**Drug Addiction Among Youth In Kashmir**

**Sumbl Ahmad khanday**

Assistant Professor

Aligarh Muslim University, Aligarh, 202002, India

E: mail - sumbl.amu.k@gmail.com

Phone: +917006219188

**ABSTRACT**

*This paper attempts to present an overview of the profile of drug addicts in order to draw scientific generalization of the prevalence and pattern of drug abuse among youth of Kashmir. Research subjects consisted of 150 Kashmiri youths, aged 15 to 30 admitted into a three inpatient/outpatient drug de-addiction centres of three districts of Kashmir valley The recorded data were analysed using a qualitative framework i.e. Thematic Content Analysis.**The study revealed that youth of Kashmir have increasingly been linked with the influence of social variables on their addictive behaviour such as age, gender, caste, marital status, religion, education, occupation and place of residence. Preventive strategies seeking to reduce the occurrence of drug abuse among those who are at greater risk, should focus on the development of influential cognitive, social skills and social bonding.*

**Keywords:**Drug abuse; Addiction; Youth, Kashmir.

**INTRODUCTION**

Shakespeare once stated that “*what’s past is prologue*” this common phrase means that what has happened in the past provides a meaningful context for, and can help to understand and predict the future in a better way. The history of drug use offers a sobering lesson to the point that the past is a prologue (Cook, 1997; Shakespeare, 2008; Kirwan, 2010). Drug abuse is the consumption of drug apart from medical need or use, in unnecessary or in excessive quantities (Bickel, Madden, Petry, 1998; Ali, 2013; Henkel, 2011; Steiner, 2019; National Collaborating Centre for Mental Health (UK), 2008). The misuse of drugs has penetrated every part of the world and increased in a greater pace with no limits. It is a chronically relapsing disorder that affects millions of people around the world and is characterized by compulsive use of addictive substances (Leshner, 1997; Brown, 1998; George & Nora, 2010; Cunningham & McCambridge, 2012). Drug misuse is the use of drugs for the purpose or conditions for which they are not suitable choice or even if they are suitable choice but used in improper dosage (WHO, 2000; WHO, 2006; Zhan et al., 2001; Kasprzak, 2000). Since, prehistoric time’s humans have used mind-altering plants (Siegel, 2005; Guerra-Doce, 2015). Ancient people found that consumption of some plants gave a feeling of ease, drowsiness, happiness, or peace (Baylen & Rosenberg, 2006). Some others gave a feeling of strength, stamina, alertness and, some produced different types of unusual experiences, terrifying visions, or a profoundly different consciousness (Burks, 1981; Reardon & Creado, 2014; Nichols, 2016). The main bases for which people are indulged in to drug use are: ritualistic, psychological and medical, which inducing the feeling of euphoria or to seeking freedom from the feelings of anxiety, depression, and dejection (De-Rios & Smith, 1977; Hudson, 1990; Khalily, 2001). The usage of these drugs is based upon a belief that it enhances physical wellbeing, metaphysical experiences and to heighten religious beliefs which are closely related to substance usage (Einstein, 1975; Lukoff & Turner, 1998; Mueller, Plevak, & Rummans, 2001; Weinandy & Grubbs, 2021)

Drug use and drug abuse co-existed for thousands of years without being considered as a social problem or even as bad (Erich Goode, 2008; De-Gonzague et al., 2019; Tsatsakis et al., 2019). It is only few hundred years ago that drug abuse emerged as a problem in the form of social evil (Dimeo, 2008). However, there is no doubt about the fact that drug abuse has a long political and historical background (Fang & Wang, 2008; Nichter et al. 2004). It has been rightly pointed out that pharmacology is older than agriculture (Henderson, 1988). From the dawn of the history man has exploited every root, twig, grain and other natural items for their possible use to satisfy his hunger and thirst, to cure his ailments, and also to heighten his state of consciousness, this exploitation of natural substances, at times enjoyed religious sanctity and has been also influenced by economic, political and medical considerations; (Baker, 1970; De-Rios & Smith, 1977; Mir, 1996). It takes on the magnitudes of a great global tragedy that engulfs people from every corner of the world, developing, developed and underdeveloped. No nation is new to using drugs for different purposes (Alexander, 2000; Bourgois, 2003; Kessler et al., 2009; Volkow, 2010; INCB, 2011; Chesang, 2013; Safdar, 2015; Islam & Hossain, 2017; WDR, 2018; Khanday, 2019; WDR, 2020). The drug abuse has never before posed such a challenge to the quality of life as it seems today in human history (Krug et al., 2002; US Department of Health and Human Services, 2016). In its initial stage, society does not make any type of interventions of this problem, since addiction was not of a very high magnitude and limited only to certain sections of society (Willis, 1976; Singh, 2020). The drugs that were in use in ancient times were not as harmful as they are today (Sarhan, 1995). Many problems of the drug abuse in recent years have had an impact on public discourse and have caused national and international concern, particularly among younger generation (Willis, 1976; Hsu, Lin, & Tsay, 2014; Warner, Kaufman & Grundmann, 2016; Okafor, 2020;). Substance abuse or dependence-producing substances have deleterious and damaging influences on the health of the nation, the economic prosperity of a country, corrupts the system, as also upon the stability and security of the country (Gordon, 1994; Rice, Kelman & Miller, 1991; UNDP, 1995; Manchikanti, 2007; National Drug Control Policy, 2011; National Drug Intelligence Center, 2011; Degenhard et al., 2018; NIDA, 2020). Addiction to Tobacco, alcohol and cigarette smoking is now considered a major global public health issue. The adverse effects of drug addiction can be perceived in all societies and none is immune from its negative effects (Volkow, 2014; Eric, 2017). The health implications involve the dissolution of human personality, mental disorientation and emotional derangement pushing the victim towards a fate from which there is seldom any hope of recovery (Crutchfield & Gove, 1984; Miczek, 1994; Wilson, 1995; Mørland, 2000). The most common abused drugs have a great affect in the nervous system, particularly brain is being targeted (Buttner, 2011; Madras & Kuhar, 2013). Some of these drugs are obtained from natural sources such as marijuana, opium, cocaine, mescaline, caffeine, nicotine, and psilocybin while others are synthetic or designer drugs (Onaivi, 2009; Feng, 2017). The consequences are far reaching, attacking the younger generation of a country and destroys the flower of a nation’s future (Wani, 2004).

