SUBSTANCE ABUSE AMONG CHILDREN IN AIZAWL, MIZORAM:

A SITUATIONAL ANALYSIS

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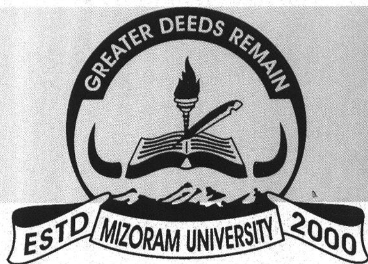
Submitted in partial fulfillment of the requirement for the Degree of Master of Philosophy in Social Work of Mizoram University, Aizawl



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

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Substance Abuse among Children in Aizawl, Mizoram: A Situational Analysis

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Interview Schedule

Schedule No____ **Date:**

I	**Personal Profile**		
1.	Name	:	
2.	Age	:	
3.	Sub-Tribe	:	Lusei/Hmar/Paite/Mara/Lai/Others
4.	Religious Denomination	:	Presbyterian/ Baptist/Catholic/Salvation Army/ UPC/Seventh Day/Others
5.	Educational Status	:	Illiterate/ Drop Out / Primary / Middle / High School / Higher Secondary / College
6.	Skill/Vocational Training	:	
7.	Name of Locality/ Institution	:	
8.	Occupation	:	
9.	If employed, Monthly Income	:	
10.	Marital Status	:	Married/Unmarried/Divorced/Widowed/ Single Parent
II	**Family Characteristics**		
11.	Type of Family	:	Nuclear/ Joint
12.	Form of Family	:	Stable/ Broken/ Reconstituted
13.	Father's/Guardians Educational Qualification	:	Illiterate/ Primary/Middle/High School/ Higher secondary Graduate/Post-Graduate
14.	Mother's Educational Qualification	:	Illiterate/ Primary/Middle/High School/ Higher secondary Graduate/Post-Graduate
15.	Father's/Guardians Occupation	:	Unemployed/ Govt. Service/ Business/ daily Labour/ Farmer/ Others
16.	Mother's Occupation	:	Unemployed/ Govt. Service/ Business/ daily Labour/ Farmer/ Others
17.	Family Monthly Income	:	
18.	Socio Economic Category of Family	:	AAY/ BPL/ APL/ Don't Know
19.	Any substance abusers in the family	:	Yes / No
20.	If Yes, Who?		Grandfather/ Father/ Mother/ Sibling/ Partner/ Cousin/Others Specify
III	**History of Substance Abuse**		
21.	Age of first initiation	:	
22.	Type of Substance(s) first used	:	
23.	Reason for intake	:	Poverty/ Experimentation/ Peer Pressure/ Depression/ Unhappy Family environment /Broken Family /Spouse/ Presence of substance abuser in the family / Experienced Physical Abuse/ Experienced Sexual Abuse/ Others
IV	**Pattern of Use**		
24.	Types,Mode, Dosage and Frequency		

Sl.No	**Types**	**Mode**					**Dosage per Use**	**Frequency of use Per week**	**Expenditure used on substance Per week**
		Smoke	**Chew**	**Drink**	**Inhaling**	**Injection**			
i	Hallucinogens								
ii	Opiates								
iii	Analgesics (Painkillers)								
iv	Tranquilizers and Sedatives								
v	Nicotine								
vi	Amphetamine								

	s								
vii	Alcohol								
viii	Others								
ix	Others								

V	**Consequences and Coping Strategies**		
25.	Consequences of Substance Abuse	:	Physical health problems/ Mental Health problems/ Problems in Studies/ Work related problems/ Financial problems/ Family Problems/ Problems in Community /Stigma and Discrimination/ Drop Out/ Others
26.	Coping Strategies of Consequences	:	

VI	**Social Support and Suggetsions**					
Sl.No	**Support Systems**	**Forms of Support**	**Quality of Support**			
			Very Good	**Good**	**Poor**	**Very Poor**
i	Family					
ii	YMA					
iii	MHIP					
iv	Church					
v	NGOs					
vi	Government					
vii	Others					
viii	Other					

27.	Suggestions to prevent Substance Abuse among Children
28.	Suggestions to improve Support Services

THANK YOU

The study attempts to highlight the situation of children abusing substances in Aizawl, Mizoram. It will delve upon the social background of the children, initiation of abuse, the factors contributing to Substance Abuse , the type of substance that are abused by children, the pattern of abuse, the consequences and coping strategies and also the social support they receive. It will also attempt to suggest measures for social work intervention and social policy relating to children and substance abuse.

The saying that “Child is the father of man” is very much true. The qualities a person imbibes as a child deepen as he grows and appear in several obvious and subtle ways in his conduct and character as an adult. Therefore, anything that affects the interest of the children affects the entire community, of which the child is but one member (Chowdhry, 1966). UNDCP(2002) states that children are the pride and future of the Nation. Today’s children are tomorrow’s adults and builder of the nation. Substance abuse in children today is becoming a major problem in India (In Commission on Narcotic Drugs Report, 1999).

Historically drugs were used for different purposes; they became part of the culture and aided it in its growth. India and China had large sections of the population smoking opium and hashish in the past. Other ancient cultures such as those of Egypt, Babylon, Greece also use these drugs as seeds of the same has been found in mummies, in ancient graves, and in pots located at the cities of Mohenjo-Daro and Harappa. According to Winkler (1967), before World War II, narcotic addiction was distributed throughout America but was not a social problem. After the War, it tended to concentrate in the slum areas of large metropolitan cities, particularly in New York City. Economic privation, negative attitude towards the law and the lack of family control over adolescence made some area a breeding place for narcotic drug abuser (In Lather, 1993).

According to Beckett (2007), the use of substance has a number of social consequences that can impact non-family life. Today, children are introduced to drugs quite early in life (Rathore et al 2017).Davies (2000) stated that Child protection includes protection of children from the illicit use of drugs (In Pachuau, 2012). This clearly shows the responsibilities of the care giver to protect children from substance abuse.

According to the Commission on Narcotic Drugs (1999), one of the unpleasant characteristics of problem in substance abuse is that it affects primarily those who are most vulnerable, such as children. The transition from adolescence to young adulthood is a crucial period in which experimentation with substance in many cases begins. Drugs may have strong appeal to adolescent who are beginning their struggle for independence as they search for identity. Due to their innate curiosity and thirst for new experiences, peer pressures, their resistance to authority, sometimes low self-esteem and problems in establishing positive interpersonal relationships, young people are particularly vulnerable to experiencing substance and substance abuse continues to emerge as a strategy to cope with problems of unemployment, neglect, violence and sexual abuse. Children particularly at the age group of 16-18 years are susceptible to the enticement of drugs. Moreover, the number of Children abusing substance is increasing, in particular in the urban areas of developing countries where street life are the common practice and other aspects including drug trafficking can be witness in a growing number are shown in various data confirming that drug abuse is high among young people living in vulnerable situations. Children who are in need of care and protection especially street children, working children, refugee and displaced children, children and youth in institutional care, child soldiers and sexually exploited children are particularly at risk of abusing drugs mainly for functional reasons (for example, to keep awake for work, to get to sleep, to reduce physical and emotional pain or to alleviate hunger).

Adolescent substance abusers are different from adult substance abusers in a number of important ways, including drug use, patterns, developmental and social factors (Winters, Stinchfield, Opland, Weller, & Latimer, 2000).Adolescents may be more susceptible than adults to the development of substance dependence syndromes, even in the absence of physiological withdrawal. The progression from casual use to dependence can also be more rapid in adolescents than in adults (Winters, 1999). Adolescents presenting for treatment typically demonstrate a higher degree of co-occurring psychopathology, which frequently precedes the onset of problem substance use and often does not remit with abstinence (Kandelet al., 1997; Riggs, Baker, Mikulich, Young&Crowley, 1995,)

India's in its Constitution focus towards narcotic drugs and psychotropic substance highlighting in Article 47 stating that "state shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health" (In Ahuja, 2014).

India has also passed the Narcotic Drugs and Psychotropic Substances Act, 1985, to consolidate and amend the law relating to narcotic drugs, making strict provisions for the control and regulation of operations relating to narcotic drugs and psychotropic substances, to provide for the forfeiture of property derived from, or used in, illicit traffic in narcotic drugs and psychotropic substances and to implement the provisions of the International Convention on Narcotic Drugs and Psychotropic Substances and for matters connected therewith (GOI, 1985).

According to Kailash (2016), The National Commission for the Protection of Child Rights reported that homeless children are the most vulnerable group for exposure to substances. One in every five of India's drug addicts is a child. Kar, Debroy, Sharma, & Islam, (2014)have also mentioned the report of World Health Organization which estimated that globally, majority of street children are indulge in substance abuse (In Rathore et al,2017).

In the Indian context, Ahuja (1982) reported in his study that a little more than one-fourth (26.1 %) of the total number of substance abuser are children. Female substance abusers are comparatively younger than that of male substance abuser. As from his study he found that from the total respondent, among female substance abuser more than half of them were 18 years of age or less in comparison to about a fourth among male substance abuser who are below the age of 18 years. Taking both male and female drug users together, 16-21 years age group were identified as the most crucial group in developing the habit of abusing substance (In Lather, 1993).

Article 33 of the United Nation Convention on Rights of the Child (UNCRC) provides children with the right to protection from the use of drugs, and from being involved in their production or distribution."States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the

illicit production and trafficking of such substances”(In LiFCoDe Operation Manual,2017)

1.1 Policies and Substance Abuse

The Narcotic Drugs and Psychotropic Substances Act, 1985 declares illegal the production, possession, transportation, purchase and sale of any narcotic drugs or psychotropic substances and makes the person, addict/trafficker liable for punishment. Use or threat of use of violence or arms by the offender, *use of minors for the commission of offence,* commission of the offence in an educational institution or social service facility are some of the grounds for higher punishment.

The Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988 states people who use children for drug trafficking can be booked as abettors or conspirators to the act.

The Juvenile Justice (Care and Protection of Children) Act, 2015 also mentions a child in need of care and protection as one who is found vulnerable and is likely to be inducted into drug abuse or trafficking. It further captures provisions for protection of children against substance abuse. It rightly says in Chapter IX (77) and 78 that ‘whoever gives, or causes to be given, to any child any intoxicating liquor or any narcotic drug or tobacco products or psychotropic substance, except on the order of a duly qualified medical practitioner, shall be punishable with rigorous imprisonment for a term which may extend to seven years and shall also be liable to a fine which may extend up to one lakh rupees’. It further states that ‘whoever uses a child, for vending, peddling, carrying, supplying or smuggling any intoxicating liquor, narcotic drug or psychotropic substance, shall be liable for rigorous imprisonment for a term which may extend to seven years and shall also be liable to a fine up to one lakh rupees’.

However, in spite of legal efforts and policies undertaken by the Government, substance abuse among children in India remains to be one of the challenges in the area of child care and protection.

1.2 Regional Scenario

In Mizoram the ND & PS Act has also been implemented by the Government to focus to the problems related to Substance Abuse. Apart from this, the government has also passed the Mizoram Liquor (Prohibition and Control) Act, 2014 replacing the Mizoram Liquor Total Prohibition (MLTP) Act, 1995 which was implemented for 17 years. This Act prohibit and control the production, manufacture, possession, transport, import, export, purchase, sale and consumption of intoxicating liquor and to provide for the imposition of excise duty thereon in the State of Mizoram and for matters connected therewith (GOM,2014).The MLPC Act also empowers everyone especially NGO's like YMA to "arrest" offenders, provided they immediately hand them over to the police or officials of the Excise and Narcotics Department (The Sangai Express, 2018).

However, like the national scenario in India, Mizoram too is not immune to the problems of Substance abuse in spite of policies initiated by the government to reduce the incidences. Few literature reveals that substance abuse among children is rampant that deserves immediate attention for more effective intervention.

The Integrated Child Protection Scheme, Mizoram record also shows that in Aizawl District, during the period of April 2015 to February 2018, there were 43 children injecting drug user; 20 children inhalant user; 5 children taking oral pills and 2 children with a problem of alcohol consumption were admitted to Children Care Institutions within mentioned year.

The reports of the Juvenile Justice Board, Aizawl District from April 2015 to February 2018 also shows that 7 children had violated the MLPC Act and has 2 cases of child substance abuse, 4 cases of children relating to ND & PS Act, 7 cases relating to drug peddling. Other activities such as theft which is the highest cases of Children in Aizawl District and Dacoity etc. are often related with child substance abuse as they are often under the influence of substance while committing the offence.

1.3 Definition and Concept

1.3.1 Children

According to the Juvenile Justice (Care and Protection of Children) Act, 2015"child" means a person who has not completed eighteen years of age.

1.3.2 Substance

A pharmaceutical preparation or a naturally occurring substance used primarily to bring about a change in an existing process or state (physiological, psychological or biochemical) can be called a drug. In simpler terms, any chemical that alters the physical or mental functioning of an individual is a drug (UNDCP, 2002)

Substance 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, LDC, Solvents and gases such as glue, petrol, lighter, fuel, hairspray, deodorant); Stimulants such as amphetamines, caffeine, cocaine, crack (chemically altered cocaine that can be smoked) (In Ralte, 2017).

In Mizoram the types of substances abused includes Opioids, Alcohol, Dendrite/Correcting fluid (a type of inhalants), Ganja, Nicotine/ Tobacco, Diazepam/ Nitrozepam/ Alprazolam (Benzodiazepines) Pepe, Cyclopam/Dicolic/Cataspa etc and Respira D (Lalhrekima, 2013).

1.3.3 Substance Abuse

According to WHO, Substance Abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Psychoactive substance use can lead to dependence syndrome - a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.

When a drug is taken for reasons other than medical, in an amount, strength, frequency or manner that causes damage to the physical or mental functioning of an individual, it becomes ‘drug abuse’. Drug Abuse leads to drug addiction with the development of Tolerance and dependence. Tolerance refers to a condition where the user needs more and more of the drug to experience the same effect and slowly drug

dependence develops. After the user becomes dependent, if the intake of drugs is abruptly stopped, withdrawal symptoms occur. Symptoms of Drug withdrawal are usually the opposite of the effects produced by the presence of the drug in the body (UNDCP, 2002).

Ralte(2017) had listed the Diagnostic Criteria for substance Dependence according to DSM-IV(1994) which 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 behavioural disorder due to psychoactive substance use and is classified as under:

a) Mental and behavioural disorders due to use of alcohol.
b) Mental and behavioural disorder due to use of opiods
c) Mental and behavioural disorder due to use of cannabis
d) Mental and behavioural disorder due to use of sedatives or hypnotics.
e) Mental and behavioural disorder due to use of cocaine.
f) Mental and behavioural disorder due to use of other stimulants, including caffeine.
g) Mental and behavioural disorder due to use of hallucinogens.
h) Mental and behavioural disorder due to use of tobacco.

i) Mental and behavioural disorder due to use of volatile solvents.
j) Mental and behavioural disorder due to multiple drug use and use of other psychoactive substance (In Ralte, 2017).

