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Expert Opinion Article

Socio-Cultural Determinants of Drug Dependence and Mental Health Vulnerabilities in Tribal Youth Populations of Arunachal Pradesh

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Abstract
Drug abuse and substance use disorders (SUDs) continues to be a significant issue in Arunachal Pradesh, India worsening the public health challenges associated with mental health especially among the youths. This article explores the links between these challenges, particularly focusing on socio-cultural and economic factors. It delves into their underlying causes and consequences, highlighting the necessity for customized, integrated approaches that cater to the region's specific needs, supported by local case studies. This review employs a narrative synthesis approach, drawing data from government reports, scholarly journals, government diaries, and rehabilitation centre reports focusing on publications in the last two decades.

Keywords: Substance abuse disorders, Arunachal Pradesh, mental health, integrated treatment, tribal youth.

Introduction:

Mental illness and drug use frequently appear together worldwide, creating a complex and dangerous health situation. It is not unusual for individuals with a mental health diagnosis or condition to also have an addiction or substance use disorder, or for those with a substance use disorder to also have mental health issues.

Sometimes, those with mental illness use substances to self-medicate or cope with their mental health condition. Conversely, people might reach for alcohol, opioids, or cannabis just to get through hard moments. Yet using these substances shifts how the brain works, makes symptoms worse, and sometimes tips the balance toward long-term dependence.

On the other hand, long-term substance abuse interferes with neurobiological systems, leading to the onset or exacerbation of psychiatric disorders. Called dual diagnosis, this gets settings, leading to more deaths by suicide or overdose while straining communities worldwide.

According to the World Health Organization, around 700,000 people take their own lives annually because of such conditions; total financial burdens run into billions (WHO, 2023). In low- and middle-income countries, the lack of access to integrated care further complicates matters, leading to underdiagnosis and poor health outcomes.

While the relationship between substance use disorder and mental illness is not fully understood, the two conditions are quite common and typically referred to as 'co-occurring.' One condition may also predispose someone to the other. That crossroads exists because substance use disorder and mental illness share common risk factors.

In India, the issue has reached terrifying proportions particularly in the North Eastern states, which are also trying to live with the intricacies of drug trafficking, addiction of youngsters, and inadequate support to rehabilitate the victims (Boro, 2024) The geographical position of the region, which borders the Golden Triangle (Myanmar, Laos, Thailand) one of the world centers of the production of narcotic substances, increases its rank as the high-risk area of inflow and spread of narcotic substances (Charlson, 2016).[1] Drug abuse has been implicated as one of the significant contributors to mental health issues in the North-Eastern region of India, apart from poverty, insurgency, political violence and superstitious beliefs and lack of infrastructure and trained professionals.

The influence of social customs, traditional practices and the strategic geographical location of Arunachal Pradesh could be some of the reasons for the higher incidence of substance use disorders. Alcohol is socially accepted and widely used in local tribal

[1]Nisha Agarwal, Khoda Meena, An Analytical Study on the Alarming Rise of Drug Addiction and Substance Abuse in North-East India, july 2025 International Journal for Multidimensional Research Perspectives vol.3(issue 7):95-107 DOI:10.61877/ijmrp.v3i7.295 p.95.

festivals and traditional rituals in the North-Eastern states of India, including Arunachal Pradesh. There is a customary brewing of homemade alcohol associated with local festivals and religious practices among the tribal population of the region, which gives rise to an early exposure to alcohol.[2] Hence, early exposure in childhood could be a strong predictor of alcohol dependence in adulthood, which could be another contributor to the higher incidence of alcohol dependence. In addition to these, socio-economic conditions and pressures, political unrest, peer-pressure and unemployment especially among the youths might lead to substance abuse disorders and eventually leading to conditions like depression, anxiety, schizophrenia, bipolar disorder, etc.

