ORIGINAL ARTICLE

Incidence of mental retardation as compared with other psychiatric disorders and necessary support to persons placed at the Public Institution for Placement of Persons with Mental Disabilities „Drin“ Fojnica, Bosnia and Herzegovina

Edin Bjelošević[1], Amar Karahmet[2], Halima Hadžikapetanović[1], Sonja Bjelošević[1]

[1]Mental Health Center, Health Center Zenica, [2]Public Institution for Placement of Persons with Mental Disabilities „Drin“, Fojnica; Bosnia and Herzegovina

ABSTRACT

Aim To compare the frequency of mental retardation with other psychiatric disorders at the Institute for Mentally Disabled Persons „Drin“ Fojnica, Bosnia and Herzegovina, to asses psychosocial condition and necessary support to persons with mental retardation.

Methods In this retrospective, descriptive and epidemiologic study neuropsychiatric findings and reports of the Institute's social services of 527 residents (beneficiaries) were analyzed in the period 2013-2014 (age, gender, mobility, years of life spent in the Institute, visits of family members and close relatives, visits to families, mental retardation – degree, required support).

Results The research included 213 (40.42%) women and 314 (59.58%) men. The average age was 39.64 years. The average number of years spent in the Institute was 10.42.Fifty-four (25.47%) examinees with mental retardation had occasional visits to their families, while 69 (32.54%) had regular visits. Thirty-four (16.04%) examinees had mild mental retardation, 70 (33.02%) had moderate retardation, 52 (24.52%) were with severe, and 56 (26.42%) with profound retardation. It was found that 66 (31.13%) beneficiaries with the diagnosis of mental retardation completely depended on other persons.

Conclusion The degree of mental retardation has a direct impact on the process of resocialization. A very small number of people diagnosed with mental retardation had been successfully involved in the process of resocialization. It is necessary work intensively on thecreation of conditions for the realization of the Independent Living Support program, thus making a step forward to deinstitutionalization.

Keywords: support, rehabilitation, psychosis

Corresponding author:
Edin Bjelošević
Mental Health Center, Health Center Zenica
Fra Ivana Jukića 2, 72000 Zenica,
Bosnia and Herzegovina
Phone: +387 32 444 411;
Fax: +387 32 242 113;
E-mail: vedin@bih.net.ba

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INTRODUCTION

The World Health Organization describes mental health as a state of wellbeing in which every person realizes its own potential and can face the normal stress of life, work productively and is capable of contributing to his/her community. Health is both physical and mental wellbeing rather than mere absence of a disease (1).

Mental retardation includes below-average intellectual functioning with significant limitation of adaptive functioning, which occurs before the age of 18 (2). According to the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-X) (3), mental retardation is defined as a condition of delayed or incomplete development of the mind characterized by impairment of skills contributing to overall development of intelligence, i.e. reasoning, speech, motor control and social contacts demonstrated during the development. Mental retardation is dividedto four sub-categories (3): mild mental retardation (IQ 50 - 70), moderate mental retardation (IQ 35 - 49), severe mental retardation (IQ 20 – 34), and profound mental retardation (IQ is below 20 (3). In the next revision, ICD-11, it is expected that the term mental retardation will be replaced either by the term intellectual disability or intellectual developmental disorder, which are already used by the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (Fifth ed.)*(DSM-5) (2,4).

Intellectual disability affects around 1-3% of the general population (5,6). Global developmental delay (GDD) occurs in psychomotor development of 3% of children under the age of 5 and is defined as developmental disorder with a delay in two or more developmental areas: gross or fine motor skills, speech, cognition (cognitive processes), social functioning and everyday activities (7). Around 75-90% of persons with intellectual difficulties have mild intellectual disability. Approximately one quarter of cases is caused by a genetic disorder (8). Due to high incidence of physical and mental comorbidity with intellectual disability, suchpersons require more attention than mere health care services and have a higher need for resources in health care than persons from the general population (9). Persons with intellectual disability need equal access to health care without any discrimination based on their disability. Without adequate health care, medical problems of persons with intellectual disability often remain unrecognized (10). Even when they are identified, such problems are often insufficiently or inadequately addressed (11,12). Such differences among persons with intellectual disability in general population significantly increase the risk for treatment of the disease and may lead to early death (13). Stigma may be a key factor for failure to ask for assistance and has a negative impact on seeking assistance. Facing and prevention of stigma and discrimination should be integral parts of a support process to all persons with mental disorders, particularly children and young people (14). Persons with intellectual disability often have poor access to medical services and their treatment involves very high costs for the health care system and the entire society (15-17). Despite those facts persons with intellectual disability are mostlyneglected in the field of mental health, where specialized services are limited. Such specialized services can be provided mainly in countries with high income, primarily western countries (18,19).

