

STATE OF IDAHO

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DESIGNATED EXAMINER SOURCE BOOK

MENTAL HEALTH CIVIL COMMITMENT PROCESS FOR ADULTS

A Resource and Training Guide for
Idaho
Designated Examiners
and Dispositioners



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Introduction to the Manual

NOTE REGARDING THE CHILDREN'S MENTAL HEALTH SERVICES ACT

****NOTE:**

Title 16 Chapter 24, the Children's Mental Health Services Act supersedes all references to minors or (minor) patients in this Source Book and in Idaho Code Title 66, Chapter 3.

*References to minors from Idaho Code Title 66, Chapter 3, are included when that statute is quoted. These occurrences are marked with ** as a reminder to refer to the Children's Mental Health Services Act.*

This is the fifth edition, of the Designated Examiner Source Book. Changes include the addition of law changes to Idaho Code as of March, 2004, an update in the policy and procedures for the state hospitals, and index and format enhancements.

The manual serves as an introduction to the pertinent statutes and may aid the examiner in such areas as the preparation and delivery of expert testimony necessary in the involuntary commitment process. As a Source Book it serves as an important reference for resolving unique and difficult questions that can occur in the commitment and disposition process.

Changes in Idaho Code since Version 4, Revised of this manual include the following:

- The Children's Mental Health Services Act (Idaho Code Title 16 Chapter 24) was passed in 1997 and became effective July 1, 1998. The provisions of the CMHSA supercede any previous references to minors in Idaho Code Title 66 Chapter 3.
- Language was added to prohibits the jailing of the mentally ill. Idaho Code 66-326 states: "...under no circumstances shall the proposed patient be detained in a nonmedical unit used for the detention of individuals charged with or convicted of penal

offenses." Similar language is included in Idaho Code 66-329 and 66-330.

- Idaho Code 66-348, Disclosure of Information, was amended to enable disclosure of records of individuals whose involuntary assessment, detention or commitment is being sought.
- Idaho Code 66-329, Commitment to Department Director, was amended to reduce the maximum term of involuntary commitment from three (3) years to one (1) year.
- Idaho Code 66-326, Detention Without Hearing, was amended to add "grave disability due to mental illness" to the existing provisions allowing for detention without a hearing.
- Idaho Code 66, Chapter 6, Declarations For Mental Health Treatment, was created to allow a competent adult to make declarations of preferences or instructions regarding consent to or refusal of mental health treatment. These instructions are intended to be followed when the person becomes incapable of making treatment decisions.
- Idaho Code 66, Chapter 3, Hospitalization of The Mentally Ill, Outpatient Commitment, amended section 317 and 339, and added sections 339A, 339B and 339C.
- Idaho Code 18-211 (1) "The appointed examiner shall also evaluate whether the defendant lacks capacity to make informed decisions about treatment."
- Idaho Code 18-211 (5) (d) An opinion whether the defendant lacks the capacity to make informed decisions about treatment. 'Lack of capacity to make informed decisions about treatment' means the defendant's inability, by reason of his mental condition, to achieve a rudimentary understanding of the purpose, nature and possible significant risks and benefits of treatment, after conscientious efforts at explanation."
- Idaho Code 18-212 (1) "...The court shall also determine, based on the examiner's findings, whether the defendant lacks capacity to make informed decisions about treatment."
- Idaho Code 18-212 (2) "...and the court shall commit him to the custody of the director of the department of health and welfare, for a period not exceeding ninety (90) days... The order of commitment shall include the finding by the court whether the defendant lacks capacity to make informed decisions about treatment."

- Idaho Code 66_327 (b), RESPONSIBILITY FOR COSTS OF COMMITMENT AND CARE OF PATIENTS. "The department of health and welfare shall assume responsibility for usual and customary treatment costs after the involuntary patient is dispositioned to the custody of the state of Idaho, beginning on the day after the director receives notice that a person has been committed into the custody of the department, until the involuntary patient is discharged and after all personal, family and third party resources are considered." (2004)

Dispositioners should take special note of Chapter 3 where criteria have been developed as guidelines to the disposition and case management of a client. Examiners should be aware of the descriptive material in Chapter 2 which presents information on those who are "likely to injure self or others" and "gravely disabled."

Included in Chapter 8 is a list of legal forms used at various points in the legal process. The DE/dispositioner is encouraged to be familiar with these forms. These forms are available through the regional community mental health program and local county prosecuting attorney's office. Various forms may appear different depending on the counties' specific format.

Idaho Code may be accessed from the Internet site,
<http://www3.state.id.us/idstat/> or
<http://www3.state.id.us/idstat/TOC/idstTOC.html>.

Preface

For planning and administrative purposes, the State of Idaho has been divided into seven service areas corresponding to the seven regions of the Department of Health and Welfare and, with the exception of two counties, corresponding to the seven Health Districts and the seven Judicial Districts. (Butte County is in Health and Welfare Region VII, but in Health District VI; Bingham County is in Health and Welfare Region VI, but in the Seventh Judicial District). In each service area, the city which is the area's population center is the site of a regional Community Mental Health Center (CMHC).

The State Mental Health Program consists of the seven regional Community Mental Health Programs and the two state psychiatric hospitals.

The CMHC's are the focal points for delivery of community mental health services to the residents of Idaho. Privately run treatment programs supplement the CMHC's in providing Assertive Community Treatment (ACT) and Psychosocial Rehabilitation programs. For psychosocial rehabilitation, the CMHC's are the Mental Health Authority for authorizing services. The CMHC's coordinate institutional placements and discharge follow-up services. They assist the courts in both civil and criminal mental health related cases, provide consultation and education to other service agencies and to the public, and are a reference resource for the development of alternative living facilities for those who are seriously and persistently mentally ill. In addition to the central CMHC's, there are a number of satellite service centers providing services in outlying areas.

The state's two psychiatric hospitals, State Hospital North (Orofino) and State Hospital South (Blackfoot), form an important link in the state's comprehensive mental health services program. These hospitals are used as an inpatient care resource by the CMHC's, private mental health practitioners, and the courts. Admissions to these facilities are through the CMHC's.

State Hospital North has a total of 50 Psychiatric beds. The beds include 30 on the more acute admissions unit and 20 on the less acute unit. Services include intensive medication management, diagnostic evaluations, treatment for psychiatric disorders, and individual and psychosocial rehabilitation. There are no services for juveniles.

State Hospital South has a total of 106 hospital beds and 29 Skilled Nursing beds. Of the hospital beds available, 16 are in the Adolescent Program, 30 are in admissions, 30 are in intermediate care, and 30 are for patients who require a longer term of care. Hospital services include intensive medication management, evaluations for courts, and individual and group psychosocial rehabilitation. The 29 Skilled Nursing beds serve patients over the age of 65 who have a variety of medical/physical health care needs as well as mental health needs. Some

individuals in need of treatment in a secure setting may also be served at State Hospital South depending on the severity of the issues involved. There is no separate secure facility at State Hospital South.

In Idaho, the care and treatment of the indigent is a county responsibility, except for those who have been committed to the State, Idaho Code 66_327, RESPONSIBILITY FOR COSTS OF COMMITMENT AND CARE OF PATIENTS. "(a) All costs associated with the commitment proceedings, including usual and customary fees of designated examiners, transportation costs and all medical, psychiatric and hospital costs not included in subsection (b) of this section, shall be the responsibility of the person subject to judicial proceedings authorized by this chapter or such person's spouse, adult children, or, if indigent, the county of such person's residence after all personal, family and third party resources, including medical assistance provided under the state plan for Medicaid as authorized by title XIX of the social security act, as amended, are considered.... If the court determines such person is unable to pay all or any part of such costs, the court shall fix responsibility ... on the county of such person's residence to the extent not paid by such person or not covered by third party resources, including medical assistance as aforesaid. (b) The department of health and welfare shall assume responsibility for usual and customary treatment costs after the involuntary patient is dispositioned to the custody of the state of Idaho, beginning on the day after the director receives notice that a person has been committed into the custody of the department, until the involuntary patient is discharged and after all personal, family and third party resources are considered in accordance with section 66_354, Idaho Code. The counties shall be responsible for mental health costs if the individual is not transported within twenty-four (24) hours of receiving written notice of admission availability to a state facility. For purposes of this section, "usual and customary treatment costs" shall include routine board, room and support services rendered at a facility of the department of health and welfare; routine physical, medical, psychological and psychiatric examination and testing; group and individual therapy, psychiatric treatment, medication and medical care which can be provided at a facility of the department of health and welfare. The term "usual and customary treatment costs" shall not include neurological evaluation, CAT scan, surgery, medical treatment, any other item or service not provided at a facility of the department of health and welfare, or witness fees and expenses for court appearances. ..."

The Security Medical Facility, operated by the Idaho Board of Corrections, has a 12-bed psychiatric unit at the Idaho Maximum Security Institution in Boise which provides psychiatric services only to men who meet the following criteria: (1) civilly committed and are to be evaluated for pre-trial or pre-sentence investigation; (2) civilly committed men acquitted of a crime before July 1, 1982, on the grounds of mental illness or found unfit to stand trial; and (3) mentally ill adult male prisoners from city, county, and state correctional institutions. Women who meet these criteria are housed in the ONE bed at the Pocatello Women's Correctional Center. These committed individuals are stabilized and returned to general population within the prison system or to local correctional institutions.

This *Source Book* is specific to the civil commitment process of people who have a mental illness. However, because of the mental health issues involved in the criminal justice system and the cross-dispositional considerations of care and treatment, the *Source Book* also examines various points that overlap the criminal justice and mental health systems of Idaho which may affect the examiner.

Updates of the *Source Book* will be posted on the Bureau of Mental Health and Substance Abuse web site at: [Http://www2.state.id.us/dhw/mentalhealth/](http://www2.state.id.us/dhw/mentalhealth/).

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Commitment - Adults	18-211	Examination of Defendant ___ Appointment of Psychiatrists and Licensed Psychologists ___ Hospitalization ___ Report.
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Designated Examiner Source Book

CHAPTER ONE

Discussion of Idaho Civil Commitment Process

“It is hereby declared by the legislature of the State of Idaho that its mentally disabled citizens are entitled to be diagnosed, cared for, and treated in as expedient a manner possible consistent with their legal rights, in a setting no more restrictive than ... (and) for a period no longer than reasonably necessary for diagnosis, care, treatment and protection, and to remain at liberty or be cared for privately except when necessary for the protection of themselves or society.”

Legislative Intent. section 1 of S.L. 1981, ch. 114

CHAPTER 1

DISCUSSION OF IDAHO COMMITMENT PROCESS

1.1 BACKGROUND

1.1.1 Civil Commitment

In the field of mental health, the term "*civil commitment*" refers to the state-sanctioned involuntary care and treatment of persons having a mentally disordered condition demonstrating the likelihood of harm to themselves or others or being gravely disabled and being judicially determined to be in need of care and treatment.

Civil commitment interventions are authorized under the state's power of *parens patriae* to act on behalf of those individual's requiring the protection and general guardianship of the state. In addition to the mental health civil commitment, the State of Idaho has three other areas of civil commitment involving differing service populations. These populations include (1) the mentally retarded and developmentally disabled (Developmental Disabilities Act); (2) youth judicially committed to the state for reasons of child protection (Child Protection Act); (3) youth committed due to juvenile offenses (Juvenile Corrections Act); and (4) children and youth committed due to mental illness (Children's Mental Health Services Act). However, it is only the mental health commitment which has a judicially determined need for care and treatment and an express authorization to provide such treatment involuntarily.

Law Enforcement Intervention

In contrast to the *parens patriae* authority of the civil commitment, the judicial basis of criminal law is the *police power* of the state. This authority allows law enforcement to intervene on behalf of the safety of the community and to commit those persons who have been found guilty of a crime to the care and custody of state correctional authorities. This is typically referred to as a "*criminal commitment*". In actuality there is some overlapping of these two basic state authorities. For example, those individuals who have been charged with a crime must be competent to stand trial, to be sentenced, etc. and if found unfit to proceed may be committed to health care facilities for care and treatment to regain competency or fitness to proceed.

For situations that do not involve "criminal commitment", the 1998 changes to Idaho Code 66-326 clarifies that if a peace officer has reason to believe that a person is gravely disabled due to mental illness or the person's continued liberty poses an imminent danger to that person or others, as evidenced by a threat of substantial physical harm, the peace officer may take the person into custody requiring the person be held in a facility.

The court has the option of committing an individual either to the Department of Health and Welfare for the purpose of treatment at an inpatient facility, or treatment on an outpatient basis. Both commitments have the similar procedures in presenting information to the court. However, inpatient commitment requires that

the client be examined by two designated examiners where outpatient commitment requires only one examination.

1.1.2 Review of Concept of Mental Illness

A significant difficulty regarding commitment of individuals to treatment programs is attaining agreement on the definition of mental illness. All states and the federal government require a statutory definition and therefore state lawmakers have had to confront the problem of identifying a definition that psychiatrists, legislators and judges have been arguing about for years.

Determining whether a person has a mental illness, is dangerous, has the capacity to give consent, and/or is unfit to stand trial, is not trivial and requires expert opinion.

TWO CRITERION FOR A MENTAL HEALTH COMMITMENT

6 The First Criterion: THE EXISTENCE OF A MENTAL DISORDER

The concept of mental disorders has been principally defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) p. xxi, published by the American Psychiatric Association in 1994. The manual describes mental disorders as having "physical" components just as "physical" disorders have "mental" components.

The DSM -IV defines Mental Disorder as "a clinically significant behavior or physiological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g, a painful symptom) or disability (i.e. impairment in one or more areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the Individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above."

Definition of Mental Illness

For purposes of civil commitment, "mentally ill" shall mean 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. [Idaho Code Section 66-317(m)]

This definition includes three primary elements which are necessary to support the finding of mental illness:

- (a) PSYCHIATRIC DISORDER -- The legal definition recognizes the presence differing types of substantial disorders including *"thought, mood, perception, orientation or memory"*.
- (b) DEGREE OF IMPAIRMENT -- the presence of gross impairment of *judgment, behavior, capacity to recognize and adapt to reality*; and
- (c) NEED FOR TREATMENT -- the mental condition *requires care and treatment at a facility*.

The realities of a person's mental impairment, not a specific diagnostic category, will ultimately determine the presence of a severe mental disorder. The disorder must be *"substantial"* and with significant consequences as manifested in *"gross impairment"*.

***The Second Criterion:** "LIKELY TO INJURE SELF OR OTHERS" or is "GRAVELY DISABLED"

The act of "likely to injure self or others" or being "gravely disabled" must be due to a mental disorder.

Definition of Gravely Disabled

"GRAVELY DISABLED shall mean a person who, as the result of mental illness, is in danger of serious physical harm due to the person's inability to provide for his essential needs." [Idaho Code Section 66-317(n)]

Definition of "Likely To Injure Himself or Others"

"LIKELY TO INJURE HIMSELF OR OTHERS" shall mean either (1) 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 (2) 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." [Idaho Code Section 66-317(l)]

EXCLUSIONS:

Idaho Code 66-329(l) excludes a person who

(1) "has epilepsy, a developmental disability, a physical disability, mental retardation, is impaired by chronic alcoholism or drug abuse, or aged, unless in addition to such condition, such person is mentally ill;"

(2) "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"

(3) "can be properly cared for privately with the help of willing and able family or friends, and 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 allowed to remain at liberty."

1.2 VOLUNTARY ADMISSION

1.2.1 Eligibility

Hospital May Admit Voluntary Patients (Idaho Code 66-318(a))

The director of any facility may admit any person as a voluntary patient under the following circumstances:

- a. Any person who is eighteen (18) years of age or older;
- b. Any individual fourteen (14) to eighteen (18) years of age may apply to be admitted for observation, diagnosis, evaluation and treatment and the facility director will notify the parent, parents or guardian of the individual of the admission; a parent or guardian may apply for the individual's release and the facility director will release the patient within three (3) days, excluding Saturdays, Sundays and legal holidays, of the application for discharge, unless the time period is extended pursuant to section 66-320, Idaho Code;
- c. Any emancipated minor;
- d. Any individual under fourteen (14) years of age upon application of the individual's parent or guardian, provided that admission to an inpatient facility shall require a recommendation for admission by a designated examiner;**(see Introduction Note, page vii)
- e. Any individual who lacks capacity to make informed decisions about treatment upon application of the individual's guardian; provided that admission to an inpatient facility shall require a recommendation for admission by a designated examiner; or

NOTE: *In paragraphs (4) and (5) above, these admissions require a recommendation for admission by a designated examiner.*

Guardian May Consent To Treatment

NOTE: *The guardian must have authority to consent to treatment. Some guardians have limited authority. It will, therefore, be necessary for the facility to verify the guardian's authority by reviewing the order of guardianship or letters of guardianship, which is an abstract of the order of*

guardianship signed by the judge and with the court's seal.

a. Any individual confined for examination pursuant to sections 18-211, 16-1814, or 16-1835, Idaho Code. [Idaho Code 66-318(a)]

NOTE: Individuals committed under Idaho Code 18-211 are involuntary patients for purposes of observation and evaluation. However, for any treatment services to be provided, they must give voluntary consent.

When the Hospital Must Refuse Admission
(Idaho Code 66318(b))

“The director of any facility must refuse admission to any applicant under this section whenever:

- (1) The applicant is not in need of observation, diagnosis, evaluation, care or treatment at the facility;
- (2) The applicant lacks capacity to make informed decisions about treatment unless the application is made by a guardian with authority to consent to treatment; or
- (3) The applicant's welfare or the welfare of society, or both, are better protected by the provisions of section 66_329 Idaho Code” (Involuntary Commitment). [Idaho Code 66-318(b)]

1.2.2 Procedures

By Department policy, all voluntary patients must be screened by Regional Mental Health Center staff before being referred to one of the State Hospitals.

In addition to other procedures utilized by individual facilities, each applicant should be oriented to the programs available at the facility and given the opportunity to decide if participation is desirable. The application for admission should be in writing and may include provision for payment of the cost of services. A review of medical/physical needs must be done to insure that the patient does not have medical problems requiring a higher level of care than the facility offers.

The facility (whether inpatient or outpatient) must determine if the applicant has the capacity to make decisions about treatment, i.e., that the client understands the purpose, nature and significant risks and benefits of treatment. If the facility determines that the applicant lacks this capacity, admission must be denied, in the absence of a genuine emergency, until substitute authority is obtained, guardian consent for those incompetent or involuntary commitments.

Definition: Lacks Capacity to Make Decisions about Treatment

“lacks capacity to make decisions about treatment’ shall mean the inability, by reason of mental illness, to achieve a rudimentary understanding after conscientious efforts at explanation of the purpose, nature, and possible significant risks and benefits of treatment.” [Idaho Code 66-317(I)]

Right to Release on Application [Idaho Code 66-319, 66-320]

Once admitted, the voluntary patient enjoys the same rights offered all other patients and, in addition, may withdraw from the facility at any time, subject only to temporary detention should involuntary commitment proceedings be initiated by the director of the facility after an evaluation. [Idaho Code 66-319]

A voluntary patient admitted in accordance with the procedure outlined in section 66-318, Idaho Code, who requests his release or whose release is requested, in writing, by his legal guardian, parent, spouse, or adult next of kin shall be released except that:

- (1) if the patient was admitted on his own application and the request for release is made by a person other than the patient, release may be conditioned upon the agreement of the patient thereto, and
- (2) if the patient, by reason of his age, was admitted on the application of another person, his release prior to becoming sixteen (16) years of age may be conditioned upon the consent of his parent or guardian, or
- (3) if the director of the facility determines that the patient should be hospitalized under the provisions of this chapter, the patient may be detained up to three (3) days, excluding Saturdays, Sundays and legal holidays, for the purpose of examination by a designated examiner and the filing of an application for continued care and treatment.

