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## EDITORIAL

# 'How long will I be here?' Factors influencing PICU length of stay

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As a PICU consultant and Responsible Clinician, I got asked that question loads. The traditional answer is 'Well, generally PICUs admit people who have been really unwell and been a risk to themselves and/or others. As things settle down for you, we will be able to work together to move you on from here. Normally, people don't stay for more than a few weeks'.

This has either led on to a response that the person does not believe they are unwell, and they should not have been admitted in the first place, or to a more fruitful discussion on engagement, treatments and planning a pathway for discharge. Sometimes I am asked what I mean by 'a few weeks'. Rather than quoting the national PICU standards which estimate length of stay, I have found that this question can be a useful way to start setting mutually agreed discharge indicators and how to achieve them. Hopefully PICU and other related care pathway services, will have given some thought to these indicators prior to admission. The admission assessment may well give an indicator of how long it could take someone to meet these.

When I was naïve (substitute that for 'younger' if you know me), I used to think that the more acutely unwell someone is, then the longer they would stay in a PICU. Severity of psychotic symptoms can play a part in length of stay. However, I have subsequently seen many individuals with deeply ingrained delusional beliefs and obvious hallucinations who have completely recovered within days. It may be that illicit substances have caused the psychosis or it could have been due to other acute precipitating factors.

Subsequently, I changed to the mistaken belief that diagnosis could have a part to play in admission length. It could be true that someone with a depressive disorder generally takes longer to recover than someone with a manic presentation, but does this reflect upon PICU admission length? Many a time I have seen patients who are still severely depressed been accepted back by acute wards

quicker than those who have recovered from a manic psychosis but still present as somewhat 'over friendly'.

Ok, so it must be the level of acute risk that is a predictor of length of stay. After all, when asked 'How long will I be here?', I replied, 'As things [*aka* acute risks] settle…'. This is echoed by the PICU National Minimum Standards: 'Length of stay must be appropriate to clinical need and assessment of risk...' (NAPICU 2014). Well, at numerous NAPICU events I have heard comments about patients who present less acute risk remaining in PICUs because of historical risks and the difficulty of managing those in conditions of less security. This highlights and emphasises that PICUs do not operate in isolation. They are part of a larger system. One cannot ignore the place of PICU within this system, the effect that PICUs have on the system, and more importantly how the system affects the PICU operation.

Thus, we are perhaps encouraged to think of how PICUs fit into providing the most effective inpatient care for someone who is acutely disturbed. This may differ by

country, organisation and local arrangements. How do we then justify PICU as a specialty in its own right? Early in the last decade, Professor Len Bowers touched upon this thorny question when he encouraged us to think of what PICUs actually do now and what they could do in the future (Bowers 2012, 2013). As one of the leading acute care researchers and thinkers of recent decades, it is worth revisiting Professor Bowers thoughts. Both editorials discussed PICU services and their function within a psychiatric care system. The first article seemed to give somewhat of a pessimistic viewpoint on the function of a PICU. Based upon absence of evidence for specific benefits or outcome measures, it asked the basic question 'What is it that PICUs are *really* aiming to do?' This was because evidence showed that what we thought they were good at (e.g. decreasing incidents or absconding on acute wards), in the overall system, introduction of PICU services was not associated with improvements.

There is no doubt that this left me somewhat disheartened. It brought to mind a paper by Zigmond (1995) that criticised 'special care wards' as being just a place to house those who displayed disruptive behaviour but did not provide positive therapeutic gains. Indeed, Bowers (2012) stated that one function of a PICU may be to 'bolster the moral order of the hospital, in that it allows sanctions or consequences for bad behaviour'. Zigmond (1995) provided impetus for improvements and NAPICU was born shortly afterwards. Could Bowers intentionally be goading the specialty into taking a critical look at itself in order to remodel the service?

Well, in the second editorial he provided possible ways in which PICUs could further define themselves and take a lead in aspects of care provision and design. Some of his proposals were as expected, such as that PICUs should be 'places of maximum therapeutic intensity' or 'specialists in rapid, reliable and valid assessment'. However, some gave pause for thought, such as 'leading in trans-admission and full trajectory treatment' (by which he meant giving an overview of, and influencing how, someone moves through and utilises the many different services available to them at various stages of illness) or 'providers of maximally efficient case management'. These ideas gave a perspective on how PICUs could and perhaps should be central in a patient journey and influence the longer-term care provided for someone with multiple needs who is extremely unwell. In my mind, in conjunction with the previous editorial, it provoked some thought to the possibility that PICUs could contribute not only to care for patients whom they serve but also to those from wards from which the patients were admitted. As Bowers put it, 'The stress on the remaining patients may well diminish...'. This could lead to decreased length of admission for both types of patients. However, good studies to demonstrate this are difficult to perform.