The war in Bosnia and Herzegovinacaused serious suffering of the population and led to devastation of psychosocial institutions, therefore, a small number of psychosocial institutions has remained operational, the Public Institute for Placement of Persons with Mental Disability “Drin” Fojnica being among them. It also accommodates patients with psychiatric disorders and provides them with psychological, social and medical support in addition to persons with mental retardation, who were its original beneficiaries.

The aim of this retrospective study was to investigate frequency of mental retardation in comparison with other psychiatric disorders at the Public Institute for Placement of Persons with Mental Disabilities „Drin“ Fojnica, Bosnia and Herzegovina (B&H), in the period 2013-2014 to asses psychosocial condition and necessary support for persons diagnosed with mental retardation depending on a degree of mental retardation.

The research will provide guidelines for the protection and promotion of mental health of persons placed in psychosocial institutions.

EXAMINEES AND METHODS

Design of the study and sample

In this retrospective, descriptive and epidemiological research using available data from medical records of 527 beneficiaries of the Public Institute for Persons with Mental Disorders (experimental group) „Drin" Fojnica, B&H,of whom 212 were with the diagnosis of mental retardation and 315 with the diagnosis of other mental diseases (control group) (psychosis,schizophrenia-SCH, persistent delusional disorder, bipolar affective disorder, surdomutism, dementia, epileptic psychosis, alcoholic paranoia, cerebral paralysis, organic delusion, autism, Down syndrome), neuropsychiatric findings and reports of the Social Services of the Institute were analyzed in the period 2013-2014. The analysis included: age, gender,mobility, years of life spent in the Institute, visits of family members and close relatives, visits to families, education, marital status, degree of mental retardation (mild mental retardation: IQ 50-70, moderate mental retardation: IQ 35-49), severe mental retardation: IQ 20–34), and profound mental retardation: IQ below 20), psychiatric diseases,psychosocial support including rehabilitation, which supports the development of cognitive, functional, communication or social skills of beneficiaries (taken by a psychologist, social worker, work therapist and professional staff in order to preserve remaining skills or develop group cohesion), required support (occasional support in some situations, permanent support of lower intensity, permanent support of higher intensity, complete dependence on others), and type of therapy (pharmacotherapy, occupational, work, music and physical therapy).

The research was approved by the Faculty of the School of Health Care, University in Zenica.

Statistical analysis

Standard methods of descriptive statistics, t-test and χ^2-test were used for testing statistical significance of the relationship of mental retardation with other mental diseases, according togender, age, education level, marital status, type of support, type of therapy, visiting home and visits by relatives, duration of stay and influence of a retardation degree on rehabilitation. The $p<0.05$ was considered as statistically significant.

RESULTS

This research included 527 examinees, of which 213 (40.42%) were females and 314 (59.58%) were males ($p< 0.01$). Of the 527 beneficiaries, 212(40.23%) were persons with the diagnosis of mental retardation, of whom 129 (60.85%) were males and 83 (39.15%) females; 315(59.77%) had the diagnosis of other psychiatric diseases, 185 (58.73%) of them were males and 130 (41.17%) females. Of all registered beneficiaries with mental retardation, 34 (16.04%) had the diagnosis of mild mental retardation, 70 (33.02%) beneficiaries with the diagnosis of moderate mental retardation, 56 (26.41%) beneficiaries with the diagnosis of severe mental retardation, 52 (24.53%) beneficiaries with the diagnosis of profound mental retardation (Table 1). Out of the total number of beneficiaries, in addition to mental retardation, the highest number had the SCH diagnosis, 212 (67.30%), followed by psychosis in 47 (14.92%) beneficiaries (data have not shown).

