CHAPTER - I
INTRODUCTION
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Education is a powerful instrument of social change and often initiates upward movement in the social structure. It helps in bridging the gap between the different sections of society. The educational scene in the country has undergone major change over the years resulting in better provision of education and better educational practices. In 1944, the Central Advisory Board of Education (CABE) published a comprehensive report called the Sergeant Report on the post-war educational development of the country. As per the report, provisions for the education of the handicapped were to form an essential part of the national system of education, which was to be administered by the Education Department. According to this report, handicapped children were to be sent to special schools only when the nature and extent of their defects made this necessary. The Kothari Commission (1964–66), the first education commission of independent India observed: “the education of the handicapped children should be an inseparable part of the education system.” The commission recommended experimentation with integrated programmes in order to bring as many children as possible into these programmes. The government’s agenda to universalise elementary education and its commitment to the Directive Principles of the Constitution are guided by the recognition that a new universal system of education should be based on equity, the redress of past imbalances and the provision of access to quality education especially for marginalised groups. Recent educational developments and the Seventy Third and Seventy Fourth Constitutional Amendments outline the possibility of entrusting basic education to the local
elected bodies in towns and villages. This would allow for community participation in education at the elementary level and would introduce radical change leading to the empowerment of learners with Special Educational Needs (SEN). Until the 1970s the policy encouraged segregation. Most educators believed that children with physical, sensory, or intellectual disabilities were so different that they could not participate in the activities of a common school (Advani, 2002). Christian missionaries in the 1880s started schools for the disabled as charitable undertakings (Mehta, 1982). The first school for the blind was established in 1887. An institute for the deaf and mute was set up in 1888. Services for the physically disabled were also initiated in the middle of the twentieth century. Individuals with mental retardation were the last to receive attention. The first school for the mentally challenged was established in 1934 (Mishra, 2000). Special education programmes in earlier times were therefore heavily dependent on voluntary initiative.

The government’s (Department of Education) initiatives after independence were manifested in the establishment of a few workshop units meant primarily for blind adults (Luthra, 1974). These units later included people who were deaf, physically impaired and mentally retarded (Rohindekar and Usha, 1988). While some provisions existed in the States it was considered the best course to assist and encourage voluntary organisations already working in the field.

The welfare approach continued in government programmes. Support was provided to voluntary organisations for the establishment of model schools for the blind, the deaf and the mentally retarded. The government set up the National Library for the Blind the Central Braille Press and employment exchanges for the disabled. It also made provisions for scholarships for prevention and early identification of disabling conditions for the development of functional skills and for aids and appliances for the disabled.

Learners with Special Educational Needs (SEN)
In India a learner with SEN is defined variously in different documents. For example, a child with SEN in a District Primary Education Programme (DPEP) document is defined as a child with disability namely visual, hearing, locomotor and intellectual (DPEP, 2001). However, the country report in the NCERT UNESCO regional workshop report titled Assessment of needs for Inclusive Education: Report of the First Regional Workshop for SAARC Countries (2000) states that SEN goes beyond physical disability. It also refers to the large proportion of children in the school age belonging to the groups of child labour or street children, victims of natural catastrophes and social conflicts and those in extreme social and economic deprivation. These children constitute the bulk of dropouts from the school system. The SSA Framework for Implementation covers children with Special Needs (SN) under the section on Special Focus Groups. While separating children with disabilities from other groups like girls, Scheduled Castes (SC), Scheduled Tribes (ST) and urban deprived children, it makes provisions for these children under the section on SEN. The Department of Education of Groups with SN in the NCERT itself initiates programmes for meeting the learning needs of the disabled and the socially disadvantaged and marginalised such as the SCs, STs and minorities.

According to the International Standard Classification of Education (ISCED-97) (UNESCO, 1997) the term Special Needs Education (SNE) means educational intervention and support designed to address SEN. The term “SNE” has come into use as a replacement for the term “Special Education”. The earlier term was mainly understood to refer to the education of children with disabilities that takes place in special schools or institutions distinct from and outside of the institutions of the regular school and university system. In many countries today a large proportion of disabled children are in fact educated in institutions under the regular system. Moreover, the concept of children with SEN extends beyond those who may be included in handicapped categories to cover those who are failing in school for a wide variety of reasons that are known to be likely impediments to a child’s optimal progress.
Whether or not this more broadly defined group of children is in need of additional support depends on the extent to which schools need to adapt their curriculum, teaching and organisation and/or to provide additional human or material resources so as to stimulate efficient and effective learning for these pupils. However, only in a few instances and documents across the various states of the country has SEN been accepted in its broad perspective. On the whole, the focus has remained on learners with specific disabilities. This view is supported by the fact that the draft Inclusive Education Scheme (MHRD, 2003) available on the website of the Ministry of Human Resources Development (MHRD) which addresses the needs of learners with disabilities focuses on the following categories of disability: visual disabilities (blind and low vision), speech and hearing disabilities, locomotor disabilities and neuro-muscular skeletal and neurological developmental disorders including cerebral palsy, autism, mental retardation, multiple disability and learning disabilities. Keeping this reality in mind the main focus of this position paper is on learners with such disabilities.

The Gender Issue

There is ample evidence that women with disabilities experience major psycho-social problems including depression, stress, lowered self-esteem and social isolation, which remain largely neglected (Nosek and Hughes, 2003). Evidence also suggests that women tend to be restricted to home-based activities, while men are likely to be supported in more public and outward-looking avenues. Stereotypes are artefacts of culture that can only be understood by exploring their relations to each other in the cultural system. Gender stereotypes interact with disability stereotypes to constitute a deep matrix of gendered disability in every culture, developed within specific historical contexts and affecting those contexts over time. While language is the most analysed site for the examination of both gender (Connell, 2002) and disability (Corker and French, 1999) they interact in many other cultural locations cinema, television, fiction, clothing and body language. Thus, cultures sustain the social relations of gendered disability in constant
reiterations of stereotypes and expectations (Meekosha). In the education scene, discrimination on account of gender has been reported in many studies. However, girls with disabilities have remained invisible both from the writings on gender and on disability. Therefore, the needs of girls with disabilities may be more special than needs of any other group and have to be addressed in all spheres of education.

**Shifting Models of Disability: Historical Progression**

The shifting approaches to disability have translated into very diverse policies and practices. The various models of disability impose differing responsibilities on the States in terms of action to be taken and they suggest significant changes in the way disability is understood. Law, policy, programmes and rights instruments reflect two primary approaches or discourses: disability as an individual pathology and as a social pathology. Within these two overriding paradigms, the four major identifiable formulations of disability are: the charity model, the bio-centric model, the functional model and the human rights model.

**The Charity Model**

The charity approach gave birth to a model of custodial care, causing extreme isolation and the marginalization of people with disabilities. Unfortunately, in some contemporary practices the reflection of this model can still be traced. For instance, the findings of an investigative project undertaken by the National Human Rights Commission of India between 1997–99 confirmed that a large number of mental health institutions today are still being managed and administered on the custodial model of care characterised by prison-like structures with high walls, watchtowers, fenced wards and locked cells. These institutions functioned like detention centres where persons with mental illness were kept chained, resulting in tragedies like the one at “Erwadi” in Tamil Nadu in which more than 27 inmates of such a centre lost their lives.
The Bio-centric Model

The contemporary bio-centric model of disability regards disability as a medical or genetic condition. The implication remains that disabled persons and their families should strive for “normalisation” through medical cures and miracles. Although biology is no longer the only lens through which disability is viewed in law and policy it continues to play a prominent role in determining programme eligibility, entitlement to benefits and it also influences access to rights and full social participation (Mohit, 2003). A critical analysis of the development of the charity and bio-centric models suggests that they have grown out of the “vested interests” of professionals and the elite to keep the disabled “not educable” or declare them mentally retarded (MR) children and keep them out of the mainstream school system, thus using the special schools as a “safety valve” for mainstream schools (Tomlinson, 1982). Inclusive education offers an opportunity to restructure the entire school system with particular reference to the curriculum, pedagogy, assessment and above all the meaning of education (Jha, 2002).
The Functional Model

In the functional model, entitlement to rights is differentiated according to judgments of individual incapacity and the extent to which a person is perceived as being independent to exercise his/her rights. For example, a child’s right to education is dependent on whether or not the child can access the school and participate in the classroom, rather than the obligation being on the school system becoming accessible to children with disabilities.

