Journal of Forensic and Legal Medicine 85 (2022) 102285

Contents lists available at ScienceDirect

Journal of Forensic and Legal Medicine

journal homepage: www.elsevier.com/locate/yjflm

Case report

Ability to consent to a sexual assault medical forensic examination in adult patients with serious mental illness

Leslie W. Miles [c,*], Eleanore Knox [a], Nancy Downing [b], Julie L. Valentine [c]

[a] University of Texas Southwestern Medical Center, Department of Psychiatry, 5323 Harry Hines Blvd, Dallas, TX, 75390-9070, USA
[b] Center of Excellence in Forensic Nursing, College of Nursing, Texas A&M University, 8447 Riverside Parkway, Bryan, TX, 77807, USA
[c] Department of Nursing, Faculty of Nursing, Brigham Young University, Provo, UT 500 KMBL, Provo, UTAH, 84602, USA

ARTICLE INFO

Keywords:
Sexual assault
Mental illness
Competency
Psychotropic
Involuntary commitment
Forensic medicine

ABSTRACT

When a patient reporting a sexual assault (SA) presents with signs and symptoms of serious mental illness (MI), medical providers or forensic examiners may have concerns regarding the ability to legally consent to a sexual assault medical forensic examination (SAMFE). Numerous encounters have occurred where a SAMFE was not offered to a cooperative adult patient because the patient exhibited signs and symptoms of MI. Medical providers and examiners may be motivated by beneficence (believing that treating the patient's MI must take priority over the SAMFE) and/or non-maleficence (a concern that the in-depth SAMFE may worsen the patient's psychological state). Situations where a patient has received psychiatric medications or is under involuntary psychiatric detention also raise capacity to consent to SAMFE concerns. This review explored these concerns and provides recommendations for conducting SAMFEs in adult patients with MI. In instances where a patient has the capacity and is cooperative, the decision to undergo, postpone, or decline a SAMFE ought to be ultimately made by the patient, rather than on their behalf by the provider, SANE or forensic examiner.

1. Capacity to consent issues for sexual assault forensic medical examinations

When an adult patient reports a sexual assault (SA), the patient's medical provider is often responsible for contacting a sexual assault nurse examiner (SANE) or forensic examiner, who then determines whether to offer a SAMFE to the patient. Typically, the examiner begins by explaining the process and purpose of the SAMFE and determines whether the patient can consent to the forensic exam by assessing the patient's ability to do the following: communicate a choice, understand relevant information, appreciate the situation and consequences, and reason about treatment options.[1,2] Some adult patients may lack capacity because their MI may interfere with their ability to communicate, understand, or rationalize the decision to have a SAMFE performed. In other cases, patients may be not be offered the SAMFE due to misunderstanding about MI and the capacity to provide informed consent. (See Figure).

1.1. Impact of delaying the SAMFE

Timeliness in performing the SAMFE is important as time-sensitive medical treatments, and the DNA evidence yield diminishes as time elapses. The current US national consensus is to collect evidence within 120 hours of the SA.[2] Delaying an exam may result in diminished efficacy of prophylactic medications, less useable DNA evidence for investigation or prosecution,[2] and additional psychological distress.

1.2. Situations to postpone or not perform SAMFE

There are certain circumstances in which the SAMFE is postponed or not offered. A SANE may determine that performing a SAMFE would be of limited utility if the patient's account suggests there would be a low yield of DNA evidence. (The yield of DNA evidence present on a victim's body can vary greatly depending on the type of assault, the time elapsed since the assault, and other contextual factors.)[3] The SAMFE may be postponed or not offered if the patient is critically medically ill and requires medical stabilization.

* Corresponding author.
E-mail addresses: Leslie_Miles@byu.edu (L.W. Miles), eleanore.knox@gmail.com (E. Knox), downing@tamu.edu (N. Downing), Julie_Valentine@byu.edu (J.L. Valentine).

https://doi.org/10.1016/j.jflm.2021.102285
Received 26 July 2021; Received in revised form 7 October 2021; Accepted 11 November 2021
Available online 20 November 2021

1.3. Mental illness

The decision to conduct a SAMFE can be impacted by the victim's signs and symptoms of MI. Sometimes a patient presents with a highly implausible assault account along with signs and symptoms of MI, such that the examiner suspects the patient's account is a delusion.[4] In these cases, providers and examiners may struggle to determine whether the patient has the capacity and/or whether the SAMFE is appropriate.[4] In our clinical experience, we have witnessed and heard cases in which the provider or examiner did not doubt the patient's capacity to consent nor suspect the SA report to be delusional, but nevertheless postponed or declined to offer the SAMFE because the patient was exhibiting symptoms of mental illness. The American Disabilities Act prohibits discrimination based on mental or physical disability, including in the context of health care.[5] Thus, if a patient with MI requests treatment for sexual assault, there must be a high bar for denial of that request. Unfortunately, there is tremendous variability from hospital to hospital and between individual providers and examiners when adult patients exhibit acute MI symptoms present for SAMFEs.