World drug report 2021 reported that, world lost a half of million people in 2019 because of global drug abuse, and caused disorders to approximately 18 million population, mostly due to opioids (WDR, 2021). Serious and often lethal illnesses are more common among drug users, particularly those who inject drugs (Stein, 1999; Khalsa, 2008; CDCP, 2018). The illicit drug trade also continues to hold back economic and social development, while disproportionately impacting the most vulnerable and marginalized, and it constitutes a fundamental threat to security and stability in some parts of the world (Jacques & Wright, 2011; Piazza, 2011; Hanson, Venturelli & Fleckenstein, 2011). Over the past year, around 275 million people have used drugs, increased up to 22 percent from 2010. United Nations survey estimated that nearly 20 million people, mostly Asians and Africans took the cannabis drug. (WDR, 2021). The International Criminal Police Organization (Interpol) conducted a study in 1970 on drug abuse in different countries which revealed that the use of narcotic drugs and psychotropic substances had considerably increased among the young people (WDR, 2018). The United Nations Drug Control Programme reports cannabis is most widely abused/consumed substances in the world i.e. (144 million people) followed by amphetamine-type stimulants (29 million people), cocaine is used by (14 million) and opiates is used around (13.5 million people, 9 million of whom are take heroin) the total number of users who used illicit drugs was reported around 180 million people, which is equal to 3% of the world population (Wani, 2004, WDR, 2021)*.* The introduction of far more dangerous substances on the scene, such as heroin, amphetamine, Lysergic Acid Diethylamide, Methaqualone, and the increasing prevalence of miss-use of drugs even among adolescents and school-going children have brought the issue in to focus around the world (Commissaris et al., 1981; Kharmawphlang, 1996; Simpson, 1997).

The qualitative change in India’s drug abuse scenario occurred after the sixties, when new varieties of narcotic drugs (Heroin, Smack, Brown sugar, Angel dust) and psychotropic substances started surfacing on the scene (Banerjee, 1963; Ministry of social welfare, 1977; ICMR, 1977; Steiner, 2019). Media reports, research reports and other publicity materials show that a non-issue becomes a critical issue in India in the eighties (Prashant, 1993; Das, 2012). The disquieting aspects of the current drug abuse problem have considerably alters the picture of the use and abuse of narcotic and psychotropic substances (Johnston, O'Malley & Bachman, 2004). The dramatization of the drug abuse evil by the media in the eighties had the desired effect on the government (Murji, 2020). Serious introspection and planning for meaningful action, both by central and state governments was taken up and efforts started at evolving a consensus on ways and means of tackling this menace (Prashant, 1993; Ray, 1996).

The drug menace, as emerging now, has proportions of genocide, preserving the younger generation’s vitality and has to be fought by the common will of humanity (Bush, 1991; Sharma, 2017; Antonova & Polishchuk, 2019). Today there are more young addicts between the ages of 15 and 24 than ever before in the history of mankind, and according to the estimate more than three quarters of these young people live in developing countries (Gore, 2011; DeWit, Offord, & Wong, 1997; Chan, 2016; Grant & Dawson, 1997; Hingson, Zha & Weitzman, 2009; Henkel & Zemlin, 2016). Youth is a resource of the whole world and cannot undermine or ignore its potential (Koller & Verma, 2017). If the potential of youth is to be properly trapped it requires great understanding of their problems, formidable challenges and lurking dangers of drug, tobacco and alcohol abuse and addiction by giving them support (Newcomb, 1995; Belcher & Shinitzky, 1998; Saxbe, 2012; Harris, Brownell & Bargh, 2009; Sarkingobir & Dikko, 2020). The youth is indeed the most vital and vibrant section of our population and our best resource which needs to be utilized for their own optimum development and for the real progress of the nation (Chidiebere, Iloanya & Udunze, 2014; Rani, 2017; Farooq, 2017). Drug abuse and addiction has to be combated and prevented for the sake of humanity, and the explosive energy of youth and its natural curiosity are to be used to build a better world (Stanton & Shadish, 1997). Therefore, greater attention needs to be paid consistently to control, manage or mitigating drug abuse through the legal, medical, social and educational levels (Stanton & Todd, 1982; Anglin & Hser, 1990). For the sake of humanity, it has to be combated and avoided, because drug dependence is century's most challenging threat to the nation's growth, to the capacity and creativity of our generation (Kharmawphlang, 1996).

