



सत्यमेव जयते



NCPCR



By Manija, 12 yrs, worked as rag picker in Delhi. She dreams of her childhood in Assam and has painted a big boat which will take her home

This Painting was chosen from the Painting Competition organized for Street Children and displayed at Arpana Art Gallery, Delhi

## Assessment of pattern, profile and correlates of substance use among children in India

National Commission for Protection of Child Rights (NCPCR)  
5<sup>th</sup> Floor, Chanderlok Building, 36 Janpath, New Delhi-110 001

# **Assessment of Pattern and Profile of Substance Use among Children in India**

**Conducted for**  
**National Commission for Protection of Child Rights (NCPCR)**  
**5<sup>th</sup> Floor, Chanderlok Building, 36 Janpath, New Delhi-110001**

**Commissioned by**  
**Working Group on Substance Abuse and Drug Addiction among Children**  
**Constituted by NCPCR**

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**Study Conducted By**  
**National Drug Dependence Treatment Centre [NDDTC],**  
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NATIONAL COMMISSION FOR  
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## FOREWORD

India is home to the highest number of child population in the world- around 440 million- out of which 243 million are adolescents constituting over 20% of the population of India. Of total adolescent population, 54% belong to 10-14 year age group and nearly 46% are in the most vulnerable age group in which the child acquires academic, cognitive, social and life skills. Recent times have witnessed a gradual increase in substance use amongst the younger population, with more people initiating substance use from an early age. WHO estimates that globally 25 to 90% children have used at least one substance of abuse.

Use of substance among children is basically due to curiosity, peer pressure and also low perception of harm, migration, poverty, street life etc, adds to the menace. Substance use among children and adolescents is of urgent public health concern. Substance use at a younger age interferes with normative age appropriate development and makes children more vulnerable to several health and psychosocial consequences. It has also been reported that generally children in conflict with law are associated with one or other form of substance, further complicating the issue of protecting them from such a situation.

In the context of ever growing substance use and drug addiction among all sections of children in India, a Working Group for "Substance Abuse & Drug Addiction among Children" was set up at NCPCR to undertake a review of existing national scenario on substance use and drug addiction among children. Though there were a few studies carried out in various settings across India by some stakeholders and social organisations, but mostly data is available from metropolitan cities only in India. Ministry of Women and Child Development and Ministry of Social Justice and Empowerment also expressed the need to undertake a study to arrive at an up-to-date assessment of the extent, trends and patterns of substance abuse among children in the country as a whole as no recent data from population survey is available.

The present study was commissioned by NCPCR in collaboration with National Drug Dependence Treatment Centre (NDDTC) of All India Institute of Medical Sciences (AIIMS) to examine the pattern, profile and correlates of substance use among Indian children. This is the first nation-wide study reaching out to a reasonably large sample of school going/out of school/street children across various cities and towns in India spanning 29 states /UTs. This study tries to capture the trend of substance use among children from cities. The study involves 135 sites from a total of 29 states and UTs across the country with a large sample size of 4024 children which included those living at home as well as living out of home (on the streets), children studying in school and those who were out of school. The study covers a comprehensive picture of demographic and substance use profile of the child.

I am sure that the study will generate interest and further consultations on the issues to the fore and will be a reliable source for all stakeholders CSOs/NGOs and students alike for the way forward to develop policy guidelines/ action plans to curb the growing menace of substance abuse among children, apart from filling in gaps on exclusive and curative centers for children in the country.

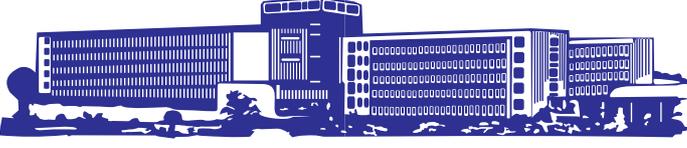
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## FOREWORD

I congratulate the National Commission for Protection of Child Rights (NCPCR) for coming up with the nation-wide study on pattern, profile and correlates of child substance use, conducted by NDDTC, AIIMS.

Child substance use is a serious public health problem. Alcohol or drug use at young age is likely to interfere with physical growth, attainment of educational and occupational goals and acquisition of basic life skills, which may cause life long consequences such as chronic diseases both physical and mental ailments. Substance use among adolescents increases the risk for a variety of complications, such as high risk sexual behaviours, road traffic accidents resulting in injury including death. It is therefore important to recognize various risk factors associated with early onset substance use. Early identification and prevention is necessary to curb the menace of substance use among children and adolescents. This study, I am told is the first of its kind from India and it will provide a good understanding of various factors related to child substance use in India. With samples taken from over a hundred cities and towns from India, the study will provide an important data base on this issue in children of diverse settings across India.

The efforts made by NCPCR towards successful completion of this study are remarkable and appreciable. I believe that findings will provide useful insights to the health care professionals working in the field, guidance for future research efforts and also provide assistance in policy making in this area. Children are the future of our nation, and the efforts at protecting and nurturing them will go a long way and improve their employment and prosperity.

I once again congratulate all those connected with these efforts.

All the best.

(Prof. Ramesh C. Deka)  
Director & CEO

New Delhi

08-08-2013



**VINOD KUMAR TIKOO**  
MEMBER

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## PREFACE

Present study is a culmination of an ongoing exercise of 18 months of untiring efforts put in by a group of concerned stakeholders in exploring the nitty-gritty's of the ever increasing menace of substance abuse observed among children, hampering their physical, psychological and social development in a stage in which they normally acquire academic, cognitive, social and life skills and attempt to map pattern, profiles and the correlates of substance use among children. It was in one of the consultation programme organised by an NGO, Childhood Enhancement through Training and Action (CHETNA) in April,2011, which I participated in, that brought to fore the prevalence of social menace of substance use among children and how it impedes the growth of children in their most vulnerable age-a reality ignored and needed urgent attention by the society to combat.

A visit to few sites including the Sarai Kale Khan bus stand, Hazrat Nizamuddin railway station, New Delhi and a ride in a local train from New Delhi to Mathura railway station in the company of children living on street, gave a brief insight to kind of life styles some of these children use to cope with their day-to-day stresses and struggles, by resorting to the use of inhalants (generally correcting ink because it is available at cheap and affordable prices) and some of the substances used to hide their pangs of routine hunger and pain inflicted by the apathy, discrimination and maltreatment by passengers, police in specific and the society at large. The substances procured from vendors available freely, out of money raised from rag picking, selling of empty plastic bottles, sale of water bottles to the passengers in the train/on the platform, etc. and at times even from pick pocketing help these children in ignoring such physical and mental trepidation by simply 'getting high', oblivious of nurturing the hazards in return, who *'instead of receiving help were being almost written off'*. The children are more vulnerable to initiate the substance use, gradually graduate into other drug use including the injectable ones, engage in sexual and other risky behaviours and suffer from the negative consequences in life, physical, social, psychological and at times even legal.

It took no time to discuss the seriousness of the issue of substance use among children in the Commission and a considered view was taken to look into the issue and a Working group was constituted to look into the growing menace. While a desk review of the documentation available revealed that some researchers have tried to assess the substance use in younger population/street children, however most have restricted to single site, local or regional studies with low to moderate sample sizes. A strong need was thus felt to examine the epidemiological aspects of child substance use in a nationwide survey to collect information on pattern, profile and correlates of substance use among children in India. The study was also aimed to collect information on family, peers, stress, psychological, physical health and legal aspects associated with substance use among children and adolescents on a scientific basis.

Despite the task being daunting and challenging as the questionnaire that almost took six months to design, keeping in mind the age of the respondents representing all the regions of the country with its diverse cultural

spectrum interwoven with the different religious sentiments with each not wanting to accept the reality that the problem exists and needed to be addressed, the Working Group went ahead to seek the approval of the Research Advisory Committee and the Technical Committee. The questionnaire had to be kept as far as possible in most simple language for effective administering. At the Commission (NCPCR), I was also conscious of the fact that the study needed a clearance of an ethics committee since the respondents were children, getting such clearance also took some time.

The study, being the first nationwide, comprehensive one to study the profile of children using substance in India, finally went rolling and included a large sample size of 4,024 with diversity of the child population in India. The sample in the study included children (boys and girls both) from all regions (north, south, east, west and north-east) of the country, with a total of 29 states/UTs and 135 sites in cities and towns. The use of tobacco, alcohol, cannabis and inhalants was reported by child substance users from almost all the states/ UTs covered in the study. This study is the first nation-wide survey reaching out to a reasonably large sample of school going / out of school/ street children across various cities and towns in India.

This original work is an attempt to highlight the profiles of children with substance use and I am sure, will do away with the misgivings normally associated with the children who are into substance use. The main objective of this study is to attempt provide a platform to share with the wider audiences such as researchers, operational experts and decision-makers, the results of technical assessments in conceptualising programmes, policies, action plans to prevent, control and manage substance.



( VINOD KUMAR TIKOO)

## Acknowledgements

National Commission of Protection of Child Rights (NCPCR) acknowledges the support it received from the members of the Working Group set up by the Commission to go into the realms of the untouched forays of substance abuse among children and who in-turn recommended the research leading to the present study “ An Assessment of Pattern , Profile and Correlates of Substance Abuse among Children in India”.

The Commission is deeply grateful to Dr. Anju Dhawan, Professor, National Drug Dependence Treatment Centre (NDDTC) , AIIMS who had consented to be the Principal Investigator for the Study and her team Dr. Ramandeep Pattanayak, Assistant Professor; Anita Chopra, Scientist-II and Ranveer Phukan, Research Assistant, NDDTC,AIIMS for relentless and untiring efforts.

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The Commission also acknowledges the crucial role played by the Regional Resource Training Centre (RRTCs) in facilitating training of NGO staff for administration of questionnaires for data collection, and supervision.

Acknowledgements are also due to the Federation of Indian Non-governmental Organisations for Drug Abuse Prevention (FINGODAP) initiated by Society for Promotion of Youth and Masses (SPYM) by lending support in terms of the expertise available in working in the areas of Drug Demand Reduction programmes with adults.

The Commission also acknowledges the tireless efforts of the staff of 102 NGOs who collected data in 135 sites across India. The Commission also acknowledges the contributions by Dr Yogesh Dube, Member NCPCR; support rendered by Mr. Parantap das, Ravi Mohan & Deeba Naseem, Consultants; Shaishta Khan, Senior Technical Expert and the Administrative and other staff of the Commission ( NCPCR).

Finally, last but not the least, the Commission is deeply grateful to over 4000 minor respondents spread over 27 states and 2 Union Territories, without whose active participative responses the study would not have fructified.

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## Abbreviations used

CDC	Centre for Disease Control
CHETNA	Childhood Enhancement Through Training and Action
CI	Confidence Interval
DAMS	Drug Abuse Monitoring System
FINGODAP	Federation of Indian Non Governmental Organisations in Drug Abuse Prevention
GYTS	Global Youth Tobacco Survey
MSJE	Ministry of Social Justice and Empowerment
NACO	National AIDS Control Organization
NCPCR	National Commission for Protection of Child Rights
NDDTC	National Drug Dependence Treatment Centre
NFHS	National Family Health Survey
NGO	Non Government Organization
NIMHANS	National Institute of Mental Health and Neuro-Sciences
NISD	National Institute of Social Defence
NYK	Nehru Yuvak Kendras
SPSS	Statistical Package for Social Sciences
SPYM	Society for Prevention in Youth and Masses
TI	Targeted Intervention
TOT	Training of Trainers
RRTC	Regional Resource and Training Centres
UNCRC	United Nation's Convention on the Rights of the Child
UT	Union Territory
WHO	World Health Organisation

## Executive Summary

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This is the first large scale, multi-site survey in India to focus exclusively on profile, pattern and correlates of substance use among child population. The survey reached out to nearly four thousand substance-using children at 135 sites in cities / towns across 27 states/ 2UTs. It represented all major regions (north, south, east, west, and north-east) of India.

The survey aimed

- (a) To collect information on pattern of substance use and profile of children using substances; and
- (b) To collect information on family, peer, stress, psychological, physical health and legal aspects associated with substance use among children.

A total of 102 NGOs, either working in the area of substance use or providing services to street children were selected in unison with the National Institute of Social Defence (NISD) and Federation of Indian Non Governmental Organisations in Drug Abuse Prevention (FINGODAP) using a purposive sampling framework. Each NGO collected data for 30 children from a site with some NGOs collecting data from two or more sites in a city/town. To facilitate staff training, data collection and supervision, eight Regional Resource and Training Centres (RRTCs) under NISD were designated as monitoring NGOs. Each NGO/site was assigned to the RRTC of the region.

Children were selected using a combination of random and convenience sampling. They were included if below 18 years of age; had used at least one substance besides tobacco in the past year and were willing to participate in the study. Before the interview, assent from the child and written informed consent from the parent or NGO staff counsellor (as a surrogate guardian, in case the parents were not available) was taken.

A 95 item interviewer administered questionnaire having sub-sections for demographic profile, family and peer related factors, stress, physical and psychological

health, substance use and legal issues was used. Besides English and Hindi, it was translated into other local regional languages (Tamil, Telegu, Malayalam, Kannada, Odiya, Bengali, Marathi, Mizo and Nepali) for ease and convenience of administration.

The survey interviewer (post graduate/graduate with field experience) from all participating NGOs underwent a two-day training prior to initiation of data collection. Trainings were delivered by trainers from RRTCs, who underwent a 5-day training of trainers (TOT) course conducted by the study investigators.

Monitoring of the study was carried out by the eight RRTCs and the investigators team by making periodic visits to participating NGOs and field/ sites.

### Key findings

#### Sample Profile

The final study sample comprised of 4,024 children between 5-18 years of age (average age: 15.6±2.1 years). Girls comprised 4.2% (n=169) of sample. Nearly 69.8% were from urban areas; 28% were currently studying in a regular school, 12.9% pursuing education through open school and rest were not studying (58.8%). Many depended on their family to support them but an equal proportion also earned their own livelihood by working part/full-time in mostly unskilled jobs. When asked about money for meeting daily expenses, 38.6% reported having enough money for substances.

Broadly, the sample comprised of two groups, as follows:

**I. Children living at home.** They formed approximately 78% of sample, and further comprised of:

- a) Out-of-school children:** Those living at home but never been/ had dropped out of school (about two thirds). In this sub-group, 65.8% was living with both parents; living with one

parent (19.8%), a step-parent (4%). Most were working/ engaged in unskilled jobs.

- b) Children living at home and going to school** ('school-going'): Only 1/3rd of those living at home were currently school-going.

**II. Children living on streets** ('street children'): This group formed nearly 22% of total sample. These children were living on streets either with their families (36.6%) or alone (42.6%). A small percentage (15.8%) was living in the shop or establishment where they worked in daytime. Nearly 85% were from urban areas; 81.5% were not going to school; and mostly earned money by rag-picking, street vending etc to sustain themselves.

### Substance use parameters

[To begin with, it is important to emphasize that all the percentages mentioned below indicate the prevalence of a particular phenomena in a purposive sample of child substance users and do not represent prevalence of a phenomena in the entire child population]

Majority of children reported lifetime use of a variety of substances. Tobacco (83.2%) and alcohol (67.7%) were the most common substances ever used followed by cannabis (35.4%), inhalants (34.7%), pharmaceutical opioids (18.1%), sedatives (7.9%) and heroin/smack (7.9%). Use of injectable substances was reported by a significant proportion (12.6%).

The current use of various substances was slightly lower compared to lifetime use and did not show a remarkably different pattern. The past month use of tobacco was reported by 74.9%, alcohol-56.8%, inhalants-30.5% and cannabis -28.9% of the sample.

The gateway substance appeared to have an early onset before the use of illicit substances. The mean age of onset was lowest for tobacco (12.3 years) followed by onset of inhalants (12.4 years), cannabis (13.4 years), alcohol (13.6 years), proceeding then to use of harder substances -opium, pharmaceutical opioids, heroin (14.3-14.9 years) and then finally use of substances through injecting route (15.1 years).

While tobacco and inhalants were used almost on a daily basis, several other substances were being used on less than daily or intermittent basis in past month (17 days- cannabis, 16 days-opioids/ sedatives/ injectable and 13 days –alcohol).

Tobacco and alcohol use was higher among those living at home compared to those living on the streets. This difference was more prominent for alcohol. The ever use, last one year and last one month use of alcohol was 71.8%, 68.2% and 60.9% among those living at home and 53.3%, 47.3% and 41.9% among those living on the street. On the other hand, the current inhalant use was higher among those living on the streets (45.9%) compared to children living at home (26.3%).

Onset of substance use was 1-1.5 years earlier among street children compared to those living at home. Among the out-of-school children, the average number of days of use for all kind of substances was higher compared to school-going children.

A variety of complications were reported by children as a result of their substance use. Of the children living at home or on streets, about 18% and 29% respectively indulged in sexual behaviour under the effects of substance, 16.9% and 20% indulged in sexual behaviour in exchange for either substances or money. Nearly half experienced physical and psychological problems related to substance use and a large proportion reported legal problems due to substance use. Most complications were higher among street children and out-of-school children. More than half of the sample experienced tolerance (55-63%) or withdrawals (56-67%) as a result of their substance use, which was relatively higher among out-of-school children and street children.

### Family related factors

The parental educational status was low with less than 10% fathers being graduates, post graduates or professionals. The occupation of the head of the household comprised largely of unskilled workers (22.6%) followed by agricultural worker/farmer (14%),

skilled workers (9.2%) and rag-picking/begging (5.8%). The average family income was INR 9,277-10,000 per month.

The family factors associated with substance use in children were :

- Substance use in a family member (57%)
- Single parent/ broken families/living with relatives/no parents (25%)
- Fights in the family (46.6%)
- History of physical/verbal abuse (45.3%)

Nearly 90% children had some contact with their family; 71.6 % had daily contact and nearly 10% denied having any contact with their family. Most reported good / average (72.8%) quality of their relationship with family while a small percentage had bad/very bad relationships.

Higher percentage of out-of-school children had a family member using substances that created problems in the family (60.1%) as compared to school going children (51.6%). Family fights and being beaten or abused by family (49.7%) was more common in out-of-school children.

### Peer related factors

Three fourths of the children reported having friends they can trust and depend upon. A large majority (82.4%) reported having close contact with friends who use substances. About 40% children had 1-2 substance using friends, 23% had 3-5 friends and a smaller proportion (11%), had more than 5 substance using friends. About two-thirds reported in affirmative on enquiring if they had non-substance using friends .School going children had higher contact with non-substance using friends (82.6%) compared to out of school children(66%).

About half of sample did not have an access to any external resources for healthy recreational interests. More than 70% children denied having any contact with an NGO and only a small proportion (7.8%) reported a daily contact with an NGO.

### Stress, physical and psychological health

The stressful situations and adverse physical/ psychological health was present in all groups, that is school-going children, out-of-school and street children, in the sample. A large proportion (58.1%) of children had encountered situations that were difficult, stressful/or very 'bad'. About 44% reported having been so sick or injured that they had to be taken to the hospital or reported the death of someone close. One third had been in a situation where they feared losing life or being severely harmed, and violence from the police or community was fairly common. More out-of-school children compared to school going reported that they had ever faced violence from the police and community (36.2% vs. 19.6%) or were in serious situation where they feared losing life or being severely harmed. (32.9% vs. 27.0%). Among other items related to physical or psychological health, 38% reported not feeling physically strong, 10.7% reported often feeling fearful, 29.4% reported usually not feeling good about self. Factors related to stress and adverse health was even more common among the street children.

A large proportion (58.3%) reported need for complete independence and 56.8% mentioned not accepting the structuring of their daily activities. When inquired whether they had plans for the future, nearly 45% reported having no plans for the future.

### Regional variations in substance use

The use of tobacco, alcohol, cannabis and inhalants was reported by child substance users from almost all the states/ UTs covered in the study. While tobacco and alcohol use are already acknowledged as a widespread problem, it is of significance to note that inhalants were commonly reported as a substance of use in children recruited from almost all states/UTs in the country. Further, use of a variety of substances was reported not only from metropolitans and cities, but from the smaller towns as well.

The preference or choice of substances showed some regional variations. Most of child sample which was recruited from Karnataka and Andhra Pradesh (85-89%) reported current use of alcohol. Highest proportion of cannabis users were present among sample included from Uttaranchal (70%) followed by Haryana (63.3%). The child substance users recruited from north-eastern state of Meghalaya had highest proportion of heroin users (27.3%); Tripura had highest proportion of inhalant users (68.3%).

Mizoram had highest proportion of sample with injectable substance use (88.6%) compared to rest of the states. A substantial proportion (11-28%) of sample contributed from the states of Maharashtra, Meghalaya, Rajasthan, Punjab, Arunachal Pradesh and Manipur had injectable substance use.

### Treatment seeking

A large majority (67.7%) had never sought any help for substance use problems. Most (43.8%) reported not having a problem due to substance use and need for help. About one-fourth acknowledged the problem but reported that they can quit on their own. A significant percentage reported problems in quitting as a result of craving (49.1%), peer pressure (40.6%), easy availability (30.2%), withdrawal (19.3%), stress (12%) and difficulty surviving on the streets without the substance (9.5%).

### Substance use among girls

A total of 169 girls constituting about 4.2% of the sample with an average age of  $14.8 \pm 2.8$  years were identified with the youngest girl being six years old. Of the girl sample, 75.7% were living at home and 24.3% living on the streets (16% with family and 7.1% alone) and one girl reported staying in the shop or establishment where she was working.

The major substances of abuse over the past month for girl users were as follows:

- Tobacco (72.8%)
- Alcohol (51.5%)
- Inhalants (37.3%)
- Pharmaceutical opioids (25.4%)
- Injectable use (32.5%) [three-fourths of them were from Mizoram]
- Cannabis (17.2%)
- Pharmaceutical sedatives (11.2 %)

Mean age of onset was less than 12 years for tobacco, inhalants and opium among girl users. However, it is to be noted that most females were recruited from five states only viz. Mizoram (28.4%), West Bengal (12.4%), Madhya Pradesh (11.2%), Uttar Pradesh (9.5%), and Delhi (6.5%) while rest of states contributed less than five users at each site.

To conclude, this nation-wide study on child substance use is the first of its kind from India with a large and diverse sample of children using substance/s (**n=4,024**) from all major regions of India.

*If we are to reach real peace in this world and if we are to carry on a real war against war, we shall have to begin with children; and if they will grow up in their natural innocence, we won't have to struggle. –Mahatma Gandhi*

## Introduction

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Children are an important asset for future of a nation. Those aged between 10 and 19 years of age constitute 22.8% of population and those aged 5-9 years comprise another 12.5% of population in India [1]. Use of tobacco, alcohol, and other substances among children and adolescents is a public health concern in several parts of the world, including India. The childhood and adolescent years are important formative years of life during which the child acquires academic, cognitive, social and life skills. Any substance abuse at this age is likely to interfere with the normal child development and may have a lasting impact on the future life [2, 3]. Not only the child, but the family and society as a whole are likely to be affected as a result of early onset substance use. Thus, this issue is a matter of national interest and priority.

Recent times have witnessed a gradual increase in substance use among younger population, with more people initiating substance use from an early age. While rave parties have increasingly come to attention, the use of various licit and illicit substances among the school students, out-of-school children and street or homeless population is also on the rise. Further, the problem is seen across all socioeconomic groups, from metropolitan cities to small towns and rural areas, with newer substances and multiple substance use also being documented. Early initiation of substance use is usually associated with a poor prognosis and more serious impact on health, education, familial or social relationships. Substance use may lead to behavioral problems, relationship difficulties and may cause disruption in studies, and even dropping out of school. At times, anti-social behaviors e.g. lying, stealing, pick pocketing etc may occur in association with early-onset substance use. Further, adolescents using substances may tend to engage in several sexual (e.g. unprotected sex) and other high risk behaviors (e.g. driving under influence, violence), predisposing them further to the negative consequences of substance use [3, 4].

In spite of the potentially serious threat posed by the childhood and adolescent substance use, only scarce literature is available from India. A few small or moderate sample studies mostly conducted at a single setting or at a local or regional level have described the prevalence and profile of substance use in younger population. Large scale surveys on substance use have mainly focused on adult population, with some collateral information available on adolescents. Consequently, substance use among children has remained grossly under-researched.

In this context, the present survey was conducted to examine the pattern, profile and correlates of substance use among Indian children. This is the first nation-wide survey reaching out to a reasonably large sample of school going/ out of school/street children across various cities and towns in India.

# Review of Literature

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## Adolescence as a critical period of development

Substance use is most commonly initiated during the adolescent years. The normal psychological development of adolescent phase is characterized by certain features which make the adolescents more prone to use substances [5]. These are as follows:

- Tendency to experiment and have novel experiences. ( more likely to use a substance just to see how it feels like)
- A heightened sense of invulnerability ('nothing can happen to me')
- Low perception of harm
- A high influence and imitation of role models (e.g. movie stars, celebrities etc)
- Wish to have adult-like experiences (including use of substances)
- Rebelliousness for the existing norms and rules; Search for an Identity
- Seeks the approval of peer group or friends much more than family (may use substances to 'fit in' the group)
- Higher cognitive functions (decision making, reasoning, impulse control) are still undergoing maturation

In view of above, the adolescents are more vulnerable to (a) initiate the use of substances, (b) engage in sexual and other risky behaviours; and (c) suffer from the negative consequences of substance use (e.g. accidents, violence etc).

## Profile of younger population in India

In order to understand the socio-demographic and health profile of younger population in India, a summary of findings from various sources is being provided [1, 6-9]. There are 243 million adolescents comprising over 20% of the total population of India. Of the total adolescent population, 54% belong to 10-14 age group and nearly 46% are in the 15-19 age group. The ratio of female to male adolescents is 882:1000. Nearly 65-70% of children are enrolled for primary school. Though literacy rates have improved in both girls and boys over decades, but there is still a massive attrition in the education system. The drop-out rates in classes I to V is around 30%, which increases to 50% by class X. The chief reasons cited for drop outs are finances, not interested in studies, required for household work and education not considered necessary. The formal school system has little to offer to the dropouts and out-of-school adolescents. Being out of school, boys often enter into unskilled work force. Nearly 9% of children in urban areas and 13% in rural areas perform paid or unpaid work.

In terms of nutritional status, malnutrition and vitamin deficiencies are common. Nearly 30% of male adolescents and 55.8% of female adolescents between 15 and 19 years are anemic. About 8% of never-married boys and 0.4% of never married girls between 15-19 years reported being sexually active, but condoms were used by only 3-15% during the first sexual encounter [6-9].

## Epidemiological aspects of Substance Use in Children/Adolescents in India

World Health Organisation (WHO) estimates that globally 25 to 90 % of children and adolescents have ever used at least one substance of abuse [10]. In the recently released Center for Disease Control (CDC) report [11] on U.S school students from grade 9-12, the ever use of alcohol was 70%, binge drinking 22%, cannabis use 40%, inhalants 11.4%, heroin 3%, injection use 2.3% and prescription drugs 20%. Not all children who experiment or use once may progress further with use of substance. However, some children especially those with biological, psychological and environmental risk factors tend to initiate and continue with the substance/s.

In Indian context, the extent, pattern and correlates of substance use among children has been assessed in few large scale and several small to moderate scale studies carried out in various settings across India. A review of the existing Indian literature on child/adolescent substance use is provided below.

### Nation-wide Surveys

In India, no large scale survey has specifically focused on substance use in the younger population. However, at least two national surveys on general population (as shown in Table I) provide some information about the use of alcohol or other substances in adolescent age groups.

The National Household Survey by Ray et al [12] was carried out on a representative male sample aged 12 -60 years, of which 21.8% (n=8,587) were between 12 and 18 years. The prevalence of current substance use in this age group was as follows: 3% for cannabis and 0.1% for opiates. It was surprisingly similar to 19-30 years age group, where alcohol and cannabis use was 19.3% and 2.6% respectively. As part of this national survey, a Rapid Assessment Survey was carried out in 14 sites which found that nearly 72% of the substance users initiated their first substance before completion of 20 years. Cannabis and alcohol were the commonest substances of initiation across various sites.

Another nationwide survey of various Health and Family welfare indices was carried out on a representative household sample across the country [National Family Health Survey 2005-06; NFHS -3] [8]. It had questions pertaining to the current use of alcohol and tobacco. Of the boys aged 15-19 years (n=13,009), 28.6% reported tobacco use and 11% reported alcohol use. Similarly, in the girls aged 15-19 years (n=24, 811), 3.5% reported tobacco use and 1% reported alcohol use. It appears to be an upward trend from the previous round of the survey (NFHS-2; 1998-99) where the prevalence of alcohol use was found to be 2.4% for boys and 0.6% for girls [13]. Further, it appears that among those who 'drink', a significant percentage of boys and girls are using alcohol at least weekly (18.3- 39.8%) or even daily (3.4-6.8%). Girls reporting the use of alcohol were using it more frequently compared to boys [8].

**Table I: National surveys: Prevalence of substance use in younger population sub-groups**

Survey [12,8]	Population sub group	Sub sample	Findings
National Household Survey; Ray et al, 2004	12- 18 years	8,587 (21.8% of total study sample)	Current prevalence: 3% for cannabis and 0.1% for opiate use
National Family Health Survey -3 <sup>rd</sup> round (NFHS-3); 2006	15-19 years	13,009 boys & 24, 811 girls	Alcohol: 11% boys & 1% girls; 20-45% using at least weekly or daily Tobacco use in 1/4 <sup>th</sup> boys

In addition to above, a large scale study for child abuse conducted across 13 Indian states, covering 12,447 children from different socio-economic strata provided some information on substance use variables as well. Nearly 32% children ( $\leq 18$  years) had used alcohol, bhang/ganja, heroin or other form of narcotics. It was also revealed that 70% of them were first exposed to substance use by their friends and relatives and nearly 12% by their parents [14].

## School-based Surveys

The Global Youth Tobacco Survey [GYTS] [15] had specifically focused on use of tobacco among children (13-15 years). The GYTS was conducted on a representative sample of students in grades 8-10 through a two-stage cluster sample (n= 10,116 students). Of the total sample, 14.6% reported currently using at least one of the tobacco products. Nearly 15% reported likelihood of initiating tobacco in the coming year. The use in boys (19.0%) was about three times higher than the girls (8.3%). Use of chewing tobacco was more common, while the current prevalence for cigarette use was 4.4%. More than half of the sample who purchased cigarettes from nearby stores was never refused a purchase even though they were under-age. Majority were exposed to the anti-smoking media messages and were taught about dangers of tobacco in schools. Nearly 60% wanted to quit, though majority had never sought any formal help for the same. The data showed that while the awareness of harm and negative perceptions of tobacco have increased, but at the same time, the prevalence, accessibility and use inside schools is also rising [15].

Few other school-based studies with variable sample sizes have also assessed the tobacco use prevalence in school going children. A systematic review of 15 such epidemiologic studies published between year 1991-2007 on Indian high-school students (6<sup>th</sup> -12<sup>th</sup> classes) was conducted [16]. The median prevalence of ever users of tobacco was 18% (Inter-quartile range IQR: 9.4-53.9%). The 13-15 years age group had the prevalence of 14% (IQR 8.5-22.5%) for boys and 6.34% [IQR: 1.9-20.0%] for girls. These findings indicate that the prevalence of tobacco ever use among high-school students in India is quite high. It has been estimated that each day, 5500 youth initiate the use of tobacco in India [17].

Only few school surveys have examined the use of other substances besides tobacco [18-22] (Table II). In a population-based study using multi-stage random sampling, 416 high school students (8<sup>th</sup> through 10<sup>th</sup> grade) from two schools were surveyed for substance use (tobacco, alcohol, cannabis) in West Bengal [18]. The overall prevalence rates among rural and urban students were 6.1% and 0.6% for illicit substance use, 8.6% and 11.0% for tobacco, and 7.4% and 5.2% for alcohol consumption respectively. Cannabis use was fairly common in rural students (4.9%) compared to urban students (0.6%). Both licit and illicit substance use was mainly associated with male students. 'Enjoyment' and 'Curiosity' were found to have a major influence in their decision to use a substance. Family members and friends were found to have a considerable influence not only on initiation but also important sources for money as well as the substance. Easy availability in the neighborhood was also an important correlate for continuation of substances.

