DRUG ABUSE AMONG YOUTH AND FAMILY ENVIRONMENT IN MANIPUR

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DECLARATION

I, Alice Devi .K hereby declared that the subject matter of this dissertation titled "Drug Abuse among Youth and Family Environment in Manipur" is the record work done by me, under the supervision of Dr.C. Devendiran, Associate Professor, Department of Social Work, Mizoram University. The contents of this dissertation did not form the basis of award of any previous degree to me or to the best of my knowledge to anybody else, and that the dissertation has not been submitted by me for any research degree to any other University or Institute.

This is being submitted to the Mizoram University for the degree of Master of Philosophy in Social Work.

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CERTIFICATE

This is to certify that the dissertation "Drug Abuse among Youth and Family Environment in Manipur" submitted by Alice Devi.K for the award of Master of Philosophy in Social Work is carried out under my guidance and incorporate the student's bonafide research.

The scholar has fulfilled all the required norms laid down for the M. Phil regulations by the Mizoram University. The thesis has not previously formed the basis for award of any degree of this university or any other and this work is a record of the scholars personal effort carried out under my guidance.

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LIST OF ABBREVIATIONS

FGD	:	Focus Group Discussion
PRA	:	Participatory Rural Appraisal
WHO	:	World Health Organisation
IDUs	:	Injecting Drugs Use
OST	:	Opiod Substitution Therapy
HIV	:	Human Immuno deficiency Virus
UN	:	United Nations
UNODC	:	United Nation Office on Drugs and Crime
AIDS	:	Acquired Immuno Deficiency Syndrome
UNAIDS	:	Unite Nations Programme on HIV/AIDS
WB	:	World Bank
WDR	:	World Drug Report
LSD	:	Lysergic Acid Diethylamide
NCDA	:	National Committee on Drug Abuse
NACO	:	National Aids Control Society
MACS	:	Manipur Aids Control Society
SASO	:	Social Awareness Service Organization
HKCSS	:	Hong Kong Council of Social Science
UNDCP	:	United Nation International Drug Control Programme
NYP	:	National Youth Policy
WY	:	World is yours
SP	:	Spasmoproxyvon
FES	:	Family Environment Scale
UNODCCP	:	United Nation on Drug Control and Crime Prevention
PWID	:	People Who Inject Drug
SAMSHA	:	Subtsance Abuse and Mental Health and Service Administration
ATS	:	Amphetamine Type Stimulants
NIDA	:	National Institute on Drug Abuse

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APA	:	America Psychiatric Association
DSM-IV	:	Diagnostic and Statistical Manual of Mental Disorders
NEP	:	Needle Exchange Programme
IV	:	Intravenous Drug
IVKVS group	:	Intravenous Killer virus Spreader Group
UNESC	:	United Nation Economic and Social Council
UNRISD	:	United Nation Research Institute for Social Development
DIC	:	Drop In Centre
ILO	:	International Labour Organisation

CHAPTER –I

INTRODUCTION

The present study explores on drug abuse among youth and family environment in Manipur.

Overview of Concepts

Drug abuse is rapidly growing a worldwide problem. The problem of drug abuse poses a significant threat to the health, social and economic fabric of families, communities, societies and nations as well. Almost every country in the world is affected by drug abuse. The problem of drug abuse has now crossed national, ethnic, religious and gender lines also. Today, the problems of Global increase of drug abuse reflect and contribute to both the national as well as international tensions. The high level of drug abuse has brought problems such as increase in violence and crime, increase in HIV/AIDS diseases, and collapse in the social structure.

Globally, it is estimated that in 2012, between 162 million and 324 million people, corresponding to between 3.5 per cent and 7.0 per cent of the world population aged 15-64, had used an illicit drug mainly a substance belonging to the cannabis, opioid, cocaine or amphetamine-type stimulants group at least once in the previous year (UNODC, World Drug Report, 2014).

Marijuana and hashish remain far and away the most popular street drugs. Almost 161 million people had used cannabis at least once, up from about 150 million a year earlier. The use of cannabis is likely to grow in coming years, said the report by UNODC. However, the use of amphetamines and ecstasy dropped, mainly in the United States and South-East Asia, the report said.

In the context of injecting drug use, the United Nations Office on Drugs and Crime (UNODC), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Bank

and the World Health Organization (WHO), had jointly estimated that the number of people who inject drugs is 12.7 million (range: 8.9 million-22.4 million). These data corresponds to a prevalence of 0.27 per cent (range: 0.19-0.48 per cent) of the population aged 15-64yrs. The problem of injecting drugs is particularly stark in Eastern and South-Eastern Europe, where the rate of injecting drug use is 4.6 times higher than the global average (World drug report 2014).

According to World Health Organization (WHO) 2005, *"Drug abuse is the consumption of a drug apart from medical need or in the unnecessary quantities*." The Encyclopaedia Americana defines the term as the excessive or addictive use of psychotropic substance for non-medical purposes. Voss expressed that drug abuse is used without a precise definition and may refer to different things in different circumstances. In the past when the term addict or abuser was used, it implied heroin users, but now it includes LSD, Cocaine, Marijuana and other substances. The concept of drug with the development of the society has been broadened from time to time.

Indian Scenario of Drug Abuse

Lather. S (1993) discusses drug problem in India is not a new phenomenon, but the number of drug abusers has never been as high as it is today. Surveys carried out Delhi, Chandigarh, Uttar Pradesh, and Andhra Pradesh has reported an alarming increase in drug abuse. They also revealed that the variety of drug abused in the past have stretched out from cannabis and its preparations to other harder drugs such as opium, barbiturates, amphetamines, tranquilizers, L.S.D., mandrax, pathedine, acrphine, alcohol, heroin. National Committee on Drug Abuse in India (Rao 1984) reported that *"there are disturbing signs which show that drug abuse in India is likely to worsen and get out of hand if the planned comprehensive and sustained measures are not taken immediately to curb the evil".* The situation is further worsened by the emergence of a new paradigm to already existing

problem, i.e., formation of a visible link between intravenous drug use to human immunodeficiency virus (HIV) and AIDS.

In 2004, UNODC and the Ministry of Social Justice and Empowerment, jointly released the National Survey on the Extent, Pattern and Trends of Drug Abuse in India, the first of its kind. It shows that the number of chronic substance-dependent individuals were as follows: 10 million (alcohol), 2.3 million (cannabis) and 0.5 million (opiates). The survey not only points to the problem of India's population having twice the global (and Asian) average prevalence of illicit opiate consumption, but also shows that the treatment resources available are not commensurate with the 'burden of work' (number of dependent drug users) requiring immediate treatment.

India is home to one of the largest HIV/AIDS epidemics in the world. In this context, there is rising concern about the large number of IDUs and the attendant risk of HIV. Sentinel surveillance data from 2003 indicates a rise from 7.4% to 14.4% in HIV prevalence amongst injecting drug users in New Delhi. Currently, injecting drug use is more closely linked to the abuse of licit opiate pharmaceuticals than to illicit drugs. India is a large manufacturer of pharmaceuticals. The law regulates their production and sale, but there is no uniformity in the monitoring of compliance with the law. This contributes to an increase in the abuse of pharmaceutical drugs. The smuggling of pharmaceuticals from India, especially codeine-based cough syrups, dextropropoxyphene and injectable buprenorphine, is a major concern for India's neighbours, particularly Bangladesh, Nepal and Sri Lanka. Other pharmaceuticals that are also commonly diverted for abuse within India as well as for smuggling include diazepam and nitrazepam.

Northeast India Scenario of Drug Abuse

North-East India is in the thick of drug abuse. Apart from the widespread use of alcoholrising, the youth have taken to the use of other psychotropic drugs like heroine

andbrown sugar, which is an adulterated form of heroine. The states of Nagaland, Manipurand Mizoram lead the pack. Besides heroine, the addicts resort to pharmaceutical drugs because they are cheaper and easily available. Pharmaceutical drugs are those, which areproduced for treating illness, but are used, in high doses to get 'high'. Cough syrups,painkillers like proxivon, pethidine etc. are the favourites. We have the youngergeneration taking to drugs by inhaling dendrite, petrol etc.

The north-east Indian states of Manipur and Nagaland, which lie along the border with Myanmar, are characterised by ethnic conflict, armed civil insurgency, a heavy military presence and high unemployment. Classified by the Indian National AIDS Control Organisation (NACO) as high HIV prevalence states, they make up 0.4% of India's population, but account for 3.0% of cumulative AIDS cases. Injecting drug use is a serious public health problem in both states, where heroin and Spasmo-Proxyvon (a synthetic opioid analgesic) are the most commonly injected drugs. Injecting drug use is a major route of HIV transmission in this region.

According to National Aids Control Organization (NACO – 2006), there are 50,000 injecting drug use (IDUs) in the northeast region of India, the majority of them in Manipur, Nagaland, Mizoram and Meghalaya. According to the United Nations Office on Drug and Crime (UNODC) report 2005, alcohol is the most commonly abused substance in all the states in India except in Mizoram. Of the states of the northeast region, clients of treatment centres in Assam, Meghalaya and Tripura, seek help mainly for problems of alcohol abuse. Although the sale of alcohol is prohibited in Manipur, Nagaland and Mizoram alcohol users are the second largest group seeking treatment services in these states after opiate users. It is worth noting that intravenous use of pharmaceutical products, the use of opiate of choice for injecting in Mizoram has been associated, unlike heroin, with higher risk of abscesses, non-healing ulcers and amputations thereby increasing the morbidity of drug users.

Manipur Scenario of Drug Abuse

Manipur is one of the poorest and least developed regions in India. While the principle mode for transmission of HIV infection in India is by heterosexual contact, the prevalence of the disease is also high in intravenous drugs users who share needles and syringes. HIV infection among IDUs first appeared in the north-eastern state of Manipur. Drug abuse was hardly known in the north-eastern state of India prior to 1980s though tobacco, alcohol abuse was there. It started rising in the early 1980s with its peak in late 1980s.

Manipur had the first HIV/AIDS in the year of 1989-90 from a female IDU patient. The geographical proximity of Manipur to Burma (Myanmar) and consequently the Golden Triangle drug trail has made it a major transit route for drug smuggling, with drugs easily available. The increase in unemployment rate combined with a highly westernised lifestyle of the youth exaggerated the highly usage of drug used in the State. General frustration, family problems, pleasure seeking,curiosity or fun, lack of societal control, and IDU as a fashion allowed intravenous drug use to emerge as a refuge for the restless youth. Along with this, poor health services, lack of political will and social unrest led to increase in the prevalence of IDU. Those close to the infected face the trauma of diagnosis, community reactions (acceptance, stigma, and discrimination), economic and emotional impact, and reaction of health care workers.

The problem of heroin abuse was started in Manipur in the year 1989. By 1989 it reaches an explosive situation. In February 1990, the first HIV (Human Immuno-Deficiency Virus) positive case in Manipur was reported from a cluster of 6 IDUs from blood samples of October 1989. In 1990 there were 20,000-40,000 addicts in Manipur with majority being heroines IDUs with sharing of needle, syringes and as a result of which 80% of IDUs become HIV infected.Another estimate in 2009 by the Social Awareness and ServiceOrganisation

(SASO), a local NGO, shows that there are 34,500 IDUs in Manipur, almost half of them are living in Imphal.

Manipur has been contributing a huge portion towards the figure, with our young ones falling prey to drugs and substance abuse menace. Users of inhalants in Manipur and users of codeine-based cough syrups in Mizoram are the third largest number of youths demanding treatment services. Cannabis (ganja) users are the second highest group of treatment seekers in Assam, Meghalaya and Tripura. Heroin use has also made inroads in Assam and Meghalaya. Tripura has lower levels of the abuse of tranquilizers as reflected in the records of addiction treatment centres.

Further, the report states that 28 percent of the population of Manipur are drug addicts, of who nearly half are injecting drug users (IDUs). Cases of drug abuse is fast rising with 12 per cent of drug addicts in the age group till 15 years, 32 per cent in the age group of 16-25 years and 56 percent in the age group of 25-35 years. Manipur is considered as one of the most affected states in terms of drug related violence and crime. At the same time, alcohol is the most commonly abused Drug in all the States in India. Although the sale of alcohol is prohibited in Manipur, alcohol users are the second largest group seeking treatment services after opiate users. Users of inhalants in Manipur are the third largest number of youths demanding treatment services.

Drug

Adrug is any substances used in the diagnosis, cure, treatment, or prevention of a disease or condition (Salerno 1999).Drugs are chemical substances legal or illegal, natural or synthetic which when taken have biological effects(therapeutic or non-therapeutic in nature) on the body of the person who is taking them. These drugs could be taken in various forms such as in liquid form alcohol, could be smoked cannabis, or pill form swallowed-

amphetamines; in powder form, sniffed cocaine or injectable Lysergic Acid Diethylamide(LSD), and in gas form and inhaled such as glue.

Drug Abuse

Drug abuse refers to "self-medication or self-administration of a drug in chronically, excessive quantities, resulting in physical and psychological dependence, functional impairment, and deviation from approved social norms" (Salerno 1999).

It is the persistent and excessive drug use inconsistent with or unrelated to medical practice. In short drug dependence produced by repeated consumption of natural or synthetic drug is generally characterized by,

- An overpowering desire or need(compulsion) to continue taking the drug and to obtain it by any means,
- A tendency to increase the dose
- A psychological and physical dependence on the effect of the drug
- Appearance of a characteristic withdrawal syndrome on withholding the drug and
- A general detrimental effect on both the patient and society (Barar1995)

Drug abuse is a global phenomenon for reasons of similarity of human nature everywhere as well as the shrinking of the globe due to the rapid advancements made in the field of transport and communications.

Drug abuse could be defined as use of any drug that causes a problem with the physical and mental capabilities normal to human being.

Parikh (1990) describe drug abuse as the use of drugs to affect the mind and body for no sound medical or scientific reason. Drug abuse may originate with the physicians, the patient seeking medical treatment or with adolescent drug experimentor. Among these patient originated abuse encompasses a longer aspect and persists despite significant efforts by the majority of physicians and pharmacists to restrict the dispensing of psychoactive agents.

Frustration, alienation, hedonism, mass media, advertisement affluence and boredom are among the factors most frequently cited as these lead to misuse of drugs by the adolescent group.

Arikiev (1975) stated that drug abuse referred to a type of maladaptive effort to relieve psychological distress by means of variety of naturally occurring and manufactured pharmaceutically active substances or drugs which alter mood, thought and behaviour. While a propensity to use drugs to alleviate distress is a universal characteristic of human beings the unmonitored and excessive use of substances is a symptomatic result of the combined effects psychological vulnerability and environmental pressure In this context, Dressler (Dressler, 1966) holds that drug abuse is a process of continuous drug addiction to get relief from domestic problems, repress, depression, resentment, or to get rid of disturbing motor restlessness and so on. Thus, it is clear that drug abuse gives an indication of uncontrolled and undirected use of those substances which have mind altering or psychoactive properties. Continuously drug abuse gives rise to a problem which influences the individual personality, human behaviour, and society, and ultimately leads to criminal behaviour.

The main drugs of abuse

Hong Kong Council of Social Science, (1998), had been grouped most of the drugs of abuse into narcotic and non-narcotic drugs. The following are as follows

1. The Narcotic drugs are also known as psychotropic drugs. They are as follows:

   (i). Opium, (ii). Morphine, (iii) Heroin (iv) Codeine,(v) Pantopan, (vi) Methadone, (vii) Etorphine, (viii) Pethidine, (ix) Oxycordone, (x) Wellconal, (xi) Tildine and (xii) Meperidine
2. The non-narcotic drugs include hallucinogenic organic solvents and stimulants. All these drugs are no less dangerous than the narcotic drugs if used without medical advice. They are as follows

(i). Hallucinogens

(ii). Lysergic Acid Diethylamide(LSD)

a. Mascaline
b. Psilocybin and psilocin
c. Phencyclohexyl piperidine or phenylclidine (PCP)
d. DOM (2,3 dimethory-4-methylanaphetamine
e. MDA (3,4) methylene-dioxyampjetomine)
f. DET (dietyltryptamaine)

(iii). Cannabis

a. Marijuana
b. Hashish
c. Ganja
d. Bhang

(iv). Organic Solvents

a. Cocaine
b. Crack
c. Amphetamines
d. Preludin

Types of Drug in Use

There are four types of drug in use currently in India. They are related to each other in that they tend to create addiction in a majority of their users. Only one of these groups is used medically as well. The other three are not in medical use in India.

Type A. Hallucinogens, such as LSD, hashish, ganja, and bhang. They are psychological in addictive, and lead to insecurity, and fear-anxiety complexes.

Type B. Opiates, such as opium, morphine, heroin, and pethedrine. These are physically addictive and lead to physical pain and cramps if not taken regularly by the addict. Preparation of these are smoked, injested or injected.

Type C. Analgesics, such as disprin, asprin, etc., which are physically addictive and are easily available with or without prescriptions from medical practitoners.

Type D. Tranquilizers, such as tryptanol, calmpose etc., which calm anxieties, insecurities, and regulate the mood of the user and induce sleep.

Of the four types of drugs in popular use among Indian youth and today, and each type is capable of creating complete addiction within a few times of their use, and definitely within a week of use.

Youth and Drug abuse

In the National policy 2003-, 'Youth was defined a person of age between 13-35 years, but in the current policy document (2014) the youth age group is defined as 15-29 years with a view to have a more focussed approach, as far as various policy intervention are concerned.

Youth is an important section of our country. Population of youth in India 13-35 years is 459 million constituting about 38% of total population of the country. It is expected to reach 574 million by 2020 (NYRS-2010). It is very important group and they have tremendous potentiality, resources and talents. At present, all over the world drug abuse is becoming an alarming problem among the youth. According to the World drug report published by the UNDCP (1997), a total of 180 million abuse drugs worldwide. Cannabis is probably the most widespread and commonly used in illicit drug.

Pattern of drug abuse

Stringent laws and enforcement activity against heroin trafficking and peddling in the early 1990s in Mizoram, and the early 2000s in Manipur, resulted in a shift among local youth towards dextropropoxyphene injecting (Panda 2002). The synthetic powder emptied from the capsules of spasmoproxyvon or proxyvon obtain from the peddlers or procured over- the counter, is injected after dissolving it in water by heating up the solution in easily available containers such as a spoon or the metallic caps of beverage bottles. The solution is then filtered through a cotton wad at the time of drawing the drug into a syringe. While one quarter to one- half of a gram of heroin generally used for one time injecting, 4-6 capsules of spasmoproxyvon or proxyvon are used for a single shot. Two to three times a day is the frequency of injecting for most of the IDUS. Glue sniffing has been observed in the recent past among street children in Meghalaya. The state of Meghalaya is currently witnessing a rise in drug use, including injecting among local youth in Shillong, the capital city, and in the neighbouring coalmine areas in other districts.

Challenges of youth in drug abuse

Drug abuser when they obtain a stable recovery they are always presumed to be on the verge of relapse as they once used to be an addict. Youth who abuse drugs may be alienated from and stigmatized by their peers. They often disengage from school, community activities because of their drug abuse behavior. They also often experiences depression, apathy, social withdrawal, rejection and isolation from the friends, family members which can cause major discrimination and hurt. Also the drug abuser are often excluded from the social gathering and abandoned by their family members and even sometime by their spouse. Discrimination restricts a person access to necessary health care, employment benefits and can discourage them from seeking help as they are discriminated by doubting their efficiency, questioning their honesty, discrimination at the work place and even getting delayed in

receiving treatment and they even ridiculed or harassed or forced to pay additional charges by the health care worker

Family Environment and youth in drug abuse

The family environment often plays a significant role in the use of alcohol and other drugs. Unstable and inconsistent family and living environment factors (e.g., transient living conditions, inconsistent caretaking, violence) resulting from substance using caretakers have been linked to the incidence of psychological and emotional development problems among their children. In families where alcohol and other drugs are used or attitudes towards their use is positive, the incidence of children's usage is higher than in families where usage is low and where attitudes towards drugs are not as permissive (Brook, Brook, Whiteman, Gordon, & Cohen, 1990; Johnson, Schoutz, and Locke, 1984). Gfroerer (1987) reported that among a sample of adolescents and their older siblings and parents, youths were twice as likely to try marijuana if there was parental or older sibling drug use. Boyd and Holmes (2002) found among a sample of African American women cocaine users that their substance use paralleled use patterns of their family members, particularly those of fathers, uncles, and brothers.

Statement of the Problem

Drug abuse among the youth is becoming a major problem in Manipur because of the drug trafficking. It is situated in the international border of Myanmar which has made it a major transit route for drug trafficking. Due to this drug use among, youth in the Northeast India, particularly in the state Manipur took a new turn. Injecting heroin (locally known as "number 4") soon took over from heroin smoking- a non-traditional form of opiate use in the region. They gradually switches from non-injecting to injecting method due to the easy availability of drugs, stress arising from socio political unrest and frustration which lead to the problems of high illiteracy levels, high degree of unemployment, extreme poverty, and

broken family which has been cited as the major causes of drugs. Also the youth have now switched into more advanced drug which is called as amphetamine drug which can be ingested, snorted, smoked, and injected lead to mental problems such as depression, hallucination, paranoia and panic attacks. As it is inexpensive they consumed it at a higher amount of dosage which is affecting families and society at large in terms of crime, violence, corruption, and drainage of human, financial and other resources that could be used for social and economic development in Manipur. Also it has become a great area of concern as according to the latest epidemiological report intravenous drug users is increasing up to 40% cases in Manipur. Keeping these views, the researcher interested to study the challenges faced by youth in Manipur in terms of understanding the drug use patterns, challenges, family environment and services offer by the institution which caters for youth in drug use.

Objectives

1. To profile the youth in drug abuse.
2. To probe into the patterns of drug abuse among youth.
3. To understand the challenges faced by the youth in drug abuse.
4. To assess the family environment of youth abusing drugs.
5. To identify the relationship between family environment and drug abuse among youth.

Hypothesis

Youth with disruptive family structure are more prone to be drug abusers.

This hypothesis is derived from the study conducted by Centre for Suicide Research and Prevention and Department of Social Work and Social Administration at the University of Hong Kong (2011).

Chapter Scheme

Chapter I - Introduction

Chapter II - Review of literature

Chapter III - Methodology

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CHAPTER –II

REVIEW OF LITERATURE

Review of literature is essential and is often given importance before conducting any study as it helps the researcher to understand the theoretical background and findings of different scholars in various aspects. Also, it gives an idea about the research gaps as well as the differences or commonality of various studies in relation to the present study. It also helps to understand the typology or method suitable for a particular study thus giving one a general idea about the significance or limitations of each method. It also widens the outlook and overall it helps in mapping out what is of core importance for the research at hand thus helping one to have a more systematic study. The present section includes various studies done by researchers across the world which are relevant for the present study.

Drugs are chemical substances that changes the way the human body works.When one swallows, inhales, apply or inject drugs into the body, they findtheir way to all parts of the body via the bloodstream. In the brain, drugs mayintensify or dull senses, alter one's sense of alertness and sometimes decreasephysical pain. The effect of the drug or substance varies depending on howmuch is taken, how often it is used, how quickly it gets to the brain and whetherother foods, drugs or substances are taken at the same time. A drug cantherefore be described as a chemical that alters the speed of cell activities.It must be noted that many drugs invoke more than one effect, e. g. alcohol acts as a stimulant and then as a depressant, while ecstasy acts as both a stimulantand as a hallucinogen (Sanca, 2004).

A drug refers to a substance that could bring about a change in the biological function through its chemical actions (Okoye, 2001). It is also considered as a substance that modifies perceptions, cognition, mood, behaviour and general body functions (Balogun, 2006). They could thus, be considered as chemical modifiers of the living tissues that could bring about physiological and behavioural changes (Nnachi, 2007).

Due to their socio-economic status, developing countries often tend to have more complex problems with the abuse of substances like alcohol, tobacco smoking, use of cannabis and the sniffing of glue and other volatile substances. With economic and social development, however, according to Scanlon (2001), this picture tends to change. Increased movement of people, better communication technology and improved socio-economic status to name but a few, also influences the drug trade and increase the drug abuse problem.

Drug abuse refers to "self-medication or self-administration of a drug in chronically, excessive quantities, resulting in physical and psychological dependence, functional impairment, and deviation from approved social norms" (Salerno 1999).

The type of drugs abused in the developing and developed countries also differs. Drug abusers in the developing countries start and often continue a lifetime of drug abuse with legal drugs, such as alcohol and tobacco smoking, and then do not move beyond the abuse of cannabis, whereas abusers in developed countries might start with the abuse of alcohol and cannabis but quickly move to more dangerous drugs or even start with the more addictive drugs like ecstasy and cocaine. How the drug abuse problem starts or continues is of minor importance compared to the millions of lives in both developed and developing countries which have been destroyed through illicit drug trade (United Nations on Drug Control and Crime Prevention (UN-ODCCP,(2001).

Ahuja (2003) illustrated the nature and impact of abusable drugs. They are divided into six categories: alcohol, sedatives, stimulants, narcotics, hallucinogens, and nicotine. Alcohol is used by some people as a normal, pleasant and sociable activity, while others take it as a spur which enables them to work. It also acts as a sedative which calms down nerves or a kind of an anaesthetic which reduces the pain of living. Alcohol relieves tension and lessens aggressive inhibition. It also impairs judgment and creates confusion.

Sedatives or depressants relax the central nervous system, induce sleep and provide a calming effect. Tranquilizers and barbiturates fall into this category. Medically, these are used in high blood pressure, insomnia, epilepsy and to relax patients before and during surgery. As depressants, they depress actions of nerves and muscles. A person's ability to think, concentrate, and work is impaired and his emotional control is weakened.

Stimulants activate the central nervous system and relieve tensions, treat mild depression, induce insomnia (keep a person awake), increase alertness, contract fatigue and expressive drowsiness, and lessen aggressive inhibitions. The most widely known stimulants are amphetamines (popularly called 'pep-pills') caffeine, and cocaine. The stimulant drugs are usually taken orally, though some (like methedrine) are taken by intravenous injection.

Narcotics, like sedatives, produce a depressant effect on the central nervous system. They produce feelings of pleasures, strength, and superiority, reduce hunger, lessen inhibitions, and increase suggestibility. Included in this category are opium, marijuana, heroin (smack), morphine, pethedine, cocaine (all opiates) and cannabis, (charas, ganja, and bhang).

Hallucinogens produce distortions of perception (seeing or hearing things in a different way than they actually are) and dream images. Their use is not advised by the medical practitioners. The well-known drug in this group is LSD, which is a man-made chemical. Usually, LSD is taken orally but it may also be injected. The effect of an average dose of LSD usually last for eight to ten hours.

Nicotine includes cigarettes, biddies, cigars, snuff and Tobacco. Nicotine has no medical use. The risk of physical dependence however, may be there. It leads to relaxation, stimulates the central nervous system, increases wakefulness and removes boredom. But frequent or heavy use of nicotine may cause heart attack, lung cancer, and bronchitis. The law does not classify this as a drug.

The social effect of these incidence was captured in a study conducted by International Labour Organization (ILO, 2005) in which it revealed that specific performance impairments, absenteeism to work, workplace violence and aggressions is high among people who depend on one drug or the other. In a related study, Hawkins, Catalona and Miller (1982) in their research of drug abuse and student performance revealed that declining grade, absenteeism from school and school activities, increasing potential for dropping out of school is high among Nigeria's students as a result of adolescent substance abuse. While Nyame, et al (2013) opined that youths under the influence of drugs tend to be unproductive besides absenteeism at work place, poor commitment, over dependence and excessive wastage of valuable resources.

Usually, drug abuse youth said that their parents hardly have any time for them. This may not be directly linked with addiction but certainly could be a factor of family alienation and hence indirectly could be responsible for addiction. Drug using habits of elders and particularly of their parents is an important factor for the status-imitation for the child and fathers habit in particular, influenced the male children (Grichting and Barber, 1989).Broken families, tension in family relationships, lack of parental control over children, addiction among parents have been cited as some of the family conditions conducive to drug abuse. It is inferred that stressful life combined with inadequate social support is also one of the major predisposing causes of drug addiction. Young people seek to become established and achieve independence. In this periodthey face many problem such as social, family and economic problems, and lack of job, home sick-ness, transfer of job, loose parental control, disturbed and broken exposure to drugs, out of schools etc. are the factors related with high risk for drug abuse (Forney, et. al. 1990).Thus, in the modern, youth are facing difficulty, even adult decisions at a much earlier age (Menon, 1989)of job, loose parental control, disturbed and

broken exposure to drugs, out of schools etc. are the factors related with high risk for drug abuse (Forney, et. al. 1990).

The drug users are more susceptible to feelings of alienations low self-worth and resentment. All these problems leads to a variety of social and psychological problems such as delinquency, depression and drug use (Miller, 1990).They do not perceive the situations realistically nor do they execute the response effectively, drug addicts lose their capacity to discharge normal functions to words their family and society. They develop the tendency of carelessness due to which discrimination between good and bad, and capacity to initiate is lost by an individual.

Although peer influences are important in explaining substance use among youth (Lane et al. 2001), family attitudes and practices are also significant. Among Hispanic/Latino youth in particular, parents have been more influential than peers (Coombs, Paulson, and Richardson 1991). Family members' attitudes about and use of substances influence youth substance use. For example, an analysis of the 1997 household survey on substance use found that youth ages twelve to seventeen who perceived that their parents would be "very upset" with marijuana, cigarettes, and binge drinking reported the lowest prevalence of use of these substances in the past year (Lane et al. 2001). Similarly, the protective influence of strong family sanctions against alcohol use reduced the use of that substance among girls in Hungary (Swaim, Nemeth, and Oetting 1995). The level of influence seems to extend to siblings. In one household study in Canada, older sibling drug use, more than parental drug use, was the dominant influence of substance use among youth (Boyle et al. 2001).

There is widespread agreement that the peer group is of great social and psychological importance during adolescence (Huba&Bentler, 1980). In addition to family influences, affiliation with substance-using peers is a strong risk factor for experimentation (Hawkins, Lishner& Catalano, 1985; Needle et al., 1986). The peer group has an important influence on

young people's attitudes, behaviours, perceptions and values. This can generate powerful protective as well as risk factors (Maxwell, 2002). Young people actively seek out peers who are similar to them, and this can reinforce both negative and positive behaviours and attitudes (Ackerman, 2003). Contact with pro-social peers has been identified as leading to improved extracurricular involvement and favourable academic and psychological outcomes (Fredricks&Eccles, 2005). Peers are also an important social resource for young people, with and without substance-use problems (Windle et al., 1991).

Longitudinal and cross-sectional studies generally support the contention that drug use among peers is one of the most important factors predicting experimentation and continued use of substances (Ennett& Bauman, 1993; Oetting& Beauvais, 1987; Wills & Cleary, 1999). Swadi (1988) found that young people who perceived their peers to be using drugs were four times more likely to have used drugs and 13 times more likely to use drugs repeatedly. The effects of peer influences on substance use can take a variety of forms, including increased availability, social modelling of substance use, peer pressure and normalisation of use (Graham et al., 1991). In a study of Dublin pupils reporting cannabis use, 64% said that they obtained the drug from a friend and 62% reported that the cannabis was "shared around a group of friends" (Brinkley et al., 1999).

Van Niekerk (1998) emphasizes that the use of illegal drugs are taking one epidemic proportions among the South African youth. Children tend to becomeinvolved with alcohol and drugs at a young age. Alcohol remains the mostcommonly abused drug in South Africa, followed by dagga (cannabis) and thedagga/mandrax (white pipe) combination. Mandrax (Methaqualone) is also sometimes used on its own. There is also considerable abuse of over thecounter and prescription medicines e.g. pain relievers, tranquiller, (includingbenzodiazepines), cough mixtures (containing codeine), and slimming tablets,as well as solvents especially glue.

Alcohol and other drug abuse are of most serious concern among American Indian populations (Beauvais et al. 1989; Segal 1989; Young 1988). Recent research has found that there is more substance abuse among American Indians than most, if not all, other ethnic minority groups in the United States (Beauvais et al. 1985, 1989; Office for Substance Abuse Prevention 1990). In the same case, alcohol and other drug abuse are becoming common in Uganda especially in Kawempe division.

