PAPERS AND ORIGINALS

Census of mental hospital patients and life expectancy of those unlikely to be discharged

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Summary

A census in a London mental hospital was performed so that the numbers of patients requiring permanent care for the next 20 to 40 years could be estimated. Of 1467 resident patients 20% had been admitted in the preceding five months and 15% in the year before that. Of the 65% who had been in hospital for over 17 months 1% (16 patients) had been in hospital for over 50 years. Altogether 257 (18%) patients would probably be discharged, 339 (23%) might possibly be discharged if there were adequate community facilities, but 871 (59%) were not likely to be discharged; 239 patients under the age of 65 who had been admitted between 1950 and 1973 were unlikely to be discharged. There were about 10 new younger long-stay patients from each year's admissions. Three conditions—schizophrenia, organic brain syndrome, and affective illness—affected 79% of the population. Fourteen per cent had been employed on admission and 28% were considered employable or possibly employable. Half of those who might be considered for discharge (296) would need a hostel. No rehabilitation was needed or possible for 40% of the patients; 299 (20%) patients were chairbound or bedridden and 400 (27%) were totally dependent on nursing and 587 (40%) partly dependent.

Twenty months after the census 361 (25%) patients had left (59 had been readmitted), 284 (19%) had died, and

822 (56%) had remained as inpatients. The most realistic future prediction was that 210 (14%) of these patients would still be in the hospital in 20 years and 43 (3%) in 40 years. In the light of these findings and the scarceness of resources current Department of Health and Social Security plans for phasing out mental hospitals must be challenged.

Introduction

The future for mental hospitals is uncertain. The Department of Health and Social Security hopes in the future to treat mental illness in psychiatric units in district general hospitals and in community facilities. These plans for the long-term care of mental illness^{1 2} suppose the validity of the implications of studies such as those of Tooth and Brooke,³ Oldham,⁴ and Baker.⁵ They also depend on the premise that most mental illness can be treated suitably in a general hospital and that there will be a considerable expansion in hospital building and an even greater development of community facilities. Any of these assumptions might be incorrect; indeed, several recent studies of patients with long-term psychiatric illness have hinted that they are. The inferences drawn by Tooth and Brooke³ were first queried by Norton in 1961.⁶ Baldwin and Hall⁷ found that it took a relatively short time to halve the population of patients with mental illness in hospitals in north-east Scotland but a very long one to eliminate it. Hailey⁸ thought that the decrease in long-stay patients would continue more slowly as the rate of reduction was curvilinear. Hailey⁸ also studied new chronic patients in the psychiatric services and found 0.5 per 1000 per year in hospital. Cross *et al.*,¹⁰ Mezey and Syed,¹¹ Fryers,¹² and Letemendia and Harris¹³ all thought that more beds would be needed than were being planned for district general hospital units under the current DHSS guide lines.

We have reviewed the patients in Tooting Bec Hospital in an attempt to estimate the numbers who will require permanent care or remain under treatment for the next 20 to 40 years.

Population studied

Tooting Bec Hospital is a London mental hospital opened in 1903

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for the care of patients with senile dementia. After 1947 some younger patients were also admitted. From 1950 until 1966 younger patients with chronic psychoses were transferred from overcrowded hospitals in the London region as there were vacancies at Tooting Bec. In 1966 the hospital acquired the responsibility for part of the borough of Wandsworth (population 90 000) and in 1969 for half the boroughs of Wandsworth and Lambeth (total population about 200 000). The hospital was also responsible for psychogeriatric patients in other parts of London. This responsibility for all those over 70 with senile dementia among the population of 4 000 000 of the old London County Council area in 1950 was gradually reduced until the hospital was responsible for only those with psychogeriatric illnesses in a population of about 250 000 in other parts of the boroughs of Lambeth and Wandsworth in 1973.

Method

In May 1973 a census of all inpatients was taken, with follow-ups at 10 and 20 months after the initial survey. Information was collected on age, sex, year of entry, possibility of discharge, need for further support and rehabilitation, demands on nursing services, and diagnosis.

