MENTAL HEALTH STATUS OF TRIBAL -A REVIEW

Dr. Namita Sinha
Ph.D. in Psychology
Magadh University Bodhgaya

Abstract

Tribal are the most marginalized social category in the country and there is little and scattered information on the actual burden and pattern of illnesses they suffer from. Tribal communities in general and primitive tribal groups are prone to disease. Also, they do not have required access to basic health facilities. They are most exploited, neglected, and highly vulnerable to diseases with high degree of malnutrition, morbidity and mortality. Researches on mental health of tribal are not much in numbers. Few studies made on them have produced inconsistent results. The aim of this study is to assess the mental health status of tribal communities. It was found that due to lack of appropriate mental health services in the rural areas the tribal population is unable to access the needful service and treatment. There is need to develop psychosocial care program for tribal to promote the positive social, physical, psychological and emotional wellbeing.

Keywords: Mental health, Tribal, Health facilities, Vulnerable, Mental health services, Psychosocial care program.

Introduction:

Mental health is described as some- thing more than a mere absence of mental disorders. Mental Health refers to a state of mind which is characterized by emotional well-being, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life (Bhagi,1992).

WHO defined “Health is a state of Complete Physical, Mental, Social and Spiritual well-being and not merely the absence of disease or infirmity”. The concept of mental health includes subjective well being perceived self-efficacy, autonomy, competence and recognition of the ability to realize one’s intellectual and emotional potential. It has been also defined as state of well-being whereby individuals recognize their abilities, or able to cope with their normal stress of life, work productivity and fruitfully contribute to their communities (Agarwal, 2007).

.

Mental health is one of the biggest causes of disability and carries enormous economic burden in India. It is estimated, from the recently reported National Mental Health Survey (2016) that one in every ten Indians is

suffering from some form of mental disorder. Especially in productive age of 20 to 40 years, prevalence of mental disorders is very high. India is home to the largest tribal populations of the world, with 8.6% of total Indian population belonging to Scheduled Tribes who constitute 705 tribal groups across India. The tribal populations have greater vulnerability to mental health issues for multiple reasons. The impact of rapid social changes alters their lifestyles, beliefs and community living. The strain of acculturation to moving to urban spaces and use of alcohol and other substances predisposes them to several mental health issues. There has been research in the broader field of mental health, carried out in India. However, mental health of tribal populations is something that has been neglected till now and needs our attention. The Indian Psychiatric Society stresses the lack of data on mental health of tribal populations and the need for conducting more research to bridge the gaps in knowledge.

There have been various initiatives taken in tribal mental health through formation of Ministry of Tribal Affairs in 1999, formation of National Commission for Scheduled Tribes in 2004, UN Declaration of Rights of Indigenous Population in 2007, there has not been much evidence generated about the mental health morbidity, mental health needs of this population, strategies to approach ST communities for service delivery, and monitoring or evaluations of any ongoing programs or those completed recently

Researches on mental health of tribal are not much in numbers. Few studies made on them have produced inconsistent results (Bhaskaran et. al., 1970; Dewan, 2009d; 2010c; Mahanta, 1979; Srivastava et. at., 1981; Verma, 1973; Wig, 1981 .

International Institute of Population Sciences (2007) reported that among the scheduled tribes or Adivasis (tribal) of India, mortality, morbidity and malnutrition rates remain particularly high when compared to the Indian population at large. Dispensation of health care services to this population, however, by the government and private sector alike, is disproportionately lacking (Ministry of Health and Family Welfare. 2002).

Ali & Eqbal (2016) found that A total of 780 male students, 5.12% of the tribal students were having emotional symptoms, 9.61% of the tribal students were having conduct problems, 4.23% of the students were having hyperactivity and 1.41% of the tribal students were having significant peer problems The objective of this study was to screen possible psychiatric disorders, using the Strengths and Difficulties Questionnaire (SDQ), in tribal adolescents of Ranchi district, Jharkhand, India. Venu Gopal and Ashok (2012) investigated the prevalence of emotional and behavioral problems among tribal and non-tribal adolescents and high prevalence of anxiety/depressed, somatic, withdrawn/depressed, thought problems and attention problems in the tribal adolescents.