1.2.3 Appointment of Temporary Guardianship

No person who is unable to consent to treatment may be admitted to a facility unless the person is involuntarily committed by court order, or unless the application for admission is made by the person's legal guardian. If the person lacks a general probate code guardian, one may be appointed under Title 66, Chapter 3, Idaho Code.

Idaho Code 66-322 contains the procedure by which temporary guardians with authority to consent to treatment are appointed for the mentally ill. While the

provisions of this section parallel those for civil commitment, there are some important differences:

- (1) The arrangement is a private one; the state is neither the consentor nor the primary service provider.
- (2) The arrangement is limited to a seven-week period.
- (3) There is no requirement for dangerousness.
- (4) The examiners must be physicians or licensed psychologists.

Proceedings for appointment of a guardian under Idaho Code 66-322 are initiated by filing a petition alleging that the proposed patient is mentally ill, that treatment is available, and that the proposed patient lacks capacity to make informed decisions about treatment. The petition must be accompanied by the certificate of a physician or licensed psychologist. The examiner need not be a "designated examiner." The certificate must state:

- (1) that the proposed patient is mentally ill;
- (2) that in the absence of treatment, the immediate prognosis is for major distress resulting in serious mental or physical deterioration;
- (3) that treatment is available which is likely to avoid serious mental or physical deterioration; and
- (4) that the proposed patient lacks capacity to make informed decisions about treatment.

When the petition is filed, the court will appoint another licensed physician or licensed psychologist to make a personal examination of the proposed patient, or if the proposed patient has not been examined, the court shall appoint two (2) licensed physicians or licensed psychologists to make individual personal examinations of the proposed patient. The provisions for notice, right to council and hearing are similar to those for civil commitment.

If, at that hearing, the court finds by clear and convincing evidence that:

- (1) The proposed patient has a severe and reliably diagnosable mental illness;
- (2) Without treatment, the immediate prognosis is for major distress resulting in serious mental or physical deterioration;
- (3) Treatment is available for such illness;
- (4) The proposed patient lacks capacity to make informed decisions about treatment; and
- (5) the relative risks and benefits of treatment or non-treatment are such that a reasonable person would consent to treatment, the court shall appoint a

person other than the treating professional as guardian of the proposed patient, with authority to consent to treatment.

Idaho Code 66-322(k) contains the procedure by which the guardian's authority may be continued for a second seven-week period. The petition for renewal must be accompanied by the certificate of the treating professional, and if the patient objects, the court must conduct a hearing.

It is possible to consolidate petitions for guardianship under Idaho Code 66-322 with applications for involuntary care under Idaho Code 66-329. However, the requirements of both sections must be satisfied, and the petitioner/applicant should be prepared to prove the facts necessary under both sections. To avoid the consolidated requirements of four examinations, the designated examiners would have to be either physicians or licensed psychologists. Consolidated proceedings would benefit those current cases when proof of dangerousness is difficult or future guardianship cases when proof of efficacy of treatment is difficult and there is evidence of dangerousness.

1.2.4 Guardians of Incapacitated Persons

In some situations where the individual will have a sustained or continued lack of capacity, impairing his ability to provide informed and reliable consent to care and treatment, a guardianship arrangement may be necessary. Under the guardianship provisions of Idaho Code 15-5-101(a) an "*incapacitated person*" is defined as:

“. . . any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause (except minority) to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person, provided, that the term shall not refer to a developmentally disabled person as defined in section 66_402(4), Idaho Code."

The criterion of an incapacitated individual is further defined as Idaho code addresses four areas:

"(1) 'Incapacity' means a legal, not a medical disability and shall be measured by function limitations and it shall be construed to mean or refer to any person who has suffered, is suffering, or is likely to suffer, substantial harm due to an inability to provide for his personal needs for food, clothing, shelter, health care, or safety, or an inability to manage his or her property or financial affairs;

"(2) Inability to provide for personal needs or to manage property shall be evidenced by acts or occurrences, or statements which strongly indicate imminent acts or occurrences; material evidence of inability must have occurred within twelve (12) months prior to the filing of the petition for guardianship or conservatorship;

(3) Isolated instances of simple negligence or improvidence, lack of resources, or any act, occurrence, or statement, if that act, occurrence, or statement is the product of an informed judgment, shall not constitute evidence of inability to provide for personal needs or to manage property;

“(4) “Informed judgment” means a choice made by a person who has the ability to make such a choice, and who makes it voluntarily after all relevant information necessary to making the decision has been provided, and who understands that he is free to choose or refuse any alternative available and who clearly indicates or expresses the outcome of his choice;” [Idaho Code 15-5-101(a)]

[See Appointment of guardian in Idaho Code 66-322 and 66-355.] The examiner should also be aware of the "Community Board of Guardians" program which makes available (in some areas of the state) trained individuals to act as guardians for incapacitated persons.

1.3 INVOLUNTARY ADMISSION

1.3.1 Emergency Detention

Only a peace officer may take an individual into emergency detention without a prior court order. "...a person may be taken into custody by a peace officer and placed in a facility, if the peace officer has reason to believe that the person is gravely disabled due to mental illness or the person's continued liberty poses an imminent danger to that person or others, as evidenced by a threat of substantial physical harm;" This is a higher level of dangerousness than that required for civil commitment. There is no requirement that the initial detention be in a mental health facility, however, "...under no circumstances shall the proposed patient be detained in a nonmedical unit used for the detention of individuals charged with or convicted of penal offenses." [Idaho Code 66-326(a)]

• *Within 24 hours* after the individual is taken into custody, the evidence of dangerousness must be presented to a court. If the court concurs with the officer's determination, it may authorize continued detention in a facility. This is one circumstance when a petition may be filed not accompanied by the certificate of a designated examiner. [See Idaho Code 66-326(a)]

• *Within a second 24-hour period*, of the court's findings that the individual is gravely disabled due to mental illness or imminently dangerous, "the court shall issue a temporary custody order requiring the person to be held in a facility, and requiring an examination of the person by a designated examiner". Under no circumstances shall the proposed patient be detained in a nonmedical unit used for the detention of individuals charged with or convicted of penal offenses. [Idaho Code 66-326(b)]

- *Within 24 hours* of the examination, the designated examiner must report to the court whether the individual is mentally ill, and either is likely to injure himself or others or is gravely disabled due to mental illness. [Idaho Code 66-326(c)]
- *Within 24 hours* of the examination, the prosecuting attorney must petition the court requesting the patient's detention pending commitment for involuntary care under Idaho Code 66-329(d).
- *Within 5 days*: "Upon the receipt of such a petition, the court shall order his detention to await hearing which shall be within five (5) days (including Saturdays, Sundays and legal holidays) of the detention order. If no petition is filed within twenty-four (24) hours of the designated examiner's examination of the person, the person shall be released." [Idaho Code 66-329(d)].

1.3.2 Application

Under Idaho Code 66-329(a)(b), the judicial proceedings for involuntary care may be initiated by the filing of an application, usually in the Magistrate's Division of the District Court where the proposed patient is found. The application must state:

- (1) the name and last known address of the proposed patient;
- (2) the name and address of the proposed patient's spouse, guardian, adult next of kin, or friend;
- (3) whether the proposed patient may be cared for privately in the event commitment is not ordered;
- (4) whether a request for release has been made (in the case of a voluntary patient being proposed for involuntary commitment); and
- (5) a statement of facts showing the proposed patient is mentally ill and either is likely to injure himself or others or is gravely disabled.

Whenever possible the application should include the following additional information:

- (1) Include the name and address of the patient's spouse, guardian, adult next of kin or friend in the application (and in the commitment order). This allows the facility to supply copies of the post-commitment reports and transfers to an interested individual.
- (2) In the event the proposed patient has property which needs care during the period of commitment, the application should so state, in order that the court in the commitment order may appoint a guardian ad litem to protect the property.
- (3) Some reference to the proposed patient's financial status should also be included, so that the court may fix responsibility for the payment of the costs of care without a second hearing.

Any such application shall be accompanied by a certificate of a designated examiner, stating that:

- (1) he has personally examined the proposed patient within the last 14 days, and
- (2) is of the opinion that the proposed patient is:
 - (a) mentally ill,
 - (b) likely to injure himself or others, or gravely disabled due to mental illness, and
 - (c) lacks capacity to make informed decisions about treatment.

If the patient refused to submit to an examination by a designated examiner, the applicant must submit a written statement to that effect. [Idaho Code 66-329(c)]

1.3.3 PRE-HEARING PROCEDURES

Second Designated Examiner

Upon receipt of an application for commitment, the court shall, within forty-eight (48) hours appoint another designated examiner to make a personal examination of the proposed patient or if the proposed patient has not been examined, the court shall appoint two (2) designated examiners to make individual personal examinations of the proposed patient and may order the proposed patient to submit to an immediate examination.

Physical Examination

If neither designated examiner is a physician, the court shall order a physical examination of the proposed patient.

Examiner Qualifications

At least one (1) designated examiner shall be a psychiatrist, licensed physician or licensed psychologist. No more than one (1) designated examiner may be a non-psychiatric physician, a holder of an earned master's level or higher degree in social work from an accredited program, a registered nurse with an earned master's level or higher degree in psychiatric nursing from an accredited program, or a holder of an earned master's level or higher degree in psychology from an accredited program. However, both examiners may not be non-psychiatrist physicians. [Idaho Code 66-329(d)]

The designated examiners have three days (72 hours) from their appointment to examine the proposed patient and file written certificates of examination with the court. The certificates must address whether the proposed patient is mentally ill and either likely to injure himself or others or gravely disabled. The certificates should also address the proposed patient's capacity to make informed decisions about treatment. [Idaho Code 66-329(d)]

Once the examiners have filed their written certificates, what happens next depends upon the content of those certificates. If the certificates state that the proposed patient is not mentally ill, or that although he is mentally ill, he is not likely to injure himself or others or is not gravely disabled, the court may dismiss the application and terminate the proceedings. If the patient has been in custody, he must be released immediately under these circumstances. However, if the designated examiner certificate states a belief that the proposed patient, due to a mental illness, is either likely to injure himself or others or is gravely disabled, then the judge must "issue an order authorizing any health officer, peace officer or director of a facility take the proposed patient to a facility in the community in which the proposed patient is residing or to the nearest facility to await the hearing"

The judge may also authorize treatment in the order, if good cause has been presented. The authorized treatment is subject to the patient's right to refuse treatment in non-emergencies. [See Idaho Code 66-346(a)(4).]

Formal Notice

A formal notice must be given to the applicant, to the proposed patient, and to either, the proposed patient's spouse, guardian, adult next of kin, or friend, sufficiently in advance of the hearing to allow them time to prepare. Notice must include:

- (1) the time and place of the hearing;
- (2) a copy of the application and designated examiners' certificates; and
- (3) the proposed patient's rights to be represented by an attorney or, if indigent, to be represented by a court-appointed attorney.

The court is required to schedule a hearing on the application for involuntary care within seven (7) days of filing the second designated examiner's certificate. However, with the consent of the proposed patient and his attorney, the hearing may be held sooner. Similarly, upon motion of the proposed patient and his attorney, the court may continue the hearing up to 14 days. This additional period may include a provision for treatment. [Idaho Code 66-329(f)]

1.3.4 The Hearing

The hearing may be conducted in as informal a manner as may be consistent with orderly procedure and the rules of evidence. While the hearing may be held in any place not likely to have a harmful effect on the proposed patient's health, many courts, because of equipment and staff, conduct the hearings in the courthouse.

At the hearing, the applicant must prove by clear and convincing evidence that the proposed patient is mentally ill and, as a result, either is likely to injure himself or others or is gravely disabled. [Idaho Code 66-329(I)] (See Exclusions, 1.1.2, Review of Concept of Mental Illness, this document.)

It should also be noted that "any existing provision of the law prohibiting the disclosure of confidential communications between the designated examiner and proposed patient shall not apply and any designated examiner who shall have examined the proposed patient shall be a competent witness to testify as to the proposed patient's condition." [Idaho Code 66-329(I)]

It needs to be pointed out to the examiner that in those cases involving a respondent who presents such a degree of dangerousness requiring a maximum security setting a consideration can be made for the court to review the guidelines of Idaho Code 66-1305 which state:

"For purposes of this chapter persons found to be both dangerous and mentally ill shall mean persons found by a court of competent jurisdiction pursuant to any lawful proceeding:

- (a) To be in such mental condition that they are in need of supervision, evaluation, treatment and care; and*
- (b) To present a substantial risk of physical harm to either persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; and*
- (c) To be dangerous to such a degree that a maximum security treatment facility is required." [Idaho Code 66-1305]*

This finding can allow the disposition and placement of the individual to the Security Medical Facility of the Department of Corrections. Idaho Code 66-1304 states as a requirement for sources of residents to this facility that the court enter such a finding in the judicial proceeding conducted in accordance with Idaho Code 66-329.

1.3.5 The Applicant's Case and Direct Testimony of the Designated Examiner

Direct testimony of the designated examiner is critical to the outcome of the case. The applicant's attorney will attempt to demonstrate to the court the need for the least restrictive treatment alternative for the proposed patient.

Toward this end, according to American Jurisprudence, "*Counsel must instruct his expert in proper courtroom attitude and demeanor . . . The examiner should be told to keep an accurate record of dates and duration of his examinations, so that he can testify forcefully and without hesitation to the facts on which he bases his opinions. Counsel should caution the witness to speak as definitively as possible and omit all language unnecessarily qualifying his opinion.*"

It is important, therefore, and for the proper treatment of the proposed patient, that the examination be as thorough as possible. For, "*Ridicule and humiliation in the courtroom is unlikely when the examiner is thorough in his examination, thoughtful in his opinions, and careful in his answers. The perfunctory examination, intuitive diagnosis, and impulsive reply may well lead to disaster.*"ⁱⁱ

Hearsay Information

Another issue in expert testimony and the attempt to discredit the expert may be whether or not the expert is testifying from hearsay information or from direct observation and examination. In Bailey and Rothblatt, we find that the rules of evidence against basing an opinion on hearsay evidence are becoming less rigid. They state:

"The modern trend, as expressed in the Federal Rules of Evidence, is to allow the expert to state his opinion based on facts and data without having to first testify regarding the facts. It is not required that the expert have personal knowledge of the facts and data upon which his testimony is based. The modern rule eliminates any necessity for the hypothetical question. The strict rules regarding the admissibility of the facts underlying the expert's opinion are also no longer necessary. Remember, however, that on cross-examination counsel may still inquire about the basis of the expert's opinion and the expert must reply."

Idaho Rules of Evidence, 703

Idaho Rules of Evidence, 703, permit an expert witness to testify based on facts perceived by or made known to him at or before the hearing. The Idaho Rules of Evidence make it clear that the expert may testify of his expert opinion even though the opinion is based on hearsay evidence that is not itself admissible, so long as the data is "of a type reasonably relied upon by experts in the particular field in forming opinions."

Rule, 703: Basis of opinion testimony by experts.

"The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to the expert at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence in order for the opinion or inference to be admitted. Facts or data that are otherwise inadmissible shall not be disclosed to the jury by the proponent of the opinion or inference unless the court determines that their probative value in assisting the jury to evaluate the expert's opinion substantially

outweighs their prejudicial effect.”

(Adopted January 8, 1985, effective July 1, 1985; amended March 5, 2002, effective July 1, 2002.)

Court Challenges

All of this means simply that the designated examiner should be prepared when using hearsay evidence as the foundation for an opinion and be prepared for challenges which test current clinical practices in Idaho against the more “modern” practices or practices of the examiner’s discipline. Otherwise, the defense attorney may use the hearsay rules to discredit or bring suspicion upon the opinion of the expert witness.

1.3.6 The Proposed Patient’s Case and Cross-Examination of The Designated Examiner

The defendant's attorney is sometimes faced with a serious dilemma of whether he can, in good conscience advocate for his client if he, the attorney, believes his client to be mentally ill? The current thinking is that the attorney is ethically required to advocate for the wishes of the proposed patient if the proposed patient can make his/her wishes known to the attorney.

If the client agrees, the attorney may request that his client be allowed to voluntarily commit him/herself.

In addition to attempting to convince the court that the proposed patient is not mentally ill and/or not dangerous, the attorney, after conferring with his client and learning of his client's wishes, may choose to show that his client can be cared for privately or that appropriate and necessary care is available without commitment.

The proposed patient's attorney may use a variety of strategies to undermine the testimony of expert witnesses whose opinions and recommendations are at variance with the wishes of his client.

Examiner’s Preparation

In addition to discrediting against hearsay evidence and testing the clinical practices of the examiner’s discipline, the patient's attorney may question the qualifications of the expert, the reliability and validity of his opinion and conclusions, and the thoroughness of his examination.

The best preparation for cross-examination beyond being thorough in your evaluation, is to be knowledgeable about the case being tried, and clear in your opinions and conclusions.

The designated examiner should be aware that studies reviewed by Beck et al. indicated that diagnostic agreement when attempting to differentiate personality disorders, psychoses, and neuroses ranged from 30% to 45%, while the upper level

of agreement was 70% when psychiatrists attempted to discriminate merely between neuroses, psychoses and character disorders.

The examiner should also be familiar with the issues and considerations of dangerousness discussed in Chapter 2.

Any of these issues may be raised by the proposed patient's attorney in advocating for his client as well as the question of least restrictive treatment alternatives. Though the dispositioner and not the designated examiner is responsible for selecting the treatment alternative once adjudication has occurred, the designated examiner is required on the "Certificate of Examination" to indicate appropriate treatment and a source of same.

1.3.7 The Court Decision

If the court finds, by clear and convincing evidence, that the proposed patient is mentally ill and likely to injure himself or others, or is gravely disabled due to mental illness, then the court shall order the proposed patient committed to the custody of the Director of the Department of Health and Welfare for an indeterminate period of time not to exceed one (1) year. [Idaho Code 66-329(k), (1998)].

The order of commitment shall state whether the proposed patient lacks capacity to make informed decisions about treatment, the name and address of the patient's attorney and either the patient's spouse, guardian, adult next of kin, or friend. [Idaho Code 66-329(m), (1998)]

If the patient has no spouse or guardian and if the patient has property which may not be cared for by the patient while confined at a facility, the court shall appoint a guardian ad litem for the purpose of preserving the patient's estate. [Idaho Code 66-329(n), (1998)]

Disposition and Notification

The department director, through his dispositioner, shall determine within twenty-four (24) hours of an order of commitment, the least restrictive available facility consistent with the needs of the committed patient for observation, care, and treatment. [Idaho Code 66-329(k)].

Within 48 hours of the disposition, the county must transport the patient to the designated facility.

- (a) After the dispositioner has designated the place of treatment, he shall notify the facility director of the disposition and of any medical, security or behavioral needs of the committed patient. The county shall deliver the patient within forty-eight (48) hours to the designated facility. Whenever practicable, the individual may be accompanied by one or more of his friends or relatives.
- (b) Pending his removal to the designated place of treatment, a patient taken into custody or ordered to be committed to the custody of the department director

pursuant to this chapter may be detained in his home, a licensed foster home, or any other suitable facility under such reasonable conditions as the dispositioner may fix, but he shall not be detained in a nonmedical facility used for the detention of individuals charged with or convicted of penal offenses. The dispositioner shall take such reasonable measures(,) to secure proper mental health care and treatment of an individual temporarily detained pursuant to this chapter.

