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# Did it change anything?

A court has convicted 14 men involved in the lynching of Madhu, a mentally ill Adivasi man. But the community's mental health crisis remains poorly understood.

**Ashfaque EJ**

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**F**ive years ago, an incident of unsettling viciousness shook the state of Kerala and made national headlines.

The incident involved a 27-year-old Adivasi man named Madhu, who belonged to the scheduled Kurumba tribe and hailed from the hamlet of Chindakki, in the panchayat of Agali, in Palakkad district. At the time, Madhu had been living in the forest for some years – according to his sister Sarasu, he shifted away from the hamlet, also known as an ooru, because he began experiencing psychological distress, and grew uncomfortable interacting with other people.

On the afternoon of February 22, 2018, Sarasu's husband Murukan received a phone call from his friend, who told him that a group of people from the village of Mukkali had caught Madhu from a cave in the forest and beaten him, accusing him of being a thief. Murukan rushed inside the house and told Sarasu this.

Sarasu panicked, and began to get ready to leave to find and help her brother. But around ten minutes later, Murukan got another phone call.

"What? Gone?" Sarasu heard him shout over the phone. She rushed to him to find out what had happened. He paced the verandah for several minutes, in a stupor. Finally, he revealed to her that Madhu had been lynched, and had died inside a police jeep on the way to the community health centre in Agali.

"I felt so dizzy after hearing the news," Sarasu said, sitting in the courtyard of her house in Chindakki in November. "My ears couldn't bear it. My chest became heavier and my head started spinning. Finally, I collapsed." She recalled that they realised how brutal the incident had been only after watching news about it on television.

According to the first-information report, filed in Agali police station, the accused

men stripped Madhu's dhoti and used it to tie both his hands. They then slapped, beat, and kicked him all over his body, including on his face and abdomen. Four of the accused recorded the video of the beating, and circulated it on social media almost immediately, intending to humiliate Madhu further, according to the FIR.

At around 2.30 pm, they made Madhu walk partially disrobed for at least three kilometres, to Mukkali junction. They forced him to sit next to a temple's hundial, or collection box. Then, joined by a few more people, they beat him further with their hands and sticks, while a sizeable crowd watched silently. Some in the crowd even casually recorded the assault on their mobile cameras. Then, according to the FIR, the first accused kicked Madhu on his chest – he fell, and his head hit a wall near the hundial.

Finally, a police jeep arrived at the scene. The residents of Mukkali and the police dragged Madhu to the jeep, which left for the Agali community health centre. But Madhu died on the way, inside the police jeep – a description of what happened inside the jeep was missing from the FIR, which records the rest of the incident in detail.

“The body was brought here in a warm state,” Dr Lima Francis, casualty medical officer of the Agali community health centre, told *Scroll*.

**“We checked his pulse, and body pressure and examined the eye pupils. They seemed dilated and fixated.” Francis confirmed Madhu’s death at around 4.30 pm.**

In the face of the public outrage against the killing, the state machinery swung into action. Within a week, the police arrested 16 people, and charged them with a range of offences, from unlawful assembly to kidnapping and murder, as well as offences under the Scheduled Caste and Scheduled Tribes (Prevention of Atrocities) Act.





In February 2018, Madhu, an Adivasi man, was lynched by a mob in Attappadi. According to doctors who worked in the region, he was particularly vulnerable because of his poor mental health. Photo: Arathi MR

But even before the trial began, reports began appearing that the accused were attempting to influence witnesses. The special public prosecutor, Rajesh K Menon, told *Scroll* that police began monitoring witnesses' phone calls and social media, and found that between March 2021 and March 2022, 11 of the accused contacted at least ten witnesses several times. In parallel, police implemented a witness protection programme, granting witnesses security cover if they requested it. Despite this, Menon said, in all 24 out of 133 witnesses turned hostile.

The trial began in June 2022, more than four years after Madhu's death. On April 4, a special court convicted 14 out of the 16 accused of various offences, including voluntarily causing hurt and unlawful assembly.