Research suggests over 40% of adult patients evaluated for a SAMFE have a history of MI[6,7] and that persons with MI are more likely to be victims of SA during their lifetime.[8] However, there has been a lack of legal or organizational guidelines that address the care of adult patients with MI reporting SA. Providers and examiners should consider various rationales when attempting to determine the appropriateness of offering a SAMFE to a person with acute MI. While these rationales are commonly cited in clinical practice, there has been limited documentation or discussion of their merit in the academic literature. This review addresses these justifications for denying or postponing SAMFE, explores concerns, and summarizes recommendations for SANEs, forensic examiners, medical and psychiatric providers.

2. Mental and behavioral symptoms

2.1. Mental illness treatment

Psychological distress and behavioral disturbances can be symptoms of a patient's MI. Many providers believe that MI symptoms must be treated until they are no longer apparent before performing the SAMFE. Forensic exams have been postponed or declined because the patient was perceived to be exhibiting MI symptoms that the provider or examiner believed must be first treated. Unfortunately, in some cases, the patient has transferred from an emergency setting to a psychiatric facility that does not have trained staff to perform a SAMFE, or communication about the need for a SAMFE is lost. This rationale for providing a SAMFE until MI symptoms are treated originated from an interpretation of US national guidelines that advise providers to "assess patients' needs for immediate medical or mental health intervention before the evidentiary exam, following facility policy."[9] Some state and hospital organizations have incorporated this language into their protocols, interpreting them to mean the presence of acute medical or MI symptoms supersedes the need for a medical forensic examination.

2.2. Scope of practice

While the SANE is a specialty nurse with expertise in the forensic sciences, performing a capacity assessment or assessing a patient's psychiatric condition may be outside their scope of practice. Likewise, a forensic examiner trained to conduct SAMFE in other parts of the world may also lack education and training about how to assess for capacity to consent in the presence of psychiatric symptoms.

2.3. Exacerbation of symptoms

There has been insufficient clarification or discussion of what psychiatric symptoms would warrant "immediate mental health intervention,"[9] thereby precluding the SAMFE. Adult patients may exhibit signs and symptoms of MI that neither interfere with their capacity to consent to the SAMFE nor the examiner's ability to perform the exam safely. Even people without MI may exhibit acute psychological distress and behavioral disturbances following a SA. When patients with a history of MI present with symptoms, they may be erroneously perceived as an exacerbation of pre-existing MI rather than an acute stress response to the SA trauma.