According to Art Linkletter (1971), the narcotics problem came into public consciousness in the late 1960s as the "drug culture," an aspect of the youth movement, or the "counter-culture," as it was frequently called. The use of the hallucinatory drug LSD, promoted by Harvard University psychologist Timothy Leary, and other narcotics soon was widely practiced in so-called hippie communities, notably in the Haight-Ashbury neighbourhood of San Francisco. By the end of the decade drug abuse was described by government officials as an epidemic, and the smoking of marijuana spread far beyond the youth culture. The use of LSD fell off rapidly by 1970, but other "hard" drugs such as "speed" and heroin persisted, education campaigns and stricter laws notwithstanding. One byproduct of growing drug use was an increase in crime, particularly in urban areas.

Drug abuse by soldiers in Vietnam was also reported to be very extensive, and many veterans returned home as addicts. In October 1970 Congress passed the toughest drug control law in history, but no great hope was entertained that laws alone could stem the situation. One of 18 the best known spokesmen in the campaign against drugs was television entertainer Art Linkletter, whose daughter had died after using LSD. On September 14, 1971, he spoke to a special United Nations audience in New York on effective ways to deal with the drug menace. Equally, Ugandan citizen have lost their children due to the effect of drug abuse.

The Southern African Democratic Alliance Countries (SADAC) region is faced with a problem of becoming a user region of drugs such as heroin, cocaine, cannabis, alcohol and tobacco. Not only drug abuse, but also drug trafficking from one country to another is becoming a public health problem (Mamoliehi2001).

Stanhope & Lancaster (1999) confirms that at least 7% of adolescents in the USA are addicted to alcohol and marijuana, even though they know about the dangers of these drugs, which means that they use the drugs in spite of the persistent, recurrent, psychological, mental and social consequences. The younger and productive age group's future is gravely endangered, as they are not fully developed physically, mentally or socially, and the drugs have more detrimental effects on their bodies. They are also easily tempted and usually not assertiveenough to say "no".

The problem with drug and alcohol abuse is that it "drains the physical, intellectual, and economic resources of each individual as well as their families, communities and countries who can often least afford it" (Herrel& Roberts 2003).

The most common drugs teens report using include alcohol, tobacco, caffeine, pot or weed (marijuana), and pills that were not prescribed to them. Other less used drugs include opiates, cocaine, amphetamines, hallucinogens, depressants, inhalants, club drugs, and performance enhancing drugs (Goldstein, 2011).

In the USA, marijuana is the most widely used illicit drug among America's youth and the number of teens using marijuana doubled between 1991 and 2001 from 1 in 10 to 1 in 5 (Mvubelo 2001). Among the youth who use drugs, approximately 60% use only marijuana. The marijuana users also tend to become younger and two-thirds of new marijuana users in the USA each year are between 12 and 17.

Marijuana is an addictive hallucinogenic drug, which is smoked by the abuser. It causes "an unnatural thirst or hunger, uncontrolled mood swings, talkativeness, impaired

perception, disturbed judgment, mind disorders, a feeling of well-being and euphoria (pleasant feeling of excitement and of escaping reality) and it alleviates anxiety" (Rehn et al 2001).

As marijuana is illegal to possess in Swaziland and in the RSA, it can be expensive to buy. Abusers therefore tend to abuse substances that are more readily available and not illegal to buy, such as glue and paint. The homeless and poor often abuse these substances. These substances have a depressant effect on the abuser when they are inhaled. They cause slurred speech, inability to focus, stupor and seizures. The individual tends to move slowly as if lethargic and has a "drugged appearance". The individual sometimes tends to become hostile and aggressive (Lopez 2001). Polish remover slows down the activities of the nervous system that control the body functions (WHO 2002).

Cocaine is an extremely addictive drug and is illegal to possess or deal with. The effects of cocaine appear almost immediately after only a single dose and disappear within minutes. It makes the user feel euphoric, energetic, talkative and mentally alert, especially to the sensation of sight, sound, and touch. It can also temporarily decrease the need for food and sleep. The short-term physiological effects of cocaine include constricted blood vessels, dilated pupils, increased body temperature, increased heart rate, and an increase in the blood pressure. Large amounts of cocaine may lead to bizarre (strange in appearance), erratic (unreliable) and violent behaviour (UN-ODCCP, 2002).

The major substances consumed recreationally in Lao PDR are opium and its derivatives, amphetamine type stimulants (ATS) and volatile substances (glue, petrol). It was estimated in 2004 that there were 8000 injecting drug users (IDUs) in Lao PDR (UNODC 2004).

Amphetamines type stimulants (ATS) are most commonly smoked (chasing the dragon: smoking the drug off tinfoil or similar) or ingested. However in 2000, a report found

the prevalence of injecting ATS among Vientiane schoolchildren that used ATS was 12% (UNDCP/ LCDC 2000). ATS are the drug of choice among 15-19 year olds (Reid and Costigan 2002).

The transition to injection from smoking of opium, heroin or ATS is a major concern. International reports suggest that injection of drugs is usually preceded by smoking, although there are reports from Vietnam, near the Lao border, of simultaneous heroin and injection initiation (Walsh 2003). Delaying time to initiation of injection, developing safe injection practices at initial injection episode or preventing transition to injection altogether are key components in reducing the trajectory of an explosive HIV epidemic in this vulnerable population. It is generally acknowledged that the sharing of injecting equipment has increased the velocity of HIV epidemics in neighbouring countries.

Heroin is most commonly injected in Thailand. Rates of injection among heroin users rose from about 50% in 1994 to nearly 80% by the end of that decade. By 2001, heroin accounted for only approximately 10% of the illicit drug market, although in Bangkok at this time there were still 40,000 opiate users of whom 90% injected (ESCAP, UNODC and UNAIDS 2001). Heroin users tend to be older than ATS users. In 2002, it was estimated that 0.5% of the general population abused opiates (UNODC 2004).

Drug abuse is a major public health problem all over the world (UNODC) (2005). The use and abuse of drugs by adolescents have become one of the most disturbing health related phenomena in Nigeria and other parts of the world (NDLEA; 1997).Several school going adolescents experience mental health programme, either temporarily or for a long period of time. Some become insane, maladjusted to school situations and eventually drop out of school. Adolescents experience mental health programme, either temporarily or for a long period of time. Some become insane, maladjusted to school situations and eventually drop out of school.

According to Fawa (2003), "Drug is defined as any substance, which is used for treatment or prevention of a disease in man and animals. Drug alters the body functions either positively or otherwise depending on the body composition of the user, the type of drug used, the amount used and whether used singly or with other drugs at the same time".

Haladu(2003) explained the term drug abuse as excessive and persistent self-administration of a drug without regard to the medically or culturally accepted patterns. It could also be viewed as the use of a drug to the extent that it interferes with the health and social function of an individual. World Book Encyclopedia (2004) defined drug abuse as the non-medical use of a drug that interferes with a healthy and productive life Manbe (2008) defined drug abuse as the excessive, maladaptive or addictive use of drugs for non-medical purpose.

Abdulahi (2009) viewed drug abuse as the use of drugs to the extent that interferes with the health and social function of an individual. In essence, drug abuse may be defined as the arbitrary overdependence or misuse of one particular drug with or without a prior medical diagnosis from qualified health practitioners. It can also be viewed as the unlawful overdose in the use of drug(s).

Odejide (2000) warned that drug abusers who exhibit symptoms of stress, anxiety, depression, behaviour changes, fatigue and loss or increase in appetite should be treated by medical experts and counsellors to save them from deadly diseases.

According to Seigal (2003), inhalants are an assortment of chemicals and toxins that when inhaled are poisonous to the brain. They include common household items such as spray paints, air fresheners, glues, correction fluids and hair spray. Inhalants can cause disorientation, hallucination, memory loss and lack of coordination. He further states that these inhalants "literally seal out the transfer of oxygen to the blood stream. The body can simply suffocate from lack of oxygen. The inhalants contain a wide variety of toxins, which

target different body parts for example the brain, the skin, liver and kidneys." Addiction to Benzene and gasoline (petrol) causes serious injury to bone marrow and to the immune system. It is toxic to the reproductive organs, causes hearing and vision loss and said to be linked to an increased risk of leukaemia.

Fishburne (2003) states that an estimated 1.5 million Americans 12 years and older are chronic cocaine users. In addition, many youngsters have been attracted to the inexpensive, high purity heroin that can be sniffed.

Drug use among youth has increased and the age at which drug use begins has dropped. Although tobacco, alcohol and marijuana are the substances mostly tried, the use of heroin, cocaine, amphetamine and inhalants is also on the rise (Bachman & O'Malley 2004).

Njuki (2004) maintains that there are so many issues confronting Africa that substance abuse is not looked at as it should be. Both illicit drug trafficking and substance abuse are increasing in Africa. Cannabis, methaqualone, heroin and alcohol are included among the drugs used across the African continent. Moreover, the injection of heroin has caused heightened concern as intravenous drug use assists in the continued spread of HIV/AIDS across Africa.

Green et al (1999) point out that young people who use substances dramatically increase their chances of becoming drug dependent, their vulnerability to life-threatening accidents and injuries, and their risk for other problems related to substance abuse. Further,the use of alcohol and other drugs in the adolescent years "has the potential to set patterns for future behaviors that have an impact on health beyond the adolescent years".

Ross, Wodak, Stowe, and Gold (1994) reported that the factors most associated with sharing needles related to the urgency of being in withdrawal and needing to inject as soon as possible. Ross and colleagues note that participants in their study "frequently indicated that (sharing) was not due to the lack of general availability (of clean needles) but to availability

at the time and place of injection". Both Power, Jones, Kearns and Ward (1996) and Hughes and Phil (2001) found that PWID would share when they were desperate for a hit and without immediate access to clean supplies. Both of these studies also note that this need to inject was largely a result of experiences of withdrawal, and individuals less dependent upon opioids were more able to wait until clean needles were available, not 104 unlike some of the youth in this study. A more recent quantitative study of PWID who were HCV negative found that access to needles (or lack thereof) was the strongest predictor of equipment sharing, and the authors suggest that those who shared were more likely to do so when experiencing withdrawal (Stein, Dubyak, Herman & Anderson,2007).

Haladu (2003) gave the following as the main causes in his study:

1. Experimental Curiosity: Curiosity to experiment the unknown facts about drugs thus motivates adolescents into drug use. The first experience in drug abuse produces a state of arousal such as happiness and pleasure which in turn motivate them to continue.
2. Peer Group Influence: Peer pressure plays a major role in influencing many adolescents into drug abuse. This is because peer pressure is a fact of teenage and youth life. As they try to depend less on parents, they show more dependency on their friends. In Nigeria, as other parts of the world, one may not enjoy the company of others unless he conforms to their norms.
3. Lack of parental supervision: Many parents have no time to supervise their sons and daughters. Some parents have little or no interaction with family members, while others put pressure on their children to pass exams or perform better in their studies. These phenomena initialize and increases drug abuse.
4. Personality Problems due to socio-Economic Conditions: Adolescents with personality problems arising from social conditions have been found to abuse drugs. The social and economic status of most Nigerians is below average. Poverty is widespread, broken

homes and unemployment is on the increase, therefore our youths roam the streets looking for employment or resort to begging. These situations have been aggravated by lack of skills, opportunities for training and re-training and lack of committed action to promote job creation by private and community entrepreneurs. Frustration arising from these problems lead to recourse in drug abuse for temporarily removing the tension and problems arising from it.

5. The Need for Energy to Work for Long Hours: The increasing economic deterioration that leads to poverty and disempowerment of the people has driven many parents to send their children out in search of a means of earning something for contribution to family income. These children engage in hawking, bus conducting, head loading, scavenging, serving in food canteens etc, and are prone to drug taking so as to gain more energy to work for long hours.
6. Availability of the Drugs: In many countries, drugs have dropped in prices as supplies have increased.
7. The Need to prevent the Occurrence of Withdrawal symptoms: If a drug is stopped, the user experiences what is termed "withdrawal symptoms". Pain, anxiety, excessive sweating and shaking characterize such symptoms. The inability of the drug user to tolerate the symptoms motivates him to continue (Ige, 2000)

Osikoya and Ali (2006) asserted that socially, a drug abuser is always pre-occupied with how to obtain drug of choice and crave for the substance. Kobiowu (2006) study revealed that the academic pursuit of those undergraduates who engages in drug misuse is not unduly jeopardized, and that the abusers do not socialize extraordinarily, contrary to seemingly populaer expectation.

Studies by Okuh (1978), Oduaran (1979) and Johnson (1979) exhibit a plethora of purposes for which students use drug. The list includes curiousity, boldness, friends-do-it,

enjoyment of social gathering, academic pressure, sound-sleep, sexual-prowess, and performance in sports. Drug abuse is a very serious problem among school adolescents and which has slowly made the average Nigerian student to be maimed, sentenced to a life of delinquency, insanity, street walking and premature death expectation.

According to Hayden Browne (1991), those young people who reach the attention of drug and alcohol agencies, the criminal justice system or the welfare system, are not typical of all young people who have ever used, or who do occasionally use, illicit drugs. Rather, the evidence indicates that those drug users have generally experienced a far more disrupted family background and are finding the processes of adjustment to school, family, and other facets of life more difficult to accomplish than most other people of their age. On the whole, their use of drugs is not the cause but more largely an effect of their distresses. Young people who begin to use drugs heavily – as distinct from those who are tentatively experimenting with substances – do so largely to escape from subjective states which are intensely disagreeable to them, such as anger, frustration, loneliness, anxiety and depression. Many are unemployed, poorly educated, estranged from their families or homeless.

Hayden Browne (1991) observed that, the challenge which presents itself to those agencies which are charged with the responsibility for improving the quality of life for such young people is to alleviate those distresses which induce so many to use drugs. Illicit drug use may be for some the predominant concern, but it should not be seen or treated as the central, or solitary, issue. Illicit drug use is neither the ultimate nor immediate cause of most of the distress among young people encountered by the welfare system; nor has it proven effective to mark drug use as the sole target for intervention in the lives of such young people, since at the same time they are often beset by problems of homelessness, hunger, unemployment, limited social and recreational 9 opportunities, and by estrangement from

their families, school and other facets of conventional society. Timely and practical assistance for young people is an imperative necessity.

Adolescents abuse both legal and illegal substances. Legal substances are socially acceptable psychoactive substances (De Miranda, 1987; Parry, 1998), and include over the counter and prescription medicines, such as pain relievers, tranquilisers including benzodiazepines, cough mixtures containing codeine and slimming tablets (Craig &Baucum, 2001; Conger, 1991; Rice, 1992). In addition, there are other agents such as solvents in glue, alcoholic beverages, nicotine and inhalants, nail polish and petrol. Illegal substances are prohibited and the use, possession or trading of these substances constitute a criminal offence (De Miranda, 1987). These substances include cocaine powder, crack cocaine, heroin, ketamine, cannabis, ecstasy, fentanyl, morphine, methaqualone (Mandrax), opium, flunitrazipam (Rohypnol), methamphetamine and Wellconal (Craig &Baucum, 2001; De Miranda, 1987; Parry, 1998).

According to Jon Rose (2000), providing services to adolescents who are using legal and/or illegal drugs raises a range of specific issues. The developmental challenges of this stage requires those engaged in their care to apply age appropriate strategies rather than simply thinking of this diverse group as mini adults. Young people who come to the attention of health and welfare professionals often use drugs as a means of coping with situational and emotional distress. While this drug use may also exacerbate problems, practical assistance in areas such as accommodation, family, recreation, financial, vocation and educational support will most often need to precede or coincide with any drug use management. Linking drug-related effects and interventions to goals identified by the client will enhance the possibility of change. This is the same effect with Kawempe division‘s case.

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Peer group influence has been noted as a key factor to drug abuse among the youth. In the social learning perspective (Akers et al. 1977) adolescents learn delinquency by modeling-exposure to friends' delinquentbehavior, peers' social approval of delinquent acts, and anticipated rewards for engaging in delinquency. Peer group influences on deviance are especially likely when there is weak bonding to the family and school (Elliott et al. 1985; Kandel 1980; Jessor and Jessor 1977; Hirschi 1969). Similarly, peer group influence is one of the biggest challenges of drug abuse in Kawempe division. As with sex, drug issues may be a secretive area for young people. This is particularly so if the young person perceives possible negative consequences for disclosure (e.g. refused accommodation, judged, probation breached or parents informed).

Craig and Olson (1990) compared cocaine abusers and heroin addicts and found cocaine addicts to show more traits of the antisocial personality style, whereas opiates addicts evinced more problems with anxiety and somatic distress.

It is also believed that the use of licit and illicit drugs is above all a symptom of various problems. People who use drugs are bored, tense, alienated, insecure, sexually inhibited, confused, and worried –not just hooked on chemicals (White and Watt, 1973). Drug abuse is frequently a regressive defence against anxiety which becomes stronger with reinforcement. But alcohol addicts and other drug addicts are often lost astray, fantasizing intolerant of frustration, narcissistic, hostile and low in self-esteem. In many individual , it

also represent an attempt on their part to respond to a need and desire for thrills, novelty, curiosity experimentation, and to control an emotional pain. Peer group pressure and drug abuser bear a close relationship. Other psychological, social or economic factor may also play an important role.

Galt (1997) reported that illicit drugs were readily available and accessible and an accepted part of youth culture, and concluded that for drug education to be successful it has to take account of different motives and patterns of drug use. In contrast Burr (1987) considered the social profile of heroin users, which included factors such as family breakdowns and high rates of truancy and delinquency prior to heroin use. The researchers argued that the "local criminal subculture in South London provided the means for rapid expansion of heroin use" and that heroin use was an extension rather than the cause of delinquent behaviour among working class youth in the study. Boys et al. (1999) sought to explore decision making with regards to drug taking and observed multiple influences, which the researchers categorised into five individual-level influences (functions of substance use, substance-related expectancies, physical/psychological state, role commitments, and boundaries) and five social/contextual-level influences (environment, availability, finance, friends, peers, and the media). Bell et al. (1998) also argued that a crucial step in becoming a regular user lies in matching the effects of the drug to the social context in which it is used.

Rosenfield (1985)defines depression as a feeling of sadness, hopelessness worthlessness and guilt reproach.

Pestonjee (1999)depression is an emotional state of dejection, feeling of worthlessness and guilt accompanied by apprehension.

Depression literally meaning 'lowering and dejection' (Webster, 2010)it is defined "as psychoneurotic disorder or psychotic disorder marked especially by sadness, inactivity, difficulty in thinking and concentration, a significance increase or decrease in appetite and

time spent sleeping, feeling of dejection and hopelessness and sometimes suicidal tendencies, a reduction in actively amount, quality or force, a lowering of vitality or functional activity."

Balogun (2006) defined Substance as an element that modifies perceptions, cognition, mood, behaviour and general body functions.

NAFDAC (2000) cited in Fareo (2012) defined the term substance abuse as an excessive and persistent self-administration of a drug or its components without due regard to its medically or ethically accepted norms.

Omage and Omage (2012), states the major causes of substance abuse among Nigerian youth are joblessness, peer pressure, search for identity, emotional and psychological stresses among others.

Ogege (2010) opined that substances abuse is not limited or attributed to a particular age grade or sex but it permeated all levels of social structures; cultural ,religious and geographical boundaries.

Idowu (1987) found that students smoke and use drugs at the instance of friends/peers, parents and television/radio advertisements. Oladele, (1989); Okorodudu and Okorodudu (2004); and Enakpoya (2009) in their studies showed that adolescents were very susceptible to the influence of their peers.

Lather. S (1993) discusses drug problem in India is not a new phenomenon, but the number of drug abusers has never been as high as it is today. Surveys carried out Delhi, Chandigarh, Uttar Pradesh, and Andhra Pradesh has reported an alarming increase in drug abuse. They also revealed that the variety of drug abused in the past have stretched out from cannabis and its preparations to other harder drugs such as opium, barbiturates, amphetamines, tranquilizers, L.S.D., mandrax, pathedine, acrphine, alcohol, heroin. National Committee on Drug Abuse in India (Rao 1984) reported that “there are disturbing signs which show that drug abuse in India is likely to worsen and get out of hand if the planned

comprehensive and sustained measures are not taken immediately to curb the evil". The situation is further worsened by the emergence of a new paradigm to already existing problem, i.e., formation of a visible link between intravenous drug use to human immunodeficiency virus (HIV) and AIDS.

According to National Aids Control Organization (NACO – 2006), there are 50,000 injecting drug use (IDUs) in the northeast region of India, the majority of them in Manipur, Nagaland, Mizoram and Meghalaya. According to the United Nations Office on Drug and Crime (UNODC) report 2005, alcohol is the most commonly abused substance in all the states in India except in Mizoram. Of the states of the northeast region, clients of treatment centres in Assam, Meghalaya and Tripura, seek help mainly for problems of alcohol abuse. Although the sale of alcohol is prohibited in Manipur, Nagaland and Mizoram alcohol users are the second largest group seeking treatment services in these states after opiate users. It is worth noting that intravenous use of pharmaceutical products, the use of opiate of choice for injecting in Mizoram has been associated, unlike heroin, with higher risk of abscesses, non-healing ulcers and amputations thereby increasing the morbidity of drug users.

Banerjee (1995) denotes that the intravenous drug users (IVDUS) constitute thelargest population in Manipur in our country, which can be painfully termed as Intravenous Killer Virus Spreader group (IVKVS Group). Most of the victims are young age group. Paul (1996) nevertheless says that all things considered, the prevalence rate of alcohol and other psychoactive drugs in the country (India) is hardly comparable to that in the West. He also stressed that, alcohol is very much a drug; but in view of its prevalence and implications, it is often kept separate from other drugs.

Sharma and Luwang (1984) conducted a study in the hilly state of Manipur and found that there is an alarming increase in the number of drug abusers. Their number increased from 6% in 1972 to 23% in 1982. This study which examined over 1,300 drug abusers revealed

that the majority of them (43.7%) were using drug for a period of more than one year and used injectable drugs like morphine and pathedine. Only 26.30% of abusers were using oral form of drugs. People in age group of 15-25 years were the maximum users of drugs. In terms of occupation, the drug abusers were maximum from the students group (71.7%). In the study conducted by Nagaraja (1985) in Andhra Pradesh, it was found that of the 1000 student's drug addicts surveyed, medical students alone accounted for 24%, while 6% were high school students. Of the drug addicts 38% were hooked on pathedine, acrphine, and heroin.

Inhalant abuse refers to the intentional inhalation of vapours from commercial products or specific chemical agents to achieve intoxication. Abusers may inhale vapours directly from a container, from a bag into which a substance has been placed, or from a rag soaked with a substance and then placed over the mouth or nose (American Psychiatric Association [APA], 2000). Intoxication occurs rapidly and is short-lived, although some abusers repeatedly or continuously self-administer inhalants to maintain a preferred level of intoxication.

Inhalant abuse and dependence criteria parallel the generic substance abuse and dependence diagnostic criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV; APA, 2000). The criteria do not include withdrawal symptoms, although some evidence suggests a characteristic withdrawal syndrome (Perron et al., 2009). Amyl nitrate, other nitrite vasodilators, and nitrous oxide are sometimes abused by inhalation, but the criteria specifically exclude them from the list of substances considered.

Inhalant use is the deliberate inhalation of volatile substances, via sniffing, snorting, bagging, or huffing, to induce a psychoactive or mind-altering effect (National Institute on Drug Abuse, 2000). It is a serious drug problem worldwide, particularly in disadvantaged

populations and among adolescents (Kozel et al., 1995;Padilla et al., 1979; Tapia-Conyer et al., 1995).

UNODC (2010) estimated that up to 20.7 million individuals in Asia and the Pacific have used ATS in the past year (Global Smart Programme, 2010). Its use is increasing in East and South East Asia and the Middle Eastern region. Amphetamine-type stimulants can be snorted, smoked, injected, or used rectally. Compared with opioids, most users of ATS administer the drug through non-injecting route.

Intake of ATS, notably the amphetamine-group substances results in euphoria, increased alertness, arousal and libido and elevated heart rate, respiratory rate, blood pressure; in addition, users perceive heightened confidence, energy levels and physical strength (Barr et al, 2006). The HIV-related risks associated with amphetamine group substance use are well documented in the literature and majority of studies demonstrate an association between amphetamine-group substance use and risk of HIV infection, in particular among men having sex with men (Colfax et al, 2010).

National surveys of adolescents in the United States have found that, after marijuana, inhalants were the second most widely used class of illicit drugs for 8th and 10th graders and were the third most widely used for 12th graders (Johnston et al., 2001). The most commonly used inhalants are glue, shoe polish, and gasoline (McGarvey et al., 1999), and inhalant users typically report family problems (Jacobs and Ghodse, 1988; McGarvey et al., 1996; Morita et al., 1996).

Glue, shoe polish, toluene, spray paints, gasoline, and lighter fluid are among the inhalants most commonly abused by young people (Substance Abuse and Mental Health Services Administration (SAMSHA 2000).

Users of inhalants in Manipur and users of codeine-based cough syrups in Mizoram are the third largest number of youths demanding treatment services. Cannabis (ganja) users

are the second highest group of treatment seekers in Assam, Meghalaya and Tripura. Heroin use has also made inroads in Assam and Meghalaya. Tripura has lower levels of the abuse of tranquilizers as reflected in the records of addiction treatment centres.

Further the report states that 28 percent of the population of Manipur are drug addicts, of who nearly half are injecting drug users (IDU). Cases of drug abuse is fast rising with 12 per cent of drug addicts in the age group till 15 years, 32 per cent in the age group of 16-25 years and 56 percent in the age group of 25-35 years. Manipur is considered as one of the most affected states in terms of drug related violence and crime. Hence, there is an urgent need to change the course of the present trends in drug use in the state and motivate the youth to join the main stream, the statement added.

At the same time, alcohol is the most commonly abused Drug in all the States in India. Although the sale of alcohol is prohibited in Manipur, alcohol users are the second largest group seeking treatment services after opiate users. Users of inhalants in Manipur the third largest number of youths demanding treatment services third largest number of youths demanding treatment services.

Stringent laws and enforcement activity against heroin trafficking and peddling in the early 1990s in Mizoram, and the early 2000s in Manipur, resulted in a shift among local youth towards dextropropoxyphene injecting (Panda 2002). The synthetic powder emptied from the capsules of spasmoproxyvon or proxyvon obtain from the peddlers or procured over- the counter, is injected after dissolving it in water by heating up the solution in easily available containers such as a spoon or the metallic caps of beverage bottles. The solution is then filtered through a cotton wad at the time of drawing the drug into a syringe. While one quarter to one- half of a gram of heroin generally used for one time injecting, 4-6 capsules of spasmoproxyvon or proxyvon are used for a single shot. Two to three times a day is the frequency of injecting for most of the IDUS. Glue sniffing has been observed in the recent

past among street children in Meghalaya. The state of Meghalaya is currently witnessing a rise in drug use, including injecting among local youth in Shillong, the capital city, and in the neighbouring coalmine areas in other districts.

Stigma is a social process where certain groups or individuals are devalued by others because of perceived undesirable attributes (Goffman, 1963). These attributes mark some point of difference or deviation away from the norm (Jones, Farina, Hastorf, Markus, Miller, & Scott, 1984). Commonly this includes perceived dangerousness or weakness of character (Goffman, 1963) as well as non-conforming behaviour (Link and Phelan, 2001; Major & O-Brien, 2005; Room, 2005; Tindal, Cook & Foster, 2010). Stigma leads to social exclusion, which can negatively impact mental and physical health and socioeconomic circumstances.

Drug use is considered one of the most stigmatised behaviours (Corrigan, Miller & Watson, 2006; Room, 2005). Socially devalued and moralised, alcohol and other drug (AOD) users are perceived as self-indulgent, lacking in self-control and weak-willed (Semple, Grant & Patterson, 2005; Tindal et al., 2010) and hence are viewed as blameworthy and less deserving of treatment (Obot, Poznyak&Monteiro, 2004; Room, 2005). There is also a perception of dangerousness, particularly given media portrayals of drug use being linked with crime (Taylor, 2008) and fear of disease associated with injecting drug use such as HIV and Hepatitis C (Tindal et al., 2010). Although such fears may not be completely unfounded, views such as this overlook the complexities of drug dependence (Obot et al., 2004) and may lead to discrimination (Link & Phelan, 2001).

Stigma was experienced through interaction with mental health professionals and social exclusion from neighbours, friends and extended family. Structural discrimination was highlighted through the provision of poor care facilities, discriminatory legislation and lack of crisis support facilities. The media was also flagged as propagating negative representations and feeding public ignorance (Angermeyer et al., 2003).

Banerjee (1995) denotes that the intravenous drug users (IVDUS) constitute the largest population in Manipur in our country, which can be painfully termed as Intravenous Killer Virus Spreader group (IVKVS Group). Most of the victims are young age group. Paul(1996) nevertheless says that all things considered, the prevalence rate of alcohol and other psychoactive drugs in the country (India) is hardly comparable to that in the West. He also stressed that, alcohol is very much a drug; but in view of its prevalence and implications, it isoften kept separate from other drugs.

Rao (2007) indicates that AIDS is associated with social stigma; AIDS is a diseasewith a difference. AIDS affected persons are subject to prejudice and discrimination. Those who are the victims of the disease are treated as "untouchable". They are branded as people with immoral character. Sharma, Y.K (2007) writes that the World Health Organization (WHO) has defined alcoholics as "excessive drinkers whose dependence on alcohol has attained such a degree that they show noticeable mental disturbance or an interference with their mental and bodily health, their interpersonal relations and their smooth, social and economic functioning or show the prodromal (beginning) signs of such developments".

Studies based on families living with HIV/AIDS also reported interpersonal discrimination such as verbal insults and violence (Bogart et al., 2008), as well as finger pointing and jeering, and being targeted for gossip (Ogunmefun et al., 2011).

Social distancing is a common reaction to stigmatised conditions. Avoidance by others is a measure often employed to determine family members' perceptions of how others relate to them when a stigma becomes known (Angermeyer& Dietrich, 2005; Green, 2003; Werner, Mittelman, Goldstein &Heinik, 2011).

Bhagbanprakash (2000) has stated the main factors responsible for the spread of 'Drug abuse' as the followings:

The increase in drug abuse mostly by youngsters is now a world-wide phenomenon. Obviously, the youth emerge as the most risk prone group in whom the illicit-drug-trade makes its deepest impression. The curiosity and quest for new experiences motivates the young people also to try the new 'drug experience', particularly when it is accessible and available. Another contributing factor to drug abuse is the peer- pressure. Young people in school, colleges, factories and farms sit, eat and work together. New ideas and experiments keep circulating in these groups influencing behaviour patterns and attitudinal changes. Many young people turn to drugs out of a sense of alienation. Youth is a period of psychological uncertainty.

A changing social environment is one of the main factors responsible for the spread of 'drug abuse' among the youth. The family structure in India plays a vital role in providing role models and conditioning attitudes and conduct. With the nuclearisation of Indian families during the last three decades, the longer absence of working parents from from homes and consequent involuntary neglect of children, the emotional and ethical support structure of the family has been fast disappearing. The children of such families constantly in need of refuge and resort seek and get in the drug-dens.

Mass unemployment of educated youth and migration of rural youth to urban centres in search of work have also played their role in precipitating abuse of drugs. While the educated youth, without jobs, take to drugs as a pastime or out of frustration, the rural migrants in the city, uprooted from their traditional social-cultural milieu resort to drugs in an attempt to overcome isolation, despair and loneliness. Away from the support and comfort of their families and homes and disillusioned by the urban alternative, the rural youth belong neither here nor there. For want of housing in an otherwise over congested town or city, they live in slums and ghettos often with criminals and anti-social elements. Here they not only fall prey to drugs but also get occasionally involved in drug trafficking for easy income.