While the crime itself received considerable coverage, another dimension of the problem also came into the spotlight as a result of it: Madhu's mental health, and the mental health of Adivasi people in Attappadi, the taluk within which Agali is located. According to Dr R Prabhudas, a government doctor who earlier worked in the region, Madhu was particularly vulnerable because of his troubled mental health. Further, Prabhudas and other doctors said, his was not an isolated instance – they had observed numerous such cases of Adivasi individuals across Attappadi, in similar states of distress.

In the aftermath of Madhu's killing, Kerala saw several calls for measures to safeguard the wellbeing of Adivasis and to ensure that such a tragedy did not recur. Some specifically demanded closer attention to the community's mental health. While some programmes were already underway, the government allocated more resources to them in the aftermath of the tragedy.

In November and December, I visited Agali to understand how these efforts were playing out. I spoke to health professionals, researchers, local activists and politicians. What emerged was a complex, troubling picture – while some work appeared to have yielded benefits for the community, some major efforts had snagged on poor execution and weak support from the government.

But a more broad critique also emerged. Adivasi activists and researchers argued that attempts to “cure” community members of mental “illnesses” were fundamentally misplaced, and that the roots of the problem ran much deeper, to the question of how they had been displaced from their lands, then subjected to systematic discrimination over centuries, a process from whose impacts the community is still suffering.

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**O**n November 18, 2022, at around 1 pm, sitting at a local tea shop near Agali's mini civil station, which houses all its government offices, I met a 20-year-old youth, dressed in a worn-out lungi streaked with mud, and an old shirt with many holes in it. He was roaming the street under the scorching sun, and murmuring to himself.

“He hails from the nearby ooru,” said Shinto K Rajan, a 35-year-old resident of Agali, who sat next to me at the old wooden bench in the tea shop. “He has been a regular presence here for a few years.” He described the young man as a “living Madhu”, a reference to the fact that both men would wander the area, similarly clothed, and in seemingly similar states of mental distress.

When I described the young man's behaviour to Dr Naveen Kumar, a psychiatrist who earlier worked in the region, he said that he had encountered several such people in the region. “Most of them were diagnosed with schizophrenia, bipolar

disorder, non-specific psychosis etc,” Kumar said. “The majority of the patients belong to the 15-35 age group.”



After Madhu's killing, the state saw protests and calls for measures to protect the well-being of the region's Adivasi people. There was particular attention on the question of their mental health. Photo: TA Ameerudheen

The first of the efforts to tackle the community's mental health problems was spearheaded by Dr Narayanan V, chief medical officer of Swami Vivekananda Medical Mission in Agali, a hospital set up in 2002. In the course of his work in the region, Narayanan realised that many of his patients, and their relatives, were suffering from mental health ailments.

According to a survey conducted by the psychiatry department of the Government Tribal Speciality Hospital, or GTSH, in Kottathara, a village in Attappadi, in 2017, there were at least 363 people affected by mental health issues in Attappadi. “Of them, around 180 are female and at least 175 were male,” said Aiswarya, a social worker in the psychiatry department of GTSH Kottathara, in December. “Around 300 of them belong to the Irula tribe, 30

belong to Kurumbas and 32 were Mudukas.”



This number represents around 1% of the around 32,000 Adivasis in the region. According to Narayanan, the expected percentage of cases of severe psychiatric ailments in any community is between 1% and 2%. While the percentage of mental health ailments in the region’s Adivasis is not strikingly high, Narayanan explained that the community has very limited access to mental healthcare, and that therefore, the problem should be treated as a crisis.

He added that the community’s difficulties are exacerbated by its social and economic vulnerability, and the fact that members have been victims of systemic discrimination for many years.

**“In the 1950s, 90% of the Attappadi population were tribes,” Narayanan said. “But according to the 2011 census, the tribal population had reduced to 34%. The existence of a community is under threat and it requires urgent attention.”**

He explained that in 2008, he and his colleagues contacted the Government Medical College in Thrissur for assistance. “The then head of department of

psychiatry, Dr Shaji KS, asked us to start a mental healthcare project at our hospital and offered technical support.”