The questionnaire used was divided into five sections: demographic, social, rehabilitation, nursing problems, and diagnosis. The demographic section, containing questions on age, sex, marital status, and employment at the time of admission to hospital was completed from the case notes by ward sisters. All patients (including those on leave) on the hospital books at midnight on 23 May 1973 were included. The nursing section was completed by senior nursing officers in conjunction with the ward sister. This section covered mobility, nursing dependence, the type of ward needed, and specific nursing problems, such as incontinence, aggression, wandering, and communication difficulties. A psychiatric social worker completed the social section, which was concerned with the likelihood of discharge, the possibilities of employment, and the patient's probable needs on discharge. They did this in conjunction with the ward staff and ward doctors when necessary. They also completed the section on the rehabilitation needs of the patients. All patients were classified into one of three groups: those likely to be discharged, those who might possibly be discharged, and those unlikely to be discharged. Those patients who could be discharged only if there were adequate support and facilities in the community (group home or hostel) were classified in the "possible discharge" group. To ensure consistency these criteria were extensively discussed and there was a good measure of agreement between social workers during pilot tests of the questionnaire on three wards. A newly appointed consultant psychiatrist completed the diagnosis from case notes and personal interview.

Follow-up—A follow-up was made at 10 and 20 months to discover the accuracy of the initial assessment of likelihood of discharge. We also reviewed the number of discharges and deaths in hospital, which enabled us to estimate the number of patients who might still need hospital services during the next 40 years. The follow-up was done from admissions registry cards. There were four groups of patients: those who had died in hospital; those who had been discharged and

were still out; those who had been discharged but readmitted; and those who had remained continuously as inpatients.

Results

DEMOGRAPHIC DATA

There were 1467 patients in the hospital on 23 May 1973: 406 (28%) men were below the age of 65 and 173 (12%) 65 or over; 261 (18%) women were under 65 and 627 (42%) 65 or over. There were three populations in the hospital: a group of younger patients (under 65) with short-term mental illnesses (211); a group of younger long-stay patients who were not likely to be discharged and who had been in the hospital for up to 25 years (456); and a large group of elderly, mostly psychogeriatric, patients (800). This last group included 16 subnormal patients who had each been in the hospital for over 50 years and who were now in the psychogeriatric group.

Discharge was likely for 257 (18%), possible for 339 (23%), and unlikely for 871 (59%) patients. There was a clear age and sex trend from group to group (table I). The likely group included more men and people aged under 65 than the possible group, which in turn included more than the unlikely group. Of the total population 48% were single, 16% married, 28% widowed, 3% divorced, 4% separated, and 1% had cohabited. The proportions of single people were similar in the three groups. The unlikely group had fewer married and more widowed people than the others. This was expected in view of the higher proportion of the elderly.

The earliest year of entry to the hospital was 1909, but all except 2% of the patients had been admitted since 1950 (15% 1950-9; 33% 1960-9; 30% 1970-2, and 20% January-May 1973). Most of those in the likely group were admitted in 1973 and the most of the remainder in 1972. Only 36 patients admitted before 1972 were likely to be discharged.

Among the younger patients (under 65) admitted in the decade 1950-9 there were 86 who were unlikely to be discharged and among those admitted in 1960-9 there were 99. In the three and a half years before the census 54 younger patients who were unlikely to be discharged had been admitted. About 10 such patients below the age of 65 seem to have been admitted each year.

OTHER DATA

Diagnosis—The major diagnoses of the patients are shown in table II. Three conditions—schizophrenia, organic brain syndrome, and affective illness—affected 79% of the total population. A total of 570 patients had a concomitant physical diagnosis: 42 were in the likely group, 78 in the possible group, and 450 in the unlikely group. Of these patients with a co-existent physical condition 58% had, as the major diagnosis, organic brain syndrome. The patients in whom an accurate diagnosis of mental illness had not been made and those with "other" conditions also included a high proportion with a physical condition (56 out of 100).

TABLE I—Likelihood of Discharge according to age and sex. Results are numbers (percentages) of patients

Likelihood of discharge	Men			Women			Total
	<65	>65	Total	<65	>65	Total	
Likely	116 (45)	12 (5)	128 (50)	95 (37)	34 (13)	129 (50)	257 (100)
Possible	144 (42)	37 (11)	181 (53)	73 (22)	85 (25)	158 (47)	339 (100)
Unlikely	146 (17)	124 (14)	270 (31)	93 (11)	508 (58)	601 (69)	871 (100)
Total	406 (28)	173 (12)	579 (40)	261 (18)	627 (42)	888 (60)	1467 (100)