Tarapot (1997) states that drug abuse has negative impact on both social and economic life in the region. The problems arising out of drug abuse by many youth has affected several families.

1.3.4 Types of substances used by children and their effects

The classifications of Addictive Drugs by UNDCP, ROSA (2002) are as below:

i) Narcotic Analgesics

In Greek the prefix 'narco' means 'to deaden' or 'benumb'. 'Analgesic' means 'pain killing or pain-relieving'. In medical terms, 'narcotic' refers to opium and opium derivatives as well as to synthetic substitutes that produced opium-like effects. Drugs belonging to this category can be studied under three broad categories: narcotic of natural origin, semi-synthetic narcotics and synthetic narcotics. Drugs belonging to the first two categories are referred to as opiates while synthetic narcotics are known as opioids.

a) Narcotics of Natural Origin

The poppy plant, Papaver somniferum is the source of naturally occurring narcotics. For thousands of years this plant has been widely cultivated for pleasurable effects of its products. Today, its cultivation has been restricted by law. Under this category, there are various sub categories that falls under the natural origin. They are:

- **Opium**

The word 'opium' is derived from the Greek word 'opion' meaning 'poppy juice'. Opium is obtained by tapping the milky fluid from unripe poppy pods. This type can be taken Oral or inhaled. Dried opium is usually boiled in water and the solution is drunk. Inhalation-Opium can also be smoked.

- **Morphine**

Morphine is the principal alkaloid (organic compound) that is extracted from opium. About 10-15% of the substance extracted from Opium is Morphine. Morphine is one of the most effective drugs for relief of pain. It is still used medically. It is usually administered through injection, subcutaneously (under the skin), intramuscularly (into muscle) or intravenously (into veins)

- **Codeine**

Codeine is another alkaloid found in Opium, though in a smaller percentage than Morphine (1-2%). Codeine is medically used as a cough suppressant. Cough syrups containing Codeine are now being used in many parts of India. This substance is taken orally with a combination of other chemicals and is available in the form of tablets and syrups.

b) Semi-Synthetic Narcotics

Under this category are the following:

- **Heroin and Brown Sugar**

Heroin is a semi-synthetic derivative of the drug morphine. Pure Heroin is a white crystalline powder and is referred to as “white sugar” by abusers. When the quality of heroin is poor, its colour is no longer white, but brown; this inferior quality is called “brown sugar”. This type of drug is taken through injection or inhalation or chased. The drug is mixed with distilled water and lime of Vitamin C tablets. The solution is then heated and filtered, using cotton to remove the sediments. Later, it is injected intravenously. It is also smoked with tobacco in cigarettes and chased by sprinkling the drug on a silver foil or place in a bent spoon and heated from beneath with a matchstick or a candle. The thick fumes which rise are taken in through the mouth with a rolled piece of paper.

c) Synthetic narcotics

Synthetic narcotics are produced only in the laboratory. They are as follows:

a) Buprenorphine and Pentazocine

Buprenorphine and Pentazocine are the most widely abused synthetic narcotic drugs. They are mostly used as painkillers in a wide variety of medical conditions. Buprenorphine was initially used to treat the withdrawal symptoms of Heroin addiction, as well as in the treatment of cancer. Later, it became a drug of abuse. This drug is taken orally in the form of tablets or injected intravenously.

When injected, the effects of narcotic analgesics are immediate and pronounced. With other routes of administration, the effects are felt only gradually. The effects include:

- A short-lived state of euphoria during which feelings of hunger and pain are not felt.
- Mental clouding, impairment of intellectual processes
- Drowsiness, sedation, apathy, decreased physical activity
- Vomiting in novice users
- Dysphoria (a feeling of unpleasantness)
- Inability to concentrate
- Itchy skin
- Constipation
- Constriction of pupil (with the exception of synthetic narcotics)
- Mood instability, reduced libido, constipation, constriction of pupils (which affects night visions) and certain types of respiratory impairments can develop. In female drug abuser menstrual irregularity occurs.

With the deprivation of narcotic analgesics, the first withdrawal symptoms are usually experienced shortly before the time of the next scheduled dose.

ii) Cannabis

Cannabis drugs are made from the Indian hemp plant- *Cannabis sativa.* This plant has been cultivated for centuries in many parts of the world for the tough fiber of its stem and for the plant's psychoactive properties. When its mind-altering properties came to light, the cultivation of the cannabis was banned. Its therapeutic potential and possible medicinal properties are being studied. As of now, cannabis

drugs do not have any medical use. The chief psychoactive substance among them is delta-9-tetra-hydrocannabinol, commonly known as THC .

The main drugs under this category include the following:

a) Ganja/ Marijuana

Ganja is prepared from the dried leaves and flowering tops of the plant. Ganja is commonly referred to as grass, pot or stuff. Ganja is usually smoked in the form of hand-rolled cigarettes (joints or reefers) or pipes specially made for this purpose.

b) Hashish/Charas

The cannabis plant has separate male and female forms. The female plant secretes a sticky resin which has a high THC concentration. The resinous secretion of the cannabis plant, which is collected and dried, is known as Hashish/Charas. Hashish ranges in color from light brown to almost black, and the THC contents in hashish ranges from 5-15%. Hashish is smoked like ganja and sometimes baked with food and eaten.

c) Hashish Oil

Hashish Oil is produced by a process of repeated extraction of the resin of the cannabis plant to get a high concentration of THC. It is highly potent with a THC concentration ranging from 20-60%. Hashish oil is a dark viscous liquid. It is usually dripped on cigarettes and smoked.

d) Bhang

This is the least potent of all cannabis drugs. Bhang contains the dried parts of the plants- leaves and stem. Bhang is a brown leafy material with dried twigs mixed in it. Bhang is usually brewed with tea or milk and drunk

The exact effects that cannabis drugs produced cannot be accurately predicted. The prior experience and expectation of the user, the potency of the drug etc. are important factors that produce the psychoactive effect. The main effects include:

- Mild euphoria followed by a dreamy state of relaxation
- Lowering of inhibitions, spontaneous laughter

- Increased auditory and visual acuity (e.g. sound seems louder and clearer, vision seems brighter and sharper)
- Sense of smell, touch and taste are often enhanced.
- Altered sense of time perception or ‘time constant effect’ (time seems to pass more slowly)
- Impaired short-term memory reduced attention span, poor concentration and disturbed thought patterns.
- Impaired ability to perform complex motor tasks.
- Splitting of consciousness- the user experiences the ‘high’, while at the same time becomes object observer of his own intoxication. He may have paranoid thoughts, and yet simultaneously laugh at them.
- A motivational syndrome where the user may lose all interest in his work.
- Sterility: Prolonged used can reduce sperm count and decrease sperm motility.

Abrupt cessation of cannabis use leads to withdrawal symptoms- sleep disturbances, loss of appetite, irritability, nervousness, anxiety, sweating and stomach upset. Depression and other psychotic symptoms may become prominent. Withdrawal symptoms usually last for less than a week.

iii) Depressants

Depressants are drugs which depress or slow down the functions of the central nervous system. The drugs which come under this category include:

a) Sedatives-hypnotics

They are depressant drugs whose primary effects are calming, sedating or inducing sleep. Barbiturates like Methaqualone, Secobarbital and Amylobarbital and Benzodiazepines like Diazepam and Lorazepam are the commonly abused drugs. It is administered orally in the form of tables or capsules. They can also be injected.

b) Alcohol

It is the product of fermentation and distillation. Ethyl alcohol is the intoxicating substance present in alcoholic beverages like beer, whisky, rum, brandy, wine etc. It is taken orally.

Sedative-hypnotics produced effects that are similar to those of alcohol. The effects include:

- Relief from anxiety and tension
- Euphoria
- Lowering of inhibitions
- Sedation, sleep with larger doses
- Poor motor coordination (especially for fine motor tasks)
- Impaired concentration and judgement.
- Slurred speech and blurred vision.
- Long term use can produce depression, chronic fatigue, respiratory impairments etc.

Withdrawal symptoms like anxiety, insomnia, weakness and nausea are usually noticed.

iv) Hallucinogens

Hallucinogens are drugs that dramatically affect perception, emotions and mental processes. Since, they distort the perception of objects reality and produced hallucinations, they are known as 'hallucinogens', and are also referred to as 'psychedelic' (mind-altering) drugs. Hallucinogenic drugs are very rarely available in India, making it the least abused class of drugs.

v) Stimulants

Stimulants are drugs which excite or speed up the central nervous. The two most prevalent stimulants are nicotine, found in tobacco products, and caffeine, the active ingredient in coffee and tea.

a) Amphetamines

Amphetamines are synthetic drugs produced entirely within the laboratory and they do not occur naturally. They are used in other countries to treat narcolepsy (an uncontrollable tendency to sleep) and sometimes in weight control programs. Ecstacy is an amphetamine-based drug currently being abused in developed country. Amphetamines were abused in India in the late 1970's by students to ward off sleep, enabling them to study through the night prior to an examination and by athletes to mask feelings of fatigue and increase their endurance. It is absorbed orally in the form of tablets or capsules.

b) Cocaine

Cocaine, a potent stimulant of natural origin, is extracted from the leaves of the coca plant. It is a odourless, white crystalline powder, with a bitter numbing taste. Cocaine was formerly used in eye, nose and throat surgery because of its ability to anaesthetize tissue and simultaneously constrict blood vessels and limit bleeding. It is no longer used medically

c) Crack

This is made from cocaine and is widely abused in developed countries like the USA and is few in India.

Amphetamines and cocaine have different mechanisms of action, but the overall impact is the same and their effects are parallel each other. The main effects include:

- a heightened feeling of well-being, euphoria
- a sense of super-abundant energy, increased self-confidence
- increased speech and motor activity
- suppression of appetite (which is why it is used in diet pills)
- an increased wakefulness that masks feelings of fatigue (the reason why amphetamines are abused by students during examinations)
- Chronic sleep problems, poor appetite, high blood pressure, rapid and irregular heartbeat, impotence, mood swings, anxiety and tension states are the long-term effects of stimulant abuse

Extreme fatigue, prolonged but disturbed sleep, voracious appetite, irritability and moderate to severe depression are the commonly reported withdrawal symptoms.

vi) Volatile Solvents

Drugs in this category are volatile hydro-carbons and petroleum derivatives like petrol, paints, nail polish remover, ether, glue, and benzene, varnish thinner and lighter fluid. This form of substance abuse is primarily found among street children who are less than 18 years old. Abuse of volatile solvents has been on the increase in the recent past. It is inhaled by sniffing.

The effects of Volatile Solvents include:

- Behavioral effects include euphoria, clouded thinking, slurred speech and staggering gait. Hallucinations occur in about 50% of the abusers. The effects are about the same as for sedative-hypnotics and many youngsters who abuse these substances end up dependent on alcohol or other sedative type drugs. Sudden death can occur due to sniffing these drugs.
- Long-term effects include psychosis and permanent brain damage. Tachycardia (increased heart beat) with possible ventricular fibrillation can occur. Damage to the liver, kidneys and heart is also possible.

vii) Other drugs of Abuse

There are a few other drugs of abuse that do not belong to any of the above categories. Abuse of the following drugs has been reported in India.

a) Muscle relaxants like carisoprodol (e.g. carisoma compound). The drug is available in the form of tablets and is abused for its depressant-like effects.
b) CNS analgesics like dextro propoxyphene (e.g. proxyvon) and dextropropoxyphene in combination with dicyclomine (e.g. spasmoproxyvon).Tablets and ampoules are available. The drug is taken orally or intravenously. The pain relieving effects are very pronounced. These drugs are usually prescribed to relieve pain following accident trauma or surgery. When their use is not carefully monitored by the supervising physician addiction can develop.
c) Anti-histamines like chlorphener-amine maleate (e.g. avil).

d) Anti-emetics like promethazine (e.g.phenargan).(Both these categories (c & d) of drugs are usually abused in combination with narcotic drugs like heroin or buprenorphine to enhance the effects.)

e) Anti-depressant drugs like amineptine (e.g. survector) that are used to elevate mood state and treat depression are sometimes abused for their sedation effects.

Prescriptions for these drugs need to be issued very carefully. The dosage needs to be reduced and withdrawn as and when the patient recovers. It is necessary to watch out for signs of tolerance. In case of tolerance, most physicians prefer to shift the patient to other categories of medication that do not produce the sought after effects.

There is no fixed terminology for children who abuse substances. In the Integrated Child Protection Scheme, Mizoram online portal, they were categorised as children using substances. In the Juvenile Justice (Care and Protection of Children) Act 2015 Chapter 1 Section 2 Clause 14 (9) one finds that those children who are found vulnerable and are likely to be inducted into drug abuse were categorised as children in need of care and protection. Further, in the Integrated Child Protection Counselling Manual, the National Council for Child Protection of Child Rights referred to them as children with substance abuse. Though the UNO has an official terminology on substance abusers as People Using Drugs (PUD), there is no specification for children as such.

This chapter highlights the various literatures on substance abuse on children at the international, national and regional level and research findings on child substance abuse within Aizawl.

According to Bilard, Ninot &Hauw, 2011, increase in the number of substance abuser is due to popularisation, accessibility, affordability, and normalisation of drugs.(In Goodman,2017)

With the harm it in corporate to society, drug abuse needs to be prevented (Dennis, Foss, & Scott, 2007). For the prevention, prolonging the drug-free days of vulnerable children becomes an operational concern (Budney, Moore, Rocha, & Higgins, 2006). Vulnerable children refer to those identified by social workers as having drug abuse experiences and are in need of rehabilitation (Lee, 2005). However, rehabilitation is a difficult task because many vulnerable children relapse into drug abuse (Sobell, Sobell, &Agarawal, 2009). A notable approach is education on the harm of drug abuse to raise knowledge of the youth and prevent drug abuse (Lilja, wilhelmsen, Larsson, & Hamilton, 2003) (In Cheung &Ngai, 2017)

Adolescent attitudes and beliefs about substance use and risk tend to change rapidly, with tolerance levels rising as adolescence progresses. Youth, to a greater extent than adults, tend to minimize the risks linked to their own substance use, with the tendency more pronounced among young men than among young women. It has long been acknowledged that young people typically give less attention to the long-term risks associated with substance use than they do to the more immediate consequences (World Youth Record, 2003).

