Introduction

Throughout centuries, the disabled have been oppressed, marginalized, and stigmatized in almost all societies. They constitute a section of the population, which is most backward, least served, and grossly neglected. Person with disability are the poorest of the poor and weakest of the weak, who have been socially, educationally and economically disadvantaged; thus having customarily denied their right to self-assertion, identity, and development. Now where is this victimization more glaring than in matters of education, employment, and physical access. Disability is not all alone sometimes impairment and handicap was used interchangeably, but these terms have different meanings and describe different concepts. To promote appropriate use of these terms, in 1980 the World Health Organization established the international classification of impairment, disability, and handicap, which define these concepts: Impairment – refers to the loss or abnormality of psychological, physical, or anatomical structure or function at the system or organ level that may or may not be permanent and that may or may not result in disability. Disability – refers to an individual limitation or restriction of an activity as the result of impairment. Handicap – refers to the disadvantage to the individual resulting from an impairment or disability that presents a barrier to fulfilling a role or reaching a goal. Disability is a relative term in so far as different cultures define their norms of being and doing differently. Conceptions of disability are therefore highly contextual and subjective.

As per 2001 census, 21.9 million or 21,906,769 people are disabled in India, who constitutes 2.13 per cent of the total population. Out of the 21,906,769 people with disabilities, 12,605,635 are males and 9,301,134 are females. This includes persons with visual, hearing, speech, locomotor, and mental disabilities. Seventy-five per cent of persons with disabilities live in rural areas, 49 per cent of disabled population is literate, and only 34 per cent are employed. The earlier emphasis on medical rehabilitation has now been replaced by an emphasis on social rehabilitation. The experience of disabled people in rural India suggests that this medical model does not adequately capture the phenomena of disability. What prevents disabled peoples in villages from living a life like anyone else, going to school, participating in family celebrations and working in fields is not individual’s impairment, but how society interpreted and reacts to it. Life is made difficult not so much by the individual’s medical condition, but mainly by a hostile physical and social environment which excludes disabled people from all spheres of social life. It is not the medical impairment, but the way in which society reacts to it, that exclude disabled from taking part in celebration, political decision-making, or religious worship.

Causes of Disability

Analysis of the causes of disability from a medical or bio-centric standpoint tends to emphasize disease, hereditary and birth defects over systemic and environmental factors. Genetic factors and lack of access to basic services can also lead to a person becoming disabled, for example, Before birth (poor nutrition, improper medication, taking drugs, smoking cigarettes, mother exposed to disease, mental or
During birth (premature delivery, complicated delivery), After birth (Malnutrition, Lack of vaccination, Infections like meningitis polio, accident, trauma, toxic substance).

Factors of Disability

There are some factors which responsible for disability, such as: Poverty and Disability - There is a high correlation between disability and poverty but very few studies have investigated how poverty and disability influence each other and with their combination create new forms of barriers. In general, people with disabilities are estimated to make up to 15 to 20% of the poor in developing countries. Inequitable economic and social policies have contributed to large numbers of people living in extreme poverty. Poor families often do not have sufficient income to meet their basic needs. Inadequate shelter, unhygienic living conditions, lack of sanitation and clean drinking water combined with poor access to health facilities lead to disability.

Malnutrition and Disability - Malnutrition in its various forms is a cause of disability as well as a contributory factor in other ailments that increase susceptibility to disabling conditions. Common micronutrient deficiencies that affect disability include: Vitamin A deficiency – blindness, Vitamin B complex deficiency – beri-beri (inflammation or degeneration of the nerves, digestive system and heart), pellagra (central nervous system and gastro-intestinal disorders, skin inflammation) and anaemia, Vitamin D deficiency – rickets (soft and deformed bones), Iodine deficiency – slow growth, learning difficulties, intellectual disabilities and goitre, Iron deficiency – anaemia, which impedes learning and activity, and is a significant cause of maternal mortality, Calcium deficiency – osteoporosis (fragile bones). At the present rate, by the year 2010 there could still be some 680 million chronically undernourished people whose disabilities are likely to have roots in micronutrient deficiencies.