**Table II: Summary of school based surveys on substance use in India**

Surveys [15,18-22]	Population sub group†	Sub sample	Findings –profile, pattern & correlates
Global Youth Tobacco Survey (GYTS): India, 2009	13- 15 years; Grade 8-10	10,116	Current prevalence of <i>any</i> tobacco use: 14.6% Boys three times higher than girls
Tsering et al, 2010 (West Bengal)	Grade 8-10; Two schools	416	Alcohol use in 5.8-7.4% of sample illicit substance use mainly in rural areas (6.1%)-cannabis common Enjoyment’ and curiosity- reasons for initiation Influence of substance using family members and friends in initiation Easy availability in the neighbourhood
Ningombam et al, 2011 (Manipur)	Grade 10-12; 17 schools	1020	Lifetime prevalence: Alcohol (29%), cannabis (14%) and opiates (12%) Boys more common Family history of substance use an important factor in substance using boys
Saxena et al, 2010 (Dehradun)	Grade 10-12; Four schools	511	Apart from licit substances, cannabis in 1.4%; opium and solvent use in 0.4% each
Qadri et al, 2013 (Ambala, Haryana)	13-19 years; Grade 7 -12 Urban and rural areas of district	1500	Substance use more in urban students from nuclear families Majority (42%) using more than one substance
Baba et al, 2013 (Kashmir)	College students ( $\leq$ 18 years); across five districts	656	One-fourth had ever used a substance Common reasons for initiation: failure of a love relationship, peer pressure and family discord

† Multi- stage/stratified random sampling used in most studies; study population likely to be representative of the geographical area

Relatively higher rates were reported from Manipur in a sample of 1020 students randomly selected from 17 schools [19]. The ever prevalence of substance use was found to be 54% [95% CI: 42%-67%] and current prevalence was 35% [95% CI: 28%-43%]. Among ever users, tobacco (46%) was used most commonly, followed by alcohol (29%), cannabis (14%) and opiates (12%). In multivariate analysis, substance use was found to be significantly higher for boys, whose father or sibling used substance [19].

In another study, 511 male students studying in 10<sup>th</sup>-12<sup>th</sup> class across four schools of a block in Dehradun district were assessed [20]. The substances used were chewing tobacco (56%), smoking (38%), alcohol use (9%), cannabis use (1.4%), opium and solvent use (0.4% each).

In a study from Ambala, Haryana [21], a stratified random sample of 1,500 school students (13-19 years; 7<sup>th</sup>-12<sup>th</sup> grades) was assessed using the self-administered WHO Model Core Questionnaire. Overall prevalence

of substance abuse was 60% for ever users and 35% for regular users. Substance abuse was significantly higher among male urban students belonging to nuclear families. Among ever users, alcohol (44.5%) was the most common substance, while tobacco (14.4%) was mostly consumed by regular users. Overall 42% were using more than one substance combination.

In a similar study of college students from Kashmir Valley [22], of which half were adolescents (n=656), the overall life-time prevalence for substance use in adolescents was 26.5 percent. Commonly cited reasons for initiation of substance use were a personal stressor (failure of a love relationship), peer pressure and family discord.

## Studies on Street Children

An estimated 18 million children live and work on streets in India [23]. In six metropolitan cities alone, the number of children living on streets is more than five lakhs, with a lakh in Delhi alone [24]. Poverty, urbanization, breakdown of families and domestic violence are the most immediate causes of this phenomenon's growing proportions.

Use of substances is particularly high in this vulnerable population, as seen in 40-70% of street children across various Indian cities [25-32] and their findings as summarized in Table III. The profile of street children using substances in India is as follows:

- The average age of initiation of substances is about 9-10 years, mostly with tobacco. Children as little as 5-7 years have been reported to initiate substances.
- Tobacco use is reported by 50-75%, alcohol by 25-50%, cannabis by 15-25% and inhalant use by 20-50% of street children.
- The use of illicit substances, including opioids, is much less common (2-3%) and usually starts after the licit substances.
- Most of the substance using street children are school dropouts (>95%).
- Majority engage in one or other form of unskilled work (rag picking, pick plastic bottles, loading/unloading etc) for about 8 hours per day to sustain themselves.
- Money earned is usually spent immediately on food, entertainment and substance use – for fear of it being stolen or snatched.
- Physical/sexual abuse is common.

**Table III: Summary of studies on substance use in street children**

Study References [25-32]	Setting	Sample size & Prevalence	Findings
Benegal, 1998; Bangalore	NIMHANS out patient in collaboration with BFSWC	321 , of which 70% used substances	Smoking tobacco 76%, Inhalants 48% Alcohol: 42% Cannabis: 15% Opioids (2%) Use progressed from gateway substances to illicit substances
Karmakar, 1998; Kolkata	Street based interview	2416 , of which 39% used substances	54.2% females used depressant substances; 42% males used cannabis regularly
Pagare, 2004; Delhi	Night shelter for street children (Prayas)	115, of which 57.4% used substances	Nicotine 54%, Alcohol 50%, Inhalants 25%
Plan India , 2006; Delhi - Bhopal	Children at 8 railway platforms between Delhi and Bhopal	684 , of which 45% used substances	Inhalants (correction fluid) was common; Illicit substances - <i>Ganja</i> and <i>smack</i> -also seen
CHETNA , 2008; Delhi	Market, railway station, religious places	63 , of which 73% used substances	Multiple substances, 3 or more, commonly seen; inhalant use common
Naik et al, 2011; Mumbai	Street based interview	217 street children, of which 44% reported substance use	Alcohol (24%), cannabis (25%) and inhalants (20%). Inquisitiveness and peer pressure cited as reasons for initiation
Ray et al, 2009; NDDTC (WHO Biennium activity) Delhi & Bangalore	Street children in contact with city NGOs	100 inhalant users	Substance use associated with <ul style="list-style-type: none"> <li>- greater unsupervised exposure to street life</li> <li>- less education</li> <li>- being employed</li> <li>- less contact with NGOs</li> <li>- more substance using friends</li> <li>- more income but not saving money</li> <li>- increased access to recreational pursuits</li> </ul>
Ray et al, 2011; NDDTC (WHO Biennium activity) Delhi & Bangalore	Inhalant using Street children in contact with city NGOs	100 inhalant users	<ul style="list-style-type: none"> <li>- Majority (71%) illiterate;</li> <li>- Mostly working as rag pickers/ street vendors</li> <li>- only 1/4<sup>th</sup> reported daily contact with family</li> <li>- stressful event/ situation reported by 15-37%</li> <li>- besides inhalants, tobacco, alcohol and opioids (3%) were abused</li> </ul>

- BFSWC : Bangalore Forum for Street and Working Children; NIMHANS : National Institute of Mental Health and Neuro Sciences; CHETNA : Childhood Enhancement Through Training and Action; NDDTC- National Drug Dependence Treatment Centre

A project/ activity under the WHO biennium (2008-09) programme undertaken by NDDTC, AIIMS and NIMHANS conducted a situation assessment at Delhi and Bangalore to assess the profile and pattern of inhalant use in out of school/street population and to assess their family, peer, social skills, psychological, health, finances and legal problems[32]. This study on situation assessment conducted with help of NGOs in these two cities found that substance use in street children was associated with greater unsupervised exposure to street life, less education, better employment, poorer hygiene, more exposure to unsafe situations, fights, less contact with NGOs, more substance using friends, more income but not saving money with family and increased access to recreational pursuits. Two-thirds of the children reported that they left home because of domestic violence and conflict in their family, along with physical abuse by family members. Substance use in fathers, marital discord in parents and assault of spouse and children during intoxicated states by parents were other significant risk factors.

Regarding risk factors in other studies, substance abuse is significantly associated with domestic violence, maltreatment of the child, nuclear families, runaway status and working status of the child [24]. Most of them took to substances as a way of street life or to remain in the peer group. When asked specifically about how they feel after taking the substance the commonest answer was that they feel relaxed and happy. Relief of boredom, hunger, depression, fear and frustration, wanting to feel good, to keep awake or get to sleep or to dream may be some of the functions served by substance use.

The data from NGOs that provide services to vulnerable children and Nehru Yuvak Kendras (NYKs) showed that the age of onset in vulnerable children was  $\leq 15$  years in majority (63.6%) [12]. Of these substance-using children, injecting use occurred in as many as 14-20% and the high risk behaviors were commonly seen. The sharing of needles was reported by 7-15% and sex with multiple partners was reported by 5-19 percent. The substance related complications such as police arrest was reported by 19-34% and family violence related to substance use by more than 50% of children [12].

Several health consequences have been reported with use of substances. In a community-based study of 554 Kolkata city street children, of which 30% used substances, sexual abuse was present in 9% of the sample. Factors such as lack of contact with family, orphan children, night stay at public place etc were documented to be associated with substance use and sexual abuse [33].

### Studies on urban slum population

As per latest census, slums form about 17% of households in India. Mostly, slums are found in cities/urban areas and children living in these urban slums are a vulnerable group because of poor living conditions and rampant poverty [34].

In a study of 260 randomly selected adolescents in an urban slum area, the overall prevalence of substance use was 32.7 percent. About 31% initiated substance use between 13-15 years of age, and peer pressure was cited as a reason in more than half of sample. Substance use by parents and peers was significantly associated with substance use, while education of parents and education about the subject were found to be protective factors [35]. In another study, among adolescents residing in urban slums of Sambalpur (43.4% substance users), the median age of substance use initiation was 15 years. The most common substances used were *Gutkha* (91.7%), powdered tobacco (71.1%), tobacco toothpaste (*Gudakhu*) (63.8%), smoking (26.6%), and alcohol (14.7%). The substance abusers used multiple substances (average of 3.34 substances per adolescent) [36].

The children belonging to broken families are often the highest substance consumers (51.2-55%) [25, 36]. A significantly higher number of adolescents resort to substance abuse when both parents are abusers (46.7%). The same impact was observed when only mothers consumed substances (43.5%) [36]. Among the common reasons for initiation, peer pressure, toothache and use by a family member were reported by urban slum dwelling boys and girls aged 5-14 years and using substances [37].

### **Profile of treatment-seeking adolescent substance users**

Most individuals start their substance use during adolescence, but treatment is usually sought after a few years when health or other psychosocial complications begin to emerge. As per the data on treatment seekers from the Drug Abuse Monitoring System [12], most persons who sought treatment at the Drug Dependence Treatment Centres initiated use during adolescence (9-10% at less than 15 years of age and 25-32% at 16-20 years of age). However, only 5 percent of treatment seekers are adolescents suggesting that most persons seek treatment after a few years of onset of substance use after they have already stepped into adulthood. Some of reasons for low treatment seeking in adolescents could be low motivation or lack of specialized adolescent treatment programmes.

The pattern of substance use in treatment-seeking adolescents appears to differ from that in school or community surveys. A chart review of 142 adolescents seeking treatment at the National Drug Dependence Treatment Centre (NDDTC), A.I.I.M.S for substance use showed that inhalants were the primary substance in 45%, opioids in 32% (heroin: 27%, propoxyphene: 4%, pentazocine: 1%), cannabis in 15% and a small percentage reported other substances (e.g. tobacco or alcohol) [38]. It is evident that although tobacco and alcohol are commonly used substances in adolescents in community, the treatment seeking child/adolescent sample is largely represented by inhalants, opioids and cannabis users.

In another retrospective study, for profile of 50 inhalant users, the mean age of initiation of first substance was  $14.13 \pm 4.27$  years and inhalants were first substances for 38 percent. Majority were aged 18 years and below (72%), with only three girls (6%) in the sample. Majority comprised of school drop-outs (82%) and were from lower socio-economic status (80%). Duration of inhalant use ranged between 1 month and 7.5 years. Use was mostly uninterrupted and 88% were dependent users. Correction fluid was the commonest product used by huffing or sniffing. A large majority (86%) had used at least one other substance besides inhalants, and 8% reported involvement in high risk sexual behaviours. Comorbid psychiatric disorder was seen in 8% and family history of substance use disorders was observed in 30% of the sample [39].

In a file review of adolescents presenting at another tertiary care centre in North India (n=85; 1978-2003) [40], many adolescents came from nuclear family (63.5%), urban background (83.5%), and were school dropouts (54.1%). Mean age at first use of the primary substance was 14.8 yrs and mean age at first presentation was 17 years. The commonest used primary class of substance was opioids (76.2%) and the commonest used opioid was heroin (36.5%). More than half (54.2%) were also nicotine dependent users. The most common reason for starting the use of substances was curiosity (78.8%). About one-fifth (21.2%) of the subjects indulged in high-risk behaviour such as having multiple sexual partners. Nearly half of the subjects had positive family history of either substance dependence (40.2%) or psychiatric disorder (5.5%). Thus, development of substance dependence in children and adolescents appear to be a combination of individual, familial and social vulnerability factors.

## Risk factors for early-onset substance use

Substance use is a multi-factorial disorder with several individual, familial and social variables acting as risk (or protective) factors. The most common reason for starting substance use during childhood and adolescence is curiosity, peer pressure and as a way to deal with low moods and with the stresses or hassles of living a street life [18, 22, 30].

**Table IV: Risk factors in various domains**

<b>Community</b>	Community disorganization Laws and norms permissive for substance use Substance availability in and around home/school Acceptance of substance use by society Social and cultural beliefs
<b>School</b>	Academic failure, truancy Little commitment to school
<b>Family</b>	Parental attitudes favourable to substance use Domestic violence/Physical abuse Family quarrels, family relationship problems Parental separation/divorce Poor family management Inadequate parent-child attachment Low parental supervision
<b>Peer</b>	Presence of deviant peer group Peer substance use Peer pressure or coercion Peer approval of substances
<b>Individual</b>	Genetic vulnerability (e.g. strong family history of alcohol dependence) Personality factors (e.g. sensation seeking, risk taking traits) Psychological factors (e.g. low self-esteem, low confidence) Learning disorders/academic difficulties Conduct problems/Early initiation of antisocial behaviour Psychiatric disorders (e.g. ADHD/Depression) Personal attitudes favourable to substance use

The common risk factors for initiation of substance use, as seen from a review of national and international literature, are shown in Table IV [3, 27, 41-44]. In case of street children, the additional risk factors for substance use are as follows:

- being on the streets (substances are taken to create boldness, drive away hunger)
- abandonment of home
- daily stresses and strains
- peer behaviour (peer pressure, coercion, acceptance in peer group)
- normalization of substance use (belief that everybody uses)
- having a wage or availability of money (all of which is usually spent on food/substances by end of day with no concept of saving)

Research has also demonstrated that many of the same risk factors apply to other behaviors such as youth violence, delinquency, school dropout, risky sexual behaviors, and under-age pregnancy. Some risk factors may be more powerful than others at certain stages in development, such as peer pressure during the adolescent years. It is important to understand that risk factors do not, in and of themselves, determine substance use and abuse. Rather, they have a cumulative effect i.e. the more risk factors a youth is exposed to, the greater the likelihood that he or she will engage in delinquent behavior or use substances.

### Common substances of abuse in children

Alcohol, tobacco and inhalants are common initial substances of abuse and have been described as ‘gateway substances’. These substances are easily available to the children. Moreover they are not illegal and there is some form of social acceptance for their use (except inhalants). However, the use of these gateway substances increases the subsequent risk of transition to harder and illicit substances [25, 45, 46].

Studies, as reviewed previously, show that the school going children who use substances are mostly using licit substances in the form of tobacco and/or alcohol. However, the out-of- school children, especially the street based, slum based and vulnerable populations are at a risk of experimenting with most hazardous substances both licit as well as illicit in nature. The hospital based samples of adolescent treatment seekers are over-represented by inhalant, cannabis and opioid users, who were more likely to be regular/dependent users.

Street children often start with tobacco products below the age of 10 years. Many of them progress to use of alcohol, inhalants and *bhang*, and some of them eventually move onto illicit substances like ganja, heroin, other opioids etc [25, 29]. Multiple substance use is also common among street children [35].

The common substances used by children and adolescents in India are shown in the box I.

#### Box I

Commonly abused substances by children	
Tobacco	
Alcohol	: (Beer, Whisky, Country Liquor)
Cannabis	: (Bhang, Ganja)
Inhalants	: (Ink Eraser /Correction Fluid, Glue, Petrol)
Opioids	: (Street Heroin, Pharmaceutical Opioids, Including Propoxyphene, Pentazocine, Buprenorphine)
Sedatives	: Diazepam, Nitrazepam, Alprazolam

### Psychosocial and health consequences of substance use

In the short term, all the substances produce euphoria or a profound sense of well-being due to their actions on particular parts and receptors of the brain. Additionally, most of the substances either produce drowsiness or excitation depending on their chemical nature. Finally, all the substances produce a decrease capacity to respond to one’s surroundings and a loss of personal and social judgement.

Substance use in early years is likely to have psychosocial and health related complications [3, 47]. The binge drinking, more common in adolescents, is related to the risk of accidents due to driving under intoxication, getting into fights and indulging in risky sexual behaviour. Other kinds of problems reported due to substance use in this age group are truancy, academic decline, dropping out of school, interpersonal problems in family, shame and stigma, loss of non-substance using friends and associated health problems. Inhalant use is associated with multiple health problems such as risk of arrhythmias, renal impairment, hepatic impairment, intellectual or memory problems [48]. Early initiation is also associated with serious problem behaviours such as selling substances, physical, sexual and emotional abuse and greater risk of development of addictive disorders in later life. Another important finding in studies on street children are that the children may be forced into or paid for or offered substances in exchange for sex [25]. In a sample of street children, of which 30% had non-tobacco use, 9% reported having been sexually abused. Some factors (age, lack of contact with family, orphan children, night stay at public place, etc.) were documented to be associated with substance use and sexual abuse [33].

The long term use of substances has an impact on a number of spheres of an individual's functioning. Various complications may occur due to substance use as follows:

- *Psychological*: Shame, guilt, low self esteem, depression, anxiety
- *Cognitive difficulties*: Attention and memory problems interfere with learning at school or acquiring the work skills
- *Academic poor performance*: Low grades, learning difficulties, at risk of dropping out
- *Familial*: Mistrust of parents, scolding, relationship problems
- *Social*: Loss of relationship with non-substance using peers, out-cast
- *Anti social activities*: May engage in stealing/lying to procure substances
- *Risky behaviours*: Driving under Influence: accidents, road rage, violence, unsafe sex, exposure to sexually transmitted infections/HIV, teenage pregnancy
- *Health damage*: Lowered immunity, risk of infectious illnesses, inhalant use may affect multiple organs, including heart and brain
- *Sudden death* may occur with inhalant use, due to suffocation, choking, heart rate disturbances (sudden sniffing death syndrome)

## Knowledge and attitudes for substance use among children

The knowledge regarding substance related harm, attitude, and opinions were assessed in a school sample of 416 students, of which 52 had ever used any one of the substances in their lifetime [18]. Level of knowledge on harmfulness of substance use among students was generally on higher side (urban: 84.6% and rural: 61.5%) and media was stated as the most frequent source of information. In spite of being aware of the harmful effects of substance use, adolescents do take up substance use and influence of peers appear to be one of the common reasons (urban: 15.4% and rural: 26.9%). Effective measures are required to encourage shaping the attitude of school children towards self-confidence and adequacy, as also to prevent risk of substance use.

The knowledge of substance related harm was, however, poor in the vulnerable less-privileged children. In studies on street children, less than one fourth of the sample had an awareness of harmful effects of substances, including inhalants. It was also described that streets provide a permissive attitude and even a 'normalization' of substance use among children, with most peers using them [49].

## KEY OBSERVATIONS FROM AVAILABLE LITERATURE

Overall, there is insufficient large scale data on profile of drug using children/adolescents and pattern and correlates of drug use in India. Yet, some inferences can be drawn from the available literature as follows:

- Substance use appear to be increasing among children and adolescents, with an upward trend seen in recent surveys
- Substance use is high in street children, but also found in the school and community surveys
- Substance use is seen in both rural and urban areas and many small towns also have problem of substance use in children
- There are likely to be regional variations in the prevalence and pattern of substance use
- Tobacco followed by alcohol and cannabis appear to be common substances of abuse in these age groups
- Inhalant are emerging as a common substance of use in younger children, especially among those who are vulnerable and under-privileged
- Treatment seeking is low in adolescents. Those who seek treatment are likely to be cannabis, inhalant or opioid users, including injecting drug users

## Rationale of the Study

Substance use among children and adolescents is of urgent public health concern. Substance use at a younger age interferes with normative age appropriate development and makes the children more vulnerable to several health and psychosocial consequences. In spite of grave dangers of substance use in younger populations, the large scale research studies for pattern and correlates of substance use in children are almost non-existent. While several researchers have tried to assess the substance abuse in younger population/street children, however most have restricted to single site, local or regional studies with low to moderate sample sizes. A review of published literature showed that most data is available from big metropolitan cities in India, but it does not imply that the phenomenon of substance use is absent in other cities. Further, there are likely to be considerable regional differences across various cities and states. Therefore, it is important to examine the epidemiological aspects of child substance use in a nation-wide survey.

This nation-wide study intends to provide information on pattern, profile and factors associated with substance use among Indian children.

## Objectives

- (a) To collect information on pattern of substance use and profile of children using substances
- (b) To collect information on family, peer, stress, psychological and physical health and legal aspects associated with substance use among children

# Methodology

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The methodology of the study was developed by the Working Group for “Substance Abuse & Drug Addiction among Children” under the National Commission for Protection of Child Rights (NCPCR).

## Study design

This was a nationwide, multi-site, cross-sectional study covering most states in the country. Both cities/towns were selected. The use of multiple sites ensured continuous coverage in all zones across the country.

## Sampling

During meetings of the study group, it was decided that the non governmental agencies/organisations (NGOs) would be involved in the collection of data. The NGO involved in collection of data included NGOs working with street children and those working with substance use. The NGO working with street children already had a presence in the community, had established trust with street children as most children reached them when in need and they would be thus be in an advantageous position. The NGO working with substance use were familiar with the process involved in reaching out to substance users and already had many adult substance users in their treatment. Substance using children also sought help from them from time to time although the percentage of treatment seekers who were children was miniscule.

A purposive sampling framework was followed in selection of the NGOs. The NGOs were identified in unison with the National Institute of Social Defence (NISD) and Federation of Indian Non Governmental Organisations in Drug Abuse Prevention (FINGODAP). Each NGO was assigned to collect data from one or more sites in a city/town. A list of NGOs that finally participated is given in Annexure II.

## Sample size

Considering the time frame for the study, it was decided that each site would collect data on 30 children who fulfil the inclusion and exclusion criteria. The children were to be interviewed at each site by the NGOs using a sample of convenience. It was estimated that the total sample size will be about 4000 children who are using substances.

## Recruitment settings

As there were two types of NGOs which would collect data therefore to avoid overlap in data collection it was finalised that -

**NGOs who are working in the area of substance abuse** would recruit children or adolescents from-

- Their own or other drug treatment centres
- Using snowballing to contact children in the community (getting children or adolescents with the help of other children or adolescents who come to them)
- Children of adult substance users who come to them for treatment
- Through awareness programmes/information in schools/community/recreational areas/Nehru Yuvak Kendras/youth organizations
- From slums/places where child labour takes place
- Shops from where purchase of substances occurs

They were advised to not visit schools to get children directly from within the school setting (to avoid stigma) although they could organize awareness activities in schools and inform them about availability of services in the NGO, thus encouraging them to come to the NGO for help. The NGO working in the area of substance abuse were asked not to collect data on street children as this data would be collected separately by NGOs working with street children. The purpose of the study was to assess the factors associated with substance use in children living in various settings (at home with families or on the streets with/without families) and in those studying in school as well as those who were out of school.

**NGOs providing services to street children** would recruit children or adolescents who access their services based on the inclusion criteria or include street children from the community (e.g. railway station, traffic signals). These children or adolescents may be school dropouts or may have never gone to school; they may be living with families or living alone. Children who are being admitted in an institutional setting may be included at the time of admission or within a period of one week.

### **Inclusion Criteria for children**

- a) Age group 18 years or less
- b) Children/adolescents who have used at least one other substance besides tobacco (alcohol, inhalants, cannabis, opiates, sedatives or any other substance) in last one year
- c) Children who are being admitted in an institutional setting may be included only at the time of admission or within a period of 1 week after admission. For children admitted in institutional settings, the time frame for the questions refers to the period just prior to admission.
- d) Informed written consent taken from the child or adolescent and the parent or NGO staff counsellor (as a surrogate guardian, in case the parents are not available)

### **Exclusion Criteria for children**

- a) Use of tobacco only in last one year
- b) Not willing to be included in the study
- c) Unable to provide information

### **Instrument**

A questionnaire developed by NDDTC, AIIMS for another study - **“Inhalant use among street children in Delhi and Bangalore- A Situation Assessment”** funded by WHO (India) [31] was modified to suit the survey design and study objectives. This questionnaire was developed based on the variables of a WHO study on street children that collected data from ten countries. It was modified to include school going and out of school children besides street children. It was then shared with the Working Group of NCCPCR on “Substance Abuse & Drug Addiction among Children” and amended by incorporating suggestions of the group. Finally, the questionnaire was field tested by administering to children and based on the feedback, further modifications were made.

The questionnaire (Annexure I) has 95 items under the following sections-1) Demographic 2) Family and peer related 3) Stress, physical and psychological health 4) Substance Use 5) Legal issues.

The following characteristics describe the questionnaire-

1. It provides adequate information to get a comprehensive picture of demographic and substance use profile of the child.
2. It is brief and concise to enable the interviewer to complete the interview within a reasonable period of time (50 to 60 minutes).
3. It is an interviewer-administered questionnaire as the target population would have variable literacy levels.
4. The language and format is simple, considering the expected level of expertise of the interviewers in the different states.
5. The questions are pre-coded, minimising the need for the interviewer to interpret response. At selected places, there is provision for noting the verbatim response.
6. The questions and possible responses have been defined and therefore serves as an instruction manual

An information sheet, informed consent from the parent/guardian and assent from the child was required before conducting the interview as approved by the Ethics Committee, AIIMS and the Working group (NCPCR). Sometimes the children had not disclosed substance use to family members and were not willing to involve the family in the process of giving consent.

Any other adult identified by the child or a staff from an NGO could sign as a surrogate guardian if the child was willing and comfortable with it. This staff had to be someone other than the person conducting the interview.

## Translation

For the benefit of the understanding of the questions by the field interviewer and for asking questions from children in different states, it was felt that interviewers would have to conduct interviews in regional languages. The most probable languages other than English or Hindi identified for translation into local regional languages were Hindi, Tamil, Telegu, Malayalam, Kannada, Odiya, Bengali, Marathi, Mizo and Nepali. The translations were done in colloquial language by the RRTCs.

## Implementation procedures

Considering the nationwide scope of the survey, it was important that its implementation was conducted in a smooth manner. The investigators team from NDDTC, AIIMS coordinated this multisite project with close involvement of the working group members. The study involved the following steps-

1. Developing the methodology
2. Data collection instrument
3. Training of trainers and training of field staff
4. Monitoring of data collection by making site visits
5. Data collation, editing and analysis

NISD and FINGODAP provided guidance in the choice of NGOs for data collection and addressing the administrative bottle-necks for the conduct of the training of field staff.

It was finalised during the working Group meetings with NISD and investigators that the eight Regional Resource and Training Centres (RRTCs) would be the monitoring NGOs as they have the capacity to conduct training and monitor data collection. Each NGO/ site was assigned to a RRTC of the region. The eight RRTCs facilitated the data collection process. The assigned tasks of the monitoring NGOs included the -Training of the field investigators of NGO/site, monitoring of data collection by making actual site visits during the course of data collection, screening of data received and sending it to AIIMS, receipt of the payment as per the budget and sending to the other NGO.

## **Field staff**

As the questionnaire was to be administered by the staff of the NGOs it was conveyed and shared that the field staff to be identified for the survey should be a post graduate and if not available then at least a graduate with some experience of working in the field setting.

## **Trainings**

**i) Training of trainers programme (TOT) -** A five day training of trainers (TOT) programme for participants from more than 10 organizations was held from 13-17 December, 2011 in Delhi. The participants included those from the eight RRTCs identified as monitoring centres for the purposes of the study. This programme was funded by NISD, Ministry of Social Justice and Empowerment. Most of these organizations were working in the area of substance use while two organizations were working with children in need of care and protection. The agenda for the training of trainers programme included the following-

- a) Presentation on overview of substances of abuse, substance use in children and street children
- b) Familiarization with the questionnaire
- c) Discussion on the guidelines for filling the questionnaire
- d) Role plays to practice the questionnaire
- e) Pilot testing the questionnaire in the field

Presentation and discussion on interviewing techniques, roles and responsibilities of field staff and RRTC coordinator for project, rapport building with children before interview were included in the training.

**ii) Training by trainers' programme -** The field staff identified for the study by the NGOs who would collect data underwent training based on a similar pattern as the training of trainers' course. The training was of two days duration and included field visits to practice filling the questionnaire. The training of field investigators was conducted regionally by the RRTCs.

The training session began with an introduction and project overview. The field staff was informed about the purpose of the study and its methodology. A special effort was made so that the training participants would understand the relevance of the study and the data that was being collected. A question by question training of each section of the questionnaire was undertaken followed by mock interviews to test their skills, knowledge and understanding of content taught. The mock interviews were trainer-led as well as conducted by trainees. Methods of rapport building, recruitment in the study were also discussed.

Children who were identified as substance users received treatment at the NGOs if they so desired as the NGO was already involved in provision of services. It was suggested that community meetings with parents and other

community members be organized to address other issues that may emerge such as any report of violence or abuse in the family.

Finally, a total of nine training courses for field staff were conducted. One of the investigators or a member of the working group was also present in most of these trainings.

## Monitoring

The monitoring of the study was at two levels. The first level was by the investigators from AIIMS. The team was regularly in contact with all RRTCs to oversee that data collection was smooth and progression of work as per schedule.

The second level was by the eight monitoring NGOs, also the RRTCs under MSJE. Each RRTC monitored the data collection by the sites. They were advised to make site visits during the data collection phase. The actual field work was supervised and monitored by the respective NGO and the RRTC. Progress updates were compiled and shared with NCPCR periodically.

Monitoring visits were made to :

- A. Tamil Nadu/Andhra Pradesh – 2 sites ( Chennai and Tirupathy), January 2013
- B. Pune and Mumbai - 4 sites, January 2013
- C. Kerala /Karnataka- 7 sites, January/February 2013
- D. Kolkata – 2 sites, April 2013

## Ethical Issues

Before the start of the study, a clearance from an ethical perspective was obtained from the institutional ethics committee of AIIMS, New Delhi. Participation in the study was purely voluntary in nature. As mentioned earlier, informed consent was obtained from the parents/guardians prior to the interview and an assent was taken from the child. Decision of a subject to participate or decline, had no bearing on services being provided in any manner by the NGO. Privacy and confidentiality during interviews was maintained during the data collection and analysis process. The data collected from the respondents was not accessible to anyone except the study team. No incentives were provided to the respondents to participate in the survey.

## Data Analysis

Each RRTC verified the proforma received by them from the NGO before collation for the number submitted. The RRTC first prepared a list of names of NGOs/ sites which had participated and submitted data by giving them a unique code and taking note of the receipt of number of forms received from each site. Thereafter, each proforma from a NGO/site was given a consecutive numbering using the RRTC code followed by site code and by numbering 1-30.

At the coordinating centre, the data entry operator was informed on the above procedures used by the RRTC and detailed coding patterns. To computerize the collected data, data entry was carried out on a specially prepared excel sheet using MS Excel. The number on the entry field was the same as the printed questionnaire for ease and accuracy. The staff was provided training on the proforma and a dry run of 5 questionnaires was keyed in and checked for consistency. Minor issues identified during this process were explained. Post completion of the data

entry, all data was edited for errors and missing field data if found was physically verified again by relocating the original filled proforma and phone calls were also made to the interviewers to verify the information. The final analysis of data to generate tables was made using SPSS software (version 19.0).

For presenting the data in an easily readable format, tables cross tables and graphic illustrations were prepared using MS Excel and other applications. The percentage in some graphs does not total to 100% as 'no response' category has been excluded. The findings and presentation of the study results address the predefined objectives. The variables on the questionnaires were also analysed comparing school going and out of school going children as well as those living with the family.