TABLE II—Principle diagnosis and likelihood of discharge. Results are numbers (percentages) of patients

Likelihood of discharge	Diagnosis									Total
	Schizophrenia	Affective illness	Organic brain syndrome	Subnormality	Alcoholism	Drug dependence	Personality disorder	Neurosis	Other or not known	
Likely	82 (32)	82 (32)	14 (5)	2 (1)	27 (11)	17 (7)	15 (6)	9 (3)	9 (3)	257 (100)
Possible	138 (41)	74 (22)	39 (11)	13 (4)	19 (5)	5 (1)	16 (5)	13 (4)	22 (7)	339 (100)
Unlikely	254 (29)	121 (14)	352 (41)	43 (5)	11 (1)	2 (0)	8 (1)	11 (1)	69 (8)	871 (100)
Total	474 (32)	277 (19)	405 (27)	58 (4)	57 (4)	24 (2)	39 (3)	33 (2)	100 (7)	1467 (100)

TABLE III—Numbers (percentages) of patients needing different types of support on discharge

Likelihood of discharge	Housing		Housing requirements					Social support needed			Other support needed			Total
	Own house	No home	None needed	Unsupervised housing	Supervised housing	Hostel	Hospital or other institution	None	Voluntary visitor	Social worker	None	Day centre	Day hospital	
Likely	120 (47)	137 (53)	115 (45)	47 (18)	11 (4)	82 (32)	2 (1)	49 (19)	23 (9)	185 (72)	206 (80)	40 (16)	11 (4)	257 (100)
Possible	77 (23)	262 (77)	65 (19)	12 (4)	30 (9)	214 (63)	18 (5)	96 (28)	38 (11)	205 (61)	217 (64)	85 (25)	37 (11)	339 (100)
Total	197 (33)	399 (67)	180 (30)	59 (10)	41 (7)	296 (50)	20 (3)	145 (24)	61 (10)	390 (66)	423 (71)	125 (21)	48 (8)	596 (100)

TABLE IV—Employment status. Results are numbers (percentages) of patients

Likelihood of discharge	Status on admission		Current status			Total
	Employed	Not employed	Employable	Possibly employable	Not employable	
Likely	75 (29)	182 (71)	152 (59)	48 (19)	57 (22)	257 (100)
Possible	76 (22)	263 (78)	61 (18)	121 (36)	157 (46)	339 (100)
Unlikely	47 (5)	824 (95)	6 (1)	17 (2)	848 (97)	871 (100)
Total	198 (14)	1269 (86)	219 (15)	186 (13)	1062 (72)	1467 (100)

TABLE V—Outcome at 20 months. Figures in parentheses are results at 10 months

Likelihood of discharge	Died		Inpatient				Discharged		Total	
			Continuously		Discharged but readmitted					
	No	%	No	%	No	%	No	%	No	%
Patients <65 years										
Likely	4 (3)	2 (1)	31 (49)	15 (23)	30 (31)	14 (15)	146 (128)	69 (61)	211	100
Possible	10 (4)	5 (2)	139 (169)	64 (78)	16 (12)	7 (5)	52 (32)	24 (15)	217	100
Unlikely	26 (16)	11 (7)	197 (217)	83 (90)	1 (2)	0 (1)	15 (4)	6 (2)	239	100
Total	40 (23)	6 (3)	367 (435)	55 (65)	47 (45)	7 (7)	213 (164)	32 (25)	667	100
Patients >65 years										
Likely	1 (1)	2 (2)	15 (21)	33 (46)	4 (3)	9 (6)	26 (21)	56 (46)	46	100
Possible	12 (10)	10 (8)	77 (98)	63 (80)	4 (1)	3 (1)	29 (13)	24 (11)	122	100
Unlikely	231 (134)	37 (21)	363 (485)	57 (77)	4 (1)	1 (0)	34 (12)	16 (2)	632	100
Total	244 (145)	30 (18)	455 (604)	57 (75)	12 (5)	2 (1)	89 (46)	11 (6)	800	100

Social factors—Table III shows the various needs that patients in the likely and possible groups might have on discharge. Altogether 47% of the likely group had their own home to return to, but this was more common among the women (57%) than the men (36%). Men needed unsupervised housing and hostel accommodation more than women, perhaps because fewer had their own homes. Fewer of the possible group (23%) had their own home, and 63% of this group might require hostel accommodation. Only 4% of the unlikely group had homes to return to, should they be discharged. We thought that most patients in each group would need the support of a social worker on discharge, though some needed no support. The possible group had a higher proportion needing no support than the likely group, but 62 of these 96 patients were women over 65, a pattern not seen in the likely group. Most patients would not need a day hospital or day centre, though more of the possible group needed this type of support than the likely group. The possibility of obtaining employment by the patients is shown in table IV. Most of those thought to be employable were in the likely group, and in this group 92% of those aged under 65 were at least possibly employable, and 33% of these had been employed when they were admitted to hospital.