Occupational Hazards - Around 90% of the workforce in India is in the unorganised sector, which is characterised by low levels of technology, low standards of safety and hazardous working conditions. Occupation-related health problems of workers employed in stone quarrying, leather industry, glasswork, weaving, diamond cutting, hand embroidery, and children employed in carpet, cracker and match industry have been recognised but have not received appropriate and sustained attention by those responsible for regulating work standards. For example, 44,000 people lost their limbs in industrial accidents during the period of Vietnam War in which 17,000 American soldiers became disabled. Wars and Disability - War has been the single largest factor responsible for causing permanent disablement not only to combatants in the battlefield but also to civilians who are forced to bear the hazards of lethal, chemical and nuclear weapons. Based on figures from a study carried out in 206 communities, including Afghanistan and Cambodia, landmine triggered disability rate among survivors is about 0.9%. About 6% of households in Afghanistan are affected by landmine accidents alone. Surveys of four countries in 1995 found that between 12% & 60% landmine victims had to sell assets to meet their medical bills.

Crime and Disability - Violent crimes underline shortcomings in the social, political and economic arrangements of a society. Many children and women are abducted to be used in prostitution, slavery and beggary. The Bhagalpur blinding case in India is a well-known and documented illustration of this menace. Traffic Hazards - Unplanned cities with narrow roads, rapid growth in number of vehicles and disregard of traffic regulations have been responsible for increasing the number of road accidents in India. If current trends continue, road accidents may become the leading cause of death and disability in the country. An expert in the field, Dr Leslie G Norman, estimates that for every road accident death there are 30-40 light injuries and 10-15 serious injuries, which may lead to disability. It is estimated that by 2020, road traffic accidents will be ranked as the third leading cause of disability in the Asian and Pacific region. Quadriplegia, paraplegia, brain damage and behavioural disorders are some common disabilities among survivors of traffic accidents.

Constitutional Framework in India

The Constitution of India applies uniformly to every legal citizen of India, whether they are healthy or disabled in any way (physically or mentally) and guarantees a right of justice, liberty of thought, expression, belief, faith and worship and equality of status and of opportunity and for the promotion of fraternity. To safeguard the interests of the
disadvantaged sections of the Society, the Constitution of India guarantees that no person will be denied ‘equality’ before the law (Article 14 of the Indian Constitution). Relevant Articles in Indian Constitution providing constitutional guarantees to all including disabled are: Article 15(1): It enjoins on the Government not to discriminate against any citizen of India (Including disabled) on the ground of religion, race, caste, sex or place of birth. Article 15(2): It states that no citizen (including the disabled) shall be subjected to any disability, liability, restriction or condition on any of the above grounds in the matter of their access to shops, public restaurants, hotels and places of public entertainment or in the use of wells, tanks, bathing places (ghats), roads and places of public resort maintained wholly or partly out of government funds or dedicated to the use of the general public. Article 17: No person including the disabled irrespective of his belonging can be treated as an untouchable. It would be an offence punishable in accordance with law. Article 21: Every person including the disabled has his life and liberty guaranteed. Article 23: There can be no traffic in human beings (including the disabled), and beggar and other forms of forced labour is prohibited and the same is made punishable in accordance with law. Article 29(2): The right to education is available to all citizens including the disabled. No citizen shall be denied admission into any educational institution maintained by the State or receiving aid out of State funds. Article 32: Every disabled person can move the Supreme Court of India to enforce his fundamental rights and the rights to move the Supreme Court.  

