A STUDY OF THE PROBLEMS OF MENTALLY RETARDED CHILDREN AND PROVISIONS FOR THEIR EDUCATION IN THE NORTH-EAST

A Thesis Submitted to
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In Education

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DEDICATED

TO

My LATE PARENTS MAKRAM ALI

AND

RAHIMAN NESSA

UNDER WHOSE PATRONAGE

I GREW THE MOST

DECLARATION

I, AZIBUR RAHMAN, do hereby declare that the thesis entitled "*A STUDY OF THE PROBLEMS OF MENTALLY RETARDED CHILDREN AND PROVISIONS FOR THEIR EDUCATION IN THE NORTH-EAST*" Submitted for the award of the degree of DOCTOR of PHILOSOPHY in Education is my Original work and that it has not previously formed the basis for the award of any degree on the same title.

Rahman

KOHIMA

(AZIBUR RAHMAN)

Dated : 24th May' **1999**

Counter Signed

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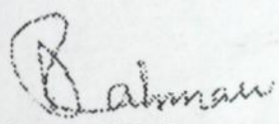

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CHAPTER - I

INTRODUCTION

• INTRODUCTION

Mental retardation is a global problem. Almost 2% of the population in any country is mentally retarded. Like all other disabilities , mental retardation is found among people of any class, cast, sex,religion , community and the nation. It is an age old problem of the world. Seguine was the first psychologist who started some organised activities on mental retardation in French in the year 1837. Actually with the advent of humanitarian movement in the twentieth century different sections of the world communites became sensitive toward the problem of mental retardation. The first institution in India for mentally retarded children was opened at Mankhurd in Bomaby in the year 1941. In the developed countries like the USA, the UK, Japan and Russia have done much for mentally retarded providing them the facilities of education and rehabilitation. Most of the third world countries including India, it still remains under pathetic Condition. Exact statistical figure of mentally retarded in India is not yet known. Because never a nationwide survey was conducted in the past. National policy on Mental Handicap (1988)[1] stated the estimated figures of 16000000 mentally retarded person in India. Shankar (1958)[2] referred that there is no certainty whether mental deficiency is more prevalent in country side or in cities. Khaparde (1987)[3] remarked that mental retardation is equally common in urban and rural areas.

The normal children usually meet the needs and demands of the society through an effective process of adjustment and communication. But what happens to a mentally retarded who is a furture hope and expectation to his family, Society

and the nation as a whole? Mental retardation is a complex and multidimentional problem. Mentally retarded persons are helpless and therefore they need care and protection from others. Retarded person are mentally subnormal, socially incompetent and intellectually inferior which affects the normal development of their personality and give them minimum opportunities to serve the society and themselves. At the present juncture both in States and Abroad the problem of equalization of educational opportunities for all became an operational problem. The NGO's, the National government and the UNO are working for the welfare of mentally retarded as well as for other disabled children.

The philosophical concept of equalization reflects in the Indian Constitution (1950)[4] of the Article 45 and Article 46. The Directive principle of state policy (Article45) declares that the state shall endeavour to provide within a period of ten years from the commencements of this constitution, for free and compulsory education for all children untill they complete the age of fourteen years. This constitutional provision has not yet implemented in the country. Article 46 emphasised the educational and economic interest of the weaker section people, to give special care and protection from social injustice and all forms of exploitation. The General Assembly of the UNO adopted the world programme of Action for the Disabled person in the year (1982)[5] emphasising the right of the Disabled person. A global meeting of expert was held at stockholm in (1987)[6] to review the programme of Action and to developed a guiding philosophy to recognise the right of the disabled. International League of societies for persons with Mental Handicap adopted Delhi Declaration (1994)[7] consisting a list of right for mentally handicap and their families. It also called on all government to disseminate and implement the guidlines of the united Nations the **STANDARD RULES ON EQUALISATION OF OPPORTUNITIES FOR DISABLED PERSONS** in partnership with organisations of disabled persons.

Mental retardation is neither a disease like cancer and tuberculosis nor it is to be possessed by demons. It is only a condition which is essentially incurable. In the classification of exceptional children, the mentally retarded children belong to the lower end of the scale of intelligence and scholastic aptitude quite opposite and contrary to the gifted who lies at the high end of this scale . Some views and openions of distinguished luminaries and social workers on mental retardation are given as follows.

In the inaugural function of first all India conference on mental retardation, smt. Indira Gandhi stated (1966)[8] that I fully realise, the government has a good deal of responsibility in this respect. I am sure that the goverment will do its best to help, specially in the field of research which is more difficult for any private organization. Again she was of the view (1967)[9] that mentally handicapped children can grow to be useful citizen provided society gives them the special attention they need. Modern science has given us new insight into the working of the mind. Research and modern drug have brought a revolution in the care and treatment of mental ailments and handicaps. Fakhruddin Ali Ahmed (1967)[10] remarked that mentally retarded children represent one of the darkest phases of human life. Being unable to see their way through life; they deserve our constant care and attention. They must be treated as human beings and we must do all that is within our power to make lives worthliving. Morarji Desai (1967)[11] expressed while the question of rehabilitation of handicapped children has engaged our attention. I think it is necessary for us to intensify our efforts in this direction. Jakir Hussain (1967)[12] remarked that it is a social obligation of the society to take care of mentally handicapped children and the duty of each one of us to foster the growth of philanthropic institutions. Rudiger vonwechman, President of U.N. general Assembly in a message (1981)[13] urged we have to remember that the problem of disabled are the problem of society as a whole and that we have the responsibility to courage and help them to lead useful and meaningful lives . This we must not

do as an act of charity but because it is their right. And by seeing that the right of the disabled are recognized and their needs fulfilled, society as a whole will benefit for the disabled who are asking to be accepted for their disabilities.

Rajiv Gandhi (1986)[14] expressed that any civilized society has a duty and responsibility towards its less privileged citizens. Handicapped children constitute a sensitive part of this section of the population. Government and voluntary organization must ensure that handicapped children get education through the latest techniques and are absorbed and rehabilitated. Such children should feel that society genuinely cares for them. Tredgold (1937)[15] defined, Mental deficiency is a state of incomplete mental development of such a kind and degree that the individual is incapable of adopting himself to the normal environment of his fellows in such a way as to maintain an existence independently of supervision, control, or external support. This definition was justified by saying that the fundamental purpose of mind is that of enabling the individual so as to adopt his conduct to the requirements of the normal environment of his race as to maintain an independent existence; that if he possesses this capacity he must be regarded as normal, but if he lacks this essential mental attributes, he must be regarded as abnormal and mentally defectives. Doll(1941)[16] recommended six points as a base to measure mental retardation in the developmental period. (i) when the child is incompetent in adjusting himself with social condition (ii) When he can not act with children of his own group like a normal child (iii) When his mental development is obstructed by ecological and behavioural factors (iv) when he is unable to do work at the maturity level expected of him (v) When he is unable to do normal work ,due to his special physical structure, and /or (vi) When some defects have developed within him which cannot be modified. Benda (1954)[17] defined, a mentally defective person is a person who is incapable of managing himself and his affairs, on being taught to do so, and who requires supervision, control and care from his own welfare and the welfare of the community . The WHO (1954)[18] defined mental retardation as incomplete or

insufficient general development of mental Capacities.

Heber (1961)[19] referred "mental retardation as subaverage general intellectual functioning which originates during the developmental period and is associated with impairement in adaptive behaviour. In the Manual of Mentally retarded Terminology and classification". Heber clarified the key terms as SUBAVERAGE which refers to performance greater than one standard deviation below the population mean of the age group involved on measures of general intelleedual functioning. GENERAL INTELLECTUAL FUNCTIONING may be assessed by performance on one or more of the various objective test which have been developed for that purpose. Though the upper age limit of the "developmental period" can not be precisely specified, it may be regarded, for practical purposes, as being at approximately sixteen years .This criterion of mental retardation is in respect to age and serves to distinguish mental retardation from other disorders of human behaviour. It is specified that the Subaverage Intellectual functioning must be reflected by impairement in adaptive behaviour. ADAPTIVE BEHAVIOUR refers primarily to the effectiveness of the individual in adopting to the natural and social demands of his environment IMPAIRED ADAPTIVE BEHAVIOUR may be reflected in (i) Maturation (ii) Learning and /or (iii) social adjustment. These three aspects of adaptation are important qualifying conditions of mental retardation for different age groups. RATE OF MATURATION refers to the rate of sequential development of self-help skills of infancy and early childhood such as sitting,crawling, standing, Walking, talking, habit training and interaction with age peers. In the first few years of life adaptive behaviour is assessed in terms of these and other manifestations of sensory- motor development. Consequently, delay in acquisition of early developmental skills is of prime importance as a crition of mental retardation during the pre-school years. LEARNING refers to the ability of acquiring knowledge as a function of experience. Learning difficulties mostly manifest in the academic situation normally in the age of schooling . SOCIAL

ADJUSTMENT is an important qualifying condition of mental retardation particularly at the adult level where it is assessed in terms of the degree to which the individual is able to maintain himself independently in the community and in gainful employment as well as by his ability to meet and conform to other personal and social responsibilities and standards set by the community. Rosen , Fox and Gregory (1972)[20] referred that mental retardation is a chronic condition present from birth or early childhood which is characterised by both impaired intellectual functioning as measured by standardised tests and impaired adaptation to the daily demands of individuals social environment. Page (1976)[21] viewed that mental deficiency is a condition of subnormal mental deficiency is a condition of subnormal mental development present at birth or early childhood and characterised mainly by limited intelligence and social inadequacy. British Mental Deficiency Act (1981)[22] Stated that mental retardation is a condition of arrested or incomplete development of mind existing before the age of 18 years whether arising from inherent causes or induced by disease or injury. The above concept of mental retardation is in complete which emphasised only the incomplete development of mind without any reference to the individual's adjustment to his environment or the difficulties he may face for his subnormal intellectual functionig. The person with Disadilities Act, 1995 (Act. 1 of 1996)[23] India referred mental retardation as a condition of arrested or incomplete development of mind of a person which is specially characteristised by subnormality of intelligence. officially the above defination is accepted in India. In this definition nothing is mentioned about the adaptive behaviour of the mentally retarded which is important criteria to indentify them. But the definition has rightly mentioned the arrested or incomplete development of mind of mentally retarded. Grossman, H.J.(1973)[24] classified mentally retarded into four catagories.

i) **Slow learner:** who are slow in learning but is capable of achieving a moderate degree of academic success. He is educated in regular classes

with adapation of regular classroom programme.

ii) **Educable mentally retarded :** They are unable to profit to a great degree from the regular school programme. But can be educated with normal children where the class is very small and teachers give special care.

iii) **Trainable mentally retarded :** They are unable to profit from the educational programmes of educable mentally retarded. They can be trained in semi skills and unskilled vocations.

iv) **Totally dependent mentally retarded:** They are markedly subnormal in intelligence and unable to be trained in self-care and needs continuous help from others. Educational classification of mental retardation quoted by Sahu (1990)[25] is shown in the following table.

Table 1.1 Relating to the catagories of mentally retarded, their I.Q. and performances.

Catagories	I. Q . level	level of performance
Educable mentally retarded	Between 50 / 55 to 70 / 75	Can perform without continuous supervision. Learn academic skills - reading, writing and arithmetic. They are educable.
Trainable mentally retarded	Between 30 / 35 to 50 / 55	Educational Programme is based on physical and social rather than intellectual skills. Trained in semi skilled and unskilled vocations to be self sufficient.
Custodial mentally retarded	Below 20 to 25	They are uneducated and untrained and totally dependent

• JUSTIFICATION OF THE STUDY

Exaltation of human personality and smooth functioning of democracy can not be achieved until education reach to all seetions of people. In democratic and secular state all individual expects the opportunity to grow and learn in accordance with their capacities. It is education that equips an individual to struggle for existence and survival in the society. Education and rehabilitation problems become a burning issue for M. R. Children, not only in the North-East but for the entire country. It is matter of concern of the teachers, doctors, psychiatrist and social workers. In every 100 population roughly 2 persons are mentally retarded who are not benefited from the normal school instructions. They need special instructions. The present study has a practical relevance to know and suggest the type of special instructions to be arranged for mentally retarded children.

The people are not conscious of mental retardation and their attitude is quite inappropriate to the mentally retarded. They are ignored and neglected consequently they are deprived of education, human rights and social justice. In a report of the National policy on Mental Handicap (1988)[26] it was referred that there are little more than 200 institutions in India with a facility of about 10,000 mentally retarded individuals. The National policy on Education (1986)[27] emphasised more for physically handicapped than the mentally retarded. The programme of Action of NPE has given educational facilities only to 1% of mentally retarded children. The persons with Disabilities Act 1995 (Act I of 1996)[28] was also silent towards education and rehabilitation and had no employment scheme and reservation of posts for mentally retarded. They are human being and are not totally useless for society. Adequate education and training enables them to do social and daily living activities. Their capacities can be compensated like other handicapped personalities. Mahesh Bhargava (1994)[29] reported that scientist Elbert Einstein's vocabulary

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*M. R. refers to Mentally retarded.

developed vary late, American president Roosevelt was handicapped by polio, famous writer and traveller Helen keller was blind and deaf and famous Indian poet surdas was blind by birth. The above personalities showed best examples by compensating their abilities. Mentally retarded children are also not exception to them at least to some degree, if they are accepted and educated. The present study will highlight the abilities of mentally retarded children in different areas of their interest.

Mental retardation is still a new field of research in India. Few research has been conducted and most of them are in matropolitan cities and in urban centers. In this regard the North-East region is more backward. Most probably no single research study has been conducted with the coverage of North-East. No initiation is taken by the concerned state governments to rehabilitate the mentally retarded. There is no statistical figures of the institutes for M. R. Children and teacher students strength are also not available in the literature. This study is undertaken at right time to recognise the existing facilities and problems of special schools as well as mentally retarded children. This study can give necessary information to the people involved for the welfare activities of mentally retarded. It is hoped that the present study would focus people's attention and can develop proper attitude towards M. R. Chiblren.

● STATEMENT OF THE PROBLEM

The problem of the study has been entitled as "A STUDY OF THE PROBLEMS OF MENTALLY RETARDED CHILDREN AND PROVISIONS FOR THEIR EDUCATION IN THE NORTH-EAST."

● OPERATIONAL DEFINITIONS

■ PROBLEMS :

The term problems concern the general, educational and

rehabilitation problems. It also concern the causation factors of mental retardation in the North-east.

■ MENTALLY RETARDED CHILDREN

Children who are suffering from the problem of mental deficiency is termed as mentally retarded children. The following operational definition is used for the present study. A merican Association on Mental Deficiency (1983)[30] stated, "Mental retardation refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behaviour and manifested during the developmental period." operational terms of this definition are clarified as follows.

■ SIGNIFICANTLY SUB-AVERAGE

A person is described as significantly sub-average if his full-scale I.Q. does not exceed 70. (How ever, a student with an I. Q. of 75 to 79 Could be classified as mentally retarded if he demonstrates deficits in adaptive behaviour)

■ GENERAL INTELLECTUAL FUNCTIONING

It is normally determined through the results obtain after individual administration of general intelligence test such as the Stanford Binet intelligence scale or wechsler intelligence scale.

■ DEFICITS

It may be manifested by slow, incomplete or arrested development. The slow developmental milestone may be reflected during infancy, childhood and early adolescence. During infancy and early childhood arrested development may be reflected in sensory-motor and communication skills. Sensory-motor skills are

turning, crawling, walking, etc. Communication skills are smiling, gesturing and speaking. Self-help skills are eating, dressing, toilet training and bathing etc. During childhood and early adolescence deficit may reflect in learing rate, Judgement and reasoning power in relation to the environment and interpersonal social relationsphips.

■ ADAPTIVE BEHAVIOUR

'Adaptive behaviour' is well defined by Grossman (1983)[31] as "the effectiveness or degree with which the individual meets the standards of personal independence and social responsibility expected of his age and cultural group."

The above definition of mental retardation seems to be the most recent and comprehensive.It reflects the modern scientific approach of mental retardation. It covered the criteria of both measured intelligence and adaptive behaviour for the identification of mentally retarded. It also clarified that low I. Q. is not the sole criterion to diagnose the mentally retarded. Low I. Q. plus impaired or deficient adaptive behaviour originating before maturity is the essential Criteria for a person to be mentally retarded. It deliberately ignored the etiology of mental retardation simply because mantal retardation may not be attributed to any specific cause or causes.

This definition is silent about the curability of mental retardation because many of its types seem to be incurable. The functional level of M. R. Children can be significantly altered and personal and social effectiveness can be maximised by adopting the appropriate means. Considering its comprehensive nature and functional aspects, it is accepted.

■ PROVISIONS FOR THEIR EDUCATION

It includes the infrastructural facilities and existing educational

and rehabilitation programmes for mentally retarded children undertaken by the government and by voluntary organisations.

• OBJECTIVES OF THE STUDY

1. To study the causative factors of mental retardation in the North-east.
2. To study the general problems of M. R. Children.
3. To study the educational problems of M.R. Children.
4. To study the provisions for the education of M. R. children
5. To study the existing rehabilitation programmes for M. R. Children.
6. To study the problems related to the rehabilitation of M. R. Children.
7. To develop an 'Action plan' for the education and rehabilitation of M. R. children.

• DELIMITATIONS OF THE STUDY

1. It is delimited to six states of the North-east, namely Assam, Meghalaya. Manipur, Mizoram, Tripura and Nagaland.
2. The present study is confined to nine special institutes for M. R. Children in the North-east and three psychiatric department of Assam and Nagaland.

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CHAPTER - II

REVIEW OF RELATED LITERATURE

- STUDIES RELATED TO HEREDITY AND ENVIRONMENT
- STUDIES RELATED TO INCIDENTAL FIGURES
- STUDIES RELATED TO URBAN-RURAL DIFFERENCES
- STUDIES RELATED TO DIAGNOSIS
- STUDIES RELATED TO TREATMENT AND EDUCATION
- STUDIES RELATED TO REHABILITATION
- REFERENCES

CHAPTER -II

REVIEW OF RELATED LITERATURE

A review is an integrated and organized discussion of the literature pertaining to a well-defined subject. It is an exalting task calling for a deep insight and clear perspective of the over all field. The review of related literature promotes a greater understanding of the problem and its crucial aspects and ensures the avoidance of unnecessary duplication. The research for reference material is time consuming but fruitful phase for investigation. A familiarity with the literature on any problem helps the researcher to discover what is already known; what others attempted to find out; what methods are attractive and disappointing and what problem remained to be solved.Here the researcher reviewed different primary and secondary sources looking through journals, reports,theses and conference proceedings, books,handbooks,dictionaries, Encyclopedias, review, bulletin, Newspaper and dissertations. Some of the comprehensive studies and related literatures are reviewed for the present study and is presented under the following heads :

- STUDIES RELATED TO HEREDITY AND ENVIRONMENT
- STUDIES RELATED TO INCIDENTAL FIGURE
- STUDIES RELATED TO URBAN-RURAL DIFFERENCES
- STUDIES RELATED TO DIAGNOSIS
- STUDIES RELATED TO TREATMENT AND EDUCATION
- STUDIES RELATED TO REHABILITATION

• STUDIES RELATED TO HEREDITY AND ENVIRONMENT :

Kalikak family study conducted by Goddard (1912)[1] and claimed that feeble mindedness had been transmitted by hereditary factors in the family from Martin Kalikak and a "nameless feebleminded girl" by whom he had an illigitimate child during American war. After the war Kalikak again married an intelligent girl from his own class. This time a large number of eminent and able members come from intelligent wife. Goddard traced both the lines of decendents for a number of generation and found many more feebleminded person among the descendents of the feeble minded wife than among those of intelligent wives. Goddard concluded that mental reterdation (feeble mindedness) is hereditary. David Stafford and Linford Rees in (1964 and 1970) [2] respectively revealed that at least 5% of babies born turn out to be mentally retarded. Linford Rees (1967)[3] reported that Mongolism was first described by Langdown and he so named it Down's Syndrome (a superfacial resemblance to oriental people). In 1959 it was found that down's syndrome was associated with an extra chromosome and the risk of a women below 25 years of age giving to a down's syndrome child is 1 in 23000 and 1 in 100 for women between 40 - 45 and 1 in 46 for women older than 45. About 1 in every 600 live births is Down's syndrome. The high infant mortality of Mongolism reduces its incidence in the general population to 1 in 1000. Belmount (1971)[4] expressed that Down's syndrome children shows less psychological disturbances in comparision to other catagories of mentally retaded. They feel more secure in home environment with warm love and affection than in an institution.

Murdock (1975)[5] reported that the occurence of phenylketonuria (PKU - damage to the brain tissue) had been found to range from 1 in every 6800 birth to 1 in every 14000 births. PKU is caused by genetic factor (recessive manner). It was first described by Folling (1934). According to Robinson and Robinson (1976)[6] Down's syndrome is probably the single most common chromosomal cause

of moderate to severe degree of mental retardation. It's risk increase with the increase in age of the mothers. Specially after 40 years. The older the mother, the greater the chance for down's syndrome. shankar (1976)[7] quoted that the percentage of the hereditary origin of mental deficiency estimated by various authorities were shown in the following table.

