Indian J. Psychiat. (1983), 25(3), 180—184

INSTITUTIONALISED MENTALLY RETARDED IN A STATE MENTAL HOSPITAL

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SUMMARY

298 institutionalised mentally retarded patients in Institute of Mental Health, Madras were studied for the aetiological factors, levels of intelligence, associated disorders and family structure and compared with 163 matched group of mentally retarded attending the outpatient services of the Institute of Mental Health. In 41% of the institutionalised the cause was unknown, 29.3% had infective aetiology, 18% formed the primary group and 6.4% were due to genetic and chromosomal factors. Statistically significant number of institutionalised were severely subnormal, had more associated disorders and poor family structure. The need for the development of exclusive residential services for the mentally retarded and community oriented approach are discussed.

Wolfensberger (1976) has traced the origin, nature and changing patterns in the residential services for the mentally retarded. Despite the dehumanizing nature of large institutions (Goffman, 1961), the total number of persons in institutions is still increasing in the United States (Scheerenberger, 1976). In the U. K. there has been an annual increase of 2% and 13% respectively in children and adult residential places and 6% in local authority day places. In 1977 the number of places provided for mentally retarded in hospitals is 52700 (DHSS, 1977).

It has been shown that severely subnormal children brought up in their own homes are more forward in their development than are those brought up in institutions (Tizard, 1960; Carr, 1970).

In India, there are no exclusive state residential care institutions for the mentally retarded. The residential care has to be provided in the mental hospitals. This is partly due to the fact that the definition of lunacy in Indian Lunacy Act, 1912 includes idiots as well as persons of unsound mind. 7.4% of the 269 chronic psychiatric patients in Hospital for Mental Diseases, Ranchi are mentally retarded (Gupta *et al.*, 1968). In Agra Mental Hospital 7.3% of the 110 long stay patients are mentally defectives, epileptics and others (Gupta *et al.*, 1980).

The present study aims at finding the chracteristics of the institutionalised mentally retarded and the factors leading to institutionalisation.

MATERIAL AND METHODS

The experimental group consisted of 298 mentally retarded patients satisfying the I. C. D. 9 criteria for mental retardation in the Institute of Mental Health, Madras. The control group consisted of matched group of 163 mentally retarded patients satisfying the I. C. D. 9 criteria, attending the out-patient services of the Institute of Mental Health regularly.

Psychosocial history, clinical examination and relevant investigations were done in all cases to assess the aetiological factors, associated disorders and family structure.

The assessment of intellectual levels should be based on whatever information is available, including clinical evidence, adaptive behaviour and psychometric findings. The I. Q. levels are provided only as a guide and should not be applied

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rigidly (W.H.O., 1978). Using the above guidelines intelligence levels were assessed and the cases split into two groups. The mildly retarded group corresponds to 317 of the I. C. D. 9 and the 'subnormal' group of the British Mental Health Act, 1959 (I. Q.—50-70). The severely retarded group corresponds to 318 of the I. C. D. 9 and the 'severely subnormal' of the British Mental Health Act (I. Q. 0-50).

RESULTS

The results of the study are as follows:

Table-1 gives the characteristics of the institutionalised group of mentally retarded.

TABLE 1. *Characteristics of the Institutionalised Mentally Retarded* (N=298)

Age	
Range	6-45
Sex	
Male	196
Female	102
Stay	
Less than 2 yrs.	42
More than 2 yrs.	256

i) Aetiology Table-2 provides the aetiological factors in the institutionalised group of mentally retarded.

TABLE 2. *Aetiological factors in the Institutionalised Mentally Retarded* (N=298)

Aetiology	Percentage
Primary	18.0
Post Encephalitic	20.3
Post Meningitic	9.0
Genetic and Chromosomal	6.4
Asphyxia Neonaturum	5.3
Causes not known	41.0

ii) Levels of intelligence: Table 3 compares the levels of intelligence between the experimental and control group. 67% of the institutionalised are severely retarded when compared to 37% of the control group.

TABLE 3. *Comparison of levels of Intelligence between the Institutionalised and the outpatient Group.*

Level of Intelligence	Institutionalised Group (N=298)	%	Outpatient Group (N=163)	%
Mildly retarded (I.Q. 50-70)	98	33	102	63
Severely retarded (I.Q. 0-50)	200	67	61	37

$X^2=37.86$; d.f.=1; $p<0.001$

iii) Associated Disorders: Table 4 compares the disorders associated with mental retardation viz., epilepsy, behaviour disorder and other handicaps like motor and sensory deficits between the institutionalised group and the outpatient group.

