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Idaho's New Crisis Hold Law

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Idaho's new crisis hold statute takes effect October 1, 2024, and allows hospitals to temporarily detain "persons with a neurocognitive disorder who are in acute crisis due to an unidentified underlying medical condition [so they] can get the care they need and return home once the underlying medical condition is resolved." (I.C. § 56-2101[1]). The new statute was intended to help fill a gap created by recent amendments to Idaho's mental hold statute. Although the new law does not provide a long-term solution for such patients, it is a step in the right direction.

MENTAL *v.* CRISIS HOLDS. As a general rule, hospitals must have informed consent from a competent patient or, if the patient lacks capacity to consent, from the patients' legally authorized surrogate decision-maker[2] to detain a patient and/or render necessary care. (I.C. §§ 39-4503 and -4504). If the patient or the patient's surrogate decision-maker consents to care, there is generally no need for a mental or crisis hold: the hospital may provide care based on the patient's or personal representative's consent. In some cases, however, it may be necessary to initiate a mental or crisis hold to detain the patient because the patient objects to needed care, lacks capacity to consent, or consent cannot be obtained from a surrogate decision-maker. Initiating a hold may also help ensure a payer source for the care rendered.

MENTAL HOLDS. Idaho's mental hold process applies if the patient has a mental illness as defined in I.C. § 66-326. Specifically, a law enforcement officer or hospital-based physician, nurse practitioner or physician assistant may detain a person if they have "reason to believe that the person is gravely disabled[3] due to mental illness or the person's continued liberty poses an imminent danger to that person or others,[4] as evidenced by a threat of substantial physical harm." (*Id.* at § 66-326(1)). This "mental hold" allows the hospital to temporarily detain the person while a court order is obtained within 24 hours authorizing a mental exam and, if warranted, initiation of commitment proceedings. (*Id.* at § 66-326). Importantly, however, the mental hold process only applies if the patient is believed to be mentally ill.

> "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 section 66-329(13)(a), Idaho Code.

(*Id*. at § 66-317(11)). As recently amended, the mental hold process does not apply to a person who has:

> a neurological disorder, a neurocognitive disorder, a developmental disability …, 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.

(*Id*. at § 66-329(13)(a)).[5] This gap in coverage for neurocognitive disorders requires a separate process for detaining persons with neurocognitive disorders; hence, the new crisis hold law…

CRISIS HOLDS. The new "crisis hold" statute applies to persons with a neurocognitive disorder, *i.e*.,

> 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)). "Neurocognitive disorder" excludes "decreased mental function due to inappropriate use or abuse of substances or medications." (*Id.* at § 56-2103(6)).

1. Standards. Under the crisis hold statute,

a person may be taken into custody[6] by a peace officer[7] and placed in a hospital,[8] or the person may be detained at a hospital at which the person presented or was brought to receive medical care, if the peace officer or a health care provider in such hospital has **reason to believe that person has a neurocognitive disorder and the person is likely to injure themselves or others**.

(I.C. § 56-2104(1), emphasis added).

"Likely to injure themselves or others" means:
(a) A substantial risk that serious physical harm will be inflicted by the person upon their own person, as evidenced by threats of suicide or threats to inflict serious physical harm on themselves;
(b) A substantial risk that serious physical harm will be inflicted by the person 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 person lacks insight into the need for treatment and is unable or unwilling to comply with treatment based on the person's medical history, clinical observation, or other clinical evidence, and if the person does not receive and comply with treatment, there is a substantial risk that the person will continue to physically, emotionally, or cognitively deteriorate to the point that the person will, in

> the reasonably near future, inflict serious physical harm on themselves or another person.

(*Id*. at § 56-2103(5)).

It is not entirely clear whether or to what extent the crisis hold statute will apply to minors. Hospitals may apply the shelter care process in I.C. § 16-2411 when detaining minors, but as with mental holds, § 16-2411 would seem to apply only if the minor has a psychiatric problem, not a neurocognitive disorder.[9] Hospitals may need to rely on the crisis hold statute if necessary to detain minors for neurocognitive disorders rather than the shelter care process in § 16-2411. Of course, the crisis hold process may be unnecessary in EMTALA situations[10] or if the minor's parent consents to the minor's care. It is not entirely clear how the new Idaho Parental Rights in Medical Decision-Making Act[11] will impact the crisis hold statute if parents object to a crisis hold initiated by the hospital.

2. Scope and Purpose. The purpose of a mental hold is to detain the patient for evaluation and potentially long-term commitment to custody of the Department of Health and Welfare ("DHW"). In contrast, the crisis hold provides only a temporary fix: it allows the hospital to detain the patient while a court order is sought authorizing a medical exam and, if approved by the court, appropriate care for up to seven (7) days following a hearing, during which time it is hoped that the patient's condition may be stabilized or a more long-term solution may be found. (I.C. § 56-2105(11)).