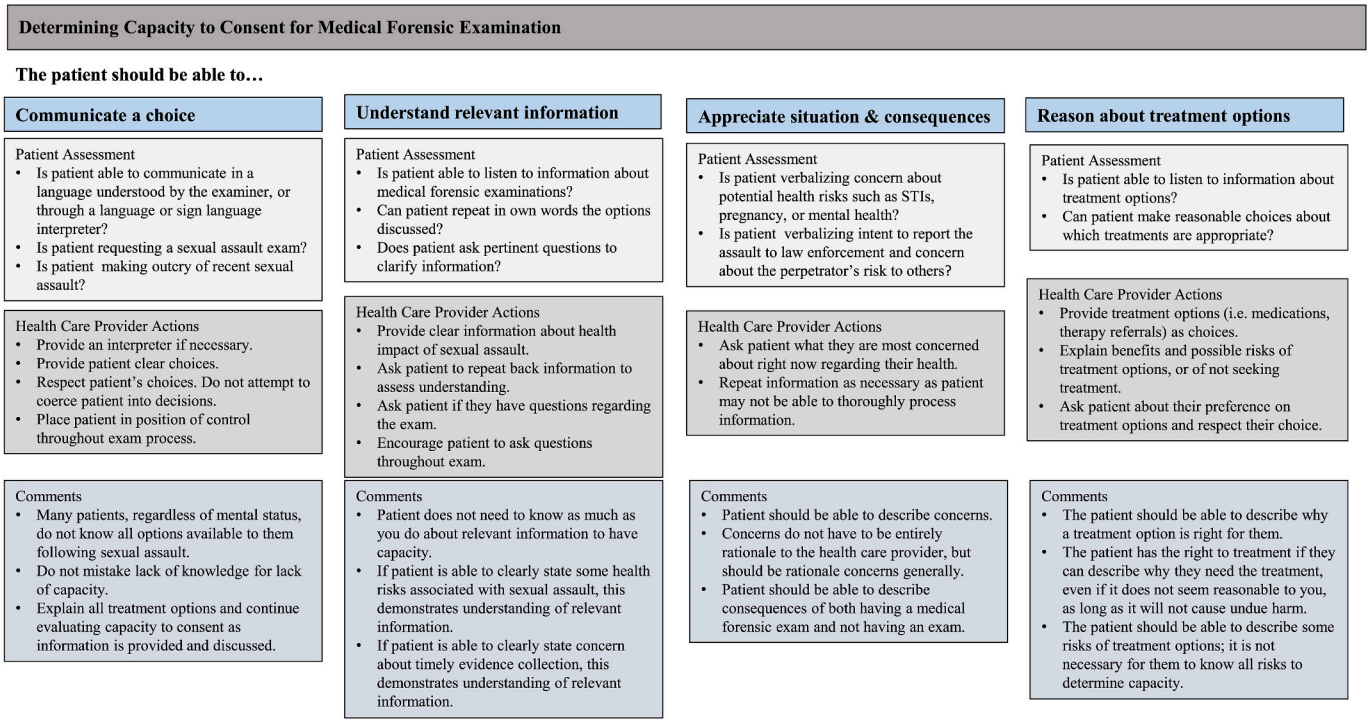

Figure 1. Determining Capacity to Consent for to Medical Forensic Examination

2.4. Postponing SAMFE

A SAMFE may also be postponed when patients present with MI symptoms, believing that after treatment, the patient may have an improved ability to provide a reliable history of the assault during the SAMFE. However, even if the observed symptoms are attributable to the person's MI, the person's symptoms may not entirely resolve, even with acute treatment. It is difficult even for mental health providers, let alone general medical providers and forensic examiners, to predict if and when psychiatric medications will improve specific features of a patient's MI symptoms. Additionally, it may take days to weeks for the patient's clinical condition to improve. During this time, prophylactic treatment windows to address health risks associated with SA close, and the quality of forensic evidence diminishes.

2.5. Suicidal and homicidal ideation

Medical providers and forensic examiners have made assumptions and overgeneralizations that resulted in not offering SAMFEs to patients expressing suicidal or homicidal ideation. For example, a patient may report on a suicide screening that the experience of being assaulted makes them wish they were dead, and a medical provider or examiner may conclude that offering a SAMFE is inappropriate based on the patient 'being suicidal.' However, the patient may have no intent to act on suicidal thoughts in the immediate future and may be able to contract for safety in the medical setting. Similarly, a patient might have thoughts of wanting to kill the person they believed assaulted them, and the medical provider or examiner may conclude the SAMFE is unsuitable due to the patient's 'being homicidal.' The patient may only harbor homicidal thoughts towards their assailant and have no intent to act on those thoughts. Because homicidal thoughts are directed towards the alleged perpetrator and not others, it may be safe to provide care. Furthermore, a patient who experiences suicidal or homicidal ideation may be willing and able to participate in the SAMFE, access medical care, and have the opportunity for legal recourse that the exam confers.

2.6. Auditory hallucinations & delusions

In cases where patients have presented and endorsed auditory hallucinations, a medical provider or forensic examiner might overgeneralize, assuming that the patient's psychosis or delusional thought content makes the patient unable to consent to the SAMFE. However, auditory hallucinations can be experienced independently of MI. Even in patients with a serious mental illness, the presence of auditory hallucinations does not necessarily indicate the presence of delusions or gross disorganization of thought. Unfortunately, these patients are not always offered the opportunity to have SAMFEs.

2.7. Exaggeration or falsifying symptoms

There have been cases where patients have had other motivations to exhibit MI symptoms which caused them to exaggerate or falsify psychiatric symptoms. For example, a patient who feels that their concerns have not been taken seriously by medical providers in the past may overemphasize the severity of their MI symptoms with the hopes of getting more thorough care. In this case, a patient might only have minimal impairments in their functioning and be able to consent to the SAMFE. Similarly, a patient motivated by a secondary gain could also exaggerate or falsify symptoms. For example, a homeless patient who reports a SA may be frightened to return to an environment where they are more vulnerable to assault and so could (consciously or unconsciously) overemphasize or falsify psychiatric symptoms to prolong their stay in a setting they perceive to be safer. In these cases, the patient actually may be fully capable of consenting to and cooperating with the SAMFE.

