Department, that only major cities/towns of the state - Aizawl, Lunglei, and Champhai had cases of drug abuse at the onset. Those who administer drugs through intravenous injection were estimated to be only three hundred. But from 1993 to 1995, the number increased by several folds.

Lallianzuala (2007) stated that even before the prevalence of smuggled heroin, cannabis was consumed by the Mizo people. Soon after the heroin takeover in the mid-1980s, other narcotic and psychotropic substances began gaining popularity. Injection of drugs such as dextro-propoxyphene (also known as Spasmo-Proxyvon), which was not supposed to be injected, was the choice for drug users in the late '80s. This has resulted in a spike in the number of HIV cases in the state along with overdoses and abscesses caused by the drug (In GOM, 2015).

According to the Indian Council of Medical Research (ICMR), drug use is more likely to rise than decrease. If proper measures are not done to combat the evil, there are alarming signals that the situation will deteriorate and spiral out of control. This is proved by the study of Addityarjee and Mohan.D, et al. (1984).

The Juvenile Justice Board of Aizawl, Mizoram reported that from April 2015 to February 2018, in most cases of theft and/or violence where the perpetrators were minors, they were found to be under the influence of alcohol or other substance.

SHALOM (2013-2018) mentioned that most youths of Aizawl did not think to abstain from alcohol, tobacco products, cannabis, cough syrup, etc. as they do not know that these are gateway drugs, often leading them to a more serious form of substance abuse.

The responses of communities in general, the church, and Mizo families show the severity of the substance misuse problem. However, prior to 15 years ago, documentation on the health and societal effects of drug use was difficult to come by (Bajpal, 2002; Mishra, 2000). Although there have been observations and hypotheses on the origins, effects, and implications of substance misuse among the Mizos (Halliday, 2009; Lalchhuana, 2013; Panda, 2006; Sailo, 2003; Tochhawng, 1995, and others), they are insufficient to provide light on substance use patterns. There is also a scarcity of literature on the effects of substance abusers on their families. It is still widely held, and incorrectly held, that only the addicted family member requires assistance. Other family members' needs and problems have received little attention. Barnard (Barnard, 2007).

Sartorius, et. al., (2015) wrote about the different mental disorders and their characteristics, how it causes burden to the family members and the coping strategies which can either increase or decrease the burden along with what and what not to say to the family members of the patients with such conditions.

Mental and emotional well-being is essential to shaping a state of health for Coloradans. People with good mental health can reach their full potential, deal effectively with life's challenges, work efficiently, and contribute meaningfully to their communities. Supporting improved mental health, reductions in substance abuse, and better behavioural health through health system integration are initiatives within the Colorado Governor's 2013 State of Health Report.

The value of family support is being widely recognised, which has a significant impact on the outcomes of children in a family. The experiences and quality time shared within a family can have an impact on the child's educational achievement, their employment, psychological and emotional adjustment, their physical and mental health, along with their status in the community and society as a whole. (Sheldon and Macdonald, 2009)

Barnard (2007) examined the effects of drug use not only on drug users themselves but also the feelings of anger, sadness, anxiety, shame, and loss that are commonly experienced by their extended family. She keeps track of how drug usage affects family dynamics and relationships, as well as the social and emotional consequences. Its influence on family members' physical and emotional wellbeing is also highlighted. The author analyses the viewpoints of practitioners such as teachers, social workers, and health experts in highlighting the frequently ignored role of grandparents in protecting the children of drug users. The conclusion reached is that present service provision, by treating problem drug users in isolation, fails to meet the needs of drug-affected families, and so loses the potential to establish family-oriented support and treatment.

Ranganathan (2002) remarked that addiction in every sense of the term is a 'family disease'. It must be reiterated among health care professionals that treatment for addiction should not be detached and include the family as a whole. The patient's relationship with his family/wife/husband is one of the most crucial components of

treatment. The concept of addiction as an incurable but treatable illness affecting the body, mind, and spirit was developed by Andres and Novick& Associates (1995).

Madan (1969) wrote that alcoholism and drug abuse are not only detrimental to the individual but also their families and society as a whole. There is an old saying, "once a drunkard, always a drunkard". No alcoholic suddenly became an alcoholic overnight. They begin by drinking moderately and slowly increase the amount to eventually become addicts or alcoholics.