- (c) The dispositioner shall notify the court, the patient's attorney and either the patient's spouse, guardian, adult next of kin or friend, of the facility to which the patient has been dispositioned. [Idaho Code 66-330(a), (b) and (c)]

Idaho Code 66-342(c) directs the court to consider the treatment needs of the patient, the security needs of the patient and available facilities. The dispositioner is responsible to take reasonable measures to secure appropriate treatment for the patient until the patient is transported to the facility. [Idaho Code 66-329(k), (m), (n)]

1.3.8 Review of Involuntary Status After Non-Criminal Commitment

The Director of the Department of Health and Welfare "or his designee" is responsible for reviewing every committed patient. By policy, this has been delegated to Regional Mental Health Program Managers or Institution Administrative Directors under whom the patient is receiving services. The review must be conducted before the end of the first 90 days of the commitment and every 120 days thereafter. The review must determine, in the case of inpatients, whether the patient may be conditionally released, and whether the commitment should be terminated. *(See section 1.6.1, Discharge of Voluntary Patient, this document).*

A report of each such review must be sent to the committing court, prosecuting attorney of the county of commitment, if any, the patient's attorney, and either the proposed patient's spouse, guardian, next of kin, or friend. [Idaho Code 66-337(a)(b)]

1.4 OUTPATIENT COMMITMENT

Definition: Outpatient Commitment

A court order directing a person to comply with specified mental health treatment requirements, not involving the continuous supervision of a person in an inpatient setting, that are reasonably designed to alleviate or to reduce a person's illness or disability, or to maintain or prevent deterioration of the person's mental or emotional functioning. (Idaho Code 66-317)

The Department of Psychiatry and Behavioral Sciences at Duke University Medical Center found Outpatient Commitment to be effective in reducing multiple hospitalizations of mentally ill persons (Swartz MS., 1999). They found that patients who continued outpatient commitment upon being discharged from a psychiatric hospital showed fewer readmissions than patients who were discharged to their home. These court ordered commitments were especially effective with patients with non-affective psychotic disorders and who had intensified outpatient treatment.

Outpatient Commitment allows the person to remain in the community under certain conditions of treatment and services which may include, but need not be limited to, taking prescribed medication, reporting to a facility to permit monitoring of the person's condition, and/or participating in individual or group therapy or in educational or vocational programs. It may stay in effect for up to one (1) year. [Idaho Code 66-339(a)] If the person does not or cannot comply, the individual can go back before the court for consideration of inpatient commitment provisions.

Idaho Code 66-339 lists outpatient commitment as an alternative to re-hospitalization for a person not meeting the conditions of a hospital conditional release.

Outpatient Commitment was adopted by the Idaho Legislature in 1998 and began as an option to inpatient commitment on July 1, 1999.

1.4.1 Criteria For Outpatient Commitment:

The court needs to determine, on the basis of clear and convincing evidence that:

1. The person is diagnosed as having a mental illness; and
2. The person, without the requested treatment
 - a. Is likely to cause harm to himself or to suffer substantial mental or emotional deterioration, or become gravely disabled, or
 - b. Is likely to cause harm to others; and
3. The person lacks capacity to make an informed decision concerning his need for treatment; and

Previous Hospitalization for Treatment of Mental Illness

4. The person has previously been hospitalized for treatment of mental illness and has by history substantially failed to comply on one (1) or more occasions with the prescribed course of treatment outside the hospital; and
5. A treatment plan has been prepared which includes:
 - a. Specific conditions with which the patient is expected to comply,
 - b. A detailed plan for reviewing the patient's medical status and for monitoring compliance with the required conditions of treatment; and
6. There is a reasonable prospect that the patient's disorder will respond to the treatment proposed in the treatment plan without having to be involuntarily committed to an inpatient facility if the patient complies with the treatment requirements specified in the court's order; and

7. The physician or treatment facility which is to be responsible for the patient's treatment under the commitment order has agreed to accept the patient.

1.4.2 Application for Outpatient Commitment

The commitment may be commenced by the filing of a written application with a court of competent jurisdiction by a friend, relative, spouse or guardian of the proposed patient, or by a licensed physician, prosecuting attorney, or other public official of a municipality, county or of the state of Idaho, regional mental health authority (RMHA) treating professional, or the director of any facility in which such patient may be. (Idaho Code 66_339B)

The application shall state (i) the name and last known address of the proposed patient; (ii) the name and address of either the spouse, guardian, next of kin or friend of the proposed patient; (iii) that more restrictive treatment would be necessary or required if the illness progressed as prior history indicated; (iv) if the proposed patient is, at the time of the application, a voluntary patient; (v) a simple and precise statement showing that the proposed patient has previously been diagnosed with a mental illness, that the proposed patient has previously refused to accept treatment outlined in a treatment plan, and is now refusing such treatment; (vi) the observations indicating the current progression of the illness, that the expected progression would more than likely result in a condition where the proposed patient is likely to injure himself or others or suffer substantial mental or emotional deterioration, or likely to become gravely disabled; and (vii) whether or not there is a less restrictive alternative.

1.4.3 Examination of Proposed Patient

The petition shall be accompanied by the report of a designated examiner. The petition shall include a statement that the examiner has personally examined the proposed patient within the last fourteen (14) days and is of the opinion that the proposed patient (i) has a history of mental illness; (ii) that as a result of the progression of this illness the proposed patient without treatment is likely to injure himself or others or suffer substantial mental or emotional deterioration, or become gravely disabled; (iii) that the proposed patient has a treatment plan that can be satisfied by outpatient services; (iv) that the proposed patient has failed to comply on one (1) or more occasions with a prescribed course of treatment; and (v) that the proposed patient now refuses or lacks the capacity to make informed decisions about the necessity for continued treatment, or (vi) a written statement by the applicant that the proposed patient has refused to submit to examination by a designated examiner.

The designated examiner shall report his findings to the court within the forty-eight (48) hours in the form of a written certificate which shall be filed with the court. If the designated examiner's certificate states a belief that the proposed patient meets the above established criteria for outpatient commitment the judge shall issue an order authorizing any regional mental health authority, health officer,

peace officer, or director of a facility to take the proposed patient to an outpatient facility in the community in which the proposed patient is residing or to the nearest place of treatment as designated by the RMHA. In addition, the court shall authorize treatment as described in the treatment plan. The conditions of the treatment plan shall be specified, and a copy of that treatment plan shall be provided to the patient as soon as practicable after the hearing. Under no circumstances shall the proposed patient be detained in a nonmedical unit used for the detention of individuals charged with or convicted of penal offenses.

If the designated examiner's certificate states a belief that the proposed patient does not meet the above established criteria for outpatient commitment, the court may terminate the proceedings and dismiss the application without taking any further action.

Every patient proposed for an outpatient commitment shall have an opportunity to be represented by counsel, and if neither the proposed patient nor others provide counsel, the court shall appoint counsel in accordance with chapter 8, title 19, Idaho Code, no later than the time the petition is received by the court.

Notice of the petition shall be given to the RMHA by the clerk of the court by mailing to an address the RMHA shall provide. In addition to the right to counsel, the proposed patient shall be afforded an opportunity to appear at the hearing, to testify, and to present and cross-examine witnesses. The proposed patient shall be required to be present at the hearing unless the court determines that the mental or physical state of the proposed patient is such that his presence at the hearing would be detrimental to the proposed patient's health or would unduly disrupt the proceedings.

The hearing shall be held at a facility, at the home of the proposed patient, or at any other suitable place not likely to have a harmful effect on the proposed patient's physical or mental health. Venue for the hearing shall be in the county of residence of the proposed patient, unless the patient waives the right to have venue fixed there. The court on its own motion may find that venue in the county where the proposed patient is found is proper, if it is in the best interest of the proposed patient. A record of the proceedings shall be made as for other civil hearings.

1.4.4 Confidential Communications

In all proceedings under this section, any existing provision of the law prohibiting the disclosure of confidential communications between the designated examiner and proposed patient shall not apply and any designated examiner who shall have examined the proposed patient shall be a competent witness to testify as to the proposed patient's condition.

If, upon completion of the hearing and consideration of the record, the court finds by clear and convincing evidence that the proposed patient

- (a) Has a mental illness; and
- (b) Has a prescribed course of treatment for this mental illness; and
- (c) Has failed to comply with a prescribed course of treatment on one (1) or more occasions outside an inpatient facility; and

- (d) Because of a deterioration resulting from the failure to comply with the prescribed course of treatment is likely to suffer substantial mental or emotional deterioration or be likely to injure himself or others, or become gravely disabled due to mental illness; the court shall order the proposed patient committed to the department only for the purposes of outpatient commitment for an indeterminate period of time not to exceed one (1) year.

The conditions of the treatment plan shall be specified, and a copy of that treatment plan shall be provided to the patient as soon as practicable after the hearing. The RMHA, through its dispositioner, shall determine within twenty-four (24) hours the least restrictive available outpatient facility consistent with the needs of the patient and the treatment plan.

The order of outpatient commitment shall state (i) whether the proposed patient lacks capacity to make informed decisions about treatment; and (ii) the name and address of the patient's attorney; and (iii) either the patient's spouse, guardian, adult next of kin, or friend; and (iv) whether or not the patient may be involuntarily medicated with medication described in the treatment plan.

1.4.5 Amendment of Treatment Plan

During the one (1) year outpatient commitment the treatment plan may be amended from time to time by the treating facility or physician. Staff of the facility in which the patient is being treated may communicate with outpatient clinicians without the patient's consent in order to develop outpatient treatment plans unless there are provisions of federal law which prohibit this. [Idaho Code 66-339B.(9)]

1.4.6 Treatment Exclusions

This law does not authorize the detention or involuntary outpatient commitment of an individual who

- (a) Is epileptic, mentally deficient, mentally retarded, impaired by chronic alcoholism or drug abuse, or aged, unless in addition to such condition, such person is mentally ill; or
- (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.

1.4.7 Termination of Commitment

The commitment may be terminated at any time by the RMHA, the treating physician, or the court. It may be renewed upon application under this section by the RMHA, the treating physician, relative, spouse, guardian, or prosecuting attorney, upon the failure of the patient to continue with a treatment plan. It may be terminated sooner by the RMHA, the treating physician, or upon application of

the patient if the patient is no longer mentally ill, or is no longer in need of following a treatment plan. [Idaho Code 66-339B]

Noncompliance

- (1) If a patient fails to comply with the requirements specified in the outpatient commitment order, and the RMHA, the physician or staff of the treatment facility believes that there is a significant risk of deterioration in the patient's conditions, the director of the facility, physician, or RMHA shall notify law enforcement.
- (2) The outpatient commitment order constitutes a continuing authorization for law enforcement, upon request of the director of the outpatient facility, the physician, or the RMHA, to transport the patient to the designated outpatient treatment facility or the physician's office for the purpose of making reasonable efforts to obtain the person's compliance with the requirements of the outpatient commitment order. However, the patient may not be detained at the facility or the physician's office for more than one (1) hour, and may not be physically coerced to take prescribed medications unless the court has entered on the outpatient commitment order an authorization for the nonconsensual delivery of prescribed medication. If a patient has been involuntarily medicated, a report of such action shall be made within twenty-four (24) hours to the court, the patient's guardian, or next of kin by the treatment provider.
- (3) If a patient fails to comply with the requirement of the court order, and the RMHA, the physician or staff of the treatment facility believes that there is a significant risk of deterioration, the RMHA, the director of the facility or the physician shall notify the original petitioner for outpatient commitment and the prosecuting attorney of the county where the patient is found and shall recommend an appropriate disposition.

Within seventy-two (72) hours of receiving the notice transmitted pursuant to this section that a patient has failed to comply with the requirements of the outpatient commitment order, the original petitioner for outpatient commitment, the RMHA and the prosecuting attorney of the county where the patient is found or resides may petition the court for a supplemental hearing, or may proceed under any other section of this chapter. If a petition for supplemental hearing is filed, the court shall hold a supplemental hearing in accordance with the procedures specified in section 66_329, Idaho Code, within forty-eight (48) hours. After hearing evidence concerning the patient's current condition and compliance with the court order, the court shall make whichever of the following dispositions it deems appropriate:

- (a) Upon finding that hospitalization is necessary to prevent the patient from harming himself or others or to prevent substantial deterioration of the patient's mental or emotional conditions, the court shall order a commitment proceeding under section 66_329, Idaho Code, and may temporarily commit the patient to an inpatient facility pending hearing on a petition or application for commitment to an inpatient facility.
- (b) Upon finding that the patient does not meet the criteria for inpatient commitment and continues to meet the criteria for outpatient commitment set forth in section 66_329B [66_339B], Idaho Code, and

that additional outpatient treatment appears warranted, the court shall renew or modify the order to outpatient commitment.

- (c) Upon finding that neither condition in subparagraphs (a) nor (b) are met, the court shall rescind the commitment order.
- (d) Nothing provided in this section shall limit the authority of any law enforcement officer to detain a patient pursuant to the emergency authority conferred by section 66_326, Idaho Code.

1.5 MENTAL HEALTH DECLARATIONS

Mental Health declarations are mechanisms for persons with mental illness who are competent to articulate their preferences in type and method of care that they receive. The declaration becomes a legal document to direct treatment during those times when the person may not be competent to express such directions.

An adult of sound mind may make a declaration of their preferences such as which medications they wish to have prescribed, places to be taken for treatment, instructions about seclusion or restraint, and other factors to be considered. This proposal provides a legal frame work for the documentation of these directives, and the actions that may be taken.

Idaho Code 66-601 through 613 specifies the contents of declarations for Mental Health Treatment, provides for designation of an agent, requires signatures and witnesses, governs the operation of a declaration to specify the powers of an agent, provides for withdrawal of an agent, provides imitations, addresses actions contrary to a declaration, governs relation to other statutes, provides limited immunity, provides penalties, and governs the form of a declaration. (*See Appendix x for detailed instructions*)

1.6 CRIMINAL COMMITMENT

As of July 1, 1982, the State of Idaho abolished the insanity defense in criminal prosecutions. In revising state law, the Legislature has declared that "*mental condition shall not be a defense to any charge of criminal conduct.*" [Idaho Code 18-207(a)]

Despite this change in law, two areas continue to exist where criminal commitment may occur. One is the issue of fitness to stand trial, addressed in Idaho Code 18-210 and 18-211. The second is the issue of mental illness as a mitigating factor in sentencing a person who has been found guilty of criminal conduct, addressed in Idaho Code 19-2523 and 19-2522.

1.6.1 Fitness to Stand Trial -- Examination

Only psychiatrists or licensed psychologists may perform court-ordered criminal examinations.

The criminal court may appoint the examiner, or may request the Director of the Department of Health and Welfare to designate an examiner. Although each Community Mental Health Center has assigned a person to act as court liaison, the Director has not formally delegated the power to appoint forensic examiners to the CMHC's. The individual assigned by the CMHC should know of available examiners in the area and be able to arrange support services for the examiner, such as securing social history, records, etc.

Payment for the Examination

It must be noted that the option to request the Department to designate an examiner does not impose a duty on the Department to pay for the examination. No examiner should express an interest in performing an examination unless payment arrangements are understood and accepted.

Conducting the Examination

The examiner may employ any method which is accepted by the examiner's profession for the examination of those alleged not to be competent to assist counsel in their defense. [Idaho Code 18-211(4)]

The examination should be completed locally on an outpatient basis. However, should the examiner find it necessary to have the defendant confined for purposes of the examination, a court may order the defendant confined (for not more than 30 days) in a suitable facility. [Idaho Code 18-211(2) and (3)]

The appointed examiner shall also evaluate whether the defendant lacks capacity to make informed decisions about treatment. [Idaho Code 18-211 (1)]

Reporting

The report of the examination must be in writing and filed in triplicate with the clerk of the court. The clerk will provide copies to the prosecuting and defense attorneys. The report must include:

- (1) a description of the nature of the examination;
- (2) a diagnosis or evaluation of the defendant's mental condition;
- (3) an opinion as to the defendant's capacity to understand the proceedings against him and to assist in his own defense.
- (4) an opinion whether the defendant lacks the capacity to make informed decisions about treatment. "Lack of capacity to make informed decisions about treatment" means the defendant's inability, by reason of his mental condition, to achieve a rudimentary understanding of the purpose, nature, and possible significant risks and benefits of treatment, after conscientious efforts at explanation. [Idaho Code 18-211(5)]

If the examination cannot be performed because of unwillingness of the defendant, the report should so state and must include, if possible, an opinion whether the unwillingness was the result of mental disorder. [Idaho Code 18-211(6)]

Fitness to Stand Trial

The fitness of a defendant to stand trial is a question of law for the trial judge to decide.

"Fitness" is defined as the present ability:

- (1) to understand the nature and object of the proceeding (e.g., trial, sentencing or punishment);
- (2) to conduct his defense in a rational manner; and
- (3) to cooperate with counsel to present any available defense.

Various factors may be considered in determining competency to stand trial, including:

- (1) any physical disabilities of the defendant or the influence of drugs;
- (2) the defendant's knowledge and understanding of the charge, the proceedings, the consequences of a plea, the verdict and sentence, and the functions of the participants in the trial process;
- (3) the defendant's ability to observe, recollect and relate occurrences, especially those concerning the incidents alleged in the information, to communicate with counsel, and to make reasoned judgments concerning the trial process; and
- (4) the defendant's social behavior, orientation as to time and place, recognition of persons, places and things, and performance of motor processes.

Competent to Participate at the Preliminary Examination

Occasionally, mental health professionals will be called upon to determine whether or not the defendant was competent to do other acts along with the criminal process. In addition to trial, sentencing and punishment, some non-Idaho courts have determined that the defendant must be competent to participate at the preliminary examination.

Confession, a Product of Mental Disease or Defect

There is a rule of law that for a confession to be admissible, it must be made knowingly and voluntarily. Occasionally, mental health professionals will be called upon to determine whether or not a confession was the product of the defendant's rational intellect and free will or whether the confession was a product of mental disease or defect. The Idaho Supreme Court has determined that *"so long as the defendant is mentally capable of understanding the meaning and consequences of the statements, a mental disturbance will not necessarily preclude the admissibility of a confession."* State vs. Powers, 96 Idaho 833,841 (1975).

Test for Determining Competency

The defendant need not be able to testify in order to be fit to stand trial. In State vs. Powers, the defendant argues that because he was unable to testify on his own behalf because of a mental disease or defect, he could not adequately assist in his own defense and therefore could not be tried. The Idaho Supreme Court did not adopt this argument, and stated:

"The test for determining competency was enunciated by the Supreme Court in Dusky v. United States where the court held that:

"it is not enough for the district judge to find that "the defendant [is] oriented to time and place and [has] some recollection of events," but that the "test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding - and whether he has a rational as well as factual understanding of the proceedings against him." [362 U.S. 402, 403]

"That test, is equivalent to the standards set forth in Idaho Code 18-210 which provides that:

'No person who as a result of mental disease or defect lacks capacity to understand the proceedings against him or to assist in his own defense shall be tried, convicted, sentenced or punished for the commission of an offense so long as such incapacity endures.'

"Thus to determine whether the appellant was competent to stand trial we must inquire whether he had the capacity to (1) understand the proceedings against him and (2) assist in his defense." [96 Idaho at 842].

1.6.2 Commitment of Those Unfit to Stand Trial

If neither the prosecuting attorney nor counsel for the defendant contests the findings reported by the examiner under Idaho Code 18-211, the court may make its determination on the basis of the report. The court shall also determine, based on the examiner's findings, whether the defendant lacks capacity to make informed decisions about treatment. If either party contests the findings, then a hearing must be held and the contesting party has the right to summon and cross-examine the examiner. [Idaho Code 18-212(1)]

If the court determines the defendant is unfit to proceed, the proceedings must be suspended. The court will then commit the defendant to the custody of the Director of the Department of Health and Welfare. If the defendant is found to be dangerously mentally ill, the court may instead commit the defendant to the Department of Corrections. In either case, the defendant is to be transported to a

state hospital, institution, or mental health center equipped to evaluate and rehabilitate such defendants. The commitment period may not exceed 90 days.