Since the 1960s the international drug traffickers started pushing drugs into the Indian society. This plagues spread like wild fire in the eighties and has hit the impressionable youth the most. The most critically affected groups of drug abuse were college and school students, the unemployed youth, offspring of broken families and the blue collared workers. Indian cities such as Delhi, Bombay, Calcutta and Madras have large number of addicts. Delhi alone is estimated to have more than a hundred thousand of addicts, although these numbers are at best intelligent guesses. It is quite possible that a much larger number may exist unexposed, where the surveyors have not been able to reach (Ahuja, 1986; Mohan et al., 1981; Khan and Krishna, 1984).

The reasons why people turn to drugs are as varied as the types of people. Some of the contributing factors identified by the United Nations (UN, 1987) are peer pressure, curiosity, ignorance, alienation, changing social structures and urbanisation and unemployment.

In the context of socio-cultural aspects, the eminent sociologists Alistair (1985) pointed out that the main social influences towards drug use relate to minority group state; parental loss, separation, disharmony or illness, low income, divorce, failure in love, a state of deprivation, peer group influence towards deviant sub-cultural activities, restricted opportunities for acceptable socialization, defective socializing influences, and easy drug availability.

The social stigma attached to drug use also makes the parents and other family members, such as sibling, unwilling to seek support from friends in schools and relatives, as it is difficult to find others who can render support in a non-judgmental way (Frye et al., 2008). Needs of the non-drug-using sibling are pushed side-lines as the family is busy struggling with the issues stemming from the drug-using child (Gregg &Tombourou, 2003). Some studies also point out the increased financial strain on the family, and its related conflicts between the parents and drug-using children, when the addicted children ask for

money to buy more drugs (Barnard, 2005). Overall, drug use in children creates significant risk to their family members, causing tremendous negative impact on them physically, emotionally and financially. It exerts a ripple effect on the entire family and may extend to other domains such as the parents work, siblings schooling, and level of social support (Gregg &Tombourou, 2003). Like the drug-users, the family members also need support in managing the emotional and related physical impact as a result of drug use in the family.

Sniffing:"involves the inhalation of vapours directly from an open container or a heated pan" (Kurtzman et al., 2001).

The stigma attached to injection drug use may present a barrier to safer injection practices. Stigma refers to an attribute that is deeply discrediting (Goffman, 1963). Injection drug use, under Goffman's typology of stigma, refers to "blemishes of individual character perceived as weak will, domineering or unnatural passions, treacherous and rigid beliefs, and dishonesty". There is a strong negative connotation attached to injection drug use (Jackson et al., 2009; MacNeil&Pauly, 2011; Rhodes et al., 2007; Simmonds &Coomber, 2009). Some PWID feel a general sense of shame and embarrassment in accessing NEPs, which may stem from fears of how the public views persons entering a NEP (Simmonds &Coomber, 2009; Jackson et al., 2009). Among drug users and non-drug users alike, "injecting carries a certain stigma that often exceeds that associated with other routes of drug use" (Jackson et al., 2009).

Ross, Wodak, Stowe, and Gold (1994) reported that the factors most associated with sharing needles related to the urgency of being in withdrawal and needing to inject as soon as possible. Ross and colleagues note that participants in their study "frequently indicated that (sharing) was not due to the lack of general availability (of clean needles) but to availability at the time and place of injection". Power, Jones, Kearns and Ward (1996) and Hughes and Phil (2001) found that PWID would share when they were desperate for a hit and without immediate access to clean supplies. Both of these studies also note that this need to inject was

largely a result of experiences of withdrawal, and individuals less dependent upon opioids were more able to wait until clean needles were available, not 104 unlike some of the youth in this study. A more recent quantitative study of PWID who were HIV negative found that access to needles (or lack thereof) was the strongest predictor of equipment sharing, and the authors suggest that those who shared were more likely to do so when experiencing withdrawal (Stein, Dubyak, Herman & Anderson,2007).

A study of PWID in New York City also found that PWID were more prone to sharing when experiencing withdrawal, and suggested that "periods of 'dope sickness' (withdrawal) are moments of exceptional vulnerability to HIV and HCV because they increase the likelihood of risky injection practices" (Mateu-Gelabert, Friedman, Sandoval, Wendel&Meylakhs, 2010). Thus, there is strong evidence to suggest that among many PWID, the combination of being in withdrawal and not having needles presents a significant barrier to the practice of safer injection and an occasion during which sharing is more likely to occur. PWID become 'vulnerable' to the power of the drug. The need to inject takes precedence over the need to use safely: "addressing immediate pain overrides long-term concerns over infections" (Mateu-Gelabert et al., 2010).

A couple of youth in this study noted negative experiences when trying to access clean needles from a hospital. Negative experiences in healthcare settings among PWID and street youth have been reported by many researchers (Drumm, McBride, Metsch, Page, Dickerson & Jones, 2003; Jackson et al., 2009; Karabanow et al., 2007; Paterson, Hirsch & Andres, 2013). In Karabanow and colleagues' (2007) study exploring the health status of street youth in Halifax, participants expressed resistance to accessing the formal health care system for fear of being approached in an unsupportive and disrespectful manner. Likewise, a study of people who use drugs in Miami found that participants were less willing to seek medical care when they felt rejected by providers or that providers were offering poor or

inconsistent care and advice (Drumm et al., 2003). Research in Nova Scotia highlights the stigmatization that people who use drugs and are HCV positive (believed to be a consequence of drug use) face in emergency departments (Paterson et al., 2013). The youth in this study had experiences that confer with this larger body of literature to suggest that the hospital environment may be stigmatizing for PWID, making the hospital a poor choice for access to clean supplies.

Lisansky (1960) noticed frustration to be one of the salient features among drugabusers. This high level of frustration is indicative of low stress tolerance among drug abuser Laskowits (1961), Rosenbel'g (1968) and Williams (19681 reported high level of anxiety and neuroticism among drug abusers group.

Rosenberg (1969) emphasized the importance of environmental factors and held the view that certain individuals developed certain personality traits, especially during adolescence which predispose them to subsequent drug abuse.

Boyd 1970 is of the view that certain environmental factors play an important role in drug addiction. Though no personality type appears to be definitely predisposed to drug abuse, but psychologists accept the possibility of vulnerability in several different personality type.

Singl and Lal (1985) reported that drug abuse has, become one of those intense problems which require serious attention and quick action due to its ill effects on overall personality.Walia (1993) reported that poverty, family environment:strains and stress of society and experimentations with drugs are the main factors which make the people addict.

Inhalants are another important class of drugs, second only to marijuana in their lifetime use prevalence rates among adolescents. Inhalants are easily available, inexpensive, and often not classified as illicit drugs in the minds of children and their parents. Inhalant use is most prevalent among younger children (8th graders or younger); in 1997, 21 percent of

8th graders, 18 percent of 10th graders, and 16 percent of 12th graders said they had bagged, huffed, or sniffed a chemical at least once in their lives. Inhalants are dangerous; even a single episode of inhalant use can cause brain damage and death (MTS 1997).

According to the United Nations Office on Drugs and Crime (2008), substance abuse is worsened by complex socio-economic challenges such as unemployment, poverty and crime in general. These social ills are devastating many families and communities. Substances from all over the world currently flood South Africa. Drug pushers are forcing young people into taking substances so that once they are hooked; they can manipulate their friends into taking substances (United Nations Office on Drugs and Crime, 2008). Too many youth seem to think of experimentation with substances as an acceptable part of transition into adulthood. Few take seriously the negative consequences of dependence on substances (Madu&Matla, 2003).

In fact, as early as in 2000 the United Nations has already warned about the rise of club drugs and cannabis, as well as their recreational use in developed countries in the West, that such use was no longer confined to a small number of marginalized youth (UN Economic and Social Council, 2001). Examples include drug abuse mentioned in the lyrics of popular songs, behavior of entertainment artists, and advertisement that targeted at youth. It had slowly become part of life among mainstream youth during their free time and become a subculture (UN Economic and Social Council, 2002). Drug use was then found not only in disco or at dance parties (UN Economic and Social Council, 2002), and it was portrayed as having a fashionable lifestyle (UN Economic and Social Council, 2001). Young people were found to become more tolerant towards drugs experimentation (UN Economic and Social Council, 2001). The United Nations therefore called for increased sharing of information among countries to address the then emerging problem at an early stage, especially because youth cultures tend to globalize (UN Economic and Social Council, 2002).

Family environment is considered the major underlying factor determining whether young people would engage in disruptive behaviors, including substance abuse. Peer influence works more as a contributing factor closer to the time of substance use initiation (Gardner et al., 2006; Kumpfer et al., 2003; UNODC, 2009)

Substance abuse is the result of a complex interaction of individual, family, peer, community, and societal factors (United Nations Office for Drug Control and Crime Prevention 2000). A consistent global finding is that substance abuse runs in families. A family history of drug abuse and dependence substantially increases the risk for such problems among members (Madianos et al. 1995; Wester-meyer and Neider 1994; Wu et al. 1996). The same pattern occurs with alcohol abuse and dependence (Curran et al. 1999; Jauhar and Watson 1995). Although genetics plays a substantial role in both alcohol (Bierut, Dinwiddie, and Regleiter 1998) and drug dependence (Tsuang et al. 1996), the family environment plays a role in both promoting and protecting from substance abuse and dependence. This section reviews some of these factors. Due to the limitations of the research designs, many of these findings are correlational and not causal.

Singh, et.al (1978) attempted to indicate that the family environment plays a great role in drug abuse behaviour. The study reveals that drug addicted persons, in general, hailed from families where at least one or two persons are affected by chain smoking or drug abuse. Khan (1985) illustrates that a number of research findings referred to earlier bring out differing views on drug-users. Some report that drug-users are creative (Buckman, 1971) while others infer that they are under-achievers. Likewise, while some observe that they are adequately integrated in the social group, others observe that they are some sort of ‘dropouts’ (James, 1969). In other words, drug-users are outstanding and also not out-standing.

The family environment often plays a significant role in the use of alcohol and other drugs. Unstable and inconsistent family and living environment factors (e.g., transient living

conditions, inconsistent caretaking, violence) resulting from substance using caretakers have been linked to the incidence of psychological and emotional development problems among their children. In families where alcohol and other drugs are used or attitudes towards their use is positive, the incidence of children's usage is higher than in families where usage is low and where attitudes towards drugs are not as permissive (Brook, Brook, Whiteman, Gordon, & Cohen, 1990; Johnson, Schoutz, and Locke, 1984). Gfroerer (1987) reported that among a sample of adolescents and their older siblings and parents, youths were twice as likely to try marijuana if there was parental or older sibling drug use. Boyd and Holmes (2002) found among a sample of African American women cocaine users that their substance use paralleled use patterns of their family members, particularly those of fathers, uncles, and brothers.

Family members' attitudes about and use of substances influence youth substance use. For example, an analysis of the 1997 household survey on substance use found that youth ages twelve to seventeen who perceived that their parents would be "very upset" with marijuana, cigarettes, and binge drinking reported the lowest prevalence of use of these substances in the past year (Lane et al. 2001). Similarly, the protective influence of strong family sanctions against alcohol use reduced the use of that substance among girls in Hungary (Swaim, Nemeth, and Oetting 1995). The level of influence seems to extend to siblings. In one household study in Canada, older sibling drug use, more than parental drug use, was the dominant influence of substance use among youth (Boyle et al. 2001).

Studies of family structure around the world have found that youth who live with both biological parents are significantly less likely to use substances or to report problems with their use, than those who do not live with both parents (Challier et al. 2000; Johnson, Hoffman, and Gerstein 1996). However, family structure alone does not appear to explain substance abuse. The characteristics of these family structures offer some clues. For example,

boys who are in care of their mothers and whose fathers are drug abusers are at increased risk for drug abuse but this is due to the genetic transmission of risk and lack of resources for effective parenting for single mothers (Tarter et al. 2001). Studies in Brazil and Saudi Arabia have noted that the quality of family relationships was more important than structure in explaining substance use (Al-Umran, Mahgoub, and Qurashi 1993; Carvalho et al. 1995).

Deustch (1982) describes family dynamics as remarkably uniform in most addicted home and significantly different from the conditions which govern most other households. There are certain specific problems they face:

- The family lives on an emotional roller coaster of embarrassment, guilt, hurt, anger and frustration.
- The addiction becomes less predictable, less reliable, financial resources are diverted for alcohol/drugs, hence family becomes insecure.
- Constant demands, growing criticism, provocation, erode the family's self-esteem.
- To protect the addict from external condemnation and to protect themselves from further embarrassment, the family may isolate itself from external contacts.

The disintegration of the family appears to be related, in some way to the problems of substance abuse. Study carried out by United Nations Research Institute for Social Development (UNRISD) and United Nations University on Mexico, show that illicit drug abuse correlates more strongly with the disintegration of the family than with poverty.

Drug and alcohol use can change depending on factors such as the availability of drugs, introduction of new drugs in drug markets, new modes of administration, and rapid social changes. Some factors play a more direct role in the causation of the drug abuse problem amongst adolescents such as certain psychological factors, for example lack of behavioural control, depression and lack of support due to chaotic home environments where there is no family stability (William & Covington 1998). Family instability may be caused by

many factors such as unrest, quarrels among family members; for example, father and mother, or parents and children (Taylor & Carry 1998).

Bronfenbrenner (2003) views the family as "a whole organism that is much more than merely the sum of individuals or groups that it comprises. During the many years that the family is together, family members develop habitual patterns of behavior and repeat these behaviors a thousand times. In this way each individual becomes accustomed to act and to respond in a specific manner within the family. Each member's actions elicit a certain reaction from another family member over and over again, and over time. These repetitive sequences give the family its own form and style. Family influences may be experienced as an invisible force. This invisible force governs the behavior of the family members every time they are together. These forces include such things as spoken or unspoken expectations, rules for managing conflicts and implicitly or explicitly assigned roles."

The relationship between the young person and his or her parents is critical in developmental terms (Youniss, 1983). Family structure is, in itself, an important variable, and several studies have shown that young people from "disrupted" families use substances more heavily and more frequently than others (Needle, Su, & Doherty, 1990; Doherty & Needle, 1991). As far as parental monitoring and discipline are concerned, it has been reported that "authoritative" parenting (Baumrind, 1991) is linked with improved outcomes in both school performance and individual development (Steinberg et al., 1989). "Authoritarian" parenting, by contrast, tends to have a negative outcome upon school performance and other behaviours (Steinberg et al., 1994).

Single parents often exert a weaker influence over their children, which reduces their ability to contrast the risk factors that contribute to early school-leaving and substance use (Dornbush et al., 1985). By contrast, two-parent families tend to have higher levels of monitoring, which contribute positively to behaviour and school performance (Fisher et al.,

2003; Borawski et al., 2003). Young people whose parents are divorced are reported to have more friends who use substances and weaker coping skills than those whose parents have not divorced (Neher& Short, 1998). Studies have found that children from broken families, those who are dissatisfied with their parents, and those who were not supervised were more likely to use drugs (Ledoux et al., 2002).

Brook and colleagues have found that low levels of parental attachment and high levels of permissiveness increase the likelihood that a young person may move from non-use or light use to moderate use (Brook et al. 1986, 1991, 1992).

A five-year follow-up study of over 1,000 families found that divorce or separation in a young person's family is a significant predictor of their experimentation with drug use and transition towards problematic use (Needle, Su & Doherty, 1990). (Stein, Newcomb and Bentler 1987) found that their family-disruption factor was significantly correlated with adolescent drug use, albeit largely mediated through lack of social conformity, suggesting that the relationship is not a direct one.

Young people from families with a history of substance misuse are likely to be influenced by these role models, as well as having easier access to the substances themselves. This access can facilitate experimentation with substance use and young people may, as a consequence, be exposed to a raft of other risk factors, including neglect, an unhealthy home environment, financial hardship, insufficient parental support or a lack of interest in school performance. Families thus play a central role in preventing substance use among young people and positive phenomena such as family cohesion, interaction and parental monitoring have been identified as key protective factors that contribute to a reduction in drug misuse (Velleman et al., 2005; Liddle, 2004; Borawski et al., 2003; Annunziata et al., 2006).

High educational attainment among parents, more positive attitudes towards education, and skilled jobs are also protective factors in relation to early school-leaving.

Similarly, young people who perceive that their families care for them and would intervene in their substance use tend to have lower levels of substance use (Scheer et al., 2000).

Diamond et al (2001) and Preboth (2000) state that drug abusers often become so obsessed with the habit that everything going on around them is ignored, including the needs and situations of other family members, leading to a breakdown of the family as an entity. Besides possible criminal behaviour brought into the home by the drug user, the family suffers varying degrees of personal anguish both physically and psychologically (Preboth 2000). Family members are affected as they watch the destruction of an individual who is close to them. When younger children see an older person or parent using drugs, they may wrongly believe that it is normal and acceptable to take drugs (Sweetney& Neff 2001)

Page, Scanlan and Gilbert (1999) maintain that parents are responsible for their children's behaviour as it reflects the way they were socialized. The WHO (2003) states that when adolescents feel connected to their families and when both parents are involved in their children's lives, it influences how adolescents feel about themselves, and the choices they make about behaviours that affect their health. Furthermore, "adolescents need to have at least one adult who is committed to their well-being. They need adults they can turn to and adults who will listen as they describe what they are experiencing and how they are coping" (WHO 2003).

Studies of family structure around the world have found that youth who live with both biological parents are significantly less likely to use substances, or to report problems with their use, than those who do not live with both parents (Challier et al. 2000; Johnson, Hoffman, and Gerstein 1996). However, family structure alone does not appear to explain substance abuse. The characteristics of these family structures offer some clues. For example, boys who are in care of their mothers and whose fathers are drug abusers are at increased risk for drug abuse but this is due to the genetic transmission of risk and lack of resources for

effective parenting for single mothers (Tarter et al. 2001). Studies in Brazil and Saudi Arabia have noted that the quality of family relationships was more important than structure in explaining substance use (Al-Umran, Mahgoub, and Qurashi 1993; Carvalho et al. 1995).

Disruptions in the family life cycle seem to characterize these single-parent households. An unstable family environment (i.e., father absence, one or both parents who had immigrated, or death of parents) was associated with substance abuse among a nationwide sample of youth in Greece (Madianos et al. 1995) White non-Hispanics/Latinos and African Americans in changed families (e.g., those that changed from two parents to single parents during the study) had the highest rates of substance initiation (Gil, Vega, and Biafora 1998). Moreover, deteriorating family environments were stronger influences of drug initiation among Hispanic/Latino immigrants than non-immigrants to the United States. Among African Americans, family structure and environment had the weakest effect on substance use and African-American youth in the care of their mothers or other adult family members, had the lowest proportion of drug onset.

Family attitudes and practices about substance abuse: Although peer influences are important in explaining substance use among youth (Lane et al. 2001), family attitudes and practices are also significant. Among Hispanic/Latino youth in particular, parents have been more influential than peers (Coombs, Paulson, and Richardson 1991).

The Study undertaken by the Centre for suicide research and prevention and the department of social work and social work administration at the University of Hong Kong (‘’consultant’’) (2011) reported that most young respondents perceived their introduction to drug use as being related to peer influence as being related to peer influence or as a matter of personal choice. Curiosity factor was also often mentioned. Also when youths were asked about their initial drug experience, it might be common for them to explain their use out of personal choice, peer pressure, and curiosity. Yet what pushed from young people to at the

first trial of drug, to the continuous use of it, and later an addiction which was somehow instigated by family experience.

Youth perspective Young people in the focus groups commonly reported that their parents' paid little attention to them. Likewise, communication with young people in their families was either lacking or ineffective, and sometimes resulted in extreme negative experiences. Another factor in well-to-do family relating to youth's drug use could be spoiling. One adult respondent confessed that his parents spoilt him both emotionally and financially. For example, his mother bought him cigarettes when he was too young to buy them legally. Likewise, when his parents found out his drug use, money was still provided, which helped finance his drug use.

These studies so far have confirmed direct association between the consumption of illicit drugs and the breakdown in the family bond. Country study (2011) on the Lao People's Democratic Republic and on Thailand attributes increasing use of heroin, opium and psychotropic substances to urbanization, rapid cultural change and a breakdown in family cohesion. The substance abuse strains the family relationships and ultimately makes the families dysfunctional and transforms them from an asset of society into a burden. Family factors like prolonged or traumatic parental absence, harsh discipline, and failure to communicate on an emotional level are usually thought or lead to, or intensify, drug abuse. While the family itself can be the source of drug problems, it can also be a potent force for prevention and treatment. There has been increased acceptance of family therapy, where more than one member of the family is involved simultaneously in therapy sessions.

From the experiences of front-line social workers and research studies, Hong Kong experiences what is considered the normalization of drug use, especially among marginal youth (Cheung and Cheung, 2006). It stems from the rise of dance club culture in the early 2000 spreading from the West to Asia and the rise of club drugs used (i.e., psychotropic

drugs) (Joe Laidler, 2005). This normalization encompasses a few aspects: occasional use of psychotropic drugs is deemed acceptable for leisure and recreation (e.g., birthday parties and festivals); misconception (specifically, underestimation) about the level of harm these psychotropic drugs entail as compared to traditional drugs like heroin; misconception of the legal consequences of psychotropic drug use, e.g., unaware that even consumption of such drugs is illegal (Hong Kong Narcotics Division, 2008). More importantly, the common terminology used to describe psychotropic drug use in Hong Kong — in Chinese it literally means "excessive use of medication" — does not carry the same connotation as "poisonous drug abuse" in its severity. The Task Force Report (Hong Kong Narcotics Division, 2008) made recommendations on changing the terminology in the future. Before the introduction of the Trial Scheme on School Drug Testing in Tai Po District in the 2009–2010 academic year, the subject of youth substance abuse was still a taboo in many schools (The Hong Kong Federation of Youth Groups, 2008). All of the above suggest that some youth drug users regard drug use as an alternative way of life, being part of a social norm within the youth subculture, and that they can make a cost-benefit drug decision. Thus, they do not consider themselves as having problems or in need of help.

From the overview of literature a few research gaps are identified. There are voluminous studies on youth drug abuse both at international and national level. But there is no study with regard to family environment on drug abuse youth in Manipur. Thus, the present study attempts to fill the research gaps by way of surveying on the family environment of drug abuse among youth.

The next chapter will discuss in detail the methodology of the present study.

CHAPTER-III

METHODOLOGY

The earlier chapter is represented overview of literature and the major research gaps therein. In this chapter the setting of the present study and methodology aspects are presented. This chapter has been divided into two major sections. The first section deals with the profile of the study area and two organisationsnamely Social Awareness Service Organisation (SASO) and Care and Foundation had been taken for the study. The second section deals with the methodological aspects of the present study such as research design, sampling, tools of data collection, sources of data, analysis operational definitions and limitations.

Profile of the study area

The study was conducted among drug abuse youth in Imphal West district of Manipur. The respondents are selected in the age group of 15-29 years who are visiting in the drop- in centresin the NGOs called SASO and Care and Foundation.

Manipur

Manipur is one of the states of India. Imphal is the capital of Manipur.As per Census 2011, the total population of Manipur at 0.00 hours of 1st March 2011 is 25, 70,390.Imphal is also the centre containing all the important administrative offices, educational institutions and private transport facilities etc. The town is growing very fast in all ways and having the characteristics of urban area.

Care and Foundation

The Care and Foundation is a non-governmental organisation established in the year 2001. Its envision attainment of quality life with healthy positive and product living for all. Its immediate mission is to mitigate the impact of drug use and HIV/AIDS by ensuring: accessibility of quality care and treatment; basic fundamental rights with over all well-

beingand sustenance for all persons infected and affected by HIV/AIDS. Their main aim is to ensure quality of life amongst person living with HIV/AIDS, hence to achieve this they provide the following services : care and support; clinical diagnostics such as CD4 count, Haemoglobin, screening of hepatitis C antibody; treatment of sexually transmitted diseases, opportunistic infections; management of overdose and abscess among IDUs (injecting drug users); follow up to ensure continuum of care and maximize adherence to ART; networking and referrals to various service providers, especially in the government and non-government health care settings.

SASO

SASO was established on 1st January, 1991 by a group of like-minded PWID (group of ex-drug users) and is currently providing services to the community of people who use drugs at three levels: field services, DIC and clinic based. Initially, their main aim was to support each other in order to live a drug free life. It is one of the first NGOs which took up home detoxification for drug users in Manipur. By organizing sporting events (with petty contributions from members and well- wishers), they started giving awareness in low profile among communities. Their services include: one-to-one interactions, group sessions and focus group discussions with IDUs; STI treatment (including partner treatment); counselling and information on HIV prevention through counsellors and part-time doctors; referral and linkages with various public healthcare services; needle-syringe exchange programme (NSEP); training and capacity building for community members; and oral substitution therapy (OST).

Pilot study

A pilot study is an initial investigation to give information that is necessary when designing a future trial ofthe study. The pilot study was conducted with eight youth in Care and foundation (DIC) randomly. From the pilot study, it was found that youth have started

consuming drugs at an early age due to curiosity, peer pressure and easy access to drug peddler. The pilot study indicates that those youth started consuming drugs orally and later they shifted to injecting drugs. Some youth started the injecting drug use and later continue with the sniffing/snorting.

Research design

The present study is cross sectional in nature and descriptive in design. The descriptive design is used to describe the various factors that are responsible for drug abuse among the youth in the present study. The study was based on primary data collected through quantitative method. The study was done by using mixed method approach. The primary data were collected in both quantitative and qualitative methods.

Sampling

Quantitative data were collected from the drug abusers using structured interview schedule purposively in the two drop in centres namely Care and Foundation and SASO. In the Care and Foundation there were 70 drug abuse youths regularly drop-in for OST where as in SASO there were 160 youths regularly drop-in for OST. The researchers selected the respondents by using stratified simple random sampling method based on their age group who are in the age between 15 and 29 years.There were total 160 respondents were taken for the study. The Family Environment Scale developed by (Moss and Moss, 1986) consists of 10 subscales was used to assess the family environment of the drug abuse youth.The qualitative data was collected by using case study method and Focus Group Discussions with drug user. The researcher used PRA technique the daily activity schedule.

Inclusion criteria

The respondents who are in the age group of 15- 29 years were included from both the two mentioned NGOs under OST.

The respondents who gave consent to be interviewed were included.

Exclusion Criteria

The respondents who are above the age group of 29 years were excluded from both the two mentioned NGOs under OST.

The respondent who refused to give consent were excluded for the study.

Tools of Data Collection

Interview schedule was used to collect primary data. The interview schedule contains different sections based on the objectives of the study. The interview schedule covers on the profile of the respondents, profile of parents, pattern of drug abuse, challenges faced by drug abuse youth and Family Environment. In order to assess the family environment of drug abuse youth a Family Environment Scale (FES) was used which was developed by Moos, B.S and Moos, R.H (1986).

Sources of Data

There were two sources of data used by the researcher. They were primary and secondary sources.The primary data was collected by the researcher with the help of structured interview schedule. The secondary data were collected from books, journals, articles, magazines, websites, and NGOs.

Description of the Scale

The Family Environment Scale developed by Moos, R.H and Moss, B.S (1986) which consists of 90 statements also it was divided into ten subscales. These sub scales measure the three dimensions of family environment namely Relationship includes the cohesion, expressiveness and conflict, Personal Growth includes independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation and moral-religious emphasis and System maintenance covers organisation control subscales. It was used in the present study to find out the relationship between drug abuse and their family

environment.The family environment scale (FES) measures (10) dimensions family environment as indicated below:

Dimensions of Family Environment Scale

Sl.No	Subscales	No.of items
1	Cohesion	10
2	Expressiveness	10
3	Conflict	10
4	Independence	10
5	Achievement-orientation	10
6	Intellectual cultural orientation	10
7	Active recreational orientation	10
8	Moral religious emphasis	10
9	Organisation	10
10	Control	10
	Total	90

The score obtained under each dimensions represent the scale of family environment in the respective domain and summation of all the score obtained under of the 10 dimensions would evolve as a global score for family environment.

Pretesting

The administered scale namely Family Environment Scale developed by Moos, R.H. & Moos, B.S. (1986). It was tested for its reliability by conducting the statistical tests of Cronbach's alpha. The value is .6.5. Since the alpha value is almost .7, the tool was found to be reliable and accepted for further data collection. Assigning a score of '1' to each correct answer and totalling the scores on the individual statements under sub-scale, a score is arrived for each of the 10 sub-scales.

Operational definitions

Drug abuse

Drug abuse refers to "self-medication or self-administration of a drug in chronically, excessive quantities, resulting in physical and psychological dependence, functional impairment, and deviation from approved social norms" (Salerno 1999).

Youth

The National Youth Policy 2014 defines youth in the age group between 15 and 29 years.

Drug abuse youth

A youth who is in the age group between 15 and 29 years, abuses a drug like spasmoproxyvon, nitrazepam, WY (world is yours), heroin, cannabis, magic mushroom, buprenorphine, amphetamine,etc. and chemically dependent on the drugs.

Focus group discussion

Focus group discussion(FGD) was conducted to explore the types of drug which was taken by the youth orally or injecting, the initiation of drug abuseand the pattern of drug use.The topic of discussion is "*to identify the reason for drug addiction and the challenges faced by the youth*." The researcher selected eight respondents for the FGD from Care and Foundation and she introduced the purpose of FGD to the group.

From the discussion, the researcher got an insight that most of the youth abuse drugs cough syrups such as Phenshydyl, Corex, Epidex, Sericodine and Bonolex to pain killers like Proxyvon,SpasmoProxyvon, Relipen, Prozep and tranquilizers such as Diazepam, Valium, Nitrogen 10 (N10); from psychoactive substances such as Morphine, Poldrom, Mandrake, Hypogento the infamous Heroin (which is also known as number 4).

Further, the youths have switched on to easily available and cheap substances like Dendrite and Correction Fluids (KoresEraz-ex). Interestingly, a few of them have begun to taste shoe polish as an intoxicant.

Nowadays, cheap and easily available substances such as Dendrite and correction fluids (Eraz-ex) are widely abused by young ones by smelling/sniffing. In this regard, school going teens are the most common in doing so.

During the discussion the researcher also come to understand the reasons for abusing drugs among youth. Young people take drugs or abuse substances for many reasons. The reasons are due to peer pressure, curiosity or fun, unemployment, broken family, depression, escape problems at home, unemployment, poverty, unrest of mind, to overcome frustration, easy access to drug peddler, cheap availability of drugs at low prices and so on so forth.

They consume drugs in different ways; initially they abuse orally and later shifting to injecting drugs use. There are different kinds of drug which they used in many ways varies from snorting to ingested to inhaled to sniffing.

The youths have started taking the drugs at a very early age due to the influence of friends and lack of knowledge on the drug education and due to the early drop out from the school. Also they stated that once started consuming the drug for at once they said that it makes them not able to stop using the drug and make them continue to use on a daily basis, which they consumed it at a very high rate amount, that lead them into a dependent use and make them into a drug addicts one.

They face a lot of challenges in the society like suspicion, lacking of self-trust, mistreatment by the family members, society or communities, social stigma which is one of the most negative impacts faced by the drug abuser, rejection by their friends, isolation from the family members, exclusion from the social gathering, marital conflict, and discrimination such as verbally abusing them, being very sarcastic and deserted or abandoned by the spouse. They are always considered to be on the verge of relapse. Also there is common adage "*once an addict always an addict"* so they have mentioned that there is always doubt in their self-efficiency, difficulties in finding jobs, questioning their honesty.

In the context of the availability of drugs and places where they gather to involve in drug abuse, during the discussion they expressed thatIDUs prefer to inject in places that offer them safety and security. Their main concern is interference from the police, pressure groups

and the village defense force, which leads to victimization, harassment and extortion. The preferred places are peddlers' places of North AOC, Lilong&Khetrigao and toilets (both public and home). In addition, one ml syringe and some cotton are supplied by the NGO-TI to the IDUs. The peddlers sell 1 ml syringe for Rs. 5. Sharing occurs during states of withdrawal; reuse and sharing of cookers are common. When IDUs reuse the syringe that they have kept in a secret place, their safety is compromised as they assume that others would not have used this syringe. Syringes and needles are not returned to the TI due to several obstacles and are disposed of in places such as dustbins, toilets, drains and injecting location.