Gabhainn and Walsh (2000) concluded that although drug prevention has broadened its horizons having "matured away from a singular focus on the individual," this area still requires a lot of work and suggested that programs working within the framework of family support should have a stronger, more specified and resourceful role to play in drug prevention.

Alexander et. al. (2000) also pointed out the existence of evidence that family-based interventions with older, at-risk youths can result in a better outcome than other forms of intervention.

The literature on family effects suggests that the "family process" can be much more important than "family structure" in developing deviant behaviors in general and also concerning drug use (ACMD, 1998, Wells & Rankin, 1991).

Wolin (1980) defined families as transactional systems in which the collective functioning of each part affects the greater whole. If one member of the family is an addict, the focus is shifted to that member and brings the family system into disorder, affecting all family members.

Kapur (1985) states that the family of a drug user and close relatives feel the most immediate effect of deterioration in relations due to their abuse. Drug users often have attitudes such as wanting to be free from authority or any form of perceived control, reducing contact with parents, strive for independence, and attempts to escape from daily responsibilities such as earning a livelihood. Drug addiction makes it difficult to maintain a healthy relationship with family, friends, and society. As such, the use and abuse of drugs prevent the mind from a healthy and natural development among all affected members.

Greene, et.al, (2012), conducted a study on 'Mental health and social support among HIV positive injection drug users and their caregivers in China'. The goal of this study was to look at the links between caregiver environment and HIV-positive injectable drug users' mental health. They used quantitative techniques to interview 100 patients and carers, with the majority of patients (60.4 percent) being male and the majority of caregivers being female (63.5 percent). A framework was created using a conceptual model. The result showed that aspects of the caregiver context were associated with the functioning and wellbeing of both HIV patients and caregivers in China. The incidence of anxiety and depression among carers was higher than the prevalence of depression among drug users in this sample.

Drug use disorders are a severe health concern, according to the United Nations Office of Drugs and Crime (2017), with a considerable impact for those afflicted and their family. Lost productivity, security difficulties, criminality, increased health-care expenses, and a slew of other negative societal effects are all substantial costs to society. In certain nations, the societal cost of illicit drug usage is estimated to be as high as 1.7 percent of GDP. (World Drug Report, 2016)

Maram (2007) wrote that recovery from addiction is one of the urgent needs of our society since the issue of dependence is volatile and causes tremendous harm to all that are exposed to it. This addiction can no longer be viewed as the user's sole problem because it also affects others within the circle of the user. Hence, it becomes an issue involving the family, community, and church.

In a research conducted by a small team of UK researchers led by Copello and Orford (2002), family members of drug users experienced severe and enduring stress, which can often lead to high levels of physical and psychological morbidity.

Research Community interventions were characterised as a set of activities coordinated in a certain region or area, with a focus on young people, parents, and organisations. Cuijpers (2009) identified examples of universal prevention in community settings such as mass media initiatives, community interventions, workplace prevention, community-based mobilization committees, and educational activities in bars and discos.

In a review of family support interventions in the Irish context,McKeown (2000) concluded that family therapy approaches are promising provided that the intervention is tailored to the family definition of need and restores the family's ability to solve their problems.

The significance and purpose of a comprehensive drug prevention program for the community are that it will enhance one's value system, give the family unity, perspective and understanding and increase awareness and concern for the issue of substance addiction in communities (Toaha, 1986).

International research suggests that interventions targeted at family support rather than specific drug intervention have greater potential and have resulted in positive social behavior, including decreased substance misuse (Zigler et al, 1992).

Thanga&Thanga (2000) wrote a book on the 'Prevention and Rehabilitation Process among the Addicts' focusing on the means and processes that can help the addict to abstain from drugs. It focuses mainly on the spiritual means i.e. through a reformation for the drug addict to abstain away from drugs and gives assurance and encouragement that they can surely overcome the struggle and not to lose hope as they will have to face hardships for the struggle is real.

The National Drug Strategy 2001-2008 (2001) strives to "significantly reduce the harm caused to individuals and society by the misuse of drugs" (p8) through the four pillars of supply reduction, prevention, treatment, and research.

1.1 Definitions and Concepts

1.1.1 Mental Health

“According to World Health Organization (1957), "mental health is defined as a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can make a contribution to his or her community". The WHO stresses that mental health "is not just the absence of mental disorder."

