De-mystifying Care of Patients with Mental Illness Following a Sexual Assault

Leslie Miles, DNP, PMHNP-BC
Julie Valentine, PhD, RN, CNE, SANE-A
Nancy Downing, PhD, RN, SANE-A
Eleanore Knox, MD
Kevin Brown, MD

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Learning outcomes: Upon completion, participants will be able to:

1) Describe the prevalence of mental illness among patients presenting for SAMFEs

2) Apply ethical principles and legal implications when determining a patient's capacity to consent for the SAMFE

3) Discuss approaches to providing SAMFEs to patients presenting with signs and symptoms of mental illness.

Definition of Mental Illness

- *DSM 5* - "mental disorder" : a syndrome that causes *clinically significant* disturbance in an individual's *cognition*, *emotion regulation*, or *behavior*
- Categories of mental illness
  - Mood disorders (depression, bipolar)
  - Anxiety disorders (generalized anxiety disorder, panic disorder)
  - Thought disorders (schizophrenia, schizoaffective disorder)
  - Trauma disorders (PTSD)
  - Personality disorders (borderline personality)
  - And many more…

Sexual Assault & Mental Illness: What Does Research Suggest?

Leslie Miles, DNP, PMHNP-BC
Julie Valentine, PhD, RN, CNE, SANE-A

Prevalence of Mental Illness

Type of Mental Disorder	Adults
Anxiety disorder	18.1%
Major depressive disorder	6.7%
Substance use disorder	3.8%
Bipolar disorder	2.6%
Eating disorder	2.1%
Schizophrenia	1.1%
Any mental disorder	26.2%

Source: Kessler RC, Chiu W, Demler O, Walters EE. Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry.* 2005;62(6):617-627.

Differentiating Severity

	National Institute of Mental Health 2014
Severe Mental Illness	4.1
Any Mental Illness	18.1

http://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml

Sexual Assault in Patients with Severe Mental Illness (SMI)

Women with SMI more likely to experience sexual violence than men, both childhood and adult.

- Rates of trauma exposure very high: 49 - 100%
- Adult sexual assault 11- 59% (median 38%)
- Sexual assault most highly associated with PTSD for women.

Grubaugh et al. (2011)

Sexual Assault has Serious Consequences in Persons with SMI

It appears that a bidirectional relationship exists, with mental health symptoms placing individuals at risk for victimization, and victimization leading to increased symptoms and impairment. In comparison to the general population, individuals with both SMI and trauma exposure are likely to present a complex clinical picture and prolonged course of illness that require specialized treatment, resulting in an increased health care burden."

Grubaugh et al. (2011)

Sexual assault across the spectrum of mental illness

What have we learned from current research study?

Sexual Assault Study

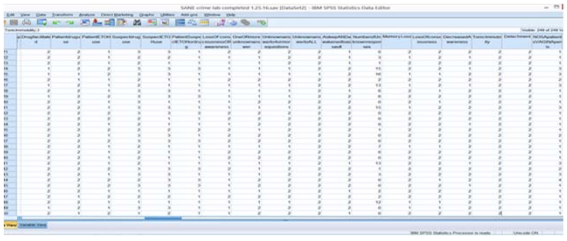
Retrospective SANE chart review (January 2016 through December 2016)

- *N* = 4,038 Patients
- 5 counties
  - Represents 78% of state of Utah

Criteria:

- Age 14 or older
- Full exam with SAK
- Reported to law enforcement

The voices of our patients



Demographic information

Mean age: 27 years (range: 14 - 93 years)

Female : 95% Male 5% (Binary gender response changed in 2016)

Race	Study Data	Utah Census (2016)
White	**79%**	91%
Black	**3%**	1.4%
Hispanic	**11%**	14%
Asian/Pacific Islander	**2%**	3.5%
American Indian	**3%**	1.6%
Other	1%	
Unknown	1%	

Mean time between assault and exam: 24 hours (0 - 408 hours)

Pre-existing mental health conditions

	Study	SAMHSA 2014*	SAMHSA UTAH 2014*
Self –disclosure MI	**36%**		
Use of Psychotropic Medication	**41%**		
Self-disclosure MI or use of psychotropic meds	**46%**		
Prevalence of MI		**18%**	**22%**
*Any MI – No substance abuse or developmental disorders			

Prevalence of self-disclosed mental illnesses

Self- Disclosed MI	%
Depression	**49**
Anxiety	**40**
Bipolar Disorder	**19**
PTSD	**13**
ADHD	**11**
Psychotic Disorder	**5**
Personality Disorder	**4**
Drug & alcohol disorders	**2**
Eating disorders	**1**