The Human Rights Model

The human rights model positions disability as an important dimension of human culture and it affirms that all human beings are born with certain inalienable rights. The relevant concepts in this model are:

Diversity

The Greek philosopher, Aristotle, once said that “things that are alike should be treated alike, whereas things that are unalike should be treated unalike in proportion to their un-alikeness”. The principle of respect for difference and acceptance of disability as part of human diversity and humanity is important as disability is a universal feature of the human condition.

Breaking down Barriers

Policies that are ideologically based on the human rights model start by identifying barriers that restrict disabled persons’ participation in society. This has shifted the focus in the way environments are arranged. In education, for example, where individuals were formerly labelled as not educable the human rights model examines the accessibility of schools in terms of both physical access (i.e. ramps, etc.) and pedagogical strategies.

Equality and Non-Discrimination
In international human rights law, equality is founded upon two complementary principles: non-discrimination and reasonable differentiation. The doctrine of differentiation is of particular importance to persons with disabilities, some of whom may require specialised services or support in order to be placed on an equal basis with others. Differences of treatment between individuals are not discriminatory if they are based on “reasonable and objective justification”. Moreover, equality not only implies preventing of discrimination (for example, the protection of individuals against unfavourable treatment by introducing anti-discrimination laws) but also goes far beyond in remedial discrimination. In concrete terms it means embracing the notion of positive rights affirmative action and reasonable accommodation.

**Reasonable Accommodation**

It is important to recognise that reasonable accommodation is a means by which conditions for equal participation can be achieved and it requires the burden of accommodation to be in proportion to the capacity of the entity. In the draft Comprehensive and Integral and International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities “reasonable accommodation” has been defined as the “introduction of necessary and appropriate measures to enable a person with a disability fully to enjoy fundamental rights and freedoms and to have access without prejudice to all structures, processes, public services, goods, information and other systems.”

**Accessibility**

The United Nations Economic and Special Commission for Asia and the Pacific (UNESCAP) has defined “accessibility” as “the measure or condition of things and services that can readily be reached or used (at the physical, visual, auditory and/or cognitive levels) by people including those with disabilities” (Rioux and Mohit, 2005).
**Equal Participation and Inclusion**

By focussing on the inherent dignity of the human being the human rights model places the individual at centre stage in all decisions affecting him/her. Thus, the human rights model respects the autonomy and freedom of choice of the disabled and also ensures that they themselves prioritise the criteria for support programmes. It requires that people with disabilities, other individuals and institutions fundamental to society are enabled to gain the capacity for the free interaction and participation vital to an inclusive society.

**Private and Public Freedoms**

The human rights approach to disability on one hand requires that the States play an active role in enhancing the level of access to public freedom and on the other requires that the enjoyment of rights by persons with disabilities is not hampered by third-party actors in the private sphere. Educational institutions and industry both in the public and private sectors should ensure equitable treatment to persons with disabilities.

**Educational Provisions for Children with Special Needs**

**Integrated Education**

In the 1970s the government launched the Centrally Sponsored Scheme of Integrated Education for Disabled Children (IEDC). The scheme aimed at providing educational opportunities to learners with disabilities in regular schools and to facilitate their achievement and retention. The objective was to integrate children with disabilities in the general community at all levels as equal partners to prepare them for normal development and to enable them to face life with courage and confidence. A cardinal feature of the scheme was the liaison between regular and special schools to reinforce the integration process. Meanwhile the National Council of
Educational Research and Training (NCERT) joined hands with UNICEF and launched Project Integrated Education for Disabled Children (PIED) in the year 1987 to strengthen the integration of learners with disabilities into regular schools. An external evaluation of this project in 1994 showed that not only the enrolment of learners with disabilities increased considerably but also the retention rate among disabled children was much higher than the other children in the same blocks. In 1997 IEDC was amalgamated with other major basic education projects like the DPEP (Chadha, 2002) and the Sarva Shiksha Abhiyan (SSA) (Department of Elementary Education, 2000).

The IEDC scheme provides for a wide range of incentives and interventions for the education of children with disabilities. These include preschool training counselling for parents, allowances for books and stationery, uniforms, transport, readers and escorts, hostel facilities and other assistive devices. The scheme provides one special teacher for every eight children with disabilities, community involvement and a resource room in a cluster of eight to 10 schools. A number of voluntary organisations are implementing the scheme in various States.
Table 1: Enrollment of Disabled Children in Schools Under
The Integrated Educational Programme (Stage: Primary)

<table>
<thead>
<tr>
<th>Area</th>
<th>Management</th>
<th>Type of Disability</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Visual Impairment</td>
<td>Hearing Impairment</td>
<td>Orthopedic Handicaps</td>
<td>Mental Retardation</td>
<td>Others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>Govt</td>
<td>1539</td>
<td>1307</td>
<td>15168</td>
<td>1066</td>
<td>2070</td>
<td>21150</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Govt</td>
<td>391</td>
<td>354</td>
<td>2189</td>
<td>188</td>
<td>80</td>
<td>3202</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>1930</td>
<td>1661</td>
<td>17357</td>
<td>1254</td>
<td>1250</td>
<td>24352</td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>Govt</td>
<td>896</td>
<td>1420</td>
<td>5072</td>
<td>1694</td>
<td>1382</td>
<td>10464</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Govt</td>
<td>982</td>
<td>1877</td>
<td>3959</td>
<td>800</td>
<td>1538</td>
<td>9156</td>
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<tr>
<td></td>
<td>Total</td>
<td>1878</td>
<td>3297</td>
<td>9031</td>
<td>2494</td>
<td>2920</td>
<td>19620</td>
<td></td>
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<tr>
<td>Total</td>
<td>Govt</td>
<td>2435</td>
<td>2727</td>
<td>20240</td>
<td>2760</td>
<td>3452</td>
<td>31614</td>
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<tr>
<td></td>
<td>Non-Govt</td>
<td>1373</td>
<td>2231</td>
<td>6148</td>
<td>988</td>
<td>1618</td>
<td>12358</td>
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<td></td>
<td>Total</td>
<td>3808</td>
<td>4958</td>
<td>26388</td>
<td>3748</td>
<td>5070</td>
<td>43972</td>
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</tr>
</tbody>
</table>

*Note:* Govt includes the Central Government and the State Governments as also Local Bodies and Non-Govt includes Pvt. Aided and Pvt. Unaided.