2.8. Immediate medical issues

Addressing mental health needs may not be comparable to critical medical health demands. Immediate medical needs presumably take precedence over the SAMFE. If a patient with urgent medical needs is not treated emergently, the patient may physically decompensate and even die. However, very few medical conditions (i.e., serotonin syndrome and neuroleptic malignant syndrome) are acutely life-threatening within the structured and supervised hospital setting.

Some pressing mental health needs can become urgent medical issues that may preclude a SAMFE– these include situations in which a patient has suicidal intent with a desire to act in the hospital, when a patient is acutely attempting to self-harm and when a patient is aggressive toward the staff.

3. Exacerbating distress and empowerment

Many health providers erroneously believe the intrusiveness of the SAMFE could intensify a patient's psychological distress and worsen the MI severity. The US Substance Abuse and Mental Health Services Administration (SAMHSA) recommends that a care provider working with victims of trauma take a "trauma-informed care" approach, in part by "seek(ing) to actively resist re-traumatization."[9] During the SAMFE, the patient is asked to recount details of the alleged assault and is offered an intensive physical examination, including evidence collection that consists of swabbing intimate parts of the body where evidence might be located, such as breasts, neck, mouth, vaginal canal, cervix, and/or anus.[2] Photographic documentation of these body parts may also be offered. We have heard medical providers and forensic examiners motivated by the concept of 'trauma-informed care' state their concern that the SAMFE is too intense and intrusive for a patient who already appears to be emotionally distressed. Thusly, motivated by non-maleficence ("do no harm"), the medical provider or forensic examiner may postpone or not offer a SAMFE to a patient presenting with signs and symptoms of MI, with the intent to avoid inflicting additional trauma.

3.1. Empowerment

The trauma-informed care approach may be misinterpreted to emphasize non-maleficence at the cost of patient autonomy. Qualitative research with adult Canadian survivors of SA (N = 20) who underwent a SAMFE found that even though a majority (n = 12) found the experience to be "very difficult," the majority (n = 14) of SA survivors would recommend undergoing the SAMFE.[10] Participants felt empowered by undergoing the SAMFE, as though they were "doing something" about their assault.[10] In some cases, participants felt dissatisfied with the SAMFE experience and reported they had been told by police and/or the forensic examiner that the SAMFE was mandatory.[10] A person who has been the victim of a SA may already feel disempowered. Medical providers and forensic examiners who paternalistically decide the appropriateness of the SAMFE on behalf of an adult patient rather than with that patient may further disempower that patient. Another qualitative study that conducted interviews with victims of SA (N = 20) found that those who received specialized care provided by SANEs reported feeling "more hope and confidence about their legal cases."[11] However, when criminal justice system personnel did not act in accordance with victim preferences (e.g., not proceeding with prosecution when the victim wanted the case prosecuted, or vice versa), victims found this to be "hurtful, disappointing and disempowering."[11] To decline to offer the SAMFE to a cooperative adult patient with capacity (particularly if they request a SAMFE) may be paternalistic and re-traumatize a patient by excluding them from the decision-making process about the most appropriate care. Providing the patient with the opportunity to make an informed decision about whether to undergo the SAMFE can empower that patient and enhance their sense of autonomy.

4. Impact of psychiatric medications

4.1. Treating symptoms

In our collective clinical experiences, we have heard numerous medical providers and forensic examiners articulate their opposition to performing a SAMFE on an adult patient who has received (voluntarily or involuntarily) a psychiatric medication. Some providers and examiners have expressed their belief that medications are forms of chemical restraint, and offering a SAMFE is inappropriate and unethical. Others have concerns that the medication is 'mind-altering' and may cause the patient to lack the capacity to provide informed consent or behave differently than they may have otherwise, including providing less truthful statements during the history portion of the SAMFE.

