FEMALE SUBSTANCE ABUSERS UNDER INSTITUTIONAL CARE IN AIZAWL, MIZORAM

ZODINLIANI RALTE

DEPARTMENT OF SOCIAL WORK

MIZORAM UNIVERSITY

AIZAWL

FEMALE SUBSTANCE ABUSERS UNDER INSTITUTIONAL CARE IN AIZAWL, MIZORAM

ZODINLIANI RALTE

Department of Social Work

Submitted in partial fulfillment of the requirement of the Degree of Master of Philosophy

in Social Work, Mizoram University, Aizawl

MIZORAM UNIVERSITY

FEBRUARY, 2017

DECLARATION

I, ZodinlianiRalte hereby declare that the subject matter of this dissertation is the record of the works done by me, that the contents of this dissertation did not form basis of the 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 in any other University/Institute.

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

Dated: 10th February 2017 (ZODINLIANI RALTE)

Place: Aizawl, MizoramDepartment of Social Work
Mizoram University
Aizawl-796004

(PROF. C. DEVENDIRAN)
Head
Department of Social Work
Mizoram University, Aizawl

(DR. HENRY ZODINLIANA PACHUAU)
Research Supervisor
Department of Social Work
Mizoram University, Aizawl

MIZORAM UNIVERSITY

FEBRUARY, 2017

CERTIFICATE

This is to certify that the dissertation, *'Female Substance Abusers Under Institutional Care in Aizawl, Mizoram'* submitted by ZodinlianiRalte for the award of Master of Philosophy in Social Work is carried out under my guidance and incorporates the student's bonafide research and this has not been submitted for award of any degree in this or any other university or institute of learning.

Dated: 10th February 2017
Place: Aizawl, Mizoram

(DR. HENRY ZODINLIANA PACHUAU)
Research Supervisor
Assistant Professor
Department of Social Work
Mizoram University, Aizawl

Acknowledgement

First of all, I would like to thank The Almighty God for His countless blessings and guidance all throughout the study.

I pay my deep sense of gratitude to my supervisor Dr. HENRY ZODINLIANA PACHUAU for his valuable guidance, his expertise and encouragement.

My deepest gratitude to Prof. C. DEVENDIRAN, Head, Department of Social Work, Mizoram University and to all the faculty and staff of the department for their immense support.

I would like to acknowledge all the participants who have contributed much to this study and for their valuable time, effort and understanding.

Finally, I would like to acknowledge all of my family members and friends who supported me during the study. First and foremost I would like to thank Mom and Dad. You have encouraged my academic interests from day one, even when my curiosity led to incidents that were kind of hard to explain. Thank You. Special thanks go to my brother and sister for the love and constant support. I am thankful to all my friends for the love and unyielding support. I owe a debt of gratitude to all the members and staffs of all the institutions where the information was gathered for the study.

Dated: 10th February 2017 **(ZODINLIANI RALTE)**

Place: Aizawl

CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

AAY	:	Antyodaya Anna Yojana
AIDS	:	Acquired Immunodeficiency Syndrome
APL	:	Above Poverty Line
ASA	:	Adolescent Sexual Assault
BPL	:	Below Poverty Line
CSAT	:	Center for Substance Abuse Treatment
DSM-IV	:	Diagnostic Statistical Manual - IV
FGD	:	Focus Group Discussion
GOM	:	Government of Mizoram
HIV	:	Human Immunodeficiency Virus
ICD	:	International Classification of Diseases
IDU	:	Injecting Drug User
NGO	:	Non Governmental Organization
PTSD	:	Post Traumatic Stress Disorder
RA	:	Rapid Assessment
SPSS	:	Statistical Package for Social Sciences
UNODC	:	United Nations Office on Drugs and Crime

CHAPTER I
INTRODUCTION

INTRODUCTION

The current study attempts to profile the socio-demographic characteristics of female substance abusers under institutional care, identify the reasons for substance abuse, understand the pattern of substance abuse, find out their perception of the programmes and services offered by the institution and their challenges and coping strategies.

Substance abuse is a common social problem in every society. It not only causes deaths and affects the life and relationship of individuals, marriage and families. Substance abuse is a major public health problem that affects society on every corner. Every community is affected by substance abuse, directly or indirectly which has a deep impact on our expenditures related to health care, lost earnings, and costs associated with crime and accidents because of substance abuse. Substances work by stimulating various parts of the human body, including certain areas of the brain. It also has a deep effect on various parts of our body such as liver damage, heart rate, high blood pressure, tremors, mood disorders, stroke, respiratory failure and coma increases.

Substance abuse problems are not only a male problem. They also affect women, mainly young women. There is a need to increase the enrolment of women in treatment, to create new treatment programmes and to increase activities to prevent substance use problems from starting at an early age. Female substance abusers also experience significant barriers to accessing treatment and are believed to be under representing in treatment settings. Cultural taboos and stigma mean their substance use problems are often not acknowledged by themselves, their families or helping professionals who could support them in seeking treatment. More often than men, women have been introduced to substances and continue to use substances with their spouses or partners, who may also be physically or sexually abusive. With little emotional support, or financial resources to pay for the treatment, child care or transportation, women find it difficult to enter and remain in treatment. Women also have more severe problems treatment than entry than men. Many have experienced trauma and use substances to cope with these experiences. They also have fewer resources in terms of education, employment and finances. At the same time, because more men than women use illicit and other substances of abuse, most treatment programmes have been designed with men in mind and do not take into account gender differences.

According to Vannicelli (1984), women are inadequately represented in research related to substance abuse. In the last 20 years, she states that women have constituted only 7 per cent of research subjects on treatment outcome..A great deal of research suggests that

women differ from men in a number of areas relating to alcohol and drug use. One difference pertains to women's biological and subjective responses to these substances. Women's bodies do not process alcohol as quickly as men and as a result they are more likely to become intoxicated on lower doses of alcohol. Women who drink heavily also face greater health risks compared to men, including cirrhosis, heart damage, and brain damage. Research also suggests that once women begin to drink regularly, they progress to alcohol dependence more quickly than men.

Tuchman (2010) stated that until recently, substance abuse was believed to be predominantly male phenomenon. Only in the last few decades, attention has shifted to female drug use and its repercussions in women. As the numbers of female drug users continue to rise, studies attempt to understand gender-specific etiological factors, phenomenology, course and outcome, and issues related to treatment with the aim to develop more effective treatment programs. Research has primarily focused on alcohol and tobacco use in women and most of the literature is from the Western countries with data from developing countries like India being sparse. This review highlights the issues pertinent to alcohol and substance use in women with a special focus to the situation in India.

Cormier et. al (2004) stated that it is challenging to provide policy-relevant information on women in the area of substance abuse, as the topic is broad. Substance abuse has been found to arise from a complex interplay of biological, genetic, psychological, social, cultural, relational, environmental and spiritual factors. Because of these, it remains a challenge for policy makers and program planners to develop and implement the very broad, collaborative, systemic responses required and to do so in a manner that links prevention, enforcement, harm reduction and treatment strategies. In spite of the overall challenges, advances in gender-specific policy and programming are especially worthy of consideration and could be of tremendous benefit to the health of women and their families.

According to the National Center on Addiction and Substance Abuse (2006), in 2003, 6 million women (ages 12 and older) were alcohol abusers or alcohol dependent. That same year, 2.6 million women were abusing or dependent upon illicit drugs. Addiction is a complex and challenging social and health problem that affects millions of women and girls every day. However, addiction in women's lives can no longer be discussed without acknowledging the violence in their lives. History of being abused drastically increases the likelihood that a woman will abuse alcohol and other drugs.

According to Covington &Kohen (1984), in one of the first studies on addicted women and trauma, 74 per cent of the addicted women reported sexual abuse, 52 per cent reported physical abuse, and 72 per cent reported emotional abuse. Addicted women were found to have been abused sexually, physically, and emotionally by more perpetrators, more frequently, and for longer periods than their non-addicted counterparts. The addicted women also reported more incidents of incest and rape. Ouimette et al. (2000) stated that studies that are more recent confirm that the majority of substance-abusing women have experienced sexual and/or physical abuse.

In India, epidemiological studies till the 1990's suggested that substance abuse problems were exclusively concentrated among male population. However, studies in the last decade have indicated the prevalence of substance abuse problems in 2 per cent to 8 per cent of women in India (Benegal, 2005). According to Joshi (2011), services for women offender are fragmented or absent all across the country, and funds are scarce for developing the comprehensive networks of community services that women need yet there is a great interest in improving services for women. Many new programs to treat women have been started or are planned in correctional system across the country.

North-eastern states of India, due to their geographic positioning among other several factors, are vulnerable to high patterns of substance abuse, as they share a common international border with Myanmar, which is known as "Golden Triangle", the world's second largest illicit opium producing country. According to Ralte (1994), it is difficult to pin point the exact time drug abuse entered Mizoram. But it has been observed that the children of the affluent were the first victims (In GOM, 2015).

According to Sailo (2003), the first alarming incidence of substance abuse prevalence was heard in the 1980's when a young man of age 24 died due to overdose of heroin. After that, there was a rise in the growth of heroin using population among the middle and upper economic society. Injecting drugs gained popularity both in urban and rural areas at the same time. Since then, the number of drugs related overdose rose every year.

Ray (2004) &Panda (2006) highlighted the National Survey on the Extent, Pattern and Trends on Drug Abuse in India (2004). According to them, alcohol is the most commonly used substance in all states except Mizoram. Out of 16,942 new treatment seekers in 3 months from 203 treatment centers, 70 per cent belong to 21-40 age group, 20 per cent were unemployed,23 per cent single, 16 per cent illiterate and 52 per cent were from rural areas. Although the sale of alcohol is prohibited in Mizoram, alcohol users are the second largest

group seeking treatment services in the state after opiate users. Further, in a Rapid Assessment (RA) of IDU conducted by SHARAN in 2006, 29 sites were selected in six states of India including Mizoram. Aizawl, Champhai, Lunglei and Saiha were selected sites for the study. The highlight of Mizoram revealed that out of the total 357 respondents, 82 (23%) were females indicating a significant level of drug use among women (In GOM, 2015).

1.1 Definition and Concept related to Substance Abuse

1.1.1 Substance

Substance for the study here refers to legal drugs (both prescribed and over the counter); illegal or street drugs (including prescription drugs that are produced and sold illegally); depressants (alcohol, anabolic steroids, heroin, methadone), hallucinogens (cannabis, LCD, solvents and gases such as glue, petrol, lighter, fuel, hairspray, deodorant); Stimulants such as amphetamine, caffeine, cocaine, crack (chemically altered cocaine that can be smoked).

1.1.2 Substance Abuse

Psychoactive substance abuse is defined as a maladaptive pattern of use indicated by continued use despite knowledge of having a persistent or recurrent social, occupational, psychological or physical problem that is caused or exacerbated by the use of by recurrent use in situations in which it is physically hazardous (Hasin et. al, 2006).

1.1.3 Drug Addiction

Drug addiction is a state of periodic and chronic intoxication detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include: 1) An overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means; 2) A tendency to increase the dose; 3) "A psychic (psychological) and sometimes a physical dependence on the effects of the drug." This definition of drug addiction includes many drugs which are not within the scope of the study, such as hypnotic and sedative drugs (barbiturates, etc.) alcohol, amphetamine, mescaline (WHO 2003).

1.1.4 Withdrawal Symptoms

Withdrawal Symptoms refer to thephysical and mental symptoms that occur after stopping or reducing intake of a drug. Symptoms may include anxiety, fatigue, sweating, vomiting, depression, seizures and hallucinations.

1.1.5 Cold Turkey

Cold Turkey refers to the abrupt and complete cessation of taking a drug to which one is addicted.

1.1.6 Female Substance Abusers

In this study, female substance abusers shall include those females, aged between 15 – 40 years, who are placed in institutions for their rehabilitation because of substance abuse.

1.2 Reasons for Substance Abuse

There can be many reasons why people abuse substance. From various studies, we see that the most common reasons for substance abuse are as follows:

a) Family Dysfunctionality
b) Family History
c) Parental Negligence
d) Ineffective Supervision
e) Peer Pressure
f) Boredom
g) Values and Norms regarding alcohol and illicit drug use
h) Low self esteem
i) Inadequate coping skills
j) Stressful life events
k) Financial Problems
l) Relationship Problems

Murthy &Nikketha (2007) has highlighted certain theories related to Substance Abuse. They are as follows:

i) Biological Theory

The medical model of addiction stated that addiction of substances is due to genetic or biological factors. Abnormal conditions that present due to brain inactivity cause discomfort, dysfunction or distress to the individual afflicted. Neurotransmitters (chemicals in the brain) play an important role in behavior. The neurotransmitter dopamine plays a major role in addiction. Increased dopamine is associated with pleasure and this pleasurable feeling may account for the initiation and maintenance of addictive behavior. Rewarding experiences,

such as drug taking, trigger the release of dopamine and effectively telling the brain “to do it again”.

ii) Social Learning Theory

According to Social Learning Theory, individuals tend to learn from the social environment that they grew up in. Therefore our parents, family, and peer groups plays an important role in shaping our addictive behavior. Social learning theory also suggests that we learned through modeling and observation. Therefore if there is an alcoholic in the family, it tends to run in the family because children modeled their parents or family members in shaping their behavior.

iii) Rational Choice Theory

Becker and Murphy 1988 put forward the rational choice theory in substance addiction,and stated that many of the habits that pervade or the substances we take; we are aware of the consequences and realized the affects of it, but we do not take control of our own situationsIn the Becker and Murphy model, individuals recognize the addictive nature of choices that they make, but may still make them because the gains from the activity exceed any costs through future addiction. That is, in this rational addiction framework, individuals recognize the full price of addictive consumption goods: both the current monetary price, and the cost in terms of future addiction: reinforcement, in that the more you partake of the activity, the more you want to partake; and tolerance, in that the more that you partake of the activity, the lower your future utility given the amount of future consumption (Becker and Murphy 1988).