*Source:* NCERT, 1998
As evident from the tables above, until 1998 integrated education was provided to 8,90,000 learners in different States till the senior secondary level (NCERT, 1998). By the year 2002, the scheme had extended to 41,875 schools benefitting more than 1,33,000 disabled children in 27 States and four Union Territories (Department of Education, MHRD, 2003). The total number of learners with SEN enrolled in regular schools under DPEP was more than 5,60,000: this represents almost 70% of the nearly 8,10,000 learners with SEN identified under this programme (DPEP, 2003). The current enrolment ratio per 1000 disabled persons between the ages of 5–18 years in ordinary schools is higher in the rural areas (475) than it is in the urban areas (444) [National Sample Survey Organisation (NSSO) 2002]. The Office of the Chief Commissioner of Persons with Disabilities stated that not more than 4% of children with

<table>
<thead>
<tr>
<th>Area</th>
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<th>Visual Impairment</th>
<th>Hearing Impairment</th>
<th>Orthopedic Handicap</th>
<th>Mentally Retardation</th>
<th>Others</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>Govt.</td>
<td>996</td>
<td>533</td>
<td>6734</td>
<td>369</td>
<td>926</td>
<td>9558</td>
</tr>
<tr>
<td></td>
<td>Non-Govt.</td>
<td>262</td>
<td>264</td>
<td>1582</td>
<td>67</td>
<td>141</td>
<td>2316</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>1258</td>
<td>797</td>
<td>8316</td>
<td>436</td>
<td>1067</td>
<td>11874</td>
</tr>
<tr>
<td>Urban</td>
<td>Govt.</td>
<td>604</td>
<td>904</td>
<td>3781</td>
<td>271</td>
<td>251</td>
<td>5811</td>
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<tr>
<td></td>
<td>Non-Govt.</td>
<td>736</td>
<td>581</td>
<td>2293</td>
<td>572</td>
<td>1467</td>
<td>5649</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>1340</td>
<td>1485</td>
<td>6074</td>
<td>843</td>
<td>1718</td>
<td>11460</td>
</tr>
<tr>
<td>Total</td>
<td>Govt.</td>
<td>1600</td>
<td>1437</td>
<td>10515</td>
<td>640</td>
<td>1177</td>
<td>15369</td>
</tr>
<tr>
<td></td>
<td>Non-Govt.</td>
<td>998</td>
<td>845</td>
<td>3875</td>
<td>639</td>
<td>1608</td>
<td>7965</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>2598</td>
<td>2282</td>
<td>14390</td>
<td>1279</td>
<td>2785</td>
<td>23334</td>
</tr>
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</table>

*Note:* Govt. includes the Central Government and the State Governments as also Local Bodies and Non-Govt. includes Pvt. Aided and Pvt. Unaided.

*Source:* NCERT, 1998
disabilities have access to education. The enactment of legislations by the State Governments has helped in facilitating access to education for all learners with SEN by introducing various entitlements like reservations, scholarships, allowances, etc. By promulgating the equal rights of learners with SEN these Acts have significantly impacted the educational policies both at the Central and State levels but the effect has been marginal. About 11% of disabled persons between the ages of 5–18 years were enrolled in special schools in the urban areas as compared to less than 1% in the rural areas (NSSO, 2002). This clearly indicates that the presence of special schools in a parallel stream does effect the enrolment of children with disabilities in regular schools. Criticising the segregation policies of the Indian government Baquer and Sharma (1997) have pointed out that: …separate special education systems lead to social segregation and isolation of the disabled thus creating separate worlds for them in adult life. Inclusive education has the potential to lay the foundation of a more inclusive society where being “different” is accepted, respected and valued. The school is the first opportunity to start this desirable and yet difficult process. It is difficult because it is wrought with fears and apprehensions on the part of parents, teachers and other children. Despite the efforts of governmental and nongovernmental organisations (NGOs) there is still a significant need to facilitate access of disabled children to educational institutions and to education in general. The first and foremost strategy for any country and especially India must be therefore to increase the access to education for learners with SEN. Though awareness is being created by the inclusion of learners with SEN in major educational programmes like the DPEP and now the SSA most of them address SEN as a segregated issue rather than as one that runs through all initiatives. This is supported by the fact that under the SSA training, linkages with parents, salaries of special educators, aids and appliances, etc. are all provided through the separate provision of one thousand two hundred rupees per disabled child per annum. The total money available for such services thus
depends on the number of disabled children identified. In addition access to curriculum and physical access to the school are also issues that need to be addressed immediately. Figure 1 depicts some of the popular models of Integrated Education being practised in India.

Though the integration of children with SEN has gathered momentum in the country since 1974 there are other possibilities for these children to gain an education. For example the National Institute of Open Schooling offers courses that have the advantage of being specially adapted to the needs of every child as well as giving the child every opportunity to progress at his/her own pace. Another example is Alternative Schooling (Advani, 2002) and community-based rehabilitation programmes. It is believed that the fundamental right to education will bring more students with SEN into ordinary schools, which will in turn provide an impetus for change and bring about a number of innovations in the field of SNE.

**Legislation**
The right of every child to education is proclaimed in the Universal Declaration of Human Rights (1948) and was strongly reaffirmed by the Jomtien World Declaration of Education for All (1990). Furthermore the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993) was an important resolution to improve the educational conditions of persons with disabilities. This had major implications for the Indian situation in the form of three legislative Acts—The Rehabilitation Council of India Act, 1992 (RCI Act) the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (PWD Act) and the National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999. While the RCI Act was solely concerned with manpower development for the rehabilitation of persons with disabilities the PWD Act comprises 14 chapters and is a significant endeavour to empower persons with disabilities and promote their equality and participation by eliminating discrimination of all kinds. It emphasises the need to prepare a comprehensive education scheme that will make various provisions for transport facilities, removal of architectural barriers, supply of books, uniforms and other materials, the grant of scholarships, suitable modification of the examination system, restructuring of curriculum, providing amanuensis to blind and low vision students and setting up of appropriate mechanism for the redressal of grievances. The National Trust Act aims at providing total care to persons with mental retardation and cerebral palsy and also manages the properties bequeathed to the trust.

**Changing Role of Special Schools**

Special schools have been set up in the past and provisions have been made for integrated education. In 1947 India had a total of 32 such schools for the blind, 30 for the deaf and three for the mentally retarded. The number of such schools increased to around 3000 by the year 2000 (NCERT-UNESCO Regional Workshop Report, 2000). Thus India at present has what Pijl and Meijer (1991) refer to as “two tracks”. In other words it has parallel but separate policies on segregation and integration. Special schools for children with
visual impairment, hearing impairment and locomotor disabilities are streamlined to follow a curriculum that is almost in line with the general education curriculum. The plus curriculum and the adaptation of instructional methodologies are followed where necessary. Children with mental retardation on the other hand require a specialised curriculum to meet their specific educational needs. Over time however there has been growing awareness that special education in special schools may be overly restrictive and instead of working outside the mainstream classrooms the special schools can work with and provide support to regular schools. Early in 1992 the Programme of Action while promoting integrated education had also suggested a Pragmatic Placement Principle. It postulated that learners with disabilities who can be educated in general schools should be educated in general schools and those studying in special schools should be transferred to general schools once they are ready to make the shift (MHRD Programme of Action, 1992). This was endorsed in 1994 by the Salamanca Statement (statement issued by the World Conference on Special Needs Education) recommendations for an alternative role for special schools. Hence special schools in their newfound identity would become a far more flexible resource by working in partnership with and creating a response to special needs not only in the alternative form of provision and intervention but within the mainstream classroom, curricula and pedagogies. Special education in other words general education is gearing for a significant move to come closer together. Briefly stated, the education of persons with disabilities in India has been recognised as an integral part of the educational system; hence, the policies and programmes adopted in recent years have been in accordance with this belief.

