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Mental Holds in Idaho

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In Idaho, a competent patient generally has the right to consent to or refuse their own healthcare. By statute,

> Any person who comprehends the need for, the nature of and the significant risks ordinarily inherent in any contemplated health care is competent to consent thereto on his or her own behalf. Any healthcare provider may provide such health care and services in reliance upon such consent if the consenting person appears to possess such requisite comprehension at the time of giving the consent.

(Idaho Code § 39-4503). If a patient is incompetent, a healthcare provider generally needs one of the following to provide care: (i) an advance directive from the patient; (ii) consent from an authorized surrogate; or (iii) statutory authority to provide treatment. (See I.C. § 39-4504). Providers who act without effective consent or statutory authority may be subject to adverse licensure action, personal injury lawsuits, and perhaps criminal liability.

Idaho law allows providers to treat incompetent persons or persons with severe behavioral health issues without consent from the patient or their authorized surrogate under the following circumstances:

1. Emergency Care. Idaho law expressly authorizes medical care in an emergency when there is no opportunity to obtain effective consent:

> If [i] the person presents a medical emergency or there is a substantial likelihood of his or her life or health being seriously endangered by withholding or delaying the rendering of such health care and [ii] the person has not communicated and is unable to communicate his or treatment wishes, the attending health care provider may, in his or her discretion, authorize and/or provide such health care, as he or she deems appropriate.

(I.C. § 39-4504(1)(l)). A separate statute provides immunity for physicians and hospitals rendering emergency care without effective consent:

> No physician or hospital licensed in this state shall be subject to civil liability, based solely upon failure to obtain consent in rendering emergency medical, surgical, hospital or health services to any individual regardless of age where [i] that individual is unable to give his consent for any reason and [ii] there is no other person reasonably available who is legally authorized to consent to the providing of such care, provided, however, that [iii] such person, physician, or hospital has acted in good faith and without knowledge

> of facts negating consent.

(I.C. § 56-1015). Note that section 56-1015 applies to any emergency "health service," which likely includes behavioral health concerns. Although there are no reported cases addressing the issue, section 56-1015 arguably protects hospitals and other healthcare providers who respond to emergent behavioral health needs even though the hospital or provider fails to follow the mental hold statutes described below.

In addition to Idaho law, the federal Emergency Medical Treatment and Active Labor Act ("EMTALA") authorizes and requires hospitals to conduct a medical screening exam to determine if the patient has an emergency medical condition and, if an emergency condition exists, to provide stabilizing treatment or an appropriate transfer to another facility. (42 U.S.C. § 1395dd; 42 C.F.R. § 489.24). "[A]n individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an [emergency medical condition]" obligating the hospital to provide stabilizing treatment. (CMS State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases (Rev. 60, 07-16-10) at Tag A2407). Per EMTALA, hospitals must generally provide stabilizing treatment for emergency conditions—including behavioral health conditions—until the patient is stabilized, admitted, or appropriately transferred to another facility. (42 C.F.R. § 489.24). EMTALA likely trumps conflicting Idaho law and provides additional authority for providing necessary, emergent care for behavioral health as well as strictly medical conditions, unless a competent patient or their authorized surrogate refuse care.

2. Mental Holds. Idaho law allows healthcare providers to hold and provide limited treatment to persons suffering from certain behavioral conditions over the patient's objection or despite the patient's inability to consent under the following circumstances.

a. 24-Hour Mental Holds. Idaho law allows physicians and advance practice professionals at a hospital to hold a patient up to 24 hours while the patient is evaluated for possible commitment for behavioral health concerns:

> a person may be taken into custody by a peace officer and placed in a facility, or the person may be detained at a hospital at which the person presented or was brought to receive medical or mental health care, if the peace officer or a physician medical staff member of such hospital or a physician's assistant or advanced practice registered nurse practicing in such hospital has reason to believe that [i] the person is gravely disabled due to mental illness or [ii] the person's continued liberty poses an imminent danger to that person or others, as evidenced by a threat of substantial physical harm….