Acts for disability

The legislative framework for the protection of the rights of disabled people is covered by given acts: The Rehabilitation Council of India Act 1992: Act sets out to regulate the training of professionals in rehabilitation and sets out a framework for a Central Rehabilitation Register. In order to give statutory powers to the Council for carrying out its duties effectively the Rehabilitation Council of India Act was passed by the Parliament which came into force with effect from 1993. The amendment in the Act in 2000 gave the additional responsibility of promoting research to the Council. The major functions of the council include the recognition of qualifications granted by Universities in India for Rehabilitation Professionals and also the recognition of qualification by Institutions outside India. The Persons with Disabilities (Equal Opportunities, protection of Rights and full Participation) Act 1995: This act provides 3% reservations for disabled people (blind or low vision, hearing impairment and locomotor disability or cerebral palsy in poverty alleviation programs, government posts, and in state educational facilities, as well as other rights and entitlement). The specific objectives of the Act are: Prevention and Early Detection of Disabilities, Education – all Government educational institutions reserves more than 3% seats for disabled. Employment – with 3% reservations the disability vacancies not filled upto be carried forward for next three years and after that the vacancy will be filled by a non-disabled person. Schemes for ensuring employment of person with disabilities are: Training and welfare, Relaxation of upper age limit, Regulation the employment, Health and safety measures. Affirmative Action – Preferential allotment of land for certain purpose – government or local authorities for: House; Setting up business; Setting up special recreation centers; Establishment of special school; Establishment of research centers; Establishment of factories by entrepreneurs with disability. Criticism of Person with Disabilities Act 1995: The Persons with Disabilities Act (PWD), 1995 has been landmark legislation for the disabled in India. This Act that is related to mental illness (MI) and provides recommendations aimed at making it an official instrument for equal opportunities, participation and protection of rights Act in its true sense. But there are some serious flaws in the Act that have to be set right to ensure equitable distribution of benefits to all. The Act defines a disabled person as one who is “suffering from 40% or more disability”. However, as far as MI is concerned, this quantification is a mystification because such a tool is unavailable. The PWD Act unfortunately, turns out to be an instrument of injustice and discrimination albeit unwittingly. According to the chairperson of the Amendments Committee, MI missed this opportunity for employment rights because of the absence of a well-informed advocacy platform that coalesced into a lobby. The National Trust for Welfare of Persons with Autism, Cerebral...
Palsy, Mental Retardation and Multiple Disabilities Act 1999: This Act provides for the constitution of a national body for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities. The main objectives are: To enable and empower persons with disability to live as independently and as fully as possible within and as close to the community to which they belong; To strengthen facilities to provide support to persons with disability to live within their own families; To extend support to registered organization to provide need based services during the period of crises in the family of persons with disability; To deal with problems of persons with disability who do not have family support. 10 National Policy for Persons with Disabilities Act 2005: The National Policy, released in February 2006 recognizes that Persons with Disabilities are valuable human resource for the country and seeks to create an environment that provides them equal opportunities, protection of their rights and full participation in society. Its aim is to ensure better coordination between various wings of the State and Central Governments. The focus of the policy is on the following: Prevention of Disabilities, Rehabilitation Measures, Physical Rehabilitation Strategies, Early Detection and Intervention, Counselling & Medical Rehabilitation. In addition to the legal framework, extensive infrastructure has been developed in India for disabled persons under this Act and includes the establishment of the following institutions: Institute for the Physically Handicapped, New Delhi, National Institute of Visually Handicapped, Dehradun, National Institute for Orthopedically Handicapped, Kolkata, National Institute for Mentally Handicapped, Secunderabad, National Institute for Hearing Handicapped, Mumbai, National Institute for the Empowerment of Persons with Multiple Disabilities, Chennai. A 2004 survey in India revealed the following: Limited information on the definition of disability; Limited information on access to education to disabled people; No mention on disability in the Indian constitution; No standardized sign language. The Disability and Rehabilitation WHO Action Plan 2006-2011: Document provides the overview of WHO’s future plan of activities, which will be carried out or coordinated by the Disability and Rehabilitation team located in the Department of Injuries and Violence Prevention, in the Non-communicable Diseases and Mental Health.