**Inclusive Education**

The National Curriculum Framework for School Education (NCFSE) (2000) brought out by the NCERT recommended inclusive schools for all without specific reference to pupils with SEN as a way of providing quality education to all learners According to
NCFSE: Segregation or isolation is good neither for learners with disabilities nor for general learners without disabilities. Societal requirement is that learners with special needs should be educated along with other learners in inclusive schools, which are cost effective and have sound pedagogical practices (NCERT, 2000) The NCFSE also recommended definitive action at the level of curriculum makers, teachers, writers of teaching-learning materials and evaluation experts for the success of this strategy. This precipitated a revision of the IEDC scheme. This revision is in progress and has to a certain extent gained ground in the country. Internationally until the end of 1980s integration remained the main issue whenever discussions were held regarding the rights of disabled persons to an appropriate education. Whereas in India integration was a major reform of the 1970s the need for inclusive education became evident from the fact that despite complete financial support under the IEDC scheme for integrating learners with special needs into the educational system only 2–3% of the total population of these learners was actually integrated into the regular schools. Dissatisfaction with the progress towards integration consideration of costs involved and the advantages of an inclusive environment in bringing about increased acceptance of learners with SEN led to demands for more radical change. The constant use of the medical model of assessment wherein educational difficulties are explained solely in terms of defects in the child led to a re-conceptualisation of the special needs (SN) task as requiring school reforms and improved pedagogy. This re-conceptualisation at both the international and national level helped in the emergence of an orientation towards inclusive education. In the 1990s inclusion captured the field after the World Conference on Special Needs Education in Salamanca in 1994 with the adoption of the Salamanca Statement and Framework for Action on Special Needs Education. This statement which was adopted by the representatives of 92 governments and 25 international organisations in June 1994 has definitely set the policy agenda for inclusive education on a global basis (UNESCO, 1994). To quote from the Salamanca Statement: We the delegates of the World Conference on Special Needs
Education hereby reaffirm our commitment to Education for All recognising the necessity and urgency of providing education to children, youth and adults with SEN within the regular education system and further hereby endorse the Framework for Action on SNE that governments and organisations may be guided by the spirit of its provisions and recommendations (UNESCO, 1994: 8)

Though in India there is no formal or official definition of inclusion, it does not only mean the placement of students with SEN in regular classrooms. The Draft Scheme on Inclusive Education prepared by the MHRD (2003) uses the following definition: Inclusive education means all learners young people with or without disabilities being able to learn together in ordinary preschool provisions, schools and community educational settings with appropriate network of support services. Inclusion means the process of educating children with SEN alongside their peers in mainstream schools. The feasibility of inclusion of such children in schools however has been an issue that has been discussed and debated extensively at various national and international forums. Inclusion remains a complex and controversial issue which tends to generate heated debates. There is a great deal of uncertainty about the definition of inclusion it is difficult to find research evidence that can provide definitive guidance as to where policy and practice should be heading.
Education is one of the essential inputs to ensure the quality of life of an individual. That is why the right to education finds a place in the constitution. The goal of universalisation of primary education provides direction to planned development efforts. To achieve this goal educational facilities have expanded enormously in the post-independence period. Millions of children have benefited from these facilities. The fruits of universalisation of primary education have not however reached some special groups of children despite its enormous expansion in the post-independence period.
National policy of Education

The National policy of Education 1968 therefore lays special emphasis on the removal of disparities and the need to equalize educational opportunity by attending to the specific wants of those who have so far been denied equal opportunity. Cut lining the steps for ensuring equal education opportunity for the handicapped the National Policy of Education states that the objective should be “to integrate the physically and mentally handicapped with the general community as equal partners to prepare them for normal growth and to enable them to face life with courage and confidence”.

The National Policy on Education - 1986 has resolved to make special effort to equalize educational opportunity for the doubly disadvantage group of disabled children. The National Policy of Education program of action stressed the need for a reach out plan to universalize primary education the group of children with motor and other mild handicaps along with the rest by 1990 in the age group 6 – 11 years and in 1995 in the age group 6 - 14 years. This group of children are to be educated in common with other children in general schools. The program of action (POA) also suggests that even those disabled children who join special schools as soon as they acquire the communication skills, self help skills and basic academic skills they may also be integrated in special schools. It implies that the educational system will have to be satisfied, providing education to large number of disabled children in general schools. To achieve this goal, review of the scheme of integrated education for the disabled and acceleration of pace of its implementation have been envisaged in the program of action.

Special Education:

Special education is the education of students with special needs in a way that addresses the students’ individual differences and needs. Ideally this process involves the individually planned and systematically monitored arrangement of teaching procedures adapted
equipment and materials accessible settings and other interventions designed to help learners with special needs achieve a higher level of personal self-sufficiency and success in school and community than would be available if the students were only given access to a typical classroom education.

Common special needs include challenges with learning, communication challenges, emotional and behavioural disorders, physical disabilities and developmental disorders. Students with these kinds of special needs are likely to benefit from additional educational services such as different approaches to teaching, use of technology, a specifically adapted teaching area or resource room.

Intellectual giftedness is a difference in learning and can also benefit from specialized teaching techniques or different educational programs but the term "special education" is generally used to specifically indicate instruction of students whose special needs reduce their ability to learn independently or in an ordinary classroom and gifted education is handled separately.

In most developed countries educators are modifying teaching methods and environments so that the maximum number of students is served in general education environments. Special education in developed countries is often regarded less as a "place" and more as "a range of services available in every school." Integration can reduce social stigmas and improve academic achievement for many students.

**Identifying students with special needs**

Some children are easily identified as candidates for special needs from their medical history. They may have been diagnosed with a genetic condition that is associated with mental retardation may have various forms of brain damage may have a development disorder or may have visual or hearing disabilities or other disabilities.
Among students whose identification is less obvious such as students with learning difficulties two primary methods have been used for identifying them: the discrepancy model and the response to intervention model. The discrepancy model depends on the teacher noticing that the students’ achievements are noticeably below what is expected. Response to intervention model advocates earlier intervention.

In the discrepancy model, a student receives special educational services for a specific learning difficulty (SLD) if and only if the student has at least normal intelligence and the student's academic achievement is below what is expected of a student with his or her IQ. Although the discrepancy model has dominated the school system for many years, there has been substantial criticism of this approach (e.g. Aaron, 1995, Flanagan and Mascolo, 2005) among researchers. One reason for criticism is that diagnosing SLDs on the basis of the discrepancy between achievement and IQ does not predict the effectiveness of treatment. Low academic achievers who also have low IQ appear to benefit from treatment just as much as low academic achievers who have normal or high intelligence.

The alternative approach ‘response to intervention’ identifies children who are having difficulties in school in their first or second year after starting school. They then receive additional assistance such as participating in a reading remediation program. The response of the children to this intervention then determines whether they are designated as having a learning disability. Those few who still have trouble may then receive designation and further assistance. Sternberg (1999) has argued that early remediation can greatly reduce the number of children meeting diagnostic criteria for learning disabilities. He has also suggested that the focus on learning disabilities and the provision of accommodations in school fails to acknowledge that people have a range of strengths and weaknesses and places undue emphasis on academics by insisting that people should be propped up in this arena and not in music or sports.

Aims of Special Education
To ensure equal educational opportunity for the disabled to be integrated with the general community the National Policy of Education has envisaged the following measures:

1. Wherever it is feasible the education of children with motor handicaps and other mild handicaps will be common with that of others.

2. Special schools with hostels will be provided as far as possible at district head-quarters for severely handicapped children.

3. Adequate arrangements will be made to give vocational training to the disabled.

4. Teacher training programs will be reoriented in particular for teachers of primary classes to deal with the special difficulties of handicapped children.