**EXISTING PHENOMENA OF DRUG ABUSE IN KASHMIR**

Drug abuse has emerged as one of the growing social problems of contemporary societies cutting across social, religious, political and economic boundaries of the global village (Pedersen, 2002; Amin, 2013; TaghiSheykhi, 2019). Since a decade, the state of Jammu and Kashmir is witnessing an increasing drug abuse scenario crippling the mental and physical wellbeing of its youth, rendering them lifeless (Sidiq et al., 2016; Manzer, Dubey & Bhat, 2017; Amin, 2013; Bhat, Rahi & Sidiq, 2015). It steadily incapacitates them, making their existence a calamity for themselves, for their family and for the whole society (Khan, 2019). Changing nature of drug abuse is worrisome as we are seeing an increase in the use of herion (Margoob et al., 2004; Rather et al., 2013). The youth who would otherwise start abusing cannabis or medicinal opioids and then would gradually shift to harder drugs are now completely shifting to heroin abuse (Naqshb, 2012; Zehra & Singh, 2021). The youth as young as 16 years of age start with the heroin abuse and rapidly shift to injectable abuse thus making them vulnerable to Hepatitis and HIV infections (Naqshb, 2012). Other than health costs, heroin drug abuse has huge economical costs thus pushing them towards petty crimes and eventually leading to drug peddling (Baba, 2013; Malla, 2019). The drug menace has cut across all social and economic strata of the society. If left unchecked, this cancer will enter into the very vitals of the society (Khan, 2019).

The state of Jammu and Kashmir and the valley in particular, has been grappling with an armed insurgency (Ganguly, 1996; Widmalm, 1997; Evans, 2000; Sikander, 2012; Ganie & Din, 2015; Rai, 2018). Incidents of violence have affected the daily lives of the population in many ways and a concern has been noted by the civil society and the government that violence is changing the social conditions of our society (Ganguly, 1996; Kaura, 2017; Faheem, 2020; Wani, Suwirta, & Fayeye, 2013). Psychiatrists and researchers in the valley believe that experiencing violence has a long term effect on one’s mental landscape predisposing one to common mental health disorders like Post-traumatic Stress Disorder (PTSD), chronic depression, anxiety (Stuart, 2003; Helfrich, Fujiura, & Rutkowski-Kmitta, 2008; Alejo, 2014). Generally, youth with such mental ailments are mostly finds their comfort from substance use (Volkow, 2005; O’Connell, Boat & Warner, 2009). Another reason for the increment of substance abuse in valley of Kashmir has been seen as easy availability of drugs, which is further linked with the geographical proximity of Kashmir valley to countries like Afghanistan, Pakistan and Iran, collectively called *Golden Crescent*, which play a major role in drug smuggling across borders of Kashmir (Prabha, 2001; Upadhyay, 2001; Naqshb, 2012; Haji, 2012; Amin, 2013; Rather, 2013; Shafi & Tabassum, 2013; Bhat, Rahi & Sidiq, 2015; Rahaman, 2014; Noor & Llah, 2015; Shafi, 2019; Malla, 2019; Adil, Farhat & Rather, 2019; Chanda, 2019).

 Kashmir is grappling with growing cultivation of opium mainly in south Kashmir (Ross, 1878; Kaul, 1997; Amin, 2013). Lush hefty fields of poppy plants can be seen in the months of April and May (Khan, 2012). Traditionally, local farmers have been cultivating poppy mainly to get the poppy seeds or “*Khash Khash”* in Kashmiri dialectic, used as bakery and other culinary items at home (Shrivastava, 2003). Young poppy pods could produce opium and opioids if incisions are made on them (Hogshire, 2004). In recent years, farmers cultivate opium for monetary reasons also while not understanding the long term consequences of it on our society. However, the police along with the excise department have started campaigns to destroy these poppy fields (Shafi, 2019).

