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24-Hour Mental Holds In Idaho: New Standards, New Problems

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Since early 2022, the Idaho legislature has modified the standards for a patient's capacity to consent to healthcare and 24-hour protective holds. This health law update summarizes the current rules for capacity and consent; the amended standards for 24-hour mental holds; and the net effect the changes may have on patients, providers, and hospitals. For information concerning protective holds for minors under I.C. § 16-2411 or 72-hour holds for voluntary inpatients under I.C. § 66-320, see our article at https://www.hollandhart.com/mental-holds-in-idaho.

Capacity and Consent.

Under Idaho law, 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 services is competent to consent thereto on his or her own behalf. Any health care provider may provide such health care services in reliance upon such a consent.

(I.C. § 39-4503).[1] If a patient is incompetent, a healthcare provider generally needs one of the following before rendering care: (i) an advance directive[2] from the patient; (ii) consent from an authorized surrogate decision-maker; or (iii) statutory or court authority to provide treatment absent consent. (*See* I.C. § 39-4504). Providers who act without effective consent or statutory authority may be subject to adverse licensure action, malpractice lawsuits, and potentially criminal liability.

Treatment Without Patient or Surrogate Consent.

Idaho law allows providers to treat incompetent persons without patient or surrogate consent 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 delay in the rendering of health care

> services to such person and [ii] the person has not communicated and is unable to communicate his or her wishes, the attending health care provider may, in his or her discretion, authorize or provide such health care services, as he or she deems appropriate, and all persons, agencies, and institutions thereafter furnishing the same, including such health care provider, may proceed as if informed valid consent therefor had been otherwise duly given.

(I.C. § 39-4504(1)(i)). 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 that individual is unable to give this consent for any reason and there is no other person reasonably available who is legally authorized to consent to the providing of such care, provided, however, that such person, physician, or hospital has acted in good faith and without knowledge of facts negating consent.

(I.C. § 56-1015). Although there are no reported cases addressing the issue, § 56-1015 arguably protects physicians and hospital personnel who respond to emergent behavioral health needs even though the hospital or provider is unable to rely on the 24-hour mental hold statute described below.

In addition to Idaho law, the federal Emergency Medical Treatment and Active Labor Act (EMTALA) authorizes and generally 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. 07-19-19) 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. 24-Hour Mental Holds—New Standards. Idaho allows police and/or physicians, physician's assistants, or advanced practice registered nurses at a hospital to detain a patient for up to 24 hours while the patient is evaluated for possible commitment for mental illness:

> 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 the person [i] 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:

> (10) "Likely to injure himself or others" means:
> (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
> (b) A substantial risk that physical harm will be inflicted by the proposed patient upon another as evidenced by behavior that has caused such harm or that 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 he will, in the reasonably near future, inflict physical harm on himself or another person.
>
> …

> (12) "Gravely disabled" means the condition of a person who, **as the result of mental illness**, has demonstrated an inability to:
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> (a) Attend to basic physical needs, such as medical care, food, clothing, shelter, or safety;
>
> (b) Protect himself from harm or victimization by others;
>
> (c) Exercise sufficient behavioral control to avoid serious criminal justice involvement; or
>
> (d) Recognize that he is experiencing symptoms of a serious mental illness and lacks the insight into his need for treatment, whereby the subsequent absence of treatment may result in deterioration of his condition such that any of the circumstances listed in this subsection may be satisfied in the near future.

(I.C. § 66-317(10), (12), emphasis added).

In 2022, the legislature amended the commitment statutes—including the 24-hour mental hold statute—to confirm that they only apply to certain psychiatric conditions, not organic or neurological disorders. Specifically, commitment proceedings under the statute are limited to those who are "mentally ill." (I.C. § 66-329).

> "Mentally ill" means a condition resulting in a substantial disorder of thought, mood, perception, or orientation that grossly impairs judgment, behavior, or capacity to recognize and adapt to reality and requires care and treatment at a facility or through outpatient treatment. However, the term "mentally ill" does not include conditions discussed in [I.C. § 66-329(13)(a)].

(I.C. § 66-317(11)). Section 66-329(13)(a) in turn states:

> Nothing in this chapter or in any rule adopted pursuant thereto shall be construed to authorize the detention [e.g., a 24-hour mental hold] or involuntary admission to a hospital or other facility of an individual who:
>
> (a) Has a **neurological disorder**, **a neurocognitive disorder**, a developmental disability as defined in section 66-402, Idaho Code, a physical disability, or any medical disorder that includes psychiatric symptomology or is primarily impaired by substance use, unless in addition to such

> condition, such person is mentally ill…; [or]
> (c) Can be cared for privately with the help of willing and able family or friends in such a way as to no longer present substantial risk to himself or others, provided that such person may be detained or involuntarily admitted if such person is mentally ill and presents a substantial risk of injury to himself or others if such care is not adequate.

(Emphasis added). Under the statute,

> "Neurocognitive disorder" means decreased mental function due to a medical disease other than a psychiatric illness, including:
> (a) Alzheimer's disease;
> (b) Frontotemporal lobar degeneration;
> (c) Lewy body dementia;
> (d) Vascular dementia;
> (e) Traumatic brain injury;
> (f) Inappropriate use or abuse of substances or medications;
> (g) Infection with human immunodeficiency virus;
> (h) Prion diseases;
> (i) Parkinson's disease; or
> (j) Huntington's disease.