**Timeline followed in the study –**

- |                                |   |  |
|--------------------------------|---|--|
| <b>Training</b>                | - | <b>January, 2012 to January, 2013</b>                      |
| <b>Data Collection</b>         | - | <b>November, 2012 to April, 2013 (at different places)</b> |
| <b>Data entry and Analysis</b> | - | <b>April to May, 2013</b>                                  |
| <b>Report</b>                  | - | <b>May to June, 2013</b>                                   |

## Operational Definitions–

- i) Children** – According to Article 1 of UNCRC (United Nation’s Convention on the Rights of the Child), “A child means every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier.” This age limit was used for the study as well.
- ii) School children** – Children who are currently enrolled and regularly going to school.
- iii) Out of school children** – Children below the age of 18 years who are not currently studying, are school dropouts or never went to school.
- iv) Substance** – Any psychoactive substance or drug which when taken into a living organism modifies one or more of its functions. The list of the substance categories used in the study include-
- Tobacco (Smoking / Chewing)
  - Alcohol (Beer, Wine, Hard Liquor, *Desi Alcohol*)
  - Cannabis (*Bhang, Charas, Ganja, Sulpha*)
  - Inhalants (Ink eraser fluid, Petrol, Glue, Iodex etc)
  - Opium (*Doda, Phukki*)
  - Heroin (*Smack, Brown sugar*)
  - Pharmaceutical opioids (Proxyvon, Tidigesic, Fortwin, Codeine containing Cough syrups etc.)
  - Pharmaceutical sedatives (Diazepam, Nitravet or number 10, Alprax, Trika etc)
  - Injectable route (any substance)
- These substances were listed base on existing knowledge from literature about substances used in India.
- v) Substance use** – Use of any psychoactive substance other than when medically prescribed.
- vi) Target population** – The population from which representative information is desired and to which inferences will be made.
- vii) Respondent** – Child being interviewed for the survey.

# Findings

## Description of total sample

As envisaged in the research protocol, the study included data from all regions of the country and the target sample was reached at all the sites. A large number of cities or towns from a total of 27 states and 2 UTs from across the country were surveyed. A list of the states from where data was collected by various NGOs and the sample size contributed from each state is shown in the annexure II. It has a large sample size of 4024 children which included children living at home and those living out of home (on the streets or at workplace), children studying in school and those who were out of school.

Besides the Metros covered for the survey - New Delhi, Bangalore, Mumbai, Chennai, Kolkata, some other cities and towns covered were Agra, Aizawal, Allahabad, Bagdogra, Bardez, Batala, Bhatinda, Bhilai, Bhopal, Bhubaneswar, Bilaspur, Bisnupur, Calicut, Chandel, Chandigarh, Churachandpur, Coimbatore, Cuttack, Darjeeling, Deoria, Dhanbad, Dimapur, Faridabad, Fazilka, Gangtok, Gurdaspur, Howrah, Imphal, Indore, Itanagar, Ittawa, Jabalpur, Jaipur, Jalna, Jalpaiguri, Tamenglong, Jammu, Jhansi, Jhunjhunu, Jowai, Jullundur, Kalimpong, Kangra, Kapurthala, Kohima, Kolasib, Kottayam, Kurseong, Murshidabad, Madurai, Muzaffarpur, Lunglei, Mathura, Mehsana, Mirik, Mohali, Morinda, Nadiad, Nagapatanum, Nagpur, Nakodar, Nasik, Nawan-Shahar, Palanpur, Pasighat, Patna, Pune, Raipur, Ram Nagar, Ranchi, Saiha, Secundrabad, Senapati, Shillong, Shimla, Siliguri, Sriganganagar, Srinagar, Surat, Talghat, Bidar, Taran-Taran, Tirupathy, Trichy, Trivandrum, Ukhrul, Visakhapatnam, Wokha and several villages adjacent to some towns.

## Recruitment of sample

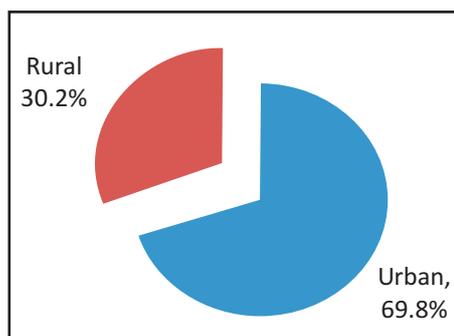
There were two types of NGOs that collected data for the study viz. NGOs working in the area of substance use and NGOs working especially for the street children. The NGOs were asked to specify the site from where the child had been identified and interviewed. It was observed that multiple methods were used by them. A list of the NGOs that collected data is given in Annexure II.

NGOs working in the area of substance use usually reported using snowball method to identify children, conducting awareness programmes in the community regarding substance use and interviewing children who came to their drug treatment centre. There were some children of substance users who were users themselves. Some children were identified from the shops which they visited to buy substances besides from the community where they lived.

NGOs working especially for the street children recruited majority from railway station, traffic signals and those coming to their NGO for services/activities.

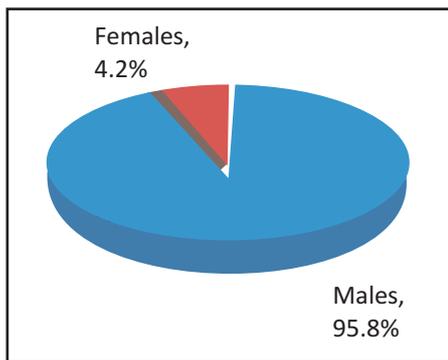
## Demographic characteristics

Figure 1



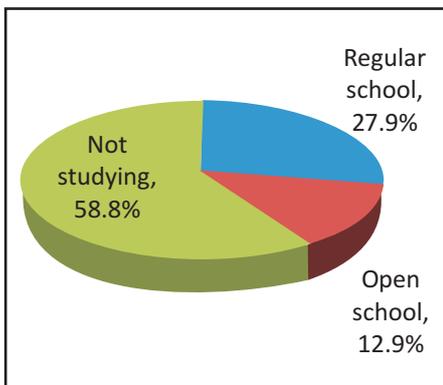
The mean age of the children was  $15.6 \pm 2.1$  years (range 5-18 years). Of the total sample, 69.8% children were living in an urban area while 30.2% were from rural areas (Figure 1).

**Figure 2**



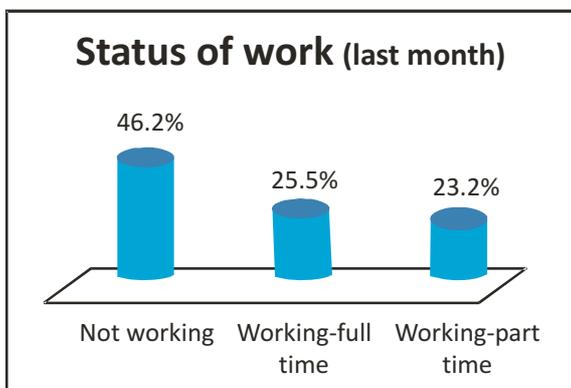
They were mostly males and only a small proportion was females (4.2%) (Figure 2); most were living at home while 22% were living on the streets or at the place where they worked. Majority (72.1%) were living at home with family and a small proportion (6.1%) was living at home with friends/relatives. An almost equal proportion was living with the family on the street (8.0%) and living alone on the street (9.3%). A smaller percentage (3.5%) was living in the shop or establishment where they were working. A significant proportion (60.0%) was living with both parents while rest were living with one parent (15.6%) or no parent (6.7%) or with a step-parent (3.0%).

**Figure 3**



One fifth of the respondents had never been to school or had been for a very short period. About one fourth each had education up to class 1-5, class 6-8 and class 9-12. Currently, 27.9% were studying in school, 12.9% were studying through open school and rest were not studying (58.8%) (Figure 3).

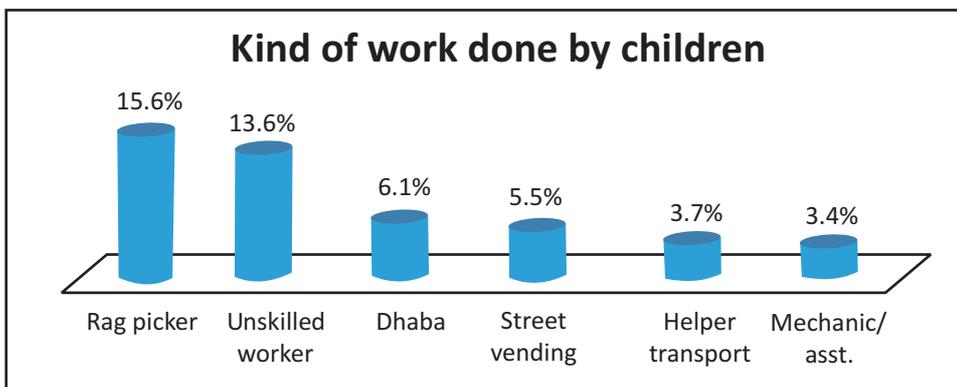
**Figure 4**



Many of the children depended on their family to support them but an equal proportion also earned their living themselves. A large proportion (46.2%) was not working (Figure 4).

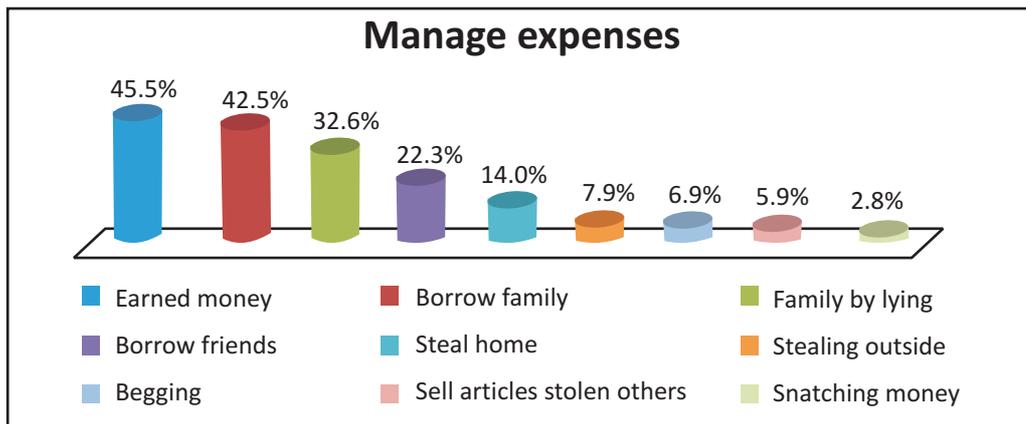
About one fourth were working fulltime and 23.2% in part time jobs.

**Figure 5**



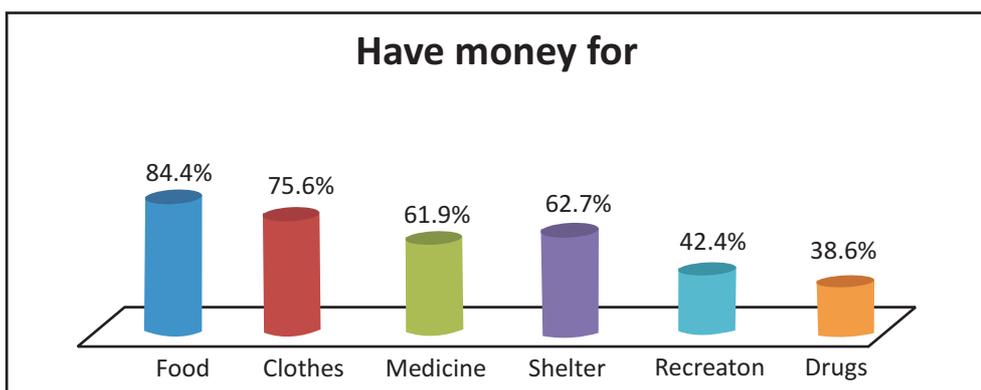
The kind of jobs being done by children is shown in Figure 5. Ragspicking, unskilled work, work in dhaba/restaurant and street level vending was common.

Figure 6



When inquired about how they managed expenses during the last one month, 45.5% said that they earned money themselves, 42.5% said that they were given money by family or borrowed from them, 32.6% reported taking money from family by lying to them, 22.3% borrowing from friends, 14.0% reported stealing from home or selling household items, 7.9% reported stealing from outside, 6.9% reported begging, 2.8% reported snatching from others and 5.9% reported helping sell articles stolen by others (Figure 6).

Figure 7



When asked whether they had money for various expenses, most said that they had money for food (84.4%) almost three fourths had money for clothes; about 62% each had money for medicines, shelter, 42.4% had money for recreation and 38.6% for substances (Figure 7).

### Family related factors

The average family income was Rupees 9277-00 in a month (family income was reported by about 73% of the children in the study). The educational status of the parents was inquired to understand the socio-economic background of the children. There were children who did not know or could not respond to this question about the father and mother (20%; 16.7%). About one fourth said that their father had never been to school or been for a very short time, another 30% had father educated till primary or middle school, 16.3% till class 9-12 and less than 10% had fathers who were graduates, post graduates or professionals. For the mothers the responses were similar although the educational status was still lower. Many of the mothers (38.7%) had never been to school or been for a very short period. Only 4.4% mothers were graduates, postgraduates or had professional training. Information was also collected about the occupation of the head of the household (HOH). The largest category

was comprised of unskilled workers (22.6%). About 14% were agricultural worker/farmer, and 9.2% were skilled workers and 5.8% were involved in rag-picking/begging. A minority was distributed across other occupational categories. About 5.5% children could not report on the occupational status of the head of the household.

Almost 90% children were in contact with the family (Figure 8). There were 71.6% children who were meeting them on a daily basis.

A small percentage said that their relationship with parents was bad or very bad (20.0%) while rest reported a good or average relationship (Figure 9).

Figure 8

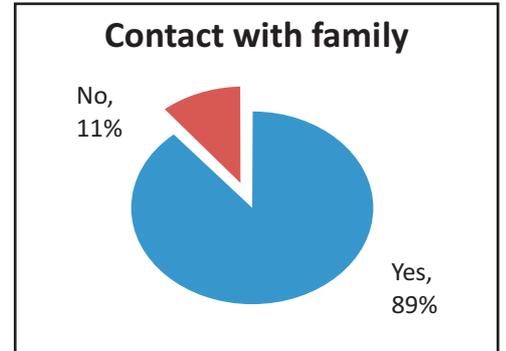
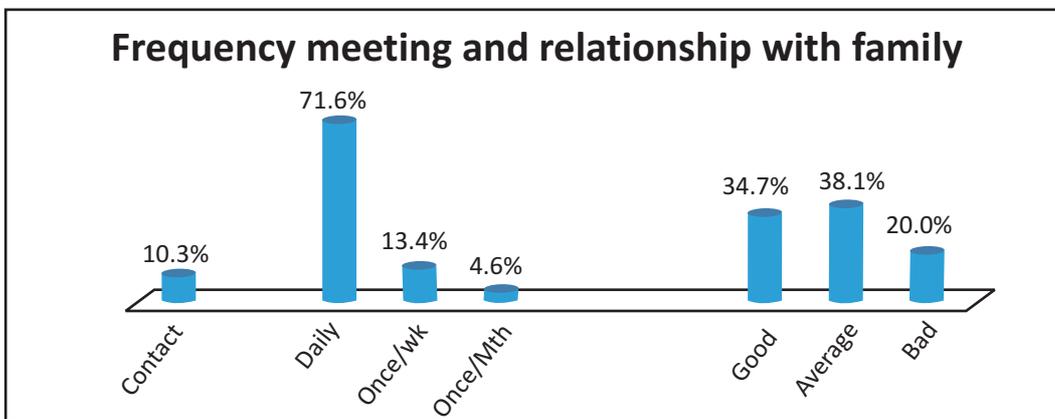
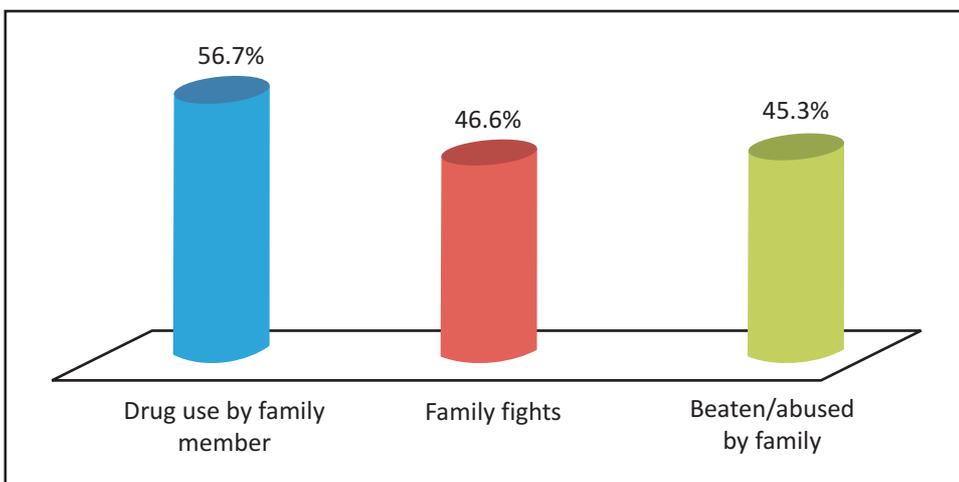


Figure 9



An alarmingly large percentage (56.7%) reported substance use by a family member that created problems for the family, 46.6% reported fights in the family and 45.3% reported being beaten up or abused by the family (Figure 10).

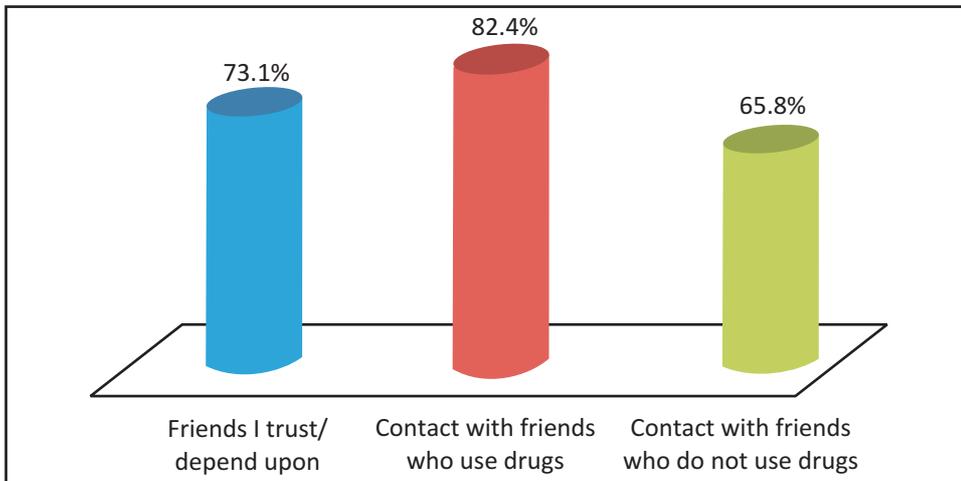
Figure 10



## Peer related factors

The respondents were also asked about their friends/peers. Three fourths of the children reported having friends

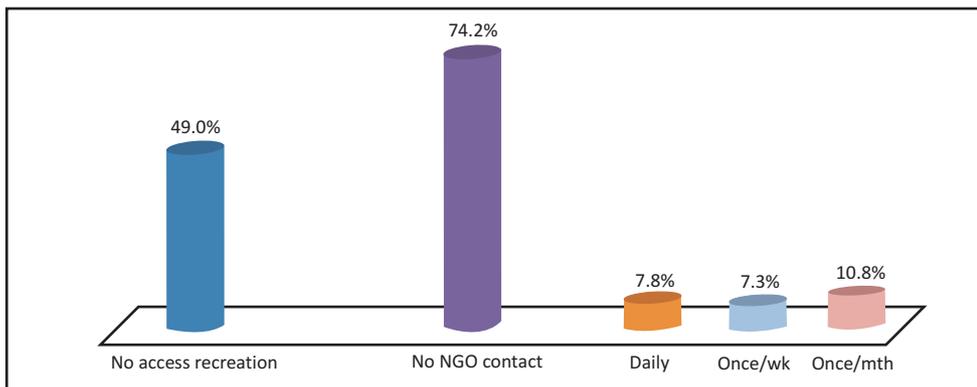
Figure 11



they can trust and depend upon and alarmingly 82.4% reported having close contact with friends who use substances and 65.8% reported having friends who are not using substances (Figure 11).

About 40% children had 1-2 substance using friends, 23% had 3-5 friends. A smaller proportion (11%) had more than 5 substance using friends.

Figure 12

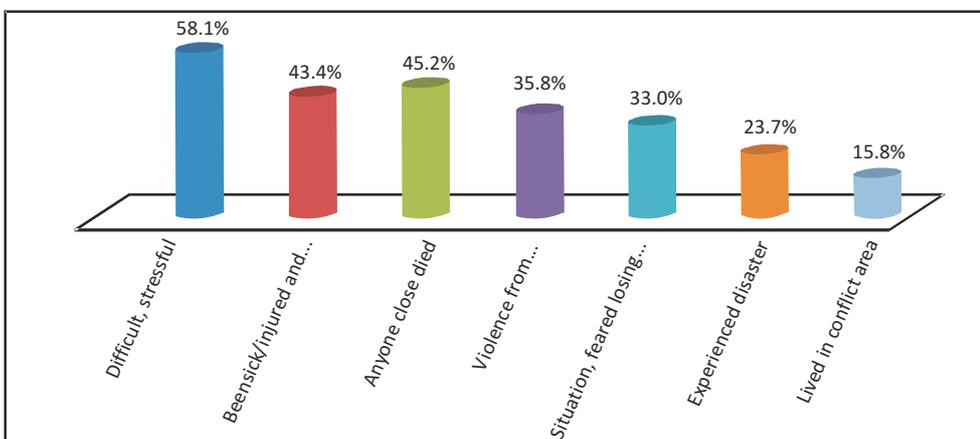


About 50% children responded that they did not have access to resources (external) for healthy recreational interests. More than 70% children were not in any contact with an NGO, only a small proportion (7.8%) was in daily contact with an NGO (Figure 12).

## Stress, physical and psychological health

A large percentage (58.1%) of children mentioned that they had encountered situations that were difficult, stressful or very 'bad'.

Figure 13

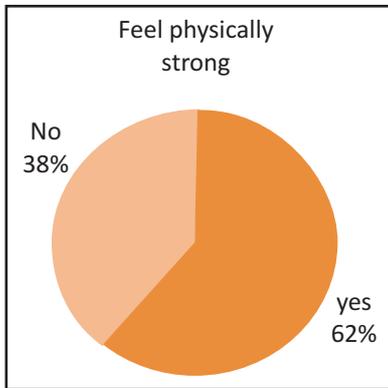


Almost 45% reported having been so sick or injured that they had to be taken to the hospital or reported the death of someone close. One third had been in a situation where they feared losing life or being severely harmed, one fourth had experienced natural disaster

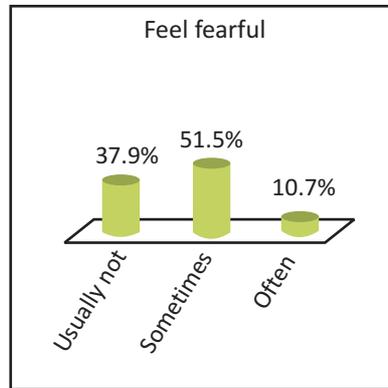
such as earthquake/flood, 16% had lived in an environment that was part of a conflict area; 35.8% had to face violence from the police or community (Figure 13).

Certain items were related to physical or psychological health- 38% reported not feeling physically strong (Figure 14), 10.7% reported often feeling fearful (Figure 15), 29.4% reported usually not feeling good about self (Figure 16),

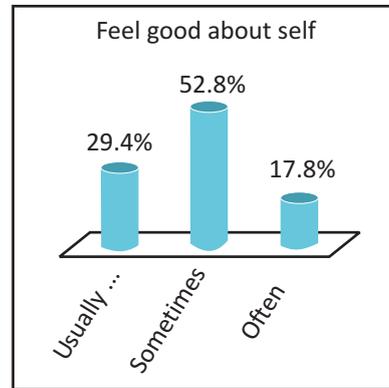
**Figure 14**



**Figure 15**

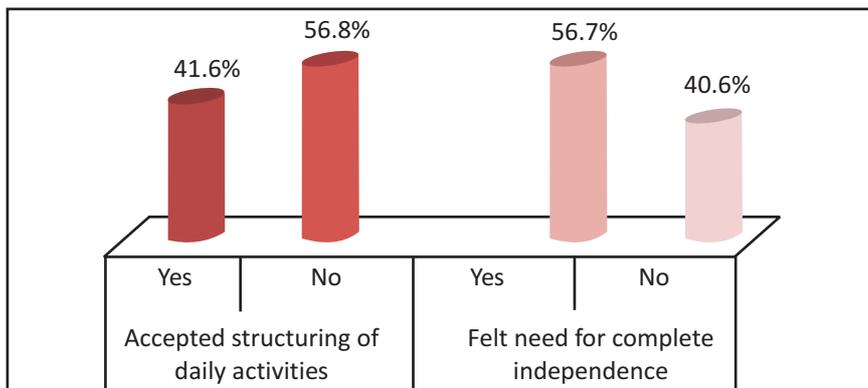


**Figure 16**



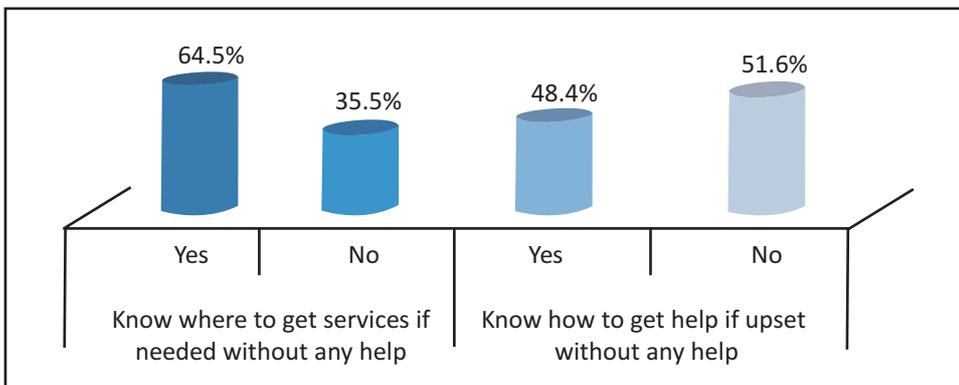
56.8% mentioned not accepting the structuring of their daily activities, 56.7% reported need for complete independence (Figure 17). When inquired whether they had plans for the future-44.7% said that usually they did not have any plans.

**Figure 17**



More than two third children reported that they did know where to get health services if they needed help while one third did not know (Figure 18). About half the children said that they knew how to get help if they were upset.

**Figure 18**

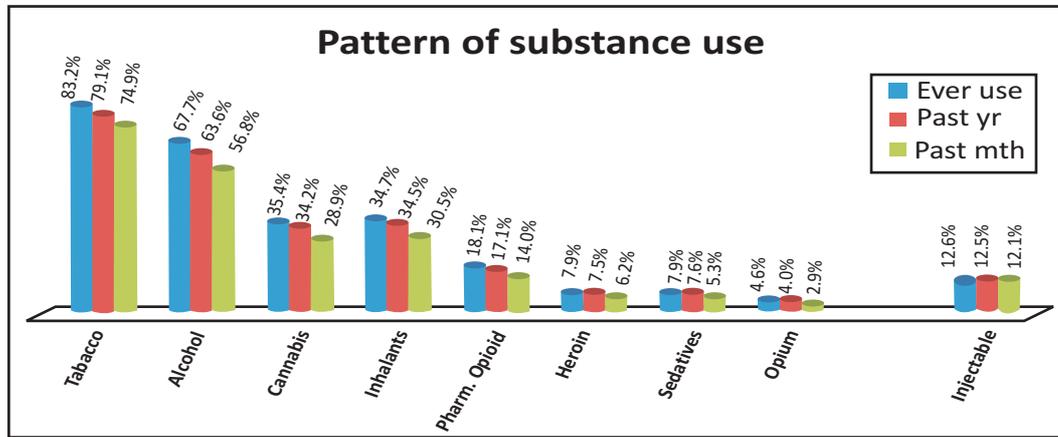


one third did not know (Figure 18). About half the children said that they knew how to get help if they were upset.

## Substance use

The following chart shows the prevalence of different substances used by the children. As can be seen, a majority of respondents reported using a variety of substances 'ever' in their lives. Apart from legal substances (tobacco, alcohol, and inhalants), cannabis, non-prescription sedatives and use by injectable route were reported by a large proportion (Figure 19).

Figure 19

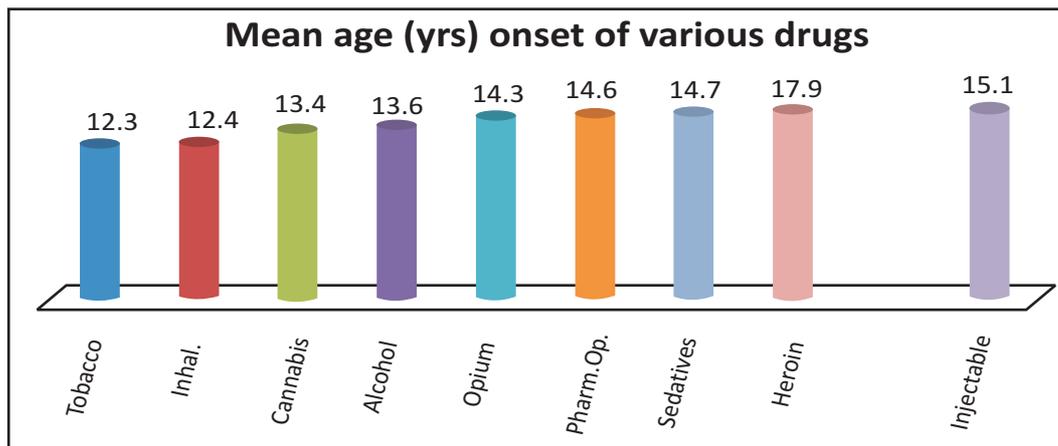


by a large proportion (Figure 19).

Tobacco and alcohol were the most common substances used ever followed by cannabis, inhalants, pharmaceutical opioids, heroin/smack and sedatives.

The first substance used by most children was tobacco (Figure 20). This was followed by onset of inhalants, cannabis, alcohol, proceeding then to use of non-injecting substances, heroin and then finally use of substances through injecting route which is evident in the chart below showing mean age of onset.

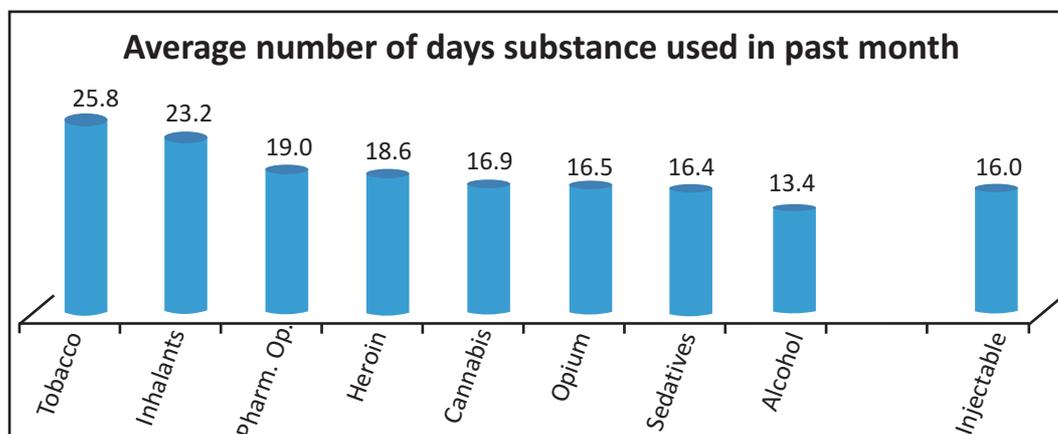
Figure 20



of non-injecting substances, heroin and then finally use of substances through injecting route which is evident in the chart below showing mean age of onset.

The figure 21 below shows the average number of days each substance was used in the last one month. For tobacco and inhalants, the use was near daily (25.8/30 days and 23.2/30 days). For all other substances, the use was intermittent and varied between 13-19 days per month.

Figure 21



For tobacco and inhalants, the use was near daily (25.8/30 days and 23.2/30 days). For all other substances, the use was intermittent and varied between 13-19 days per month.

## Regional variations in substance use

There were some regional variations regarding preference of substances being used by children during the past month as shown in Annexure III. The use of tobacco, alcohol, cannabis and inhalants was present in almost all the 27 states/ 2UTs studied and the use of heroin/smack and pharmaceutical opioids in children was also present in the majority of the states/UTs. Substance use in children was not limited to the metros but was also seen in smaller towns.

**Tobacco** - A larger percentage of children from Meghalaya reported past month use of tobacco (96.4%) followed by Nagaland (95.8%), Sikkim (93.1%), Uttaraanchal (90.0%). It was lowest from Goa (36.7%). 69.7% children in Delhi reported its use in last month.

**Alcohol** - Most children from Karnataka reported past month use (88.9%) followed by Andhra Pradesh (84.7%), Chandigarh and Haryana (80%). Low percentage of alcohol use was reported from Delhi (23.1%) and Tripura (35.0%).