Ministry of Social Justice and Empowerment, in pursuance of the provisions of Section 32 of the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (1 of 1996), had constituted an Expert Committee on the 30th December, 2010 under the Chairmanship of Additional Secretary, Ministry of Social Justice and Empowerment. The Expert Committee, with the help of three sub-committees, made an in-depth study of various jobs performed in Government of India Ministries/Departments, public sector undertakings and autonomous bodies including Universities. The Sub-committees also reviewed jobs notified in 2007 and prepared a detailed list of Groups A, B, C and D posts which were identified suitable for persons with disabilities. The Expert Committee submitted its report on 24th January, 2012. The Central Government accepted the report and the list of posts identified for Persons with Disabilities has been published vide Notification No.16-15/2010-DD-III dated 29th July 2013. 11

Programmes and concessions for the disabled

Government of India has taken the responsibility of providing optimal environment to ensure full participation of the persons with disabilities. In this context, it has introduced a number of welfare programs, schemes, concessions and facilities for educational, vocational and economic rehabilitation.

Education: Children’s educational allowance: - The reimbursement of tuition fee in respect of physically handicapped and mentally retarded children of the Central Government employee has been enhanced from Rs.50/- to Rs.100/- per month.

Scheme of integrated education for the disabled children - Under the scheme, handicapped children are sought to be integrated in the normal school system. 100% assistance is provided to the States/UTs for education of children suffering from certain mild handicaps in common schools with the help of necessary aids, incentives and specially trained teachers.

Financial assistance to persons with disabilities: - The National Handicapped Finance and Development Corporation NHFDC, a subsidiary under the Ministry of Social Justice and Empower-
ment, Government of India, promotes infrastructure development schemes directly leading to income generation. This corporation provides self-employment opportunities to the persons with disabilities by providing loans at very low rates of interest. **Travel concession:** By **Rail** - Orthopedically handicapped persons / mentally retarded persons with an escort, on production of a medical certificate, are eligible to 75% concession. By **Air** - Locomotors disabled persons with 80% disability are allowed 50% concession in Indian Airlines. **Employment of handicapped:** Assistance to disabled persons in getting gainful employment either through special cells in National Employment Exchanges or through Special Employment Exchanges for physically handicapped. Up to 100% financial assistance is provided in the case of special cells and 80% in the case of Special Employment Exchanges to state governments / union territory administrations. **Communication:** Educated unemployed persons are eligible for allotment of STD, PCOs. The educational qualifications for the applicants are 8th or middle class passed from rural areas, at least matriculation or high school for urban areas. **Conveyance allowance:** Orthopedically handicapped with disability of lower extremities will be paid transport allowance at double the normal rates. Handicapped employees who have been provided with government accommodation within a distance of 1 kilometre from the place of work or within the campus, the allowance shall be admissible at normal rates. **Miscellaneous programmes:** **Family pension to disabled children** - Handicapped children shall be eligible for the benefit of family pension even if they have been born after the retirement of the Government Servant from a marriage solemnized after retirement. **Ad-hoc allotment of central pool residential accommodation to the physically handicapped employees** - Government employees suffering from tuberculosis, cancer and physically handicapped persons may get adhoc allotment of general pool residential accommodation on request after recommendation of the special recommendation committee and on the approval of the urban development ministry.  

**Certification in Disability**

The medical boards have been constituted at the State level, District level and Taluk level to assess the percentage of disability / the level of disability/ and then to issue disability certificates whose disability is more than 40% and above. The composition of the Medical Board is as follows: State Level Medical Board, District Level Medical Board, Taluk Level Medical Board.

Because of the UN proclamation in 1981, subsequent declaration of Decade for Disabled and the Biwako Millenium Framework of Actions in 2003, extended further from 2003-2012, to which India is a signatory, it is binding on the member countries to protect the rights, provide equal opportunities and empower persons with disability. The guidelines notified, are for assessment of disability in the respective area/body part (function) and to quantify in terms of percentage of disability, to avail facilities & concessions viz. Reservation in job, Travel concession, soft loan for entrepreneurship development, Scholarship, Income Tax / Custom rebate, Age relaxation in employment etc. As per the Act, authorities to give a disability certificate will be a medical board duly constituted by the central and state government. According to the PWD Rules, 1996, the Committee recommended that certification of disability for the purposes of the Act had to be carried out by a medical board comprising of the following members: (a) The Medical Superintendent/Principal/Director/Head of the institution or his nominee Chairperson, (b) Psychiatrist—Member, (c) Physician — Member. At least two of the members, including Chairperson of the board must be present and sign the disability certificate. The certificate would be valid for a period of five years for those whose disability is ‘temporary’ and are below the age 18 years. For those who acquire permanent disability, the validity can be shown as ‘permanent’ in the certificate. When there are no chances of variation in the degree of disability, a permanent disability certificate is given. The PWD Act (1995) did not prescribe guidelines for evaluation and assessment of mental illness and the specific procedures for certification. With regard to assessment of disability related to mental illness it was agreed that the Indian Disability Evaluation and Assessment Scale (IDEAS, 2002) developed by the Rehabilitation Committee of the Indian Psychiatric Society (IPS) through a Task Force should be used with modifications for the purposes of the Act.
Measurement of Disability for mental illness