Immediate rehabilitation needs in hospital—Fourteen per cent of the patients were thought suitable for open employment, 5% for sheltered employment outside the hospital, 7% for industrial therapy, 27% for occupational therapy, and 7% for employment in the hospital. No rehabilitation was needed or possible for 40% of the patients. Most of those in the likely group aged under 65 needed open employment. Among the possible group 49 of the 62 needing open employment were men under 65. Most of those requiring occupational therapy were women. Few of the unlikely group required any rehabilitation, and most of the remainder needed occupational therapy. There was little prospect of outside employment for members of this group.

Nursing—Most of the patients in the likely group needed acute or medium stay wards and most of those in the possible and almost all of those in the unlikely groups were thought to need long-stay wards. Sixty-five (4%) of the patients were bedridden and 234 (16%) were chairbound; 587 (40%) were partly dependent on nursing and 400

(27%) were totally dependent. Only among the unlikely group were there many bedridden or chairbound patients. Eighty-five per cent of these patients were women over 65. Three-hundred-and-ninety patients were incontinent, 290 had communication difficulties, 87 were deaf, 40 were blind, 218 (mostly elderly) patients were described as wanderers or absconders, and 92 had problems with excessive drinking. Inebriety was far more common among patients in the likely and possible groups than among those in the unlikely group and was mainly among men aged under 65. Blindness, deafness, difficulties in communication, and incontinence all showed a similar pattern. Each was far more common in the unlikely group than in the possible group, where in turn it was slightly more common than in the likely group. In the unlikely group each of these problems was most common among the women aged over 65, 55% of whom, for example, were incontinent.

FOLLOW-UP AT 10 AND 20 MONTHS

The validity of the classification was measured by the results at 10 and 20 months. Of those in the likely group 67% had been discharged at 20 months (58% at 10 months). A further 13% had been discharged but readmitted again at both 10 and 20 months. Only 20% of the likely group had not been discharged at all; there had been five deaths. In the possible group 24% had been discharged and 5% discharged and readmitted at 20 months (13% and 4% respectively at 10 months). There were 22 deaths in this group. In the unlikely group only 6% had been discharged and 0.5% discharged and readmitted at 20 months (2% and 0.3% at 10 months). We thought that 257 people would probably leave and 339 possibly leave with 871 remaining. In fact 361 left (59 of whom were readmitted) and 284 died, which left 822 patients who had been inpatients continuously for 20 months from the census. This suggests that only a quarter to a third of the possible group would be likely to leave—that is, unless there were much greater provision of alternative services in the community only the numbers estimated as likely to be discharged would in fact be discharged (tables V and VI).

TABLE VI—Outcome at 20 months according to diagnosis. Figures in parentheses are results at 10 months

Diagnosis	Died		Alive		Total	
	No	%	No	%	No	%
<i>Patients <65 years</i>						
Organic brain syndrome	9 (7)	23 (18)	30 (32)	77 (82)	39	100
All other diagnoses	31 (16)	5 (3)	597 (612)	95 (97)	628	100
Total	40 (23)	6 (3)	627 (644)	94 (97)	667	100
<i>Patients >65 years</i>						
Organic brain syndrome	159 (106)	43 (29)	207 (260)	57 (71)	366	100
All other diagnoses	85 (39)	20 (9)	349 (395)	80 (91)	434	100
Total	244 (145)	30 (18)	556 (655)	70 (82)	800	100