Table 1. Gender distribution of beneficiaries according to psychiatric disorders

	No (%) of beneficiaries with							
	Mental retardation			Other psychiatric disorders*			Total	p
Gender	Males	Females	Total	Males	Females	Total		
	129 (62.6)	83 (37.4)	212 (100)	185 (58.7)	130 (41.3)	315 (100)	527 (100)	p<0.01
Degree of mental retardation								
Mild	19 (14.73)	15 (18.07)	34 (16.04)					
Moderate	47 (36.43)	23 (27.71)	70 (33.02)					
Severe	34 (36.36)	22 (26.51)	56 (26.41)					
Profound	29 (22.48)	23 (27.71)	52 (24.53)					

*Psychosis, SCH, persistent delusional disorder, bipolar affective disorder, surdomutism, dementia, epileptic psychosis, alcoholic paranoia, cerebral paralysis, organic delusion, autism, Down syndrome

The highest number of examinees with mental retardation was aged d 31-40 years, 64 (30.19%), and 19-30 years, 45 (21.22), while those with the diagnosis of other psychiatric diseases were aged 51-60 years, 97 (30.80%) and 41-50 years, 86 (23.30%) (Table 2).

The highest number of examinees with the diagnosis of mental retardation had no education, 179 (85.24%), while the highest number of examinees with the diagnosis of other psychiatric diseases had secondary school education,164 (52.06) (Table 2).

Table 2. Demographic characteristicsof beneficiaries

Age (years)	No (%) of beneficiaries with Mental retardation	Other psychiatricdisorders*	Total
0-18	9 (13.68)	4 (1.27)	33 (6.26)
19-30	45 (21.22)	19 (6.03)	64 (12.14)
31-40	64 (30.19)	41 (13.02)	105 (19.92)
41-50	39 (18.40)	86 (23.30)	125 (23.72)
51-60	20 (9.43)	97 (30.80)	117 (20.88)
61 and more	15 (7.07)	68 (21.58)	83 (15.74)
Education			
No any	179 (85.24)	70 (22.22)	249 (47.20)
Primary school	30 (14.15)	68 (21.59)	98 (18.60)
Secondary school	3 (1.41)	164 (52.06)	167 (31.68)
High school	0	10 (3.17)	10 (1.90)
University education	0	3 (0.95)	3 (0.6)
Marital status			
Married	0	20 (6.34)	20 (3.83)
Not married	207 (97.64)	163 (51.75)	370 (70.20)
Divorced	2 (0.94)	83 (26.35)	85 (16.13)
Widow(er)	3 (1.42)	49 (15.56)	52 (9.84)

The highest number of examinees from both groups were not married 370 (70.22%) (Table 2).

The highestnumber of beneficiaries, 216 (40.99%), had stayed in the Institute for 6-10 years, of whom 71 (33.49%) with the diagnosis of mental retardation and 145 (46.03%) with the diagnosis of other psychiatricdiseases (Table 3).

The highest number of the examinees, regardless of their basic disease, needed continuous assistance of lower intensity, 69 (32.55%) examinees with mental retardation and 141 (44.76%) examinees with other psychiatric diseases ($p < 0.05$). Persons with mild and moderate mental retardation primarily demonstrated the need for occasional assistance in some situations, 30 (14.15%), or with permanent support of lower intensity, 69 (32.55%), while persons with severe and profound mental retardation primarily needed continuous support of higher intensity, 47 (22.17%), or they were completely dependent on others, 66 (31.13%) ($p<0.01$) (Table 3).

There was a statistically significant difference in the type of therapy applied to the group of examinees with mental retardation as compared with the group of examinees suffering from other diseases ($p<0.01$). Although all examinees from both groups received certain pharmacotherapy, yet in the group of examinees with mental retardation there was a significantly higher percentage of those who get other therapeutic techniques in addition to pharmacotherapy (primarily physical therapy and occupational and music therapy), while in the group of examinees with other diseases, occupationaltherapy is mostly applied in addition to pharmacotherapy (Table 3).

Visits of relatives did not have any statistical significance in terms of determining the intensity of the need for psychosocial support at the Institute ($p>0.05$). There was a statistically significant difference in the intensity of necessary psychosocial support to the examinees in relation to visits to the family ($p< 0.01$). Periodic visits to their primary family have proved to be a significant positive factor in the process of resocialization (Table 3).