Schilit and Gomberg (1991) mentioned the reason for initiation into drugs also includes the search for pleasure, to relieve stress and tension or provide a temporary escape. Peer pressure is strong especially for young people and the media plays a large role in teaching what we can and should avoid pain and maximise pleasure.

According to Lather (1993), girls sometimes use drugs to control weight, others used it to study for examinations, still others to get a high or to achieve euphoric state for composing musical rock concert, poetry or even deliver speech confidently on the stage and face the audience. There is also strong evidence that drug addicts come from unsatisfactory home background. The addicts tend to come more often from

families characterised by emotional disturbance, distance, poor father-son relationship, and instability in the family relationship. Faulty socialization too leads to conflict between roles and value systems of adolescence and parents. Parents who are overly dominant tend to have children who abuse drug while parents whose child rearing practises encourage autonomy, independence and reward good behaviour more than they punish misbehaviour have children who less often take to drugs. Structured intra-familial relationship, inter-familial relationship, homelessness, love, happiness and closeness are essential in order to resist the epidemic spread of drug addicts. Characteristically, an addict has an over powering need or compulsion to continue taking the drug no matter what means may be required to secure the supply of it. Drug abusers seldom leave successful lives by their own standards or anybody else. Over a period of time they lose interest in school, jobs and family.

Kapur (1985) states that drug taking is a social hazard and not simply a problem for the addict himself or herself. Parental pressures and those of relatives create problems for the youth, peer pressure where the child has been misled by their friend into a habit of substance abuse which they cannot break out from. The desire for the company of the opposite sex to relief a feeling of utter loneliness, during which one felt the need to be comforted. It has also been misunderstood that drug use is good for career and helps in studies. Many innocent children find themselves as victim to the lure of this myth.

According to Mattoo &Basu (2003), child substance abusers are very frequently prone to delinquent behaviour and anti-social activities .They are also at a higher risk of contracting blood-borne and sexually transmitted infections like HIV/AIDS and STD (sexually transmitted diseases), Hepatitis, especially when they share infected needles to inject substance and/ or are forced or lured to unprotected sexual acts under the influence of a substance abuse. Millar &Stermac (2000) stated that the physical ill effects of children who abuse substance include physical strains and pressures, shivering, feeling pain and sleepy, the frequency of respiration is reduced and heart rate gets accelerated. These children suffer from absenteeism, school dropouts, poor performance, aggressive behaviour, bullying, fighting, suppressed anger, criticism, isolation, rejection, cheating, stealing, lying, truancy, low self-esteem, loneliness, guilt, feelings of helplessness, fears of abandonment, and chronic depression

manipulating become their usual defensive behaviours in school and at home (In Rathore et al,2017).

According to a study conducted by Savita et. al, children of substance abuse parents constitute a high risk group predispose to the development of psychiatrict disorder or substance abuse. According to Clark et. al (2004), the experience of children growing up with parents who have drug problems in the earliest year will have forever marked most of the children, although to varying extend. That some manage to find a way through it to become healthy adults is testimony to the amazing resiliency of some children. However, it is clear that many have difficulties in adolescent and early adulthood and not the least of these in the likelihood that they will go on to use drugs problematically themselves (In Barnard, 2006).

Sexuality and substance use are closely linked as the continuous use of drugs could affect various parts of the body, including sexual and reproductive organs. The individual may have a low concept about self and the future and/or an impulsive and risk-taking tendencies, which may manifest in their behaviours, impairment of judgement, loosening of inhibitions and blackout often set in after consumption of substances (Rego &Gandevia, 2005).

Bekman, Cummins and Brown (2017) in their study regarding the influence of alcohol-related cognitions on personality-based risk for alcohol use during adolescence has found that the role of potentially malleable cognitive process in adolescent decision making regarding alcohol use have direct prevention and intervention implications for helping to reduce risky alcohol use among high risk adolescents.

World Youth Record (2003) shows that alcohol, tobacco and cannabis have remained the substances most commonly used by youth around the world. The first substances used are generally tobacco, alcohol and, in some communities, inhalants; the age of first use is usually lower in developed countries. The use of substances (with the exception of inhalants in some regions) almost always increases with age, so among students the highest rate of use is generally recorded in the last two years of secondary school, continuing into early adulthood in most countries. In almost all regions boys are more likely than girls to use all substances (exceptions are the non-medical use of medications in a number of countries and alcohol and tobacco use in

several European countries) and are more likely to use them in risky ways. Rates of alcohol and tobacco use by students in Europe appear to be the highest in the world, and figures indicate that illicit drug use rates are highest among students in Australia and North America (Canada and the United States). Although data are not readily available, the lowest rates of use for all substances appear to be in countries strongly influenced by Islam, where prohibitions are more likely to be clear and strictly enforced.

Ahuja (2014) has mentioned that according to a recent survey, India has at least 7.5 crore drug addicts. A study conducted by PGIMER has claims that drug abuse has increased among youngsters in the 16-25 age group. Data gathered by researchers over a period of three decades, from 1978-2008, shows that 22 per cent of the patients in the first decade (1978-88) belonged to the 16-25 years age group, the percentage went up to 31.5 per cent in the third decade (1999-2008).The study also shows that there has been an increase in opioid dependency cases over the decades. A study conducted on drug abuse among school children in Delhi, Bombay, Calcutta and Madras by Mohan among about 2000 high school students shows that 63 per cent students were using drugs; a very large number of them took painkillers, smoked cigarettes or consumed alcohol. Only 0.2 per cent to 0.4 per cent took sedatives, stimulants and narcotic drugs. This shows that drug abuse among high school students is very limited.

According to Tarapot (1997), drug abuse was totally unknown in Mizoram. As per the preliminary survey conducted by the Mizoram Excise Force drug abuse was largely confined to Aizawl, Lunglei and Champhai Town. The number of intravenous user within the whole of Mizoram was estimated at three hundred only. But during 1993 to 1995 intravenous drug users were increased by several hundreds. With an area of about 2,55,182 sq km. The north eastern region of India comprises seven states among which particularly Manipur, Nagaland and Mizoram have become smuggling route of heroin from the Golden Triangle and other areas in Myanmar. Narcotic drugs including heroin are easily available in the region. It is distressing to note that Marijuana (Ganja) and other Narcotic drug are smuggled out of Manipur to the North Eastern region and other parts of the country. Until the end of 1983 Morphine was commonly used by drug abuser in the North eastern state. The number of drug addicts in Manipur is estimated to be between 40,000 to 45,000, Nagaland

over 10,000 and Mizoram below 10,000. Since the early eighties Manipur, Nagaland and Mizoram have been in the news because of increasing problems of drug abuse among youths and related issues. The majority of the drug addicts are in the age group of 15 to 30 years.

The Juvenile Justice Board, Aizawl, Mizoram during April 2015 to February 2018 report shows that certain cases of theft and hurt which constitute the majority of cases occurs when the children are under the influences of alcohol or substance.

A baseline survey on extent & pattern of drug use in Mizoram, 2017 from the report of various de-addiction centres highlights that the initiative age of substance abuse is at the early age of 15 years. Starting usually with tobacco and/or volatile solvents, progressively moving into alcohol and cannabis within the next two years, by the time the child reach maturity, they try out pharmaceutical opioids and within one year they experiment with injecting. While opium and sedatives are initiated at 20 years of age, heroin is introduced at a slightly older age (GOM, 2017).

Pachuau(2015) also found that majority of the family of the vulnerable children in Mizoram abuse tobacco, followed by those children whose other member consumed alcohol and one whose family member took adhesives. From here we also see that substance abuse among parents is very high, that increases vulnerability of children in Mizoram.

SHALOM (2013-2018) have also mentioned that most of the youth in Aizawl did not know that Alcohol, tobacco products, Ganja and cough syrup etc are Gateway Drugs and thus do not restrain themselves from these substance thus leading the child to indulge in a more serious form of substance and eventually leading to abusing the substance.

The reasons why people abuse substance includes family dysfunction, family history, Parental negligence, ineffective supervision, peer pressure, boredom, values and norms regarding alcohol and illicit drug use, low self-esteem, Inadequate coping skills, stressful life events, financial problems and relationship problem(Ralte, 2017).

Mizoram Social Defence and Rehabilitation Board (1999)had mentioned the effect of substance abuse as a person becomes incompetent to exhibit a daily normal behaviour, it also affects interrelationship of a person with another person and also his

spirituality. A child may not be able to continue education as it divert their attention on how to get the substance, and with the high demand of money, the child may be engaged in stealing, thus becoming a child in conflict with law.

According to a professional counsellor in a de-addiction centre in Aizawl, majority of their clients come from poor income family. Due to poverty, the parents' educational statuses are low and they have low parenting skills. Because of this, the children are easily lured into experimenting of drugs because of peer pressure. Further, some children drop out from school and remain idle, providing ample time for indulging into substances.

From the above literature, one can see that in-depth studies have been made particularly on youth and even in some cases and countries on Children. In India too, several researches have been conducted on drug abuse in the last three decades by professional from different streams (Ahuja, 2014) and also by the social workers. Though evidences of data exist with regard to children, they are very few and such sources do not have a complete and thorough understanding of children abusing substances. What is known from the available literature is that initiation usually takes place when they were much younger as children. Therefore, this evidence of early initiation to drugs by children is also an indication about the need to study children who have been affected by this social problem.

2.1 Research Gaps

In Mizoram there are few research on substance abuse however, there are no research particularly focussing on children who abuse substances. Data also reveals that child substance abuse is prevalent in the Mizo society. An in depth study has not been conducted to study the socio-demographic background of child substance abusers, their pattern and of abusing substances, the challenges they face and their coping strategies. With a view to fill these gaps that exist in relations to children who abuse substances, this research will highlight a comprehensive picture on the situations and live experience of children who abuse substance in Mizoram.

2.2 Statement of the problem

Substance Abuse in Mizoram is widespread across all districts with greater concentration in Aizawl. Youth mostly in their reproductive age are the most affected

and initiation into various drugs predominantly occurs before the age of 18 years. Several studies have been conducted by numerous researchers but most studies are based on adult substance abusers in Mizoram. The study on child substance abusers have been neglected and in-depth research has not been carried out on the subject. Hence, as a result of this, there exist research gaps on children and substance abuse in Mizoram. This research will fill the gaps and highlight the socio-demographic back ground of children who abuse substances, understand the reason for initiation to drugs, find out the mode of intake, the pattern of drug use and abused. It will also find out the consequences and challenges faced by the children and also probe into the coping strategies and social support they receive.

2.3 Objectives

1. To profile the socio-demographic background of children abusing substances in Aizawl, Mizoram.
2. To understand the pattern of substance usages among children abusing substances in Aizawl, Mizoram
3. To find out the consequences of substance abuse among children abusing substances and the coping strategies they utilise to cope with the challenges they face as a result of substance abuse.
4. To find out the dimensions of social support children abusing substances receive in their care and rehabilitation.
5. To suggest measure for social work intervention and social policy related to children and substance abuse.

2.4 Chapter Scheme

The Study is divided according to the following chapters:

1. Introduction
2. Review of Literature
3. Methodology
4. Results and Discussion
5. Conclusions

This study is exploratory in design. Mixed methods are applied which involves an approach to enquiry that contains qualitative and quantitative techniques.

3.1 Source of Data Collection

Primary Data are collected from children abusing substances. Secondary data are also collected from other sources such as parents/ guardians/stake holders and relevant literature and documents obtained from government and non-government agencies.

3.2 Sampling Procedure

The unit of study is a child who abuse substances from institutions and communities and all children who abuse substances in Mizoram constitute the population of the study.

A Multi-Stage Sampling procedure was used for selection of sample. Based upon highest populated District in Mizoram, Aizawl District was selected. In the second stage, institutions involved in the rehabilitation of children abusing substances were identified. Bawngkawn community that has the highest cases of children in conflict with law in the Juvenile Justice Board was also selected to identify the sample. From the community, list of children who abuse substance were collected from community leaders. Selection of the children was based upon Diagnostic Criteria for Substance Dependency according to DSM IV approach (1994) and Psychoactive Substance Disorder given by WHO (1993).All children who fit the criteria given by DSM IV approach (1994) and WHO (1993) were considered. For quantitative interview, 70 children were identified and for qualitative study, 22 children were identified. Overall, a total of 92 children who abused substances formed the sample size.

3.3 Tools of Data Collection

A semi-structured interview schedule formed the tool for data collection to collect information with regard to the objectives of the study. The contents of the tools were generated from different sources related to substances abuse and primarily based its foundation on DSM IV approach (1994) and WHO (1993). A pilot study

was also conducted to test the reliability of the tool and changes were made accordingly. Focus Group Discussions were also used to collect information. In-depth interviews were conducted to understand the lived experience of the children.

3.4 Data processing and Analysis

Data was analysed by using Microsoft Excel and SPSS Package. Descriptive analysis and simple frequency was used to highlight the findings of the study. Case vignettes are also presented to understand the lived experiences of children who abuse substances in Aizawl, Mizoram.

3.5 Ethical Considerations

Working with children who abuse substances is a sensitive topic that requires professional inputs and confidentiality. The names of the homes/ institutions were withheld to maintain confidentiality. Informed consent was acquired from the concerned authorities and the children and only those who gave their due consent formed the sample.

This chapter shall highlight the results and discussions of the findings of the study. It is divided into 9 (nine) sections that includes the socio, demographic profile,

1. **Socio-Demographic Profile**

This section covers the socio- demographic profile such as age-group, sub-tribe, religion/denomination, educational status, skills/vocational training of children, occupation of children, nature of work if employed, monthly income of full time worker, monthly income of part time worker, marital status of children, type of family, form of family, father's/guardian's educational level, mother's educational level, father's/ guardian's occupation, mother's occupation, family monthly income and socio economic category of family.

Table 1 Age Group

Sl.No	Age Group	Frequency	Percent
1	15-18 Years	55	78.6
2	10-14 Years	15	21.4
	Total	**70**	**100**

Source: Computed

Table 1 shows the distribution of respondents according to their age group. The table shows that majority(78.6%) of the children belong to the 15-18 years age group while a little over a fifth (21.4%) of them belong to 10-14 years age group.

Table 2 Sub-Tribe

Sl.No	Sub-Tribe	Frequency	Percent
1	Lusei	43	61.4
2	Non-Mizo	8	11.4
3	Hmar	7	10
4	Lai	6	8.6
5	Paite	5	7.1
6	Mara	1	1.4
	Total	**70**	**100**

Source: Computed

Table 2 indicates the distribution of children according to their sub-tribe. From the table, we see that majority (61.4%) of the children belongs to the Lusei tribe, followed by more than a tenth (11.4%) of them who are Non-Mizos, consisting of the Bru, Gorkhali, Kawl, Assamese and Bihari. A tenth (10%) of the children belong to the Hmar tribe and less than a tenth of the children belong to the Lai tribe (8.6%), Paite (7.1%) and a very few of them belong to the Mara tribe (1.4%).