Table 2.1 Percentage of hereditary origin of mental deficiency.

In 1869Galton thought that it was in about	100 % cases
In 1906Woods thought that it was in about	85 % cases
In 1912Goddard thought that it was in about	77 % cases
In 1920Hollingworth thought that it was in about	90 % cases
In 1929Tredgold thought that it was in about	80 % cases
In 1934Doll thought that it was in about	33 % cases
In 1934Penrose thought that it was in about	29 % cases
In 1935Burt thought that it was in about	14 % cases

Khaparde, s. (1987)[8] expresed that an analysis of 470 cases of mental retardation in the clinics of the All India Institute of Medical Sciences 40.1% of the cases were found mentally retarded because of genetic and chromosomal factors.

Arnold Gassel (1940)9 remarked that environmental factors influence an individual's adaptive behaviour, his personality and intelligence. The best answer was given by Arnold Gassel in his book, " Wolf children and human child". The fact he narrated was that a missionary found two children in a Wolf's den at Lucknow (1920) who were taken by wolves from their family. These children lived many years with them. They were rescued from the forest, kept in hospital

and found that they were not better than the brutes. They were "Ramu and Kamala". Gassel expressed that the social behaviour of Kamala bore the impress of wolfish ways and predudices.

The younger children tried to allure and entice her to play, but to no avail. She would sit aloof in a corner for hours at a strength, her back to the children,her face to the wall bestowing only forced or furtive glances on her well meaning would be companions".

He remarked that Anna was an illigitimate child who was kept away from any company except her mother till five years of age when she was discovered, she was "Just bones drawn over them" expressed the police officer who discovered her. She failed to develop as human being and survived for only five more years with exceptional care. At her death at ten and half years she had the intelligence of a child of two and half years.

Goldfarb (1945)[10] found positive relationship between maternal deprivation and mental deficiency.

Charles (1953)[11] carried out a longitudinal study of a group of 206 individuals, all of whom, when at school had an I.Q. below 70 and had spent more than one year in "opportunity rooms" in Nabraska because of low intelligence coupled with other clinical and educational evidence of mental subnormality. Beller found among the mentally subnormal group more cases with unsatisfactory work histories than among the normal group, 41% as against 15% being in receipt of poor relief during the depression. More of them had been before the courts and their social adjustment tended to be inferior to that of the control group. Damle (1952)[12] examined many socio-psychological factors that operate in the case of mentally retarded children. He held factors like order of birth, age group, education, occupation, income of parents, rates of sibling death, mothers physical condition during pregnancy, food given in infancy etc. are closely related with mental

retardation. He concluded that in most of the cases socio-spychological factors are responsible. His findings disclosed that most of the mentally retarded children were first in order of birth and majority of them belong to business service group and fall inthe income group of Rs.100 - Rs.200. Wadia (1954)[13] in his book "The Handicapped child" has enunciated that the causes of mental retardation are socio-psychological factors like poverty, Siblings, malnutrition and deprivation to the Indian population. Jones (1954)[14] conducted a comprehensive review of research on social class and intelligence, came in an article crimichel manual of child Psychology. It was found that intelligence and social class have a positive relation and environmental opportunities substancially influence intellectual development. Kent and Devis (1957)[15] in a study found that different types of parental discipline is associated with child's I.Q. levels. Wortis (1958)[16] revealed, poverty is a major factor that determines the nature and degree of mental retardation. Clark and Clark (1960)[17] expressed that mental retardation has a connection with deprivation. Major dimension of early childhood deprivation according to them were social isolation, cruelty and neglect, institutional upbringing, adverse child rearing practices and separation experiences across a wide range of severity. Socio-economic and cultural deprivation are important factors contribute to mental retardation.

In an American study (1960)[18] quoted by Barthakur, revealed that over use of vitamin could be harmful.It was found that in the U.S.A many pregnant mothers started taking vitamin D in large measures in the mistaken assumption that they would improve their health and fatal development. It was subsequently discovered that excessive vitamin D in the mothers bloodstream caused hypercalcemia (excess calcium) in the foetus,which lead to mentel deficency.kuppuswamy (1961)[19] conducted a survey in muysore city, where not a single retareded child comes from the high socio-economic group. Amesur (1962)[20] referes that poor social condition, bad nutrition, insanitary surroundings, poor parental guidance are usually associated with low economic factors and with subnormal

intelligence. There is a negative correlation between size of the family and intelligence. Children of later pregnancy also show a higher percentage of mentally defectives. Kirk (1962)[21] summarised different studies of the environmental effects on mentallly retarded children are as follows. FIRSTLY different case studies conformed that deprived environment is the cause of mentlal retardation But the case studies are some what ambiguous and do not show necessarily that a change of enviroment changed that status of the cases perceptibly. SECONDLY the environment of mentally retarded children was changed by placing them in foster home. The result show that intellectual development of children is affected in varying degrees by the type of home in which they are placed. The THIRD opproach had been the comparison of the intelleetual level of children coming from different environments. But regarding findings it had no any clear conclusion. The FOURTH approach was the investigation of the effects of environmental enrichment and school programmes on the development of retarded children. The findings of the studies had been controversial. It was concluded that altering rate of development through environmental enrichment is possible while others contended that it is impossible.

Study of Marfatia (1963)[22] revealed that after birth, psychological, educational, cultural and social factors influence the developing mind. The poor living conditions or lack of adequate care of children during infancy and early childhood are important contributory causes of mental retardation. Graham et al (1963)[23] refered that children with a history of breathing difficulty showed more neurological abnormalities and intellectual disorder than normal controls. Due to this dysfunction of the liver in the newborn, a disease called Kernicturus occurs which also lead to mental retardation. Gunnar Dybwad (1964)[24] on the basis of many studies concluded that socio-cultural and economic factors play a decissive role in determining the degree of mental retardation, a mild form of retardation. Seeta Sinclair (1964-65)[25] conducted many studies on mental retardation and

concluded that biggest single cause of mental retardation is sub-cultural or familial mental retardation. Because parents with a low I.Q. can not compete for a high position or work which tend to drift to low-paid work and an environment which is culturally low and not stimulating so that the children of these parents have not only an inherited low level of intelligence but also deprive environment which further prevents any improvement in their condition. Robinson and Robinson (1965)[26] stated that significant relationship exist between socio-economic class and a wide variety of variables, health, education and the general welfare suffer in the lower socio-economic classes of almost of all countries in comparison to more fortunate classes. Aims and purposes, abilities and achievements all tend to very significantly with social class. Kishore, lstiaq quoted the study result of Jaya Nagaraja (1965)[27] which indicated that heavy incidence of mental retardation occured in culturally deprived population. The adverse social, economic and cultural conditions play an important role in the causation of mental retardation. Mental retardation according to her, is not a static condition but is related to the educational and social level of the community in which the individual happens to live. Karl Frankestein (1965) [28] stated that environmental causes of mental retardation are growing up under externalizing influence of extreme poverty and educational institutional care and impersonality of primary relationships under conditionig of institutional routine. Later lack of intellectual stimulation and placeness of the paternal immage, emotionally conditional blocking, regression or distortions, psychotic personality disorder and certain types of delinquent behaviour. These environmental and personality factors produce feeblemindedness entering into configuration with other specific or non-specific factors. Cultural fusion and insurity and weakness of parental guidance and stimulation also contribute to mental retardation. Ramanujan etal (1966)[29] of B.M. Institute, Ahmedabad conducted survey on six Municipal Schools of Ahmedabad to determined the incidence of slow learners, the finding referred that the retardates generally belong to lower socio-economic group. The sub-cultural

environment of such children was also reported to be not very conducive and stimulating. They held socio-economic factors responsible for mental retardation. Das Gupta (1967)[30] revealed that cultural deprivation is one of the important factors that contribute to mental retardation. He pointed out that mostly moderate and mild retarded group contain a large number of culturally deprived persons and their intelligence can be raised by adopting various remedial measures. Studies undertaken by Srivastava, Shankar and Pandey et. al (1967) [31] expressed that in India the under developed level of culture in country side, lack of educational and technological development and the absence of demands on the individual resources generally result in the underdevelopment of the latent potentialities of the people. Hence a large number of persons in rural areas and also among the urban population remain pseudo-retarded. Puri (1967)[32] conducted a study and concluded that the problem of continued maladjustment in the mentally retarded children can be avoided to a greater degree by a) understanding the particular emotional needs of the child. b) Setting up of guidance cells at many educational institutions if possible. c) discovering emotional maladjustment in the earliest stages. d) taking remedial measures . Bijou (1968)[33] reported four environmental factors responsible for placing restrictions on developmental opportunity. a) Abnormal anatomical or physiological function b) Deficient reinforcement and discrimination histories c) Disadvantageous reinforcement of undesirable behaviour d) Severe aversive stimuli. The interaction of these and other process such as disruption of the mother child relationship accounts for retarding influence. Das (1968)[34] held cultural deprivation as one of the factors that favours intellectual subnormality. To him cultural deprivation refers to a complex set of conditions.The conditions are contributed by an unstimulating environment, lack of verbal commence with adults, poor sensory experience and other deteriorating environmental factors generally associated with poverty. The ill effects of cultural deprivation not only affect intelligence but also in verbal communication. Kuppuswamy (1968)[35] conducted a survey in mysore city which

revealed that a relatively higher incidence of mental retardation occured among the socio economic group. Takrani (1969)[36] was of the view that sensory deprivation,motor deficit, nutritional deficiency, language difficulties, cultural deprivation etc. Contribute to mental retardation. To him cultural deprivation as represented by non- stimulating social or family evironment and in adequate schooling play vital role in the field of mental retardation. Srivastava (1970)[37] study report reffered that the number of mentally retarded children increased with the number of sibling. It was also reported that parent child relationship plays a vital role in the adjustment of such retardates. Teja, verma and shah (1971)[38] conducted a comperative study of the background factors in mentally retarded and emotionally disturbed children. They viewed that mental retardation was found to be associated positively with rural background, family history of mental retardation and organic psychosis. Mental retardation has no relation with age, sex, income, sibling, size of the family, rivalry, neurotic traits and family history of neurosis. But preponderence of male mentally retarded in the ethnic population as a whole was observed. According to Hellman and Pritchard (1971)[39] 5% of the pregnancies may be accompanied by some viral infection having their dangerous effects upon the unborn during the first three months. Due to this infection, certain damaging agent get in causing measles, chicken pox, small pox, polio and rubella. Rubella is said to be one of the most acute infection leading to mental retardation. Chess, korn and Fernander (1971)[40] reported that moderate mental retardation in 25% of rubella infected children and mild retardation in another 25 % such as deafness, cataract and malformaion of the heart. Bouer (1972)[41] found that various birth and envivonmental hazards and infectious diseases affect more the poor class. The pregnant mothers of the poor class rarely get proper care and food. There is hence greater risk for mental retardation to their child than the affluent and rich mothers. Winick and Rosso (1972)[42] viewed that malnutrition in pregnant rats results in about 15 % reduction in the number of brain cells in their offspring. They also

found that malnutrition in human resulted in Significantly lower birth weights in infants. Lower birth weight indicates lower brain weight and reduced intellectual ability. Niswander and Gordon (1942)[43] reported that the death rate for low birth weight infants is 25 times greater than for normal weight infants. The rest who survive, the rate of neurological abnormality is 3 times higher than the normal weight babies. Istiaq (1973)[44] Conducted a socio-Psychological study on mental retardation at the university of Lucknow. The finding of the study indicated that most of the mentally retarded students come from uncongenial surrounding and low socio economic class. Grossman (1973)[45] viewed that mental retardation may cause due to psyho-social disadvantage. White and watt (1973)[46] observed that in lower and lower middle socio economic groups, both parents used to go out to earn their living as the father's pay is not sufficient to maintain the family. Consequently when mother go out to work the responsibility of the child falls either on the servant or baby sitter or older sibling or a relative. Keeping this in mind they remarked that one result of this arrangement is that the interchanges necessary for successful parent child relationships are missing and intellectual, Social and emotional growth can be hampered. Studies Conducted by jones et. at (1974)[47] indicated that the use of thyroid and small pox vaccines or inocculation with anti tetanus serum may lead to neurological disorder and mental deficiency. Study conducted by coldman, Kufman and liebman (1974)[74] found that out of 55 children weighting less than 3 pounds at birth and at the age of five 58% child had less than 80I.Q. and only 30% were attending regular schools. Milkovich and vendenberg (1974)[49] reported about the adverse effect of minor tranquilisers such as chlordiazepine and meprobamate (Librium and Miltown). Similarly, RH in compatibility, increased age, radition, poisoning and stress in the mother also lead to subnormal mental development. Injuries prior to birth may also have adverse effects upon the foetus. Shephard (1974)[50] found that intoxication and use of unsafe drugs may cause mental retardation. It was reported that at least 20 drugs can

produce defects in the unborn child which may lead to mental retardation. Carbon monoxide, lead, arsenic, quinine and other substances may lead to mental retardation. Thalidomide may produce limbless, eyeless retarded babies in 20% of the women urging it. Thus the use of unsafe durgs may bring genuine damage to the unborn child in the form of mental retardation. Biswas (1975)[51] Conducted a comparative study on the family backgrourd of mentally retarded and the normal children. The study revealed that more mentally retarded children come from poor family background. Borthakur (1978)[52] reported that dropping of Atom bomb on Hiroshima (August 6 1945) and Nagachaki (August 9, 1945) affected the expectant Japanese women who were within a mile and a half of the explosion. The mother gave birth to babies with damaged brain and deformed skulls. This observation lead to investigation which indicated that pregnant women who received heavy doses of x rays gave birth to babies with malformed eyes. Studies conducted by Benda et at. (1983)[53] which indicated that the families of the retarded were educationally backward and economically deprived.

• STUDIES RELATED TO INCIDENTAL FIGURE

UNESCO (1955)[54] had reported an estimated proportion of various grades of mentally subnormal children in a school population. According to its report 2.56 percent of children in the school population was mentally subnormal whose I. Q. was lower than 70. The following table will make it more clear.

Table -2.2 Estimated proportion of various grades of mental subnormality.

Degree of mental Subnormality	Terms used	Approximate I.Q.Level	Approximate percentage in the School population	
Serve subnormality	idiot	0------19	0.06	
Moderate Subnormality	imbecile	20------49	0.24	2.56
Mild Subnormality	feeble minded	50-----59	2.26	
Dull-Normal	Dull &Backward	70-----85 &90	10.00	

Indian Council of Mental Hygiene (1959)[55] revealed that about 1% of the population is mentally retarded in India. Marfatia (1968)[56] estimated that 30 lacks of mentally defectives are available in India. WHO (1968)[57] reported that 1- 3% ot the population are being mentally retarded. Kupuswamy (1968)[58] conducted a study at Mysore city and reported that 1.14% of the population are mentally retarded in the city. verma (1968)[59] Conducted a study at Nagpur which conchuded that 3.01% of the population are mentalhy retarded. prabhu at al (1970)[60] Conducted a survey in Delhi and pointed out that 85% of the retarded sought advice from quacks. Further if was noted that less than1/5 of the parents in the survey had any real idea about the potentiality of their children. Gupta (1970)[61] on the basis of his analysis of 300 mentally retarded cases. reported that majority of the cases, were severely retarded and belonged to the age group 1- 10 years. He also reported that the ratio of mental retardation between male and female was 2.1. Sethi of the department of psychiatry. Lucknow medical college, conducted a Survey (1972)[62] in Lucknow city and neighbouring villages. He reported that 23 out of every 1000 person (2.3%) in U. P. suffer from mental deficiency. Comparing with southern states he concluded that the rate of mental deficiency is much higher in U. P. The finding of this study also revealed that boys were more prone to mental retardation than gisls. It, was also reported that 74.5% of the retarded belong to the age group of 1-10 years. Sethi et al. (1972)[63] reported that 2.53% of the population of Lucknow was found mentally retarded. Shankar (1976)[64] reported that the figures of incidence of mental retardation in India is 34,50,000 out of which idiots constitute 75000, the imbeciles 1125000 and morons 22,50,000. Rao (1979)[65] reported that about 3% of the population may be identified as mentally retarded to some point in their lives and approximately 0.5% of pre-school children are mentally retarded. Survey conducted (1981)[66] during the international year of Disabled in India indicated that approximately 3% of the population are mentally retarded. Among these 1% come under severely retarded catagory. From a child population of about 6 million

it has been calculated that approximately 2 million children are mentally retarded which means 33% of the child population are placed under mentally retarded catagory, where as 3% of the total population is in that catagory. A ten years long study was conducted at kasturba Medical colleg Hospital, Delhi by kumaraswamy et al (1976-1986)[67] on the child upto 14 years of age. The sample of the study constitutes 1386 out of which 686 (50.63%) were found mentally retarded. Of these 38.54% had mil retardation, 22.29% had moderate retardateion, 24.30% had severly retarded, 14.24% had profoundly mentally retarded and 18.51% of the retarde had behavioural problems. The family history of mental retardation was found in 5.39% cases, the male retarded 58% and female retarded 42%. The nuclear family had in incidence of 66.33%, the jont family had 33.76% and the single child family had 7%. Again the incidence in first child was 24.48% , in middle child was 36.88%, last child was 31.63%, in consangainity 23.90% among Hindu it was 75.07%, among muslim 13.99% and among christican 10.93%. The diagnsotic break up of the Sample of 1386 patient is given below.

Table 2. 3 Diagnostic break up.

Diagnosis	No	%
Mental retardation	686	50.63
Dyslexia(Specific developmental delay)	153	11.29
Epilepsy	166	12.25
Conduct disorder	34	2.51
Emotional disorder	135	9.96
Psychosis	29	2.14
Hyperkinesis	38	2.80
Neuresis	27	1.90
Organic mental disorder	21	1.55
Other	65	4.80
N.Y.D.	13	0.96
Nil Psychiatric	128	9.45

Total: 1386

The above study was concentrated to 686 mentally retarded cases only. Therfore the break up of the study population of 686 M.R. Cases on degree of retardation and various Socio-demographic variables are shown as follows :

Table 2.4 Distribution on Socio-demographic Variables

	MILD M.R.	MODERATE M.R.	SEVERE M.R.	PROFOUND M.R.	M.R. Nos.	TOTAL
AGE UP TO						
1 yr. 11months	16	11	9	1	5	42
2-5yrs.11months	54	27	34	22	11	148
5-9yrs.11months	114	68	53	41	9	285
10 yrs.& over	65	42	61	28	15	211
SEX						
Male	151	76	96	51	28	399
Female	98	72	61	41	15	287
RELIGION						
Hindu	184	115	115	70	31	515
Muslim	36	23	19	13	5	96
Christian	29	10	23	9	4	,75
TYPE OF FAMILY						
Nuclear	163	98	98	67	29	455
Joint	86	50	59	25	11	231
BIRTH ORDER						
Only child	19	7	12	7	3	48
First child	69	36	36	19	8	168
Middle child	80	54	74	29	16	253
Last child	81	51	35	37	13	217
CONSANGUINITY						
Absent	195	112	121	66	28	522
Present	54	36	36	26	12	164

National Policy on Mental Handicap (1988) [68] stated that the number of mentally handicapped persons in the country is nearly 16 million of which 2.5

to 3 million individuals would be with moderate to severe degrees of mental handicap.It has been found to be slightly higher in the rural than in the urban areas. Swaminadhan(1994)[69], member,Planning Commission, reported that according to WHO around 2-3% of the population in India is mentally retarded which means about 20 million people come under this catagory.

• STUDIES RELATED TO URBAN RURAL DIFFERENCES

Schemidt (1938)[70] followed up the graduates of a rural school near Berlin and found that the people who had higher grade in school were the ones who generally gravitated toward the metropolis, while those ranking lower in grades stayed in the countryside. Brugger (1939) and sarason (1959) also found a similar tendency in four districts in switzerland. Studies conducted by smith (1942-1943)[71] on the university of kansas freshmen; Nelson (1942) on State college of washington frest men and hyde kingsley (1944) on draftees from the Boston area. The findings of the studies conformed that urbar children do better in intelligencc test than rural children specially on verbal items. Both children and adult who lived in cities are more "intelligent" than those who live in rural areas. The findings were based on three kinds of data, test results on school children, entrance test for college students and rejection rates for draftees in college students and draftees in both world wars. Ginzberg and Bray (1953)[72] conducted studies based on world war II and korean war data. They concluded that at least in the united states, regional differences in intelligence correspond rather closely to regional differences in urban areas. The rural urban defferences witnessed generally in terms of regional level. Shankar (1958)[73] reported that mentally retarded children come both from the urban and rural areas and there is no certainty whether mental deficiency is more prevalent in the countryside or in cities it still a controversial issue. According to sarason and ladwin (1959)[74] three explanation could be given in support of the above phenomena. (1) the ability of the cities with a more concentrated tax base

and more children available as students to build better schools, attract better teachers and assign students to classes all of whose members have approximately equal level of performance. (2) Selective migration which meant that the more capable people in rural areas or small towns motivated to have resources and moved to city to improve their status, leaving their duller fellows behind. (3) The city, through the stimulation and competition induced by a larger number of interpersonal relationships and throngh the wider range of experience available, provides a better opportunity to develop the skills important for an intelligence test. Cassel (1973)[75] reported that the incidence of mental retardation is consistantly higher in poor urban areas, However from this obervation alone it can not be Concluded that economically deprive children are prone to mental retardation. Khaparde (1987)[76] reported by indicating research studes from different parts of the country that mental retardation is as common in India as it is elsewhere and it is equally common in rural and urban areas. A member of planning commission, swainadhan (1994)[77] reported that ironically 80% of the mentally ratarded come from rural areas.