(I.C. § 66-317(13)). The apparent effect is that the 24-hour mental hold process in § 66-326 is limited to those patients who present with psychiatric disorders, not organic, neurological conditions such as those listed in § 66-317 unless the patient also suffers a psychiatric disorder, *i.e.*, a "mental illness" as defined in the statute.

a. "Mentally Ill" Patients. Assuming the patient is mentally ill and either gravely disabled or likely to harm themselves or others, then the following process applies:

- 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, initiate 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. In 2023, the Supreme Court adopted Administrative Rule 100 concerning mental holds.

The rule confirms that:

> Whenever a person is taken into custody or detained by a peace officer or medical staff member without a court order pursuant to Idaho Code section 66-326(1) or Idaho Code section 16-2413, the evidence supporting the claim that: (i) the person is gravely disabled due to mental illness or imminent danger, as provided in section 66-326, or (ii) that an emergency exists with respect to the child, as provided in section 16-2414, must be electronically filed with the court by the prosecuting attorney within twenty four (24) hours of the time the person was placed in custody or detained.

(Idaho Court Admin. R. 100(a)), available at https://isc.idaho.gov/icar100.

- 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 absent contrary request by a competent patient or his/her surrogate. (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 absent contrary request from the patient or surrogate. (I.C. § 66-326(4)).

- Upon receipt of the petition 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. Not Mentally Ill but Posing Risk to Themselves or Others. The foregoing process does **not** apply to those who are not "mentally ill," *i.e.*, those with dementia or other neurocognitive as opposed to a psychiatric behavioral health problem. By limiting 24-hour mental holds per § 66-326 and commitments per § 66-329 to those who are "mentally ill" and defining "mentally ill" to exclude neurocognitive disorders—including dementia, Alzheimer's, and similar disorders—the legislature has created a huge gap in care for behavioral health patients. As amended, § 66-326 does not permit a hospital to hold such persons, nor does it allow such persons to be committed under the expedited process in § 66-329. Idaho Code § 66-406 does have a commitment process for developmentally disabled persons, but

> "Developmental disability" means a chronic disability of a person that **appears before the age of twenty-two (22)** and:
>
> (a) Is attributable to an impairment, such as intellectual disability, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; and
>
> (b) Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and
>
> (c) Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services that are of lifelong or extended duration and individually planned

and coordinated.

(I.C. § 66-402(5), emphasis added). Thus, § 66-406 proceedings will not apply to most adults who suffer adult-onset dementia or other neurologically based behavioral health concerns. And even in § 66-406 cases, the hospital generally lacks authority to detain the developmentally disabled person pending any commitment proceeding once an emergent condition is resolved unless the patient is competent or valid consent is obtained from an authorized surrogate decision-maker.

The net effect of the recent amendments is that the legislature has intentionally or unintentionally created an alarming gap in care and protection for those patients with behavioral health concerns not caused by a psychiatric condition. Aside from saving state resources, there does not appear to be any justification for distinguishing the care and protection offered to those suffering from behavioral health problems due to psychiatric illness from those with neurocognitive or other disorders, but that appears to be the current statutory scheme. Within that gap, hospitals and healthcare providers are often left with the burden of trying to care for, house, or place these patients without state resources, guidance, or protection.

Summary. If a patient is competent to consent to his or her own care, a provider should generally provide care consistent with the patient's wishes. If the patient lacks consent, the provider should generally obtain effective informed consent from an authorized surrogate-decisionmaker. In the case of an emergency, a provider may render care necessary to address the emergent situation while effective consent or refusal of consent is obtained. If effective consent is obtained, a hospital does not necessarily need to invoke a 24-hour mental hold; however, when the patient or surrogate refuses necessary care or if the hospital believes that commitment proceedings should be initiated to obtain extended care for the patient, the hospital may initiate the 24-hour hold, but only if the patient is “mentally ill,” i.e., suffers from a psychiatric illness within the definitions in I.C. §§ 66-317, -326 and -329. Unfortunately, if the patient is not “mentally ill,” the hospital's options and state resources are limited under the current statutes. Informed consent should be obtained from the competent patient or authorized surrogates while the hospital attempts to care for or place the patient.

Until the government dedicates more resources to behavioral health concerns, providers and hospitals will continue to struggle with the appropriate disposition of behavioral health patients. In the meantime, hospitals and healthcare providers should update their policies and processes for 24-hour mental holds and may want to seek a legislative or judicial fix to the disparate impact that recent Title 66 amendments have on behavioral health patients and their healthcare providers.

[1] Unfortunately, recent amendments to the general consent statute arguably changed the standard from a subjective test deferential to healthcare providers to an objective test. For more information about that change, see our article at https://www.hollandhart.com/the-idaho-medical-

consent-act-recent-amendments.

[2] As recently amended, “advance directive” or “advance care planning document” is generally “[any] document that represents a competent person's authentic expression of such person's wishes concerning health care services.” (I.C. § 39-4502(1)).