Table 3 Religion/Denomination

Sl. No	Denomination	Frequency	Percent
1	Presbyterian Church	44	62.9
2	The Salvation Army	8	11.4
3	United Pentecostal Church	6	8.6
4	Baptist Church of Mizoram	4	5.7
5	Evangelical FCI	4	5.7
6	Local Christian Denomination	3	4.2
7	Catholic Church of Mizoram	1	1.4
	Total	**70**	**100**

Source: Computed

Table 3 shows the religious denomination of children. The table shows that majority of the children belongs to Presbyterian denomination (62.9%) followed by Salvation Army which constitute more than a tenth (11.4%) of the total number of children, Less than tenth of the children belong each belong to The Salvation Army (8%), United Pentecostal Church (4%), Baptist Church of Mizoram (5.7%), EFCI (5.7%) and Local Christian Denomination (4.2%). Very few (1.4%) of the children belong to the Catholic Church of Mizoram.

Table 4 Educational Status

Sl.No	Status	Frequency	Percent
1	Drop out	31	44.3
2	High School	20	28.6
3	Middle School	16	22.9
4	Illiterate	2	2.9
5	Higher Secondary School	1	1.4
	Total	**70**	**100**

Source: Computed

Table 4 highlights the distribution of children according to their Educational Status. The table shows that the number of drop outs among the children is very high (44.3%). Further, more than a fourth (28.6%) of the children are from the High School and more than a fifth (22.9%) of them are from the Middle School. Interestingly, there are 2.9 per cent of the children are illiterate and very few (1.4%) of them are from the higher secondary level.

Table 5 Skills/Vocational Training of children

Sl.No	Courses	Frequency	Percent
1	Music	49	70
2	Computer	32	45.7
3	Painting	7	10
4	Craft	2	2.9
5	Tailoring	1	1.4

Source: Computed

Table 5 shows the various courses undertaken by the children. There were some children who undertook more than one course. From the table, we can see that most of the children (70%) undergo music course followed by those (45.7%) who take computer course. A tenth (10%) of the children take painting course and very few (2.9%) of them take up craft as their skills/vocational training course. Last but not the least, fewer (1.4%) children engage in tailoring course.

Table 6 Occupation

Sl.No	Occupation	Frequency	Percent
1	Unemployed	43	61.4
2	Daily Labour	24	34.3
4	Informal Service Industry	2	2.9
6	Company Employee	1	1.4
	Total	**70**	**100**

Source: Computed

Table 6 shows the distribution of children according to their occupation. From the table, we see that majority (61.4%) of the children are unemployed while more than a third (34.3%) are engaged in daily labour. Further, few children (2.9%) work in informal service industry (Tea Stall and Car Wash) and fewer (1.4%) works as a company employee.

Table 7 Nature of work

Sl.No	Nature	Frequency	Percent
1	Full Time	14	51.9
2	Part Time	13	48.1
	Total	**27**	**100**

Source: Computed

Table 7 indicates the nature of work among those who are employed. The table shows that a little more than half (51.9%) of the children work full time while less than a half (48.1%) of them work on a part time basis.

Table 8 Monthly Income of full time worker

Sl.No	Income	Frequency	Percent
1	Rs. 1000-5000	7	50.0
2	Rs. 5000-10000	7	50.0
	Total	**14**	**100**

Source: Computed

Table 8 indicates the monthly income of full time worker of children. The table shows that half (50.0%) of the children earn between Rs.1000-5000 while another half (50.0%) of them earn between Rs.5000-10000.

Table 9 Monthly Incomes of Part Time Workers

Sl. No	Income	Frequency	Percent
1	Rs.1000-4000	11	84.6
2	Rs.8000	1	7.6
3	Rs 800	1	7.6
	Total	**13**	**100**

Source: Computed

Table 9 shows the monthly income of children who work on a part time basis. From the table, we see that majority (84.6%) of the children earn Rs.1000-4000 followed by less than a tenth of them who earn Rs. 8000. There were another 7.6 per cent of them who earn Rs.800.

Table 10 Marital Status of Children

Sl. No	Status	Frequency	Percent
1	Unmarried	66	94.3
2	Married	4	5.7
	Total	**70**	**100**

Source: Computed

Table 10 highlights the marital status of children. Findings indicate that among the children, only the females were married. While majority (94.3%) of them was married less than a tenth (5.7%) of them were married.

Table 11 Type of Family

Sl.No	Type	Frequency	Percent
1	Nuclear Family	41	58.6
2	Joint Family	29	41.4
	Total	**70**	**100**

Source: Computed

Table 11 shows the type of family of the children. The table shows that more than half (58.6%) of the children comes from a nuclear family while less than half (41.4%) of the children belong to a joint family.

Table 12 Form of Family

Sl.No	Form	Frequency	Percent
1	Stable	35	50.0
2	Broken	31	44.3
3	Reconstituted	4	5.7
	Total	**70**	**100**

Source: Computed

Table 12 reflects the distribution of children according to their form of family. The table shows that half (50.0%) of the children belong to a stable family while less than a half of them belong to a broken family . Less than a tenth (5.7%) of then children comes from a reconstituted family.

Table 13 Father's/Guardians' Educational Level

Sl.No	Level	Frequency	Percent
1	Don't Know	45	64.3
2	High School	12	17.1
3	Middle School	5	7.1
4	Graduate	3	4.3
5	Primary School	2	2.9
6	Post Graduate	2	2.9
7	Higher Secondary School	1	1.4
	Total	**70**	**100**

Source: Computed

Table 13 shows the educational level of the Father/ guardian of the children. From the table, we see that majority (64.3%) of the children did not know their father's/guardian's educational level. Among those who know, more than tenth (17.1%) of the children reported that their father/guardian studied till the middle level. Less than a tenth (7.1%) of them reported as having father/guardian who reached till the graduate level. Very few of the children had fathers/Guardians who studied till the primary, post graduate and higher secondary level.

Table 14 Mothers Educational Level

Sl. No	Level	Frequency	Percent
1	Don't Know	42	60.0
2	High School	11	15.7
3	Higher Secondary School	5	7.1
4	Middle School	4	5.7
5	Illiterate	3	4.3
6	Primary School	2	2.9
7	Graduate	2	2.9
8	Post Graduate	1	1.4
	Total	**70**	**100**

Source: Computed

Table 14 shows the distribution of children according to their mother's educational level. The table indicates that majority (60%) of the children are unaware about their mother's educational level. More than tenth (15.7%) finished their high school, followed by less than a tenth (7.1%) of the children who reported that their mothers finished the higher secondary school. A few of the children reported that their mothers completed their middle school, are illiterate, primary school, graduate and post graduate level.

Table 15 Fathers /Guardians Occupation

Sl.No	Occupation	Frequency	Percent
1	Daily Labour	24	34.3
2	Unemployed	14	20.0
3	Government Service	14	20.0
4	Driving	8	11.4
5	Business	5	7.1
6	Farmer	5	7.1
	Total	**70**	**100**

Source: Computed

Table 15 highlights the occupation of the children's' father/guardian. The table shows that more than a third (34.3%) of the children had fathers/guardians whose occupation was daily wage laborer, followed by children (20% each) whose parents were unemployed and Government servants. A little more than a tenth (11.4%) of the children's' fathers/guardian were drivers and less than a tenth (7.1% each) of the children had fathers/guardians who were businessmen and farmers.

Table 16 Mother's Occupation

Sl.No	Occupation	Frequency	Percent
1	Unemployed	23	32.9
2	Daily Labour	22	31.4
3	Business	16	22.9
4	Government Service	3	4.3
5	Agriculture	3	4.3
6	Service Industry	2	2.9
7	NGO worker	1	1.4
	Total	**70**	**100**

Source: Computed

Table 16 indicates the distribution of children according to the occupation of their mother. The table shows that less than a third (32.9%) of the children did not know their mother's occupation. Among those who knew, less than a third (31.4%) reported that their mothers worked as a daily labourer and more than a fifth (22.9%) of the children reported that their mothers were involved in business. Less than a tenth each reported that their mother's occupations were agriculture, service industry and NGO worker.

Table 17 Family Monthly Income

Sl.No	Income	Frequency	Percent
1	Don't know	35	50.0
2	Rs.10000-50000	21	30.0
3	Rs.5000-9000	12	17.1
4	Rs.3000-4000	1	1.4
5	Above Rs. 50000	1	1.4
	Total	**70**	**100**

Source: Computed

Table 17 shows the family monthly income of the children. From the table, we see that half (50%) of the children did not know their family's monthly income. Among those who know, less than third (30.0%) of the total children reported that their family earned a monthly income of Rs.10000-50000 while more than a tenth (17.1%) of the children had families who earned Rs.5000-9000. as shown in Table 18. A few of the children's' family earned a monthly income of Rs.3000-4000 and Above Rs.50000.

Table 18 Socio Economic Category of Family

Sl.No	Category	Frequency	Percent
1	Don't know	28	40.0
2	BPL	23	32.9
3	APL	13	18.6
4	AAY	6	8.6
	Total	**70**	**100**

Source: Computed

Table 18 shows the distribution of children according to their socio-economic category. The table shows that less than half (40%) of children do not know the socio economic category of their family. Among those who know, less than a third (32.9%) of the total children belong to BPL family followed by less than a fifth (18.6%) who belongs to APL family and less than a tenth (8.6%) who belongs to AAY family.

2. History of Substance Abuse

This section highlights the history of substance abuse and includes categories such as presence of substance abuser in the family, type of substances abused by family members, age of first initiation to substances by child, type of substance first abused and reason for substance abuse.

Table 19 Substance Abuser in the Family

Sl. No	Member	Frequency	Percent
1	Father	21	36.2
2	Sibling	15	25.9
3	Mother	10	17.2
4	Grandfather	7	12.1
5	Uncle	3	5.2
6	Cousin	2	3.4
	Total	**58**	**100**

Source: Computed

Table 19 highlights the distribution of children according to substance abusers in family. There were children who had more than one member in the family who abused substances. From the table we see that among those who abused substances, more than a third (36.2%) of the children’s fathers abused substances and more than a fourth (25.9%) of the children had siblings who abused substances. Less than a fifth (17.2%) of the children had mothers who abused substances and more than a tenth (12.1%) of the children had grandfathers who abused substances. A few of them had uncles and cousins who abused substances.

Table 20 Type of Substances abused by Family Members

Sl. No	Type	Frequency	Percent
1	Alcohol	45	64.3
2	No.4	4	5.7
3	Marijuana	2	2.9
4	Denrite	2	2.9
5	Pills	2	2.9

Source: Computed

Table 20 illustrates the types of substance abused by family members of the children. . The table shows that majority (64.3%) of the children had family members who abused alcohol while less than a tenth each had family members who abused No 4 (Heroine), marijuana, dendrite (Adhesive) and Pills.

Table 21 Age Group of first Initiation to Substance by the Child

Sl. No	Age group	Frequency	Percent
1	13-15 Years	28	40.0
2	10-12 Years	26	37.1
3	7-9 Years	10	14.3
4	16 -17 Years	6	8.6
	Total	**70**	**100**

Source: Computed

Table 21 indicates the distribution of children according to the age of their first initiation to substances. The table shows that less than half (40.0%) of the children first initiation to substance abuse was when they were 13-15 years of age followed by more than a third (37.1%) of the children whose first initiation to substances was when they were 10-12 years of age. More than a tenth (14.3%) of the children first initiated substances when they were only 7-9 years of age and less than a tenth (8.6%) of the children were 16-17 years when they first abused substances

Table 22 Types of Substance first abused

Sl. No	Type	Frequency	Percent
1	Alcohol	19	27.1
2	Tobacco	16	22.9
3	Marijuana	14	20.0
4	Denrite	13	18.6
5	Pills	5	7.1
6	No-4	2	2.9
7	Correcting Fluid	1	1.4
	Total	**70**	**100**

Source: Computed

Table 22 shows the distribution of children according to the types of substances first abused. From the table, we see than more than a fourth (27.1%) of the children reported that alcohol was the substance they first abused while less than a fourth (22.9%) of them reported that tobacco was the first substance they abused followed by a fifth (20.0%) of the children who reported that marijuana was the first substance they abused. Further, less than a fifth (18.6%) of the children reported that dendrite was the first substance they abused and for some the first substance they abused were pills, No. 4 (Heroine) and correcting fluid.

Table 23 Reason for Substance Abuse

Sl. No	Reason	Frequency	Percent
1	Experimentation	49	70.0
2	Peer Pressure	20	28.6
4	Unhappy Family environment	6	8.6
3	Depression	2	2.9
5	Presence of Substance abuser in the family	2	2.9

Source: Computed

Table 23 highlights the distribution of children according to the reason for substance abuse. From the table, we see that majority (70.0%) of the children abused substances because of experimentation while more than a fourth (28.6%) of the children abused substances because of peer pressure. Less than a tenth (8.6%) of the children abused substances because of unhappy family environment and a few (2.9% each) of the children abused substances because of depression and presence of substance abuser in the family.

3. Present Pattern of Substance Abuse

This section covers present pattern of substance abuse by the children which includes types of substance abused, mode of intake, dosage per use, frequency of intake and expenditure incurred per week.

Table 24 Types of Substances abused

Sl. No	Type	Frequency	Percent
1	Alcohol	41	59.0
2	Tobacco	40	57.1
3	Marijuana	29	41.4
4	Dendrite	24	34.3
5	No.4 (Heroine)	17	24.3
6	Pills	11	16.0
7	Cough Syrups	1	1.4

Source: Computed

Table 24 illustrates the types of substance abused by the respondent. Findings indicate that the children abused different types of substances at the same. The table indicates that more than half (59.0%) of the children abused alcohol followed by a close 57.1 per cent who abused tobacco and less than half (41.4%) who abused marijuana. More than a third 934.3 per cent of them abused dendrite and a fourth (24.3%) of them abused No.4 (Heroine). More than a tenth (16.0%) of the children abused pills and very few (1.4%) abused cough syrups.

Table 25 Mode of intake

Sl. No	Mode	Frequency	Percent
1	Smoke	51	73.0
2	Drink	42	60.0
3	Inhaling	28	40.0
4	Injecting	17	24.3
5	Chew	16	23.0

Source: Computed

Table 25 shows the distribution of children according the mode of intake. The table shows that majority (73.0%) of the children smoke and more than half (60.0%) drink while more than a fourth of the children inhale. A fourth (24.3%) of them inject and less than a fourth (23.0%) chew.

