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Editorial
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Disability, Rehabilitation & Society

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Disability: In ancient India there had been available descriptions of learned persons like ASHTAVAKRA. Even after deformities at 8 places in his body he lived gracefully and competed with all learned able bodied contemporary personalities of his time with his sharp knowledge. Insightful thinking and foreseeable nature. There are several such examples. Which signifies that limitations arising out of any disability is only in thinking as a mental barrier .But the moment a person with disability realises that he/she has several remaining positive potentials to move ahead ; that generates the feeling …. " I can do , successfully move ahead & I can achieve."

There had always been a major concern about severely mentally and physically challenged persons with disability requiring custodial care. In the ancient Indian Society they were respected and regarded and looked after by the families and community .Parents of Shravan Kumar were confined due to mobility restrictions of old age but Shravan Kumar carried them on his shoulder for pilgrimage.

In the late 18th century and beginning of 19th century also known to be a period of political awareness in India; Christian Missionaries of Europe established Institutional Care for the persons with disability/ies slowly with gradual passage of time as per need and demand these centres turned out to be Special Schools and Rehabilitation Centres for the persons with disability. By this time the public and state both began to pay attention to Visually Challenged persons and persons with Hearing Disability. As these two categories were distinctly known to the people as compared to Locomotor & Intellectual disability. At that point of time there was no clear cut differentiation between Mental Retardation (now known as Intellectual disability) and Mental Illness.

'Sharp Memorial for the Blind'was the first school for the Visually challenged children established in the year 1887 at Amritsar. Around the same time services for other categories of disability, especially Hearing disability, were also established in the country. Which has led to the drawing up of an uniform Indian Braille Code and Sign Language around the beginning of 1940s. This is known to be the beginning of services for the persons with Disability in India.

'International Year for the disabled-1981' emerged as a great impetus to the services or persons with disability in India. As per the details available in the literature; Country celebrated the Centenary of Services to the Visually Challenged persons in the year 1987 (AICB & CBM, 1987). During 1980s national institutes were established to serve different categories of Persons with disability i.e Ali Yavar Jung National Institute for Speech & Hearing Disabilities (AYJNISHD: Mumbai), National Institute for Locomotor Disabilities (NILD: Kolkata), National Institute for the Empowerment of Persons with Visual Disabilities (NIEPVD: Dehradun) , National Institute for the Empowerment of Persons with Intellectual Disabilities (NIEPID: Secunderabad) & Swami Vivekanand National Institute of Rehabilitation , Training & Research (SVNIRTAR: Cuttack).

One Institute existed prior to the establishment of these National Institutes in Delhi i.e. erstwhile I.P.H. is now known as Pandit DeenDayal Upadhyaya National Institute for the Persons with Physical Disabilities (PDUNIPPD).

Another two National Institutes set up in the recent past are National Institute for the Empowerment of Persons with Multiple Disabilities (NIEPMD: Chennai) and National Institute of Mental Health & Rehabilitation (NIMHR: Sehore). Main role of these National Institutes is to function as an apex body in the country with the objectives i.e. 1/. Service Delivery and developing replicable service models 2/. Man power Development, to cater to the needs and to ensure quality service delivery to this population; 3/.Research and 4/. Community oriented services to assist persons with disabilities in the community.

Apart from these National Institutes , through a network of Non Governmental Organizations throughout the country, services to the persons with disability/ies were also expedited ; successfully and pervasively. By the mid1990s there was a realisation that the categorical disability wise institutional care should be merged into the composite nature of service delivery to help persons with different categories of disability/ies at one place. This was the time when Regional Rehabilitation and training centres were established in different regions of the country supported with District Rehabilitation Centers on an experimental basis.