Over ten years has passed since Bowers' comments, and now maybe a good time to reflect on how the specialty of PICU has measured up to his challenges. That is hard to answer, because, as always, the climate has changed. Different types of services have developed out of changes in commissioning (Dye *et al*. 2016) and there have been failed attempts to categorise and cluster patient need in combination with the financial demand that accompanies this need (NHS England 2016). So perhaps we are not operating within the same framework.

Despite this, clinicians working in PICU and the actual services provided by a PICU have a central role to play in not only what they are designed to do (i.e. acute care) but also in longer term management. The traditional pathway of care is to admit a patient from an acute ward and, when 'things have settled', return them to the originating ward. Sometimes there are continuing risks displayed by an individual that necessitate further care within a setting with some security but one that is more rehabilitative in philosophy. At other times further care that is even more specialised, or possibly even outside of the health environment, is required. These pathways are themselves an indicator of need and determine care provision (Kearney et al. 2013). Our recent study regarding PICU length of stay has shown that, beyond symptoms or risk, care pathways also influence how long someone remains on a PICU (Dye *et al*. 2023). The type of pathway itself has more influence on how long someone remains in a PICU than assessing the needs using the UK official 'clustering' tool. More than this, the type of care pathway is more relevant to predicting PICU length of stay than diagnosis, age, gender, or even the specific PICU to which someone is admitted.

Why do the specific arrangements within the surrounding PICU care pathway to which someone is transferred have such an influence upon length of stay? Examining the data showed that those transferred to longer secure care settings had a longer PICU stay than other patient types but that this varied between units. We are planning a further paper which may reveal that delay in transfer (i.e. the 'extra' length of time that a patient remained upon a PICU from when they were deemed fit to be transferred) varies between patient types. Unsurprisingly, those who were transferred to longer secure settings had a longer delay. Despite this, there was a difference between the units in length of stay for patients moving to longer secure care.

Pragmatically, it is easy to understand why this group of patients stay longer. Although the proportion needing this type of care is relatively small, commissioning arrangements necessitate a multitude of procedures for such a transfer to occur, these beds are not easy to come by and these types of patients have enduring and complicated risks. In other words, it is an example of PICUs operating

within a larger system and how this system affects PICU function. Drawing upon the PICU possibilities outlined by Bowers (2013), it may well be that those PICUs which are more efficient in case management and/or boundary melding have more robust arrangements to enable effective pathway implementation for such patients.

There is no doubt that agreed patient care plans to work towards must be in place (hopefully prior to admission) for individuals in the care of PICU services. This begs the question, 'agreed by whom?' Sometimes what is clinically indicated is hard to get across to others and those PICUs that have truly risen to some of Len Bowers' challenges will be serving their patients in a better fashion. I suppose this demonstrates that it's not all about patient-specific direct clinical needs or associated care, but how to influence the wider system may be a predictor of PICU length of stay. This is especially pertinent for pathways of care involving certain patient types. Dix (2007) touched upon this when he discussed care pathways and argued that the success of PICU care provision is ultimately defined by interactions between teams within the surrounding mental health services and approaches. This was over 15 years ago... have we risen to that challenge? I would argue not. Is PICU length of stay therefore all too often defined by the service rather than patient needs? Put simply, which part of the service 'shouts the loudest'? If so, then this should disappoint the PICU clinical community as well as motivate us to do better. After all, if it is the design and possibly the professional personalities within the care pathway which is centrally important to PICU length of stay, then these are issues over which clinicians have pretty much total control. The same could not be said for the acuity of symptoms or levels of clinical risk. Maybe then, it really is up to us to do better and Professor Bowers may have showed us how as far back as 2013.

I am sure that we will continue to hear complaints about delays in transfer from a PICU and about unresponsiveness of PICUs in admitting those who require such a service. Perhaps we need to also hear about and celebrate improvements, and what was needed to make improvements in these care pathways.

How long am I going to be here? A very straightforward and frequently asked question in a PICU that deserves a better answer than I would argue we have hitherto been able to produce. A better understanding of the care pathway system rather than psychiatric pathology, could enable me/us to answer this question in a more acceptable fashion than in my normal blathering fashion in the first paragraph of this editorial.

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