The term "mental health" refers to our mental, behavioural, and emotional well-being.' It's not only about the lack of mental illnesses or impairments; it's about how we think, feel, and act. Mental illness can have a negative impact on daily

living, relationships, and even physical health. It also includes a person's ability to enjoy life - to attain a balance between life activities and efforts to achieve psychological resilience. It is determined by a range of socio-economic, biological, and environmental factors".

1.1.2 Social Support

Social support, according to Demareyet al. (2005), is "an individual's impression that he or she is liked and appreciated by individuals in his or her social network." Meadows (2007) defines social support as “beliefs and/or perceptions that suggest an individual is a member of an interpersonal relationship including parents and peers.” Davison et al., (2000) believed that social support talks about the person's needs for support with close others and provides it when others experience distress which might provide a person with a forum to share and deal with a wide range of issues.

1.1.3 Drug

Drugs were termed 'pharmakon' by the ancient Greeks, a word that meant both poison and medicine. According to UNODC (2000), drug refers to "substances subject to international control". It refers to any chemical that has the potential to heal disease or improve physical or emotional well-being in medicine. Any chemical agent that changes the biochemical or physiological processes of tissues or organisms is referred to as pharmacology. In popular use, the term "drug" refers to psychoactive substances, and more particularly, illegal drugs."

1.1.4 Drug use/Drug Abuse

In the context of international drug control (2000), drug abuse/drug use refers to the use of any substance under international control for purposes other than medical and scientific, including use without a prescription, in excessive dose levels, or over an unjustified period.

1.1.5 Drug abuse-related harm

According to UNODC (2000), this term refers to "any adverse social, physical, psychological, legal or other consequence of drug use which is experienced as harmful to a drug user and/or those living with or otherwise affected by a drug user's actions."

1.1.6 Addiction

WHO (1994) defined addiction- drug or alcohol as, "repeated use of a psychoactive substance or substances to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits a determination to obtain psychoactive substances by almost any means".

From the above definition, we can know that 'addiction' is a term of long-standing and variable usage. The addict's life may be dominated by drug abuse, causing him or her to neglect all other activities and obligations, which may have a negative impact on family members as well as the society in which the addict lives..

1.1.7 Drug Addiction

According to WHO (1957), "drug addiction is a state of periodic or chronic intoxication produced by the repeated consumption of a drug (natural or synthetic)".

"It's characteristics include:

1. An overpowering desire or need (compulsion) to continue taking the drug and to obtain it by means;
2. A tendency to increase the dose;
3. A psychic (psychological) and sometimes a physical dependence on the effects of the drug"
4. An effect detrimental to society and individual". (WHO,1957).

WHO (2003) defined drug addiction as "A psychic (psychological) and sometimes a physical dependence on the effects of the drugs".

Addiction is a chronic, typically relapsing brain illness that involves compulsive drug intake and usage, with negative effects not just for the addict but also for others around them. Drug addiction is classified as a brain disease because it alters the structure and function of the brain. Although most people take drugs voluntarily, repeated use affects the person's decision making ability and self-control while at the same time, creates an intense craving for the drug. These physical, as well as psychological changes, are the main hurdles drug addicts face in quitting their addiction. (Jha 2009:152)

1.1.8 Family Member

Family members refer to any member, child, or adult who lives together in a household in either a nuclear or joint-related through blood or affinity or kinship or adoption.

1.2 Effects of Substance Abuse

Diagnostic criteria for Substance Use Disorder according to DSM-V (2013) is based on a pathological pattern of behaviours related to use of the substance which is divided into four groups, with a total of eleven criteria. The four criteria are criterion A, B, C, and D. Criterion A consist of Criteria 1-4 of impaired control, Criterion B comprises of criteria 5-7 of social impairment, Criterion C (criteria 8-9) consist of risky use and Criterion D (criteria 10-11) consist of pharmacological criteria. Substance use disorder can range in intensity from light to severe, with mild involving two or three criteria, moderate involving four to five, and severe involving six or more. The following are the criteria:

1. The person may consume more of the substance or for a longer period of time than was planned.
2. The individual may indicate a persistent desire to reduce or restrict substance use, as well as multiple unsuccessful attempts to do so.
3. The person may spend a significant amount of time getting the material, using it, or recovering from its effects.
4. Craving
5. Recurrent substance abuse can lead to failure to meet important role responsibilities at work, school, or at home.