At the time of nearly one and half decade after completion of the International Year for the Persons with Disabilities; there was a growing realisation about needs and requirements of new facilities and provision of services. Most significant and urgent need of the time was 'A Legislation'. Thus in 1995 'Person with Disability Act' (MOSJ&E, 1995) ensuring equal opportunities ,protection of rights,& full participation of persons with disability came into being . Which included seven categories of Disabilities; i.e. Blindness , Low Vision, Leprosy Cured , Hearing Impairment, Locomotor Disability & Mental Illness. The Rights of

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Persons with Disabilities (RPwD) Act 2016 was an updated version which covered 21 different disabilities (MOSJ&E, 2016)

PWD Act 1995 had significant bearing on two very important issues 1/. Care of parentless and homeless severely disabled persons and such persons requiring custodial care and 2/. Addressing the grievances of these persons by way of protecting their rights as per provisions of the PWD Act 1995.

Which anticipated the establishment of two more National Organizations as per act passed by the Parliament.

1/. National Trust for the welfare of Persons with Autism, Cerebral Palsy. Mental Retardation and Multiple Disabilities Act-1999a.

2/. Chief Commissioner for Persons with Disabilities Act -1999 b. Manpower development as one of their primary objectives was taken up by NIs and several NGOs to fulfil this need. For the purpose of preparing a National Register of Rehabilitation professionals and accreditation of various training courses; 'Rehabilitation Council of India' was established in the mid 1990s, passed as an act by Parliament. Clinical Psychologists were identified as Rehabilitation Professionals by RCI. This was the entry point of Clinical Psychologists into the world of Rehabilitation not by chance rather by choice. As the association (IACP) was looking for an agency/ council to bring all the members under one umbrella organisation to register for licensing to practise as professionals.

Surprisingly till September, 1993 as per Gazette notification of Govt. of India (1993) Clinical Psychologists were listed as professionals under Ministry of Health & Family Welfare with the qualification of 'Diploma in Medical Psychology'. The first nomenclature of the course which was awarded to first few batches, who qualified from NIMHANS (erstwhile Institute of Mental Health) in the initial years.

About the size of this population; i.e. Persons with disability in India; figures reported by NSS (2018) and Statistical Profile provided by Census (Govt. of India 2016) are considered reliable figures and the same is being used in policy planning and implementation by GOI and by the States all over the country. Incidence reported was 86 per one Lakh population.

According to NSS (2018) 2.2% of the total population of the country are the victims of Disability (Rural 2.3%, Urban 2.0%, Male 2.4% and Female 1.9%).

GOI; Census (2016) reports that there are 2.68 Crore persons with disability in the country; which constitutes 2.21% of the total population. Out of which 69% persons with disability resided in rural areas.

Rehabilitation: Rehabilitation was known earlier basically as a matter of charity .Providing food grains and distribution of clothes and woollen clothes to persons with disability, especially during winter was seen usually on a routine basis or mostly on social occasions. In the current scenario rehabilitation is known as process which begins from the day of commencement of disability in the form of an incurable ailment or nonreversible condition by a medical doctor and till the time person is well integrated in his society after completion of his schooling, education, vocational training and gainfully employed in a job to look after himself and his family.

Across all the categories of disability some of the priority areas which needs to be compulsorily looked into, and thoroughly addressed are:

- Early detection and Early intervention/home based training in the lower age group including
- preschool age to minimise developmental lag,
- Schooling of Children with special needs and higher education as per need and preference,
- Care of children who needs custodial care,
- Crisis Intervention services for the victims of accidental and acquired disability as immediate help to cope up with the crisis/loss of limb or function,
- Deciding trade for vocational training of a person with disability as per one's abilities based on his/her psychological assessment of attention, memory , intelligence, psycho-motor coordination and personality,
- Pre Discharge counselling before leaving the institutional training setup with details of job and employment opportunities,
- Placement in a job for gainful employment to integrate the person into his family and society,
- Looking into the Disability and Sexuality aspect and resolving the issues related to sexuality as significant component of Rehabilitation if Person with disability is married or planning to mary or in any other situation when person with disability if facing complexities on account of his /her problem/s in sex life,
- Community oriented services for wider coverage, cost effectiveness and without compromising with the quality of service delivery , including generation of awareness leading to change in attitude of people in the community , highlighting the remaining positive potentials of the persons with disability,
- Preparation and production of multilingual awareness material, guidelines and manuals to be used by rehabilitation professionals and special educators working at different levels in different settings.