3. Notice to Family. Upon initiating a crisis hold, "a good faith effort shall be made to provide notice to the person's legal guardian, parent, spouse, or adult next of kin of the person's physical whereabouts and the reasons for taking the person into custody." (I.C. § 56-2104(7)). The statute does not specify who gives the notice; as a practical matter, it likely falls to the hospital. If the patient is incompetent and the patient's surrogate decision-maker consents to care by the hospital or otherwise, there may be no need to continue the crisis hold process: the hospital may rely on the consent of the surrogate decision-maker. (*Id*. at § 39-4504). If a surrogate decision-maker cannot be found or the decision-maker refuses necessary care, the hospital may need to continue the crisis hold process.

4. Court Process. As with the mental hold statute, a hospital seeking to initiate a mental hold must seek court authorization to hold the patient for longer than 24 hours. Unlike the mental hold statute, however, the crisis hold judicial process does not result in a final disposition of the patient: at most, the court can only authorize the hold for up to 7 days post-hearing. As a practical matter, the purpose of the crisis hold (*i.e*., to allow the hospital to render temporary stabilizing care) will likely have been achieved long before any crisis hold hearing or final court decision and is really unnecessary if the hospital obtains consent from a surrogate decision-maker. Nevertheless, a hospital pursuing a crisis hold for whatever reason (including, perhaps, to obtain a payer source) must jump through the judicial hoops to ensure the patient's rights are protected.

a. Petition the Court. If a crisis hold is initiated, "the evidence supporting the claim that the person with the neurocognitive disorder is likely to injure themselves or others must be presented to a duly authorized court within twenty-four (24) hours from the time the person was placed in custody or detained." (I.C. § 56-2104(1)). In a mental hold, the local prosecutor is tasked with filing the initial petition.[12] In a crisis hold, however, the statute and associated court rules do not specify who is responsible for petitioning the court for the initial order. Presumably, the local prosecutor will file the petition, but the hospital should work with the local prosecutor's office and court in advance to confirm that the prosecutor will do so and/or the process for initiating the petition.

b. Initial Court Order. If the court finds there is reason to believe the person is (i) likely to have a neurocognitive disorder and (ii) likely to injure themselves or others, "the court shall issue a temporary protective placement custody order requiring the person to be held in a hospital and requiring an examination of the person by a health care provider in such hospital within twenty-four (24) hours of the entry of the order of the court." (I.C. § 56-2104(2)). The statute only contemplates an order authorizing protective custody; it does not expressly address authorization for treatment. If the person needs healthcare services—especially care beyond routine board, room and support services[13]—the hospital should ask the court order to authorize necessary healthcare during the crisis hold unless consent for such treatment is obtained from the patient or surrogate decision-maker.

c. Examination by Hospital. In a mental hold, the mental exam is conducted by a designated examiner approved by DHW. In crisis holds, the exam is to be performed by a healthcare provider in the hospital in which the person is being detained. (I.C. § 56-2104(2)). The statute does not specify the qualifications for the provider performing the exam. Per the court's order, the exam must take place within twenty-four (24) hours from the court's initial order and "the health care provider … shall make findings and report to the court within twenty-four (24) hours of the examination." (*Id*. at § 56-2104(3)). If the examining provider determines that "the person no longer meets criteria for protective custody, the person shall be deemed to be a voluntary patient and subject to release" unless care is otherwise authorized by the patient or surrogate decision-maker. (*See id*. at § 56-2104(4)).

d. Petition by Prosecutor. If the examining hospital provider finds that the person is (i) likely to have a neurocognitive disorder and (ii) is likely to injure themselves or others, "the prosecuting attorney shall file, within twenty-four (24) hours of the examination of the person, a petition with the court

requesting the person's continued protective placement pending review proceedings pursuant to section 56-2105." (I.C. § 56-2104(5)). Section 56-2105 contains specific requirements concerning an application for a crisis hold that presumably applies to the prosecutor's petition under § 56-2014, including the required content and support. (*Id*. at § 56-2105(1)-(2)). "If no petition is filed within twenty-four (24) hours of the [hospital] examination …, the person shall be released from the protective placement." (*Id*. at § 56-2104(6)). Of course, before releasing the patient the hospital must consider its obligations under EMTALA as well as discharge regulations.

e. Court Order Pending Hearing. Upon receipt of a petition for continued protective custody, "the court shall order the person's detention to await hearing" to determine whether and on what terms the protective custody may continue. (I.C. § 56-2104(6)). The hearing shall take place "within five (5) days, including Saturdays, Sundays, and legal holidays, of the protective placement order." (*Id*.). Again, if the hospital has not done so, it may want to ensure the order authorizes necessary care pending the hearing.