5. Voluntary effort for education of the disabled will be encouraged in every possible way.

Children differ from each other in a variety of ways i.e. physically, intellectually, socially, emotionally etc. In most cases such differences are of little significance and yet some children deviate from normal to such a degree that they need special attention. These are exceptional children. The problem of exceptional children is not new. Every community has its own exceptional children. Visually handicapped, crippled, deaf and hard of hearing, speech handicapped, socially maladjusted, mentally retarded – all these will come under the category of exceptional children. Educators should know the types of exceptional children of their schools and also should know the types of services needed and those that are available locally. They should have some broad and general understandings about the problems of exceptional children and the role of the school and related agencies in helping to meet the needs of other children in contemporary education.
The humanitarian movement grew as communication facilities increased. Men became more interdependent. Compulsory education began to become part of our social picture. Knowledge of medical diagnosis and treatment increased. Educational methodologies especially for the blind and for the deaf are being developed in all its factors. Fewer blind, deaf and crippled children were perceived merely as individuals who were only to be cared for and protected from the inevitable and often harsh attitudes that regarded them as unable to care for themselves wholly or in part. More and more, many of those handicapped came to be recognized as capable of being benefited from some education or trainings as capable of contributing at least in part if not wholly to their own maintenance. The provisions made for exceptional children have come to be quite varied to nature and probably will continue to be even more varied. To many persons special education means only the provision of special classes in the schools. But there are also residential schools for blind and deaf children. These schools play important educational roles. Some special teachers work in hospitals for crippled children. Other teachers go to the homes for children who are physically unable to attend the schools. Speech therapists may work with only one child at a time. Other special educationists render constant services to school personnel like this special education provisions include much more than special classes. To stain all these ends the central government as well as the state governments also should come forward to make some kind of financial provision for the welfare of the handicapped children in their respective budgets.

**Special Needs Education in India**

In pre-independent India the country had a few special schools for children with intellectual impairment run by non-Government organization, a few mentally retarded persons admitted to mental hospitals and many stayed at home. India has come a long way since independence in the area of disability rehabilitation. There has been a shift in the lifestyle of people with disabilities from charity to
right. It is no more the wish and choice of the giver to provide education, vocational training and rehabilitation but the right of the person with disability to receive the support.

The Government of India has set up four national level institutes to effectively implement government schemes for persons with disabilities to develop human resources to deal with disabilities to develop service models to conduct research and to document and disseminate information. These are: National Institute of the Visually Handicapped, National Institute for Hearing Handicapped, National Institute for Orthopedically Handicapped, National Institute for the Mentally Handicapped. The Institute for Physically Handicapped and National Institute of Rehabilitation, Training and Research are two more national level institutes of rehabilitation. In addition, the District Rehabilitation Centre (DRC) scheme has been initiated in 10 States aiming at preventive measures and comprehensive rehabilitation. To train manpower for DRCs four Regional Rehabilitation Training Centres have been established.

An important turning point has been the National Policy on Education (1986). This policy for the first time included a section on disabilities (Section 4.9). Briefly the points made in this section include;

- Education of children with mild disabilities will be in regular schools.
- Children with severe disabilities will be in special schools with hostel facilities in district headquarters.
- Vocationalisation of education will be initiated.
- Teachers training programmes will be reoriented to include education of disabled children.
- All voluntary efforts will be encouraged.
Today there are about 37 diploma programmes in the field of special education and about 3 offering the B.Ed. degree. The Rehabilitation Council of India (RCI) a statutory body under the Ministry of Social Justice and Empowerment regulates these courses for the education, training and management of persons with disabilities.

The District Primary Education Programme (DPEP) is another major step towards Universalisation of Primary Education wherein children with special needs are also included. A number of districts are implementing the programme. Inclusive education being the concept world over the DPEP aims at including the children at primary level (up to Class V) with suitable teacher preparation, infrastructure facilities and aids and appliances. In addition, there are over 1,100 special schools run by NGOs with Government support.
Special Needs Education in Some Developed Countries:

United States

In 1975, the United States Congress passed the Education for all Handicapped Children Act (EHA) in response to discriminatory treatment by public educational agencies against students with disabilities. The EHA was later modified to strengthen protections to people with disabilities and renamed the Individuals with Disabilities Education Act (IDEA). The federal laws require states to provide special education consistent with federal standards as a condition of receiving federal funds.

IDEA entitles every student to be a free and appropriate public education (FAPE) in the least restrictive environment (LRE). To ensure a FAPE, a team of professionals from the local educational agency meet with the student's parents to identify the student's unique educational needs to develop annual goals for the student and to determine the placement, program modification, testing accommodation, counselling and other special services that the student needs. Parents become part of the multidisciplinary team along with the local educational agency professionals and collaborate with team members to make decisions on educational placement. These choices are recorded in a written Individualised Education Programme (IEP). The school is required to develop and implement an IEP that meets the standards of federal and state educational agencies. Parents have the option of refusing Special Education services for their child.

Under IDEA students with disabilities are entitled to receive special educational services through their local school district from age 3 to age 18 or 21. To receive special education services a student must demonstrate a disability in one of the 13 specific categories including autism, developmental disability, specific learning disability, intellectual impairment, emotional and/or behavioural disability, speech and language disability, deaf-blind, visual impairment, hearing impairment, orthopaedic or physical impairment,
other health impaired including attention deficit disorder (ADD), multiple disabilities and traumatic brain injury. Depending on the students' individual needs they may be included mainstreamed or placed in a special school and/or may receive many specialized services in a resource room or self-contained classroom. In addition to academic goals the goals documented in the IEP may address self-care social skills physical speech and vocational training. The program placement is an integral part of the process and typically takes place during the IEP meeting

**Special education in England**

*Special education in England* is the responsibility of the government of the United Kingdom and the term "special educational needs" is used to describe the needs of children who need additional provision in order to make progress. This includes children with moderate or severe learning difficulties and physical, neurological or sensory disabilities (such as hearing, motor and visual disabilities) as well as needs such as dyslexia, dyspraxia, autism, asperser syndrome, attention-deficit hyperactivity disorder (ADHD).

**France**

In France, they do not have a dedicated term for the child population in need of specific measures adapted to their special educational needs. The current terminology (disabled children, un-adapted children, school adaptation and integration, administrative or legal protection of youth, specialised education, adapted education, etc.) comes with particular references and connotations and is weighted with historical context. There is no expression in use today, which signifies that children or adolescents with special schooling and educational needs require particular care and monitoring in well-defined options, distinct from the ordinary educational system.
The education of children and adolescents with serious difficulties, either through disability or illness is based on an infrastructure, which has slowly grown into a very dense network. This network includes four sectors: the public education system, under the authority of the Ministry of Education the medico-educational sector, under the authority of the Ministry of Health, Youth and Sports, the socio-educational sector, under the authority either of the Ministry of Labour, Social Relations and Solidarity or the Ministry of Justice and the health sector.

**Development of Special Needs Education in Japan and Some Current Problems**

1. The special education in Japan before World War II

   Special education began in Japan in the latter part of the 19th century. The first special school, a school for children with visual disabilities and children who were deaf, was established in Kyoto in 1878. The first special class a class for children with intellectual disabilities was set up in 1890 in Matsumoto City, Nagano Prefecture. In other words, special education for these has 127 and 115 years’ history respectively until now. The number of special schools and special classes for children with various kinds of disabilities had increased favourably until around 1930, but thereafter the rise of militarism and the War devastated the special education. At the end of the World War II, the external number of special schools for children with blindness and deafness was still more than 100, but most schools were burned by air raids or the children were forced to move to rural area without school teaching. In the case of special classes, all were closed except one in Tokyo, at which the children also moved to rural area... The special education had to be reconstructed after the World War II based on the philosophy of democratic education, which was introduced by the educational policy of the occupation army.

2. Development of Special Education in Japan since the End of the 2nd World War:
The new education law was enacted in 1947 and 6-3 compulsory education system started. The development of special education was rapid; firstly, the special schools for children with blindness and deafness were reconstructed and secondly, special classes mainly for children with intellectual disability increased in number. Thirdly, the special schools for children with intellectual disability, with physical disability and with health impairment, which had also increased in number, became compulsory education schools in 1979. In 1979, the total number of special schools and the children was respectively 837 and 88,847 and total number of special classes and the children was respectively 20,865 and 115,711. The development of special education since the end of the World War II is divided in 3 terms:


(2) Movement of integrated education-Dumping. – 2000.