Narayanan recounted that he visited the college, where he underwent an observership in psychiatry. He then returned to Agali, and began treating basic cases at the hospital. Patients with more serious symptoms would be referred to a specialist psychiatrist who visited the hospital once a month. The treatment protocol at Swami Vivekananda included counselling, medication, and home visits to support families.

These problems received further attention in 2013, as a result of a series of infant deaths in Attappadi – in all, 33 infants died in the region that year. As this crisis unfolded, National Rural Livelihood Mission volunteers visited Adivasi hamlets to identify children who were malnourished. During the visit, they realised that many in the Adivasi community were also suffering from several other health problems, including mental illnesses.


Dr Seema Bhaskar, former mission manager of NRLM in Attappadi, said that ground-level workers, such as the Accredited Social Health Activists, or ASHAs, health animators, and Scheduled Tribe promoters, took many of the patients to

the Government Medical College, Thrissur, Government Mental Health Centre, Kozhikode, and other medical institutes. Health animators are workers under the NRLM, whose role is to monitor health problems at an ooru and ensure treatment. A Scheduled Tribe promoter, under the state government's Integrated Tribal Development Project, is tasked with helping Adivasi people access benefits due to them, including health services. It is mandatory to have a promoter and a health animator at every ooru.

The efforts of these workers yielded some results. "The condition of a few improved," Bhaskar said.

Lakshmi, a health animator, recounted helping one young woman who she said "faced mental issues due to her marital problems". The workers "took her to Thrissur medical college. As none of her family members were willing, I volunteered to stay with her for more than three weeks at the hospital," Lakshmi said.





A spot in Mukkali where Madhu was beaten by a mob. According to the FIR, at one point he was kicked and fell, and hit his head on a wall. He was taken to a hospital after this, but was declared dead on arrival. Photo: Arathi MR

A third initiative, to address mental health problems in the region, was undertaken by GTSH Kottathara.

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Dr Naveen Kumar, who worked with the hospital, explained that from the end of 2015 onwards, the psychiatry department conducted periodical visits to the oorus to build a rapport with the community. Patients with more serious ailments would be admitted for treatment to hospitals in the region.

Aiswarya, the social worker in GTSH, explained that the department also conducted awareness camps in the oorus. “Our session mainly covers topics to break the stigma and the misconceptions among tribes regarding mental health,” she said. The team also conducted training sessions for promoters and community volunteers “on how to deal with mental health issues”, as well on the problems of alcohol and substance abuse.

These efforts were intensified in the aftermath of Madhu’s death.

One major new effort was led by the Thaikula Sangham, an Adivasi women empowerment organisation formed in 2001 and registered in 2008, which has an active presence in at least 190 oorus, with a 10-member committee in every ooru. The organisation chiefly focuses on busting illegal drug manufacturing and liquor brewing operations, as well as protecting women against atrocities, and empowering them.

But during her field visits to different oorus, Thaikula Sangham vice president Shivani K and her colleagues noticed many mentally unstable individuals, including young women, wandering the streets. “A few of the women had been sexually exploited,” she said.

**Madhu’s lynching served as motivation for the organisation to embark on a mission to provide medication, food and shelter to those individuals.**

They formed a team of five and collaborated with health animators, Scheduled Tribe promoters, and GTSH Kottathara for the rehabilitation process. Dr Prabhudas, then the superintendent of the hospital, provided travel allowances to allow the team to hire a jeep to transport patients, as well as food. “The

promoters, health animators, and community volunteers notify us about the patients. Following that, our team visits the concerned ooru and convinces the patient to come with us. We woo the patients by offering them food or other desirable objects,” said Sivani.

She added that they successfully managed to rehabilitate around 68 people.

As more patients were brought in, GTSH Kottathara grew overcrowded. To solve this problem, in September 2019, the government approved the transfer of these patients to Karunyasram, an old age centre, run by the ITDP, in the hamlet of Kavundikkal, which had the capacity to accommodate 50 people, and at the time had only two residents.

At this time, the government also took over the project, absorbing it into an initiative called Punarjani, which the chief minister had announced in the immediate aftermath of Madhu’s death – but which until then had seen no progress on the ground, according to Shivani. Karunyasram had been chosen in 2018 as the intended centre of work for Punarjani, but it was only in September 2019 that it began to function as such, with the patients that had been identified by Thaikula Sangham.

