

Care of Psychotic Patient

SART Listesrv

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Issue: SAFE/SART clinicians in New York City are beginning to formally consider what constitutes best practice care for patients who present with what appear to be psychotic processes (delusions, lack of reality testing, etc.) and report sexual assault. We are interested in discovering similar work / recommendations from centers SAFE/SART centers throughout the country.

As we begin to consider how to best care for these patients, here are some of the relevant questions and discussions:

- 1) Patients who are truly psychotic often do not have capacity to provide meaningful informed consent. In New York, explicit informed consent is required for every step of the sexual assault forensic exam. Most sexual assault examiners (SAEs) consider such informed consent critical – for the last thing they want to do is re-violate a sexual assault victim. (The exception, of course, is any care necessary to medically stabilize or treat emergent injuries; such care is covered by the emergency care doctrine and does not require explicit informed consent).

SAEs concerned about ensuring informed consent recommend simultaneously taking steps to a) stabilize the psychotic patient and to b) preserve potential evidence through non-invasive measures (i.e. – ensuring the patient doesn't shower, preserving any clothing that might have evidence on it in line with chain of custody protocol, etc). Then, once stable and able to consent to care, the patient will be offered a full exam. Such recommendations address the forensic end of the exam. Fewer clinicians have shared their viewpoints on providing STI/HIV/pregnancy prophylaxis to psychotic victims who cannot demonstrate capacity to consent. Because of the time frame for optimizing the efficacy of these medications, this needs to be addressed as well (whether to administer such medication while a patient is still psychotic).

Some local providers have questioned whether such a victim-centered approach to evidence collection in a psychotic patient would endure as a best practice if the patient had obvious injuries, or if the assault was witnessed, or there was other explicit evidence. Would such circumstances change the necessity of gaining informed consent from the patient?

- 2) Another issue is one of discrimination. Is it discriminatory NOT to perform a sexual assault kit on a psychotic patient who states s/he was sexually assaulted but who cannot demonstrate capacity to consent? Given all that we know about the disproportionate victimization of mentally ill patients, is requiring informed consent somehow negligent? Is there a difference in how you would handle

forensic versus medical (prophylactic treatment) in such cases? Some local clinicians argue that we must **MEDICALLY** treat the psychotic patient who states s/he was sexually assault as soon as possible (provide prophylaxis etc), but they question the ethics of performing the evidence collection. Their argument is that if the patient is too mentally ill to tell what happened to him/her, then there is virtually no chance successfully prosecuting such a case. Under such circumstances, the risk of re-traumatizing (or traumatizing) the patient could exceed any benefits of the forensic exam. However, those same clinicians fear that there are situations where DNA evidence alone might lead to a successful prosecution. This complicates designing a best-practice algorithm.

Response:

- I don't know NY law on informed consent, but one thought might be to have a system in place where you could have a guardian appointed in an emergency hearing to represent the patient.
- Another idea is to check with child protection or adult protective services to see what they do in other situations where people lack the capacity to consent.