• STUDIES RELATED TO DIAGNOSIS

Diagnosis indicates identification of the problem of mental retardation. I. Q. level and general intellectual functioning, the level of adaptive behaviour and develop mental milestones are some of the important Criteria to identify mentally retarded children for their treatment and education. Doll (1941)[78] reported that the concept of "Social Competence" is the valid criteria for detection of mental retardation. Penrose (1949)[79] remarked that social criteria are not only changeable but they are relative and not absolute. Hence to make a diagnostic inference of mental retardation solely on the basis of a finding of social incompetence in a particular environment at a particular time in unjustifiable since the same person might well be found competent is a different environment or to different standards. In support of this argument Arthur (1950)[80] cited actual cases in which application of the criterion of social competence would place a person in the

awkward position of having to consider a mentally retarded in one situation but not in another. Tredgold (1952)[81] rejected both educational achievement and performance on standardized intelligence tests as satisfactory criteria of mental retardation. He considered that social competence was "not only the most logical and scientific concept of mental deficiency, but the only criteria which the community can justify." The fifteenth report (1968)[82] of the Expert committee on Mental Health stressed the limitations of I.Q. and the concept of social competence as sole criteria of mental retardation. It has emphasized the legal and social definitions and classification of retardation in the culture. According to British Psychiatrist linford Rees (1967)[83] following land marks helps for recognising mental retardation among infant and children. By comparing the development of suspected subnormal cases with the normal developmental milestones mentally retarded children can be identified.

Table - 2.5 Developmental milestone and age level

DEVELOPMENTAL MILESTONE	NORMAL AGE
Smiling in response to the mothers overtures	6 weeks
Grasping an object	3 months
Ability to go for an object and get it	5 months
Ability of lift head from the supine When Lying on a firm surface.	6 months
Walking when held with hands	9-10 months
Walking without support	13-15 months
SPEECH DEVELOPMENT	**NORMAL AGE**
Able to say 'Mum, mum'	6 months
Able to say 'Da Da' Ma, Ma, Ma	8-9 months
Able to say one or two words with meaning	10-11 months
OTHER USEFUL POINTERS	**NORMAL AGE**
Turning head to a sound	3 months
chewing	6 months
playing games	6months
Imitate parents coughing, putting tongue and knocking on table	6-9 months
wave hand and say 'good bye'	10 months
Feeding self with a cup and placing it back on the tablewithout help	15 months

Shankar (1976)[84] stated that a scientific diagnosis of mental ratardation have four approaches (a) Medical examination by the pediatrician (b) Psychological or psychometric examination (c) Achievement or diagnostic tests in school subjects or school report if the child has some schooling (d) developmental history of the child from birth onwards. Rao (1979)[85] was of the view that the peak period for recognition of mental retardation is betwecn 6 years to 16 years of age when formal schooling seems to be started. Gore (1980)[86] viewed that mental retaration can be measure on I. Q. range. The average I. Q. range is between 84 to 116. If the I.Q. of a child is below it that will be a mentally retarded case. Children with borderline mental retardation are generally not distinguishable from normal children except for the fact that they can not study beyond matriculation and seem to be exceptionally dull. The voluntary Health Association of India (1989)[81] remarked that Developmental Milestones of mentally retarded child is dalayed. He does not grow at the same rate as normal children grow. Parents must be concerned if a child is not able to do some particular activities meant for him even by the time given in the second column in the following table.

The Association has given some of the common milestones of development that can help to identify the normal behaviour of the child.

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* Developmental Milestones indicated that all children grow step by step. These steps are like milestones on a road which tell how much of the road is still left. Children are able to do a particular activity by a particular period. These steps are called Milestones of Development.

Table 2.6. Comparison of development betwen normal and mentally retarded children.

Milestones	Normal age range	Milestone delay
Recognises mother	1- 3 months	4 months
Smiles	1-4 months	6 months
Rolls over	4-5 months	6 months
Holds head steady when placed on stomach or flat surface	2 -6 months	6 months
Sits without support	5 - 10 months	12 months
Stands without support	9-14 months	18 months
walks well	10 - 20months	20 months
Says pa-pa, ma- ma	10-12 months	3rd year
Talks in 2-3 Sentences	16-30 months	4th year
Feeds self	2-3 years	4th year
Tells name	2-3 years	4th years

Sahu (1990)[88] reported that mentally retarded child is slower in sensory motor developmant. Their reaction time is more than the normal child .

Table - 2.7 Stimulus and reaction time of M.R. Children.

Stimulus	Response of retarded (in Second)
Touch	0.12
Hearing	0.12
Sight	0.15
Cold	0.15
Warmth	0.18
Smell	0.20
Taste	0.30
Pain	0.40

Mangal (1994)[89] stated that mentally retarded children can be detected by foetus examination, urine or blood test, assessment of intellectual

functioning and adaptive behaviour. Adaptive behaviour can be observed and assessed by Adaptive Behaviour scale and Minnesota Developmental programming systen.

• STUDIES RELATED TO TREATMENT AND EDUCATION

Kraft (1961)[90] remarked that seguines optimism to the curability of idiots assumed a great driving force behind the establishment of special schools for the mentally defectives in the first half of nineteenth century. Kirk (1962)[91] conducted a longitudinal study on the effects of pre-school education on the development of educable mentally retarded children. The study findings were (I) per school training tended to increase the developmental rate of retarded children. (2) children from psychologically deprived homes tended to either retain their rate of development or increase the rate during and after the pre-school period while those did not receive pre-school experience tended to drop or remain the same in rate of development (3) children in the institution who received training at the preschool level showed remar–kable gains in rate of growth while those who were not given pre-school experience and remained on the wards tended to drop in rate of growth (4) children placed in foster homes and also in the pre-school changed markedly in rate of growth (5) children from relatively adequate homes, not given pre-school experience tended to hold their rate of growth during the pre-school period but increased their rate when they entered school at the age of 6. This indicated that the age of 6 is not too late for increasing developmental rate, provided the children come from relatively adequate homes. In reference to the effect of early schooling, kirk concluded that "the evidence presented indicates that, with reference to mental development, either (a) the deprivation of the children in this experiment displaced their inherent rate of growth one level downward and school experience restored it lower, or (b) the first diagnosis represents the inherent rate of growth, and the school experience dis-placed this rate of growth one level

upward. It would appear that although the upper limits of development for an individual is genetically or organically determined, the functional level or rate of development may be accelerated or depressed within the limits set by the organism. Somato psychological factors and the cultural milieu (in cluding schooling) are capable of influencing the functional level within these limits" philips (1965)[92] stated that the methods of seguine were introduced in the special education of mentally defectives in ltaly by Meria montessori and later on used by her in the education of normal children. The Montessori and kindergarten methods are very close to the techniques developed by Itard to treat the savage of Aveyron. A study Conducted by st. Xavier (1969)[93] revealed that number of mentally subnormal children in greater Bombay is 4031 out of which only 17.1% were in special schools. Bandura (1969)[94] conducted research on learning by imitation, show that it has been possible to teach moderately and severely retarded subject the basic skills of using the telephone through observational Learning. Gardner (1970)[95] referred that many professionals believed that behavioural methods have been the most effective form of treatment for the problem of the mentally retarded person. Kirk (1972)[96] emphasising the service of special classes for TMR has remarked that it relieves the parents of retarded children of some responsibility and helps them to see their children disabilities more realistically. He further viewed that the effects of special classes on TMR children are hard to assess. He said "in variably, the children improved from year to year, but whether this improvement stemed from the programmes or from maturation was hard to know" Dunn (1973)[97] expressed, "It is unfortunate that in many cases TMR children becomes a failure from the special education in the sense, they learn nothing more than what they would have learnt at home. Robinson and Robinson (1976)[98] Supported the normalisation of education for mentally retarded children. They viewed that the special classroom is an isolating experience and the children from special classes

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* TMR indicates trainable Mentally Retarded.

within regular public schools are avoided by other pupils and often feel lonely, unwanted and negatively valued. On the contrary in the normalisation approach,. EMR children play with their normal peers and classmates and feel that they are one among the entire group. It was also viewed that EMR children are "better able to achieve socially and academically if they are exposed to models than their own".

Ardhapurkar (1976)[99] stated that the first organised programme for the mentally retarded were started in 1837 by a french psyhiatrist named seguine. The first school of such children was opened in Massachussets in 1848, followed shortly by another school in New york and then in pennsylvania. The first professional organisation known as American Association of Mental Deficiency was started by Medical officers of institutions in 1876. In India the first institution began functioning in 1941 at Mankhurd in Bombay. Ankoliv (1980)[100] Conducted a survey in Maharastra. The study revealed that the maximum number of schools are 31 in Maharasta out of a total 81 in the whole country. Out of 31 institute of the state 22 were located in Bombay alone. Shortage of trained teachers were also high lighted in the survey where only 35% of the teachers in special schools for M.R. were trained. Mahanty (1984)[101] reported that in 1975 the number of mentally retarded institition in India was 160. She also stated that in recent years behavioural modification by reward and punishment has proved to be a very effective technique in treating the mentally retarded persons. Regarding the treatment of M.R. children she expressed that in Russia Individual contred educational programmes for mentally retarded are arranged at the institute of Defectology in Moscow. A child is first diagnosed as a mentally retarded by the age of 16 month and till the onset of puberty the individualised programmes are prepared from miltidisciplinary points of view and implemented for the child, which enable to over come the problem of mental retardation with the onset of puberty.

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* EMR indicates Educable Mentally Retarded.

Khaparde (1987)[102] remarked that the research studies from different parts of the country have shown that with the latest methods of treatment and prevention available in modern helth care, the chronicity and disability can be avoided in about 80% of the cases. Complete and lasting recovery is possible in 60% of the cases. In a report "National policy on Mental Handicap" (1988)[103] it was revealed that there are little more than 200 institutions in India with a facility of or care of about 10,000 mentally retarded individuals. The inadequacy of services is clear as the current services do not cover even 1% of the mentally handicapped persons, only a few of them are residential and others provide only day care facilities. Recently subsidy is given to mentally handicapped to travel by train. The meager services currently available are unevenly distributed in the variours parts of the country. The majority of the intitutions are in big cities and some bigger towns. Nearly 60-70% of the major towns do not have any facilities. Another service lacuna is the Lack of facilities for those above the age of 18 years. Research in special Education 'A Trend Report' Jangira & Mukhapadhyay (1988)[104] reported that 19 studies have been conducted so far in mental retardation. It represents almost $^1/_3$ of the total research studies reported in specialeducation. The maximum number of researches appeared during 1975-79. Eleven studies involved survey of one kind or another.

Table 2.8 DISTRIBUTION OF STUDIES IN MENTAL RETARDATION NATURE

PERIOD	Ph.D	Institutional	Survey Teacher.Trg.	Test & Mate rial Development	Inter Vention	Others	Total
1965-69	1	1	2	—	—		2
1970-74	2	—	2	—	—		2
1975-79	7	1	3	5	—		8
1980-84	3	—	3	—	—		3
1985-87	4	—	1	—	3		4
Total	17	2	11	5	3		19

Choudhary (1994)105 reported that there are 1000 special schools at the national level where 50,000 students are enrolled. There are 23 Special employment exchanges and 55 special cells in India.

• STUDIES RELATED TO REHABILITATION

Mundy (1957)[106] Conducted a study in Britain and reported that the stimulation provided by community living resulted in more intellectual gain than residence in an institution for the mentally retarded. Linford (1967)[107] reported the research findings in England had shown that young medium grade subnormal children who were cared for in small groups which tried to provide a substitute family environment, developed social and verbal ability more rapidly than a comparable group of children who remained in a village ward of mental deficiency hospital. Recent studies of learing disabilities of adult imbeciles shown that some of them attained the standards necessary for employment in open industry and others become self-supporting in sheltered work shops. Many such patient can live at home or in hostels and travel to work each day. Zaetz (1969)[108] conducted an occupational training progrcamme for montally retarded children and found that there had been a potential link between recreation programme and participation in the sheltered workshop. Mitchell and smeriglio (1970)[109] on the basis of their study concluded that moerately and severely retarded children, when institutionalised in an environment providing only routine nursing care, failed to make any noticeable progress in over all absolute level of social competence during the first three years of institutionalisation. They did not lose skills brought from home, but they failed to learn any new eating and dressing routines and they did not develop in constructive play, work habits, social co-operativeness and communi cation skills, as they would have under better circumstances. Worse yet, as they advanced in locomotion and general self-help at the expected rate, their impoverishment in other areas gave them a typical pattern which might make them even less comprehensible and thus

less acceptable at home. They found that cognitive development proceeded at the appropriate rate, in institutionalised mentally retarded individuals who were enrolled in academic school programmes. However. Children in the same institution and with the same initial I. Q. who did not attend academic school programmes shown a significant mean drop in I.Q. They concluded that institutionalisation of mentally retarded should be recommended only when it is certain that specialized teaching programmes administered by non-attendent personnel, will actually be received by the child from the movement he is admitted to the institution. Balla Butterfield and Zigler (1974)[110] reported that institutionatisation have positive effect on MR children. The effects of institutionalisation varied with the individuals pre institutinoal life experiences, the environment of the particular institution and the diagnostic skills of the investigator. One alternative to residential treatment is the 'group home'. It is a type of boarding house in which a fixed number of retarded people stay together with some professional staff who look after them. They learn some vocational tasks taking part in group therapy. The group home is much better than the large institutions and it has many of the facitities of real home for the retarded person. Pratibha (1979)[111] remarked that mentally retarded children are not totally uesless to themself and society. They can not do certainthings while they can do certain others, all of which depend upon the degree and severity of mental retar dation. Ganguly (1993)[112] extensively reviewed the various projects of UNICEF and commented that NGO's and funding agencies have tended to have a project bound approach in which the implementing agency "does CBR" often inadvertently leading to a dependency on the outside agent which is, in fact, the opposite of what has been aimed at. A UNICEF report (1994)[113] revealed that 40 rehabilitation projects (supported by it) was evaluated, while appreciating the innovativeness and commitment of NGO's have raised few concerns relating to CBR approach. (a) The NGO projects tend to remain as pilot projects covering limited population (b) The NGOs which receive fund from UNICEF for a limited period tend to depend soley

on UNICEF funds resulting in inability to continue the Project. (c) The monitoring of the projects and the innovative strategies and process was weak and poor (d) In implimenting innoative projects NGO's had to operate and function in isolation with child related and welfare project implemented or supported by governmat or local bodies (e) Most of the NGO's work concentrated in higher age group instead of 0-6 years age group (f) The most effective way is that the NGO's had to work in conjunction with the primary health care to intervene childhood disability (g) In some areas the operational programmes of NGO's were overlaping and duplicating where several NGO's existed (h) In some backward area where the problem is severe, there is no NGO's to undertake any programme (I) NGO's are not enthusiastic to participate in any government programme like District Rehabilitation centre scheme. A who sponsored seminar (1994)[114] on "the role of voluntary organisation for prevention of Mental Retardation and Mental illness Through CBR Approach" reported that the GOI started (1985) CBR project for the rural areas in collaboration with different departments and the NGO's working in the field of rehabilitation. GOI has set up 11 DRC's Covering 198 blacks with a total population of 39.9 millin. Four RRC's are providing training at various levels including Anganwadi workers. At the district level there would be a medical officer trained in rehabilitation with a fully equiped van for organi sing field services. Roughly it would cover 10 to 15 lakh population. It was also reported that the institute of management of the DRC evaluated the project after 4 years of its functioning which showed that in general DRC has made considerable impact, of course there were many areas of deficiencies. One major deficiency was that it established itself, as bureaucratic structure failing in effective co-ordination involving the communtiy and in networking

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* NGO refers to Non-governmental organisation.
* CBR refers to Community Based Rehabilitation.
* GOI refers to Government of India.
* DRC refers to District Rehabilitation Centre.
* RRC refers to Regional Rehabilitation Centre.

with available sources. The report also mentioned few NGO's who have done outstanding contribution in the field of rehabilitation. These are samadhan (New Delhi) seva-in Action (Bangalore), CBR Project run by THPI (Hyderabad). The UNICEF founded projects are Action Aid (Bengalore), THPI Sponsored, RCBR centre for mentally retarded (Lalacheruvu).

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* THPI refers to Thakur Hariprashad institute of Research and Rehabilitation for Mentally Handicapped
* RCBR refers to Rural Community Based Rehabilitation

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CHAPTER - III

METHODOLOGY : PLAN AND PROCEDURE

- NORMATIVE SURVEY METHOD
- PLAN OF THE STUDY
- POPULATION AND SAMPLE OF THE STUDY
- CONSTRUCTION OF RESEARCH TOOLS
- ADMINISTRATION OF RESEARCH TOOLS
- REFERENCES

CHAPTER - III

METHODOLOGY : PLAN AND PROCEDURE

• NORMATIVE SURVEY METHOD

For the present study the normative survey method was used to investigate different social and educational problems of mentally retarded children. Rehabilitation was another major concern of the investigation. A survey was conducted for the present study to know the existing problems and facilities of mentally retarded children in different special schools of the North- East. Quantitative and qualitative information like infrastructural and behavioural problems, academic information and the working condition of the schools were emphasised.

• PLAN OF THE STUDY

The present study is well planned and divided into six chapters Firts is concerned with introductory chapter, Second chapter is concerned with review of related literature, third chapter deals with methodology- plan and procedue, Four chapter is related to analysis and interpretation of data, fifth chapter was findings of the study and sixth and last chapter contained the action plan and suggestions for further study.

• POPULATION AND SAMPLE OF THE STUDY

Population of the study covers the mentally retarded children of six North-East states studying in the special schools of Assam, Manipur,Meghalaya, Mizoram, Tripura and Nagaland. The area of the present research study is too large. But the population in regard to special schools are small. Sample selected

for the study is almost typical with population. Arunachal Pradesh is excluded form the study as no special school for the education of mentally retarded children exist till the time of data collection. During data collection principals gave the information officially and not by all teachers. Because responses may contradict with each other. It was also very difficult to meet the principal, teachers, and psychiatrist as they had been busy in their own programme. The population in regard to special schools in the North-East was 12 out of which 3 institutes were not for the education of M.R children but for the education for multiple handicapped.

Looking into the nature of population and its non-availability the purposive sampling method was used. Out of 12 special schools 9 had been selected for the present study. Sample selected within the institutes were 9 Principals and 20 special teachers, 6 parents of the mentally retarded and 4 psychiatrist from three psychiatry department and one director from the directorate of social welfare was also selected purposively. The sample of the study is shown in the following table.

Table 3.1 Sample of the population

Sahayika - A special school to help children with special needs, Guwahati
Shishu Saroothi- Special School, Guwahati
Monvikash Kendra - Special School for mentally retarded,Guwahati
B.B.Paul Mental Development Home, Imphal
Ch. ibohal institute for mentally retarded, Imphal
Dwarjinkyrmen- Special School, Shillong
Marry Rice Centre for Special education, Shillong
Swabalamban - An institute for mentally retarded children, Agartala
Gilead Special School - Aizwal
Department of Psychiatry, Guwahati Medical College and Hospital, Bhangagarh
Psychiatric Clinic, Panbazar,Guwaahti
Mental Hospital, Kohima
Directorate of social welfare,Govt. of Manipur, Imphal.
Number of Principals of the selected institutes of the North-East is 9
Number of Teachers of the special schools of the North-East is 20
Number of Psychiatrists of the Department of Psychiatry is 4
Number of parents of mentally retarded children is 6.

• CONSTRUCTION OF RESEARCH TOOLS FOR THE PRESENT STUDY

The research tools had been constructed by the researcher after going through related literature on mental retardation. Necessary instruction was given by the guide to develop the research tools. In the first try out and after the construction of the tools the researcher consulted with experts. After considering the suggestions given by the experts,necessary modification was made and few items of the questions were deleted from the tools. The final draft of the research tools used in the present study are enclosed in appendix No. II, Appendix No. III, Appendix No. IV.

■ QUESTIONNAIRE :

The questionnaire is an important data collection tool for socio-psychological information which consist a number of printed questions each logically connected with the central task of the research. Compilation of a questionnaire is essentially a translation of the principal objectives into the language of questions in a complex and painstaking procedure.The questionnaire consist of the following two types of questions.

i) **Closed type questions :**

The closed type of questions were constructed to collect definite type of information where respondents replied in either "yes" or "No". Putting tick mark against the options. For example; Do you get assistance from voluntary organisation? Yes / No.

ii) **Open type questions :**

In case of open questions the respondents were given the opportunity to reveal their experiences through the questions by expressing their views. The motive of the questions were to get detail information. The respondents had to comment for the questions. For example do you have uniform syllabus for educable

and trainable group of mentally retarded? Yes/No Comment.