6. The user may continue to use the substance despite persistent or recurrent social or interpersonal difficulties caused or aggravated by the substance's effects.
7. Substance abuse may cause important social, occupational, or recreational activities to be discontinued or diminished.
8. This might take the shape of recurring drug usage in physically dangerous situations.
9. The individual may continue to use the substance despite having a chronic or recurring physical or psychological ailment that is likely to have been caused or exacerbated by it.
10. Tolerance
11. Withdrawal

According to WHO (1993), psychoactive substance disorder is defined as a mental and behavioural disorder due to psychoactive substance use and are classified as under:

1. Mental and behavioral disorders due to use of alcohol.
2. Mental and behavioral disorders due to use of opioids.
3. Mental and behavioral disorders due to use of cannabis.
4. Mental and behavioral disorders due to use of sedatives or hypnotics.
5. Mental and behavioral disorders due to use of cocaine.
6. Mental and behavioral disorders due to use of other stimulants, including caffeine.
7. Mental and behavioral disorders due to use of hallucinogens.
8. Mental and behavioral disorders due to use of tobacco.
9. Mental and behavioral disorders due to use of volatile solvents.
10. Mental and behavioral disorders due to multiple drug use and use of other psychoactive substances.

The following is the ICD-10 coding and classification for Mental, Behavioral, and neurodevelopmental disorders caused by drug abuse, as found in Chapter -5:

Mental and Behavioral Disorders due to...	Code
...use of alcohol	F10
...use of opioids	F11
...use of cannabis	F12
...use of sedatives, hypnotics, anxiolytics	F13
...use of cocaine	F14
...use of other stimulants, including caffeine	F15
...use of hallucinogens	F16
...use of nicotine	F17
...use of inhalants	F18
…use of other psychoactive substances and multiple drug use	F19

The devastating effect and consequences of substance abuse effect not only the users but also the family members and the community as well. Although a number of awareness and prevention programs have been carried out, only half of the picture is painted to fully tackle the harmful consequences that substance abuse can cause on the individual, family, and society. Therefore, it is necessary to take into account the effects that substance abuse can cause so that there may be a greater emphasis on why awareness for the prevention of addiction need to be spread on a larger scale.

1.3 Statement of the Problem

Drug abuse is one of the most burning problems in society as drug is a multifaceted and multidimensional problem. Meanwhile, the mental health of the affected family members is also shaken socially. Mental health is essential for overall health and well-being and should be recognized in all young and elderly people including the drug users as well as their family members with the prime importance of physical health.

Making a diagnosis is the first step toward improving one's mental health. Unfortunately, mental health issues are often misdiagnosed and neglected, leaving many victims to struggle alone.

Palen (1979) says drug use is considered a social issue as it precludes people from living responsibly and from exhibiting self-control. Despite the fact that the Mizos have been extensively influenced by industrialization and westernisation, the general public has negative attitudes and perceptions about injecting drug usage, which leads to stigmatisation and discrimination of those who use it including their family members. These families often cope alone with the problem of their child's addiction in secret for several years, causing more strain and distress to the family. The family faces emotional turmoil due to embarrassment, guilt, anger, and frustration. The family may ultimately choose to isolate themselves from external contacts to avoid further pain and embarrassment. Although there are few social support systems such as rehabilitation centers, homes, drop-in-centers, etc., yet, they are not sufficient enough to meet the needs of the drug user and their family members.

Also, the perception and attitude of the society towards the affected family members and the user themselves plays an important role in the treatment process of drug users.

1.4 Objectives

1. To higlight the socio-demographic profile of family members of drug users in Aizawl, Mizoram
2. To explore the mental health status of family members of drug users in Aizawl, Mizoram
3. To find out the social support system of family members of drug users in Aizawl, Mizoram
4. To find out the relationship between mental health and social support of family members of drug users in Aizawl, Mizoram.
5. To suggest measures for social work interventions and policy to improve mental health and social support for family members of drug used s in Aizawl, Mizoram

1.5 Chapter Scheme

Chapter 1 – Introduction

Chapter 2 – Review of Literature

Chapter 3 – Methodology

Chapter 4 – Results and Discussion

Chapter 5 – Conclusion

METHODOLOGY

Design

The study is exploratory in design and cross-sectional in nature. Mixed research method i.e. Quantitative and Qualitative methods were used for the study. The field of study was conducted within Aizawl Municipality area.