(3) Development of special needs education. – Present.

**Mental Retardation:**

Mentally retarded or handicapped children are less clever than the rest of the children. Even so, a few mentally handicapped persons have written stories and poetry and painted beautiful pictures and had shown other surprising talents. A normal child learns many skills and develops his abilities very quickly during the first few years of his life. “A mentally handicapped child is one whose learning and development has been delayed or slowed down for one reason or another. Mental handicap, also called mental retardation is a delay or slowness in mental development”.

The job of totally educating the handicapped, to a large extent was neglected by therapeutic disciplines including educators, physical, occupational, speech and hearing therapists. This was so because the training was fragmented: a) Gross and fine motor
Development became the exclusive domain on physical and Occupational Therapy b) Communication skill development became the particular province of speech and hearing therapy.

Earlier, the primary aim of the special educators was to teach the child Reading, Writing and Number Work. Other areas like physical therapy, speech therapy, etc., were neglected. Therefore other professionals, physiotherapists, occupational therapists, speech therapists – stepped in to fill the vacuum created by the special educators. While this was generally true it was also beginning to be felt that some drastic change was needed in the concept of total education.

For example, Vallututti had this to State: “Now educators can no longer ignore the total educational needs of all students. No longer should the student be split into part, with his tongue allotted to the speech therapist; his hands to the occupational therapist and his legs to the physical therapist. Educators must assume, at long last, the inherent responsibility for teaching the person as a whole. Educators will continue, however, to require the professional advice and assistance of medical and paramedical specialists, who will continue to serve as essential resource people”.

**Types of Mental Retardation**

1) **Hyperactivity**

Hyperactivity is characterized by the inability to concentrate on anything for more than a few seconds at a time.

2) **Memory Defects:**

Memory defects may for example be difficulty in remembering things hard, so that a child is unable to speak sensibly.

3) **Perceptual problems:**
Perceptual problems where a child is unable to recognize or copy shapes (visual perception) or sound (auditory perception).

4) **Unequal delay:**

Even if a child’s development is delayed in all areas, it is unlikely that he will be equally delayed in each. For example, a 10 year old mentally handicapped child might be able to:

i) Move like a 2 year old: (walk into ball when trying to kick it; hold on to a wall when walking up and down stairs, putting both feet on each step).

ii) Listen to long stories with interest – like a 4 year old.

iii) Speak like a 2 1/2 year old.

iv) Sort colours like a 4 year old.

v) Look after younger children like a 5 year old.

5) **Emotional problems:**

When the mentally retarded child first comes to the special school he/she is quite likely to have emotional problems which prevent him/her from doing as well as he could do. These emotional problems may result from stress at home where the mother may feel unable to cope with the child. The child may feel himself/herself to be a failure. If a child is overprotected at home he/she may be frightened by being in a strange place among unfamiliar people. When a close and loving relationship is formed with the teacher, a child may overcome many of his/her emotional difficulties within a few months and then make quite rapid progress in all areas.

6) **No Clear illness:**
Mental handicap is not a condition that can be cured. However, it is possible that a child who is thought of as mentally handicapped may later on in life not be thought of in this way. If an adult person is described as mentally handicapped it means that he is both less clever than a normal person and that he does not do the normal things expected by society. If a person has learned to do the normal things expected by society he should no longer be described as mentally retarded. Normal activities vary from one social group to another, a young adult with the mental development of a 7 year old child, who has had a little help from his family may seem quite normal if he is a farm worker or labourer or a house keeper.

A young adult with a mental development of 12 years will be considered retarded if all his family and social circle are highly educated professional people. This shows that there is no clear dividing line between mentally handicapped and “normal” people. Some people are a little less clever than average, some are very much less clever and there is every possible stage in between. Many mentally handicapped people need just a little help to lead normal lives, but there remain some who will need a lot of help all through their lives.

**Mental Retardation and Mental Illness:**

Some people are confused between mental retardation (mental handicap) and mental illness. Mental illness is quite a different condition. A person who is mentally ill may have normal or high intelligence and may even be highly educated. But as a result of stressful experiences or because of some physical illness affecting the brain, his behaviour becomes strange even though he knows how to behave normally.
When a mentally retarded person behaves in an abnormal way it is usually because he has not learned the correct way to behave. The mentally retarded person needs to be taught how to behave normally. The mentally ill person needs help a psychiatrist to overcome his illness so that he can return to normal everyday life and behaviour.

The mentally retarded child is an exceptional child. The exceptional child is difficult to define, for the term represents many different medical, psychological and educational grouping of children. “Essentially, an exceptional child is one who deviates intellectually, physically, socially, or emotionally so much from what is considered to be normal growth and development that he is unable to receive maximum benefit from a regular school programme, requires a special class or supplementary instructions and service”.

The roots of the field of special education can be traced to the beginning of man himself. They are linked to primitive times when men first became aware of those whose appearance and behaviour differed from the expectations of the majority. Over the course of history, such differences have been reacted to in a variety of ways that have ranged from the cruel to the human. “Those who were different have been destroyed, tortured, exercised, sterilized, ignored, exiled, exploited and even considered divine”.

**Causes of Mental Handicap:**

Causes of severe mental handicap fall into two main groups: brain damage and abnormal genetic conditions. “Lack of stimulation” is a further cause or group of causes.

1) **Brain Damage:**
Brain damage can be caused by something going wrong before birth, or at the time of birth, or later. At birth the common causes of damage are lack of oxygen (which may be a result of prolonged labour) or too much pressure on the baby’s head. Before birth the baby can be damaged by the infections. For example, rubella (‘German Measles’) is a mild illness for the mother but if she gets it during the first three months of pregnancy it may result in the baby being blind, deaf and mentally retarded. Even milder infections, which the mother may not be aware of having, can sometimes damage the baby’s brain. Congenital syphilis may result in mental handicap. Certain physical features may also go with this condition making it recognisable, but teachers should beware of discussing this disease with families as they will certainly be offended. Drugs taken by the mother may damage the expected baby and also X-Rays at certain stages of pregnancy.

Brain damage after the child is born can result from many causes: High temperature (fever) can produce brain damage: And so can low body temperature which may arise if the baby is not wrapped warmly enough in winter or is left in a cold bath.

Jaundice from infection or from difference in type of parent’s blood. If it is known that a husband’s blood group is positive and his wife’s is negative, they should consult their doctor.

Encephalitis – brain infection – may be a complication of other illness.

Injury – a blow on the head producing brain damage may result from many causes.

Malnutrition: Brain damage can result from not getting enough food in early childhood. There are also rare conditions, e.g., Phenylketonuria, where the child’s body cannot use food properly resulting in brain damage caused by poisons produced in his/her body. In some mountainous areas children may suffer from lack of iodine in their diet, producing a severe disability called cretinism.

Drugs – an overdose may also produce brain damage.
All the causes listed above are known to produce brain damage. Those of us who are not doctors should not be concerned to identify the causes of a particular child’s injury. Even in countries where every cause is carefully studied in 40% of cases the cause is still unknown.