The use of psychiatric medications to treat agitation is not a form of chemical restraint. The US Centers for Medicare & Medicaid Services (CMS) defines chemical restraint as "any drug used for discipline or convenience and is not required to treat medical symptoms."[12] The American Association for Emergency Psychiatry's Project BETA Seclusion and Restraint workgroup noted that "chemical restraint" is an outdated and misused term that does not apply to current medical treatment.[13] A regularly scheduled or "PRN" (as-needed) psychiatric medication administered to treat MI symptoms does not qualify as a chemical restraint.[14] Even when a medication is administered in an emergent situation involuntarily to a patient to prevent harm to self or others (including antipsychotics and anxiolytics), this is not considered a chemical restraint because it is consistent with the indicated use of the prescribed medication.[14] Using a medication that works on the brain to treat symptoms of a patient's MI to improve their condition is not a form of restraint. "One would never hear of 'chemically treating the diabetic' or 'chemically relieving the asthmatic,' but it is still possible to hear about 'chemically restraining the schizophrenic."[14] While not all agitation in patients with MI is a symptom of their MI, patients who experience MI may have more difficulty self-regulating their emotions and behavior, particularly after an event as stressful as experiencing a SA. When a patient becomes agitated, it may endanger patient and staff safety. Agitation may also impair a patient's ability to effectively communicate their needs, making it more difficult for the medical team to address those essentials. According to the standards of care, psychiatric medication to treat psychiatric illness is not a chemical restraint but rather a therapeutic intervention to alleviate a psychopathologic process.[14]

4.2. Cognitive impairment

It is also erroneous to assume that psychiatric medications will necessarily impair an patient's cognitive ability to participate in a forensic examination. However, a medication could be overly sedating that a patient could not participate in a SAMFE. One of the goals of treatment with medication is to improve the patient's cognition, which is supported by research demonstrating that patients with depression and psychotic illness experience improvements in cognition when treated with psychiatric medications appropriate for their MI.[15,16,17] Particularly patients who experience symptoms of psychosis (i.e., disorganized thought, internal preoccupation, distress from experiencing hallucinations, disorganized behavior) or mania (i.e., disorganized thought, pressured speech, psychomotor restlessness), may benefit from medications to mitigate symptoms so patients can participate in the SAMFE. Certain classes of psychiatric medications, including benzodiazepines and highly anticholinergic medications, may decrease processing speed. However, there is no reason to believe a patient who has taken any class (or a combination thereof) of psychiatric medications at an appropriate dose will provide a less factual account than if that patient had not taken those medications.

5. Involuntary psychiatric detention

5.1. Capacity to make decisions

We have heard medical providers and forensic examiners assume that adult patients under involuntary psychiatric detention do not have the capacity to make decisions and decline to offer a SAMFE because of the belief that the patient would not consent to an exam. Providers rationalize that a patient under involuntary psychiatric detention cannot provide consent for a SAMFE and/or is too 'dangerous' or 'disabled' to be offered a SAMFE. Forensic examiners and providers have also reasoned that being under involuntary psychiatric detention indicates that the acuity and severity of the patient's current mental state makes a SAMFE inappropriate.

While a patient may lack the capacity for other reasons, being under involuntary psychiatric detention does not by itself mean a patient is not competent and cannot consent to medical treatment, including to a SAMFE. In a landmark ruling, the United States First Circuit Court of Appeals established in Rogers v. Okin that a patient committed to a mental institution assumed to be competent has the right to make treatment decisions in non-emergency conditions.[18] Some patients may lack capacity because their MI may interfere with their ability to understand or rationalize the decision to have a SAMFE performed. However, we contend it should not be assumed this is the case for all patients under involuntary psychiatric detention. Research suggests that the majority of patients in an inpatient psychiatric setting have capacity.[19] Based on established criteria for capacity,[1] an assessment of each patient should inform the decision-making process of medical providers and forensic examiners as to whether the patient can consent to the SAMFE and whether offering the SAMFE is appropriate. It is precisely because an adult patient under involuntary psychiatric detention does not have the liberty to leave one facility and seek care at another facility that efforts should be made to facilitate, rather than postpone or deny, a SAMFE to cooperative patients with capacity under involuntary psychiatric detention.

5.2. Delaying

We have also heard providers and examiners express the need to delay a SAMFE until the patient is no longer under emergency detention. Unnecessarily postponing the SAMFE risks delaying appropriate medical treatment and decreasing the amount and quality of forensic evidence. Furthermore, patients may be transferred to psychiatric facilities that do not offer the SAMFE services.

5.3. Dangerousness

We have also observed medical providers and forensic examiners expressing concern that being under involuntary psychiatric detention indicates a patient is 'dangerous' (possibly aggressive or hostile). Consequently, they decline to offer these patients a SAMFE out of concern for their own safety. Undeniably, health care provider safety is a serious concern. The Occupational and Safety Administration (OSHA) estimates that US healthcare providers are about four times more likely to be victims of serious workplace violence than workers in other sectors, and the rates of violence against healthcare workers are even higher in mental health care settings.[20] Violence against healthcare workers is prevalent worldwide.[21] However, a patient under involuntary psychiatric detention may not be a danger to others. US case law has established involuntary psychiatric detention may also be employed if there is "extreme likelihood that if the person is not confined he will do immediate harm to himself,"[22] including when a patient is so "gravely disabled" they are unable to provide for their own basic needs. A patient who is considered dangerous to themselves because they harbor suicidal ideation or because their illness impairs their ability to care for themselves in the outpatient setting is not necessarily a threat to others.