**Cannabis** - A highest of 70% from Uttaraanchal followed by Haryana (63.3%), Meghalaya (50.9%) reported last month use of cannabis. It was lowest from Goa and Tripura (1.7%). Delhi and Chattisgarh had 34% children reporting its use.

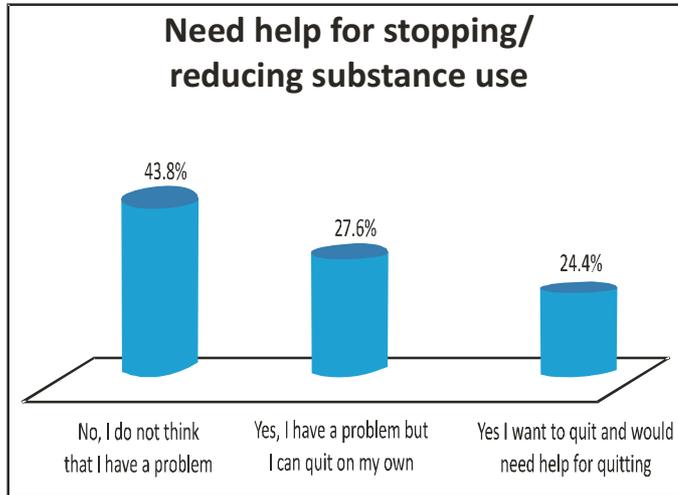
**Inhalants** - Past month use of Inhalant was highest in Tripura (68.3%) followed by Madhya Pradesh (66.5%), Maharashtra (60.6%), Sikkim (49%), Haryana (46.7%), Orissa (40%), Delhi and Rajasthan (39%), Manipur (32.3%), Meghalaya (30.9%). A low percentage from Tamil Nadu, Andhra Pradesh, Uttaraanchal, Jammu & Kashmir, Himachal Pradesh and Gujarat were reported (7-8%) and was lowest in Goa (5.0%).

**Heroin** - Past month use of heroin in children was highest in Meghalaya (27.3%), Punjab (19.3%), Jharkhand (16%), Jammu and Kashmir (13.3%) and Orissa (11.7%). Its use was reported by 9-10% in Delhi/ Uttar Pradesh/ West Bengal. Practically no child reported heroin use in Andhra Pradesh, Kerala, Tamil Nadu, Goa, Tripura, Himachal Pradesh, Gujarat and Bihar.

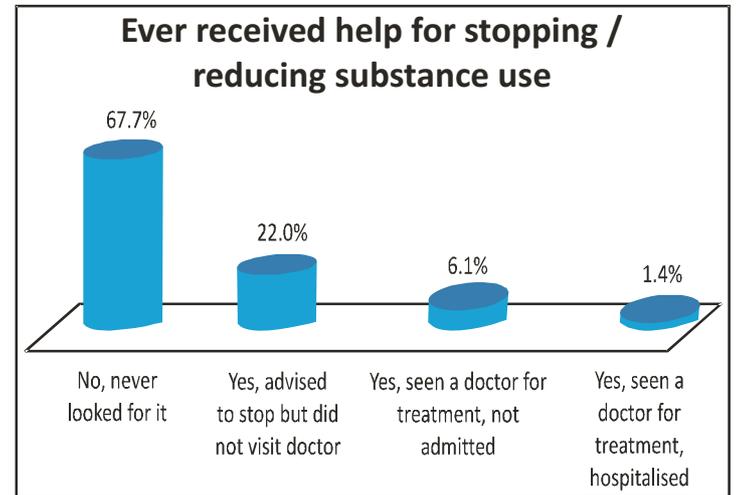
**Injectable use** - A high of 88.6% children from Mizoram followed by Meghalaya and Rajasthan (25%), Maharashtra (23.5%), Punjab (13%), Arunachal Pradesh, Manipur and Madhya Pradesh (11%) reported past month injectable use. It was 7% and below in other states. No child reported injectable use in states of Andhra Pradesh, Karnataka, Kerala, Tamil Nadu, Goa, Tripura, Himachal Pradesh, Gujarat, Bihar, Uttaraanchal, Jammu and Kashmir and Chattisgarh.

When asked whether they need help for stopping or reducing substance use, many of the children felt that they do not have a problem due to their substance use (Figure 22) and 67.7% had never looked for help, 22.0% had been advised to seek help from a doctor and only 1.4% had been hospitalised for treatment for substance use (Figure 23).

**Figure 22**

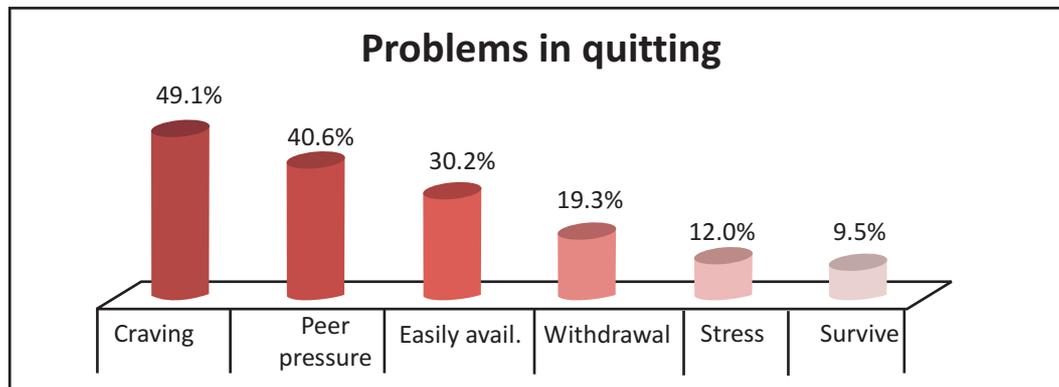


**Figure 23**



Children reported experiencing difficulty in quitting. The figure 24 below presents the proportion of respondents reporting experiencing difficulty due to various problems when attempting to quit substance use. They reported craving, peer pressure, easy availability, withdrawal, stress and difficulty surviving on the streets without the substance.

**Figure 24**

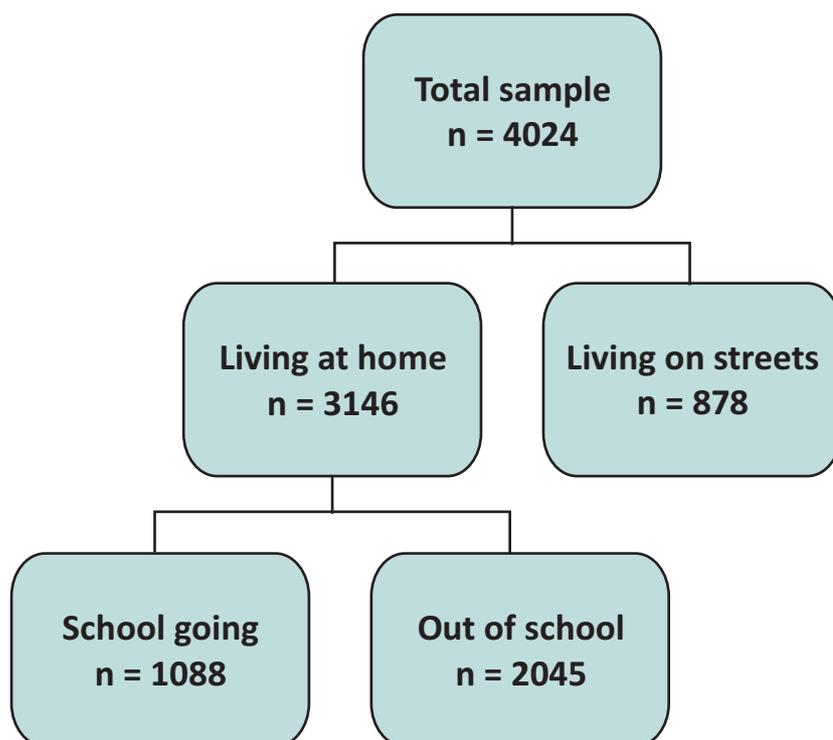


For further analysis, the sample was divided into two groups based on the question - *Where do you live/sleep these days in the last month (for those in institutional setting, please respond in the period prior to institutionalization/admission)?*

For the purpose of operationalising, the children who were living at home with family or with friends/relatives were categorised as “children living at home (n=3146)” and those who were living on the street/footpath/railway platform and in the shop/establishment where they worked were categorised as “living on the streets (n=878)” (Figure 25).

Section A in the results section pertains to this group.

**Figure 25**



The sample was also divided into groups based on the question - *Currently studying in school or not (last one month)*. All children living at home and currently studying in a regular school were categorised as ‘school going (n=1088)’ and those studying in open school or not studying were categorised as ‘out of school (n=2045)’. The results in section B in the results section follow this categorisation.

Children who could not be categorised due to missing information were excluded from the results in section A and B but have been included in the total sample.

## Section A

### Children living at home or on the streets

The sample size of children living at home was 3146 and living on the street was 878 children. The following set of tables pertains to this sample and excludes no response cases. The mean age of those living at home was  $15.8 \pm 1.9$  years and those on the streets at  $14.8 \pm 2.4$  years. The distribution by gender was very similar in both the groups (Figure 26).

Figure 26

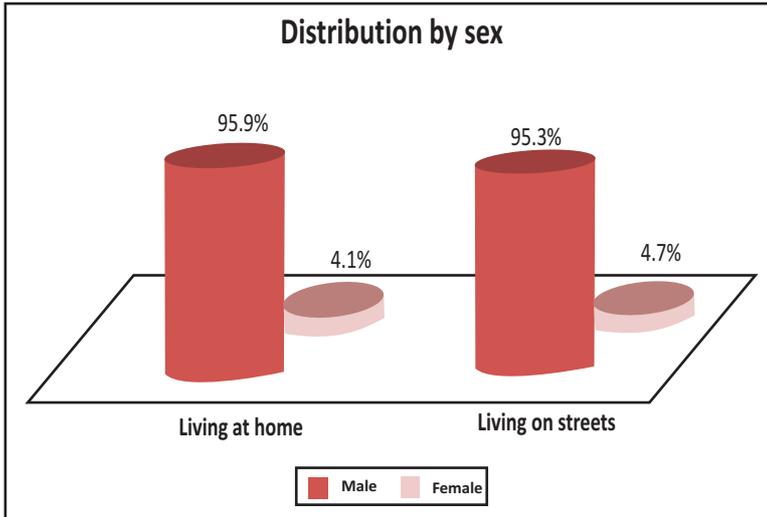
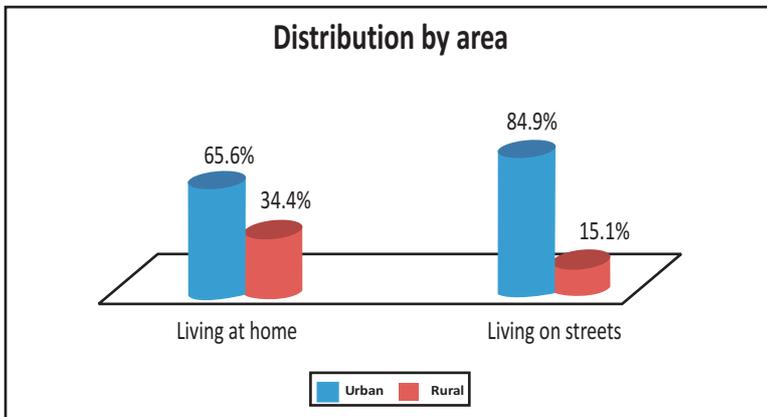


Figure 27



Most of the children living on the streets were from urban areas (84.9%) and a small proportion (15.1%) were living in rural areas (Figure 27).

<b>Table 1</b>		
<b>Living arrangements</b>	<b>At home (n=3146)</b>	<b>On streets (n=878)</b>
Home (with family)	2900 92.2%	
Home(with friends/relatives)	246 7.8%	
With family (Street/footpath/ railway platform )		321 36.6%
Alone (Street/footpath/ railway platform )		374 42.6%
Shop/establishment where working		139 15.8%

Of the total group of street children, 15.8 % lived in the shop or establishment where they worked, 42.6% lived alone on the street and 36.6% were living on the street with the family. Of the group of children living at home, 92.2% were living with the family and 7.8% were living with friends and relatives (Table1).

<b>Table 2</b>			
		<b>At home (n=3146)</b>	<b>On streets (n=878)</b>
Educational status	Never been to school/ very short period	424 13.5%	395 45.0%
	Never been to school/ attended NFE classes	71 2.3%	80 9.1%
	Class 1-5	729 23.2%	267 30.4%
	Class 6-8	850 27.0%	92 10.5%
	Class 9-12	1058 33.6%	37 4.2%
Currently studying in school ( last one month)	Yes, in regular school	1088 34.6%	33 3.8%
	Studying through open school	394 12.5%	124 14.1%
	Not studying in school	1651 52.5%	716 81.5%

The educational attainment in the street children group was much less. A larger percentage of the street children had never been to school or been for a very short time (45.0%) as compared to children living at home (13.5%) but a few had attended NFE classes. One third of the children living at home had educational attainment beyond middle school. Overall, 65% of the children living at home were out of school as compared to 95.6% of those who were categorised as street children (based on the criteria mentioned above). Currently, 34.6% of the children living at home and 3.8% of the street children were studying in regular school. An almost equal percentage in both groups was studying in open school (12.5% and 14.1%) (Table 2).

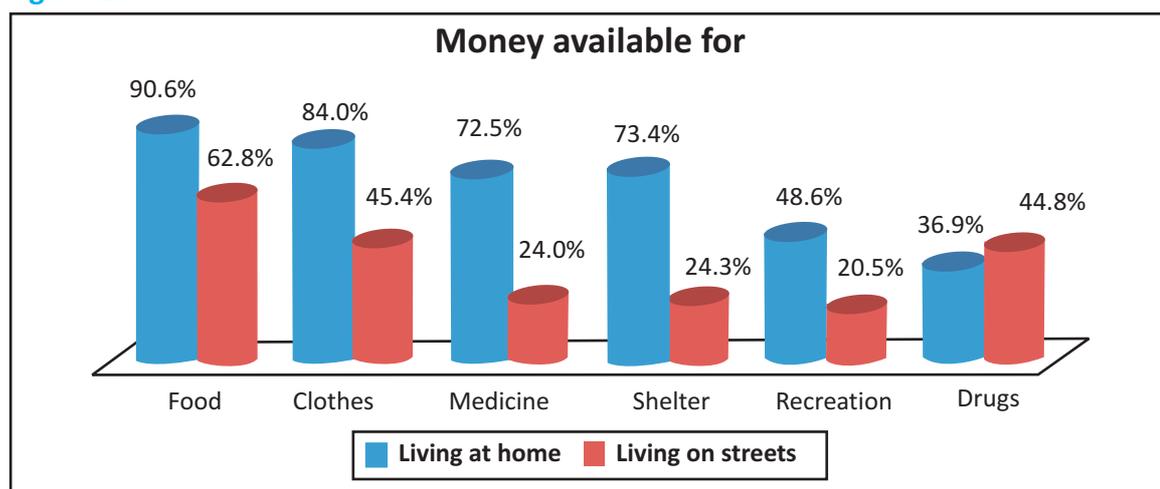
		<b>At home (n=3146)</b>	<b>On streets (n=878)</b>
Kind of work done by child	Rag picker/Kabadi	236 7.5%	393 44.8%
	Street level vending	155 4.9%	67 7.6%
	Dhaba/Restaurant waiter	156 5.0%	89 10.1%
	Mechanic / assistant	115 3.7%	20 2.3%
	Helper in transport	119 3.8%	30 3.4%
	Unskilled worker/ labourer	441 14.0%	105 12.0%
Status of work (last one month)	Currently working- full time	661 21.0%	364 41.5%
	Currently working- part time	661 21.0%	272 31.0%
	Currently not working	1724 54.8%	136 15.5%

A large percentage of street children were working full-time or part-time (72.5%) (Table 3). Many of the children living at home also reported working (42.0%). More children living at home were working as unskilled workers or labourer (14.0%) and a larger percentage of the children living on the streets were working as rag-pickers (44.8%). However, some children living at home also were working as rag-pickers/*kabadi* (7.5%). The other kinds of work that was reported by children in both the groups was - street level vending, working in a restaurant/*dhaba*, working as a mechanic/assistant, helper in transport.

Significantly higher percentage of children living at home managed expenses by borrowing or were given money by the family (52.3%), took money by lying to the family (39.5%), borrowed from friends (23.1%) and 15.5% reported stealing from home (Table 4). Significantly higher percentage of children on the streets managed their expenses through their own income (65.6%), begging (23.1%), stealing from outside (14.9%) or selling stolen articles (9.5%), snatching from others (6.4%).

<b>Manage expenses</b>	<b>At home (n=3146)</b>	<b>On streets (n=878)</b>
Given/borrowing money from family	1646 52.3%	64 7.3%
Take money from family by lying to them	1242 39.5%	68 7.7%
Steal from home/ selling household items	489 15.5%	75 8.5%
Earned money	1255 39.9%	576 65.6%
Borrow from friends	728 23.1%	169 19.2%
Stealing from outside	187 5.9%	131 14.9%
Begging	76 2.4%	203 23.1%
Snatching money from others	58 1.8%	56 6.4%
Helping sell articles stolen by others	156 5.0%	83 9.5%
Other means	27 0.9%	26 3.0%

**Figure 28**



Significantly larger percentage of children living at home said that they had money for food, clothes, medicines, shelter and recreation as compared to the street children. Larger percentage of the street children (44.8%) compared to those living at home (36.9%) mentioned that they had money for substances (Figure 28).

### Family and peer related factors

		<b>At home (n=3146)</b>	<b>On streets (n=878)</b>
Educational status of father	Never been to school/ very short period	666 21.2%	291 33.1%
	Class 1-5	592 18.8%	125 14.2%
	Class 6-8	433 13.8%	51 5.8%
	Class 9-12	623 19.8%	31 3.5%
	Graduate	306 9.7%	8 0.9%
	Post graduate/ professional	64 2.0%	3 0.3%
Educational status of mother	Never been to school/ very short period	1090 34.6%	466 53.1%
	Class 1-5	518 16.5%	92 10.5%
	Class 6-8	435 13.8%	30 3.4%
	Class 9-12	513 16.3%	29 3.3%
	Graduate	147 4.7%	1 0.1%
	Post graduate/ professional	26 0.8%	4 0.5%

Even in the sample of children living at home, the educational status of the parents was low (Table 5). One fifth of the children living at home stated that their father had never been to school or been for a very short period. The educational status of the father and mother was significantly poorer in the street children group although a large proportion of street children also said that they did not know the status of education of the parents or did not respond; 41.6% could not tell about the education of the father and 28.9% about the education of the mother.

A large percentage of children were not aware of their family income. Among those who were living with family, their monthly average income was Rs. 9845±10359 while among those on the streets, it was Rs. 5629±6877 in a month.

The occupational status of the head of the household (HOH) was unskilled work in 16.9%, rag-picking/begging in 14.6% of the street children; 3.6% mentioned that the HOH was unemployed. There were a few children living on streets who reported that the HOH was employed in other professions such as a farmer, skilled worker, sales worker, clerical staff etc (Table 6).

<b>Table 6</b>		
Occupational status of head of household	<b>At home (n=3146)</b>	<b>On streets (n=878)</b>
Not applicable as not living with family	100 3.2%	288 32.8%
Unemployed	194 6.2%	32 3.6%
Rag picking/ begging	106 3.4%	128 14.6%
Agricultural worker/ farmer	508 16.1%	46 5.2%
Unskilled worker/farmer	761 24.2%	148 16.9%
Skilled worker	343 10.9%	27 3.1%
Sales worker	262 8.3%	29 3.3%
Clerical staff	203 6.5%	4 0.5%
Professional	184 5.8%	12 1.4%
Others	385 12.2%	37 4.2%

More than 50% of the children living at home said that the HOH was working as a farmer or a skilled or unskilled worker although a small proportion (6.2%) also said that the HOH was unemployed or doing rag-picking or begging.

<b>Table 7</b>			
		<b>At home (n=3146)</b>	<b>On streets (n=878)</b>
Contact with Family	Yes	3008 95.6%	583 66.4%
	No	138 4.4%	295 33.6%
Frequency of meeting family	Daily	2703 85.9%	179 20.4%
	Once/week	204 6.5%	335 38.2%
	Once in last month	106 3.4%	81 9.2%
	No contact with family	133 4.2%	283 32.2%
Relationship with family	Good	1281 40.7%	117 13.3%
	Average	1280 40.7%	252 28.7%
	Bad	441 14.0%	215 24.5%
	Very bad	80 2.5%	69 7.9%
	Not applicable/ no family	63 2.0%	225 25.6%

One third of the street children on streets were not in contact with the family and 20% were in daily contact with the family.

Significantly higher percentage of children living at home reported that their relationship with the family was good or average while the rest (18.5%) said that it was bad, very bad or they could not comment as they were not in contact with the family or had no family. More than 50% children living on the streets reported bad or very bad relationship or no relationship with the family (as they were not in contact with the family) (Table 7).

<b>Table 8</b>		
	<b>At home (n=3146)</b>	<b>On streets (n=878)</b>
Substance use by family member that creates problems for family	1797 57.1%	485 55.2%
Family fights	1420 45.1%	456 51.9%
Beaten and abused by family	1389 44.2%	435 49.5%

The percentage who reported substance use by family member that created problems for the family, family fights and being beaten and abused by the family was very high in both the groups and was higher in the children living on the streets (Table 8).

<b>Table 9</b>			
		<b>At home (n=3146)</b>	<b>On streets (n=878)</b>
Access to resource for recreational interests	Yes	1651 53.7%	245 30.7%
	No	1421 46.3%	552 69.3%
Frequency of contact with NGO	No contact	2415 77.7%	505 60.8%
	Daily	202 6.5%	104 12.5%
	Once a week	183 5.9%	103 12.4%
	Once a month	307 9.9%	118 14.2%

A large percentage of children in both settings stated that they did not have access to recreational pursuits although access to recreational avenues was better for children living at home (Table 9).

About 39.2% street children were in contact with an NGO as compared to 22.3% children living at home. The frequency of contact was either daily or less often (once a week/once a month) (Table 9).

### Stress, physical and psychological health

The responses for indicators related to stress were quite high in both groups but were significantly higher in the street children. They reported that 62.6% had been in a situation that was very difficult/bad, 53.1% had been so sick in the past that they had to be taken to a hospital, 40.9% reported being in a situation where they feared losing their life or being severely harmed, 18.7% had lived in a conflict ridden area and (55.1%) mentioned that they had faced violence in the past from the police or the community (Table 10).

<b>Table 10</b>		
	<b>At home (n=3146)</b>	<b>On streets (n=878)</b>
Anything happened that has been very difficult/ stressful/something <i>bad</i>	1790 56.9%	549 62.6%
Ever been sick, injured that needed to go to hospital	1282 40.8%	466 53.1%
Anyone close has died	1408 44.8%	410 46.7%
Ever been in a situation where feared losing life or being severely harmed	968 30.8%	359 40.9%
Ever experienced natural disaster (earthquake, flood, fire)	769 24.4%	185 21.1%
Ever lived in environment -part of conflict area	470 14.9%	164 18.7%
Ever had to face violence from police/ community	957 30.4%	484 55.1%

There were no differences in the reporting of death of a close family and experience of some natural disaster between the groups.

<b>Table 11</b>			
		<b>At home (n=3146)</b>	<b>On streets (n=878)</b>
Feel physically strong (last month)		2005 63.7%	476 54.2%
Feel good about self (last month)	Usually not	831 26.6%	336 39.9%
	Sometimes	1667 53.4%	425 50.5%
	Often	624 20.0%	81 9.6%
Feel fearful (when not intoxicated)(last month)	Usually not	1226 39.4%	270 32.1%
	Sometimes	1577 50.7%	458 54.5%
	Often	308 9.9%	113 13.4%
Accepted structuring of daily activities		1387 45.6%	286 34.3%
Felt need for complete independence		1819 59.1%	463 55.1%
Have plans for future	Usually not	1339 42.9%	450 53.2%
	Sometimes	1418 45.4%	318 37.6%
	Often	366 11.7%	78 9.2%
Know where to get health services if needed without any help		2089 66.4%	508 57.9%
Know how to get help if upset without any help		1482 47.1%	465 53.0%

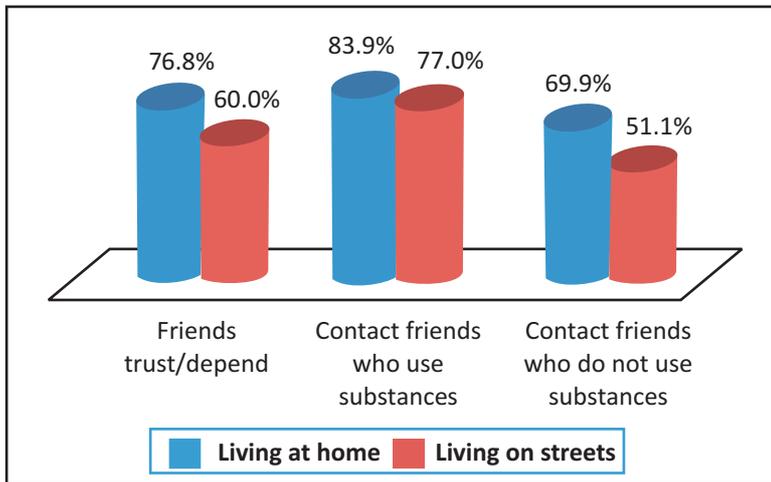
Many children in both the groups stated that they did not feel physically strong, did not feel good about themselves and felt fearful. These percentages were higher in street children.

Many children in both the groups reported *not* accepting the structuring of their daily routine and many of them reported the need for complete independence. More than 40-50% children in both the groups usually did not have any plans for the future. More than half the children in both the groups stated that they knew where to get help if needed (Table 11).

## Peers

Large number of children in both groups had friends they could trust and had close contact with substance using friends. A somewhat higher percentage of children living at home reported having friends that they can trust and depend upon (76.8%) compared to those living on the streets (60.0%). Surprisingly, a larger percentage of children living at home had contact both with substance using friends (83.9%) as well as non-substance using friends (69.9%) compared to those on the streets. The percentage of street children who reported being in contact with substance users and non-using friends were quite large as well (Figure 29).

Figure 29

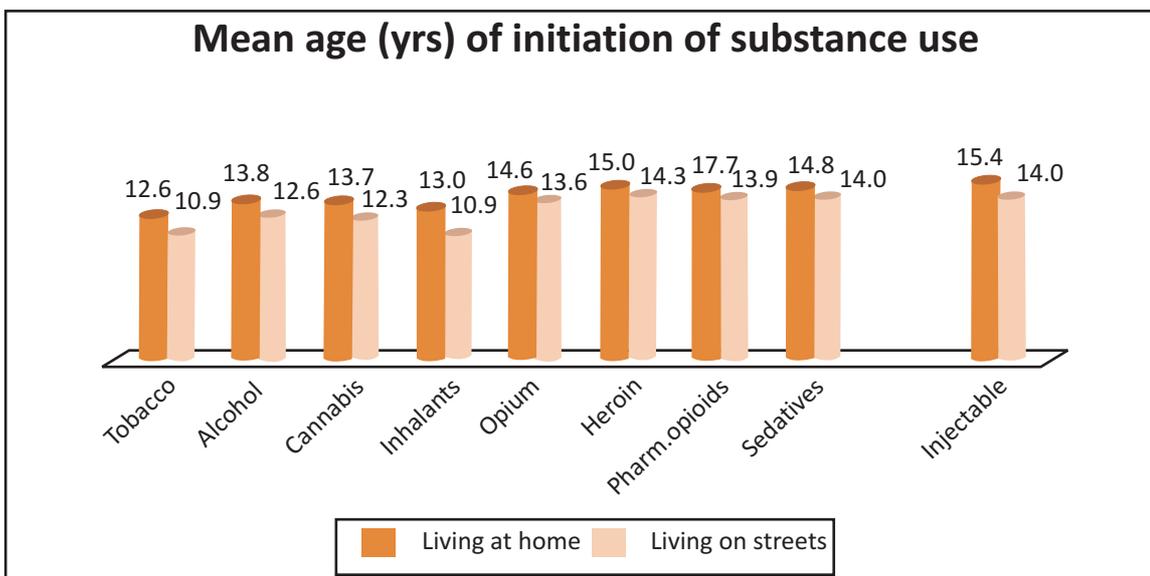


living at home had contact both with substance using friends (83.9%) as well as non-substance using friends (69.9%) compared to those on the streets. The percentage of street children who reported being in contact with substance users and non-using friends were quite large as well (Figure 29).

## Substance use

**Age of onset** - As is expected and generally believed, the age at initiation into use of all substances - tobacco, alcohol, cannabis, opium, heroin, pharmaceuticals as well as injectable use was lower for children living on streets (Figure 30).

Figure 30



<b>Table 12</b>			
		<b>At home (n=3146)</b>	<b>On streets (n=878)</b>
Tobacco	ever use	2644 84.0%	705 80.3%
	past year	2525 80.3%	656 74.7%
	last month	2400 76.3%	614 69.9%
Alcohol	ever use	2258 71.8%	468 53.3%
	past year	2145 68.2%	415 47.3%
	last month	1916 60.9%	368 41.9%
Cannabis	ever use	1134 36.0%	289 32.9%
	past year	1063 33.8%	312 35.5%
	last month	889 28.3%	274 31.2%
Inhalants	ever use	979 31.1%	416 47.4%
	past year	946 30.1%	442 50.3%
	last month	826 26.3%	403 45.9%
Opium	ever use	132 4.2%	54 6.2%
	past year	109 3.5%	50 5.7%
	last month	96 3.1%	20 2.3%

Tobacco and alcohol use were the commonest substances of used followed by cannabis and inhalants, pharmaceutical opioids, sedatives, heroin and opium. Tobacco and alcohol use was higher in those living at home than those living on the streets and this difference was much more prominent for alcohol than tobacco. The ever use, last one year and last one month use of alcohol was 71.8%, 68.2% and 60.9% among those living at home and 53.3%, 47.3% and 41.9% among those living on the street.

Cannabis lifetime use was higher (36%) among those living at home while last one year and last one month use was a little higher in the children living on the street. For all these substances, the percentage of last one month, last one year and lifetime use was quite close (Table 12).

The percentage of inhalant users (lifetime, last one year and last one month) was higher in the children living on the street than in children living at home. Last one month inhalant use was present in 26.3% of the children living at home and 45.9% of the children who were living on the street.

The lifetime and last one year use of opium was higher in the children living on the street than in children living at home.

		<b>At home (n=3146)</b>	<b>On streets (n=878)</b>
Heroin	ever use	240 7.6%	76 8.7%
	past year	227 7.2%	75 8.5%
	last month	198 6.3%	52 5.9%
Pharmaceutical opioids	ever use	651 20.7%	79 9.0%
	past year	616 19.6%	74 8.4%
	last month	498 15.8%	66 7.5%
Sedatives	ever use	284 9.0%	33 3.8%
	past year	274 8.7%	33 3.8%
	last month	184 5.8%	31 3.5%
Injectable route	ever use	448 14.2%	61 6.9%
	past year	442 14.0%	59 6.7%
	last month	434 13.8%	51 5.8%

Ever use of heroin, last one year and last one month use was quite similar in both the groups although last one month use was slightly higher in the street children.

Pharmaceutical opioid use was much higher in children living at home than those on the streets. Lifetime use in of pharmaceutical opioids in children living at home and children living on the streets was 20.7% and 9.0%, last one year use was 19.6% and 8.4%, and last one month use was 15.8% and 7.5% respectively. This was also true for sedatives although the percentage using it was much lower. Ever injectable use was higher (14.2%) in this sample of children living at home as compared to the street children (6.9%).

On the query of days of substance use during the past one month, it was observed that average number of days of use of tobacco, alcohol, cannabis and inhalants was slightly higher in those living on streets while number of days of use of opium, heroin and injection was slightly higher in those living at home but was not on a daily basis for most of the substances used.

<b>Table 13</b>		
<b>Size of substance using network of friends</b>	<b>At home (n=3146)</b>	<b>On streets (n=878)</b>
Usually take substances alone	763 24.2%	267 30.4%
Between 1-5 Friends	1305 41.5%	292 33.3%
Between 6-10 Friends	733 23.3%	194 22.1%
Between 11-15 Friends	270 8.6%	87 9.9%
More than 15 Friends	65 2.1%	31 3.5%

Most of the children were not using substances alone in each of the two groups. The largest proportion in both the groups was of those who were using with 1-5 friends (Table 13).