Source of Data

Data were collected from both primary and secondary sources. The primary sources were collected from adult female or male family members affected by drug abuse. Secondary source were collected from government and non-government reports and records.

Method of Sampling

A multi-stage sampling procedure was utilized to collect the sample. In the first stage, a list of rehabilitation centers in the Aizawl Municipality area was collected. In the next stage, all admitted clients who are drug users and addicts residing within the Aizawl Municipality area were identified from the rehabilitation centers, and from the identified clients their home address were collected with their consent. In the next stage, from the address, families were identified. The final selection of the sample was based on the consent of the family members. The sample size for the quantitative study was 60. From the qualitative study, the sample size was 20 which included 8 case studies and 12 key informant interviews. Overall, the sample size was 80.

Tools of Data Collection

A semi-structured interview schedule was used as the tool for data collection to collect information with regards to the objectives of the study. Qualitative data were also collected with the help of case studies and key informant interviews.

The tool included a standardized questionnaire based on Warwick-Edinburgh Mental Well-being Scale (WEMWBS) developed by a group of researchers at the Universities of Edinburgh and Warwick in the year, 2007 to support the development of an evidence base relating to public health which encompasses the promotion of

well-being, the prevention of mental illness and recovery from mental illness. This scale was used to find out the mental health of the family members of drug users. It is a fourteen (14) items scale worded positively relating to the main components of 'positive mental wellbeing' covering both subjective well-being and psychological functioning. It has the ability to capture both eudaimonic and hedonic perspectives on wellbeing (people's functioning, social relationships, sense of purpose, and personal development) (e.g. feelings of happiness, optimism, cheerfulness, relaxation).

To find out the social support of family members of drug users, a 5 point structured scale was constructed to measure 3 items each such as the availability, quality and adequacy of social support across various dimensions of social support *viz.* basic needs support, emotional support, physical health support, mental health support, support in life skills and instrumental support. The different dimensions of social support were constructed based on John and Katherine (2008), Schwarzer, Knoll &Rieckmann (2003), Dunst, Trivette, & Cross (1986), Schaefer, Coyne, & Lazarus (2002), Olsson et.al. (2015), and Cutrona and Suhr (1992). The different agent of supporters were also constructed based on the study of Chhangte (2017), Meral and Cavkaytar (2012), Lifshitz and Glaubman (2004), Teklu (2010), Parette et.al (2010), Mishra & Gupta (2006) and Lalmuanpuii (2016).

Table I : Reliability test of Scale of WEMWBS

Number of Items	**14**
Cronbach's Alpha	**0.830 (n=60)**
Parallel	**0.836 (n=60)**

Source: Computed

Table I shows the reliability test of scale for Warwick Edinburgh Mental Well-Being Scale (WEMWBS). The table shows that there are 14 items in this scale and the reliability test for this scale based on Cronbach's Alpha is 0.830 and 0.836 based on Parallel test.

Table II: Reliability test of Scale of Social Support

Number of Items	**54**
Cronbach's Alpha	**0.849 (n=60)**
Parallel	**0.854 (n=60)**

Source: Computed

Table II represents the reliability test of scale of social support across six dimensions for primary, secondary and tertiary supporters. We can see from the table

that there are 54 items in this scale and the reliability test for this scale based on Cronbach's Alpha is 0.849 and reliability test based on Parallel is 0.854.

Table III: Reliability Test of Scale of Social Support by Primary Supporters

Number of Items	**18**
Cronbach's Alpha	**0.926 (n=60)**
Parallel	**0.929 (n=60)**

Source: Computed

Table III highlights the reliability test of scale of social support by primary supporters. The table shows that there are 18 items in this scale and the reliability test for this scale according to Cronbach's Alpha is 0.926 and Parallel test is 0.929.

Table IV: Reliability test of Scale of Social Support by Secondary Supporters

Number of Items	**18**
Cronbach's Alpha	**0.954 (n=60)**
Parallel	**0.955 (n=60)**

Source: Computed

Table IV depicts the reliability test of scale of social support by secondary supporters. It is evident from the table that there are 18 items in this scale and the reliability test for this scale based on Cronbach's Alpha is 0.954 and 0.955based on Parallel test.

TableV: Reliability test of Scale of Social Support by Tertiary Supporters

Number of Items	**18**
Cronbach's Alpha	**0.966 (n=60)**
Parallel	**0.968 (n=60)**

Source: Computed

Table V shows the reliability test of scale of social support by tertiary supporters. The table shows that there are 18 items in this scale. The reliability test of this scale according to Cronbach's Alpha is 0.966 and Parallel reliability test for this scale is o.968.