The assessment tools have already been existed for the visually impaired, hearing impaired and orthopaedic handicap and persons with mental retardation. These people are certified by the authentic body and become eligible by having disability certificates to avail the benefits under the PWD Act 1995. But there was no assessment tools for the certification of mentally ill people and yet these people are not availed any benefits even as disabled. Looking that perspective and to justify these people rehabilitation committee of Indian Psychiatric Society has developed the assessment tool for disability certification in 2002. This tool is known as Indian Disability Evaluation and Assessment Scale in short IDEAS. This IDEA has opened new horizon for mentally ill people. This committee has developed clear guideline to make use of it very easy. General Guidelines: IDEAS are suited best for the purpose of measuring and certifying Disability. It is therefore a brief and simple instrument, which can be used, even in busy clinical settings. Some training is required in the use of IDEAS. This is to be used only on out patients and those living in the community. Not appropriate for in-patients. Rating should be done only based on interviews of the Primary Care Givers. Case records and patients interviews can be used to supplement information. Only in rare instances when no primary care giver is available should be the rating is based only on patient interview. This should then be documented. The gender specification “he” has been used for convenience and refers to both genders. Patients with only the following diagnosis as per ICD or DSM criteria are eligible for disability benefits: Schizophrenia, Bipolar Disorder, Dementia, and Obsessive Compulsive Disorder. Duration of illness: The total duration of illness should be least two years. For the purpose of scoring, the number of months the patients was symptomatic in the last two years (MI 2Y – months of illness in the last two years) should be determined.

Only the Psychiatrist can do diagnosis and certification. Trained social workers, psychologist, or occupational therapists can do administration of IDEAS. Psychiatric Disability will be reassessed every two years and re-certified. The feasibility of doing this in the rural areas will however have to be examined. Items in IDEAS: Self-care: Includes taking care of body hygiene, grooming, and health including bathing, toileting, eating and taking care of one’s health. Interpersonal Activities (Social Relationship): Includes initiating and maintaining interactions with others in a contextual and socially appropriate manner. Communication and Understanding: Includes communication and conversation with others by producing and comprehending spoken/ written/ nonverbal messages. Work: Three areas are Employment/ House work/ Education measures any one aspect. 1-Performing in Work/ Job: Performing in work / employment (paid) employment / self-employment family concern or otherwise. Measures ability to perform tasks at employment completely and efficiently and in proper time. Includes seeking employment. 2- Performing in Housework: Maintaining household including cooking, caring for other people at home, taking care of belongings etc. Measures ability to take responsibility for and perform household tasks completely and efficiently and in proper time. 3- Performing in school / college: measures performance in education related tasks. Scoring: 0 – No Disability, 1 – Mild Disability, 2 – Moderate Disability, 3 – Serve Disability, 4 – Profound Disability. Total Score (range 0-20). Percentage: For the purpose of welfare benefits, 40% will be cut off point. The scores above 40% have been categorized as Moderate, Severe, and profound based on the Global disability score. This grading will be used to measures change overtime. 0-No disability = 0%, 1-7 – Mild Disability = < 40%, 8 and above > 40%, (8-13 moderate disability; 14-19 Severe Disability; 20 Profound Disability).14

