The effect of collateral information on involuntary psychiatric commitment

Martin Witkin, DO

Collateral information is a key component obtained during the psychiatric admission process whereby clinicians gather information provided about the patient from the patient's known contacts. Despite its usefulness in formulating an assessment and plan, collateral information may be misleading and create false biases that lead clinicians to uphold or prolong an involuntary commitment. This raises concern for the need to screen for misleading collateral information, as involuntary admission to an inpatient psychiatric setting can have lasting negative effects on individuals for whom inpatient psychiatric care is not indicated.[1]

Here I describe a case in which collateral information obtained about a patient was a primary factor in that patient's involuntary commitment. However, the patient's subsequent behavior observed on an inpatient psychiatric unit was entirely inconsistent with those behaviors described by the collateral informant to be "continuous and dangerous."

CASE

Mr. M, age 18, presented to an emergency psychiatric center for evaluation of dangerous and aggressive behavior. He had a history of autism spectrum disorder (ASD), which was well managed with oral risperidone. He was petitioned for an involuntary psychiatric admission by his foster mother, who reported that Mr. M was aggressive and dangerous, often punching holes in the walls of their home, and that he threatened to assault his foster siblings on several occasions. She detailed a progressively declining history for Mr. M and said that he was "constantly talking to voices in his head that absolutely consume him," to the extent that Mr. M could not pay attention to his daily tasks. The admitting psychiatrist upheld the petition for involuntary admission, citing that based on the foster's mother collateral information, Mr. M was deemed to be a danger to others and therefore fulfilled criteria for involuntary psychiatric admission.

Once admitted to the inpatient psychiatric unit, Mr. M was observed to be pleasant, cooperative, and fully engaged in the milieu. At no point during his 7-day admission was he observed to be internally preoccupied or remotely disorganized. Mr. M was switched from oral risperidone to oral haloperidol because he developed acute gynecomastia, and was discharged home.

Does collateral information lead to unfair bias?

The importance of collateral information on the psychiatric admission process must not be understated. It is an opportunity to hear a first-hand account of behaviors consistent with an acute psychiatric disturbance, and guides us in formulating a clinically appropriate assessment and plan. But what

Dr. Witkin is a PGY-1 Psychiatry Resident, Department of Psychiatry, Albert Einstein Medical Center, Philadelphia, Pennsylvania.

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happens when our patients' close contacts or informants provide misleading or unintentionally suboptimal collateral information? How must we reconcile the ethical and legal obligation we have to balance patient autonomy with beneficence?

Studies examining patients' attitudes toward involuntary admissions have routinely found that patients are less likely than clinical staff to view the involuntary admission as clinically justified.[2] Consistent with these findings, Mr. M did not view his admission as necessary. At first, he seemed to lack insight regarding the events precipitating his involuntary admission, describing himself not as responding to internal stimuli, but rather, "imaginative because I have autism." As time went on, though, it was clear that his account of his behavior was in fact correct.

Mr. M's diagnosis of ASD further complicated the over-reliance on misleading collateral information provided by his foster mother, because the admitting psychiatrist invariably perceived Mr. M as a poor historian. A study examining how subjective histories described by patients with neurologic or psychiatric disorders are perceived by clinicians found physicians had a tendency for negative stereotyping and placed less credence on those patients' subjective histories.[3] Other literature has similarly concluded that there is an urgent need to carefully weigh information supplied to us by collateral informants because the first-hand accounts of perceivably dangerous behavior often are incomplete or misleading.[4-5]

Clinical Point

First-hand accounts of perceivably dangerous behavior often are incomplete or misleading

Ideas for improvement: respecting patient autonomy

These issues underscore the need for a more thorough review of collateral information to ensure that patient autonomy is not unjustly violated. How do we implement these necessary ideas without creating further undue burden during the admission process? Certainly, I am not suggesting that we evaluate the collateral informant to the degree that we evaluate the patient. However, I have outlined some suggestions for ensuring we act in our patients' best interest when processing collateral information during an admission:

• **Until proven otherwise, the patient's story is true.** If our patient maintains descriptions of his behavior that exist in stark opposition to the collateral information we obtain, we should only *not* believe the patient if his presentation suggests he may be acutely impaired or a poor historian (such as profound disorganization, overt psychosis, or failing to have capacity).

• **Treat symptoms, not diagnoses.** In this case, Mr. M was described by his foster mother to be psychotic in addition to having ASD, and an inexperienced psychiatrist may have initiated a titration to a higher antipsychotic dose. However, in the absence of any observable signs of aggression or psychosis, there was simply no indication for further titration of his antipsychotic.

• **Document, document, document.** When collateral information is supplied to us, it is crucial that we maintain a detailed account of this information. If we have a reason to believe that a patient poses an immediate danger to himself or others, we should carefully document our reasoning so that changes in behavior (if any) can be observed on a day-to-day basis.

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