<b>Table 14</b>			
		<b>At home (n=3146)</b>	<b>On streets (n=878)</b>
Need help for stopping/reducing substance use	No, I do not think that I have a problem	1310 43.0%	396 46.6%
	Yes, I have a problem but I can quit on my own	874 28.6%	204 23.9%
	Yes I want to quit and would need help for quitting	750 24.6%	198 23.5%
Ever received help for stopping/reducing substance use	No, I never looked for it	2002 67.0%	589 69.9%
	Yes, someone advised me to stop but I did not visit a doctor	687 23.0%	156 18.6%
	Yes, seen a doctor for treatment of substance use but was not admitted	171 5.7%	65 7.7%
	Yes, seen a doctor for treatment of substance use and was hospitalised too	47 1.6%	7 .8%

More than 50% children in both the groups felt that substance use is a problem.

Most of the children in both the groups had never sought help and only a very small percentage had been to a doctor (Table 14).

<b>Table 15</b>		
	<b>At home (n=3146)</b>	<b>On streets (n=878)</b>
Experienced craving when trying to quit	1583 50.3%	394 44.9%
Experience peer pressure	1327 42.2%	305 34.7%
Substances easily available	966 30.7%	251 28.6%
Difficult to tolerate withdrawals	594 18.9%	182 20.7%
Difficult to cope with stress	388 12.3%	96 10.9%

Both the groups reported craving, peer pressure, easy availability, difficult in tolerating withdrawals and coping with stress (Table 15) as reasons for difficulty in stopping substance use.

<b>Table 16</b>		
	<b>At home (n=3146)</b>	<b>On streets (n=878)</b>
Substance use is harmful	2291 72.8%	554 63.1%
Experience intoxication that impaired performance	1677 53.3%	354 40.3%
Got into fights under effect of alcohol/substances	1336 42.5%	452 51.5%
Indulged in sexual behaviour under effect of alcohol/substances	570 18.1%	252 28.7%
Indulged in sexual behaviour to get substances or money for substances	532 16.9%	176 20.0%
Experienced physical problems due to alcohol/substances	1493 47.5%	436 49.7%
Experienced sadness/anxiety due to or related to substance use	1563 49.7%	446 50.8%

The opinions of children were obtained to assess problems/complications due to substance use. Significantly higher percentage of children living at home thought that substance use is harmful, had experienced intoxication that impaired performance as compared to children living on the streets (Table 16).

Significantly higher percentage of children living on streets reported that they had indulged in sexual behaviour under effect of substance, indulged in sexual behaviour for substances or money as compared to children living at home.

## Legal issues

The children in both the groups reported breaking the law for fun or to be accepted by peers.

<b>Table 17</b>		
	<b>At home (n=3146)</b>	<b>On streets (n=878)</b>
Broken law for fun or be accepted by peers to survive in the streets (last month)	750 23.8%	267 30.4%
Done something dangerous to earn money or get food, clothes, shelter (last month)	500 15.9%	340 38.7%
If in trouble, know where to get free legal help	871 27.7%	249 28.4%

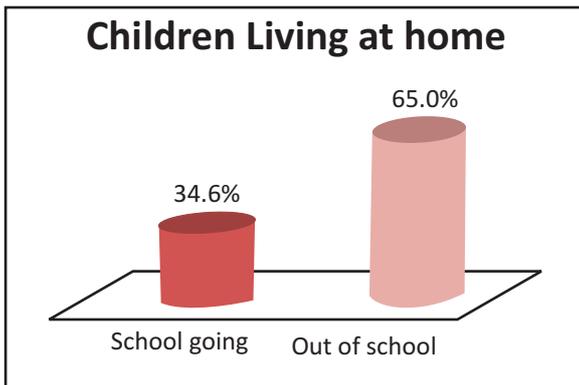
More street children said that they had done something dangerous to earn money or get food, clothes, shelter in the last month as compared to those living at home (Table 17).

## Section B

### Children studying in school or out of school but living at home

In the total sample, the category of out of school children included children living at home as well as those living on the streets. As this was a heterogeneous population, therefore in this section the results for school going children and out of school children living at home have only been discussed and excludes no response cases. Among 3146 children living at home, a total of 1088 (34.6%) children were school going and 2045 (65%) were out of school children (Figure 31).

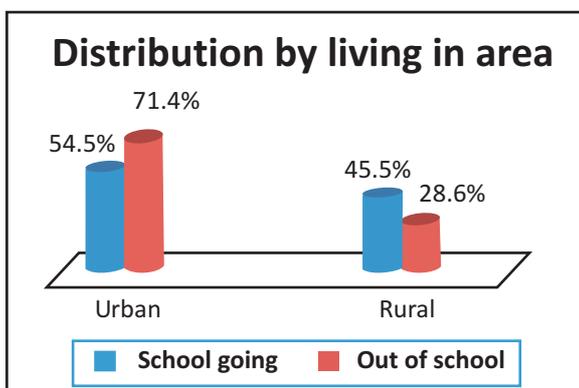
Figure 31



Among out of school children, 19.2% were studying through open school while 80.7% were not studying at all.

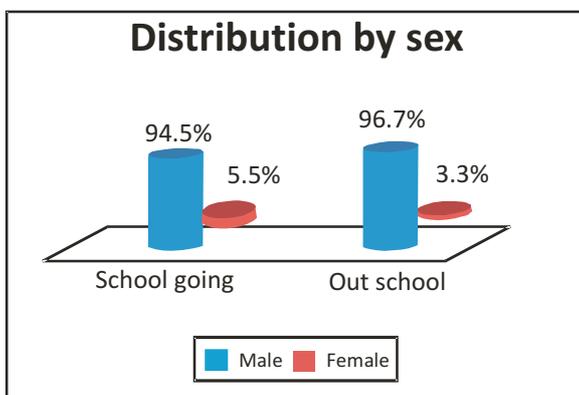
The mean ages of school going children and that of out of school children was similar and was  $15.7 \pm 1.8$  years and  $15.8 \pm 2.0$  years respectively.

Figure 32



A larger percentage of out of school children were from urban areas (71.4%) as compared to school going children (54.5%) (Figure 32).

Figure 33



The proportion of females in the school going sample was higher (5.5%) as compared to out of school children (3.3%) (Figure 33).

<b>Table 18</b>		
<b>Education</b>	<b>School going (n=1088)</b>	<b>Out of school (n=2045)</b>
Never been to school/ very short period	6 0.6%	418 20.4%
Never been to school/ attended NFE classes		70 3.4%
Class 1-5	78 7.2%	650 31.8%
Class 6-8	323 29.7%	527 25.8%
Class 9-12	680 62.5%	378 18.5%

Most of the school going children were not working although 2.7% reported working part-time.

Among out of school children, 31.5% were working full time while 30.8% were working part-time (Table 19).

Among out of school children, 20.4% had never been to school or been for a very short period; the rest who had dropped out of school reported having studied till class 1-5 (31.8%), class 6-8 (25.8%) and 9-12 (18.5%) respectively.

Those children currently in school were mostly in class 6-8 (29.7%) or in class 9-12 (62.5%) (Table 18).

<b>Table 19</b>		
<b>Current work status</b>	<b>School going (n=1088)</b>	<b>Out of school (n=2045)</b>
Full-time	8 0.7%	644 31.5%
Part-time	29 2.7%	629 30.8%
Not working	1045 96.0%	678 33.2%

<b>Table 20</b>		
<b>Kind of work done by child</b>	<b>School going (n=1088)</b>	<b>Out of school (n=2045)</b>
Rag picker/Kabadi	4 0.4%	228 11.1%
Street level vending	2 0.2%	148 7.2%
Dhaba /Restaurant waiter	3 0.3%	151 7.4%
Mechanic / assistant	3 0.3%	112 5.5%
Helper in transport	4 0.4%	115 5.6%
Unskilled worker/labourer	6 0.6%	434 21.2%
Do not work		496 24.3%

A small percentage of school going children were working (Table 20).

Most out of school children were working as unskilled workers (21.2%), as rag pickers (11.1%) and 5-7% was doing other work.

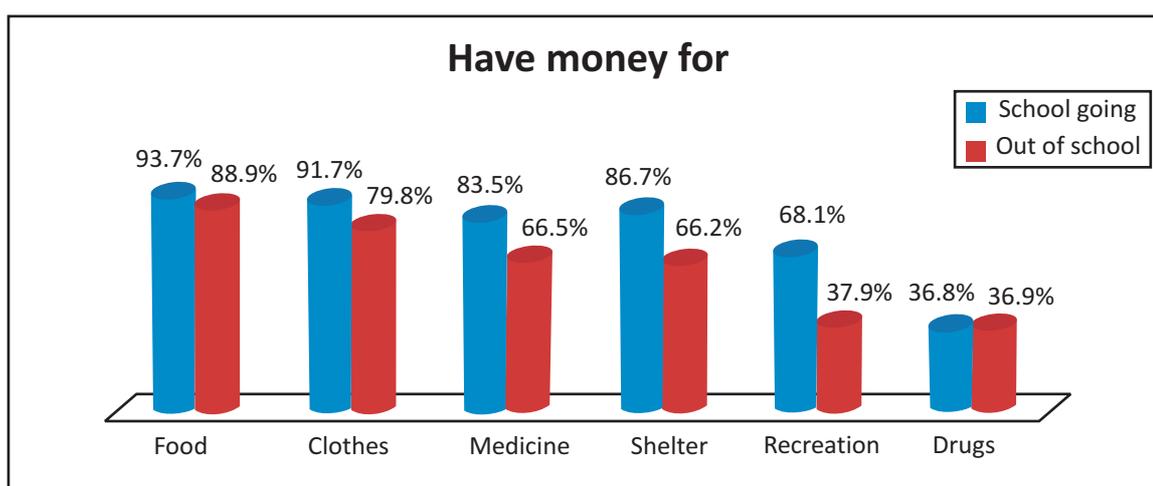
There were 24.3% out of school children living at home who were neither studying nor doing any work.

Table 21		
Manage expenses	School going (n=1088)	Out of school (n=2045)
Given/borrowing money from family	796 73.2%	850 41.6%
Take money from family by lying to them	601 55.2%	639 31.2%
Steal from home/ selling household items	191 17.6%	296 14.5%
Earned money	87 8.0%	1157 56.6%
Borrow from friends	262 24.1%	466 22.8%
Stealing from outside	23 2.1%	164 8.0%
Begging	9 0.8%	67 3.3%
Snatching money from others	13 1.2%	45 2.2%
Helping sell articles stolen by others	29 2.7%	127 6.2%
Other means	4 0.4%	23 1.1%

The major source of income for the school going children was different from out of school children. The school going children mentioned their income as- “given money by parents or borrowed from them” (73.2%) followed by taking money from family by lying to them (55.2%), and stealing from home/selling household items (17.6%) (Table 21).

The major source of income for the out of school children was their own earning (56.6%). Larger percentage of out of school children were involved in stealing from outside (8.0%), begging (3.3%), helping sell articles stolen by others (6.2%) and snatching money from others (2.2%). Borrowing from friends was similar for both groups.

Figure 34



Higher percentage of the school going children had money for food, clothes, medicines, shelter and recreation (Figure 34). In comparison, percentage of children who reported having money for substances was similar in both groups (36.8%).

## Family and peer related factors

The educational status of the father was lower in out of school children; 29.0% reported that their father had never been to school/been for a very short period as compared to 6.6% school going children. There were 18.5% out of school children who could not provide information about the educational status of their father (Table 22).

<b>Table 22</b>			
		<b>School going (n=1088)</b>	<b>Out of school (n=2045)</b>
Educational status of father	Never been to school/ very short period	72 6.6%	593 29.0%
	Class 1-5	162 14.9%	429 20.9%
	Class 6-8	159 14.6%	274 13.4%
	Class 9-12	353 32.4%	270 13.2%
	Graduate	221 20.3%	85 4.2%
	Post graduate/ professional	50 4.6%	14 0.7%
	Do not know/ no response	71 6.5%	379 18.5%
Educational status of mother	Never been to school/ very short period	170 15.6%	919 44.9%
	Class 1-5	174 16.0%	343 16.8%
	Class 6-8	211 19.4%	224 11.0%
	Class 9-12	326 30.0%	187 9.1%
	Graduate	122 11.2%	25 1.2%
	Post graduate/ professional	19 1.7%	7 0.3%
	Do not know/ no response	66 6.1%	340 16.6%

The educational status of the mother was also lower in out of school children; 44.9% reported that their mother had never been to school/been for a very short period as compared to 15.6% school going children. There were 16.6% out of school children who could not provide information about the educational status of their mother.

<b>Table 23</b>		
Occupational status of head of household	School going (n=1088)	Out of school (n=2045)
Unemployed	41 3.8%	153 7.5%
Rag picking/ begging	11 1.0%	95 4.6%
Agricultural worker/ farmer	198 18.2%	299 14.6%
Unskilled worker/farmer	122 11.2%	637 31.1%
Skilled worker	169 15.5%	174 8.5%
Sales worker	94 8.6%	168 8.2%
Clerical staff	144 13.2%	59 2.9%
Professional	136 12.5%	48 2.3%
Others	148 13.6%	237 11.6%
Not known	16 1.5%	79 3.9%

The head of the household was a skilled /unskilled worker in 39.6% out of school children; unemployed in 7.5% children , rag-picking or begging in 4.6 percent. The percentages were 26.7%, 3.8% and 1.0% respectively in school going children. The occupation of the father was sales worker, clerical staff or professional in one third of the school going children (Table 23).

The family monthly average income was Rs. 14208±13022 among school going children and Rs. 7527±7632 per month for those who were out of school.

<b>Table 24</b>			
		School going (n=1088)	Out of school (n=2045)
Contact with Family	Yes	1065 97.9%	1930 94.4%
Frequency of meeting family	Daily	995 91.5%	1698 83.0%
	Once/week	42 3.9%	161 7.9%
	Once in last month	29 2.7%	75 3.7%
	No contact with family	22 2.0%	111 5.4%
Relationship with family	Good	536 49.3%	735 35.9%
	Average	427 39.2%	852 41.7%
	Bad	112 10.3%	328 16.0%
	Very bad	9 0.8%	70 3.4%
	Not applicable/ no family	4 0.4%	59 2.9%

Higher percentage of school children were in daily contact with their family as compared to out of school children (Table 24).

A larger percentage of school going children reported good relationship with their family while a larger percentage of out of school children stated that their relationship with the family was bad.

<b>Table 25</b>		
	<b>School going (n=1088)</b>	<b>Out of school (n=2045)</b>
Substance use by family member who creates problems for family	561 51.6%	1230 60.1%
Family fights	394 36.2%	1024 50.1%
Beaten and abused by family	369 33.9%	1017 49.7%

Family problems in the form of substance use by family, family fights and being beaten or abused by the family were common in both the groups (Table 25). Higher percentage of out of school children had substance use by a family member that created problems in the family (60.1%) as compared to school going children (51.6%). Family fights were more common in out of school children (50.1%). Similarly, they reported being beaten or abused by family more commonly (49.7%) in comparison to school going children (33.9%).

### Case Vignette 1

Vikas (name changed) was a 14 year old boy who was a student of class IX with history of inhalant use (ink eraser fluid) for last 2 years and tobacco use for last 3 years. He had history of academic decline following onset of inhalant use and was now attending classes irregularly. He often stole money from home for inhalant use and had also stayed out at night sometimes to use inhalants with his friends. He had many substance using friends. He also had a scar on the face that a boy had inflicted on him in a fight and he felt very distressed about it. He liked taking risks and getting into fights. He stayed with his father and mother. Both parents were working and he was often unsupervised at home after his school hours. There was history of alcohol abuse in the father and fights between parents over alcohol abuse. The father also blamed his mother for use of substances by the child and this led to lot of distress in the mother.

<b>Table 26</b>		
	<b>School going (n=1088)</b>	<b>Out of school (n=2045)</b>
Have friends I trust and can depend upon	912 83.8%	1492 73.0%
Have close contact with friends who use substances	906 83.3%	1730 84.6%
Have close contact with friends who do not use substances	857 78.8%	1338 65.4%

Majority of children in both the groups stated that they had friends they could trust. Lesser number of out of school children had friends they could trust and depend upon (73.0%) while more than 80% of school going children gave an affirmative response to this question.

Most of the children in both the groups (>80%) had close contact with substance using friends and close contact with non-using friends (Table 26). School going children had higher contact with friends who do not use substances compared to out of school children.

Table 27			
		School going (n=1088)	Out of school (n=2045)
Access to resource for recreational interests	Yes	738 68.8%	902 45.4%
	No		
Frequency of contact with NGO	No contact	854 79.0%	1553 77.1%
	Daily	49 4.5%	150 7.4%
	Once a week	65 6.0%	117 5.8%
	Once a month	113 10.5%	194 9.6%

Access to recreational resources was higher in school going children (68.8%) as compared to out of school children (45.4%) (Table 27).

More than 75% children in both the groups denied any contact with an NGO while more than 20% were in contact with an NGO on a daily, weekly or monthly basis.

### Stress, psychological and physical health

Table 28		
	School going (n=1088)	Out of school (n=2045)
Anything happened that has been very difficult/ stressful/ something <i>bad</i>	597 54.9%	1187 58.0%
Ever been sick, injured that you needed to go to hospital	381 35.0%	899 44.0%
Has anyone close to you died	427 39.2%	973 47.6%
Ever been in a situation where feared losing life or being severely harmed	294 27.0%	672 32.9%
Ever experienced natural disaster(earthquake, flood, fire)	289 26.6%	477 23.3%
Ever lived in environment - part of conflict area	182 16.7%	287 14.0%
Ever had to face violence from police/ community	213 19.6%	741 36.2%

The stressful events reported were common in both the groups but more common in out of school children (Table 28). These were “anything happened that was difficult, stressful or bad” reported by 58.0%, sickness or injury that required being taken to the hospital (44.0%), death of a close person (47.6%), ever been in a situation where feared losing life or being severely harmed (32.9%) in out of school children. The report of being in a natural disaster or living in a conflict ridden area was higher in school going children. Larger percentage of out of school children reported that they had ever faced violence from the police and community (36.2%).

<b>Table 29</b>			
		<b>School going (n=1088)</b>	<b>Out of school (n=2045)</b>
Feel physically strong (last month)	Yes	765 70.3%	1235 60.4%
Feel good about self (last month)	Usually not	246 22.7%	580 28.6%
	Sometimes	548 50.6%	1112 54.9%
	Often	289 26.7%	335 16.5%
Feel fearful (when not intoxicated) (last month)	Usually not	436 40.2%	786 39.0%
	Sometimes	557 51.4%	1012 50.2%
	Often	91 8.4%	217 10.8%

Children in both the groups did not feel physically strong, did not feel good about themselves and felt fearful. This was somewhat higher in the out of school children (Table 29).

<b>Table 30</b>			
		<b>School going (n=1088)</b>	<b>Out of school (n=2045)</b>
Accepted structuring of daily activities	Yes	597 56.8%	790 39.9%
Felt need for complete independence	Yes	657 61.1%	1161 58.3%
Have plans for future	Usually not	386 35.5%	951 47.0%
	Sometimes	549 50.6%	859 42.4%
	Often	151 13.9%	215 10.6%
Know where to get health services if needed without any help	Yes	793 72.9%	1288 63.0%
Know how to get help if upset without any help	Yes	528 48.5%	945 46.2%

Many children also did not accept structuring of their daily routine and did not have any plans for the future (Table 30). All these were reported more often in out of school children.

Overall majority of the children reported that they knew where to get health services if they needed help but a relatively lower percentage knew where to get help if they were upset.

## Substance use

More than 80% children (both school going and out of school) were ever users of tobacco and about three fourth had used tobacco in last one month. Tobacco and alcohol use was higher in school going children than out of

<b>Table 31</b>			
		<b>School going (n=1088)</b>	<b>Out of school (n=2045)</b>
Tobacco	ever use	942 86.6%	1692 82.7%
	past year	899 82.6%	1616 79.0%
	last month	845 77.7%	1546 75.6%
Alcohol	ever use	833 76.6%	1413 69.1%
	past year	806 74.1%	1328 64.9%
	last month	683 62.8%	1224 59.9%
Cannabis	ever use	388 35.7%	736 36.0%
	past year	354 32.5%	700 34.2%
	last month	278 25.6%	601 29.4%
Inhalants	ever use	339 31.2%	637 31.1%
	past year	321 29.5%	622 30.4%
	last month	272 25.0%	552 27.0%
Opium	ever use	25 2.3%	106 5.2%
	past year	20 1.8%	89 4.4%
	last month	19 1.7%	77 3.8%
Heroin	ever use	45 4.1%	194 9.5%
	past year	43 4.0%	183 8.9%
	last month	33 3.0%	164 8.0%

school children and this difference was much more prominent for alcohol than tobacco in the sample. The ever use, last one year and last one month use of alcohol was 76.6%, 74.1% and 62.8% among school going and 69.1%, 64.9% and 59.9% among out of school children. Cannabis lifetime use was similar in both groups (35% approximately) while the last one year and last one month use was a little higher in the out of school children. The percentage of inhalant users (last one year and last one month) was higher in the out of school children. Lifetime inhalant use was similar in both the groups (31%). The last one month inhalant use was present in 25.0% of the school going children and 27.0% of the out of school children (Table 31). In the sample ever use of heroin was 4.1% in school going and 9.5% in out of school children and last one month use was 3% and 8.0% respectively.

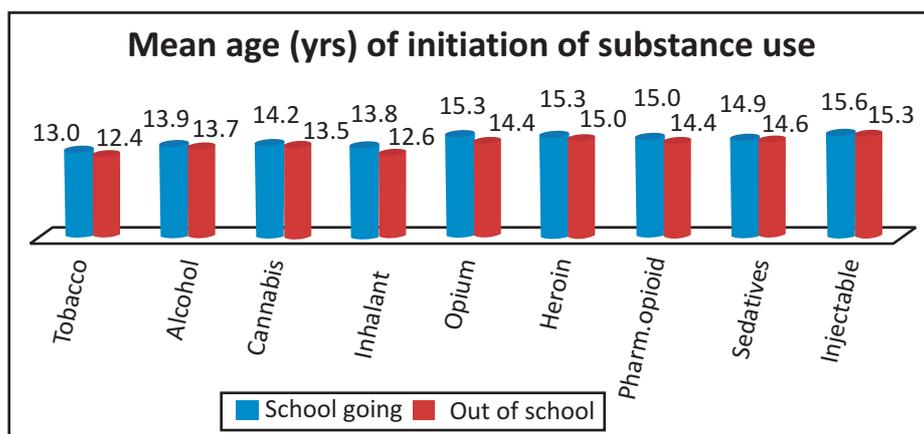
Pharmaceutical opioids	ever use	264 24.3%	386 18.9%
	past year	245 22.5%	370 18.1%
	last month	190 17.5%	307 15.0%
Sedatives	ever use	117 10.8%	167 8.2%
	past year	109 10.0%	165 8.1%
	last month	66 6.1%	118 5.8%
Injectable route	ever use	171 15.7%	277 13.5%
	past year	166 15.3%	276 13.5%
	last month	164 15.1%	270 13.2%

Lifetime and past year use of Pharmaceutical opioid was higher in school going children than out of school children; last one month use was higher in school going children (17.5%) compared to out of school group (15.0%).

Lifetime and past year use of sedatives was higher in school going children than out of school children although the percentage using it was much lower than for other substances. Ever use of sedatives was reported by 10.8% school going children and 8.2% out of school children. Past month use was similar at about 6.0 percent.

Ever injectable use was higher (15.7%) among school going children as compared to the out of school children (13.5%). Past month injectable use was reported by 15.1% in school going and 13.2% out of school children.

Figure 35



The age at onset of various substances was found to be different in the two groups (Figure 35). As is expected, the age at initiation of use of all substances - tobacco, alcohol, cannabis, inhalants, opium, heroin, pharmaceuticals as well as injectable use was lower for children who were out of school.

Size of substance using network of friends	School going (n=1088)	Out of school (n=2045)
Usually take substances alone	207 21.4%	462 23.9%
Between 1-5 Friends	524 54.5%	1042 54.7%
Between 6-10 Friends	160 16.6%	276 14.5%
Between 11-15 Friends	38 3.9%	74 3.8%
More than 15 Friends	31 3.2%	49 2.6%

On the query of days of use of substances during the past one month, it was observed that average number of days of use of all substances-tobacco, alcohol, cannabis, inhalants, opium, injectable use, pharmaceutical opioids and heroin was higher among those who were out of school.

Most children were taking substances with friends. The size of substance using network was not very different in the two groups (Table 32).

		<b>School going (n=1088)</b>	<b>Out of school (n=2045)</b>
Need help for stopping/reducing substance use	No, I do not think that I have a problem	476 44.6%	830 42.2%
	Yes, I have a problem but I can quit on my own	297 27.8%	569 28.8%
	Yes, I want to quit and would need help for quitting	227 21.3%	523 26.6%
Ever received help for stopping/reducing substance use	No, I never looked for it	655 64.0%	1337 68.5%
	Yes, someone advised me to stop but I did not visit a doctor	252 24.6%	434 22.3%
	Yes, seen a doctor for treatment of substance use but was not admitted	67 6.5%	104 5.3%
	Yes, seen a doctor for treatment of substance use and was hospitalised	18 1.8%	29 1.5%

More than 40% children in both the groups thought that substance use was not a problem and more than 20% wanted help for quitting. This figure being higher in out of school children (Table 33).

Children in both groups reported having never looked for help for stopping / reducing substance use and only a small percentage in both the groups had seen a doctor for their substance use.

### **Case Vignette 2**

Satyan (name changed), 17 year old boy reported using tobacco from the age of 9 years, cannabis and heroin from 14 years of age on a daily basis and alcohol occasionally. For last 5 months, he had started injecting substances and also reported sharing needles/syringes on 1-2 occasions. He had never been tested for HIV infection.

He dropped out of school 5 years back after failing in class V. He had academic difficulties in school and lack of interest in studies. When he was in school, he only smoked cigarettes. Cannabis and heroin use started 2 years after dropping out of school.

Satyan stole money from home for his substance use (spent Rs 100-200 every day) and had also stolen scrap iron once, when he got caught and was beaten up. He reported shame, stigma and said that he always looked down at the floor while walking through his neighborhood. He had a loving family and stayed with his parents and siblings. His father was a school teacher and mother a housewife. There was no history of substance use or any conflict in the family. His relationship with family members had deteriorated due to substance use. He was often beaten up by the family in an attempt to make him give up substance use. Satyan had never sought treatment in the past but presently wanted treatment to give up substance use. The family had tried to send him to learn some vocational skill on 2-3 occasions but was not successful. Substance use was quite common in his neighborhood and he had several substance using friends. In fact, he had lost contact with all non-substance using friends.

<b>Table 34</b>		
	<b>School going (n=1088)</b>	<b>Out of school (n=2045)</b>
Do you think substance use is harmful	833 76.6%	1448 70.8%
Experience intoxication that impaired performance	584 53.7%	1083 53.0%
Driven a vehicle after consuming alcohol/substances	356 32.7%	698 34.1%
Got into fights under effect of alcohol/substances	375 34.5%	955 46.7%
Indulged in sexual behaviour under effect of alcohol/substances	168 15.4%	401 19.6%
Indulged in sexual behaviour to get substances or money for substances	202 18.6%	329 16.1%
Experienced physical problems due to alcohol/substances	463 42.6%	1027 50.2%
Experienced sadness/anxiety related to substance use	481 44.2%	1080 52.8%
Got into legal problems due to substance use	348 32.0%	816 39.9%
Experienced tolerance	607 55.8%	1292 63.2%
Experienced withdrawal	618 56.8%	1363 66.7%

Majority of the children in both the groups mentioned that they thought that substance use was harmful although this knowledge was higher in school going children (Table 34).

The children in both groups reported experience of intoxication, driving after consuming substance, physical problems, sadness/anxiety and legal problems due to substance use. They also had experienced tolerance and withdrawal.

A small percentage also reported that they had indulged in sexual behaviour to get the substance. A higher percentage of out of school children reported many of these problems.

<b>Table 35</b>		
	<b>School going (n=1088)</b>	<b>Out of school (n=2045)</b>
Experienced craving when trying to quit	563 51.7%	1017 49.7%
Experience peer pressure	521 47.9%	798 39.0%
Substances easily available	318 29.2%	647 31.6%
Difficult to tolerate withdrawals	187 17.2%	406 19.9%
Difficult to cope with stress	123 11.3%	264 12.9%

The children in both groups reported challenges such as craving, peer pressure, easy availability of the substance, withdrawals and difficulty in coping with stress while trying to quit (Table 35).

### Legal issues

A few children in both the groups had broken the law for fun or done something dangerous to earn money for their basic needs (Table 36).

<b>Table 36</b>		
	<b>School going (n=1088)</b>	<b>Out of school (n=2045)</b>
Broken law for fun or be accepted by peers to survive in the streets ( last month)	236 21.7%	511 25.0%
Done something dangerous to earn money or get food, clothes, shelter ( last month)	122 11.2%	378 18.5%

## Substance use in girls

### Key findings

- There were 169 girls in the study sample, having a mean age 14.8 years (S.D. 2.8) and age range 6-18 years.
- Most females were recruited from the states of Mizoram (28.4%), West Bengal (12.4%), Uttar Pradesh (9.5%), Arunachal Pradesh (7.7%), Madhya Pradesh (7.1%), Delhi (6.5%), Manipur (5.3%) while rest of states contributed less than eight users at each site.
- Of these, 75.7% were living at home and 24.3% living on the streets (16% with family and 7.1% alone on the streets) and only one girl reported staying in the shop or establishment where she was working (Figure 36).