Mathias, Goicolea, Kermode, Singh, Shidhaye & Sebastian (2015) found that for decades, Indian national policy has sought to legislatively benefit SC and ST, for example, the Reservation in Admission Act 2006 and

the Protection of Civil Rights Act 1955. Despite such measures, and even after controlling for socioeconomic status (years of schooling, housing quality, indebtedness), members of SC and ST groups in this study had more than twice the risk for depression compared to the General Caste. ; It is likely that persisting social structures of exclusion and discrimination are more penetrating than legislation, and that they continue to create relative deprivation, reduce agency and exclude people.

But Satyanarayana et al (2017) found that the prevalence of anxiety disorders was 26.3% in urban participants, 23.7% in tribal high school participants and 18% in rural high school. The prevalence of major depressive disorder in the present study was highest among urban high school participants i.e. 4.1% compared to 3.5% in rural and 1.6% in tribal. The prevalence of suicidality among this study participants was highest among rural high school participants (6.5%) to urban 6.2% and least in tribal (3.2%). The prevalence of ADHD (Attention Deficit Hyperactive Disorder) in this study was highest among urban high school participants i.e. 4.1% compared to 2% in rural and 2.2% in tribal. As children with ADHD mature in adolescence, leads to academic failures, demoralization, poor self-esteem, high rates of injuries, substance abuse and delinquency.

Dewan, R. (2012) found that only ethnicity is associated with mental health of tribal school teachers. Tribal seem to have better mental health than non-tribal. The finding collaborates earlier researches showing the relationship of mental health of individuals with their ethnicity (Bhaskaran, et. al., 1970; Dewan, 2009d; 2008a; Hassan,1986; Mahanta, 1979; Murphy, 1993 Srivastava et. at.,1981; Verma, 1973; Wig,1981). She also found insignificant effects of marital status on mental health of tribal and non-tribal school students. However, some studies have indicated that married women lag un-married women in mental health (Booth et. al, 1984; Fanous et. al, 2002), while others have confirmed the finding of present research ((Davar, 1999; Dewan, 2010c). Stress has also not found any significant effect on mental health of married and non-married tribal and non-tribal school teachers‟ sample. There are researches to indicate that mental health is affected only by very high stress ((Jamal & Baba,2000; Rai et. al., 1977; Singh and Dubey, 1977)

The round table meeting was hosted on 28th August 2017 by The George Institute for Global Health India in partnership with other organizations. The round table meeting facilitated dialogue around various aspects of tribal mental health focusing on issues related to lack of data and research in tribal mental health and the importance of bringing this neglected community into the mainstream. Some topics touched upon were service needs of the tribal community, the role of socio-economic development in tribal communities that affect mental health and the need for strengthening the evidence base for bringing in policy changes and practice around mental health in Scheduled Tribe communities.

Data from a research conducted by The George Institute for Global Health India, in the West Godavari district of Andhra Pradesh shows that almost 5% population in Scheduled Tribe Areas in the region suffer from common mental disorders like stress, depression, anxiety and suicide risk. The data generated from the **Systematic Medical Appraisal, Referral and Treatment (SMART) Mental Health Programme**, also suggests that the mental disorder burden among tribal in the West Godavari district of Andhra Pradesh are similar to populations in other rural areas in the region. The concept of the SMART Mental Health interventions was to bring in innovative models of healthcare delivery to bridge the gap in service provision and use the power of mobile technology to reach out to remote areas and develop applications which can be used by lay health care workers or primary care doctors with limited mental health training.