■ CONTENTS OF THE QUESTIONNAIRE :

The contents of the questionnaire consists of three main sections i.e. section (A) and section (B)and section (c). Each section had some sub-sections.

Section (A) Problems of Education in the institutes :

It's sub-sections are as follows.

Financial Information:

It was Concerned with the nature and type of assistance given to the institute. The role played by Center, state, local body and other NGO's were also emphasised. Example: Do you get financial assistance from the Central government.? Yes\No.

Classroom Information :

It includes number of Classroom , duration of class, number of male and female student, problems of attention and interet of M.R.S. tudents and wastage and stagnation. Example:Do you have any problem of wastage and stagnation? Yes\No.

Information about Curriculum :

It is Concerned the nature and type of Subjects included in the Curriculum, whether the Curriculum is uniform for educable and trainable M.R.Children or different Curriculum is followed in different institutes.

Teaching-learning method:

It consists of information of different teaching learning methods used in special schools. Whether lecture method, individualised instruction, playway method, reward and punishment, Cues and prompt etc.

Behavioural Problems:

This problem is related to daily living activities. It is concerned

with behaviour disorder, habit disorder, adjustment Problem, hyperactivity, agressiveness, urination asnd eating problem are important items.

Information about teaching Staff :

It includes number of teacher in the institutes. Male and Female number, and teacher pupil ratio in the special schools of the North-East.

Section (B)- Existing facilities of Education:

It's sub-sections are as follows :

It includes the information like age of admission and up to which level the education is given, and number of seats available in the institutes etc.

Infrastructural facilities :

It is related to the physical facilities available in the institutes. The nature and type of school, whether the school is government, govrnment aided or private, residential or day Care Center, special or integrated. Other facilities like Common room, library sanitation facility, Water supply, light facility, furniture and equipment are the concern of the study.

Extra Curricular Programmes :

It is Concerned with the Co-curricular programmes available in the institutes like play ground, indoor and outdoor games, provision of excursion etc.

Guidance and Counselling :

The supporting services available in the institute like parent teacher Association, guidance and Counselling services for students and parents of M.R. children, parents attitudes to M.R. children etc.

Medical Service :

The nature and type of services rendered to M.R. Children are

concerned with medical service. Whether any health center or hospital is existing or medical team is visiting to the institute for the treatment of M. R. Children.

Section (c)-Problem of Rehabilitation :

It covers the following items.

Vocational training :

The existing vocational training programme, scholarship, loan facilities, vocational training facilities for girls Example. Do the retardeds have Sheltered workshop? Yes\No.

Employment Programmes :

It is Concerned with the existing programme of employment in the institutes for M. R. Children in the North-East States. Example. Does the M.R. Children have any service quota ? Yes\No.

INTERVIEW SCHEDULE :

Interview Schedule had four section.

Section (A) Information from Home:

Family income, characteristics of M.R. Children, field of interest of M.R Children are the subjects of it.

Section (B)- Educational Information :

Whether the M.R. Children can pass the examination or interest in study and get pleasure in school.

Section (C)- Environmental information:

It included the attitude of the neighbours to M. R. Children and their parents, whether M. R. Children are inferior to others.

Section (D)- Behavioural Information:

It is same as with the behavioural Information mentioned earlier in questionnaire.

CASE STUDY:

The purpose of case study was to know the causative factors of mental retardation in the North- East states. The questions of case study was

concerned with prenatal causes, neo-natal causes and post natal causes. Socio-economic condition of the family and intelligence quotient of M.R. Children was also the concern of case study. Few examples: (i) Is the mental retardation in your child is inherited? Yes/No.

Was the mother too old at the time of birth of the child ? Yes/No. if yes mention the age.

Was mother under mental shock and tension during pregnancy period ? Yes/No.

• ADMINISTRATION OF RESEARCH TOOLS:

In the first trial the researcher used the mail service for the data collection. Trial for data collection through postal communication failed as no positive response was send back the authorities of the institutes. Therefore the researcher had to visit personally the institutes of six North-East" states. A Certificate was issued by the supervisor in favour of the concerned authorities. The researcher approached the authorities of the institute to give a hand of co- operation in data collection programme. Before administration of tools the respondents were instructed that this is "A study of the problems of mentally retarded children and provisions for their education in the North-East. Some information related to the topic are wanted from you. The questionnaire and case study proforma were distributed to the concerned person and authorities and instructed to go through the questionnaire and case study proforma carefully so that valid information could be expected. The interview schedule was dealt by the researcher himself while interviewing. The respondents were assured on the eve of data collection that the information given by them would keep confidential and will be used only for research purpose. Each tools and techniques and its administration procedures are discussed as follows:

QUESTIONNAIRE :

Questionnaire is a list of questions related to various aspects of the study which were sent to a number of person for them to answer. It is an important device for securing answers to questions by using a form.The questionnaire were administered on 9 principals and 20 special teacher of the special institute. The responses were recorded by the principals and teachers. Before administration of the questionnaire the questions were explained by the researcher to aviod invalid responses.

INTERVIEW SCHEDULE :

Interview Schedule is a set of questions which were used to suppliment the objective information and evidences on mental retardation by a first hand knowledge of the behavioural characteristics, feelings and sentiments. The researcher first made a good rapport with the interviewee. When the atmosphere was favourable, the interview was started. Interview Schedule was administered to parents of the mentally retarded children. The researcher administered the interview schedule while visiting Imphal, Gauhati, Shillong, Agartala and Aizwal. Formal interviewer was conducted and questions were asked from the interview schedule. Respondents responses were recorded by the interview immediately. Mentally retarded children were not selected for interview as they had very low comprehensive power, low intellectual capacity, poor verbal communication and inadequate adaptive behaviour. The interview schedule consists of both open and closed questions.

CASE STUDY :

The case study of the mentally retarded children studying in special schools of the North-East was made to prove in depth the causes of mental retardation. Mentally retarded patient who visited psychiatric clinic, mental hospital and department of psychiatry was also the concern of case study. The sourses of information for case study were the parents of the mentally retarded children, principles of the special schools, psychiatrist of mental hospital and the department

of psychiatry. The purpose of case study was to know the causes and factors that contribute to mental retardation. The ultimate aim was to suggest the preventive and remedial measures to combate the problems of mental retardation. The original diagnostic record was also taken from the diagnostic center, department of psychiatry, Gauhati medical college and Hospital. The content of the case study was to know the pre-natal, neo-natal and post-natal causes. Environmental, Socio-economic condition, intelligence quotient and hereditary factors were also emphasised as the important issue of case study.

Total number of case studies conducted were twenty seven . The researcher visited Gauhati, Imphal, Agartala, Shillong, Aizwal and Kohima to conduct case studies. The list of case studies conducted are shown in the following table

Table 3.2 showing case studies in different states

State	Deptt/ Institute/ Association	No of studies
Assam	Deptt of psychiatry, G M C, Bhangagarh (Gauhati)	5
	Psychiatric Clinic, Panbazer, (Gauhati)	1
	Sahayika, Bamunimaidam (Gauhati)	1
	Shishu Saroothi, Birubari (Gauhati)	1
	Directorate of Social Welfare, Govt. of Monipur	1
Manipur	The All India Parents associon of Mentally retarded, (office) Imphal.	1
	B.B. Paul Mental Development Home, Imphal	2
	Ch. Ibohal Institute, Sangai parou Imphal	1
Meghalaya	Dwarjinkyrmen, Stony land (Shillong)	5
	Marry Rice Centre, Laithumkhrah (Shillong)	2
Tripura	Swabalamban, (Agartala)	3
Mizoram	Gilead Special School, (Aizawl)	1
Nagaland	Mental Hospital, Aradura, (Kohima)	3
		Total = 27

5 Case studies were conducted in outdoor patient of the department of psychiatry, Gauhati Medical College and Hospital, 1 Case study was conducted in the psychiatric

clinic, Panbazar, (Gauhati), 1 from Shishu Saroothi, Gauhati, 1 from directorate of Social Welfare, Govt of Monipur,Imphal. 1 from the office of the All India Parents Assocation of Mentally Retarded, Imphal, 2 from B.B. Paul Mental Development home, Imphal , 1 from Ibohal Institute For Mentally handicapped, Imphal, 3 from Swabalamban, Agartala, 5 case studies from Dwarjinkyrmen, Shillong, 1 from Giead special school, Aizwal and 3 case studies conducted in Mental Hospital, Kohima.

The case studies stated above were found very significant for the present study. These case studies were exclusive type and information were precise and authentic regarding the causes of mental retardation.

Observation Technique :

Observation technique is systematic viewing and consideration to the larger unit of activity on specific observed phenomena.Participant and non participant observation techniques were administered for data collection.The researcher got the previllege to participate different educational programmes and co-curricular activities with mentally retarded students in special schools of the North-East. He observed their behaviour, personality Characteristics, level of adjustment etc. Perhaps the greatest validity of observation techniques were that of recording the observed beahaviour of the students as it occurs during the normal activities they performed. Finally it can be remarked that the wholeadministrative procedure of data collection in different states were painstaking for researcher regarding money, time, labour and stamina. But theover all result was a total success.

Some of the special institutes and mental Hospital are shown in the following pages.

Sahayika - A special school (building) to help children with special needs (Guwahati)

Sahayika - A Special School to help children with special needs, Guwahati

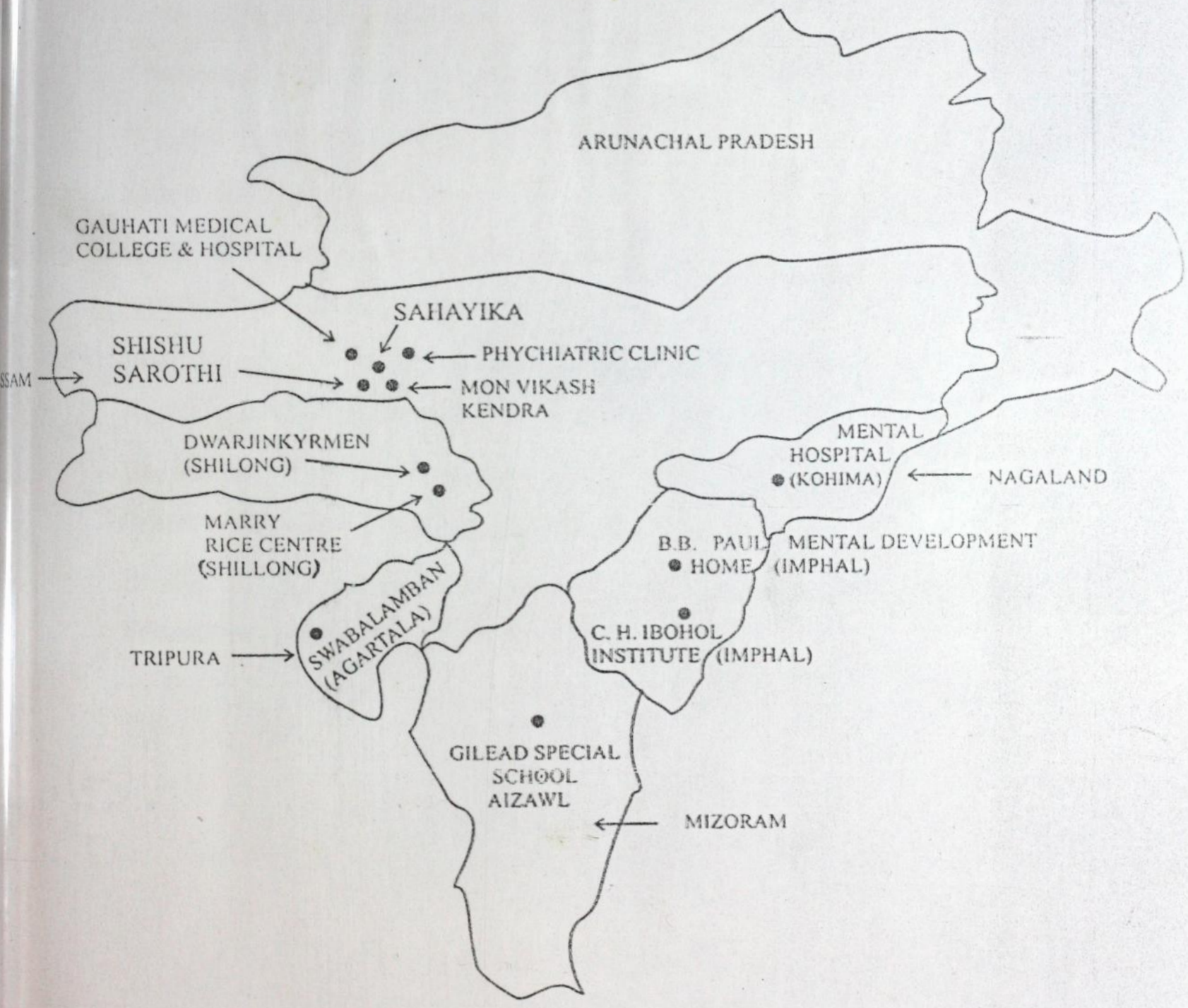
Shishu Saroothi (School building) located at Birubari, Ramkrishna Mission Road, Guwahati.

Shishu Saroothi (School bus)

School building (Shishu Saroothi)

Mental Hospital located at Aradura (Near tourist lodge) Kohima, is Shown above.

TABLE 3.1 NORTH-EAST MAP INDICATING SPECIAL SCHOOLS, MENTAL HOSPITAL AND PHYCHIATRIC DEPARTMENT



The samples of the study are indicated by sign aginst the institutes in the above North-east Map

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CHAPTER - IV

ANALYSIS AND INTERPRETATION OF DATA

- CAUSES OF MENTAL RETARDATION
- GENERAL PROBLEMS OF MENTALLY RETARDED CHILDREN
- EDUCATIONAL PROBLEMS OF MENTALLY RETARDED CHILDREN
- EDUCATIONAL PROVISIONS FOR MENTALLY RETARDED CHILDREN
- EXISTING REHABILITATION PROGRAMMES IN THE SPECIAL SCHOOLS OF THE NORTH-EAST
- PROBLEMS RELATED TO THE REHABILITATION OF MENTALLY RETARDED CHILDREN

CHAPTER - IV

ANALYSIS AND INTERPRETATION OF DATA

Analysis of data means processing, editing, coding, tabulation of data and use of statistical techniques if necessary. Editing the data indicates checking the raw data for accuracy, usefulness and completeness. Coding the data indicates converting or transforming the data into meaningful catagory mostly into numerical forms or under different heads. Tabulation of data indicates recording the classified data accurately into tabular form. Only useful data is recorded in mathematical or statistical term. Data analysis concentrates for the verification of the objectives or hypothesis of the study. F.N. Kerlinger defined analysis of data means catagorizing, ordering; manipulating and summerising of data to obtained answer to the research questions. Interpretation of data is a process of stating. What the findings show. What do they mean and what is their significnce? The researcher critically examined the data using the statistical techniques of percentages and ratios for the purpose of interpreting the data. Collected data was analysed under the following heads in view of the study.

- CAUSES OF MENTAL TETARDATION IN THE NORTH-EAST.
- GENERAL PROBLEMS OF MENTALLY RETARDED CHILDREN IN THE NORTH-EAST.
- EDUCATIONAL PROBLEMS OF MENTALLY RETARDED CHILDREN IN THE NORTH-EAST

- EDUCATIONAL PROGRAMMES FOR MENTALLY RETARDED CHILDREN IN THE NORTH-EAST.
- REHABILITATION PROGRAMMES FOR THE MENTALLY RETARDED CHILDREN IN THE INSTITUTE OF THE NORTH-EAST.
- PROBLEM RELATED TO REHABILITATION OF MENTALLY RETERDED CHILDREN IN THE INSTITUES OF THE NORTH-EAST.

- **CAUSES OF MENTAL RETARDATION IN THE NORTH-EAST**

- PRE - NATAL CAUSES
- NEO - NATAL CAUSES
- POST - NATAL CAUSES
- SOCIO - ECONOMIC CAUSES
- INTELLIGENCE QUOTIENT

PRE - NATAL CAUSES :

Out of 27 case studies conducted in the North-East the prenatal cause for mental retardation was found in fourteen cases.It constitutes 51.85%. Pre-natal causes are as follows:

– Six cases of chromosomal abnormality were found as the causes of mental retardation in the present study. It constitutes 22 % causes of mental retardation

– Three cases of consanguine marriage were found which caused mental retar dation among children. It constituted 11 % of mental retardation.

– Three cases of M. R. Children were found due to over aged pregnancy. It contitutes 11% in the North-East. The age level of the expectant

mother ranges from 34-38 years.

–The case studies revealed that pre-natal mental shock caused mental retardation among children. In the North-East out of 27 cases, two cases of mental shock and tension among expectant mother were found which caused mental retardation among their children. It constitutes 7.41% . It was found that the expectant mother was not treated well in laws. She had persistant caugh and physical weakness she could not sleep well and used to roll on the ground .

NEO-NATAL CAUSES :

Out of 27 case studies conducted in the North-East six cases of mental retardation were due to neo-natal cause. It constitutes 22% in the North-East. Perinatal causes are as follows.

– Deprivation of oxygen during birth caused mental retardation among children. Four cases in the present study was found as mentally retarded due to lack of oxygen. Which caused by the deprivation of oxygen during birth. It indicated 14.81% of mental retardation in the North-East. These children had breathing difficulty and had no birth cry. Oxygen was not given to them and as a result thein brain was damaged. They were blue born babies.

– Two cases of mental retardation was caused by premature birth. It caused by pre-matured birth. It constituted 7.4%

POST NATAL CAUSES :

Seven cases of mental retardation was due to post-natal causes. It constituted 25.93% in the North-East.

– Two cases of mental retardation was caused by infectious disease. It constituted 7.41% of mental retardation in the North-East. The fact was that a six year old child had an attack of para-typhoid which caused him being mentally retarded. He also become physically handicapped. His upper and lower limbs

become weak and he found difficulty in walking. He had also behavioural problems. Another child was found mentally retarded who had an attack of Jaundice just after 15 days of his birth. He had yellow coloured skin.

— 3.70% of mental retardation was caused by brain disorder. A five years old child started epileptic fits with Convulsion, unconciousness and tongue biting. Epilepsy used to take place 1-2 episodes a year. He gradually started showing the features of mental retardation.

— 3.70% of mental retardation was caused by accident in the North-East. A two year old child falled into hot water. Water entered into his brain and head began to enlarge. It lead him to mentally retarded.

Three cases of mental retardation were deprived of breast milk. Mothers were employed who had no time to feed their children as they used to leave home early in the morning and come back late in the evening.Children wasbottle feeded which caused mental retardation among children. It comprised of 11%in the North-East. A diagnostic break up of 27 case studies conducted in the North- East are shown in the following table.

Table. 4.1 Diagnostic break up of case studies.

Causes of mental retardation	No. of M.R. children	Percent
Chromosomal abnormality	6	22.22
Consanguine Marriage	3	11.11
Over aged pregnancy	3	11.11
Pre- natal mental shock & tension	2	7.41
Deprivation of oxygen during birth	4	14.81
Pre- matured birth	2	7.41
Infectious disease	2	7.41
Brain disorder (Epilepsy)	1	3.70
Accident	1	3.70
Bottle feeding	3	11.11

Total No. of cases = 27

SOCIO-ECONOMIC CONDITION :

Socio-economic status of 24 families of mentally retarded children were studied in the present investigation. It was found that mental retardation occured among people from all levels of socio-economic status. The case study result revealed that 21% of mentally retarded children were from upper income group, 42% of them come from middle income group and 37% come from low income group. It is shown in the following table.

Table 4.2 incidence of mental retardation in different income groups.

Class	Income group(per month)	incidence	percent
upper class	Above Rs 6000	5	21%
middle class	Between Rs 3000-6000	10	42%
lower class	Below Rs 3000	9	37%

INTELLIGENCE QUOTIENT :

I.Q. level data of ten M.R students were available in the present study. Data analysis indicated that M.R. Children have low level than the normal children. I.Q.The present study revealed that the highest level of I.Q. was 71 and lowest was 12.5.The analysis comprised of three groups i.e. educable, trainable and custodial. Out of 10 cases 3 students were educable, 5 students were trainable and 2 students were custodial. It indicated that 30% of the students are educable, 50% trainable and 20% custodial. The analysis of data is shown in a tabular form as follows.

Table 4.3 level of intelligence quotient against mental age and chronological age.

M.R Children	Mental Age	Chronological Age	I.Q	Type	Total	percentage
A	5 years	7 years	71	Educable	3	30%
B	10 ,,	15 ,,	67			
C	10 ,,	17 ,,	59			
D	12 ,,	26 ,,	46	Trainable	5	50%
E	3 ,,	8 ,,	37.5			
F	3 ,,	9 ,,	33			
G	7 ,,	24 ,,	29			
H	6 ,,	23 ,,	29			
I	2 ,,	12 ,,	17	Custodial	2	20%
J	2 ,,	16 ,,	12.5			

● GENERAL PROBLEMS OF MENTALLY RETARDED CHILDREN IN THE NORTH-EAST

– It was found that out of 27 cases fourteen M.R.Children could not adjust with the situation of life. It means 51.85% of M.R.Children could not adjust effectively with their per groups as they could not express and communicate properly in day to day life situation. They were also found lazy and clumsy.

