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ORIGINAL ARTICLE

Discharge location as a predictor of prolonged length of stay in an inpatient psychiatric hospital: a retrospective study

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Objective: This study examines discharge location as a predictor for prolonged length of stay (LOS) in an inpatient psychiatric hospital.
Methods: Retrospective study of 2,717 adult patients in an inpatient psychiatric hospital in New York. The outcome variable of LOS was < 25 days vs. $\geqslant 25$ days. Multivariate logistic regression analysis was used. We adjusted for demographics, psychiatric diagnosis, medical history, and psychiatric history.
Results: Discharge to supportive housing (OR: 2.34, 95%CI 1.89-2.89, $p < 0.001$), a long-term psychiatric facility (OR: 44.48, 95%CI 17.70-111.78, $p < 0.001$), nursing home/assisted living facility (OR: 10.38, 95%CI 4.49-24.01, $p < 0.001$), and substance abuse rehabilitation center (OR: 2.16, 95% CI 1.31-3.58, $p = 0.003$) were each significantly associated with increased odds for LOS $\geqslant 25$ days. Discharge to a jail/correctional facility (OR: 0.43, 95%CI 0.19-0.93, $p = 0.032$) was significantly associated with decreased odds for LOS $\geqslant 25$ days. No significant associations were found for medical/surgical floors and short-term psychiatric facilities. These significant findings for discharge locations persisted even adjusting for often-studied variables.
Conclusion: As discharge location is associated with LOS, we recommend that mental health care providers begin safe discharge planning from the day of admission and involve a multidisciplinary team with the goal of stabilizing the patient as soon as possible.

Keywords: length of stay; inpatients; hospitalization; psychiatric hospitals

Introduction

Psychiatric inpatient hospitalization is a crucial component of treating and stabilizing patients with severe mental illness.[1,2] The average length of stay (LOS) for psychiatric inpatient hospitalization ranges from 17.9 days to 55.1 days.[3,4] A prolonged psychiatric inpatient stay is associated with reduced quality of life,[1] increased healthcare costs,[1] and lower satisfaction and stigma.[5] LOS for psychiatric inpatient hospitalization can be influenced by health insurance companies, which seek to minimize LOS as a cost-cutting measure. For example, the United States government insurance of Medicaid denied 1.5% of all inpatient mental health authorizations compared to 0.4% for outpatient mental health authorizations.[6]

Many factors have been studied for association with psychiatric inpatient LOS. These include demographic variables, psychiatric diagnosis, medical history, psychiatric history, and discharge location. We review what is known about these factors and add what aspects of these factors can benefit from additional research.

Demographic factors are associated with psychiatric inpatient LOS. Age over 55 years[7] and older age overall are associated with longer LOS.[8,9] There are mixed findings regarding sex and LOS. In some reports males had longer LOS,[7,10] in others males had shorter LOS,[11,12] and in others sex was not associated with LOS.[4,9,13] Non-White race/ethnicity (Asian, Black, mixed ethnicity, and Native American) is associated with a longer LOS.[10,14,15] Among non-White populations, Asians had the longest LOS.[14] Marital statuses of single, unmarried, or not in a relationship are each associated with longer LOS.[7,16] Mixed findings have been reported for associations of language with LOS; one study found that inpatient hospital stays, except for psychiatry and neonatal care, were longer for Spanish-speaking patients as compared to English-speaking patients.[17] However, another study reported that the language in which patients received services was not associated with psychiatric inpatient LOS.[11]

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There are also mixed findings regarding diagnosis of different mental illnesses and psychiatric inpatient LOS. Several studies report that schizophrenia, schizophrenia-spectrum disorder, and psychosis are associated with longer LOS compared to mood disorders, anxiety disorders, and personality disorders.[4,7,10,18] However, another study reported that affective disorders are associated with increased LOS compared to psychotic, neurotic, and personality disorders.[12] Whether substance use is associated with psychiatric inpatient LOS is also unclear; some report substance use disorder as associated with longer LOS,[3] while others report substance use disorder as associated with shorter LOS.[8,12]

Medical comorbidities are common among those with chronic psychiatric disorders.[19] Psychiatric diagnoses such as depression, anxiety, and psychosis are all positively associated with chronic medical illnesses such as diabetes, hypertension, and cardiovascular disease.[19,20,21] There are mixed findings for the impact of medical comorbidities on psychiatric inpatient LOS, with some authors reporting longer LOS[22,23] and others reporting no association with LOS.[24,25]