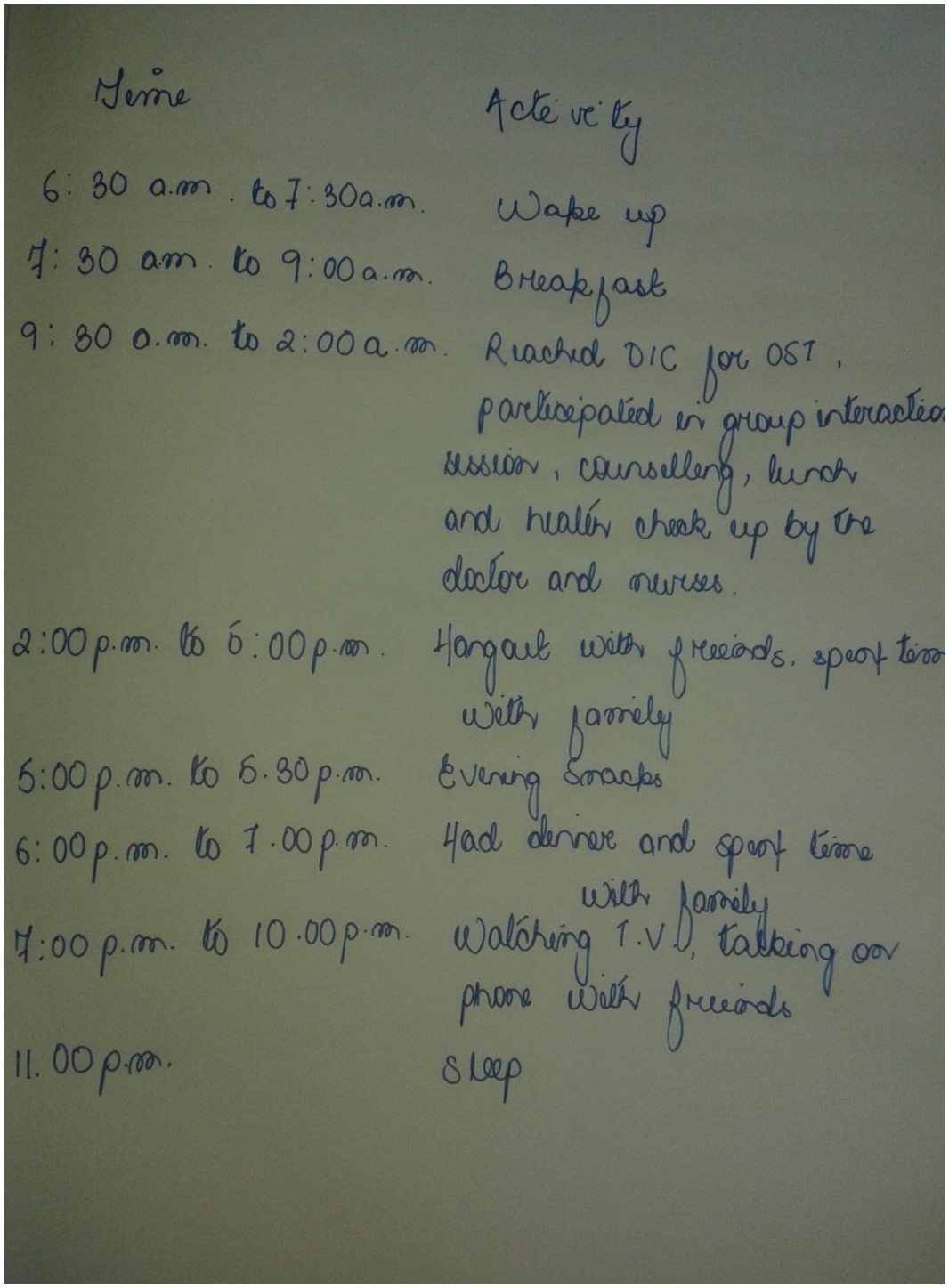
Moreover, the researcher conducted one PRA (Participatory Rural Appraisal)technique among youth who abuse drugs. It is one of the important methods to get information with a short span of time. The researcher conducted one of the PRA exercisesdaily Activity Schedule.

Daily Activity Schedule

Daily Activity Schedule is a popular PRA method used to explore the activities of an individual, group or community. This method forms part of the family of temporal PRA methods. The basis of temporal analysis is hours or periods of the day. It depicts not only the various activities but also the duration of those activities. Its visual nature makes it an attractive method.

From the Daily Activity Schedule, it was found that respondents wake up between 6:30 a.m. – 7:30 a.m. From 7.30 a.m. - 9.00 a.m. they read newspapers and get ready to go for the DIC.9.30 a.m. – 2.00 p.m. they reached the Drop in Centre(DIC) for taking OST and participated with the group interaction session for addiction. They were given counselling by the social worker also lunch break was given for half an hour and health check-up was done

Daily Activity Schedule of Drug Abuse youth



Time	Activity
6:30 a.m. to 7:30a.m.	Wake up
7:30 a.m. to 9:00a.m.	Breakfast
9:30 a.m. to 2:00a.m.	Reached DIC for OST, participated in group interaction session, counselling, lunch and health check up by the doctor and nurses.
2:00p.m. to 6:00p.m.	Hangout with friends, spent time with family
5:00p.m. to 5.30p.m.	Evening Snacks
6:00p.m. to 7.00p.m.	Had dinner and spent time with family
7:00p.m. to 10.00p.m.	Watching T.V, talking on phone with friends
11.00p.m.	Sleep

by the doctors and nurses. From 2.00 p.m. – 5.00 p.m. they hang out with friends. From 5.00 p.m. – 5.30 p.m. they had evening tea and snacks. They had dinner at 6.00 p.m. – 7.00 p.m. and spent time with their family. They spent 7.00 p.m. – 10.30 p.m. for watching T.V and talking on phone with friends. They sleep at 11.00 p.m. onwards.

From the Daily Activity Schedule, it can be seen that participants had been engaged in their own activities and had no quality time with their parents. It can also be seen that the time spent by the respondents with their parents was only during the dinner time.

The researcher conducted a casestudy withdrug abuse youth:

CASE-1

Name	:	Ramananda
Age	:	23
Gender	:	Male
Educational level	:	Graduate but didn't complete
Religion	:	Hindu
Marital status	:	Unmarried
Family type	:	Joint family
Family size	:	Medium
Form of family	:	Stable
Locality	:	Urban
Occupation	:	Private Business

Mr.RamanandacomesfromSinjamei, Imphal West District. He hails from a middle class socio economic-background.He is the second order among the siblings. He has one elder brother and one younger sister.His parents are working in government sector.He started consuming drugs when he was in class 8that that time he was only 13years old. He studied his higher secondary in the Manipur. He went to do his graduation in Christ College Bengaluru. He studiedup to Graduation 2nd year but he didn't complete his studies due to the drug addiction problem.At the same time, he was having a relationship with one girl who was also from Manipur. The relationship with that girl was not healthy.

Initially, he started abusing the drug by oral and later shifted to (IDU). He started consuming the drug Cannabis by orally and later shifted to consuming drugs such as, Heroin or Brown sugar by smoking, Nitrazepam or Diazepam tablets, Antihistamine tablets, Amphetamines type substances and Spasmoproxyvon by injecting. These activities were intensified within 5years of progression of abusing drugs from oral to injection. Further, he used other drugs by Inhaling/Sniffing or Smoking as Whitener, Marijuana, Hashish, Cocaine, Opium, Magic Mushroom, LSD (Lysergic Acid Diethylamide) and Mescaline. He indulged in taking drugs due to curiosity and easy access to drug peddler. The main reasons for abusing drug because of Boredom, Depression, and Escape problems at home as well as get rid from the relationship problem.

Mr. Ramananda consumed Heroine and Brown Sugar for almost 3years continuously and exchanging syringes with his peers which led him to affect HIV positive. He also adopted different strategies to continue the use of drugs by selling his own personal belonging such as mobile phone, laptop, and even selling their family belonging to others. He also said that when he was put into the rehabilitation Centre by their family, instead of reducing the drug usage he comes to know more aware about the different drug names and easily availability of drugs in the black market from the other drug addicts who had been already admitted in the Centre. So, when he came out of the rehabilitation Centre, he started buying the drug from the drug peddler with his friends contact.

He faced a lot of challenges, social stigma and discrimination from the family members, relatives, society, friends and health care worker. He mentioned the other challenges lacking of self-trust, mistreatment by the others, difficulties in finding jobs, questioning his honesty, verbally abusing him, being very sarcastic to him, looking down and watch with suspicion as he was always presumed to be on the verge of relapse. He also mentioned that at the health care he was quiet often treated unsatisfactorily by forcing him to

pay the additional charges. He also said that once used the drugs it's very difficult for him to stop using the drug as he become a dependent user andhe had withdrawal, blackout or flashback which are the symptoms of drug dependent.

At present, he is visiting Care and Foundation Centre which is a non-governmental organization which works for the HIV/AIDS patients giving the treatment, medication, counselling and therapy to the infected people. He is regularly going to the DIC to take the ART (Antiroviral therapy) and OST (Opiod Substitution Therapy).

Data processing and Analysis

The quantitative data collected through field survey was processed through Microsoft excel and with the help of computer software SPSS package. To analyse the data statistical methods of averages, percentage, ratios, correlation and proportions was used. The qualitative data was processed with the use of transcript and has been presented in the form of reports.

Limitations

The study was conducted with limited samples only with two drop in centres. It is not adequate enough to generalize the findings in the context of whole Manipur.The study has been conducted using quantitative data predominantly and time is also one of the limitations to conduct in-depth interviews with the drug abuse youth.

The next chapter will present in detail the results and discussion of the present study.

CHAPTER –IV

RESULTS AND DISCUSSIONS

In this chapter, an attempt has been made to present the result of the analysis of the data collection through questionnaire from Care and Foundation and SASO, NGOs working for the Drug addiction. The information provided by the respondents was analyzed according to the objectives of the study. The data were analyzed quantitatively.

This chapter is divided into five sectionsbased on the objectives of the present study. The first section contains the profiles of the respondents which include name, age, gender, educational level, religion, marital status, family type, and family size, form of family, locality and occupation. The second section consists of profile of parents which encompasses father's education, father's occupation, fathers monthly income, mother's education, mother's occupation, mothers monthly income and total household income. The third sections contain pattern of drug abuse in terms of injection, method, reason, age of first drug use, age of first injecting use, duration, frequency, progression, mode of needle use, reuse of needles, reason for reusing the equipment, types of drug use orally, types of drugs injected, sniffed or inhaled, types of drug smoked, types of drug chew or eaten, length of injecting career, different pattern of drug use, and factors. The fourth segment consists of challenges faced by the drug abuse youth such as biggest fear, employer, behave, discrimination, rehabilitation, suspicion, blackout or flashback, medical problems, spouse problem, illegal activities, strategies, stigma and discrimination from the family members. The last part of the chapter is composed of relationship between family environment and drug abuse among youth.

Table 4.1 Profile of the Respondents

Sl. No	Characteristics	Age		Total N= 160
		16- 24 yrs. n = 70	25 -29 yrs. n= 90	
I	**Education**			
	Primary	3	1	4
		4.3%	1.1%	2.5%
	High School	31	43	74
		44.3%	47.8%	46.2%
	Higher Secondary	22	32	54
		31.4%	35.6%	33.8%
	Undergraduate	13	14	27
		18.6%	15.6%	16.9%
	Postgraduate	1	0	1
		1.4%	.0%	.6%
II	**Religion**			
	Hindu	55	65	120
		78.6%	72.2%	75.0%
	Muslim	11	12	23
		15.7%	13.3%	14.4%
	Christian	4	13	17
		5.7%	14.4%	10.6%
III	**Marital Status**			
	Married	17	47	64
		24.3%	52.2%	40.0%
	Unmarried	53	27	80
		75.7%	30.0%	50.0%
	Separated	0	4	4
		.0%	4.4%	2.5%
	Divorced	0	12	12
		.0%	13.3%	7.5%
IV	**Family type**			
	Joint	15	17	32
		21.4%	18.9%	20.0%
	Nuclear	53	62	115
		75.7%	68.9%	71.9%
	Extended	2	11	13
		2.9%	12.2%	8.1%

V	**Family Size**			
	Small	15	26	41
		21.4%	28.9%	25.6%
	Medium	53	60	113
		75.7%	66.7%	70.6%
	Large	2	4	6
		2.9%	4.4%	3.8%
VI	**Form of Family**			
	Stable	62	70	132
		88.6%	77.8%	82.5%
	Broken	4	13	17
		5.7%	14.4%	10.6%
	Step or reconstituted family	4	7	11
		5.7%	7.8%	6.9%
VII	**Locality**			
	Urban	64	72	136
		91.4%	80.0%	85.0%
	Rural	6	18	24
		8.6%	20.0%	15.0%
VIII	**Drop-in-Centre**			
	Care and Foundation	15	30	45
		21.4%	33.3%	28.1%
	SASO	55	60	115
		78.6%	66.7%	71.9%
IX	**Occupation**			
	Govt.Servant	4	3	7
		5.7%	3.3%	4.4%
	Private Business	18	35	53
		25.7%	38.9%	33.1%
	Daily Labour	18	38	56
		25.7%	42.2%	35.0%
	Others	30	14	44
		42.9%	15.6%	27.5%

Source: Computed

The profile of the respondent were presented in nine sub-sections viz., age, educational level, religion, marital status, family type, family size, form of family, locality, and occupation. (See table 4.1).

The respondent educational levels were classified into five levels viz., primary, high school, higher secondary, and undergraduate, postgraduate. Regarding educational level of the respondents, more than two third (46.2%) had attained high school in which (47.3%) were in the age group of 25-29years and (44.8%) were in the age group of 16-24years. Followed by more than one third (33.8%) had attained higher secondary while more than one tenth (16.9%) had attained undergraduate. In addition, the mean age of the respondents were 24.43±2.75 (Mean±SD) andless than one tenth (.6%) attained post graduate. The table shows that majority of the respondents educational level is high school.

The respondent religion was divided into three types Hindu, Muslim, and Christian. Three fourth of the respondents (75.0%) were from the Hindus and more than one tenth (14.4%) were belonged to Muslims and Christians constituted the lowest religion (10.6%). Therefore, the table reveals that majority of the respondents were belonged to Hindu religion.

The respondent Marital Status was divided into four type's viz., Married,Unmarried, Separated, and Divorced. Half of the respondents (50.0%) were unmarried followed by more than one third (40.0%) of the respondents were married while less than one tenth (7.5%) were divorced. The lowest were constituted by separation (2.5%). Thus, the table shows that majority of the respondents were unmarried.

The family was divided into three types namely Joint, Nuclear and Extended families. The findings indicated that more than two third (71.9%) of them were from nuclear family followed by one fifth (20.0%) were belonged to the joint family. The remaining less than one tenth of the respondents belonged to the extended family (8.1%). Hence the table reveals that majority were from nuclear family.

The size of the family was divided into three types viz. small, medium, and large. The findings indicated that medium size family was the highest percentage among the respondents comprising about (70.6%) while one fourth (25.6%) respondents were from small size family. Large family constituted the lowest which is less than one tenth (3.8%). Therefore, the table shows that majority were belonged to the medium size family.

The form of the family was divided into three types namely, stable, broken, step or reconstituted family. Majority of the respondents were belonged to stable family (82.5%) followed by more than one tenth were from broken family (10.6%). The remaining constitute less than one tenth (6.9%) which belongs to the step or reconstituted family. Hence, the table reveals that majority were from stable family.

The locality of the respondents was divided into two types namely Urban and Rural. Findings indicated that majority of the respondents were from the urban locality (85.0%) and more than one tenth were belonged to the rural locality (15.0%). The table reveals that majority were from urban locality.

The researcher took two drop in centres namely Care and Foundation and SASO. Among the respondents more than two third (71.9%) were from SASO in which two third (66.7%) of them were in the age group of 25 -29 years. The remaining respondents (28.1%) of them were belonging to the Care and Foundation. From the data we come to conclusion that majority of the respondents were from SASO.

The occupations of the respondents were divided into three types. Govt. Servant, privatebusiness,dailylabour and others. It was observed that more than one third (35.0%) of the respondents were working as a daily labour followed by one third of the respondents were working as private business (33.1%) while more than one fourth (27.5%) were working in other sectors such as carpenter, mechanic, construction worker and aless than one tenth

(4.4%) were working inGovernment services. The table shows that majority were working as daily labour.

The table 4.2 shows the profile of the respondents parents, which were divided into seven sub-sections viz.,father'seducation,father'soccupation,father's income, mother's education, mother's occupation,mother's income andtotal household income (see table 4.2).

The profile of the respondents' parents were classified into seven levels viz., no response, primary, high school, higher secondary, undergraduate, postgraduate, and illiterate. Regarding education of the respondents father, the highest level attained was higher secondary school (25.0%) followed by almost one fourth was given no response (24.4%). More than one fifth (23.8%) of the respondent's father were belonged to undergraduate followed by more than one tenth attained high school (13.1%) while one tenth (10.0%) had attained primary school. Post graduate and illiterate constituted the lowest educational level which comprises of (2.5%) and (1.2%). The table shows that majority of the respondents father had attained higher secondary educational level.

Regarding the occupation of the respondent's father, it was observed that more than one third (37.5%) were working as self-employment followed by one fourth (25.5%) were unemployed while more than one fifth (23.1%) were working in government services and more than one tenth (13.1%) were working as agriculture/farmer. In the category of No Response and others were constituted the lowest as (6%). The table reveals that majority were working as self-employment.

The respondents father income were divided into five categories viz., i) No response, ii) Rs 3000-10,000, iii) Rs 10000-20000, iv) Rs 20000-30000 and v) Rs 30000 and above. It was observed that more than half (53.1%) of the respondents were given no response while more than one fourth income (26.9%) were in the range of Rs 3000-10000 while more than one tenth (11.9%) were in the range of Rs 10000-20000. A less than one tenth (5.1%) of the

Table 4.2 Profile of the Respondents' Parents

Sl.No	Characteristics	Age		Total
		16-24yrs. n=70	25-29yrs. n=90	
I	**Fathers'Education**			
	No Response	18	21	39
		25.7%	23.3%	24.4%
	Primary School	5	11	16
		7.1%	12.2%	10.0%
	High School	8	13	21
		11.4%	14.4%	13.1%
	Higher Secondary School	19	21	40
		27.1%	23.3%	25.0%
	Undergraduate	18	20	38
		25.7%	22.2%	23.8%
	Postgraduate	2	2	4
		2.9%	2.2%	2.5%
	Illiterate	0	2	2
		.0%	2.2%	1.2%
II	**Fathers' Occupation**			
	No Response	0	1	1
		.0%	1.1%	.6%
	Unemployed	18	22	40
		25.7%	24.4%	25.0%
	Agriculture /farmer	8	13	21
		11.4%	14.4%	13.1%
	Govt.Servant	18	19	37
		25.7%	21.1%	23.1%
	Self –employment	25	35	60
		35.7%	38.9%	37.5%
	Any others specify	1	0	1
		1.4%	.0%	.6%
III	**Fathers Income(Monthly)**			
	No Response	46	39	85
		65.7%	43.3%	53.1%
	Rs 3000-10000	11	32	43
		15.7%	35.6%	26.9%
	Rs 10000-20000	7	12	19
		10.0%	13.3%	11.9%
	Rs 20000-30000	1	4	5
		1.4%	4.4%	3.1%
	Rs 30000 and Above	5	3	8
		7.1%	3.3%	5.0%
	Mean	**6373.13±9918.28**		

IV	**Mothers Education**			
	No Response	29	38	67
		41.4%	42.2%	41.9%
	Primary School	15	14	29
		21.4%	15.6%	18.1%
	High School	4	10	14
		5.7%	11.1%	8.8%
	Higher Secondary School	13	12	25
		18.6%	13.3%	15.6%
	Undergraduate	7	5	12
		10.0%	5.6%	7.5%
	Postgraduate	0	4	4
		.0%	4.4%	2.5%
	Illiterate	2	7	9
		2.9%	7.8%	5.6%
IV	Mothers Occupation			
	No Response	2	0	2
		2.9%	.0%	1.2%
	Unemployed	44	54	98
		62.9%	60.0%	61.2%
	Agriculture /farmer	1	3	4
		1.4%	3.3%	2.5%
	Govt.Servant	10	9	19
		14.3%	10.0%	11.9%
	Self –employment	13	21	34
		18.6%	23.3%	21.2%
	Any others specify	0	3	3
		.0%	3.3%	1.9%
V	**Mothers Income**			
	No Response	62	62	124
		88.6%	68.9%	77.5%
	Rs 3000-10000	7	21	28
		10.0%	23.3%	17.5%
	Rs 10000-20000	0	6	6
		.0%	6.7%	3.8%
	Rs 20000-30000	1	1	2
		1.4%	1.1%	1.2%
	Mean	**2018.75±5703.87**		
VI	**Total Household Income**			
	No Response	43	34	77
		61.4%	37.8%	48.1%
	Rs 3000-10000	12	35	47
		17.1%	38.9%	29.4%
	Rs 10000-20000	8	13	21
		11.4%	14.4%	13.1%
	Rs 20000-30000	1	5	6
		1.4%	5.6%	3.8%
	Rs 30000 and Above	6	3	9
		8.6%	3.3%	5.6%
	Mean	**7129.37±10518.75**		

Source: Computed **Mean±SD**

respondents father's income ranges from Rs 30000 and above while less than one tenth (3.1%) were in the range of Rs 20000-30000. The table shows that majority gave no response as they don't know about their parent's income.

The educational qualification of the respondents' motherwere classified into seven levels viz., no response, primary, high school, higher secondary, undergraduate, postgraduate, and illiterate. In these classifications, more than one third (41.9%) of them were given no response followed by more than one tenth (18.1%) of them had attained primary school while more than one tenth (15.6%) had attained higher secondary and less than one tenth (8.8%) had attained high school and (5.6%) had constituted the illiterate while the lowest (2.5%) educational level attained was postgraduate. The table indicated that majority of them had given no response towards their mother educational level.

Regarding the occupation of the respondent's mothers it was observed that more than half (61.2%) of the respondents mothers were unemployed followed by more than one fifth (21.2%) who were working as self- employed while more than one tenth (11.9%) were working in government services. Both less than one tenth (1.9%) and (1.2%) constituted the others and no response. The table reveals that majority of them were working as self-employment.

The respondents mother income were divided into five categories viz., i) No response, ii) Rs 3000-10,000, iii) Rs 10000-20000, and iv) Rs 30000 and above. More than three fourth (77.5%) had given no response while more than tenth (17.5%) said their income is between Rs 3000-10000 followed by less than one tenth (3.8%) said their income is between Rs 20000-30000. A less than one tenth (1.2%) were in the lowest income from Rs 30000 and above. Therefore, the table shows that majority gave no response.

The total household of the income were classified into five categories viz., i) No response ii) Rs 3000-10000 iii) Rs 10000-20000 iv) Rs 20000-30000 and v) Rs 30000 and

above. More than one third (48.1%) gave no response followed by more than one fourth (29.4%) said their income is between Rs 3000-10000 while more than one tenth (13.1%) said their income is between Rs 10000-20000 while less than one tenth (3.8%) said their income is between Rs 20000-30000. A less than one tenth (5.0%) said their income is Rs 30000 and above. From the table we come to understand that majority of the respondents' families' total income was given no response.

Table 4.3 shows the pattern of drug abuse and age. Among the respondents more than two third (71.9%) had injected drug in which (75.7%) were within the age of 16-24years and (68.9%) between the age of 25-29years while less than one tenth (3.8%) injected drug in past one week in which (2.9%) were within the age of 16-24years and (4.4%) between 25-29years. The table indicated that majority of them injected drug and their age range were from 16-24 years. Therefore, the table shows that majority had gone for injection use.

Table 4.3 Pattern of Drug Abuse Age

Sl.No	Characteristics	Age		Total N=160
		16-24yrs. n=70	25-29yrs. n=90	
I	**Pattern of Injection use**			
	No response	5	3	8
		7.1%	3.3%	5.0%
	Injected Drug	53	62	115
		75.7%	68.9%	71.9%
	Injected drug in past one week	2	4	6
		2.9%	4.4%	3.8%
	Injected drug in past one month	8	14	22
		11.4%	15.6%	13.8%
	Daily injection use	2	7	9
		2.9%	7.8%	5.6%

Source: Computed

Table 4.4 Pattern of the Drug Abuse by Locality

Sl.No	Characteristics	Locality		Total N=160
		Urban n=136	Rural n=24	
I	Pattern			
	No response	8	0	8
		5.9%	.0%	5.0%
	Injected drug	101	14	115
		74.3%	58.3%	71.9%
	Injected drug in past one week	6	0	6
		4.4%	.0%	3.8%
	Injected drug in past one month	18	4	22
		13.2%	16.7%	13.8%
	Daily injection use	3	6	9
		2.2%	25.0%	5.6%

Source: Computed

Table 4.4 shows the pattern of drug abuse by locality. Among the respondents less than three fourth (71.9%) injected drug in which (74.3%) from urban and (58.3%) from rural. The lowest were less than one tenth (3.8%)had injected drug in past one week in which (4.4%) were from urban locality. A less than one tenth (5.0%) gave no response while more than one tenth (13.8%) said they had injected drug in past one month followed by a less than one tenth (5.6%)said they had gone for daily injection use. Therefore, the table reveals that majority had gone for injecting drug abuse.

Table 4.5 Method of Initiationof Drug abuse by age

Method of initiation	Age		Total N=160
	16-24 yrs. n=70	25-29 yrs. n=90	
Oral	50	64	114
	71.4%	71.1%	71.2%
Injection	12	17	29
	17.1%	18.9%	18.1%
Sniffing	8	9	17
	11.4%	10.0%	10.6%

Source: Computed

Table 4.5 shows the methods of initiation drug abuse by age. It was observed that less than three fourth (71.2%)started with the oral drug use in which (71.4%) from 16-25 yearsand (71.1%) from 25-29 years followed by more than one fifth (18.1%) started with the injection

use in which (18.9%) from rural and (17.1%) from urban while more than one tenth (10.6%) started with the sniffing in which (11.4%) were from rural and (10.0%) from urban. Thus, the table reveals that majority had started their drug use pattern with the oral use firstly and in age group between 16-24 years.

Table 4.6 Method of Initiation of Drug Abuse andLocality

Method of initiation	Locality		Total N=160
	Urban n=136	Rural n=24	
Oral	50	64	114
	71.4%	71.1%	71.2%
Injection	12	17	29
	17.1%	18.9%	18.1%
Sniffing	8	9	17
	11.4%	10.0%	10.6%

Source: Computed

The Table 4.6 shows method of drug use and locality. Among the respondents more than two third (71.2%) had started with the oral in which (71.4%) were from urban and (71.1%) from rural followed by more than one tenth (18.1%) started with the injecting in which (18.9%) from rural and (17.1%) from urban while more than one tenth (10.6%) started with sniffing in which (11.4%) from urban and (10.0%) from rural. Therefore, the table indicated that majorityhad started their initiation by oral and they belonged to urban locality.

The reason for drug use were classified into ten types viz., peer pressure, depression or to relieve stress, curiosity or fun, easy access to drug peddler, cheap availability of drug, partner influence or influence of friends, broken family, social and family stress, to overcome frustration, and others.

Table 4.7 Reasons for drug abuse

Sl.No	Characteristics	Age		Total N= 160
		16-24yrs. n=70	25-29yrs. n= 90	
I	Peer pressure			
	Yes	32	34	66
		45.7%	37.8%	41.2%
II	Depression or to relieve Stress			
	Yes	6	11	17
		8.6%	12.2%	10.6%
III	Curiosity or fun			
	Yes	36	44	80
		51.4%	48.9%	50.0%
IV	Easy access to drug peddler			
	Yes	23	20	43
		32.9%	22.2%	26.9%
V	Cheap availability of drug			
	Yes	8	11	19
		11.4%	12.2%	11.9%
VI	Partner influence or friends			
	Yes	5	14	19
		7.1%	15.6%	11.9%
VII	Broken family			
	Yes	6	4	10
		8.6%	4.4%	6.2%
VIII	Social and family stress			
	Yes	1	3	4
		1.4%	3.3%	2.5%
IX	To overcome frustration			
	Yes	3	6	9
		4.3%	6.7%	5.6%
X	Others			
	Yes	1	4	5
		1.4%	4.4%	3.1%

Source: Computed

The Table 4.7 shows the reasons for drug abuse by age. More than one third (41.2%) said yes to peer pressure in which (45.7%) were within the age of 16-24years and (37.8%) were within the age of 25-29years. More than one tenth (10.6%) had said yes to depression or relieve stress in which (12.2%) within the age of 25-29years and (8.6%) within the age of 16-24years. While nearly half (50.0%) of the respondents said yes to curiosity or fun in which (51.4%) were within the age of 16-24years and (48.9%) within the age of 25-29years. Thus, majority said yes to curiosity or fun.

More than one fourth (26.9%)said yes to easy access to drug peddler in which (32.9%) were in the age group of 16-24years and (22.2%) were in the age group of 25-29years. More than one tenth of the respondents (11.9%) said yes to cheap availability of drug in which (12.2%) were in the age group of 25-29years and (11.4%) were in the age group of 16-24years.

While more than one tenth (11.9%) said yes to partner influence or friends in which (15.6%) were in the age group of 25-29years and (7.1%) were in the age group of 16-24years.Hence, the table reveals that majority had said no to partner of influence of friends.

Followed by less than one tenth (6.2%) said yes to broken family in which (8.6%) were in the age group of 16-24yearsand (4.4%) in the age group of 25-29years. Followed by less than one tenth (2.5%)had said yes to social and family stress in which (3.3%) were in the age group of 25-29years and (1.4%) in the age group of 16-24years.

While less than one tenth (5.6%) said yes to overcome frustration in which (6.7%) were in the age group of 25-29years and (4.3%) in the age group of 16-24years. Followed by less than one tenth (3.1%) of the respondents said yes to others reason for drug use such as overprotective, relationship break up, marital problems in which (4.4) were in the age of 25-29years and (1.4%)were in the age of 16-24years. Hence, the table indicated that majority had started using drugs due to curiosity or fun.

TheTable 4.8 shows the respondent's age at initiation drug abuse by locality. There were more than half of respondents (56.9%) had started using drug at the age 14-17years in which (58.1%) were from urban and (50.0%) were from rural followed by one fifth (20.6%) of the respondents started at the age of 18-21years while more than one tenth (16.9%) started between the age of 22years and above. A little less than one tenth (5.6%) respondents started using drug at the age of 10-13years in which (5.9%) from urban and (4.2%) from rural. Therefore, the table reveals that majority had started using drug at the age of 14-17years.

Table 4.8 Respondents 'Age at Initiating Drug abusebyLocality

Sl. No	Characteristics	Locality		Total N=160
		Urban n=136	Rural n=24	
I	**Age at Initiation**			
	10-13years	8	1	9
		5.9%	4.2%	5.6%
	14-17years	79	12	91
		58.1%	50.0%	56.9%
	18-21years	28	5	33
		20.6%	20.8%	20.6%
	22years and above	21	6	27
		15.4%	25.0%	16.9%

Source: Computed

The Table 4.9 shows age at first injecting drug by locality. Among the respondents more than one third (34.4%) started injecting drug use at the age of 16-19years followed by more than one fourth (29.4%) started at the age of 23years and above while more than one fifth (24.4%) at the age of 16-19years. A less than one tenth (6.9%) said they had never gone for injecting use while less than one tenth (5.0) started injecting use at the age of 12-15years. Thus, the table indicated that majority were started injection drug use at the age of 16-19years.