Data Analysis

Microsoft Excel and the SPSS Package were used to analyze the data. Simple frequency and descriptive statistics were highlighted to interpret the findings of the study related to the socio-demographic profile, mental health, and social support of family members of drug users in Aizawl Mizoram. The Mental Health of family

members of drug users were analysed based upon the WEMWBS protocol of measuring the scales. The level of social support received by family members across the dimensions of social support was also analyzed using the Social Support scale that was developed. Pearson's Correlation Coefficient statistics was also analysed to find out the relationship between Mental Health and Social Support of family members of drug users. It also included findings related to suggestions for effective measures for improving mental health and social support.

Inclusion Criteria

Any female or male adult individual from a family who had been affected by drug abuse were the respondent for the study and only those who gave consent formed the sample.

Ethical Consideration

Prior permission and informed consent were sought from the family members and confidentiality was maintained. Changes were made accordingly to fit the context and to reduce any imposition.

Operational Definition

In this study the Warwick-Edinburgh Mental Well-being Scale (WEMWBS), a 14-item mental well-being scale that covers subjective well-being and psychological functioning that was developed by a collaboration of academics from the Universities of Edinburgh and Warwick in 2006, was used. Mental well-being, according to the developers, is described as a person's psychological functioning, life satisfaction, and ability to form and maintain mutually beneficial relationships. The capacity to retain a feeling of autonomy, self-acceptance, personal progress, life purpose, and self-esteem are all important aspects of psychological health.

In this study, social support referred to support given by Primary Supporters (family members), Secondary Supporters (peers, relatives, community and NGOs) and Tertiary Supporters (Government agencies) across six (6) dimensions of social support such as basic needs support (fooding, shelter, clothing), emotional support (love, care, concern, empathy, sympathy), physical health support (medical attention, provisions and services), mental health support (professional counselling, guidance,

and psychiatric care and services), support in life skills (education and training including vocational training), and instrumental support (sponsorship, donation, aid or help in form of money, aids, appliances, goods).

In this study, only people using, abusing, or addicted to psychoactive drugs such as Central Nervous System (CNS) Depressants (Alcohol is not included), Hallucinogens, Mood modifiers (Major Tranquilizers and Antidepressants), Narcotic Analgesics, and Stimulants were included. Opium, Cannabis, Heroin, LSD, Barbiturates, and other narcotics are examples which have adverse social, physical, psychological, legal or other consequences which are harmful to drug users, user or the addict and those he/she is living with or affected by his/her action.

In this study, the family members include only adults, male or female who lives with the person using or abusing drugs and is related to him or her through blood, marriage/affinity, kinship or adoption.

CONCLUSION

The study attempts to profile the socio- demographic characteristics of family members of drug users, find out the mental health status and the social support system that they receive within their family, from secondary as well as tertiary supporters across various dimensions. It will also delve into understanding the relationship between mental health and social support. It also attempts to suggest measures for effective interventions to improve mental health and social support for family members affected by drug use.

Drug abuse is a major problem being faced in many parts of the world. It not only causes pain and suffering to the individuals involved, but also those around them which includes their family members, relatives and the society as a whole. Drug, being a multifaceted and multidimensional problem, has an impact on the mental health of the family members of drug users. The mental health of the affected family members is shaken socially. Also, the social support system of the affected family members from primary, secondary and tertiary supporters has an impact on their mental health and further helps in the recovery process.

Although the percentage of drug users in Mizoram is quite high, there are negligible studies in regards to the affected family members. As a result of this, we are more or less unaware of their mental health status. The family members themselves are also generally unaware of their mental wellbeing and measures that can be taken to improve their mental health. The social support received by the family members also needs to be strengthened through various measures and interventions in order to provide a more effective support system. More studies in this topic can help in creating more awareness and also help in identifying better measures that can be implemented to improve the mental health and support system of the affected family members.

The study is exploratory in design and cross-sectional in nature. Mixed research methods i.e. quantitative and qualitative methods are used for the study. For this study, data was gathered from both primary and secondary sources in the Aizawl Municipal area. Primary sources include family members affected by drug use and secondary source include information collected from government and non-government reports and data.