The phenomenon of drug abuse in Kashmir has been existing since times immemorial, but in recent years it has taken the shape of an epidemic which affected the entire social structure and become one of the most threatening problem in contemporary times (Rather, 2013; Khan, 2019). Consumption of brown sugar is spreading in almost all the localities (Sidiq et al, 2016). Houseboats, hotels and tabas are becoming peddler’s paradise (Agarwal, 1995). It has been seen that tobacco, cannabis, alcohol, benzodiazepines (sleeping pills, like alprax, valium), opiates (like codeine, heroin, morphine), brown sugar, Inhalants (like fevicol SR, glue, paint thinner, petrol, shoe polish, etc.) are the major drugs abused in the state of Jammu and Kashmir (Bhat, 2015; Sidiq et al., 2016; Manzer, Dubey & Bhat, 2017; Kumar, 2021). Another report published on the occasion of the International Day against Drug Abuse and Drug Trafficking, has estimated that almost 60000 people have taken drugs for one or the other reason (Health Education Bureau, 1983). According to a survey conducted by UNDCP, there are seventy thousand drug addicts in Kashmir division alone including four thousand women, and 65% to 70% of students (UNDCP, 2008; Naqshb, 2012; Lone & Mircha, 2013; Noor & Llah, 2015; Bhat, 2017; Wani & Singh, 2017; Khanday, 2018; Wani, 2021). Government Psychiatric Disease Hospital published their statistical reports where 90% of abusers belong to the age group of 17 to 35 years with a lifetime prevalence of drug addiction (Wani & Singh, 2017). Kashmir valley has 2.11 lakh drug abusers and these figures have increased manifold in last years (Magroob, 2008). It is worth mentioning here that substance abuse is not acceptable behaviour in our society and thus the figures might only reflect the tip of the iceberg and there may be a huge hidden population of drug addicts in state (Bhat, 2015). Kashmiri young addicts would first abuse cannabis or medicinal opioids and then gradually shift to harder drugs like heroin, brown sugar. But now, many people start with heroin abuse and gradually shift from oral to injectable consumption (Gasior, Bond & Malamut, 2016; khan, 2019)). The most common substances of abuse in 2018 includes opioids 27.26%, cannabis 24.14%, benzodiazepines 2.4%, alcohol 4.17%, inhalants 11.1%, nicotine 1.55%, and poly-substances 38.9% were more predominant in the age group of 11 to 25 years (Rather, 2013; Bashir et al., 2015; Bilques et al., 2015; Farhet et al., 2015; Malla, 2019; Rather et al., 2021). A National Survey led by the National Drug Dependence and treatment centre (NDDTC) and All India Institute of Medical Sciences (AIIMS) in collaboration with Sher-i-Kashmir Institute of Medical Sciences (SKIMS) through Respondent Dependent Sampling Survey (RDSS) reported that Anantnag and Srinagar districts showed higher use of Alcohol i.e. 3.5% and Opioids 4.91%, in addition to this, cannabis were found 1.31%, benzodiazepines 1.54%, inhalants 1.22% and Hallucinogens 0.01% (Police Drug De-addiction and Rehabilitation Centre, 2019).

**PATIENTS IN KASHMIR**

There are various governmental and non-governmental NGOs/Counselling centers and De-Addiction centers in the State of Jammu and Kashmir, working hard for curbing this drug menace. (NDDTC & AIIMS, 2019; Observer, 2022). Data base provides the information of the number of patients visiting Out Patient Department (OPD) with drug related problems. People of different age groups come voluntarily or through referenced persons to these de-addiction centers for detoxification (Mangilal, Kumari & Kavitha, 2014). Drug De-Addiction Centre Srinagar, administered by Jammu and Kashmir police department received 2,521 patients in the Out-Patient Departments (OPDs) and 276 in In-Patient Departments (IPDs) (The Federal, 2020). In 2017, there were 2,981 OPD patients and 454 IPD patients. In 2018, the number of OPD cases had shown an increase to 3500 while IPD patients increased to 731 (Gowher, 2020). According to the Database of Government Medical College Srinagar, and associated hospitals, the number of patients with substance abuse visiting OPD in the year 2016-2017 was 6157 and between January 2017 and December 2017 it was 6550 (GMC, 2019). In between 2018-19, almost 46,000 patients were treated at the Shri Maharaja Hari Singh (SMHS) hospital alone, out of which more than 12,000 were treated via OPDs (Tribune, 2016; The Hindu, 2017; Kashmir Walla, 2019). In addition, there has also been a steep rise in the number of heroin addicts in the Valley; the official records of the Department of Psychiatry at SMHS hospital reveal that out of 342 people admitted to the hospital from 01 January 2019 to 20 June 2019, at least 309 patients were found to abuse heroin (Margoob et al., 2004; Rather, 2018; Wire, 2019; Mugloo, 2019; Wion, 2021; Decan hearled, 2021, 2022). Officials blame the easy availability of the drugs for the increase in the number of drug users (Naqshb, 2012; Amin, 2013). According to the estimates by Deccan Chronicle about 200 people between 15 to 30 years of age visited the de-addiction centers with severe withdrawal symptoms. Many were admitted to different wards and kept under observation, while others were sent away after the completion of complete medication and therapies (Vikram, 2019). A survey by the Ministry of Social Justice and Empowerment claims that 4.9 percent of the Jammu & Kashmir population has been abusing opioid drugs (Ali, 2019). Thus, according to the existing data Kashmir is witnessing an alarming increase in drug consumption particularly among youth, since the past three years there seems a registering jump from gradual increase to rapidly increase of all drug addicts treated at government-run facility centers (Dar, 2019).