Table 4.9 Age at First Injecting Drug and Locality

Injecting use age	Locality		Total N=160
	Urban n=136	Rural n=24	
Not applicable	10	1	11
	7.4%	4.2%	6.9%
12-15years	7	1	8
	5.1%	4.2%	5.0%
16-19years	31	8	39
	22.8%	33.3%	24.4%
20-22years	51	4	55
	37.5%	16.7%	34.4%
23years and above	37	10	47
	27.2%	41.7%	29.4%

Source: Computed

The Table 4.10 shows the duration of injection use and locality. It was observed that one third of the respondents (33.1%) used injection for almost 2-4years in which (36.0%) were from urban and (16.7%) from rural while more than one fifth (20.6%) said they had used injection for 1years or lesser followed by more than one fifth (16.2%) said they had used injection for almost 5-7years followed by more than one fifth(22.5%) used injection for about 8years and above. The least was less than one tenth (7.5%) said it's not applicable to them as they had never started with the injection in which (8.1%) from urban and (4.2%) from rural locality. Hence, the table reveals that majority of the duration for injection used was for almost 2-4 years.

Table 4.10 Duration of Injecting Drug Abuse and Locality

Duration	Locality		Total N=160
	Urban n=136	Rural n=24	
Not applicable	11	1	12
	8.1%	4.2%	7.5%
1 yr.or lesser	30	3	33
	22.1%	12.5%	20.6%
2-4yrs.	49	4	53
	36.0%	16.7%	33.1%
5-7yrs.	23	3	26
	16.9%	12.5%	16.2%
8yrs. and above	23	13	36
	16.9%	54.2%	22.5%

Source: Computed

The Table 4.11 shows the frequency pattern of drug use by age. It can be observed that vast majority (93.1%) gave response to daily injection use in which (94.4%) were in the age group of 25-29years while less than one tenth (6.9%) gave response to not applicable as they had not started with the injection use in which (8.6%) were in the age of 16-24years and (5.6%) in the age of 25-29years. Therefore, the table shows that majority started with frequency of daily injection use as they were addicted to drug.

Table 4.11 Frequency of Drug Abuse by Age

Frequency	Age		Total N=160
	16-24yrs.	25-29yrs.	
Not applicable	6	5	11
	8.6%	5.6%	6.9%
Daily injection use	64	85	149
	91.4%	94.4%	93.1%

Source: Computed

The Table 4.12 types of drug use orally were classified into ten types namely, cannabis, cannabis and alcohol, heroin or brown sugar by smoking,codine based cough syrup, nitrazepam or diazepam tablets,dextropropoxyphene, antihistamine tablets, volatile solvents(glue, thinner), amphetamines type substances, and hallucinogenic (magic mushroom, hashish). Regarding the use of cannabis more than one third (38.8%) said yes to cannabis in which (42.9%) were in the age group of 16-24years and (35.6%) were in the age group of 25-29years.

Followed by more than one third (32.5%) of the respondent said yes to cannabis and alcohol in which (34.3%) were in the age group of 16-24years and (31.1%) were in the age group of 25-29years.While more than two third (66.9%) of the respondents said yes to heroin or brown sugar by smoking in which (77.1%) were in the age group of 16-24years and (58.9%) were in the age group of 25-29years.

Followed by one fifth (20.0%) of the respondents said yes to codine based cough syrup in which ((10.0%) were in the age group of 16-24years and (27.8%) were in the age group of

25-29years.While more than one third (44.4%) said yes to nitrazepam/diazepam tablets in which (48.6%) whereinthe age group of 16-24years and (41.1%) in the age of 25-29years.

Table 4.12Types of Drug Abuse Orally

Sl. No.	Types	Age		Total N =160
		16- 24yrs. n=70	25 -29 yrs. n= 90	
I	Cannabis			
	Yes	30	32	62
		42.9%	35.6%	38.8%
II	Cannabis and Alcohol			
	Yes	24	28	52
		34.3%	31.1%	32.5%
III	Heroin or brown sugar by smoking			
	Yes	54	53	107
		77.1%	58.9%	66.9%
IV	Codine based cough syrup			
	Yes	7	25	32
		10.0%	27.8%	20.0%
V	Nitrazepam or diazepam tablets			
	Yes	34	37	71
		48.6%	41.1%	44.4%
VI	Dextropropoxyphene			
	Yes	4	11	15
		5.7%	12.2%	9.4%
VII	Antihistamine tablets			
	Yes	5	4	9
		7.1%	4.4%	5.6%
VIII	Volatile solvents (glue, thinner)			
	Yes	1	5	6
		1.4%	5.6%	3.8%
IX	Amphetamine			
	Yes	6	9	15
		8.6%	10.0%	9.4%
X	Hallucinogenic (magic mushroom, hashish)			
	Yes	1	8	9
		1.4%	8.9%	5.6%

Source: Computed

Followed by less than one tenth (9.4%) said yes to dextropropoxyphene in which (5.7%) were in the age group of 16-24years and (12.2%) in the age of 25-29years. A less than one tenth (5.6%) said yes to the use of antihistamine tablets in which (7.1%) were in the age range of 16-24years and (4.4%) were in the age range of 25-29years. While less than one tenth (3.8%) said yes to the use of volatile solvents such as glue, thinner in which (1.4%) were in the age range of 16-24years and (5.5%) were in the age range of 25-29 years. While less than one tenth (9.4%) said yes to amphetamines type substances in which (8.6%) were in the age of 16-24years and (10.0%) were in the age of 25-29 years. Followed by less than one tenth (5.6%) said yes to the use of hallucinogenic substances in which (1.4%) were in the age of 16-24years and (8.9%) were in the age of 25-29years. Thus, the table indicated that majority said they smoked Heroin or brown sugar by smoking.

The Table 4.13 shows that more than two third (74.4%) said yes to injection of heroin use. So it clearly shows that majority had gone for the heroin injection use as it is highly addictive drug. Therefore, the table shows that majority had injected drug. While more than one fifth (21.9%) said yes to injection of heroin or brown sugar mixed with others drug.

While one fifth (20.0%) had said that yes to injection of buprenorphine. While more than one tenth (16.2%) had said yes to buprenorphine mixed with other drugs. While less than one tenth (2.5%) had said yes to diazepam. Followed by less than one tenth (4.4%) had said yes to the injecting use of dextropropoxyphene. Thus, the table reveals that majority had gone for heroin injection.

Table 4.13 Types of Injected Drug

Sl.No.	Types	Frequency	Percent
I	Heroine or brown sugar		
	Yes	119	74.4
II	Heroine or brown sugar mixed with others drug		
	Yes	35	21.9
III	Buprenorphine		
	Yes	32	20.0
IV	Buprenorphine mixed with other drug		
	Yes	26	16.2
V	Diazepam		
	Yes	4	2.5
VI	Dextropropoxyphene		
	Yes	7	4.4

Source: Computed

The Table 4.14 shows that more than one third (43.1%) said yes they had use glue for sniffing or inhaled. Followed by less than one tenth (5.6%) said yes to the use of solvents for sniffing or inhaled. While less than one tenth (1.3%) said yes to the used of aerosol.

While more than one fifth (23.1%) had said yes to whitener. Regarding the use of shoe or polish remover for sniffing or inhaled a less than one tenth (7.5%) had said yes they had sniffed or inhaled shoe or polish remover. Thus, the table reveals that majority had sniffed/inhaled glue.

Table 4.14Types of drug use either for sniffing/inhaled

Sl.No	Sniffing/inhaled	Frequency	Percent
I	Glue		
	Yes	69	43.1
II	Solvents		
	Yes	9	5.6
III	Aerosol		
	Yes	2	1.3
IV	Whitener		
	Yes	37	23.1
V	Shoe or polish remover		
	Yes	12	7.5

Source: Computed

The Table 4.15 shows that majority (80.0%) had smoked marijuana in which (82.9%) were in the age group of 16-24years and (77.8%) were in the age group of 25-29years Therefore, the table reveals that majority said they smoked marijuana.Followed by more than one tenth (11.9%) had said yes to hashish in which (7.1%) are in the age of 16-24yrs and (15.6%) are in the age of 25-29yrs.

While less than one tenth (8.8%) had said yes to cocaine in which (5.7%) are in the age of 16-24years and (11.1%) are in the age of 25-29years. Followed by less than one tenth had said yes to others such as (WY) world is your, opium, brown sugar, and magic mushroom. Thus, the table reveals that majority had smoked marijuana.

Table 4.15 Types of drug smoked

Sl.No	Drug smoked	Age		Total N=160
		16-24yrs.	25-29yrs.	
I	Marijuana			
	Yes	58	70	128
		82.9%	77.8%	80.0%
II	Hashish			
	Yes	5	14	19
		7.1%	15.6%	11.9%
III	Cocaine			
	Yes	4	10	14
		5.7%	11.1%	8.8%
IV	Others			
	Yes	4	6	10
		5.7%	6.7%	6.3%

Source: Computed

The Table 4.16The types of drug chew or eaten. A less than one tenth (6.3%) had said yes they had chew or eaten magic mushroom in which (8.6%) are in the age of 16-24years and (4.4%) are in the age of 25-29years. Followed by more than two third (72.5%) said yes to ganja in which (77.1%) were in the age group of 16-24years and (68.9(%) were in the age group of 25-29years. Thus, the table reveals that majority said they had chew/eaten ganja.While one tenth (10.0%) said yes to LSD in which (8.6%) are in the age of 16-24years and (11.1%) are in the age of 25-29years.Followed by less than one tenth (6.3%) said yes to

mescaline in which (8.6%) are in the age of 16-24years and (4.4%) are in the age of 25-29years. Therefore, the table indicated that majority said they had chew/eaten ganja.

Table 4.16 Types of Drug Chew or Eaten

Sl.No	Types	Age		Total N=160
		16-24yrs.	25-29yrs.	
I	Magic mushroom			
	Yes	6	4	10
		8.6%	4.4%	6.3%
II	Ganja			
	Yes	54	62	116
		77.1%	68.9%	72.5%
III	LSD			
	Yes	6	10	16
		8.6%	11.1%	10.0%
IV	Mescaline			
	Yes	6	4	10
		8.6%	4.4%	6.3%

Source: Computed

Table 4.17 Respondents Exposure on Use of Common Drugs by Age

Sl.No	Common Drugs	Age		Total N=160
		16-24yrs. n=70	25-29yrs. n=90	
I	SP/N10			
	Yes	61	74	135
Source:Computed		87.1%	82.2%	84.4%
II	Smoke or eaten opium			
	Yes	58	59	117
		82.9%	65.6%	73.1%
III	Tranquilizers			
	Yes	66	72	138
		94.3%	80.0%	86.2%
IV	Smoke tobacco			
	Yes	69	86	155
		98.6%	95.6%	96.9%
V	Alcohol beverage			
	Yes	66	83	149
		94.3%	92.2%	93.1%

The Table 4.17shows the respondents' exposure on use of common drugs by age. Majority (84.4%) said they took SP/N10 in which (87.1%) were in the age group of 16-24years and (82.2%) were in the age group of 25-29years. Therefore, the table reveals that majority had taken SP/N10 tablets.

Followed by more than two third (73.1%) said they had smoke opium in which (82.9%) were in the age group of 16-24years and (65.6%) in the age group of 25-29years. Therefore, the table indicated that majority had smoked opium.While majority (86.2%) said they had taken the tranquilizers in which (82.9%) were in the age of 16-24years and (65.6%) in the age group of 25-29years.Hence, the table reveals that majority had taken tranquilizers.Followed by vast majority (96.9%) said they smoke tobacco product in which (98.6%) were in the age of 16-24years and (95.6%) were in the age of 25-29years. Therefore, the table indicated that majority had smoked tobacco product.

While vast majority (93.1%) had taken alcohol in which (94.3%) in which were in the age of 16-24years and (92.2%) were in the age of 25-29years. Thus, the table reveals that majority of the respondents exposed to consuming alcohol.

Table 4.18Duration of Injecting Drug Abuse by Age

Duration	Age		Total N=160
	16-24yr. n=70	25-29yrs. n=90	
No response	1	2	3
	1.4%	2.2%	1.9%
1-2years	64	74	138
	91.4%	82.2%	86.2%
3-4years	5	6	11
	7.1%	6.7%	6.9%
4-5years	0	2	2
	0.0%	2.2%	1.2%
5years and above	0	6	6
	0.0%	6.7%	3.8%

Source: Computed

The Table 4.18 shows duration of injecting drug abuse by age shows that less than one tenth (1.9%) gave no response as they did not start with the injection use followed by majority (86.2%) said their duration of injecting is more than 1-2years in which (91.4%) were in the age of 16-24years and (82.2%) were in the age of 25-29years while less than one tenth (6.9%) said their duration of injecting drug is 3-4years followed by less than one tenth (1.2%) said their duration of injecting drug is for around 4-5years. A less than one tenth (3.8%) said they had use for 5years and above. Therefore, the table reveals that majority of them had continued the injecting use for almost 1-2years.

Table 4.19 Different Patterns of Drug Abuse by Age

Sl.No	Characteristics	Age		Total N=160
		16-24yrs. n=70	25-29yrs. n=90	
I	Recreational use			
	Yes	28	44	72
		40.0%	48.9%	45.0%
II	Situational use			
	Yes	17	9	26
		24.3%	10.0%	16.2%
III	Experimental use			
	Yes	42	51	93
		60.0%	56.7%	58.1%
IV	Intensive use			
	Yes	2	9	11
		2.9%	10.0%	6.9%
V	Dependent use			
	Yes	51	57	108
		72.9%	63.3%	67.5%

Source: Computed

The Table 4.19 shows the different pattern of drug use which were classified into five types namely, recreational use, situational use, experimental use, intensive use and dependent use. More than one third (45.0%) said yes to recreational use in which (40.0%) are in the age of 16-24years and (48.9%) are in the age of 25-29years. While more than one tenth (16.2%) said yes to the situational use in which (24.3%) are in the age of 16-24years and (10.0%) are in the age of 25-29years. Followed by more than half (58.1%) said yes to experimental use in which (60.0%) were in the age of 16-24years and (56.7%) were in the age of 25-29years.

Followed by less than one tenth said (6.9%) said yes to intensive use in which (2.9%) are in the age of 16-24years and (10.0%) are in the age of 25-29years. Followed by more than two third (67.5%) said yes to dependent use in which (72.9%) were in the age of 16-24years and (63.3%) were in the age of 25-29years. Therefore, the table shows that majority said yes to dependent use.

Table 4.20 shows that factors for starting drug use in which it is classified into ten types namely, boredom, increased availability of drug at low price, poverty, lack of jobs and economic frustration, depression, relationship at home, family problems, lack of proper interest at drug education, escape problems at home, lack of drug education within family and in educational settings.

More than one third (35.6%) said yes to boredom factor in which (41.4%) were in the age of 16-24years and (31.1%) were in the age of 25-29years. Followed by more than one fifth (20.6%) said yes to increased availability of drug at low price in which (20.0%) were in the age of 16-24years and (21.1%) were in the age of 25-29years.

Table 4.20 Factors Causing Drug Abuse by Age

Sl.No	Characteristics	Age		Total N=160
		16-24yrs. n=70	25-29yrs. n=90	
I	Boredom			
	Yes	29	28	57
		41.4%	31.1%	35.6%
II	Increased availability of drug at low prices			
	Yes	14	19	33
		20.0%	21.1%	20.6%
III	Poverty			
	Yes	15	13	28
		21.4%	14.4%	17.5%
IV	Lack of jobs and economic frustration			
	Yes	4	10	14
		5.7%	11.1%	8.8%
V	Depression			
	Yes	26	37	63
		37.1%	41.1%	39.4%

VI	Relationship at home			
	Yes	6	17	23
		8.6%	18.9%	14.4%
VII	Family problems			
	Yes	18	24	42
		25.7%	26.7%	26.2%
VIII	Lack of proper interest on education			
	Yes	39	43	82
		55.7%	47.8%	51.2%
IX	Escape problems at home			
	Yes	9	22	31
		12.9%	24.4%	19.4%
X	Lack of drug education within family and in education			
	Yes	32	44	76
		45.7%	48.9%	47.5%

Source: Computed

Followed by more than one tenth (17.5%) said yes to poverty in which (21.4%) were in the age of 16-24years and (14.4%) were in the age of 25-29years.Followed by less than one tenth (8.8%) said yes to lack of jobs and economic frustration in which (5.7%) were in the age of 16-24years and (11.1%) were in the age of 25-29years.

While more than one third (39.4%) said yes to depression in which (37.1%) were in the age of 16-24years and (41.1%) were in the age of 25-29years. Followed by more than one tenth (14.4%) said yes to relationships at home in which (8.6%) were in the age of 16-24years and (18.9%) were in the age of 25-29years.

Followed by more than one fourth (26.2%) said yes to family problems in which (25.7%) were in the age range of 16-24years and (26.7%) were in the age range of 25-29years. Followed by more than half (51.2%) said yes to lack of proper interest at drug education in which (55.7%) were in the age group of 16-24years and (47.8%) were in the age group of 25-29years.

Followed by more than one tenth (19.4%) said yes to escape problems at home while (12.9%) were in the age of 16-24years and (24.4%) were in the age of 25-29years. Followed

by more than one third (47.5%) said yes to lack of drug education within family and in educational settings in which (45.7%) were in the age of 16-24years and (48.9%) were in the age of 25-29years. Thus, the table reveals that majority said yes because of lack of proper interest at education.

The Table 4.21 shows the challenges of drug abuse youth by age. A less than one tenth (3.8%) gave no response as they had not face any discrimination in which (2.9%) were in the age of 16-24years and (4.4%) were in the age of 25-29years followed by more than one third (34.4%) faced social stigma in which (35.7%)were in the age of 16-24years and (43.3%) were in the age of 25-29years while more than one third (34.4%) said yes to lacking self-trust in which (35.7%) were in the age of 16-24years and (33.3%) were in the age of 25-29years. More than one tenth (14.4%) said they faced mistreatment from others in which (20.0%) were in the age of 16-24years and (10.8%) were in the age of 25-29years. The rehabilitation treatment constituted the lowest of less than one tenth (7.5%) in which (5.7%) were in the age of 16-24years and (8.9%) were in the age of 25-29years. Therefore, the table reveals that majority said they faced social stigma.

Table 4.21 Challenges Faced by Drug Abuse Youth by Age

Sl.No	Characteristics	Age		Total
		16-24yrs. n=70	25-29yrs. n=90	
I	**Challenges**			
	No response	2	4	6
		2.9%	4.4%	3.8%
	Lacking self- trust	25	30	55
		35.7%	33.3%	34.4%
	Social stigma	25	39	64
		35.7%	43.3%	40.0%
	Mistreatment by others	14	9	23
		20.0%	10.0%	14.4%
	The rehabilitation treatment	4	8	12
		5.7%	8.9%	7.5%

II	**Employment discrimination**			
	No response	44	29	73
		62.9%	32.2%	45.6%
	Difficulties in finding jobs	12	22	34
		17.1%	24.4%	21.2%
	Questioning their honesty	7	12	19
		10.0%	13.3%	11.9%
	Discrimination at workplace	5	19	24
		7.1%	21.1%	15.0%
	Doubting their efficiency	2	8	10
		2.9%	8.9%	6.2%
III	**People behaviour**			
	Stay away from me	25	41	66
		35.7%	45.6%	41.2%
	Pay some respect and interest as others	37	39	76
		52.9%	43.3%	47.5%
	Look down upon me	5	4	9
		7.1%	4.4%	5.6%
	Very sarcastic	3	6	9
		4.3%	6.7%	5.6%
IV	**Discrimination byfamily members**			
	No response	1	2	3
		1.4%	2.2%	1.9%
	Don’t visit me	42	44	86
		60.0%	48.9%	53.8%
	Don’t eat with me	18	35	53
		25.7%	38.9%	33.1%
	Don’t sit with me	3	6	9
		4.3%	6.7%	5.6%
	Verbally abused me	4	3	7
		5.7%	3.3%	4.4%
	Deserted me	2	0	2
		2.9%	.0%	1.2%

Source: Computed

Followed by employment discrimination more than one third (45.6%) gave no response as they did not faced any discrimination at the workplace in which (62.9%) were in the age of 16-24years and (32.2%) were in the age of 25-29years followed by more than one fifth (21.2%) faced difficulties in finding jobs as they were always presumed to be on the verge of relapse in which (17.1%) were in the age of 16-24years and (24.4%) were in the age

of 25-29years while more than one tenth (11.9%) faced challenges of questioning their honesty in which (10.0%) were in the age of 16-24years and (13.3%) were in the age of 25-29years. A more than one tenth (15.0%) faced discrimination at their workplace in which (7.1%) were in the age of 16-24years and (21.1%) were in the age of 25-29years. Doubting their efficiency constituted the least of less than one tenth (6.2%) in which (2.9%) were in the age of 16-24years and (8.9%) were in the age of 25-29years. Thus, the table shows that majority gave no response.

Followed by people behave towards you in the society more than one third (41.2%) said people stay away from them in which (45.6%) were in the age of 16-24years and (35.7%) were in the age of 25-29years followed by more than one third (47.5%) said people pay some respect and interest as others in which (52.9%) were in the age of 16-24years and (43.3%) were in the age of 25-29years while less than one tenth (5.6%) said people look down upon them in which (7.1%) were in the age of 16-24years and (4.4%) were in the age of 25-29years. being very sarcastic constituted the least of less than one tenth (5.6%) in which (4.3%) were in the age of 16-24years and (6.7%) were in the age of 25-29years. Hence, the table shows that majority pay some respect and interest as others.

Regarding the discrimination from the family members a less than one tenth (1.9%) gave no response followed bymore than half (53.8%) said their family members don't visit them in which (60.0%) were in the age of 16-24years and (48.8%) were in the age of 25-29years while more than one third (33.3%) said their family members don't eat with them in which (25.7%) were in the age of 16-24years and (38.9%) were in the age of 25-29years. A less than one tenth (5.6%) said their family members don't sit with them in which (4.3%) were in the age of 16-24years and (6.7%) were in the age of 25-29years followed by less than one tenth (4.4%) said their family members verbally abused them in which (5.7%) were in the age of 16-24years and (3.3%) were in the age of 25-29years. The family members

deserted them constituted the least of less than one tenth (1.2%) in which (2.9%) were in the age of 16-24years and (.0%) were in the age of 25-29years. Hence, the table reveals that majority their family members don't visit them.

The Table 4.22 shows the challenges faced by drug abuse youth after the treatment from the Drop in Centre (DIC) by Age. More than half (61.9%) said that they were fear of going to the rehabilitation centre in which (58.6%) were in the age of 16-24years and (64.4%) were in the age of 25-29years. Therefore, the table shows that majority they were fear of going to the rehabilitation centre.

Table4.22 Challenges faced by Drug abuse Youth after the Treatment in Drop- in-Centre (DIC) by Age

Sl.No	Characteristics	Age		Total N=160
		16-24yrs. n=70	25-29yrs. n=90	
I	Fear of rehabilitation			
	Yes	41	58	99
		58.6%	64.4%	61.9%
II	Harder time finding and keeping jobs			
	Yes	41	73	114
		58.6%	81.1%	71.2%
III	Suspicion			
	Yes	57	64	121
		81.4%	71.1%	75.6%
IV	A week without using drug			
	Yes	22	40	62
		31.4%	44.4%	38.8%
V	Blackout/flashback			
	Yes	53	70	123
		75.7%	77.8%	76.9%
VI	Medical problems			
	Yes	26	58	84
		37.1%	64.4%	52.5%
VII	Spouse/parents problems			
	Yes	53	71	124
		75.7%	78.9%	77.5%
VIII	Need drug everyday			
	Yes	63	70	133
		90.0%	77.8%	83.1%

Source: Computed

Followed by more than two third (71.2%) said yes they had harder time in finding and keeping the jobs after the addiction recovery in which (58.6%) were in the age of 16-24yearsand (81.1%) were in the age of 25-29years.Thus, the table reveals that majority said they had harder time in finding and keeping the jobs after the addiction recovery.

Followed by more than two third (71.2%) said yes they were watch under suspicion as they were always presumed to be on the verge of relapse in which (58.6%) were in the age of 16-24years and (81.1%) were in the age of 25-29years. Therefore, the table indicated that majority said they were always watched under suspicion.

Followed by more than one third (38.8%) said yes they can get through a week without using drug in which (31.4%) were in the age of 16-24years and (44.4%) were in the age of 25-29years. Thus, the table shows that majority said they can get through a week without using drug

Followed by more than three fourth (76.9%) said yes they had blackout or flashback in which (75.7%) were in the age of 16-24years and (77.8%) were in the age of 25-29years. Hence, the table reveals that majority said they had blackout and flashback.

Followed by more than half (52.5%) said yes they had medical problems because of drug use in which (37.1%) were in the age of 16-24years and (64.4%) were in the age of 25-29years. Hence, the table reveals that majority said yes they had medical problems due to drug abused.

Followed by more than three fourth (77.5%) said yes because of the drug abuse they had problems between their spouses and parents in which (75.7%) were in the age of 16-24years and (78.9%)were in the age of 25-29years. Thus, the table reveals that majority said they had problems between their spouse and parents.

Followed by majority (83.1%) said yes they need a drug to deal with everyday problem in which (90.0%) were in the age of 16-24years and (77.8%) were in the age of 25-

29years. Therefore, the table indicated that majority they need a drug to deal with everyday problem.

The Table 4.23shows Challenges faced by the Respondents towards Give up the Drug Abuse by Age. Followed by less than one tenth (7.5%) said they were often able to stop using drug when they want in which (10.0%) were in the age of 16-24years and (5.6%) were in the age of 25-29years followed by more than one third (33.1%) said they were rarely able to stop using drug when they want to in which (25.7%) were in the age of 16-24years and (38.9%) were in the age of 25-29years while less than one tenth (7.5%) said they were frequently able to stop using drug when they want to in which (2.9%) were in the age of 16-24years and (11.1%) were in the age of 25-29years followed by half (51.9%) said they were never able to stop using drug when they want to in which (61.4%) were in the age of 16-24years and (44.4%) were in the age of 25-29years. Therefore, the table shows that majority said they were rarely able to stop using drug when they want to.

Table 4.23 Challenges Faced by the Respondents towards Give-up the Drug Abuse by Age

Sl. No	Characteristics	Age		Total
I	Stop drug	16-24 yrs.	25-29 yrs.	
	Often	7	5	12
		10.0%	5.6%	7.5%
	Rarely	18	35	53
		25.7%	38.9%	33.1%
	Frequently	2	10	12
		2.9%	11.1%	7.5%
	Never	43	40	83
		61.4%	44.4%	51.9%

II	**Illegal activities**			
	Frequently	11	16	27
		15.7%	17.8%	16.9%
	Sometime	42	48	90
		60.0%	53.3%	56.2%
	Often	10	12	22
		14.3%	13.3%	13.8%
	Rarely	4	6	10
		5.7%	6.7%	6.2%
	Never	3	8	11
		4.3%	8.9%	6.9%
III	**Health care treatment satisfaction**			
	Yes	25	45	70
		35.7%	50.0%	43.8%
	No	45	45	90
		64.3%	50.0%	56.2%
IV	**If yes how**			
	No response	30	37	67
		42.9%	41.1%	41.9%
	Been ridiculed/harassed	7	20	27
		10.0%	22.2%	16.9%
	Forced to pay extra	31	26	57
		44.3%	28.9%	35.6%
	Delayed in treatment	2	4	6
		2.9%	4.4%	3.8%
	Others	0	3	3
		.0%	3.3%	1.9%
V	**Strategies adopted to continue drug**			
	No response	43	38	81
		61.4%	42.2%	50.6%
	Sold personal or family belonging to buy	3	12	15
		4.3%	13.3%	9.4%
	Stolen money or valuables from others to buy drug	2	5	7
		2.9%	5.6%	4.4%
	Managed from income	12	19	31
		17.1%	21.1%	19.4%
	Asking money from someone	10	16	26
		14.3%	17.8%	16.2%

Source: Computed

Followed by engaged in illegal activities in order to obtained drug more than one tenth (16.9%) said they were frequently engaged in illegal activities in order to obtained drug in which (15.7%) were in the age of 16-24years and (17.8%) were in the age 25-29years followed by more than one half (56.2%) said they sometime engaged in illegal activities in order to obtained drug in which (60.0%) were in the age of 16-24years and (53.3%) were in the age of 25-29years while more than one tenth (13.8%) said they often engaged in illegal activities in which (14.3%) were in the age of 16-24years and (13.3%) were in the age of 15-29years followed by less than one tenth(6.2%) said they were rarely engaged in illegal activities in which (5.7%) were in the age of 16-24years and (6.7%) were in the age of 25-29years.Aless one tenth (6.9%) said they had never engaged in illegal activities in order to obtained drug in which (4.3%)were in the age of 16-24years and (8.9%)were in the age of 25-29years. Thus, the table reveals that majority said they were sometime engaged in illegal activities in order to obtained drug.

Regarding the healthcare treatment satisfaction followed by more than one third (43.8%) said yes they were satisfied with the treatment they received from the healthcare settings in which (64.3%) were in the age of 16-24years and (50.0%) were in the age of 25-29years while more than half (56.2%) said no they were not satisfied with the treatment they received from the health care settings in which (64.3%) were in the age of 16-24years and (50.0%) were in the age of 25-29years. Therefore, the table shows that majority said no they were not satisfied with the treatment they received from the healthcare settings.

Followed by more than one third (41.9%) gave no response as they were not been ridiculed, harassed or insulted in which (42.9%) were in the age of 16-24years and (41.1%) were in the age of 25-29years while more than one tenth (16.9%) said they had been ridiculed, harassed or insulted in which (10.0%) were in the age of 16-24years and (22.2%) were in the age of 25-29years followed by more than one third (35.6%)said they were forced

to pay additional charges in which (44.3%) were in the of 16-24years and (28.9%) were in the age of 25-29years. A less than one tenth (3.8%) said they had been delayed in their medical treatment in which (2.9%) was in the age of 16-24years and (4.4%) were in the age of 25-29years. A less than one tenth (1.9%) were from the others such taking extra money or bribe. Hence, the table reveals that majority said they had been, ridiculed harassed or insulted.

Regarding the strategies adopted to continue the use of drugs followed by more than half (50.6%) gave no response as they did not adopted any strategies in which (61.4%) were in the age of 16-24years and (42.2%) were in the age of 25-29years while less than one tenth (9.4%) said they sold personal or family belongings to buy drug in which (4.3%) werein the age of 16-24years and (13.3%) were in the age of 25-29years followed by less than one tenth (4.4%) said they had stolen money and other valuable from other to buy drug in which (2.9%)were in the age of 16-24years and (5.6%)were in the age of 25-29years while more than one tenth(19.4%) said they managed from their income in which (17.1%) were in the age of 16-24years and (21.1%) were in the age of 25-29years. Asking money from someone constituted more than one tenth (16.2%) in which (14.3%) were in the age of 16-24years and (17.8%) were in the age of 25-29years. Therefore, the table shows that majority gave no response.

The Table 4.24 shows the stigma and discrimination faced from family and society. A less than one tenth (6.2%)said they were always excluded from social gathering in which (11.4%) were in the age of 16-24years and (7.8%) were in the age of 25-29years followed by less than one tenth (7.5%) said they were moderate in which (5.7%) were in the age of 16-24years and (8.9%) were in the age of 25-29years while more than one fourth said they were sometime excluded from social gathering followed by more than half (56.9%) they had neverexcluded from social gathering. Therefore, the table shows that majority said they had never been excluded from social gatherings.

Followed by less than one tenth (9.4%) said they were always abandoned by spouse in which (4.3%)were in the age of 16-24years and (13.3%)were in the age of 25-29years while a less than one tenth (3.1%) said they were moderate in which (2.9%) were in the age of 16-24years and (3.3%) were in the age of 25-29years followed by more than one tenth (16.9%) said they had abandoned by spouse in which (15.7%) were in the age of 16-24years and (17.8%) were in the age of 25-29years.Thus, the table reveals that majority had not been abandoned by their spouse as their marital status is mostly unmarried.