After a journey of 4 decades from 1981(IYDP) to 2023 (after excluding the disasterous phase of COVID 19

Pandemic) a remarkable change is distinctly visible in the area of education , rehabilitation , job placement and community oriented services.

Persons with disability/ies are seen today studying in Universities, they are employed by Banks, Railways, as teachers in schools and several other such organisations in the public and private sector. A few of them have entered into the country's top level administrative services. In sports they have also proved their competence. Generation of awareness about disability, rehabilitation using them as main themes and success stories has been done sufficiently and significantly by mass media especially Indian Films in the last four decades.

Two more service provisions made by the Government of India are worth mentioning as they have facilitated rehabilitation of disabled in India by way of placement of persons with disability in jobs and promotion of self-employment .

'Vocational Rehabilitation centres' on experimental basis were established at two places initially at Mumbai & Hyderabad in 1968 in collaboration with the US government under the Ministry of Labour and Employment. Intention in establishing these centres was to look into the vocational & psychological needs of the person with disability and to render rehabilitation assistance to them with a focus on skill acquisition through vocational training and subsequently placing them in jobs including self-employment .

These initial efforts of two VRCs were noted to be gratifying which led to the establishment of VRCs under the same Ministry. Currently 21 VRCs are functional in the country and helping persons with disability (Narasimham,2017; Singh 2005).

National Handicapped Finance & Development Corporation' is another service provision (1997) made by the Government of India to pay loans to the persons with disability above the age of 18 years with at least 40% of disability. This helps persons with disability in setting up a work environment or a small business to keep them involved as self-employed persons.

Last but not the least is ALIMCO (Artificial Limb Manufacturing Corporation):

Under MOSJ&E is manufacturing state of the art technology based aids and appliances and making these high quality devices to the people with disability/ies all over the country through its network.

Like TeleMedicine/ Telemental health; there has been a mention of the Tele-Rehabilitation system mainly for empowering parents and their children with disabilities in India (Moorthy et.al.2021) . Strength and weakness analysis of the system needs to be kept in mind to ensure quality service delivery to the children with disability.

Further system helps in filling up the gaps between access to sustainable rehabilitation services and non sustainable patchy temporary solutions . Only time will tell the success of this system. During Pandemic followed by s lockdown advantages of the telemental health/ telemedicine was seen worldwide. But that was the only option available at that time.

Provision of equal educational opportunity to children with disability in the last 40 years moved from special schooling to integrated education and now entered into a phase of inclusive education. Another important area 'Easy access to public places ' there has seen facilitative improvement but considering the need and vast population of the country still further substantial work is needed for wider coverage nationwide (Krishna 2021). Now pathways of progress to promote further work are distinctly visible.

To cater to the service needs of this population manpower development programmes were launched by the mid-1980s ; and these programmes moved successfully , with additions as per need and requirements . In mid - 1990s RCI became the monitoring agency of the manpower development programmes with a provision of accreditation of these training programmes. Clinical Psychologists were identified and categorised by RCI as Rehabilitation professionals with all ups and downs and controversies of that time. Thus by the mid 1980s a good number of clinical psychologists joined the posts under MOSJE in NIs, RRTCs, Regional centres of NIs and DRCs; this trend continued nearly for a decade. Even VRCs attracted Clinical Psychologists and for their significant contribution to the area of Disability & Rehabilitation they have been honoured by the Honourable President of India.

The Erwadi Fire Incident on 6th August, 2002 has been proved to be a significant event in inclusion of the country's severely mentally ill as a potential significant group in need of Psychosocial Rehabilitation with a serious consideration under a service provision to provide health insurance to the mentally ill.