Prevalence of use of psychiatric medications

	Study N= 4,038	Medco 2010* National	Medco Mountain West
Psych Med Use	**41%**	**25% (F) 20% (M)**	**15%**
Medco: Antidepressants, Anti-anxiety, ADHD, Antipsychotics			
**No Bipolar Medications			

	Study (Reported use)	CDC 2010*	NIMH 2000*	NHNES 2010*
Antianxiety	16%	6%	8%	
Antidepressants	28%	12%	7%	8% 10%(F)
Atypical Antipsychotics	11%		1%	
Bipolar Meds	10%	5%	3%	
Sleep Aid Meds	10%	6%		4% 5% (F)
Stimulants/ADD or ADHD meds	6%		4%	
Typical Antipsychotics	1%		1%	

Prior History of Sexual Assault (*N*=2,045)

- Association with medical problems: $p = .000$
- Association with chronic physical health problems: $p = .000$
- Association with self-disclosure MI: $p = .000$
- Association with psych med use: $p = .002$

Confirms ACE Study Findings

http://www.cdc.gov/violenceprevention/acestudy/findings.html

Are there differences in patients with mental illness seen for SAFEs?

Associated with physical health problems and chronic health problems

Race (increased mental illness in white patients)

Suspect relationship (increased stranger and unknown relationship; decreased spouse/partner relationship)

Location of assault (increased outside, other, and unknown locations; decreased house/apartment and car)

Assailant actions (increased suspect violent actions: use of a weapon, grabbed/held, hit, strangled, and use of restraints)

Are there differences in patients with mental illness seen for SAFEs? *(continued)*

Increased drug facilitated assault

Increased patient use of drugs prior to assault

Decreased patient use of alcohol prior to assault

Increased genital injuries

How does this compare to other research?

Female psychiatric patients (*n*=361) vs. women in general population (*n*=3138) (Khalifeh, et al., 2015)

- Women with SMI were at **10x higher risk** in past 1 year

National Crime Victimization Survey – general population (*n*=32,449) vs. patients with SMI (*n*=936) (Teplin, McClelland, Abram, & Weiner, 2005)

- Patients with SMI were at **17.2X higher risk** in past 1 year

Systematic review of 11 studies comparing persons with SMI with general population (Khalifeh, Oram, Howard, & Johnson, 2016)

- Patients with SMI were at **6X higher risk** in past 1 year

How does this compare to other research?

- Patients with MI diagnosis (N=467):
  - More likely to be penetrated
  - Less likely to be a victim of DFSA

  Brown, DuMont, Macdonald et at al., 2013

Implications of Research Findings…

What do the research findings mean to practice?

SANE/SAMFE and Mental Illness: Assessing Capacity

Nancy Downing, PhD, RN, SANE-A

Duty to Care

- “Nurses have a duty to care for patients and are not at liberty to abandon them” (ANA, 2015).
- “Nurses have the right to a work environment that is safe for themselves and their patients” (ANA, 2001).

Ethical Principles: Duty to Care

- Autonomy
- Non-maleficence
- Beneficence
- Justice

Beauchamp & Childress, 2009

Ethical principles

Autonomy	Non-maleficence	Beneficence	Justice
• Respect for patient's right to make health care decisions about themselves • There should be a high bar for a HCP to deny a patient care they seek • If a patient makes an outcry of sexual assault, determine capacity and consider offering a medical forensic examination	• Do no harm – obligation not to inflict harm • Includes negligence – absence of due care/departure from professional standards • Denying a cooperative patient with capacity a medical forensic exam may be negligence	• Doing good and preventing/removing harm • Offering a medical forensic exam when a patient has a sexual assault outcry is promoting their rights	• Equal access to a medical forensic exam for all patients • Not offering a medical forensic exam to a cooperative patient with capacity based on an acute mental disorder may be denying them justice

Determining Capacity to Consent

- Not the same as competency determination
- Competency is a legal determination; capacity is a medical determination
- A patient can be involuntarily committed, have signs and symptoms of acute mental illness **AND** have capacity to consent for a medical forensic exam

Capacity to Consent

- A systematic review of literature indicates many HCP do not understand issues of capacity including how to assess capacity.
- Paternalism in determining capacity and consent issues prevalent among physicians and nurses.

