Legal Representation is Associated with Psychiatric Readmissions

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Abstract: The legal representation at District Psychiatric Boards hearings of psychiatric inpatients committed under a Compulsory Admission Order is a very important but insufficiently studied issue. This study aimed 1) to review the practice of legal representation in the western world and Israel, and 2) to test the hypothesis that the legal representation of compulsorily committed psychiatric patients at their discharge hearings is associated with their subsequent readmission. A random sample of 153 compulsorily committed patients discharged in 2003 was drawn from Israel's National Psychiatric Case Register and their psychiatric readmission over the next two years was reviewed. The 109 patients who were discharged with legal representation (the index group) were compared with the 44 patients who were discharged without legal representation (the control group). Although the groups were comparable on all sociodemographic and background clinical characteristics the patients from the index group had significantly more readmissions and inpatient days over the follow-up period than the control group. The results suggest that the involvement of lawyers in the discharge process is associated with more readmissions and more inpatient time. The possible reasons for this and its implications are discussed.

Keywords: Lawyer, legal representation, psychiatric inpatient, readmission, inpatient days.

INTRODUCTION

In the last three decades research on frequent psychiatric readmissions has reported the possible influence of a number of patient-related and service-related factors (Riecher-Rossler & Rossler, 1993; Salize & Dressing, 2004). Among the patient-related variables, male gender (Hodgin, 1992; Lidz *et al.*, 1993; Eronen *et al*., 1996), a diagnosis of schizophrenia (Riecher *et al.*, 1991; Cuffel *et al*., 2002), a history of admissions (Bernardo & Forchuk, 2001) and the first admission being compulsory (Munk-Jorgensen *et al.*,1991; Fennig *et al*. 1999; Heilbrun *et al.*, 1999; Feigon & Hays, 2003; Bauer *et al.*, 2007) are the main factors associated with readmission. Among the service-related factors predicting readmission are a short hospital stay (Colenda & Hamer, 1989; Figueroa *et al.*, 2004) and inadequate community services (Klinkenberg & Calsyn, 1996). One important service-related factor, however — legal representation at District Psychiatric Board (DPB) hearings for psychiatric inpatients committed under a Compulsory Admission Order — has been insufficiently studied (O'Brien *et al.*, 1995; Singh, 1996; South Australia Mental health Act, 1993; Myers, 1997), even though legal representation exerts a considerable influence on DPB rulings.

The Legal Representation of Mental Patients in Civil Commitment Proceedings in Western Countries

Many bodies of mental health legislation override liberty by allowing the compulsory commitment and outpatient treatment of severely psychotic patients who present a danger to themselves or others (South Australia Mental health Act, 1993). A recent widespread and much-debated innovation is legal representation for compulsorily committed patients. In most countries the representative is a lawyer, but in Austria, for instance, the representative may also be a social worker or psychologist. The right to counsel is in many respects the key to all other safeguards in civil commitment proceedings. Attorneys help mental patients facing compulsory commitment understand their rights, provide legal advice in exercising those rights and guide their clients through the legal thicket. Even patients in the most acute states, who invariably lack insight into their need for hospitalization and treatment, request their lawyer to get them discharged. Some lawyers then become overzealous in fighting for their patients' discharge, sometimes prematurely, so that the same patient is readmitted some days later because of exacerbation of their mental state (Singh, 1996). These patient representatives, usually lawyers, are perhaps driven by the need to 'sustain their credibility' before the Board, although counsel should not regard a Board ruling as reflecting on their professional competence (Myers, 1997). A common claim against legal representation at Board hearings is that while it does not significantly increase the patient's chance of being successfully discharged, it does significantly lengthen the hearings (O'Brien, 1995).

In the U.S.A, the key court ruling on right to legal representation is Gideon v. Wainwright (Gideon, 1963). This ruling — based on the principle of due process — confirmed the statutory right to get free legal representation to those facing incarceration for criminal charges who cannot pay for their own defense. No less than criminal defendants facing jail or prison for criminal behavior, people suffering from

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mental illness are likewise entitled to the assistance of counsel when the government seeks to deprive them of their personal liberty and self-determination and they need to be represented at the hearings of Mental Health Review Tribunals and stressed the importance that the patients' right to liberty be legally defended. The statutory right of mental patients to be represented has also been discussed by the Supreme Court, which found that patients had a federal constitutional right to be represented by a state-sponsored attorney in civil commitment hearings. Nowadays every state makes some provision for the appointment of counsel when the patient is indigent. In the case of mental patients, who are often incapable of standing up for their rights, the right to counsel is of the utmost importance (Mc Nabb, 1942).