Followed by less than one tenth (3.1%) said they were always abandoned by their family in which (4.3%) were in the age of 16-24years and (2.2%) were in the age of 25-29years while less than one tenth (8.8%) said they were moderately abandoned by their family members in which (4.3%) were in the age of 16-24years and (12.2%) were in the age of 25-29years followed by more than one third (36.9%) said they were sometime abandoned by their family members in which (32.9%) were in the age of 16-24years and (40.0%) were in the age of 25-29years while more than half said they were never abandoned by their family members in which (58.6%) were in the age of 16-24years and (45.6%) were in the age of 25-29years. Hence, the table indicated that majority had never been abandoned by their family members.

Table 4.24 Stigma and Discrimination Faced from Family and Society

Sl. No	Characteristics	Age		Total
I	Excluded from social gathering	**16-24yrs. n=70**	**25-29yrs. n=90**	
	Always	1	9	10
		1.4%	10.0%	6.2%
	Moderate	4	8	12
		5.7%	8.9%	7.5%
	Sometime	23	24	47
		32.9%	26.7%	29.4%
	Never	42	49	91
		60.0%	54.4%	56.9%
II	Abandoned by spouse			
	Always	3	12	15
		4.3%	13.3%	9.4%
	Moderate	2	3	5
		2.9%	3.3%	3.1%
	Sometime	11	16	27
		15.7%	17.8%	16.9%
	Never	54	59	113
		77.1%	65.6%	70.6%
III	Abandoned by family			
	Always	3	2	5
		4.3%	2.2%	3.1%
	Moderate	3	11	14
		4.3%	12.2%	8.8%
	Sometime	23	36	59
		32.9%	40.0%	36.9%
	Never	41	41	82
		58.6%	45.6%	51.2%
IV	**Teased/sworn at**			
	Always	1	8	9
		1.4%	8.9%	5.6%
	Moderate	6	10	16
		8.6%	11.1%	10.0%
	Sometime	35	40	75
		50.0%	44.4%	46.9%
	Never	28	32	60
		40.0%	35.6%	37.5%

V	**Lost respect**			
	Always	11	18	29
		15.7%	20.0%	18.1%
	Moderate	16	17	33
		22.9%	18.9%	20.6%
	Sometime	28	36	64
		40.0%	40.0%	40.0%
	Never	15	19	34
		21.4%	21.1%	21.2%
VI	**Rejection**			
	Always	8	7	15
		11.4%	7.8%	9.4%
	Moderate	11	16	27
		15.7%	17.8%	16.9%
	Sometime	33	35	68
		47.1%	38.9%	42.5%
	Never	18	32	50
		25.7%	35.6%	31.2%
VII	**Isolated**			
	Always	18	36	54
		25.7%	40.0%	33.8%
	Moderate	12	9	21
		17.1%	10.0%	13.1%
	Sometime	28	34	62
		40.0%	37.8%	38.8%
	Never	12	11	23
		17.1%	12.2%	14.4%

Source: Computed

Followed by less than one tenth (5.6%) they were always teased or sworn at in which (1.4%) were in the age of 16-24years and (8.9%) were in the age of 25-29years while one tenth (10.0%) they were moderate in which (8.6%) were in the age of 16-24years and (11.1%) were in the age of 25-29years followed by more than one third said they were sometime teased or sworn at in which (50.0%) were in the age of 16-24years and (44.4%) were in the age of 25-29years while more than one third (37.5%) said they never got teased or sworn at by others in which (40.0% were in the age of 16-24years) and (35.6%) were in the age of 25-29years. Therefore, the table shows that majority of them had never been teased or sworn at.

Followed by more than one tenth (18.1%) said they were always lost respect in which (15.7%) were in the age of 16-24years and (20.0%) were in the age of 25-29years while more than one fifth (20.0%) said they were moderate in which (22.9%) were in the age of 16-24years and (18.9%) were in the age of 25-29years followed by more than one third (40.0%) said sometime they lost the respect in which (40.0%)were in the age of 16-24years and (40.0%)were in the age of 25-29years while more than one fifth (21.2%) said they never lost their respect in which (21.4%) were in the age of 16-24years and (21.4%) were in the age of 25-29years. Thus, the table reveals that majority of them lost their respect sometime.

Followed by less than one tenth (9.4%) said they were always rejected by others in which (11.4%) were in the age of 16-24years and (7.8%) were in the age of 25-29years followed by more than one tenth (16.9%) said they faced moderate rate when it comes to rejection in which (15.7%) were in the age of 16-24years and (17.8%) were in the age of 25-29years while more than one third (42.5%) said they were sometime rejected by others in which (47.1%) were in the age of 16-24years and (38.9%) were in the age of 25-29years followed by more than one fourth said they never got rejected by others in which (25.7%) were in the age of 16-24years and (35.6%) were in the age of 25-29years. Thus, the table shows that majority were sometime faced rejection.

Followed by more than one third (33.8%) said they were always isolated by others in which (25.7%) were in the age of 16-24years and (40.0%) were in the age of 25-29yearswhile more than one tenth (13.1%) said they were moderately isolated in which (17.1%) were in the age of 16-24years and (10.0%) were in the age of 25-29years followed by more than one third (38.8%) said they were sometime isolated by others in which (40.0%) were in the age of 16-24years and (37.8%) were in the age of 25-29years while more than one tenth (14.4%) said they were never isolated by the others in which (17.1%) were in the age of 16-24years

and (12.2%) were in the age of 25-29years. Therefore, the table shows that majority of them sometime were isolated by the others.

The Table 4.25 shows the ten sub scales classification of the family environment scale viz., cohesion, expressiveness, conflict, independence, achievement, orientation, intellectual cultural orientation, active recreational orientation, moral religious emphasis, organization and control.

Cohesion it refers to the degree of the commitment, help and support family members provide for one another. More than one third (46.2%) said their cohesion is low in which (52.9%) were in the age of 16-24years and (41.1%) were in the age of 25-29years while more than half (53.8%) said their cohesion level is high in which (47.1%) were in the age of 16-24years and (58.9%) were in the age of 25-29years. Thus, the table reveals that majority had high in cohesion.

Expressiveness it refers to the extent to which family members were encouraged to act openly and to express their feelings directly. More than three fourth (79.4%) said their way of expressiveness is low in which (84.3%) were in the age of 16-24years and (75.6%) were in the age of 25-29years while more than one fifth (20.6%) said their way of expressiveness is high in which (15.7%) were in the age of 16-24years and (24.4%) were in the age of 25-29years. Therefore, the table shows that majority were low in expressiveness

Conflict refers to the amount of openly expressed anger, aggression, and conflict among family members. Majority (83.1%) said their conflict is low in which (84.3%) were in the age of 16-24years and (82.2%) were in the age of 25-29years while more than one tenth (16.9%) said their conflict is high in which (15.7%) were in the age of 16-24years and (17.8%) were in the age of 25-29years. Hence, the table indicated that majority had low conflict.

Table 4.25 Respondents Level of Family Environment by Age

Sl. No	Characteristics	Age		Total N=160
		16-24yrs. n=70	25-29yrs. n=90	
I	**Cohesion**			
	Low	37	37	74
		52.9%	41.1%	46.2%
	High	33	53	86
		47.1%	58.9%	53.8%
II	**Expressiveness**			
	Low	59	68	127
		84.3%	75.6%	79.4%
	High	11	22	33
		15.7%	24.4%	20.6%
III	**Conflict**			
	Low	59	74	133
		84.3%	82.2%	83.1%
	High	11	16	27
		15.7%	17.8%	16.9%
IV	**Independence**			
	Low	51	47	98
		72.9%	52.2%	61.2%
	High	19	43	62
		27.1%	47.8%	38.8%
V	**Achievement Orientation**			
	Low	19	34	53
		27.1%	37.8%	33.1%
	High	51	56	107
		72.9%	62.2%	66.9%
VI	**Intellectual-cultural orientation**			
	Low	58	66	124
		82.9%	73.3%	77.5%
	High	12	24	36
		17.1%	26.7%	22.5%
VII	**Active recreational orientation**			
	Low	56	57	113
		80.0%	63.3%	70.6%
	High	14	33	47
		20.0%	36.7%	29.4%

VIII	**Moral religious emphasis**			
	Low	33	43	73
		47.1%	44.4%	45.6%
	High	37	50	87
		52.9%	55.6%	54.4%
IX	**Organization**			
	Low	29	51	80
		41.4%	56.7%	50.0%
	High	41	39	80
		58.6%	43.3%	50.0%
X	**Control**			
	Low	48	57	105
		68.6%	63.3%	65.6%
	High	22	33	55
		31.4%	36.7%	34.4%

Source: Computed

.Independence refers to the extent to which family members were assertive, self-sufficient and make their own decisions. More than half (61.2%) said their independence level is low in which (72.9%) were in the age of 16-24years and (52.2%) were in the age of 25-29years while more than one third (38.8%) said their independence level is high in which (27.1%) were in the age of 16-24years and (47.8%) were in the age of 25-29years. Therefore, the table shows that majority had low independence.

Achievement-orientation refers to the extent to which such activities were cast into an achievement oriented or competitive framework. More than one third (33.1%) said their achievement level is low in which (27.1%) were in the age of 16-24years and (37.8%) werein the age of 25-29years while more than two third (66.9%) said their achievement is high in which (72.9%) were in the age of 16-24years and (62.2%) were in the age of 25-29years. Therefore, the table reveals that majority were high in achievement orientation.

Intellectual –cultural orientation refers to the degree of interest in political and social issues and intellectual, cultural activities. More than three fourth (77.5%) said their intellectual orientation is low in which (82.9%) were in the age of 16-24years and (73.3%) were in the age of 25-29years while more than one fifth (22.5%) said their intellectual

orientation is high in which (17.1%) were in the age of 16-24years and (26.7%) were in the age of 25-29years. Thus, the table indicated that majority is low in intellectual orientation.

Active recreational orientation refers to the extent of participation in social and recreational activities. More than two third (70.6%) said their active recreational orientation is low in which (80.0%) were in the age of 16-24years and (63.3%) were in the age of 25-29years while more than one fourth (29.4%) said their active recreation orientation is high in which (20.0%) were in the age of 16-24years and (36.7%) were in the age of 25-29years. Thus, the table indicated that majority low in active recreational orientation.

Moral religious emphasis refers to the degree of emphasis on ethical and religious issues and values. More than one third (45.6%) said their moral religious is low in which (47.1%) were in the age of 16-24years and (44.4%) were in the age of 25-29years while more than half (54.4%) said their moral religious is high in which (52.9%) were in the age of 16-24years and (55.6%) were in the age of 25-29years. Therefore, the table shows that majority were high in moral religious emphasis.

Organization refers to the degree of importance of clear organization structure in planning family activities and responsibilities. Half (50.0%) said their organization is low in which (41.4%) were in the age of 16-24years and (56.7%) were in the age of 25-29years while half (50.0%) said their organization is high in which (31.4%) were in the age of 16-24years and (36.7%) were in the age of 25-29years. Hence, the table reveals that majority were both low and high in organization.

Control refers to the extent to which set rules and procedures were used to run family life. More than half (65.6%) said their control level is low in which (68.6%) were in the age of 16-24years and (63.3%) were in the age of 25-29years while more than one third (34.4%) said their controllevel is high in which (31.4%) were in the age of 16-24years and

(36.7%)were in the age of 25-29years. Therefore, the table shows that majority were low in control.

Table 4.26 Comparisons Mean Scores by Age

Sl. No.	Dimensions	Age				Total N= 160	
		16- 24 yrs. n= 70		25 -29 yrs. n= 90			
		Mean	S.D.	Mean	S.D	Mean	S.D
I	Cohesion	5.2	2.0	5.5	1.9	5.4	2.0
II	Expressiveness	3.8	1.5	4.4	1.5	4.1	1.5
III	Conflict	3.8	1.6	4.0	1.5	4.1	1.5
IV	Independence	4.8	1.2	5.1	1.4	5.0	1.3
V	Achievement	6.2	1.3	5.8	1.5	6.0	1.4
VI	Intellectual Cultural Orientation	4.4	1.4	4.6	1.5	4.5	1.5
VII	Active recreational orientation	4.6	1.6	4.6	1.9	4.4	1.8
VIII	Moral religious Emphasis	5.4	1.5	5.5	1.4	5.5	1.4
IX	Organisation	5.6	1.7	5.1	1.9	5.3	1.8
X	Control	4.5	1.4	4.7	1.5	4.6	1.4

Source: Computed

The Table 4.26 shows comparison of mean scores by age on the Family Environment. There are three dimensions namely relationship the sub scales includes cohesion, expressiveness and conflict, personal growth refers to independence, achievement orientation, intellectual-cultural orientation and moral-religious emphasize, and system maintenance denotes organisation and control. The table shows that there is a good achievement orientation among the respondents in their family because the highest mean score (6.0) in which the younger age (16 – 24 years) represents more. Followed by the moral religious emphasis mean score (5.5) in which also the younger age (16 – 24 years) represents morehigh.

With respect to cohesionthe mean score in the age group 25-29 is (5.5) which is higher than 16-24years respondents (m=5.2), the total mean is 5.4. Similarly respondents

mean in the age group 25-29years of expressiveness 4.4 is higher than 16-24years respondents (m=3.8), total mean is 4.1. In conflict the respondents mean in the age group 25-29years 4.0 is higher than 16-24yra respondents (m=3.8), total mean is 4.1. In independence the mean score of 25-29years respondents is 5.1 higher than 16-24years (m=4.8) the total mean is 5.0. Similarly achievement orientation of respondents age 16-24years 6.2 is higher than 25-29years of respondents (m=5.8), total mean is 6.0. Similarly intellectual cultural orientation respondents age 25-29years 4.6 is higher than respondents age 16-24years (m=4.4), total mean is 4.5 followed by active recreational orientation both in the age group 16-24years and 25-29years (m=4.6) there is no variationtotal mean is 4.4. Also in moral religious emphasis age group 25-29years respondents 5.5 is higher than the age group of 16-24years. Similarly in organisation respondents 16-24years age 5.6 is higher than 25-29years respondents (m=5.1), total mean is 5.3. Control age group of 25-29years respondents 4.7 is higher than 16-24years respondents age (m=4.5), total mean is 4.6. Hence from the table we come to know that significant difference in the relationship dimension especially in cohesion and expressiveness in the family environment of the respondents. With regard to personal growthdimension there is significant difference in achievement orientation and moral religious emphasis.

The Table 4.27 shows the descriptive statistics of family environment of respondents. Among the dimensions achievement is high (m=6.06) as their relationship is good with the family members next moral religious emphasis is high (m=5.52) followed by cohesion (m=5.43) next organisation is high (m=5.39) similarly independence is high (m=5.04) followed by control (m=4.67) followed by intellectual cultural orientation (m=4.52) followed by active recreational orientation (m=4.41) followed by expressiveness (m=4.19) and the last is constituted by conflict (m=4.00). Form the table we come to understand that in the dimension of relationship cohesion is high, in the dimension of personal growth achievement

and moral religious emphasize is high, and in the dimension of system maintenance organisation is high while comparing their mean scores and standard deviation.

Table 4.27 Descriptive Statistics of Family Environment of Respondents

Dimensions	Subscales	N	Minimum	Maximum	Mean	S.D
Relationship	Cohesion	160	0	9	5.43	2.01
	Expressiveness	160	1	7	4.19	1.54
	Conflict	160	1	8	4.00	1.57
Personal Growth	Independence	160	1	8	5.04	1.39
	Achievement	160	2	9	6.06	1.46
	Intellectual Cultural Orientation	160	0	9	4.52	1.50
	Active Recreational Orientation	160	1	8	4.41	1.83
	Moral religious Emphasis	160	0	8	5.52	1.48
System maintenance	Organization	160	0	9	5.39	1.88
	Control	160	1	8	4.67	1.49

Source: Computed

Table4.28 Comparisons of Means Scores by Locality

Locality	Urban n= 136		Rural n= 24		Total N= 160	
	Mean	S.D	Mean	S.D	Mean	S.D
Cohesion	5.4	1.9	5.0	2.2	5.4	2.0
Expressiveness	4.1	1.6	4.6	1.1	4.1	1.5
Conflict	3.8	1.4	4.7	1.7	4.0	1.5
Independence	5.1	1.3	4.6	1.6	5.0	1.3
Achievement	6.1	1.4	5.2	1.2	6.0	1.4
Intellectual Cultural Orientation	4.5	1.4	4.5	1.6	4.5	1.5
Active Recreational Orientation	4.3	1.9	4.6	1.3	4.4	1.8
Moral religious Emphasis	5.5	1.4	5.2	1.3	5.5	1.4
Organization	5.4	1.7	4.7	2.4	5.3	1.8
Control	4.7	1.5	4.5	1.3	4.6	1.4

Source: Computed

The Table 4.28 shows comparison of mean scores by locality on the Family Environment. There are three dimensions namely relationship the sub scales includes cohesion, expressiveness and conflict, personal growth refers to independence, achievement orientation, intellectual-cultural orientation and moral-religious emphasize, and system maintenance denotes organisation and control. The table shows that there is a good achievement orientation among the respondents in their family because the highest mean score (6.0) in which the urban represents more. Followed by the moral religious emphasis mean score (5.5) in which also the urban represents more high.

With respect to cohesionthe mean score in the urban (5.4) which is higher than rural (m=5), the total mean is 5.4. Similarly respondents mean in the urban area of expressiveness 4.6 is higher than rural area (m=4.1), total mean is 4.1. In conflict the respondents mean in the rural is higher (4.7) thanurban respondents (m=3.8), total mean is 4.0. In independence the mean score of urban 5.1 higher than rural (m=4.6) the total mean is 5.0. Similarly achievement orientation of respondents urban (m= 6.1) is higher than rural (m=5.2), total mean is 6.0. Similarly intellectual cultural orientation here is a similar mean in urban and rural l(4.5).Followed by active recreational orientation rural (m=4.6) is higher than urban (m=4.3) and the total mean is 4.4. Moral religious emphasis urban (m=5.5) is higher than rural (m=5.2) and the total mean is 5.5. Similarly in organisation urban (m=5.4) is higher than rural (m= 4.7) and total mean is 5.3. In control urban (m= 4.7) is higher than rural (m=4.5)and the total mean is 4.6. Hence, from the table we come to know that significant difference in the relationship dimension especially in cohesion and expressiveness in the family environment of the respondents. With regard to personal growth dimension significant difference in achievement orientation and moral religious emphasize in the urban area. Therefore, the table clearly shows that the urban youth have much better family environment than rural youth.

The Table 4.29 shows the Correlates of Family Environment of the Respondents. Correlation is statistical procedure used to determine the degree to which two or more variables vary together. Spearman's rank correlation coefficient was also used since the distribution is far from normal and variables have outlier values. The table shows the correlation between family environments. It was found out that there is no correlation between marital status and form of family of the respondents. There is association between locality and age, marital status and form of family of the respondents at 0.05 (.159, -.183,(.159) level of significance. There is association between cohesion and form of family at 0.05 (-.174) level of significance and also which is a negative correlation**.** The association shows that the family environment is not healthy in cohesion. There is association between expressiveness and age form of family and cohesion at 0.01 (.159, -.175, .358) of significance. There is association between conflict and locality, cohesion and expressiveness at 0.01 (.201, -.433, -.173) level of significance.

These association also shows that there no healthy personal relation with their family members.There is association between independence and cohesion at 0.05 (.178) level of significance. There is association between achievement orientation and locality, cohesion and conflict at 0.01 (-.220, .264, -.265) level of significance. There is association between intellectual cultural organization and cohesion at 0.01 (.299) level of significance. There is association between active recreational orientation and age, cohesion, expressiveness, intellectual cultural organization at 0.01 (.168, .389, .169, .363) level of significance. There is association between moral religious emphasis and form of family, cohesion, expressiveness, conflict, achievement orientation and intellectual cultural organization at 0.01 (-.181, .387, .301, -.197,) level of significance. There is association between organization and form of family, cohesion, conflict, achievement orientation, active recreational orientation,

moral religious emphasis at 0.01 (-.212, .594, -.304, .340, .321, .265, .281). There is association between control and independence at 0.05 (-.180) level of significance.

Therefore, from the correlation matrix, we found out that there is an association among the youth of their family members especially with locality and age, marital status and form of family, cohesion and form of family which is not healthy, expressiveness and age, form of family and cohesion, conflict and locality, cohesion and expressiveness, independence and cohesion, achievement and locality, cohesion and conflict, Intellectual cultural orientation and cohesion, Achievement-recreational orientation and age and cohesion, moral –religious orientation and form of family, cohesion, expressiveness, conflict, achievement orientation, and intellectual cultural orientation, organization and form of family, cohesion conflict, achievement orientation, Intellectual cultural orientation, Active-recreational orientation, and moral religious emphasize. Finally there is an association with control and independence. Hence the table shows clearly there no good association the family members since there is very high association with cohesion.

Table 4.29 Correlates of Family Environment of the Respondents

Variables	Age	MS	FoF	Locality	Cohsn.	Express.	Conft.	Indep.	AO	ICO	ARO	MRE	Orgn.	Contrl.
Age	1													
MS	.019	1												
FoF	.112	.064	1											
Locality	**.159***	**-.183***	**.159***	1										
Cohesion	.076	-.089	**-.174***	-.073	1									
Express.	**.217****	-.035	**-.175***	.117	**.358****	1								
Conflict	.064	.058	.127	**.201***	**-.433****	**-.173***	1							
Indep.	.100	-.062	-.013	-.114	**.178***	.016	-.077	1						
Achievmt.	-.138	-.047	-.122	**-.220****	**.264****	.123	**-.265****	-.004	1					
ICO	.074	-.016	-.077	-.007	**.299****	.151	-.099	-.038	.118	1				
ARO	**.168***	-.010	.067	.060	**.389****	**.169***	-.116	.071	.106	**.363****	1			
MRE	.028	-.012	**-.181***	-.076	**.387****	**.301****	**-.197***	.077	**.166***	**.199***	.148	1		
Orgn.	-.133	.024	**-.212****	-.133	**.594****	.112	**-.304****	.151	**.340****	**.321****	**.265****	**.281****	1	
Control	.061	-.075	.005	-.038	-.014	-.117	-.003	**-.180***	.126	.108	.000	.045	.092	1

*.Correlation is significant at the 0.05 level

**. Correlation is significant at the 0.01 level

***Abbreviation**: **MS**-marital status, **FoF**-form of family, **Cohsn**-cohesion, **Express**-expressiveness, **Conft**-conflict, **Indep**-independence, **AO**-achievement orientation, **ICO**-intellectual cultural orientation, **MRE**-moral religious emphasis, **Orgn**-organisation, **Contrl**-control*

Table 4.30 Correlates of Family Environment and Drug Abuse among Youth

Dimn.	Var.	Coh.	Exprness	Conft.	Indep.	Achvmt.	ICO	ARO	MRE	Orgn.	Control	MoDA	DoIDUs	FoIDUs
Relshp.	**Coh.**	1												
	Exprness	**.358****	1											
	Conft.	**-.433****	**-.173***	1										
PG	**Indep.**	**.178***	.016	-.077	1									
	AO	**.264****	.123	**-.265****	-.004	1								
	ICO	**.299****	.151	-.099	-.038	.118	1							
	ARO	**.389****	**.169***	-.116	.071	.106	**.363****	1						
	MRE	**.387****	**.301****	**-.197***	.077	**.166***	**.199***	.148	1					
Sysmain.	**Orgn.**	**.594****	.112	**-.304****	.151	**.340****	**.321****	**.265****	**.281****	1				
	Control	-.014	-.117	-.003	**-.180***	.126	.108	.000	.045	.092	1			
Patterns	**MoDA**	.059	.059	-.012	.082	-.003	-.038	-.039	.090	-.002	.084	1		
	DoIDUs	-.045	.027	**.169***	-.065	**-.276****	-.032	.082	-.025	**-.170***	.145	-.001	1	
	FoIDUs	-.147	-.051	.046	.030	-.104	**-.236****	-.046	-.059	-.103	.065	**.190***	**.307****	1

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Abbreviations: ***Dimn****-dimensions,* ***Var****-variable,* ***coh****-cohesion,* ***exprness****-expressiveness,* ***conft****-conflict,* ***indep****-independence,* ***achvmt****-achievement,* ***ICO****-intellectual cultural orientation,* ***ARO****- achievement recreation orientation,* ***MRE****-moral religious emphasis,* ***Orgn****-organisation,* ***Control****,* ***MoDA****-method of drug abuse,* ***DoIDUs****- Duration of injecting drug users,* ***FoIDUs****-frequency of injecting drug users,* ***Relshp****-relationship,* ***PRG****-personal growth,* ***Sysmain****-system maintenance.*

The Table 4.30 shows the correlates of family environment of drug abuse among youth. There was an association between expressiveness and cohesion at 0.05 level of significance. With regard to conflict, there was a significant association between cohesion and expressiveness at 0.01 and 0.05 levels of significance. Further, these associations were negatively correlated, which shows that the relationship dimension was not good among the respondents. Further, there was an association with independence and cohesion significant at 0.05.

With regard to achievement orientation there was a significant association between cohesion and conflict at 0.01. Further, intellectual cultural orientation there was an association with cohesion significant at 0.01. With regard to Active Recreation Orientation there was an association with cohesion significant at 0.01 and expressiveness significant at 0.05 and intellectual cultural orientation significant at 0.01. These associations show that the personal growth dimension was conducive for the respondents.

The table shows that there was an association with moral religious emphasis and cohesion, and expressiveness both these were significant at 0.01 and conflict, achievement orientation and intellectual cultural orientation were also significant at 0.05. With regard to organisation there was an association with cohesion, conflict, achievement orientation, intellectual cultural orientation, achievement recreational orientation and moral religious emphasis were significant at 0.01. These associations show that the respondents were having a good moral religious emphasis.

Further, there was an association between control and independence at 0.05 level of significance.

With regard to duration of injecting drug use there was an association with conflict at 0.05, achievement orientation at 0.01 and organisation 0.05 levels of significance. Further, frequency of injecting drug users there was an association with intellectual cultural orientation at 0.01, methods of drug abuse significant at 0.05 and duration of injecting drug users significant at 0.01 levels of significance. The table shows that the duration of drug use and frequency of drug use were mutually exclusive to prone for drug use.

Table 4.31 Correlates of Form of Family and Reasons for Drug Abuse

Characteristics	FoFmly.	PP	Depresn.	C or F	EA to DP	CAoD	PI or F	Bkn. Fmly.	SFS	TOF	Others
FoFmly.	1										
PP	.002	1									
Depresn. or RS	-.066	-.042	1								
C or F	.099	-.152	-.101	1							
E A to DP	-.112	.151	-.026	.042	1						
CAoD	-.115	.046	.124	.058	.126	1					
PI or Friends	-.047	**-.229****	-.001	**-.213****	**-.179***	-.015	1				
Broken Family	-.026	-.059	.079	-.103	.018	.145	-.015	1			
SFS	.069	.028	**.205****	.000	-.007	**.189***	.065	.124	1		
TOF	.009	.016	-.084	-.081	.036	-.090	-.006	.049	-.039	1	
Others	.077	-.005	-.062	.036	-.109	.045	-.066	.102	-.029	.112	1

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Abbreviation:*Fofmly.-form of family, **PP**-peer pressure, **Depresn**.-depression or to releive stress, **C or F**-curiosity or fun, **EA to DP**-easy access to drug peddler, **CaoD**-cheap availability of drugs, **PI or F**- partner influence or friends, **Bkn. Fmly**.-broken family, **SFS**-social family stress, **TOF**-to overcome frustration, others.*

The Table 4.31 shows the correlates of form of family and reason for drug abuse among the respondents. There was an association with partner influence or friends with peer pressure and curiosity or fun were significant at 0.01 and easy access to drug peddler significant at 0.05. All these three associations were negatively correlated which shows that they were not at all creating a healthy atmosphere that to not preventing on drug abuse. With regard to social family stress there was a significant association with depression at 0.01 and cheap availability of drugs significant at 0.05. These associations were also more favourable for the respondents.Thus, the table reveals that most of the drug abuser was influenced by the peer pressure, curiosity and cheap availability of drugs.

Abbreviation:Dim*-dimension,* ***Dom./Var****-domain/variable,* ***coh****-cohesion,* ***expres****-expressiveness,* ***conft****-conflict,* ***inde****-independence,* ***AO****-achievement orientation,* ***ICO****-intellectual cultural orientation,* ***ARO****-active recreational orientation,* ***MRE****-moral religious emphasis,* ***Orgn****-organiation,* ***Cotrl****-control,* ***RU****-recreational use,* ***SU****-situational use,* ***EU****-experimental use,* ***IU****-intensive use,* ***DU****-dependent use. (See table no 4.32)*

The Table 4.32 shows the correlation between family environment and different behavioural drug use model. There was an association with expressiveness and cohesion at 0.01 level of significance. With regard to conflict there is an association with cohesion at 0.01 and expressiveness at 0.05 levels of significance. Further, there was an association with independence and cohesion at 0.05 level of significance. With regard to achievement there was an association with cohesion at 0.01. Further there is an association with intellectual cultural orientation and cohesion at 0.01 levels of significance. The table shows that there was an association with active recreational orientation and cohesion at 0.01, expressiveness at 0.05 and intellectual cultural orientation at 0.01 levels of significance. With regard to the moral religious emphasis, there was an association with cohesion and expressiveness at 0.01, achievement and intellectual cultural orientation significant at 0.05 levels of significance. The table shows that there was an association with organisation and cohesion, conflict,

achievement, intellectual cultural orientation, active recreational orientation, and moral religious emphasis at 0.01 levels of significance.

With regard to control there was an association with independence significant at 0.05. Further, situational use there was an association with expressiveness at 0.05 level of significance. The table shows that there was an association with experimental use and independence at 0.01 level of significance, active recreational orientation and recreational use were significant at 0.05 and situational use significant at 0.01 level. Further, intensive use there was an association with active recreation orientation at 0.01level. The table shows that there was an association with dependent use, cohesion and achievement orientation at 0.01 level of significance. With regard to dependent use there was an association with cohesion and achievement orientation at 0.01, moral religious emphasis at 0.05 and control, experimental use, and intensive use at 0.01 levels of significance.

Therefore, from the correlation matrix, we found out that there is an association among family environment and different behavioural models of drug use especially with the three dimensions namely relationship, personal growth and system maintenance with cohesion. These result shows that the respondent were having over freedom in family as well as well as the most of the respondents were abused the drugs due to experimental use and trapped into the problem of drug abuse and most of the respondents were dependents of drugs.

The next chapter will discuss the conclusions and suggestions of the present study based on the objective.

Table 4.32 Correlation between Family Environment and Different Behavioral Drug Use Models

Dim.	Dom./Var.	Coh.	Expres.	Conft	Inde.	AO	ICO	ARO	MRE	Orgn.	Cotrl.	RU	SU	EU	IU	DU
Relshp.	**Coh.**	1														
	Expres.	**.358****	1													
	Conft.	**-.433****	**-.173***	1												
PG	**Inde.**	**.178***	.016	-.077	1											
	AO	**.264****	.123	**-.265****	-.004	1										
	ICW	**.299****	.151	-.099	-.038	.118	1									
	ARO	**.389****	**.169***	-.116	.071	.106	**.363****	1								
	MRE	**.387****	**.301****	**-.197***	.077	.166*	.199*	.148	1							
Sys. Main.	**Orgn.**	**.594****	.112	**-.304****	.151	**.340****	**.321****	**.265****	**.281****	1						
	Cotrl.	-.014	-.117	-.003	**-.180***	.126	.108	.000	.045	.092	1					
Diff. UM	**RU**	-.095	-.081	.044	.042	.011	.074	-.084	-.035	.025	-.065	1				
	SU	-.082	**-.164***	.054	.062	-.145	-.072	.061	-.052	-.080	.006	-.131	1			
	EU	-.035	.065	.076	**-.251****	.010	.060	**.232****	**-.191***	-.089	.001	**-.167***	**-.212****	1		
	IU	-.101	.034	-.063	-.098	.095	-.152	**-.331****	.062	.017	**.157***	-.081	-.120	**-.197***	1	
	DU	**.315****	.069	-.072	**.249****	-.028	.064	.093	**.187***	.119	-.081	**-.225****	-.095	**-.375****	**-.289****	1

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

CHAPTER -V

CONCLUSION AND SUGGESTIONS

The present study explores drug abuse among youth and family environment in Manipur. Youth is an important section of our country. Population of youth in India 13-35 years is 459 million constituting about 38% of total population of the country. It is expected to reach 574 million by 2020 (NYRS-2010). It is very important group and they have tremendous potentiality, resources and talents. At present, all over the world drug abuse is becoming an alarming problem among the youth. According to the World drug report published by the UNDCP (1997), a total of 180 million abuse drugs worldwide. Cannabis is probably the most widespread and commonly used in illicit drug. Youth are vulnerable to this problem in almost every society. Due to the problem of drug abuse, many youth face many challenges as an individual, family and peer groups. Family is one of the important institutions which makes individual to regulate his lifestyle with conducive and congenial environment. In order to know the drug abuse youth family environment, the present focuses on the following objectives:

1. To profile the youth in drug abuse.
2. To probe into the patterns of drug abuse among youth.
3. To understand the challenges faced by the youth in drug abuse.
4. To assess the family environment of youth abusing drugs.
5. To identify the relationship between family environment and drug abuse among youth.