A semi-structured interview schedule formed the tool for data collection in order to gain information to achieve the objectives of the study. The tool also included standardized questionnaire based on Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) to find out the mental health status of the affected family members which were divided into low, medium and high mental health depending on the overall score on the scale

In order to find out the social support of family members of drug users, five (5) point structured scale was used to measure three items each such as the availability, quality and adequacy of social support across various dimensions of social support *viz*. basic needs support, emotional support, physical health support, mental health support, support in life skills and instrumental support. Case studies and participatory techniques which include Key Informant Interviews were also conducted to collect information and knowledge to meet the objectives of the study. Data were analysed by using Microsoft Excel and SPSS Package. Simple frequency and descriptive statistics were highlighted to interpret the findings of the study. The sample size for the quantitative study was sixty (60) and twenty (20) for qualitative study. The sample for quantitative study was collected from any female or male individual who has been affected by drug abuse and only those who gave consent.

5.1 Major Findings

The study was able to generate relevant findings about the family members of drug users in Aizawl, Mizoram. The following are the key findings:

1. The age group 20-39 years had the highest number of respondents, followed by 40-59 years, and 60-75 years had the least number of respondents.
2. Female responders made up more than half of the total.
3. The Lusei sub-tribe accounted for the majority of the respondents.
4. The Presbyterian Church is comprised by over half of the respondents.
5. With regards to the type of family, majority of the respondents were from nuclear family and only small amounts were from joint family.
6. Almost all the respondents were from a stable family and only few respondents were from broken and reconstituted family.

7. One- third of the respondents had an educational level of high school, followed by higher, graduate, primary, middle and post graduate level of education.
8. The family occupation of a significant number of respondents was Government servant and business.
9. Nearly half of the respondents' family monthly income was between Rs. 10,000-30,000.
10. Majority of the respondents were from the APL category while the other respondents were from other category. However, there were also those who do not have any category.
11. From the WEMWBS scale, it was found that more than half of the respondents fall under the medium mental health category , followed by those in the low mental health category and only less than a tenth fall in the high mental health category. So, from the study, we can find that there are very few respondents who have high mental health which is essential for a healthy living. Therefore, there is still scope for improving mental health. *This findings is consistent to the study conducted by Sartorius, et.al.(2015) talking about the different mental disorders and their characteristics and how it causes burden to the family.*
12. From case vignettes, it was found that majority of the respondents suffered from mental issues leading to health problems which even led to losing hope and suicidal ideation. Due to the grief, guilt and stress that has been poured upon them, many a times, they lack sleep which causes problems in their normal routine. This findings is consistent to the study by *Figlie, et, al., (2004) where the affected family members including children face shyness, inferiority feelings, depression, family conflict and need for warm-heartedness.*
13. It was found that emotional abuse existed within the affected family members leading to family dysfunction and strain. *This is also consistent with the findings of Barnard (2007) where the effects of drugs caused the feelings of anger, sadness, anxiety, shame, and loss by the affected family members. Also, according to Deutsch (1982), the family is experiencing emotional turmoil as a result of humiliation, guilt, wrath, and frustration.*

14. Through Key Informant Interviews, it was found that many family members were in denial and found it hard to accept the fact that there exists a drug user in their family. *This finding is consistent with the study of Butler and Bauld (2005) where the families often cope alone with the problem of their child's addiction in secret for several years.*
15. The overall findings from social support scales indicates that the availability, quality and adequacy of social support is medium respectively with regards to support from primary, secondary and tertiary supporters across various dimensions. The dimensions include- basic need, emotional need, physical health, mental health, life skills and instrumental need. *This finding is consistent to the study of Palen (1979) mentioning that drug use is considered a social issue but the affected family members cope alone with their problems.*
16. The overall availability of social support from primary supporters is high along with quality and the adequacy across various dimensions. However, the quality and adequacy of life skills is medium with the adequacy of mental health.

    This finding is consistent with the study of Sheldon and Macdonald where growing awareness of the importance of family support plays an important role. Also, Zigler, et, al., (1992) through their research suggested that interventions targeted at family support have greater potential.
17. From the findings, the overall availability, quality and adequacy of social support from secondary supporters is medium respectively. However, it is high in terms of the availability of emotional need. *This finding is consistent to the study of Alistair (1985) where he mentioned that the main social influences on drug use relates to minority group society, parental loss, alienation, disharmony or disease, low income, divorce, relationship failure and peer group impact. Also, it is consistent to the study by Ritanti, et, al (2017), where it was found that the family received unfair treatment from society while expecting support.*
18. The overall social support from tertiary supporters with regards to availability is medium, quality is also medium but the adequacy of social

support is low. However, besides the availability and quality of all the other dimensions, it is low with regards to basic needs.