In Australia, the states or provinces are the body which makes provision for legal representation at civil commitments. New South Wales' Mental Health Act, 1990, for example, provides that every person liable to compulsory commitment has the right to appear before a magistrate with state-paid counsel. Singh points out: "Some would maintain that it is crazy that a mentally ill person can properly instruct his/her solicitor. However the 1990 Mental Health Act demands that all patients be provided with legal representation irrespective of their state of mind." [19, p. 445]. According to article 27 of updated in 1993 the 1990 Mental Health Act: "In every appeal to the Board, the person to whom proceedings relate is entitled to be represented by counsel in accordance with this section" [20, p.17].

In England, compulsory commitment is dealt with by a Mental Health Review Tribunal (MHRT). Every mentally ill person who appeals to a MHRT has the right to legal counsel funded by Legal Aid. The Law Society publishes a list of solicitors who are approved for MHRT representation and the patient may choose his representative from this list.

In Israel, all psychiatric hospitalizations, both voluntary and compulsory, are regulated by the Mental Patients Treatment Act, 1991, (MPTA) (Mental Patients Treatment Act, 1991). DPBs review civil Compulsory Admission Orders (CAOs) issued by a District Psychiatrist and hear appeals. They can decide to extend the CAO or not. With respect to compulsory commitments under criminal law, the DPBs rule on matters of leave, stay extension and discharge.

The Background to the Amendment to Israel's Mental Patients Treatment Act

Until 2004 the MPTA (Mental Patients Treatment Act, 1991), provided legal representation for the mentally ill only in criminal proceedings. In all other circumstances, including the whole compulsory admission process before DPBs, there was no legal obligation for the patient to be legally represented. Only a few compulsorily admitted patients hired lawyers at their own expense to represent them before a DPB. The others either lacked the means or they and their families did not know of their right to legal representation. The new amendment (Amendment 5 to the Mental Patients Treatment Act, 2004) lays down the entitlement to legal representation, by a lawyer, for all patients committed under a CAO, or in outpatient care under a Compulsory Outpatient Care Order (COCO), and at all DPB hearings and appeals. The Amendment lays down that adult patients sent to hospital or outpatient care by court order will be represented by a public defender appointed under the Public Defender Act, 1995, while adult patients sent to hospital or outpatient care by a District Psychiatrist's order will be entitled to representation by a lawyer appointed under the Legal Aid Act, 1972.

A second provision of the Amendment states that the medical director of a hospital, or someone authorized by him for this purpose, must inform a patient, or his guardian if there is one, of his right to be legally represented. Whenever the patient's wish cannot be ascertained because of his incompetence or psychotic state and the patient has no legal guardian, this notification shall be issued to a relative. The Amendment also provides that the patient be given sufficient opportunity by hospital staff to meet with his lawyer, so as to ensure his proper representation.

The Amendment constitutes a big step forward in the empowerment of mental patients and the expansion of their individual rights. It helps balance individual rights against the rights of society. Moreover, making patients and their families aware of their right to representation, and making that representation available regardless of the financial situation of patient and family, will ensure that the opinions and wishes of patients are given a much wider hearing and their rights as individuals better respected.

The exact wording of this Amendment is as follows:

After Article 29 there shall be inserted Article 29a, as follows:

29a. Right of Representation

(a) In hearings before a District Psychiatric Board and in appeals of the Board's rulings, the patient is entitled to be represented by legal counsel.

(b) Should a patient have been hospitalized under a Compulsory Admission Order, or be in outpatient care under a Compulsory Outpatient Care Order, he is entitled to be represented in hearings as aforesaid in sub-clause (a) by a lawyer appointed to provide legal services under the Legal Aid Act, 1972.

(c) Should a patient have been sent to hospital or outpatient care by court order, he is entitled to be represented in hearings as aforesaid in sub-clause (a) by a public defender appointed under the Public Defender Act, 1995.

(d) The provisions of sub-clauses (a) and (b) shall not apply to the hearings of a District Psychiatric Board with regard to children and adolescents, as aforesaid in Article 24a, or to appeals against those Boards' rulings.

(e) The medical director of a hospital, or someone authorized by him for this purpose, shall inform a patient soon after his admission, and if there is a guardian also his guardian, that he has the right to be represented under the provisions of this Article; should the wishes of the patient be unascertainable because of his medical condition and the patient has no legal guardian, the said notification shall be issued to a relative; should the patient request representation by a lawyer in accordance with the provisions of this Article, or should his guardian or relative request this, the wishes of the patient being unascertainable because of

his medical condition, the patient shall be given sufficient opportunity to meet with the lawyer in order to be properly represented.

(f) The Minister of Justice, in consultation with the Minister of Health, and with the approval of the Knesset Labor, Health and Social Affairs Committee, shall draw up regulations for the implementation of this Article.

The present study examined data with respect to a cohort of compulsorily hospitalized patients discharged from two Israeli mental health centers in 2003. The aim was to test the hypothesis that the legal representation of civil mental patients before a District Psychiatrist Board is associated with more subsequent psychiatric readmissions and longer subsequent hospital stays.