Lamont, Jeon, & Chiarella, 2013

Capacity Requirements

To demonstrate capacity, patients must be able to:

- communicate a choice
- understand relevant information
- appreciate the situation and its consequences
- reason about treatment options

Applebaum, 2007

Able to Communicate a Choice - Assessment

Patient behavior	Health care provider assessment	Additional considerations
• Is patient able to communicate either in English or through a language or sign language interpreter? • Is patient requesting a sexual assault exam? • Is patient making outcry of recent sexual assault?	• Please tell me more about what happened to you. • What health care concerns are most important to you right now? • Explain treatment options and evaluate appropriateness of patient response.	• Many patients, regardless of mental status, do not know all options available to them following sexual assault. • Do not mistake lack of knowledge for lack of capacity.

Able to Understand Relevant Information - Assessment

Patient behavior	Health care provider assessment	Additional considerations
• Is patient able to listen to information about medical forensic examinations? • Can patient repeat in own words the options discussed?	• Here are some health issues people face following sexual assault. Tell me what health issues are a concern for you as a result of the assault. • Here are options for collecting evidence following sexual assault. What are your thoughts about my collecting evidence for you now?	• Patient does not need to know as much as you do about relevant information to have capacity. • If patient is able to clearly state some of health risks associated with sexual assault, this demonstrates understanding of relevant information. • If patient is able to clearly state concern about timely evidence collection, this demonstrates understanding of relevant information.

Able to Appreciate Situation & Consequences - Assessment

Patient behavior	Health care provider assessment	Additional considerations
• Does patient verbalize concern about potential health risks such as STIs, pregnancy, or mental health? • Does patient verbalize concern about safety and options for reporting to LE, campus authorities, family, etc.?	• What potential risks to your safety and health concern you most right now? • What concerns for your safety and health do you have after you leave here today?	• Patient should be able to describe concerns. • Concerns do not have to be entirely rational to the health care provider, but should be related to sexual assault. • Patient should be able to describe consequences of both having a medical forensic exam and not having an exam.

Able to Reason about Treatment Options- Assessment

Patient behavior	Health care provider assessment	Additional considerations
• Is patient able to listen to information about treatment options? • Can patient make reasonable choices about which treatments are appropriate?	• Which of the treatment options I have described do you believe are right for you at this time? • What are some of the risks of the treatment options I described?	• The patient should be able to describe why a treatment option is right for them. • The patient has the right to treatment if they can describe why they need it • The patient should be able to describe risks of treatment options; it is not necessary for them to know all risks to determine capacity.

Is the SANE/SAMFE Appropriate? Assessing Other Factors in Patients with Mental Illness

Eleanore Knox, MD
Kevin Brown, MD

How might we conceptualize mental illness in the context of whether the SAMFE is appropriate?

- **Capacity :** Does the mental illness impair the patient's capacity to consent to the SAMFE? *As discussed by Nancy*
- **Safety:** Are there features of the patient's mental illness which make the SAMFE unsafe to perform?
  - Unsafe for the examiner? Unsafe for the patient?
- **Logistically:** Are there features of the patient's condition and presentation that make performing the SAMFE logistically challenging?
- **Other:** Hearing voices and/or having delusions? Under involuntary psychiatric detention? Having taken psychiatric medications?

General principles:

Assess the patient for yourself & gather more information. The decision to perform a SAMFE should be based more on the patient's *current presentation* than a diagnosis in the chart.

- The chart diagnosis is may not be correct
- Mental illness is heterogeneous: not every chart history of mental illness is a serious mental illness
- Some conditions can be episodic, and symptoms can fluctuate over time

Be cognizant of overgeneralizations and diagnostic overshadowing

- Overgeneralizations
- Diagnostic overshadowing

Understanding motivation and secondary gain

Safety of the examiner

- A 34 year old male with a history of alcohol and methamphetamine use presents to your facility, yelling repeatedly “I’m gonna kill him!” The medical team is able to clarify with the patient that he was told he was raped by an acquaintance when passed out from substance use. The patient appears to be visibly intoxicated (is slurring his words) and is yelling and throws things in the exam room towards staff who attempt to intervene.
- A 27 year old woman with a history of depression presents to your facility, saying her landlord forcibly entered her apartment and raped her. She tells you “I’m gonna kill him!”

What if a patient is “homicidal”?

Patients who have experienced a sexual assault may harbor violent fantasies or wishes towards their perceived assailant (that may or may not be related to their mental illness)

They may or may not actually intend to act on these fantasies (ideation vs intent)

The presence of homicidal ideation against their perceived assailant does **not** indicate that the patient is necessarily going to be hostile towards the medical staff or forensic examiner

Are people with serious mental illness generally more violent?