– The study revealed that 77.78% of the M.R. Children had some behavioural complain. The major complain was negativism, quarrel some, restless, irrelevant talk, delayed development, forgetfulness, poor attention, low intelligence, childish behaviour, violent, self injurious, speech and hearing defect, disobedient, tearing clothes, throwing food, attention seeking behaviour, more demanding nature, biting other's stubborn and short tempered, lazy and inferior to other etc. The present study revealed that out of eighteen cases ten were found having inferiority

complex which constituted 55.55%.

— Information of 32 cases of mentally retarded children were available with reference to agressiveness. Thirteen M.R.Children were found aggressive that constituted 40.63% .

— Out of 27 cases twentytwo M.R.Children were found having hyperactivity. Hyperactivity comprised of 81.48%. They are restless unstable and can not concentrate for long.

— Regarding self-harming attitude out of 35 cases of mentally retarded children ten students were found having the problem of self-injuriousness. It comprised of 28.57%

— Out of 33 M.R. Children 22 had physical problems.It indicated that 70.79% of the M.R. children had physical problem.

— Regarding attitude toward M.R.children it was found that 29.41% of the neighbours were indifferent, 17.65% were unfavourable and 52.94% had favourable attitude towards M.R. Children. It was also found that 75% of the neighbours had favourable attitude towards the parents of M.R. Children, 18.75% indifferent and 6.25% were unfavourable.

— Regarding eating problem the study revealed that out of 23 cases twentyone cases of mentally retarded children had eating problem. The problem was over eating, inability to take solid food. It comprised 91.30%.

— Regarding behavioural disorder it was found that out of thirty three cases thirty two M.R.Children had behaviour and habit disorder. It comprised of 96.97% The behavioural disorders were nailbiting, thumbsucking, passing urine inside the room and in public places, sleep disturbance and fear to animal, hand and face movement, finger play, flapping & picking nose.

• EDUCATIONAL PROBLEMS OF MENTALLY RETARDED CHILDREN IN THE NORTH-EAST :

Table : 4.4 Residential facilities (Existing and Non-axisting)

Facilities Existing			Non-Existing Facilities		
Institutes	**Total No.**	**%**	**Institutes**	**Total No.**	**%**
Mon-vikash kendra (Special School for the mentally Retarded)	2	22	Sahayika Shishu Sarothi Mary Rice centre Dwarjinkyrmen B.B.Paul mental Development Home Swabalamban Gilead Special School	7	77.78
Ch. Ibohol Institute (For Mentally Retarded)					

— Regarding residential problem it was found that out of nine special schools seven had no residential facilities for the students. This figure indicated that 77.78% of the special schools had no residential facilities at all in the North-East.

— Regarding permanent site and building it was found that out of nine special schools three had no permanent site and building of its own. It comprised of 33%. It is shown in the following table.

Table 4.5 Rental and own school building.

Rental building			Own building		
Institutes	**Total No.**	**%**	**Institutes**	**Total No.**	**%**
Sahiyika Marry Rice Centre Swabalamban	3	33	Mon-Vikash Kendra Shishu Sahothi Gilead special school Pwarjinkyrmen B.B.Paulmental Development Home Ch. Ibohal Institute.	6	66.67

— Regarding Sanitation facility it was found that out of nine institute eight had good sanitation facility. It comprised of 88.89%. Institutes. 11% institutes had no sanitation facility. B.B. paul Mental Development Home had no sanitation facilities. The following table have shown the school in which sanitation facilities of the institutes.

Table 4.6 sanitation facilities of the institutes.

Sanitation facilities (Availability)			sanitation facility (Non-availability)		
Institutes	**Total No.**	**%**	**Institutes**	**Total No.**	**%**
Gilead special school Mon Vikash Kendra Shishu Sarothi Swabalamban Sahayika Ch.Ibohal institute Dwarjinkyrmen Mary Rice Centre	8	88.89	B.B.Paul Mental Development Home	1	11.11

— It was found that out of nine special schools eight had good water supply. It constituted 88.89% 11% of the institutes had no water supply. B.B. paul Mentally Development Home for Mentally Retarded had no water supply facility. The following table have shown the school in which water supply facilities are available.

Table 4.7 information about water supply

Availability of water supply			Non availability of water supply		
Institutes	**Total No.**	**%**	**Institute**	**Total No.**	**%**
Gilead special school Mon-vikash Kendra Shishu Sarothi Swabalamban Sahayika Ch. Ibohal Institute Dwarjinkyrmen Marry Rice Centre	8	88.89	B.B. Paul Mental Development Home for Mentally Retarded	1	11

— It was found that 100% of the special schools had proper light facilities.

— Regarding student Common room it was found that out of nine institute only three had this facility. It comprised 33%. It indicated that 66.64% of the Special school had no student common room. The following table have shown the school indicating the availability and non-availability of common room against the schools.

Table 4.8 Institutes and common room facilities.

Availability of student common room			Non availability of Student common room		
Institutes	**Total No.**	**%**	**Institutes**	**Total No.**	**%**
Mon Vikash Kendra Swabalamban Ch. Ibohal Institute	3	33.33	Gilead special school Shishu Sarothi Sahayika B.B. Paul Mental Development home Dwarjinkymen Marry Rice Centre.	6	66.67

— The study indicated that out of nine special schools three had their library. It means 33% of the institutes had the Library facility. 66.64% of the institutes deprived this facility. The following table have shown the school indicating the availability and non- availbility of library facilities against each school.

Table 4.9 Institutes and library facilities

Availability of Library			Non availability of Library		
Institutes	**Total No.**	**%**	**Institutes**	**Total No.**	**%**
Mon Vikash Shishu sarothi Ch. Ibohal Institute Retarded children	3	33.33	Gilead Special school Swabalamban Sahayika B.B. paul Mental Development Home Dwarjinkyrmen Marry Rice Center.	6	66.67

— The present study revealed that there is no problem of wastage in the special education for M.R.children. But stagnation was found as a major problem which constituted 87.50% of M.R.student in special school of the North East.Education of M.R. Children demands a lot of exposures.

— The present study revealed that out of nine institutes two could not manage the teacher's salary regularly. It means in the north East 22% of the institutes failed to pay the salary of the teachers regularly. The sufferer institutes are swabalamban and B.B. Paul mental Development Home.

— Regarding grant in aid it was found that 66.67% of the institutes of the North-East was not getting grant in aid from the state government out of nine institutes only three institutes got the grant from the concerned states. The following table indicated the schools whitnes aids are getting or not.

Table 4.10 Institutes and state assistance

Grant in Aid getting from stste govt.			Grant in Aid not getting from the State govt.		
Institutes	**Total No.**	**%**	**Institutes**	**Total No.**	**%**
Mon vikash Kendra			Sahayika		
Marry Rice Centre	3	33.33	Shishu Sarothi		
Dwarjinkyrmen			Swabalamban		
			B.B.Paul Mental	6	66.67
			Development Home		
			Ch. Ibohal Institute		
			Gilead Special School		

— Regarding Grant in Aid from the central government. It was found that 77.78% of institutes of the North-East were getting grant in aid from the central government. But this grant was not regular. Two institutes were deprived of grant in Aid from the Central government. It comprised of 22%. The following table indicated the availability and non-availability of grant in aid from the Central government against the special school.

Table 4.11 Institues and central assistance.

Grant in Aid Available from Centralgovt.			Grant in Aid Non available		
Institutes	**Total No.**	**%**	**Institutes**	**Total No.**	**%**
Swabalamban			Sahayika		
Ch. Ibohal Institute			Marry Rice centre.	2	22.22
B.B paul mental					
Development Home	7	77.78			
Dwarjinkyrmen					
Gilead special school					
Shishu Sarothi					
Mon vikash kendra					

— 66.67% of the institutes were getting financial assistance from the voluntary organisation. The prominent welfare organisations assisted the special institutes are Guwahati Mental Welfare Society, society for the welfare of the Disabled shillong Lions club of manipur and Guwahati, Rotary club (Manipur) CASA (Manipur) Local youth club (Imphal), Inner wheel Club (Guwahati) QXFAM (India) Trus etc. Public undertakings also assisted i.e. Indian oxygen limited, Oil

India Limited Etc. and Ladies club of NF Railways. Ladies and children's Recreation centre (Shillong). The present study revealed that out of nine special institutes five institutes were getting donation from the local bodies and four institutes had not this facilities. It means 55.56% of the Institute was getting donation from the local bodies. 44.44% institutes are deprived of this facilities. The following table indicated the institutes which were donated by the local bodies.

Table 4.12 institutes getting financial assistance from local body

Donation by local body (Existing)			Donation by local body (Non-existing)		
Institutes	**Total No.**	**%**	**Institutes**	**Total No.**	**%**
B.B. Pual Mental Development Home Dwarjinkyrmen Gilead special School sahayika Monvikash kendra.	5	55.56	Shishu Sarothi Marry Rice Centre Ch. Ibohal instituite Swabalamban	4	44.44

— It was found that out of nine institutes four had not playground of their own. It indicated that 44.44% of the institutes of the North East had no play ground. It was show in the following table.

Table 4.13 Institutes with and without playground

Institutes with playground			Institutes without playground		
Institutes	**Total No.**	**%**	**Institutes**	**Total No.**	**%**
Mon Vikash Kendra Shishu sarothi Sahayika B.B. Paul Mental Development Home Ch. Ibohal institute	5	55.56	Gilead special school Swabalamban Marry Rice centre Dwarjinkyrmen	4	44.44

— Parent teacher Association was found significant for better out put and normal functioning of the system. The data analysis indicated that four institutes out of 9 had no parent teacher Association which constituted 44.44% institutes of the North East.The following table indicated it clealy.

Table 4.14 Parent-Teacher Association

With parent teacher association			Without parents teacher Association		
Institutes	**Total No.**	**%**	**Institutes**	**Total No.**	**%**
Mon Vikash Kendra Shishu Sarothi Dwarjinkyrmen Swabalamban Marry Rice Centre	5	55.56	Sahayika Ch. Ibohal Institute B.B. Paul Mental Development Home Gilead Special School	4	44.44

— Research data indicated that 100% of the special institutes for M.R. Children in the North East had no permanent health service. Three out of nine special institutes had no medical visiting team which comprised 33% institutes. Part time medical visiting team was giving service to 66.67% of the institutes. The following table shows it clearly.

Table 4.15 Medical service in the special institutes

Medical service available			Medical service non-available		
Institutes	**Total No.**	**%**	**Institutes**	**Total No.**	**%**
Gilead Special School Sahayika shishu Sarothi Mon vikash Kendra Swabalamaban Ch. Ibohal Institute	6	66.67	Dwarjinkymen Marry Rice Centre B.B. paul Mental Development Home	3	33.33

— In the present study data analysis indicated that 50.09% of theM.R.children was not interested in studies. According to the information given by the parents and teachers of M.R.Children the span of attention was very poor. The present study revealed that out of twenty one M.R. Children fifteen had poor comprehensive power. Data analysis indicated that 71.43% of the M. R. Children comprehended simple and easy talk of their parents and teachers.28.57 Percent of the M.R.Children did not comprehend even the simple talk.

• EDUCATIONAL PROVISIONS FOR THE MENTALLY RETARDED CHILDREN IN THE NORTH EAST.

— The research data revealed that age of admission was different from one school to another school. Admission starts from 3-6 years for pre primary or nursery classes. 77.78% of the institutes had 3 years of age criteria for preprimary or nursery classes. In 22.22% of the institute's admission criteria was 6 years for preprimary class. Different Classes and age of admission are shown in the following table .

Table 4.16 Age criteria for admission.

Name of the institute	Admission Age(years)	Class Group	Admission Age(years)	Class Group
MonVikash Kendra	6 years	PreParatory	18"	Vocational
B.B.PaulMental Developmet	6 "	Pre-primary	18"	Secondary
Sahayika	3 "	Nursery	25years	Oral Matriculation
Shishu Sarothi	3 "	Play Group	18 "	Functional
Ch. Ibohal Institute.	3 "	Pre-primary	18 "	Vocational
Dwarjinkyrmen	3 "	Play group	16 "	Functional
Marry Rice Centre	3 "	Pre-School	25 "	Vocational
Swabalamban	3 "	Pre-primary	10 "	Pre-vocational
Gilead Special School	3 "	Academic	18 "	Functional

— The Total number of seat available in the institutes are 696. The individual figure of each institute is as Sahayika 60, Shishu Sarothi 70, Mon-Vikash Kendra 110, B.B.paul Mental Development Home 75, Ch. Ibohal institute

100, Dwar Jinkyrmen 50, Marry Rice centre 60, Swabalamban 56, and Gilead special school 115. The figure is shown in the following table.

Table 4.17 Individual figures of seat in different schools in the North East

School	No. of seat
Sahayika	60
Shishu Sarothi	70
Mon Vikash Kendra	110
B.B paul Mental Development Home	75
Chungkhum Ibohal Institute	100
Dwar Jinkyrmen	50
Marry Rice Centre	60
Swabalamban	56
Gilead Special School	115
Total =	696

— out of nine, seven institutes are purely under private management and rest two are under govt. aided system. The private institutes are sahayika, shishu Sarothi, Mon Vikash Kendra. B. B. paul Mental Development home. Marry Rice Centre. Swabalamban and gilead special school. The Govt. aided institutes are chungkhum ibohal institute and Dwarjinkyrmen. 77.78% of the institutes were private and 22% were govt aided. Private and govt. aided institutes are shown in the following table.

Table 4.18 List and figures of Private and Govt. aided institutes in the North East.

State	No. of private school	No. of Govt. Aided school
Assam	3	———
Manipur	1	1
Meghalaya	1	1
Tripura	1	———
Mizoram	1	———
Total =	7	Total = 2

— The special school for mentally retarded children in the North-East is mostly day care Centre. Residential School are few. out of nine school only two are residential. It comprised of 22% and seven institutes are day care centres. It comprised of 77.78%. Out of two residential school, one is located at Guwahati (Mon vikash Kendra) and another at Imphal (Chungkham Ibohal Institute). The following table will show the figures of residential school and day care centre

Table 4.19 Figures of Residential school and day care centre

State	No. of Residential school	No. of Day care Centre
Assam	1	2
Manipur	1	1
Meghalaya	———	2
Tripura	———	1
Mizoram	———	1
Total	2	7

— Class room are adequate but the quantity is very poor. Classroom are unhygenic. The figures of classroom are as Sahayika 5, Shishu Sarothi 8, Mon vikash Kendra 15, B.B. paul Mental Development Home 6, chungham Ibohal Institutes 15, Dwarjinkyrmen 6, Marry Rice Centre 7, Swabalamban 6, and Gilead Special school 7. School wise figures of classroom are shown in the following table.

Table 4.20 Number of Classroom against each school

Name of school	No. of class room
Sahayika	5
Shishu sarothi	8
Mon Vikash Kendra	15
B.B.Paul Mental Development Home	6
Chungkhm Ibohal Institute	15
Dwar Jinkyrmen	6
Marry Rice Centre	7
Swabalamban	6
Gilead Special school	7

— 83 teachers are enrolled in the special school of the North-East states. The number of male teachers are 20. It covers 24.10%. The number of female teachers in the special schools are 63. It covers 75.90% (24.10%) and 63 (75.90%) It means women are more dedicated towards the Teaching The number of teachers working in special school of the North-East are Assam 31, Manipur 25, meghalaya 14, Tripura 6, and Mizoram 7. The highest enrolment of teacher is in Assam 31 and lowest is in Tripura 6. The teachers enrolment is shown in the following table.

Table 4.21 Enrolment of teacher based on sex.

		No. of Teacher		
State	**Name of School**	**Male**	**Female**	**Total**
Assam	Sahayika	1	6	7
	Shishu sarothi	1	9	10
	Mon Vikash Kendra	5	9	14
Manipur	B.B paul Mental Devt. Home	1	10	11
	Ch. Ibohal Institute		5	9 14
Meghalaya	Dwarjinkyrmen	—	7	7
	Marry Rice Centre	—	7	7
Tripura	Swabalamban	3	3	6
Mizoram	Gilead special school	4	--3	7
	=	20	63	83

— The strength of mentally retarded student in North-East States are 575. The Male mentally retarded student are 338 whiche covers 58.78%. The female students are 237 in number which covers 41.22%. The male mentally retarded students surpass the female number. The number of mentally retarded students in Assam is 216. Manipur 146, Meghalaya 107, Tripura 56, and in Mizoram 50. The highest number of mentally retarded student are in Assam 216 and the Lower is in mizoram 50. The figures of students against each institutes is shown in the following table.

Table 4.22 Students Enrolment in school based on sex

		No. of Teacher		
State	**Name of School**	**Male**	**Female**	**Total**
Assam	Sahayika	35	25	60
	shishu sarothi	37	17	54
	Mon vikash Kendra	62	40	102
Manipur	B.B. paul mental Development Home	28	43	71
	Ch.Ibohal institute	47	28	75
Meghalaya	Dwarjinkyrmen	32	16	48
	Mary Rice Centre	36	23	59
Tripura	Swabalamban	34	22	56
Mizoram	Gilead special school	27	23	50
	Total =	338	237	575

— The teacher-student ratio in sahayika is 1.9, Shishu sarothi 1.5, Monvikash kendra 1.7 B.B. paul Mental Development Home 1.6, Ch.Ibohal Institute 1:5, Dwarjinkyrmen 1:7, Marry Rice Centre 1:8, swabalamban 1:9, Gilead Special School 1:7 out of 9 Special institutes of the north-East three have the optimum teacher student ratio. The institutes are Shishu sarothi, B.B.paul Mental Development Home and ch.Ibohal Institute. The figures are indicated in the following table.

Table 4.23 institution wise teacher student ratio.

Institutes	No of teacher	No of Student	Teacher student ratio
Sahayika	7	60	1:9
Shishu Sarothi	10	54	1:5
Mon Vikash Kendra	14	102	1:7
B.B.Paul Mental Devet. Home	11	71	1:6
Ch.Ibohal Institute	14	75	1:5
Dwarjinkyrmen	7	48	1:7
Marry rice Centre	7	59	1:8
Swabalamban	6	56	1:9
Gilead Special School	7	50	1:7

— The teacher student ratio in Assam is 1:7, Manipur 1:6 Meghalaya 1:8, Tripura 1:9 and Mizoram 1:7. The teacher Student ratio is optimum only in Manipur. In the North-East the teacher student ratio in the special school for mentally retardrd children is 1:7. The figures are shown in the following table.

Table 4.24 state wise teacher- student ratio

states	No. of teacher	No. of student	Teacher student ratio
Assam	31	216	1:7
Manipur	25	146	1:6
Meghalaya	14	107	1:8
Tripura	6	56	1:9
Mizoram	7	50	1:7
North-East	83	575	1:7

Types of classes in different institutes are as follows

— Sahayika has four classes i. e. Nursery Class, Pre-Primary, Primary, oral school. Shishu Sarothi has five classes i. e. Play group, Functional group, Functional academics, Academic group, special teaching unit. In Mon Vikash Kendra Students are grouped. i. e. Pre-Paratory group, It consist of pre-academic and pre-vocational group. Educable group, consist of Educable senior and educable Junior. Vocational group consist of vocational senior vocational junor group. B.B. Paul Mental Development Home have Pre Primary classes with the provision of pre-academic and pre-vocational class. Primary classes consist of Academic section and vocational section. Secondary classes are of Academic and vocational. Ch. Ibohal Institute has five classes i. e. pre-primary, Primary class and Secondary Class; Pre-Vocational and Vocational classes. Dwarjinkymen has five classes i.e. Play group, Special training unit, Junior functional group, Middle School and senior wing. Marry Rice center has classified student into six groups i.e play school, Nursery, Kindergarten, Academic, pre-functional & functional Academic. functional academic classes are Educable and Vocational trainable. Swabalamban has six classes i.e Pre-primary class Primary class, Secondary class, Pre-vocational class, Recreational and Physiotherapy. Gilead special school has seven classes i.e Academic class, senior functional, Junior, Reception, Deafsection, Silk Screen printing unit and out patient department. Institution wise classes are shown in the following table.

Table 4.25 Institution and type of classes.

Name of institution	State	Type of Classes introduced
Sahayika	Assam	Nursery, pre-primary, primary and oral school
Shishu Sarothi	"	Play group, Functional group, Functional academics, Academic group special teaching unit
Mon Vikash Kendra	"	Pre-Primary group, Educable group, vocational group.
B.B. Paul Mental Development Home	Manipur	Pre-Primary class, Primary and sacondary class
Ch.Ibohal Institute	"	Pre-Primary, primary, secondary, prevocational and vocational classes.
Dwarjinkyrmen	Meghalaya	Playgroup,Special training unit, junior functional, middle school $ Senior wing.
Marry Rice centre	"	Play school, Nursery, Kindergarten, Academic. Pre-functional &Functional Academic.
Swabalamban	Tripura	Pre-Primary, Primary, Secondary classes.
Gilead Special school	Mizoram	Academic class, Senior functional, Junior functional, Reception,deaf section, Silk Screen printing unit & out Patient Department.