Upon admission to the facility, the defendant must again be evaluated as to his mental condition. The court must also order a progress report to be filed (no time frame is provided in the statute regarding this progress report except the 90-day maximum commitment period), which shall include an opinion whether the defendant is fit to proceed or, if not, whether there is a substantial probability that the defendant will be fit to proceed within the foreseeable future. If such substantial probability exists, the court may order continued commitment of the defendant for an additional 180 days. If at any time the facility director determines that the defendant is fit to proceed, it must be reported to the court. All such reports must be filed in triplicate with the clerk of the court.

If the court determines that the defendant is unfit at the end of 90 days, and there is no substantial probability that he will be fit within the foreseeable future, then involuntary commitment proceedings shall be instituted. [Idaho Code 66-329] The same proceedings will be instituted for the defendant placed on a continued commitment (180 days) and who, at the end of that period, continues to be unfit to proceed.

1.6.3 Consideration of Mental Illness in Sentencing

Idaho Code 19-2522 and 29-2523 address the consideration of mental illness in sentencing and the requirements of the examiner in the process.

Examination

Similar to the "unfit to proceed" status, examiners are limited to psychiatrists or licensed psychologists. They may use any method of evaluation accepted by their profession for examining those alleged to be suffering from mental illness or defect. The report, which must be filed in triplicate with the clerk of the court, must address the following areas:

- (1) a description of the nature of the examination;
- (2) a diagnosis, evaluation, or prognosis of the mental condition of the defendant;
- (3) an analysis of the degree of the illness or defect and level of functional impairment;
- (4) whether treatment is available for the mental condition;
- (5) analysis of the relative risks and benefits of the treatment or non-treatment; and
- (6) consideration of risk of danger which the defendant may create for the public at large.

Authorization of Treatment

The court may authorize treatment in a penal setting, in addition to sentencing, as provided by law, after considering the issues addressed by the examiner's report. Such treatment may be authorized during the period of confinement or probation as specified in the sentence ordered by the court.

Idaho Codes states:

"If by the provisions of section 19-2523, Idaho Code, the court finds that one convicted of a crime suffers from any mental condition requiring treatment, such person shall be committed to the board of correction or such city or county official as provided by law for placement in an appropriate facility for treatment, having regard for such conditions of security as the case may require. In the event a sentence of incarceration has been imposed, the defendant shall receive treatment in a facility which provides for incarceration or less restrictive confinement." [Idaho Code 18-207(2)]

1.7 PATIENT DISPOSITION

Upon commitment, the patient is placed in the custody of the Department of Health and Welfare for the purpose of care and treatment. It is the State Mental Health Program which has the responsibility to determine what services are necessary and appropriate and what setting or facility is most appropriate for providing these services. Since the court does not commit to a facility but to the state agency it is possible to use either inpatient or outpatient services and to use various combinations of services more appropriate to the patient needs. *Chapter 3 discusses the dispositioner role and the disposition process.*

1.8 DISCHARGE, CONDITIONAL RELEASE, REHOSPITALIZATION

1.8.1 Consideration of Mental Illness in Sentencing

Any voluntary patient shall be released from an inpatient facility if it is determined that "continued care or treatment is no longer appropriate," [Idaho Code 66-319] that is, when hospitalization is no longer necessary.

A voluntary patient, other than a criminal defendant admitted for examination, who requests his release or whose release is requested, in writing, by his legal guardian, parent, spouse, or adult next of kin shall be released except that:

- (1) if the patient was admitted on his own application and the request for release is made by a person other than the patient, release may be conditioned upon the agreement of the patient thereto, and

- (2) if the patient, by reason of his age, was admitted on the application of another person, his release prior to becoming sixteen (16) years of age may be conditioned upon the consent of his parent or guardian, or
- (3) if the director of the facility determines that the patient should be hospitalized, the patient may be detained up to three (3) days, excluding Saturdays, Sundays and legal holidays, for the purpose of examination by a designated examiner and the filing of an application with the court for continued care and treatment. [Idaho Code 66-320(a)]

The date and time of any request for release shall be entered in the patient's clinical record. If the request for release is denied, the reasons for denial also shall be entered in the patient's clinical record. [Idaho Code 66-320(c)]

1.8.2 Discharge of Involuntary Commitment

A review of the involuntarily committed patient's case must be conducted before the end of 90 days and every 120 days thereafter. (*See section 1.3.8, Review of Involuntary Status After Non-Criminal Commitment, this document*)

The commitment must be terminated and the patient discharged if the patient:

- (1) is no longer mentally ill, or
- (2) is either no longer likely to injure himself or others, or
- (3) is no longer gravely disabled.

A report of each such review and determination must be sent to the committing court, prosecuting attorney of the county of commitment, if any, the patient's attorney, and either the proposed patient's spouse, guardian, next of kin, or friend. [Idaho Code 66-337(a)(b)]

1.8.3 Discharge of Criminal Commitments

For any patient admitted under the now repealed Idaho Code 18-214, acquitted of criminal charges prior to July 1, 1982, on grounds of mental disease or defect (Not Guilty by Reason of Insanity - NGRI), or committed under Idaho Code 18-212(e) and Idaho Code 66-329, not fit to proceed, notification of intention to release from an inpatient facility must be provided to the committing court and prosecuting attorney at least 30 days before such release. The court shall determine whether the conditions justify the release, and may order an independent examination of the patient. [Idaho Code 66-337(b)(c)]

1.8.4 Conditional Release of Criminal Commitments

Defendants committed before July 1, 1982, following acquittal on grounds of mental disease or defect, are committed for an indeterminate period of time so long

as they remain dangerous to themselves or others, whether or not they are mentally ill or need treatment. When the administrator of the facility determines that such a defendant may be conditionally released without danger, he must make an application to the court. The court then must appoint two examiners who are either psychiatrists or licensed psychologists to examine the defendants and file reports. Normally, the administrator's application will be accompanied by a report which will satisfy one of the two required reports.

The 1987 Legislature re-enacted the provisions of Idaho Code 18-214 setting forth the procedures for the evaluation and conditional release of individuals who had previously been acquitted on the grounds of mental disease or defect. The examiner is referred to Idaho Code 66-337 (d) which contains the reference to the conditional release provisions of this population.

The statutes make no provision for conditional release of patients committed under Idaho Code 16-1814, 18-211, or 18-212.

1.8.5 Consideration of Mental Illness in Sentencing

Idaho Code 66-339 addresses the procedure for rehospitalization of a patient on conditional release. A court hearing is required, and the procedure is similar to that used for an involuntary commitment, except that the application must include a precise statement of the facts showing that the patient either has violated a condition of the release, is in need of outpatient commitment, or is again in need of placement in an inpatient treatment facility. The other exception is that the hearing must be held within five days (see Chapter 3).

1.9 CIVIL RIGHTS

1.9.1 Right to Treatment

Idaho Code 66-324 gives the director of any facility the authority to receive involuntary patients for observation, diagnosis, care and treatment. The law does not specifically ascribe to patients any "right to treatment."

Courts have found in both directions on this issue. That is, some have found that an involuntarily committed patient has a right to treatment; others have not. At this point in time in Idaho, involuntarily committed persons have some choice in the mode of treatment and have the right to be treated humanely.

1.9.2 Right to Refuse Treatment

Idaho Code 66-346(a)(4), on rights to communication and visitation, states that patients have the right to refuse specific modes of treatment. This phraseology would seem to be consistent with nationally recommended practices of not

requiring electroconvulsive therapy, experimental treatments, or specific treatment techniques without the consent of the patient, and not requiring specific medication without consent and/or due process procedures.

Denial of Patient's Rights

Idaho Code 66-346 specifically states that *"only in cases of emergency or when a court has determined that a patient lacks capacity to make informed decisions about treatment, may the director of a facility deny a patient's rights under subsection (a)(4) [to refuse specific modes of treatment] to this section."* Further, a statement must be immediately entered in the treatment record explaining the reasons for denial of a patient's rights and, if the patient was committed by court order, copies of the entry in the treatment record shall be submitted to the committing court and to the patient's spouse, guardian, adult next of kin or friend, and attorney, if the patient has one.

1.10 PRIVACY OF COMMUNICATION

1.10.1 Between Attorney and Client

Idaho Code 66-346 speaks to issues of client/attorney communication in at least two specific ways. Sub-section (a)(1) states that *"every patient shall have the following rights: To communicate by sealed mail or otherwise, with persons, inside or outside the facility and to have access to reasonable amounts of letter writing material and postage,"* and in sub-section (a)(5) *"to be visited by his attorney at all times."* Idaho Code regarding commitment of mentally ill persons does not specify what level of privacy is to be afforded to a patient during a visit by his attorney.

1.10.2 Between Examiner and Client

Idaho Code 66-329(I) addresses this issue specifically, stating: *"In all proceedings under this section, any existing provision of the law prohibiting the disclosure of confidential communications between the designated examiner and proposed patient shall not apply and any designated examiner who shall have examined the proposed patient shall be a competent witness to testify as to the proposed patient's condition."* There can be no question that the intent of the lawmakers is that no designated examiner may withhold information regarding his examination of the proposed patient for all proceedings under the mental illness statutes on the basis of client-therapist confidentiality. However, Idaho Code 66-329(I) does not generally abrogate the examiner's or facility's duty to withhold the client's confidential information in all instances outside Title 66, Chapter 3 proceedings. The examiner should there maintain the strictures of the client-therapist relationship. These considerations would also apply in other instances where an examiner has been appointed as part of a judicial proceeding, e.g., a Idaho Code 19-2522 examination, Idaho Code 18-211, etc.

1.10.3 Confidentiality of Client Records

Consent is required before information about a patient or proposed patient is transferred from one professional and/or facility to another outside of the State Mental Health Program.

In Legal Rights of Mentally Disabled Persons Paul Friedman's task force on Mental Health and Human Rights' Task Panel on Legal and Ethical Issues made six recommendations regarding confidentiality. These are:

- (1) Federal and state laws should recognize the principle that patients must have access to their mental health records and the opportunity to correct errors therein.
- (2) Except where otherwise required by law, confidentiality of mental health information must be strictly maintained by all persons who have contact with such information. *Mental health professionals must alert their patients at the outset of therapy about special conditions under which complete confidentiality cannot be maintained.* States should also enact strong penalties for the inappropriate release of confidential materials by mental health professionals without the patient's consent.
- (3) Consent forms for release of information concerning patients' histories should be limited to particular items of information in their records relevant to the specific inquiry posed by third parties who have a legitimate need for such information. Blanket release forms should be prohibited, and non-specific requests for information should not receive response. Consent to release information should be of limited duration and should be revocable by the patient at any time. A record should be maintained in each patient's file describing what information has been released, when, to whom, and for what purposes.
- (4) Employers' questions to job applicants and employees must be related to objective functioning skills directly relevant to the specific job for which the applicant or employee is being considered.
- (5) Third-party insurers should be encouraged to utilize peer review or other similar mechanisms which allow an evaluation of the necessity and appropriateness of treatment to be conducted while the patient's identity remains anonymous. Centralization and sharing of personal information without the express written consent of the patient or client should be prohibited.
- (6) The Task Panel has reviewed and generally supports the report of the Privacy Protection Study Committee, Personal Privacy in an Information Society, concerning confidentiality of medical records. Implementation of that Commission's recommendations should be required not just in Medicare/Medicaid institutions, as the report suggests, but by all facilities maintaining mental health records.

If these suggestions are followed, neither problems of breach of confidentiality nor any laws presently in effect in Idaho should be abridged, and mental patients and their families should be secure in the knowledge that information which could negatively affect their lives after successful treatment would not be transmitted to inappropriate persons.

1.11 COSTS OF SERVICES

1.11.1 Examinations

Idaho Code 66-327(a) clearly delineates responsibility for cost of commitment. The line of responsibility is:

- (1) the proposed patient;
- (2) the proposed patient's spouse or adult children;
- (3) the county of the proposed patient's residence after all personal, family, and third-party resources, including medical assistance from Medicaid, have been utilized.

Variations on this format may occur from county to county, or between a county and various service providers. Designated examiners should become familiar with billing and payment policies and procedures that apply to any given county. If a question arises, contact the prosecuting attorney in said county.

1.11.2 Treatment Costs

Idaho Code 66-327(b) outlines fiscal responsibility for the care of patients who have been committed, dispositioned, transported, and admitted to a facility. The line of responsibility is the same as for commitment costs, except that the Department of Health and Welfare, instead of the county, is responsible after all personal, family, and third-party resources have been utilized. The care and treatment costs are limited to "usual and customary treatment costs" and specifically exclude "neurological evaluation, CAT scan, surgery, medical treatment, any other item or service not provided at the facility of the department of health and welfare, or witness fees and expenses for court appearances".

Idaho Code 66-354 (a) and (b) also address the issue of payment for treatment. These sections outline what relatives may be held responsible for the patient's expenses. The director of the facility may make inquiry into the financial resources of the patient and responsible relatives, and collect such expenses "in whole or in part". If payment is not received, the facility director may institute a civil suit against the person or persons liable for such payment. Those responsible for the expenses and charges for the commitment, care and treatment of a person with a mental illness are the husband for the wife, and the wife for the husband; the parent for his or her minor child or minor children ** (see Introduction Note, page vii), and the children for their parents.

1.12 QUALIFICATIONS AND APPOINTMENT OF DESIGNATED EXAMINERS

(See Designation of Designated Examiners and Dispositioners, Community Mental Health Program Policy and Procedures Manual.)

1.12.1 Between Attorney and Client

Idaho Code 66-317(e) defines a designated examiner as *"any person designated by the Department Director as specially qualified by training and experience in the diagnosis and treatment of mental or mentally related illness and conditions."* This section of the Code goes on to delineate what levels of educational and experiential accomplishment are required in each of the professions from which a person may serve as a designated examiner.

". . . At least one (1) designated examiner shall be a psychiatrist, licensed physician or licensed psychologist; no more than one (1) designated examiner may be a physician not practicing psychiatry, a holder of an earned master's level or higher degree in social work from an accredited program, a registered nurse with an earned masters level or higher degree in psychiatric nursing from an accredited program, or a holder of an earned master's level or higher degree in psychology from an accredited program." [Idaho Code 66-329(d), also 66-317(e)]

(See appendix, Designation of Designated Examiners and Dispositioners, Community Mental Health Program Policy and Procedures Manual for information on the qualifications to become an examiner.)

1.12.2 Procedure for Appointment

(See appendix, Designation of Designated Examiners and Dispositioners, Community Mental Health Program Policy and Procedures Manual.)

- (1) Individual applies with the Regional Mental Health Program Manager, who will forward application to the Director of the Department of Health and Welfare through the Regional Director.
- (2) Initial appointments are for one year, renewals for three years.
- (3) Status of current appointments is available from Bureau of Mental Health and Substance Abuse at 450 W. State, Boise, Idaho 334-5528.



Designated Examiner Source Book

CHAPTER TWO

Risk Assessment Considerations

CHAPTER 2

RISK ASSESSMENT CONSIDERATIONS

2.1 REVIEW OF COMMITMENT RISK ASSESSMENT CRITERIA

If, in addition to a finding of being mentally ill and upon hearing and considering the record, the court finds by clear and convincing evidence that the proposed patient, because of such condition, is *likely to injure himself or others or is gravely disabled*, the individual may be committed to the Department of Health and Welfare for care and treatment.

2.1.1 Likely to Injure Self of Others

Definition:

- 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 which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm. [Idaho Code 66-317(l)]*

2.1.2 Gravely Disabled

Definition:

Gravely disabled "...shall mean a person who, as the result of mental illness, is in danger of serious physical harm due to the person's inability to provide for his essential needs. [Idaho Code 66-317 (n)]

2.1.3 Special Considerations of the Examination

There are a number of considerations of the above standards which will be important for the examiner to take into account as s/he performs the examination and testifies in court. Judgements issued by local courts vary from jurisdiction to

jurisdiction. The examiner is advised to discuss the views of the prosecutors and local courts with local designated examiners who are experienced with the local proceedings or directly with local judges. Under the criminal code a person can make a threat on another person, but if they don't have the means to carry out the threat they will more likely not be charged. Under the civil code the opinion of a well prepared testimony by the examiner is highly respected by the court. The examiner must ask himself what kind of witness will the proposed client be. There are times when the proposed client does not visually display behavior of mental illness and yet the examiner's conclusion from the examination is that the client's condition is seriousness enough to warrant commitment. This is when the examiner must be prepared to present a stronger case.

- a. The definition does not explicitly go beyond physical harm to include emotional injury, psychic trauma or mental distress. It also does not explicitly include property damage as a separate basis of commitment. Substantial property damage may be included in the consideration of behavior which has "*caused harm or which places another person or persons in reasonable fear of sustaining such harm*".
- b. The (judgment) discretion standard of "*likely to injure*" varies from court to court, however, an interpretation often made by the court of a "*substantial risk*" is a level of risk above the standard of "*more likely than not*" level of probability. It must be more than possible, it must be probable.
- c. There is no stated standard for the proximity of harm. The combination of "*likely to injure*" and "*substantial risk*" suggests a standard less stringent and more flexible than "real and present danger of substantial harm" or the law enforcement standard of "*imminent risk*" of harm.
- d. For the purpose of assessing a substantial risk of physical harm, the prediction of harm cannot be based solely on descriptions of the person's mental condition. The requirement of "*behavior*" usually means a "*recent overt act*" which could include threats, attempts of harm or actual harm or conduct which places another person in reasonable fear of sustaining harm.
- e. The definition does not include a standard for the severity or degree of the harm necessary or predicted as a prerequisite to the finding of likely to injure self or others but does require "*serious physical harm*" under the definition of gravely disabled.

The following three sections discuss further issues and information relative to "*likely to injure self*", "*likely to injure others*" and "*gravely disabled*".

2.2 ASSESSMENT OF LIKELY TO INJURE SELF

2.2.1 Behaviors of Self Injury

Categories of included behaviors are broadly defined but break down into three general areas:

- (1) threats of suicide or suicidal actions;
- (2) threats, attempts or acts of self-maiming or self-mutilation;
- (3) threats, attempts or acts of other self-injurious behavior;
- (4) disabled behavior (see gravely disabled).

2.2.2 Prediction of Suicide

Like the prediction of other forms of violence, our ability to PREDICT SUICIDE is extremely limited. Pokorny (1983), a leading researcher in this area, states in his conclusion that *"we do not possess any item of information or any combination of items that permit us to identify to a useful degree the particular persons who will commit suicide, in spite of the fact that we do have scores of items available, each of which is significantly related to suicide."*

Pokorny goes on to note that *"It is simply not feasible to maintain one fourth of psychiatric patients on "suicidal precautions" indefinitely"*.

- a. Unlike other forms of aggression, suicide can only be successfully committed once. For any one individual there can be no pattern of actual suicide.
- b. The factors of many risk variables in combination with a relatively low incidence rate result in significant over-prediction and overestimation of the event.
- c. Those factors such as social, situational, interactional, internal states, etc. which contribute to suicidal behavior are subject to considerable variation in intensity over very brief periods of time. It is therefore essential that the time lag between a meaningful suicide assessment and a prediction of suicide be short.
- d. Mental health interventions cannot prevent an ultimate behavior or eliminate risk.

The mental health professional can provide assistance through helping to determine the presence of known or suspected risk factors and provide assessment and management within the confines of professional judgment, current knowledge and therapeutic limitations. The validity of a diagnosis of a person in a "suicidal crisis" is substantially better than any long term predictions. It is important for the examiner to be familiar with this area of the professional literature.