(I.C. § 66-326(1)). As defined by the statute:

> "Mentally ill" means a person, who as a result of a substantial disorder of thought, mood, perception, orientation, or memory, which

> grossly impairs judgment, behavior, capacity to recognize and adapt to reality, requires care and treatment at a facility or through outpatient treatment.

(I.C. § 66-317(12)).

> "Gravely disabled" means a person who, as the result of mental illness, is:
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> (a) In danger of serious physical harm due to the person's inability to provide for any of his own basic personal needs, such as nourishment, or essential clothing, medical care, shelter or safety; or
>
> (b) Lacking insight into his need for treatment and is unable or unwilling to comply with treatment and, based on his psychiatric history, clinical observation or other clinical evidence, if he does not receive and comply with treatment, there is a substantial risk he will continue to physically, emotionally or mentally deteriorate to the point that the person will, in the reasonably near future, be in danger of serious physical harm due to the person's inability to provide for any of his own basic personal needs such as nourishment, essential clothing, medical care, shelter or safety.

(I.C. § 66-317(13)).

> "Likely to injure himself or others" means either:
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> (a) A substantial risk that physical harm will be inflicted by the proposed patient upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on himself; or
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> (b) A substantial risk that physical harm will be inflicted by the proposed patient upon another as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or
>
> (c) The proposed patient lacks insight into his need for treatment and is unable or unwilling to comply with treatment and, based on his psychiatric history, clinical observation or other clinical evidence, if he does not receive and comply with treatment, there is a substantial risk he will continue to physically, emotionally or mentally deteriorate to the point that the person will, in the reasonably near future, inflict physical harm on himself or another person.

(I.C. § 66-317(11)). Based on a strict reading of the statute, a person who is "[l]ikely to injure himself or others" may be placed on a 24-hour mental hold even if he or she does not suffer from a "mental illness"; however, they cannot be committed unless there is a determination that the patient suffers from a mental illness. (I.C. § 66-326(4); see also I.C. § 66-329(4)). The 24-hour mental hold statute does not apply to an individual who has epilepsy, a developmental disability, physical disability, or intellectual disability, who is impaired by chronic alcoholism or drug abuse, or who is aged unless such person is mentally ill in addition to suffering from such

condition. (I.C. § 66-329(13)).

- Upon initiating the hold, notice must be given to the patient's immediate relatives of the patient's location and reasons for detaining the patient. (I.C. § 66-326(5)). The purpose of the hold is to temporarily detain the person for examination and, if necessary, initiation of commitment proceedings. To that end:
- Upon initiation of the hold, the hospital should notify the local prosecutor.
- Within 24 hours of the initiation of the hold, the prosecutor must petition the court for an order authorizing the hospital to hold the patient while a designated exam is conducted. If the court authorizes the designated exam and continued detention, the hospital should comply with the hold and provide treatment as specified in the order. If the court declines to order the exam, the hospital must release the patient unless there is another basis to hold the patient, e.g., (i) the patient consents; (ii) if the patient is incompetent, the authorized surrogate consents; or (iii) EMTALA applies and requires continued care or treatment pending discharge. (I.C. § 66-326(2)).
- Within 24 hours of a court order authorizing the designated exam, the designated examiner must complete the exam and submit the report to the court. (I.C. § 66-326(3)).
- Within 24 hours of the exam and report recommending commitment, the prosecutor must initiate commitment proceedings. If no petition is filed within 24 hours of the exam, the person must be released from custody unless (i) the hospital has obtained consent from the patient or the patient's authorized surrogate, or (ii) EMTALA applies and requires continued care or treatment. (I.C. § 66-326(4)).
- Upon receipt of the petitioner from the prosecutor, the court may order continued detention pending a commitment hearing, which must occur within five days. (I.C. § 66-326(4)).