**RESEARCH METHOD AND APPROACH**

**Research site**

Presently there are 13 de-addiction centres in Kashmir valley. These centres are administrated by both private and government organizations working for the betterment of drug addicts particularly focused upon youth. These de-addiction centres are situated across various districts of Kashmir. In the present study, the researcher has selectively taken three government-recognized de-addiction centres from three districts namely Anantnag district from south Kashmir, Barmullah district from north Kashmir and Srinagar district from central Kashmir, which were approached after the proper approval of concerned authorities. The general intent of these centres is to enable the patient to confront substance dependence and stop substance abuse to avoid the psychological, legal, financial, social, and physical consequences that can be caused

**The participants**

Research subjects consisted of 150 Kashmiri youths, within age group of 15 to 30. The above age group takes into consideration according to the official document of National Youth policy published by ministry of youth affairs. Respondents were admitted into a three inpatient/outpatient drug de-addiction centres of three districts of Kashmir valley. 50 respondents were selected from each de-addiction centre. For comparison purposes, the taken age group were divided into three age groups i.e. (15-20), (21-25) and (26-30) according to their past and current use of illicit drugs. Distribution of the age group is 15-20 (n=47), 21-25 (n=43) and among the age group 26-30 its (n=60).

Utilizing a purposive nonprobability sampling, the data collection procedure ensured a nearly equal proportion of samples (33.3% from each centre), Utilizing census data and other official records to compare the study findings with county statistics, we found no pronounced dissimilarities on several demographic descriptors from the existing scientific literature. The only exception was found, a higher incidence of ease availability or accessibility of drugs since 2015.

To enhance data validity, we avoided the usual techniques of survey methodology. Instead of obtaining data from captive subjects in rehabilitation centers, researcher conducted interviews with youngsters in informal settings, mean to say in their native language (Kashmiri) in order to avoid the language barrier that could probably affect the information. All the sample subjects were interviewed at de-addiction centers after the proper approval of the concerned authorities of those centers. Because the study focuses on illegal behaviors, we felt that the most accurate information could be obtained by contacting directly to substance abuse youths at legal and official centers.

**Data Analysis approach**

The research took the form of in-depth open ended interviews through interview schedules of approximately one hour with every respondent. With the permission of the respondents, the interviews were recorded on interview schedules, audiotape and transcribed. During the stay in de-addiction centers, the main aim in my mind is to uncover the stated variables, in order to understand patterns of drug abuse among the targeted population. The data material discussed here does not claim to be representative of a wider population. With respect to the qualitative analysis, once the interviews had been recorded, the resulting data were processed via a descriptive thematic analysis technique with an emphasis on the qualitative evaluation of the data. This involved multiple readings of the data and identifying connections, patterns, and themes within data (Braun & Clarke, 2006; Grbich, 2013). Thematic analysis can be conducted through various approaches, but the most common approach follows a six-step process which includes Familiarization, Coding, Generating Themes, Reviewing Themes, Defining and Naming Themes and Writing Up (Jack, 2019). On the similar grounds, after the collection of data, the same process is adopted in the present study in order to draw a scientific generalization.

**RESULTS AND DISCUSSION**

A study of respondent’s social characteristics forms an important aspect of a scientific research. It helps in having a close look in various aspects of the respondents. It helps in finding out the direct and indirect relation of dependent and independent variables, the impact of socio-economic conditions on the incidence of drug abuse and on the attitudes of the respondents towards a particular malady. The study of age, religion, caste, sex, domicile, marital status, educational qualification etc. prove useful in ascertaining the personalities of respondents to a greater extent and consequently their reaction towards a particular situation. Therefore, in the present study, an attempt has been made to gauge the influence of social characteristics on drug addicts, so as to make an in-depth study of causal and other compulsions leading to such addiction.

**Distribution of study subjects according to age:**

Analysis of **Table-1,** the age composition of inmates has been classified into following three categories i.e. 15 to 20 years, 21 to 25 years, and 26 to 30 years. Majority of the respondents i.e., 60 out of 150 (40%) belonged to the age group of 26-30 years, followed by 47 (31.3%) who belonged to 15 to 20 years, and 43, (28.6%) belonged to 21 to 25 years. Therefore, findings of the above table show that the age group between 26 to 30 years are more prone to addiction. (See, table-1).

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| --- |
| **(n)=Number of the Respondents, (N)= total Number of Respondents And %=Percentage of the Respondents**  |
| **Age** | **(n)** | **%** |
| 15-20 | 47 | 31.3 |
| 21-25 | 43 | 28.6 |
| 26-30 | 60 | 40 |
| **Total** | **150** | **100** |

**Distribution of study subjects according to gender:**

Analysis of the **Table-2**, the composition of gender of the inmates depicts that all the study participants are male population because of the absenteeism of female addicts in de-addiction centres. This might be a reflection of the fact that women might not seek help from drug de-addiction centres due to social taboos particularly in Kashmir. (See, table-2).