In the recent past (last two decades) in the name of increasing demand and limited supply of Clinical Psychologists as rehabilitation professionals, more training centres were granted permission by RCI to train clinical psychologists. Doubts have been raised about the resources, facilities, infrastructure and availability of sufficient clinical material at these recognized training centres for Clinical Psychologists. Which shows that RCI as an accreditation body miserably failed in exercising quality control while granting permission to

the training centres in the last 15 years and justifying the same in the name of demand and supply.

Another important issue currently under consideration of the Government of India is the nomenclature of the training curriculum of clinical Psychologists. As UGC has abolished M.Phil. Course all over the country after implementation of New Education Policy. The only apprehension of the Clinical Psychologists in the country is that there is likelihood of diluting the course by making this " Full time Practical, Clinical, Residential supervised training " of two years into postgraduate (M.A) level University degree, irrespective of the concern of international trend . We should not forget that a good number of Clinical Psychologists are employed in mental health service centres and universities of the western countries and there, they are not earning only their livelihood, rather they have been able to extend their remarkable thoughtful leadership to enrich the discipline of Clinical Psychology in the west. This is the continuing trend which should not be interrupted.

The regard and respect given to the profession of Clinical Psychology in the west is not available to the profession in India; although clinical Psychologist has been defined as Mental Health Professional by The Mental Health Care Act (2017). Clinical Psychologists working in India have not been given a status which they deserve and the profession is still in search of its Identity even when the country is celebrating 'Amrit Mahotsava' of freedom in the country. It has already been recorded in the history of mental health service delivery that Training of Clinical Psychologists in India has successfully completed more than 6 decades successfully, with all prescribed norms and standards. This fact is still verifiable in ground reality, which cannot be suppressed.

Apart from all these issues under discussion; Clinical Psychologists have significantly contributed to the area of disability and rehabilitation applying multidisciplinary team approach in service delivery, manpower development, research and community oriented services. Now a precise account with better description is available about guidelines, manuals and resource books (Relekar et.al., 2021, AYJNISHD, 2023; NIEPID, 1989 & 1990; NIEPVD,2017 & 2018; Singh,1989;1990), on Education, Rehabilitation, and Community Oriented Services. The work done is much more than what is described here.

Society: Social aspect of Disability & Rehabilitation is linked to Parents of children with disability, care givers in the family, village leaders/workers, agencies serving this population in the community and overall integration of a person with disability into his family and society.

Community Oriented services also known as Community Based Rehabilitation and in the field of mental health the same is known as Community Mental Health. Entry of Community Mental Health was much earlier than Community Based Rehabilitation. The Community Mental Health Movement began in the US in the 1960s and reached India in the beginning of 1970s. Raipur Rani run by PGIMER, Chandigarh & Sakalwara run by NIMHANS were best known Community Mental Health service models in those earlier days. Lack of financial support interrupted functioning of these projects, however in the recent past with the sustained financial support of MOHFW; GOI these programmes have revived in the name of District mental Health Programme. Which will be taken over by the different State Governments of the country in due course of time.

Community Based Rehabilitation Services for persons with disability in India are known prominently under 4 major service modalities as under:

1/. Rehabilitation Experts train persons with disability in their home environment in rural areas as their need and age (Jain, 1983),

2/. Rehabilitation Experts train field workers raised from the community itself where the person/s with disability resided. These trained field workers provide training in their home environment, according to client's age and need (Punani & Rawal, 1987; Jaekle, 1977),

3/. Rehabilitation experts train field workers raised from the community itself at training centres equipped with all kinds of training facilities. These trained field workers enrol parents or any other family member (of person with disability) to extend desired training to him or her according to client's age and need (Mathur, Choksi & Singh 1984, 1985, 1986).

4/. Early detection. Prompt referral and introduction of preliminary rehabilitation services through composite rehabilitation camps (NIVH, 1991).