During the hold, the hospital may provide necessary care relevant to the hold. The hospital may use restraints or seclusion if necessary for the patient's safety or the safety of others consistent with federal and state requirements. (I.C. § 66-345). The hospital may transfer a mental hold patient to another facility, and the other facility may receive a mental hold patient, so long as the transfer satisfies EMTALA requirements. (I.C. §§ 66-324 and 66-326(6)).

Hospitals and providers involved in a mental hold are generally immune from liability for their actions so long as they act in good faith, comply with the procedures in the mental hold statute, and act without gross negligence. (I.C. § 66-341).

b. Protective Hold for Minors. In addition to or as an alternative to the 24-hour mental hold statute,[1] Idaho law allows a peace officer to “take a child into protective custody and immediately transport the child to a

treatment facility for emergency mental health evaluation" if the officer:

> has probable cause to believe … that the child is [i] suffering from serious emotional disturbance as a result of which he is likely to cause harm to himself or others or [ii] is manifestly unable to preserve his health or safety with the supports and assistance available to him and that immediate detention and treatment is necessary to prevent harm to the child or others.

(I.C. § 16-2411(1)). Similarly, if a child shows up at a hospital,

> [a] health care professional [i.e., a physician, physician's assistant, or advance practice registered nurse practicing at a hospital] may detain a child if such person determines that an emergency situation exists [as defined below]…, and such person has probable cause to believe that the child [i] is suffering from a serious emotional disturbance as a result of which he is likely to cause harm to himself or others or [ii] is manifestly unable to preserve his health or safety with the supports and assistance available to him and that immediate detention and treatment is necessary to prevent harm to the child or others.

(I.C. § 16-2411(2)). As defined by the statute:

> "Emergency" means a situation in which the child's condition, as evidenced by recent behavior, [i] poses a significant threat to the health or safety of the child, his family or others, or [ii] poses a serious risk of substantial deterioration in the child's condition which cannot be eliminated by the use of supportive services or intervention by the child's parents, or mental health professionals, and treatment in the community while the child remains in his family home.

(I.C. § 16-2403(6)).

> "Serious emotional disturbance" means an emotional or behavioral disorder, or a neuropsychiatric condition which results in a serious disability, and which requires sustained treatment interventions, and causes the child's functioning to be impaired in thought, perception, affect or behavior. A disorder shall be considered to "result in a serious disability" if it causes substantial impairment of functioning in family, school or community. A substance abuse disorder does not, by itself, constitute a serious emotional disturbance, although it may coexist with serious emotional disturbance.

(I.C. § 16-2403(13)).

> (10) "Likely to cause harm to himself or to suffer substantial mental or physical deterioration" means that, as evidenced by recent behavior, the child:
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> > (a) Is likely in the near future to inflict substantial physical injury upon himself; or

(b) Is likely to suffer significant deprivation of basic needs such as food, clothing, shelter, health or safety; or

(c) Will suffer a substantial increase or persistence of symptoms of mental illness or serious emotional disturbance which is likely to result in an inability to function in the community without risk to his safety or well-being or the safety or well-being of others, and which cannot be treated adequately with available home and community-based outpatient services.

(11) “Likely to cause harm to others” means that, as evidenced by recent behavior causing, attempting, or threatening such harm with the apparent ability to complete the act, a child is likely to cause physical injury or physical abuse to another person.

(I.C. § 16-2403(10)-(11)).

If the hospital does not have an appropriate facility to provide emergency behavioral health care, it may send the child to an appropriate treatment facility. The health care professional shall notify the parent or legal guardian, if known, as soon as possible and shall document in the patient's chart the efforts to contact the parent or guardian. If the parent or guardian cannot be located or contacted, the health care professional shall report the matter as soon as possible but no later than twenty-four (24) hours to the Idaho Department of Health and Welfare (“DHW”) or an appropriate law enforcement agency. The child may not be detained against the parent or legal guardian's explicit direction unless the child is taken into protective custody by a peace officer, except that the child may be detained for a reasonable period of time necessary for a peace officer to be summoned to the hospital to determine whether the patient should be taken into protective custody and transported to a treatment facility for emergency evaluation and possible admission. (I.C. § 16-2411(2)).