The consequences of these issues affect individuals, create disruptions within families, and place burdens on society in terms of crime and economic losses. Atonu Choudhuri reported in the leading newspaper 'The Telegraph' on 30–31 May 2007 that Arunachal Pradesh's drug problem was reaching 'alarming proportions,' transitioning from traditional, long-term homegrown opium addiction to newer, more dangerous narcotics. While opium had been used in rural areas for generations, it was being replaced by heroin and brown sugar, particularly in urban areas. The report highlighted that young people were turning to these new-age narcotics for 'fun' or recreational use.

There was a noted increase in the consumption of drugs via smoking and injecting. The report noted that anti-narcotics efforts at the time were primarily focused on supply, with limited treatment options for addicts.[3]

An epidemiological study has highlighted that high early alcohol initiation (mean age 12.4 years) in years among tribal youth reflects strong cultural acceptance, with underage drinking influenced by ethnicity, geography, and socio-cultural norms.[4] An earlier assessment, which presented only inter-state variations, found that Arunachal Pradesh had the highest prevalence of underage drinking among all 28 Indian states. High alcohol use is associated socio-cultural practices among diverse communities in Arunachal Pradesh.

[5] This includes the custom of drinking *apong*, a local alcoholic fermented rice-based beverage that is accepted for mass consumption as a celebration during rituals, ceremonies, religious events, and harvest festivals.[6] Cultural norms and family practices play a pivotal role in shaping adolescents' attitudes toward alcohol.

Additionally, peer clustering of risky behaviors, such as tobacco use, significantly increases the likelihood of alcohol use among adolescents.[7] Educational and economic disparities across districts (e.g., Kurung Kumey, Tirap) may further exacerbate vulnerability through limited opportunities and psychosocial stress.[8] Parental alcohol consumption and cultural modeling of drinking also play a significant role in normalizing underage drinking within households and communities.[9]

These factors, underline the importance of targeted, culturally grounded interventions tailored to the unique profiles of each district.According to the Arunachal Pradesh disease burden, profile-1990 to 2016, depressive disorder, anxiety disorder and schizophrenia were among the top 15 causes of Years Lived with Disability (YLDs). Tobacco, alcohol and drug use were the constant risk factors for most deaths and disabilities from 1990 to 2016, which were found more among males. Psychiatric disorders were one of the leading causes of disability and mortality.[10] Substance abuse disorders are the most

[2] Alee NT, Hasan A, Aijaz A. Mental health and psychological problems in north east India. International Journal of Social Sciences Review. 2018;6: pp.817–820. [Google Scholar]

[3] Bhattacharya Debraj, Chaudhuri D.N.,Ghosh Buddhadeb, A community battles drug addiction a case study of Bordumsa Anchal Samiti, Arunachal Pradesh. (Ministry of Panchayat Raj, Government of India by Institute of Social Sciences.) p.19

[4] Chaturvedi HK and Mahanta J. Sociocultural diversity and substance use pattern in Arunachal Pradesh, India. *Drug Alcohol Depend* 2004; 74(1): pp.97–104.

[5] Shrivastava K, Pramanik B, Sharma BJ, et al. Ethnic fermented foods and beverages of Arunachal Pradesh. In: Tamang J (eds) *Ethnic fermented foods and beverages of India: Science History and Culture*. Singapore: Springer, 2020, pp.41–84.

[6]Chaturvedi HK, Bajpai RC and PandeyA. Predictors of substance use in the tribal population of Northeast India: Retrospective analysis of a cross-sectional survey. *J Addict Res Ther* 2016.

[7]Chaturvedi HK, Bajpai RC and Tiwari P. Association of religion and cultural tradition with alcohol use among some tribal communities of Arunachal Pradesh, India. *Journal of Ethnicity in Substance Abuse* 2019;18(2): pp.296–308. https://doi.org/10.1080/15332640.2017.1355766

[8] Parmar A, Bhatia G, Sharma P, et al. Understanding the epidemiology of substance use in India: A review of nationwide surveys. *Indian Journal of Psychiatry* 2023;65(5): pp.498–505.

[9] Mahanta B, Mohapatra P, Phukan N, et al. Alcohol use among school-going adolescent boys and girls in an industrial town of Assam, India. *Indian J Psychiatry* 2016; 58(2): p.157.