Table 26 Dosage per use of Alcohol

Sl. No	Dosage	Frequency	Percent
1	3 - 5 glasses	18	43.9
2	½ - 2 glasses	15	36.6
3	6 glasses and above	8	19.5
	Total	**41**	**100**

Source: Computed

Table 26 shows the distribution of children who abuse alcohol according to their dosage per use of alcohol. The table shows that less than half (43.9%) of those who abuse alcohol report that their dosage is 3- 5 glasses per use while more than a third (36.6%) of them report that their dosage range from ½ - 2 glasses per use and less than a fifth (19.5%) of them report that their dosage is 6 glasses and above per use of alcohol.

Table 27 Dosage per use of Marijuana

Sl. No	Dosage	Frequency	Percent
1	½ - 3 joints	27	93.1
2	4 - 6 joints	2	6.9
	Total	**29**	**100**

Source: Computed

Table 27 highlights the distribution of children who abuse marijuana according to their dosage per use. From the table, we see that majority of those who abuse marijuana report that their dosage range from ½ -3 joints per use while less than a tenth (6.9%) report that their dosage is between 4-6 joints per use.

Table 28 Dosage per use of No.4 (Heroine)

Sl. No	Dosage	Frequency	Percent
1	½ - 1red cap	14	82.4
2	2 - 3 red cap	3	17.6
	Total	**17**	**100**

Source: Computed

Table 28 indicates the distribution of children who abuse No.4 (Heroine) according to their dosage per use. The table shows that majority (82.4%) of the children who abuse No.4 (Heroine) report that their dosage is between ½-1 red cap per use while less than a fifth (17.6%) of them report that their dosage is 2-3 red cap per use.

Table 29 Dosage per use of Dendrite

Sl. No	Dosage	Frequency	Percent
1	¼ - ½ Tube	13	54.2
2	1-2 Tubes	11	45.8
	Total	**24**	**100**

Source: Computed

Table 29 shows the distribution of children who abuse dendrite according to their dosage per use. From the table, we see that more than half(54.2%) of the children who abuse dendrite report that their dosage is ¼- ½ tube per use while less than half (45.8%) of them report that their dosage is 1-2 tubes per use.

Table 30 Dosage per use of Pills

Sl. No	Dosage	Frequency	Percent
1	9 tablets and Above	5	45.4
2	2 - 5 tablets	3	27.3
3	6 - 8 tablets	3	27.3
	Total	**11**	**100**

Source: Computed

Table 30 highlights the distribution of children who abuse pills according to their dosage per use. The table shows that less than half (45.4%) of the children report that their dosage per use is 9 tablets and above while more than a fourth (27.3%) report that their dosage is 2-5 tablets per use and similarly less than a fourth (27.3%) of them report that their dosage is 6-8 tablets per use.

Table 31 Dosage per use of Cough Syrup

Sl. No	Dosage	Frequency	Percent
1	2 bottles	1	100

Source: Computed

Table 31 shows the distribution of children who abuse pills according to their dosage per use. From the table, we see that only one female respondent abused pill and her dosage per use is 2 bottles.

Table 32 Dosage per use of Tobacco

Sl. No	Dose per use of Tobacco	Frequency	Percent
1	½ - 2 Sticks	37	92.5
2	3 Sticks and Above	3	7.5
	Total	**40**	**100**

Source: Computed

Table 32 shows the distribution of children who abuse tobacco according to their dosage per use. The table indicates that majority (92.5%) of them report that their dosage is ½-2 Sticks while a few (7.5 %) of them report that their dosage is 3 Sticks and Above.

Table 33 Frequency of Substance intake per Week

Sl. No	Frequency	Substances						
		Alcohol N=41	Marijuana N=29	Dendrite N=24	No.4 (Heroin) N=17	Pills N=11	Tobacco N=40	Cough Syrup N=1
1	Don' Know	2 (4.9)	1 (3.4)	1 (4.2)	1 (5.9)	0 (0.0)	5 (12.5)	0 (0.0)
2	According to Availability	6 (14.6)	2 (6.9)	1 (4.2)	0 (0.0)	0 (0.0)	1 (2.5)	0 (0.0)
3	1-3 Times	20 (48.8)	11 (37.9)	13 (54.2)	3 (17.6)	2 (18.2)	4 (10.0)	1 (100.0)
4	4-6 Times	4 (9.8)	2 (6.9)	3 (12.5)	0 (0.0)	2 (18.2)	2 (5.0)	0 (0.0)
5	Every Day	9 (22.0)	13 (44.8)	6 (25.0)	13 (76.5)	7 (63.6)	28 (70.0)	0 (0.0)

Source: Computed Figures in parenthesis indicates percentages

Table 33 highlights the distribution of children according to the frequency of substance intake per week. From the table, we see that among those who abuse alcohol, almost half (48.8%) of them report that they drink 1-3 times per week while more than a fifth (22.0%) of them report that they drink every day. Further, more than a tenth (14.6%) report that they drink alcohol according to availability of alcohol and less than a tenth (9.8%) of them report that they drink 4-6 times a week.

The table also reveals that among those who abuse marijuana, less than half (44.8%) of them report that they smoke every day, followed by more than a third (37.9%) who smoke 1-3 times a week(37.9%) and less than a tenth (6.9% each) report that they smoke according to availability and 4-6 times a week.

Among those who abuse dendrite, more than half (54.2%) of them they inhale 1-3 times per week followed by those (25.0%) who inhale every day. More than a tenth (12.5%) report that they inhale 4-6 times a week and less than a tenth (4.2%) inhale according to the availability of the substance in a week.

From the table, we also see that among those who abuse No.4 (Heroin), majority (76.5%) of the children report that they inject everyday followed by those (17.6%) who inject 1-2 times a week.

For those who abuse pills, the table shows that majority (63.6%) of the children take it every day followed by less than a fifth (18.2 % each) who take 1-3 times and 4-6 times per week.

Further, the table shows that among those who abuse tobacco, majority (70.0%) of them smoke everyday followed by a tenth (10.0%) of them who smoke 1-3 times a week. Less than a tenth (5.0%) of them smoke 4-6 times a week and few (2.5%) of them smoke according to availability.

Lastly but not the least, there was only one female child who abused cough syrup and she drinks 1-3 times a week.

Table 34 Expenditure incurred for Substances per Week

Sl. No	Expenditure	Substances						
		Alcohol N=41	Marijuana N=29	Dendrite N=24	No.4 (Heroin) N=17	Pills N=11	Tobacco N=40	Cough Syrup N=1
1	Don't Know	6 (14.6)	4 (13.8)	1 (4.2)	5 (9.4)	0 (0.0)	2 (5.0)	0 (0.0)
2	Treated by Others	10 (24.3)	7 (24.1)	5 (20.8)	0 (0.0)	1 (9.1)	7 (17.5)	0 (0.0)
3	Below Rs.1000	22 (53.7)	18 (62.1)	18 (75.0)	0 (0.0)	8 (72.7)	31 (77.5)	1 (100.0)
4	Rs.1000-5000	3 (7.4)	0 (0.0)	0 (0.0)	5 (9.4)	2 (18.2)	0 (0.0)	0 (0.0)
5.	Rs.5000-10000	0 (0.0)	0 (0.0)	0 (0.0)	6 (35.3)	0 (0.0)	0 (0.0)	0 (0.0)
6.	Rs.17500	0 (0.0)	0 (0.0)	0 (0.0)	1 (5.9)	0 (0.0)	0 (0.0)	0 (0.0)

Source: Computed   Figures in parenthesis indicates percentages

Table 34 shows the distribution of children according to the expenditure incurred for the substances they abuse per week. The table, shows that among those who abuse alcohol, and apart from those (14.6%) who do not know how much they spend, more than half (53.7%) of them report that they spend below Rs. 1000 per week while a fourth (24.3%) of them are treated by others and less than a tenth (7.4%) of them spend Rs.1000-5000 in a week.

From the table, we also see that among those who abuse marijuana, apart from those (13.8%) who do not know how much they spend, majority (62.1%) of them report that they spend below Rs.1000 per week followed by a fourth (24.1%) of them who are treated by others.

The table also reveals that among those who abuse dendrite, apart from those (4.2%) who do not know how much they spend, majority (75.0%) of them spend below Rs.1000 while a fifth (20.8%) of them are treated by others.

The table also shows that among those who abuse No.4 (Heroin), and apart from those (9.4%) who do not know how much they spend, more than a third (35.3%) of them spend Rs.5000-10000 followed by less than a tenth (9.4%) who spends Rs.1000-5000 per week. Further, we also see that only one child spend Rs.17500 per week which constitutes 5.9 per cent of children who abuse N.4 (Heroin).

For those who abuse pills, majority (72.7%) of the children spend below Rs.1000 followed by less than a fifth (18.2%) of them who spend Rs.1000-5000. Very few of them are treated by others.

Further, from the table, we also see that among those who abuse tobacco, and apart from those (5.0%) who do not know how much they spend, majority (77.5%) of them spend below Rs.1000 per week followed by less than a fifth (17.5%) of them who are treated by others.

Lastly but not the least, there was only one female child who abused cough syrup and she spends below Rs.1000 per week.

4. Consequences of Substance Abuse and Coping Strategies of Children

This section covers the consequences faced by children as a result of substance abuse and the strategies they utilize to cope with the challenges they face.

Table 35 Consequences of Substance Abuse

Sl. No	Consequences	Frequency	Percent
1	Physical Health Problem	39	55.7
2	Family problem	37	52.9
3	Mental Health problem	30	42.9
4	Problem in studies	30	42.9
5	Problems in community	29	41.4
6	Drop out	15	21.4
7	Financial problem	14	20.0
8	Social stigma and discrimination	14	20.0
9	Work related Problem	2	2.9

Source: Computed

Table 35 shows the distribution of children according to the consequences of substance abuse. Findings indicate that there are multiple consequences faced by children because of their substance abuse.

The table shows that more than half (55.7%) of the children reported as having physical health problems because of substance abuse followed by a close 52.9 per cent of the children who face family problem as a result of substance abuse. There are those children (42.9 % each) who also face problems in studies and problems in the community. More than a fifth (21.4%) of the children dropped out as a result of substance abuse and a fifth (20 % each) face financial problem and social stigma and discrimination. Very few (2.9%) of the children face work related problems as a result of substance abuse.

Table 36 Coping Strategies

Sl. No.	Strategies	Frequency	Percent
1	Not socializing	29	41.4
2	Keeping good company	15	21.4
3	Self Actualization	28	14.0
4	Self discipline	8	11.4
5	Joining Gospel team	2	2.9

Source: Computed

Table 36 shows the distribution of children according to the coping strategies they use when faced with challenges because of substance abuse. The table reveals that less than half (41.4%) of the children cope by not socializing while more than a fifth (21.4%) cope with their challenges by keeping good company and more than a tenth (14.0%) of them cope through self actualization. There were a little more than a tenth (11.4%) of the children who cope by disciplining themselves and a few (2.9%) who cope by joining gospel team.

5. **Dimensions of Social Support**

This section covers the social support children receive from various sources, the form and quality of social support they receive.

Table 37 Social Support System

Sl. No	System	Frequency	Percent
1	Family	67	96.0
2	Government	66	94.0
3	Young Mizo Association (YMA)	34	49.0
4	Church	28	40.0
5	NGOs	9	13.0
6	Joint Action Committee (JAC)	3	4.0
7	Mizo Hmeichhe Insuihkhawm Pawl (MHIP)	2	3.0

Source: Computed

Table 37 indicates the distribution of children according to the social support they receive from various systems. The findings reveal that children received multiple supports from various sources in the community. The table shows that majority (96.0%) received support from the family and a close 94 per cent of the children received support from the government also. Almost half (49.0%) of the children reported as having supported by the Young Mizo Association (YMA), the largest youth organization in Mizoram and 40 per cent of children report as being supported

by the Church. More than a tenth (13.0%) of them report as being supported by the NGOs working in the area of substance abuse and a few of them also receive support from the Joint Action Committee (JAC), a community based committee represented by leaders of the community and the Mizo Hmeichhe Insuihkhawm Pawl (MHIP), the largest women organization in Mizoram.

Table 38 Form of support by various Support Systems in the community

Sl. No	Form	Frequency	Percent
1	Counselling by family	66	94.0
2	Medical Checkup by family	66	94.0
3	Rehabilitation by Government	66	94.0
4	Counselling by YMA	27	39.0
5	Home visit by youth leaders of the church	20	29.0
6	Counselling by youth leaders of the church	20	29.0
7	Conducting Gospel Camping by church	20	29.0
8	Counselling by NGOs working in the area of Substance Abuse	8	11.0
9	Counselling by MHIP	3	4.0
10	Blood test by NGOs working in the area of Substance Abuse	1	1.0

Source: Computed

Table 38 highlights the distribution of children according to the various forms of social support they receive from social support systems in the community. The table shows that the children receive multiple forms of support from various sources within the social support system of the community. From the table, we see that majority (94.0%) of the children report as having received counseling and medical checkup by their family. Similarly, majority of the children (94.0%) also receive support in the form of rehabilitation from the government. More than a third (39.0%) of the children receive support in the form of counseling by the YMA and more than a fourth (29.0% each) receive support in the form of home visit, counseling and gospel camping from church leaders. A little more than a tenth (11.0%) of the children receive support in a form of counseling from NGOs working in the area of substance abuse. Very few (4.0%) of them receive support in the form of counseling by MHIP and fewer (1.0%) receive support in the form of blood test by NGOs working in the area of substance abuse.

Table 39 Quality of Social Support

SL.No	Source	None	Very Poor	Poor	Good	Very Good	Total	Mean
1	Family	3	1	9	29	28	70	3.1
2	Government	6	0	5	47	12	70	2.8
3	Church	40	0	7	16	7	70	1.3
4	YMA	39	4	12	12	3	70	1.1
5	NGOs	62	0	1	1	6	70	0.4
6	MHIP	68	0	0	0	2	70	0.1
7	JAC	68	1	1	0	0	70	0.0
	Total Average Mean							1.3

Source: Computed

Table 39 shows the distribution of children according to the quality of social support they receive from various support systems in the community. The quality of support is measured by a four point scale where 4 is Very Good, 3 is Good, 2 is Poor and 1 is very Poor. The table reveals that the quality of support given to children by the family and the government is very good while the quality of support given by the church, the YMA, the NGOs working in the area of substance abuse, MHIP and JAC is poor. Overall, the table shows that quality of social support received by children who abuse substances from social support system in the community is poor.