Table 3.Types of psychosocial support

Duration of stay in the Institute (years)	No (%) of beneficiaries with Mental retardation	Other psychiatricdisorders*	Total	p
0-5	37 (17.45)	92 (29.21)	129 (24.48)	
6-10	71 (33.49)	145 (46.03)	216 (40.99)	
11-15	22 (10.38)	44 (13.97)	66 (12.52)	
16-20	33 (15.57)	14 (4.44)	47 (8.92)	
21-25	19 (8.96)	7 (2.22)	26 (4.93)	
26-30	16 (7.55)	6 (1.90)	22 (4.17)	
>30	14 (6.60)	7 (2.22)	21 (3.98)	
Intensity of support				
Occasional support in some situations	30 (14.15)	86 (27.30)	116 (22.01)	< 0.01
Permanent support of lower intensity	69 (32.55)	141 (44.76)	210 (39.85)	< 0.05
Permanent support of higher intensity	47 (22.17)	63 (20.00)	110 (20.87)	
Completely dependent on others	66 (33.13)	25 (7.94)	91 (17.27)	
Type of therapy				
Pharmacotherapy	212 (100.00)	315 (100.00)	527 (100.00)	<0.001
Occupational	33 (45.56)	37 (11.74)	70 (13.28)	
Work	14 (6.60)	47 (14.92)	61(11.57)	
Physical	24 (11.32)	9 (2.86)	33 (6.26)	
Music	27 (12.73)	2 (0,63)	29 (5.50)	
Visits of relatives				
YES	69 (32.54)	66 (20.95)	135 (25.61)	>0.05
NO	143 (67.46)	249 (79.05)	392 (74.39)	
Visiting home				
YES	20 (9.43)	37 (11.74)	57 (10.81)	< 0.01
NO	192 (90.57)	278 (88.26)	470 (89.19)	

DISSCUSSION

The research included 527 beneficiaries placed in the Public Institute for Mentally Disabled Persons „Drin“ Fojnica, B&H, of whom 40.23 %were with mental retardation and 59.77 %with other mental diseases. A large percent of beneficiaries (77.11) with other mental diseases has

beenfoundin another institution in B&H(the Institute for Placement of Persons with Mental Disabilities "Bakovici", Fojnica; Nada Sušić-Sijerčić, personal communication, 2015). Such a ratio of beneficiaries could be expected because the number of psychosocial institutions for placement of persons with psychiatric disorders other than mental retardation has decreased in B&H, so they are placed in institutions intended for placement of persons with mental retardation. Studies conducted worldwide have shown that mentally retarded persons are accommodated more often in apartments for independent living with the control of relevant services (20,21).

The highest number of beneficiaries with mental retardation was below30 years of age(34.90%) and 31-40 years (30.19%). Such an age structure corresponds to the studies indicating that life expectancy of mentally retarded persons is shorter than in healthy persons (13).Life expectancy of persons with mental retardation is shorter than in general population (22) (average age was 39.64 years).

Male/female structure of beneficiaries from this study(54.82 vs 44.88%) was similar tothe gender breakdown of the Institute for Placement of Persons with Mental Disabilities "Bakovici", Fojnica, B&H (Nada Sušić-Sijerčić, personal communication, 2015), similarly as in other studies conducted worldwide (22).

According to the results of this study, average years of beneficiaries spent at the Institute was 10.42 years.Long-term placement raises concerns from the professional-psychiatric, ethical and legal aspect. Stigmatization prevents natural resocialization of persons with mental retardation, which affects the course of the therapeutic process (14).

The results of this research have shown that 82.54% of persons with mental retardationwerecapable moving withinthe Institute's area, 6.13% persons were with difficult movement, 11.32% persons were unable to move. Persons with deep mental retardation have serious limitations in communication and mobility and they need permanent assistance and care (3). Profound mental retardation is connected with decreased life expectancy, particularly those who are unable to move (22).

According to records on visits to families, 9.43% examinees with mental retardation occasionally went to their families, while 90.57 examinees did not go to their families. The examinees who occasionally visited their families had a statistically significantly less need for psychosocial support during their stay at the Institute regardless of their basic disease. Occasional visits to primary family have proved to be a significant positive factor in the process of resocialization(20).

Based on the assessment of psychosocial condition and required support in this report it has been proven that persons with mild and moderate mental retardation demonstrate primarily the need for occasional support in some situations (14.15%) or continuous support of lower intensity (32.55%), while persons with severe and profound mental retardation primarily show the need for permanent support of higher intensity (22.17%) or they are completely dependent on others (31.13%). The examinees with lower degree of mental retardation also need a lower intensity of psychosocial support – the level of necessary support is proportional to the level of mental retardation of the examinees – that link (correlation) is significant (3).