f. Hearing and Disposition. Although the statute is not entirely clear, it appears that the hearing must be conducted consistent with the hearing requirements in § 56-2105(7)-(13), which section generally applies to petitions for emergency protective custody placements, not crisis holds. (*See* I.C. § 56-2104(5)). The hearing process generally requires notice to the patient and family members; the opportunity for the person to be represented by counsel; and the right to present evidence. Following the hearing,

> [i]f … the court finds by clear and convincing evidence that the person [i] likely has a neurocognitive disorder and [ii] is likely to injure themselves or others, the court shall order the person to be placed under protective custody of a suitable medical

> hospital for observation, care, and treatment **for an indeterminate period of time not to exceed seven (7) days**.
>
> (*Id*. at § 56-2105(11)) (emphasis added). The statute does not address what happens after the court-ordered 7-day (or less) placement period ends. Presumably, before that time expires the hospital must either stabilize the patient, arrange for an appropriate discharge, or obtain appropriate consent to continue caring for the patient.

5. Early Termination of Crisis Hold. Unlike mental holds, the crisis hold statute expressly authorizes a hospital to unilaterally terminate a crisis hold:

> If at any time after the person is placed in protective custody the health care provider in such hospital conducting the examination determines the person no longer meets criteria for protective custody, the person shall be deemed to be a voluntary patient and subject to release.

(I.C. § 56-2104(4)). It is not clear how that termination would affect pending court proceedings or how such court proceedings should be terminated, especially if proceedings were commenced pursuant to § 56-2105. As a practical matter, the court and county prosecutor would likely be happy to terminate protective custody proceedings, but the hospital should communicate its intent to the prosecutor and/or court.

6. Transfers. Importantly, the crisis hold statute expressly allows—or at least does not prohibit—"a hospital from transferring a person who has been detained … to another hospital that is willing to accept the transferred person for purposes of observation, diagnosis, evaluation, care, or treatment." (I.C. § 56-2105(8)). It is not clear how such a transfer would affect any pending court proceedings concerning the crisis hold or payment for the holds.

7. Alternative Process: Application for Emergency Placement. In addition to or as an alternative to the crisis hold process in §56-2104, § 56-2105 allows a friend, relative, spouse, guardian, hospital-based healthcare

provider, facility director, prosecuting attorney, or other public official to commence "[p]roceedings by a hospital for the involuntary care and treatment of persons likely to have a neurocognitive disorder who are in acute crisis due to an underlying medical condition." (I.C. § 56-2105(1)). The statute sets forth requirements and timelines for the proceedings, including the requirements for the initial application to the court, medical examinations, and ultimately a hearing as described above. However, like the crisis hold, the court's final order may only authorize care for up to seven (7) days. (*Id*. at § 56-2105(11)).

8. Payment. Thankfully, the crisis hold statute places responsibility for the cost of crisis hold care on the patient, the patient's insurance (including Medicaid), and/or DHW. (I.C. § 56-2107). As a practical matter, confirmation of a payer source may become a significant motivation for initiating a crisis hold because other laws already allow a hospital to provide needed care on a temporary basis in most cases.[14] Under the crisis hold statute, the court may order the patient to pay the costs of care; hospitals should ensure the court order includes that requirement. (*Id*. at § 56-2107(3)). In addition, the statute allows third parties (including the hospital) to apply for Medicaid on behalf of the patient. (*Id*. at § 56-2107(4)). If the cost of care ultimately falls to DHW, DHW will pay at the applicable Medicaid rate. (*Id*. at § 56-2107(5)).

9. Reporting Protective Placements. Beginning April 30, 2025, hospitals must report on a quarterly basis all crises holds or emergency placements of patients with neurocognitive disorders. (I.C. § 56-2106(1)). The reporting requirements are set forth in § 56-2106(2), but we anticipate further guidance from DHW.

CONCLUSION. The crisis hold statute helps address the coverage gap created by recent amendments to the mental hold statue, but it does not fill the gap. First, it only applies to those with neurocognitive disorders within the meaning of the statute. There is no process for other patients with debilitating conditions who do not have a neurocognitive disorder or mental illness, including those with developmental disabilities or those who suffer the effects of substance abuse. (*See* I.C. § 66-317(13)). Second, the crisis hold statute provides only a temporary solution: it only allows the hospital to hold the patient for a maximum of fifteen (15) days plus whatever time it takes the court to consider the facts and issue its orders. Unlike the mental hold process, the purpose of the crisis hold court process is not to commit the patient to permanent placement; instead, it is to give the hospital time to stabilize the patient or transition the patient to a more appropriate long-term situation. Whether that can be accomplished depends on the patient's condition and available resources for the patient's long-term care which, unfortunately, are often insufficient to meet the ongoing and growing needs of patients with neurocognitive disorders.