LIFE EXPECTANCY

To estimate future bed requirements for these patients the population expected to survive for given periods was calculated. Patients with organic brain disorders were included in a separate group, as they have a much higher mortality rate in hospital than other patients. For patients with other diagnoses a life table technique was used. Full life tables for England and Wales are calculated for census years only, and the most recently available at the time of the hospital census was that for 1960-2.¹⁴ This table makes it possible to estimate the future size of any population given its age and sex structure. The numbers of patients expected to survive for periods from 5 to 40 years are shown in table VII. Two assumptions must be made: that the age-specific death rates remain constant for the period of projection, and, more seriously, that the death rates for the whole population apply to the population of Tooting Bec Hospital. To take account of the second assumption a second calculation was made in which the death rates were twice those given in the life table. As table VII shows, on this assumption the expected number of survivors after 20 years was reduced by 18% compared with the first calculation; the technique is robust to quite large changes in death rate. Some check on the reliability of these estimates can be made from the number of deaths recorded after 10 and 20 months. Based on normal life expectancy 28 deaths would be expected in 10 months. Fifty-five deaths were recorded in the first 10 months and a further 61 in the next 10 months, which suggested that the numbers of survivors might have been over-estimated using normal life expectancy. There were insufficient data to enable a life table to be estimated specially for these patients but calculation of the number of expected survivors if the probability of death is twice that for the whole population is shown separately in the table, and this does not disagree with the number of deaths at 10 and 20 months.

Among patients with the organic brain syndrome there were 168 deaths at 20 months (113 at 10 months). Of the 365 patients aged 65 or more 159 had died at 20 months (106 at 10 months). Nine of the 39 aged less than 65 had died at 20 months (7 at 10 months). Since we could not obtain age-specific death rates for patients with organic brain syndrome we assumed these to be constant for two groups: those below 65 and those 65 and over, and the actual number of deaths at 10 and 20 months were used to project the possible numbers of deaths up to 10 years (table VIII). Since more survivors might be expected at 10 years calculating from the deaths at 20 months the survivors in this group may have been underestimated, but the numbers were small, and in terms of long-term management this group did not present the same type of problem as other patients.

TABLE VII—Expected number of patients surviving for various intervals of time excluding patients with organic brain syndrome

Likelihood of discharge	Years after census				
	0	5	10	20	40
<i>Expected survivors based on life table No 12</i>					
Likely	244	230	212	168	77
Possible	299	268	233	164	55
Unlikely	519	402	304	162	32
Total	1062	900	749	494	164
<i>Expected survivors if probabilities of death are twice the above</i>					
Likely	244	224	199	147	58
Possible	299	253	210	138	36
Unlikely	519	353	247	118	19
Total	1062	830	656	403	113

TABLE VIII—Expected numbers of patients with organic brain syndrome surviving for various intervals

Year after census:	0	1	2	3	4	5	10
No of expected survivors each year based on death rate at 10 months	405	270	180	121	81	55	8
No of expected survivors each year based on death rate at 20 months	405	304	229	173	131	99	26

PATIENTS REMAINING IN HOSPITAL

Combining the data for the different groups showed that in five years slightly more than 500 of the original census population may possibly have remained continuously in Tooting Bec Hospital, the rest having died or been discharged. The greatest part of this fall in the number of patients will be due to deaths among the present psychogeriatric population. There will then be a period of 20 to 40 years before the remaining patients from the 1973 cohort leave.

Even making the most optimistic assumption (that all "possibles" will be discharged) 118 patients will probably remain in the hospital for the next 20 years and 19 for 40 years. Making more realistic assumptions (that hospital building programmes will be slowly put back and postponed till they disappear into the 21st century and that in a decade of economic crisis, inflation, and reduced local authority budgets there will be little or no increase in the development of community facilities for the mentally ill, which hardly exist at present in inner London) 256 patients will probably remain in the hospital for the next 20 years and 55 for 40 years (even when it is assumed that the death rate of those remaining in hospital is considerably higher than for the rest of the population). Even if one-third of the "possibles" was discharged there would be 210 patients after 20 years and 43 after 40.

Discussion

Wing¹⁵ has estimated that the accumulation of "new long-stay" patients in psychiatric hospitals amounts to at least 50 per 100 000 population and that there are at present 120 per 100 000 population of "old long-stay" patients. Both these sorts of patients will require a protected environment elsewhere if all mental illness is to be treated in acute district general hospital units with 0.5 beds per 1000 population in the future. Our survey has shown that in this teaching district there is no possibility of providing services within the DHSS guidelines as there is no realistic possibility of alternative provisions.