Figure 36

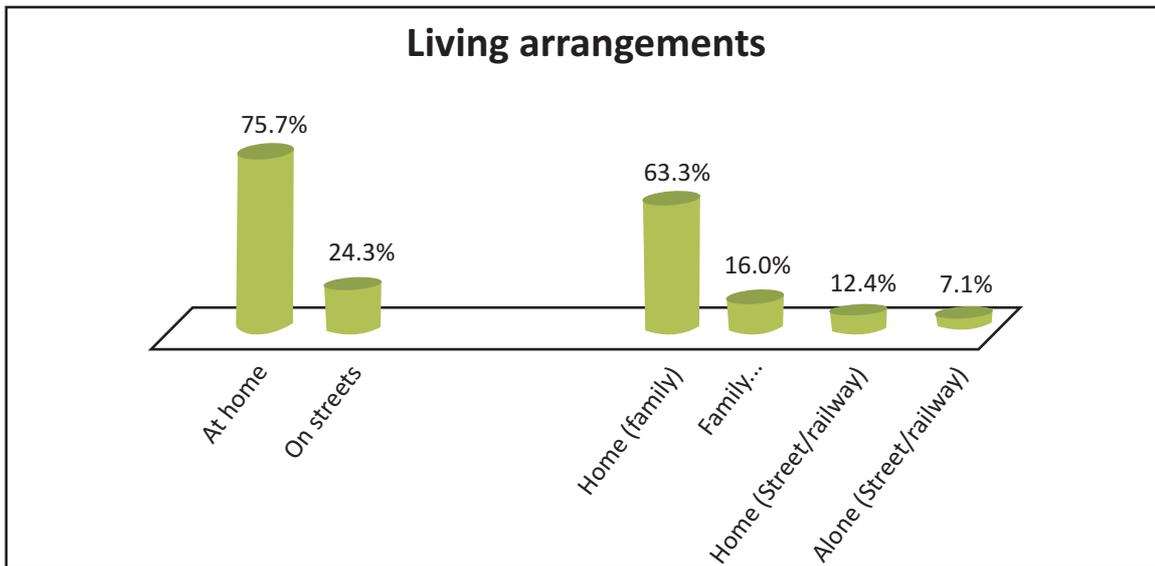
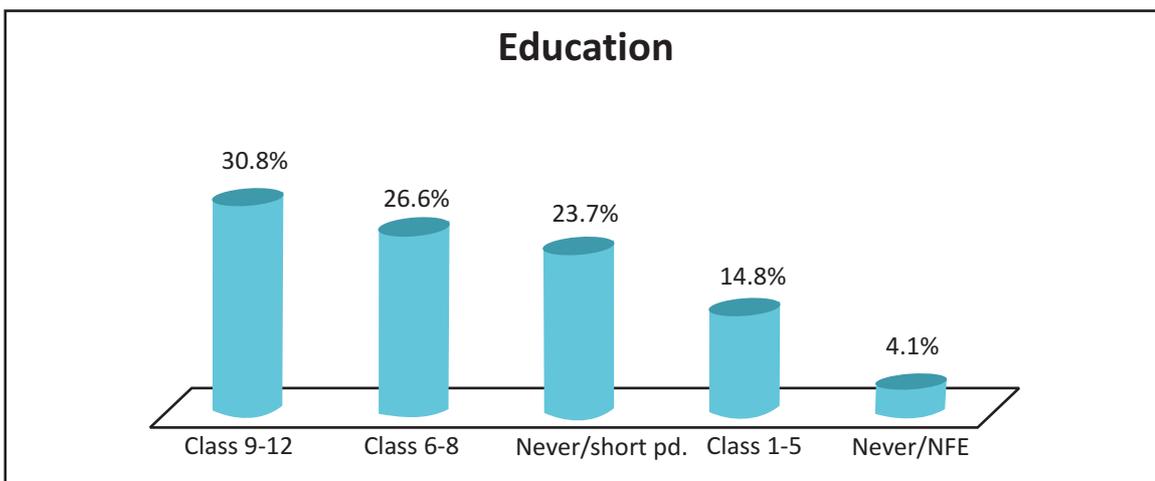


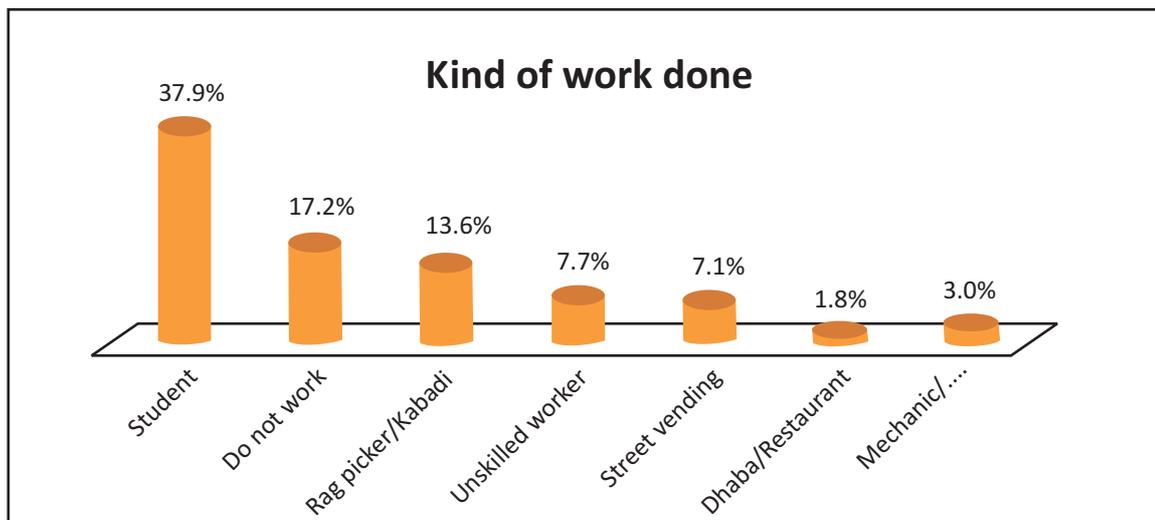
Figure 37



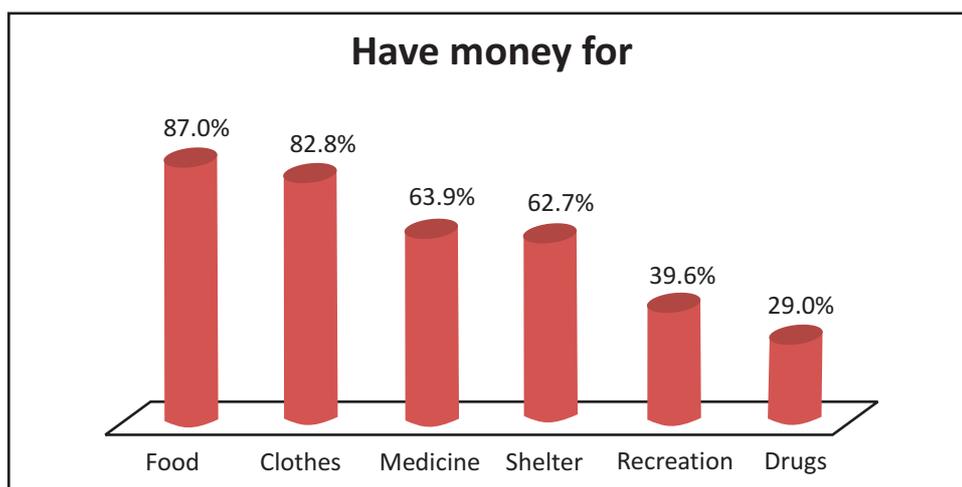
Of the total sample, 51.5% were living with parents, 20.7% with one parent and 4.1% with a step parent.

Almost one fourth had never been to school and only 4.1% reported attending NFE classes, 14.8% were educated till primary and more than 25% were educated till class 6-8 and 9-12 each (Figure 37). At present, 36.7% were school going and 63.3% were out of school; 9.5% were studying through open school. A total of 17.2% were not studying or working (Figure 38); 14.8% were working full time and 21.9% part-time The nature of occupation was- rag pickers-13.6%; unskilled workers-7.7% and street level vendors-7.1% besides others. For managing expenses- 53.8% were given money by family or borrowed from them, 36.7% took money from family by lying to them, 33.7% earned money, 21.3% borrowed from friends, 17.2 were begging, 12.4% stole from home or sold household items, 3.6% stole from outside and 3.6% helped sell articles stolen by others.

**Figure 38**



**Figure 39**



- More than 80% had money for food, clothes, more than 60% had money for medicines, shelter; 40% had money for recreation and 29% for substances (Figure 39)..

## Family and peer related factors

- The educational status of the father was inquired- 18.3% said that their father had never been to school or been for a very short period, 21.3% did not know the educational status of their father and more than 10% reported that their father was a graduate or a professional. The educational status of their mother was lower-33.1% said that their mother had never been to school or been for a very short period, 15.4% did not know the educational status of their mother and 3% reported that their mother was a graduate or a professional.
- The occupation of the HOH reported was unskilled worker or skilled worker by more than one fourth girls, Sales worker (10.7%), Clerical Staff and Professionals (8.3% each), rag picking or begging (10.7%) and unemployed (8.3%)
- There were 91% who were in contact with their family and 80% were in family contact on a daily basis.
- When inquired about relationship with the family, 75.7% said that it was good / average and 18.3% said that it was bad or very bad (Figure 40).

Figure 40

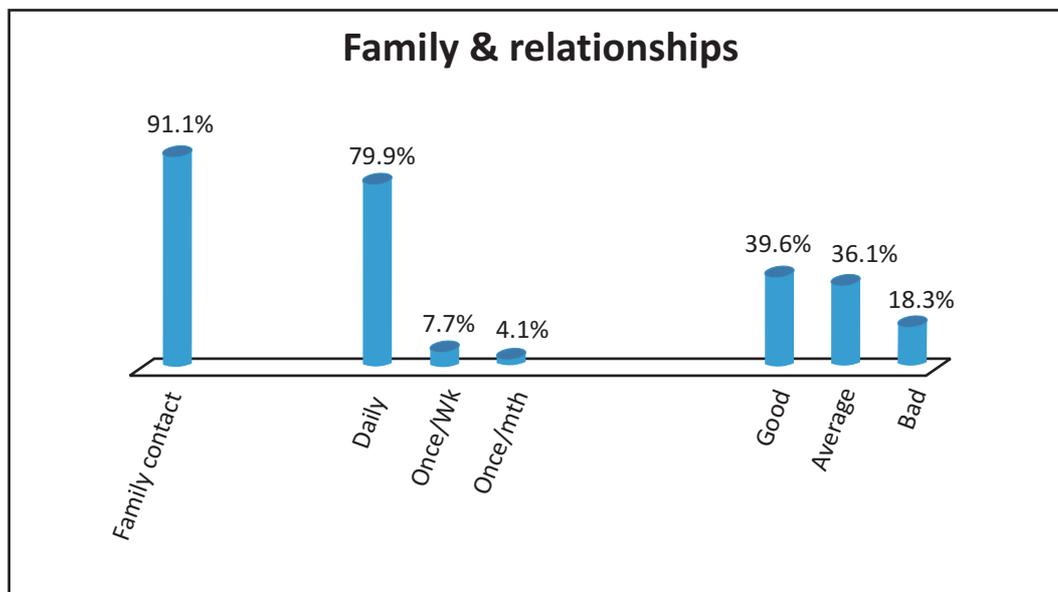
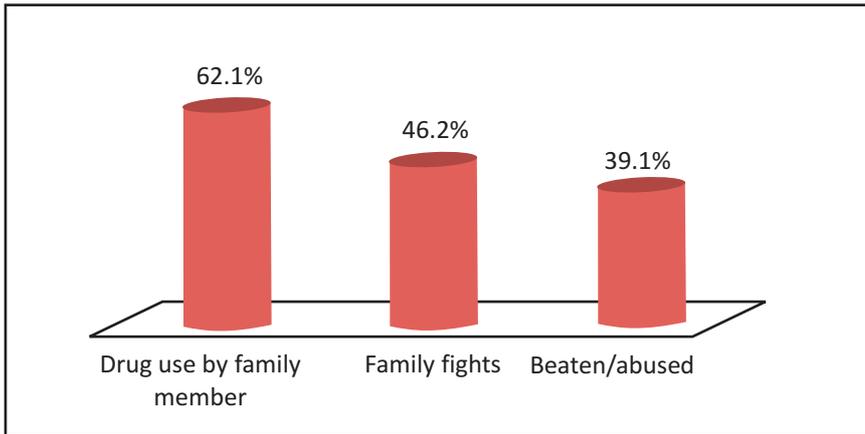
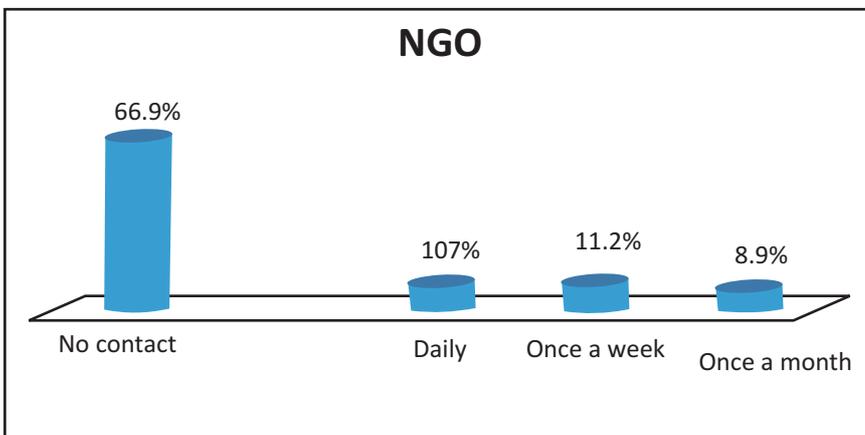


Figure 41



- Among girl sample, 62.1% reported substance use by family member that created problems for the family, 46.2% reported fights in the family, 39.1% said that they were beaten up or abused in the family (Figure 41).
- More than 70% girls said that they had friends they could trust and depend upon; 78.1% had close contact with friends who used substances, 45% had only 1-2 substance using friends and 21% had 3-5 friends; 66.3% also had close contact with friends who did not use substances, 34.3% had only 1-2 substance using friends and 20.7% had 3-5 non-using friends. Access to recreational resources was reported by 41.5 percent.
- One third of the girls were in either daily or less frequent contact with NGOs (Figure 42).

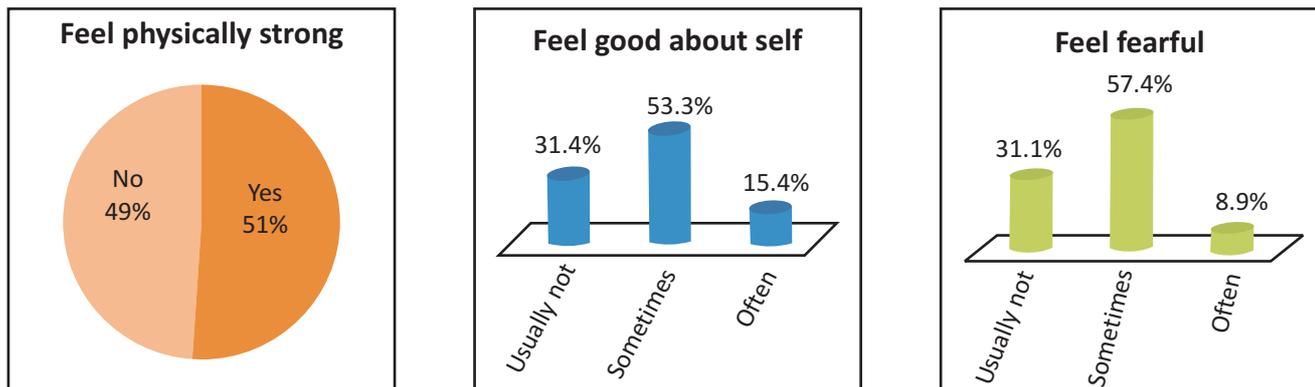
Figure 42



### Stress, Physical and Psychological health

- Almost two third had experienced situations that were difficult, stressful or bad. About half of them had been so sick or injured that they needed to go to a hospital, had a death of a close family member. More than one third had been in a situation where they feared losing life or coming to being severely harmed, 20% had experienced natural disaster and more than 10% had lived in a conflict area. Thirty per cent reported that they had to face violence from the police or the community.

**Figure 43**



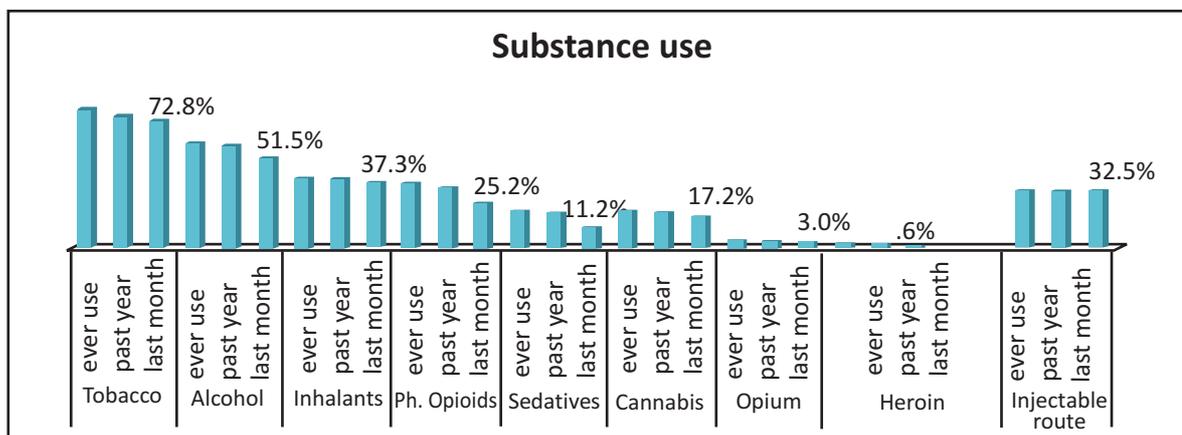
- There were 49% girls who said that they did not feel physically strong, 31.4% did not usually feel good about themselves and 8.9% said that they often felt fearful (Figure 43).

When inquired about accepting structuring of daily activities, 8.3% did not respond, 66.9% felt need for complete independence, 39.1% accepted structuring of daily activities, 37.3% said they did not usually have plans for future. A total of 63.3% said that they knew where to get health services if they needed help and 52.1% knew how to get help if upset.

**Substance use**

Ever use of Tobacco was reported by 79.3%, last one year use by 75.7%, last one month use by 72.8%; alcohol ever use by 59.8%, last one year use by 58%, last one month use by 51.5%; inhalant use ever and in last one year by 39.6% and in last one month by 37.3%; pharmaceutical opioid ever use by 36.7%, last one year use by 34.3%

**Figure 44**



and last one month use by 25.4%; sedative use ever by 20.7% and last one month use by 11.2%; cannabis use ever by 20.7%, past one year use by 20.1%, past one month use by 17.2%, opium and heroin use ever by 3% and 2.4% respectively. One third of the respondents were using injectable substances in last one month (Figure 44).

## Discussion

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This is the first nation-wide, comprehensive study to describe the profile of children using substances in India. In addition, the study also assessed the pattern and correlates of substance use among children. Detailed information was collected on demographic, family and peer related, stress, physical and psychological health related variables and legal issues besides inquiring about substance use. It is to be noted here that the study did not assess the prevalence of substance use among children; rather it focused on children who were using substance/s.

The major strengths of the study include a large sample size (n=4,024) and the diversity of the child population that it studied. The sample included children from all regions (north, south, east, west and north-east) of the country, with a total of 27 states/2 UTs, and more than 100 cities and towns represented in the sample. While the upper age limit was kept at 18 years, no lower age cut-off was provided. Any child (boy/girl) who was using any substance besides tobacco in last one year could be included if he/she could provide information about various parameters irrespective of his/her age. The youngest child included in the sample was five years of age. Girls constituted about 4.3% of the total sample, which provided a sufficient sub-sample (n=169) to make observations about this sub-population. Girl substance users have remained a hidden population in previous studies from India and only a little information is available on their profile or pattern of substance use.

The study questionnaire was quite extensive and was translated into multiple regional languages. It received inputs from all members of the working group, who were from varied backgrounds and brought their own expertise into the discussions to refine the questionnaire and methodology of study. Based on their inputs and field testing, the questionnaire was revised. The study was possible because of the combined efforts of people from different organizations across India coming together. In spite of the large number of data collection sites, adequate attention was given to ensure that the field workers at all the sites received proper training for administration of the questionnaire. The training gave emphasis on establishment of rapport and ensuring that the child felt comfortable enough to provide information on substance use related issues. Besides, the staff involved in data collection was from NGOs working with substance users or street children in the area, and had prior experience of being involved in research studies. The interviewers were, thus, adequately sensitized and conversant with such data collection exercises. The study questionnaire was designed in a manner that the less sensitive questions were included first followed by questions related to the more sensitive issues such as substance use and legal aspects in the later part of questionnaire. Ethical issues were adequately addressed.

The translation of the questionnaire and trainings were done regionally by the RRTCs who were in regular contact with the NGOs and were familiar with their capacity as well as regional issues. Monitoring of data collection was done by the RRTCs. Site visits were made by the RRTCs and the investigators to some of the sites for a quality check.

Broadly, the study sample had following kind of child substance users:

- I. Children living at home [approx 78% of sample]
  - (a) Children living at home but dropped out of school or never went to school (referred to as “out-of-school” children). Most of them were working/engaged in unskilled jobs
  - (b) Children living at home and going to school (“school-going”) Of children living at home, 2/3<sup>rd</sup>s were out-of-school and 1/3<sup>rd</sup> were school-going

II. Children living on streets (“street children”) [approx 22% of sample]: They were mostly not going to school and earning from rag-picking, street vending etc in order to sustain themselves.

Although a few studies are available on pattern or correlates of substance use among street children and school-going children, but little is known about the children who are out-of-school and living at home as they have not been represented much in previous studies. Reaching out to this population group represents another merit of the current study.

The inclusion criteria were deliberately kept broad to include any non-tobacco substance user in past one year. The study attempted to include children using gateway substances such as alcohol and inhalants as well and did not focus exclusively on those who abused harder substances such as cannabis, opium or heroin only or used in a dependent manner only. The rationale was that the licit substances are more commonly initiated in children and a better understanding of the gateway substances, including alcohol and inhalants, and their progression to illicit substance use in children may help in planning for the prevention and treatment efforts in this population.

### Substance use parameters

To begin with, it is important to re-emphasize that all the percentages mentioned below indicate the prevalence of a particular phenomena in a purposive sample of child substance users. The denominator comprises of children who had reported use of any substance besides tobacco in past one year. *These figures do not represent prevalence of phenomena in the entire population of school going, out of school or street children.*

### Major substances and frequency of use

Among the total sample (n=4,024), tobacco followed by alcohol were the two most common substances used over lifetime, past year or past month. Cannabis was third common among the substances used over lifetime, but was replaced by inhalants among the substances used more recently (past year or past month). Overall, the proportion of children who used cannabis or inhalants was not as different from each other. The current (past month) use of tobacco was reported by 74.9%, alcohol by 56.8%, inhalants by 30.5% and cannabis by 28.9% of the sample.

In absence of any prior large-scale study, these findings reveal the pattern of substance use among a national sample of children who have used at least one substance other than tobacco over the past year. Two national household surveys on substance use [12] and family health [8] have also found alcohol and tobacco to be common substances preferred by those who were aged 18 years or less. The figures from the current study cannot, however, be compared directly to the prevalence figures from general population surveys or any of the other community/school surveys.

Following substances emerged as the major substances of abuse (in decreasing order of frequency) in the entire sample of children using substances:

- Tobacco
- Alcohol
- Cannabis and Inhalants
- Pharmaceutical Opioids
- Injectables
- Heroin
- Prescription drugs/sedatives

The study findings reveal that almost all substances were used for more than 50% of the days in the past month (ranging from average 26 days for tobacco to 23 days for inhalants to 17 days for cannabis and nearly 16 days for opioids/sedatives/injectables). While tobacco and inhalants were used almost on a daily basis, rest of substances appear to be used on less than daily or intermittent basis. While the study did not focus on making a diagnosis per se, more than 60% of the sample had reported experiencing withdrawals and/or tolerance from a substance. This coupled with the fairly regular frequency of use of certain substances is indicative that dependent use of one or more substances may be present in a significant percentage of children.

The proportion of users reporting lifetime use of one or more substances was not as different from those reporting the past year or past month use. This was true for most substances of abuse. Children who had used substance/ever or over the past year appeared to continue using the substances currently as well. It is cautioned here that it was not a general population sample, and it is possible that the sampling may have included more children towards the severe end of the spectrum.

Alcohol was more likely to be used by school going children compared to out-of-school children. The use of inhalants and certain illicit substances (heroin, current use of cannabis) was, however, more common among out-of-school children living at home compared to school-going children. The out-of-school children may represent children who have never been to school or dropped out of school before or after the onset of substance use. In any scenario, a low educational status and being a drop-out from school pose a risk factor for early initiation of substance use and more regular use of substances. In contrast to school going children who mostly use licit substances in the form of tobacco and/or alcohol, the out-of-school children and vulnerable populations are at a higher risk of experimenting with most hazardous substances both licit as well as illicit in nature [18, 20, 25]. Further, it was observed from present study that average number of days of use for all kind of substances were higher among those who were out-of-school compared to school-going children.

Certain substances, especially inhalants, had a markedly higher prevalence among the street sample compared to children living at home. Inhalants form an easily available, accessible (from nearly stationary shops) and relatively cheaper substance of abuse, and hence, may be preferred more often by street children. Previous researchers have also described that inhalants are used quite often by street children [25, 27]. Certain substances (alcohol, prescription drugs/sedatives, and injectable substances) were used more commonly and also more frequently by those living at home compared to those living on streets. This finding of more common/frequent use of prescription and injectable substances by those living at home appears to be a bit surprising and is most likely due to sampling bias towards the child substance users living at home. Those using harder substances/using them more frequently are likely to be 'known substance users' in their neighbourhood, and consequently had more chances to be included in the study by the NGO working in the area. In contrast, those using a substance less frequently or only on an occasional basis may be able to hide their substance use and had less likelihood to be contacted for inclusion in the study.

### Age at initiation

The average age at tobacco use initiation was lowest (12.3 years) followed by inhalants (12.4 years), cannabis (13.4 years) and alcohol use (13.6 years). The opioids and pharmaceutical drugs were initiated, on an average, between the age of 14-15 years followed by injectable use (15.1 years). This is typically indicative of the gateway theory of progression of substance use, with licit and common substances started early progressing later on to

use of harder/illicit substances. Research has demonstrated that the use of these gateway substances (tobacco, alcohol, inhalants) increases the subsequent risk of transition to harder and illicit substances [25, 44, 45].

The age at initiation was slightly lower for children who were out-of-school compared to those going to school. Similarly, as expected, the mean age for initiation of all substances was lower among children living on streets compared to those living at home. The street children initiated the use 1-1.5 years earlier on an average for various substances compared to their counterparts living at home. As seen from previous Indian studies on street children, they often start with tobacco products below the age of 10 years. Many of them progress to use of alcohol, inhalants and *bhang* and some of them eventually move onto illicit substances like *ganja*, heroin, other opioids etc. [25, 29].

### Substance use among children across various states of India

Use of certain substances (tobacco, alcohol, cannabis and inhalants) was common among child substance users across all the 27 states/ 2 UTs included in the study. While tobacco and alcohol use has been well documented as a wide-spread problem, it is of significance to find that inhalants were commonly reported as a substance of use in children recruited from almost all states/UTs in India. Further, inhalant users were reported not only from metropolis and cities, but from the smaller towns as well.

The preference or choice of substances appeared to show some regional variations across the country. Most of child sample which was recruited from Karnataka and Andhra Pradesh (85-89%) reported current use of alcohol. Highest proportion of cannabis users were present among children included from Uttaranchal (70%) followed by Haryana (63.3%). The child substance users recruited from north-eastern state of Meghalaya had highest proportion of heroin users (27.3%), Tripura had highest proportion of inhalant users (68.3%) and Mizoram had highest proportion of sample with Injectable use (88.6%) compared to rest of the states.

Besides Mizoram, a substantial proportion of samples (11-28%) contributed from the states of Maharashtra, Meghalaya, Rajasthan, Punjab, Arunachal Pradesh and Manipur had injectable use. Practically no child reported the use of heroin or injectable substances in a few states (e.g. Andhra Pradesh, Kerala, Tamil Nadu, Goa, Tripura, Himachal Pradesh, Gujarat, Bihar etc).

### Substance use among Girls

Overall, the sample included 169 girls, which constituted about 4.3% of the sample. The mean age was  $14.8 \pm 2.8$  years, the youngest girl was six years of age. In absence of prior studies, this is a reasonably large sample of girl substance users, and findings form an important source of information for future reference.

The major substances of abuse used over the past month among girl substance users were as follows:

- Tobacco (72.8%)
- Alcohol (51.5%)
- Inhalants (37.3%)
- Pharmaceutical opioids (25.4%)
- Injectable use (32.5%) [*three-fourths of them were from Mizoram*]
- Cannabis (17.2%)
- Pharmaceutical sedatives (11.2 %).

It was observed that the pharmaceutical opioids, sedatives and injectable substances were much more common while cannabis use was relatively less common among girl substance users compared to rest of the sample. One third of the respondents reported using injectable substances ever, over past year and over past month, which is a cause for concern. About 75% of the girls sample who were injecting substances was from Mizoram. There is some evidence from prior Indian studies that the substance use, when present, may be more severe among girls e.g. in NFHS-3, the girls who reported the use of alcohol were using it more frequently compared to boys [8].

The mean age of onset was considerably low for tobacco, inhalants and opium. All of them on an average initiated below 12 years of age. This indicates a very early onset in a significant proportion of girls using substances. However, it needs to be kept in mind that the girl sample was not representative of all states in India (as it was recruited mainly from 5 states, with Mizoram contributing one-fourth). This may have influenced the findings, and limited the generalizability of findings for girl users. More research is needed before making definitive conclusions.

### Help-seeking and problems in quitting substance use

Majority felt that they do not have a problem due to substance use (43.8%) or if they have a problem, they can quit on their own (27.6%). Only 1/4<sup>th</sup> of the sample felt that they needed help for quitting substances. The common reasons for not being able to quit as reported by children were as follows :

- (a) Craving (49.1%)
- (b) Peer pressure (40.6%)
- (c) Easy availability of substances in the locality (30.2%)
- (d) Withdrawals (19.3%)
- (e) Stress (12.0%)
- (f) Substances as a necessity for survival (9.5%)

It is interesting to note that only a small proportion (7.5%) of sample had ever sought any formal treatment for their substance use. Only a small proportion (7.8%) of children was in daily contact with an NGO working in their area while 74.2% children were not in any contact with an NGO. As per DAMS data [12], less than 5% of treatment seekers across the country comprised of children at or below 18 years of age. Some reasons for low treatment seeking in this age group could be low motivation or lack of availability of specialized adolescent treatment programmes. Further, there are only a limited number of centres which provide drug treatment services in India and these are also not optimally functional in many areas. There are 122 drug De-addiction Centres run by Ministry of Health and Family Welfare in addition to 438 Treatment-cum-Rehabilitation & counselling Centres supported by Ministry of Social Justice and Empowerment (MSJE, 2008). Even in areas where such services are available, treatment may not be sought for child substance users due to various reasons e.g. lack of motivation, perceived stigma or lack of understanding about the nature of substance use disorders. There is a need to raise the community awareness for substance use among children and efforts need to be made to facilitate treatment seeking in younger population.

### Complications due to substance use

A variety of complications were reported by children as a result of their substance use. Of the children living at home or on streets, about 18% and 29% respectively indulged in sexual behaviour under the effects of substance,

16.9% and 20.0% indulged in sexual behaviour in exchange for either substances or money. As the study was cross-sectional, it might be difficult to comment about the directionality of the association. These findings indicate that presence of substance abuse in a child may facilitate, in some ways, the involvement in sexual behaviours e.g. impaired decision making or disinhibition may occur under influence of a substance, which may make a person more likely to indulge in sexual behaviours. Similarly, there is also a suggestion that at least some of substance users are being provided with substances in exchange for sex. The association between early onset substance use and involvement in sexual behaviours has also been observed in previous small scale studies from India [38, 39, 48]. Some risk factors may be common for both substance use and sexual abuse in childhood (e.g. lack of contact with family, orphan children, night stay at public place, etc) especially in case of vulnerable and street children. The use of substances itself may make a child more vulnerable to sexual or other abuses.

Nearly half of sample experienced physical and psychological problems related to substance use and a large proportion reported involvement in legal problems due to substance use, with more complications seen in street children as expected. Most complications were on higher side for street children and out-of-school children living at home.

More than half of the sample experienced tolerance (54-63%) or withdrawals (56-67%) as a result of substance use. The presence of tolerance and/or withdrawals, which signifies a dependent use of a substance, was relatively more in case of out-of-school children living at home and among street children.

### Demographic characteristics

The mean age of the sample was  $15.6 \pm 2.1$  years. Only a small proportion (4.3%) comprised of girls. Nearly one-fifth of sample (22%) was living on streets, either alone or with their families who also lived on streets. The mean age of children living on streets was slightly younger ( $14.79 \pm 2.4$  years) compared to those living at home ( $15.76 \pm 1.9$  years).

Of the total sample, 69.8% children were living in an urban area, while rest were from a rural area. The street children largely (85%) belonged to urban areas. Many of the street children may have come to cities after running away from their homes, or they may have come from the rising urban slum population with unhygienic living conditions and lack of basic civil amenities, making them a socio-economically vulnerable group.

Currently, only 28% of sample was studying in formal school, while rest had either enrolled through open school or were not studying. Thus, although the study largely included children living at home, it had a large percentage of out-of-school children. Among the sample living at home, more than two-thirds (65%) were out-of-school children. Available showed a consistent relationship between dropping out of school and substance use In a review of literature of studies published over past 15 years [50]. As this study is cross-sectional, it will not be possible to state in what percentage of children the substance use started earlier followed by dropping out of school and in what percentage, the substance use followed dropping out of school. As expected, only 14.7% street children had educational attainment beyond primary school.

Many children in the sample earned their living by working part-time or full time. A larger percentage of street children were working (80%) as expected, however about two-thirds of out-of-school children living at home were also working and earning themselves. Therefore, a large proportion of out-of-school sample spent eight or more hours in a day away from home, possibly unsupervised by parents. Raggicking, *kabadi* work, and street level vending were common occupations among children.

When asked whether they had money for various expenses, about 45% of street children reported that they have money to spend on substances. Children living on streets are often bullied by older children, and at times, their money or other belongings are snatched by them. In absence of a place to save or hide the day's earnings, most street children tend to spend their money by end of day. Food, entertainment or substances are common sources of expenditure for them. Many of them may not know the basic life skills which are often learned at home or school during childhood. An aspect which can be used during treatment is to enhance the life skills of these children through interventions which can be easily understood and applied by them. A Life skills package developed in Indian context and tested among street inhalant users is an example of psychosocial interventions which may be useful for this population [31, 32].

### **Family and Peer Related Factors**

In this study, substance by other family members, conflict in the family, history of physical/verbal abuse, family contact and relationship with parents were studied as factors associated with substance use.