1.3 Affects of Substance Abuse

Diagnostic Criteria for Substance Dependence according to DSM-IV (1994) stated that a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period such as:

a) Tolerance.
b) Withdrawal.
c) The substance that is often taken in larger amounts or over a longer period than was intended.
d) There is a persistent desire or unsuccessful efforts to cut down or control substance use.
e) A great deal of time is spent in activities necessary to obtain the substance.

f) Important social, occupational, or recreational activities are given up or reduced.
g) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

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

a) Mental and behavioral disorders due to use of alcohol.
b) Mental and behavioral disorders due to use of opiods.
c) Mental and behavioral disorders due to use of cannabis.
d) Mental and behavioral disorders due to use of sedatives or hypnotics.
e) Mental and behavioral disorders due to use of cocaine.
f) Mental and behavioral disorders due to use of other stimulants, including caffeine.
g) Mental and behavioral disorders due to use of hallucinogens.
h) Mental and behavioral disorders due to use of tobacco.
i) Mental and behavioral disorders due to use of volatile solvents.
j) Mental and behavioral disorders due to multiple drug use and se of other psychoactive substances

The affects of substance abuse differs to person to person depending on the amount and longetivity of their substance use. Effects of substance abuse can be divided into effects on Individual, Family and Community.

Substance abuse has harmed and shortens the lives of many. Addiction or abuse of substance is a complicated and complex disease which tortures the addict of their well being (physical, emotional as well as psycho-social)

The devastating effect and consequences of substance abuse affects not only the users but also the family and community in which they lived in. Even though a number of actions have been carried out regarding awareness and prevention of addiction, only half of the picture is painted in order to fully tackle the harmful consequences of substance abuse leaves on the individual, family and society, it is necessary that the effects need to be taken into account so that it may be emphasized why awareness for addiction prevention need to be spread on a larger scale.

1.3.1 Effects on Individual

Substance abuse makes a person emotionally unstable, and makes him retorted to violence and makes him an unstable person, a liar and a deceiver. He does not only psychologically harm himself but also makes him physically weak and disoriented. There can also be many medical complications such as lung disease, liver cirrhosis, tuberculosis and hepatitis.

1.3.2 Effects on Family

Substance abuse not only affects an individual but it disturbs the whole family system. It create chaos in the family, occurred domestic violence, it also brings emotional damage to the whole family. The family could not maintain its own homeostasis and creates dysfunctionality in the family. It also puts financial pressure on the family.

1.3.3 Effects on Community

A person who abuses substance may impose himself or herself as a threat and poses danger to his own community.The lying and deceiving is not limited only to family but grows to neighbors, friends and colleagues which leads to people betrayed and trust. The diseases that are cause by substances are contagious and dangerous for the community. Substance abuse also creates bringing illicit drugs in the community.

1.4 Social Work Intervention and Substance Abuse

The first role of a social worker in working with substance abuse disorder is assessment and diagnosis. Assessment helps to look at an individual in a holistic view, keeping in view of the socio demographic data, history of substance intake, personal history, family history, the nature and causes of substance abuse and afterwards came to a clinical diagnosis as substance abuse is considered as mental illness.

As proposed by Prochaska and Di Clemente, motivational interventions are based on the motivational psychology which is based on the stages of change model and provided a general and practical approach for changing behaviors associated with substance use disorders. The stages of motivational cycle include Pre-contemplation, contemplation, preparation, action, maintenance and relapse.

Motivational Interviewing is a therapeutic technique which is client centered and directive aims at enhancing motivation to change by resolving client ambivalence. The principles include expressing empathy, develop discrepancy, avoid argumentation, roll with

resistance and support self efficacy. The social worker uses these guiding principles to enhance the clients motivation (Sekar et al, 2007)

Relapse is a state where an individual goes back to his alcohol consumption a period of abstinence. Social worker also need to deal with an individual to prevent relapse by teaching the client identifying and handling high risk situations, how to handle cravings, drink refusal skills and assertive training and dealing with faulty cognitions like overconfidence, helplessness.

Substance use disorder usually runs in the family and is a family problem.The family plays an important role and good support is required for the client in combating his problem.The social worker should deals with the family not only with an individual.

Group treatment is effective in working with a substance use disorder client. The other group members can act as a role model and plays an instrumental role in shaping the behavior of the client. The client should have a place to ventilate, catharsis and should have cohesiveness in the group and should develop group feelings.

Social Workers should also conducts awareness programmed at schools and college and sensitize the students to substance abuse disorders. Students maybe educated about the effects of alcohol on individual, family and community and skills to avoid substances.

1.5Research Gaps

There is a paucity of research on women with Substance Abuse in India especially in Mizoram where female substance abuse is common and psychosocial interventions are neglected.According to Tuchman (2010), research has primarily focused on alcohol and tobacco use in women and most of the literature is from the Western countries with data from developing countries like India being sparse.The available studies have shed some light on the profiles and characteristics of women with substance abuse but on the whole the role of psychosocial factors has been given limited attention.An in depth study has not yet been conducted to assess the profile, factors of substance abuse, patterns of substances abuse, perceptions of services provided by centres and challenges and coping strategies of female substance abusers in Mizoram.As a result of this gap, there are no concrete data available with regards to female substance abusers under institutional care in Mizoram. Therefore, with the above in mind, the present study aims to fill the gaps in relation to socio- demographic profile, pattern of substance abuse, reason for substance abuse, perception of services and the challenges and coping strategies of female substance abusers.

1.6 Statement of the Problem

Despite continued attempts to understand and eradicate drug and alcohol abuse in Mizoram there is no sign that it is abating. It is a complex problem because there are so many reasons why people fall into abusing substances in the first place. Unless all these reasons are considered, it will be difficult to effectively tackle the problem. Substance Abuse is a real problem in many parts of the world. It not only causes pain and suffering for the individuals involved, but also those around them and society as a whole.

The status of women in Mizoram is still poor despite the high literacy percentage in Mizoram. Women are often neglected and abused and as a result, they tend to resort to substance abuse. Voices of women are not heard especially in a patriarchal society like Mizoram. Family situations, high divorce rates, high incidence rate of child abuse, interpersonal difficulties and the non-existence of proper rehabilitation centres exclusively for women, lack of trained professionals such as de-addiction specialist, marriage therapist, as well as psycho social services of psychiatric settings increases vulnerability of women in Mizoram. Substance abuse among women in India is increasing and it has significant impact on their health and well-being. Despite being a fast growing problem, substance abuse among women has not been examined in detail in India let alone in Mizoram and with this in mind the study attempts to profile the socio-demographic characteristics of female substance abusers under institutional care, identify the reasons for substance abuse, understand the pattern of substance abuse, find out their perception on the programmes and services offered by the institution and the challenges and coping strategies faced and undertaken by them.

1.7Objectives

1) To profile the socio-demographic characteristics of female substance abusers.
2) To identify the reasons for substance abuse among female substance abusers under institutional care.
3) To understand the pattern of substance abuse among female substance abusers under institutional care.
4) To find out the perception of female substance abusers on the programmes and services offered by the institution.
5) To find out the challenges and coping strategies of female Substance Abusers under institutional care.

1.8 Chapter Scheme

Chapter 1: Introduction

Chapter 2: Review of Literature

Chapter 3: Methodology

Chapter 4: Results and Discussion

Chapter 5: Conclusion

CHAPTER II

REVIEW OF LITERATURE

REVIEW OF LITERATURE

This chapter shall highlight the various literatures that is reflective of the objectives of the study. It shall highlight various studies at the international, national and regional level.

Gender is an important variable to consider in substance abuse treatment research. The proportion of females among substance abuse treatment clients has increased over the past decade, and female clients currently constitute about one third of the treatment population. Female substance abusers experience a number of barriers to receiving treatment, including child care responsibilities, stigmatization, and inability to pay for treatment. Female substance abusers are more vulnerable than male substance abusers to some of the physiological effects of substance use, and substance abuse among females is rooted more often in psychosocial problems and traumatic life events. These important gender differences suggest the need for specialized treatment programming for women (Brady & Ashley 2005).

According to Cohen &Hien (2006), 80 percent of women who are seeking treatment for substance use disorders report a lifetime history of sexual assault, physical assault, or both. Comorbid posttraumatic stress disorder (PTSD) rates in this population range from 30 to 59 percent, with even higher lifetime rates. It has also come to light that a majority of women with a dual diagnosis of PTSD and a substance use disorder were victims of childhood abuse and are vulnerable to repeated traumas in adulthood. Women with both disorders appear to have more severe clinical profiles than those with just one of these disorders and tend to present with a variety of additional problems, including other psychiatric disorders and interpersonal deficits.

Alcoholic women are significantly more likely to marry at a younger age and have their first child earlier, have less education, and are more likely to be employed in blue collar settings than non-alcoholic women. They are significantly less likely to be working outside the home, and employed alcoholic women are more likely to report boredom in the workplace than employed non-alcoholic women. The lives of alcoholic women include more than their familial roles. The study thus come to the conclusion that more attention to issues of education, employment, and occupational status on the part of health care providers is needed (Gomberg et. al, 1999).`

Substance abuse is a substantial problem among women, who represent up to 30 percent of the patients in substance abuse treatment. Gender-specific risk factors, including having experienced interpersonal trauma and violence, underscore the need for tailored interventions for women in addiction treatment programs. Up to 80 percent of women

seeking substance abuse treatment report lifetime histories of sexual and/or physical assault, and many of these women have symptoms of posttraumatic stress disorder (Denise et. al. 2004).

Substance abuse among pregnant women has become the focus of increasing societal concern fuelled by the potential adverse health and psychosocial consequences for their children. Most studies of chemically dependent mothers derive their samples from substance abuse treatment programs. Departing from this approach, Smith, Moss Wells, Moeti, and Coles (1990) conducted a study of a group of women who had recently delivered an infant prenatally exposed to cocaine. Mothers enrolled in alcohol and drug treatment programs were compared to those who did not seek treatment for their addiction. Smith et al. found that the non-treatment sample was less impaired in their social and psychological functioning than women who were receiving drug treatment. This study is noteworthy because it indicated that women who enter treatment programs may be significantly different from women with substance abuse problems who do not get treatment (In Marcenko& Spence, 1995).

Brady and Rendall (1999) conducted a study on gender differences in substance use disorders. The goals of this study were to explore gender differences in demographic variables, psychiatric comorbidity, and personality disorders in individuals with substance use disorders and the result findings conclude that men were significantly more likely to have a higher household income and to be alcohol dependent. Further, women were significantly more likely to have another disorder in addition to substance use disorder, particularly anxiety disorders, but these gender differences were not substantially different from the gender prevalence of these disorders in the general population. Men had more affective disorders relative to women than would be expected from the general population data. Female alcoholics had substantially more psychopathology than male alcoholics, and generally these differences were consistent with the ratios of these disorders in the general population. For cocaine users, female/male ratios of anxiety and affective disorders were inconsistent with general population ratios and indicated more psychopathology than would be expected in male cocaine users.

Niv&Hser (2006) conducted a longitudinal study and examined service needs, utilization and outcomes for women-only programs (WO) and women in mixed gender programs (MG) and the result stated that compared to women in MG programs, women in WO programs were more likely to be White, less educated, physically abused in the past 30 days and in residential treatment (as opposed to outpatient treatment). Women in WO

programs also had greater problem severity a number of domains including alcohol, drug, and family, medical and psychiatric. They utilized more treatment services and had better drug and legal outcomes at follow-up compared to women in MG programs. Program type was not predictive of treatment retention/completion or outcomes in other domains (i.e., alcohol, employment, family, medical and psychiatric).The greater problems severity of women treated in women only programs and their better drug and legal outcomes suggest that these specialized services are filling an important gap in addiction services.

Marshal (2003) conducted a study on the effects of alcohol use on marital functioning and sixty studies were reviewed that tested the relation between alcohol use and one of three marital functioning domains (satisfaction, interaction, and violence). The results shows that alcohol use is maladaptive, and that it is associated with dissatisfaction, negative marital interaction patterns, and higher levels of marital violence.

Amaro et al (1999) shows the data on the profile and history of childhood abuse from a study of 66 Latinas enrolled in a residential substance abuse treatment program. Data were gathered through interviews conducted at program entry and findings have important implications for the course of treatment, how history of abuse is handled in residential treatment, and support services needed by clients.Of 210 subjects interviewed, 36 per cent had a lifetime diagnosis of alcohol abuse or dependence. Thirty-one percent were currently drinking hazardous amounts of alcohol. The study found that in Latinos on primary care settings, alcohol abuse and dependence are common.

Brady & Ashley (2009), on their study stated that substance abuse treatment specifically designed for women has been proposed as one way to meet women's distinctive needs and reduce barriers to their receiving and remaining in treatment. However, relatively few substance abuse treatment programs offer specialized services for women, and effectiveness has not been fully evaluated. The studies also found positive associations between these six components and treatment completion such as length of stay, decreased use of substances, reduced mental health symptoms, improved birth outcomes, employment, self-reported health status, and HIV risk reduction. These findings suggest that to improve the future health and well-being of women and their children, there is a continued need for well-designed studies of substance abuse treatment programming for women.

Neff & Waite (2007) conducted a study on male versus female substance abuse patterns among incarcerated juvenile offenders. The data include information on approximately 5,000 incarcerated juveniles (89 percent males, 11 percent females).

Comparisons across gender indicate similarity with respect to alcohol and marijuana, but earlier age of onset and greater current use among females for most other substances. Regression analyses reveal similarity across genders in the pre-eminence of peer substance use as a predictor, but mixed results with respect to the influence of family factors and victimization

When developing addiction treatment for females, research shows that services need to be provided in a holistic and woman-centered approach that reflects an understanding of the realities of women's and girls' lives and that addresses and responds to their challenges and strengths. Further, the link between understanding women's addiction and creating effective treatment programs for women lies in understanding the unique characteristics of women's psychological development and needs (Covington, 2007).