If the child is taken to a “treatment facility” (i.e., a facility or program that is licensed and approved by the DHW to provide behavioral health services for minors), the facility must accept the child and promptly examine the child to determine if the child meets the criteria for emergency evaluation and potential inpatient treatment as set forth in the statute. (I.C. § 16-2413).

c. 72-Hour Hold. The 72-hour hold only applies to “voluntary patients” of a “facility.” (I.C. § 66-317). A “facility” is any hospital, institution, mental health center or other organization designated in accordance with rules adopted by the Department of Health and Welfare as equipped to initially hold, evaluate, rehabilitate or provide care or treatment for the mentally ill, e.g., a psychiatric hospital or hospital with a psychiatric unit. (I.C. § 66-320). A “voluntary patient” is an individual admitted to a facility for observation, diagnosis, evaluation, care or treatment pursuant to I.C. § 66-318, i.e., (i) if the patient is over age 18 or is an emancipated minor, the patient has requested care; (ii) if the patient is over age 14 or older, the patient requests care and the parents are notified of the request; (iii) if the patient is under age 14 and is in an inpatient facility, the parent or guardian

has requested care and a designated examiner has recommended care; and (iv) if the adult patient lacks capacity to make informed treatment decisions and is in an inpatient facility, the guardian requests care and the designated examiner requests care. (I.C. § 66-318).

If a voluntary patient in a facility requests release, or the authorized surrogate requests the patient's release, the facility director or a practitioner who has been granted admitting privileges may detain the patient for up to three days (excluding Saturday, Sunday and holidays) to obtain a designated examination and, if necessary, initiate commitment proceedings. (I.C. § 66-320(3)). The director or practitioner should document the facts warranting the detention.

No "Medical Hold." Contrary to common belief, there is generally no "medical hold" in Idaho: a competent patient or, in most cases, the patient's authorized surrogate generally has the right to refuse medical care even though doing so may result in harm to the patient. (I.C. §§ 39-4503 and 39-4504). In such cases, the provider generally must respect the competent patient's or surrogate's decision unless the situation fits within the mental hold statutes identified above. If a surrogate's refusal of care rises to the level of child abuse or vulnerable adult abuse, the provider should report the matter to the appropriate authorities to respond.

Suggestions. The following steps may help hospitals as they evaluate whether a mental hold is appropriate.

1. Determine if the patient has sufficient capacity to consent to their own care pursuant to I.C. § 39-4503. If the patient has sufficient capacity, obtain consent to provide required care consistent with the consent. If the patient refuses, document the patient's capacity and informed refusal, and discharge the patient unless the provider determines that the patient is "likely to injure himself or others" within the meaning of the mental hold statute, I.C. §§ 66-317 and 66-326.
2. If the patient lacks capacity or is a minor, attempt to obtain consent from the patient's authorized surrogate per I.C. § 39-4504. There is generally no need to initiate a mental hold if the authorized surrogate consents to appropriate care. (I.C. § 39-4504). If the minor poses a risk to himself or others, the hospital may detain the minor as necessary to summon the parents or guardian or initiate a protective hold per I.C. § 16-2411.
3. If the patient lacks capacity and the provider is unable to obtain consent from the authorized surrogate due to time or circumstances, provide necessary emergency care while the provider seeks to locate and obtain consent from an authorized surrogate. (I.C. §§ 39-4504 and 16-2411).
4. If the provider cannot obtain consent from the patient or authorized surrogate due to time or circumstances and the patient otherwise satisfies the criteria for a mental hold or protective custody, initiate the mental hold process set forth above, and document the relevant factors supporting the decision.

5. Continue to evaluate the patient's condition for changed circumstances and respond appropriately.

[1] By its express terms, 66-326 applies to any person; it is not expressly limited to adults or emancipated minors. Nevertheless, some prosecutors have suggested that, in the case of minors, I.C. § 16-2411 applies instead of § 66-326.

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