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[1] Although the legislation was originally drafted as I.C. § 56-1901 *et seq*., it appears that it will actually be codified at I.C. § 56-2101 *et seq*.

[2] "'Surrogate decision-maker' means the person authorized to consent to

or refuse health care services for another person as specified in [I.C. § 39-4504(1)]," (I.C. § 39-4502(20)), *i.e.*,

> (a) The court-appointed guardian of such person;
>
> (b) The person named in another person's advance care planning document as the health care agent of such person pursuant to section 39-4510, Idaho Code, or a similar document authorized by this chapter if the conditions in such advance care planning document for authorizing the agent to act have been satisfied;
>
> (c) If married, the spouse of such person;
>
> (d) An adult child of such person;
>
> (e) A parent of such person;
>
> (f) The person named in a delegation of parental authority executed pursuant to section 15-5-104, Idaho Code;
>
> (g) Any relative of such person;
>
> (h) Any other competent individual representing himself or herself to be responsible for the health care of such person.

(I.C. § 39-4504(1)).

[3] "Gravely disabled" means

> the condition of a person who, as the result of mental illness, has demonstrated an inability to:
>
> (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(12)).

[4] "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.

(I.C. § 66-317(10)).

[5] The mental hold statute states,

> Nothing in this chapter or in any rule adopted pursuant thereto shall be construed to authorize the detention 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;
>
> (b) Is a patient under treatment by spiritual means alone, through prayer, in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof and who asserts to any authority attempting to detain him that he is under such treatment and who

> gives the name of a practitioner so treating him to such authority; 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.

(I.C. § 66-329(13)). For more information concerning the mental hold statute along with the gap in coverage created by recent amendments, see our article at https://www.hollandhart.com/24-hour-mental-holds-in-idaho-new-standards-new-problems.

[6] "'Protective custody' means when a peace officer detains a person and takes such person to a hospital. The peace officer shall make every reasonable effort to protect the person's health and safety while the peace officer takes reasonable steps to protect the peace officer's safety. Protective custody under this section is not an arrest." (I.C. § 56-2103(8)).

[7] "'Peace officer' means "an employee of a law enforcement agency that is a part of or administered by the state or any political subdivision of the state and whose duties include and primarily consist of the prevention and detection of crime and the enforcement of penal, traffic, or highway laws of the state or any political subdivision of the state…." (I.C. § 56-2103(7)).

[8] "'Hospital' means a medical hospital as defined in section 39-1301, Idaho Code, including freestanding emergency departments." (I.C. § 56-2103(4)).

[9] Under I.C. § 16-2411(2),

> A health care professional may detain a child if such person determines that [i] an emergency situation exists as defined in this chapter, and such person has probable cause to believe that [ii] the child is suffering from a serious emotional disturbance as a result of which he is likely to cause harm to himself or others or

> 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)).
>
> "Emergency" means a situation in which the child's condition, as evidenced by recent behavior, poses a significant threat to the health or safety of the child, his family or others, or 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 a diagnostic and statistical manual of mental disorders (DSM) diagnosable mental health, 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….
>
> (I.C. § 16-2403(13)).
>
> [10] The EMTALA interpretive guidelines state:

	A minor (child) can request an examination or treatment for an EMC. The hospital is required by law to conduct the examination if requested by an individual or on the individual's behalf to determine if an EMC exists. Hospital personnel should not delay the MSE by waiting for parental consent. If after screening the minor, it is determined than no EMC is present, the staff can wait for parental consent before proceeding with further examination and treatment.

(CMS, SOM App. V, *Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases* (7/19/19).

[11] I.C. §32-1015. For more information about the new Parental Rights Act, see our articles at https://www.hollandhart.com/new-limits-on-minor-consents-in-idaho and https://www.hollandhart.com/idahos-new-parental-consent-law-faqs.

[12] Idaho Court Admin. R. 100(a).

[13] The statute contemplates that the hospital may recover cost for routine medical care, which "includes hospital costs, including routine board, room, and support services." (I.C. 56-2107(1)(b)).

[14] For example, EMTALA generally allows the hospital to provide stabilizing care if the patient has an emergency medical condition unless the patient is competent and objects. If the patient is incompetent, I.C. § 39-4504(1)(i) also allows the hospital to provide needed emergency care until it can obtain consent from an authorized surrogate decision-maker. Thus, in most cases the only time a crisis hold would really be needed to authorize hospital care would be if a competent patient or surrogate decision-maker refused necessary care.