The Thiruvananthapuram-based non-governmental organisation Sri Sathyasai Orphanage Trust Kerala was given the responsibility to run the centre. The Scheduled Tribe welfare department allotted Rs 30 lakh to the social justice department to renovate the building, and buy furniture and install other facilities.

While the government agreed to cover the costs of doctors, medicines, and the maintenance of the building, the orphanage trust agreed to take care of expenses related to food, clothing, and rehabilitation of inmates. The trust also agreed to meet the expenses of nursing staff and caretakers and offer vocational training to the inmates. The GTSH psychiatry department was given the responsibility of monitoring the facility.

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**W**hile Punarjani was the most ambitious plan yet to tackle the mental health problems of the region, the project has been beset with problems from the start.

For one, the workers of the Adivasi women collective, Thaikula Sangham, argued

that they had laid the ground for the project before the government stepped in – and that when it did, it disregarded their efforts. “Dr Prabhudas invited us to a meeting on the Punarjani project, convened by the Ottappalam sub-collector, held at Karunyasramam,” Thaikula Sangham president Bhagavati said.

**“The then ITDP project officer Vani Das was not happy with our presence. She shouted at us that we were not invited and asked to get out. We felt humiliated. It’s us who took all the risks of traveling to different areas and brought the tribals to this centre.”**

Vani Das did not respond to emailed questions from *Scroll* about the alleged incident.

Some also criticised the Punarjani project for the lack of Adivasi representation in it. “Karunyasramam was intended to rehabilitate Adivasi mental health patients and to ensure that they are getting proper shelter, food and medication,” said VS Murukan, Adivasi Action Council vice chairman. “Inclusion of an Adivasi organisation in the supervision would have been ideal.”

He added that though there were many “efficient Adivasi individuals, organisation and collectives” in the region, none had been included in the execution and supervision of such welfare schemes and projects, including the Integrated Tribal Development Project and the National Rural Livelihood Mission. “They were always recruited to do the bottom-level work,” he said. “The governance and execution of such schemes were always handled by upper-caste Malayalis or handed over to NGOs who have political connections, and were headed by non-Adivasis. The non-inclusivity of Adivasis is nothing but racial discrimination. Adivasis were always ruled.”





Madhu's home in Chindakki. Doctors in the region argue that while the proportion of people with mental illnesses is not unusually high, the problem is a crisis because of their socioeconomic vulnerability. Photo: Arathi MR

There have also been reports of problems in managing the programme. According to a story published in January 2022 in the *Malayala Manorama*, although a supervising committee was set up with the Ottappalam sub-collector as the chairman and the Palakkad district social justice officer as the convenor, only a few meetings had been held.

Further, the report noted that the government had issued an order that a contract be signed between the parties involved in the project, specifically the ITDP, the Sathyasai trust and the relevant bureaucrats, but that this had not been done even after four years.

By the end of 2021, the Sathyasai trust decided to withdraw from the project, saying that it was short of funds as a result of the economic effects of Covid-19. According to the same report, up to that point, the trust had spent around Rs 16 lakh for the implementation of the project.

The trust's withdrawal was followed by further problems. Assistant midwifery staff at the centre explained that after this, salaries stopped being disbursed. They told *Scroll* that they were paid only till 2021 December. "Our salary is Rs 9,000 per month," Divya, who is an assistant midwife at the centre, said in early December. "More than eight months of our salary is pending. The cook's salary was reduced from Rs 10,000 to Rs 6,000. She was also not paid for more than six months."

The fund crunch severely affected the quality of care at the centre. For instance, she explained, the mattresses of the inmates had been removed a year earlier after a bed bug attack, but the ITDP was yet to approve the request for new

mattresses. For now, she said, inmates were managing with just a sheet over their beds.