Research indicates severe MI does not independently predict future violent behavior; past violence and substance use more accurately predict violent behavior.[23] When considering whether to offer a SAMFE, assessing the risk of harm to others should be based on actual patient presentation features (i.e., verbal threats, aggressive behavior, history of violence) rather than involuntary psychiatric status hold or assumptions about violence by persons with MI.

The presence of signs and symptoms such as experiencing hallucinations or responding to internal stimuli, delusions, and reporting suicidal and/or homicidal ideation should not independently dissuade medical providers and forensic examiners from offering the SAMFE to cooperative patients who have capacity.

6. Creditability of the forensic examiner

6.1. Discredit examiner's testimony

A forensic examiner may be called to testify in the trial of the accused sexual perpetrator as a fact witness (to testify on what was said and observed during the exam) or as an expert witness (to testify on their opinion as to the cause of observed injuries). The defense attorney for the accused may attempt to discredit the examiner's testimony in several ways: imply that if a patient was exhibiting MI symptoms, the patient could not have consented to the exam; discredit information provided by the patient as unreliable; and attempt to cast doubt on the reliability of records by pointing out inconsistencies (e.g., one provider charted that a patient's thought process was linear, while another provider charted the patient's thought process was disorganized). A patient's presentation can fluctuate dramatically even over minutes, which would account for differences in providers' assessments. Documentation that a patient was "calm and cooperative" during one examination and "agitated" during a later assessment may both be accurate descriptions of a patient's behavior, even in patients without a history of MI.

6.2. Examiner's reputation

A forensic examiner may be concerned a defense attorney's attack on their credibility could damage their professional reputation. In our collective experience, we have met multiple forensic examiners who have had this experience on the stand, thusly deterring them from performing the SAMFE on patients with signs and symptoms of MI.

6.3. Examiner's expertise

While the examiner is often an expert in forensic health care, the examiner may not be qualified to provide psychiatric assessment and treatment by training or expertise. Consequently, it may be beyond the scope of practice for a forensic examiner to testify about the nature of a patient's psychiatric illness. All patients (with or without MI) have varying cognitive faculties that may impact their ability to provide a history of the SA to a forensic examiner during the SAMFE. However, it is erroneous to assume that all patients with MI are cognitively impaired and thus will provide an inaccurate history of their experience. Even patients with a history of severe and chronic MI can give an accurate account of their SA.

7. Recommendations

7.1. Access to SAMFE

We assert that adult patients with serious MI with an outcry of SA who are cooperative and demonstrate the capacity to make medical decisions should have the same information and access to a SAMFE as any other patient. James Charlton, a disability empowerment advocate, coined the phrase, "Nothing about us without us."[24] We argue this principle can also guide the care of patients with MI presenting after a SA, both on the individual and systems levels. Medical providers and forensic examiners should collaborate with patients on the individual level about whether to proceed with, postpone, or decline a medical forensic examination rather than deciding for the patient.

- Each patient should be assessed for capacity based on the established criteria for capacity (even when displaying signs and symptoms of MI and/or are under involuntary psychiatric detention).
- The determination regarding the appropriateness of offering a SAMFE to patients with acute MI symptoms should be based on a patient's capacity to consent, with limited exceptions:
    - o In cases where the patient is physically aggressive or threatening the medical provider or forensic examiner, the safety of the staff must be prioritized, and the exam postponed until the patient no longer exhibits these behavioral disturbances.
    - o In cases where the patient expresses acute suicidal intent or is actively engaging in self-harm and declines to contract for safety for a SAMFE, the exam must be postponed until the patient's dysphoria has improved and they can be safe in the immediate future.
    - o If the patient has excessive psychomotor agitation that might logistically interfere with a medical forensic exam, the SAMFE may need to be postponed until the patient is less physically agitated.
    - o In instances where the patient has the capacity and is cooperative, the SAMFE should be offered, regardless of the perceived presence of signs and symptoms of MI. The patient ought to ultimately decide whether they want a SAMFE.

7.2. Consent documentation

Written informed consent is legally required and must be obtained prior to a SAMFE by the health care provider.[2] National recommendations also include obtaining ongoing verbal consent throughout the SAMFE.[2] If consent for any or all of the SAMFE is declined, the health care provider should note the consent change in the chart documentation.