2.2.3 Assessment of Suicide Potential

The assessment of suicide potential of clients of all ages is the more common area of risk assessment of "likely to injure self". In the absence of any recognized effective measuring instrument, clinicians tend to use the following parameters to assess suicide potential:

Presenting Factors

- (1) signs and symptoms of depression or psychosis, recognizing that these may present differently in different age groups;
- (2) feelings of hopelessness;
- (3) suicidal thoughts or impulses;
- (4) a suicidal plan;
- (5) an available weapon or other means;
- (6) termination behavior such as giving away belongings or writing a suicide note;
- (7) high-stress life circumstance such as:
 - (a) from a broken or stressful home setting;
 - (b) emotional disorder in the family;
 - (c) significant recent losses;
 - (d) inadequate coping skills;
 - (e) history of impulsive behavior; and
 - (f) chronic alienation, instability or isolation from others.

2.2.4 High Risk Indicators of Suicide Potential

- a. suicide attempt -- present and history (60% of suicide completers have had at least one prior attempt);
- b. lethality of method -- gun vs. drug overdose (in Idaho, guns are the most prevalent means of suicide for both sexes);
- c. overt or indirect suicide talk or threats -- 80% of completers communicate their intention to commit suicide;
- d. specificity of suicide plan -- the more thought and dedication put into a plan (time, place, means and circumstance) the greater the risk;
- e. availability of means -- if the means is on hand or otherwise easily available the higher the risk;

- f. depressed or anxious mood due to depression -- 50%-70% of suicide completers are clinically depressed;
- g. significant recent loss -- spouse, parent, job, etc.;
- h. unexpected change in attitude -- suddenly cheerful, angry or withdrawn;
- i. unexpected change in behavior -- making a will, buying a gun, giving away possessions;
- j. males present a higher risk than females -- males represent 80% of suicide completers in Idaho, whereas females represent 90% of attempters;
- k. family history of suicide -- a family history of suicide substantially increases the risk of other members;
- l. drug/alcohol variable -- in over 50% of suicide completions, substance abuse is a factor;
- m. mental disorder -- among the general population a serious mental disorder is a factor in less than 10% of suicide completers; however, among the seriously mentally ill, the suicide rate is ten times greater than the general population;
- n. recent psychiatric hospitalization -- approximately 1 in 10 males who made an attempt serious enough to warrant hospitalization will go on to complete the act (for females it is approximately 1 in 100); (Shaffer, et al, 1987)
- o. lack of support system or intervention resources -- the lack of available or accessible intervention supports increases the risk.

2.2.5 Assessment Data to be Obtained and Evaluated

The American Psychiatric Association stated in 2004 that "mental illnesses are biological, arising in part from disturbances in brain or other body system chemistry; they are psychological, manifesting in disturbances in thought and/or emotion; and they are social, arising in part from patients' social and cultural environment how they are raised, the norms of their community, what sorts of stress they face in their everyday lives. Psychiatrists always take into account these three intertwined areas of an ill person's life in diagnosis and in designing an effective treatment plan. However, they are not always helpful in predicting behavior." (APA, 1998) http://www.psych.org/public_info/violence.pdf

- a. What is the individual's intention? Why does he/she want to die?
- b. Does he/she have a suicide plan? The more specific the plan, the greater the potential to act.
- c. How lethal is the method? The higher the lethality, the greater the risk.

- d. Is there a psychiatric or organic illness present? If so, what is it, and what is the suicide potential related to that illness? For instance, the lifetime rate of suicide among the severely depressed is approximately 15%.
- e. What is the potential for an impulsive versus premeditated act?
- f. Is the precipitating crisis likely to be resolved?
- g. What are the recent losses?
- h. Has the individual made plans for the future?
- i. Does the individual have available support from family, friends or professional community?

2.2.6 Behaviors of Self Injury

Estimates vary on the *ratio of number of suicide attempts to completions*, however, it is estimated that the completion rate is 1% to 10% of the attempt rate. Suicide attempts are not reported in Idaho. Approximately, 1/100 or 1/200 of the general population will make a suicide attempt. (Center for Disease Control.)

2.2.7 Behaviors of Self Injury

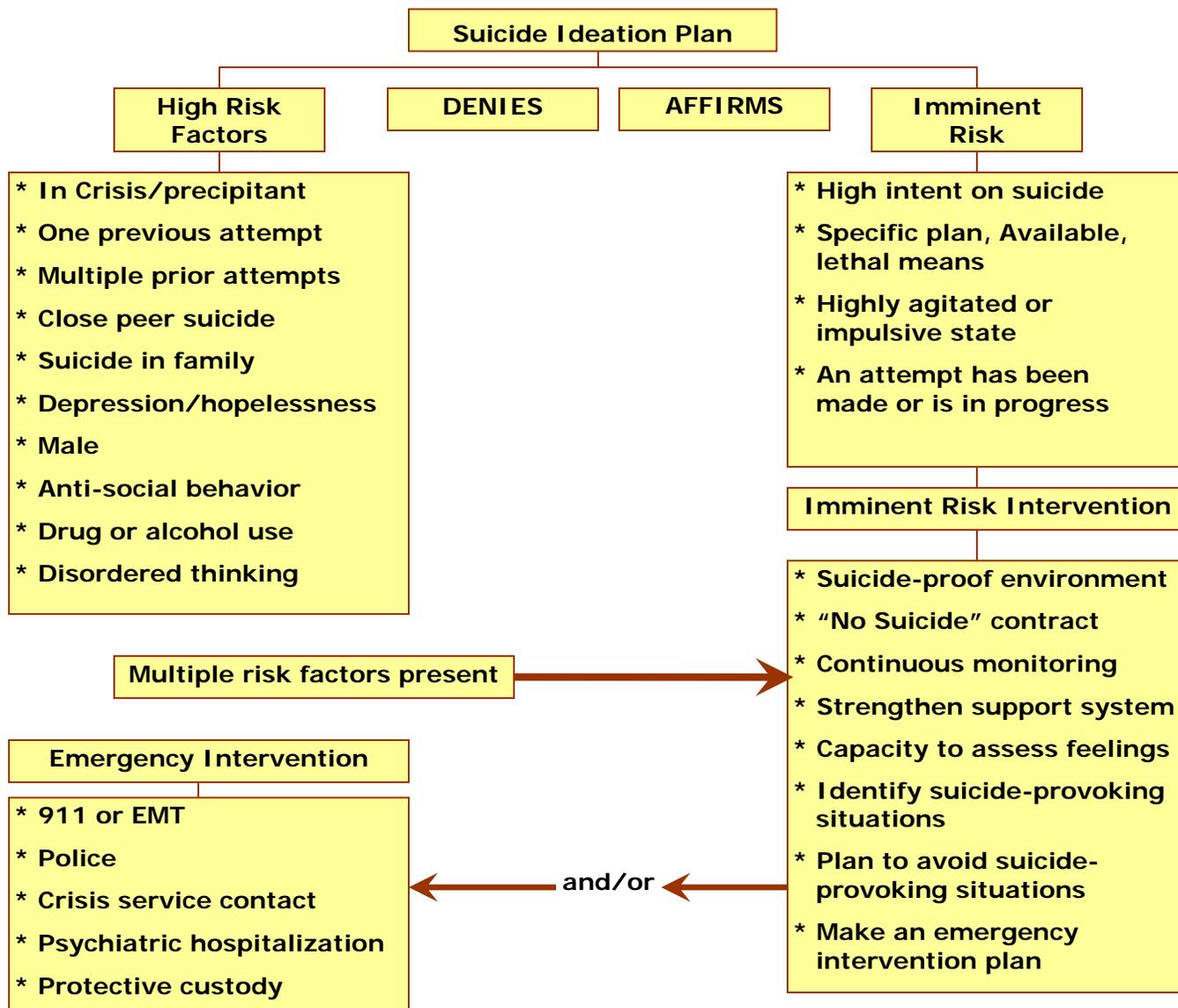
- a. Suicide is second leading cause of death in young people (under 24 years of age). This is up from the third leading cause of death two years ago. (Alcohol, Drug Abuse and Mental Health Administration, 1987)
- b. The adolescent suicide (15-19 yrs. of age) rate is approximately 14.3 per 100,000.
- c. A Youth Risk Behavior Surveillance, United States, 2003, surveyed students in grades 9 through 12. The results showed that 28.6% of students nationwide had felt so sad or hopeless almost every day for >2 weeks in a row that they stopped doing some usual activities. Nationwide, 16.9% of the students had seriously considered attempting suicide during the 12 months preceding the survey, 16.5% of students nationwide had made a plan to attempt suicide and 8.5% of students had actually attempted suicide one or more times. The prevalence of having attempted suicide was higher among female (11.5%) than male (5.4%) students. (Grunbaum, 2003)
- d. Few children (under 14) commit suicide. In the 10-14 age range approximately 2-5 children commit suicide each year in Idaho. (Sanchez, 1988)
 - (1) Shaffer (1987) in his research of suicide completers (n=175) reports that many dead boys (under 14 yrs of age) in his study were not depressed but suffered from poor impulse control, committing suicide shortly after an acute precipitation at a time when their intent was certainly high, but could

have been predicted to diminish had they survived. They usually acted in a highly effective method by hanging or shooting themselves.

- (2) Younger children are more likely to make suicide attempts with less lethal drugs than adults thus there is a smaller proportion of completed suicides attributable to overdose in the young. (Center for Disease Control, 1985).
 - (3) Suicide becomes increasingly more common after puberty and the incidence increases in each of the teen years, to reach a peak at age 23.
- e. Suicide ideation in adolescence is common. Shaffer, Whitaker et. al. (1987) found 40% of a total population of about 5000 teenagers resident in rural New Jersey had entertained suicidal ideas and 5% of the population under study reported having made a suicide attempt.
 - f. Eighty percent (80%) of adolescent victims of suicide provided prior threats or warnings of their intent. These warnings were one to six months of the suicide. Trautman, et. al. (1984) found the typical suicide attempter did not plan the attempt more than 15 minutes in advance.
 - g. Both boys and girls are most likely to commit suicide with a firearm. The next most common for boys is hanging. The next most common for girls is jumping from a height (Center for Disease Control, 1985).
 - h. About four times more girls than boys make suicide attempts, but boys are much more likely to die: about 11% of (reported) males' attempts were fatal, compared to 0.1% of females', a ratio of more than 100:1. (Stone, 1999)
 - i. Drug overdose, which accounts for 90% of suicide attempts, is an increasingly unusual method for completed suicide. Girls account for 90% of suicide attempts and, in Idaho boys account for 80% of completed suicides which is somewhat higher than the national average. Boys are 6 times more likely to commit suicide than girls. (Sanchez, 1988)
 - j. Very few suicide attempts or completions occur without a precipitant event. Many teenagers commit suicide very shortly (within hours) after finding out that they are in trouble, when they are afraid and uncertain about what the consequences will be (Shaffer, 1974). Family disputes are common precipitant events for suicide attempters. Other less common precipitants include rejection and humiliations, e.g., failing in school, dispute with girlfriend, etc.
 - k. Seventy-eight percent of suicides occur in the family home between the hours of 3 p.m. and midnight.
 - l. Teenagers attempt suicide roughly 10 times more frequently than adults. This is the third leading cause of death among 15-19 year-olds. (Stone, 1999)
 - m. Of suicide completers, bipolar symptoms were common and depressive features were nearly always found in association with some other diagnosis, Brent (1987).

- n. The second most common emotional disorder in suicidal adolescents is conduct disorder. Twenty to thirty percent of adolescents with an apparent conduct disorder develop a major psychiatric illnesses five years later (Meeks, 1986).
- o. Among teenagers who do suffer from psychosis the suicide rate is extremely high. Manic-depressive or schizophrenic psychosis in teenagers are relatively rare disorders in this age group.
- p. Learning disabilities appear to be common in this group with estimates ranging from 40-60%.
- q. Imitation may be an important facilitating factor of the suicidal behavior of young people (Gould and Shaffer, 1986). Give special attention to peer suicide deaths known by the adolescent.
- r. A family history of suicide increases the risk factor six fold. A high proportion of suicide completers have had a first or second generation relative who had previously attempted or committed suicide.
- s. More often than not adolescents will be forthright regarding their suicidal intentions or ideations, however, when there is a denial the evaluator may have to rely on collateral data and a psychosocial history including assessment of known high risk factors.
- t. Juveniles in adult jail facilities have a suicide rate 4.6 times youth of the general population. Additionally, the suicide rate for juveniles in adult jail facilities is 7.7 times larger than the suicide rate in juvenile detention facilities. (Lowell, H.D., 1980) Jail suicide is more frequent than prison suicide. (Stone, 1999)

SUICIDAL ADOLESCENT ASSESSMENT AND INTERVENTION STRATEGIES



Consider Emergency Intervention if:

- * Adolescent is not receptive to intervention; or
- * Adolescent has lost self-control and is agitated and impulsive; or
- * Suicidal attempt or plan is highly lethal.

Consider Imminent Risk Intervention if:

- * Adolescent is willing and responsive to help;
- * Adolescent has control over conduct; and
- * Suicide plan is vague or means has low lethality.

2.3 ASSESSMENT OF LIKELIHOOD TO INJURE OTHERS

Likely to injure others is usually referred to as "dangerousness" which includes acts that are characterized by the application or overt threat of force and is likely to result in injury to other persons. Violent behavior is usually considered synonymous with dangerous behavior. (See Idaho Code definition)

Dangerousness or violence by psychiatric patients is an uncommon occurrence but a common area of assessment for clinicians.

The FACT Sheet from the American Psychiatric Association, Nov. 1998 reports that the APA Statement on Prediction of Dangerousness, says that "psychiatrists have no special knowledge or ability with which to predict dangerous behavior. Studies have shown that even with patients in which there is a history of violent acts, predictions of future violence will be wrong for two out of every three patients.' The Association also states that recent research suggests that people with neurological impairments and psychoses are at greater risk of becoming violent. Neurological impairments—usually stemming from diseases such as Huntington's chorea or from head injuries which damage the brain—can have psychological effects, interfering with a person's ability to interpret what is real, and to act or relate to others appropriately (Volkow ND, Tancredi L., 1987; Tardiff K, Sweillam A., 1980; Krakowski M, Czobor P., 1994; Krakowski M, Convit a, Jaeger J, et. al., 1989) http://www.psych.org/public_info/violence.pdf

2.3.1 Prevalence of Violence Among Mentally Ill Populations

"Studies to date have shown an increased risk for violence among [certain] individuals with mental illness compared to the general population; mental illness increases the likelihood of having a violent incident." But, "The absolute risk posed by mental illness is small, and only a small proportion of the violence in our society can be attributed to the mentally ill" (Mulvey, 1994)

There is evidence suggesting that patients with no history of arrests prior to hospitalization have lower post-release arrest rates than does the general population. (Sosowsky, 1980) For example, most people with a diagnosis of schizophrenia are not violent. In fact, they may be more likely to be victims of violence than perpetrators (Bridgeman, 1994).

Monahan's (1992) conclusion of an extensive review of the research on violence and mental disorder stated that there is a limited connection between mental disorder and violence. The recent NIMH Epidemiological Catchment Area Study estimated that about 90 percent of persons with current mental illnesses are not violent within one year (Swanson, et al., 1990). Violent behavior of persons with mental illnesses represents only a minor contribution to all violent crimes. The greatest risk of violence is from those who have dual diagnoses, i.e., individuals who have a mental disorder as well as a substance abuse disorder (Swanson, 1994; Eronen et al., 1998; Steadman et al., 1998).

There is a small elevation in risk of violence from individuals with severe mental disorders (e.g., psychosis), especially if they are noncompliant with their medication (Eronen et al., 1998; Swartz et al., 1998). Yet the risk of violence is much less for a stranger than for a family member or person who is known to the person with mental illness (Eronen et al., 1998). *In fact, there is very little risk of violence or harm to a stranger from casual contact with an individual who has a mental disorder.* The overall contribution of mental disorders to the total level of violence in society is exceptionally small (Swanson, 1994).

To the degree that supportive services are available, used, and effective, persons with mental illnesses pose no greater threat to the community than other individuals. If these elements are not in place, some persons with mental illnesses may commit violent acts that will lead to their arrest. Intensive Case Management programs [such as Assertive Community Treatment (ACT)] have shown considerable promise for helping small groups of persons with mental disorders who are violent (Dvoskin and Steadman, 1994).

2.3.2 General Factors Related to Violent Behavior

Certain types of symptoms, especially disorders in which people perceive threats against themselves, may increase the probability of risk of violence in persons with mental illnesses. "It may be that inappropriate reactions by others to inappropriate reactions by others to psychotic symptoms are involved in producing the violent/illegal behavior" (Link, 1992) The conditions likely to increase the risk of violence are the same, whether a person has a mental illness or not. Studies of violence and mental illness have shown that people with mental illness who come from violent backgrounds are often violent themselves - a finding that echoes the incidence among the general population (Gelles R. 1987) (See http://www.psych.org/public_info/VIOLLEN~1.cfm).

Precipitative factors interact in complex ways and, in some patients, lead to repeated episodes of combative behavior, and in others, to a rare outburst.

- (1) Some patients react to these factors by frequently being out of control and readily triggered to react with violent and impulsive behavior.
- (2) There are other patients who appear outwardly quiet, subdued, presumably long-suffering, and perhaps over-controlled who may respond with violence only once in the course of their lifetime. (Tupin, 1983)

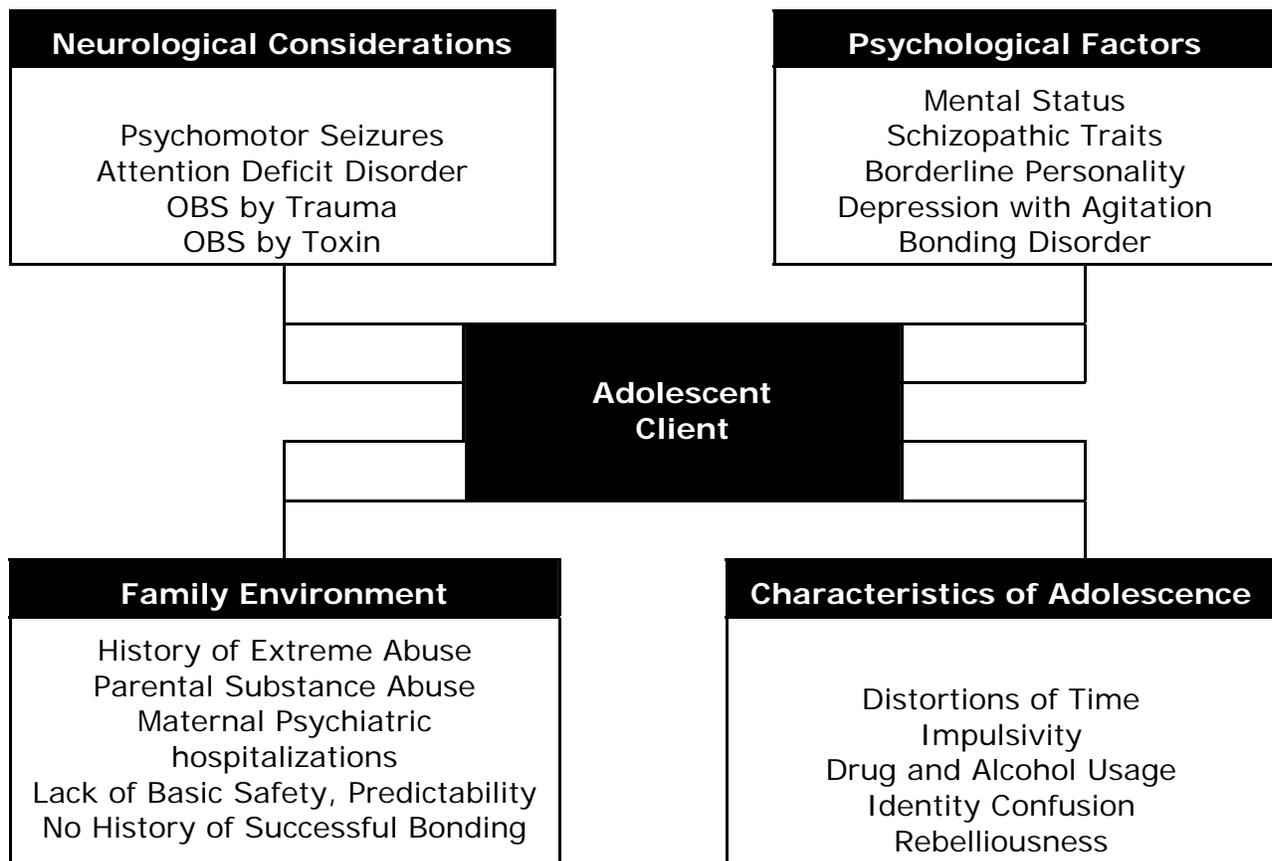
Mental Illness, Substance Abuse and Violence

People who have a mental illness without a substance abuse diagnosis are involved in significantly less community violence than people with a co-occurring substance abuse diagnosis. Those without a substance abuse diagnosis have about the same

prevalence of violence as other people living in their communities. Those who have a co-occurring disorder, for the first several months after discharge from a hospital, have a significantly higher prevalence of violence than those in the community who only have symptoms of substance abuse. The type, target and location of violence is very similar compared to those persons having a mental illness and those who do not have a mental illness. (See MacArthur Research Network on Mental Health and the Law, April, 1999: <http://macarthur.virginia.edu/violence.html>).