Hurdles in accessing the benefits & services

Apart from that there are many problems facing by People with Disabilities to access the services easily, such as: Employment - There seems to be a lack of coordination between different government services so that people with disabilities are unclear about which Commonwealth or State agencies can provide them with assistance. Information about the financial and health impacts of entering the open workplace is hard to find, there is limited or delayed access to open employment services. Financial - Additional transport, support and other costs associated with work, many of which are not
subsidised foregoing the Disability Support Pension and associated benefits, such as the Pensioners Health Care Card. **Inflexible working environment** - Difficulties with physical access to the workplace, and getting to and from work, inadequate adjustments and adaptations to workplace equipment, inflexible working hours. **More limited opportunities for people with disabilities** - Poor links between State-administered school and post-school programs and Commonwealth-administered disability employment services, under-representation in the vocational, education and training systems, limited scope and variety of jobs offered to people with disabilities, lower possibilities for promotion, lower paying jobs & lower retention rates.

**Issues related to Psychiatric Disability**

Impact of disability on Psychiatric Disability is based on the major four functional aspects of person which are: (I) **Psychological issues of Psychiatric Disability**-Individuals with psychiatric disability experiences a wide range of symptoms that affect psychological and cognitive function, and their needs are multifaceted and complex. Although the benefits of medication in the treatment of psychiatric disability are substantial, medication usually does not cure the condition but rather controls the symptoms. Individuals often have residual symptoms, deficits and impairments as a result of their condition and may be subjected to periodic relapses with recurrence of symptoms. Individuals with psychiatric disability may be particularly vulnerable to stress and may lack the ability to withstand the pressure or to cope with the normal stressors of everyday life. They may have limited problem solving ability or find it difficult to engage in self-directed activity. Others experience subjective distress, such as an inner sense of weakness, jealousy, or anxiety, although function in most of their life is minimally disturbed. Some psychiatric disabilities are characterized by disorganization of mental capacities, which can affect individuals ability to function in an unstructured environment.(II) **Lifestyle Issues of Psychiatric Disability** - The degree to which psychiatric disability affects individual’s lifestyle depends on a great extent on the nature of the condition. Some psychiatric disabilities so severely impair individual’s ability to carry on the activities of daily living that constant supervision or hospitalization is necessary. In other instances, individuals are able to carry on these activities, but in an altered manner. At times the treatment itself requires lifestyle changes. Individuals may need to rearrange their schedules so that they can attend therapy sessions. Some medications used in the treatment of psychiatric disability may require special lifestyle considerations. For example, the use of MAO inhibitors in the treatment of depression requires careful monitoring of diet. Other medications have side effects, such as drowsiness and sedation that also affects daily functioning. In addition subjective manifestations of lowered self-esteem and self-confidence may make it more difficult for individuals to form intimate relationship. (III) **Social issues of Psychiatric Disability**- The impact of a psychiatric disability on social function also depends on the nature of the condition. Individuals who experience mania as part of their disability may enjoy the euphoria and feel that it contributes to their social well-being. Even though attitudes of society become more accepting of individuals with mental illness, family members may continue to be resistant to recognizing the problem and pursuing the appropriate treatment. If however individuals manifest bizarre, abusive, or socially offensive behaviour, family members or others within a social group may avoid the individual altogether, leaving him or her socially isolated. Other psychiatric disabilities may lead to social withdrawal. Families of individuals with psychiatric disability may experience a variety of stresses engendered by the condition. In some instances the demand of care giving may require family members to curtail their social activities or alter their relationship with friends and acquaintances. The time commitments of care giving may lead to neglect of other family member’s needs, further disrupting the family as a unit. Social barriers are frequently erected against individuals with mental disorders and against their families. Social stigma may be the result of fear of individual’s behaviour, ignorance about psychiatric disability, or feelings of inadequacy interacting with those who have psychiatric disability. Regardless of the cause the result can be a source of continuing stress for individuals and their families, as well as barrier to social activity and interaction. (IV) **Vocational Issues of Psychiatric Disability**- Individuals with
psychiatric disability have a condition that limits their capacity to perform certain tasks and functions and their ability to perform certain roles. The ability to work depends on the type of disability, the type of work in which they are involved, and the attitude of those within the work setting. Although work is important to increase self-esteem for those with a number of disabilities, it can be an especially strong therapeutic tool for those with a psychiatric disability. Job restriction may be related to job pressure or ability to work with others, regardless of the individual’s level of skill or physical and cognitive ability to perform work related tasks. Some medications used in treatment may produce side effects such as drowsiness or sedation that could adversely affect work performances. Individual’s reactions to the work environment, including noise and distractions, should be taken into account as should their level of personal responsibility and ability for self-direction and decision making. Some individuals may need more structured work environment; in some instances, a workshop environment may be preferable. The unemployment rate for individuals with psychiatric disabilities continues to be high. Although it is believed that people with psychiatric disability have been significantly discriminated against in the workplace, the extent to which discrimination exist is difficult to determine because of lack of relevant data.