Some key outcomes of the intervention were:

- Mental health services use increased from 0.8% to 12.6%
- Depression and anxiety scores amongst those who were screen positive reduced significantly the following intervention
- ASHAs were able to follow up on 80% of screen positive cases
- Use of mobile health to provide mental health services were appreciated by all stakeholders
- ASHAs felt empowered by the training and took initiatives of their own to motivate people to seek care

Stakeholders at the roundtable discussed that data, research and services for mental health need to be vastly improved in the country so that the mental health problems of the community can be addressed in a better and effective manner.

Some of the key recommendations given during the roundtable were:

- Identifying research questions subsequently leading to the formation of a task force
- Bring in new innovative models of service delivery such as utilizing ASHA workers for preliminary screening and referral
- Bring in technology intervention for better screening and decision making
- Bring in a culturally relevant model of healthcare delivery.

Tribal Communities and Mental Health – Key Challenges and Issues Prof. R.S. Murthy (Retd.), National Institute of Mental Health & Neuro Sciences (NIMHANS), shared the key challenges faced by tribal communities related to loss, trauma, alienation. Prevalence estimates from past research hint at increased alcohol and substance use, high suicide rates, risk of depression and intimate partner violence. He stressed on:

• Developing universal, targeted and person-focused interventions,

• The gaps in knowledge and the need to conduct participatory research,

• Understand local perceptions about mental health and help-seeking,

• Identify risk factors and ascertain the role of larger environmental and government policies on mental health, and

• Identify appropriate interventions, were some of the key points that need to be addressed through future research

He also mentioned the need for development of a community-based approach including self-care techniques to provide mental health services and to document and disseminate evidence.

Conclusion

It was found that the tribal had significantly higher proportion of mental problem than non-tribal. There is a need for universal health coverage with preferential care for the tribal. There is a prevalence of emotional and behavioral problems in tribal adolescent population. There is lack of appropriate mental health services in the rural areas and tribal population is unable to access the appropriate service and treatment. There is need to develop psychosocial care programmed for adolescent to promote of positive social, physical, psychological and emotional wellbeing appropriate to their cultural context.

References:

Agarwal, M. L. (2007). Economic Aspects of the Mental Health System and Mental Health at Work Place. *Industrial Psychiatry Journal*. 16 (2), 63-72.

Ali A, Eqbal S. Mental health status of tribal school going adolescents: a study from rural community of Ranchi, Jharkhand. *Telangana Journal of Psychiatry* 2016;2(1):38-41.

Balgir RS. Dimensions of rural tribal health, nutritional status of Kondh tribe and tribal welfare in Orissa: a biotechnological approach. Proceedings of the UGC Sponsored National Conference on Human Health and Nutrition: A Biotechnological Approach (Lead Lecture), 12-13th December 2004. Thane. pp. 47-57.

Bhagi, M. and Sharma, s. (1992). Encyclopaedic Dictinary of Psychology, New Delhi: *Ammol Publication.*

Bhaskaran, K., Seth, B.C. and Yadav, S. N. (1970). Migration and Mental Ill Health in Industry. *Indian Journal of Psychiatry*. (12), 102-116.

Booth, A., Johnson, D. R., White, J. N., & John, N. E. (1984). "Women, Outside Employment and Marital Instability". *American Journal of Sociology*. 90:567-83

Davar, B. V. (1999). Mental health of Indian Women: A Feminist Agenda. Sage, New Delhi.

Dewan, R. (2012). Stress and Mental Health of Tribal and Non-Tribal Female School Teachers in Jharkhand, INDIA. *International Journal of Scientific and Research Publications,* 2(10), 1012-1015.

Dewan, R. (2010c). Effects of Religion, Age and Marital Status on Mental Health of Tribal Female Factory Workers in Jharkhand. Women's Link, 16 (1), 26-29.

Dewan, R. (2009d). Impact of Gender, Stress and Marital Status on Mental Health of Tribal Teachers of Ranchi University in Jharkhand", *Research Journal of Social Sciences and Humanities,* 6 (1), 1-12.

Dewan, R. (2008a). Women Empowerment and Health Modernity: A Socio-Psychological Study of Tribal and Non-Tribal in Jharkhand'. *Journal of Economic and Social Development*. 4 (1 & 2), 62-78.

