Psychiatric Step-Down Care: Racing with Turtles?

By Dr Lim Boon Leng, Editorial Board Member

"Slow medicine" should not just connote a slowing of tempo in the treatment for the individual, but recognition that the needs are distinctly different during these differing phases of the illness process.

Mr X has chronic schizophrenia. He has no family. For the last ten years, he has been taking his antipsychotic medications religiously. One seemingly normal morning, he felt weak on one side of his body while mopping the floor of his flat and fell to the floor. Luckily for him, he had left his front door open and a passerby called for an ambulance. No one would have noticed otherwise.

Mr X was warded in a general hospital and he was told that he had a stroke. After a week, he was still having difficulties in walking independently. He was surprised when he was told that he could be discharged and would be transferred to the "mental hospital". After all, he was last admitted to the Institute of Mental Health ten years ago. During the morning round the next day, the psychiatrists attending to him appeared equally confused about his admission when they realised that he was in remission for schizophrenia and had no psychotic symptoms. Mr X did not quite understand what they meant when he overheard them lamenting that he was a social admission. He continued to stay for another three months, slowly recovering his strength before he was eventually discharged at his insistence.

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The recent National Day Rally was an interesting one for me. Prime Minister Lee Hsien Loong talked about "fast medicine" in an acute setting where patients are provided intensive treatment, and subsequently transferred to a community hospital where "slow medicine" and rehabilitation are provided for individuals who are not quite ready to go home. Such a concept appeals to me. While we hope to deliver intensive treatment in the acute psychiatric wards to patients with acute psychological break downs but in reality, step-down care or "slow medicine" is limited in the psychiatric speciality, and acute psychiatric wards end up having to attend to a mixed bag of patients, fast or slow.

Where psychiatric care per se is concerned, step-down facilities include inpatient rehabilitation wards, clubhouse rehabilitation centres and psychiatrically-themed nursing homes. These centres are often poorly integrated with the acute settings, conducting their independent assessments for the acceptance of psychiatric patients into their facilities. Opinions of referring psychiatrists are limited to filling of referral forms, and the referring psychiatrists who are likely to be in the best position to comment on the needs of the patients have little say in the acceptance process. Weeks and indeed months may pass as these centres consider (and reconsider) the referrals and repeatedly interview the patients, hoping to cherry-pick those most likely to fulfill their desired outcomes and key performance indicators. When patients are accepted, more than a handful are found unsuitable and u-turned back to the acute wards. Mostly, adjustment problems with behavioural difficulties are to blame, though a change in setting can sometimes exacerbate psychiatric conditions.

Consequently, acute psychiatric wards have to double up to provide step-down programmes. Sometimes this is out of necessity as once admitted, discharging patients to step-down facilities or back to their own homes is often a challenging task. Yet, early rehabilitation is necessary to prevent institutionalisation and dependency, much like how physiotherapy is crucial in preventing muscle weakening in bed ridden patients. Mental weakening and institutionalisation may occur as quickly, if not quicker than physical de-conditioning, particularly in our vulnerable population.

To make matters worse, long-term stay in a psychiatric hospital continues to be regarded by many as the only reasonable option in the treatment and placement of a patient with severe mental illness. Historically, state

psychiatric institutions have been seen as the custodians of those with severe mental illnesses. Despite the advances made in pharmacological treatment as well as psychosocial therapies that make community care of persons with mental illness not just possible but desirable, stigma against those with mental illness remains firmly rooted in our society and many in the general public still hold the idea that the mentally unwell should be kept away. While the psychiatric discipline continues to advocate for community care for our patients, society at large may view such efforts negatively and think that we are simply shirking our duties and responsibilities.

Surely, it will be most convenient for psychiatrists and acute ward clinicians to comply with family requests and to give up on difficult referrals. However, it would be unethical and unjust for us to bow down to these societal expectations and to allow the limited resources in acute care to be depleted and abused. Leaving those who require "slow medicine" in the acute ward will lead to unnecessary overcrowding and deprive those who are in need of "fast medicine" the care that they deserve. It is also an open question whether those in need of "slow" or rehabilitative medicine can receive their appropriate therapy in the acute setting. Indeed, "slow medicine" should not just connote a slowing of tempo in the treatment for the individual, but recognition that the needs are distinctly different during these differing phases of the illness process. Likewise step-down care is a misnomer when many therapies are actually stepped up during the rehabilitative phase.

For Mr X, it is telling that he was not even able to receive the appropriate "slow medicine" he required for his physical ailment. I can only hope that his transfer to our acute psychiatric ward was initiated by an ignorant house officer who mistook our hospital for a community hospital. With the roll out of the mental health blueprint, efforts are underway for an integrative model of care for our patients. Networking with step-down care facilities has been intensified and greater resources are allocated to community care. Although the idea of close proximity of step-down care facilities to the acute hospital is an attractive one and will possibly aid in communication and transfer, ideological closeness and alignment between those providing "fast" and "slow medicine" must be achieved for real integrative care to prevail. SMA

Boon Leng is flabbergasted that a bowl of prawn mee can cost $10 in a non air-conditioned road side stall. He wonders about a career change... unfortunately he cannot cook to save his life.