Psychosocial Issues of Mental Retardation - The opinions and expectations most people have about themselves are influenced to a great degree by the behaviour of those around them. When minimum expectation or lack of belief in individual’s ability to achieve is communicated, the chances for individuals to progress in attaining goals are diminished. Because a number of inaccurate and stereotypical ideas about individuals with mental retardation still exist, barriers to reaching optimal function and independence continue to be present. Although societal and employer attitudes are changing slowly, there is continued need for education and integration of individuals with MR into society and into the workplace. Although all individuals with MR can experience stresses due to societal stereotypes and attitudes, individuals with mild MR may confront specific stresses because they may appear normal to others and consequently limitations may not be recognised as a disability. Lack of acceptance and devaluation can result in low self-esteem and isolation, which in turn can lead to deviant behaviours or acting out. In more severe cases, a psychiatric disorder may be developed as a means of coping.

Vocational issues of Mental Retardation - The level of occupational functioning for individual with MR depends to some extent on the degree of disability. Because mental retardation is often accompanied by other medical conditions, the physical limitations associated with any medical condition must also be considered. Individuals with MR usually perform better in a structured environment. Many individuals may need to be taught how to function independently and may need accompanying social skill training. Although there has been heightened effort and interest towards increasing integrated employment opportunities for individuals with mental retardation, rehabilitation outcomes, especially for individuals of racial and ethnic underrepresented groups, have been less than ideal.

Studies related to disability in specific psychiatric disorders

Disability, a limitation in functioning, occurs in association with a number of diseases. Inability to perform social roles and restricted ability to function at expected levels are the usual consequences of it. Schizophrenia: Although the problems and experiences associated with schizophrenia are often distressing, the effects of the disorder can be pervasive. A significant number of people continue to experience long-term impairments, and as a result schizophrenia can have a considerable effect on people’s personal, social and occupational lives. A European study of six countries found that over 80% of adults with this diagnosis had some persistent problems with social functioning, though not all of them were severe. The best predictor of poorer functioning in the long term was poor functioning in the first 3 years post-diagnosis. It has found that 80% remained unemployed. The disabilities experienced by people with schizophrenia are not solely the result of recurrent episodes or continuing symptoms. Unpleasant side effects of treatment, social adversity and isolation, poverty and homelessness also play a part. These difficulties are not made any easier by the continuing prejudice, stigma and social exclusion associated with the
The 28 greatest barriers to diagnosis.\textsuperscript{18} **Affective Disorder:** Researchers found in their studies that in depression the chances of complete recovery are not as high as we believed earlier. Most of the patient continues to have the residual symptoms and hence disabilities also persist even during euthymic period.\textsuperscript{19,20} Researchers reported significantly more disability in patients of affective disorder than controls in areas like job status, annual income, interpersonal relationship, recreational activity and overall satisfaction. In comparison to other disorders like schizophrenia and anxiety disorder, affective disorders have found to be associated with less disability.\textsuperscript{20} **Obsessive Compulsive Disorder:** OCD is also a chronic and disability illness with working course. It affects all spheres of life of an individual and his family members. In comparison studies, disability level in OCD in found to be more than other anxiety disorder.\textsuperscript{21} OCD causes dysfunction and disability includes such circumstances as diminished social networks, stigma, poverty, unemployment as a lack of belonging. **Mental Retardation:** Mental retardation is a highly prevalent and highly disabling condition. It is generally considered that 2% of the Indian population constitutes persons with mental retardation. In India prevalence of mental retardation varies from 0.22-32.7 per thousand populations. According to American association of Mental deficiency, “Mental retardation can be defined as a significantly sub average general intellectual functioning, resulting or associated with concurrent impairment in adaptative behaviour and is manifested during the developmental period”. It has found that the parents of children with Mental Retardation registered high depression and anxiety scores, and the majority met the criteria for possible clinical depression and/or anxiety. They were more tired, desperate, and more displeased, sad, depressed, helpless, and embittered.\textsuperscript{22}