Greenfield et. al. (2010) in their study, "Substance Abuse in Women" stated that gender differences in substance-use disorders and treatment outcomes for women with substance-use disorders have been a focus of research in the last 15 years. The initiation, use patterns, acceleration of disease course, and help-seeking patterns are affected by gender differences in biologic, psychological, cultural, and socioeconomic factors. Important gender-specific factors also predict women's substance abuse treatment entry, retention, and outcomes. Understanding the basic biological mechanisms that underlie these gender differences in vulnerability and responsiveness to substances will enhance the development of gender-specific treatments.

Johnson (1986) in his study, "Women's Health: Issues in Mental Health, Alcoholism and Substance Abuse" stated that the prevalence of illicit drug use is higher among men than women, but new drug use occurs at twice the rate for females as for males. However, the 1984 National Institute of Mental Health Epidemiologic Catchment Area Survey shows drug abuse and dependence to be the second most commonly reported disorder for women. He further stated that "women addicts are more entrapped, at earlier ages, by social and economic conditions, and have fewer ways out of the addiction pattern.

The relationship between domestic violence and patterns of drinking and drug abuse for survivors is undoubtedly complex. The stigma associated with substance use problems for women is exacerbated for some by religious and cultural issues (Taylor, 2003). There is nevertheless significant evidence of the vulnerability of survivors of domestic violence to substance use. Most of the studies explore alcohol use, though there is an

emerging literature on drug use and, of course, the dual use of alcohol and a range of drugs together (In Humphreys et al, 2005).

A study conducted by Mironet. al. (2013), stated that a history of childhood abuse has been consistently linked to heightened risk for adverse outcomes across the lifespan, including a great number of alcohol use and adolescent sexual assault (ASA). The study also revealed that experiencing various forms of child maltreatment increases one's risk of experiencing sexual victimization in adolescence; a factor that has been shown to mediate the effect of child abuse on prospective problem drinking. Also researchers have begun to explore the added role of lack of self-compassion in the pathway from childhood abuse to alcohol related problems.

Over the past decade, research has consistently linked childhood sexual abuse to PTSD, depression, and substance abuse. Women with a history of childhood sexual abuse often turn to alcohol and drugs to self-medicate their symptoms of PTSD. Substance abuse impairs their ability to function effectively in all areas of their lives, including engaging in risky sexual behaviors that may expose them to HIV/AIDS. Furthermore, evidence suggests that drug dependency may further lead women to exchange sex for money or drugs in risky unprotected encounters. Women with substance abuse problems are more likely to have experienced co-occurring childhood sexual abuse and PTSD than women with no history of substance abuse and may not benefit from HIV prevention strategies that do not consider these co-occurring problems and their relationship to risky behaviours (El-Bassel et. al, 2009).

The report, Global Illicit Drug Trends, 2003, indicates that, while cannabis is the most widely used illicit substance, it is not the substance that generates the most demand for treatment. Rather, opiates compose the most serious problem substance in the world and generate the most illicit drug treatment demand overall. In Asia, Australia and Europe, the greatest treatment demand is for opiate abuse (though methamphetamine abuse is generating the most treatment demand in South-East Asia). In North and South America, cocaine abuse generates the most treatment demand, with heroin almost equaling cocaine in North America. The exception is Africa, where the greatest treatment demand is for cannabis. Recent data indicate the upsurge of cannabis-related treatment demand in North America and Europe (UNODC, 2004).

The most recent United Nations report that discusses gender differences with respect to substance abuse, Global Illicit Drug Trends, 2002, indicates that women represent an

estimated 10 per cent of substance users in some traditional Asian societies, 20 per cent in countries of the former Union of Soviet Socialist Republics and Latin America and about 40 per cent in North America and some European countries. The intersection of injecting drug use, sex work and unsafe sexual practices has become a significant factor in the increased risk of HIV among women, particularly in Asia, Eastern Europe and North America. Although the prevalence of illicit substance use may be lower among women than men, women are more likely to use pharmaceutical drugs (both illicit and prescribed), the highest rates of use, at least in Europe and North America, occurring among older women (UNODC, 2004).

In India, epidemiological studies till the 1990's suggested that substance abuse problems were exclusively concentrated among male population. However, studies in the last decade have indicated the prevalence of substance abuse problems in 2 per cent to 8 per cent of women in India (Benegal, 2005). According to Joshi (2011), services for women offender are fragmented or absent all across the country, and funds are scarce for developing the comprehensive networks of community services that women need yet there is a great interest in improving services for women. Many new programs to treat women have been started or are planned in correctional system across the country.

In a recent study conducted in 2012, amongst 41.5 million illicit drug users, more than 42 per cent were women, suggesting a male/female ratio of 1.4:1. In case of prescription drug abuse, several studies report their use to be higher in women than men, particularly for narcotic analgesics and tranquilizers. The study reported that 5.9 per cent of females consumed alcohol at least once in the past year, as compared to 32.7 per cent of men. Direct comparison of most other drug use is not possible as no national level survey on substance abuse in women has been conducted in our country. The earliest national studies dating back to 1980s report negligible drug use rates among women with alcohol use in 3.2 per cent, and barbiturates, cannabis, heroin, pethidine, morphine use in as low as 0.1–0.3 per cent of women. Four large epidemiological studies in the early 1990s, with sample sizes varying from 4000 to 30,000, revealed that 6–8 per cent of women had ever used drugs in their lifetime. Multiple studies document increased heroin use in large cities like Mumbai, Kolkata, and Delhi, during this time (Lal et. al, 2015).

Nebhinani et al (2013) conducted a study on 100 women substance abusers seeking treatment at a de-addiction center between September 1978 and December 2011 in North India. The findings highlights the socio-demographic profile of women substance abusers, the forms/types of drugs abused, reasons for substance abuse and follow up visits and abstinence.

According to it, 65 per cent were married, 61 per cent were from the urban areas, 59 per cent came from a nuclear family, 56 per cent were based housewife, 69 per cent had good to fair social support. The commonest substance abused was tobacco (60%), followed by opioids (27%), alcohol (15%), and benzodiazepines (13%). The common reasons for initiation of substance use were to alleviate frustration or stress (49%) and curiosity (37%). Family history of drug dependence (43%), comorbidity (25%), and impairments in health (74%), family (57%), and social domains (56%) were common. Only a third of the sample paid one or more follow visit, and of those 58 per cent were abstinent at the last follow-up. A significant predictors identified were being non-Hindu and higher educational years for abstinent status at follow-up.

According to Malik et al (2015), 20 per cent of the respondents reported presence of childhood adverse experience (e.g. Physical abuse, sexual abuse & neglect).From his findings, the mean age of the sample was 38 years. Among these, 54.2 per cent were married and 30 per centwere separated or divorced. Alcohol dependence was present in 80 per cent of the sample size, followed by nicotine dependence in 54 per cent of the patients. Furthermore, from the current research marital discord and interpersonal conflicts with other family members were common contributing factors for substance use. Adverse life events and interpersonal conflicts are significant contributing factors to substance use among women.

The most important domains to screen for when working with women with SUDs are substance use, psychiatric and medical co morbidities, childhood and adulthood adverse life events, marital and interpersonal functioning and occupational difficulties. Based on these assessments, appropriate psychosocial interventions can be planned (Kanika et. al, 2015).

Kermode et al (2012) conducted a study in North-east India – a challenge for HIV and found out that the most problematic substance for women from Nagaland was alcohol, and for women from Manipur it was heroin. The most commonly identified health problems were primarily related to the women's drug and alcohol use, reproductive health and mental health. Other problems of major concern included social exclusion, violence, children's welfare, and financial difficulties. The expressed service needs of these women were women-only integrated health services, women-only detoxification and rehabilitation services, mental health services, desensitization of mainstream health workers, free access to medicines, assistance to meet basic needs, and a safe place for engaging in sex work prevention services.In North-eastern States, heroin use in women was found to be high at 14 per cent (Lal et. al, 2015).

Pandey&Datta (2014) conducted a study on the socio-economic and demographic characteristics of alcohol and other substance abusers, undergoing treatment in Sikkim. From the findings, majority were male while only less than a tenth were females. Majority of the participants were in the school dropout group or school completed group. Most of the respondents were occupationally unemployed, urban residents, Nepali by ethnicity, single, and Hindu by religion. The minimum age for starting of alcohol was 5 years and 7yearrs for drugs. Knowledge about AIDS and its transmission among patients undergoing treatment was satisfactory. Wide availability of alcohol and cold climate of Sikkim make the State susceptible for alcohol use and misuse and thus indirectly for other substance use. Alcohol drinking among parents, sibling and friends found to be important risk factor.

Tochhawng (1995) identified several causal factors for substance abuse in Mizoram. The rapid and radical social change, moral degradation in Mizo Society, decline of the social control system, the rampant corruption, the mass media, influence of western lifestyle and music, weakness of family institution, certain traditional practices such as smoking and drinking rice beer (In GOM, 2015).

Lallianzuala (2007), stated that consumption of cannabis was well known even before the spill-over of the smuggled heroin, which later developed into a takeover (a state of consumption) in the mid 1980's. Since then, the use of other Narcotics drugs and Psychotropic substances gained popularity. Injecting the non-injectable drug dextro-poxyphene (Spasmo-Proxyvon) was the most common pattern and choice of drug use in the late 80's among the PUD. Since then, there has been a spurt in the HIV cases as well as deaths due to overdoses and abscesses caused by injecting drug in the state (In GOM, 2015).

The Center for Substance Abuse Treatment (CSAT) is convinced that addicted women can be helped through comprehensive programs designed specifically for women, treating the factors associates with women's substance abuse. Evidence shows that effective treatment programming does empower these addicted women offenders to overcome their substance abuse, to lead a crime free life and to become productive citizens. Effective women-centered treatment, whether in a prison or community setting benefits a woman and her children (In Kassebaum, 1999).

Hmingthanmawii (2000), in her study suggested that the state government should pay more attention to the existing detoxification and rehabilitation centresrun by various voluntary organization by assisting them financially. She also recommended trained professionally staff and fewer inmates to facilitate a higher success rate.

CHAPTER III

METHODOLOGY

METHODOLOGY

3.1 Design

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

3.2 Source of Data Collection

Data were selected from both primary and secondary sources. Primary sources were collected from the female substance abusers placed under institutional care. Secondary sources were collected from government and non-governmental records.

3.3 Method of sampling

The respondents were identified from all institutional settings who gave consent within Aizawl City that provided rehabilitation services to female substance abusers. All the females under these institutions who gave their consent formed the sample size. The sample consists of only females aged between 15-40 years. The overall size was 90.

3.4 Tools of data collection

A semi-structured interview schedule was used as the tool for data collection to collect information with regard to the objectives of the study. Focus group discussions and participative techniques were also used to collect information from the respondents. In-depth interviews were conducted to understand the lived experience of the respondents.

3.5 Data Analysis

The data were analyzed by using Microsoft Excel and SPSS Package.Case vignettes are also presented to understand the lived experiences of female substance abusers under institutional care.

3.6Ethical Consideration

A pilot study was conducted to check the reliability of the tool. Changes were made accordingly to fit the context and to reduce any imposition. Only those institutions and females who have given their consentwere included in the study.

CHAPTER IV

RESULTS AND DISCUSSION

RESULTS AND DISCUSSION

This chapter shall discuss the findings of the present study in different sections based upon the objectives of the research.

4.1 Personal Characteristics

This section will highlight the findings related to the personal characteristics of the respondents namely age group, sub-tribe, religion, denomination, education, domicile, marital status, occupation, family characteristics and socio-economic category.

Table 1: Age Group

Sl.No	Age	Frequency	Percent
1	**18-30**	46	51.1
2	**30 – 40**	37	41.1
3	**15-18**	6	6.7
4	**40 and Above**	1	1.1
	Total	90	100

Source: Computed

Table 1 shows the distribution of the respondents according to their *age group*. From the table, we see that more than half (51.1%) of the respondents are from the age group 18-30 years followed by 41.1 per cent who belong to the age group of 30-40 years. A significant number (6.7%) of the respondents were children who belonged to the age group 15-18 years while 40 years and above age group constitute only 1.1 per cent of the sample size.

This finding also reflects the study by Johnson (1986) who stated that female substance abusers are more entrapped, at earlier ages, by social and economic conditions.

Table 2 : Sub-Tribe

Sl.No	Tribe	Frequency	Percent
1	**Lusei**	62	68.9
2	**Hmar**	9	10.0
3	**Paite**	6	6.7
4	**Mara**	6	6.7
5	**Lai**	6	6.7
6	**Non-Mizo**	1	1.1
	Total	90	100

Source: Computed

Table 2 represents the distribution of the respondents according to their *Sub-Tribe*. From the table, it is evident thatmore than half of the respondents (68.9%) belong to the Lusei sub-tribe followed by females from the Hmar sub-tribe, who constitute a tenth (10.0%) of the total respondents. The rest of the respondents are distributed equally among the sub-tribe Paite, Mara and Lai sub-tribes while Non-Mizo females constitute only 1.1 per cent.

Table 3: Religion

Sl.No	Religion	Frequency	Percent
1	**Christian**	84	93.3
2	**Others**	6	6.7
	Total	90	100

Source: Computed

Table 3 represents the *religion* of the respondents. From the table, we see that majority the respondents (93.3%) are Christians while a few were from the Others (Hindu and Buddhist) category who constitute 6.7 per cent.