Adolescent Aggression

Adolescent aggression may be related to such factors as: (Miller, 1986).



2.3.3 Factors Related to the Probability of Violence

- a. Current behavior. Note whether the patient's speech, posture, or motor activity is suggestive of anger or agitation which may escalate to violence. Is a startle response present? (indicative of anxiety or substance induced withdrawal) (Walker, 1983).
- b. Active thoughts, threats or plan. The presence of active threatening statements demonstrating desire or intent of homicide, assault or other violence.

The risk is significantly increased with the presence of specific plan and means to carry out threats of violence.

- c. Does he have a past history of violence? How recent? What type? Toward whom or what?
- d. Is he currently intoxicated or has recently used drugs or alcohol?
- e. What is the diagnosis? Paranoid schizophrenia, organic disorders, antisocial personality disorder, borderline personality disorder, paranoid personality disorder, mania and profound depression are all associated with violence (Walker, 1983).

*All threats of violence should be taken seriously.
Assess precautions needed to be taken to prevent injury to self or others.*

2.3.4 Discussion of Prediction of Violence

As with suicide, research has indicated there is considerable difficulty and poor reliability and validity present when experts attempt to predict future dangerousness. Most courts are reluctant to accept predictions of dangerousness which do not include threats or physical acts within a specified preceding period of time. Ennis and Litwach (1974) report from the studies they have reviewed that predictions of dangerousness are highly fallible. There are so many risk variables and the incidence is so low that almost all statistical strategies will overestimate the risk and over predict the event. There are so many unstable contributing factors which can vary dramatically over brief periods of time.

In efforts to predict and treat violence, it is important to recognize that risk fluctuates over time. Violent behavior is a product of the interactions between an individual and his/her environment. The level of risk depends on many varying factors other than mental disorder, thus increasing or decreasing the risk of violence by persons with mental illnesses (Campbell, Stefan and Loder, 1994)

Walker (1983) suggests three possible predictors of the potential for violence: (a) diagnosis, (b) the patient's past history and (c) the patient's behavior.

- a. Diagnosis: The following types of patients are at greater risk for violent behavior:
 - (1) patients experiencing drug intoxication or withdrawal, especially amphetamine and phencyclidine (PCP) abusers;
 - (2) patients experiencing alcohol intoxication or withdrawal;
 - (3) delirious patients (a medical etiology must always be considered when a patient presents with violence);

- (4) paranoid schizophrenia -- patients can become violent when they misperceive others as threatening;
 - (5) catatonic schizophrenia -- patients who may strike out at anything or anybody during periods of catatonic excitement;
 - (6) mania -- patients may erupt into violent acts at the smallest provocation or incident;
 - (7) profoundly depressed patients who are considered strong risks for suicide-homicide acts;
 - (8) patients with antisocial, borderline, and paranoid personality traits, who are especially prone to violence when they present with drug withdrawal or when the clinician begins a probing interview despite their refusal to cooperate.
 - (9) drug addicts, who may become violent when their attempts to manipulate for more drugs fails;
 - (10) chronic schizophrenia -- patients may become violent when their demands for hospitalization are refused.
- b. Past history -- Blomhoff, Seim and Friis (1990) found that the best single predictor of violence was a history of previous violence. (Blomhoff, S., Seim, S., & Friis, S. (1990). Frequently, the clinician compiles this history from three sources prior to and during the interview;
- (1) patient's prior treatment records (these should be reviewed prior to interviewing a potentially dangerous patient, if at all possible);
 - (2) collateral sources (friends, arresting or accompanying police officer);
 - (3) the patient.

Rofman, Askinazi, and Fant (1980) point out that verbalization of violent intention/threat has the same predictive quality as past history of violence.

- c. Along with history of previous violence, Walker (1983) proposed the following predictive factors in a patient's history as indicating increased risk.
- (1) conviction of criminal homicide;
 - (2) history of homicidal threat;
 - (3) lack of suicidal threats -- Patients who make homicidal threats without previous suicidal attempts are thought to be a greater homicide risk (MacDonald, 1976).
 - (4) assaults -- The type of previous assaults may be predictive of the patient's dangerousness, e.g. a patient with history of fist fights may be

- relatively less dangerous than a patient who has previously used weapons and been involved in brutal assaults.
- (5) symbolic acts of murder -- e.g. hanging of dolls or shooting the pictures of relatives.
 - (6) social class -- Violence is more common in the lower socio-economic groups than in higher socioeconomic groups.
 - (7) depressed mood -- Frequently assailants experience dysphoria or depression prior to assaults (Rada, 1981).
 - (8) fire setting, enuresis, and cruelty to animals during childhood;
 - (9) truancy, fighting in school, and temper tantrums during childhood (the two preceding factors are associated with Antisocial Personality Disorder).
 - (10) abused as a child;
 - (11) owning and using weapons;
 - (12) poor job or school record;
 - (13) drug or alcohol abuse;
 - (14) the presence of a friend or relative who provokes violent acts;
 - (15) the presence of a plan to kill or injure someone.
- d. The greater the numbers of the above factors present in a patient's social history and clinical presentation, the greater the potential that the patient may act out in a violent manner.
- (1) These factors, of course, must be evaluated by the clinician in light of environmental factors present which could trigger violent behavior as well as those which serve as controls. A high degree of violence in the family of origin and a high level of aggression on admission accompanied by an absence of anxiety are significant correlations found by Blomhoff, S., Seim, S., & Friis, S. (1990).
 - (a) For example, some patients may not act out violently if a sufficient show of force is made by the presence of a number of personnel.
 - (b) While such displays of force may inhibit the violent impulses of some patients, in other patients with different presenting complaints, diagnostic and psychosocial histories, the opposite effect can be produced.

(2) Violence can be a means to test the limits of the staff or facility (Lehmann, Padilla, Clark, and Loucks, 1983).

e. Other possible precipitating factors:

- (1) fear of hospitalization;
- (3) frustration with treatment or holding facility;
- (4) sensing rejection from family or staff;
- (5) conflict with interpersonal relationships, e.g., infidelity, threatened divorce, etc.

2.3.5 Factors Associated with Violence Recidivism

FACTORS	ASSOCIATION WITH VIOLENCE
a. Prior arrest for violent crime	Probability of future violence increases with each prior criminal act. Various studies indicates that recidivism risk exceeds 50% for persons with more than five prior offenses.
b. Current age	Strong association between youth and criminal activity.
c. Age at first serious offense	Violence potential greater for offenders who were juveniles when the first serious offense occurred. Chronic juvenile offenders at greatest risk.
d. Sex	Males at significantly higher risk than females.
e. Race	Blacks at higher risk than other races.
f. Socioeconomic and employment status	Lower status and job instability associated with higher incidence of crime.
g. Opiate or alcohol abuse	Abusers at higher risk than non-abusers.
h. Family environment	Stable, supportive family environment associated with relatively lower k..
i. Peer environment	Higher risk associated with "bad company."
j. Availability of victims	Higher risk if offender's prior violence has been toward a broad range of victims, or if there is history of multiple assaults on narrow class of victims who remain available.
k. Availability of alcohol or weapons	Risk increases with heavy drinking and ready access to weapons.

* Adapted from J. Monahan, Predicting Violent Behavior: An Assessment of Clinical Techniques, (1981).

Studies of each of the above factors have identified phenomena that correlate positively with individual violence. However, there is no formula to integrate these factors in a reliable manner. On a case by case basis these factors in combination with a reconstructive interview aimed at disclosure of the personal and situational variables which may contribute to the violent response may make them useful.

2.4 ASSESSMENT OF GRAVELY DISABLED

When Gravely Disabled (See definition), the patient does not threaten actual violence to themselves, but may demonstrate:

- a. A mental illness which manifests itself in neglect or refusal to administer self-care; and such neglect or refusal poses a real and present threat of substantial harm to their physical well-being.
- b. Not expressly stated but this condition often involves an inability or lack of competence to determine whether or not treatment for his or her mental illness is necessary.
- c. These concerns must go beyond lifestyle considerations of conduct which may annoy, disgust, offend or otherwise cause mental upset to the majority of the community.

The "gravely disabled" standard focuses on attributes of the person's mental condition as well as on specific instances of conduct. A person is gravely disabled if he or she, because of a mental illness and if left to provide his or her care, is unable to provide for his or her essential needs, thus placing the person in danger of serious physical harm. The mental illness must substantially impair the person's ability to make appropriate decisions necessary to provide for basic human needs or to engage in necessary activities of daily living. Such specific instances of conduct, such as self neglect or refusal to obtain necessities, may demonstrate the person's inability to provide for essential needs.

2.5 DUALY DIAGNOSED: MENTAL ILLNESS AND SUBSTANCE ABUSE

2.5.1 Idaho Code Considerations

The Idaho Legislature has *excluded* from the involuntary commitment standard those individuals who may have a diagnosis of alcoholism or substance abuse and do not otherwise have a diagnosis of a mental illness (See Exclusions in *Section*

1.1.2, this document). Idaho does not have a civil commitment procedure for individuals who have the condition of chronic alcoholism. The "Alcoholism and Intoxication Treatment Act" (AITA) [Idaho Code 39-3] provides for treatment for habitual misusers, favors the avoidance of criminal proceedings, and encourages voluntary treatment. Idaho Code 39-307A does have provision for brief protective custody.

"A person who appears to be incapacitated by alcohol or drugs shall be taken into protective custody by a law enforcement officer and forthwith brought to an approved treatment facility for emergency treatment. If no approved treatment facility is readily available he may be taken to a city or county jail where he may be held until he can be transported to an approved treatment facility, but in no event shall such confinement extend more than twenty-four (24) hours. A law enforcement officer, in detaining the person and in taking him to an approved treatment facility, is taking him into protective custody and shall make every reasonable effort to protect his health and safety. In taking the person into protective custody, the detaining officer may take reasonable steps to protect himself. A taking into protective custody under this section is not an arrest. No entry or other record shall be made to indicate that the person has been arrested or charged with a crime." [Idaho Code 39-307A (b)]

The examiner is encouraged to review the Idaho AITA provisions.

The dually-diagnosed individual having both a mental illness and a substance abuse disorders is a condition included under the provisions of the mental health civil commitment standard.

Few states do include chronic alcoholism or substance abuse as a stand alone condition under the criteria of their mental health civil commitment code. (Beis, 1984) Many state hospitals unless they have drug/alcohol specialized treatment units have general admission policies which preclude the admission of persons whose primary problem is one of alcohol addiction. Idaho has the Alcohol Treatment Unit (ATU) at State Hospital North which accepts patients for the care and treatment of alcohol or substance abuse.

2.5.2 Prevalence of Dually-Diagnosed Clients

Dually-diagnosed clients -- independent of rural or urban settings -- were estimated to comprise an average of 31% of the total mental health caseload -- an average of 1 out of every 3 clients served in the community mental health program (Caragonne, et al., 1987). This study further reported the chronically mentally ill populations comprised 52% of mental health caseloads. Further, when analyzed by geographic location, 60% of the rural mental health caseloads were composed of chronically mentally persons, while 48% of urban/suburban caseloads were estimated to be made up of chronically mentally persons. In terms of inpatient settings, a wide range of prevalence figures are reported. A literature review

suggests substance abuse may be present in 31% to 78% of psychiatric inpatient populations.

Abuse of and dependence on drugs, alcohol and other substances in schizophrenia are being increasingly recognized and well documented in the literature. It has been suggested that up to 60% of patients with schizophrenia use illicit drugs (Addington J, Duchak V, 1997).

The following observations have been reported in the literature:

- (a) Drug abuse is a common problem in the management of psychiatric inpatients, often undetected by routine inquiry during admission (Hall, et al., 1979);
- (b) In both inpatient and outpatient studies a significant rate of drug and alcohol abuse has been observed among psychiatric patients who have not been diagnosed as substance abusers. Undetected drug use results in misdiagnosed patients, with therapists tending to label them schizophrenic (Hall et al., 1977, 1979).
- (c) Patients seen in outpatient settings are not usually queried as to the presence or absence of substance abuse (Ramsey et al., 1983).
- (d) Therapists tend to perceive severe character pathology in any patient who abuses substances and therefore can focus inappropriately on the character disorder issues to the exclusion of other key elements (Hall, et al., 1978).
- (e) Substance abuse, in approximately 30% of cases of early onset psychiatric impairment, occurred subsequent to development of a major psychiatric impairment and development of chaotic lifestyles.
- (f) Treatment outcomes are adversely affected by undetected substance abuse in both inpatient and outpatient treatment settings.

2.5.3 The Young Chronically Mentally Ill

Schwartz and Goldfinger (1981), Pepper et al. (1981), Bachrach, (1982) all provide characterizations of the young chronically mentally ill patient. These patients are depicted as:

- (a) Young transient males;
- (b) Little or no history of state hospitalizations;
- (c) Frequent interactions with emergency psychiatric and crisis units;
- (d) Intermittent involuntary short-term stays in local inpatient units;

- (e) Few skills and no natural support systems;
- (f) Exhibit, under stress, disorders in reality testing, extreme anger and depression, impulsive aggression, and self-destructive behavior.

The work of Pepper, et al. (1981), Neffinger and Schiff (1982) provides an outline of necessary service models to treat this client sub-group. Their approach defines functional descriptions of young psychiatrically impaired clients due to the variety of diagnoses which they can present, and the need to intervene in community-based services from multi-programmatic locations and structures as opposed to more controlled, less flexible service environments.

A review of the clinical characteristics, diagnostic and behavioral features reveal this group to present major problems with assessment and intervention. These problems include:

- (a) Ego deficits in the area of reality testing, impulse control, and affective modulation;
- (b) Wide behavioral fluctuations over time;
- (c) Regular or intermittent use of psychoactive drugs;
- (d) Extensive distortion or denial, deficiencies in reality testing, leading to discontinuities and disorganization in presenting a background history; and
- (e) Severe borderline pathology.

2.5.4 Psychiatric Impairment and Alcoholism

Schuckitt (1983) offers an overview of diagnostic and treatment considerations associated with alcoholism in the presence of other psychiatric disorders. The author makes a distinction between:

- (a) Primary alcoholism, e.g. an individual with major life problems related to drinking; and
- (b) Secondary alcoholism, in which a psychiatric diagnosis is paramount.

Depression, described in adults as sustained negative affect in the absence of schizophrenia, drug abuse, alcoholism, organic brain disease, or personality disorder, is conventionally looked upon as a primary mood disorder. Depressions secondary to medical-neurological illnesses, substance abuse and other non-affective primary psychiatric disorders including schizophrenia and personality disorders are general recognized clinical phenomenon. They can present as major depressive episodes, but they often occur either as minor affective illness or as chronic intermittent Dysthymia. They may be misdiagnosed as a primary affective illness unless there is a careful ascertainment of a clinical history and patterns of substance abuse. (Himmelhoch, 1987)

Schuckitt (1983) asserts that the majority of primary alcoholics will develop serious affective disturbances while they are drinking heavily. These disturbances will later dissipate and not require treatment with antidepressants or lithium. The presence of psychiatric symptoms, e.g. alcoholic withdrawal, hallucinations and/or paranoid delusions, which the author suggests may dissipate without active treatment, requires careful diagnosis to ascertain whether alcoholic psychosis or schizophrenia is present, due to marked differences in the types of treatment required.

Others (Tyndel, 1974) assert the development of the alcoholic disease process is inconceivable without underlying psycho pathology. Alcoholism is the outcome of attempts to deal with the discomfort caused by psychopathological processes and associated social difficulties.

Freed (1984) provides a comprehensive review of empirical and theoretical publications relating to the relationship between alcohol and manic-depressive disorders. Freed characterizes the relationship between alcohol and manic-depressive illness as remaining unclear. Alcohol is both a depressant and stimulant and is used by persons with affective disorders to reestablish emotional homeostasis. Freed asserts there is no consensus regarding the use, antecedents of use, effects, or characteristics of those abusing alcohol.

There is evidence of a correlation between depressive illness and alcohol abuse, however, the evidence for causal relationship between alcohol abuse and bipolar disorders is more equivocal. Incidence of alcohol use is noted as characteristic of individuals presenting manic-depressive conditions, but no distinction is made between drinking as a function of a manic stage and drinking as a function of a depressive stage. Most research appears to define excessive alcohol abuse during manic stages as occurring in individuals seeking to decrease manic symptoms, and discounts the role of alcohol in self-treatment of depression.

Schuckitt (1970,1971) asserts the presence of two distinct entities with two different prognoses -- alcoholism and sociopathy. Three clinical groups are defined in the context of the need to differentiate primary illness from a secondary manifestation of another problem. These groups are:

- (1) Primary alcoholics: No history of any psychiatric disorder antedating alcohol abuse;
- (2) Sociopathic or antisocial personality: A chronic disorder with onset prior to 15 years of age, manifesting in at least four of the following problem areas, truancy, runaway, police offenses, rage, sexual promiscuity, transient behavior, persistent use of alias;
- (3) Sociopathic alcoholism: Manifested by the onset of alcoholism in a person with ongoing antisocial personality or sociopathy.

The argument is presented that it is necessary to distinguish the sociopath who drinks heavily from the alcohol abuser who engages in a limited sphere of antisocial acts. Schuckitt suggests careful history taking to determine etiology of these two types of alcohol abuse, recommending history taking in the following areas:

- (1) Natural history of drinking problems;
- (2) Marital and job history;
- (3) Presence or absence of familial sociopathic alcoholism.

Schneier and Siris (1987) present a comprehensive review of substance use and abuse in persons with schizophrenia. Despite considerable variation in research methodologies the authors conclude there is broad research agreement that schizophrenic groups use of amphetamines and cocaine, cannabis, hallucinogens, inhalants, caffeine, and tobacco was significantly greater than or equal to use by control groups consisting of other psychiatric patients or normal subjects. Schizophrenic groups use of alcohol, opiates, and sedative-hypnotics was significantly less than or equal to use by control groups. The authors conclude that substance abuse is clearly an important frequent co-diagnosis in persons with schizophrenia.

Provider characteristics appear to be a factor in the positive evaluation and intervention activities on behalf of this population. Researchers have identified the following provider considerations:

- (1) Covert drug abuse markedly and negatively distorted both diagnosis and client management, yet was undetected by clinicians in a majority of instances during both diagnosis and treatment process.
- (2) Therapists behaved differently with drug abuse patients, misdiagnosing four times more than with comparable controls, missing appointments with them seven times more often, and referring them ten times more often to other therapists or agencies. (Hall et al., 1977)

2.5.5 Alcohol, Drugs and Violent Behavior

Alcohol and drug use and abuse appear to be significant factors in suicidal behavior and acts of aggression toward others. The epidemiology or sociology of alcohol and other drugs as a factor in violent behavior is poorly understood. The vexing question in reviewing the literature in this area is the extent that substance abuse is etiologic, enabling or merely an incidental finding.