2) Genetic Causes of Mental Handicap:

In some babies the handicap is a result of a defect in the mechanism of inheritance from parents. The most common type of mental handicap in this class is Down’s syndrome or Mongolism. Down’s syndrome is not hereditary in genetic material – the baby has too many “chromosomes” in each cell. Down’s syndrome is much more likely to occur in children of older mothers. In Britain, one child in 10,000 of those born to mothers under 25 years old is a Down’s syndrome child, but one child in 50 of those born to mothers over 40 years old is affected. Similar figures may be expected in Pakistan and elsewhere. Down’s syndrome is usually easy to recognize. Persons with this condition have slanting eyes, flat nose and mouths, often open tongues and sometimes hang out. They often get chest infections. They are usually friendly and outgoing and enjoy entertaining others particularly by imitating people. However, they often learn to control their families so as to get their own way. Their speech is often delayed and spoken language is well behind language comprehension. This is because their nasal passages are often poorly developed leading them to breathe through the mouth and making speech more difficult. They also often suffer from catarrh which may cause some difficulties with hearing. The teacher should be aware that when a Down’s pupil has a cold she may have problems in hearing, which should improve when the cold has cleared.

There are hundreds of other known genetic abnormalities but they are all very rare so we are not likely to meet many of these conditions such as small head, extra fingers or dwarfism. These conditions occur when the material of heredity (called a ‘gene’) is
altered by chance. For many of these conditions it is necessary for the same abnormal gene to be inherited from both the parents if the child himself is to be affected. In Western countries there is evidence that the average person carries several abnormal genes. The chances of a person with an abnormality marrying someone with the same abnormality gene are very small in Western countries – for the most common abnormal genes, it is a chance of one in one hundred thousand.

However, the situation in many parts of Pakistan and India is very different. An abnormal gene may arise in a person’s hereditary structure by chance without that person being affected and this gene will be passed on to some of his children and grandchildren. If the grandchildren follow the custom of marrying a cousin, there is a high probability that the cousin has the same abnormal gene – so some of these children will inherit the same abnormal gene from both parents, which will result in them being handicapped.

3) Not Enough Stimulation:

A third group of causes of mental handicap is under stimulation. If a normal baby were to grow up in a dark silent room with nothing interesting for her hands to touch and no contact with other people, she would learn – nothing. Very few children grow up in such a limited way. But the child who gets very little attention from other people, staying in one room or on one piece of furniture and having nothing interesting to explore will learn much less than she might have done in a more interesting place. If the child is placed in interesting surroundings and is allowed to start exploring in the way a baby would do, she will make rapid progress. The younger she is when the programme of stimulation begins, the greater is the chance of reaching a near normal standard. A number of physically handicapped children will be found to fall into this category because their parents (with the best of intentions) confine them to lying on a bed with nothing to do.
4) **Ways of thinking about causes:**

There are many false ideas about causes of mental handicap. Some people blame evil spirits or feel that it is a punishment for doing something wrong. We should try to discourage those ideas. Most important parents must be helped not to blame themselves nor feel guilty. Instead they should concentrate on the future how to help their child to learn as much as possible.

The types of causes listed with the exception of malnutrition (and particularly iodine deficiency if treatment is begun while the child is still very young) are medically incurable. Parents will have taken their child to doctors and been told that she cannot be cured. We must help families to understand that although the medical condition will remain the same, the child can be helped to develop and so to have a more normal life. Usually he/she is not sick and his/her development might have slowed down but with proper stimulation it can be helped along and she will learn.

5) **Epilepsy (Fits):**

Fits occur in children who are mentally normal as well as in those who are mentally retarded. Fits can usually be controlled by taking medicine in the correct quantity. Controlling the fits will make the child who suffers from then more acceptable in the community. If not controlled, some kinds of fits can cause brain damage. There are several medicines which can stop fits. They should be prescribed by a doctor. There may be side effects such as drowsiness, skin rashes etc. It is important to find the lowest dose of drug that will stop the fits (or, where the fits cannot be stopped, the dosage resulting in the least fits without unwanted side effects). For this reason it may be necessary to make many visits to the doctor until the correct dosage can be fixed.

If a child has a fit in school, one must ensure that he is not in a position where he might fall or hit his head against sharp objects. One must not fuss over or try to put anything in the person’s mouth if he/she is sleepy. When he/she comes out from a fit, he/she
should be allowed to sleep until wakes up. One should not make a fuss if he/she is incontinent during a fit and has no control over this.

If it happens often some spare clothes should be kept in school.

**Handling the Mentally Retarded:**

The teacher’s job is to make sure that pupils learn. It is not the job of the teacher to find out the cause of a particular child’s mental health. However, the teacher needs to know something about causes since many parents commit mistakes and so not to blame them unnecessarily. The teacher should not ask probing questions about cause. Care must be taken never to make parents feel that they are blamed. If the teacher feels that there is a danger of more impaired children being born into one family it is better for the matter to be discussed between the family and a specialist doctor.
The teacher and the handicapped child:

The teacher of the handicapped child has an impregnable irresponsibility which makes many demands. If he puts into practice the things that will provide the most favourable opportunities for the development of his charges, he will realize in the course of his work that he must know much about his students and their abilities and disabilities. He must be concerned with what he can do to improve the interpersonal relationships between himself and the children under his direction. The teacher should act as a teacher, counsellor and therapist. The teacher should provide for integrated experiences with the child’s peer groups. The teacher must be constantly aware that he is dealing with children and that the subject matter, teaching methods, special equipment and services are only for the purpose of developing the children under his charge.

The status of the handicapped:

The attitude of the non handicapped towards the handicapped in society places the latter in a minority status not greatly different from the status of more commonly identified minority groups. Although great efforts have been made to improve the social position as well as the physical and psychological conditions of the handicapped, it would appear that further gains might be achieved through the application of sound sociological procedures. The handicapped having a definite minority status is supported by Rogers G. Barker who stated: “The minority status of the physically disabled, which is due to the negative attitudes of the physically normal majority, who would seem to be in almost all respects similar to the problem of racial and religious under privileged minorities, although it may will be that the source of negative attitude toward the physically disabled is even deeper and less rational. We cannot go into the problems of education, clinical psychology, propaganda, learning and politics which are involved here. When and as these problems are solved with respect to these other minorities, the solution may be applied to the physically handicapped”
Efforts to equalize educational opportunities for the handicapped as compared with the non-handicapped have been made through the years. To meet the needs of the handicapped adequate additional funds for special services and facilities for proper education are needed. To develop through research improved educational practices and methods adequate number of specially trained teachers are needed. This in turn increases the knowledge and understanding of all teachers in regard to exceptional children so that they can adequately serve them. The dedicated effort is to devise more effective means of providing services to handicapped children in sparsely populated areas. Vocational rehabilitation and employment services through physical correction training of retraining and job finding will reduce the minority status of handicapped persons.

**Behaviour and Aberrant Behaviour:**

Behaviour can be defined as the manner in which one behaves or the actions or reactions of a person or animal in response to external or internal stimuli.

The noun behaviour has 4 senses:

1. the action or reaction of something (as a machine or substance) under specified circumstances
2. (behavioural attributes) the way a person behaves towards other people
3. (psychology) the aggregate of the responses or reactions or movements made by an organism in any situation
4. manner of acting or controlling oneself

**Aberrant or Abnormal Behaviour:**
What is aberrant or abnormal behaviour? That is one of the most difficult questions psychologists have to answer. It is difficult because it is also hard to define what is normal. It is hard because what's normal at one point in time may be abnormal at another and what's normal in one environment may be quite abnormal somewhere else.

Typically, a psychologist (or psychiatrist) qualified to judge whether behaviour is normal or abnormal does not get involved in that decision at the beginning. Usually someone's behaviour has already been judged abnormal by one or more friends, family members or co-workers before they are consulted. What does that mean? Consider the following. Some person close to the subject may follow a course of behaviour that after a while puts him/her in a state of constant anger, fear, or anxiety. The person would then want to call in a professional to see whether a label should be placed on this person's pattern of behaviour. If a label can be found, the person would feel justified in trying to persuade that person to accept treatment that would try to change his or her behaviour back to normal.