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| --- |
| **(n)=Number of the Respondents, (N)= total Number of Respondents And %=Percentage of the Respondents**  |
| **Gender** | **(n)** | **%** |
| Male | 150 | 100 |
| Female | 00 | 00.0 |
| **Total** | **150** | **100** |

**Distribution of study subjects according to Marital Status:**

Analysis of the **Table-3** depicts that majority of the respondents are belongs to the category of unmarried population i.e. 29 (68%). Followed by married population 29 (19.3%), and the rest is the divorced population which is 19 (12.6%). Obviously, discord with, or absence of a spouse seem to make much difference to the habit of drug abuse. This might reflect the fact that teenagers are more vulnerable with the experimentation of new traits in their life. (See, table-3).

|  |
| --- |
| **(n)=Number of the Respondents, (N)= total Number of Respondents And %=Percentage of the Respondents**  |
| **Marital Status**  | **(n)** | **%** |
| Married  | 29 | 19.3 |
| Unmarried  | 102 | 68 |
| Divorced  | 19 | 12.6 |
| **Total (N)** | **150** | **100** |

**Distribution of study subjects according to religion:**

Analysis of the **Table-4,** the religious composition of the drug addicts depicts that two major religions are clearly found dominant in different parts of Jammu and Kashmir, respondents were found to follow either Islam or Hinduism. Majority of the respondents i.e., 141, (94%) out of 150 respondents were Muslims and the rest 09 (6%) were Hindus. (See, table-4).

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| --- |
| **(n)=Number of the Respondents, (N)= total Number of Respondents And %=Percentage of the Respondents**  |
| **Religion** | **(n)** | **%** |
| Hindu  | 09 | 06 |
| Muslim | 141 | 94 |
| Sikh | 00 | 00 |
| **Total (N)** | **150** | **100** |

**Distribution of study subjects according to caste:**

Analysis of the **Table-5,** the distribution of caste categorization depicts that majority of the respondents i.e., 91, (60.6%) out of 150 were belonged to middle Caste. The second majority i.e., 31, (20.6%) belonged to Lower Caste and the rest i.e., 28, (18.6%) belonged to upper caste. Middle caste respondents also belonged to socially, educationally, and economically middle segment of society. (See, table-5).

|  |
| --- |
| **(n)=Number of the Respondents, (N)= total Number of Respondents And %=Percentage of the Respondents**  |
| **Caste** | **(n)** | **%** |
| Upper caste  | 28 | 18.6 |
| Middle Caste  | 91 | 60.6 |
| lower caste  | 31 | 20.6 |
| **Total (N)** | **150** | **100** |

**Distribution of study subjects according to educational status:**

Analysis of the **Table-6,** the distribution of educational status depicts that majority of the respondents i.e., 40, out of 150 (26.6%) were educated up to High School. The second majority i.e., 34, (22.6%) were Graduates. the third majority i.e., 26, (17.3%) were educated up to Primary School. Those who educated up to Senior Secondary School were 23, i.e., (15.3%) respondents out of 150. The rest i.e., 15, (10%) were post-graduates followed by 09 respondents i.e., (6%) who were educated up to middle school. the lowest number of respondents i.e., 03, (2%) could read and write *kashour* (Kashmiri dialect) but had no formal education and none of the respondents were illiterate. (See, table-6).

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| **(n)=Number of the Respondents, (N)= total Number of Respondents And %=Percentage of the Respondents**  |
| **Level of Education**  | **(n)** | **%** |
| Primary School  | 26 | 17.3 |
| Middle School  | 09 | 06 |
| High School | 40 | 26.6 |
| Senior Secondary school  | 23 | 15.3 |
| Graduation  | 34 | 22.6 |
| Post-Graduation  | 15 | 10 |
| Literate | 03 | 02 |
| **Total (N)** | **150** | **100** |

**Distribution of study subjects according to occupational status:**

Analysis of the **Table-7,** the distribution of the occupational status depicts that majority of the respondents i.e., 58, out of 150 (38%) were student. The second majority i.e., 52, (34%) were self-employed. The third majority i.e., 20, (13.3%) were labourer. This was followed by 12, i.e., (8%) were employed in private section. The rest i.e., 8, (5.3%) were government employee. (See, table-7).

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| --- |
| **(n)=Number of the Respondents, (N)= total Number of Respondents And %=Percentage of the Respondents**  |
| **Occupation**  | **(n)** | **%** |
| Government Employee  | 08 | 5.3 |
| Private Job  | 12 | 08 |
| Self Employed  | 52 | 34 |
| Labour  | 20 | 13.3 |
| Student | 58 | 38.6 |
| **Total (N)** | **150** | **100** |

**Distribution of study subjects according to place of residence:**

Analysis of the **Table-8,** the distribution of the residential areas depicts that respondents belonged to three districts of Kashmir valley and their adjoining areas, where majority of the respondents came from the places of urban setting i.e. 90, 60% fallowed by 60, i.e. 40% percent of the respondents from rural setting. (See, table-8).