6. Suggestions

This section covers the suggestion given by the children for prevention of substance abuse among children and also includes suggestions made by them to improve social support service in the community

Table 40 Suggestion for Prevention of Substance Abuse among children

Sl. No	Suggestion	Frequency	Percent
1	Abstinence	40	57.1
2	Keeping good peers	17	24.3
3	Less socializing and learning good habits	5	7.1
4	Obeying parents	4	5.7
5	Going to school	1	1.4

Source: Computed

Table 40 shows the distribution of children according to the suggestion for prevention of Substance Abuse among children. From the table, we see that more than half (57.1%) of the children suggested for abstinence to prevent substance abuse among children while a fourth (24.3%) of the children suggested for keeping good peers for prevention of the same. Less than a tenth (7.1%) suggested for less

socializing and learning good habits while 5.7 per cent of them suggested for obedience of parents. Lastly but not the least, very few (1.4%) suggested for going to school to prevent substance abuse among children.

Table 41 Suggestion to improve Social Support Service

Sl. No	Suggestion's	Frequency	Percent
1	More awareness	25	35.7
2	More counseling services	17	24.3
3	Good family environment	11	15.7
4	Vocational training programme	3	4.3

Source: Computed

Table 41 shows the distribution of children according to the suggestion they made to improve support services in the community. The table highlights that more than a third (35.7%) of the children suggested for more awareness followed by a fourth (24.3%) of them who suggested for more counseling services and more than a fifth (15.7%) of the children suggested for good family environment to improve social support services in the community. Further, less than a tenth (4.3%) of the children suggested for vocational training programme.

7. Case Vignettes

In-depth interviews were conducted in order to understand the lived experiences of children abusing substance in Aizawl, Mizoram. These interviews were conducted with 3 (three) girls and 3 (three) boys abusing substances.

7.1 Case 1

Sawma (Fictitious) is a 17 year old boy who was born out of wedlock. He was not abandoned as such and both his parents stayed together. However, soon after, he was born, his parents separated. After the separation, his father remarried and had three children. However, he would often visit Sawma whenever he visited Aizawl. Sawma was very close to his father as a result of this. Sawma's mother never remarried however, she had a son elder to Sawma from another person. She worked as a teacher in a Government School and supported and looked after her children. They lived in a joint family with his maternal parents and uncle.

Sawma went to a formal school till class 8. He left formal schooling but continued his studies through open education. He first got acquainted with alcohol

and later No. 4 (Heroine) from his friends. Though he abstained in the beginning, he could no longer 'not be a part of it' as all his friends were indulged in substance abuse. It was in 2014 that he first started abusing drugs.

In 2015, when his father passed away, he was deeply affected by his tragic loss that he started abusing substances on a regular basis to ease his pain. He mainly abuses No 4 (Heroine) which he takes everyday and also consumes alcohol and pills (Alprazolam)

In weekdays he enjoys going out with his friends who abuse substances with him. But on Sundays, he would stay home and consume alcohol. This continued till 2017 when he decided to stop. However, as fate would have had it, just when he was aboutn to have a new life, he was diagnosed of HIV in February 2018 which he believed that he acquired it from unprotected sex. This tragic news was a huge blow to him and feeling lost and depressed, he continued using drugs again. He also has a habit of stealing whenever he was high.

Analysis of Case 1

The case shows that the demise of parents greatly affects a child emotionally, as in the case of Sawma, although he had tried substance before it is only after the demise of his father that he started to abuse the substance even more. It also shows how peer pressure is an important influencing factor for substance abuse. Risk factors that crops up with substance abusers such as unsafe sex also creates other surmounting problems and in this case, Sawma's news of being diagnosed as HIV positive cound be a perfect example of it which leads to further deterioration of hope and more indulgence in substance abuse among children in Aizawl, Mizoram. This case also reveals how children abuse multiple forms of substances in Aizawl, Mizoram.

7.2 Case 2

Dina (Fictitious) is a 11 year old boy who lives with his father, three biological siblings and one half brother and step mother. His biological mother ran away with another man when he was still an infant. Since then, his father looked after Dina and his siblings by working as a daily labourer.

Dina's father remarried to a single mother who had a son older than Dina and his siblings. Dina's half brother also works in a car wash and his step mother sells vegetables in the market. Dina's elder brother also works as a truck handy man. Dina and his brother Mawia (Fictitious) goes to a Government Middle School in their community, currently studying in class 5 and 6.

Dina along with his brother Mawia started smoking tobacco at a very young age and Dina had already inhaled Dendrite (Adhesive) when he was in Class 3. According to him, his friends tempted him to take Dendrite because under its influence, he would be able to command the wind the winds to blow, fly the moon and play with the clouds at his will. With such tempting world, he started using it and eventually became dependent to it. In weekdays, he inhaled the substance after school and in holidays he along with his brother Mawia would inhale one full tube.

One day, his father found out about their behaviour and punished them with a cane. As is it would have created some change in them, they stopped taking the substance for three days and continued taking it after that. They often run away from school as their interest in studies faded eventually with their habitual behaviour taking its toll on them.

Analysis of case 2

This case vividly reveals the background of children who abuse substances - a mother who abandons her children for another man and children left without any maternal care. Though these experiences could have some contributing factors in this case, Dina's case is more about how younger children are more vulnerable to substance abuse through peer pressure. Being indulged in substances as young as when children are in Class 3 reveals how the problem of substance abuse has penetrated social fabric in Aizawl at its core. This case also reveals how substance abuse leads to truancy of children and then later lead to drop out?

7.3 Case 3

Mala (Fictitious) is a 15 years old boy whose parents divorced and whose mother remarried with another man to have two other children between them. Though Mala did not know much about his biological father's whereabouts, he knew that his

father was a substance abuser. Mala had one brother and both of them were looked after by their grandparents.

Mala’s main reason for initiation to substances was because of experimentation. He started smoking Tobacco at the age of 8 and when he was 10 years old, he started abusing Alcohol and smoking Ganja at least once a month. Then, his habits turned to inhaling Dendrite at the age of 13 and then as if his experimentation would not stop, he started injecting No 4 (Heroine) at the age of 14 years. Among all the substances he abused, he enjoyed Ganja the most which he smokes very regularly.

Mala related that since he was ashy and timid person, the ‘high’ that he gets from the substances that he abuses gives him confidence when he was with his friends. However, he also informed that he use to have anxiety, suicidal ideations and attempts, aggressive outburst and hallucinations. As a result of this, he was taken to various psychiatrists. He wanted to stop his behaviour and as such his grandparents admitted him to a rehabilitation centre in 2018.

Analysis of case 3

This case highlights experimentation as an important factor leading to substance abuse. It also reveals that one abuse of substances leads to another and more serious cases of substances that are abused eventually. Further, in Mala’s case we also see that a person’s personality traits such as shyness and timidity can also be one contributing factor that acts as a defence mechanism which further promotes substance abuse. Last but not the least, similar to the earlier case, we see how children at a very young age indulge in substance abuse and how in time, substance abuse cause*s* various psychiatric disorders such as anxiety, suicidal ideation, aggressiveness and outbursts.

7.4 Case 4

Rini (Fictitious) is a 16 year old girl whose parents divorced when she was very young. She is the eldest among the siblings. She along with her siblings stayed with their mother until her father took her from her mother when she was only 5 years. From then on, she stayed with her father. At times she would also stay with her

mother according to convenience. Her mother and father remarried to different persons.

In 2015, when she was staying with her mother, she was introduced to substances (Pills) by her friend. Eventually, she dropped out from school when she was studying in Class 7 in 2016 blaming it on her weakness in studies.

Her mother became aware of her habit in the initial stage of her substance abuse. She was advised and scolded and she stopped taking pills for a while. When she returned back to her father, and having nothing to do at home, since she dropped out, she became bored, and to ease her boredom, she took Pills (Spasmodart) again. She took 5-6 pills at a time, twice a week. Her step brother caught her and she stopped for a while. Soon after, due to peer pressure, she continued again and her dosage became heavier with time and each intake.

Analysis of Case 4

Rini's case reveals that there is no gender difference in the factors that contributes to substance abuse. Though there would have been specks of social factors such as divorce of parents and living in both parent's house according to convenience which could act as a trigger to substance abuse, we see that peer pressure is the main factor for Rini to indulge in substance abuse. This case also reveals how a child becomes a drop out after abusing substances and how such circumstances leaves a child idle without any outlet leaving the child to be at risk of being vulnerable to substance abuse.

7.5 Case 5

Kimi (Fictitious) is a 17 year old adolescent girl whose parents had divorced when she was very young. She is looked after by her mother who works in a government office. Her mother remarried in 2014 and they had one child. Soon after their marriage, she divorced her husband because of his drinking habits. Her biological father also got married with another person and they have 5 children.

Kimi was first introduced to drugs (Pills) by her friends when she was studying in Class 6. She dropped out from school at the age of 13 years after finishing

class 8 in 2015. During this time she abused drugs twice a week and gradually her dosage increased in 2017 when she started taking it every day.

She took Temfix, initially 3 pills at a time, twice daily, later followed by other Pills such as Eldospas, Cyclopam, Alprazolam, Spasmodart and Spasmolar. Due to her behaviour, she found it difficult to fit in a normal family environment, as she was most of the time under the influence of the substance she took.

There were times when she could not even go home because she was 'too high' and in 2017, there were times when she did not even go home at all. Due to her behaviour, her family environment got affected. She felt lonely and started developing the habit of stealing. Seeing her daughter in such a helpless situation, her mother decided to admit her in a rehabilitation centre with the hope of her abstaining from drugs. During her stay in the centre, from a medical check-up conducted, she came to know that she had acquired Hepatitis C which she believed to have acquired from an unprotected sex. She hoped that she will be able to abstain from the substance and her future plan includes going to school or taking up a tailoring course for her skill development.

Analysis of Case 5

Kimi's case also reveals how peer pressure leads to substance abuse among children. It also shows how substance abuse leads to drop out and how school drop outs become more vulnerable to substance abuse. Further, this case also highlights how children as a result of substance abuse remain outside their homes and how it affects the family and the emotions of the child. This case also reveals, how unprotected teenage sex leads to health problems and these could all be an indication of how substance abuse leads to further problems. It also shows how family intervention and rehabilitation centres can motivate children to abstain from drugs and live a normal life befitting of a child.

7.6 Case 6.

Jenny (Fictitious), is 17 years old teenage girl whose parents were substance abusers. Her father died of alcohol related abuse in 2014 and her mother is a recovering addict who works in a Rehabilitation centre. Jenny has two elder brothers

who also abuses substances. One is in a rehabilitation centre and the other is convicted for stealing in the District Jail.

Jenny dropped out from school when she was in Class 9 in 2015 and she eloped with a person who introduced her to No 4 (Heroine). Although they were not together anymore, Jenny continued taking the same with the thought that she could stop whenever she wanted to. However, the drug took a toll on her and when she tried to stop it, the withdrawal symptom was too much for her to bear and so she could not overcome it and continued abusing it and in time in a much higher dosage that seemed to give her the right kind of 'kick' giving her confidence and energy.

She worked in a shop to earn and she stayed out of their home quite often, spending the nights, sleeping in corridors of buildings within the city. She suffered from health problems and would steal and lie quite often. Her family do not have a permanent residence and their application for shelter given by the government was rejected. So they live with their relatives in Aizawl.

Jenny was eventually admitted in a rehabilitation centre in February 2018. During her stay, she found that she was diagnosed of HIV/AIDS in March and she believed that she acquired it from unprotected sex or sharing of needles.

Analysis of Case7

This case reveals that a presence of substance abuser in the family especially the mother and father increases the vulnerability of the children to substance abuse. Lack of family support has led Jenny to experience circumstances to leave her home with another man who introduced her to the drug. This case also reveals how such lack of support leaves the child helpless wondering away from home and nowhere to go to and nothing to consider as her own. We also see how it leads to other social problems related to health and behavioural problems such as stealing and lying. To make things worse, children also become vulnerable to HIV/AIDS because of unprotected sex or sharing of needles.

8. Focus Group Discussion

A focus group discussion was also conducted with the children in order to garner more participation of the children during the research process. The findings has

brought about qualitative data about children who abuse substances in Aizawl, Mizoram. The Focus Group Discussion was conducted with two groups, one being 8 boys who abuse substances and the other being 10 girls who abuse substances. The discussion mainly covered topics regarding the causes, types and consequences of substance abuse (d) and suggestion to solve problems of substance abuse among children.

8.1 Focus Group Discussion with Boys

The findings are as follows:

a) The types of substances that are commonly abused by male children in Aizawl are No.4 (Heroine), Alcohol, Dendrite, Pills (Alprazolam, Nap 10, Tramadol SR), Codeine, Marijuana, Corex, Petrol, Correcting fluid, and Omni.

b) Substance Abuse leads to depression, temper tantrums, stealing, mood swings, carelessness, failure in life and health related problems such as HIV/AIDS and physical disability.

c) Substance Abuse also leads to family disputes and mistrust among the family members, it breaks the family apart, disgrace to the family, degrade the family and may also a sense of alienation from the family.

d) Socially, a child who abuse substance is despised by their peers in the community, alienation from the community and disputes among friends in the community. They are also considered as misfits by the community members and they face stigma from the community members.

e) Suggestions to solve the problem of substance abuse include organizing gospel camping for children abusing substance, Vocational training porgrammes in their interest area, maintaining confidentiality in the community about them, awareness regarding child rights in the community as many community leaders are unaware of child rights.

8.2 Focus Group Discussion with Girls

The findings are as follows:

a) The types of substance that are commonly abused by female children in Aizawl are Alcohol, Pills (Alprazolam, Tramatore SR, Tumi Spas,

Spasmolar/Spasmodart, Peptica, Control, Endospas), No-4 (Heroine), Dendrite/Fevicol, Marijuana, Correcting fluid and Avatar.

b) The common reasons for female children being engaged into substance abuse include experimentation, peer pressure, unhappy environment, escapism, stubbornness due to envy of a normal family in the cases of broken family.
c) Substance Abuse leads to depression, behavioural problems like strealing, effects health and appearances of a person, failure in life, leads to disparity and family disputes and mistrust among the family members.
d) Socially children who abuse substances are treated as misfits in the community and they experience stigma.