MATERIALS AND METHODOLOGY

All patients discharged in 2003 from two mental health centers, the first in Israel to provide patients legal representation, were identified from the National Psychiatric Case Register. Details that might disclose the identity of the subjects under study were excluded. The data of this cohort (n=153) were reviewed for subsequent readmissions throughout the two years following the index discharge date. Their background sociodemographic and clinical characteristics were collected — age, gender, marital status, clinical diagnosis, number of previous psychiatric admissions, length of previous admissions, length of the last admission preceding the index discharge, number of readmissions in the two years following index discharge, time elapsed before readmission and legal status on readmission.

The sample comprised 88 men and 65 women (57.5% and 42.5% respectively); mean age was 38.5 years ±13.2 (range 19-81 years). A majority of patients (136, 82%) were single or divorced. A total of 130 patients (85%) had a primary diagnosis of schizophrenia at the index discharge, 13 (8%) had a primary diagnosis of mood disorder, 6 (4%) of personality disorder, and 4 (3%) of substance abuse disorder. The discharged cohort was divided into two groups: 1) patients who were legally represented at the index discharge hearing (n=109) and 2) those who were discharged without legal representation (n=44). Differences between the groups were tested by chi square tests or (if needed) Mann-Whitney proportional two (non-matched) samples tests for nominal data, and t-tests for continuous data. The level of statistical significance was set at $p<0.05$. All analyses were performed using the Number Cruncher Statistical System (NCSS-2000; NCSS Statistical Software, Kaysville, Utah).

RESULTS

The study results are summarized in Table **1**. The two groups had similar sociodemographic profiles and, before the index discharge, also a similar clinical profile: they did not differ by either the number of patients diagnosed with schizophrenia ($z=0.02$, $p=.89$) or the number of patients admitted voluntarily ($z=1.83$, $p=0.7$) or compulsorily ($z=1.20$, $p=.23$), or both ($z=0.06$, $p=.96$). Likewise, there were no statistically significant differences between the groups by total duration of previous hospitalizations ($t=0.21$, $p=.83$) and duration of the index hospitalization ($t=0.51$, $p=.61$).

In contrast, significant between-group differences in readmission rates were found after the index discharge. For the follow-up period, there was more patients readmitted in total ($z=5.44$, $p<.001$), readmitted voluntarily ($z=2.86$, $p<.01$) and more patients with both voluntarily and compulsory rehospitalizations ($z=2.10$, $p<.05$) in the index group than the control group. Correspondingly, markedly less patients with no readmission for the follow-up period was noted in the control group than in the index group ($z=5.19$, $p<.001$). The duration of readmissions was also significantly longer in the index group (50.2±74 days vs. 5±13 days; $t=6.15$, $p<.001$), whereas the control group spent far more days out of hospital (155±142 days vs. 62.6±86 days; $t=4.03$, $p<.001$).

DISCUSSION

The results of this study show that patients represented by lawyers are more frequently readmitted after discharge than unrepresented patients. Furthermore, patients from the represented group are readmitted sooner and stay longer in hospital. Taken together, the findings lend support to our hypothesis that the legal representation of compulsorily committed patients before a DPB hearing for early discharge is associated with readmission, both voluntary and compulsory.

The evidence supporting our hypothesis is buttressed by the fact that the two groups did not differ on previous admission history, that is, the number and duration of previous hospitalizations, including the index admission. This finding is interesting by itself, because it stands in obvious contrast to the studies that concluded that a history of previous admissions is the only variable which differentiates patients who are readmitted from those who are not (Bernardo & Forchuk, 2001). Likewise, our findings challenge Myers' study (1997), which found that non-offender patients discharged by a mental health tribunal did not differ significantly from those refused discharge in a subsequent 2-year survival period in the community, in readmission rate or in final outcome.

One possible explanation for our findings is that the lawyers representing the patients at DPB hearings are mainly driven by the patient's urgent wish to be immediately released from hospital, rather than by considerations of the patient's welfare and health. Using all available legal arguments and weapons, the lawyers succeed in getting their client discharged, often prematurely, before they complete their course of treatment. One could argue that patients who demand legal counsel are mainly the ones who are convinced of their sanity and who therefore deny any need for their hospitalization. They believe that legal assistance gives them a better chance of being discharged. These are also the non-compliant patients, who lack insight into their pathology and who will most probably stop their medication soon after discharge, thus increasing the risk of readmission and becoming revolving-door patients (Craig *et al.*, 2000; Ram *et al.*, 1992; Rosca *et al.*, 2006).