Deivasigamani TR.Psychiatric morbidity in primary school children: An epidemiological study. *Indian J Psychiatry*, 1990;32:235–40.

Development MoHR. Central educational institutions (reservation in admission) act. India: Ministry of Human Resource Development, 2006. 37.

Empowerment MoSJa. Protection of Civil Right Act. PCR 1955. India, 1955. 38. Patel

Fanous, A., Gardener, C. O., Presscott, C., A., Concron, & Kendler, K. S. (2002). Neuroticism Major Depression and Gender: A Population Based Twin Study. Psychological Medicine. (32), 719-728.

Hassan, M.K. (1986), Impact of Industrialization on Mental Health of Tribal, Social Change, vol. 16 (4), 30-33.

International Institute of Population Sciences. National Family Health Survey 2, 1998-99. Online. Accessed 30 June 2007. [www.nfhsindia.org/india2.html].

Jamal, M. & Baba, V. V. (2000). Job Stress & Burnout among Canadian Managers & Nurses: An Empirical Examination. *Canadian Journal of Public Health*, Nov / Dec. [

Kessler RC, Berglund PMBA, Demler O, et al. Life time prevalence and age-of-onset distributions of DSM-IV disorders in the National Co morbidity Study Replication. Arch Gen Psychiatry,2005;62(6):593-602.

Mahanta, J. (1979). Mental health and achievement motivation of Juang tribe in changing socio- cultural setting. Unpublished Ph.D. Thesis, Bhubaneswar: Utkal University

Mathias,K., Goicolea,I., Kermode,M., Singh,L., Shidhaye,R. & Sebastian,M.(2015). Cross-sectional study of depression and help-seeking in Uttarakhand, North India. *BMJ Open*,5.

Ministry of Health and Family Welfare. 2002. National Health Policy.

Murphy, J. M. (1973). Socio-cultural change and Psychiatric disorder among rural yourubas in Negeria, Ethos. (1) 239-262.

Sarkar AB, Kapur M, Kaliaperumal VG. The prevalence and pattern of psychological disturbance in school going middle childhood children. NIMHANS J, 1995;13:33–41. 15.

Sarkhel S, Sinha V.K., Arora, M., Desarkar, P. (2006). Prevalence of conduct disorder in schoolchildren of Kanke. *Indian J Psychiatry*, 48(3),159-64.

Satyanarayana, P.T., Prakash, B., Kulkarni, P., Kishor, M., & Renuka, M. A. (2017). comparative study of prevalence of mental abnormalities among high school children in tribal, rural and urban Mysuru district, Karnataka, India. *Int J Community Med Public Health*, 4,809-813.

Singh, R. & Dubey, G. P. (1977). Psycho-social, stress in certain psycho somatic diseases. Paper presented at the International Seminar on Stress in Health and Diseases, Banaras Hindu University, Varanasi.

Srivastava, R. K., Shobha, S. and Seth, M. (1981). Culture contact and adjustment patterns of Tharu tribal girls in India International Association for Cross-Cultural Psychology (Abstracts) Bhubaneswar: Utkal University. [31]

Venkata JA, Panicker AS. Prevalence of Attention Deficit Hyperactivity Disorder in Primary School Children. *Indian J Psychiatry*, 2013;55:338-42.

Venu Gopal D.V. and Ashok A. Prevalence of Emotional and Behavioral Problems among Tribal and Non-tribal Adolescents. *Journal of the Indian Academy of Applied Psychology*, 2012;38(1):63-67.

Verma, L. P. (1973). Mental disorders among the Adivasis. *Journal of Clinical Psychiatry*, 1, 21-29. [32]

WHO. Child Mental Health Atlas. Geneva, Switzerland: WHO, 2005. Available on-line at: http://www.who.int/mental_health/resources/Child_ado _atlas.pdf

Wig, N.N. (1981). Incidence of severe mental illness in India: no less than West. Medical Times, 1, 1.