[10] Kena , Bagra , Doke , Yubeya , Kothapallic, Patterns of Psychiatric Illness in a Tertiary Care Centre of Arunachal Pradesh: An Observational Study MAEDICA – a Journal of Clinical Medicine 2022; 17(3): pp.628-635

frequently observed patterns of psychiatric illness (77.63%), followed by anxiety disorders (6.19%), psychotic disorders (5.12%), mood disorders (1.88%) and organic psychosis (0.54%). In terms of dual diagnosis, alcohol dependence and schizophrenia (3.77%) were most frequently observed, followed by tobacco dependence and schizophrenia (2.16%). The majority of those with substance abuse had opioid dependence (43.93%), followed by alcohol dependence (29.92%) (Figure 1).

[11] Substance abuse was found to be higher among the younger age group (72.57%), followed by the middle age group (22.22%) and older age group (5.21%) (Table 1). [12]Among the patterns of psychiatric illness, substance abuse (83.50%) was more common in males, followed by those with dual diagnosis (7.74%) and anxiety disorder (3.70), whereas in females, substance abuse (54.05%) and anxiety disorders (16.21%) were the most commonly encountered conditions (Table 2).[13]

The pattern of psychiatric illness burden was more common among people with the indigenous faith belief system than other religions. Among different faith and religions, substance abuse was found to be more common among people following the indigenous faith (89.81%), followed by Christians (76.22%) and Hindus (69.44%).[14]

According to the Magnitude of substance use in India 2019 report, the male and female ratio for alcohol dependence was 17:1.

A high prevalence of alcohol dependence (7.2%) was reported in Arunachal Pradesh compared to the national average of 2.7%. Opioid dependence was also reported to be higher in Arunachal Pradesh (2.65%) than the national average of 0.26%. A previous study of household survey in Arunachal Pradesh showed a higher prevalence of opioid use among males (10.26%) as compared to females (2.1%).