— The present investigation revealed that lecture method was not found suiable to teach the mentally retarded children in the North-East. 100% of the special institutes in the North-East followed the repetition method in the teaching learning process of M.R. Children. It was found Suitable for the M.R.Children.

— Nine institute out of nine followed individualised institution. It comprised 100% of the institutes in the North-East . Educable and trainable M.R. children had different abilities and they were allowed to do at their own pace. Group teaching was also practised to make the retarded more socialised.

— Both reward and punishment method was found suitable which had a positive impact in behaviour modification of M.R. Children. 100% of the special institutes followed reward and punishment to modify the student's behaviour The correct responses of the M.R.Students reinforced varbally like Ok, Thank you, go ahead, excellent, good, etc. It was found that reinforcing judgement should not associate the person but to his work. For example Poonam did the right work, therefore she should be reinforced "good work, Poonam" or "excellent performance Poonam" instead of saying "good girl Poonam". It was reported that though punishment is not a psychologically sound method yet it was found practical for M.R.children. Mental punishment used in the institutes were scolding, discouraging, ignoring and withdrawing from the situation. Mild physical punishment were used like slapping, up and down, and climbing the steps etc.

— The present investigation indicated that 100% of the special schools followed learning by doing method. It was reported that this method developed the self-help skill in daily living activities among M.R. children.

— As per the report and observation it was found that 100% of the institutes followed music and songs as the process of teaching and learning for M.R. children. Devotional songs, partiotic song and group songs were practised in the schools. Example "Ishware Allah teroname. Sabko Sommati De Bhgwan", Sa re jaha se asha — Hindustha hai hamara and "we shall over come some day

"etc. It was found that group songs could develop we feeling and confidence among mentally retarded children.

— Regarding curriculum it was found that the special institutes of the north-east followed a variety of curriculum. Dwarjinkyrmen followed the curriculum of spastics society of Eastern India and the Indian institute of cerebral palsy. Sahayika followed special curriculum developed by National Institute for Mentally Handicapped (NIMH), Madras Developmental Programme Scheme , (MDPS), Individual Training Programme (ITP), Shishu Saroth followed both normal and special school curriculum. Special curriculum was developed by Indiam Institute of cerebral palsy (IICP) and spastics society of Eastern India (SSEI) Calcutta. Mon Vikash Kendra followed both normal special curriculum. Normal curriculum was used with some modification and their special Curriculum was developed by National institute for Mentally Handicap (Secunderabad). Marry Rice Centre also followed normal and special curriculum. Their special curriculum was developed by the spastics society of Eastern India (Culcutta) and Indian Institute of Cerebral Palsy. B.B.Paul Mental Development Home followed the special curriculum developed by the National Institute for Mentally Handicapped Ch. Ibohal instutute also followed the special curriculum of NIMH, ITP, and MDPS. Gilead special school followed both normal and special Curriculum of NIMH and SSEI. The following table will show the nature of curriculum followed by the institutes.

Table 4.26 Institutes and Nature of curriculum

Instituts	Nature of Curriculum followed
Sahayika	Special Curriculum of NIMH (National Institute for Mentally MDPS (Madras Developmental Programmes Scheme) & I T P (Individual Training Programme)
Shishu Sarothi	Normal Curriculum (modified), Special Curriculum of the Indian Institutes of Cerebral Palsy and Spastics society of Eastern India.
Mon Vikash Kendra	Normal curriculum (modified), special curriculm of the National Institute for Mentally Handicap.
Marry Rice Centre	NormalCurriculum (modified), Model curriculum (self developed), special Curriculum of the spastics society of eastern India and Indian Institute of Cerebral palsy.
B.B.Paul Mental Development Home	Special Curriculum of the National Institute for Mentally Handicapped.
Ch. Ibohal Institute	Curriculm develop by National Institute for Mentally Handicapped.
Swabalamban	Special Curriculum of the Natinal Institute for Mentally Handicap, individualised Training Programme and Madras Developmental Programme Scheme.
Gilead Special School	Normal Curriculum (Modified), Curriculuim developed by National Institute for Mentally Handicapped and spastics society of Eastern India.
Dwarjinkyrmen	Special curriculum of the spastics Society of Eastern India Institute of cerebral palsy.

— Educational and Vocational Curriculum of the special schools of the North-east followed the following Curricular Programmes. Pre-primary class Consisted of two groups (a) Pre-Primary academic group and (b) Pre-primary

Vocational group. Pre- primary Acadamic group is concerned with Pre-reading knowledge, Pre-writing knowledge and Self- helf Skills. pre-reading knowledge is concerned with different pictures of fruits, birds, animals, human figures and body parts. Pre-writing knowledge gives training how to draw lines, how to hold a pen and pencil, making ball, matching the objects, naming the objects and identification of objects. Self- help skills Concerned with dressing, undressing,eating, drinking, toilet training and bathing to make the child self- dependent. The subjects concerned with pre-primary vocational group are paper cutting, paper folding & unfolding, Paper pasting, threading the neddle and beasns. Primary group consist of two classes (a) Primary academic class and (b) Primary vocational class. For the student of primary academic group empahasis is given to develop sensation, perception and conception. The concept of numbers, money, time, colour and name is given. Knowledge is given for 3RS - reading, writing and simple arithmetic. Primary vocational group included weaving (handloom) training, Knitting sweater, stocking and shocks, mafler, file, exercise book and envelop. It also included cleaning the floor, washing clothes and utensils, making tea,bathing,combing and burning candle etc. Secondary Academic group gives education of 3 R's -reading, writing and simple arithmetic. It also try to develop the concept among M.R. Children. Secondary Vocational group is concerned with same programme of primary vocational group except tailoring.

— The present study revealed that the special schools of the north-east organises different co-curricular programmes for mentally retarded children. The indoor and outdoor games were carrom, Ludo, chess, badminton, Valleyball, Football, Basketball and cricket. Moreover race competition, song, music and dance are also arranged for M.R. Children. It was found that these programmes developed the communication power and make them more socialised. The study also indicated that 55.56% of the institutes had playground in their institutes.

— 55.56% of the special institutes in the North-East had Parent-teacher association. The institutions are indicated in the following table.

Table 4.27 Parent- Teacher Association

Name of the Institute	Place
Dwarjinkyrmen	Shillong
Marry Rice Centre	Shillong
shishu Sarothi	Guwahati
Swabalamban	Agartala
Mon Vikash Kendra.	Guwahati

— Regarding guidance service it was found that out of nine institutes six had guidance services. It indicated that 66.67% institutes of the North-East had guidance Programmes. These institutes are shown in the following table.

Table 4.28 Institutes with guidance service

Name of the Institute	Place
Swabalamban	Agartala
Sahayika	Guwahati
Shishu sarothi	Guwahati
Gilead special school	Aizawl
Dwarjinkyrmen	Shillong
Mon Vikash Kendra	Guwahati

— Regarding, Parent's counselling it was found that 100% of the institutes had parent's counselling in the North-East States.

• EXISTING REHABILITATION PROGRAMMES IN THE SPECIAL SCHOOL OF THE NORTH-EAST

— Three special schools of the North-East had sheltered workshop. It constituted 33% of the special school of the region. The schools are sahayika, Ibohol institute of mentally retarded children and Mon vikash Kendra. Vocational training programme is existing in sheltered workshop. Weaving; Knitting and Carpentry and so on. The machines and equiptment for weaving and knitting are either managed by the institute or by National Institute of Mentally Handicapped and Spastics Society of Eastern India. Sewing and handloom machines are used for tailoring, making napkins and swals. Carpentry included making wooden furniture, Wood cutting and hammering. Mon Vikash Kendra had a power driven grinder; chalk making mould and envelop making machine which are helping the mentally retarded to be rehabilitated.

— It was found that loan facilities for self-help employment were available only in 2 institutes. It constituted 22% of the total institutes of the region. The institutes are sahayika and Mon Vikash Kendra. Salable products are produced like basket, garland, drawing, Painting file, envelop, album. handkerchief screen printing bag which can be sold in the market.

— It was found that five out of nine special schools had special training for girls. It confirmed that 55.56% of the special school had special training programme for mentally retarded girls. The institutes are B.B. Paul Mental Development Home, CH. Ibohal Institute, Dwarjinkyrmen, Sahayika and Mon Vikash Kendra.

- Out of 9 special institutes only three had scholarship facility. It comprised of 33% institutes. These are Ch. Ibohal institute, B.B. Paul Mental Development Home and Mon Vikash Kendra.

• PROBLEM RELATED TO REHABILITATION OF MENTALLY RETARDED CHILDREN IN THE NORTH

— Six out of nine institutes had no sheltered workshop which comprised of 66.67% institutes of the North-East. The institutes are Shishu sarothi (Guwahati), B.B. Paul Mental Development Home (Imphal), Marry Rice Centre (Shillong), Dwarjinkyrmen (Shillong), Gilead special school (Aizwal), Swabalamban (Agartala)

Seven out of nine institutes of the region had no loan facilities for self-employment of M. R. Children.

These institues constituted 77.78% in the North-East region. The institutes without selfemployment facilities are shown as follows The institutes are Dwarjinkymen Meghalaya (Shillong), Shishu Sarothi Assam (Guwahati), B.B. paul Mental Development Home Manipur (Imphal), Ibohal Institutes for mentally Retarded Manipur (Imphal) Gilead Special School Mizoram (Aizawl) Swabalamban Tripura (Agartala).

Four out of nine institutes had no special training facilities for girls. It comprised of 44.44% institutes. The instituties are Gilead special School (Aizawl), Swabalamban (Agartala) Marry Rice Centre (Shillong), Shishu Sarothi (Guwahati).

— Six out of nine institutes had no scholarship facilities. It means 66.67% of the institutes in the North East region had no scholarship facilities. The instituties are Dwarjinkyrmen, Shishu sarothi, Marry Rice Centre, Swabalamban, Gilead special school, Sahayika,

—The present study confirmed that reservation quota for mentally retarded is not available in the North-East states.

CHAPTER - V

FINDINGS OF THE STUDY AND CONCLUSIONS

- CAUSATIVE FACTORS OF MENTAL RETARDATION
- GENERAL PROBLEMS OF MENTALLY RETARDED CHILDREN
- EDUCATIONAL PROBLEMS OF MENTALLY RETARDED CHILDREN IN THE NORTH-EAST
- EDUCATIONAL PROVISIONS FOR MENTALLY RETARDED CHILDREN IN THE NORTH-EAST
- EXISTING REHABILITATION PROGRAMMES
- PROBLEMS RELATED TO REHABILITATION OF MENTLLY RETARDED CHILDREN
- A COMPARISION BETWEEN PRESENT STUDY FINDINGS AND PAST FINDINGS
- CONCLUSION

CHAPTER - V

FINDING OF THE STUDY AND CONCLUSIONS

• CAUSATIVE FACTORS OF MENTAL RETARDATION IN THE NORTH-EAST

The analysis and interpretation of twenty seven cases studies conducted in the North-East confirmed the following causes of mental retardation.

— Pre-natal causes of mental retardation comprised of 51.85%. The Pre-natal causes were chromosomal abnormalities, over aged Pregnancy, Consanguine marriage and Pre-natal mental shock.

— Chromosomal abnormalities for the causes of mental retardation comprised of 22% in the present study.

— Mental retardation in the North-East due to over aged pregnancy of the mother was found to be 11%. It was also observed that age level of the expectant mother of M. R. Children ranges from 34-38 years.

— Consanuine marriage constituted 11%of the causes of mental retardation in the North-East.

— Pre-natal mental shock and tention among expectant mother caused mental retardation among their children to the extent 7.41% in the North-East.

— Neo-natal causes of mental retardation comprised of 22% of the cases in the North-East. Pre-natal causes of mental retardation were deprivation

of oxygen during birth (including breathing difficulty and absence of birth cry) and Pre-matured birth.

— 14.81% of the mental retardation of the North-East were caused by deprivation of oxygen during birth of the babies. It was also found that the mentally retarded babies were born and the absence of birth cry.

— 7.41% cases of mental retardion were found in the North-East which were caused by Pre-matured birth.

— Post-natal causes of mental retardation comprised of 25.93% in the North-East. The observed Post-natal causes of mental retardation were infectious diseases like para-typhoid and jaundice, brain disorder (epilepsy), Accident (Fall in to hot water), and deprivation of breast milk.

—7.41% cases of mental retardion were found in the North-East which were caused by infections diseases (Jaundice and Para-typhoid) in infancy and early childhood.

— 3.70% of mental retardation was caused by brain disorder i.e. epilepsy. The study indicated that a five year old child started epileptic fits 1-2 episodes per year. He gradulally started showing the features of mental retardation.

— Mental retardation was caused by accident of fall into hot water during early infancy. It was found that a two years old child developed mental retardation when hot water entered into brain and his head began to enlarged. It comprised 3.70% of mental retardation in the North-east.

— Mental retardation was accured among children who were deprived of breast milk and were bottle feeded. It constituted 11% of the mental retardation in the North-East.

— The present study result confirmed that mental retardation occured among people of any socio-economic status. The case study results indicated

that 21% of mentally retarded children came from upper income proup, 42% of them came from middle income group and 37% came from low income group in the North-East.

The study confirmed that M.R. children have low I.Q. than the normal children. Highest level of I.Q. among M.R. Children studied in the North-East was 71 and lowest I.Q. was 12.50. The study also indicated that 30%of M.R. Students were educable, 50% of them were trainable and 20% were custodial.

• GENERAL PROBLEMS OF MENTALLY RETARDED CHILDREN IN THE NORTH-EAST

— The study result revealed that in the North-East 51.85% of M.R children had poor adjustment with their Peer groups due to the lack of proper expression and communication.

— 77.78% of the mentally retarded children had behavioural complain in the North-East.

— 55.55%of the mentally retarded children were found having inferiority complex in their behaviour.

— It was found that 40.63% of the M.R.Children were aggressive in the North-East.

— The study revealed that 81.48% cases of mentally retarded children were hyperactive in the North-East.

— It was found that 28.57% of the Children had self injurious attitude.

— Physicalproblems constituted 70.79% among mentally retarded children in the region.

—The study indicated that 29.41% of the neighbours were indifferent towards M.R. Children. 17.65%were found unfavourable and 52.94% had favourable attitude to M.R. Children. It was also revealed that 75%of the neighbours had favourable attitude to the parents of M.R. Children, 18.75% were indifferent and 6.25% were unfavourable.

— 91.30% of M.R. Children were found having eating problem in the North-East.

— Research finding indicated that habit disorder constituted 96.97% in the North-East among the mentally retarded children.

• EDUCATIONAL PROBLEMS OF MENTALLY RETARDED CHILDREN IN THE NORTH-EAST

— The study result indicated that 77.78% of the special schools in the North-East had no residencial facility.

— It was found that 33% of the special school in the North-East had no parmnent site and own building.

— 11% of the special schools for M.R. Children in the North-East had no good sanitation facilities and water supply.

— The present study indicated that 66.64% of the special schools had no students common room and library facilities.

— The study indicated that there was no problem of wastage in the special schools of the North-East. But stagnation was found as a major problem which represented 87.50% of M.R. Student in the region.

— It was found that 22% of the institutes were unable to pay the salary of the teachers regularly which affected the smooth functioning of the schools.

— The study result indicated that 66.67%of the institutes of the North-East had no grant in Aid from the respective state government. 22% of the special school for M.R. Children in the North-East had no grant in aid from the central government. 33% of the special schools had no financial assistance from the voluntary organisation. 44.44% of the special schools had been deprived of the donation from the local bodies.

— The research study indicated that 44.44% of the institutes in the North-East had no play ground of their own.

— Parent teacher Association was found very significant for functional growth as a Supporting service of the institute. But 44.44% of the special institute had no Parent-teacher Association in the region.

— It was found that 100% of the institutes for M.R. Children in the North-East had no permanent health service. Only 33% institutes had part time service from the medical visiting team.

— The present study result confirmed that M.R. Children had low span of attention and poor comprehensive power. 59.09% of M.R. Children had no interest in studies. 71.43% of M.R. Children in the North-East comprehended simple and easy talk of their parents and teachers. 28.57% of the M.R. Children did not understand even simple talk.

• EDUCATIONAL PROVISIONS FOR M.R. CHILDREN IN THE NORTH-EAST

—The research data reavealed that age criteria of admission was differnt from one school to another school and from one group to another group.In 77.78% of the institutes, admission criteria was 3years for Pre primary or nursery classes and 22% of the institutes had 6 years age criteria for the same class. It was

found that number of seats available in the nine special institutes of the North-East were 696.

— It was found that 77.78% of the special schools of the North-East were purely under private management and they are day care centres. 22% of the institutes were residential and goverment aided. The study also revealed that number of classes in the institutes were adequate but the qualities were very poor.

— The number of teacher enrolled in the special schools of the North-East were 83. The male teacher comprised of 24.10% and Female teacher comprised of 75.90%. It indicated that service given by the female teacher for the education of M.R. Children were more appreciating than that of the male teacher in the North-East.

— The study reveled that 575 M.R. Children are enrolled in the special schools of the North-East out of which 58.78% were male student and 41.22% of the students were female.

—The study indicated that the teacher student ratio in the special schools of M.R. Children in the North-East was 1:7. Out of nine special schools of the North-East three had optimum teacher-student ratio which comprised of 33%.

— It was found that special sschool of the North-East followed the folloing classes in the institutes for the mentally retarded chidren. The classes were nursery, preprimary, play group, primary group, educable, functional and vocational group, academic and secondary classes.

— Regarding method it was found that lecture method is not suitable for the M.R. Children.100% of the special institutes of the North-East followed individualised institution, repetition method, reward and punishement, learing by doing method, music and songs. It was indicated that both rewarded

and punishmnt had positive impact in behaviour modification of M.R. Children in the North-East. It was also found that learning by doing method developed self help skills among M.R. Children in daily living activities and group song developed we feeling and confidence among M.R. Children.

— Special schools of the North-East followed several curriculum like modified normal curriculam,curriculum of the National Institute for Mentally Handicapped Individuaised Training programme, Madras Developmental Programme Scheme, Spastics Society of Eastern India, Institute of Cerebral Palsy curriculum.

— The Present study revealed that the special schools of the North-East followed academic and vocational curricular programmes. In academic curriculum education is concerned with 3RS,- Reading, writing and simple arithmetic. Pre reading, pre-writing and self-help skills are also developed among M.R. Children. The vocational programme consisted paper cutting, paper folding & unfolding, paper pasting, weaving, kniting, making file, envelop and exercise book, and tailoring. Both academic and vocational programmes of the curriculum were to develop conception and self-help skills among M.R. Children.

— The study indicated that 100% of the special institutes of the North-East had light facilities and 55.56% of the institutes had play ground of their own. It was also found that co-curricular programmes for M.R. Children included indoor and outdoor games in addition to cultural programmes. These programmes developed communication power and socialisation of the M.R. Children.

— 66.67% of the institutes for M.R. Children in the North-East had guidance service and 100% of the special institutes had parents counselling.

• EXISTING REHABILITATION PROGRAMMES IN THE SPECIAL SCHOOLS OF THE NORTH-EAST

—33%of special institutes in the North-East had sheltered workshop.Different vocational training programmes are exercised in sheltered workshop like weaving, knitting, tailoring and carpentry. Sahayika, Chunkhum Ibohal institute for mentally retarded and Mon Vikash Kendra had the sheltered workshop.

— The study revealed that loan facilities for self employment were available in 22% of the special schools of the North-East. The institutes were Sahayika and Mon Vikash Kendra.

— The present study result indicated that 55.56% of the special institues had special training facilities for female mentally retarded students.

— 33% of the special institute had special training facilities.The institute were Chunkhum Ibohal institutes, B.B. Paul Mental Development Home and Mon Vikash Kendra.

• PROBLEMS RELATED TO REHABILITATION OF MENTALLY RETARDED CHILDREN IN THE NORTH-EAST

— Regarding rehabilitation problem it was found that 66.67% of the special institutes for M.R. Children in the North-East had no sheltered workshop.

— The study indicated that 77.78% of the institutes had no loan facilities for self-help employment for M. R. Children.

— It was found that 44.44% of the special institutes in the North-East had no special facilities for M.R. girl students.

— The present study indicated that 66.67% of the special institutes in the region had no scholarship facilities for M.R. Students.

— The present research study confirmed that reservation quota for job for mentally retarded were not available in the North-East.

• A COMPARISION BETWEEN PRESENT STUDY FINDINGS AND PAST FINDINGS

— All India institute of Medical sciences revealed that 40.10% of M. R. Cases were found due to genetic and chromosonl abnormalities (Stated by khaparde's 1987) The present study findings indicated 44.44% of M. R. Cases in the North-East due to gencitc and chromesomal abnormaltioes.

— Spitz (1945) and Goldfarb (1943 & 1945) found positive relationship between maternal deprivation and mental deficenay. The present study also revealed that pre natal maternal mental shork Caused mental retardation among children.

— Mysore study Conducted by kupuswamy (1961, 1968) Ahmedabad study of Ramajujam (1966). Lucknow university study by Ishtiaq (1973), and status of the family of M.R. Children. All study findings indicated that a relatively higher incidence of mental retardation occured among the lower socio economic group. The present study result indicated that only 37% of M. R. children come from lower income group, 42% come from middle income group and 21% come from upper come group.