Table 4: Denomination

Sl. No	Denomination	Frequency	Percent
1	**Presbyterian**	43	47.8
2	**United Pentecostal Church**	16	17.8
3	**Baptist**	12	13.3
4	**Local Denomination**	7	7.8
5	**No Denomination**	6	6.7
6	**Roman Catholic**	3	3.3
7	**Salvation Army**	3	3.3
	Total	90	100

Source: Computed

Table 4 represents the *denomination* of the respondents. The table shows that less than a half (47.8%) of the respondents are from the Presbyterian Church followed by 17.8 per cent of the respondents who belongs to the United Pentecostal Church (UPC). More than a tenth (13.3%) of the respondents are Baptist followed by less than a tenth of the respondents who belong to Local denomination (Seventh-day Adventist Church, KohranThianghlim, Lairam Jesus Christ Baptist Church, and the Evangelical Church of Maraland, Independent Church of India and the Evangelical Free Church of India), Roman Catholic and The Salvation Army.

Table 5: Level of Education

Sl. No	Level	Frequency	Percent
1	**Higher Secondary**	44	48.9
2	**High School**	31	34.4
3	**Middle**	5	5.6
4	**Graduate**	5	5.6
5	**Primary**	3	3.3
6	**Illiterate**	1	1.1
7	**Post Graduate**	1	1.1
	Total	90	100

Source: Computed

Table 5 shows the distribution of the respondents according to the *level of their education*. The table shows that about almost half (48.9%) of the respondents studied till the higher secondary level followed 34.4 per cent of the respondent who studied till high school level. Less than a tenth (5.6 %) of respondents studied till the Middle and the Graduate level. Only 3.3 per cent studied till the Primary level and a very few of the respondents were illiterate and post graduate.

Table 6: Domicile

Sl.No	Domicile	Frequency	Percent
1	**Urban**	80	88.9
2	**Rural**	10	11.1
	Total	90	100.0

Source: Computed

Table 6 shows the *domicile* of the respondents. Majority (88.9 per cent) resides in urban area and more than a tenth(11.1%)of the respondents settled in rural area.

This finding can also be related to the study by Nebhinani et al (2013) who in his study highlights the socio-demographic profile of women substance abusers and in his study, he found that among the respondents from his study, 61 per cent were from the urban areas.

Table 7: Marital Status

SL. No	Marital Status	Frequency	Percent
1	**Unmarried**	45	50.0
2	**Divorce**	27	30.0
3	**Married**	12	13.3
4	**Widowed**	6	6.7
5	**Total**	**90**	**100**

Source: Computed

Table 7 highlights the distribution of the female substance abusers according to their *marital status.* The table shows that half of the respondents (50%)were unmarried and followed by 30 per cent who were divorced. More than a tenth (13.3 %) were married, and less than a tenth (6.7%)were found to be widows.

Table 8: Occupation

Sl.No	Occupation	Frequency	Percent
1	**Unemployed**	57	63.3
2	**Business**	25	27.8
3	**Govt. Service**	4	4.4
4	**Daily Labour**	4	4.4
	Total	**90**	**100**

Source: Computed

The data pertaining to *occupation* of the respondents is presented in table 8.It is evident from the table that more than half (63.3%) of the respondents are unemployed. More than a fourth (27.8%) of the respondents were engaged in business while less than a tenth (4.44%) were engaged in government service and daily labour.

This finding can be linked with the study by Kanika et al (2015) who also stated occupational difficulties is an important indicator of substance abuse among females.

Table 9: Family Characteristics

Type of Family			
I	**Type**	**Frequency**	**Percent**
	Nuclear Family	88	97.8
	Joint Family	2	2.2
	Total	**90**	**100**
Form of Family			
	Form	**Frequency**	**Percent**
II	**Stable**	52	57.8
	Broken	21	23.3
	Reconstituted	17	18.9
	Total	**90**	**100**
Family Monthly Income			
III	**Income**	**Frequency**	**Percent**
	Rs.5000 -10000	17	18.9
	Rs.20000-30000	15	16.7
	Rs.10000-20000	14	15.6
	Rs.40000 and above	14	15.6
	Rs.30000-40000	12	13.3
	Total	**90**	**100**

Source: Computed

Table 9 shows the distribution of respondents according to their *family characteristics* that include *type of family, form of family and family monthly income*. With reference to the type of family, it is evident that majority of the respondents (97.8%) comes from a nuclear family wile a very few (2.2%) comes from joint family. This shows the increasing trend of change taking place from joint family to nuclear family and this change in family characteristic can be attributed to the processes of the urbanization, industrialization, migration and modernization. This finding also reflects the study by Nabhinanni et al (2013) who also found 59 per cent (more than half) among his respondents were from a nuclear family.

With regard to the form of family, the table also shows that more than half (57.8%) of the respondents comes from a stable family while a significant amount (23.3%) of the

respondents come from a broken family and 18.89 per cent comes from a reconstituted family.

Further, with reference to the family monthly income, we also find that 18.9 per cent of the respondents family has a monthly income between Rs.5000-Rs.10,000 followed by those (16.7%) of the respondent's family whose monthly income is between Rs.20,000-Rs.30,000. This is followed by the respondents family (15.6%) who earn between Rs. 10,000-Rs.20,000 and Rs. 40,000 and above. More than a tenth (13.3%) of the respondents family earn between Rs. 30,000-Rs.40,000.

Table 10: Socio-Economic Category

Sl.No	Category	Frequency	Percent
1	**APL**	54	60.0
2	**Don't Know**	22	24.4
3	**BPL**	14	15.6
	Total	**90**	**100**

Source: Computed

Table 10 shows the distribution of the respondents according to their socio-economic category. The table also shows that majority (60%) of the respondents comes from the APL category while a fourth (24.4%) of the respondents do not know their socio-economic category. More than a tenth (15.6%) of the respondents were from the BPL category.

4.2 Reasons and Pattern of Substance Abuse

This section shall discuss the findings related to the reasons and pattern of substance abuse that will include tables related to substance abusers in family, age of first intake, motivator, and reason for substance abuse, types of substance used, frequency of intake and dosages.

Table 11: Substance Abusers in Family

Sl.No	Abusers	Frequency	Percent

		N=90	N=100
1	**Sibling**	18	20.0
2	**Mother**	3	3.3
3	**Partner**	3	3.3
4	**Father**	2	2.2
5	**Cousin**	2	2.2
6	**Grandfather**	1	1.1
	Total	**29**	**32.2**

Source: Computed

Table 11 highlights information regarding substance abusers among family members. The table shows that among the respondents, 32.2 per cent have substance abusers in their family. Among those who have substance abusers in the family, 20 per cent of the respondents reported that their sibling abused substances. Less than a tenth (3.3%) reported that their mothers and partners were substance abuser followed by 2.2 per cent who reported that their fathers and cousins abused substances. Very few (1.1%) of the respondents reported that their grandfather abused substances.

Table 12: Age of first intake

Sl.No	Age	Frequency	Percent
1	**12 - 18**	42	46.7
2	**18 - 30**	38	42.2
3	**30 -40**	10	11.1
	Total	**90**	**100**

Source: Computed

Table 12 represents the age at which the respondents first indulged in substance. From the table, we find that nearly half (46.7%) of the respondents had their first intake of substance when they were between the age group 12-18 years of age while a close 42.2 per cent of them first took substances when they were between the age group 18-30 years. More than a tenth (11.1%) reported that they first took substances when they were between 30-40 years of age. Therefore, it can be stated that majority of the respondent's first intake of substances occurred mostly when they were adolescence and young adults. The use of substances among adolescents is a public health concern and has been studied extensively in many parts of the world.

This finding also reflects the study of Windle (1999), and the study by Neff & Waite (2007) who found that alcohol use is prevalent in adolescent and young adult group.

Table 13: Motivator for Substance use

Sl.No	Motivator	Frequency	Percent
1	**Peers**	40	44.4
2	**Self**	40	44.4
3	**Partners**	5	5.6
4	**Cousins**	3	3.3
5	**Sibling**	2	2.2
	Total	**90**	**100**

Source: Computed

Table 13 represents the distribution of respondent's according to who motivated them to take substances. From the table, we see that less than half (44.4%) of the respondent's motivators were their peers while exact same number (44.4%) of the respondents reported that it was self-motivation. Less than tenth of the respondents reported that they were first motivated by their partners, cousins and siblings.

The findings also reflect the study by Nebhinani et al (2013) who also found that among the female substance abusers in his study, 37 per cent were out of curiosity.

Table 14: First Type of Substances Abused

Sl.No	Substance	Frequency	Percent
1	**Alcohol**	41	45.6
2	**No 4 (Heroin)**	11	12.2
3	**Cough Syrup**	10	11.1
4	**Dendrite**	8	8.9
5	**Marijuana**	5	5.6
6	**Correcting Fluid**	5	5.6
7	**Proxyvon**	5	5.6
8	**Pills**	5	5.6
	Total	**90**	**100**

Source: Computed

Table 14 represents the first type of substances abused by the respondents. The table shows that less than half (45.6 %) reported that they first abused alcohol followed by more than a tenth (12.2%) who reported that they first abused No.4. A close 11.1 per cent of the respondents first abused cough syrup followed by less than a tenth of the respondents who first abused dendrite, marijuana, correcting fluid, proxyvon and pills.

Table 15: Reasons for Abusing Substances

Sl.No	Reasons	Frequency N=90	Percent N=100
1	**Experimentation**	59	65.6
2	**Peer Pressure**	37	41.1
3	**Experienced Abuse**	35	38.9
4	**Depression**	24	26.7
5	**Family Problems**	11	12.2
6	**Spouse pressure**	8	8.9
7	**Poverty**	6	6.7
8	**Environment**	4	4.4
9	**Abandonment**	4	4.4

Source: Computed

Table 15 shows the distribution of respondents according to the reason for abusing substances. It is evident from Table 13 that majority (65.6%) of the respondents abused substances because of experimentation. Less than half (41.1%) of the respondents reported that they abused substances because of peer pressure followed by 38.9 per cent of the respondents who reported that they abused substances as result of abuse experienced by them. Further more than a fourth (26.7%) of the respondents reported as having abused substances because of depression and more than a tenth (12.2 %) of them reported that it was because of family problems. Less than a tenth of the respondents reported that they abused substances because of spouse pressure, poverty, environment and abandonment.

The findings reflects the study of Malika et. al. (2015), who also found that 20 per cent of the respondents reported presence of childhood adverse experience (e.g. Physical abuse, sexual abuse & neglect).

Table 16: Present Type of Substances Abused

Sl.No	Substances	Frequency N=90	Percent N=100
1	**Alcohol**	66	73.3
3	**No 4 (Heroin)**	43	47.8
2	**Marijuana**	18	20.0
4	**Cough Syrup**	14	15.6
5	**Dendrite**	8	8.9
6	**Parvon**	8	8.9
7	**Pills**	4	4.4
8	**Correcting Fluid**	3	3.3

Source: Computed

Table 16 represents the distribution of respondents according to the present types of substances abused by them. The table shows that the respondents abused multiple types of substances. Among the substances abused, majority (73.3%) abused Alcohol followed by less than half (47.8%) of the respondents who abused No 4. More than a fifth (21.1%) of the respondents abused marijuana while more than a tenth of the respondents abused cough syrup. Less than a tenth of the respondents abused dendrite, parvon and pills.

Table 17: Frequency of Substance Intake per Week

Sl.No	Frequency	Substances							
		Alcohol N=66	No. 4 (Heroin) N=43	Marijuana N=18	Cough Syrup N=14	Dendrite N=8	Parvon N=8	Pills N=4	Correcting Fluid N=3
1	1-3 Days	7 (10.6)	1 (2.3)	3 (16.7)	2 (14.3)	2 (25.0)	1 (12.5)	0 (0.0)	1 (33.3)
2	3-6 days	14 (21.2)	5 (11.6)	3 (16.7%)	1 (7.1)	2 (25.0)	1 (12.5)	0 (0.0)	0 (0.0)
3	Everyday	32 (48.5)	28 (65.1)	6 (33.3)	9 (64.3)	2 (25.0)	3 (37.5)	4 (100.0)	1 (33.3)
4	Subject to availability of any amount	13 (19.7)	9 (20.9)	6 (33.3)	2 (14.3)	2 (25.0)	3 (37.5)	0 (0.0)	1 (33.3)

Source: Computed *Figures in parenthesis indicates percentages*

Table 17 represents the distribution of respondents according to the respondent's frequency of substance intake per week. The table shows that among the respondents who abused alcohol, almost half (48.5%) of them consumed alcohol everyday followed by more than a fifth (21.2%) who consumed3-6 days a week. A close19.7 per cent of those who abused alcohol consumed whenever it was available and a tenth (10.6%) of them consumed 1-3 days a week. Among the respondents who abused No.4, majority of them (65.1%) took it every day followed by a fifth (20.9%) of them took it whenever it was available. More than a tenth (11.6%) of those who abused No 4 took it 3-6 days a week and a few (2.3%) of them took it 1-3 days a week. Moreover, among the respondents who abused marijuana, a third (33.3%) of them total smoked everyday and another third (33.3%) smoked whenever available. They were followed by a sixth (16.7%) of those who abused the same who smoked 1-3 days a week and another sixth (16.7%) who smoked 3-6 days a week. Among those who abused cough syrup, the table shows that majority (64.3%) of them consumed it every day followed by more than a tenth (14.3%) of them who consumed it 1-3 times a week and another 14.3 per cent who consumed it whenever available. Less than a tenth (7.1%) consumed it 3-6 days a week. Among those respondents who abused dendrite, equal number of respondents (25% each) took the substance every day, 1-3 days a week, 3-6 days a week and whenever available. Further, among the respondents who abused parvon, equal number of respondents (37.5% each) consumed it everyday and whenever available while another equal number of them (12.5% each) consumed it 1-3 days a week and3-6 days a week. Among the respondents who abused pills, all of them abused it every day and last but not the least, among those who abused correcting fluid equal number of respondents (33.3% each) took it every day, 1-3 days a week and whenever available.