Figure 1: Pattern of psychiatric illness among study cases

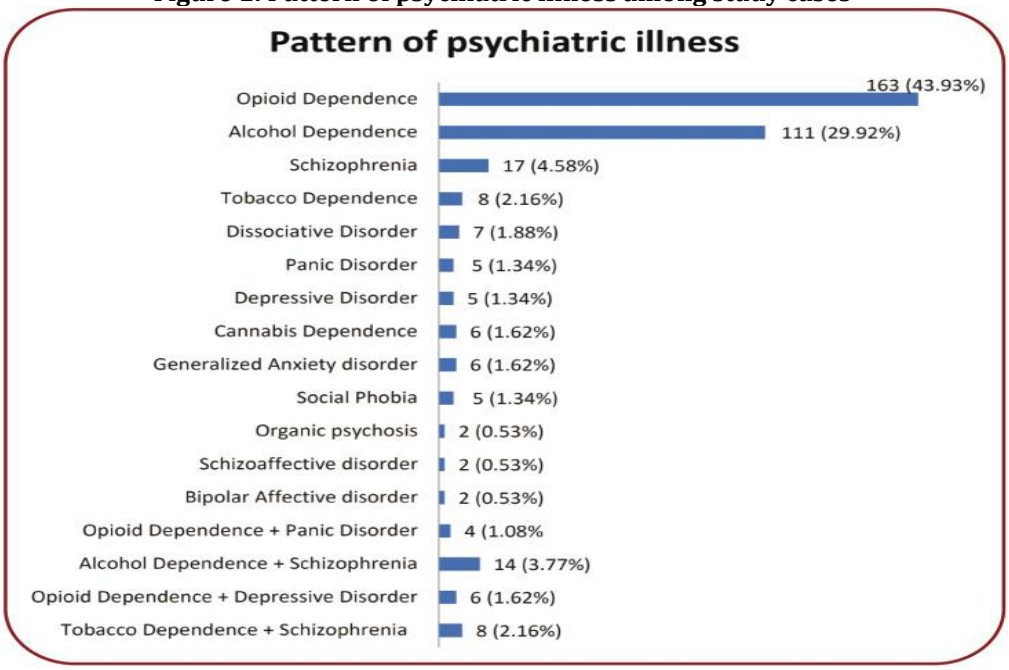

Table 1: Pattern of psychiatric illness according to the age group

https://doi.org/10.26574/maedica.2022.17.3.628

[11] Ibid, p.630

[12] Ibid, pp. 630-31

[13] Ibid, pp. 631-32

[14] Ibid, p.632

Disorder	Age group (years)			χ^2 -value	p-value
	18-34 (n=248)	35-50 (n=95)	≥51 (n=28)		
Organic psychosis (n=02) (delirium, dementia)	-	-	02 (100%)	6.382	0.001
Substance use disorder (n=288) (alcohol, opioid, tobacco, cannabis dependence)	209 (72.57%)	64 (22.22%)	15 (5.21%)		
Psychotic disorder (n=19) (schizophrenia, schizoaffective disorder	9 (47.36%)	8 (42.11%)	2 (10.53%)		
Mood disorder (n=07) (bipolar affective disorder, depressive disorder)	2 (28.58%)	4 (57.14%)	1 (14.28%)		
Anxiety disorder (n=23) (Generalised anxiety disorder, panic disorder, social phobia, dissociative disorder)	12 (52.17%)	8 (34.78%)	3 (13.04%)		
Cases with dual diagnosis (n=32)	16 (50%)	11 (34.37%)	5 (15.62%)		

*p<0.05 was statistically significant

Table 2: Pattern of psychiatric illness according to the age group

Disorder	Males (N=297)	Females (N=74)	χ^2-value	p-value
Organic psychosis (delirium, dementia)	1 (0.34 %)	1 (1.35 %)	10.374	0.001
Substance use disorder (alcohol, opioid, tobacco, cannabis dependence)	248 (83.50 %)	40 (54.05%)		
Psychotic disorder (Schizophrenia, schizoaffective disorder	10 (3.36%)	09 (12.16%)		
Mood disorder (bipolar affective disorder, depressive disorder)	04 (1.34%)	03 (4.05%)		
Anxiety disorder (generalised anxiety disorder, panic disorder, social phobia, dissociative disorder)	11 (3.70%)	12 (16.21%)		
Cases with double diagnosis	23 (7.74%)	09 (12.16%)		

Table 3: Psychiatric illness pattern according to religion

Disorder	Indigenous faith (N=203)	Christian (N=122)	Hindu (N=36)	Muslim (N=10)	χ^2 - value	p- value
Organic psychosis	2 (0.98%)	-	-	-	8.095	0.0483
Substance use disorder	166 (81.77%)	93 (76.22%)	25 (69.44%)	4 (40%)		
Psychotic disorder	10 (4.92%)	6 (4.92%)	2 (5.55%)	1 (10%)		
Mood disorder	1 (0.49%)	5 (4.09%)	-	1 (10%)		
Anxiety disorder	12 (5.91%)	7 (5.73%)	3 (8.33%)	1 (10%)		
Cases with double diagnosis	12 (5.91%)	11 9.02%)	6 (16.66%)	3 (30%)		
Grad total	203 (100%)	122 (100%)	36 (100%)	10 (100%)		

Etiology and Risk Factors

This lethal combination of substance addiction and psychological problems is determined by a complicated interplay of biological, environmental, and cultural aspects. The indigenous people are prone to taking a greater risk because of genetic susceptibility, as they are located nearer to the Myanmar border, and therefore, drugs like opium and cannabis are easily transmitted and the drug consumption level reaches up to 25% in certain regions. Extra vulnerabilities are caused by life hardship, including poverty, unemployment, and fragmentation of the family, particularly in marginalized youth. Although statistics tend to concentrate on the male sex, women are at a special risk due to domestic instability and lack of access to healthcare, which often results in the co-occurring conditions remaining undiagnosed. This is usually an intergenerational cycle because the children of addicted parents tend to have trouble with their behavior. Environmental factors like severe winters, which are the cause of indoor drug use and migrating to the city to find employment, are also a major factor as they expose individuals to new drugs and cultural alienation. Traditionally, alcohol-based festivals as in the case of traditional festivals of the local tribes can unwillingly act as gateway to drugs experimentation. The chemical imbalances in the brain manifested as dopamine dysregulation, which is the specific effect of opioid use that is coded in the body and exacerbates depression symptoms. The lack of awareness is further increasing these risks because most communities continue to perceive mental illness symptoms as evil spirits instead of medical conditions to be treated, which postpones life-saving measures.