Benefits of the "Composite Rehabilitation Camp" approach are still available to persons with disability throughout the country under the AIP Scheme of MOSJ&E. Initially the service model was tried out on an experimental basis as per instruction of the MOSJ&E in the remote rural hilly area of Uttarakhand through 14 composite rehabilitation camps organised at different parts of the region (now a state) i.e. Srinagar (Garhwal), Kotdwar, Gwaldam, Joshimath and Pithoragarh, from 1988 to 1991. Total beneficiaries were 3012 under 4 categories Locomotor, Hearing and Speech, Intellectual and Visual disability. The CBR model was proved to be cost effective for which all 4 national institutes provided manpower to render the services.

Recently during COVID 19, Clinical Psychologists through their association, IACP extended the facility of nationwide multilingual helpline to help the victims. A

good number of Clinical Psychologists are working now in the District Mental Health centre which is a community set up. There is a need to generate data based on the work of Clinical Psychologists in DMHPs.

As far as care of persons with disability, severely mentally ill or even elderly persons is concerned; as per our Indian cultural tradition and well integrated sociocultural living this population has been well taken care of by the family members in the society . Hence they are well integrated in the community.

Generation of awareness about disability and rehabilitation more specifically to minimise pathways of care, stigma and to promote early early detection and early intervention, people in the community are now sensitised and thoroughly aware. This was not the situation three decades back. Worldwide spread message of Disease Burden & investment by the Government in generation of awareness supplemented with contribution of mass media and films have played significant role in bringing out this positive change in the the attitude of people in the community. Clinical Psychologists irrespective of their work place and affiliation had been sincerely part & parcel of these programmes.

What needs to be done to promote the profession of Clinical Psychology & Status of Clinical Psychologists in the country to utilise their services effectively

1/. Current trend to produce a large number of Clinical Psychologists in the name of demand and supply should stop. As this is resulting in producing a standardised labour force to work like technicians in place of adding more Mental Health professionals. Demand is hardly 50 Clinical Psychologists per year whereas the country is producing 500 Clinical Psychologists every year being trained at 50 centres in different parts of the country, duly recognized by concerned accreditation body/ies.

There is a need to exercise control in granting permission to the institutes -GOs & NGOs highly aspirant to run the course for training Clinical Psychologists. Example of 'Medical Council of India' is there which ultimately turned out to be 'National Medical Commission'. Why? Reasons are best known to all concerned. In Rajasthan 12 posts are vacant for a long time; however in this state permission has been granted to 12 centres in the last two years, to train Clinical Psychologists.

2/. Training of Rehabilitation Psychologists commenced in the country much earlier but their scope is diminishing. Employment opportunities available to Rehabilitation Psychologists are interchanging being filled up by Clinical Psychologists irrespective of the concern of eligibility, roles & responsibilities. This needs to be looked into seriously.

3/. 'Continuing Rehabilitation Education' for Clinical Psychologists is not adequate and is being done as a ritual where trainers are seen as less qualified than trainees. CRE should be organised and leading mental health service centres like NIMHANS, CIP or at National Institutes in 4 regions of the country to uniformly cater to the needs of updating the knowledge and skills of Clinical psychologists nationwide.

4/. Admission to Ph.D. Clinical Psychology Course should be permissible only to the applicants with qualifying degree to practise as Clinical Psychologists in the country. Just like M.B.B.S is the well accepted degree and only qualified M.B.B.S. doctors are eligible to apply for P.G.courses (M.D.).

5/. The National Medical Commission has prescribed only one post of Clinical Psychologists per medical college, which is also under the category of technician and not as professional. This needs to be looked into by the commission because status given to the Clinical Psychologists puts them back in the early post-independence era.

Apart from all these issues, there has been a mention of discrimination in employing Clinical Psychologists under DMHP scheme with regard to their payable remuneration based on their qualification. This should be avoided in future.

Let us hope that training of Clinical Psychologists with introduction of new nomenclature will be more encouraging and gratifying.

This Special issue depicts the kind of work currently going on in the country and addresses issues related to Disability, Rehabilitation & Society.

Editor

*With inputs from Presidential Address of the author (2009), which could not be published due to transition phase of Change in IJCP: Editorship, either the manuscript was skipped or lost, as an error.

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