**She added, “Even if we are not getting a salary, we cannot leave this job. Most of the inmates cannot manage a day without our support. We cannot betray them.”**

Activists involved in the Punarjani project also noted that the project was hampered by the transfer of key personnel. Dr Prabhudas was transferred to the Tirurangadi Taluk hospital in November 2021, after which, according to Shivani, the travel and food allowance to the Thaikula Sangham was halted, making it difficult for the organisation to continue its work. “We were unable to carry out the rehabilitation mission,” she said. Seema Bhaskar, the former mission manager of the National Rural Livelihood Mission in Attappadi, was dismissed in 2018, while involved in the work that preceded and was later merged with Punarjani; she currently works with an NGO in Delhi. According to [news reports](#), she was removed because she participated in protests following Madhu’s lynching.

“The transfer of sincere and efficient officers who spearheaded a project or

played a pivotal role would either halt it or slow it down,” said GTSH tribal executive officer Kalisamy.

Seeking responses on these allegations and criticisms, I tried contacting the Ottapalam sub-collector over the phone multiple times through January and February. I also emailed questions to the sub-collector, police officials and the project officer of ITDP. As of publication, they had not responded.

I visited the ITDP project officer VK Suresh Kumar’s office on December 10 to ask about these problems. The officer argued that I would have to obtain special permission from higher authorities for any information related to Adivasi people, and refused to discuss the Punarjani project. “Why does everybody want to do research on Adivasis?” he said. “There is no issue in Attappadi. It’s you people, the outsiders, creating problems.” He then ordered me to leave.

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**S**ome believe the problem with these projects runs much deeper than their mismanagement.

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In a 2018 [article](#) written in the aftermath of Madhu’s killing, titled, “How Kerala’s

poor tribals are being branded as mentally ill,” IIT Hyderabad PhD scholar Sudarshan R Kottai, who has done research on community mental health programmes among Adivasis in Wayanad, described such efforts as “paternalistic governance”. He argued that they failed “to locate mental health problems in the broader spectrum of personal, social, political, and economic lives”.

Further, he wrote, “The shabbily dressed tribal, the street-dweller and those with marginalised sexual identities all question the ‘normal,’ but find themselves slipping into the category of the ‘mentally ill.’ Mental illness thus becomes a means of social control”.

According to VS Murukan of the Adivasi Action Council, “If a person is denied their rights and faces discrimination at multiple levels and is denied dignity, it will take a toll on mental health.”

He recounted an instance from within his own family. “Me and my father, a leader of the Irula tribe, were arrested in 2021 by police in a fabricated case,” he said. “My father was tortured and humiliated by the police.” Police did not respond to emailed questions from *Scroll* about these allegations.

Even after his father was released, Murukan said, “the trauma stayed with him”. He felt that he had been humiliated in front of his people, Murukan said, “and he became so depressed”.

**Similarly, he said, “Many Adivasis who have been to jail and arrested under false fabricated cases also had mentally suffered and preferred living in isolation.”**

Of them, he noted, “Many dropped government jobs and dropped out of educational institutes. Many people got addicted to alcohol and drugs.” He added, “These factors exacted a high toll on mental health.”

Maruti, secretary of Thaikula Sangham, who has led many raids against both legal and illegal liquor vendors, blamed non-Adivasis for the problem of alcohol addiction in the region. “Earlier, instead of giving money as wages, many non-Adivasis paid Adivasis by supplying alcohol,” she said. “They are deliberately making our men addicted.”

Maruti also explained that while there was an informal ban on alcohol in Attappadi, bootleggers operated freely, charging Adivasis exorbitant rates for low-quality liquor.

Inhabitants of the region also carried deep psychological wounds inflicted by popular culture's depiction of them, according to VH Dirar, a writer and former director of the Attappady Hills Area Development Society. He noted that the word "Attappadi" was used in many films, plays, and in fiction and non-fiction, to indicate a place whose inhabitants were less civilised, lacked culture, were unhygienic, and had low intelligence. Such work had heavily influenced the perception and treatment of the Adivasi community, he noted.

"Many young Adivasis who went outside the ooru for education or employment were subjected to caste discrimination, harassment, humiliation and felt alienated," Dirar said. "Many of them discontinued their studies and came back to their ooru."