**Gaps to be Filled:** **Lack of Surveillance Systems:** The preliminary step to conduct research in any field demands a baseline data about the prevalence, incidence and distribution of a disease. Due to the lack of a universal definition of disability and its types and categories, there are no reliable figures available for the prevalence of disability in India. The differences seen in the estimates in Census, 2001 and NSSO, 2002 are the best indications of the discrepancies in understanding and the conceptualization of the term ‘disability’. There is a major issue of under reported cases of disability in the country because of the lack of national level registration and identification system of the persons with disability. There are numerous examples of excluded disability categories, including autism, thalassemia, haemophilia, and many learning disabilities.\textsuperscript{2,23} The social stigma attached to the disability is also likely to contribute to underestimation. **Management and Treatment:** There is a need of systematic and organized community based rehabilitation facilities to identify and take care of persons with disability wherein they can be managed and treated. There is a need to develop the evidence based guidelines to provide services for the effective diagnosis, care, understanding the cause, management, treatment and prevention of various types of disabilities; along with the need to evaluate these health systems at the both primary and secondary levels. **Lack of Priority:** As there is no direct mortality associated with the various types of disabilities, they remain at the bottom of the government’s priority list. There is no mention of disability either in the constitution or the millennium development goals (MDG), thus the treatment and prevention of disability does not demand much attention. It is pointed out the reason for their neglect as the thought by experts and organizations that the needs of people with disabilities will be taken care of by some disability-specific group or programme.\textsuperscript{24} The 28 greatest barriers to inclusion of people with disability in MDG is stigma and prejudice.\textsuperscript{25,26} **Evaluation and audit of the guidelines:** The results of the survey conducted by ESCAP in 2004 demands an evaluation of the regulation of international and national policies and guidelines for persons with disability to ensure their correct, effective and fruitful functioning.\textsuperscript{27} The World Bank report also highlights the different institutional and other issues which hinder the implementation of the disability policies.\textsuperscript{28} **Integrated Research Programmes:** There are numerous NGO’s conducting small scale research activities on disability like Monovikas Kendra (West Bengal), Handicapped Development Foundation (Manipur), Mobility India (Uttar Pradesh), Disability India Network (Din), Disability India Information Resources (DIIR). There is a need to identify coordinate such organizations and actively involve them.
in policy formulation, planning, implementation, monitoring in disability in India.

Conclusion

In India, the numbers of disabled are so large, their problems are complex, available resources also scarce, social stigma still attached and people attitudes so damaging. Attitudinal barriers engrained as part of India’s historical response to disability must be changed through education programs for both teachers and the general populace. These programs require financial and collaborative commitment from key national and state education stakeholders, and partnership with universities to support research-based initiatives. It is only legislation which can eventually bring about a substantial change in a uniform manner. Although legislation cannot alone radically change the fabric of a society in a short span of time, it can nevertheless, increase accessibility of the disabled to education and employment, to public buildings and shopping centres, to means of transport and communication. Therefore, in country like India mainstreaming of these people is challenging issue. For achieving this task it’s necessary to change public attitudes, remove social stigma, provide barrier free environment, needs reformation in the area of policy and institutional level.

References

7. Constitution of India (1950), New Delhi, Govt.