Previous psychiatric history can influence psychiatric inpatient LOS. One study reported that more than four previous psychiatric admissions were associated with longer LOS.[25] However, a nationally representative, extensive sample of 677,684 patients from the United States did not find any association between the number of previous psychiatric admissions and LOS.[26] Conversely, another study reported that previous psychiatric admission was associated with shorter LOS.[11] Suicidal ideation[9] and imminent danger to self or others are associated with longer LOS.[7] However, another study reported that a suicide attempt was associated with shorter LOS.[8]

Discharge location can impact psychiatric hospitalization LOS. Discharge to a long-term psychiatric facility is associated with longer LOS,[27] as is discharge to supportive housing and nursing facilities.[10] There are mixed findings with homelessness, with some that report longer LOS,[10] while others indicate it is country-specific, where in the United Kingdom, Italy, and Belgium, homeless patients had longer LOS, while in Germany, they had shorter LOS.[3]

Although there are studies on the association of certain discharge locations with psychiatric hospitalization LOS, there are many additional discharge locations, such as jail/correctional facilities, substance abuse rehabilitation centers, and short-term psychiatric facilities, that have not been studied. We comprehensively studied the association of discharge locations with psychiatric hospitalization LOS, adjusting for the many potentially relevant covariates among demographic factors, psychiatric diagnoses, medical history, and psychiatric history.

Methods

Setting

This was a retrospective study of adult patients 18 years and older admitted to the psychiatric unit at Nassau University Medical Center, located in the Long Island suburb of East Meadow, New York, United States. Data were obtained from January 1, 2018, through November 30, 2023. We excluded patients aged $<$ 18 years and those who died during hospitalization. For patients with multiple hospitalizations, we only included their latest visit. We selected LOS $\geqslant$ 25 days as cases and LOS $<$ 25 days as controls. This cutoff value was chosen based on the mean value reported in a previous study.[4] We collected twice the number of controls (LOS $<$ 25 days) as compared to cases. Controls were chosen for twice the number of cases for each month, where we began with the list of people discharged at the beginning of the month.

Variables

The demographic variables of interest were age, sex (female/male), race/ethnicity (White, Black, Hispanic, Asian, and other), and marital status (married, single/never married, and divorced/separated). Language was categorized as English, Spanish, Haitian Creole, or other. Psychiatric diagnoses were schizophrenia, bipolar disorder, depressive disorder, anxiety disorder, and substance use disorder. Medical history variables were diabetes mellitus, hypertension, stroke, and traumatic brain injury. Psychiatric history variables were suicidal history and multiple psychiatric hospitalizations. Discharge locations were categorized as discharge to home, supportive housing, long-term psychiatric facility, jail/correctional facility, nursing home/assisted living facility, substance abuse rehabilitation center, medical/surgical floor in hospital, or short-term psychiatry facility. The outcome variable of LOS was $<$ 25 days vs. $\geqslant$ 25 days.

Statistical analysis

The continuous variable of age was described as mean and SD, and the categorical variables as counts and percentages. Analysis of variance compared the continuous variable of age. The Pearson chi-square test was used to compare the categorical variables, except when the expected cell size was less than 5, where Fisher's exact test was used. All variables significantly differing in the univariate analyses were included in the multivariate logistic regression analysis for the outcome of LOS $\geqslant$ 25 days. All p-values were two-tailed. The alpha level for significance was $p < 0.05$. IBM SPSS Statistics version 29 and Stata SE version 17 were used for the analyses.

Ethics statement

Ethics approval was received from the hospital's institutional review board. A waiver for informed consent was obtained due to the retrospective nature of the study.

Results

Overall, 66.8% of patients (n=1,815) had LOS $<$ 25 days and 33.2% (n=902) had LOS $\geqslant$ 25 days. Table 1 describes the sample characteristics. Regarding demographics, the group with a LOS $\geqslant$ 25 days had a

Table 1 Comparison of sample characteristics between patients with and without prolonged length of stay in an inpatient psychiatric unit