Impacts and Consequences

Addiction of drugs and problems with mental health produce a devastating circular effect and damage individuals, their families, and the community. In the case of the affected person, these co-occurring disorders cause serious physical health problems such as liver failure, breathing difficulties, and increased chances of being overdosed or committing suicide. Individuals who abuse drugs such as opium or use needles also have an extremely high risk of being infected by serious diseases such as HIV or Hepatitis C. These personal tensions are soon transferred to the family, where money tends to be spent on drugs or treatment as spouses become the target of domestic violence, endure extreme emotional stress and complete financial destruction. The children of such homes are especially susceptible, and they tend to fail school, develop slowing development, increase the chance of repeating the cycle of poverty and addiction. The whole community is affected by this outside the home as more people commit more crimes and the economy suffers. Addiction in a farming region, such as the Arunachal Pradesh, means fewer productive individuals, resulting in fewer income and food per person. The crisis is also a strain on the public resources with the local hospitals and police being involved in dealing with more emergencies and drug related crimes. These problems are exacerbated by the fact that in remote villages, there is no basic infrastructure, such as ambulances, and thus, more often than not, it takes too long to save the life of an overdose victim. Lastly, the belief that people will be judged and therefore, feel social shame prevents people to seek help and the cycle of addiction runs uninterrupted through the generations.

Regional Case Studies

As an example of how deadly duo manifestations appear, a number of empirical case studies of Arunachal Pradesh demonstrate the interaction of substance use disorders (SUDs) with mental health. In a community-based study of 3,421 individuals within Khamti, Singpho, Tangsa and Tutsa tribes, that were aged 15 years and above, Chaturvedi (Chaturvedi, et al. 2013) described a 44% prevalence of alcohol use disorder. In the same study, he revealed a 7.8% prevalence of opium being commonly used, especially in traditional medicine, to treat insomnia and pain worsening underlying mental disorders, such as anxiety. Respondents said that they used opium to relax the mind in stressful seasons in the farming industry, although with time, they became tolerant, anxious when trying to quit, and experienced depressive episodes, and one in five respondents reported a co-morbid mood disorder. They conducted a follow-up study of the same group of participants in 2019 and reported an alcohol use disorder of 39.1%. It was revealed during interviews that family conflicts around addiction contributed to the increased mental load among members; as a result of which there were increased rates of domestic violence.

Singh (2013) investigated 218 members of the Idu Mishmi tribe (19-85 years old). The work reported prevalence of alcohol use disorder (36.2%), comorbid with depression (8.3%), anxiety (6.4%), and suicidal attempts (14.2%). Bidirectional association was demonstrated; alcohol is used as self-medication to ease the state of mental distress, but it increases suicidal ideation. In one of these instances, a farmer of 35 years old started drinking due to depression caused by crop failure which grew progressively to daily dependency and two suicide attempts. In another case study 177 Idu Mishmi (15-70 years old) by Singh and Rao (2018), recorded suicidal attempts at 22.03%. These suicidal tendencies were often intertwined with alcohol dependence.

An example of co-occurring conduct disorders and family stress in the youth of Arunachal region is presented in a qualitative case of de-addiction

community work in the Itanagar Capital Region (ICR). A case in point is 20-year-old male with a substance abuse history developing compulsive theft to finance his addiction, which brought him to a rehabilitation facility. His extreme behavior is explained by the interplay of family stress and the lack of control by his family due to his addiction, which led to the propagation of the cycle (Taso and Bage, 2024). In one more study in Lower Dibang Valley district, cannabis usage is estimated at 28% with 12% of them having schizophrenia-like symptoms, due to genetic influences and the ease of access (Regional Surveys, 2023). These studies highlight how culture condones the use of drugs such as opium, as well as how social and economic factors continue the cycle. The situation is accentuated by the inadequate infrastructure of the state to tackle such addictions. With only 6 de-addiction centers in the state, it is simply very difficult to make recovery from such SUDs (Chakraborty et al., 2011).