Tooting Bec Hospital has a population that differs from those of other mental hospitals because of past admission policies. There are now more psychogeriatric patients than there will be in the future, and there are many patients in the hospital with severe chronic illness and multiple handicaps. The population can be classified into two groups. One of these is a short-stay group that makes fewer demands on the nursing services in the hospital but makes heavier demands on the rehabilitation and social services. The other larger group is of long-stay patients. Most of these have schizophrenia, organic brain syndrome, or affective illness. Many are elderly and suffer from coexistent physical disorders. They make much heavier demands on the nursing services but fewer on the social services than the short-stay group. Many are severely handicapped and are most unlikely to be discharged.

In discussing the setting up of units in district general hospitals and the concurrent run down of mental hospitals the DHSS has stated¹:

"When all the new general hospital departments to serve the area are in operation and only a comparatively small number of patients remain in the mental hospital, it should become possible to close the mental hospital by transferring these remaining patients to other appropriate hospitals. Some patients might be transferred to mental hospitals whose closure programme is less advanced, while others, for whom more general care would be suitable, might be transferred to hospitals serving local communities. So far as possible, patients should be transferred to hospitals close to their homes."

Tooting Bec is a hospital that has already had a number of long-stay chronically ill patients transferred to it from other hospitals.

The ill effects of discharging patients "into the community" when there are no community facilities have been commented on by Rollin¹⁶:

"If the emphasis for the care of chronic psychotics is to be shifted from the mental hospitals to the community, then "community care" must be something more than a hollow catch phrase. If hostels . . . are to be the answer . . . then there must be many more of them. The ever increasing number of cases remanded in custody for psychiatric report is evidence that the remand prisons are subserving the function of the former observation wards."

In the circumstances it seems wiser to accept the lack of alternative accommodation and consider how present mental hospitals could be upgraded to provide continuing and better care in the reorganised Health Service, rather than hope that they will eventually wither away. This hope seems to have relied too much on wishful thinking and too little on evidence. It would be more realistic to accept that chronic handicaps, including chronic mental illness, will continue and that in considering priorities in future it might be better to concentrate on improving needed facilities rather than using scarce resources on unproved but expensive areas of medicine.

The medical model that if people with mental illness were all treated in general hospitals they would get better is a myth. To assume that people with mental illness would get better if they were treated in general hospitals is obviously nonsense. Their prognosis depends, apart from other factors, on the quality of the staff and the resources available, and not on the type of hospital. Some mental illness is not curable, though all mentally ill patients can be helped to a limited extent with symptomatic treatment and management. Some illnesses produce lifetime incapacity. Mental hospitals provide asylum as well as treatment and look after people who may otherwise be neglected. Some people will require permanent care, help, and treatment, whether at home, in a community hostel or in hospital. If funds are short and there is no likelihood of expansion of community facilities this should be accepted in planning.

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Identification and definition of long-stay mental hospital population

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Summary

In a study to identify and define a central group of long-stay psychiatric patients who are resistant to discharge 422 were found who had been in hospital for eight to 23 years. These "problem" patients represented 40% of all long-stay patients. The total number of years that they had spent in hospital was nearly double that of the remaining patients. They were mostly unvisited, unoccupied, and single, and most were suffering from schizophrenia or organic psychosis. Half were in a good or reasonably good state of mental health, and three-quarters were in a good or reasonably good state of physical health. The findings have implications for the rehabilitation and treatment of these patients and also for the provision of community aftercare facilities.

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Introduction

With the plan to run down and eventually close the large mental hospitals in England and Wales and provide treatment in modern psychiatric units in general hospitals,¹ what to do with the 60 000 long-stay patients still in the mental hospitals remained a problem. We believe that within every population of long-stay psychiatric patients there is a group that presents special problems of rehabilitation and discharge. Furthermore, we believe that the existence of such "problem" groups is the main factor in maintaining the stability of long-stay populations in mental hospitals.

Our aim, therefore, was, firstly, to identify the problem group at Tooting Bec Hospital, and, secondly, to define its demographic and clinical characteristics, with the hope that the possibilities for rehabilitation would be enhanced.

Present study

POPULATION

Tooting Bec Hospital is a large mental hospital for psychiatric illnesses of all kinds except those in which the basic problem is subnormality of intelligence. During the period of study a total of 1292 inpatients were being treated. Physical and psychotherapeutic methods of treatment are used but the emphasis is on physical methods, such as psychotropic drugs and electric convulsion therapy.