Table 18: Dosage per intake of Alcohol

Sl.No	Dosage	Frequency	Percent
1	**1-6 Glass**	35	53.0
2	**Subject to availability of any amount**	14	21.2
3	**¼ - ½ Bottle**	11	16.7
4	**1 Bottle**	3	4.5
5	**1 ½ Bottle**	3	4.5
	Total	**66**	**100**

Source: Computed

Table 18 shows the distribution of respondents according to their dosage per intake of alcohol. From the table, we see that more than half (53%) of the respondents consume one to six glasses per intake while more than a fifth (21.2%) of them drink subject to availability of any amount. A sixth (16.7%) of them drink ¼ - ½ bottle per intake foll0wed by an equal number of respondents (4.5% each) who drink 1 bottle and 1 ½ bottle per intake.

Table 19: Dosage per intake of No.4 (Heroin)

Sl.No	Dosage	Frequency	Percent
1	**½ - 2 Bottle caps**	27	62.8
2	**Subject availability of any amount**	11	25.6
3	**2-4 Bottle Caps**	5	11.6
	Total	**43**	**100**

Source: Computed

Table19 represents the dose of the respondent's per intake of No 4. The table shows that majority of the respondents take ½ - 2 bottle caps per intake while more than a fourth (25.6%) of them take it subject to availability of any amount. More than a tenth (11.6%) of the respondents who abuse No 4 take 2 – 4 bottle caps per intake.

Table 20: Dosage per intake of Marijuana

Sl.No	Dosage	Frequency	Percent
1	**4-6 drags**	10	55.5
2	**1-3 drags**	3	16.7
3	**7 and Above drags**	3	16.7
4	**Subject to availability of any amount**	2	11.1
	Total	**18**	**100**

Source: Computed

Table 20 shows the respondent's dose of marijuana per intake. From the table, we see that more than half (55.5%) of those respondents who abuse marijuana smoke 4-6 drags per intake. Equal number of respondents (16.7% each) smoke 1-3 drags and 7 and above drags per intake while more than a tenth (11.1%) of them smoke subject to availability of any amount.

Table 21: Dosage per intake of Cough Syrup

Sl.No	Dose	Frequency	Percent
1	**½ - 2 Bottles**	4	28.6
2	**2-4 Bottles**	3	21.4
3	**4 - 6 Bottle**	3	21.4
4	**6 – 8 Bottles**	2	14.3
5	**Subject to availability of any amount**	2	14.3
	Total	**14**	**100**

Source: Computed

Table 21 shows the distribution of respondents according to their dosage per intake of cough syrup. From the table, we see that more than a fourth (28.6%) drink ½ - 2 bottles of cough syrup per intake followed by an equal number (21.4% each) of them who drink 2-4 bottles and 4-6 bottles per intake. Another equal number of respondents (14.3% each) drink 6-8 bottles and subject to availability of any amount.

Table 22: Dosage per intake of Dendrite

Sl.No	Dose	Frequency	Percent
1	**2 Cubes and Below**	6	75.0
2	**3-4 Cubes**	1	12.5
3	**Whenever Available**	1	12.5
	Total	**8**	**100**

Source: Computed

Table 22 shows the distribution according to the dosage per intake of dendrite. The table indicates that majority of the respondents who took dendrite take 2 cubes and below per intake followed by an equal number (12.5% each) of them who take 3-4 cubes per intake and subject to availability of any amount.

Table 23: Dosage per intake of Parvon

Sl.No	Dosage	Frequency	Percent
1	**3-6 Capsules**	7	87.5
2	**1-3 Capsules**	1	12.5
	Total	**8**	**100**

Source: Computed

Table 23 highlights the distribution of the respondents according to the dosage per intake of parvon. From the table we see that among those who abused parvon, majority of them consume 3-6 capsules per intake while more than a tenth (12.5%) of them consume 1-3 capsules per intake.

Table 24: Dosage per intake of Pills

Sl.No	Dosage	Frequency	Percent
1	**6 - 8 Pills**	2	50.0
2	**1 – 2 Strips**	2	50.0
	Total	**4**	**100**

Source: Computed

Table 24represents the dose of pills taken by the respondents per intake. The table shows that an equal number (50% each) of those who abuse pills take 6-8 pills per intake and 1-2 strips per intake. The study by UNODC (2004) stated that women are more likely to use pharmaceutical drugs, both illicit and prescribed drugs

Table 25: Dosage per intake of correcting fluid

Sl.No	Dosage	Frequency	Percent
1	**1-2 Bottle**	3	100.0
	Total	**3**	**100**

Source: Computed

Table 25 shows the distribution of the respondents according to their dosage per intake of correcting fluid. The table shows that all those who abuse correcting fluid take 1-2 bottles per intake.

4.3. Challenges and Coping Strategies relating to Substance Abuse

Table 26: Challenges

Sl.No	Problems	Frequency (N=90)	Percent (N=100)
1	**Physical Health**	65	72.2
2	**Mental Health**	65	72.2
3	**Family Problems**	56	62.2
4	**Problems in community**	44	48.9
5	**Financial Problems**	28	31.1
6	**Work Related Problems**	21	23.3
7	**Problems in studies**	20	22.2
8	**Stigma and Discrimination**	20	22.2

Source: Computed

Table 26 represents the challenges faced by the respondents resulting from their substance abused. From the table, we see that the respondents have multiple challenges. Among the challenges, majority (72.2%) of the respondents have physical and mental health challenges followed by more than half (62.2%) of the respondents who face family problems. Almost half (48.9%)of the respondents face problems in community and less than a third (31.1%) of them have financial problems. We also find that equal number of respondents (22.2% each) face problems in their studies and experience stigma and discrimination.

These findings can be related to the study by Amaro et al, who in their study found that a significant majority (80%) from the respondents reported a childhood history of abuse and mental health problems (76%) and health problems (68%).

Table 27: Coping Strategies

Sl.No	Strategies	Frequency (N=90)	Percent (N=100)
1	**Suffer Alone**	90	100.0
2	**Getting High**	28	31.1
3	**Seeking Medical Help**	28	31.1
4	**Socializing with friends**	13	14.4
5	**Getting angry**	7	7.8
6	**Praying**	6	6.6
7	**Borrowing money**	1	1.1

Source: Computed

Table 27 shows the distribution of the respondents according to their coping strategies when faced with challenges because of substance abuse. The table shows that all (100%) of the respondents cope with their challenges by suffering alone followed by an equal number of them (31.1 % each)who cope with their challenges by getting high and seeking for medical help. More than a tenth (14.4%) of them cope by socializing with their friends and less than a tenth (7.8%) of them cope by getting angry. There were those (6.6%) who cope by praying and very few (1.1%) cope by borrowing money.

4.4 Institutionalization Particulars and Perception on the Programs and Services offered by the Institution

This section will highlight the particulars relating to the institutions, their nature, admission particulars of the respondents and their perception on the programs of the institutions.

Table 28: Institution Particulars

Sl.No	Nature	Frequency	Percent
1	**Government**	1	25.0

2	**Non-Government**	3	75.0
		4	100.0

Source: Computed

Table 28 shows the distribution of the institution according to their nature of functioning. The table shows that only one (25%) institution functions as a government undertaking while the rest (75%) functions as a non-governmental unit.

Table 29: Admission Particulars

	Year of Admission	**Frequency**	**Percent**
I	2016	88	97.8
	2015	2	2.2
II	**Reason for Admission**		
	Family Pressure	52	57.8
	For want of abstinence	35	38.9
	Community pressure	2	2.2
	Doctor's pressure	1	1.1
III	**Admitted By Whom**		
	Family	67	74.4
	Self	22	24.4
	NGOs	1	1.1
IV	**Duration of Stay**		
	One - Three Months	30	33.3
	Three - Six Months	29	32.2
	Six - Nine Months	18	20.0
	Nine months and above	13	14.4

Source: Computed

Table 29 highlightsthe admission details of the respondents in all the institutions. From the table, we see that with regards to the year of admission, majority (97.8%) were admitted in the year 2016 while only a few (2.2%) were admitted in 2015. With regards to the reason for admission to the institution, more than half (57.8%) were admitted because of family pressure followed by more than a third (38.9%) of the respondents who were admitted

because of want of abstinence. Only a few respondents (2.2%) were admitted because of community pressure and 1.1 per cent were admitted because of doctor's pressure.

Table 30: Perception on Services and Programmes

Sl.No	Statements	Mean	Std. Deviation
1	**Workers are efficient**	2	1
2	**The home environment is good**	2	1
3	**Quality of food is good**	2	1
4	**The home provides good services for abstinence**	2	1
5	**The home provides good services for me to reintegrate in the community**	2	1
6	**My spiritual need is being taken care of properly**	1	1
7	**Counselling provisions are available to take care of my Mental health**	1	1
8	**I have stopped taking drugs because of the services provided in the home**	1	1
9	**The home provides good services in gender sensitivity**	1	1
10	**Vocational services are provided**	1	1
11	**The home provides services to improve my relationship with my family**	1	1
12	**Health professionals take good care of my Physical Health**	1	1
13	**Average Total**	2	1

Source: Computed

Table 30 represents the perception of the respondents on the services and programmes offered by the institution. The perception of the programmes were measured by using 4 point scale such as Totally Disagree=0, Disagree=1, Agree=2 and Totally Disagree=3. These scales were measured through 12 positive statements about the quality and quantity of services provided in the institutions. From the table, we find that programmes and services related to workers efficiencies, home environment, quality of food, services for abstinence and reintegration were good according to the perception of the respondent's. However, the services and programmes relating to spiritual care, availability of counselling provisions,

abstinence as a result of services provided, gender sensitivity, provisions of vocational services, services for improvement of relationship with family and physical health provisions were not good according to the perception of the respondents. But when the average mean was calculated, we find that the overall services provided by the institution is good.

4. 3 Challenges and Coping Strategies relating to Institutions

Table 31: Challenges faced in Institution

Sl.No	Challenges	Frequency (N=90)	Percent (N=100)
1	**Mental health challenges**	49	54.4
2	**Physical health challenges**	29	32.2
3	**Difficulty in changing behaviour**	20	22.2
4	**Boredom**	20	22.2
5	**Withdrawal symptoms**	18	20.0
6	**Difficulty in improving family relationship**	7	7.8

Source: Computed

Table 31 represents the challenges faced by the respondents in the institutions. From the table we see that the respondents reported multiples challenges. Among the challenges faced, we find that more than half (54.4%) of the respondents face mental health challenges followed by less than a third (32.2%) of them who face physical health challenges. There were equal number of respondents (22.2% each) who face challenges relating difficulty in changing behaviour and boredom. A fifth (20%) of the respondents reported that they suffer from withdrawal symptoms and less than a tenth of the respondents reported that they face difficulty in improving family relationship.

Table 32: Coping Strategies of challenges faced in institutions

Sl.No	Strategies	Frequency (N=90)	Percent (N=100)
1	**Suffer alone**	59	65.6
2	**Acceptance**	28	31.1
3	**Praying**	26	18.9
5	**Sharing with friends**	8	8.9
6	**Cold turkey**	4	4.4
7	**Singing**	4	4.4
8	**Reading books**	4	4.4
9	**Health Check-up**	3	3.3
10	**Exercising**	1	1.1

Source: Computed

Table 32 shows the different strategies that the respondents used to cope with the challenges faced within the institution. From the table, we see that majority (65.6%) of them suffer alone while less than a third (31.1%) of them cope by accepting their challenges. Less than a fifth (18.9%) of the respondents resort to prayer as their coping mechanism and less than a tenth (8.9%) share with friend when faced with challenges. Equal number of respondents (4.4% each) cope by cold turkey, singing and reading books. A few (3.3%) go for health checkup while a very few of them (1.1%) exercise.

4.3.1 Focus Group Discussion

A Focus Group Discussion was also conducted in order to generate participation and understand better the challenges faced by the respondents in the institutions and society and the coping strategies used by them to solve their challenges. The group discussion was conducted among ten female substance abusers each from three Institutions. The findings are under the following points:

4.3.1.1 Challenges Faced

1) They face various problems in the society thatis attached to stigma and discrimination. Because of this, most of the respondents felt alienated and isolate themselves from the community and church activities.

2) There is no proper social support in the society concerning the female substance abusers.

3) They face problems in their family. Either they were neglected in decision-making and in times of health problems or they were thrown out from their house.

4) They experience abuse and assault from their partners or spouse.

5) They face adjustment problems in the institutions.

6) They also face health problems as the institution does not provide proper health facilities.

7) They are not content with the counseling services provided in the institutions.

8) There was no scope to improve their relations with their family because of lack of services for family reintegration.

4.3.1.2 Coping Strategies

1) They isolate themselves from others.
2) They read books, newspapers or magazines.
3) They pray.
4) They share their problems with their friends in the institutions.
5) Some just suffer alone quietly.
6) Others inform their problems to the workers of the institutions.

Table 33 Suggestions to improve services and programmes

Sl.No	Suggestions	Frequency (N=90)	Percent (N=100)
1	**Regular Counselling Services**	33	36.7
2	**Family Reintegration programmes**	32	35.6
3	**Improving Vocational Training Programmes**	24	26.7
5	**Proper Health Services**	19	21.1
6	**Improve quality of food**	12	13.3
7	**Adequate water supply**	9	10.0
8	**Equal treatment by workers**	8	8.9
9	**Services for spiritual development**	5	5.6
10	**Proper Recreational Programmes**	5	5.6
11	**Gender Sensitive programmes**	4	4.4

Source: Computed

Table 33 represents the distribution of respondents according to their suggestions to improve the services and programmes of the institutions. The table shows that the respondents gave multiple suggestions. Among the suggestions made by them, more than a third (36.7%) of the respondents suggested for regular counseling services while a close 35.6 per cent of them suggested for family reintegration programmes. More than a fourth (26.7%) suggested for improvement of vocational training programmes and more than a fifth (21.1%) suggested for proper health services. Further, more than a tenth (13.3%) of the respondents suggested for improvement in the quality of food and a close tenth (10%) suggested for adequate water supply. There were also those respondents (8.9%) who suggested for equal treatment by workers and those (5.6% each) who suggested for services for spiritual development and proper recreational programmes. Last but not the least, 4.4 per cent of the respondents also suggested for fender sensitive programmes and services.