Variable	< 25 days (n=1,815)	⩾ 25 days (n=902)	p-value
Demographics			
Age, mean (SD) (years)	38.8 (13.82)	42.6 (15.34)	< 0.001
Age > 37 years (yes)	836 (46.1)	510 (56.5)	< 0.001
Sex (male)	1,142 (62.9)	559 (62.0)	0.631
Race/ethnicity			0.004
White	869 (47.9)	408 (45.2)	
Black	606 (33.4)	313 (34.7)	
Hispanic	201 (11.1)	82 (9.1)	
Asian	69 (3.8)	62 (6.9)	
Other	70 (3.9)	37 (4.1)	
Marital status			0.002
Married	199 (11.0)	61 (6.8)	
Single or never married	1,430 (78.8)	747 (82.8)	
Divorced or separated	186 (10.2)	94 (10.4)	
Language			0.066
English	1,527 (84.1)	759 (84.1)	
Spanish	197 (10.9)	79 (8.8)	
Haitian Creole	33 (1.8)	23 (2.5)	
Other	58 (3.2)	41 (4.5)	
Psychiatric diagnosis			
Schizophrenia (yes)	510 (28.1)	484 (53.7)	< 0.001
Bipolar disorder (yes)	458 (25.2)	163 (18.1)	< 0.001
Depressive disorder (yes)	493 (27.2)	138 (15.3)	< 0.001
Anxiety disorder (yes)	379 (20.9)	115 (12.7)	< 0.001
Substance abuse disorder (yes)	1,010 (55.6)	317 (35.1)	< 0.001
Medical history			
Diabetes mellitus (yes)	197 (10.9)	128 (14.2)	0.012
Hypertension (yes)	368 (20.3)	217 (24.1)	0.024
Stroke (yes)	3 (0.2)	2 (0.2)	0.669
Traumatic brain injury (yes)	37 (2.0)	20 (2.2)	0.760
Psychiatric history			
Suicide history (yes)	583 (32.1)	154 (17.1)	< 0.001
Multiple psychiatric hospitalizations (yes)	161 (8.9)	190 (21.1)	< 0.001
Discharge			
Discharge location			< 0.001
Home	1,290 (71.1)	416 (46.1)	
Supportive housing	323 (17.8)	285 (31.6)	
Long-term psychiatric facility	5 (0.3)	93 (10.3)	
Jail/correctional facility	53 (2.9)	8 (0.9)	
Nursing home/assisted living facility	8 (0.4)	29 (3.2)	
Substance abuse rehabilitation center	70 (3.9)	25 (2.8)	
Medical/surgical floor in the hospital	54 (3.0)	40 (4.4)	
Short-term psychiatric facility	12 (0.7)	6 (0.7)	

Data presented as n (%), unless otherwise specified.
Fisher's exact test was performed for stroke.

significantly older mean age ($p < 0.001$), a greater percentage of patients aged > 37 years ($p < 0.001$), a greater percentage of those of Asian race/ethnicity ($p = 0.004$), and those single or never married ($p = 0.002$) as compared to those with a LOS < 25 days. Regarding psychiatric diagnosis, the group with a LOS ⩾ 25 days had a significantly greater percentage of patients with schizophrenia and a significantly lesser percentage of those with bipolar disorder, depressive disorder, anxiety disorder, and substance abuse disorder as compared to the group with a LOS < 25 days (all $p < 0.001$). For medical history, the group with a LOS ⩾ 25 days had a significantly greater percentage of those patients with diabetes mellitus ($p = 0.012$) and hypertension ($p = 0.024$) as compared to the group with a LOS < 25 days. As for psychiatric history, the group with a LOS ⩾ 25 days had a significantly greater percentage of multiple psychiatric hospitalizations and a significantly lesser percentage of suicide history as compared to those with a LOS < 25 days (all $p < 0.001$). Finally, for discharge location, those with a LOS of ⩾ 25 days had a significantly greater percentage of discharge to supportive housing and long-