Deinstitutionalization of services for persons with mental retardation has come into the focus of disability policy in many countries. The new policy includes integration, equality and deinstitutionalization (20). In most cases studies support this strategy (21).Within the mental health reform in B&H, the Federation of B&H has started a project of mental health in the community (23).After the implementation of the program of enabling persons with mental retardation inB&H to live in the community, with the aim of their true inclusion in the local community, ten beneficiaries from this study moved into houses rented by the Institute in its vicinity. Allof them have continued their life in the community with the assistance of employees of the "Drin" Institute. Out of those ten beneficiaries, six have the diagnosis of moderate mental retardation, while four beneficiaries are diagnosed with mild mental retardation suggestingthat a very low number of persons with mental retardation have been successfully included in the process of resocialization. Persons accommodated in apartmentsliving with the support of a community improve their skills, social interaction and general quality of life (20). Following new trends at the territory of the municipality of Zenica, ahumanitarian or-

ganization providedaccommodation (housing) for persons with mental retardation where they receive coordinated care.

In conclusion, the resocialization process is affected by many factors, ranging from the deinstitutionalization process to stigmatization of persons with mental retardation by the society. It is necessary to work intensively on the implementation of projects related to the construction of new accommodation capacities and accessory facilities, which should become functional in terms of creating conditions for the implementation of the project of independent living with support, thus making a step forward to deinstitutionalization in order to adopt modern European trends and solutions in this field of social life. It is essential to ensure humanization of housing and living for persons placed at the Institute. Activities supporting persons with intellectual disabilities should be expanded.

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Conflict of interest: None to declare.

REFERENCES

1. Anonymous. The World Health Report 2001. Mental Health: New understanding, New Hope. World Health Organization, 2001.http://www.Who.int/whr/2001/en/ (02 October 2015)
2. Anonymous. American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (5th ed.). Arlington, VA: American Psychiatric Publishing, 2013.
3. Svjetskazdravstvenaorganizacija. MKB-10 –Međunarodnaklasifikacijabolestisrodnihzdravstvenihproblema. Desetarevizija. Svezak 1. Prijevod: Hrvatskizavodzajavnozdravstvo. Zagreb: Medicinskanaklada,1994.
4. Carulla LS, Reed M G, Vaez-azizi M L, Cooper S A,Leal R M, Bertelli M, Adnams C, Cooray S, Shoumitro D, Dirani L A, Girimaj S C, Katz G, Kwok H, Luckasson R, Simeonsson R, Walsh K, MunirK, Saxena S. Intellectual developmental disorders: towards a new name, definition and framework for "mental retardation / intellectual disability" in ICD-11. World Psychiatry 2011; 10:175-80.
5. Bradley EA, Thompson A, Bryson SE. Mental retardation in teenagers: prevalence data from the Niagara region, Ontario. Can J Psychiatry 2002; 47:652-9.
6. Leonard H, Wen X. The epidemiology of mental retardation: challenges and opportunities in the new millennium. Ment Retard Dev Disabil Res Rev 2002; 8:117-34.
7. Shevell M, Ashwal S, Donley D. Practice parameter: evaluation of the child with global developmental delay. Neurology 2003; 60: 367-80.
8. Daily DK, Ardinger HH, Holmes GE. Identification and evaluation of mental retardation. Am Fam Physician 2000; 61:1059-67.
9. Polder JJ, Meerding WJ, Bonneux L, van der Maas PJ. Healthcare costs of intellectual disability in the Netherlands: a cost-of-illness perspective. J Intellect Disabil Res 2002; 46:168-78.
10. US Department of Health and Human Services. Closing the Gap: ANationalBlueprint to improve the Health of Persons with Mental Retardation. Washington, DC: US Department of Health and Human Services, 2002. http://www.surgeongeneral.gov/topics/mentalretardation/(10 February 2016).
11. Ouellette-Kuntz H, Garcin N, Lewis MES, Minnes P, Martin C, Holden JJA. Addressing health disparities through promoting equity for individuals with intellectual disability. Can J Public Health 2005; 96:8-22.
12. Beange H, McElduff A, Baker W. Medical disorders of adults with mental retardation: a population study. Am J Ment Retard 1995; 99:595-604.
13. Fisher K. Health disparities and mental retardation. J NursScholarsh 2004; 36:48–53.
14. Clement S, Schauman O, Graham T, Maggioni F, Evans-Lacko S, Bezborodovs N, Morgan C, Rüsch N, Brown JS, Thornicroft G. What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. Psychol Med 2015; 45:11-27.
15. Beange H. Caring for a vulnerable population: Who will take responsibility for those getting a raw deal from the health care system? MedJ Aust1996; 164:159-60.
16. Eastgate G, Lennox NG. Primary health care for adults with intellectual disability.
17. AustFam Physician 2003; 32:330-33.
18. Ben-Shlomo Y, Kuh D. A life course approach to chronic disease epidemiology: conceptual models, empirical challenges and interdisciplinary perspectives.Int J Epidemiol 2002; 32:285-93.
19. Braveman P. Health disparities and health equity: Concepts and measurement. Annu Rev Public Health 2006; 27:176-94.
20. Braveman P, Gruskin S. Defining equity in health. J Epidemiol Community Health2003; 57:254-58.
21. Mansell J. Deinstitutionalization and community living: Progress, problems and priorities. J Intellect Dev Disabil 2006; 31:65-76.
22. Molony H, Taplin J. Deinstitutionalization of people with developmental disability.Australia and New Zealand Journal of Developmental Disabilities2009; 109-22.
23. Eyman RK, Grossman HJ, Chaney RH, Call TL.The Life Expectancy of Profoundly Handicapped People with Mental Retardation. N Engl J Med 1990; 323:584-89
24. Čerkez G, Latinović M, Kapetanović T, Puratić V. Mental health in South-Eastern Europe. Med Arhiv 2007; 61:49.