4.4 Case Vignettes

In-depth interviews were conducted in order to understand the lived experience of the female substance abusers. These interviews were conducted with three female substance abusers from different institutions. They are presented as under.

4.4.1 Case 1

Mawii (fictitious) is a 21-year-old female who lived with her mother in one locality in Aizawl. Mawii was born out of wedlock and she was told that her father married another woman to form a different family. Her mother was an alcoholic and earned her living by selling illicit alcohol and heroin(locally called No.4). Her mother is only in her late 30s and she is a beautiful attractive woman as described by Mawii. Because of this, Mawii said that her mother's customers often slept around with her.

Mawii passed Class 12 and continued her studies in a reputed college in Aizawl until she got pregnant and dropped out from college. It seemed that the fate that her mother experienced in the past cycled in Mawii's life because her boyfriend did not want to marry her too. There was not much attention from her mother as she had a problem of her own. Much to her dismay, she also learnt that her boyfriend had another girlfriend whom he also made pregnant. She was saddened by this news and to cope with her depression she started abusing alcohol and eventually she resorted to drugs and soon after she became dependent on the drug she took, to become an addict. It seemed as if her misery clutched her to the core when she found out that she was HIV positive during the 6^{th} month of her pregnancy.

After this horrific news, she withdrew herself from society and friends and alcohol and heroin became her only strategy and friend to cope with her problems. It seemed that Mawii's tragedy would never end when she again found out that she had a miscarriage a few months later. She was deeply hurt, lonely bored and depressed. Finally, she decided that this was enough and for want of change and abstinence from her addiction, she decided to admit herself in a rehabilitation centre. During her stay, she recalled that, because of her determination, her addiction subsided slowly. She was also happy to learn that her mother had entered a camp to change her behavior during her institutionalization. Her mother often visited her in the centre she was placed in and this improved their relationship to a great deal. She finally felt a sense of ease in her life and after 9 months of stay in the institution, she was released to live with her mother who has changed her behavior and trade. Till now, they have not relapsed and her mother earns a living by opening up a small petty business shop in their house. Presently, Mawii is under Anti-Retroviral Therapy and goes to one centre every Thursday to treat herself.

4.4.1.1 Case Discussion of Case 1

This case shows how broken family affects the life of family members. Mawii's case is a perfect description of the effects and consequences of substance abusing parents that led to other problems such as pre-marital sex, early pregnancy, addiction and HIV/AIDs. However, from this case, we also learn that services that were available to rehabilitate both daughter and mother became a window for them to rehabilitate themselves.

4.4.2 Case 2

Mami (fictitious), a 25-year-old female, lived in a village far from the Capital city of Aizawl. She was the only child of her parents. She studied till the middle school level and dropped out after that. Her father passed away when she was 20 years old and soon after his death, her mother was diagnosed of cancer. Since the stage of cancer was already late, her treatment had little effect. Besides this, their poverty restricted them from getting the proper treatment for cancer. Her mother died after two years of her father's death. After the ill fate that befell Mami, she had to live with her close family friend whom she calls her uncle. Her uncle earns his living by driving a Sumo and supports both him and Mami. Her uncle looked after her with care and understanding until a year passed when he started coming home drunk. He would attempt to seduce her for sexual intercourse and when she refused, he would physically abuse her and threaten her that if she refused, he would throw her out of the house. Somehow, Mami was able to escape his sexual intentions until one day when he brought home a grape wine and forced her to drink. She eventually got drunk and her uncle took advantage of the situation, touched her, and ultimately forced himself into her. She recalled that she had no more strength and sense to escape the horrid incident.

The incident kept on repeating after the first and every time she refused, her uncle would abuse her physically and threaten her. This kept on for two years long and she became helpless and depressed. Eventually, she became an alcoholic. Soon after, she learnt that she was 4 months pregnant. Having learnt about this news, her uncle forced her to have an abortion to which she refused bluntly. Her uncle then decided to place her in an institution where they looked after female substance abusers. When he admitted her, she was drunk and not in her senses. She related that during her admission to the institution, her uncle had informed the authorities that she was just known to him from his village and since she had no one to look after her, he helped her to go to the institution. After her placement, she had a medical check-up where she eventually found out that she was HIV positive. Nevertheless,

the institution accepted her and rehabilitated her. She bore a son soon after, and fortunately, her son was negative much to her happiness.

Her son is 5 years old now and they live in the institution where she works as a volunteer. The institution supports her and her 5-year-old son. She wishes to leave the institution and start a business where she can support herself and her son.

4.4.2.1Case Discussion of Case 2

The case of Mami depicts how early death of parents increases the vulnerability of females. With no one to look after her, she had to be under the custody of her close family friend who became the reason for her misery. Persistent abuse, harassment and forced intimation led Mami to a situation beyond her control that eventually made her an alcoholic and HIV positive patient. What seemed as a never-ending torment ended when her uncle decided to admit her on false pretext. The institution she was placed in eventually became her home and safe ground in terms of her and her child health. Here, we also see that instructions do play supporting roles for traumatic females to rehabilitate themselves.

4.4.3 Case 3

Lali (Fictitious) is a 49 year old, recovering addict and an HIV positive patient. She has had two marriages and has been divorced from her first marriage where she had one son who is now 20 years of age. Her former husband was a heroin addict and an alcoholic. She recalled that they divorced not because of any problems they faced. It was a sole mutual understanding.

She remarried eventually with her second husband and settled in the outskirt of Aizawl city with their 12-year-old daughter. Lali and her husband earned their living by brewing and selling illicit liquor. However, trade did not generate enough income to support the family. Knowing this, Lali's sister invited them to take part in her more profitable business of smuggling drugs and selling liquor. They eventually agreed to her invitation and helped her sister's trade of smuggling drugs from Champhai district besides their additional income from selling illicit liquor. They found that their participation in her sister's trade was profitable as her sister promised and they were more stable financially.

Having involved herself in drug smuggling, her sister would often tempt her to experiment on the drugs they smuggled. However, she would refuse with every invitation. One day, they had a small feast and she experimented on parvon, an illicit drug smuggled in parts of Mizoram. The effect was such that Lali did not enjoy at all. She vomited and had a serious headache. She slept for two whole days. Her sister told her that she would get better if

she injects herself with heroin. She did as told and she found that the effect was much better than that of parvon. The drug stimulated her to work the whole day without getting tired. The next day her sister injected her with the same drug and she felt refreshed and energetic much to the liking of her sister who felt that it stimulated her to be active in household chores and her work. Sometimes, when her sister would tempt her to use the drug, she would fight with her but eventually, she became dependent on heroin. During this event, her husband was caught doing their illicit trade and was sent to jail where he stayed for 7 months. Even after he was bailed, they continued to help her sister for four long years.

Her health began to deteriorate and when she had a health checkup, her blood tested positive. The doctor referred her to an institution where they looked after female substance abusers and HIV positive patients as she was still dependent on the drug. After her admission she suffered from withdrawal symptoms. As there were no services for detoxification, she went cold turkey much to her agony.

She has been staying in the institution for six months now and her health status is improving. She wishes to stop her habit and addiction for want of a drug-free-life with her husband and child. Since her admission to the institution, there was no sign of her sister's concern and lost contact with her. She was angry and hurt at her sister and said that even if she goes out from the institution she will not contact her ever again. She regrets her life and blames her sister for her ordeal and still regrets the fact that she started entering a drug life very late when she was 46 years old.

4.4.3.1 Case Discussion of Case 2

This case highlights how poverty as well as environment increases scope for woman's vulnerability to become associated not only in addiction but also in the trade itself. There was not much chance for Lali to have a choice of her own. Her sister's persistent in tempting her to take drugs as well as her husband's dependence on drug reveal the fact that the environment that she lived in eventually led her to addiction as well as to be positive. Like other cases, institutions again were a window for her to be treated and get proper shelter for her treatment against her addiction and her health.

4.4.3.2Analysis of Three Cases

The three cases above depicts the extreme vulnerability of the girl child as well as females because of factors relating to substance abusing parents, early death of parents, poverty and environment that leads to a series of other social problems that female face

which include pre-marital sex, early pregnancy, physical , sexual and emotional abuse, depression, addiction and HIV/AIDs.

The cases also show that female substance abusers face multi-faceted problems because of their experience in life. Further, we are also able to find that from the cases, services provided by institutions became a safe haven for the females to rehabilitate themselves.

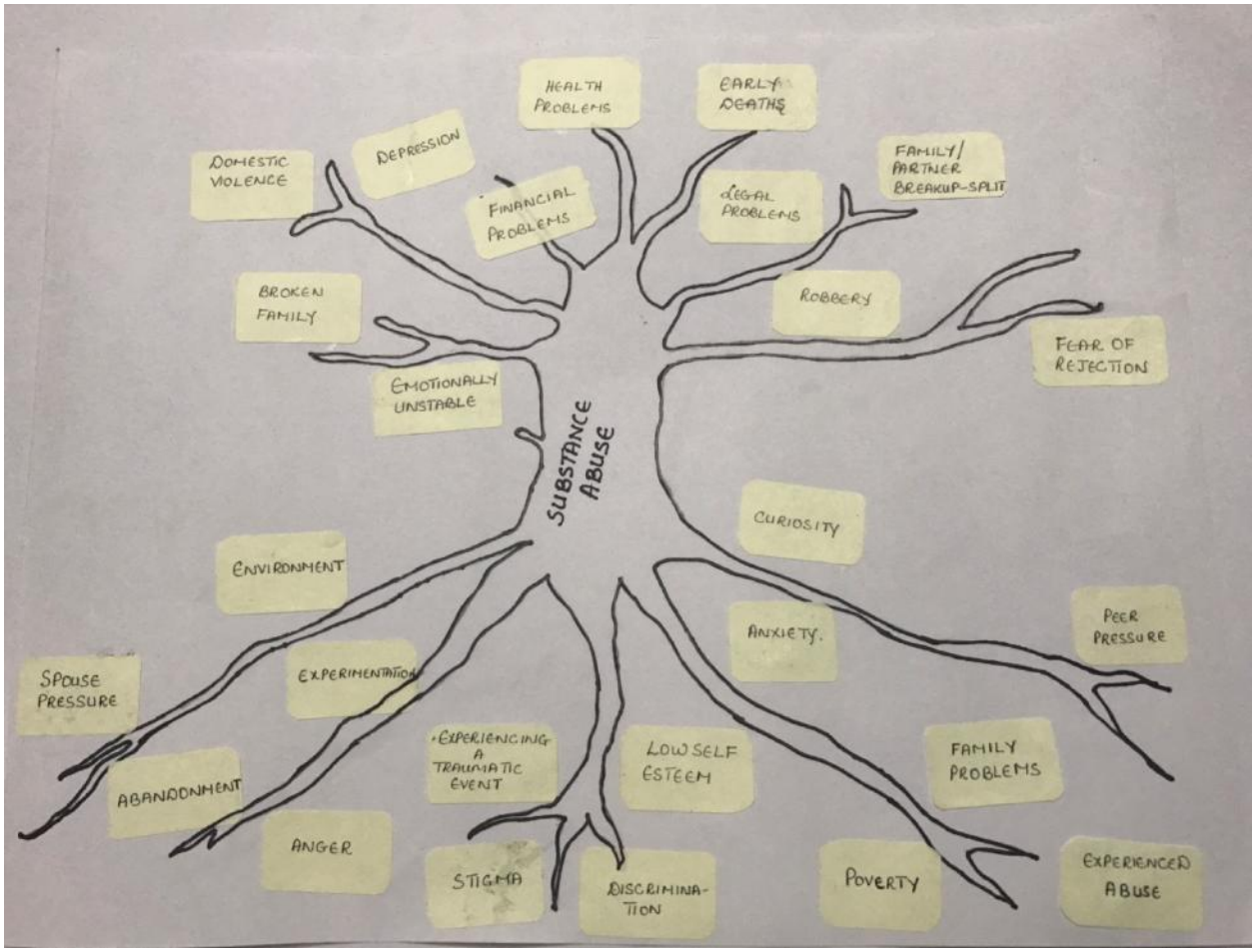
4.5Participatory Techniques

This section shall highlight the findings from participatory techniques that was used during the research process. Two techniques such as causal tree analysis and daily activity schedule.

4.5.1 Causal Tree Analysis

A causal tree analysis was conducted with ten female respondents in institution I.