Hypothesis

Youth with disruptive family structure are more prone to be drug abusers.

This hypothesis is derived from the study conducted by Centre for Suicide Research and Prevention and Department of Social Work and Social Administration at the University

The present study was conducted among drug abuse youth in Imphal West district of Manipur. The respondents are selected in the age group of 15-29 years who are visiting in the drop- in centres in the NGOs called SASO and Care and Foundation.

The present study is cross sectional in nature and descriptive in design. The study was based on primary data collected through quantitative method. The study was done by using mixed method approach. The primary data were collected in both quantitative and qualitative methods. The Family Environment Scale developed by (Moss and Moss, 1986) consists of 10 subscales was used to assess the family environment of the drug abuse youth. The qualitative data was collected by using case study method and Focus Group Discussions with drug user. The researcher used PRA technique the daily activity schedule. The quantitative data collected through field survey was processed through Microsoft excel and with the help of computer software SPSS package. To analyse the data statistical methods of averages, percentage, ratios, correlation and proportions was used. Qualitative data was processed with the use of transcript and has been presented in the form of reports.

In this chapter conclusion and suggestions of the present study is presented. It has been divided into sections and sub-sections.

Conclusion

The conclusions of the present study are discussed below:

5.1 Profile of the Respondents

The findings from the study revealed that more than half were belonging to the age group of 25 – 29years and their mean age was 24.42years and more than one third had attained high school level. In context of religion, three fourth of the respondents were from Hindu religion while half of the respondents marital status were married.

More than two third of the respondents were belonging to the nuclear family and more than two third were from medium size family. More than three fourth of the respondents were belonging to a stable family and vast majority were from urban locality. More than two third occupations of the respondents were mostly working as daily labour.

The findings from the study revealed that one fourth respondent's father had attained higher secondary level while more than one third was working as self-employed.

While more than one third gave no response on their mother educational qualification and more than one fifth were working as self-employed.

5.2 Pattern of drug abuse age

More than two third of the respondents had injected drugs in which more than three fourth were in the age of 16-24years and more than two third were in the age of 25-29years and almost three fourth were from urban locality and more than half were from rural locality. With regard to the method of initiation of drug abuse by age that less than three fourth of the respondents had started with the oral drug use. In the reason for drug abuse, majority had started taking drugs due to curiosity or fun.

Majority of the respondents started consuming drugs at the age of 14-17years. While more than one third of the respondents started injecting at the age of 16-19 years. One third of the respondents used injection in between 2-4years. With regard to the frequency of drug use according to age group, vast majority gave response to daily injection use.

With regard to the types of drug use orally more than one third said yes to cannabis followed by one fifth of the respondents said yes to codine based cough syrup while more than one third said yes to nitrazepam/diazepam tablets.

With regard to the types of drug injected more than two third of the respondents said yes to heroin or brown sugar by injecting.

With regard to types of drug use either for sniffing/inhaled majority of the respondents had sniffed/inhaled glue.

Types of drugs through smoking majority had smoked marijuana. Followed types of drugs by chew or eaten, most of the respondents had chew or eaten ganja. In regards to respondents exposure on use of common drugs by age, majority said they took SP/N10 followed by more than two third said they had smoke opium while majority said they had taken the tranquilizers followed by vast majority said they smoke tobacco productwhile vast majority had taken alcohol. Duration of injecting drug abuse by age, majority said their duration of injecting is more than 1-2years.

The different pattern of drug use more than two third said yes to dependent use. Factors of drug abuse, more than one third said yes to boredom factor while more than one fifth said yes to increased availability of drug at low price. Followed by more than one tenth said yes to povertywhile a less than one tenth said yes to lack of jobs and economic frustration followed bymore than one third said yes to depressionfollowed by more than one tenth said yes to relationships at homewhile more than one fourth said yes to family problems. Amore than half said yes to lack of proper interest at drug educationfollowed by more than one tenth said yes to escape problems at home while more than one third (47.5%) said yes to lack of drug education within family and in educational settings. Thus, the table reveals that majority factors of drug abuse were due to lack of proper interest at education.

5.3 To understand the challenges faced by the Drug abuse youth

More than one third faced social stigma while more than one third gave no response as they did not faced any discrimination at the workplace while more than one third (47.5%) said people pay some respect and interest as others. Regarding the discrimination from the family members more than half said their family members don’t visit them.

The challenges faced by drug abuse youth after the treatment from the Drop in Centre (DIC) by Age. More than half said that they were fear of going to the rehabilitation centre followed by more than two third said yes they had harder time in finding and keeping the jobs after the addiction recovery followed by more than two third said yes they were watch under suspicion as they were always presumed to be on the verge of relapse while more than half said no they cannot go through without using drugs. A more than three fourth said yes they had blackout or flashback.

Followed by more than half said yes they had medical problems because of drug use while more than three fourth said yes because of the drug abuse they had problems between their spouses and parents followed by majority said yes they need a drug to deal with everyday problem. Half of said they were never able to stop using drug when they want to more than one half said they sometime engaged in illegal activities in order to obtained drug.

Regarding the health care treatment satisfaction more than half said no they were not satisfied with the treatment they received from the health care settings while more than one third gave no response as they were not been ridiculed, harassed or insulted

Regarding the strategies adopted to continue the use of drug followed by more than half gave no response as they did not adopt any strategies.

The stigma and discrimination faced from family and society more than half they had never excluded from social gathering while more than two third said they had never been abandoned by their spouses while more than half said they were never abandoned by their family members while more than one third said they never got teased or sworn at by others followed by more than one third said sometime they lost the respect while more than one third said they were sometime rejected by others.

5.4 Assessment of family environment of youth abusing drugs

The ten sub scales classification of the family environment scale viz., cohesion, expressiveness, conflict, independence, achievement, orientation, intellectual cultural orientation, active recreational orientation, moral religious emphasis, organization and control. A more than half said their cohesion level is high while more than three fourth said their way of expressiveness is low followed by majority said their conflict is low while more than half said their independence level is low. Almost more than two third said their achievement orientation is high. Also more than three fourth said their intellectual cultural orientation is low. More than two third said their active recreational orientation is low while more than half said their moral religious is high. In reference to the organisation it was found that majority were both low and high in organization. Almost more than half said their control level is low. The Descriptive Statistics of Family Environment of Respondents reveal that in the dimension of relationship cohesion is high, in the dimension of personal growth achievement moral religious emphasize is high, and in the dimension of system maintenance organisation is high while comparing their mean scores and standard deviation.

Comparisons of Means Scores by Locality

The study clearly shows that significant difference in the relationship dimension especially in cohesion and expressiveness in the family environment of the respondents. With regard to personal growth dimension significant difference in achievement orientation and moral religious emphasize in the urban area. Therefore, the table clearly shows that the urban youth have much better family environment than rural youth.

Correlates of Family Environment of the Respondents

It was found that from the correlation matrix, there is an association among the youth of their family members especially with locality and age, marital status and form of family, cohesion and form of family which is not healthy where the hypothesis is proved at 0.05 level

of significance, expressiveness and age, form of family and cohesion, conflict and locality, cohesion and expressiveness, independence and cohesion, achievement and locality, cohesion and conflict, Intellectual cultural orientation and cohesion, Achievement-recreational orientation and age and cohesion, moral –religious orientation and form of family, cohesion, expressiveness, conflict, achievement orientation, and intellectual cultural orientation, organization and form of family, cohesion conflict, achievement orientation, Intellectual cultural orientation, Active-recreational orientation, and moral religious emphasize. Finally, there is an association with control and independence. The findings show clearly there is no good association with the family members with cohesion.

Correlates of Family Environment and Drug Abuse among Youth

The table shows that the duration of drug use and frequency of drug use were mutually exclusive to prone for drug use.

Correlates of Form of Family and Reasons for Drug Abuse

The table reveals that most of the drug abuser was influenced by the peer pressure, curiosity and cheap availability of drugs.

Correlation between Family Environment and Different Behavioral Drug Use Models

Therefore, from the correlation matrix, we found out that there is an association among family environment and different behavioural models of drug use especially with the three dimensions namely relationship, personal growth and system maintenance with cohesion. These result shows that the respondent were having over freedom in family as well as well as the most of the respondents were abused the drugs due to experimental use and trapped into the problem of drug abuse and most of the respondents were dependents of drugs.

Suggestions

The result from the present study shows that majority of the youth age group 25-29years had attained high school level due to drug addiction they cannot continue their further education as a result, they were drop out of the school. So, within the institutional settings NGOs should develop a package on the sensitisation of ill effects of drugs and causes and consequences in the surrounding areas of schools.

Since, majority of respondents had injected heroin of which they were infected with the virus because of sharing needles and equipment's. Therefore, it is recommended that harm reduction programmes should be organised by the NGOs like needle and syringe programmes (NSP) and Opioid substitution therapy (OST). The youth, must be made aware of the heroin prevention policy and HIV prevention programmes in order to prevent youth from initial stage of injecting drug use.

Further, many youth had indulged into drugs due to curiosity or to relieve stress at the age group of 14-17yrs. Therefore, it is recommended that at the young age onwards they should get exposed to the healthy environment. In addition, most of the respondents were dependent user on drugs. Therefore, it is suggested that they may be referred to social workers and professional counsellors and rehabilitation centres. After-care support programs must be availed, to enable them to cease drug abuse and become normal and productive members of society. Family members and communities need to be provided with information, support and counselling to assist with relapse prevention. They may also attend counselling and support groups for recovering dependents. For this to be successful, after-care support programmes need to be conducted in their communities so that family members and youth recovering from drug dependence may attend on a regular basis.

On the other hand, majority had faced stigma and discrimination within the family members and in health care. So, it is recommended that NGOs should conduct awareness

campaign on the HIV/AIDS transmission in order to make the parents to understand how the disease is spread and how to provide social and psychological support and care for the drug abusers. Due to these activities, the youth can get the treatment freely from the health services without the fear of stigma and reduced the risk of being exposed to HIV which would lessen the chance of HIV transmission to others like spouse or partner. Providing rehabilitation to the community about addiction; it build public awareness of the problem of stigma and discrimination toward injecting drug users as well as support and commitment to stop stigma and discrimination and counselling centres for drug control should be established in every community by the government or private individuals. Qualified health counsellor should be employed in helping drug addicts or those dependent on drugs by givingthem special counselling on how to go about the withdrawal system.

The family environment cohesion is very weak as there is not much commitment, help and support from the family members towards the respondents. Therefore, it is recommended that the family system should be strengthened through community awareness like commitment by making them to feel that all the family members is precious and through communication as it helps family members feel connected to one another by being open, honest, kind, listening their problems and trusting them. Positive communication involves both talking and listening, and family members feel open to share their opinions.

In terms of expressiveness is weak because there was no healthy personal relationships within the family members as they were not encouraged to act openly or express their feelings directly. Therefore, it is recommended that parenting program for parents and siblings of youth drug abusers aim to offer ways for families to establish family environment.

Identifying and reducing the risk factors relating to youth drug use;Enhancing protective factors and strengthening the family functioning and attached bonding, maintaining effective communications and harmonized relationships with parents through

family-based intervention like parental or family training, addressing the needs for youth, their families & the broader community and acknowledging the importance of supporting parents and the families to build healthy families at an early stage so that youth can benefit from growing up in a positive environment.

Empowering youth and their families to combat the rise and the spread of drug abuse. Focusing on the drug issue not only among the school youths, but also school drop-out, unemployed or working youngsters.Motivating and encouraging them to give up drugs, awakening the desire to make changes in one's life style, creating the realization that it is essential to take an active part in the treatment programme, and thereby willingness to make adjustments in order to recover.

The NGOS can provide outreach worker such as counsellor or social worker by educating families on strategies that fortify families, by identifying and enhancing family strengths, assisting families with their mobilizing resources and help family to reorganize.

Further the NGOs exclusive working for drug abuse youth could follow the suggestions is given below in order combat against the drug menace in a collaborative effort:

- Oral substitution therapy: Based on the premise that IDUs switch to oral and safer modes of drug use through regular and fixed doses of medication that significantly reduce the desire for heroin and associated injecting which in turn also prevents HIV and other blood borne viruses, and helps in improving the quality of life by reducing stress and effects caused due to drug withdrawal symptoms. OST also gives the opportunity for direct observation of the IDUs and so helps in bringing about a behavioural change in them, important in helping to prevent a relapse.
- Needle syringe exchange programme (NSEP): Needle Syringe Exchange Program primarily involves providing new needles/syringes to IDUs and collecting old, used needles/syringes. To promote safer injecting practices, all IDUs are encouraged to

participate in the NSEP at the DIC or clinic, where they can obtain clean needles and syringes. It also supplies other equipment to prepare and consume drug such as filters, mixing container and sterile water. Its main aim was to reduce the transmission of HIV and other blood borne viruses caused by the sharing of injecting equipment.

- Overdose management: To reduce the number of deaths from drug overdose, the project has organized a community led overdose management system, and all nurses at the NGO-run clinics are equipped with naloxone to treat overdoses. It is a necessary component required for addressing emergency situations resulting from mixing or overdosing of drugs, and includes free-of-cost provision and injection of a life-saving drug.
- Referrals.Injecting drug users are referred as needed to government-run integrated counselling and testing centres for HIV testing and counselling, to drug detoxification or rehabilitation centres, and to antiretroviral therapy centres and directly observed treatment short-course centres for treatment of HIV/AIDS and tuberculosis, respectively.
- Detoxification is undertaken for those who want to stop the use of drugs completely. It is provided by through two types of services: home-based and clinic based. The clinic-based detoxification is for those IDUs who do not have family members or lack family support. On the other hand, home-based detoxification is for those whose families are ready to take on the care of their family member.
- Regular one-to-one interactions, group sessions and focus group discussions with IDUs conducted in the DICs or in the community/household (often in the form of support groups) help to elicit information on their problems and needs, provide information on HIV and other STIs, safer injecting and sexual practices (including

condom promotion), and address their expectations as community beneficiaries from the project.

- Counselling for HIV testing and STI prevention, undertake most of the need-based counselling relating to care and support for an individual (e.g. family counselling, counselling for spouses/partners of IDUs, etc. It can outreach workers, peer educators. Counselling is provided at various levels, not only as a means to provide psycho-social support but also to provide accurate information about issues and services related to HIV/AIDS, and to encourage those infected with HIV to 'live positively' i.e. support in adjusting to new 'social identity' and to be careful with their health.

BIBLIOGRAPHY

Abdulahi Z. (2009). "Drug abuse among youths: Strategies for school counseling", *TheNigerian Society of Educational Psychologists*, Jos: Nigeria. pp. 131-136.

Ackerman J. (2003). Delinquents and their friends: The role of peer effects and self-selection. PhD thesis, Dept. of Sociology, Pennsylvania State University.

Adeoti Y.F. (2010). Factors Influencing Substance Abuse among Undergraduate Student in Osun State, Nigeria. African Research Review; An International Multi-Disciplinary Journal, Ethopia Vol.4 (4).

Ahuja R. (1981). Youth and Drug Abuse. In d. Mohan (Ed.) Current Research in Drug Abuse in India pp. 32-43.

Ahuja R. (1992).*Social Problems in India* (New Delhi: Rawat Publications).

AhujaS.(2003). Isolation and Characterization of impurities. In: Ahuja, S., Alsante, K.M. Eds., Handbook of Isolation and characterization of impurities in pharmaceuticals, Academic press, Elsevier, USA, pp. 2.

Akers R.L. Deviant Behavior (1977).A Social Learning Perspective. Belmont, CA: Wadsworth.

Al-Umran K. MahgoubO., and Qurashi N., (1993). "Volatile substance abuse among school students of eastern Saudi Arabia".Annals of Saudi medicine 13(6): pp.520–524.

American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorders. 4th Edition. Washington, D.C.: American Psychiatric Press.

Angermeyer M. C., Schulze, B., & Dietrich, S., (2003). Courtesy stigma: A focus group study of relatives of schizophrenia patients. Social Psychiatry & Psychiatric Epidemiology, pp.38, 593-602.

Angermeyer M. C., & Dietrich, S., (2005). Public beliefs about and attitudes towards people with mental illness: A review of population studies. ActaPsychiatricaScandinavica, pp.113, 163-179.

Annunziata D. Hogue, A.,Faw L.,&Liddle H., (2006).“Family Functioning and School Success in At-Risk Inner-City Adolescents”. Journal of Youth and Adolescence, 35(1), pp. 105-113.

Bachman J & O’Malley P.,(2004).*Monitoring the future.*Michigan: University of Michigan.

BararF.S.K. (1995).Essentials of Pharmacotherapuetics. S. Chand and Company Ltd., Delhi.

Barnard M. (2005). Drugs in the family: the impact on parents and siblings. UK: Centre for Drug Misuse Research, Glasgow University. Retrieved May 22, 2010, from *http://www.jrf.org.uk/publications/drugs-family-impact-parents-and-siblings*

Bell D.C (1998).An experimental test of retention in residential and outpatient programs. American Journal of Drug and Alcohol Abuse. 1994;20: pp. 331–340.

Bronfenbrenner C. (2003). *Parent-child relationship in the transition to adolescence: continuity and change in interaction*. Newbury Park: Sage.

Diamond GS.Barrette K.,&Tejeda M.,(2001). Multidimensional family therapy for adolescent drug abuse: results of a randomised clinical trial. *American Journal of Drug and Alcohol Abuse*, 15(2) pp. 12.

BalogunS.K. (2006).“Chronic intake of separate and combined alcohol and nicotine on body maintenance among albinorats”, *Journal of Human Ecology, 19(1) pp. 21-24.*

Baumrind D. (1991).“The influence of parenting style on adolescent competence and substance use”. Journal of Early Adolescence, 11(1), pp. 56-95.

Beauvais F, Oetting ER (1988), Indian youth and inhalants: an update. In: *Epidemiology of Inhalant Use: An Update*, Crider RA, Rouse BA, eds. NIDA Research Monograph 85,

DHHS publication no. ADM 89–1577. Rockville, MD: National Institute on Drug Abuse, pp. 34–48.

Bhagbanprakash(2000).*21st Century : Development Challenges.* Common Wealth Youth Programme. Chandigarh: Asia Centre Publication

Bierut I. Dinwiddie, S., &Regleiter, H., (1998). Familial transmission of substance dependence: alcohol, marijuana, and cocaine and habitual smoking: a report from the collaborative study on the genetics of alcoholism. *Archives of General Psychiatry*, 55(11), pp. 982–988.

Bogart L. M.Cowgill, B. O., Kennedy, D., Ryan, G., Murphy, D. A., Elijah, J., & Schuster, M. A. (2008). HIV-Related stigma among people with HIV and their families: A qualitative analysis.

Borawski E. Landis, C.,Lovegreen, L.,Trapl, E., (2003). "Parental Monitoring Negotiated Unsupervised Time, and Parental Trust: The Role of Perceived Parenting Practices in Adolescent Health Risk Behaviours". Journal of Adolescent Health, 33, pp. 60-70.

Brinkley A. Fitzgerald, M.,& Greene S., (1999). Substance use in early adolescence: A study of the rates and patterns of substance use among pupils in Dublin. Dublin: Eastern Health Board.

Brook J. Whiteman, M.,& Finch S., (1992). "Childhood aggression, adolescent delinquency and drug use: A longitudinal study". Journal of Genetic Psychology, 153, pp. 369-383.

Brook J. Whiteman, M., Cohen, P.,& Tanaka, J., (1991) "Childhood precursors of adolescent drug use: A longitudinal analysis". Genetic, Social, and General Psychology Monographs, 118(2), pp. 195-213.

Brook J. Whiteman, M., Gordon, A., Nomura, C.,& Brook, D., (1986). "Onset of adolescent drinking: A longitudinal study of intrapersonal and interpersonal antecedents". Advances in Alcoholism and Substance Abuse, 5, pp. 91-110.

Boyle M. H. Sanford, M.,Szatmari, P.,Merikangas, K., and Offord, D. R. (2001). "Familial influences on substance use by adolescents and young adults". Canadian journal of public health/revue canadienne de santepublique 92(3): pp. 206–209.

Boys A. Marsden, J.,& Griffiths, P., (1999). Substance use among young people.

Boyd P. (1970). Heroin addiction in adolescence.Journal of psychosomatic research, 14, pp. 295-301.

Brook J.S. Brook, D.W.,Whiteman,M., Gordon, A.S., & Cohen, P., (1990). The psychosocial etiology of adolescent drug use: A family interactional approach. *Genetic, Social & General Psychology Monographs,* 116 (2), pp. 112 -267.

Buckman J. (1969). Psychedelic drugs as adjuncts to analytic psychotherapy. In R.E. Hicks, P.J. Fink, & V.B.O. Hammett (Eds.), Psychedelic drugs New York: Grune and Stratton. pp. 210-216.

Carvalho V. Pinsky, I., De Souza e Silva, R.; and Carlini-Cotrim, B., (1995)."Drug and alcohol use and characteristics: A Study among Brazilian High School Students." addiction 90 pp.65–72.

Challier B. Chau, N., Predine, R.,Choquet, M.,Andlegras, B., (2000)."Associations of Family Environment and Individual factors with tobacco, alcohol, and illicit drug use in adolescents".European journal of epidemiology 16 pp.33–42.

Cheung N. & Cheung, Y., (2006). Is Hong Kong experiencing normalization of adolescent drug use.Some reflections on the normalization thesis. Substance Use & Misuse, pp. 41.

Colfax(2010).Amphetamine-group substances and HIV. *Lancet*. ;376: pp. 458–474.

Coombs R. H. Paulson, M. J., and Richardson, M. A., (1991).“Peer vs. Parental influence in substance use among Hispanic and Anglo children and adolescents”.Journal of youth and adolescence 20 pp.73–88.

Corrigan P. W. Miller, F. E., and Watson, A. C., (2006). Blame, shame, and contamination: The impact of mental illness and drug dependence stigma on family members. Journal of Family Psychology, 20, pp.239-246.

Craig G. J. andBaucum, D., (2001).Human development. (9th ed.). London: Prentice Hall.

Conger J. J. (1991). Adolescence and youth: Psychological development in a changing world. (4th ed.). New York: HarperCollins Publishers Inc.

Curran S. Stoltenberg, S., Hill, E.,Mudd, S., Blow, F., and Zucker, R., (1999). Gender differences in the relationships among s, family history of alcohol disorders and alcohol dependence.*Journal of Studies on Alcohol,* 60(6), pp. 825–832.

Craig R.J. & Olson, (1990).MCMI comparison of Cocaine abuser and Heroin addicts. Journal of Clinical Psychology, Vol 46 (2), pp. 230-237

De Miranda S. (1987). Drugs and drug abuse in Southern Africa. Pretoria: Van Schaik.

Deutsch C. (1982). *Broken bottles, broken dreams: Understanding and helping the children of alcoholics.* New York: Teachers College, Columbia Univ.

Doherty W. and Needle, R., (1991). “Psychological adjustment and substance use among adolescents before and after a parental divorce”. Child Development, 62(2), pp. 328-337.

Dornbusch S. Carlsmith, J.,Bushwall, S., Ritter, P.,Leiderman, H.,Hastorf, A., and Gross, R., (1985).“Single Parents, Extended Households and the Control of Adolescents”. Child Development, 56(2), pp. 326-341.

Enakpoya E. (2009). “Prevalence of drug abuse among Nigerian adolescents: Implication for counseling”, *The Counsellor*, Vol. 26, No 2.

Ennett S. Bauman, K., (1993). “Peer group structure and adolescent cigarette smoking: a social network analysis”. Journal of Health and Social Behavior, 34(3), pp. 226-236.

ESCAP/ UNODC/ UNAIDS (2001).Injecting drug use and HIV vulnerability: choices and consequences in Asia and the Pacific. Report to the Secretary General for the Special Session of the General Assembly on HIV/AIDS. Bangkok.

Fareo D.O (2012). Drug Abuse among Nigeria’s Adolescents Strategies for Counseling; The journal of International Social Research.Vol.5 No.20.

Fawa M.S. (2003). *Drug abuse eradication programme in schools: The relevance of team, approach alternative, in A. Garba (Ed) Youth and drug abuse in Nigeria: Strategies for counselling, management and control, Kano: Matasa Press.*

Fredricks J. &Eccles, J., (2005). “Developmental benefits of extracurricular involvement: Do peer characteristics mediate the link between activities and youth outcomes”. Journal of Youth and Adolescence, 34, pp. 507-20.

Fishburne PM. (2003). Effects of cocaine on chronic cocaine users.*Focus Adolescent Service Report 2003*. Washington: American Psychiatric Association.

Fisher P. Leve, L., O’Leary, C.,Leve, C., (2003). “Parental Monitoring of Children’s Behaviour: Variation Across Stepmother, Stepfather and Two-Parent Biological Families”. Family Relations, 52(1), pp. 45-52.

Forney A. M. Forney, P. D., Sheets, K., and Sitorius, M., (1990). The Relationship between Stress and Substance Use among First-year Medical Students: An exploratory Investigation. Journal of Alcohol and Drug Education, 35, pp. 54-65.

Frye S. Daw, S.,Harnett, P.,Kowalenko, S., and Harlen, M., (2008).Supporting the families of young people with problematic drug use. Australia: Australian National Council on Drugs.

Galt M. (1997). Illicit drug availability in rural areas and attitudes toward their use: Young people talking. *Health Education Journal*, 56, pp. 17-34.

Gardner F. Burton, J., and Klimes, I., (2006).Randomised controlled trial of a parenting intervention in the voluntary sector for reducing child conduct problems: outcomes and mechanisms of change. Journal of Child Psychology and Psychiatry, 47 (11), pp. 1123-1132.

Graham J. Marks, G., and Hansen, W., (1991). "Social influence processes affecting adolescent substance use', Journal of Applied Psychology". 76(2), pp. 291-8.

Gregg M. and Toumbourou, J., (2003). Sibling peer support group for young people with a sibling using drugs: A pilot study. Journal of Psychoactive Drugs, 35 (3), pp. 311 – 319.

Green S.J all D.S &Ottoson, PT.,(1999). *Drug abuse and crime*. Washington, DC: Executive Office of the President.

Grichting W. L. and Barber, J. G., (1989).The Impact of Quality of Family Life on Drug Consumption. International Journal of the Addictions, 24, pp. 963-971.

Goffman E. (1963). Stigma: Notes on the management of spoiled identity. New York: Simon & Schuster.

Jacobs AM, Ghodse AH. Delinquency and regular solvent abuse: an unfavourable combination? Br J Addict. 1988;83: pp. 965–968.

Johnston LD, O'Malley PM, Bachman JG (2001), *Monitoring the Future National Survey Results on Drug Use, 1975–2000: Secondary School Students* NIH publication no. 01–4924, Vol. I, Rockville, MD: National Institute on Drug Abuse.

Jones E. E. Farina, A.,Hastorf, A., H. Markus, H., Miller, D. T.,& Scott, R. A., (1999). Social stigma: The psychology of marked relationships. New York: WH Freeman and Company.

Goldstein M. A. (2011).Adolescent substance abuse. In M. A. Goldstein, TheMassgeneral Hospital for Children Adolescent Medicine Handbook: Part 3 (pp. 155-165). New York: Springer.

Haladu A.A. (2003). Outreach strategies for curbing drug abuse among out-of-school youth in Nigeria: A challenge for community Based Organization (CBOS), in A. Garba (ed). *Youth and drug abuse in Nigeria:* Strategies for counselling, management and control. Kano: Matosa Press.

HawkinsJ.D. Lishner, D., and Catalano, R.F., (1985). Childhood predictors and the prevention of adolescent substance abuse, in C.L. Jones & R.J. Battjes (Eds.) Etiology of drug abuse: Implications for prevention, NIDA Research Monograph No. 56. Washington, DC: U.S. Government Printing Office, pp. 75-126.

Hawkins J.D & Miller, J.Y (1982).Risk and protective factors for alcohol and other drugs problems in adolescence and early adulthood; Implication for substance abuse prevention, *Psychological Bulletin 112 (1), pp. 64-105.*

Hayden Brown (1991).*Report On Services Required For Adolescents With Drug-Related Problems* Taskforce Community Involvement Centre, Melbourne pp.3-4.

Herrel J.M. and Roberts, D.,(2003).Children of mothers with serious substance abuse.*American Journal of Substance Treatment in Children and Adolescents,* 2(2): pp. 4-10.

Huba G. &Bentler, P., (1980). "The role of peer and adult models for drug taking at different stages in adolescence". Journal of Youth and Adolescence, 9(5), pp. 449-465.

Hughes R.A. & Phil, D., (2001). Assessing the influence of need to inject and drug withdrawal on drug injectors' perceptions of HIV risk behavior. Journal of Psychoactive Drugs, 33(2), pp. 185-189.

IdowuA. (1987). "Prevalence of smoking and drug abuse among students in Ilorin metropolis: Implications for Counselling", *Journal of Education,* Vol. 7, pp.85-97.

James I.P.(1969).Delinquency and heroin addiction in Britain.Brit.J.Crim.9, pp.108.

Joe Laidler K. (2005). The rise of club drugs in a heroin society: The case of Hong Kong. Substance Use & Misuse, 40, pp. 1257 – 1278.

Jon Rose (2000). High Risk Youth – Alcohol & Other Drug Use, DrugNet Web www.drugnet.info/parent_child/youth.doc Page.

Johnson M.P. (1979)."Power Relaxations and affective style as determinants on confidence in impression formation in a game situation", *Journal of Experimental Social Psychology,* 7, pp. 98-100.

Jessor R. &Jessor, S. L., (1977). Problem behavior and psychological development: A longitudinal study of youth. New York: Academic Press.

Khangembam Indira (2014). "Social problems among the adolescents of Manipur" Role of Parents and Teachers.Journal of Northeast India Studies Vol. 4(1), Jan.-Jul. pp. 13-21.

Kozel N. Sloboda, Z., De La Rosa, M., (1995). *Epidemiology of Inhalant Abuse: An International Perspective.* NIDA Research Monograph 148, NIH publication pp. 95–3831 Rockville, MD: National Institute on Drug Abuse.

KobiowuS.V. (2006). "The social and academic implications of drug abuse among undergraduates: A case study of the ObafemiAwolowo University, Ile-Ife, Nigeria", *International Journal of Psychosocial Rehabilitation.*11(1), pp. 661 68.

Kumpfer K. Alvarado, R., and Whiteside, H., (2003). Family-based interventions for substance use and misuse prevention. Substance Use and Misuse, 38 (11), pp. 1759-1789.

Kurtzman T. L. Otuska, K. N.,& Wahl, R. A., (2001).*Inhalant Abuse by Adolescents*. Journal of Adolescent Health, Volume 28, Issue 3, March 2001, pp. 170-180.

Lather S. (1993). *Drug abuse among students*.

Ledoux S. Miller, P.,Choquet, M., (2002). "Family structure, parent-child relationships, and alcohol and other drug use among teenagers in France and the United Kingdom". Alcohol and Alcoholism, 37(1), pp. 52-60.