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| --- |
| **(n)=Number of the Respondents, (N)= total Number of Respondents And %=Percentage of the Respondents**  |
| **Place of residence** | **(n)** | **%** |
|  Urban  | 90 | 60 |
| Rural  | 60 | 40 |
| **Total (N)** | **150** | **100** |

**DISCUSSION OF PRIMARY DATA**

The present study examined the influence of selected variables such as age, gender, caste, religion, marital status, educational status, occupation and place of residence on the behaviour of drug addicts admitted in de-addiction centres. The analysed sample was consisted of 150 respondents of past and current drug users. The age composition of the respondents were 15 to 30 years, which in India, is the official age group of youth defined by the National Youth Policy document published by Ministry of Youth Affairs 2014. The age group of 15-30 is divided under three subsets, in order to find out the dominant age group that falls into the trap of drug addiction. The proportional distribution of age group 15-30 is (15-20, n=47, 31.3%), (21-25, n=43, 28.6%) and (26-30, n=60, 40%). Majority of the respondents i.e., 60 out of 150 (40%) belonged to the age group of 26-30 years, followed by 47 (31.3%) who belonged to 15 to 20 years, and 43, (28.6%) who belonged to 21 to 25 years. The study of Maruf, Khan & Jahan (2016) substantiates the findings in this context. Data of the present study is in conformity with the earlier findings that age group between 26 to 30 years are more prone to addiction. It also brings out that, this age group is the most active age group of the general population in which environmental influences are more pronounced. Another variable is gender, which is defined as a system of social organization with a set of behavioural prescriptions that are believed to follow biological characteristics. These perceptions of gender are socially constructed and shaped by socio-cultural structures and processes over time (Sterling, 2012). In the present study all of the 150 respondents were male and there were no female. This might be a reflection of the fact that women might not seek help from drug de-addiction centres due to social taboos. This statement is supported by one of an earlier study conducted by National Institute on Alcohol abuse and Alcoholism where they highlighted that women are more likely than men to face multiple barriers to accessing substance abuse treatment and are less likely to seek treatment.Secondly, women might not have reached a state of addiction where they needed the drug de-addiction centre’s solace. The marital status of the drug-dependents was categorized into married, unmarried and divorced. Results shows that majority of the respondents belongs to the category of unmarried i.e. 68 percent and the percentage of marred addicts was 19.3 per cent, followed by divorced which is 12.6 percent. The figures of this section reflects the fact that the population of unmarried group are more prone to abuse illicit drugs because of the curiosity of experimentation with illicit drugs typically begins during the teenage. The findings of this variable is consistent with the study of [SAMHSA, 2008](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3025448/#R195); Chen & Kandel, 1995. From the very beginning religion has been found to be a protective factor against any deviant act of an individual. There may be a prohibition for an act in a particular religion but at the same time, it may not be considered as a deviant act in another religion. According to census 2011, the total population of district Srinagar is 1,236,829 out of whom (95.19%) are Muslims and (3.44%) are Hindus. The population of district Anantnag is 1,078,692 out of whom (97.99%) are Muslims and (1.22%) are Hindus and the district Barmullah has 1,008,039 population, out of whom (95.15%) are Muslims and (3.4%) are Hindus. Therefore, two major religions are clearly dominant in different parts of Jammu and Kashmir. However, in terms of total population, Islam dominates the Kashmir valley with 68.31% followed by 28.44% which are Hindus (Census, 2011). In the present study, respondents were found to follow either Islam or Hinduism. Majority of the respondents i.e., 141, (94%) out of 150 respondents were Muslims and the rest 09 (6%) were Hindus. The findings of this study is consistent with the study of Arfken & Ahmed, (2016). However, it can be said that religion has ceased to have much control over an Individuals behaviour and deviance. It seems to weaken the social fabric and lessen the control mechanism that religion traditionally exercised over society. Being a part of the broader Indian social system, the society of Kashmir has also been affected by traditional caste system, where Muslims dominate the broader area of society and are stratified on the basis of caste. In the present study caste categorization mentioned by Dabla (2012) and Wani (2013) in study of social stratification among Muslims in Kashmir is adopted. They revealed three-fold divisions of caste in Kashmir, i.e., Upper Caste, Middle Caste, and Lower Caste. The upper caste consists of Syeds, Piers, Baghdadi, Ulemas, and Sheikhs. Wattal, Waza, Chopan, Ganai, Dobi, Hajjam, Hanji are at the bottom of the hierarchy, and the rest of the castes occupy the middle position in the caste hierarchy. In the present study, majority of the respondents i.e., 91, (60.6%) out of 150 were belonged to middle Caste. The second majority i.e., 31, (20.6%) belonged to Lower Caste and the rest i.e., 28, (18.6%) belonged to upper caste. The finding of this variable is consistent with the study of Sharma (1996) in sociocultural perspective of substance use in India, where he also highlighted that fact that middle caste people are more vulnerable to drug addiction. In relation to education, which is the milestone of a nation’s development provides knowledge and skills to the population, as well as shaping the personality of the youth of a nation. Education plays an important role in determining the values, attitude, behaviour, and living conditions of an individual (Idris et al, 2011). In the present study respondents had different educational level which is divided as, Primary School, Middle School, High School, Senior Secondary School, Graduation, and Post-graduation. Majority of the respondents i.e., 40, out of 150 (26.6%) were educated up to High School. The second majority i.e., 34, (22.6%) were Graduates. the third majority i.e., 26, (17.3%) were educated up to Primary School. Those who educated up to Senior Secondary School were 23, i.e., (15.3%) respondents out of 150. The rest i.e., 15, (10%) were post-graduates followed by 09 respondents i.e., (6%) who were educated up to middle school. the lowest number of respondents i.e., 03, (2%) could read and write *kashour* (Kashmiri dialect) but had no formal education. None of the respondents were illiterate. In this regard, findings of the present study are consistent with the findings of Lal (2011) where he also disclosed that majority of the drug addicts were educated up to high school. However, the findings are inconsistent with the work of Kubica (1990) & Sethi (1979) based on secondary sources, were they found that majority of the inmates were illiterate. A study of the occupation of the respondents gives a better understanding of their economic status and living conditions which are reflected in their behaviours (Roberts & Lee, 1993). It is believed that the occupation of a person has a due impact on his other spheres of life. The nature of occupation determines the relationship with the family as well as with society. Sometimes parental occupation provides less space for proper socialization of their children which can lead to deviant behaviour (Amin, 2013). In the present study respondents were found to be either, Government Employee, Private employee, Self-employed, Labourer or Student. Majority of the respondents i.e., 58, out of 150 (38%) were student. The second majority i.e., 52, (34%) were self-employed. The third majority i.e., 20, (13.3%) were labourer. This was followed by 12, i.e., (8%) were employed in private section. The rest i.e., 8, (5.3%) were government employee. In this regard, findings of the present study are consistent with the findings of Amin (2013) where majority of the respondents were found students. However, it can be said that youth spend much of their time in educational institutions where officials can provide knowledge and tools to prevent and reduce involvement of youth towards drug abuse and should provide an appropriate environment to implement prevention programs that seek to reduce the risk factors and increase the protective factors of substance use and abuse among youth. Finally, the population of the world has their own ways of living with distant places, living lifestyles may be different but every society has its own place of residence. Some people live in rural areas, some live in urban areas and, some reside in semi-urban or in semi-rural areas. Youth from different residential contexts may be more or less vulnerable to drug abuse because they are exposed to different levels of risk and protective factors for drug use and/or because the magnitude of the associations between risk and protective factors, drug abuse varies across residential contexts due to environmental dissimilarity (Rhew et al, 2011). In the present study, respondents belonged to three districts of Kashmir valley, each district is divided on the basis of rural-urban continuum. It has been found that majority of the respondents came from the places of urban setting i.e. 90, 60% fallowed by 60, i.e. 40% percent of the respondents. The section of residence indicated the fact that exposure towards illicit drugs are more in urban areas than rural areas. Ompad & fuller (2005) also reported in their study “The Urban Environment and, Drug Use and Health” that the drug abuse has a strong relationship with the environment of urban setting.