7.3. Collaboration

It is vitally important that medical providers collaborate with forensic examiners. Sharing information about medication administered to a patient to address MI symptoms, especially if the drugs are sedating, is vital to communicate. Depending upon the medication duration of action and time given, the forensic examiner may want an additional dose if needed as the SAMFE proceeds to address patient needs.

7.4. Advocacy

Psychiatric providers should advocate for patients and educate their colleagues regarding the capacity of adult patients with acute MI to consent for medical treatment. On a systems level, health care providers concerned about this issue can encourage advocacy organizations like the National Alliance for the Mentally Ill (NAMI) to familiarize themselves with these barriers to care that patients with MI face so they can take an active role in the discussion. Professional organizations would do well to develop and disseminate clear and comprehensive guidelines for the care of patients with MI who report a SA.

7.5. Professional expertise

It is an unfortunate reality that defense attorneys will likely continue to discredit health care providers and forensic examiners in defense of their clients. The use of these tactics should not dissuade the forensic examiner from offering the SAMFE to a patient reporting a SA who also exhibits signs and symptoms of MI. We recommend that during the trial,

the forensic examiner explain the capacity assessment process and that the patient met all criteria to consent to the exam – they were able to communicate a choice, understand relevant information, appreciate the situation and consequences, and reason about treatment options. This can counter assertions that the patient was unable to consent due to their MI. If pressed, forensic examiners are able to explain that the assessment of psychiatric illness is not within their scope of practice.

7.6. Further research

Finally, we call for additional research on this topic to identify and address issues related to the care of patients with MI making an outcry of SA. Limited research exists that examines discrepancies between the rates of SAMFEs offered to patients with MI versus those without MI.[6] There may also be additional patient characteristics (e.g., age, race/-ethnicity, intellectual disability, incarceration status, substance use, homelessness) that influence the likelihood of the SAMFE being offered and/or performed.

8. Conclusion

Persons with MI may be particularly vulnerable to SA. A history of MI should never be cited as the sole criteria for declining to offer a SAMFE to an adult patient; medical providers and forensic examiners should determine the appropriateness of providing the SAMFE based on the patient's current ability to consent to and cooperate with the exam. When a patient with MI presents for care following SA, they may present with acute signs and symptoms of MI or be also manifesting symptoms of an acute stress response to the SA trauma.

Additionally, having received psychiatric medications and/or being under involuntary psychiatric care should not be cited as the sole rationale against offering a SAMFE to an adult patient with capacity. The ultimate determination of whether to undergo, postpone or decline the SAMFE in a cooperative patient with capacity should be made by that patient. Mental health advocacy organizations and professional medical, psychiatric, and forensic organizations should develop and disseminate clear guidelines for working with patients with MI.

Credit

Leslie Miles: Conceptualization, writing original draft, writing - review and editing.

Eleanor: Conceptualization, writing original draft, writing-review and editing.

Nancy Downing: Conceptualization, writing-review and editing.

Julie Valentine: Conceptualization, writing-review and editing.

Declaration of competing interest

The authors declare that there is no conflict of interest.

Acknowledgements

None.