Liddle H. (2004). "Family-based therapies for adolescent alcohol and drug use: research contributions and future research needs". Addiction, 99(suppl. 2), pp. 76-92.

Link B. G. & Phelan, J. C., (2001). Conceptualising stigma. Annual Review of Sociology, 27, pp. 363-385.

Lisam K.S. (2004). "HIV/AIDS and You", Indian AIDS Consortium Imphal, pp.236.

Lisasky E.S.(1960). The etiology of alcoholism: The role of psychological predisposition. Quarterly Journal of Studies on Alcoholism, 21, pp. 314-343.

Lopez AD. (2001). Poisonous paint thinners and polish removers. *Family Practice News*, 10(7), pp. 12-19.

Madianos M. Gefou-Madianou D. Richardson C. and Stefanis C. (1995).Factors affecting illicit and licit drug use among adolescents and young adults in Greece.*ActaPsychiatricaScandinavica*, 91(4), pp. 258–264.

Major B. and O'Brien, L. T., (2005).The social psychology of stigma. Annual Review of Psychology, 56, pp. 393-421.

Maxwell K. A. (2002). "Friends: The Role of Peer Influence across Adolescent Risk Behaviors". Journal of Youth & Adolescence, 31(4), pp. 267-277.

Mamoliehi P. (2001). *Drug use and trafficking in the South African Democratic AllianceCountries*. Mbabane: Swaziland Printers.

Manbe, D.A. (2008). "Crime and drug abuse among Nigerian youths: A critical examination in World Health Organization(WHO)", *Expert committee on drug dependence,* 28th Report (unpublished).

McGarvey, EL, Canterbury, RJ, Waite, D. Delinquency and family problems in incarcerated adolescents with and without a history of inhalant use. *Addict Behav*. 1996;21:537–542.

McGarvey, E.L., Clavet, G.J., Mason, W., Waite, D. Adolescent inhalant abuse: environments of use.*Am. J. Drug Alcohol Abuse.* 1999;25: pp. 731–741.

Miller L. (1990). Neuro - Psychodynamics of Alcoholism and Addiction : Personality, Psychopathology, and Cognitive Style. Journal of Substance Abuse Treatment, 7, pp. 31-49.

Miller, N.S., and Gold, M.S. (1991). Dual Diagnoses: Psychiatric Syndromes in Alcoholism and Drug Addiction. *American Family Physician* 43(6):2071-2076.

Moos R.H. and Moos, B.S., (1986). *Manual: Family Environment Scale*. Palo Alto: Consulting Psychologists Press.

Monitoring the Future Study (1997). Rockville, MD: National Institute on Drug Abuse.

Morita N.(1996). Relationship between solvent inhalation and antisocial behavior: special emphasis on two types of violence seen in solvent abusers. *Psychiatry Clin Neurosci*.;50: pp. 21–30.

Mvubelo M. (2001). *Substance abuse assessment in adolescents*. Mbabane: Swaziland Printers.

National Drug Law Enforcement Agency (1997).*Drug data collection and research,* Lagos:

National Institute on Drug Abuse (2000).Inhalant Abuse DHHS publication no. 00–3818. Rockville, MD: National Institute of HealthDrug Demand Reduction Unit, National Drug Law Enforcement Agency.

Needle R. McCubbin, H., Wilson, M.,Reineck, R., Lazar, A., and Mederer, H., (1986). "Interpersonal influences in adolescent drug use: The role of older siblings, parents, and peers". International Journal of the Addictions, 21(7), pp. 739-766.

Needle R. Su S. & Doherty, W., (1990). "Divorce, remarriage, and adolescent drug involvement: A longitudinal study". Journal of Marriage and the Family, 52(1), pp. 157-169.

Neher L. & Short, J., (1998)."Risk and protective factors for children's substance use and antisocial behaviour following parental divorce". American Journal of Orthopsychiatry, 68(1), pp. 154-161.

Njuki C. (2004). Drugs across the African community.*Journal of the General Board of Global Ministries (GBGM),* 12(7), pp. 4.

Nnachi R.O. (2007). *Advanced psychology of learning and scientific enquiries*, Enugu: *J.J. Classic Publishers Ltd.*

Nyameh J. Yakubu, M.I., Teru, S., and Titus, A., (2013). Economic Implications of Drug Abuse among the YOUTH; Journal ofEconomics and Sustainable Development Vol.4, No.11.

Obot I. S.Poznyak, V., and Monteiro, M., (2004). From basic research to public health policy: WHO report on the neuroscience of substance dependence. Addictive Behaviours, 29, pp. 1497-1502.

Odejide A.O. (2000). "Research, prevention and treatment of alcohol and drug abuse in Nigeria: Problem and prospects".*Paper Presented at the 10th Anniversary Lecture of CRISA.*Jos (5th October).

Oduaran D. (1978).*Psychological guidance of the school child.*Ibadan, Evans Books.

Ogunmefun C. Gilbert, L., and Schatz, E., (2011). Older female caregivers and HIV/AIDS-related secondary stigma in rural South Africa. Journal of Cross Cultural Genterology, 26, pp. 85-102.

OgegeS.O. (2010). Drug Prohibition and Problems of Conformity in Nigeria: Journal Psychology V.1 (2), pp.91-97.

OettingE.R. andBeauvis, F., (1989).Epidemiology and correlates of alcohol use among Indian adolescents living on reservations. In: Spiegler, D.L.; Tate, D.A.; Aitken, S.S.; and Christian, C.M., eds. *Alcohol Use Among U.S. EthnicMinorities.* National Institute on Alcohol Abuse and Alcoholism Research Monograph No. 18. DHHS Pub. No. (ADM) 89–1435. Rockville, MD: the Institute, pp. 239–267.

Oetting E. and Beauvais, F., (1987).“Peer cluster theory, socialization characteristics, and adolescent drug use: a path analysis”.Journal of Counseling Psychology, 34(2), pp. 205-313.

OkuhB.(1978). *“Problems of secondary school learners*”, *Careers*.Vol.2, No 3.

OsikoyaK.A. and Ali, A., (2006). Perception of drug abuse among Nigerian undergraduates.*World Journal of MedicalSciences.*1(2), pp. 133-139.

Okoye N.N. (2001). “The adolescents and hard drugs: A psychological concern in R.U.N”. Okonkwo and R.O. Okoye (eds). *The Nigerian adolescent in perspective.*A Publication of the Nigerian Society for Education.

Okorodudu R. and Okorodudu,G.N., (2004). “An overview of conduct problems of the Nigerian child”, *Journal of the Nigerian Society for Educational Psychologists. (NICEP),* pp. 76-83.

Olaelle J.O. (1980). *Guidance and Counselling: A functional approach, Lagos: John Lad Enterprises.*

OmageE.I. and Omage,M.I., (2012). Illicit Drugs Use And Dependency Among Teenagers And Young Adults In Oredo Local Government Area, Benin City, Nigeria; European Journal Scientific Research; September edition Vol.1 No20.

Pestonjee D. M. (1999). Stress and Coping. The Indian Experience. New Delhi.

Padilla ER. Padilla, AM., Morales, A.,Olmedo, EL., Ramirez, R., (1979). Inhalant, marijuana, and alcohol abuse among barrio children and adolescents. Int J Addict 14, pp. 945–964.

Page RM. Scanlan, A., and Gilbert, P.,(1999). Multiproblem youth.*Journal of Delinquency, Substance Use and Mental Health*, 15(10), pp. 13-27.

Paterson B. Hirsch, G., and Andres, K., (2013).Structural factors that promote stigmatization of drug users with hepatitis C in hospital emergency departments. International Journal of Drug Policy, in press.

Perron BE.et al.(2009).Inhalant withdrawal as a clinically significant feature of inhalant dependence disorder.Medical Hypotheses. 73(6), pp. 935–937. (PMC Free Article).

Power R. Jones, S., Kearns, G., and Ward, J., (1996).An ethnography of risk management amongst illicit drug injectors and its implications for the development of community-based interventions. Sociology of Health & Illness, 18(1), pp. 86-105.

Reid G. and Costigan, G.,(2002).Revisiting the 'Hidden Epidemic'.A situational assessment of drug use in Asia in the context of HIV/AIDS. Centre for Harm Reduction. Melbourne, pp. 240

Rice F. P. (1992). *The adolescent: Development, relationship and culture*. (7th ed.). London: Allyn& Bacon.

Rehn M. Jenkins, J., and Cristal, A.,(2001). Relationships matter: impact of parental and peer factors on teen and young adult substance abuse. *American Journal of Public Health*, 21(15), pp. 107-118.

Room R. (2005). Stigma, social inequality and alcohol and drug use. Drug and Alcohol Review, 24, pp. 143- 155.

Rosenfield A. H. (1985). Depression, Dispelling Despair. Psychology Today, pp. 19.

Rosenberg C.M. (1969). Young drug addicts: Background and personality, Journal of Nervous and Mental Diseases, 148, pp. 65-73.

Ross M.W.Wodak, A., Stowe, A., and Gold, J., (1994). Explanations for sharing injection equipment in injecting drug users and barriers to safer drug use.Addiction, 89, pp. 473- 479.

Salerno SE. (1999).*Global consumption of alcohol by youth.* Geneva: World Health Organization.

Scanlon C. (2001). Effects of drug use in communities.*Journal of Community Issues,* 7(15), pp. 40-46.

Sanca (South African National Council for Alcohol and Drug Dependence) (2004).*Everything you always wanted to know about alcohol and other drugs.* Durban: Printermaster.

Scheer S. Borden, L.,Donnermeyer, J., (2000). "The relationship between family factors and adolescent substance use in rural, suburban and urban settings". Journal of Child and Family Studies, 9(1), pp. 105-155.

Seigal D. (2003). Poisons: an assortment of chemicals and toxins. *American Journal of Delinquency*, 10(8), pp. 4-21.

Semple S. J. Grant, I. and Patterson, T. L., (2005). Utilisation of drug treatment programs by methamphetamine users: The role of social stigma. The American Journal on Addiction, 14, pp. 367- 380.

Sharma S.G. and Luwang, N.C., (1984).Drug abuse rampant in Manipur.*The Times of India,* pp. 4.

Singh R.A. et al.(1992). Cases of buprenorphine abuse in India. ActaPsychiatricaScandinavica86(1), pp. 46-48. Abstract Available.

Singh G. and Lal, B., (1985). Alcoholism in India. Indian Journal of Psychiatry, 21, pp. 39-45.

Stein J. Newcomb, M.,&Bentler, P., (1987). "An eight-year study of multiple influences on drug use and drug use consequences". Journal of Personality and Social Psychology, 53(6), pp. 1094-1105.

Stein M.D. Dubyak, P., Herman, D., and Anderson, B.J., (2007). Perceived barriers to safe-injection practices among drug injectors who remain HCV-negative. The American Journal of Drug and Alcohol Abuse, 33, pp. 517-525.

Steinberg L. Lamborn, S., Darling, N., Mounts, N., and Dornbusch, S., (1994). "Over-time changes in adjustments and competence among adolescents from authoritative, authoritarian, indulgent and neglectful families". Child Development, 65(3), pp. 754-770.

Steinberg L. Elmen, J., and Mounts, N., (1989). "Authoritative parenting, psychosocial maturity and academic successes among adolescents". Child Development, 60, pp. 1424-1436.

Swadi H. (1988). "Adolescent drug taking: role of family and peers". Drug & Alcohol Dependence, 21(2), pp. 157-160.

Swaim R. Nemeth, J., and Oetting, E., (1995). "Alcoholuse and Socialization Characteristics Among Hungarian Adolescents: path models." drugs and society 8(3/4), pp. 47–63.

Stanhope L. and Lancaster, P.,(1999). Community health nursing: process and practice for promoting health. 3rd Edition. St Louis: Mosby.

Substance Abuse and Mental Health Services Administration (SAMHSA 2005).Office of Applied Studies .Inhalant Use and Delinquent Behaviors among Young

Adolescents. National Survey on Drug Use and Health; The NSDUH Report, March 17.

Tarter R. Schultz, K.,Kerisci, L., and Dunn, M., (2001). "Does Living with a Substance Abusing Father Increase Substance Abuse Risk in Male Offspring.Impact on Individual, Family, School, and Peer Vulnerability Factors". *Journal of Child and Adolescent Substance Abuse* 10(3) pp. 59–71.

Tapia-Conyer R. Cravioto, P., De La Rosa, B., Velez, C., (1995). Risk factors for inhalant abuse in juvenile offenders: the case of Mexico. Addiction pp. 43–49.

Tindal C.Cook K., and Foster, N., (2010).Theorising stigma and the experiences of injecting drug users in Australia.Australian Journal of Primary Health, 16, pp. 119-125

Tsuang M. Lyons, M.,Eisen, S., Goldberg, J., True, W., Lin, N., Meyer, J., Toomey, R.,Faraone,S., and Eaves, L., (1996). Genetic Influences on DSM III-R Drug Abuse and Dependence: A Study of 3,372 Twin Pairs. *American Journal of Genetics*, 67(5), pp.473–477.

Taylor C. and Carry, P.,(1998). *Family and social influence on the development of the child's competence*. New York: Wile

Taylor S. (2008). Outside the outsiders: Media representations of drug use. Probation Journal, 55(4), pp. 369-387.

UNDCP/ LCDC (Lao National Commission on Drug Control and Supervision) (1999/2000). Annual poppy survey Vientiane

United Nations Development Programme (UNDP 2001). *Global Status Report on Alcohol*. New York: Guilford Press.

United National International Drug Control Programme (UNDCP 1997). World Drug Report. New York, Oxford University Press.

United Nations on Drug Control and Crime Prevention (UN-ODCCP 2002).*World Health Report 2002*. New York: Guilford Press.

UNODC (2004).Amphetamine type stimulants in East Asia and the Pacific. Analysis of 2003 Regional ATS Questionnaire: Regional and National Overviews of ATS and Other Drug Trends and Related Data Collection Systems. Bangkok.

United Nations Organizations on Drug Council (UNODC 2005). "World Health Organization Expert Committee on Dependence Producing Drugs. Fourteenth Report Urban Adolescents", *Child Development,* 61, pp. 2032-2046.

United Nations Office for Drug Control and Crime Prevention.(2000). *World Drug Report 2000*.New York: United Nations Publications.

UNODC.https://www.unodc.org/documents/eastasiaandpacific/2011/09/global-ats 2011/ATS_Global_Assessment_2011_Exec_ Summary.pdf

UNODC (2014). World drug report (www.unodc.org/nigeria)

Van Niekerk A. S. L.(1998). *Drugs: what you and your child should know.* Bloemfontein: Kagiso.

Velleman R. Templeton, L., and Copello, A., (2005). "The role of the family in preventing and intervening with substance use and misuse: A comprehensive review of family interventions, with a focus on young people". Drug and Alcohol Review, 24(2), pp. 93-109.

WaliVarinder(1993).Drug addiction on the risk, Tribune, pp. 3.

Walsh N.(2003).Assessment of Centre for Harm Reduction's activities in Viet Nam. Centre for Harm Reduction. Melbourne. Unpublished paper

Werner P. Mittelman, M. S., Goldstein, D., and Heinik, J., (2011). Family stigma and caregiver burden in Alzheimer's disease. 52(1), pp. 89-97.

White R.W. and Watt, N.F., (1973). The abnormal personality(fourth edition).New York: The Ronald Press Company.

William K. and Covington, B.,(1998). *Factors that can influence the development of adolescent depression*. New York: Guilford Press.

Wills T. Cleary, S., (1999). "Peer and adolescent substance use among 6th- to 9th-graders: latent growth analysis of influence versus selection mechanisms', Health Psychology, 18, pp. 4Windle, M., Miller-Tutzauer, C., Barnes, G. &Welte, J. (1991) 'Adolescent perceptions of help-seeking resources for substance abuse', Child Development, 62, pp. 179-189.

World Health Organization (WHO). 2002. *Tobacco control: country profiles*. Geneva: WHO.

World Health Organization Expert Committee on Dependence Producing Drugs under United Nations Organizations on Drug Council (UNODC 2005). Fourteenth Report Urban Adolescents. *Child Development*, 61, pp. 2032-2046.

Youniss J. (1983). "Social construction of adolescence by adolescents and parents"". In H. Grotevant& C. Cooper (Eds.), New directions for child development: Vol. 22. Adolescent development in the family. London: Jossey Bass, pp. 93-109.

www.unodc.org/pdf/india/publications/south_Asia_Regional_Profile_Sept_2005/10_india.pdf.

9th International Day against Drug Abuse and Illicit Trafficking (2014) at IboyaimaShumangLeelaShanglen, Palace Compound, Imphal on 26th June :Pix - Deepak Oinam.

DRUG ABUSE AMONG YOUTH AND THEIR FAMILY ENVIRONMENT IN MANIPUR

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Interview Schedule

Schedule No …… **Date ……..**

Investigator ……

Profile of the respondents

Sl.No.	**Characteristics**	**:**	
1.	Name		……
2.	Age	:	..…….yrs
3.	Gender	:	Male □ 2. Female □
4.	Educational level	:	Primary □ 2. High school □3.Higher secondary 4. Undergraduate□5 Post graduate□6. Illiterate
5.	Religion	:	Hindu □2. Christian□ 3. Muslim□
6.	Marital status	:	Married□ 2. Unmarried□ 3. Separated□ 4. Divorced□
7.	Family type	:	Nuclear□ 2. Joint□ 3. Extended □
8.	Family size	:	Small□ 2. Medium□ 3. Large□
9.	Form of family	:	Stable□ 2. Broken□3. Reconstituted /step family□
10.	Locality	:	Urban□2. Rural□
11.	Occupation	:	Govt. servant□ 2. Private Business□ 3. Daily labour□4. Others□
II	**Profile of Parents**		
12.	Father's Education	:	……class/std.
13.	Father's Occupation	:	1. Unemployed□ 2. Agriculture/Farmer□ 3. Government Servant□ 4. Self-employment□ 5. Any other Specify……..
14.	Father's Monthly Income		……
15.	Mother's Education		…….class/std.
16.	Mother's Occupation	:	1. Unemployed□ 2. Agriculture/Farmer□ 3. Government Servant□ 4. Self-employment□ 5. Any other Specify……..
17.	Mother's Monthly Income	:	…..……
18.	Total Household Monthly Income	:	..……..……..

Pattern of drug abuse

19. Pattern of injection use:

1.	Ever injected drugs		2.	Injected drug in past one week	
3.	Injected drug in past one month		4.	Daily injection use	

20. Method of drug use at initiation

1.	Oral		2.	Injection		3.	Sniffing		4.	Others	

21. Reason for initiating drug use

1.	Peer pressure		2.	Depression or relieve stress	
3.	Curiosity or fun		4.	Easy access to drug peddler	
5.	Cheap availability of drugs		6.	Partner influence/ influence of friends	
7.	Broken family		8.	Social and family stress	
9.	To overcome frustration		10.	Others	

22. Age of first drug use

1.	10-13yrs		2.	14-17yrs		3.	18-21yrs		4.	22yrs and above	

23. Age of the first injecting use

1.	12-15yrs		16- 19yrs		3.	20-22yrs		4.	23yrs and above		

24. Duration of the injecting use

1.	1yr Or lesser		2.	2-4yrs	3.	5-7yrs		4.	8yrs and above		

25. Frequency of injection use

1	Daily injection use		2.	About 1-2days a week	
3.	About 3-4 days a week		4.	About 5-6 days a week	
3.	At least once a day in week				

26. Progression from oral drug use to injection use

1	IV drug use within two yrs of oral use		2.	IV drug use within three yrs after oral drug use	
3.	Prior to oral drug use		4.	Others	

27. Mode of Needle use

1.	Single use		3.	Multiple use	
2.	Sharing with friends		4.	Others	

28. Reuse of needles and injecting equipment

1.	Always	2.	Sometime		3.	Rarely		4.	Never	

29. Reason for reusing the equipment

1.	Irregular supply of equipment		2.	High cost	
4.	Uncomfortable accessing materials / injecting equipment's		4.	Others	

30. Types of drug use orally

1.	Cannabis		2.	Cannabis and alcohol	
3.	Heroin or brown sugar by smoking		4.	Codine based cough syrup	
5.	Nitrazepam or diazepam tablets		6.	Dextropropoxyphene	
7.	Antihistamine tablets		8.	Volatile solvents(glue ,thinner etc)	
9.	Amphetamines type substances		10.	Hallucinogenic (magic mushroom, marijuana hashish)	

31. Types of drugs ever injected

1.	Heroin or brown sugar		2.	Heroin or brown sugar mixed with other drugs	
3.	Buprenorphine		4.	Buprenorphine mixed with other drugs	
5.	Diazepam		6.	Dextropropoxyphene	

32. Have you ever sniffed or inhaled such thing as

1.	Glue		2.	Solvents		3.	Aerosol	
4.	Whitener		5.	Shoe or polish remover				

33. Types of drugs ever smoked

1.	Marijuana		2.	Hashish	3.	Cocaine		4.	Others	

34. Types of drugs ever chew or eaten

1.	Magic mushroom		2.	Ganja		3.	LSD		4.	Mescaline	

Sl.No	Characteristic	Yes	No
35.	Have you ever taken SP (Spasmoproxyvon) or N10 (Nitrazepam) tablet without medical prescription?		
36.	Have you ever smoker or eaten opium?		
37.	Have you ever taken any tranquilizers without doctor's prescription?		
38.	Have you ever chewed or smoked any tobacco product?		
39.	Have you ever taken any alcohol beverage such as wine, beer, whisky, rum etc.?		

40. Length of injecting career

1.	1-2 yrs		2.	3-4 yrs		3.	4-5yrs		4.	5yrs and above	

41. Different pattern of drug use

1.	Recreational use		2.	Situational use		3.	Experimental use	
4.	Intensive use		5.	Dependent use				

42. Factors causing respondent drug abuse

1	Boredom		2.	Increased availability of drug at low prices	
3.	Poverty		4.	Lack of jobs and economic frustration	
5.	Depression		6.	Relationship at home	
7.	Family problems		8.	Lack of proper interest at education and	
9.	Escape problems at home		10.	Lack of drug education within family and in educational settings	

To understand the challenges faced by the drug abuse youth

43. What is the biggest fear that you have?

	Lacking self-trust		3.	Mistreatment by others	
	Social stigma		4.	The rehabilitation treatment	

44. If you are an employer what are the challenges that you face from the following?

	Difficulties in finding jobs		3.	Discrimination at workplace	
	Questioning their honesty		4.	Doubting their efficiency	

45. How do people behave with you in the society?

	Stay away from me		2.	Pay some respect and interest as others	
3.	Look down upon me		4.	Very sarcastic	
5.	Discrimination from others		6.	Others	

46. In what way have you felt discriminated against (treated badly) by your family?

	Don’t visit me		2.	Don’t eat with me	
3.	Don’t sit with me		4.	Verbally abuse me	
5.	Deserted me		6.	Don’t touch me	

Sl.No	Characteristics	Yes	No
47.	Do you fear that you will be forced to keep in rehabilitation centre if your addiction rate increases?		
48.	Do you have a harder time finding and keeping the jobs after addiction recovery?		
49.	Do people watch you under suspicion as you are always presumed to be on the verge of relapse?		
50.	Can you get through aweek without using drugs?		
51.	Have you had blackout or flashback as a result of drug use?		

52.	Have you had any medical problems as a result of drug use such as memory loss, breathing or hepatitis?		
53.	Has drug use created problems between you and your spouse or parents		
54.	Do you feel like you need a drug to deal with everyday problem?		

55. Are you always able to stop using drugs when you want to?

1.	Often		2.	Rarely		3.	Frequently		4.	Never	

56. Have you engaged in illegal activities in order to obtain drug?

1.	Frequently		2.	Sometime		3.	Often		4.	Rarely		5.	Never	

57. Had a health care worker treated you unsatisfactorily at medical treatment or care?

1. Yes	2. No

58. If yes means how.

1.	Been ridiculed , harassed or insulted		2.	Forced to pay additional charges	
3.	Delayed in treatment		4.	Others	

59. What are the strategies do you adopted to continue the use of drugs?

1.	Sold personal or family belonging to buy		2.	Stolen money valuables from other to buy drug	
3.	Managed from income		4.	Asking money from someone	
5.	Others				

60. What forms of stigma and discrimination did you face from the following?

Sl.no	Forms	Always	Moderate	Sometime	Never
1.	Excluded from social gathering				
2.	Abandoned by spouse				
3.	Abandoned by family				
4.	Teased or sworn at				
5.	Lost respect				
7.	Rejection				
8.	Isolated				

IV Family Environment

Instruction to the client/parent: Please read the instruction carefully. If the statement describes your family, put a mark for true and if it does not describe your family put a mark against false. If you are not sure give an answer based on what your family is like most of the time. Make sure you respond to all the statements.

Sl.No.	Statement	True	False
1	Family member really help and support one another		
2	Family members often keep their feelings to themselves		
3	We fight a lot in our family		
4	We don't do things on our own very often in our family		
5	We feel it is important to be the best at whatever you do		
6	We often talk about political and social problems		
7	We spend most weekends and evenings at home		
8	Family members go to church/temple/mosque fairly often		
9	Activities in our family are pretty carefully planned		
10	Family members are rarely ordered around		
11	We often seem to be killing time at home		
12	We say anything we want to around home		
13	Family members rarely become openly angry		
14	In our family , we are strongly encouraged to be independent		
15	Getting ahead in life is very important in our family		
16	We rarely go to lectures, plays or concerts		
17	Friends often come over for dinner or to visit		
18	We don't say prayers in our family		
19	We are generally very neat and orderly		
20	There are very few rules to follow in our family		
21	We put a lot of energy into what we do at home		
22	It is hard 'to blow off stream' at home without upsetting somebody		
23	Family members sometimes get so angry they throw things		
24	We think for ourselves in family		
25	How much money a person make is not important to us		
26	Learning about new and different things is very important in our family		
27	Nobody in our family is active in sports or other games		
28	We often talk about the religious meaning of festivals or other holidays		
29	It is often hard to find things when you need them in our household		
30	There is one family member who makes most of the decisions		
31	There is a feeling of togetherness in our family		
32	We tell each other about our personal problems		
33	Family members hardly ever lose their tempers		
34	We come and go as we want to in our family		
35	We believe in competition and may the best man win		

36	We are not that interested in cultural activities		
37	We often go to movies, sports, events, camping etc		
38	We don't believe in heaven or hell		
39	Being on time is very important in our family		
40	There are set ways of doing things at home		
41	We rarely volunteer when something has to be done at home		
42	If we feel like doing something on the spur of the moment we often just pick up and go		
43	Family members often criticizes each other		
44	There is very little privacy in our family		
45	We always strive to do things just a little better the next time		
46	We rarely have intellectual discussion		
47	Everyone in our family has a hobby or two		
48	Family members have strict ideas about what is right and wrong		
49	People change their minds very often in our family		
50	There is a strong emphasis on following rules in our family		
51	Family members really back each other up		
52	Someone usually gets upset if you complain in our family		
53	Family members sometimes hit each other		
54	Family members almost rely on themselves when a problem comes up		
55	Family members rarely worry about job promotions, school grades etc.		
56	Someone in our family play a musical instrument		
57	Family members are not very involved in recreational activities outside work or school		
58	We believe there are some things you just have to take on faith		
59	Family members make sure their rooms are neat		
60	Everyone has an equal say in family decisions		
61	There is very little group spirit in our family		
62	Money and paying bills is openly talked about in our family		
63	If there is an disagreement in our family, we try hard to smooth things over and keep the peace		
64	Family members strongly encourage each other to stand up for their rights		
65	In our family we don't try that hard to succeed		
66	Family members often go to the library		
67	Family members sometime attend courses or take lesson for some hobby or interest(outside of school)		
68	In our family each person has different ideas about what is right and wrong		

69	Each person's duties are clearly defined in our family		
70	We can do whatever we want to in our family		
71	We really get along well with each other		
72	We are usually careful about what we say to each other		
73	Family members often try to one-up or out-do each other		
74	It is hard to be by yourself without hurting someone's feelings in our household		
75	Work before play is the rule in our family		
76	Watching TV is more important than reading in our family		
77	Family members go out a lot		
78	The religious texts are very important in our home		
79	Money is not handled carefully in our family		
80	Rules are pretty inflexible in our household		
81	There is plenty of time and attention for everyone in our family		
82	There are lot of spontaneous discussions in our family		
83	In our family, we believe you don't ever get anywhere by raising your voice		
84	We are not really encouraged to speak up for ourselves in our family		
85	Family members are often compared with others as to how well they are doing work or school		
86	Family members really like music, art and literature		
87	Our main form of entertainment is watching TV or listening to the radio		
88	Family members believe that if you sin you will be punished		
89	Dishes are usually done immediately after eating		
90	You can't get away with much in our family		

PARTICULARS OF THE CANDIDATE

NAME OF THE CANDIDATE : ALICE DEVI.K

DEGREE : M.PHIL

DEPARTMENT : SOCIAL WORK

TITLE OF DISSERTATION : Drug abuse among youth and their family environment in Manipur

DATE OF PAYMENT OF ADMISSION :

COMMENCEMENT OF SECOND SEMESTER :

APPROVAL OF RESEARCH PROPOSAL :

1. **Board of professional studies: 20th April 2015**
2. **SCHOOL BOARD: 1st May 2015**
3. **REGISTRATION NO. & DATE: MZU/M.Phil./235 of 01.05.2015**
4. **DUE DATE OF SUBMISSION:**

(DR.C. DEVENDIRAN)	**(DR.KANAGARAJ ESWARAN)**
Associate Professor	**Head, Department of Social Work**
Mizoram University	**Mizoram University**

BIO-DATA

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Class	Subject	Board/university	Percentage	Division
H.S.L.C	Science, social science, maths	BOSEM	46	2nd
H.S.S.L.C	Science	COHSEM	60	1st
BACHELOR OF ARTS	Psychology, literature, sociology	BANGALORE UNIVERSITY	53	2nd
MASTER OF SOCIAL WORK	Mental health	BANGALORE UNIVERSITY	65	1st

Field work experience (M.S.W) in Bangalore

ECHO (Empowerment of Children and Human Rights Organisation): It is a non-government organisation working for the children in difficult circumstances. Their main aim is to empower children in conflict with law and children in need of care and protection. The main activities in this field work is visiting transitional home for boys and conducting case studies and group works. Also in Happy kids taken classes and conducted games and visited for home visits. In juvenile home the students conducted classes and taught basic foundation of computer. Also in special home taken classes and make a study about the programme and the activities.

ECHO (Empowerment of Children and Human Rights Organisation Bangalore): ECHO believes that, with proper care, all children can grow into responsible and self-sufficient citizens of our society. ECHO is a leading NGO in whole of India who initiated and now monitoring and helping implementation of Juvenile Justice Act 2000. The students visited Special home (Convicted children by juvenile justice board) taken classes, case studies counselling, games and other activities and Happy Kids (crime prevention program) taken case studies, conducted group work, classes, home visits and play activities. Help in field survey and in research data collection program. To acquired adequate understanding on various social problems and cultural realities and the role and funding of the centre in the helping process.

Sangama is a sexual minorities, sex workers and people living HIV human rights organization for individuals oppressed due to their sexual preference. The students has participated in awareness programmes of Sangama, attended weekly meeting in drop in centre's where she has interacted with sexual minority community (Lesbian, Kothi, Gay, Homosexual, hijras, jogappas and other sexual minority) and observed with interaction with each other and participated in cultural programmes.

Manasa Nueropsychiatric Hospital: The main activities in this field work is taking case history of patients both (outpatient and inpatient), involved in patient ward visits on a daily basis to interact with the patients. Also going for home visits attending classes conducted by the doctor and clinical psychologists.Given a presentation on "The role of psychiatric social worker in Psychiatric setting".

NIMHANS (National Institute of Mental Health and Neurosciences): as a part of the field work block training programme the students was posted in different units to learn the application of social work in the field of Mental Health in general along with exposure in clinical work in particular. Also attended half day workshop on breaking bad news held at the Department of social work.