Majority of the children (72.1%) were living at home with family while a significant proportion (60.0%) was living with both parents and rest were living with either one of the parents or with step-parent/relatives. The street children especially reported a bad or very bad relationship with parents and some were not in contact with their family. About one-third of out-of school children reported a bad relationship with their parents. About 58% of sample reported presence of substance use in a family member that created problems for the family. Familial quarrels and being beaten/abused by family members was reported by a large proportion of children living at home or on streets. Family influences such as parental substance use, physical abuse and poor quality of relationship between parents and children are a known risk factor for substance use among children and has been reported internationally [51, 52]. Presence of substance use in another family member may act through a variety of mechanisms to increase a child's susceptibility to substance use. It may increase the genetic risk or by means of negative role modeling. Further, substance use in a family member often leads to familial quarrels or discord, poor supervision of the children, lack of parental involvement in child's activities and may pose several other environmental risk factors for the child e.g. easy availability of substance.

Many of these well established risk factors for child substance use were prominent in the study sample:

- Lower socio-economic status, as evident by the educational status of the parents and occupational status of the head of the household, although the study included some children from the upper socioeconomic strata as well.
- Substance use in a family member.
- Single parent/broken families, more than 40% of children living at home did not have a family with both parents.
- Fights in the family were reported by children living either at home or streets.
- History of physical/verbal abuse

While the current study did not venture into 'cause or consequence' for these familial factors, but many of these familial factors have been reported previously to increase the risk for various mental and behavioural disorders in children, including an increased risk for substance use. Poor family bonding and attachment to parents has been linked to increase in likelihood of substance use in children [53], while close emotional ties with parents is a protective factor for substance use [54].

The most powerful of the social influences for substance use at a younger age is that of peer influence. The association with the peers who approve the use of substances or use substances themselves predisposes a child to substance use [55, 56]. In the present study, more than 80% school-going and out-of-school children had close contact with friends who use substances. The number of substance using friends reported was somewhat more in the out-of-school children. From the perspective of prevention, it is important to impart basic skills to children such as resisting peer pressure and being assertive to say 'no' when offered substances by peers. An enhanced contact with the non-substance using friends is often recommended as part of the treatment process for the children using substances.

### **Stress, Physical and Psychological Health**

Several kinds of stressful events or situations that cause psychological stress and ill-health were seen in the sample. A large proportion of children had encountered situations that were difficult, stressful or very bad. Many of them reported having been so sick or injured that they had to be taken to the hospital or faced the death of someone close. One-third had been in a situation where they feared losing life or being severely harmed, and more than one-third had to face violence from the police or community. While certain situations e.g. being in a life-threatening situation were more common among the street population, a substantial proportion of out-of-school children living at home also reported facing violence from police/community.

Many children had experienced problems due to substance use like : impaired performance, physical problems, sadness/anxiety etc. The subjective perception of physical health was poor in many of them. About 30% of the sample reported usually not feeling good about self. It indicates presence of psychological ill-health and a low self esteem/self-image among the children. One of the components of the life skills package developed for street users is to focus on enhancing the self-esteem of the child, by making them understand his/her unique qualities through a series of simple and interactive exercises. It is thus important to target the psychological aspects of a child using substances, which may help in long term relapse prevention.

Children using substances often lead unstructured and at times, chaotic unorganized lives. More than half of children were not keen on structuring of their daily routine and felt a need for independence and very few appeared to think about plans for the future. While it may be the result of chronic substance use, it can also be a behavioural trait. Nonetheless, this may have to be dealt with carefully during the delivery of psychosocial interventions to such children. As suggested by the 'need for independence', the children using substances may not be too receptive of the instructions from authority or a sudden attempt at structuring their daytime. The interventions have to take into account the child's perspective and should have enough flexibility and adaptability for using them on this population.

### **Limitations**

This study cannot give an estimate of prevalence of substance use among children but gives useful information on pattern and correlates of substance use. Certain limitations are acknowledged and following methodological considerations may be kept in mind while interpreting the results:

- The sampling was done by snow-balling and other such techniques. Having a purposive sample limits the generalizability of findings. However, at the same time, an effort was made to represent almost all states/UTs; and over a hundred cities and towns to include a diverse sample from various regions of the country.

- As sample was mostly recruited by NGOs working with substance users and street children, it may have represented a sample which is towards the severe end of spectrum
- The survey questionnaire was translated into multiple languages for ease of administration to children who may be more conversant in local languages. While due precautions were taken to ensure accuracy of translation and preference was given to the conveyance of meaning of a term rather than the literal translation, but the back-translations of the translated questionnaire were not carried out.
- The study does not give an emphasis on the presence or absence of a dependence syndrome. Rather, the focus of the study is on various factors and complications related to any kind or pattern of substance use. Further, inclusion of a diagnostic exercise/ instrument may have posed further time constraints and burden in terms of more intensive training of lay interviewers.
- The girl sample was recruited mainly from a few states only, and large number of sites did not send any data for girl users or had recruited < 5 girls per site. Therefore, the findings of girl substance users have only a limited generalizability to the country and are likely to represent more severe users. On the other hand, it also conveys that the girls using substances continue to remain a largely hidden population, which is difficult to reach.
- The monitoring exercise for data quality was largely qualitative, although re-interviews were also conducted on a small sample to get quantitative estimates for reliability.

## Conclusion and Recommendations

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**Recommendation 1 :** The study has highlighted the pressing need of initiating programmes for prevention and treatment. There is need to sensitize the state governments and all the important stakeholders about the problem of substance use among children in the country.

Action to be taken by NCPDR/Ministry of Women and Child Development immediately: The report of this study may be widely disseminated and shared with the concerned departments in the central and all the state governments (Ministry of women and child development, Ministry of Health, Ministry of Social Justice and empowerment, Ministry of Education, Ministry of Youth and Sports, Ministry of Labour and Employment, NACO/SACS).

**Recommendation 2:** Prevention programmes must target multiple settings and multiple risk factors particularly vulnerable children such as children of substance users, children injecting substances, street children, children involved in child labour, trafficked children, children of sex workers and any other category most at risk.

Action to be taken: Appropriate ministry/department such as MWCD under ICPS, NACO, Ministry of Labour, MSJE, Ministry of Health. Preventive interventions must be developed for this category of children and evaluated as well as linked with services. Evidence based programmes should be developed and promoted.

**Recommendation 3:** Prevention in schools should include universal prevention programmes such as education and life skill programmes. School going children who are at risk should have access to professional counselling in the school setting.

Action to be taken: By the Ministry of Education and Ministry of Women and Child Development. 1) Life skill programmes should be developed and evaluated in the cultural context for substance use prevention and then widely disseminated 2) Posting at least one full time trained psychologist in schools for counselling by the Ministry of Education/State education departments 3) Training of counsellors in life skill based prevention programmes, identification and management of children at risk to be conducted with support from institutions familiar with substance use prevention issues in children.

Prevention programmes should also focus on providing life skills education and teach methods to handle stress besides creating awareness as knowledge of harm in itself is not sufficient for prevention of substance use. This issue needs to be kept in mind in planning the design of any prevention programmes. Prevention programmes must target the risk factors in the family. Prevention programmes should also focus on resisting peer pressure and how to say no if offered substances by friends. Prevention efforts must also work towards developing healthy recreational avenues for children.

Prevention programmes must focus on preventing initiation of tobacco and alcohol. They should also focus on tobacco and alcohol users so that they do not progress to use of other substances.

**Recommendation 4:** There is need for availability of specialized treatment services for children who are using substances. These services should be available in government hospitals; NGO funded by MSJE and also by NGOs that provide services to street children. Detoxification should be available at government run de-addiction centres with rehabilitation in NGO/Community setting with linkage with NGOs.

The settings in which the services are provided should be child sensitive, safe and taking care of the needs of the children. Treatment programmes must try to involve the family in treatment and address the family issues as a part of the treatment process.

**Recommendation 5:** Rehabilitation efforts focussing on skill building and vocational training should be provided by NGOS

**Recommendation 6:** Juvenile homes and Children homes should have service provision for substance using children through linkage with treatment services.

Action to be taken by Ministry of women and child development.

**Recommendation 7:** There is need for provision of services by the TI NGOs to children who are injecting substances.

Action to be taken by NACO/SACS.

**Recommendation 8:** Prevention efforts must target both demand and supply reduction efforts. Supply reduction efforts should limit availability of tobacco and alcohol near residential areas and schools.

Action to be taken: By the appropriate departments for supply reduction (Excise department for tobacco and alcohol control, NCB for illicit substances, DCGI for pharmaceutical drugs).

**Recommendation 9:** Size estimation of substance using children should be carried out in specific high risk areas, metropolitan cities, and conflict areas.

**Recommendation 10:** School based surveys should be conducted at a national level based on a representative sample.

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# Annexure I - Questionnaire

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## **General Instructions**

**Target Population:** The child/adolescent selected for the study should fulfill following

**1) Inclusion Criteria** (*include children who have the following criteria*)

- a) Age group 18 years or less
- b) Children/adolescents who have used at least one other substance besides tobacco (alcohol, inhalants, cannabis, opiates, sedatives or any other substance) in last one year
- c) Children who are being admitted in an institutional setting may be included only at the time of admission or within a period of 1 week after admission.
- d) Informed written consent taken from the child or adolescent and the parent or NGO staff counsellor (as a surrogate guardian, in case the parents are not available)

**2) Exclusion Criteria** (*Exclude children who have the following criteria*)

- a) Use of tobacco only in last one year
- b) Not willing to be included in the study
- c) Unable to provide information

These children / adolescents may be studying in school or they may be school dropouts or may have never gone to school; they may be living with families or living alone; they may be living at home or may be street children or may be having some other living arrangements. Children who are being admitted in an institutional setting may be included at the time of admission or within a period of 1 week. There is no lower age limit for inclusion in this study.

**1. Who will fill the questionnaire:**

This questionnaire will be filled up by-

- a. NGOs who are working in the area of substance abuse
- b. NGOs who are working with children or adolescents in need of care and protection such as street children

The NGOs that are working with street children will collect data on street children only while NGOs that are working in the area of substance use will collect data from school going and out of school children who are not street children.

**2. From where will the target population be taken:**

- a) **NGOs who are working in the area of substance abuse/ NGOs working with non-street children** could take children or adolescents from-
  - a. Their own or other drug treatment centres
  - b. Using snowballing to contact children in the community (getting children or adolescents with the help of other children or adolescents who come to them)
  - c. Children of adult substance users who come to them for treatment

- d. Through awareness programmes/information in schools/community/recreational areas/Nehru Yuvak Kendras/youth organizations
- e. From slums/places where child labour takes place
- f. Shops from where purchase of substances occurs

They should not visit schools to get children directly from within the school setting although they can organize awareness activities in schools and inform them about availability of services in the NGO, thus encouraging them to come to the NGO for help. They should also not collect data on street children as this data will be collected separately by NGOs working with street children. So, they should not approach NGOs working with street children and also should not approach the street children directly in the community or in Juvenile justice/children homes to collect data from there.

- b) NGOs who provide services to street children** should take children or adolescents who access their services based on the inclusion criteria mentioned earlier or could include street children from the community.
3. The questionnaire provides adequate information to enable us to get a comprehensive picture of demographic and substance use profile of the individual.
  4. The questionnaire is brief and concise to enable the interviewer to complete the interview within a reasonable period of time (50 to 60 minutes).
  5. Since target population is expected to be a mixed one with respect to literacy levels, an interviewer-administered questionnaire was regarded more appropriate rather than a self-administered one.
  6. The language and format of the questionnaire has been kept simple, considering the expected level of expertise of the interviewers.
  7. All the questions are pre-coded, minimising the need for the interviewer to note down a response. This will also make the task of data entry and subsequent analysis easier. At selected places however, there is provision for noting the response of the subject as well.
  8. The questionnaire has multiple sections: Demographic parameters, Family and peer related factors, Physical and psychological health, Substance use and Legal issues.
  9. The questionnaire itself serves as an instruction manual describing the individual questions and defining the possible responses.

**Each organization should get the informed consent signed and then proceed to fill the questionnaire for each of the 30 children/adolescents who they screen and who fulfill the criteria based on the inclusion and exclusion criteria.** For children admitted in institutional settings, the time frame for the questions refers to the period just prior to admission.

## General Details

i.	<b>The name of the organization collecting the data-</b>	
ii.	<b>Address of the organization</b>	
iii.	<b>Name and Contact number of the person collecting data</b>	
iv.	<b>The organization is a-</b> 1. NGO working in the area of substance abuse/NGOs working with non-street children 2. NGO working with street children	<input type="checkbox"/>
v.	3. <b>For NGOs working in the area of drug abuse/ non-street children This child has been recruited for the study from the following source(s)- Please tick more than one response if applicable e.g. if a child came to know of the drug treatment centre through a school based awareness programme and then came to the treatment centre, then both will be marked</b>  1. Drug treatment centre 2. Using snowballing with the help of peers to contact in the community 3. Children of adult substance users who come to them for treatment 4. Through awareness programmes/information in schools/ community/ recreational areas/ Nehru Yuvak Kendras/youth organizations 5. From slums/places where child labour takes place 6. Shops from where purchase of substances occurs	<input type="checkbox"/>
vi.	<b>For NGOs working with street children (Please tick more than one response if applicable)</b>  1. Child comes to the NGO for some of the services/activities 2. Soon following admission to an institutional setting 3. From the community (e.g railway station, traffic signals etc.)	<input type="checkbox"/>
vii.	<b>Place from where the child is recruited</b>	
	Name of the city/ village/town.....	
viii.	Name of the state.....	
ix.	<b>Is this child living in an urban or rural area</b>  <div style="display: flex; justify-content: center; gap: 20px;"> <span>1=Urban</span> <span>2=Rural</span> </div>	<input type="checkbox"/>
x.	<b>Name and address of the monitoring NGO where data entry is being done</b>	

Interviewer should approach the child in a non-threatening manner. It is advisable to establish a rapport through exchange of introduction, pleasantries and some casual conversation before beginning the actual interview, even if the respondent has been briefed about the purpose / nature of the interview by someone else.

**NOTE: If only tobacco has been used in last one year, then terminate the interview.**

## Introduce yourself

Good morning/afternoon! My name is \_\_\_\_\_. We are trying to collect information on various aspects like family, peer, physical and psychological health, legal and substance use among the children. We need to ask you some personal questions. We assure you that the information provided by you shall be kept confidential and used for the purpose of the research only. It will not be disclosed to others. The information provided by you will not have any bearing on the services that are being provided to you by the centre.

The interview will last for about an hour. If you agree to give the interview, it is really important that you are willing to be open. Is it all right to begin?

11. Date Of Interview : \_\_/\_\_/\_\_\_\_\*

Subject ID Number : \_\_\_\_\*\*

12. ID number of the subject that is provided by monitoring NGO:.....\*\*\*

*\*Date of interview is filled up as dd/mm/year*

*\*\*Subject ID number is a two digit no. from 01 onwards*

*\*\*\*ID number of the subject provided by monitoring NGO will be the subject ID number preceded by the code given to the monitoring NGO*

All the questions need to be filled up completely. When in doubt specify / write in detail the response rather than marking any of the options based on the guesswork.

If the child/adolescent is admitted recently in an institutional setting/in-patient setting, all questions refer to the period just prior to admission.

**Project: An assessment of pattern, profile and correlates of Substance use among children in India**

**Information Sheet (Child and Guardian)**

**Date**

**i) Aims and methods of the research**

The outcome of the study would be to provide information on the pattern and profile of school going, out of school, and street children using substances. Such information would help in the development of programmes to prevent, control and manage illicit substances and alcohol abuse. The child would be providing information on a questionnaire which has been developed in line with the objectives of the study. This information will be collected by 142 NGOs from across the country, each NGO collecting data from 30 children. The questionnaire will be administered by the NGO staff and will take approximately one hour to respond.

**ii) Benefit out of study-** The study will understand the factors associated with use of any substances/drugs in terms of family, friends/peers, health and stress related factors. The study would help to formulate an action plan to deal with problem of substance use in children.

**iii) Any Risk to subject-** There is no risk to any participant in this study.

**iv Maintenance of confidentiality of records** Some of the questions asked may be embarrassing /require confidential information. All efforts will be made to conduct the interview in privacy. The information obtained from this study will be kept with utmost confidentiality and the child's name will not be quoted or referred to anywhere.

**v) Provision of free treatment for research related injury** There is no major risk involved in participating in the study.

**vi) Compensation of subjects for disability or death resulting from such injury.** There is no provision of compensation out of this study as there is no risk involved.

**viii) Freedom of individual to participate and to withdraw from research at any time without penalty or loss of benefits to which the subject would otherwise be entitled.** You will be free to withdraw from the study at any stage without giving any reason. This involves no penalty or loss of benefits.

**Project: An assessment of pattern, profile and correlates of Substance use among children in India**

**Subject information sheet (child)**

**Date**

**The interviewer will share these conditions/principles that will be followed during the interview with the child.**

A visitor/ visitors from ..... come to talk with me, I feel	☺ ☹	to talk with them.
They are trying to understand about my family, friends/peers, health, stress and use of any substances/drugs . They will ask me about my life, I feel	☺ ☹	to tell them about things.
This work can help to develop an action plan in the country to deal with the problem of substance use, I feel	☺ ☹	about this.
They will spend time as much an hour talking with me, I feel	☺ ☹	to spend time talking with them.
If it is too long for me, I might ask to go playing with friends or have a rest. I feel.	☺ ☹	that I can take a break.
My name will not be disclosed and will remain hidden. I feel	☺ ☹	that my name will be hidden.
They have told me that my sharing or refusing to share my experience for this interview will not affect the services I receive from them, I feel	☺ ☹	about that

**Project: An assessment of pattern, profile and correlates of Substance use among children in India**

**Informed consent form (Guardian)**

The contents of the information sheet dated ..... that was provided have been read carefully by me / explained in detail to me, in a language that I comprehend, and I have fully understood the contents. I confirm that I have had the opportunity to ask questions. The nature and purpose of the study and its potential risks / benefits and expected duration and other relevant details have been explained to me in detail. I understand that the participation of the child is voluntary and that he/she is free to withdraw at any time, without giving any reason, without his/her legal right being affected.

The information shared will be used only as a part of the report prepared by or for NCPCR in the larger interest of children of the country who get into substance use and need to be prevented and protected. At no point of time and under no circumstances the identity and confidentiality of the child will be revealed.

Respecting the dignity, privacy and right of the child who is into substance use, the consent is being signed.

Signature of the child

\_\_\_\_\_

(Signature / Left Thumb Impression)

Date:

Place:

Signature of the parent/guardian/ or surrogate guardian NGO\*

\_\_\_\_\_

(Signature / Left Thumb Impression)

Date:

Place:

Interviewer signature:

- Surrogate guardian NGO is not the NGO staff who is involved in the study

**Questionnaire for ONE-TO-ONE INTERVIEW**

Demographic Factors									
13.	<b>Age (in years)                      How old are you?</b> <i>If the subject is not sure of his exact age or date of birth ask him to arrive at an approximate figure</i>	<input type="text"/> <input type="text"/> Years							
14.	<b>Sex</b>  <div style="border: 1px solid black; display: inline-block; padding: 2px;">1=Male</div> <div style="border: 1px solid black; display: inline-block; padding: 2px;">2=Female</div>								
15.	<b>Living arrangement:</b> Where do you live/sleep these days in the last month (for those in institutional setting, please respond in the period prior to institutionalization/admission)?  <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>1. Home (with family)</td></tr> <tr><td>2. Home (with friends / distant relatives)</td></tr> <tr><td>3. Street / footpath / railway platform with family</td></tr> <tr><td>4. Alone on the street / footpath / railway platform</td></tr> <tr><td>5. Shop / establishment where I work</td></tr> <tr><td>6. Other (Specify) _____</td></tr> <tr><td>7. Not Known</td></tr> </table>	1. Home (with family)	2. Home (with friends / distant relatives)	3. Street / footpath / railway platform with family	4. Alone on the street / footpath / railway platform	5. Shop / establishment where I work	6. Other (Specify) _____	7. Not Known	<input type="checkbox"/>
1. Home (with family)									
2. Home (with friends / distant relatives)									
3. Street / footpath / railway platform with family									
4. Alone on the street / footpath / railway platform									
5. Shop / establishment where I work									
6. Other (Specify) _____									
7. Not Known									
16.	<b>If living with family</b>  <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>1. Not applicable as not living with family</td></tr> <tr><td>2. Living with both parents</td></tr> <tr><td>3. Living with one parent</td></tr> <tr><td>4. Living with a step parent</td></tr> <tr><td>5. Living with no parent</td></tr> </table>	1. Not applicable as not living with family	2. Living with both parents	3. Living with one parent	4. Living with a step parent	5. Living with no parent	<input type="checkbox"/>		
1. Not applicable as not living with family									
2. Living with both parents									
3. Living with one parent									
4. Living with a step parent									
5. Living with no parent									
17.	<b>Educational status (till last class passed)</b>  <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>1. Never been to school/been for very little time</td></tr> <tr><td>2. Never been to school but attended NFE Classes</td></tr> <tr><td>3. Class I-V</td></tr> <tr><td>4. Class VI-VIII</td></tr> <tr><td>5. Class IX-XII</td></tr> </table>	1. Never been to school/been for very little time	2. Never been to school but attended NFE Classes	3. Class I-V	4. Class VI-VIII	5. Class IX-XII	<input type="checkbox"/>		
1. Never been to school/been for very little time									
2. Never been to school but attended NFE Classes									
3. Class I-V									
4. Class VI-VIII									
5. Class IX-XII									
18.	<b>Currently studying in school or not (last one month)</b>  <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">1=Yes, in regular school</td> <td style="width: 33%;">2=studying through open school</td> <td style="width: 33%;">3= No</td> </tr> </table>	1=Yes, in regular school	2=studying through open school	3= No	<input type="checkbox"/>				
1=Yes, in regular school	2=studying through open school	3= No							

19.	<b>If currently a student, then studying in which class.</b> Please specify class.....	<input type="checkbox"/>										
20.	<b>If school dropout (not attended school in last one month), then duration for which not going to school</b>	....years/ ....months /....days										
21.	<b>What kind of work do you primarily do? (last one month)</b> <table border="1" data-bbox="248 501 762 1093"> <tr><td>1. Student</td></tr> <tr><td>2. Rag picker / kabadi</td></tr> <tr><td>3. Street level vending</td></tr> <tr><td>4. Dhaba / restaurant/ waiter</td></tr> <tr><td>5. Mechanic / assistant</td></tr> <tr><td>6. Helper in transport</td></tr> <tr><td>7. Unskilled worker / laborer</td></tr> <tr><td>8. Do not work</td></tr> <tr><td>9. Unclassifiable</td></tr> <tr><td>10. Not Known</td></tr> </table>	1. Student	2. Rag picker / kabadi	3. Street level vending	4. Dhaba / restaurant/ waiter	5. Mechanic / assistant	6. Helper in transport	7. Unskilled worker / laborer	8. Do not work	9. Unclassifiable	10. Not Known	<input type="checkbox"/>
1. Student												
2. Rag picker / kabadi												
3. Street level vending												
4. Dhaba / restaurant/ waiter												
5. Mechanic / assistant												
6. Helper in transport												
7. Unskilled worker / laborer												
8. Do not work												
9. Unclassifiable												
10. Not Known												
22.	<b>Status of work (last one month) Tell me more about your work</b> <table border="1" data-bbox="248 1169 762 1406"> <tr><td>1. Currently working (full-time)</td></tr> <tr><td>2. Currently working (part-time)</td></tr> <tr><td>3. Currently not working</td></tr> <tr><td>4. Not Known</td></tr> </table>	1. Currently working (full-time)	2. Currently working (part-time)	3. Currently not working	4. Not Known	<input type="checkbox"/>						
1. Currently working (full-time)												
2. Currently working (part-time)												
3. Currently not working												
4. Not Known												

*Interviewer to use own judgment depending upon the time spent by the respondent in any job. If the person is involved in more than 2 jobs consider the total time spent working. If the respondent is a student and also working, then tick working full-time or part-time as applicable. If the respondent is a student only and is not working, then tick "currently not working".*

<p><b>23.</b></p>	<p><b>How did you manage your expenses in the last month? (tick more than one response if applicable)</b></p> <table border="1"> <tr><td>1. Given money by family or borrowing from family</td></tr> <tr><td>2. Taking money from family by lying to them</td></tr> <tr><td>3. Stealing from home/selling household items</td></tr> <tr><td>4. Earned money</td></tr> <tr><td>5. Borrowing from friends</td></tr> <tr><td>6. Stealing from outside</td></tr> <tr><td>7. Begging</td></tr> <tr><td>8. Snatching money from others</td></tr> <tr><td>9. Helping to sell articles stolen by others</td></tr> <tr><td>10. Others (Specify)</td></tr> <tr><td>11. Not known</td></tr> </table>	1. Given money by family or borrowing from family	2. Taking money from family by lying to them	3. Stealing from home/selling household items	4. Earned money	5. Borrowing from friends	6. Stealing from outside	7. Begging	8. Snatching money from others	9. Helping to sell articles stolen by others	10. Others (Specify)	11. Not known	<p><input type="checkbox"/></p>
1. Given money by family or borrowing from family													
2. Taking money from family by lying to them													
3. Stealing from home/selling household items													
4. Earned money													
5. Borrowing from friends													
6. Stealing from outside													
7. Begging													
8. Snatching money from others													
9. Helping to sell articles stolen by others													
10. Others (Specify)													
11. Not known													
<p><b>24.</b></p>	<p><b>Did you usually have money for access to the following in last one month - (if living with family and the family provides requirements such as food, clothes, then consider the response as “)-tick all the responses that are applicable</b></p> <table border="1"> <tr><td>1. Food</td></tr> <tr><td>2. Clothes</td></tr> <tr><td>3. Medicines in case of illness</td></tr> <tr><td>4. Shelter</td></tr> <tr><td>5. Recreation</td></tr> <tr><td>6. Drugs</td></tr> </table>	1. Food	2. Clothes	3. Medicines in case of illness	4. Shelter	5. Recreation	6. Drugs	<p><input type="checkbox"/></p>					
1. Food													
2. Clothes													
3. Medicines in case of illness													
4. Shelter													
5. Recreation													
6. Drugs													

<b>Family and Peer Related Factors</b> <i>Tell me more about your family-</i>													
<b>25. Education of the father</b> (please fill if the respondent knows the education of father even if father is not alive or living separately)	<table border="1"> <tr><td>1. Never been to school/been for very little time</td></tr> <tr><td>2. Class I-V</td></tr> <tr><td>3. Class VI-VIII</td></tr> <tr><td>4. Class IX-XII</td></tr> <tr><td>5. Graduate</td></tr> <tr><td>6. Post graduate/professional</td></tr> <tr><td>7. Don't know</td></tr> </table>	1. Never been to school/been for very little time	2. Class I-V	3. Class VI-VIII	4. Class IX-XII	5. Graduate	6. Post graduate/professional	7. Don't know	<input type="checkbox"/>				
1. Never been to school/been for very little time													
2. Class I-V													
3. Class VI-VIII													
4. Class IX-XII													
5. Graduate													
6. Post graduate/professional													
7. Don't know													
<b>26. Education of the mother</b> (please fill if the respondent knows the education of mother even is mother if not alive or living separately)	<table border="1"> <tr><td>1. Never been to school/been for very little time</td></tr> <tr><td>2. Class I-V</td></tr> <tr><td>3. Class VI-VIII</td></tr> <tr><td>4. Class IX-XII</td></tr> <tr><td>5. Graduate</td></tr> <tr><td>6. Post graduate/professional</td></tr> <tr><td>7. Don't know</td></tr> </table>	1. Never been to school/been for very little time	2. Class I-V	3. Class VI-VIII	4. Class IX-XII	5. Graduate	6. Post graduate/professional	7. Don't know	<input type="checkbox"/>				
1. Never been to school/been for very little time													
2. Class I-V													
3. Class VI-VIII													
4. Class IX-XII													
5. Graduate													
6. Post graduate/professional													
7. Don't know													
<b>27. Occupation of the head of the household if living with family (at home or on streets)</b>	<table border="1"> <tr><td>1. Not applicable as not living with family</td></tr> <tr><td>2. Unemployed</td></tr> <tr><td>3. Involved in rag-picking/begging etc.</td></tr> <tr><td>4. Agricultural worker/farmer</td></tr> <tr><td>5. Unskilled manual worker (helper/labour etc)</td></tr> <tr><td>6. Skilled worker (e.g. machine operators/craftsmen/plumber/carpenter etc)</td></tr> <tr><td>7. Sales worker (sales related occupation)</td></tr> <tr><td>8. Clerical staff</td></tr> <tr><td>9. Professional (technical/administrative/managerial)</td></tr> <tr><td>10. Others (Specify)</td></tr> <tr><td>11. Not known</td></tr> </table>	1. Not applicable as not living with family	2. Unemployed	3. Involved in rag-picking/begging etc.	4. Agricultural worker/farmer	5. Unskilled manual worker (helper/labour etc)	6. Skilled worker (e.g. machine operators/craftsmen/plumber/carpenter etc)	7. Sales worker (sales related occupation)	8. Clerical staff	9. Professional (technical/administrative/managerial)	10. Others (Specify)	11. Not known	<input type="checkbox"/>
1. Not applicable as not living with family													
2. Unemployed													
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7. Sales worker (sales related occupation)													
8. Clerical staff													
9. Professional (technical/administrative/managerial)													
10. Others (Specify)													
11. Not known													

28.	Approximate total monthly income of the family in Rupees.....						
29.	Did you have contact with your Family in the last month? <div style="border: 1px solid black; display: inline-block; padding: 2px;">1=Yes</div> <div style="border: 1px solid black; display: inline-block; padding: 2px; margin-left: 10px;">2=No</div>	<input type="checkbox"/>					
30.	If yes, how often did you meet your Family? <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="padding: 2px;">1. Daily</td></tr> <tr><td style="padding: 2px;">2. Once /week</td></tr> <tr><td style="padding: 2px;">3. Once in last one month</td></tr> <tr><td style="padding: 2px;">4. If no contact, mention the duration for which no contact .....years.....months</td></tr> </table>	1. Daily	2. Once /week	3. Once in last one month	4. If no contact, mention the duration for which no contact .....years.....months	<input type="checkbox"/>	
1. Daily							
2. Once /week							
3. Once in last one month							
4. If no contact, mention the duration for which no contact .....years.....months							
31.	How would you rate your relations with your family in the last month? <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="padding: 2px;">1. Good</td></tr> <tr><td style="padding: 2px;">2. Average</td></tr> <tr><td style="padding: 2px;">3. Bad</td></tr> <tr><td style="padding: 2px;">4. Very bad</td></tr> <tr><td style="padding: 2px;">5. Not applicable / no family</td></tr> </table>	1. Good	2. Average	3. Bad	4. Very bad	5. Not applicable / no family	<input type="checkbox"/>
1. Good							
2. Average							
3. Bad							
4. Very bad							
5. Not applicable / no family							
32.	Is there anyone in your family who uses / used alcohol or substances frequently and created problems for the family?  <div style="border: 1px solid black; display: inline-block; padding: 2px;">1=Yes</div> <div style="border: 1px solid black; display: inline-block; padding: 2px; margin-left: 10px;">2=No</div> <div style="border: 1px solid black; display: inline-block; padding: 2px; margin-left: 10px;">3= not applicable</div>	<input type="checkbox"/>					
33.	Are there fights frequently in your family e.g. between parents?  <div style="border: 1px solid black; display: inline-block; padding: 2px;">1=Yes</div> <div style="border: 1px solid black; display: inline-block; padding: 2px; margin-left: 10px;">2=No</div> <div style="border: 1px solid black; display: inline-block; padding: 2px; margin-left: 10px;">3= not applicable</div>	<input type="checkbox"/>					
34.	Were you often beaten up or abused by the family?  <div style="border: 1px solid black; display: inline-block; padding: 2px;">1=Yes</div> <div style="border: 1px solid black; display: inline-block; padding: 2px; margin-left: 10px;">2=No</div> <div style="border: 1px solid black; display: inline-block; padding: 2px; margin-left: 10px;">3= not applicable</div>	<input type="checkbox"/>					
<i>Tell me more about your friends</i>							