19. From the qualitative study it was found that rather than support from friends and society, the affected family members often faced shame and mockery, are being criticized and condemned, which led them to withdrawal from society as well as church activities. They often face discrimination and stigmatization from the society.
20. Almost all the respondents did not receive any financial support from the government as well as other supporters which led to many financial issues.
21. The findings related to the correlations between mental health and social support among the family members of drug users reveals that there is no correlation between mental health and availability, quality and adequacy of social support by primary supporters across dimensions. Moreover, there is no correlation between mental health and availability, quality and adequacy of social support by secondary supporters across dimensions. Further, there is no correlation between mental health and availability, quality and adequacy of social support by tertiary supporters across dimensions
22. Majority of the respondents suggested that reliance on religious faith and prayer is helpful to improve mental health, suggestions to have self-determination by the drug user, support and care from other family members, support and care from the government, support and care from NGOs, support and care from friends and lastly, doing hobbies and pastimes as a means of improving their mental health, has been suggested. The majority of responders in the qualitative study agreed the same.
23. Majority of the respondents suggested emotional support to improve social support, followed by support from family in matters such as household chores, establishment of rehabilitation and camping centre by the government, church, NGOs., non-stigmatization and discrimination, counselling, awareness, financial support from government and suggestions for drug users to be taken good care by professionals. These suggestions were also found in the qualitative study as well.

5.2 Suggestions

Here are suggestions to improve mental health and social support for the family members of drug users in Aizawl, Mizoram:

1. One of the main consequences of drug use is its impact on mental health of the drug user as well as on the family members.Although there have been several research on the effects of drugs on the user, there have been little studies on the mental health of impacted family members. Therefore, the need for conclusive studies in this topic is of the utmost importance in order to improve the mental health of the affected family members which will in turn help in the recovery process of the drug users.
2. There should be more studies on the social support received by the affected family members in order to improve the support system across all dimensions from different level of supporters.
3. Family is one of the strongest support system for drug users. However, family members often do not have the essential knowledge and skills to provide the required support. Training courses could be offered to the affected family members in order to provide a more efficient support system.
4. According to the findings, the majority of respondents in the WEMWBS have medium mental health and are ignorant of their own mental health status. They should be educated about the importance of mental health as well as their own mental health status so that they may take appropriate steps to enhance their mental health.
5. There is still a lot of stigmatization and discrimination towards not only drug users, but also their family members. Sensitization and awareness on drug user as a disease must be initiated at the grass root level to reduce stigma and discrimination. The church can play a leading role in society in Mizoram as they have higher influence than other NGOs.
6. There is a need for an open counselling centre for the affected family members. The presence of these centres will greatly help to improve the mental health as well as provide a better coping strategy for the family members, to help them function normally in society.

7. Family based intervention and prevention programmes should be provided to parent(s), partner(s), children and siblings to improve skills in relationship and communication among family members.
8. There is very little to no support from secondary and tertiary supporters. The government, the church and the NGOs such as YMA, MSACS etc. needs to strengthen their existing support and also extend their support system to the affected family members as well.
9. Government organizations must increase their support by establishing affordable centres for rehabilitating drug users. Similarly, support from society must also be strengthened to improve interest in the care and rehabilitation of drug users and their families.
10. Institutions providing care and rehabilitation services must improve their services in the area of health, counselling, home visit, follow up and family re-integration programmes. Moreover, these institutions should also provide recreational activities which include the affected family members.
11. As the family members have indicated through the study, they rely strongly on faith-based interventions. Thus, the churches should organize programmes and home visit more frequently for the drug users. This will also give assurance of peace and relief to the family members.
12. Media being an important source of information and knowledge, should play an important role in providing awareness to the public with regards to the importance of mental health and social support that can be provided to family members of drug users.
13. One of the biggest factor for relapse among drug users is the lack of knowledge and proper skills to take care of them by their family members. Meanwhile, many a times, family members are unwilling and reluctant to receive family counselling and support system for the user.As a result, it is necessary to raise awareness in this area.

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