In terms of suicidal behavior, there is reason to believe that substance abuse as a factor in suicide is as great a problem for adolescents as for adults. The association between drugs and suicide attempts was emphasized by McHenry, Tishler and Kelly (1983), who found that adolescent suicide attempters were more inclined to use drugs, and adolescent drug abusers were more inclined to make suicide attempts as compared to the control groups. Similarly, Frederick, Resnick and Wittlin (1973) reported that suicide attempts were common in drug abusers, while Garfinkel, Froese and Hood (1982) found more psychiatric illness and alcoholism in the families of youth suicide attempters and also more substance abuse in the young patients themselves compared to non-suicidal patients.

In all ages, substance abuse can be regarded as a sub-intentioned form of high risk taking. In some situations, such as automobile accidents, drugs and alcohol is at least facilitating. In other situations of violence, drugs and alcohol may be directly causative by releasing aggressive impulses which would have otherwise remained under control.

The examiner should keep in mind any factors of alcoholism or drug use when evaluating a client for a mental illness.

2.6 THERAPIST AND PATIENT SAFETY CONSIDERATIONS

Some studies suggest that about 25% of mental health professionals have been attacked by a patient and almost 75% have been involved with an assaultive patient at some point in their professional lives (Whitman, Armac and Dent, 1976).

2.6.1 Behavior Indicators of Imminent Potential for Violence

- (1) Posture -- A patient posed in vigilant position, fist gripped, on the edge of the chair or standing. A threatening manner must be approached with extreme caution.
- (2) Speech -- Violence is more probable when a patient is speaking in a loud and threatening manner.
- (3) Motor activity -- Caution should be taken if a patient is pacing in a rapid or agitated manner, gesturing in ways which suggest martial arts training or imitation of such, or when making sudden, unexpected movements.
- (4) Startle response -- This can be indicative of drug or alcohol withdrawal or heightened anxiety.
- (6) Other indicators -- for example, may be door slamming, fist pounding or shaking, refusal to speak, facial coloration, increased respiration rate, intensity of eye contact, and, of course, the displaying of weapons.

2.6.2 Psychotherapeutic Considerations

- (1) A clinician's ability to respond therapeutically to an overtly hostile and threatening patient in a manner which does not trigger an episode of acting out is probably a function of at least four factors:
 - a. training in handling violent patients;
 - b. clinical experience;
 - c. therapeutic creativity;

- d. luck.
- (2) A clinician attempting to threaten or intimidate a volatile patient may be behaving in a manner which is tantamount to inviting the patient to punch him/her out. Such patients must be approached with –
- a. respect;
 - b. gentleness;
 - c. openness;
 - d. the good sense not to confront the patient unless he represents an immediate danger to himself or others. In this type of situation, the clinician is well advised to have sufficient staff back-up readily available to respond to overt violence.
 - e. a non-blaming, non-judgmental attitude;
 - f. a supportive rather than challenging posture.
- (3) Clinicians may be well advised to have several verbal responses ready should they find themselves confronted by a potentially violent patient. Comments should be gauged to deflect, disengage, distract an angry or frightened patient. Whitman et. al (1976) have suggested a number of verbal maneuvers which are listed below:
- a. "Why don't you tell me exactly what you are angry with me about?"
 - b. "Let's agree that any physical blows are out of order here."
 - c. "I am not going to do anything to harm you."
 - d. "Maybe you would rather leave than lose control of yourself."
 - e. "You are scaring me so I cannot help you."
- (4) The use of paradoxical statements can be effective when dealing with some volatile patients.
- a. The belief here is that some patients may threaten violence to manipulate the therapist into doing what the patient wishes.
 - b. Other patients may fear their violent impulses; therefore, when therapists prescribe the behavior, they demonstrate to the patient that they are not frightened by the potential of violence, but rather that they are in control of the situation.
 - c. The therapist prescribing the threatened behavior can have the effect of de-potentiating the threat. Following are two examples of paradoxical intervention.
 - (a) "You can go ahead and be just as angry as you want to be right now, but you need to know that we will do whatever we need to do to keep you and ourselves safe."

- (b) "I can see that you are very angry right now. You may believe that if you just break something or hurt someone you will suddenly feel better. That's an option you have, but I am not so sure it will really get you what you want."

Of course, this type of response needs to be delivered with the utmost caution, sincerity and respect for the present struggle of the patient. In addition, the therapist should be well aware of the availability of back-up staff.

2.6.3 Environmental-Physical Interventions

Patients who are already assaultive and unable to control such behavior require restraint in order to prevent injury.

- a. The staff in emergency rooms, inpatient units and jails are generally well trained and equipped to respond to such situations.
- b. Management and treatment of violent patients in a manner which provides the maximum safety possible to the treating outpatient clinician requires staff training and administrative policy which addresses the unique therapeutic problems these patients present.
- c. Ongoing management of the violent patient can utilize the treatment options of medication, psychotherapy, family therapy and Day Treatment.

2.6.4 Organizational Response to Potential Dangerousness

- (1) Star (1984) suggests staff training should include ways to recognize potentially violent patients (see material above on diagnosis, history, and behavior) and management of clinician's internal and behavioral response to such patients.
 - a. Clerical and support staff can be trained to identify patients who appear agitated or volatile, to alert clinical staff prior to the interview of the possible danger.
 - b. Non-clinical staff can have designated roles and training in the controlling of an assaultive patient.
- (2) Clear administrative policy concerning procedures to follow with violent patients can minimize the risk to the therapist. Star (1984) lists a set of steps outpatient units can implement in their intake procedures to increase worker safety:
 - a. A code is established and used by the receptionist to alert the worker to the possibility that a patient may be dangerous.

- b. The worker contacts a back-up worker, and they interview the patient together.
 - c. Prior to the interview the program manager or supervisor is alerted to the situation.
 - d. the patient is seen in a room with at least two exits, no loose objects which can be thrown, and cushions which can serve as protective devices.
 - e. The program manager or supervisor telephones during the interview to assess from the worker, through yes and no questions, the level of danger.
 - f. If there is no answer the program manager or supervisor investigates immediately and contacts the police.
- (3) In all treatment settings it is crucial for clinicians working with violent patients to properly document their work. Documentation of patient behavior provides:
- a. a data base upon which current and future clinical decisions can be made;
 - b. a means of charting, over time, the biopsychosocial factors which contribute to or deter violent behavior;
 - c. a record to demonstrate the course and appropriateness of staff action, should a legal defense ever be required.
- (4) "Failure to communicate and follow established procedures" are cited by Kroll and Mackenzie (1983) as the basis for five successful suits against psychiatrists and hospitals in cases involving violent patients. Such cases point out the necessity for clinicians to –
- a. Provide "adequate information" to relevant parties;
 - b. Follow policies and procedures of the treating facility in treating violent patients; and
 - c. Warn potential victims of violent patients should other means of defusing potential dangerous situations fail (Knapp and Vandecreek, 1982), e.g.:
 - i. having the patient agree to dispose of lethal weapons;
 - ii. civil commitment;
 - iii. bringing the potential victim into therapy with the patient.
- (5) Some mental health centers or facilities have established "team procedures" as a Center response to potentially dangerous clients. These procedures often can involve relevant community agencies and organizations necessary for the provision of intervention services.

2.6.5 Duty to Warn

The Idaho courts have not expressly found a "Tarasoff Duty". However, examiners are probably best advised to act if such a duty exists. Anytime an examiner believes a patient poses a serious threat of violence to another, the examiner should take professionally reasonable action to prevent the harm to the other person. Such action may include communicating the threat to the intended victim and law enforcement personnel and arranging for the patient's voluntary or involuntary hospitalization.

Courts have held that a duty to warn others of a patient's potential for violent conduct arises when the patient:

- (1) has a history of violence,
- (2) Verbalizes a threat of injury to an identified person, and
- (3) Has or expresses an apparent motive.

Even if two of the elements are present, an examiner may have a duty to warn. Courts have held further that a duty to warn is discharged by notifying the intended victim and law enforcement authorities of the threat posed by the patient.

In the absence of any other professional guidelines applicable to the examiner's profession, it is advised that disclosure should occur only when there are sufficient indications of dangerousness to lead a clinician to reasonably conclude the individual will act out violently toward a specific person, and that only the information necessary to prevent the foreseen dangerous act should be divulged.

2.7 DOCUMENTATION OF RISK ASSESSMENT

2.7.1 Community Mental Health Program

There are several areas of documentation of risk assessment in the Clinical Record System for the Community Mental Health Program. This section is applicable to Designated Examiners of the Department of Health and Welfare Community Mental Health Program.

- a. BRIEF CONSULTATION AND SCREENING REPORT (BCSR) - Documents clinical screenings, face-to-face emergency contacts and Designated Examiner evaluations.
- b. INTAKE SUMMARY - contains a "Risk Indicators" Section.

2.7.2 Other Documentations

RISK INDICATORS: It is important to gathering information to formulate a clinical opinion regarding the level of risk toward the client or toward others. This information includes suicide/homicide lethality, factors or data which may influence likelihood to injury self or others, and, when appropriate, data relevant to considerations regarding the client's being gravely disabled. Relevant data includes presence or absence of suicide or homicide ideation, plans for homicide or suicide, means to accomplish injurious acts, fear levels of those around the client and basis of their fear, history of injurious behavior, and current threatening behavior. The client history of aggressive actions toward self or others is important data to be reported here.

EVALUATION SUMMARY -- This contains essentially the same risk assessment considerations as the Intake Summary and is used to perform formal evaluations including "fitness to proceed" examinations, evaluations to determine need for care and treatment within correctional facilities, professional consultation evaluations, etc.

PROGRESS NOTES – Progress Notes require ongoing documentation of service delivery and change in patient condition, including consideration of change in risk status.

COURT REPORTS – These reports will require statements of basis of continuing need of judicial commitment. Criteria includes statements that the patient continues to meet the standard of both mentally ill and likely to injure self or others or gravely disabled.

DISCHARGE SUMMARY – This summary requires a statement of risk status of the patient at time of discharge from care and treatment.

2.7.3 Exemptions from Liability

Because liability is a factor of decision-making regarding patients who present considerations of dangerousness, the Idaho legislature included a provision of liability exemption in Idaho Code.

"No agency, public or private facility, nor an employee of a public or private facility, nor the superintendent, professional person in charge, or attending staff of any such facility, nor any public official performing functions necessary to the administration of this chapter, nor a peace officer responsible for detaining or transporting a person pursuant to this chapter, shall be civilly or criminally liable for detaining, diagnosing, transporting, treating or releasing a person pursuant to this chapter; provided that such duties were performed according to the procedures of this chapter in good faith and without gross negligence." [Idaho Code 66-341]__



Designated Examiner Source Book

CHAPTER THREE

Disposition & Case Management Considerations

CHAPTER 3

DISPOSITION AND CASE MANAGEMENT CONSIDERATIONS

3.1 REVIEW OF CASE MANAGEMENT RESPONSIBILITIES

3.1.1 Responsibilities

In all cases of an individual committed to the Department of Health and Welfare under the auspices of Idaho Code 66-329, one of the nine administrative and service units of the State Mental Health Program (seven regions and two state hospitals) will have the service and attendant case management responsibilities for the patient. These responsibilities include:

- 6 an assessment and determination of initial appropriate level of care and the appropriate facility for provision of necessary care and treatment;
- 6 ensuring the provision of necessary and appropriate mental health services;
- 6 providing necessary linkage with requisite services, including assistance with access and utilization of resources such as arrangement for admission, aiding with transportation, application for entitlements, etc.
- 6 meeting legal notification requirements of the court, family, next of kin, attorney, etc., of the initial disposition and subsequent redispersions;
- 6 monitoring of service delivery, client progress, attending to changing needs and determining whether to conditionally release, discharge or terminate the commitment of the patient, and meeting initial 90-day legal reporting requirements (and every subsequent 120 days thereafter);
- 6 making periodic redeterminations of least restrictive level of care and effecting change of disposition consistent with client service needs; and
- 6 when necessary and appropriate, acting as a system advocate for the patient to help ensure protection of rights, entitlements and assurances.

3.1.2 Medical Needs of Patient

In making the disposition decision, the dispositioner must consider the medical, security, and behavioral needs of the patient. It is the responsibility of the dispositioner to inquire of the physician designated examiner (or, in the case of two non-physician designated examiners, the physician completing the physical

examination) about any known medical condition which would impact the choice of treatment facilities. If questions exist regarding the patient's medical condition, the dispositioner should arrange for a telephone conference between the physician raising the question and the qualified medical personnel at any facility being considered. This will insure that the facility has the standard of care available to address the patient's medical needs before the disposition is made. In discussions with local physician examiners, the dispositioner should keep in mind that the following physical conditions are deemed sufficient to render a patient untreatable, from a physical standpoint, at a state hospital facility:

- (1) physically handicapped and/or non-ambulatory patients, primarily requiring nursing home care, who can be managed in a nursing home that is appropriately staffed to provide for mental health treatment;
- (2) electrolyte imbalance;
- (3) terminal malignant disease requiring special therapeutic procedures not available at state hospitals;
- (4) severe crippling/neurological degenerative diseases requiring special therapeutic procedures not available at state hospitals (e.g., myasthenia gravis with respiratory compromise);
- (5) any individual who is comatose or semi-comatose;
- (6) a chronic debilitating progressive disease requiring extensive medical or surgical nursing care (e.g., an unstable cardiac condition, an unstable diabetic).
- (7) Patients suffering from acute infectious process, who also have a concomitant psychosis, should be referred after the acute infectious process has been safely resolved.
- (8) Suspected cases of head trauma should be thoroughly screened neurologically before referral to state hospitals. A stable, conscious condition is required.
- (9) Acute serious overdose with drugs or alcohol should be referred only after proper detoxification is verified by normal blood levels.

If the patient requires medical care which is not within the scope of the facility's services, the dispositioner shall communicate with the court that the disposition is to be effective upon completion of the prescribed course of treatment, and shall recommend to the responsible party that such needed medical attention be provided.

3.1.3 Least Restrictive Treatment

In making the disposition decision, the dispositioner must consider the least restrictive treatment alternative available and appropriate to the treatment needs of the patient.

"The department director, through his dispositioner, shall determine within twenty-four (24) hours the least restrictive available facility consistent with the needs of each patient committed under this section for observation, care and treatment." [Idaho Code 66-329(k)]

The least restrictive alternative in involuntary civil commitment proceedings is the combination of therapeutic and preventive interventions provided by mental health and human services providers, judges, attorneys, law enforcement personnel, and others, including the respondent and the petitioner, that:

- (a) is conducive to the most effective and appropriate treatment and care that will give the mentally disordered person a realistic opportunity to improve his or her level of functioning; and
- (b) is no more restrictive of a person's physical, social, or biological functioning than is necessary to achieve legitimate state purposes of protecting society and providing mental health treatment and care.

In balancing the interests of the individual, his or her family, and the state, a determination of less restrictive alternatives should consider and weigh a number of factors, including:

- (a) the environmental restrictiveness of the treatment setting;
- (b) the psychological or physical restrictiveness of behavioral, chemical, or biological treatments;
- (c) clinical variables, including the person's behavior as it relates to the legal criteria for involuntary civil commitment;
- (d) the relative risks and benefits of treatment alternatives;
- (e) the family and community support available in the person's environment;
- (f) the quality or likely effectiveness of the alternative care and treatments; the duration of treatment;
- (g) the likelihood that a person may pose a risk to public safety;
- (h) the availability, cost and accessibility of alternative treatment and care;
- (i) the likelihood of the person's cooperation or compliance with the conditions of alternative treatment programs; and
- (j) mechanisms for monitoring and reviewing the compliance.

The least-restrictive-alternative doctrine is not a doctrine of failure requiring a test of inadequate levels of care before placement at higher levels of care are justified; it is not a doctrine reducible to a concrete set of operations applicable to every case; and it is not all encompassing in that correct application will determine the correct placement in each and every case. The doctrine requires a balancing of factors that are related to one another and cannot be viewed in isolation and without consideration of available resources. The concept seems to have a clearer meaning in legal and constitutional terms concerning infringement of personal

freedom and liberty than it does to procedures and programs of mental health services.

"Treatments are more or less restrictive according to the needs of the patient for whom they are employed: an unnecessary treatment is always highly restrictive, but the restrictiveness of an indicated modality varies with the degree of freedom it is likely to restore to the patient who receives it" (Gutheil, et al, 1983)

Although the Idaho commitment law does not contain a specific section on least restrictive treatment, it does state in Idaho Code 66-318(b):

"The director of any facility must refuse admission to any applicant under this section whenever:

- "(1) The applicant is not in need of observation, diagnosis, evaluation, care or treatment at the facility;
- "(2) The applicant lacks capacity to make informed decisions about treatment unless the application is made by a guardian with authority to consent to treatment; or
- "(3) The applicant's welfare or the welfare of society, or both, are better protected by the provisions of section 66-329 (involuntary commitment), Idaho Code."

Idaho Code 66-329(l) states:

"Nothing in this chapter or in any rule or regulation adopted pursuant thereto shall be construed to authorize the detention or involuntary admission to a hospital or other facility of an individual who:

"(3) can be properly cared for privately with the help of willing and able family or friends, and provided, that such persons may be detained or involuntarily admitted if such persons are mentally ill and present a substantial risk of injury to himself or others if allowed to remain at liberty."

The law addresses least restrictive setting again in Idaho Code 66-342(a), stating: "Upon the recommendation of a facility director, a dispositioner may redetermine the least restrictive available facility for involuntary patients who are not, at the time of the redetermination, in an inpatient treatment facility."

From this point, the law goes on to differentiate some levels of restrictiveness of care:

Idaho Code states:

". . . For purposes of this section, a group living setting shall be considered more restrictive than the patient's home; a supervised residential facility shall be considered more restrictive than a group living setting; and an inpatient

treatment facility shall be considered more restrictive than a supervised residential facility. A facility director may request subsequent redeterminations." [Idaho Code 66-342 (a)]

Idaho Code 66-342 (c) goes on to further to state that an involuntary patient may appeal any change in disposition to a more restrictive level of treatment through the committing court within 30 days of the notice of change in disposition.

This section also requires that *"A list of the foregoing rights shall be prominently posted in all facilities and brought to the attention of the patient by such means as the board of health and welfare shall designate."* A good "rule of thumb" is that every form or treatment or habilitation conducted within a public institution should be authorized by some form of proper consent. Further there are three elements of consent: capacity, information, and volition.

3.2 INITIAL DISPOSITION GUIDELINES

3.2.1 Inpatient Facility

The primary initial disposition choices are to either inpatient facility environments or to non-inpatient facility environments. The following outlines these two primary choices and suggests a standard or criteria to guide these choices.

Inpatient treatment facility -- means a facility *"in which an individual receives medical and mental treatment for not less than a continuous twenty-four (24) hour period [Idaho Code 66-317(j)]. and which has been "designated in accordance with regulations adopted by the Board of Health and Welfare as equipped to evaluate, rehabilitate or to provide care or treatment, or both, for the mentally ill."* [Idaho Code 66-317(g)]

Facilities included within the scope of this definition would be the state hospitals, community hospitals with a psychiatric service, free-standing psychiatric hospitals, the adolescent program at State Hospital South, and the Special Care Program for severely emotionally disturbed children (NICH). Nursing homes or other inpatient facilities may qualify if individuals under commitment require placement in these facilities for the purposes of treatment of their psychiatric disorder and the facility has been designated in accordance with regulations adopted by the Board of Health and Welfare as equipped to provide care or treatment, or both, for persons with a mental illness.