Key Findings

A cumulative understanding of all the existing research point towards SUD as a very alarming situation in the context of psychiatric problems in Arunachal Pradesh, that point towards an increasing mental health vulnerability, especially among adolescent (more than 40 percent prevalence). Etiological concepts highlight an overlapping of cultural endemism (e.g. traditional intoxicants), exogenous (border trafficking) and endogenous (genetic and psychosocial stressor) factors, where one factor feeds off another in a vicious cycle. Consequences of acute individual dangers such as overdose and infectious comorbidities often lead to systemic consequences such as familial breakdown and socioeconomic erosion. It is also important to note that not only gender but also intergenerational disparities worsen inequities, and programmatic assessments demonstrate that combined, culturally resonant interventions carry promising results in lessening the relapse and morbidity. Several case studies of various tribes confirm a high level of comorbidity (e.g., alcohol with depression and suicidality), and the need to respond to this issue in a more balanced and multifaceted way to prevent further deterioration. The results also indicate that underreporting is prevalent because of social stigmas, which implies that the true prevalence can be exponentially higher in rural communities.

Discussion

The findings are aligned with other researches in the world on the dual diagnosis, however, the case with Arunachal Pradesh with its tribal population and border position necessitates the call for a local adaptation. The combination of therapies works, but there are problems such as stigma associated with tribal communities and inadequacy of resources. The case studies highlight the need to have community entrenched measures to address intergenerational cycles. The lack of funds on mental health, which is less than 1 percent of state health budget, also exist as a challenging policy gap.

The other native territories have provided a relative insight of how ethno-psychiatry can be utilized whereby the traditional treatment is incorporated alongside evidence-based treatment to increase compliance.

Prevention and Paths Forward

Prophylaxis to this “deadly duo” hinges on enlightenment and precocious intervention. Locale specific school programs instill risk consciousness, which creates resilience through recreation activities such as sports or arts (Tsering et al., 2010). Examples include community mobilizations, such as Drugs Choro, Nuksaan Se Bacho, which involves non-governmental groups, women groups, tribal councils to monitor frontiers and eliminate stigma (Taso and Bage, 2024). Future oversight in Nasha Mukt Bharat Abhiyaan promotes adaptable strategies, which includes beneficial practices like yoga (American Psychiatric Association, 2015). Intersectoral governance, healthcare, and indigenous groups collaboration are essential to overweight efficacy. Narratives of recoveries in Bordumsa, Tawang and such others are also record of strength, which attest to the fact that unified efforts are capable of breaking long-established rhythms. The prevention goes further to the border patrols, which are merged with health education, school screening of early signs, and media campaigns in their native languages. Some of the avenues to go are global drug control partnerships and research groups to monitor trends.

Conclusion

The intertwining of mental health issues and addiction in Arunachal Pradesh highlights an acute region-specific challenge. Here, the ‘deadly duo’ of mental health problems and substance use disorders create self-reinforcing cycles, whereby each issue amplifies the other. The research synthesizes evidence on high prevalence, multi-dimensional and complex origins. This was exemplified in the case of the suicide-alcohol use comorbidity within the tribes. Utilizing empirical evidence, driven state alliances, and field/community specific innovations will enable the state to reduce this phenomenon of the ‘deadly duo’ to reach a state of improved psychosocial health and mental equity. Future research should focus on longitudinal outcome trends to fine-tune the strategies to an optimum level of reach. In addressing the duo, Arunachal Pradesh is not looking to simplify an issue, it is looking to transform an untapped region of potential to free its people from the grasp of a deadly duo.