Increased rates of violence in people with serious mental illness occurred **only when there was co-morbid substance abuse**

A person with severe mental illness without substance abuse and history of violence has the same risk of being violent as any person in the general population

Increased risk of violence was associated with:

- Perpetuated violence (history of acting violently, history of being in juvenile detention)
- Substance abuse
- Victim of violence (physically abused by parents in childhood)
- Other factors (male sex, younger age, poverty, unemployment)

Stratifying “agitation”

Mild and moderate : attempt to de-escalate and explain

- Pacing, restlessness
- Yelling, demanding, signs of aggression (tensing muscles, clenching fists) but not being violent

Severe : **Postpone offering the SAMFE**

- Acutely threatening to harm staff
- Actually violent with staff (punching, kicking, pushing, biting)

Safety of the patient - suicidal ideation

Statistics:

- 4% of adults had serious thoughts of suicide in the last year, 1.1% made suicide plan in the last year, 0.6% attempted suicide in the last year.

Trauma-informed care, and balancing paternalism vs autonomy

- Trauma-informed care: “Actively resist re-traumatization” (SAMHSA)
- Deciding the SAMFE is not appropriate *on behalf of* the patient may be paternalistic
- Providing the patient with information about the exam, collaborating with them to answer any questions, and honoring their decision (to undergo, postpone, or decline the SAMFE) may empower the patient and honor autonomy

Stratifying suicidal thinking

Ideation

- Wishing could go to sleep and not wake up
- Thinking about taking the steps to end your life

Intent

- Immediate intent vs future intent
- If a patient is having the thoughts to end their life with intent to act on these thoughts *in the immediate setting*, and cannot contract for safety with the team even when the SAMFE is explained, **postpone the SAMFE**

Hallucinations- when should they preclude offering a SAMFE?

- About 5% of people in the general population experience hallucinations
- Can occur not only in psychotic illnesses (schizophrenia) but also mood disorders (depression, bipolar), personality disorders and *healthy individuals!*
- Hallucinations alone should not preclude offering the SAMFE to a cooperative patient with capacity

Does a delusion not related to the outcry of sexual assault indicate that the outcry itself is a delusion?

No!

Some patients have chronic delusions and may even have a good degree of insight about the illogical nature of their beliefs

- "I can't tell if this is true or not, but I think people from the government may be spying on me"

Is the outcry a delusion?

"I was raped by Santa Claus": Responding to disclosures of sexual assault in mental health inpatient facilities

"Lack of coherence of the disclosure, however, does not correlate to the lack of veracity of the account."

- Recent assault that is implausibly described
- Triggered disclosure of a past assault
- Repetitive disclosure of an assault
- "Delusional disclosure" - "in our experience, this type is less likely than the first three types, and caution must be taken in reaching this conclusion."
- Intentional false disclosure (3% of police reports)

Ashmore, T., Spangaro, J., McNamara, L. (2015). International Journal of Mental Health Nursing.

Can patients who have received psychiatric medications participate in the SAMFE?

YES!

Psychiatric medications are the standard of care for psychiatric illness, and are not forms of "chemical restraint"

- CMS: chemical restraint: "any drug that is used for discipline or convenience and is not required to treat medical symptoms"
- Project BETA: "the goal of medicating the agitated patient is not sedate but to calm him… a calm, conscious patient is one who can participate in his own care and work with the crisis clinician."

Psychiatric medications may actually improve cognition (thereby improving ability to participate in an exam)

Can patients under involuntary detention consent to a SAMFE? Are they "dangerous"?

Consent: **Yes**, patients maintain their ability to consent to treatment decisions even when they have been involuntarily committed to psychiatric care

Dangerousness: A person can be involuntarily detained if there is concern that because of the person's mental illness, they are at imminent risk of harm to self or others

- Suicidality, homicidality, not caring for oneself
- Of these, which put the examiner at risk?

What other features might logistically interfere with the SAMFE being performed?

Speech - disorganized thought process (flight of ideas)

Behavior - Hypermotor agitation, restlessness

Bottom-Line Recommendations

Assess the patient in person if possible

Factors that may actually make it **unsafe** for an exam to be performed:

- Pt has severe agitation, and is threatening or making acts to harm the staff
- Pt has suicidal ideation with intent to act in the hospital, and cannot contract for safety with the team

Situations that (in the absence of other factors) should not dissuade you from offering the exam to a patient who is calm and cooperative:

- Pt is having passive thoughts about hurting themselves or their perceived assailant, but no intent to act
- Pt is under an involuntary psychiatric hold
- Pt has received psychiatric medications
- Pt reports hearing hallucinations or is responding to internal stimuli