9. Participatory techniques

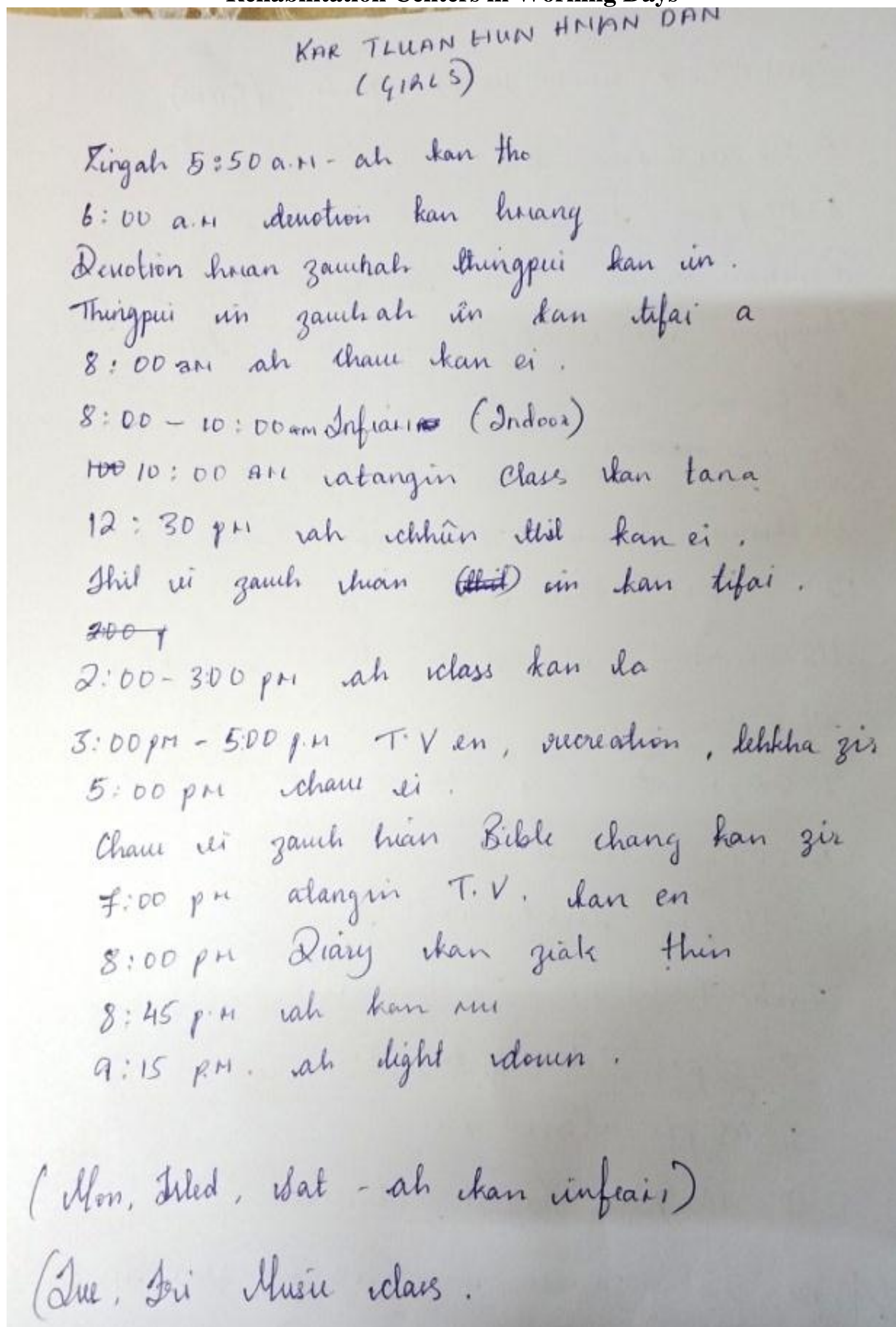
Daily Activities Schedule was also conducted with the children who were in the rehabilitation centre in order to find out the activities of children in placed in rehabilitation centers and those living in communities with their families.

Diagram 1 shows the Daily Activities Schedule of Non School Going Girls placed in rehabilitation centre during Working Days. The Diagram shows the following activities:

a) They wake up at 5:30 am.
b) They have devotion at 6:00
c) After Devotion, they drink tea and clean the surroundings.
d) They have morning meal at 8:00 am
e) After Meal, they have indoor recreational activities till 10:00 am.
f) They start Vocational Classes at 10:00 am till 12:30pm.
g) At 12:30 pm, they have afternoon snacks.
h) After snacks, they clean the surroundings.
i) This is followed by work duties till 2;00 pm
j) They continue Vocational Classes from 2:00 pm till 3:00pm.
k) They have recreational activities like watching TV, play and study till 5:00 pm.
l) They eat dinner at 5:00 pm.
m) After dinner they study verses in the Bible.
n) Then, they watch TV till 7:00 pm

Diagram 1

Daily Activities Schedule of Non-School Going Girls placed in Rehabilitation Centers in Working Days



KAR TLUAN HUN HMAN DAN
(GIRLS)

Zingah 5:50 a.m - ah kan tho
6:00 a.m devotion kan hmang
Devotion hman zawhah thingpui kan in.
Thingpui in zawh ah in kan tifai a
8:00 am ah chaw kan ei.
8:00 – 10:00 am Infiamna (Indoor)
10:00 AM atangin Class kan tan a
12:30 pm vah chhûn thil kan ei.
Thil ei zawh chuan in kan tifai.
2:00 - 3:00 pm ah class kan la
3:00 pm - 5:00 p.m T.V en, recreation, lehkha zir
5:00 pm chaw ei.
Chaw ei zawh hian Bible chang kan zir
7:00 pm atangin T.V. kan en
8:00 pm Diary kan ziak thin
8:45 p.m vah kan mu
9:15 p.m. ah light down.

(Mon, Wed, Sat - ah kan infiam)
(Tue, Fri Music class.

o) At 8:00 pm the children write their diary.

p) At 8:45 pm, they go to bed.

q) Lights down at 9:15 pm

Diagram 2
Daily Activities Schedule of Non-School Going Girls placed in Rehabilitation Centers on Sundays

SUNDAY. A HUN HMAN DAN (GIRLS)

5:50 am ah kan tho.

6:00 am devotion

Devotion zawh hian thingpui kan in.

Thingpui in zawhah in kan tifai.

8:00 am chaw ei.

9:15 am inkhawm a.

Inkhawm banah TV. infiam (Indoor)

12:30 pm thil kan ei a

Thlum thil ei zawh hian in kan tifai a.

1:00pm - 5:00pm T.V. en,

5:00pm chaw ei.

6:15 pm Inkhawm tan

7:00pm T.V. en

8:00 pm Diary kan ziak

8:45 pm Kan mu

9:15 pm Light down.

(Wed, Sat zanah kan inkhawm thin)

Diagram 2 shows the Daily Activities Schedule of Non School Going Girls placed in Rehabilitation Centers on Sundays. The Diagram shows the following activities:

a) They wake up at 5:30 am.
b) They have devotion at 6:00
c) After Devotion, they drink tea and clean the surroundings.
d) They have morning meal at 8:00 am
e) At 9:15 am, they go to Church
f) After Church, they watch TV and play indoors.
g) At 12:30 pm we have afternoon snacks.
h) After snacks, we clean the surroundings.
i) At 1:00 pm to 5:00 pm, they watch TV.
j) They eat dinner at 5:00 pm.
k) At 6:15 pm, they go to Church
l) After Church, they watch TV till 8:00 pm.
m) At 8:00 pm they write their diary.
n) At 8:45 pm, they go to bed.
o) Lights down at 9:15pm.

Diagram 3 shows the Daily Activities Schedule School Going Boys placed in Rehabilitation Centers on Working Days. The Diagram shows the following activities:

a) They wake up at 6:00 am
b) They have devotion at 6:30 AM
c) They have morning tea at 6:45 pm
d) They study at 7:30 am. In Tuesdays and Thursdays, they go to the gym.
e) They have devotion at 8:00 am
f) They have morning meal at 8:30 am
g) They start class from 9:30 am -10:00 am.
h) On Mondays and Wednesdays, they attend vocational classes at 11:00 am
i) At 12:30 pm, they have afternoon snacks
j) They continue Class at 2:30 pm. In Tuesdays and Thursdays, they play.
k) They study from 3:00 pm – 4:00 pm
l) They have evening devotion at 5:00 pm

Diagram 3
Daily Activities Schedule for School Going Boys placed in Rehabilitation Centres on Working Days

DAILY ACTIVITY SCHEDULE ON WEEKDAY FOR SCHOOL GOING CHILDREN

6:00 - Zing thawh.

6:30 - Zing devotion.

6:45 - Zing thingpui.

7:00 - Lehkha zir. – Tuesday leh thursday ah gym ~~kua~~ hun kan nei thin.

8:00 - devotion.

8:30 - Zing chaw.

~~10:00~~ Monday ~~ah chu~~ leh wednesday ah chuan 9:30 ah class kan nei a.

Tuesday, Thursday, Friday ah chuan dar 10:00 ah class kan nei.

Monday leh wednesday ah dar 11:00 ah vacational class kan nei a.

12:30 - chhun thlei.

2:30 - class – Tuesday leh thursday ah dar 2:30-ah inkhelh.

3:00-4:00 → Lehkha zir.

5:00 - thlai devotion.

5:30 - Tlai chaw ei.

6:00-7:15 - T.V. En.

7:15-7:30 - dairy leh dairy inventory vel ziak a thai.

7:30 - devotion.

8:00 - Mut.

m) They have dinner at 5:30 pm

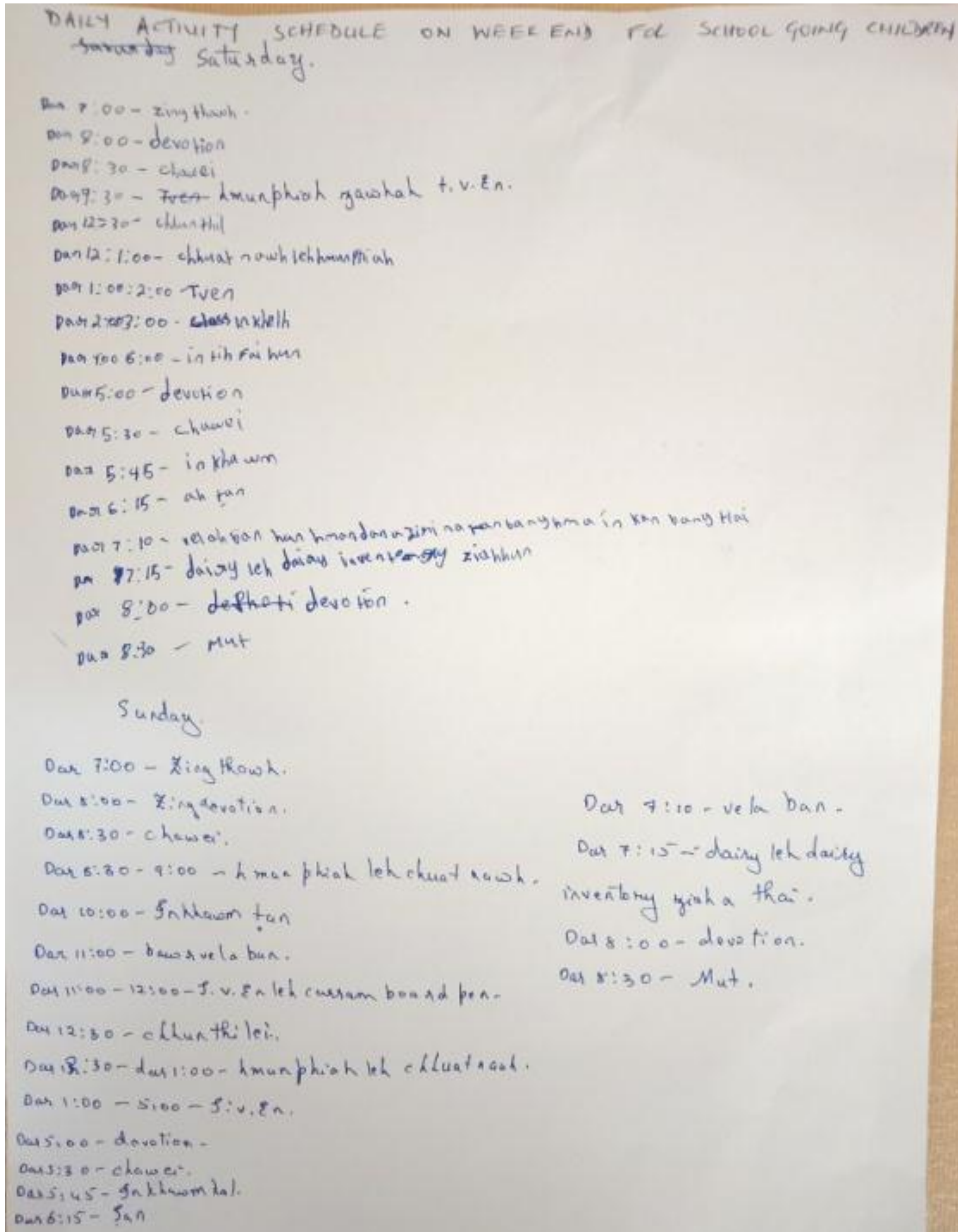
n) They watch TV from 6;00 pm – 7:15 pm

o) They write their diary from 7:15 pm -7:30 pm

p) They have devotion at 7:30 pm

q) They sleep at 8:00 pm

Diagram 4
Daily Activities Schedule for School Going Boys placed in Rehabilitation Centres on Weekends


DAILY ACTIVITY SCHEDULE ON WEEK END FOR SCHOOL GOING CHILDREN

Saturday.

Dar 7:00 – Zing thawh.
Dar 8:00 – devotion
Dar 8:30 – chawei
Dar 9:30 – hmunphiah ngawhah t.v. en.
Dar 12:30 – chhunthil
Dar 12:1:00 – chhuat nawh leh hmunphiah
Dar 1:00–2:00 – Tuen
Dar 2:00–3:00 – inkhelh
Dar 4:00–6:00 – in tih fai hun
Dar 5:00 – devotion
Dar 5:30 – chawei
Dar 5:45 – inkhawm
Dar 6:15 – ah tan
Dar 7:10 – velahban hun hmandan a ziak na pan bang hma in kan bang Hai
Dar 7:15 – dairy leh dairy inventory ziahhun
Dar 8:00 – devotion.
Dar 8:30 – Mut

Sunday

Dar 7:00 – Zing thawh.
Dar 8:00 – Zing devotion.
Dar 8:30 – chawei.
Dar 8:30 – 9:00 – hmun phiah leh chhuat nawh.
Dar 10:00 – Inkhawm tan
Dar 11:00 – bawr vela bun.
Dar 11:00 – 12:00 – T.v. En leh carram board pen.
Dar 12:30 – chhunthilei.
Dar 12:30 – dar 1:00 – hmunphiah leh chhuat nawh.
Dar 1:00 – 5:00 – T.v. En.
Dar 5:00 – devotion.
Dar 5:30 – chawei.
Dar 5:45 – Inkhawm hal.
Dar 6:15 – Tan
Dar 7:10 – vela ban.
Dar 7:15 – dairy leh dairy inventory ziah a thai.
Dar 8:00 – devotion.
Dar 8:30 – Mut.