The following criteria may be helpful in making the determination to disposition to an inpatient facility:

CRITERIA

- (a) The individual, due to mental condition, is not likely to respond to available alternative methods of care and without inpatient care the immediate prognosis is for major distress resulting in serious mental deterioration; or
- (b) The individual is in need of services at an inpatient facility which cannot be otherwise administered safely and effectively outside the inpatient environment; or
- (c) No less restrictive treatment environment is available to provide the necessary protection, care and treatment.

3.2.2 Non-Inpatient Facility

Non-inpatient facility -- is a non-medical facility (less than 24-hour medical supervision) which offers mental health care and treatment and is designated in accordance with regulations adopted by the Board of Health and Welfare as equipped to evaluate, rehabilitate or to provide care or treatment, or both, for the mentally ill. [Idaho Code 66-317(g)]

Such facilities would include mental health centers, residential care facilities, including foster care, drug/alcohol treatment centers, the juvenile diagnostic unit or other facilities offering evaluation, rehabilitation, care or treatment services to the mentally ill.

CRITERIA

The following criteria may be helpful in making the determination of disposition to a non-inpatient facility:

- (a) The individual, based on treatment history, current conduct and clinical condition, has a mental condition responsive to available treatment which would reasonably ameliorate the likelihood of injury to self or others; and
- (b) The individual is capable of surviving safely in the community with available supervision from family, friends, or others; or resides in a residential facility capable of providing the necessary protective oversight; and
- (c) The individual, with supervision, is sufficiently compliant to cooperate with ongoing care and treatment necessary to prevent relapse or deterioration in the mental condition.

3.3 CHANGE OF DISPOSITION

The following outlines the types of *Change of Disposition* possibilities outlined in Idaho Code. A "Change of Disposition" and "meeting necessary notification requirements" are required for each of these situations.

3.3.1 Conditional Release

Conditional release -- means an involuntarily committed patient who is without imminent risk or harm due to mental illness may be released from an inpatient facility and dispositioned to an outpatient facility with conditions. The release must be pursuant to a written treatment plan. [Idaho Code 66-338 (1998)]

Idaho Code does not specify the criteria or provide a specific guideline for the utilization of this mechanism; however, it does provide the authority for the Department of Health and Welfare through the department director or his designee, to establish such reasonable conditions as necessary to allow for effective outpatient care and treatment.

Generally, the conditions of release will require a course of outpatient treatment for the patient. As a guideline for this determination, the following criteria are recommended:

CRITERIA

- (a) The individual is without imminent risk or harm due to mental illness; and
- (b) The individual no longer meets the guideline criteria for inpatient disposition; and
- (c) The individual does meet the guideline criteria for non-inpatient disposition.

3.3.2 Rehospitalization

Proceedings for the rehospitalization of a patient conditionally released from an inpatient treatment facility may be commenced by the filing of a written application with a court of competent jurisdiction by a prosecuting attorney, judge, designated examiner or other person interested in the patient's welfare. [Idaho Code 66-339(a)]

The court shall authorize an outpatient commitment as set out in section 66-339A, Idaho Code, or authorize a dispositioner to enter a change of disposition to an inpatient treatment facility if, at the hearing, conducted substantially as a hearing under section 66-329, Idaho Code, the court finds by clear and convincing evidence that the patient:

1. Has a mental illness;
2. Either (i) has violated a condition of the release or (ii) is again in need of placement in an inpatient treatment facility; and
3. Either (i) is likely to injure himself or others; (ii) is gravely disabled; or (iii) that the course of the patient's particular mental disorder is such that the patient is likely to injure himself or others or become gravely disabled within the foreseeable future if the patient is not placed in an inpatient treatment facility.

A dispositioner determines the least restrictive available inpatient treatment facility consistent with the needs of the patient that is being rehospitalized. The Department of Health and Welfare assumes responsibility for the usual and customary treatment costs, as defined in section 66-327(b), Idaho Code, after the patient is dispositioned and transported to a state facility. This section of Idaho Code states that "usual and customary treatment costs" includes routine board, room and support services rendered at a facility of the Department of Health and Welfare; routine physical, medical, psychological and psychiatric examination and testing; group and individual therapy, psychiatric treatment, medication and medical care which can be provided at a facility of the Department of Health and Welfare. The term "usual and customary treatment costs" shall not include neurological evaluation, CAT scan, surgery, medical treatment, any other item or service not provided at a facility of the Department of Health and Welfare, or witness fees and expenses for court appearances.

The criteria for rehospitalization are different than the criteria for the initial commitment. Under the above criteria, there may be different combinations. It is possible to have the Disposition court-authorized for a committed individual who is again in need of inpatient care and, without inpatient care, may in the foreseeable future become likely to injure himself or others. It is also possible to have the court authorize the rehospitalization on the criteria of (1) mental illness, (2) violation of condition of release, and (3) current likelihood to injure self or others. These and other combinations allow for rehospitalization based on either clinical criteria or community protection criteria.

3.3.3 Change To A More Restrictive Level Of Care

Change to a more restrictive level of care -- means making a redetermination of need for a change in disposition for those who are not, at the time of redetermination, residing in an inpatient facility. A group living setting shall be considered more restrictive than the involuntary patient's home; a supervised residential facility shall be considered more restrictive than a group living setting; and an inpatient treatment facility shall be considered more restrictive than a supervised residential facility. Subsequent redeterminations may be made. [Idaho Code 66-342]

Notice of change of disposition must be filed with the committing court and sent to the patient's attorney and to either the patient's spouse, guardian, adult next of kin or friend. The patient may appeal any change in disposition to a more restrictive level of treatment within thirty (30) days of notice of the change in disposition. The court will consider the treatment and security needs of the involuntary patient and available facilities and may affirm or modify the change in disposition. [Idaho Code 66-342]

If the patient is not on a conditional release status from inpatient care and now requires inpatient care and treatment a judicial hearing or prior court approval is not required.

At any time during a period of court-ordered commitment and disposition to an inpatient or outpatient mental health facility, a respondent's condition improves but

the respondent remains in need of involuntary mental health services which are available in a less restrictive setting than those provided by the facility, the individual(s) responsible for the respondent's care and treatment should effect a transfer to a less restrictive facility. Another option for less restrictive treatment is when the respondent resides in inpatient care, a conditional release may be utilized which may include ongoing outpatient treatment or a combination of outpatient and inpatient care and treatment.

3.3.4 Transfer Between Inpatient Facilities

The Department of Health and Welfare may authorize the transfer of a patient between inpatient facilities to meet the mental health needs of the patient.

This transfer is considered lateral and specific appeal rights are not noted in Idaho Code. However, notice of the change of disposition must be made to the committing court, to the patient's attorney, and either the patient's spouse, guardian, or adult next of kin or friend. The 120-day review requirements and report of determination continue to be the responsibility of the Department of Health and Welfare.

3.3.5 Interstate Compact Transfers

Interstate compact transfers are transfers of individuals committed under Idaho Code 66-329 to other states which are members of the interstate compact.

These transfers are administered through the auspices of the Division of Family and Community Services and the procedural considerations are outlined in division policy.

3.4 TRANSFER OF COMMITMENT

Transfer of commitment -- means the administrative transfer between organizational service units of the Department of Health and Welfare who are responsible for the care, treatment and review responsibilities of the committed individual.

Administrative transfers are necessary to insure that the responsibilities for the provision of necessary care and treatment to the committed individual are being met and the necessary administrative support functions are being provided. The organizational service units of the Department of Health and Welfare are the state institutions and the seven regional service areas. The service and administrative responsibilities for the care and treatment of individuals committed to the Department of Health and Welfare through the provisions of Title 66, Chapter 3 are the responsibility of the State Mental Health Program -- the Community Mental Health Program and the state mental hospitals. A transfer of commitment is effected by a Change of Disposition.

3.5 REVIEW AND TERMINATION OF COMMITMENT

Individuals committed to the Department of Health and Welfare under Idaho Code 66-329 must be reviewed at the end of the first 90 days of the commitment and every 120 days [Idaho Code 66-337] thereafter for the one (1) year tenure of the commitment, to determine whether to conditionally release, discharge or terminate the commitment of the patient. [Idaho Code 66-329(k), (1998)]

3.5.1 Guidelines for Making Release Decisions from Inpatient Care

Kroll and Mackenzie (1983) present a decision table for analyzing the risk of a patient's dangerousness to others after being released from a psychiatric inpatient facility. The protocol identifies high-risk factors in the person's current status, historical factors, and treatment response as well as environmental factors that may be relevant. The authors add the qualifying conditions to the instrument of (1) the lack of mathematical probabilities cannot be assigned to individual items or to groupings of items and (2) there is insufficient data to weight the items.

The advantage to this decision-making checklist approach is to help ensure that statically relevant high-risk factors will not be overlooked due either to clinician bias, to subjective factors attributed to the patient or to information overload due to multiple variables to process when the dispositioner is considering a change in disposition. The paradigm also takes into account social and environmental considerations of the discharge plan.

The authors overall advocate for a risk management approach to decision-making recognizing that decisions to release potentially dangerous patients will not be free of risks. The risk management approach includes:

Risk Assessment consists of identification of the events involved and the full range of possible consequences, estimation of the probability of occurrences of events and consequences, and evaluation of all of these consequences.

Risk Evaluation consists of the sociopolitical process that involves an individual's ethical and social value judgments and the decision-making environment which influences risk-taking decision-making.

Risk Reduction consists of the development and implementation of a pragmatic program to identify and correct factors that lead to unacceptable or unnecessary risk-taking (recognizing that certain levels of risk are unavoidable).

The authors call for the explication of decision-making where possible. Documentation should include clear descriptions of decisions and actions and explanations or justifications for such decisions. Further, the authors note that negligence is to make decisions in ignorance of, or to disregard, readily identified and relevant information not from making an informed error of judgment.

The decision-table may be useful to the examiner/dispositioner who must make a determination for the committed patient of the appropriate setting for treatment.

3.5.2 Termination Criteria

The termination of commitment is required when the committed patient is:

1. no longer mentally ill; or
2. no longer likely to injure himself or others; or
3. no longer gravely disabled. [Idaho Code 66-337 b]

The criteria for termination are different than the standard for commitment in that each element is independent of the others. The Idaho Code does not provide a standard of evidence or provide any other guideline for making this determination. The following guidelines are offered.

Termination of commitment should be considered when the following criteria are met:

CRITERIA:

- (a) The individual is competent to consent to necessary care and treatment, is reliably willing to give voluntary consent, and has demonstrated his/her cooperation with necessary treatment; or
- (b) The individual is not competent to give informed consent, a guardian or legal consenting authority is available and willing to consent to necessary care and treatment, and the guardian has demonstrated his/her cooperation with necessary treatment [Idaho Code 66-329(l)(3)]; or
- (c) The individual no longer meets either the non-inpatient conditional release or the inpatient dispositional criteria.

3.5.3 Termination Procedures

1. An assessment based on the above factors is made by the assigned Case Manager on an ongoing basis, but no less frequently than every 120 days.

2. If, in the opinion of the Case Manager who is not a Designated Examiner, the committed individual meets the termination criteria, a case review by a Designated Examiner needs to be completed. All determinations shall be reviewed by the Clinical Director.
3. Additional factors to consider should include, but are not limited to:
 - (a) current clinical symptomatology;
 - (b) family and personal history, including treatment history;
 - (c) ability and motivation to follow the prescribed treatment plan;
 - (d) capacity to make informed decisions about treatment;
 - (e) evidence of recent conduct which may indicate presence of behavior consistent with the definition of "likely to injure self or others";
 - (f) level of functioning and factors relevant to the definition of "gravely disabled";
 - (g) current clinical record and course and response to treatment, including other staff observations;
 - (h) results of clinical interview or other assessment methods.
4. The Case Manager should consult with the appropriate regional staff if the patient is in the state hospital, or consult with appropriate hospital staff if the patient is on conditional release, and seek agreement as to the determination.
5. Unless clinically contraindicated and so documented, the Case Manager should consult with the parents, spouse, or guardian.
6. Within the confines of rules regarding confidentiality, the Case Manager should consult with the relevant private-sector or other mental health provider(s).
7. Where clinically indicated and within the rules of confidentiality, the Case Manager should consult with other parties who have an existing relevant interest in the patient's care and well-being, e.g., police, school officials, social service worker, etc.
8. The Case Manager should consult directly with the committed patient about continuation or termination of the commitment.
9. A report of each review and basis of the determination shall be sent to the committing court, prosecuting attorney of the committing county, patient's attorney, and either the patient's spouse, guardian, adult next of kin or friend.



Designated Examiner Source Book

CHAPTER FOUR

Criminal Provisions

4.1 HOSPITAL ADMISSION FOR EVALUATION

Courts may authorize admission of a defendant to hospital for evaluation only if admission is necessary for the evaluation.

"If the examiner determines that confinement is necessary for purposes of that examination, the court may order the defendant to be confined to a jail, a hospital, or other suitable facility for that purpose for a period not exceeding thirty (30) days. The order of confinement shall require the county sheriff to transport the defendant to and from the facility and shall notify the facility of any known medical, behavioral, or security requirements of the defendant." [Idaho Code 18-211(3)]

4.2 COMMITMENT OF DEFENDANTS UNFIT TO STAND TRIAL

Courts may commit defendants who are unfit to stand trial.

1. "If the court determines that the defendant lacks fitness to proceed . . . the court shall commit him to the custody of the director of the department of health and welfare, for a period not exceeding ninety (90) days, for care and treatment at an appropriate facility of the department of health and welfare or if the defendant is found to be dangerously mentally ill as defined in section 66-1305, Idaho Code, to the department of correction for a period not exceeding ninety (90) days. The order of commitment shall include the finding by the court whether the defendant lacks capacity to make informed decisions about treatment. [Idaho Code 18-212(2)]
2. The court may authorize placement at the Security Medical Facility, if found dangerously mentally ill. [Idaho Code 18-212(2)]
3. If at the end of the initial ninety days:
 - a. Defendant is fit to proceed, criminal proceedings shall resume. [Idaho Code 18-212(3)]
 - b. Defendant is unfit to proceed, but likely to become fit in the foreseeable future, commitment may be extended for an additional one hundred eighty (180) days. [Idaho Code 18-212(2)]
 - c. Defendant is unfit to proceed, and not likely to become fit in the foreseeable future, defendant is released unless proceedings under Idaho Code 66-329 are instituted and the defendant is civilly committed.
4. If at the end of an additional one hundred eighty (180) days:

- a. Defendant is fit to proceed, criminal proceedings shall resume. [Idaho Code 18-212(3)]
- b. Defendant is unfit to proceed, defendant must be released unless proceedings under Idaho Code 66-329 are instituted and the defendant is civilly committed.

4.3 MENTAL HEALTH TREATMENT IN THE PENAL SETTING

Courts may authorize mental health treatment for defendants in the penal setting.

"If by the provisions of section 19-2523, Idaho Code, the court finds that one convicted of a crime suffers from any mental condition requiring treatment, such person shall be committed to the board of correction or such city or county official as provided by law for placement in an appropriate facility for treatment, having regard for such conditions of security as the case may require. In the event a sentence of incarceration has been imposed, the defendant shall receive treatment in a facility which provides for incarceration or less restrictive confinement." [Idaho Code 18-207]



Designated Examiner Source Book

CHAPTER FIVE

Definitions / References

DEFINITIONS

Department Director	the director of the state Department of Health and Welfare
Designated examiner	any person designated by the department [of health and welfare] director as specially qualified by training and experience in the diagnosis and treatment of mental or mentally related illnesses or conditions. Such persons shall be psychiatrists, licensed psychologists, licensed physicians, a holder of an earned masters level or higher degree in social work from an accredited program, a registered nurse with an earned masters level or higher degree in psychiatric nursing from an accredited program, or a holder of an earned masters level or higher degree in psychology from an accredited program." [Idaho Code 66-317(e)] The Department's Community Mental Health Program Policy and Procedures Manual interprets this code to include "an earned masters level or higher degree from a program in counseling".
Dispositioner	a designated examiner employed by or under contract with the Department of Health and Welfare and designated by the Department Director to determine the appropriate location for care and treatment of involuntary patients.[Idaho Code 66-317(f)]
Emancipated Minor	an individual between fourteen (14) and eighteen (18) years of age who has been married or whose circumstances indicate that the parent_child relationship has been renounced.
Facility	any public or private hospital, sanatorium, institution, mental health center or other organization designated in accordance with rules adopted by the Board of Health and Welfare as equipped to initially hold, evaluate, rehabilitate or to provide care or treatment, or both, for the mentally ill.
Gravely disabled	a person who, as the result of mental illness, is in danger of serious physical harm due to the person's inability to provide for his essential needs.
Inpatient Treatment Facility	a facility in which an individual receives medical and mental treatment for not less than a continuous twenty_four (24) hour period.
Lacks capacity to make informed decisions about treatment	means the inability, by reason of mental illness, to achieve a rudimentary understanding after conscientious efforts at explanation of the purpose, nature, and possible significant risks and benefits of treatment.
Licensed physician	an individual licensed under the laws of this state to practice medicine or a medical officer of the government of the United States while in this state in the performance of his official duties.

Likely to injure himself or others means either:

- (1) 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
- (2) 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.

Mental Disorder

The DSM -IV defines Mental Disorder as “a clinically significant behavior or physiological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g, a painful symptom) or disability (i.e. impairment in one or more areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the Individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.”

Mental Health Declarations

statements written by competent persons with mental illness who are competent, to articulate their preferences in type and method of care that they receive, for the times when they may not be competent to express such directions.

Mentally ill

For purposes of civil commitment, the definition of mental illness must be specific to Idaho Code: *Mentally Ill -- shall mean 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.* [Idaho Code Section 66-317(m)]

This definition includes three primary elements which are necessary to support the finding of mental illness:

- (a) Psychiatric Disorder -- The legal definition recognizes the presence differing types of substantial disorders including “*thought, mood, perception, orientation or memory*”.
- (b) Degree of Impairment -- the presence of gross impairment of *judgment, behavior, capacity to recognize and adapt to reality*; and

	<p>(c) Need for Treatment -- the mental condition <i>requires care and treatment at a facility</i>.</p> <p>The realities of a person's mental impairment, not a specific diagnostic category, will ultimately determine the presence of a severe mental disorder. The disorder must be "<i>substantial</i>" and with significant consequences as manifested in "<i>gross impairment</i>".</p>
Outpatient commitment	a court order directing a person to comply with specified mental health treatment requirements, not involving the continuous supervision of a person in an inpatient setting, that are reasonably designed to alleviate or to reduce a person's illness or disability, or to maintain or prevent deterioration of the person's mental or emotional functioning. The specified requirements may include, but need not be limited to, taking prescribed medication, reporting to a facility to permit monitoring of the person's condition, or participating in individual or group therapy or in educational or vocational programs. Outpatient commitment may be up to one (1) year.
Patient, Involuntary	an individual committed pursuant to section 18-212, or 66-329 Idaho Code
Patient, Voluntary	an individual admitted to a facility for evaluation pursuant to section 18_211 or 20-520, Idaho Code, or admitted to a facility for treatment pursuant to section 66_318, Idaho Code.
Physician, Licensed	an individual licensed under the laws of this state to practice medicine or a medical officer of the government of the United States while in this state in the performance of his official duties.
Supervised residential facility	a facility, other than the individual's home, in which the individual lives and in which there lives, or are otherwise on duty during the times that the individual's presence is expected, persons who are employed to supervise, direct, treat or monitor the individual.
Supervised Residential Facility	a facility, other than the individual's home, in which the individual lives and in which there lives, or are otherwise on duty during the times that the individual's presence is expected, persons who are employed to supervise, direct, treat or monitor the individual.

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