Učestalost mentalne retardacije u odnosu na druge psihijatrijske poremećaje i potrebna podrška kod osoba smještenih u Zavodu za zbrinjavanje mentalno invalidnih lica „Drin“ Fojnica u Bosni i Hercegovini

Edin Bjelošević[1], Amar Karahmet[2], Halima Hadžikapetanović[1], Sonja Bjelošević[1]

[1]Centar zamentalnozdravlje, JU Dom zdravljaZenica; [2]JU Zavodzazbrinjavanje mentalnoinvalidnihlica „Drin“, Fojnica; Bosna i Hercegovina

SAŽETAK

Cilj Uporediti učestalost mentalne retardacije s drugim psihijatrijskim poremećajima u Zavodu za zbrinjavanje mentalno invalidnih lica „Drin“ u Fojnici te utvrditi procjenu psihosocijalnog stanja i podrške potrebne osobama s dijagnozom mentalne retardacije.

Metode U ovom retrospektivnom, deskriptivnom i epidemiološkom istraživanju analizirani su neuropsihijatrijski nalazi i podaci dobiveni iz izvještaja Socijalne službe Zavoda (starosna dob, spol, pokretljivost, godine provedene u Zavodu, posjete članova porodice i bliskih srodnika, posjete porodici, stepen mentalne retardacije i potrebna podrška) za 527 osoba (korisnika) smještenih u periodu od 2013. do 2014. godine.

Rezultati Istraživanje je obuhvatilo 213 (40,42%) žena i 314 (59,58%) muškaraca. Prosječna dob ispitanika bila je 39,64 godina. Prosječan broj godina provedenih u Zavodu je 10,42. Pedeset i četiri (25,47%) ispitanika s mentalnom retardacijom imala su povremene posjete obitelji, a 69 (32,54%) je imalo redovne posjete. Trideset i četiri (16,04%) ispitanika imalo je blagu mentalnu retardaciju, 70 (33,02%) umjerenu, 52 (24,52%) tešku, a 56 (26,42%) duboku. Utvrđeno je da 66 (31,13%) korisnika s dijagnozom mentalne retardacije u potpunosti ovise o drugim osobama.

Zaključak Stepen mentalne retardacije ima direktan utjecaj na proces resocijalizacije. Veoma se mali broj osoba s dijagnozom mentalne retardacije uspješno uključuje u pomenuti proces. Potrebno je intenzivno raditi na realizaciji projekata vezanih za izgradnju novih smještajnih i pratećih objekata, koji bi trebali da profunkcioniraju u smislu stvaranja pretpostavki za realizaciju projekta „Samostalno stanovanje uz podršku“, te tako načiniti korak ka deinstitucionalizaciji.

Ključne riječi: podrška, rehabilitacija, psihoza