References

1. American Psychiatric Association. (2015). *Youth substance abuse and co-occurring disorders* (Y. Kaminer, Ed.). American Psychiatric Association Publishing.
2. Atkins, C. E. (2014). *Co-occurring disorders: Integrated assessment and treatment of substance use and mental disorders* (2nd ed.). PESI Publishing & Media.
3. Chakraborty, K., Neogi, R., & Basu, D. (2011). Correlates of opium use: Retrospective analysis of a survey of tribal communities in Arunachal Pradesh, India. *BMC Public Health, 11*, Article 361. https ://doi .org/1 0.118 6/1471-2458-11-361
4. Chandler, R. K., Dombrowski, K., & Matthews, C. R. (Eds.). (2022). *Co-occurring mental illness and substance use disorders: Evidence-based integrative treatment and multicultural application*. Routledge.
5. Channaveerachari, N., Varambally, S., Thirthalli, J., Andrade, C., Gangadhar, B. N., & Murthy, P. (2024). Underage drinking, prevalence and predictors in Arunachal Pradesh, India: Analysis of National Family Health Survey (NFHS-5) data. *Indian Journal of Psychiatry, 66* (8), pp.723–729. https ://doi.or g/10.41 03 /indianjpsychiatry.indianjpsychiatry 123 24
6. Chaturvedi, H. K., & Mahanta, J. (2004). Prevalence and pattern of substance abuse at Bandardewa, a border area of Assam and Arunachal Pradesh. *Indian Journal of Psychiatry, 46*(3), pp.268–271.
7. Chaturvedi, H. K., Bajpai, R. C., & Tiwari, P. (2013). Substance use among tribal population in Arunachal Pradesh: A community-based survey. *Indian Journal of Psychiatry, 55*(Suppl 1), S56.
8. Chaturvedi, H. K., Bajpai, R. C., & Tiwari, P. (2019). Substance use among tribal population in Arunachal Pradesh: A follow-up survey. *Indian Journal of Psychiatry, 61* (Suppl 3), S456.
9. Hendrickson, E. L. (2009). *Living with co-occurring addiction and mental health disorders: A handbook for recovery*. Hazelden Publishing.
10. Kena, T., Bagra, I., & Panyang, R. (2022). Patterns of psychiatric illness in a tertiary care centre of Arunachal Pradesh: An observational study. *Cureus, 14*(11), e31025. https ://do i.org /10.7759/cureus.31025
11. Kumar, N., & Chadda, R. K. (2024). Prevalence of mental health problems and substance use among school-going adolescents of tribal ethnicity: A preliminary study from North-East India. *Journal of Indian Association for Child and Adolescent Mental Health, 20*(2), pp.123–130. https://d oi.org/10. 1177/097 313 422 412 39190
12. Minkoff, K., & Cline, C. A. (2023). *Counseling individuals with co-occurring addictive and mental disorders: A comprehensive approach*. Springer Publishing Company.
13. Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. Guilford Press.
14. Rao, P. S. S., & Kuruvilla, T. (1992). A study on the personality correlates of alcohol dependence. *Indian Journal of Psychiatry, 34*(4), pp.323–327.
15. Singh, J., & Rao, V. (2018). Suicidal attempts among Idu Mishmi tribe of Arunachal Pradesh. *Indian Journal of Psychiatry, 60* (Suppl 4), S502.
16. Singh, J., Singh, N. K., & Dkhar, B. (2013). Mental health problems in Idu Mishmi tribe of Arunachal Pradesh. *Indian Journal of Psychia try, 55*(Suppl 1), S57.
17. Taso, K., & Bage, B. (2024). A study of inclusive community substance abuse approach in ICR, Arunachal Pradesh. *ResearchGate*. http s:// doi.o rg/10.13140/RG.2.2.12345.6789
18. Tsering, D., Pal, R., & Dasgupta, A. (2010). Substance use among adolescent high school students in India: A survey of knowledge, attitude, and opinion. *Journal of Pharmacy and Bioallied Sciences, 2*(2), pp.137–140.
19. Watkins, T. R., Lewellen, A., & Barrett, M. (2001). *Dual diagnosis: An integrated approach to treatment*. Sage Publications.