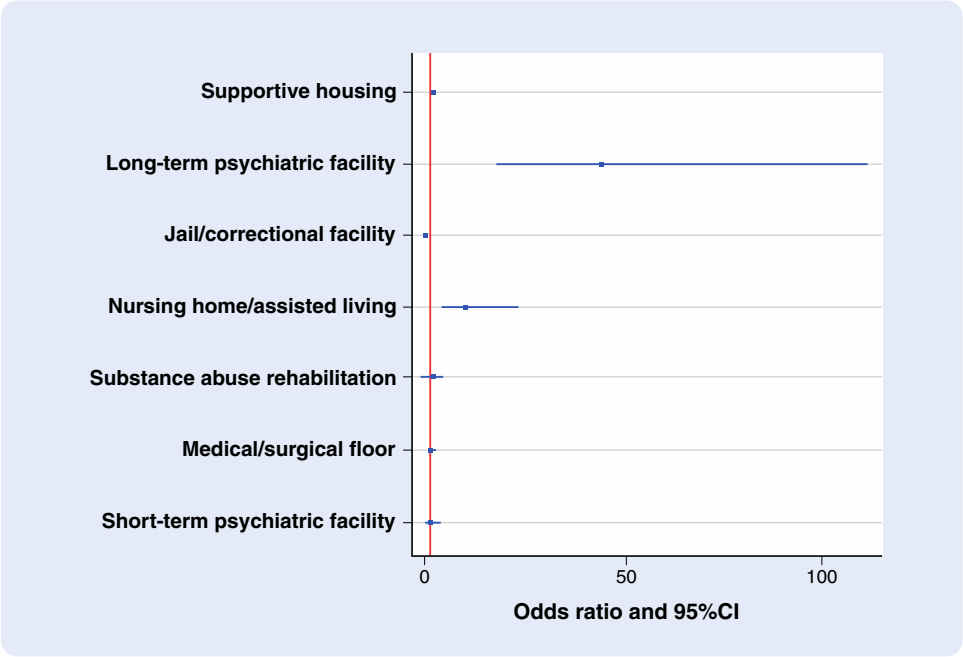


Figure 1 Summary of odds ratios and 95%CIs for discharge location.

term psychiatric facilities and a significantly lesser percentage of discharge home as compared to those with a LOS $<$ 25 days (all $p < 0.001$).

Table 2 shows the multivariate logistic regression analysis for a LOS $\geqslant$ 25 days. Model 1 shows that older age, Asian race/ethnicity, marital status single or never-married, schizophrenia, multiple psychiatric hospitalizations, and discharge to supportive housing, long-term psychiatric facility, nursing home/assisted living, and substance abuse rehabilitation were each significantly associated with increased odds for LOS $\geqslant$ 25 days. Substance abuse disorder, suicide history, and discharge location of jail/correctional facility were each significantly associated with decreased odds for a LOS $\geqslant$ 25 days. As the Box-Tidwell test showed that the continuous variable of age did not meet the logistic regression assumption of a linear relationship between the logit transformation of the outcome variable and the continuous variable, model 2 was conducted with age as a categorical variable. The same significance pattern occurred in model 2 as in model 1. Figure 1 shows the outcomes for the main factor of discharge location.

Discussion

We found for the main factor of discharge location that supportive housing, long-term psychiatric facilities, nursing home/assisted living, and substance abuse rehabilitation were each significantly associated with increased odds for psychiatric inpatient LOS $\geqslant$ 25 days, whereas discharge to a jail/correctional facility was significantly associated with decreased odds for psychiatric inpatient LOS $\geqslant$ 25 days. Also, among the often-studied factors of demographics, psychiatric diagnosis, medical history, and psychiatric history, we found that older age, Asian race/ethnicity, being single or never married, schizophrenia, and multiple psychiatric hospitalizations were each significantly associated with increased odds for a LOS $\geqslant$ 25 days. Substance abuse disorder and suicide history were each significantly associated with decreased odds for a LOS $\geqslant$ 25 days.

For the main factor of discharge location, compared to the reference of home discharge, many other discharge locations (i.e., supportive housing, long-term psychiatric facility, nursing home/assisted living, and substance abuse rehabilitation) were each significantly associated with increased odds for a LOS $\geqslant$ 25 days. One exception was discharge to a jail/correctional facility, which was significantly associated with decreased odds for a LOS $\geqslant$ 25 days. Discharge locations without significant associations for LOS were medical/surgical floor and short-term psychiatric facilities. Previous research reports longer LOS for discharge to long-term psychiatric facilities[27] and supportive housing and nursing facilities.[10] Our findings are consistent with this pattern. Greater functional impairment has been previously suggested as a reason for longer LOS for discharge to a nursing home and supportive housing.[10] In addition, we suggest longer LOS for not only supportive housing and nursing facilities, but also for long-term psychiatric facilities, because it takes time to find an available facility and there are fewer open beds available. We suggest that the shorter LOS for jail/correctional facilities can occur because of pre-planned placement and easier availability of correctional facilities for patients with mental health needs. Furthermore, jail/correctional facilities provide immediate continuity of medical and psychiatric care, and therefore these patients have a shorter LOS than those discharged to home, who

Table 2 Multivariate logistic regression analysis for prolonged length of stay of 25 or more days in an inpatient psychiatric unit