Diagram 4 shows the Daily Activities Schedule of School Going Boys placed in Rehabilitation Centers on Weekends. The Diagram shows the following activities:

a) They wake up on 7:00am
b) They have devotion at 8:00 am
c) They have morning meal at 8:30 am.
d) Cleaning chores are done from 9:30am till 12:30 pm
e) At 12:30 pm, an afternoon snack is served.
f) The cleaning chores continue till 1:00pm
g) They watch TV from 1:00-2:00pm.
h) From 2:00 pm till 5:00pm, the children play
i) They have devotion at 5:00 pm.
j) They have dinner at 5:30 pm
k) They have evening devotion at 5:45 pm.
l) They have dairy inventory period till 8:00 pm
m) They sleep at 8:30pm.

The activities schedule for Saturday and Sunday are almost similar except that on Sundays, devotion starts at 10:00 am till about 11:00 am. The children relax after the service and afternoon snack is served at 12:30 pm. During 12:30 pm- 1:00 pm, the children perform their work duties and after that they watch TV till 5:00 pm. Evening devotion starts at 5:00 pm followed by dinner at 5:30 pm after which the schedule are similar with Saturdays.

Diagram 5 shows the Daily Activities Schedule of Non-School Going Boys placed in Rehabilitation Centers on Working Days. The Diagram shows the following activities:

a) They wake up at 6:00 am
b) They have devotion at 6:30 am
c) After devotion, they have morning tea.
d) At 7:00 am, they have a time for Physical fitness activity by going to Gym. They also watch TV and study in some days.
e) They have morning meal at 8:00 am.
f) They have Vocational Classes from 10:00 am.
g) They have afternoon snacks at 12:30 pm

Diagram 5
Daily Activities Schedule for Non-School Going Boys placed in Rehabilitation Centers on Working Days

Week days (Kar lhuan a hun hman dan)

Monday, Wednesday, Friday

6:00 - Zing thawh hun
6:30 - Dinosion (~~...~~) leh thingpui leh chhang.
7:00 - Gym.
8:00 - Chaw ei
10:00 - Vocational class.
12:30 - Chhun thingpui.
2:00 - Class.
2:30 - Football.
4:30 - Football ban hun.
5:00 - Chaw ei hun
7:30 - Dinosion.
8:30 - Light down

Tuesday, Thursday.

6:00 - Zing thawh hun.
6:30 - Dinosion, thingpui leh chhang.
7:00 - T.v leh lehkhabu te kan chhiara.
8:00 - Dinosion chuan chaw ei.
8:00 - 12:30 - T.v leh lehkhabu te kan chhiar a.
12:30 - Chhun thingpui.
12:30 - 5:00 - kan awm awl.
5:00 - ~~Dar~~ Dinosion leh chaw ei
5:00 - 7:30 - Kan awm awl.
7:30 - Dinosion
8:30 - Light down.

h) From 2:00 pm, the classes resume

i) After classes, they play football at 2:30

j) Dinner is served at 5:00 pm

k) They have devotion from 7:30 pm.

l) Lights a down at 8:30 pm.

Diagram 6
Daily Activities Schedule for Non-School Going Boys placed in Rehabilitation Centers on Week Ends

WEEK END (KAR TAWP A HUN HMAN DAN)

Saturday

7:00 AM Ah zing thawh a chuan kan thawh hma ni chuan zingah - Devotion kan hmang lo a.

8:30 AM Ah Devotion kan hmanga chuan chaw kan eia. chaw ei - kham ah hmun kan tifela chhuat te kan nawt a chuan kan Duty - te kan tih zawh ah Dam Dawi ei tur pei in an eia.

10:00 Ah kion hna thawh tur a awm changin kan thawka chuan hna thawh tur a awm loh chuan DAR 10:00 Atanga DAR 12:00 - hichu Lehkhabu chhiar nan leh Tv en nan te hun kan hmang.

12:30 Ah chhun thil kan ei a chuan chhuat kan nawta DAR 12:30 - Atanga DAR 5:00 pm inkar chu engvak mah kan tilo.

5:30 Ah Devotion kan hmanga chuan chaw kan eia.

6:15 Ah kan in khawma DAR 6:30 Ah kan tana

7:30 Ah Diary kan ziaka chuan Devotion kan hmanga.

8:00 Ah kan mua chuan 8:30 Ah light Down.

Sunday

7:00 Ah kan thoa

8:30 Ah Devotion leh chaw ei chuan hmun tih fai.

9:15 Ah kan in khawm a DAR 10:00 Ah kan bang.

10:00 Atanga 12:00 chu Tv. kan ena.

12:30 Ah lunch kan eia. 12:30 Atanga 5:30 PM chu MOVIE kan ena - a changin Sir ten min leng pui a.

5:30 Ah Devotion kan neia chaw kan eia

6:14 Ah KAN IN khawma 7:30 Ah Devotion leh Diary kan ziaka -

8:30 Ah light Down

Diagram 6 shows the Daily Activities Schedule of Non-School Going Boys placed in Rehabilitation Centers on Weekends. The Diagram shows the following activities:

a) On Saturday, they wake up on 7:00pm.
b) Morning devotion and meal starts from 8:30 am.
c) Work duty follows
d) From 10:00 am till 12:30 am, the children have library period.
e) After lunch, the children relax, watching TV and play.
f) They have dinner at 5:30 pm.
g) Evening devotion starts at 6:15 pm
h) At 7:30 pm, they write their diary
i) They sleep at 8:00 pm.

On Sunday, devotion starts from 9:15 am till 10:00 am. They watch TV till 5:30 pm. The staffs also sometimes take the children for outing during this period. At 5:30 pm, the children have dinner after which the schedule is similar.

Table 42 Daily Activities Schedule of Children from the communities who Abuse Substances

Working Days		Holidays	
Time	**Activities**	**Time**	**Activities**
6:00 am	They wake up	**8:00 am**	They wake up
7:30 am	They eat morning meal	**8:00 am-9:00 am**	Leisure Time
8:00 am	They go to school	**9:00 am**	Morning Meal
2:30 pm	School is over	**9:00 am -10:00 pm**	Leisure time/Playing or Hanging out with friends /Studying/Doing Drugs / Dinner
2:30 pm-5:00 pm	Leisure time/Playing or Hanging out with friends/Studying/ Doing Drugs	**10:00 pm**	Sleep
5:00 pm	Dinner		
5:15 pm -9:00 pm	Leisure time/Playing indoor /Studying/Going to friends place/ Doing Drugs	**-**	**-**
9:00 pm	Sleep		

Table 42 shows the Daily Activities of children from the communities who abuse substances. The table shows that apart from their daily normal routine, on working days, frequency of indulging in substances is more on working days than holidays while time spent for indulging in substances is more in holidays than in working days.

When comparing the children placed in Rehabilitation centres and those from the communities, we can see that the children from the communities who are not placed in rehabilitation centres are more vulnerable to substance abuse.

Children are the pride and future of the Nation, today's children are tomorrow's adults and builder of the nation due to the abundant availability of substance in the community and also because of the certain driving factor substance abuse in children today is becoming a major problem in India. The transition from adolescence to young adulthood is a crucial period in which experimentation with substance in many cases begins. Due to their innate curiosity and thirst for new experiences, peer pressures, their resistance to authority, sometimes low self-esteem and problems in establishing positive interpersonal relationships, young people are particularly vulnerable to experiencing substance and substance abuse continues to emerge as a strategy to cope with problems of unemployment, neglect, violence and sexual abuse.

The Government of India has made certain policies and laws pertaining to the reduction of Substances in the country as well as the policy to prevent the availability and initiation of substances.

In Mizoram, HIMNA MADAT was recently implemented under the leadership of the District Commissioner, Aizawl which consist of representatives from the Health Department, the Social Welfare Department, Education Department and other stakeholders with the main aim in preventing substance abuse among children. A curriculum was framed which will be implemented in schools for students. Social Welfare Department alone has also implemented certain programs to address to children abusing substance. The report of Integrated Child Protection Society, Mizoram from its inception since 2012 shows that children with problem of substance abuse are increasing and the establishment of rehabilitation centres for Children having problems of Substance Abuse prove that Substance Abuse among children have become a social problem in the community.

The different types of substance according to UNDCP, ROSA (2002) includes narcotic analgesics under which comes the Opium, Morphine, Codeine etc, Cannabis includes marijuana which is the common substance abused by children in Aizawl. Among the Depressants, Alcohol is mostly abused by children. The classification also includes hallucinogens, stimulants under which comes the cocaine. Volatile substance like dendrite, correcting fluid is abused by a high number of children. Other drugs such as Proxivon are also popular in the Aizawl.

With an objective to study the demographic background of children abusing substances in Aizawl, their pattern of substance usages, the consequences of substance abuse and the dimensions of social support, the study was conducted among children abusing substance in Aizawl.

A Multi-Stage Sampling procedure was used for selection of sample. A semi-structured interview schedule formed the tool for data collection to collect information with regard to the objectives of the study. The contents of the tools were generated from different sources related to substances abuse and primarily based its foundation on DSM IV approach (1994) and WHO (1993). Focus Group Discussions were also used to collect information. In-depth interviews were conducted to understand the lived experience of the children and participatory techniques were also used. A total of 92 children formed the sample.

5.1 Major Findings

The major findings from the study are listed in the following points:

1. There were more children who belong to higher age group (15-17 yrs) though the number of lower age group (10-14 years) is significantly high. There were children younger than 10 years of age too. This was consistent with the findings in the Case studies where children indulge in substance abuse at a very young age.
2. Majority of the children belong to the Lusei tribe, and non-mizo children also constitute a high per centage.
3. Majority of the children belong to the Presbyterian Denomination.
4. Almost half of the children drop out from school and significant number of children reaches only till high school level. Very few of them reached higher secondary level. This finding is also consistent with the findings from case studies where children involved in substance abuse have a high rate of drop out incidences.
5. Most of the children took up vocation training classes for the development of their skills. This could be because majority of the children were from rehabilitation centres where the centres offered such services.
6. There was significant number of children who were employed or had worked either part time or full time earning fair amount of income.

7. There were few cases of children who were married and this was found among girls only. This shows their vulnerability not only to the substances but also to child marriage.
8. Almost half of the children came from broken families. This is also consistent with the findings from the case studies where majority of the children come from broken families.
9. Educational level of parents is relatively low.
10. Significant number of children belongs to BPL families. However, there were those who also come from other socio economic categories.
11. About half of the children have a family member who abuse substance, alcohol being the major one. This is also consistent with the findings of some case studies.
12. First initiation to drugs starts mainly between 13-15 years followed by 10-12 years and 7-9 years of age. This is consistent with the findings in the case studies. Alcohol is the common substance first abused by children and from the case studies smoking was a common phenomenon. And then later to other types of drugs.
13. The major reason for abusing substance is experimentation, peer pressure, unhappy family environment, depression and presence of substance abuser in the family. This is also consistent with the findings from the case studies.
14. Children abuse different types of substances at the same time. Alcohol is frequently abused by children followed by tobacco and cough syrup is the least substance that is abused by children. Findings from the qualitative study also indicate that children abuse different types of substances.
15. The dosage of substances taken by the children is high compared to their age group.
16. The frequency of substances abused in a week is also found to be high. Among the children those who take No.4 (Heroine), Tobacco and Pills constitute the highest frequency (Everyday) and children taking marijuana also has a high frequency. The frequency of abuse of alcohol and dendrite in a week is also significantly high.
17. Significant number of children indulges in substances through others treating them while majority of them spend up to Rs.1000 in a week. Among the

children, children who abuse No. 4(Heroine) spend the most in week and they spend as much as Rs.1000 to Rs. 17500.

18. The major consequences of substance abuse includes physical health problem, family problem, mental health problem, problem in studies and problems in communities. Other problems includes drop out, financial problems, social stigma and discrimination, and work related problems. These findings are also consistent with the qualitative studies.
19. The major coping strategies of children include not socializing and keeping good company. Others include self actualization and self discipline and joining gospel team.
20. Majority of the children receive social support fromt heir family and the government. Organisations like the Young Mizo Association (YMA) and the Church are also important supporters. Other supporters are NGOs involved in substance abuse, Joint Action Committees and Mizo Hmeichhe Insuihkhawm Pawl (MHIP).
21. The major forms of support the children receive include counselling services, medical check up, Home Visits and Gospel camping services.
22. The findings indicate that the overall quality of social support is poor. Among supporters, the quality of social support provided to children is very good while the rest are poor.
23. Suggestions for prevention of substance abuse among children include abstinence, keeping good peers, less socialisation, learning good habits, obeying parents and going to school. This is also consistent with the findings from the focus group discussion.
24. Suggestions to improve social support service include more awareness and counselling in the community, good family environment and vocational training programmes. This is also consistent with the findings from case studies and focus group discussions

5.2 Suggestion

a) More awareness should be provided targeting children on the consequences of substance abuse and the addiction so that children can abstain from substances.

b) Although family provides the strongest support system, their approach towards a child with a problem are not professional enough and child centric, thus producing less positive results. Quality parenting knowledge, style and skills is required. This can be done through offering training courses to parents from vulnerable populations.

c) More rehabilitation centres with qualitative and professional care may be set up.

d) Vocational training with good job security should be introduced so that children who drop out of school will be able to engage themselves in activities to support themselves financially when they attain majority.

e) Except for family and Government rehabilitation, support system in the community is very weak, thus the local NGO such as Young Mizo Association(YMA), Mizo Hmeichhe Insuihkhawm Pawl(MHIP) should strengthen their existing support and also to take the matter more seriously in preventing , supporting and rehabilitation of children abusing substance.

f) As many children face problems in the community including stigmatization and discrimination, the need for more sensitization among the community member towards the support needed by children abusing substance so that these children would not stray away from the community.

g) The concerned Government Department and other civil societies should take measure towards the supply reduction and also demand reduction. This will reduce substance abuse among children.

h) There is more scope for social work intervention in the area of substance abuse among children. Methods of social work may be utilised in rehabilitation process and preventive models can also be used among the children. Social work research on Families of children who abuse substances can be conducted to find out the relationship between this primary institution and substance abuse. Secondary institutions such as Communities, NGOs and governments may also be studied at length to understand how dynamics within a community has relationship with substance abuse among children in Aizawl, Mizoram.