Another possible reason for premature discharge and consequent readmission may be the fact that most of these patients were compulsorily committed in an acute psychotic state, constituting an immediate danger to themselves or others (Article 9a of the MPTA). After one or two week-hospitalization and medical treatment most of these patients

Table 1. Sociodemographic and Clinical Characteristics of Patients Represented by a Lawyer vs. not Represented by a Lawyer

Characteristic	Patients Represented by Lawyer (n=109) n	%	Patients Not Represented by Lawyer (n=44) n	%	Significance Test
Gender					
Male	63	57.8	25	56.8	χ^2=0.029, df=1, p=.92[a]
Female	46	42.2	19	43.2	
Age (years)	38.5±13.2		38.5±13.3		
Marital status					
Single	79	72.5	31	70.4	χ^2=0.35, df=2, p=.72
Married	20	18.3	7	15.9	
Divorced	10	9.2	6	13.6	
Diagnosed with schizophrenia	91	83.5	37	84.0	z=0.02, p=0.89[b]
Previously admitted patients					
Voluntarily	30	27.5	6	13.6	χ^2=3.11, df=3, p>.25
Compulsorily	10	9.2	7	15.9	
Both	55	50.4	22	50.0	
No prior admissions	14	12.8	7	15.9	z =0.50, p=.62
Duration of prior admissions (days)	68.8±82.1		65.2±98		t=0.21, p=.83[c]
Duration of index hospitalization (days)	32±61		27±52.6		t=0.51, p=.61
Number of readmitted patients	75	68.8	9	20.5	z=5.44, p<.001
Voluntarily	34	31.2	4	9.1	z=2.86, p<.01
Compulsorily	22	20.2	4	9.1	z=1.65, p=.10
Both	19	17.4	2	4.5	z=2.10, p<.05
No readmissions	34	31.2	34	77.2	z=5.19, p<.001
Rehospitalization days	50.2±74		5±13		t=6.15, p<.001
Days out of hospital	62.6±86		155±142		t=4.03, p<.001

Mean scores±SD are shown for continuous variables.
[a]Chi-square statistics.
[b]Mann-Whitney proportional two (non matched) samples test, z-value.
[c]Two-tailed t-tests, t-value.

are still psychotic and potentially dangerous but their dangerousness in less severe, no longer imminent or obvious. Under these circumstances, Article 9a does not allow their continued commitment and the grounds for hospitalization need to shift from imminent dangerousness (Art. 9a) to potential dangerousness (Art. 9b). Such a shift is, under current law, legally impossible, compelling a DPB to discharge the patient. This legal anomaly is currently the object of great debate. Paradoxically, a patient who was initially compulsorily committed under Article 9b of the Act will most probably remain hospitalized for longer than an acute psychotic and dangerous patient, because at the subsequent hearing he still matches the original criterion of potential danger.

Doctors argue that, even if the patient does not meet the strict legal criteria for compulsory hospitalization, there are grounds to allow continued inpatient care in order to let the course of treatment reach its defined end, and that the provisions of the law should, therefore, be interpreted broadly. Although this might entail some limited infringement of the patient's right to freedom, even of his dignity, this infringement, if there is any, is to be weighed against the potential risk to public safety. Furthermore, the health of the prematurely released patient may in the end be damaged.

With respect to patients not legally represented, we believe that DPBs tend to take into consideration the overall benefit to a patient and his/her best medical interests, whereas legal counsel tends to represent only the patient's wish to be discharged. Moreover, whereas the lawyers take no responsibility for their client's mental state or for the potential consequences of premature discharge, psychiatrists do

see themselves as responsible for those developments and, in the nature of things, are therefore more likely to insist on a full course of treatment and that the patient remain under inpatient care until he has sufficiently recovered. Another pertinent consideration is the financial cost to the health care system of repeated readmissions.

Certain limitations are inherent in this study because its cross-sectional and retrospective design precludes inferring causal relations between the variables studied, and permits only associative relations. It is possible that the patients who are interested in legal representation, compared to those who do not ask for it, are the ones who experience hospitalization more negatively, or are more non-trusting of, or hostile to, the system, and more non-compliant to treatment. A further prospective study, taking into account these limitations, is needed to support the conclusions we draw from our findings.

CONCLUSIONS

We conclude that there are grounds to change the lawyers' approach from one of only considering the short-term benefit of discharge to their client to a more long-term perspective, which also takes into account the consequences of premature discharge to both patient and society. In our opinion, despite the benefit of legal representation in respect of preserving mentally ill patients' human rights and dignity, it does not keep the necessary balance between medical and legal considerations. The patient's wish for freedom and discharge outweighs his need for treatment to the neglect of his right to health and the interests of public safety. To resolve the problem of balancing the right to freedom and self-determination, on the one hand, with the need for authorities to quickly admit patients to treatment who present a danger to self and others, a dialogue and exchange of relevant knowledge should be set in motion between clinicians and lawyers. This dialogue may result in a pre-hearing agreement and a joint application by both parties as to the duration of the patient's hospitalization.

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