Judgment of abnormality is complex but important in several ways. For instance, in a job situation, the person first needs to know what others think is normal behaviour. Abnormal behaviour at work can have serious results not only for the persons involved but for those dependent on him or her for support. A number of different sets of factors -- individual, environmental and societal -- must be brought to bear in diagnosing someone's behaviour as "abnormal." Though infrequent, abnormal behaviour reflecting mental illness does occur.

**Bases for Defining Abnormality**

Aberrant, abnormal, or deviant behaviour fall broadly into three categories – statistical, personal and social. A statistical definition of normality, considers a behaviour that applies to almost all humans - how clean one keeps his/her home? Someone who walks around with a cleaning rag all the time would be considered compulsively neat. Someone who simply drops papers, clothes, or
whatever, at the moment he or she is done with them, would be considered abnormally sloppy. By this definition, if someone to be normal, demands conformity. Abnormality is hard to define since the behaviour being measured is on a continuum.

The borders between normal and abnormal can be very hard both to define and to defend. It must be admitted that the personal feelings of happiness and adequacy should play a role in their definition of abnormal behaviour. Any one may at some time seek professional help for problems that are not even visible to their friends or family. Yet, even here there are difficulties in definition. The internal discomfort that would cause one person to seek help might be considered normal wear-and-tear by another. And one got to exclude organic (physical) causes before one can say a purely psychological problem is involved. Sometimes one may seek professional psychological help because they think that they've got an emotional-behavioural problem. Actually, however, there may be a physiological explanation for their feelings perhaps an internal chemical imbalance or a disease. One describes elsewhere, often times the first judgment of abnormality may be made by their friends. This is an example of where their eccentric behaviour, if judged eccentric by social norms, may be called abnormal. If the person always goes out to water your yard only when it's raining outside, people may begin to watch the person more closely. If the person acts as if the persons are mortally afraid of some harmless thing (called having a phobia), again people will call his behaviour abnormal.

One of the best means of identifying abnormal behaviour is to start by acknowledging the wide variety of sources of influence of our behaviour. This leads to a wide range of human behaviours that are or may be acceptable. Thus, developing a precise definition of abnormal behaviour is very difficult. Let us try it this way: Abnormal behaviour exists if one finds that one or more of three conditions exist. First is subjective discomfort. If the person feels uncomfortable and it influences (a) others around you, (b) your ability to maintain yourself personally and (c) your ability to do your work, then the person probably needs help. Second is eccentricity in
behaviour. If the person is not behaving predictably relative to your environment, then your behaviour is abnormal. Speech normally reflects rational thinking, so incoherent speech is a good indicator of eccentric behaviour. It is important that this eccentricity causes the person discomfort and that it noticeably affects the comfort of others around you.

Third, if there is a change in your behaviour in relation to your previously accepted behaviour, then in some sense the person is acting abnormally. A comparable physical example would exist if the person has always perspired easily and suddenly found that even on very hot days the person was not perspiring. The person would begin to suspect something was wrong. "Normal" for you, however, might be a rate of perspiring that would cause others to think they were sick. The same applies to your behaviour. Such changes might mean that the person needs professional help.

**Need and Significance of the Study:**

People with intellectual disability are known to present behaviour disorder in a larger proportion than the general population. Since such problems reduce the chances for community integration and access to educational, leisure and occupational activities (Rojahn & Helsel, 1991), it is essential to be able to evaluate those challenging behaviours. The greatest difficulty for the educational staff involves the management of disruptive behaviours, which are a source of stress for training teams, the families and the residents themselves. However, no rating instruments assessing behaviour disorder exist at the moment in Telugu language.

The interest of Indian educators for psychological assessment tools is at the origin of an international exchange that has started a specific collaboration linked to the reality on the ground. Their interest was mainly directed to a fast and effective way to assess behavioural disorders that constitute a major problem in their daily care activity (Varisco, Kempf- Constantin Lehotkay et al. 2009). To
quantify and qualify behavioural troubles, the Aberrant Behaviour Checklist scale (ABC, Aman, Singh, Stewart et al., 1985 a and b, 1987, 1995) is a remarkable assessment tool, easily applicable and especially allowing for the observation of possible improvements in time (Galli Carminati, Constantine Schaya et al., 2004). The sensitivity areas of the ABC for an Indian population with intellectual disability have already been discussed, we can mention: aggression, self-mutilation, destructive behaviour, grasping behaviour, motor stereotypes, echolalia and stereotyped language, hyperactivity and irritability. From the relational point of view, one must also add dysfunction in social relations, inhibition, often isolation and inappropriate sexual behaviour.

The purpose of this investigation was to enable educators of the Lebenshilfe Institute to express a personal judgment to measure success or failure in their care, while taking into account the efforts being deployed for its success. This allows investigating and preventing possible exhaustion of the educational team and asking questions about the effectiveness of the strategies adapted so far.

The Research Questions:

The research had been conducted by keeping three factors in mind and they are presented.

1. How is the checklist prepared in Telugu language and validated for the assessment of Aberrant Behaviour?

2. How is the relationship between staff’s satisfaction regarding caring, challenging behaviour and Psycho-Educational Profile (PEP-R) in a population of young Indians with Intellectual Disabilities (ID)?

3. What are the influences of various Intervention Techniques incorporated for controlling and modifying aberrant behaviour at Lebenshilfe in improving the life skills of the individuals?

Objectives of the Present Study:
1. To validate the Aberrant Behaviour Checklist in Telugu language, means to evaluate the factor structure and the psychometric characteristics of this version. The researcher postulates the factor structure of this Telugu version to be comparable to the original English version. Concerning the reliability, the translated ABC will present a good internal consistency in its items and subscales and a good inter-rater reliability. Test-re-test reliability.

2. To determine if a relationship exists between the level of skills (PEP-R) of a person with intellectual disability and the severity of the challenging behaviours (ABC). In addition, to investigate whether a relationship is present between the behavioural disorders (ABC) and the self-evaluation of the educators on the satisfaction and effectiveness of their care (VAS).

3. To study the influence of various intervention strategies adapted at Lebenshilfe for training and educating the mentally retarded individuals.

Limitations of the Study:

All the studies for this research were carried out and adopted at Lebenshilfe School by a team of highly committed, trained and motivated individuals under the guidance and supervision of the researcher, Mrs. T. Saraswati Devi for enhancing the quality of life to the mentally retarded children. The research was in collaboration with the Department of Psychology and Para-Psychology Andhra University and Psychiatric Unit of Mental Development (Unité de Psychiatrie du Développement Mental, UPDM) – Division of Mental Health and Psychiatrie – Geneva University Hospitals and University of Geneva, Switzerland

Chapterisation:
Chapter I, entitled Introduction presents a brief background conceptualisation on special education, behaviour problems, abnormal behaviour and the need for its assessment. It presents a brief description about the Lebenshilfe institute where the research had been carried out. Finally, need for the study, objectives of the study and limitations of the study were presented.

Chapter II entitled Review of Related Literature presents the research carried out in the field of special education, inclusive education and particularly with the works related to mental retardation, abnormal behaviour.

Research Methodology is presented in Chapter III. This chapter basically describes the methods and strategies chosen for the study.

Chapter IV is titled as Validation and Application of Aberrant Behaviour Assessment Checklist in Telugu Language. It explains all the methods, assessments and validation and deals with the determination of a relationship existing between the level of skills (PEP-R) of a person with intellectual disability and the severity of the challenging behaviours.

Chapter V deals with Studies on Interventions Techniques and their influence on the aberrant behaviour. This chapter presents the strategies used at Lebenshilfe and the outcomes of the interventions.

Chapter VI deals with conclusions, generalisations and suggestions for further study.

Bibliography and Annexure are given at the end.