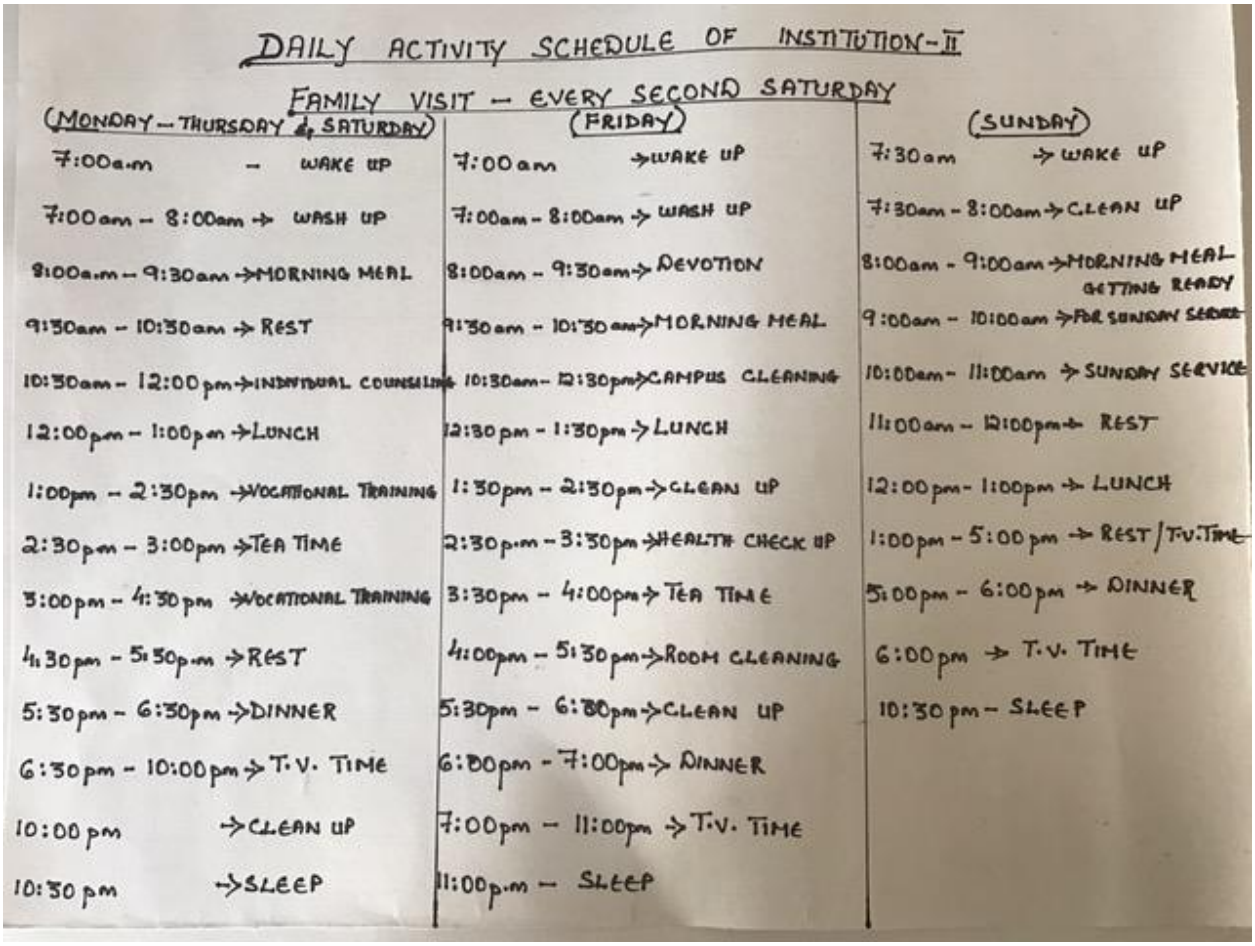
Figure 1: Causal Tree Analysis



4.5.2 Daily Activity Schedule

A daily activity schedule was conducted among the female respondents of institution I.

Figure 2: Daily Activity Schedule



CHAPTER V

CONCLUSION

CONCLUSION

The study attempts to profile the socio-demographic characteristics of female substance abusers under institutional care, identify the reasons for substance abuse, understand the pattern of substance abuse, find out their perception on the programmes and services offered by the institution and the challenges and coping strategies faced by them.

Substance Abuse is a real problem in many parts of the world. It not only causes pain and suffering for the individuals involved, but also those around them and society as a whole.Substance abuse among women in India is increasing and it has significant impact on their health and well-being. Despite being a fast growing problem, substance abuse among women has not been examined in detail in India let alone in Mizoram and with this in mind the study attempts to profile the socio-demographic characteristics of female substance abusers under institutional care, identify the reasons for substance abuse, understand the pattern of substance abuse, find out their perception on the programmes and services offered by the institution and the challenges and coping strategies faced by them.

The status of women in Mizoram is still poor despite the high literacy percentage in Mizoram. Women are often neglected and abused and as a result, they tend to resort to substance abuse. Voices of women are not heard especially in a patriarchal society like Mizoram. Family situations, high divorce rates, high incidence rate of child abuse, interpersonal difficulties and the non-existence of proper rehabilitation centres exclusively for women, lack of trained professionals such as de-addiction specialist, marriage therapist, as well as psycho social services of psychiatric settings increases vulnerability of women in Mizoram.

The study is Exploratory in design and cross sectional in nature. Mixed research methods i.e. quantitative and qualitative methods are used for the study. The study was conducted within Aizawl City.Data was collected from both primary and secondary Sources. Primary sources were collected from the female substance abusers placed under institutional care and secondary sources were collected from government and non-governmental records.

A semi-structured interview schedule formed the tool for data collection to collect information with regard to the objectives of the study. Focus Group Discussion and Participative techniques were also used to collect information. An in-depth interviews was also conducted to understand the lived experience of the respondents. Data were analyzed by using Microsoft Excel and SPSS Package. Descriptive analysis was used to highlight the findings of the study. Case vignettes are also presented to understand the lived experiences of

female substance abusers under institutional care.Purposive sampling procedure was used. The sample size consists of only females aged between 15-40 years. The sample was selected from institutional settingsproviding rehabilitation services to female substance abusers within Aizawl City.

5.1Major Findings

The study was able to generate relevant findings about female substance abusers in Aizawl, Mizoram. The major findings are under the following points:

Most of the respondents were from the adolescent and young adult age group.

i) Majority of the female substance abusers were from the Lusei sub-tribe.
ii) Almost all of the respondents were literate.
iii) Nearly half of the respondents belong to the Presbyterian denomination.
iv) Majority of the respondents reached the high school and the higher secondary level. Very few were graduation above.
v) Majority of the females are from urban areas.
vi) Half of the respondents were unmarried while a significant amount were divorced, married and widowed.
vii) Majority of the respondents were unemployed.
viii) With regards to the family characteristics, almost all of the respondents were from nuclear families, more than half of them were from stable family, and a significant amount from broken and reconstituted family.
ix) Family income ranged from rupees 5000 to 40,000 and above.
x) Most of the respondents are from the APL category, while a significant amount does not know their socio-economic category and are BPL.
xi) More than a third of the respondents have family members who abused substance. Among whom their sibling is the highest.
xii) Age at first intake started when they were adolescent and young adult age group.
xiii) Peers and friends were the primary motivators for abusing substances.
xiv) Almost half of the respondents abused alcohol first followed by heroin, cough syrup, dendrite, marijuana, correcting fluid, proxyvon and pills.
xv) The major reason for abusing substance were experimentation, peer pressure, experiencing abuse in the past, depression followed by family problems, spouse pressure, poverty, environment and abandonment.

xvi) Majority of the respondents presently abuse alcohol followed by heroin, marijuana, cough syrup, dendrite, proxyvon, pills and correcting fluid.

xvii) Almost half of the alcohol abusers drink everyday in a week.

Majority of the respondents who abuse heroin take it everyday in a week.

xviii) A third of those who abuse marijuana smoke everyday and subject to availability of any amount.

xix) Among those who abuse cough syrup, majority of them take it everyday.

xx) More than fourth of the respondents each take dendrite 1-3 days a week, 3-6 days week, everyday and subject to availability of the amount.

xxi) More than a half of those who abuse parvon take it everyday and subject to availability of any amount.

xxii) All those who abuse pills abuse it everyday.

xxiii) A third of those who abuse correcting fluid, each take it 1-3 days a week, everyday and subject to availability of any amount.

xxiv) Among those who abuse alcohol, more than half of them drink 1-6 glasses per intake.

xxv) Majority of those who abuse heroin take ½ - 2 bottle caps per intake.

xxvi) More than half of the respondents who abuse marijuana smoked 4-6 drags per intake.

xxvii) More than a fourth of those who abuse cough syrup take ½ - 2 bottles per intake.

xxviii) Majority of those who abuse dendrite take 2 cubes and below per intake.

xxix) Majority of those who abuse parvon take 3-6 capsules per intake.

xxx) Equal numbers of respondents who abuse pills take 6-8 pills and 1-2 strips per intake.

xxxi) All those who abuse correcting fluid take 1-2 bottles per intake.

xxxii) Challenges as a result of abusing substances includes physical health challenges, mental health challenges, family problems, problems in community, work related problems, problems in studies, stigma and discrimination. The coping strategies for these challenges include suffering alone, getting high, seeking medical help, socializing with friends, praying and borrowing money.

xxxiii) Most of the institutions where the females are placed are looked after by non-government organization.

xxxiv) Almost all the respondents were admitted in 2016. Reasons for admission were family pressure, for want of abstinence, community pressure and doctor's pressure. Majority of them were admitted by their family followed by self admission and NGOs. Their duration of stay in the institution range from 1-9 months and above.

xxxv) Perception of services and programmes of the institution were good in relation to workers efficiency, home environment, quality of food, provisions for abstinence and provisions of re-integration in the community while the scale of perception was low with regards to provisions for spiritual development, counseling provisions, abstinence programme, gender sensitivity, vocational services, provisions for family relationship building, and provisions of health. Overall, the scale of perception was high with regards to services and programmes of all the institution.

xxxvi) The challenges faced in the institution include mental health challenges, physical challenges, difficulty in changing behaviour, boredom, withdrawal symptoms and difficulty in improving family relationship. The coping strategies used when facing these challenges include suffering alone, accepting, sharing with friends, cold turkey, singing, reading books, health check-up and exercising.

xxxvii) Findings in the focus group discussion reveals that female substance abusers have no proper social support, negligence from the family, abuse from partner and spouse, adjustment problems, health and mental health related problems and problems relating to family re-integration.

xxxviii) The respondents suggest improving services and programmes in the institutions include regular counseling services, family re-integration programmes, proper health services, improvement in quality of food, adequate water supply, equal treatment by workers, services for spiritual development, proper recreational programmes and gender specific programmes.

xxxix) From the in-depth interview, we are able to see certain risk factors such as substance abusing parents, early death of parents, poverty and environment as mediating factors for females to abuse substances that directly or indirectly lead to consequences, of other social problems faced by female substance abusers such as pre-marital sex, early pregnancy, physical sex and emotional abuse, depression, addiction and HIV/AIDs. Another interesting finding reveal that institutions in Mizoram act as a safe haven for females to escape from their horrid lives and rehabilitate themselves and re-integrate themselves with their family.

5.2 Suggestions

There should be more intervention on prevention among children, adolescents and young adults because significant of the respondents come from younger age group.

i) The Church must play roles in harm reduction programmes related to substance abuse.
ii) To reduce dropouts, social support must be strengthened.
iii) Community intervention programmes related to primary and secondary prevention must be initiated.
iv) Oral substitution therapy programmes must be strengthened to reduce addiction and frequency of drug abuse.
v) The State as well as civil society organizations must strengthen and improve harm reduction and supply reduction programme.
vi) Awareness on drug addiction as a disease must be initiated at the grass root level to reduce stigma and discrimination.
vii) Government organizations must increase their support by establishing centres for rehabilitating women abusing substances. Similarly support from society must be strengthened to improve interest in the care and rehabilitation of substance abusers.
viii) Institutions providing care and rehabilitation services must improve their services in the area of health, counseling, home visit, follow up and family reintegration programmes. Moreover, recreational facilities must be improved to garner interest from the clients.
ix) Family based prevention programs should be provided to parent(s), partner(s) and children to improve skills in relationship and communication among family members.
x) There is a need for new and improved drug abuse and addiction Treatment Centre and Counselingcentre that addresses to gender sensitivity. The absence of these facilities has sidelined the needs of female substance abusers and poses public health and safety risk.
xi) Appointment of full time Case Workers/Counselor in schools to address drug and alcohol abuse and physical and psychological issues among the children and also for family intervention.
xii) Improved training opportunities and skills of the staffs working in all rehabilitation and treatment centres in Mizoram.Based on the findings on the occupational status and suggestions that were given by the respondents, improved and marketable vocational skills training is crucial as an extended program.

There is great scope for social work intervention in the area of substance abuse. More interventions in the field of women welfare and drug addiction in the area of social work research can be undertaken.

APPENDICES

BIBLIOGRAPHY

Amaro, H., Nieves, R., Johannes, S.W., &Cabeza, N, M, L. (1999). Substance abuse treatment: Critical Issues and Challenges in the Treatment of Latina women. Hispanic Journal of Behavioural Sciences, 21(3), 266-282. doi: 10.1177/0739986399213005.

American Psychiatric Association (1994). Diagnostic and Statistical manual of mental disorders: DSM-IV. https://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/DSM4/

Becker, G. S., & Murphy, K. M. (1988).A Theory of Rational Addiction.Journal of Political Economy. The University of Chicago Press, 96 (4), 675-700. http://www.jstor.org/stable/1830469.

Benegal, V. (2005). India: Alcohol and Public Health. Society for the Study of Addiction, 100(8), 1051-1056. doi: 10.1111/j.1360-0443.2005.01176.x.

Berkman, L.F., Glass, T., Brissette, I., &Seeman, T.E. (2000). From social integration to health: Durkheim in the new millennium. Social Science and Medicine, 51(6), 843-857. doi: 10. 1016/S0277-9536(00)00065-4.

Brady, T.M., & Ashley, O.S. (2005). Women in Substance Abuse Treatment: Results from the Alcohol and Drugs Services Study (ADSS). http://H:/10.1.1.439.783%2010.pdf.

Brady, K.T., & Randall, C. L. (1999). Gender differences in substance use disorders. Psychiatric Clinics of North America, 22(2), 241-252. doi: 10.1016/S0193-953X(05)70074-5.

Compton, W.M., Thomas, Y.F., Stinson, F.S., & Grant, B.F. (2007). Prevalence, Correlates, Disability, and Comorbidity of DSM-IV Drug Abuse and Dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archive General Psychiatry*, 64 (5), 566-76. doi:10.1001/archpsyc.64.5.566.