— Grahamet al (1963) found that children with a history of breathing difficulty showed more neurological abnormalities and intellectual disorder among children. The present study result revealed the similar indication of brain demaged due to the hitory of breathing difficulty during birth.

— White and watt (1973) observed that in lower and lower middle socio economic groups both parents used to go out to earn their living and the responsibiliy of the child falls either on the servant or other relative. As a result

parent child relationship are missing and intellectual, social and emotional growth of the child are hampered. The present study referred the similar fact that the mother was govternment Servant and the child was bottle feeded by the caretakers. It affected the mother child relationship consequently child lacked the growth rate and become mentally retarded.

— Mohanty referred (1984) that behavioural modification by reward and punishment has proved to be a very effective technique in treating the mentally retaded persons. The present study also confirmed that reward and punishment was found suitable which had positive impact in behaviour modification of M. R. Children.

• CONCLUSION :

There are a large number of causes of mental retardation. In the present study thirteen causes of mental retardation was found where 51.85% Comprised of pre natal causes, 22% comprised of neo-natal cause and 25.93% comprised of post-natal cause. M. R. Children had behavioural problems. Poor adjustment, inferiority complex. Self-injurious, agressive, hyperactive and eating problem were found among them. Play ground health care and stagnation was some of the major probem. The mental retarded Children was less interested, less attentive and had poor comprehensive power. The teacher student ratio in the special schools of the North-East was 1:7. Basically academic and vocational education was provided in the special schools. The items of academic classes was 3 Rs- reading, writing and arithmetic. Education was also provided to form the concept of M.R. Children. Weaving. Knitting & tailoring were some of the important items of vocatioal programmes to make them self dependent. Individualised instruction, repetition, reward and punishmet. learing by doing were some of the important method of instruction. Loan facitilies, Scholarship, special training for

girls and sheltered workship in the special schools were not satisfactory. Rehabititation facilities were insufficient. Servces provided by various voluntary organisation and the NGO's in different states were really significant for the cause of M.R. Chilrden. Gauhati Mental Welfare society (GMWS), The society for the welfare of the Disabled (Shillong), All Tripura SC/ST and Minority Upliftment council (Agartala) Lions club of Guwahati and Manipur, Rotary club of Manipur, lnner wheel club of Guwahati, Ladies club of N. F. Railway (Guwahati), Youth club of Imphal and some Public undertakings like indian Oxygen limited, oil India limitted and OXFAM (India) Trust assisted the Special schools. State and central government. are almost indifferent towards the problemes of M. R. Children. Ministry of Social welfare (govt. of India), National Institute for Mentally Handicapped, Spastics Society of Eastern India (SSEI) Calcutta) also assisted the special schools by providing funds, aids and equipments for the education and rehabilitation of M.R. Children. Their assistance was irregular and inadequate. Necessary educational and vocational programme may be taken in joint responsilsility of the government and the NGO's for the North-Eastern region.

CHAPTER - VI

ACTION PLAN AND SUGGESTIONS FOR FURTHER STUDY

- PREVENTION OF CAUSATIVE FACTORS
- IDENTIFICATION AND TREATMENT
- AWARENESS PROGRAMME AND EDUCATIONAL MEASURES
- REHABILITATION PROGRAMMES
- SUGGESTIONS FOR FURTHER STUDY

CHAPTER - VI

ACTION PLAN AND SUGGESTIONS FOR FURTHER STUDY

- **ACTION PLAN**

On the basis of findings an attempt is made to suggest a guideline for future course of action that can be taken for the welfare and education of mentally retarded person. The Action plan includes the following areas of mental retardation]

- PREVENTION OF CAUSATIVE FACTORS
- IDENTIFICATION AND TREATMENT
- AWARENESS PROGRAMME And EDUCATIONAL MEASURES
- REHABILITATION PROGRAMMES

• PREVENTION OF CAUSATIVE FACTORS

A massive programme on maternal and child health care may be developed at different levels with joint responsibility of the state and central govternment. The NGO's should also be involed in this programme to reduce the prenatal, neonatal and post natal causes of mental retardation.

Over aged pregnancy may cause mental retardation among new born baby. Mother should not be conceived after 34 years of age. It will help to reduce the probable risk of mental retardation. Genetic and pregnancy counselling may be available for all women to help in this regard.

Consanguine marriage is getting popularity in the North-East. The research findings indicated that marriage among blood relatives caused genetic and chromosomal abnormalites among the child. It resulted in mental retardation. Consanguine marriage should be discouraged and inter caste marriage should be encouraged.

It is observed that expectant mother who experienced mental shock and hypertension due to some reason may give birth to mentally retarded child. They should be free from any kind of mental shock and nervous tension to avoid the problem of mental retardation among children.

The changing attitude of the women towards job and the financial need of the middle class family compel both the parents to work in office. The child is looked after by the care takers. Mother has no time to feed the breast milk and as a result the child is bottle fitted. The growth of bottle feeded children are lower than the normal children. This may cause mental retardation among them. The public health centre and mass media can play a significant role to popularise the concept of breast feeding instead of bottle feeding.

Premature birth may cause mental retardation among children. The expectant mother should be vigilant to the problem of mental retardation and other diseases. Mother should go to health centre for regular cheek up.

Sometimes newborn babies are deprived of oxygen during birth and get breathing difficulty. It caused brain damage and the baby become mentally retarded. In such cases the babies should be given oxygen immediately to prevent birth asphyxia and brain damage.

• IDENTIFICATION AND TREATMENT

Multidisciplinary expert team consisting clinical psychologist, should undertake different diagnostic measures in each district level hospitals of the states.

Children suffering from epileptic fit in infancy or early childhoo may cause mental retardation. The parents should consult the doctors immediately. Epilepsy can be identified early and can be treated in time.

Children attacked by post-natal joundice and para-typhoid during infancy or early chilhood may cause mental retardation among them. Para-typhoid and joundice can be identified soon and proper treatment may be given to the child.

Delayed development and low I. Q. may cause mentalrtaerdation. Parents can observe it through the daily life adjustment of their children. Psychiatrist should be consulted immediately to develop the growth rate and I. Q. level.

• AWARENESS PROGRAMMES AND EDUCATIONAL MEASURES :

NGO's and state government may launch special awareness programme on mental retardation. Mass media can also be involved in this regard to remove misconception and discrimination towards mentally retarded. Statewise essay competition, drawing and painting exibibition can be arranged by the state Directorate of social welfare.

Government can establish information and documentation centre in each state of the North-East for handicapped children including mental retardation. These centres can distribute pamphlete, audio-visual aids and posters for this purpose.

Special schools of the North-East are lacking proper infrastructure including school building, residential facilities, water supply, sanitation, play ground

and health service. The state or central government may donate land or land can be alloted in concessional rate. Health and education department can sanction building grant to develop the infrastructure of the school.

Number of special schools in the North-east are inadequate to the needs of mentally rettarled children. All special schools are located in the capital cities. These schools can be established in rural areas for the proper coverage of rural M. R. Children. Special education and integrated educational programme should run simultaneously. All normal schools must have a provision of admission for Mild M.R. Children. Educational programmes should be especially arranged to the needs of students.

Stagnation was found as a major problem for M.R. Children in special schools. The expert committee may assess and scrutinise the educational services regularly. It can check the sub-standard causes of education in Special Schools.

A national institute for mentally retarded can be established in the North-East with research and training facilities. The curriculum for the special schools may be developed by this institute in collaboration with the SCERT of the concerned states.

Each university of the North-East may open a special education department to under take various programmes on handicapped including mental retardation.

Special transportation facilities should be given to handicapped children. Bus and train fair concession may be given to them. The government may ensure books, stationaries and other educational aids and equipments to M.R. Children in free of cost.

The institutes that are lacking supporting services like guidance and counselling and parents teacher association, may take necessary action in this

regard.Supporting services can bring the functional development of educational programmes.

Each special schools of the North-East may have behavioural and physio-therapy which can contribute for modification of behaviour and functional growth of M.R. Children.

• REHABILITATION PROGRAMME

Rehabilitation is a big issue for M.R. Children in the North-East. Mentally retarded can not work like a normal person. They need special arrangement to compensate their abilities. Each special school may have one sheltered workshop with vocational training facilities for the rehabilitation of mentally retarded.

Reservation provision for mentally retarded person is not available in the Disabled 1995 (Act 1 of 1996). Mentally retarded person can not compete for the open post. The deficiencies of the Disabled Act of 1996 should be removed and at least 1%of job can be reserved for mentally retarded. The state governments of the North-East can also take necessary steps in this regard.

The Integrated Rural Development Programme can be flexible for the mentally retarded person in the North-East. It can give better scope for the self-employment of mentally retarded person.

The central government should establish District Rehabilitation centers (DRC) in the North-East like other part of the country. Community Based Rehabilitation (CBR) programme may also be started in the North-East to meet up the problem of rehabilitation.

Special employment exchange may be set up in district and state level for registration of mentally retarded person for suitable job.

Special schools and vocational training centre may be empowered to certify that mentally retarded individual is fit for a particular job though he may

not have minimum educational qualification required for the post .

District and state level cell centres may be set up for marketing products prepared by mentally retarded. Sale tax may be exempted from it.

State and central government may introduce scholarship for mentally retarded students. This is a constitutional obligation of the government to take necessary action for the welfare of the weaker section people.

• SUGGESTIONS FOR FURTHER STUDY

The following areas are suggested for further studies.

- Studies on the problems related to implementation of National Policy for mentally handicap
- Studies with the coverage of all group of disabilities.
- Comparision on the effectiveness of integrated education and special education programme.
- Co-rrelational studies on mental retardation and other associated handicapness.
- Studies on supporting services related to the welfare of mentally retarded.
- Studies on the evaluation of different welfare scheme for M.R. Children.
- Comparative studies on the services of government and NGS,s relating to education and rehabilitation of Mentally retarded.
- Studies on the impact of mentally retarded persons on the family.
- Studies on effectiness of preventive measures to arrest mental retardation.
- Studies on the practices of yoga for mentally retarded persons.
- Studies to develop effective remedial measures for mental retardation.
- A nation wide survey on the prevalence of various kinds of disabilities among children.
- Studies to identify the suitable jobs for mentally retarded.

SUMMARY

- INTRODUCTION
- STATEMENT OF THE PROBLEM
- OPERATIONAL DEFINITIONS
- OBJECTIVES OF THE STUDY
- METHODOLOGY
- POPULATION AND SAMPLE
- TOOLS USED
- STATISTICAL TECHNIQUES
- DELIMITATIONS OF THE STUDY
- FINDINGS OF THE STUDY
- ACTION PLAN

SUMMARY

• INDRODUCTION

Mental retardation is a global problem. People often misunderstand that mental retardation is a disease. It is not a disease like cancer and tuberculosis but a condition. There is a popular proverb that 'prevention is better than cure', is more applicable to control mental retardation. It is a matter of great concern to psychiatrist, psychologist and social workers.

Mentally retarded person is socially incompetant, mentally subnormal and intellectually inferior from birth or an early stage. In the classification of exceptional children the mentally retarded children belong to lower end of the scale of intelligence and scholastic optitude quite opposite to the gifted who lies in the high end of this scale. Lower level of intellectual functioning reflect in their adaptive behaviour.

Education and rehabilitation of M.R. children has become a challenge for society. It was an age old problem of the world. The first educational activities on mental retardation was started by seguine in French in the year 1837. Meria Montessori of Itali contributed her DIdactic Apparetus to the education of mentally deficient children. In India the first institute for mentally retarded was established at Mankhurd in Bombay in 1941. In a report National Policy on Mental Handicap" (1988) it was stated that there are little more than 200 institutions in India with a facility of about 10000 mentally retarded individuals.

At present mental retardation has become a centre of great attraction. The NOGS, National government and the UNO have launched welfare programmes for the education and rehabitation of M.R. Children. Article46 of the India constitution has emphasised the educational and economic interest of the weaker

section including handicapped to give special care and protection from social justic and all forms of exploitation . Mentally retarded can not provide satisfactory service for society but they are not totally useless. They can do something in which field they are educated and trained. It is unfortunate that the Disabled Act 1995 (Act. 1 of 1996) had not given weightage of job reservation for mentally retarded.

The national policy on Mental Handicapped (1988) estimated that there are 16000000 mentally retarded person in India. Shankar (1958) reported that there is no certainty whether mental retardation is equally common in rural and urban areas.

Mentally retarded children are of different types.Grossman(1973) classified mentally retarded into four catagories, namely i) Slow learner ii) Educable mentally retarded iii) Trainable mentally retarded and (iv) Totally dependent mentally retarded.

• STATEMENT OF THE PROBLEM :

The statement of the problem is "A study of the promlems of mentally retarded children and provisions for their education in the North-East.

• OPERATIONAL DEFINITIONS :

■ PROBLEMS :

The term problem refer to the general educational and rehabilitation problem. It also concern the causative factors of mental retardation in the North-East

■ MENTALLY RETARDED CHILDREN :

The children who are suffering from the problems of mental deficiency is termed as mentally retarded children. For the purpose of the present

study the following operational definition has been accepted.

American Association on Mental Deficiency (1983) defined "Mental retardation refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behaviour and manifested during the developmental period."

■ PROVISIONS FOR THE EDUCATION OF M.R.CHILDREN:

Educatonal provisions include the infrastructural facilities and existing educational and rehabilitation programmes for mentally retarded children undertaken by the government and by the NOG's.

• OBJECTIVES OF THE STUDY

i) To study the causative factors of mental retardation.

ii) To study the general problems of M.R. Children.

iii) To study the Educational Problems of M.R. Children.

iv) To study the provisions for the eduation of M.R. children.

v) To Study the existing rehabilitation programmes for M.R.children.

vi) To study the problem related to rehabilitation of M.R. children.

vii) To develop an " Action Plan" for the education and rehabilitation of M.R. children.

• METHODOLOGY

Normative survey method was used for the present study. Analysis and interpretation of data was done both quantitatively and qualitatively. The sources of data was primary and first hand information. It covered the educational and rehabilitation programmes for M.R. children in the North-East. It also concrned the

general problems and causes of mental retardation in the North- East.

• PLAN OF THE STUDY

The present study is well planned and divided into six chapters Firts is concerned with introductory chapter, Second chapter is concerned with review of related literature, third chapter deals with methodology- plan and procedue, Four chapter is related to analysis and interpretation of data, fifth chapter was findings of the study and sixth and last chapter contained the action plan and suggestions for further study.

• POPULATION AND SAMPLE

Population of the study covers the M.R.children of six North East states ,namely Assam, Meghalaya, Manipur, Mizoram, Tripura and Nagaland . Out of 12 special school in the Six North East states 9 schools are selected purposively. Three Psychiatric Department one directorate of social Welfare office was also selected. The sample within the institutes comprised 9 principals and 20 teachers. It also comprised 6 parents of mentally retarded children and 4 psychiatrists from the department of psychiatry.

• TOOLS USED

The Present study used case study ,questionnaire, observation and interview schedule for data collection.

• STATISTICAL TECHNIQUES

Analysis and interpretation of data was followed by the calculation of percentage and ratio in the present study.

• DELIMITATION OF THE STUDY

— The study is delimited to six states of the North-East namely Assam, Meghalaya, Manipur. Mizoram,Tripura And Nagaland. Arunachal pradesh is excluded from the study as no special school for the education of M.R.children exist till the time of data collection.

— It is confined with 9 special schools for M.R.children in the North-East and the three psychiatric department of Assam and Nagaland.

• FINDINGS OF THE STUDY

■ CAUSATIVE FACTORS OF MENTAL RETARDATION IN THE NORTH-EAST

The present study revealed that thirteen causes of mental retardation was found in the North-East. The causes are genetic and chromosomal abnormalities, over-aged pregnancy, Consanguine marriage, pre-natal maternal mental shock, deprivation of oxygen during birth, pre-matured birth, para-typhoid. Jaundice,epilepsy, accident, bottle feeding, socio-economic status, & low level of I.Q. These causes (excluding socio-economic status and the I.Q) are catagorised into three parts namely pre-natal Neo-natal and post-natal causes. Pre-natal causes comprised of 51.85%, Neo-natal causes comprised of 22% and post natal causes comprised of 25.93% of mental retardation.It was found that mental retardation occured among people of any socio-economic status representing 21% of the upper class, 42% of the middle class and 37% of the lower class. The study also indicated that the I.Q. range of mentally retarded children lies between 12.50-71 and 30% of M.R. Students are educable 50% are trainable and 20% are custodial.

■ GENERAL PROBLEMS OF MENTALLY RETARDED CHILDREN IN THE NORTH EAST

The general problems coverd the behavioural problems, habit disorder, physical problems and attitude of neighbours towards M.R. children and their parents. The study indicated that poor adjustment was found among 51.85% of M.R.children, behavioural complaints of 77.78%. Inferiority complex of 55.55%, agressive of 40.63%, hyperactive of 81.48%, Self-injurious of 28.57%, physical problems of 70.79%, eating problems of 91.30% and habit disorder of 96.97% in the North East. It was also indicated that 52.94% of neighbours had favourable attitude towards M.R.children, 17.65% unfavourable attitude and 29.41% of them were indifferent. Regarding attitude towards parents of M.R.children it was found that 75% of the neighbours had favourable attitude, 6.25% were unfavourable and 18.75% of them were indifferent.

■ EDUCATIONAL PROBLEMS OF MENTALLY RETARDED CHILDREN IN THE NORTH-EAST:

In the North-East 77.78%institutes had no residential facilities, 33% institutes had no own building, 11% institutes had no water supply and sanitation facilities 66.64% institutes had no student's common room and library 100% institutes had no parmanent health centre and 44.50% institutes had no parents teacher association. The study also indicated that 66.67% institutes deprived of grant from the state government 22% institutes deprived of grant in aid from the central govrnment 33% institutes did not get donation from the NGOS and 44.44% institutes did not get donation from local bodies. In the Present study it was found that 59.09% M.R.Student were not interested in studies, 28.57% of them could not understand evensimple talk, stagnation problem was of 87.50% and teachers salary was not regular in 22% institutes.

■ EDUCATIONAL PROVISIONS FOR M.R.CHILDREN IN THE NORTH-EAST

The findings of the study indicated that 83 teachers and 575 students were enrolled in the special schools of the North-East . Teacher student ratio comprised 1:7. Male and female teacher comprised 24.10% and 75.90% respectively. The male and female student constituted 58.78% and 41.22% respectively. The institutes followed modified normal curriculum and special curriculum. Special curriculums were NIMH curriculum, SSEI Curriculum and IICP Curriculum. Academic and vocational programmes were included in the Curriculum to develop conception and self-help skills among M.R.Children. Academic instruction was related to reading,Writing and Simple arithmetic. Vocational instruction was for weaving, Knitting, tailoring, Carpentry, file making and envelop making. Co-curricular programmes covered both indoor and outdoor games. The study revealed that individualised instruction, repetition,learning by doing,reward and punishment and songs and music were suitable methods in the teaching -learning process of M.R.children.Guidance service and parents Counselling were available in 66.67% and 100% institutes respectively. The study also indicated that 77.78% of the institutes are purly under private management and are day care centres. Residential and govtrnment aided institutes constituted 22.22% in the north-East

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*NIMH refers National institute of mentally handicap,

* SSEI Refers spastics Society of Eastern India.

*IICP refers Indian Institute of cerebral palsy

■ EXISTING REHABILITATION PROGRAMMES IN THE SPECIAL SCHOOLS OF THE NORTH-EAST

The finding of the present study revealed that sheltered workshops were existing in 33% special institutes. The institutes were Sahayika, Ch. Ibohol institutes and Mon Vikash Kendra. Loan for self-employment were available in 22% institutes. The institutes were sahayika and MonVikash kendra. 55.56% institutes had special training programmes for girls. The institutes were Ch. Ibohol Institute, B.B.paul Mental Development Home, Dwarjinkyrmen, Sahayika and Mon Vikash Kendra. 33% institutes had scholarship facilities. The institutes were Ch. Ibohal Institute, B.B.Paul Mental Development Home and Mon Vikash Kendra.

■ PROBLEMS RELATED TO REHABILITATION OF MENTALLY RETARDED CHILDREN IN THE NORTH-EAST

The present study revealed that the rehabilitation programmes in the special schools were not satisfactory. 66.67% institutes had no sheltered workshop. The institutes were shishu sarothi B.B.Paul Mental Development Home, Marry Rice Centre, Dwarjinkyrmen, Gilead special school and swabalamban Loan facilities for self-employment were not available in 77.78% institutes. The institutes were Marry Rice Centre, Dwarjinkymen, Shishu Sarothi, B.B. Paul Mental development Home, Ch. Ibohal institute, gilead Special School and Swabalamban. 44.44% institutes had no special training facilities for girls. The institutes were Gilead Special School, Swabalamban, Marry Rice Centre and Shishu Sarothi. 66.67% institutes were deprived of scholship facilities. The institutes were Dwarjnkyrimen, Shishu Sarothi, Marry Rice Centre, Swabalamban, Gilead Special School and Sahayika. It was also found that reservation quota was not existing for M.R.Children in the North-East.