Variable	Model 1 OR (95%CI)	p-value	Model 2 OR (95%CI)	p-value
Demographics				
Age (years)	1.01 (1.006-1.02)	< 0.001	-	-
Age > 37 years (yes)	-	-	1.33 (1.08-1.64)	0.008
Race/ethnicity				
White	1.00		1.00	
Black	0.84 (0.67-1.04)	0.114	0.82 (0.66-1.02)	0.080
Hispanic	0.94 (0.68-1.30)	0.695	0.91 (0.66-1.26)	0.567
Asian	1.84 (1.23-2.77)	0.003	1.77 (1.18-2.66)	0.006
Other	1.18 (0.74-1.89)	0.491	1.12 (0.70-1.79)	0.638
Marital status				
Married	1.00		1.00	
Single or never married	1.50 (1.06-2.13)	0.022	1.44 (1.02-2.04)	0.039
Divorced or separated	1.37 (0.89-2.10)	0.152	1.37 (0.89-2.10)	0.149
Psychiatric diagnosis				
Schizophrenia (yes)	1.92 (1.53-2.42)	< 0.001	1.93 (1.53-2.43)	< 0.001
Bipolar disorder (yes)	0.91 (0.70-1.17)	0.457	0.92 (0.71-1.18)	0.504
Depressive disorder (yes)	0.85 (0.65-1.11)	0.232	0.85 (0.65-1.12)	0.244
Anxiety disorder (yes)	0.91 (0.70-1.18)	0.481	0.90 (0.69-1.16)	0.406
Substance abuse disorder (yes)	0.53 (0.43-0.64)	< 0.001	0.52 (0.42-0.63)	< 0.001
Medical history				
Diabetes mellitus (yes)	0.88 (0.66-1.18)	0.391	0.90 (0.67-1.21)	0.480
Hypertension (yes)	0.82 (0.64-1.05)	0.120	0.88 (0.69-1.12)	0.285
Psychiatric history				
Suicide history (yes)	0.62 (0.49-0.79)	< 0.001	0.63 (0.49-0.80)	< 0.001
Multiple psychiatric hospitalizations (yes)	2.47 (1.91-3.20)	< 0.001	2.47 (1.91-3.20)	< 0.001
Discharge				
Discharge location				
Home	1.00		1.00	
Supportive housing	2.31 (1.86-2.86)	< 0.001	2.34 (1.89-2.89)	< 0.001
Long-term psychiatric facility	44.17 (17.58-110.99)	< 0.001	44.48 (17.70-111.78)	< 0.001
Jail/correctional facility	0.42 (0.19-0.92)	0.030	0.43 (0.19-0.93)	0.032
Nursing home/assisted living	8.92 (3.83-20.80)	< 0.001	10.38 (4.49-24.01)	< 0.001
Substance abuse rehabilitation	2.17 (1.31-3.60)	0.003	2.16 (1.31-3.58)	0.003
Medical/surgical floor	1.57 (0.98-2.51)	0.062	1.60 (1.00-2.56)	0.050
Short-term psychiatric facility	1.49 (0.51-4.37)	0.470	1.55 (0.53-4.52)	0.420

The Box-Tidwell test showed that the continuous variable of age did not meet the logistic regression assumption of a linear relationship between the logit transformation of the outcome variable and the continuous variable. Nagelkerke R^2: Model 1 = 0.28; Model 2 = 0.27. OR = odds ratio.

may need a continuity-of-care setup before discharge. Our reference category of patient discharge to home has longer LOS because it takes time to set up such continuity of psychiatric care in the outpatient setting and there are fewer spots for outpatient appointment availability, while discharge to correctional facilities does not require setting up an appointment with clinicians for continuity of psychiatric care.

The often-studied factors of demographics, psychiatric diagnosis, medical history, and psychiatric history can have varied significance patterns. We compare how our findings are similar or different from the previously published research and provide reasons for our findings. Demographics of increased age, Asian race/ethnicity, and single/never married status were each significantly associated with increased odds for a LOS $\geqslant$ 25 days. Our findings for increased age are similar to what has been previously reported.[7-9] We suggest that increased age is associated with increased LOS because, as one ages, multiple medical comorbidities accrue that need to be treated alongside mental health conditions before discharge. In addition, we speculate that elderly patients have less social support in the community, and it takes time to find supportive housing and day programs for this population. Our findings for the Asian race/ethnicity are similar to what has been previously reported.[14] Those of Asian race/ethnicity face higher stigma related to mental illness than White persons,[28] and this can lead to delayed treatment-seeking, with more severe psychiatric illness during hospitalization that requires longer LOS before discharge. In addition, we speculate that this population lacks adequate social support, and may need to stay in hospital longer until a discharge location with adequate social support is found. Our findings for single or never-married individuals are also similar to what has been previously reported.[7,16,29] We speculate that this association can likewise occur because of inadequate social support and the time involved in finding adequate social services and programs for these patients before discharge.