Covington, S. (2007). Working with Substance Abusing Mothers: A Trauma-Informed, Gender-Responsive Approach. The Source, 16 (1), 1-11. http://www.centerforgenderandjustice.org/assets/

Covington, S., &Kohen, J. (1984).Women, Alcohol, and Sexuality. Advances in Alcohol & Substance Abuse, 4 (1), 41-56. doi: 10.1300/J251v04n01-05.

Engel, R.J., Schutt, R.K. (2005). The Practice of Research in Social Work. New Delhi: Sage Publications.

Greenfield, S.F., Back, S.E., Lawson, K. & Brady, K.T. (2010).Substance Abuse in Women. Psychiatric Clinics of North America, 33(2), 339-355. doi: 10.1016/j.psc.2010.01.004.

GOM (2007).Situational Assessment of Substance Abuse and IRCA Program in Mizoram.Aizawl, MSD&RB, Social Welfare Department, Government of Mizoram.

Halliday, R.S. (2009). An Evaluation of the Care Provided for Substance Abuse Addicts in Mizoram: Towards Developing an Appropriate Model of Care. New Delhi: Cambridge Press.

Heather, N., &Vuchinich, R. E. (2003).Choice, behavioural economics and addiction.Elsevier.https://books.google.co.in/books/

Hmingthanmawii (2000). A case study of Rescue Centre Annexe, Dilkawn, Sihphir, Mizoram (Unpublished practical work submitted in partial fullfillment of the requirement of the degree of Bachelor of Education). Mizoram University, Aizawl.

Johnson, E.M. (1974). Substance Abuse and Women's Health. Associations of Schools of Public Health, 102, 42-48. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1478037/

Joshi, B.K. (2011). Addiction and Substance. Jaipur: Pointer Publishers.

Kassebaum, P.A. (1999). Substance Abuse Treatment for Women Offenders: Guide to Promising Practices. U.S. Department of Health and Human Services.http://23-Substance-Abuse-Treatment-for-Women-Offenders-Guide-to-Promising- Practices-114%208.

Kermode, M., Songput, C.H., Sono, C.Z., Jamir, T.N., & Devine, A. (2012). Meeting the needs of women who use drugs and alcohol in North-east India–a challenge for HIV prevention services.BMC Public Health, 12(1), 825.doi: 10.1186/1471-2458-12-825.

Lake, S., & Kennedy, M.C. (2015). Health Outcomes Associated with Illicit Prescription Opioid Injection: A systematic review. *Journal of Addictive Diseases*, 35(2), 73-91. doi:10.1080/10550887.2015.1127712.

Lalnunthara.(1997). Factors Causing Drug Abuse in Mizoram.Aizawl: Hrangziki, RamhlunVengchhak.

Malik, K., Benegal, V., Murthy, P., Chand, P., Arun, K., &Suman, L.N. (2015). Clinical audit of women with Substance use Disorders: Findings and Implications. *Indian Journal of Psychological Medicine,* 37(2), 195.doi: 10.4103/0253-7176.155620.

Marshal, M.P. (2003).For better or for worse?The effects of alcohol use on marital functioning. Clinical Psychology Review, 23(7), 959-997. doi: 10. 1016/j.cpr/2003.09.002.

Murthy, P &Nikketha, S, B, S. (2007). Bangalore: NIMHANS, De-addiction Centre.

Neff, J.L., & Waite, D.E. (2007). Male versus female substance abuse patterns among incarcerated juvenile offenders: Comparing strain and social learning variables. Justice Quarterly, 24(1), 106-132. doi: 10.1080/07418820701201024.

Nebhinani, N., Sarkar, S., Gupta, S., Natu, S.K &Basu, D. (2013) Demographic and clinical profile of substance abusing women seeking treatment at a de addiction center in north India. Industrial Psychiatry Journal,22 (1), 12-16. doi: 10.4103/0972-6748.123587.

Niv, N., &Hser, Y.I. (2007). Women-only and mixed-gender drug abuse treatment programs: Service, needs, utilization and outcome. Drug and Alcohol Dependence, 87, 194-201. doi:10.1016/j.drugalcdep.2006.08.017.

O'Hare, T. (2005).Evidence-Based Practices for Social Workers. Chicago: Lyceum Books, Inc.

Ouimette, P.C., Moos, R.H. & Finney, J.W. (2000).Two-year mental health service use and course of remission in patients with substance use and post-traumatic stress disorders. Journal of Studies on Alcohol and Drugs, 61(2), 247-253. doi:10.15288/jsa.2000.61.247.

Pandey, S.K., Datta, D., Dutta, S., Verma, Y. &Chakradarti, A. (2015).Socio-economic and demographic characteristics of alcohol and other substance abusers, undergoing treatment in Sikkim, a north east state of India. Journal of Pharmacy &BioAllied Sciences, 7 (2), 151-155. doi: 10.4103/0975-7406.148778.

Prashant, S. (1993).Drug Abuse and Society. New Delhi: Ashish Publishing House.

Patricia, C.J., Robert, P.O., Sherry, S.H., & Maurice, D. (2000).Validation of a System Classifying Female Substance Abusers on the basis of Personality and Motivational Risks Factors for Substance Abuse. Psychology of Addictive Behaviours, 14 (3), 243-256. doi: 10.1037/0893-164X.14.13.243.

Prochaska&DiClemente (1983).Stages of Change Model/Transtheoretical Model.Retrieved from https://www.prochange.com/transtheoretical-model-of-behavior-change.

Schilit, Gomberg, E.S.L. (1991). Drugs and Behavior. New Delhi: Sage Publications.

Sekar, K., Parthasarathy, R., &Muralidhar, D. (2007). Bangalore: NIMHANS Publication No. 65.

Sharma, R.D, (1988). Research Methods in Social Sciences, New Delhi: A.H. Marwah for National Book Organisation.

Tochhawng, R. (1995). Problems of Drug Abuse in Mizoram and the Role of the Church. (Unpublished thesis submitted in partial fulfilment for the Bachelor of Divinity. AizawlThoelogical College, Aziawl.

Tuchman, E. (2010). Women and Addiction: The Importance of Gender Issues in Substance Abuse Research. *Journal of Addictive Diseases*.doi: 10.1080/10550881003684582.

Vannicelli, M. (1982).Barriers to treatment for alcoholic women. American Psychological Association, 5(1), 29-37. doi: 10.1016/0306-4603(95)00041-0.

WHO (1993). The ICD-10 classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research. http://www.who.int/classifications/icd/en/GRNBOOK.pdf

WHO Expert Committee on Drug Dependence. (2003). *WHO Expert Committee on Drug Dependence: thirty-third report* (Vol. 33). World Health Organization.

Female Substance Abusers under Institutional Care in Aizawl, Mizoram

Interview Schedule

(Confidential and for Research Purpose Only)

Research Scholar

Ms. ZodinlianiRalte ZodinlianaPachuau

M.Phil Scholar

Department of Social Work,

Mizoram University

Supervisor

Dr. Henry

Asst. Professor

Department of Social Work,

Mizoram University

Schedule Number : **Date :**

I. PERSONAL DETAILS

1. Name (Optional) :
2. Age :
3. Sub-Tribe : Lusei/Hmar/Paite/Mara/Lai/Other (_____)
4. Religion : Christian/Hindu/Muslim/Buddhist/Other (_____)
5. Religious Denomination :
6. Educational Qualification : Illiterate/Primary/Middle/High School/Higher Secondary/Graduate/Post Graduate
7. Address :
8. Marital Status : Married/Unmarried/Divorced/Widowed
9. Any Children? : Yes/No
10. If Yes? How many? :
11. Occupation : Unemployed/Govt. Service/Business/Daily Labour Farmer/Other(_____)

II. FAMILY DETAILS

12. Type of Family : Nuclear Family/Joint Family/Other
13. Form of Family : Stable/Broken/Reconstituted
14. Socio-Economic Category : AAY/BPL/APL/Don't Know
15. Father's Educational Qualification : Illeterate/Primary/Middle/High School

16. Mother's Educational Qualification	:	Illeterate/Primary/Middle/High School Higher Secondary/Graduate/Post Graduate
17. Father's Occupation	:	Unemployed/Govt. Service/Business/Daily Labour/ Farmer/Others(_____)
18. Mother's Occupation	:	Unemployed/Govt. Service/Business/Daily Labour/ Farmer/Others(_____)
19. Family Monthly Income	:	
20. Any Substance Abusers in the Family:		Yes/No
21. If Yes? Who?	:	Grandfather/Father/Mother/Sibling/Partner/ Cousin/Uncle/Other(_____)

III. SUBSTANCE ABUSE DETAILS

22. Type of Substance First Used	:	
23. Motivator	:	
24. Reason for Substance Abuse	:	Poverty/Experimentation/Peerssure/ Depression/Family Background/ Spouse/Environment/Abandonment/Sex Worker/Other(_____)

25. PATTERN OF SUBSTANCE ABUSE

SL.No.	Substance	Mode					Dosage per week	Dosage per use
		Smoke	Chew	Drink	Inhaling	Injection		
i	Alcohol							
ii	Marijuana							
iii	No 4							
iv	Methamphetamine							
v	Proxyvon							
vi	Cough Syrup							
vii	Dendrite							
viii	Parvon							
ix	Others(_____)							

26. CHALLENGES AND COPING STRATEGIES RELATING TO SUBSTANCE ABUSE

Sl.No.	Challenges	Coping Strategies
i	Physical health problems	
ii	Mental health problems	
iii	Problems in studies	

iv	Work related problems	
v	Financial problems	
vi	Family problems	
vii	Problems in community	
viii	Stigma and Discrimination	
ix	Others (_____)	

IV HOME PARTICULARS

27	Institution	
28	Owner	
29	Year of admission	
30	Reason for admission	
31	Admitted by whom	Self/ Family/ NGO /Government/Others (_____)
32	Duration of stay	

33. PERCEPTION ON THE PROGRAMMES AND SERVICES OFFERED BY THE INSTITUTION

Sl.No	Perception	Totally Disagree	Disagree	Agree	Totally Disagree
i	Institution environment is good				
ii	Workers are efficient				
iii	Quality of food is good				
iv	Health professionals take good care of my				

	physical health				
v	Counseling provisions are available to take care of my mental health				
vi	My spiritual needs are being taken care of properly				
vii.	The institution provides services to improve my relationship with my family				
vii.	The institution provides good services for abstinence				
viii	I have stopped taking drugs because of the services provided in the home				
ix	The home provides good services in gender sensitivity				
x	Vocational services are provided				
xi	The home provides good services for me to reintegrate in the community				
x	Others				

34. CHALLENGES AND COPING STRATEGIES IN INSTITUTION

Sl.No	Perceived Challenges	Coping Strategies
i		
ii		
iii		
iv		
v		

35. SUGGESTIONS

i	
ii	
iii	
iv	
v	

PARTICULARS OF THE CANDIDATE

NAME OF CANDIDATE	:	ZodinlianiRalte
DEGREE	:	M.Phil
DEPARTMENT	:	Social Work
TITLE OF DISSERTATION	:	Female Substance Abusers Under Institutional Care in Aizawl, Mizoram
DATE OF PAYMENT OF ADMISSION	:	11th August 2015
COMMENCEMENT OF SECOND SEM	:	22nd February 2016

APPROVAL OF RESEARCH PROPOSAL

1. BPGS	:	13th April' 2016
2. SCHOOL BOARD	:	22nd April' 2016
3. REGISTRATION NO.& DATE	:	M.Z.U/M.Phil./342 of 22.04.2016
4. DUE DATE OF SUBMISSION	:	10th February 2017
5. EXTENSION (IF ANY)	:	N.A.

(PROF.C.DEVENDIRAN)

Head

Department of Social Work

Mizoram University

BIO-DATA

Name	:	ZodinlianiRalte
Sex	:	Female
Date of Birth	:	21st July, 1989
Educational Qualification	:	Master of Social Work
Marital Status	:	Unmarried
Contact No	:	8575129975
Email id	:	atey973@gmail.com
Permanent Address	:	B-22, Babutlang, Zarkawt, Aizawl, Mizoram, 796007

Details of educational Status

Class	Subject	Board/University	Percentage	Division
H.S.L.C	—	Mizoram Board of School Education	58	Second
H.S.S.L.C	Arts	Mizoram Board of School Education	46	Third
Bachelor of Social Work	BSW	Mizoram University	50	Second
Master of Social Work	Social Work	Mizoram University	61	First

Related Experience

- **Field Work at ZoramEntu Pawl (Z.E.P):** The field work experience lasted for 23 days. The main objective was to develop professional social work skills and values and at the same time to understand and to learn about the agency's activities, programmes and services. During the field work, the researcher attended the various programmes and activities offered by the agency. Rapport building, case studies, home visits and group work were the work done by the researcher during the field work.

- **Field Work at ICDS(urban):** The field work experience lasted for 26 days. The objectives of the field work were to develop skills and apply theory through field work practice, to develop professional attitudes and values of social work. Rapport Building, Group work, Case Studies, Presentation, Visiting various Anganwadi centres, and Observation visit were the work done during the field work.

- **Field work at Thuampui Community:** The theme of the community field work was Substance Abuse and carried out for two semesters during the M.S.W programme. The major activities include a detailed study of the community through interaction with the NGO's as well as the C.B.O leaders, and also interaction with the church leaders, Observation Visit, P.R.A, Transact walk Social Survey, case study and focused group Discussion.

- **Field work at Lungsei Village:** To gain better knowledge and understanding of the livelihood of the rural people, 10 days of field work was attended between 27th February- 8th march 2015 . During the Field work, the livelihood of the village people were studied through Survey Questionnaires and Participatory Rural Appraisal. Various activities were also conducted with the residents of the village.

- **Participated short term course on "Research Methodology for Research Scholars:** The Scholar Participated in a U.G.C- Sponsored One Week Course on Research Methodology for Research Scholars, which was held on 20th-26th June, 2016 at Human Resource development Centre, Mizoram University.