35.	Do you have friends you can trust and depend upon and are in contact with them?  <div style="display: flex; justify-content: center; gap: 20px;"> <span>1=Yes</span> <span>2=No</span> </div>	<input type="checkbox"/>												
36.	Do you have friends who you are in close contact with and who are using any substances? (Any substance besides tobacco)  <div style="display: flex; justify-content: center; gap: 20px;"> <span>1=Yes</span> <span>2=No</span> </div>	<input type="checkbox"/>												
37.	How many drug using friends did you have in the last month? (Any substance besides tobacco)  <table border="1" style="margin-left: 20px;"> <tr><td>1</td><td>0-None</td></tr> <tr><td>1</td><td>1-2</td></tr> <tr><td>2</td><td>3-5</td></tr> <tr><td>3</td><td>6-10</td></tr> <tr><td>4</td><td>&gt;10</td></tr> <tr><td>5</td><td>Not Applicable/no drug using friends</td></tr> </table>	1	0-None	1	1-2	2	3-5	3	6-10	4	>10	5	Not Applicable/no drug using friends	<input type="checkbox"/>
1	0-None													
1	1-2													
2	3-5													
3	6-10													
4	>10													
5	Not Applicable/no drug using friends													
38.	Did you have friends who you are in close contact with and who are NOT using any drugs in the last month?  <div style="display: flex; justify-content: center; gap: 20px;"> <span>1=Yes</span> <span>2=No</span> </div>	<input type="checkbox"/>												
39.	How many NON-drug using friends did you have in the last month?  <table border="1" style="margin-left: 20px;"> <tr><td>1</td><td>0-None</td></tr> <tr><td>2</td><td>1-2</td></tr> <tr><td>3</td><td>3-5</td></tr> <tr><td>4</td><td>6-10</td></tr> <tr><td>5</td><td>&gt;10</td></tr> <tr><td>6</td><td>Not Applicable</td></tr> </table>	1	0-None	2	1-2	3	3-5	4	6-10	5	>10	6	Not Applicable	<input type="checkbox"/>
1	0-None													
2	1-2													
3	3-5													
4	6-10													
5	>10													
6	Not Applicable													
40.	Do you have access to resources ( <i>external</i> ) to healthy recreational interests (like playing games etc)?  <div style="display: flex; justify-content: center; gap: 20px;"> <span>1=Yes</span> <span>2=No</span> </div>	<input type="checkbox"/>												
41.	If yes, Specify _____													

<b>42.</b>	Frequency of contact with any NGO in the last month (please tick the closest applicable response)									
	<table border="1" style="width: 100%;"> <tr> <td style="width: 5%; text-align: center;">1.</td> <td>No contact.</td> </tr> <tr> <td style="text-align: center;">2.</td> <td>Daily</td> </tr> <tr> <td style="text-align: center;">3.</td> <td>Once /week</td> </tr> <tr> <td style="text-align: center;">4.</td> <td>Once/month</td> </tr> </table>	1.	No contact.	2.	Daily	3.	Once /week	4.	Once/month	<input type="checkbox"/>
1.	No contact.									
2.	Daily									
3.	Once /week									
4.	Once/month									

**Stress, Physical and Psychological Health**

*The questions that follow inquire about major stressful events that you may have experienced in your life-*

<b>43.</b>	Has anything happened to you in your life that has been very difficult/stressful/something bad?			
	<table border="1" style="display: inline-table; margin-right: 10px;"> <tr> <td style="padding: 2px 10px;">1=Yes</td> <td style="padding: 2px 10px;">2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>
1=Yes	2=No			
<b>44.</b>	Have you ever been so sick or injured that you needed to go to the hospital?			
	<table border="1" style="display: inline-table; margin-right: 10px;"> <tr> <td style="padding: 2px 10px;">1=Yes</td> <td style="padding: 2px 10px;">2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>
1=Yes	2=No			
<b>45.</b>	Has anyone close to you died?			
	<table border="1" style="display: inline-table; margin-right: 10px;"> <tr> <td style="padding: 2px 10px;">1=Yes</td> <td style="padding: 2px 10px;">2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>
1=Yes	2=No			
<b>46.</b>	Have you ever been in a situation where you feared losing your life or being severely harmed?			
	<table border="1" style="display: inline-table; margin-right: 10px;"> <tr> <td style="padding: 2px 10px;">1=Yes</td> <td style="padding: 2px 10px;">2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>
1=Yes	2=No			
<b>47.</b>	Have you ever experienced a natural disaster, such as an earthquake, flood or fire?			
	<table border="1" style="display: inline-table; margin-right: 10px;"> <tr> <td style="padding: 2px 10px;">1=Yes</td> <td style="padding: 2px 10px;">2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>
1=Yes	2=No			
<b>48.</b>	Have you ever lived in an environment which is part of a conflict ridden area (terrorism or insurgency or militancy)?			
	<table border="1" style="display: inline-table; margin-right: 10px;"> <tr> <td style="padding: 2px 10px;">1=Yes</td> <td style="padding: 2px 10px;">2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>
1=Yes	2=No			
<b>49.</b>	Have you ever had to face violence from the police/community?			
	<table border="1" style="display: inline-table; margin-right: 10px;"> <tr> <td style="padding: 2px 10px;">1=Yes</td> <td style="padding: 2px 10px;">2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>
1=Yes	2=No			

*The questions that follow inquire about your physical and psychological health in last one month-*

<b>50.</b>	Did you feel physically strong in the last one month?			
	<table border="1" style="display: inline-table; margin-right: 10px;"> <tr> <td style="padding: 2px 10px;">1=Yes</td> <td style="padding: 2px 10px;">2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>
1=Yes	2=No			

51.	<p>Did you feel good about yourself in the last one month?</p> <table border="1" data-bbox="247 235 510 403"> <tr> <td>1.</td> <td>Usually not</td> </tr> <tr> <td>2.</td> <td>Sometimes</td> </tr> <tr> <td>3.</td> <td>Often</td> </tr> </table>	1.	Usually not	2.	Sometimes	3.	Often	<input type="checkbox"/>
1.	Usually not							
2.	Sometimes							
3.	Often							
52.	<p>Did you feel fearful (when not intoxicated) in the last month?</p> <table border="1" data-bbox="247 499 505 678"> <tr> <td>1.</td> <td>Usually not</td> </tr> <tr> <td>2.</td> <td>Sometimes</td> </tr> <tr> <td>3.</td> <td>Often</td> </tr> </table>	1.	Usually not	2.	Sometimes	3.	Often	<input type="checkbox"/>
1.	Usually not							
2.	Sometimes							
3.	Often							
53.	<p>In the last one month could you accept the structuring of your daily activities</p> <table border="1" data-bbox="619 772 896 840" style="margin-left: auto; margin-right: auto;"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>				
1=Yes	2=No							
54.	<p>In the last one month did you feel the need for complete independence</p> <table border="1" data-bbox="616 952 893 1019" style="margin-left: auto; margin-right: auto;"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>				
1=Yes	2=No							
55.	<p>Did you have plans for your future in the last month?</p> <table border="1" data-bbox="252 1131 501 1310"> <tr> <td>1.</td> <td>Usually not</td> </tr> <tr> <td>2.</td> <td>Sometimes</td> </tr> <tr> <td>3.</td> <td>Often</td> </tr> </table>	1.	Usually not	2.	Sometimes	3.	Often	<input type="checkbox"/>
1.	Usually not							
2.	Sometimes							
3.	Often							
56.	<p>Do you know where to get health services if you needed (with or without the help of parents or school or guardians/NGO)?</p> <table border="1" data-bbox="619 1451 896 1518" style="margin-left: auto; margin-right: auto;"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>				
1=Yes	2=No							
57.	<p>Do you know how to get help if you are upset (with or without the help of parents or school or guardians/NGO)?</p> <table border="1" data-bbox="622 1675 900 1742" style="margin-left: auto; margin-right: auto;"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>				
1=Yes	2=No							

## Substance Use

Now I would like to know about all the substances including tobacco, which you may have been consuming, for example have you consumed these substance (s) in the period mentioned.

Mark the appropriate box as ✓ even if the respondent has used the substance only once during the specified period. 'Injectable route' refers only to use of substances through this route in a non-medical context.

Substances	Ever in lifetime		Last 1 year		Last 30 days		Age at first use (in years)	If used in last 30 days, number of days the substance used
	1=Yes	2=No	1=Yes	2=No	1=Yes	2=No		
58. Tobacco (smoking / chewing)	1=Yes	2=No	1=Yes	2=No	1=Yes	2=No		
59. Alcohol (beer, wine, hard liquor, desi alcohol)	1=Yes	2=No	1=Yes	2=No	1=Yes	2=No		
60. Cannabis ( <i>Bhang, Charas, Ganja, sulpha</i> )	1=Yes	2=No	1=Yes	2=No	1=Yes	2=No		
61. Inhalants (ink eraser fluid, petrol, glue, iodex etc) Tick the inhalant used- a) Ink eraser fluid b) Petrol c) Glue d) Any other. Please specify.....	1=Yes	2=No	1=Yes	2=No	1=Yes	2=No		
62. Opium ( <i>Doda, phukki</i> )	1=Yes	2=No	1=Yes	2=No	1=Yes	2=No		
63. Heroin ( <i>Smack, brown sugar</i> )	1=Yes	2=No	1=Yes	2=No	1=Yes	2=No		
64. Pharmaceutical opioids (proxyvon, tidigesic, fortwin, codeine containing cough syrups etc.)	1=Yes	2=No	1=Yes	2=No	1=Yes	2=No		
65. Pharmaceutical sedatives (diazepam, nitravet or number 10, alprax, trika etc)								
66. Injectable route (any substance)	1=Yes	2=No	1=Yes	2=No	1=Yes	2=No		
67. Others (specify)	1=Yes	2=No	1=Yes	2=No	1=Yes	2=No		

Mark the appropriate box as ✓ even if the respondent has used the substance only once during the specified period. 'Injectable route' refers only to use of substances through this route in a non-medical context.

68.	<p>Which of these substances have been used daily for one month at any point of time</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="padding: 2px;">1=Yes</td> <td style="padding: 2px;">2=No</td> </tr> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 20px;">1.</td><td>Tobacco (smoking / chewing)</td></tr> <tr><td>2.</td><td>Alcohol</td></tr> <tr><td>3.</td><td>Cannabis (<i>Bhang, Charas, Ganja, sulpha</i>)</td></tr> <tr><td>4.</td><td>Inhalants (ink eraser fluid, petrol, glue, iodex etc)</td></tr> <tr><td>5.</td><td>Opium (<i>Doda, phukki</i>)</td></tr> <tr><td>6.</td><td>Heroin (<i>Smack, brown sugar</i>)</td></tr> <tr><td>7.</td><td>Pharmaceutical preparations (tablets, cough syrups, injections etc.)</td></tr> </table>	1=Yes	2=No	1.	Tobacco (smoking / chewing)	2.	Alcohol	3.	Cannabis ( <i>Bhang, Charas, Ganja, sulpha</i> )	4.	Inhalants (ink eraser fluid, petrol, glue, iodex etc)	5.	Opium ( <i>Doda, phukki</i> )	6.	Heroin ( <i>Smack, brown sugar</i> )	7.	Pharmaceutical preparations (tablets, cough syrups, injections etc.)	<table border="1" style="width: 100%; height: 100%;"> <tr><td style="width: 20px; height: 20px;"></td></tr> </table>								
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7.	Pharmaceutical preparations (tablets, cough syrups, injections etc.)																									
69.	<p>The primary substance of use or the substance you prefer the most? (Please tick one response)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 20px;">1.</td><td>Tobacco (smoking / chewing)</td></tr> <tr><td>2.</td><td>Alcohol</td></tr> <tr><td>3.</td><td>Cannabis (<i>Bhang, Charas, Ganja, sulpha</i>)</td></tr> <tr><td>4.</td><td>Inhalants (ink eraser fluid, petrol, glue, iodex etc)</td></tr> <tr><td>5.</td><td>Opium (<i>Doda, phukki</i>)</td></tr> <tr><td>6.</td><td>Heroin (<i>Smack, brown sugar</i>)</td></tr> <tr><td>7.</td><td>Pharmaceutical preparations (tablets, cough syrups, injections etc.)</td></tr> </table>	1.	Tobacco (smoking / chewing)	2.	Alcohol	3.	Cannabis ( <i>Bhang, Charas, Ganja, sulpha</i> )	4.	Inhalants (ink eraser fluid, petrol, glue, iodex etc)	5.	Opium ( <i>Doda, phukki</i> )	6.	Heroin ( <i>Smack, brown sugar</i> )	7.	Pharmaceutical preparations (tablets, cough syrups, injections etc.)	<table border="1" style="width: 100%; height: 100%;"> <tr><td style="width: 20px; height: 20px;"></td></tr> </table>										
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7.	Pharmaceutical preparations (tablets, cough syrups, injections etc.)																									
70.	<p>How difficult is it for you to obtain the substance you have mentioned in the previous question (question no. 69)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 20px;">1.</td><td>Very difficult</td></tr> <tr><td>2.</td><td>Difficult but not too difficult</td></tr> <tr><td>3.</td><td>Easy but not too easy</td></tr> <tr><td>4.</td><td>Very easy</td></tr> </table>	1.	Very difficult	2.	Difficult but not too difficult	3.	Easy but not too easy	4.	Very easy	<table border="1" style="width: 100%; height: 100%;"> <tr><td style="width: 20px; height: 20px;"></td></tr> </table>																
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71.	<p>Where do you procure this substance from?</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 20px;">1.</td><td>Tobacco/wine shop</td></tr> <tr><td>2.</td><td>Pharmacy or chemist shop</td></tr> <tr><td>3.</td><td>Any other shop</td></tr> <tr><td>4.</td><td>From a drug peddler</td></tr> <tr><td>5.</td><td>From friends</td></tr> <tr><td>6.</td><td>Any other.....</td></tr> </table>	1.	Tobacco/wine shop	2.	Pharmacy or chemist shop	3.	Any other shop	4.	From a drug peddler	5.	From friends	6.	Any other.....	<table border="1" style="width: 100%; height: 100%;"> <tr><td style="width: 20px; height: 20px;"></td></tr> </table>												
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72.	<p>Size of usual drug using network (of friends/relatives etc.) in the last month</p> <p><i>The size of drug using network refers to the number of drug users among friends / relatives with whom the respondent <u>interacts</u> regularly even if they are not <u>using drugs together</u></i></p> <table border="1" data-bbox="204 331 694 607"> <tr> <td>1.</td> <td>(Usually takes drugs alone)</td> </tr> <tr> <td>2.</td> <td>Between 1 to 5</td> </tr> <tr> <td>3.</td> <td>Between 6 to 10</td> </tr> <tr> <td>4.</td> <td>Between 11 to 15</td> </tr> <tr> <td>5.</td> <td>More than 16</td> </tr> </table>	1.	(Usually takes drugs alone)	2.	Between 1 to 5	3.	Between 6 to 10	4.	Between 11 to 15	5.	More than 16	<input type="checkbox"/>
1.	(Usually takes drugs alone)											
2.	Between 1 to 5											
3.	Between 6 to 10											
4.	Between 11 to 15											
5.	More than 16											
73.	<p>Do you think that drug use is harmful</p> <table border="1" data-bbox="539 674 855 734"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table> <p><i>Respond as Yes if the subject considers even one drug that he/she is using as harmful.</i></p>	1=Yes	2=No	<input type="checkbox"/>								
1=Yes	2=No											
<b>Have you experienced the following due to drug/alcohol use-</b>												
74.	<p>Intoxication that impaired performance</p> <table border="1" data-bbox="539 925 855 985"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>								
1=Yes	2=No											
75.	<p>Driven a vehicle after taking large amounts of alcohol</p> <table border="1" data-bbox="528 1064 850 1124"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>								
1=Yes	2=No											
76.	<p>Got into a fight under the effect of alcohol or drugs</p> <table border="1" data-bbox="528 1202 847 1263"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>								
1=Yes	2=No											
77.	<p>Indulged in sexual behaviour under the effect of alcohol or drugs</p> <table border="1" data-bbox="533 1341 852 1402"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>								
1=Yes	2=No											
78.	<p>Have you had sexual activity to get drugs or money for drugs</p> <table border="1" data-bbox="533 1469 852 1529"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>								
1=Yes	2=No											
79.	<p>Experienced some physical problems due to alcohol or drug use</p> <table border="1" data-bbox="536 1608 855 1668"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>								
1=Yes	2=No											
80.	<p>Experienced sadness or anxiety due to drug use or problems related to drug use</p> <table border="1" data-bbox="536 1758 855 1818"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>								
1=Yes	2=No											
81.	<p>Got into legal problems due to drug use (caught by the police even if case not registered or caught by the community)</p> <table border="1" data-bbox="536 1953 855 2013"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table>	1=Yes	2=No	<input type="checkbox"/>								
1=Yes	2=No											

82.	Indicator of tolerance ( <i>inquire for the primary drug of use mentioned in question 69</i> ): Have you experienced that compared to the earlier phase when you started taking drugs, you now have to consume in larger amount to get the same effect? <div style="text-align: center;"> <table border="1" style="display: inline-table; margin-right: 10px;"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table> </div>	1=Yes	2=No	<input type="checkbox"/>								
1=Yes	2=No											
83.	Indicator of withdrawal ( <i>inquire for the primary drug of use mentioned in question 69</i> ): Have you experienced that whenever you do not take the drug / take reduced amount of the drug you experience some discomfort? <div style="text-align: center;"> <table style="display: inline-table; margin-right: 10px;"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table> </div>	1=Yes	2=No	<input type="checkbox"/>								
1=Yes	2=No											
84.	Have you ever considered stopping / reducing use of drugs in the last month? <div style="text-align: center;"> <table border="1" style="display: inline-table; margin-right: 10px;"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table> </div>	1=Yes	2=No	<input type="checkbox"/>								
1=Yes	2=No											
85.	Have you ever been able to stop use of drugs? <div style="text-align: center;"> <table border="1" style="display: inline-table; margin-right: 10px;"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table> </div>	1=Yes	2=No	<input type="checkbox"/>								
1=Yes	2=No											
86.	If yes, for how many months (in the most recent attempt)? <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">1.</td> <td>Less than 1 month</td> </tr> <tr> <td style="text-align: center;">2.</td> <td>Between 1 to 3 months</td> </tr> <tr> <td style="text-align: center;">3.</td> <td>More than 3 months</td> </tr> <tr> <td style="text-align: center;">4.</td> <td>Not applicable</td> </tr> </table>	1.	Less than 1 month	2.	Between 1 to 3 months	3.	More than 3 months	4.	Not applicable	<input type="checkbox"/>		
1.	Less than 1 month											
2.	Between 1 to 3 months											
3.	More than 3 months											
4.	Not applicable											
87.	When was your most recent attempt to quit drugs? <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">1.</td> <td>Less than 1 month back</td> </tr> <tr> <td style="text-align: center;">2.</td> <td>Between 1 to 3 months back</td> </tr> <tr> <td style="text-align: center;">3.</td> <td>More than 3 months back</td> </tr> <tr> <td style="text-align: center;">4.</td> <td>Not applicable</td> </tr> </table>	1.	Less than 1 month back	2.	Between 1 to 3 months back	3.	More than 3 months back	4.	Not applicable	<input type="checkbox"/>		
1.	Less than 1 month back											
2.	Between 1 to 3 months back											
3.	More than 3 months back											
4.	Not applicable											
88.	Do you think, you need some help for stopping / reducing use of drugs? <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">1.</td> <td>No, I do not think that I have a problem</td> </tr> <tr> <td style="text-align: center;">2.</td> <td>Yes, I have a problem, but I can quit on my own</td> </tr> <tr> <td style="text-align: center;">3.</td> <td>Yes, I want to quit and would need help for quitting</td> </tr> <tr> <td style="text-align: center;">4.</td> <td>Any other (Specify)</td> </tr> </table>	1.	No, I do not think that I have a problem	2.	Yes, I have a problem, but I can quit on my own	3.	Yes, I want to quit and would need help for quitting	4.	Any other (Specify)	<input type="checkbox"/>		
1.	No, I do not think that I have a problem											
2.	Yes, I have a problem, but I can quit on my own											
3.	Yes, I want to quit and would need help for quitting											
4.	Any other (Specify)											
89.	Have you ever received any help for stopping / reducing use of drugs? <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">1.</td> <td>No, I never looked for it</td> </tr> <tr> <td style="text-align: center;">2.</td> <td>Yes, someone had advised me to stop but I did not visit a doctor</td> </tr> <tr> <td style="text-align: center;">3.</td> <td>Yes, I have seen a doctor for treatment of drug use, but was not admitted</td> </tr> <tr> <td style="text-align: center;">4.</td> <td>Yes, I have seen a doctor for treatment of drug use and was hospitalized too</td> </tr> <tr> <td style="text-align: center;">5.</td> <td>Any other (Specify)</td> </tr> </table>	1.	No, I never looked for it	2.	Yes, someone had advised me to stop but I did not visit a doctor	3.	Yes, I have seen a doctor for treatment of drug use, but was not admitted	4.	Yes, I have seen a doctor for treatment of drug use and was hospitalized too	5.	Any other (Specify)	<input type="checkbox"/>
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5.	Any other (Specify)											

90.	What difficulty do you experience in quitting? (you can tick more than one response)		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	1.	Craving	
	2.	Peer pressure	
	3.	Easy availability of substances	
	4.	Difficult to tolerate withdrawals	
	5.	Difficult to survive on the street without substances	
	6.	Difficult to cope with stress	
	7.	Any other. Specify .....	
8.	Not applicable		

**Legal Issues**

91.	Did you break the law for fun or to be accepted by peers or to 'survive in the streets' in the last month? (breaking the law besides through purchasing and consuming drugs)	<input type="checkbox"/>	
	<table border="1"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table>		1=Yes
1=Yes	2=No		

92.	Did you do anything dangerous to earn money or to get food, clothes, shelter, etc in the last month?	<input type="checkbox"/>	
	<table border="1"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table>		1=Yes
1=Yes	2=No		

93.	Do you know where to get free legal help in case you are in trouble?	<input type="checkbox"/>	
	<table border="1"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table>		1=Yes
1=Yes	2=No		

94.	Can you suggest what in your opinion can be done to prevent substance use in children or adolescents? ..... .....	
-----	---	--

95.	Do you think that the information provided is consistent and reliable and this questionnaire should be included in the data that is being collected?	<input type="checkbox"/>	
	<table border="1"> <tr> <td>1=Yes</td> <td>2=No</td> </tr> </table>		1=Yes
1=Yes	2=No		

**Thank you for the interview!**

## Annexure II - Number of respondents from each state

		Male	Female	Total
Jammu & Kashmir (n=90)	SPYM	87	3	90
Punjab (n=239)	Abhivyakti Foundation	29		29
	Ambuja Cement Foundation	60		60
	Francis Newton Mission Hospital	30		30
	Indian Council of Social Welfare (ICSW)	29	1	30
	Morning Glory Public Society	30		30
	SPYM	30		30
	Swami Vivekanand Med. Mission	30		30
Chandigarh (n=60)	Family Planning Association of India (FPAI)	31		31
	SPYM	29		29
Himachal Pradesh (n=60)	GUNJAN ORG.	30		30
	HPVHA	30		30
Uttaranchal (n=30)	Kumaun Agriculture And Greenery Advancement Society	30		30
Haryana (n=60)	SHARAN SOCIETY	29	1	30
	YOUTH AFFAIR ORG.	30		30
Delhi (n=347)	Asian Society for Entrepreneurship Education & Development (ASEED)	29	1	30
	CHETNA	28		28
	DON BOSCO ORGNISATION	28	2	30
	SHARAN	30		30
	SPYM	221	8	229
Uttar Pradesh (n=171)	Basudev Tiwari Samaj Samiti	30		30
	CHETNA	70	11	81
	DVSU SAMITI	25	5	30
	Smt.Kaushalya Devi Pmv Society	30		30
Rajasthan (n=120)	Global Foundation Society	30		30
	Manohar Bal Mandir Samiti	60		60
	N.A.V.V. SANSTHAN	30		30
Gujarat (n=149)	Nasha Bandhi Mandal	30		30
	Navjivan Integrated Rehabilitation Center For Addict	30		30
	Navprabhat Integrated Rehabilitation Center For Addict	30		30
	Parivartan De-Addiction Center	27	2	29
	Sardar Vallabhbai Patel Integrated Rehabilitation Center For Addicts	28	2	30

		Male	Female	Total
Chattisgarh (n=122)	Chattisgarh Prachar Evam Vikas Sansthan	30		30
	Kalyani Society Welfare & Research	62		62
	Sankalp Nasha Mukti Kendra & Punravas Kendra	30		30
Bihar (n=90)	Alp Sankhyak Avam Harijan	30		30
	Sister Nivedita Memorial Trust	60		60
Jharkhand (n=90)	Association For Social Health In India	30		30
	The Calcutta Samritans	60		60
West Bengal (n=361)	Association For Social Health In India	64	8	72
	CINI URBAN UNIT	28	2	30
	Human Development & Research Institute	90		90
	SPYM	139	11	150
	WBVHA	19		19
Orissa (n=60)	ODD FOUNDATION	28	2	30
	SWARAJAYA	30		30
Andhra Pradesh (n=98)	Association For Social Health In India	33	1	34
	DON BOSCO	29		29
	People's Action for Social Service (PASS)	35		35
Karnataka (n=90)	Don Bosco Yuvodaya	30		30
	Kittur Rani Channamma Mahila Mandal	30		30
	LINK IRCA	30		30
Kerala (n=119)	DON BOSCO VEEDU SOCIETY	30		30
	SURAKSHA IRCA	30		30
	TRADA	30		30
	TRIVANDRUM SOCIAL SERVICE SOCIETY(TSSS)	26	3	29
Tamilnadu (n=146)	AVVAI	17		17
	FIRE	38	1	39
	SOCSEAD	30		30
	Trishul de-addiction centre	29	1	30
	TTK HOSPITAL	30		30
Maharashtra (n=404)	Anusaya Shikshan Prasarak Mandal	30		30
	Don Bosco Research Centre	217	6	223
	MAHATAMA GANDHI DE-ADDICTION CENTRE	30		30
	MUKTANGAN	29	1	30
	National Addiction Research Centre (NARC)	31		31
	NAVJEEVANI I.R.C.A. B.A.J.S.S.	30		30
	SAHARA ALHAD	30		30

		Male	Female	Total
Sikkim (n=60)	Association For Social Health In India	21	8	29
Goa (n=60)	AASHA KIRAN TRUST	30		30
	Margaret Bosco Bal Sadan	26	4	30
Arunachal Pradesh (n=90)	Arunachal Pali Vidyapith Society	30		30
	Self Reliance Society	25	5	30
	Tribal Development Foundation	22	8	30
Nagaland (n=120)	Bethesda Youth Welfare Centre	30		30
	Kripa Foundation	60		60
	Prodigals Home	27	3	30
Manipur (n=387)	Association For Social Health In India	89		89
	Born Again	30		30
	Galaxy Club	30		30
	integrated women and children development centre ( lwcdc)	29		29
	Kripa Foundation	30		30
	RADIANCE IRCA	30		30
	RDS,IRCA	30		30
	Rural Development Foundation Association	29	1	30
	S C M	21	8	29
	People's Welfare Organization	30		30
	Y D A	30		30
Mizoram (n=228)	Link Worker	20	5	25
	Agape Moral Reformation Organisation (AMRO)	25	5	30
	Faith Home	23	7	30
	Ferrando Integrated Women Development Centre (Peace Home)	21	9	30
	Mara Chano Py (MCHP)	23	7	30
	Mizo Hmeichhe Insuihkhawm Pawl (MHIP)	30		30
	Samaritan Society of Mizoram	18	12	30
	Women Anti Drugs Association	20	3	23
Tripura (n=60)	SPYM	60		60
Meghalaya (n=55)	KRIPA FOUNDATION	27		27
	VHAM	28		28
Madhya Pradesh (n=89)	Ashirwad Nasha Mukti Kendra	26	3	29
	Lok Kalyan Jansabha	30		30
	NSPSK SAMITTI	21	9	30
	<b>Grand total</b>	<b>3855</b>	<b>169</b>	<b>4024</b>

## Annexure III - State-wise substance use in the respondents

States/UTs	Tobacco	Alcohol	Cannabis	Inhalants	Opium	Heroin	Pharm. opioids	Sedatives	Injectable
<b>Jammu &amp; Kashmir</b>	73 81.1%	63 70.0%	41 45.6%	7 7.8%		9 10.0%	9 10.0%	12 13.3%	
<b>Punjab</b>	217 80.4%	130 48.1%	122 45.2%	69 25.6%	42 15.6%	52 19.3%	36 13.3%	22 8.1%	35 13.0%
<b>Chandigarh</b>	25 86.2%	23 79.3%	14 48.3%	9 31.0%	4 13.8%	1 3.4%			2 6.9%
<b>Himachal Pradesh</b>	46 76.7%	36 60.0%	24 40.0%	5 8.3%					
<b>Uttaranchal</b>	27 90.0%	22 73.3%	21 70.0%	2 6.7%		1 3.3%	1 3.3%		
<b>Haryana</b>	39 65.0%	48 80.0%	38 63.3%	28 46.7%	1 1.7%	3 5.0%	1 1.7%		2 3.3%
<b>Delhi</b>	242 69.7%	80 23.1%	119 34.3%	136 39.2%	9 2.6%	32 9.2%	26 7.5%	23 6.6%	9 2.6%
<b>Uttar Pradesh</b>	118 69.0%	76 44.4%	43 25.1%	49 28.7%	5 2.9%	17 9.9%	10 5.8%	14 8.2%	9 5.3%
<b>Rajasthan</b>	95 79.2%	50 41.7%	21 17.5%	47 39.2%	2 1.7%	6 5.0%	20 16.7%	1 0.8%	30 25.0%
<b>Gujarat</b>	86 57.7%	89 59.7%	13 8.7%	12 8.1%	1 0.7%				
<b>Chattisgarh</b>	60 49.2%	42 34.4%	42 34.4%	41 33.6%	1 0.8%	3 2.5%	2 1.6%	9 7.4%	
<b>Bihar</b>	50 55.6%	66 73.3%	25 27.8%	12 13.3%			2 2.2%		
<b>Jharkhand</b>	58 64.4%	55 61.1%	13 14.4%	28 31.1%	2 2.2%	15 16.7%	8 8.9%	5 5.6%	2 2.2%
<b>West Bengal</b>	318 88.1%	242 67.0%	138 38.2%	105 29.1%	4 1.1%	35 9.7%	111 30.7%	50 13.9%	26 7.2%
<b>Orissa</b>	51 85.0%	31 51.7%	32 53.3%	24 40.0%	5 8.3%	7 11.7%	38 63.3%	1 1.7%	3 5.0%

States/ UTs	Tobacco	Alcohol	Cannabis	Inhalants	Opium	Heroin	Pharm.op	Sedatives	Injectable
<b>Andhra Pradesh</b>	67 68.4%	83 84.7%	12 12.2%	7 7.1%					
<b>Karnataka</b>	73 81.1%	80 88.9%	22 24.4%	25 27.8%		2 2.2%			
<b>Kerala</b>	88 73.9%	72 60.5%	24 20.2%	40 33.6%			5 4.2%		
<b>Tamil Nadu</b>	126 86.3%	113 77.4%	15 10.3%	11 7.5%					
<b>Maharashtra</b>	289 71.5%	210 52.0%	107 26.5%	245 60.6%	9 2.2%	14 3.5%	8 2.0%	3 0.7%	95 23.5%
<b>Sikkim</b>	27 93.1%	23 79.3%	14 48.3%	14 48.3%	1 3.4%	2 6.9%	20 69.0%	9 31.0%	1 3.4%
<b>Goa</b>	22 36.7%	37 61.7%	1 1.7%	3 5.0%					
<b>Arunachal Pradesh</b>	74 82.2%	67 74.4%	44 48.9%	14 15.6%	15 16.7%	8 8.9%	9 10.0%		10 11.1%
<b>Nagaland</b>	115 95.8%	89 74.2%	17 14.2%	44 36.7%		1 0.8%	19 15.8%	3 2.5%	1 0.8%
<b>Manipur</b>	319 82.4%	233 60.2%	70 18.1%	125 32.3%	1 0.3%	17 4.4%	137 35.4%	41 10.6%	43 11.1%
<b>Mizoram</b>	145 63.6%	122 53.5%	65 28.5%	30 13.2%	8 3.5%	10 4.4%	74 32.5%	15 6.6%	202 88.6%
<b>Tripura</b>	35 58.3%	21 35.0%	1 1.7%	41 68.3%			12 20.0%	1 1.7%	
<b>Meghalaya</b>	53 96.4%	35 63.6%	28 50.9%	17 30.9%		15 27.3%	15 27.3%	6 10.9%	14 25.5%
<b>Madhya Pradesh</b>	76 85.4%	46 51.7%	37 41.6%	39 43.8%	6 6.7%		1 1.1%		1 1.1%



Exhibition of some of the paintings made by Street Children & children into substance abuse titled "WE TOO EXIST" organized by NGO CHETNA at Arpana Art Gallery, Siri Fort Institutional Area, New Delhi, From 1st to 5th May, 2013.