- **ACTION PLAN**

An 'Action Plan' is developed under the following heads

- PREVENTION OF CAUSATIVE FACTORS
- IDENTIFICATION AND TREATMENT
- AWARENESS PROGRAMME AND EDUCATIONAL MEASURES
- REHABILITATION PROGRAMMES
- PREVENTION OF CAUSATIVE FACTORS

Maternal and child health care programme can be launched at different levels to check the Pre-natal, Neo-natal and post-natal causes of mental retardation.

Genetic and pregnancy counselling may be available for all women to prevent the genetic and chromosomal abnormalities among children.

Expectant mother should be free from mental shock and tension to avoid the risk of mental retardation among children .In case any child get breathing difficulty during birth due to the deprivation of oxygen the child may be given oxygen immediately.

Breast feeding should be encouraged and bottle feeding should be discourage for proper mental growth of the child.

- IDENTIFICATION AND TREATMENT

A team consisting clinical psychologist, psychiatric social workers, audiologist and physio-therapist should diagnose the causes of mental retardation among children in district level hospital. Epilepsy, Jaundice and Para-typhoid should be identified in infancy and early childhood and proper treatment can be given in time.

■ AWARENESS PROGRAMME AND EDUCATIONAL MEASURES

Central and provincial goverment and the mass media may involve in the awareness programmes on mental retardation. Information and Documentation centre may be established in each state to highlights various problem related to mental retardation. Building grant and land donation may be given for the construction of school building. Special and integrated education should run simultaneously and special school can be established at rural areas. A National Institute can be established for M.R.Children having research and training facilities. in the North-East Parent-Teacher Association and guidance and counselling services should be emphasised in each institutes. Behavioural and physio-therapy can be introduced in each institute. Books, stationaries and free transportation may be available for M.R. Children.

■ REHABILITATION PROGRAMME

Mentally retarded children need sheltered workshop in special institutes to compensate their abilities.

The deficiencies of the Disabled Act.1995 (Act.1 of 1996) can be removed and 1% of job reservation can be given to mentally retarded person.Mentally retarded person can be entitled to take the benefit from Integrated Rural Development Programme (IRDP). The National government can established District Rehabilitation centre (DRC) in the North East. Community Based Rehabilitation(CBR) Programme should be started and implemented effectively with the help of NGO's involved in the welfare activities.

Special employment exchange may be set up for the registration of mentally retarded. Special intitutes will be the legal authority to certify the fitness of the candidate for the appointment. Sale tax exemption can be given and

sale centre may be set up for marketing product of M.R.children. Scholarship, loan facilities and other welfare scheme may be introduced soon for M.R.Children.

• SUGGESTIONS FOR FURTHER STUDY

The Areas for further studies are suggested as follows:

- Studies on the problems related to implemention of National policy for mentally handicapped (1988)
- Studies with the coverage of all groups of disabilities.
- Comparision on the effectiveness of integrated education and special education programme.
- Co-rrelational studies on mental retardation and other associated handicapness.
- Studies on supporting services related to the welfare of mentally retarded.
- Studies on the evaluation of different welfare scheme for M. R. Children.
- Comperative studies on the services of government and NGOS relating to education and rehabilitation of mentally retarded.
- Studies on the impact of mentally retarded persons on the family.
- Studies on the effectiveness of preventive measures to arrest mental retardation.
- Studies on the practices of Yoga for mentally retarded person.
- Studies to develop effective remedial measures for mental retardation.
- A Nation-wide survay on the prevalence of various kinds of disabilities among children
- Studies to identify the suitable jobs for mentally retarded.

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APPENDIX - I

Covering Letter

Department of Education
Nagaland University
Kohima

Dated. Kohima, the 96

To,

Sir / Madam,

Certified that Mr. Azibur Rahman, Ph.D.Student, has been doing research in the University of Nagaland, under my supervision on the topic "**A study of the problems of mentally retarded children and provisions for their education in the North-East**". May I request you to extend your valuable co-operation to complete his research work ?

Sincerely your's

(Dr. S.K. Gupta)
Professor & Head,
Department of Education,
Nagaland University,
Kohima- 797 001

Instruction : This is **"A study of the problems of mentally retarded children and provisions for their education in the North-East."** For this purpose important questions are set in the following proforma. You are requested to go through the proforma carefully and try to give reliable and valid information for the same. Justify your answer by indicating tick mark against the questions and write few lines for the specific questions wherever necessary. Your information is completely confidential and will be used only for research purpose.

Faithfully your's

Azibur Rahman (Ph.D.Student)

Lecturer, Department

of Education, Mount Olive

College, Kohima,

Nagaland

APPENDIX - II

CASE STUDY PROFORMA TO STUDY THE CAUSES OF MENTAL RETARDATION IN THE NORTH-EAST

SECTION (A) PERSONAL AND FAMILY INFORMATION

1. Sex of the child :
2. Chronological age :
3. Mental age :
4. Class in which studying :
5. Family income per annum :

SECTION (B) INFORMATION ABOUT THE CAUSES OF MENTAL RETARDATION

6. Is the mental retardation in your child inherited? Yes/No. If so, Who was mentally retarded in the family?
7. Whether the child is mental handicap due to abnormal cell? Yes/No
8. Is the parent from the blood relative? Yes/No. If Yes, from What relation are they ?

9. Was it a premature birth Which caused mental retardation in your child? Yes/ No. If yes, mention the age.

10. Was the mother too old at the time of birth of the child ? Yes/No. If yes mention the age.

11. Was the mother too young at the time of birth of the child ? Yes/No. If yes, indicate the age.

12. Was the mother under mental sock and tension during the pregancy period? Yes/No.

13. Did the mother take medicine/drugs to abort the child? Yes/No.

14. Was there brain damage of the baby during or after birth? Yes/No. If yes, indicate the cause from the following options.

    a) Serious ailment of pregnant mother.

    b) Intake of harmful drugs

    c) Accident of either mother or child.

15. Did the expectant mother suffered from iodine deficiency during the period of birth of the child? Yes/No.

16. Was there any carelessness on the part of dai or doctor during delivery time ? Yes/No.

17. Was the mother nourished well in laws during pregency ?Yes/No

18. Did your baby take bottle milk since his/her birth? Yes/No. If yes, What was the reason?

19. Was it an infectious disease which caused mental retardation in your child ? Yes /No If yes name the disease.

20. Was the baby inocculated against disease like whooping Cough, diphtheria, tetanus, Polio, tuberculosis etc. well in the time ? Yes /No.

21. Was it a brain disorder (Epilepsy) Which caused mental retardation in your child ? Yes/No. If yes indicate.

22. Did your toddler consume poison like phenal, Naphthelene, acids etc. due to your negligence ? yes/No. If yes indicate.

23. Did he/she fall sometime from the bed in infancy and get injured ? Yes/No. If yes, What part of the head were injured?

APPENDIX- III

INTERVIEW SCHEDULE FOR PARENTS

SECTION : (A) PERSONAL AND FAMILY INFORMATION:

1. What is your family income per annum?

2. Whenever you talk to your child does he/she comphrehends what you say ? Yes/No. Give example.

3. In What activities is your child interested ? Indicate them.

4. What are the characteristics of your child ?

5. If your child does something wrong how do you correct him ?

SECTION (B) EDUCATIONAL INFORMATION :

6. Does your child take interest in study ? Yes/No

7. Can your child pass in examination ? Yes/No

SECTION(C) ENVIRONMENTAL INFORMATION :

8. What is the attitude of your neighbours towards your child ? Favourable /

unfavourable / indifferent .

9. What is the attitude of your neighbours towards you ? Favourable/ Unfavourable / indifferent.

10. Does your child feel inferiour to other children Yes/No.

SECTION (D) BEHAVIOURAL INFORMATION :

11. Can your child adjust with normal children ? Yes/No

12. Do you have any Complaint about your child ? Yes/No. If yes, indicate them.

13. Is your child agressive ? yes/No. If yes specify them.

14. Is your child hyperactive ? yes/No. If yes indicate them.

15. Have you observed any physical problem in your child ? Yes/NO if yes, indicate them.

16. Does your child have eating problem ? Yes/No. If yes, indicate.

17. Is there any behaviour or habit disorder in your child ? Yes/No . If Yes. indicate them.

18. Does he/she pass urine in inappropriate places ? Yes/No

APPENDIX IV

QUESTION NAIRE FOR TEACHERS

SECTION (A) EDUCATIONAL PROBLEMS IN THE INSTITUTE

A. FINANCIAL INFORMATION.

1. If your institute gets grant in aid from the state governmet? Yes/No. If yes indicate the amount.

2. Do you get financial assistance from central government. Yes/No Give your remark.

3. Do you get assistance from voluntary organisation ? Yes/No. If Yes, indicate the name of organisation

4. Does your institute get donation from local body ? Yes/No.

B. CLASS ROOM INFORMATION

5. How many classes you have in your institute ? Name them.

6. What is duration for a class ?

7. What is the number of male student ?

8. What is the number of female student ?

9. Do you feel that the progress of M.R. student is satisfactory in studies ? Yes/No.

10. Do you have the problem of wastage and stagnation ? Yes/No. Give reason.

11. Does the M.R.children face difficulty in differentiating things or object? yes/ No. Give example.

(C) INFORMATION ABOUT CURRICULUM

12. Does your institute have special curriculum ? Yes/No

13. Who is constructing the curriculum for special school?

14. What subject are taught to the M.R.Students ?

15. Do you have your own educational programme ? Yes / No.

(D) INFORMATION ON TEACHING - LEARNING METHOD:

16. Can M.R.Student be benefited from lecture method Yes/No.

17. Do you think that repetition method is beneficial for the education of M.R.Students ? Yes/No.

18. Do you follow individualised instruction to teach M.R.student ? Yes / No.

19. Do you think that reward and punishment have positive impact in behaviour modification of mentally retarded children ? Yes/No.

20. Do you use learning by doing method to train the mentally retarded students ? yes/No If yes indicate some of them.

21. Do you have musical instruction system for teaching the mentally retarded in your institute? Yes/No.

(E) BEHAVIOURAL INFORMATION:

22. Is there any complaint about M.R. children. Yes/No. If yes, mention them.

23. Do you think that M.R.Children are agressive ? Yes/No. If Yes. specify.

24. If M.R.Children are hyperactive ? Yes/No If Yes, mention them.

25. Can M.R. Children adjust with situation ? Yes/No

26. Have you observed any physical problem in M.R. Children ? Yes /No . If Yes indicate them.

27. Do the M.R.children have eating problem ? Yes/no

28. Have you observed any behaviour or habit disorder in M.R.Children ? Yes/ No. If yes, indicate them.

29. Do the M.R.children have a habit of passing urine at inappropriate places? Yes/No.

(F) INFORMATION ABOUT TEACHING STAFF:

30. What is the strength of teacher in your institute?

31. Indicate the number of male teacher .

32. Indicate the number of female teacher .

SECTION (B) : EXISTING FACILITIES OF EDUCATION

A. ADMISSION

33. Name the classes for which provisions of education are available in the institute.

34. What is the age criteria of admission ?

35. Indicate the number of seats in your institute.

B. INFRASTRUCTURAL FACILITIES

36. Mark the answer with tick (v) Sign

    i) Whather the institute is (a) Goverment b) Govt. aided c) Private

    ii) If the institute is (a) Residential b) Day Care Centre.

    iii) What type of educational programme is existing ?

    a) Special education b) Integrated education

37. Do you have student common room in your institute ? Yes/No

38. Do you have Library? Yes/No.

39. Do you have sanitation facility ? Yes/No.

40. Do you have water supply in your institute ? Yes/No.

41. Do you have light facilities in the institute ? Yes/No.

42. Indicate the number of classroom in your institute ?

(C) CO-CURRICULAR ACTIVITIES

43. DO you have play ground in the institute ? Yes/No

44. In what type of games and sports they are interested ? Mention them.

(D) GUIDANCE AND COUNSELLING

45. Do you have guidance service in your institute ? Yes/No.

46. Do you have guidance service in your institute ? Yes/No.

47. Do you have parents Counselling ? Yes/No.

(E) MEDICAL SERVICE

48. Do you have permanent health service in your institute? Yes/No

49. Do you have medical visiting team for M.R.Children ? Yes/No

SECTION (C) PROBLEM OF REHABILITATION

50. Do you have scholarship for mentally retarded students ? Yes/No

51. Does mentally retarded have the reservation quota for job? Yes/No

52. Do you have sheltered workshop for M.R.Students? Yes/No

53. Does your institute have special training facilities for girls ? Yes/No. If yes, indicate the nature of training.

APPENDIX - V

TO WHOM IT MAY CONCERN

This is to certify that Mr. Azibur Rahman a Ph. D. Scholar of the University of Nagaland has visited to Mental hospital, (Kohima) for data Collection in connection with his research work. The data was collected under the topic " A STUDY OF THE PROBLEMS OF MENTALLY RETARDED CHILDREN & PROVISIONS FOR THEIR EDUCATION IN THE NORTH - EAST." on 15. 03. 97

P. Ngully
MBBS; DPM; MIPS
Medical Officer in Charge
Mental Hospital, Kohima

Dated : 15. 03. 97

Medical Officer Incharge
Mental Hospital Kohima

GOVERNMENT OF ASSAM

GUWAHATI MEDICAL COLLEGE & HOSPITAL

DEPARTMENT OF PSYCHIATRY

GUWAHATI-781 032 : ASSAM : INDIA

No. MC/Psy/20/90/984, Date 29.1.97.

TO WHOM IT MAY CONCERN.

Certified that Mr. Azibur Rahman, Ph.D. student of Nagaland University has studied four cases of mental retardation in the department of Psychiatry, Gauhati Medical College, in connection with his thesis on the topic " A study of the problems of mentally retarded children and provision for their education in North East". I hope the case study will help him in his research project.

(Prof.P.D.Das,)
M.R.C.Psych.(U.K.)
Head of the Deptt. of Psychiatry,
Gauhati Medical College,Guwahati.

.....

Society For Rehabilitation Of Spastic Children

AIZAWL—796001, MIZORAM.
(Affiliated to Spastic Society of Eastern India, Calcutta)
(Regtn. No. SR—13 of 1989)

Ref No. ..... Date 8th January 1997

TO WHOM IT MAY CONCERN

Certified that Mr. A. Rahman, Research Scholar of Nagaland University, have visited our Institute and have collected data(information) from 6th January 1997 to 8th January 1997.

I wish him a bright future.

8/1/97

(Mrs. Chhingpuii)
Director of Services
Gilead Special School for
Multihandicapped Children
Post Box 130, Aizawl

Dr. Jayanta Das
M.B.B.S. (DIB), D.P.M.(RANCHI), FIPS
CONSULTANT PSYCHIATRIST

Psychiatric Clinic
S. C. Goswami Road,
Opp. Sukleswar Temple
PANBAZAR, GUWAHATI-781 001
0361-564801 (Residence)
Phone : 515188 (CLINIC)

Consulting Hours :
9-00 a.m. to 12-00 a.m.—2-00 p.m. to 5-00 p.m.
Week Days—SATURDAY & SUNDAY—9A.M—12 A.M.

DOCTOR WILL NOT BE AVAILABLE FOR CONSULTATION AFTER 5 P.M.

NOT VALID FOR MEDICO-LEGAL PURPOSES

TO WHOME IT MAY CONCERN

Certified that Mr. Asibur Rahman, a Ph.D student of Nagaland University, has collected data (case record) from my clinic for his Thesis. I hope this case study can fullfil his requirement.

I wish him all successful in life.

31/1/97

(Dr. Jayanta Das)
MBBS. (DIB) D.P.M.(Ranchi) FIPS
S.C. Goswami Road,
Pan Bazar, Guwahati-1.

Dr. J. Das
M.B.B.S., D.P.M.
Consultant Psychiatrist
Regd. No.

SHISHU SAROTHI
Spastics Society of Assam
Centre for Special Education
Off RK Mission Burnbari
~~K.K. Bhatta~~ Road, ~~Chenikuthi~~ Guwahati - 781003. 16
Registration No. 3469 of 1987-88
Affiliated to Spastics Society of Eastern India
Donations exempted from Income Tax under Sec. 80 G.
All donations to Building Fund **fully exempted** from Income Tax under Sec. 35AC.

Dr. S.K.Gupta
Professor & Head
Department of Education
Nagalad University
Kohima -797 001

25.2.97

Dear Dr. Gupta,

This is in response to your letter introducing Mr. Azibur Rahman and his research on the problems of mentally retarded children and the provision for their education in the North East. Mr.Rahman visited our institute last month when we were busy with our in-house teachers' training programme. Even now our staff are preoccupied with their case studies etc.

However we have filled up the enclosed two questionnaires and are sending them to you. Please note that our institution caters to the needs of children affected with Cerebral Palsy and its associated disabilities. Our children's primary problem is physical. Some children do have associated problems of mental retardation and learning disabilities. Hence our efforts are oriented more to achieving physical abilities while simultaneously tackling associated problems.

We would also like to draw your attention to the extremely insensitive phraseology of the questionnaire. The mentally retarded person deserves more dignity and should be referred to in a more caring way as a 'person' rather than as a 'retarded'.

We hope you will find the enclosed questionnaire useful for the survey.

Yours truly

Mira Kagti

Ms. Mira Kagti
Chairperson.

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DWAR JINGKYRMEN

School for Children in need of Special Education

Run by : **Ladies and Children's Recreation Centre**

Affiliated to the Spastics Society of Eastern India, Calcutta

Regd. No. 24 Meghalaya Societies Registration Act

STONYLAND
SHILLONG – 793 003

Ref. No. DJ/4/5/97 REGISTERED *Date*..... 13.6.'97

Mr. Azibur Rahman,
Lecturer& Head, Department of Education,
Mount Olive College,
Kohima, Nagaland-797001

Dear Sir,

I am enclosing herewith the questionaire duly filled in by a few parents of the students of this school. It was under a random selection.

Regret the delay in returning the forms; do hope your research is a success.

Yours faithfully,

(ZEENAT A ALI)
PRINCIPAL

TO WHOM IT MAY CONCERN

This is to certify that Mr. Azibur Rahman, Lecturer in the Department of Education, Mount Olive College, Kohima, Nagaland, has been doing PH.D. on the topic "A Study of the Problems of Mentally Retarded Children and Provision for their Education in North-East". He has collected data/information on the subject from this Department of Social Welfare, Government of Manipur and two Special Schools for the M/R Students viz., the B.B.Paul Mental Development Home, Mongsangei & the Ch. Ibohal Institute for the Mentally Retarded, Sangai Parou, which are run under the aegis of this Department.

I wish him success.

Imphal,
The 19th Dec., 1996.

(R.K. Dhani Sana Singh)
Social Welfare Officer,
Department of Social Welfare,
Government of Manipur

SOCIAL WELFARE OFFICER
Dept. of Social Welfare
Govt. of Manipur

-(o)-

Ph: 22003 (Office)
Code: 0385

Mary Rice Centre for Special Education
(Centre for the Disabled Child)
St. Edmund's Campus,
Laitumkhrah, Shillong - 793003
Meghalaya, India
21st April '97.

TO WHOM IT MAY CONCERN.

This is to certify that Mr. Azibur Rahman, of the Department of Education, Nagaland University, Kohima, collected data from our Centre (address given above), and visited it in December '96, and familiarised himself with the history of the Centre, and interviewed the Director. He also read all the previous Annual Reports. Because it was holiday time, he could not meet parents and staff members, but I supplied as much as information as was possible.

Thanking you,

ACGill.
Project Director
Centre for the
Disabled Childs

(PROJECT DIRECTOR)

M.R.C.S.E. (-DC)
Date 21/4/97
SHILLONG.

SWABALAMBAN

(PIONEER INSTITUTE FOR MENTALLY RETARDED & MULTIPLE HANDICAPPED CHILDREN)

(Affiliated by : **N. I. M. H., SECUNDERABAD, GOVT. OF INDIA**)

Organised by : ALL TRIPURA SCH. CASTES, TRIBES & MINORITY UPLIFTMENT COUNCIL

Office : RAMNAGAR ROAD NO.-1,
2ND LANE, AGARTALA.
PIN-799002

Phone : 6264/6408
S.T.D. Code No. : 0381.
Post Box No. : 21.

Ref.No. MR-SPL-SL—

Date 4-1-1997

I am glad to know that Mr. Azibur Rahaman Ph. D, student of Nagaland University came to our institute at Agartala for taking information about- mental retarded child, Parents, & teacher facilities etc from 1-1-97 to 4-1-97.

Thanking you.

4-1-97

Principal,
SWABALAMBAN
(Special School for Mentally Retarded)
Indranagar, Tripura (W).

SAHAYIKA

Regd. No. 4006 of 1990-91

GUWAHATI CHILD GUIDANCE CENTRE

(To help children with special needs)

GOVT. PRESS ROAD, BAMUNIMAIDAM, GUWAHATI-781021

Telephone : 550951 : 551995

সহায়িকা

Feb. 3 1997

DR. Gupta,

It was nice to have H/R. Azibur Rahman amidst us for his work on his Ph. D. thesis.

Our teachers have given full co-operation to help him. Any farther help you need from here, please, let me know.

With best wishes,

Sincerely Yours,

Kalpana Bezbaruah.
Child Psychologist
Director, Sahayika.