References

1. Appelbaum PS. Assessment of patients' competence to consent to treatment. *NEJM*. 2007;357(18):1834–1840. https://doi.org/10.1056/nejmcp074045.
2. US Department of Justice Office of Justice Programs National Institute of Justice. *National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach*; 2017. Report # NCJ 250384 https://www.ncjrs.gov/pdffiles1/nij/250384.pdf. Accessed July 21, 2021.
3. Fonnelop AE, Johannessen H, Heen G, Molland K, Gill P. A retrospective study on the transfer, persistence and recovery of sperm and epithelial cells in samples collected in sexual assault casework. *Forensic Sci. Int.Genet.* 2019;43. https://doi.org/10.1016/j.fsigen.2019.102153.
4. Ashmore T, Spangaro J, McNamara L. 'I was raped by Santa Claus': responding to disclosures of sexual assault in mental health inpatient facilities. *Int J Ment Health Nurs*. 2015;24(2):139–148. https://doi.org/10.1111/inm.12114.
5. Rosenbaum S. The Americans with disabilities act in a health care context. In: Field MJ, Jette AM, eds. *The Future of Disability in America*. National Academies Press; 2007:426–452.
6. Brown R, Du Mont J, Macdonald S, Bainbridge D. A comparative analysis of victims of sexual assault with and without mental health histories: acute and follow-up care characteristics. *J Forensic Nurs*. 2013;9(2):76–83. https://doi.org/10.1097/JFN.0b013e31828106df.
7. Miles L, Valentine JL, Mabey L, Downing N. Mental Illness as a Vulnerability for Sexual Assault: A Retrospective Study of 7,453 Sexual Assault Medical Forensic Examinations. [(Manuscript submitted for publication)].
8. Khalifeh H, Johnson S, Howard LM, et al. Violent and non-violent crime against adults with severe mental illness. *Br J Psychiatry*. 2015;206(4):275–282. https://doi.org/10.1192/bjp.bp.114.1478439.
9. *U.S. Department of Justice Office on Violence against Women. A National Protocol for Sexual Assault Medical Forensic Examinations*; September 2004. https://www.ojp.gov/pdffiles1/nij/206554.pdf. Accessed July 21, 2021.
10. Du Mont J, White D, McGregor M. Investigating the medical forensic examination from the perspectives of sexually assaulted women. *Soc Sci Med*. 2009;68(4):774–780. https://doi.org/10.1016/j.socscimed.2008.11.010.
11. Campbell R, Bybee D, Ford J, Patterson D. Systems change analysis of SANE programs: identifying the mediating mechanisms of criminal justice system impact: Project summary. https://www.ncjrs.gov/pdffiles1/nij/grants/226497.pdf; 2009. Accessed June 23, 2021.
12. *Medicare State Operations Manual Provider Certification*. Department of Health and Human Services; Sept 2000. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R20SOM.pdf. Accessed June 23, 2021.
13. Wilson MP, Pepper D, Currier GW, Holloman GH, Feifel D. The psychopharmacology of agitation: consensus statement of the American association for emergency Psychiatry Project BETA psychopharmacoloy workgroup. *West J Emerg Med*. 2012;13(1):26–34. https://doi.org/10.5811/westjem.2011.9.6866.
14. Zeller S. *The End of Chemical Restraints: Expert Opinion*; March 2017. https://www.psychiatryadvisor.com/home/practice-management/the-end-of-chemical-restraints-expert-opinion/. Accessed June 23, 2021.
15. Rosenblat J, Kaker R, McIntyre R. The cognitive effects of antidepressants in major depressive disorder: a systematic review and meta-analysis of randomized clinical trials. *Int J Neuropsychopharmacol*. 2016;19(2):1–13. https://doi.org/10.1093/ijnp/pyv082.
16. Davidson M, Galderisi S, Weiser M, et al. Cognitive effects of antipsychotic drugs in first-episode schizophrenia and schizophreniform disorder: a randomized, open-label clinical trial (EUFEST). *Am J Psychiatr*. 2009;166(6):675–682. https://doi-org.erl.lib.byu.edu/10.1176/appi.ajp.2008.08060806.
17. Desamericq G, Schurhoff F, Meary A, et al. Long-term neurocognitive effects on antipsychotics in schizophrenia: a network meta-analysis. *Eur J Clin Pharmacol*. 2014;70(2):127–134. https://doi.org/10.1007/s00228-013-1600-y.
18. Rogers v. Okin, 638 F. Supp. 934 (D. Mass. 1986).
19. Okai D, Owen G, McGuire H, Singh S, Churchill R, Hotopf M. Mental capacity in psychiatric patients: systematic review. *Br J Psychiatry*. 2007;191:291–297. https://doi.org/10.1192/bjp.bp.106.035162.
20. Occupational Safety and Health Administration. *Workplace Violence in Health Care*; December 2015. https://www.osha.gov/Publications/OSHA3826.pdf. Accessed June 23, 2021.
21. Vento S, Cainelli F, Vallone A. Violence against healthcare workers: a worldwide phenomenon with serious consequences. *Publ Health Forum*. September 2020. https://doi.org/10.3389/fpubh.2020.570459.
22. Lessard v. Schmidt. 349 F. Supp. 1078(E.D. Wis. 972), Vacated and Remanded, 414 U.S. 473, on Remand, 379 F. Supp. 1376 (E.D. Wis. 1974), Vacated and Remanded, 421 U.S. 957 (1975), Reinstated, 413 F. Supp. 1318 (E.D. Wis. 1976).
23. Elbogen EB, Johnson SC. The intricate link between violence and mental disorder: results from the national epidemiologic survey on alcohol and related conditions. *Arch Gen Psychiatr*. 2009;66(2):152–161. https://doi.org/10.1001/archgenpsychiatry.2008.537.
24. Charlton J. *Nothing about Us without Us: Disability Oppression and Empowerment*. University of California Press; 2000.