The Government Tribal Specialty Hospital in Kottathara. After Madhu's death, the hospital became the centre of an effort to support the mental health of the region's Adivasi community, but soon grew overcrowded. Photo: Special arrangement

While health professionals recognised that poverty, malnutrition, caste discrimination, physical and sexual abuse, and uncertainties over land rights were having a detrimental effect on the Adivasi community's mental health, some argued that they downplayed these factors. "Unfortunately, not enough research has been done to substantiate the observations," Dr Narayanan said.

Kottai, the research scholar at IIT Hyderabad, argued that community health measures in the region failed to address these deeper problems. "The term community mental health comprises two terms: community and mental health," he said. "The main stakeholder of the programme is the community, and they must be consulted to address the structural issues including social, political and cultural."

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He noted that community mental health professionals "diagnose poverty and other social sufferings as individual psychiatric 'disorders' to be treated with free medicines."

For a [research report](#) published in June 2020 in the International Journal for Equity in Health on the Attappadi Adivasi community's access to healthcare, author Mathew Sunil George conducted interviews with Adivasi communities in the region to understand problems they faced with the delivery of healthcare services. George found that doctors and health professionals had not sought the opinions of Adivasi community leaders about how best to provide healthcare to their communities.

**“They felt that given their ‘illiterate’ status, doctors and other health professionals did not see their views as important,” the paper noted.**

Further, the community was not informed or consulted about key events, such as the arrival of mobile medical units to villages. “Healthcare staff did not inform village heads even when an MMU visited a village,” the paper noted. “They failed to use this as an opportunity to actively engage the community.” Thus, the units “would generally arrive at the villages after most of the community had left for their daily work”.

Village leaders explained that if they had known about the visits, they would have discussed the matter with the community, and convinced them to remain in the village on those occasions. “The exclusion of village leaders and their councils – the traditional decision makers, was common across all programmes,” the paper stated.

Kottai believes that mainstream health professionals simply don't have the expertise to deal with the problem. He pointed out that the syllabus of most psychiatry and psychology institutes follow the Western "biomedical" approach, which does not address socio-political and economic factors, including caste and gender discrimination, in the Indian context. "There are no chapters on stigmatised or criminalised Indian tribes, vulnerable tribes and the issues faced by them," he said.

Kottai argued that an effective solution would have to address the broader socio-political suffering of these communities, and treat it as a challenge pertaining to social justice and rights, rather than only mental health. "If mental health practitioners failed to address the root causes and rather diagnosed these problems as a mental illness, and opted for treatment using psychotropic medicines, many people facing similar problems would be treated in that way," he told *Scroll*. This, he argued, would lead to "an increase in the number of patients getting diagnosed day by day" and result in "the commodification of health". He added, "In an ideal system, the solution should be either to eradicate the disease, or to reduce the number of patients."

Dirar argued that cultural sensitisation of officers, health professionals, and volunteers involved in health programmes in the region could be a step towards

tackling this challenge, even if the same prevalent clinical approach to the problem was followed. “Preserving and propagating the positive elements of tribal wisdom, enabling them as a self-sustainable society, promoting their traditional medication practices, would evoke a sense of identity, and can boost dignity, pride and build confidence and make them less prone to mental health issues,” he said.

Before leaving the small restaurant opposite the Agali Civil Station where I spoke to him, VS Murukan echoed all those concerns. “It’s not merely the land that the Adivasi lost, but his soil, woman, family, dignity, culture, and everything,” he said. “All of these losses have a high toll on our mental health.”

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He added, “The government, bureaucrats, politicians, and the non-Adivasis are responsible for it. Mental health issues among Adivasis are mostly rooted in centuries of systematic injustice. Madhus are not born, but created.”

In Chindakki, Madhu’s sister Sarasu recounted an incident that her brother had told her about.

One day, he had been walking towards the cave where he stayed, when “he came

across a group of elephants, drinking water from a nearby stream,” Sarasu said. On hearing this, she said, “Oh god! Weren’t you afraid?”

She recounted that he replied, “ No, they were not even bothered about my presence. I walked silently in between them.” Then, she remembers him saying, “ No need to worry. Nothing will happen to me. I knew almost all the animals in the forest and they all knew me. None of them will attack me.”

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