Among psychiatric diagnoses, schizophrenia was significantly associated with increased odds for a LOS $\geqslant$ 25 days, while substance abuse disorder was significantly associated with decreased odds for a LOS $\geqslant$ 25 days. Previous research for LOS reports mixed findings for schizophrenia/psychosis, with many reports of longer LOS[4,7,10,18] and some reports of shorter LOS.[12] Our findings are similar to those of studies reporting longer LOS. We suggest that patients with psychosis/schizophrenia have longer LOS because this severe condition can take longer to stabilize as compared to other mental illnesses. Furthermore, patients with psychosis have poor insight into their illness, and are thus more likely to be non-adherent to psychiatric treatment. Sometimes the treatment team needs court approval to continue inpatient treatment, which contributes to longer LOS. Previous research for LOS reports mixed findings for substance use, where some report longer LOS[3] and some report shorter LOS.[8,12] Our findings were of an association with shorter LOS. We suggest that this occurs because substance use disorders, including intoxication and withdrawal, require less time to stabilize compared to severe mental illness. In addition, we speculate that substance-induced psychiatric disorders are less severe, their symptoms resolve quickly (in a matter of days) once substances are metabolized, and psychiatric medication is required for a shorter period.

We did not find any association of either diabetes mellitus or hypertension with LOS. Although medical comorbidities of diabetes and hypertension are positively associated with psychiatric disorders,[19,20] we are unaware of any literature on the association of such medical comorbidities with psychiatric inpatient LOS. We speculate that these medical comorbidities are either controlled upon arrival to psychiatric hospitalization, or if uncontrolled, appropriate medical consults are managed simultaneously with psychiatric treatment, so that the medical comorbidity can be stabilized within 25 days and will not be associated with a LOS $\geqslant$ 25 days.

For psychiatric history, we found that multiple psychiatric hospitalizations were associated with increased odds for a LOS $\geqslant$ 25 days, while a history of suicidality was associated with decreased odds for a LOS $\geqslant$ 25 days. Previous research has reported mixed findings for multiple psychiatric hospitalizations, with some reporting longer LOS,[25] some showing no association,[26] and some reporting lower LOS.[26] Our findings are similar to those of studies reporting longer LOS. We speculate that patients with multiple psychiatric hospitalizations could be treatment-resistant, non-adherent to medications, and possibly homeless. Treatment-resistant cases of depression, mania, or psychosis may require adequate medication management and other interventions such as electroconvulsive therapy to stabilize, and medication non-adherence may need treatment over the patient's objections, which would involve a hearing at a mental health court and thus prolong LOS. Previous research reports mixed findings for suicidal ideation/behavior, with some reporting suicidal ideation as associated with longer LOS[9] while suicide attempt is associated with shorter LOS.[8] Our findings are that suicide behavior is associated with shorter LOS; we speculate that patients who endorse suicidal thoughts or behavior are treated more aggressively.

The strength of our study is the emphasis on different discharge locations and LOS. One limitation is that this study may be generalizable only to United States settings, and not to other countries with different healthcare systems and discharge location options. Future prospective, multisite research on the association of discharge location and LOS would be useful to address this limitation.

In conclusion, we found that discharge from an inpatient psychiatric hospitalization to supportive housing, a long-term psychiatric facility, nursing home/assisted living facility, or substance abuse rehabilitation center was associated with increased odds of a LOS $\geqslant$ 25 days. In contrast, discharge to a jail/correctional facility was associated with decreased odds of a LOS $\geqslant$ 25 days. We recommend that mental health care providers start discharge planning from the date of admission and involve a multidisciplinary team with the goal of stabilizing the patient as soon as possible.

Disclosure

The authors report no conflicts of interest.

Data availability statement

The data are available from the corresponding author upon request.

Author contributions

YRG: Conceptualization, Data curation, Investigation, Methodology, Project administration, Supervision, Writing – original draft.
PD: Data curation, Investigation, Writing – review & editing.
JF: Conceptualization, Formal analysis, Investigation, Methodology, Supervision, Visualization, Writing – review & editing.
CA: Data curation, Investigation, Writing – review & editing.
BBG: Data curation, Investigation, Writing – review & editing.
All authors have read and approved of the final version to be published.

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