**Conclusion**

From last twenty years, the valley of Kashmir has been grappling with an armed insurgency. Occurrences of violence affected the daily lives of the population in many ways and a concern has been noted by the civil society and the government that violence is changing the social conditions of our society. In general population, norms and values of the society regarding drug abuse have become less favourable to the excessive consumption of illicit drugs. Unfortunately, the abuse of illicit drugs has remained stable or increased very rapidly, as indicated by de-addictions and treatment centres. It seems that the use of illicit drugs is becoming concentrated in high-risk groups. Therefore, the above findings show the importance of public participation and rehabilitation centres in preventive strategies. These findings may become ground for the drug professionals in order to prevent the predicted subjects from this deadly menace. If communities, health professionals, official members are to become protective pathways for healthy environment, they must have to take responsibility for addressing, prioritizing and identifying risks in the society and for implementing preventive strategies in order to reduce the prominent risks and boost the environment of social integration and attachment to the community standards. Preventive strategies seeking to reduce the occurrence of drug abuse among those who are at greater risk should focus on the development of influential cognitive, social skills and social bonding from the very beginning and should promote the strong societal standards in response to drug abuse.

**Acknowledgements**

We are very thankful to the staff of Government De-Addiction centers of Kashmir valley, India, for their great cooperation and help. We are also thankful to the admitted drug patients who agreed to take part in our study.

**Conflicting Interests**

None declared

**Author Details:**

Sumbl Ahmad khanday: Ph.D Research scholar, Department of Sociology, Aligarh Muslim University, India.

**Funding information**

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

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**Corresponding Author:** Full name of Corresponding author (Dr. Sumbl Ahmad Khanday)