TABLE 4. *Comparison of Associated Disorders between the Institutionalised and the Outpatient Group.*

Associated disorders	Institutionalised Group (N=298) N	%	Outpatient Group (N=165) N	%	X^2
Epilepsy	152	51.0	22	13.5	63.09
Behaviour Disorder	200	67.0	22	13.5	121.33
Other deficits	154	51.7	40	24.5	31.84

All X^2 values significant at $p<.001$

iv) Family structure : Table 5 compares the family structure of the experimental and the control group.

TABLE 5. *Comparison of Family structure between the Institutionalised and the Outpatient Group.*

Family Structure	Institutionalised Group (N=298)		Outpatient Group (N=163)	
	N	%	N	%
Both Parents	58	19	133	82
Single Parent	118	40	30	18
Nil	122	41	—	—

X^2=179.70; d.f.=2; $p<0.001$

DISCUSSION

i) Aetiology : The aetiology is not known in 41% of the cases because of non-availability of information. The information was lacking in these cases because majority of the children are abandoned individuals and they are certified and admitted through police and the parents do not want to be identified in many cases. In another 18% of the cases, inspite of the available history, a definite cause could not be ascertained and hence given the label primary. 29.3% of the cases were due to post-encephalitic or post-meningitic sequalae. The importance of infective aetiology in our cases has already been discussed (Somasundaram, 1968). 6.4% of the cases are due to genetic or chromosomal disorder and these are mainly contributed by Tuberous Sclerosis and Down's syndrome. That these disorders are not uncommon has already been stressed (Somasundaram, 1968; Somasundaram and Papakumari, 1978). Comparison of the statistics of the aetiological factors in the present series with the aetiological factors of the mentally retarded in an earlier study (Somasundaram, 1968) does not reveal significant difference excepting in the category of 'causes unknown'. The increase in the group in the present series is mainly due to the non-availability of information. Berg & Kirman (1959) could not identify causal factors in 31% of the cases. Angeli and Kirman (1971) in the series of 645 cases found 327 cases to be unclassified.

ii) Levels of intelligence: The present study reveals that the institutionalised mentally retarded are more severely retarded than the control group and that it is statistically significant ($p<0.001$). Tizard and Grad (1961) found that those in the institutions were found to the extremely handicapped when compared to those staying at home (62 : 25). The authors point out that the scroes obtained by subjects in the hospital may under-estimate their abilities because they had no opportunity to do the things assessed in the Vineland test. This lack of opportunity may also have actually retarded the subjects. Saenger (1960) found that the degree of retardation was found to be highly related to institutionalisation.

iii) Associated Disorders : The institutionalised group has significantly more associated disorders like epilepsy, behaviour disorder and other deficits ($p<0.001$). Behaviour disorder is seen as a common reason for institutionalisation in this study. Saenger (1960) found that cases with severe motor deficit, epilepsy, and behaviour problems were most likely to be institutionalised. Tizard and Grad (1961) found that many in the home groups did not have any other problem other than mental handicap. Carr (1974) observed that institutionalisation was highest where the child had many problems. Corbett and Pond (1979) studied the prevalence of epilepsy in all known severely retarded children in a London suburb and found that one third of the children with severe retardation had a history of seizu-

res at sometime during life and 19% had at least one fit during the previous year.

iv) Family structure : The family conditions are found to be very poor in the institutionalised group. 41% of the institutionalised patients do not have a parent and 40% have only one parent. The majority in the control group (82%) have both parents and are tolerated better at home. Inspite of the difficulties, humiliation, inconveniences and problems of management these families manage to adjust to having a mentally retarded at home. Tizard and Grad (1961) and Caldwell and Guze (1960) also found that most families adjust to the situation of having a handicapped child at home.

This study reveals that the patients with severe mental retardation, more associated disorders like behaviour disorder, epilepsy and other deficits and poor family structure are institutionalised. That these factors are present in a statistically significant proportion in the institutionalised than in the mentally retarded attending the outpatient services imply that these factors contribute to institutionalisation to a significant extent. Since 41% of the institutionalised do not have a parent, the need to care them in institutions becomes imperative. Mental Hospitals today represent the major pool of residential accommodation for the mentally retarded and this is likely to be the case for many years to come. Institutional care is almost equated with custodial care. Special services for the mentally retarded in the form of behaviour modification, training activities in work habits and attitudes and special education are almost totally lacking in our country. The development of separate residential services for the mentally retarded as existing in Western countries is essential. The type of services provided should include day care for children and adults, educational centres for children and adults, occupation and training for adults, hospital services and residential care in the community (Craft, 1979). While almost all agree that there is a place for hospitals treating the mentally retarded, the concept of small homely neighbourhood units has evolved for the vast majority, visited by members of the multidisciplinary team on a community basis in Northern America (Roecher, 1979). Similar community oriented approach should be evolved in our country also.

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