Psychiatric Bulletin (1992), **16**, 431–432

Rehabilitation in a district general hospital

W. T. ASTRID MADDOCKS, Associate Specialist; and PETER D. MADDOCKS, Consultant Psychiatrist, Wexham Park Hospital, Slough SL2 4HL

The Psychiatric Unit at Wexham Park Hospital has served a population of 230,000 with no entry to long-stay beds since 1972. There have been between 45 and 60 available beds for all types of mental illness except dementia. Various group homes and unstaffed half-way houses have been started, but the accumulation of more disabled patients showed the need for both a staffed group home, and rehabilitation to fit them for it. There was no separate ward or building in the hospital which could be used, and so rehabilitation had to be arranged on an acute ward. The staffed group home has a lower staff-patient ratio than a hospital hostel.

Four beds on one ward were allocated for a rehabilitation group which would have a separate kitchen and lounge. It was intended that the patients should work together in procuring, preparing and eating their own food; that they should be responsible for the cleaning of their own areas and have a separate programme of activities. There would be a regular medical review of patients, in an informal way, creating a more normal pattern of discussion and advice. When able, the patients should also self medicate under supervision.

It was planned that the rehabilitation team should have two designated nurses of whom one should be trained, a quarter to one half the time of an occupational therapist and regular social work input. It was agreed that the patients should be looked after by one medical team during their time on the programme, although they might come from six medical teams in the district, and would revert to the original team afterwards. The project was planned and is overseen by a Multidisciplinary Rehabilitation Committee which meets about every six weeks. It has now been running for six years.

At the end of the 13 years from 1972 to 1985 only three in-patients had spent more than one year continuously in hospital, but a number of patients had had many admissions and some had spent years in other hospitals.

Any patient who was thought likely to benefit was considered, the only requirement being some spark of motivation. In all, 46 patients were interviewed, 42 came onto the programme, only four declined. Most had had a long illness, only 9 had been ill for a year or less. The 42 patients had totalled 121 admissions and the average length of illness was 9.3 years. There were 26 men and 16 women, the average age being 33.9 years, ranging from 18 to 70, but three quarters were under 45 years of age. Initially all patients were transferred from an acute bed but later on, as the programme appeared successful some patients were brought into hospital for rehabilitation from their own, or parental homes, where they were managing poorly or had become "institutionalised" within the community. In total, 34 patients were transferred to the rehabilitation group from an acute bed, and 8 from the community. They spent an average of six months in the group, the longest being two years.

Of the 42, 10 went out to their own homes, 17 went to various types of sheltered accommodation, 5 went to a relative's, usually a parental home, 7 did not succeed and were transferred back to an ordinary bed or failed in their placement and returned to hospital; 3 are continuing rehabilitation.

Of the 32 patients now living outside hospital, 6 are working, 24 have not been readmitted, 8 have had 11 admissions between them but these have been short, and they have returned to their own homes. A few of the more able patients have been able to start a training course, or obtain voluntary or part-time work while in the rehabilitation group, and this has eased the transition to living in the community.

The decision to give a trial to anyone who showed even minimal interest meant that there were bound to be failures as the difficulties of self-discipline, persistence and working with others became apparent. However, it was a matter of satisfaction to find how many people did manage to improve with consistent and caring advice, firmness and encouragement; and the success of an individual in overcoming problems was often respected and appreciated by other group members. Illness and inability, unless disabling were accepted, although two became more unwell with the responsibility and the increased pressure that it entailed.

The solution devised is not ideal but it is reasonably effective and inexpensive. We found that in order to run rehabilitation in an acute ward there are various essential components.

(a) The group must have its own territory from which other patients are excluded unless invited; this is not easy on a ward with disturbed patients.

(b) It is necessary to have designated nursing staff, but the pull from the acute side is difficult to resist when staffing is short and there are particularly acute cases. The personalities of the staff are as important as their qualifications.
(c) A budget is essential; initially the patient would "shop" from the hospital stores for their weekly shopping but this was not adequate. Now there is a budget which is held by the nurse, but the patients plan their meals for the week and then buy from the supermarket. The team is allowed a budget of up to £4,500 per year, half of which comes from the catering budget. The sum of £15 per person per week was allocated for food and this appeared realistic in relation to the Social Security Benefit likely to be received.
(d) The small size of the group, rarely more than four, allows no one to get lost and appears to enhance cohesiveness, mutual support and personal growth. It can be encouraging to see the development of warmth, kindness and humour in people who had apparently little interest in others before.
(e) Occasional treats such as a meal in a restaurant, or other outing, is regarded as educative, both in learning, budgeting for it and in social behaviour. Visiting an ex-patient's social club is an activity which can be continued after discharge, and many patients continue to see each other in unofficial self-help groups offering support and friendship.
(f) Occupational therapist's time is essential, as is social worker help with placement.

Ultimately rehabilitation is only as good as the aftercare and, while some patients need sheltered group living, others are better living alone. We are very fortunate that Slough Council is sympathetic to the long-term mentally ill and will rehouse them in single person accommodation. There are several staffed group homes, and unstaffed half way houses and group homes are in our area, some of which are jointly managed by a voluntary organisation, Social Services and Health. A network of care has been built up which consists of monitoring by general practitioners and in out-patient clinics, support from community psychiatric nurses and social workers, social interaction in day centres and befriending by volunteer workers and with good communication between all of these. When no better facilities are available, it is possible to rehabilitate people successfully from an acute ward in a District General Hospital.

Psychiatric Bulletin (1992), **16**, 432–434

Sketches from the history of psychiatry

Quite sane: the true syndrome of Baron Munchausen; and a case report of Ophthalmic Munchausen syndrome

ANDREW J. MCBRIDE, Consultant Psychiatrist, CDT, Llwyn Yr Eos Clinic, Church Village, Mid Glamorgan CF38 1RN

Since Asher's original christening of Munchausen's syndrome, (Asher, 1951) many different clinical presentations have been described, including the abdominal, by proxy, dermatological, neurological, psychiatric and pyrexial variants (Blackwell, 1968). By contrast, virtually no attention has been paid to the medical history of Raspe's eponymous hero (Raspe, 1775), some authors suggesting that this was not recorded (Wingate, 1951; Sjoberg, 1951). While the fictional Baron's supposed memoirs are unreliable, sketchy and recorded by different hands, they do shed some light upon his health and attitude to physicians.

Outlined below is the recorded medical history of the fictional Baron Munchausen. A case of Ophthalmic Munchausen's syndrome, which shares some features of the Baron's story is reported for the first time.

Quotations and page numbers, shown in square brackets [], are from Carswell (1948), whose scholarly return to the earliest editions provides an invaluable corrective to other modern editions which are usually selective and confused.